Hull and East Yorkshire Hospitals NHS Trust

NHS

Quality Account 2016/17

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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 their 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 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 patients, members of the public and its stakeholders that as an NHS healthcare organisation we are scrutinising each and every one of our services, providing particular focus on those areas that require 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 2017. 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 2016/17 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 2016/17

Statement on Quality from the Chief Executive

Welcome to Hull and East Yorkshire Hospitals NHS Trust's 2016/17 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 2017/18. It demonstrates our commitment to continue improving our services and provide high quality, safe and effective care to our patients 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 79 to 84) we set out the quality and safety improvement priorities for 2017/18. These priorities were identified through consultation with staff, Trust members, Health & Well Being Boards, Healthwatch, Clinical Commissioning Groups and the local community. As a result the following quality and safety improvement priorities were identified:

Safer Care (Patient Safety)

- Avoidable Hospital Acquired Infections
- Avoidable Hospital Acquired Pressure Ulcers
- Nutrition and Hydration
- Venous Thromboembolism (VTE)
- Avoidable Patient Falls
- Medication Safety
- Deteriorating Patient

Better Outcomes (Clinical Effectiveness)

- Sepsis
- Resuscitation Equipment and Checklists Compliance
- Compliance with National Standards for Interventional Procedure Checklists
- Avoidable Mortality

Improved Experience (Patient Experience)

- Learning Lessons
- Patient Experience

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 86 to 95). 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 2016/17 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.

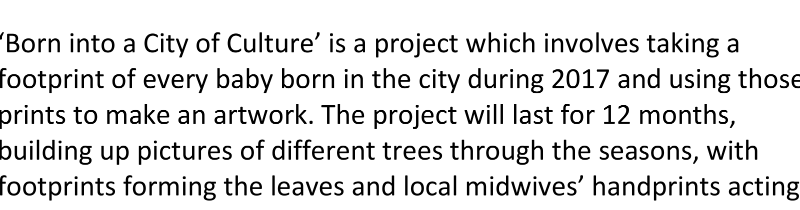
We hope that you enjoy reading this year's Quality Account.

Chris Long
Chief Executive

Overview of 2016/17 – Celebrating Success

The following table provides an overview of our successes during 2016/17. Some of the year's highlights include:

March 2017	**Cancer care boosted with share of £130m funding** The Radiotherapy Team at Castle Hill Hospital was one of the first in the country to benefit from a share of £130 million for new equipment. Back in October 2016, the Chief Executive of NHS England, Simon Stevens, announced a national fund to modernise radiotherapy equipment over the next two years. Hull and East Yorkshire Hospitals NHS Trust was lucky enough to be one of the first to receive funding, and now a new Varian Truebeam Linear Accelerator (Linac), valued at £1.7m, has been installed in the Queen's Centre for Oncology and Haematology. The new radiotherapy treatment is more accurate, but in certain patient groups, the technology allows us to more carefully monitor patients' treatments and enables us to assess and make modifications to treatment. This has the potential to reduce side effects and increase the effectiveness of the treatment we are delivering. The Truebeam can also help to reduce treatment time for patients with head and neck cancers, for example, from 20 minutes to just 15. This is a huge benefit for patients, as each person receiving treatment has to wear a beam direction shell to restrict their movement. This can be daunting, especially for those who are already anxious or may be claustrophobic, so it will help us to improve patient experience too.	
	30,000th TLC bear presented to hospital staff The TLC bears help health professionals to earn children's trust and communicate with them in a way they can understand. TLC Teddies have achieved a local landmark: 10 years and 30,000 bears donated to local hospitals and the 30,000th one was to Hull and East Yorkshire Hospitals NHS Trust. Hull City AFC players Alfred N'Diaye and Oumar Niasse and former Tigers captain Ian Ashbee called into the Children's Emergency Department (ED) at Hull Royal Infirmary to mark the occasion.	
February 2017	**Hospitals' investment pays off as apprentices dominate regional awards shortlist** Investment in apprenticeships and a commitment to growing the local workforce is paying dividends. More than 100 apprentices were appointed by Hull and East Yorkshire Hospitals NHS Trust since the summer of 2013, and for the third consecutive year, the team features heavily in an awards shortlist published by Health Education England (HEE). Eight individuals working across Hull Royal Infirmary and Castle Hill Hospital were shortlisted in six award categories of the 2017 NHS Yorkshire and Humber Talent for Care Awards, including Apprentice of the Year, the Support Staff Learner Award, and Rising Star. The Talent for Care Awards are designed to promote support staff learning opportunities and highlight the many benefits that investment in training and development makes to organisations and communities.	

January 2017	**Hospitals offer better access to information** Patients can get condition specific information at the touch of a button, thanks to one small but significant change made to hospital leaflets. Scannable square barcodes, commonly known as QR codes, have been added to all patient leaflets published on Hull and East Yorkshire Hospitals NHS Trust's website. This means that, simply by scanning a leaflet's code with a QR reader installed on a mobile phone or tablet, a person can download a copy of the information straight to their device whilst they are still in the clinic.	
	Baby steps for year-long City of Culture arts project A special project designed to celebrate every baby born during Hull's City of Culture year was launched.  'Born into a City of Culture' is a project which involves taking a footprint of every baby born in the city during 2017 and using those prints to make an artwork. The project will last for 12 months, building up pictures of different trees through the seasons, with footprints forming the leaves and local midwives' handprints acting as the supporting tree trunks. 'Born into a City of Culture' will be displayed in the main entrance to Hull and East Yorkshire Women and Children's Hospital on the Hull Royal Infirmary site throughout 2017. Once the artwork has been displayed in the hospital for the year, the plan is to then move it elsewhere in the community so more people can see and enjoy it. The 'Born into a City of Culture' project has been made possible through a grant from the City of Culture's Creative Communities Programme.	
December 2016	**New hospital helipad gets the go-ahead** Approval was given for the new helipad to be built at the rear of Hull Royal Infirmary. Members of Hull City Council's Planning Committee gave the green light for the proposals to demolish three existing buildings on the Hull Royal Infirmary site for them to be replaced with the new landing pad. Hull Royal Infirmary serves the region as a Major Trauma Centre, regularly receiving emergency patients via helicopter and organising patient transfers via air ambulance. A number of providers currently fly in to Hull Royal Infirmary, including Yorkshire Air Ambulance and Embrace, the children's air ambulance based in Barnsley, South Yorkshire. Demolition work has commenced and the helipad is expected to be ready and operational by the middle of 2017.	
	Special memory boxes set to ease grief of an early pregnancy loss Families in East Yorkshire who lose a baby at an early stage of pregnancy will now receive a special 'Forget-Me-Not' memory boxes to bring comfort and to help them grieve. Hayley Ellenton, a Staff Nurse at Hull Women and Children's Hospital, Hull Royal Infirmary, recognised the need to create something more bespoke for parents who lose a child either due to miscarriage, ectopic or molar pregnancy. Hayley set up the Forget-Me-Not Fund to raise money to purchase and fill the boxes, which will be given to women who have suffered the early loss of a baby on Cedar Ward at the Women and Children's	

	Hospital and via the Early Pregnancy Assessment Unit (EPAU). The Forget-Me-Not memory boxes are set to contain: • A packet of forget-me-not flower seeds to plant in remembrance • A journal, for writing down thoughts and feelings • A candle and a form of words to bring comfort and remembrance • A bespoke pendant, which can be used or worn in whichever way a lady feels most comfortable • A memorial certificate to mark the day the pregnancy was lost • Information on local and national sources of advice and support The pendant was designed specifically for the Forget-Me-Not Fund by Willerby-based jewellery designer, Kate Hunter.	
November 2016	**Patients benefit from new £1m hospital scanner** Patients requiring potentially life-changing investigations now benefit from a new, state-of-the-art scanner which was installed at Hull Royal Infirmary. The new 1.5T Siemens Aera MRI scanner, valued at around £1 million, was hoisted into place in the hospital's MRI Centre. The machine performs body scans to help identify and diagnose conditions such as cancer and epilepsy, for example, but can also be used to examine brain development in children, to investigate cartilage and ligament damage, and even look between the ears for the causes of hearing loss. This investment is part of an ongoing programme within Hull and East Yorkshire Hospitals NHS Trust to update and replace ageing radiography equipment. This latest scanner replaced a previous model which has been in use for the last 24 years, and the surrounding areas of the MRI Centre have also been transformed to provide a new recovery area for patients and additional patient changing facilities.	
	Hull programme team shortlisted for Macmillan Excellence award The Hull Macmillan Programme team was shortlisted for a prestigious award recognising their inspirational work supporting people affected by cancer in the area. Helen Sowden, Programme Manager and Lucie Osborne, Project Manager who work on the Macmillan Cancer Support Improvement Programme for Brain Tumour and Central Nervous System (CNS) Cancers, were nominated by colleagues in the Integration Excellence Award category. The Integration Excellence Award is awarded to individuals who have successfully developed integrated cancer care services through creating exciting new initiatives, products and services. The Macmillan Improvement Programme for Brain Tumour and CNS Cancers is the first Macmillan redesign project to focus on improving the patient experience for people with rare and complex cancers.	
October 2016	**£80K boost for breast screening in the Humber region** A local charity set up in April 2015 to fundraise for potentially life-saving equipment achieved its target. Thanks to the generosity of local people, businesses and community groups, the Clarity Appeal enabled state-of-the-art equipment valued at £80,000 to be installed at Castle Hill Hospital in Cottingham.	

<table>
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<td>The innovative Tomosynthesis diagnostic tool uses x-ray imaging to create a 3D image of breast tissue. Clinicians are given a more detailed and accurate view of any suspicious areas, helping to reduce the number of biopsies taken from healthy patients in order to rule out malignant diagnosis.

The technology also enables many different images to be taken at the same time, and is much quicker than traditional mammography, so women spend less time undergoing the procedure, thereby reducing any associated stress or discomfort.</td>
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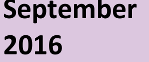
<td rowspan="2">
September 2016</td>
<td>**National hospital first as Trust introduced Recreational Coordinators to elderly wards**
Hull and East Yorkshire Hospitals NHS Trust has created two apprentice Recreational Coordinator posts to help improve the experience of older people in hospital.

Often considered the ‘gold standard’ in care homes, the use of recreational staff in acute hospitals has been so far unheard of, making Hull and East Yorkshire Hospitals NHS Trust the first in the country to introduce such a role. Recreational Coordinators provide activities and entertainment for all older people on the wards to occupy their time and make them feel happy and cared for.</td>
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<td>**Project to tackle isolation in older people reaches industry award shortlist**
The Health Service Journal announced that the Bridlington Pathfinder Project has reached the finals of this year’s Health Service Journal (HSJ) Awards. The project aimed at tackling isolation and improving older people’s well-being in East Yorkshire.

The project was piloted amongst the over-75s who were registered with three participating GP practices in Bridlington. Patients were invited to have a free health and well-being review using the internationally recognised EASYCare tool to identify any issues which may affect, or have potential to affect, their health and well-being, such as loneliness or poor quality housing. Participants were then signposted to, or put in touch with, further sources of local help and support.

As well as earning a 93% satisfaction rate amongst those taking part, the project has, to date, helped to identify gaps in local services for this patient group, including help with arthritis, carers support, and access to rural transport. What’s more, signposting to sources of financial advice has enabled 77 of the 1,100 participants to access collective benefits of more than £307,000, which would otherwise have gone unclaimed.</td>
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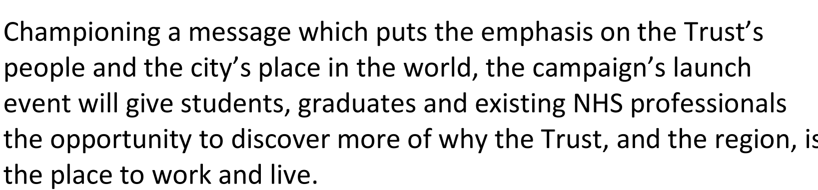
May 2016</td>
<td>**The new culture for NHS recruitment in Hull as ‘remarkable’ campaign tells the world how it’s done**
Hull and East Yorkshire Hospitals NHS Trust launched a “groundbreaking” campaign, helping to reverse the recruitment crisis in the NHS whilst having a positive impact on staff morale.


Championing a message which puts the emphasis on the Trust’s people and the city’s place in the world, the campaign’s launch event will give students, graduates and existing NHS professionals the opportunity to discover more of why the Trust, and the region, is the place to work and live.</td>
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Part 2: Review of our Quality Achievements

This section includes:

- An overview of the 2016/17 Quality and Safety improvement priorities
- A detailed update on the performance, achievements and further improvements against the 2016/17 priorities

Overview of 2016/17 – Performance against Priorities

The following table provides an overview of performance against all targets during 2016/17. We recognise that not all of our quality and safety improvement priorities for 2016/17 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 2017/18.

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 12 to 37, detailed on the relevant priority area pages.

Quality and Safety Improvement Priority	Target	Status
Medication Safety	Achieve reconciliation of medicines on admission to hospital for 80% of our patients within 24 hours	
	Implementation of Aria electronic prescribing for 80% of chemotherapy prescriptions	
	Increase the number of Pharmacist non-medical prescribers by 20%	
Deteriorating Patient (Adult)	Maintain 95% compliance with the completion of observations (NEWS) and actioned appropriately	
	Achieve 90% of DNACPR orders have documented discussions with the patient and/or their relatives including best interest discussions where appropriate	
	Achieve 95% compliance with the completion of the daily resuscitation equipment checks	
	Maintain >=95% compliance with the completion of the monthly resuscitation equipment checks	
Avoidable Hospital Acquired Pressure Ulcers	To have no avoidable hospital acquired grade 3 pressure ulcers	
	To have no avoidable hospital acquired grade 4 pressure ulcers	
	To have a 50% reduction in the number of avoidable hospital acquired unstageable pressure ulcers	
	To have a 50% reduction in the number of avoidable hospital acquired Suspected Deep Tissue Injuries (STDI)	
	To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers	
	Achieve 95% compliance with the skin care bundle	
	Compliance with the 14 day root cause analysis investigation completed	
Nutrition and Hydration	Achieve a 25% reduction in the number of referrals made to Dietician Team, once the baseline has been established	
	Reduce the number of Datix incidents relating to dietician referral delay to <=50	
	100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration from September 2016	
Avoidable Patient Falls	Falls with harm to be consistently below the England average	
	20% reduction in the number of falls per 1000 bed days for wards identified as target areas	
	Patient falls rated moderate or above to be below the baseline of 42	
	Serious Incidents resulting in fractured neck of femur or other injury to be below the baseline of 17	
	Reduce the number of falls at all levels	
Venous Thromboembolism (VTE)	Achieve 95% compliance with the VTE Risk Assessment	
	Maintain 0 VTE Serious Incidents	

Avoidable Hospital Acquired Infections	To have no hospital acquired MRSA bacteraemia
	To maintain the hospital acquired Clostridium Difficile to <=53
	To maintain the hospital acquired MSSA to <=46
	To maintain the hospital acquired E. Coli to <=95
Sepsis	Achieve 90% of patients with a news score of 5 or one off score of 3 assessed for Sepsis in the Emergency Department
	Number of staff trained for sepsis pathway (target to be monitored during 2016/17 to establish the baseline data for further monitoring in 2017/18)
Missed and Delayed Diagnosis	95% of all plain film reported within 14 days of performing by HEYHT staff
	95% of all urgent/critical test results acknowledged within 14 days by HEYHT staff
	100% of all urgent/critical test results acknowledged within 28 days by HEYHT staff
Avoidable Mortality	Maintain a stable level for SHMI (data point 110)
	Maintain the level of HSMR in line with peer group (data point 90.4)
	Maintain the level of RAMI in line with peer group (data point 99)
Care for Older People	10% reduction in the number of patients over the age of 65 years who breach the 4 hour performance target
	10 reduction in the number of patients over the age of 65 years who present to the Emergency Department who are admitted for ongoing care and treatment
	5% reduction in the readmission rates (30 day / 90 days) for patients over the age of 65 years
Care for People with Mental Health Needs	Development and implementation of the mental health patient pathway
	Achieve compliance with the Mental Health Liaison Team service specification
Handover Arrangements	95% of all estimated date of discharge recorded on Cayder within 24 hours of patient being admitted
	% of all board rounds taking place each day (AM and PM)
Learning Lessons	Never Events – no repeat Never Events
	Repeat Serious Incidents – reduction in the top 5 themes
Patient Experience	Achieve 95% of patients who would recommend the Trust to their friends of family
	Achieve 90% of formal complaints closed within the 40 day target and actions recorded where appropriate
	Increase the number of volunteers to 425 to benefit patients in clinical areas

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 2016/17:

The aim of the medication safety priority was 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 patients.

The specific aims of this project were:

- To improve patient safety by reducing the number of missed doses and improving safety on the use of specific high risk medications - anticoagulants, opioids, injectable sedatives and insulin*
- To maximise patient benefits of electronic prescribing with Lorenzo and Aria
- To improve the storage, security, and recording of administration of medicines
- To ensure controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited

This priority aimed to achieve the following specific targets by the end of March 2017:

- Achieve reconciliation of medicines on admission to hospital for 80% of our patients within 24 hours
- Reduce by 20% the number of patients who have missed a dose of the following high risk medications; anticoagulants, opioids, anti-infectives and insulin*
- Implementation of Aria electronic prescribing for 80% of chemotherapy prescriptions
- Increase the number of Pharmacist non-medical prescribers by 20%

*The target was discontinued because the Trust no longer completed the Medication Safety Thermometer

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Achieve reconciliation of medicines on admission to hospital for 80% of our patients within 24 hours	41%	46%	
Implementation of Aria electronic prescribing for 80% of chemotherapy prescriptions	64.9%	81%	
Increase the number of Pharmacist non-medical prescribers by 20% (Increase to 11)	6	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 has continued to implement the medication safety improvement project during 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan. This was to ensure that the changes made were embedded following an increase in resources and pharmacy support to ward areas and to continue to improve the management of medicines across the Trust.

Although the medicine reconciliation on admission to hospital within 24 hours for 80% of patients was not achieved, it is important to recognise that medicines reconciliation for patients at any time during their admission regularly reaches

80%. The Trust has recruited new pharmacy staff to increase support to the Acute Admissions Units to improve the medicines reconciliation rate within 24 hours. This rate could be further improved by transferring more resource to the Acute Admissions Units; however this would compromise patient's safety and experience on discharge in other areas of the Trust. Enhanced reporting has also been commissioned from Cayder which will allow the Pharmacy staff to obtain more accurate medicines reconciliation data, enabling easily identification of patients who have not been reconciled on admission and to send a daily report highlighting these patients for action. This improvement work will continue during 2017/18.

A new monthly medicine management ward review, undertaken jointly by pharmacy and nursing staff was introduced across the Trust in July 2016 to monitor the management of medicines at ward level. This included the monitoring of the management and documentation of controlled drugs, monitoring of fridge temperatures and completion of the checklist, ensuring that any deviations from the required temperatures were escalated in a timely manner and the safe and secure storage of medicines on ward. The reviews are completed jointly each month by the ward pharmacist and the charge nurse so that any issues or areas for improvement are immediately identified and actions plans agreed to improve patient safety and the overall management of medicines.

All of the changes and improvements made were supported by staff awareness and learning sessions. The Pharmacy Department held 'learning at lunchtime' sessions across both Hull Royal Infirmary and the Castle Hill Hospital to maximise learning from the areas of improvement and to ensure the improvements made were understood and embedded. Key medicine management issues and learning were also shared across the organisation through the Trust's Learning Lessons newsletter and Safety Bulletins to raise staff awareness and shared learning. They were also discussed at a number of forums such as the Charge Nurse and Senior Nurse meetings to ensure the appropriate actions were taken in those areas identified as requiring improvement.

The implementation of the Aria electronic prescribing was successfully achieved during 2016/17, which meant that 80% of chemotherapy prescriptions were electronically prescribed and patients received their prescriptions safely in a timelier manner, reducing waiting times and improving the patient's experience. Continued improvement work will be undertaken on e-prescribing during 2017/18.

The number of pharmacist independent prescribers has increased during 2016/17 from 6 to 11, with plans for more pharmacists to undertake this training. These new pharmacist prescribers are now running their own clinics for lipid management, pulmonary rehabilitation, and are prescribing parenteral nutrition for adults and children.

Further improvements identified:

It has been identified that further improvements on the management of medicines is required and it is therefore a quality and safety priority for 2017/18 (see page 81) and it will also be included in the Trust's Quality Improvement Plan for 2017/18. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be:

- Reducing the number of missed doses. This will initially introduce a pilot scheme on ward 9 at HRI involving pharmacy support for the morning drug rounds to identify any drugs not available and facilitate ordering in a timely manner. Assessment of the scheme will result in good practice being shared across the Trust
- Introducing inpatient electronic prescribing and medicines administration. The first phase will take place on ward 29 at the Queens Centre during 2017/18, with a view to then extend to the other wards in the Queens Centre before further roll out
- Reviewing the medicines discharge process to identify improvements in patient safety and experience. This will include reducing the average turnaround times for discharge prescriptions dispensed in the hospital pharmacy
- Further improving medicines reconciliation rates and introducing a 'safety net' system to help focus resource on those patients admitted more than 48 hours ago whose medicines have not been reconciled
- Increasing the use of patient's own drugs for appropriate patients
- Ensuring that there is a medicines management training programme available for appropriate staff

Deteriorating Patient – Adult

Early recognition of a patient's deterioration through the use of observations will enable appropriate planning and escalation of care.

What we aimed to achieve in 2016/17:

The aim of this priority was to ensure early identification of a patient's deterioration, to identify which patients require end of life support and to ensure treatment and escalation plan and the end of life care plans are documented, including a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order form to avoid inappropriate attempts at resuscitation. This project will also ensure that further improvements are made on the completion of the daily and monthly resuscitation equipment trolley checks.

This priority aimed to achieve the following specific targets by the end of March 2017:

- Maintain 95% compliance with the completion of observations (NEWS) and actioned appropriately*
- Achieve 90% of DNACPR orders have documented discussions with the patient and/or their relatives including best interest discussions where appropriate
- Achieve 95% compliance with the completion of the daily resuscitation equipment checks
- Maintain >=95% compliance with the completion of the monthly resuscitation equipment checks

*This target was discontinued because the Trust decided to change the monitoring arrangements for this and stopped the wards from completing the self-assessments used to monitor this target.

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Achieve 90% of DNACPR orders have documented discussions with the patient and/or their relatives including best interest discussions where appropriate	80%	70%	
Achieve 95% compliance with the completion of the daily resuscitation equipment checks	75%	93%	
Maintain >=95% compliance with the completion of the monthly resuscitation equipment checks	96%	95%	

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 deteriorating patient improvement project during 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan.

The Recognition of Deteriorating Patient policy was revised and relaunched to incorporate the completion of e-observations and documentation of the revised NEWs charts and monitoring arrangements. The policy was re-launched supported by a training package to all staff to ensure early identification of a deteriorating patient through the monitoring of the completed NEWs charts and e-observations and appropriate and timely escalation. The completion of the NEWs charts and appropriately and timely escalation was monitored on a monthly basis using the HEY Safer Care Tool audit and was linked to the 'Maintain 95% compliance with the completion of observations (NEWS) and actioned appropriately' target reported in the 2015/16 Quality Accounts. Overall performance was 99.7% and all wards were rated as gold or silver for their overall performance in the management of the deteriorating patient. During 2016/17 the Trust decided to discontinue the 'Maintain 95% compliance with the completion of observations (NEWS) and actioned appropriately' target due to changes in monitoring arrangements which meant the wards no longer self-

assessed against the standards for assessing compliance with the management of the deteriorating patient and the associated target. A clinical observation audit of the recognition of the deteriorating patient was introduced to monitor the implementation of the Recognition of Deteriorating Patient policy. The first audit was undertaken in December 2016 where a minimum of 10 observation charts were audited on each ward across the organisation. This was the first audit undertaken under the revised monitoring arrangements and it will be completed on an annual basis. The next audit will be undertaken during 2017/18. A summary of the results are as follows:

- The escalation process as stated in CP 236 Recognition of the Deteriorating Patient Policy is not fully being followed by staff and staff were not always documenting escalation when patients are triggering a NEWS score 1 – 4
- The “Vital Signs” care plan did not always document any individualised care e.g. patient requires lying & standing blood pressure. The frequency stated within the care plan rarely matches the stated frequency on the observation chart
- 62% of observations are performed to stated frequency on observation chart or earlier than planned
- 38% of observations are performed later than the stated frequency on the observation chart e.g. performed over an hour late than required
- Incomplete sets of observations are the most common reason for a NEWS score not to be calculated
- 9% of NEWS scores are calculated incorrectly and acted upon

Following the roll out of e-observations on wards 11 (Stroke) and 110 (Stroke) at Hull Royal Infirmary and 14 (Colorectal) and 15 (Urology) at Castle Hill Hospital a review comparing the reasons for non-escalation on a ward with e-observations and a ward without was completed. The barriers to achieving full escalation and areas for improvement were identified following the review and improvement work will be undertaken to further roll out the implementation of the Recognition of Deteriorating Patient policy supported by staff training and the roll out of e-observations. E-observations will ensure automatic escalation to the appropriate clinician for timely action.

The Trust continues to monitor the completion of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order forms through a monthly audit of 10 forms completed by the Resuscitation Team. The performance against this target has fluctuated between compliant and non-compliant throughout 2016/17; however there is a noted improvement in the overall completion of the DNACPR orders and the discussions with the patients and relatives and the Care Quality Commission (CQC) did not report any areas of concern following the June 2016 comprehensive inspection. The Trust has decided to adopt and implement the new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process and documentation. The ReSPECT process creates a summary of personalised recommendations for a person’s clinical care in a future emergency which they do not have capacity to make or express choice. The aim of the process is to respect both patient preferences and clinical judgment and includes their recommendation on whether or not CPR should be attempted if the person’s breathing or heart stopped. A new quality improvement project has been established for 2017/18 to implement the ReSPECT process across the organisation.

Further improvements were made against the completion of the daily and the monthly resuscitation checks with 100% of monthly checks completed and 90% of daily checks completed. Although the target for the daily checks was not achieved it has improved from 75% in 2015/16 to 93% in 2016/17. Changes to the monitoring of the resuscitation equipment checks were made. All wards now have a year’s checklist and flow chart booklet, to aid checking and changes were made to the Trust Resuscitation policy to clarity over grade of staff suitable to check equipment and areas with bespoke trolleys such as critical care. The completion of the daily and monthly checks and the auditing of the content of the trollies will continue to be monitored as part of the Resuscitation Equipment and Checklists Compliance quality improvement plan for 2017/18.

Further improvements identified:

This project will not be carried forward however further work will focus on the roll out of the Wi-Fi programme to further improve the identification and escalation of a deteriorating patient in a timely manner and to continue to roll out the training programme for staff to ensure all staff are competent and receive refresher training on the recognition of deteriorating patients from the NEWs charts and e-observations.

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 and can be 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 2016/17:

The aim of this priority was to prevent any patient developing avoidable hospital acquired pressure ulcers. This project also aimed to ensure that the appropriate risk assessments are undertaken to identify patients who are at risk of developing pressure ulcers, as well as the implementation of the skin care bundle.

This priority aimed to achieve the following specific targets by the end of March 2017:

- To have no avoidable hospital acquired grade 3 pressure ulcers
- To have no avoidable hospital acquired grade 4 pressure ulcers
- To have a 50% reduction in the number of avoidable hospital acquired unstageable pressure ulcers
- To have a 50% reduction in the number of avoidable hospital acquired Suspected Deep Tissue Injuries (STDI)
- To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers
- Achieve 95% compliance with the skin care bundle*
- Compliance with the 14 day root cause analysis investigation completed

* The target was discontinued due to a new method of investigation and analysis being implemented

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
To have no avoidable hospital acquired grade 3 pressure ulcers	1	1	
To have no avoidable hospital acquired grade 4 pressure ulcers	6	0	
To have a 50% reduction in the number of avoidable hospital acquired unstageable pressure ulcers (i.e. no more than 8)	16	13	
To have a 50% reduction in the number of avoidable hospital acquired Suspected Deep Tissue Injuries (STDI) (i.e. no more than 23)	47	35	
To have a 25% reduction in the number of avoidable hospital acquired stage 2 pressure ulcers (i.e. no more than 84)	112	52	
Compliance with the 14 day root cause analysis investigation completed	Not collected	81%	

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 hospital acquired pressure ulcers improvement project during 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan.

Through raising awareness of pressure ulcers Hull and East Yorkshire Hospitals NHS Trust continue to reduce the number of avoidable hospital acquired pressure ulcers. In 2016/17 the improvement plan has reduced the number of all avoidable pressure ulcers by 45% compared to the figures from 2015/16. Despite not meeting all of the Quality Improvement Programme's ambitious aims and objectives, key initiatives have improved the safety of our patients. For example a successful education package was launched and delivered to all clinical staff resulting in more than 80% of our staff gaining skills and knowledge in pressure ulcer prevention.

Engagement within the organisation of our senior leaders led to the Health Groups supporting secondments into roles within the Tissue Viability team. This released the Tissue Viability Matron and the Tissue Viability Nurse to focus on providing education sessions and support to clinical areas delivering their own pressure ulcer prevention action plans. The team expansion also enabled the specialist nurses to commence other improvement works including support for patients requiring specialist wound care not pressure ulcer related, improved patient safety in the use of negative wound pressure therapy and cost-driven equipment and dressing reviews.

Further improvements identified:

It has been identified that further improvements on avoidable hospital acquired pressure ulcers are required and it is therefore a quality and safety priority for 2016/17 (see page 80) and it will also be included in the Trust's Quality Improvement Plan for 2017/18. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be:

- To continue to undertake the investigations of harm within a 14 day time period to prevent the missed opportunity to understand specific improvement requirements and to inform learning lessons
- To continue to deliver the bespoke e-learning package and achieve improved compliance
- Bespoke training with third year student nurses with their final placement to prepare for the staff nurse roll. This will include:- risk factors, category and recognition of pressure ulcers, reporting and investigation of Hospital Acquired Pressure Ulcer
- Review of skin integrity care plan
- Mandatory tissue viability/pressure ulcer prevention training for all available clinical staff
- Training the future workforce through collaborative working with Hull and Manchester Universities in providing 'Hi5' student ward rounds
- Robust and transparent investigations of pressure ulcer harms within a 14 day time period with a clear investigation outcome, lesson learned and action plan.
- Clear evidence of providing duty of candour obligations
- Sustain profile of pressure ulcer harm reduction and lessons learned through engagement with all four Health Groups, Governance and Risk teams

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 2016/17:

The aim of this priority was 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 2017

- Achieve a 25% reduction in the number of referrals made to Dietician Team, once the baseline has been established*
- Reduce the number of Datix incidents relating to dietician referral delay to <=50*
- 100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration from September 2016

*These targets were discontinued due to changes in the DATIX codes which meant the information was unreliable and inaccurate and therefore the targets could not be appropriately monitored.

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
100% of wards to achieve 85% compliance on the Ward Quality Assurance Dashboard for Nutrition and Hydration from September 2016	Not collected	89.5%	

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 nutrition and hydration improvement project during 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan.

During 2015/16 a new nutrition and hydration assessment tool was implemented across the Trust and the main focus for improvement identified for 2016/17 was to develop and embed robust and accurate monitoring of compliance rates for the completion of the amended nutrition and hydration assessment tools. Early in 2016 this was achieved and all ward's compliance with the tools are now monitored and reported quarterly through the Ward Quality Assurance Dashboard for Nutrition and Hydration. The results are inputted onto an electronic dashboard therefore results are readily available and allow wards to be benchmarked against other wards across the Trust.

The CQC, during their re-inspection of the Trust in May 2015 had identified concerns with the consistency of the implementation of the red top/lid/jug/tray systems on several wards. The red system is used to highlight patients who require assistance with eating and drinking. During 2016 the system was reviewed and incorporated within the newly amended Nutrition and Hydration Care Plan. During the CQC's comprehensive inspection in June 2016 there were no concerns raised regarding the red system or its consistency within the Trust.

Further improvements identified:

It has been identified that further improvements on nutrition and hydration are required and it is therefore a quality and safety priority for 2017/18 (see page 80) and it will also be included in the Trust's Quality Improvement Plan for 2017/18. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be:

- The identification of baseline of Nutrition and Hydration data through a review of audit proforma and regular auditing
- Delivery of the fluid balance training package to all relevant additional staff members
- Review of roles and placement of Nutritional Apprentices, Ward Hostesses and Housekeeping
- Continuous review of areas for improvement identified through regular auditing to further improve performance

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 incident 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 2016/17:

The aim of this priority was to consolidate the work that took place during 2015/16. The project in 2015/16 saw significant improvements on the reduction in falls with moderate and above harm. The project during 2016/17 was to build on this work. The focus was placed on improving compliance with assessment documentation; increasing education, awareness and lessons learnt, as well as increasing the roll out of tested interventions.

The project work during 2016/17 also put increased focus on low harm falls. This is an area that the Trust did not see a reduction on numbers during 2015/16.

This priority aimed to achieve the following specific targets by the end of March 2017:

- Falls with harm to be consistently below the England average
- 20% reduction in the number of falls per 1000 bed days for wards identified as target areas
- Patient falls rated moderate or above to be below the baseline of 42
- Serious Incidents resulting in fractured neck of femur or other injury to be below the baseline of 17
- Reduce the number of falls at all levels

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Falls with harm to be consistently below the England average	Below	Below	Green
20% reduction in the number of falls per 1000 bed days for wards identified as target areas	6.90	6.39	Red
Patient falls rated moderate or above to be below the baseline of 42	42	51	Red
Serious Incidents resulting in fractured neck of femur or other injury to be below the baseline of 17	17	5	Green
Reduce the number of falls at all levels	2560	2538	Green

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 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan which resulted in significant improvements on the severity of the harm caused when patients fell.

Achievements against the delivery of this project have been identified through the review and launch of a revised Falls Policy, following which the falls team embarked upon a programme of audit work which included a review of the e-

learning staff training package and a review of the falls documentation and assessment tool including the application of falls assessments for patients over the age of 65.

The falls incidents reported during the year were reviewed to identify if there were any themes and trends in the days and times when falls incidents occurred, level of harm and the areas of falls occurring. The review identified the key areas for focused falls improvement work to be undertaken. In addition to the information gathered, a weekend mobility training roll out plan was developed and implemented along with the re-launch of the “Staying Safe in Hospital” leaflet.

Further actions and recommendations surrounding Serious Incident (SIs) falls investigations were introduced including a process for the Risk Team to provide the Falls Team with monthly updates on lessons to learn and recommendations for improvement. Further arrangements are now in place for all falls with a fracture (reported in Datix) to be reviewed by a Health and Safety Manager in order that any reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR) cases can be identified and reported within the timeframe specified. Learning Lessons bulletins have been circulated across the organisation with a guidance document to all staff regarding the criteria and process for RIDDOR reportable incidents.

The Trust falls intranet site has been re-launched following the many updates to ensure staff have access to relevant information, revised documentation and assessment tools. Further staff education surrounding Multi Factorial Assessment Tool-(MFAT) to incorporate falls prevention within the moving and handling training has been arranged with the Education and Training Department for roll out during 2017/18.

Further improvements identified:

It has been identified that further improvements on further reducing the number of avoidable patient falls and learning lessons are required and it is therefore a quality and safety priority for 2017/18 (see page 81) and it will also be included in the Trust’s Quality Improvement Plan for 2017/18. For more information on the Trust’s Quality Improvement Plan see page 72.

The focus for further improvements will be:

- To continue to embed the revised processes and resources introduced in order to enhance the improvements already made during 2016/17
- Completion of the audit of compliance against RIDDOR guidance and to address any areas identified for improvement
- Continued completion of root cause analysis investigations into patient falls and identification of lesson to learn and areas for further improvement
- Full roll out of the weekend mobility plan including risk assessments
- Continued monitoring of the reduction of the avoidable patient falls and the level of harm
- Roll out of the Multi Factorial Assessment Tool (MFAT) training

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 2016/17:

The aim of this priority was 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.

This priority aimed to achieve the following specific targets by the end of March 2017:

- Achieve 95% compliance with the VTE Risk Assessment
- Maintain 0 VTE Serious Incidents

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Achieve 95% compliance with the VTE Risk Assessment	77.95%	81.59% (Q3)	
Maintain 0 VTE Serious Incidents	0	2	

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 VTE improvement project during 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan.

Improvement work was undertaken on the completion of the VTE risk assessments with the removal of the assessment from the drug chart to one electronic VTE risk assessment on Lorenzo to ensure greater consistency. The electronic form was then supported by the activation of the clinical indicators section which allows staff to easily identify, track and complete clinical tasks in Lorenzo including the status of the completion of the risk assessment. Patients VTE status is now also discussed at handover and safety briefings using the Lorenzo clinical indictor tool and any not completed or reviewed are actioned.

Awareness of the VTE e-learning module was improved and it was mandated that all doctors would be required to complete the training. The completion of the VTE e-learning module was monitored during 2016/17 and the completion rate has increased from 460 in 2015/16 to 986 in 2016/17. A total of 1446 staff have now completed the VTE e-learning module.

Further improvements identified:

It has been identified that further improvements on VTE are required and it is therefore a quality and safety priority for 2017/18 (see page 81) and it will also be included in the Trust's Quality Improvement Plan for 2017/18. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be:

- Activation and implementation of the Lorenzo 'live' system to enhance the monitoring of the completion of VTE risk assessments and reviews for patients admitted onto wards
- Development and implementation of the VTE 24 hour risk assessment form on Lorenzo
- Achieve compliance with NICE GC92 (Venous Thromboembolism in adults admitted to hospital; reducing the risk)

Avoidable Hospital Acquired Infections

What we aimed to achieve in 2016/17:

The aim of this priority was 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.

This priority aimed to achieve the following specific targets by the end of March 2017:

- To have no hospital acquired MRSA bacteraemia
- To maintain the hospital acquired Clostridium Difficile to <=53
- To maintain the hospital acquired MSSA to <=46
- To maintain the hospital acquired E. Coli to <=95

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
To have no hospital acquired MRSA bacteraemia	2	2	
To maintain the hospital acquired Clostridium Difficile to <=53	46	44	
To maintain the hospital acquired MSSA to <=46	37	43	
To maintain the hospital acquired E. Coli to <=95	95	67	

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 undertaken an ambitious programme of improvements to assist in the achievement of the aim and associated performance targets for this project. The first of which involved a review of furniture within the Emergency Department (ED), in particular the Children's Emergency Department and any compromised surfaces were addressed to remove any infection risks. A Toy Cleaning guideline has also been developed to assist ward areas. The Emergency Department along with the Infection Prevention and Control Team conducted a cleanliness and integrity review of all ED trollies and a designated trolley wash area in the Emergency Department is being considered. New cleaning checklists for the specific Emergency Department environment and equipment have been developed. The Infection Prevention and Control Team implemented a programme of quarterly visits to the Emergency Department to assess and rate Infection Prevention and Control practices. The results of which are disseminated to the department managers for action if required.

A review of existing cleaning checklists, along with responsibility matrix and green 'I am Clean' stickers, which state the last date the equipment was cleaned, has been completed and as a result all Trust forms have been amended and standardised. As a result of this review, new Clinell wipe dispensers have been installed across the organisation.

A programme of activity which relates to further improving staff knowledge and competence in relation to hygiene was commenced. This included reviewing the Hand Hygiene Competency Framework and supported training for staff along with the Hand hygiene monthly audit tool being redeveloped and launched in July 2016. To support this all ward areas received revised '5 Moments of Hygiene' posters to display for staff.

Two policies have also been developed; Infection Prevention & Control Practice in the Operating Department and a Theatre Discipline Policy which includes clarification on shoe cleaning, personal possessions such as handbags and use of personal mobile phones.

Further improvements identified:

It has been identified that further improvements on Infection Prevention and Control are required and it is therefore a quality and safety priority for 2016/17 (see page 80) and it will also be included in the Trust's Quality Improvement Plan for 2016/17. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be:

- Scoping current continence management and sharps management within the Trust to identify any areas that can be improved which will have a positive effect on avoidable hospital acquired infections
- Assessment of existing Infection Prevention and Control education and information available for staff
- Continuous review of areas for improvement identified through regular auditing

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 2016/17:

The aim of this project was to continue the implementation of the sepsis pathway across the organisation. The focus of the project was 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 2017:

- Achieve 90% of patients with a news score of 5 or one off score of 3 assessed for Sepsis in the Emergency Department
- Number of staff trained for sepsis pathway (target to be monitored during 2016/17 to establish the baseline data for further monitoring in 2017/18)

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Achieve 90% of patients with a news score of 5 or one off score of 3 assessed for Sepsis in the Emergency Department	78%	90%	
Number of staff trained for sepsis pathway (target to be monitored during 2016/17 to establish the baseline data for further monitoring in 2017/18)	Not collected	636	

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 Sepsis improvement project during 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan.

A clear pathway for sepsis within the Emergency Department has been introduced. As part of this process the team have spent a significant amount of time training individuals (internally and externally), listening to their feedback, and implementing revised training to ensure the department can deliver the best possible outcomes for these patients. The Emergency Department has shown consistent improvement during the year with the pathway from 0% compliance in August 2015 when it was introduced to maintain above 90% compliance since July 2016. The team regularly visit the area to provide them with feedback on how they are doing, good and bad practice and listening to any concerns or worries that individuals may have. This ongoing dialogue and communication helps to ensure that the department continues to feel supported in their improvement journey.

The team has worked hard in the last 12 months to ensure that it is in a stronger position to deliver care and training related to sepsis and is leading on this work at a regional level. The bespoke training sessions that the team provide has ensured that not only the Trust, but our partners as well have a sufficiently skilled workforce. The team play an active part in regional and national events to share our learning and best practice. In addition, the team have begun work, which it will continue to progress, which combines sepsis training with antimicrobial stewardship teaching to ensure that the Trust is ahead of the curve for work that must be completed in 2017/18. The team has introduced innovative

ways of working including the development of a virtual sepsis ward in Cayder that identifies patients within the Emergency Department and the wider Trust. This work is being reviewed at a regional level in order for other Trusts to learn from the Trust's experience.

The work that the team has done has made a significant difference to patients. With early identification and detection of deterioration key care and treatment can be delivered in a timely manner. This can greatly reduce the risk for patients and where possible lead to better outcomes. This was key to improvements made in the recent CQC inspection, where no areas of concern were raised relating to sepsis and the CQC sepsis mortality alert has been closed at a national level.

Further improvements identified:

It has been identified that further improvements on sepsis are required and it is therefore a quality and safety priority for 2017/18 (see page 82) and it will also be included in the Trust's Quality Improvement Plan for 2017/18. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be:
The sepsis improvement project over the next two years will focus on improving patient care and patient safety. The project will focus on the continued implementation of the sepsis pathway across the organisation. In order to achieve this, a number of activities will be undertaken. It is clear that a dedicated resource has in the past 12 months improved the care to our patients with 90% compliance with the sepsis screening being achieved in the Emergency Department. As such, the intention is that a second Sepsis Nurse will be appointed. This will allow focused work to continue within the Emergency Department and the Acute Assessment Unit as well as provide sufficient resource to ensure optimal care of patients with sepsis becomes embedded across all wards at both Hull Royal Infirmary and Castle Hill Hospital.

The Trust has worked hard in the last 12 months to ensure that it is in a stronger position to deliver care and training related to sepsis and is leading on this work at a regional level. In the next two years this work will continue and the organisation will play an active part in regional and national events to share our learning and best practice. In addition, the Trust has begun work, which it will continue to progress, which combines sepsis training with antimicrobial stewardship teaching. The Trust has always had a very strong antimicrobial stewardship policy reflected in our low antibiotic usage figures and low numbers of multi resistant organisms. We are now ahead of the curve with this combined teaching approach especially in view of the combined CQUIN next year.

Training and education is at the forefront of the work that will be undertaken during this period. This will increase staff understanding, improve interest amongst teams and wards which will lead to increased promotion of the subject which in turn will lead to enhanced care of our patients. Whilst extensive training has been undertaken in the past 12 months, this will be consolidated and built on in the next year. Link nurses have been identified and trained on most wards; this will continue so that all wards will have a least 1 link nurse and there will be bi-monthly refresher for these nurses. Training has commenced with 4th and 5th year medical students and this is set to continue in the next two years with opportunities for training student nurses through the local universities also being explored. To enhance care and enable data collection, a virtual sepsis ward will continue to be developed on Cayder. This will allow for all patients with a NEWs score of 5 and above or those on restricted antibiotics to be identified easily for rapid access treatment and care as required.

Missed and Delayed Diagnosis

Missed and delayed diagnosis is the failure to diagnose a condition early enough to effect a cure or achieves maximum survival.

What we aimed to achieve in 2016/17:

The aim of this priority was to reduce the time from plain film performing to reporting. A flag system will be introduced to ensure that all urgent and/or unexpected test results are acted on for all HEY patients. Achievement of these aims will improve patient safety and reduce the number of missed and delayed diagnosis Serious Incidents.

This priority aimed to achieve the following specific targets by the end of March 2017:

- 95% of all plain film reported within 14 days of performing by HEYHT staff
- 95% of all urgent/critical test results acknowledged within 14 days by HEYHT staff
- 100% of all urgent/critical test results acknowledged within 28 days by HEYHT staff

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
95% of all plain film reported within 14 days of performing by HEYHT staff	52.2%	98.8%	
95% of all urgent/critical test results acknowledged within 14 days by HEYHT staff	77.4%	92.5%	
100% of all urgent/critical test results acknowledged within 28 days by HEYHT staff	97.2%	96.5%	

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 Missed and Delayed Diagnosis improvement project during 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan.

Positive improvements have been made towards achieving the overall aim of the project enabling the Trust to work smarter in the reporting of results, in providing improved safety for patients and in reducing the number of missed and delayed diagnosis Serious Incidents (SIs) reported.

A business case was approved and the Trust outsourced the radiology reporting backlog, which was successful in reducing the backlog of radiology reports. An increase in in-house radiology reporting was achieved through additional training, introduction of Neuro, MSK and plain film locums and negotiation of additional consultant appointments.

New systems and processes were embedded and a full escalation procedure was introduced to ensure that every x-ray result was automatically, electronically, communicated to the referring clinician for action. The results are flagged through a Harvard traffic light system, which is audited on a monthly basis to ensure all results are acted upon and clinicians are held to account when results are not actioned. There is an open reporting culture and any concerns are escalated and investigated in real time and actions taken to learn lessons and improve services. The new system was shared with external stakeholders both nationally and locally and it has been deemed as best practice. The Royal College of Radiologists (2016) undertook an audit of radiology communication systems for critical, urgent and unexpected significant findings. This reported 154 departments and only 11 had a robust electronic system which

ensured doctors were alerted to important results and were checking, through the system, that the results were read and acted upon. At the time of the CQC comprehensive inspection in June 2016 HEYHT had implemented the Harvard traffic light system which does exactly what the Royal College of Radiologists were reporting as a robust electronic system.

Further improvements identified:

The project will not be carried forward 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.

Avoidable Mortality

What we aimed to achieve in 2016/17:

The aim of this priority was 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 2017:

- Maintain a stable level for SHMI (data point 110)
- Maintain the level of HSMR in line with peer group (data point 90.4)
- Maintain the level of RAMI in line with peer group (data point 99)

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Maintain a stable level for SHMI (data point 110)	Data point 110	95.4 (Dec 16) – better than peer	
Maintain the level of HSMR in line with peer group (data point 90.4)	Data point 90.4	119.7 (Jan 17) – worse than peer	
Maintain the level of RAMI in line with peer group (data point 99)	Data point 90	98 (Dec 16) – better than peer	

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:

Although officially launched nationally by the Improvement Academy in November 2016, the new Structured Judgement Review methodology had already begun within Hull and East Yorkshire Hospitals Trust as of summer 2016, when the Clinical Outcomes Manager was appointed to post. A large amount of work was undertaken to ensure that the Trust can undertake standardised mortality reviews, across all specialties. Work is still ongoing to ensure that a robust system is in place (utilising the Business Intelligence Analyser and Lorenzo System) and efforts are focused on engaging as many Clinicians as possible with the new system.

As a new process the main driver during this year has been to introduce a bespoke training package into the Trust. The training has been devised in-house with support from the Improvement Academy and associated resource pack. Training sessions have been held across the Surgery Health Group as a pilot site with attendees made up of consultants, matrons and nurse specialists. To support this, a standard operating procedure was introduced alongside processes for supporting the Serious Incident process. Reviews have begun within the Surgery Health Group, and training sessions/one to one ad-hoc sessions are now planned to include the remaining 3 Health Groups (Medicine, Clinical Support and Family and Women's). In addition, themes and trend reports are beginning to be produced and options are being explored to use the process to review near misses.

The Trust is one of the first Trusts to adopt the new structured review method to this extent, and the new method has potential to grow and develop into an essential service to allow the reduction of avoidable harm and avoidable death.

Further improvements identified:

The avoidable mortality priority has been identified as a quality and safety priority for 2017/18 (see page 83) and it will also be included in the Trust's Quality Improvement Plan for 2017/18. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be on increasing the focus from learning from deaths during 2017/18 following the publication of two key national documents; the National Guidance on Learning from Deaths (National Quality Board) and Learning from Deaths (CQC). This project will focus on the processes being introduced for reviewing deaths and how the organisation learns from these.

Key activities during this year will include:

- Involvement in the joint Trust and Improvement Academy learning project
- Development of processes for reporting and learning procedures
- Development of mortality dashboard
- Engaging in training with the Royal College of Physicians
- Implementation of the structured case note review process into Stroke services

Care for Older People

What we aimed to achieve in 2016/17:

The aim of this priority was to have better case management of the frail elderly person in conjunction with health care partners, particularly in relation to the emergency acute pathway. This project will also look to develop, in partnership with other provider's further end of life care planning and management of the community management of the frail elderly.

This priority aimed to achieve the following specific targets by the end of March 2017:

- 10% reduction in the number of patients over the age of 65 years who breach the 4 hour performance target
- 10% reduction in the number of patients over the age of 65 years who present to the Emergency Department who are admitted for ongoing care and treatment
- 5% reduction in the readmission rates (30 day / 90 days) for patients over the age of 65 years

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
10% reduction in the number of patients over the age of 65 years who breach the 4 hour performance target	44.7%	42%	
10% reduction in the number of patients over the age of 65 years who present to the Emergency Department who are admitted for ongoing care and treatment	58.2%	57%	
5% reduction in the readmission rates (30 day / 90 days) for patients over the age of 65 years	18.8%	12.4%	

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 2016/17 the Frailty Project has developed a number of initiatives to improve how we care for our frail elderly patients. During this time the Trust has developed and introduced a multidisciplinary Frailty Intervention Team (FIT). This team is made of people from a wide range of services and professions. They have been working alongside the Emergency Department team in our Majors department during the afternoon, as resources allowed. By encompassing the principles of comprehensive geriatric assessment and multi-disciplinary team (MDT) working, the aim is to prevent unnecessary admission into hospital from the Emergency Department (ED). The number of elderly patients being admitted from ED has dropped by 6.8% in patients aged > 75 years or more since this was introduced. Since the team began extending sessions from 09:00 – 5:00 when resources allow - 61% of patients seen by the FIT team are not admitted.

Further improvements identified:

This project will not be carried forward because the Trust is assured with the systems and processes put into place to date. There will however be further improvement work undertaken through the existing monitoring arrangements in place rather than through a 'quality improvement project' will focus on pursuing the business case to secure the future of FIT working, to introduce Rapid Access Clinics for Older People on the Hull Royal Infirmary site and to implement a Frailty Screening Form in ED to support these models of care. As a result of the work of the team, the Trust is currently on track to receive the £1.6 million associated with the Frailty CQUIN. £1 million has already been achieved and the business case will be pursued to enhance the funding available to ensure all improvement works can be carried out.

Care for People with Mental Health Needs

What we aimed to achieve in 2016/17:

The aim of this priority was to develop mental health patient pathways in conjunction with partner organisations and agencies to ensure the needs of patients attending the Emergency Department with mental health needs are met.

This priority aimed to achieve the following specific targets by the end of March 2017:

- Development and implementation of the mental health patient pathway
- Achieve compliance with the Mental Health Liaison Team service specification

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Development and implementation of the mental health patient pathway	Not collected	Completed	
Achieve compliance with the Mental Health Liaison Team service specification	Not collected	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:

Humber Mental Health Foundation Trust have worked in partnership with Hull and East Yorkshire Hospitals NHS Trust to establish two pathways for patients with mental health needs, the first of these has been to provide a mental health practitioner situated within the Emergency Department 24 hours a day, providing patients with direct access to a specialist who can diagnose them and make arrangements for their care.

The second pathway involves inpatients in mental health facilities requiring acute access to secondary care for assessment or admission. These patients can now bypass the Emergency Department and can directly access the acute service they require. This removes the need for these patients to be assessed via the Emergency Department and to receive more timely access to assessment and any required treatment.

These pathways reduce the pressure on staff and resources within the Emergency Department and also reduce the anxiety and stress of patients. In addition they also support Humber Mental Health and its patients by reducing the amount of time staff are away from their locality units reducing the impact on the care of these patients.

Further improvements identified:

This project will not be carried forward however further work will focus on working with partner organisations to improve the care of mental health patients within our setting with a view to reducing our MH frequent attenders by 20%.

A 2 year programme has been put in place to provide care plans for our cohort of frequently attending mental health patients. This work is in partnership with Yorkshire Ambulance Service, Humber Mental Health, Humberside Police and a number of other agencies. The outcome of this work is for each agency to understand their role in ensuring these patients receive the relevant care they require and not use HEYH ED as a default option. A plan to engage GP surgeries has been defined and will be taken forward over the coming months.

Also, similar care plans have been identified for frequent attenders who have not been diagnosed with a mental health condition.

The Mental Health Liaison Programme Implementation Group has been formed to aid in the delivery of the 'Core 24' service standard as set out by NHSE. Funding has been secured to support this initiative over 17/18 and 18/19, as although HFT have implemented this service within ED and Acute Services, due to staffing resource the standard cannot always be achieved.

This group will support the following outcomes:

- The provision of a 24/7 mental health liaison services to HEYHT
- Provide a 1 hour response time to emergency referral and a 24 hour response to urgent ward referrals
- Ensure the service meets the staffing levels required for Core 24 service

The group is currently in the process of holding stakeholder engagement sessions with all the agencies involved and families / carers of patients diagnosed with a mental health condition.

In addition the 'Crisis Care Concordat', a multi-agency group formed to focus on all operational issues which have arisen affecting the care of this patient group, with a view to improving these issues as they arise.

Handover Arrangements

What we aimed to achieve in 2016/17:

The aim of this priority was to ensure that patients have management plans and estimated date of discharge reviewed daily to ensure that progress to discharge is managed effectively.

This priority aimed to achieve the following specific targets by the end of March 2017:

- 95% of all estimated date of discharge recorded on Cayder within 24 hours of patient being admitted
- % of all board rounds taking place each day (AM and PM)*

*This target was discontinued however, all wards at Hull Royal Infirmary now following the SAFER system which includes daily board rounds. A review of roll out to Castle Hill Hospital is under way.

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
95% of all estimated date of discharge recorded on Cayder within 24 hours of patient being admitted	95%	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:

During 2016/17 the Trust worked with its partners to develop 'SAFER', which is a patient flow bundle that standardised the process for managing patient flow through hospitals. If the SAFER bundle is applied consistently (with minimal variation) it will improve the effectiveness of patient flow across the organisation. All medical wards at Hull Royal Infirmary wards are now delivering SAFER to include Board Rounds.

Further improvements identified:

This project will not be carried forward however further work will focus on enhancing the approach to delivery of improved discharge in conjunction with the Improvement Academy and will focus initially on the medical wards. An individual project is underway to review the patient flow through the Cardiology wards and will continue during 2017/18 to ensure improvements are made to the services. An alternate approach to the delivery of Board Rounds on surgical wards is currently being discussed to incorporate the differences experienced on these wards, such as the use of Surgical Admissions Lounge and the medical input required. This work will also continue during 2017/18 to improve ensure the appropriate use of services at the right times during the patients admission in hospital.

Learning Lessons

What we aimed to achieve in 2016/17:

The aim of this priority was to improve learning from Serious Incidents and Never Events so that the organisation understands the root causes that contributed to those incidents and what improvements have been made as a result. This should be visible through the implementation of sustainable changes and improvements.

The priority aimed to achieve the following specific targets by the end of March 2017:

- Never Events – no repeat Never Events
- Repeat Serious Incidents – reduction in the top 5 themes

Actual outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Never Events – no repeat Never Events	3	2	
Repeat Serious Incidents – reduction in the top 5 themes	Treatment Delay - 19 Patient Fall - 18 Delayed Diagnosis - 17 Pressure Ulcer (3or4) - 11 Surgical / Invasive Procedure - 10	Treatment Delay – 18 Patient Fall – 8 Delayed Diagnosis – 2 Pressure Ulcer – 4 Surgical / Invasive Procedure - 2	

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 Learning Lessons improvement project during 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan.

Significant progress has been made towards improving the way the organisation learns lessons. Key activity has focused on the following areas:

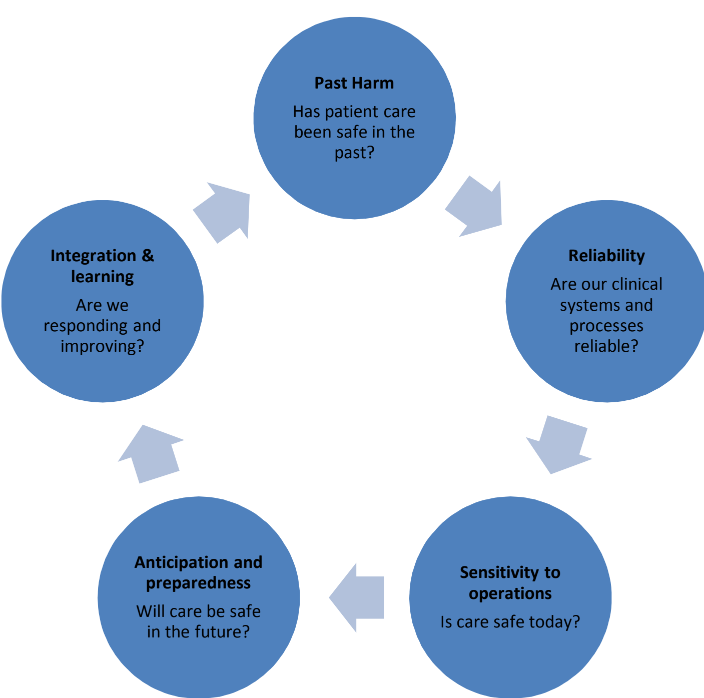
Understanding issues – processes have been developed to ensure information is easily accessible to identify themes and trends. Aggregated data, survey results, audit information and actions from Serious Incidents have been incorporated and reviewed via the CIRCLE group. In addition the Trust has been an active member of a regional learning group which is working towards the development of an accredited professional qualification programme.

Communication methods – clear communication channels have been embedded during the year including the learning lessons newsletter and the safety bulletin. Both provide staff across the Trust with key information to help improve the care delivered.

Further improvements identified:

The learning lessons priority has been identified as a quality and safety priority for 2017/18 (see page 84) and it will also be included in the Trust's Quality Improvement Plan for 2017/18. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be:
The Trust has been accepted onto the phase 2 pilot of introducing a new methodology for monitoring safety and learning lessons. The Quality Framework the Trust has adopted is taken from one devised by the Health Foundation (*Measuring and Monitoring Safety)* consists of five domains with associated questions and activities. This allows the organisation, speciality, department, ward or team to understand the quality and safety of the service they provide. This Framework is intended to be a tool used over time to build a true picture of quality and will provide information on areas that have the greatest opportunity to impact on change.



The intention of the framework is to move away from the emphasis on past harm and provide information of future risk and resilience. It enables a move away from a culture of assurance to one of enquiry. All five domains are equally important and it promotes a proactive, upstream thinking leading to clear quality improvement.

During 2017/18 the organisation will be supported by the Improvement Academy to pilot the framework. Key quality improvement projects have been selected to trial the process. These are Mortality, Sepsis and Pressure Ulcers.

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 learn 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 2016/17:

The aim of this priority was to seek and act on feedback from patients, relatives and carers. This enables the Trust to learn what is working well and what requires further improvement and to use feedback to inform required service changes. The project aimed to improve the standard of information provided to patients to ensure they receive relevant information and are able to make informed decisions. This ensures the services we provide are more responsive to patients.

The priority aimed to achieve the following specific targets by the end of March 2017:

- Achieve 95% of patients who would recommend the Trust to their friends of family
- Achieve 90% of formal complaints closed within the 40 day target and actions recorded where appropriate
- Increase the number of volunteers to 425 to benefit patients in clinical areas

Actual Outcome:

The following table provides performance data against the targets:

Target	Performance 2015/16	Performance 2016/17	Status
Achieve 95% of patients who would recommend the Trust to their friends of family	94.59%	97.70%	
Achieve 90% of formal complaints closed within the 40 day target and actions recorded where appropriate	76%	61.60%	
Increase the number of volunteers to 425 to benefit patients in clinical areas	376	537	

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 2016/17 to assist in the achievement of the overall aim and associated targets which were carried forward from the 2015/16 quality improvement plan.

Many improvements have been made during 2016/17 to enhance how the Trust encourages and deals with feedback from patients, relatives and carers. A Patient Experience Strategy has been developed which is supported by a work plan to deliver the objectives identified within the strategy to improve the Patient Experience service. This coupled with the development and roll out of a patient experience dashboard for Health Groups allows the identification of themes and trends from PALS and complaints which are shared through quality reports and used to inform lessons learned and service improvement.

The monitoring arrangements of patient information leaflets (PILS) has improved following the use of the Trust IT system: Covalent, which enables Health Groups to access the latest information and to identify when leaflets are due for review in advance allowing the authors to review the content and approve the leaflet to ensure the information does

not become out of date and patients are receiving up to date and accurate information to help inform their decisions about care and treatment and to provide advice and guidance following procedures.

The Trust continues to grow its list of valued volunteers, surpassing the target set, which is extremely encouraging.

Further improvements identified:

The patient experience priority has been identified as a quality and safety priority for 2017/18 (see page 84) and it will also be included in the Trust's Quality Improvement Plan for 2017/18. For more information on the Trust's Quality Improvement Plan see page 72.

The focus for further improvements will be:

- Approval and implementation of the Patient Experience Strategy and supporting work plan
- Continued roll out of the patient experience dashboard within all Health Groups to assist in informing staff of service changes and improvements
- Further development of the Interpreters Service with the implementation of an Interpreters Policy supported by associated resources including a "Browse Aloud" service for the visually impaired and a telephone interpreting service which will aim to enhance the patient experience for those where English is not their first language.

Making a difference through the Voice of the Patient

Part 3: Review of our Quality Performance

This section includes:

- Trust performance for 2015/16 and 2016/17 against the NHS Outcomes Framework quality indicators and planned actions the Trust intends to/has taken to improve performance
- 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
- Information on the Yorkshire and Humber Improvement Academy and HEYHT improvement work undertaken in 2016/17
- NHS Staff Survey Results – KF26 and KF21

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
- Friends and Family Test for patients for Accident and Emergency and Inpatients

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	2015/16	2016/17	National Average	Best performer	Worst performer
• the value of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period*	110	112	100	68	118
• the banding of the SHMI for the Trust for the reporting period*	1	1	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*	22.8%	24.6%	28.5%	10.6%	54.6%

*Most recent data on HSCIC for period April 2015 - March 2016, published in September 2016

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:

- Identifying avoidable mortality as a quality and safety priority and inclusion on the quality improvement plan for 2016/17. Actions taken and improvements achieved during 2016/17 through the delivery of the quality improvement project can be found on page 29.
- Identifying avoidable mortality to continue as a quality improvement project on the 2017/18 quality improvement plan. It will continue to implement and embed the new structured review method to ensure it develops into an essential service tool to allow the reduction of avoidable harm and avoidable death. Further information on actions taken and achievements will be reported in next year's Quality Account.

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	2015/16	2016/17	National Average	Best performer	Worst performer
• groin hernia surgery	64.6	58.6	50.6	88.9	12.5
• varicose vein surgery	85.7	93.3	81.8	100	50
• hip replacement surgery	100	85.9	89.4	100	66.7
• knee replacement surgery	100	85.8	81.6	100	50

* Most recent (Provisional) data From NHS Digital covers April 2016 - September 2016, published in February 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:

- The Trust will focus its attention to improving compliance with and outcomes from the varicose vein surgery. A new consultant 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	2015/16	2016/17	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	8.1%	9.6%	9.1%	0.5%	15.4%
• 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	6.5%	7.3%	7.2%	3.8%	10%

* Taken from CHKS for period April 2016 to February 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:

- The actions for improvement in relation to discharge will continue to be delivered through the Acute Pathway Project which is monitored by the Improvement Portfolio Board chaired by the Chief Executive.

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

Prescribed Information	2015/16	2016/17	National Average	Best performer	Worst performer
The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.	67	67.5	69.6	86.2	58.9

* Most recent data from HSCIC covers April 2015 - March 2016, published in August 2016

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:

- Identifying patient experience as a quality and safety priority and inclusion on the quality improvement plan for 2016/17. Actions taken and improvements achieved during 2016/17 through the delivery of the quality improvement project can be found on page 23.

- Identifying patient experience to continue as a quality improvement project on the 2017/18 quality improvement plan. It will continue to use feedback from patients, carers and relatives to inform learning lessons and service improvement. Further information on actions taken and achievements will be reported in next year's Quality Account.

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	2015/16	2016/17	National Average	Best performer	Worst performer
Friends and Family Test – Question Number 12d – Staff – The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to 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.	69.7%	79.3%	79.6%	98.1%	49%

* Most recent data from NHS England covers April 2016 - September 2016 (Cumulative), published in December 2016

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:

- Identifying patient experience as a quality and safety priority and inclusion on the quality improvement plan for 2016/17. Actions taken and improvements achieved during 2016/17 through the delivery of the quality improvement project can be found on page 36.
- Identifying patient experience to continue as a quality improvement project on the 2017/18 quality improvement plan. It will continue to use feedback from patients, carers and relatives to inform learning lessons and service improvement. Further information on actions taken and achievements will be reported in next year's Quality Account.

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	2015/16	2016/17	National Average	Best performer	Worst performer
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	80.6%	82.8%	95.6%	100%	78.7%

* Most recent data from NHS England covers April 2016 - September 2016 (Cumulative), published in December 2016

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:

- Identifying VTE as a quality and safety priority and inclusion on the quality improvement plan for 2016/17. Actions taken and improvements achieved during 2016/17 through the delivery of the quality improvement project can be found on page 22.
- Identifying VTE to continue as a quality improvement project on the 2017/18 quality improvement plan. It will continue to work towards achieving 95% of patients receiving a VTE risk assessment within 24 hours admission. Further information on actions taken and achievements will be reported in next year's Quality Account.

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

Prescribed Information	2015/16	2016/17	National Average	Best performer	Worst performer
The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the rate per	16.4	12.9	14.1	0	66

Prescribed Information	2015/16	2016/17	National Average	Best performer	Worst performer
100,000 bed days of cases of C difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.					

* Most recent data from Gov.uk Statistics covers April 2015 - March 2016, published in July 2016

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:

- Identifying avoidable hospital infections as a quality and safety priority the quality improvement plan for 2016/17. Actions taken and improvements achieved during 2016/17 through the delivery of the quality improvement project can be found on page 23.
- Identifying avoidable hospital infections to continue as a quality improvement project on the 2017/18 quality improvement plan. It will continue to ensure compliance with the Health and Social Care 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. Further information on actions taken and achievements will be reported in next year's Quality Account.

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

Prescribed Information	2015/16	2016/17	National Average	Best performer	Worst performer
• the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,	30.33	32.71	40.77	71.81	21.15
• the number and percentage of such patient safety incidents that resulted in severe harm or death	0.4%	0.4%	0.4%	0%	1.7%

* Most recent data from Gov.uk Statistics covers October 2015 - March 2016, published in September 2016

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:

- Identifying learning lessons as a quality and safety priority the quality improvement plan for 2016/17. Actions taken and improvements achieved during 2016/17 through the delivery of the quality improvement project can be found on page 34.
- Identifying learning lessons to continue as a quality improvement project on the 2017/18 quality improvement plan. It will continue to assist the organisation with a change in culture from one of assurance to one of enquiry. Further information on actions taken and achievements will be reported in next year's Quality Account.

The table below details performance against the Friends and Family Test for patients for Accident and Emergency and Inpatients

Prescribed Information	2015/16	2016/17	National Average	Best performer	Worst performer
Friends and Family Test – Patient - The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all Acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2) Accident and Emergency (types 1 and 2)	77.1%	88.2%	86.2%	99.1%	47.3%
Inpatients	96.2%	97%	95.7%	100%	74.2%

* Most recent data from NHS England covers April 2016 – December 2016 (Cumulative), published in May 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:

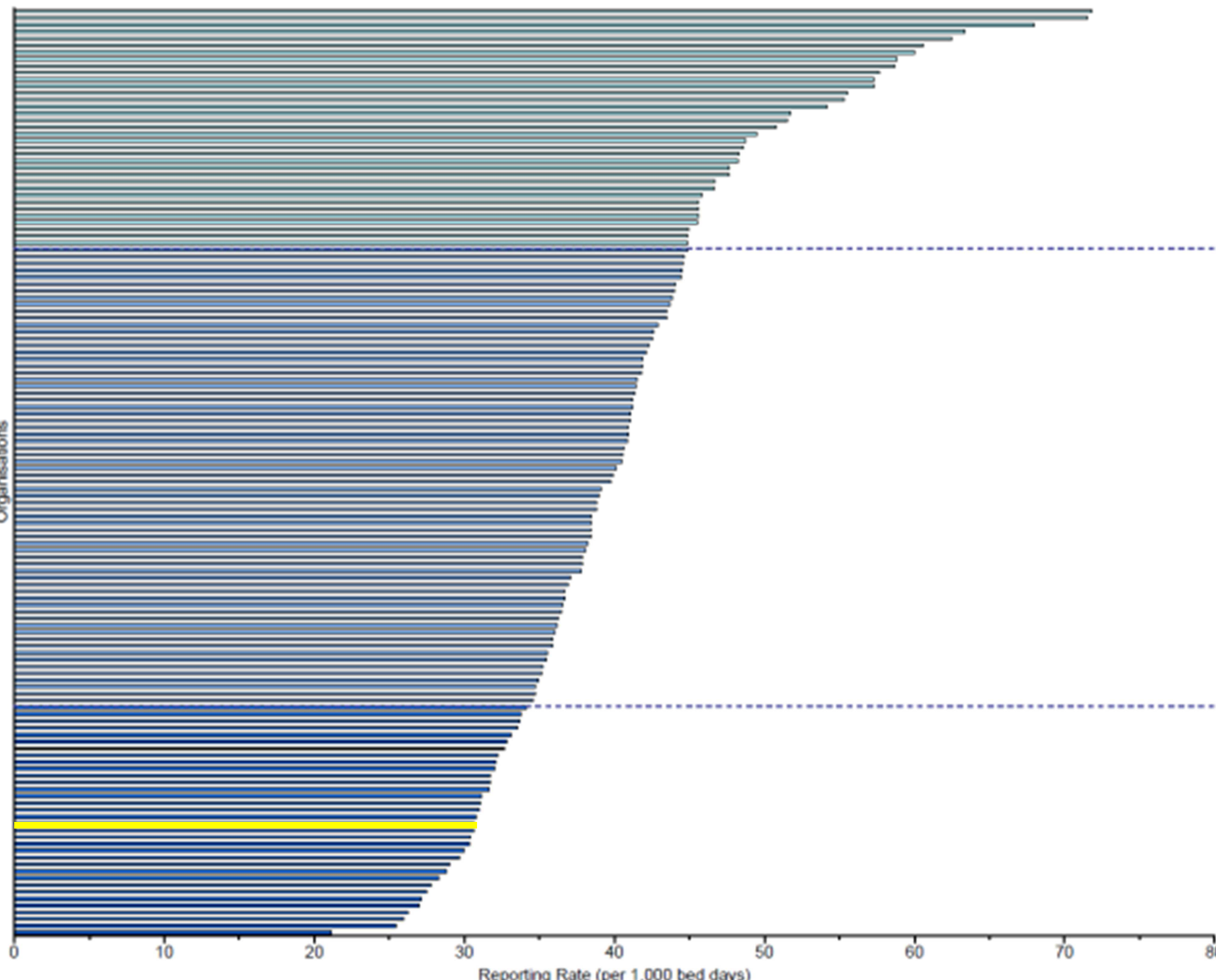
- Identifying patient experience as a quality and safety priority and inclusion on the quality improvement plan for 2016/17. Actions taken and improvements achieved during 2016/17 through the delivery of the quality improvement project can be found on page 36.
- Identifying patient experience to continue as a quality improvement project on the 2017/18 quality improvement plan. It will continue to use feedback from patients, carers and relatives to inform learning lessons and service improvement. Further information on actions taken and achievements will be reported in next year's Quality Account.

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 'Learning Lessons' 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 shows the Trust to be below average for reporting of patient safety incidents. This is the same position the Trust reported in last year's Quality Account.

Figure 1: Patient safety incidents per 1000 admissions for the period of 1 April 2016 to 30 September 2016



*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. The Trust appears to be reporting in line with the cluster on degree of harm, which is the same position, reported in last year's Quality Account. The top 10 types of patient safety incident reported between April and September 2016 are detailed in Figure 3.

Figure 2: Incidents reported by degree of harm for Large Acute organisations for the period from 01 April to 30 September 2016

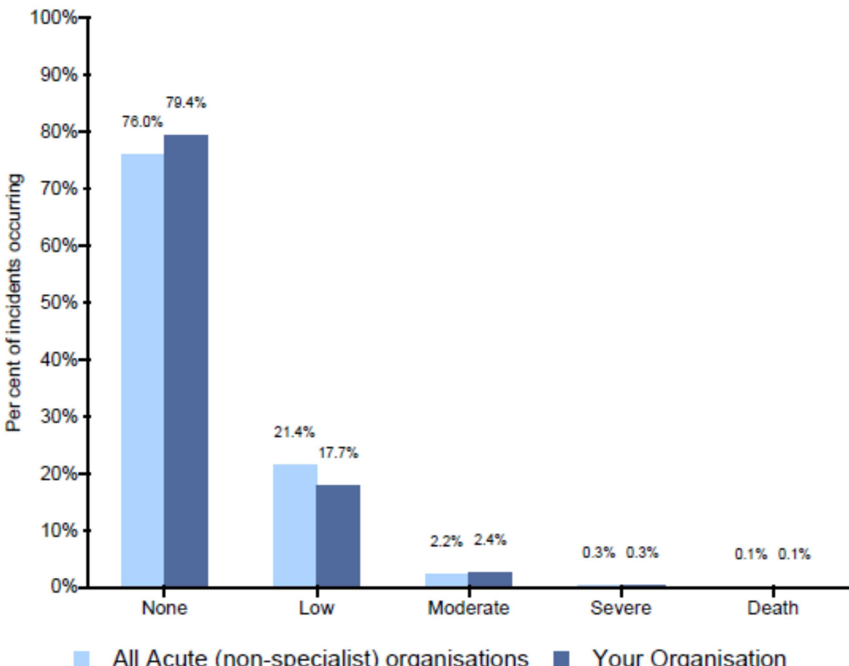
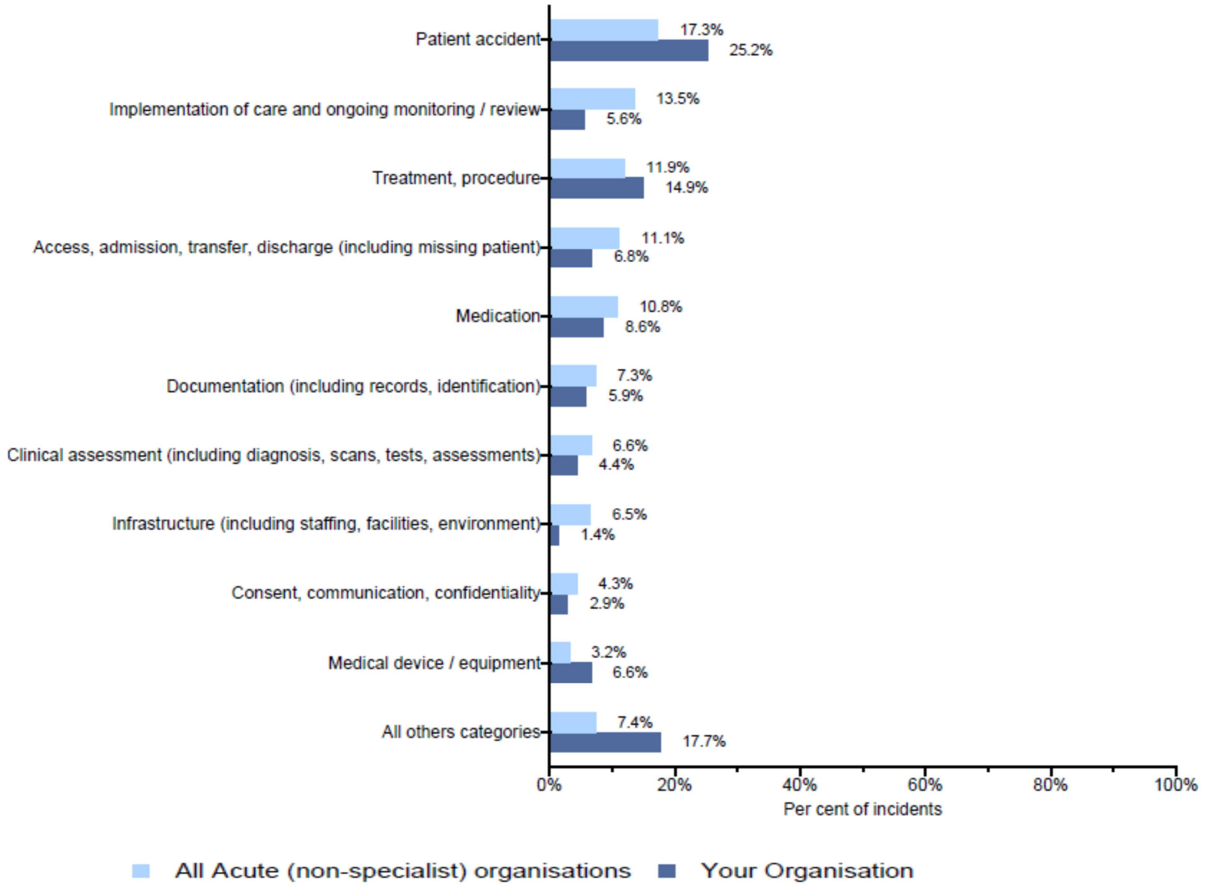


Figure 3 shows the top 10 types of incidents reported within our reporting cluster compared against the number reported by the Trust. The top 10 types of incidents remain the same as reported in last year's Quality Account.

Figure 3: Top patient safety incidents reported by %



The above graphs are taken from the latest National Patient Safety Agency National Reporting and Learning Service (NRLS) data report published March 2017.

Risk and incident management was identified as a quality improvement project on the 2015/16 and 2016/17 Quality Improvement Plan. The aim of these projects was to ensure that there were effective systems and processes in place to ensure incidents, Serious Incidents and risks are managed both effectively and timely. Through the delivery of the two quality improvement projects a significant amount of work was undertaken to review the processes that were in place to manage incidents and risks across the organisation and to make the required improvements to ensure there were robust processes embedded in practice which resulted in effective incident and risk management.

The changes to practice and improvement in the incident and risk management processes include:

- Full review of the incident form on DATIX including the coding criteria, quality of recording and how incidents were investigated and acted upon. Revisions made to the reporting form to improve the recording and categorisation of incidents. This informed an improvement in the quality of investigations, actions taken and lesson learned
- Improvements made to the Serious Incidents (SIs) processes for escalation and the declaration of Serious Incidents. The templates for Serious Incident reports were amended and relations with our Commissioners have improved creating a more open, transparent and honest dialogue on SIs reported. The work has also resulted in an improved rating by commissioners from limited assurance to significant assurance.
- Reduction in the number of incidents with investigations taking more than 28 days achieved
- Investigations proportional to the level of severity of incident, i.e. no and minor severity undergo a shorter investigation than those of a moderate or above investigation
- The risk management processes and systems received an external review. The external review confirmed that risk management systems in place were sound and fit for purpose
- The development of a corporate risk register which is aligned to the Trust's 7 goals detailed in the Trust Strategy for 2016-2021
- Following the CQC comprehensive inspection in June 2016, the CQC reported that staff understood their responsibilities regarding incident reporting. Staff were encouraged to report incidents and knew how to. This identified a positive and open reporting culture. The CQC also noted the timeliness of the incident investigations and the sharing of lessons learned.
- The staff survey results for 2016 show improvements for question KF30: Fairness and effectiveness of procedures for reporting errors, near misses and incidents. This was one of the top five ranking scores for the Trust in 2016. HEYHT scored an average of 3.76 against the national average of 3.72.

The risk and incident management quality improvement plan will not be carried forward onto the 2017/18 Quality Improvement Plan because the required improvements were made and assurance was received that there were robust systems in place to ensure incidents and risks were managed and in an effective and timely manner across the organisation. The Risk Team will continue to monitor the effectiveness of the processes and will undertake some further improvement work; however this will be delivered through 'business as usual' and will be monitored through regular updates to the Operational Quality Committee and externally to the monthly Serious Incident Panel and through Contract Management Board.

Further actions include:

- Review and revision of the risk management training packages to ensure they are fit for purpose
- Full launch and implementation of new Corporate Risk Register, including a review of risk register on DATIX
- Development of incident form training packages
- Review of the incident investigation page
- Review and revision of the Risk Management policy

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 declared in each year:

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

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

Types of Serious Incident and Never Events declared during 2015/16 and 2016/17

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

The Trust reported more Serious Incidents in 2015/16 than in other years reported above. After this peak, the numbers of Serious Incidents (including Never Events) reduced during 2016/17. The Trust feels that this shows a balance of reporting, and increased confidence that we are reporting the right incidents. During 2016/17 the Trust has further developed on the improvements made during 2015/16 regarding the Serious Incident processes and methods for investigation. Hull and East Yorkshire Hospitals NHS Trust believes, at the end of 2016/17 that while we still have Serious Incidents occurring, our response to these 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 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 can be issued for a number of reasons. Alerts can be issued for newly recognised patient safety issues, potentially where incidents have resulted in death or severe harm to a patient and where many healthcare providers will have limited knowledge or experience of the risk. 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.

In January 2014 NHS England launched the new National Patient Safety Alerting System (NPSAS) which provides urgent information to healthcare providers via CAS through a three stage alerting system. The NPSAS system encourages the sharing of information between organisations so that the best possible practice can be widely adopted throughout the NHS.

Coordination of patient safety alerts including those issued through the NPSAS is carried out by the Risk Management Team who work with various Trust departments and Health Groups to facilitate compliance and monitor ongoing work or action plans used to address the issues raised.

NHS England NPSAS alerts issued 2016/17 and the Trust's progress

Reference	Alert Title	Issue Date	Deadline	Trust Response
NHS/PSA/RE/2016/003	Patient safety incident reporting and responding to Patient Safety Alerts	20-Apr-16	03-Jun-16	Action complete and matter resolved
NHS/PSA/W/2016/004	Risk of death and severe harm from failure to recognise acute coronary syndromes in Kawasaki disease ...	11-May-16	22-Jun-16	Action complete and matter resolved
NHS/PSA/RE/2016/005	Resources to support safer care of the deteriorating patient (adults and children)	12-Jul-16	31-Jan-17	Action complete and matter resolved
NHS/PSA/RE/2016/006	Nasogastric tube misplacement: continuing risk of death and severe harm	22-Jul-16	21-Apr-17	Action complete and matter resolved
NHS/PSA/RE/2016/007	Resources to support the care of patients with acute kidney injury	17-Aug-16	17-Feb-17	Action complete and matter resolved
NHS/PSA/D/2016/008	Restricted use of open systems for injectable medication	07-Sep-16	07-Jun-17	Action is necessary: ongoing
NHS/PSA/D/2016/009	Reducing the risk of oxygen tubing being connected to air flowmeters	04-Oct-16	04-Jul-17	Action is necessary: ongoing
NHS/PSA/W/2016/010	Risk of death and severe harm from error with injectable phenytoin	09-Nov-16	21-Dec-16	Action complete and matter resolved
NHS/PSA/W/2016/011	Risk of severe harm and death due to withdrawing insulin from pen devices	16-Nov-16	11-Jan-17	Action complete and matter resolved

Working with the Improvement Academy

Over the past year, the Yorkshire and Humber Improvement Academy has continued to work with frontline teams within the Trusts to improve patient safety through a variety of projects.

Huddling up for Safer Healthcare

During 2016/17 the Medical Elderly base wards at Hull Royal Infirmary have been using their safety huddles to focus on improving pressure ulcer care, with impressive results.

Huddles are a daily, short (5 – 10 minutes) discussion involving all members of the team, which focus a specific patient harm (that has been decided by the team) such as falls, pressure ulcers, or patients at risk of deterioration. They provide a non-judgemental, no-fear space in the daily workflow of ward staff where team members can develop confidence to speak up and jointly act on any safety concerns they have. Once embedded the huddle becomes a vehicle for ward teams to continually learn and improve.

The teams have reduced their collective number of hospital acquired pressure ulcers (HAPUs) by 55% (from 53 incidents in 2015/16 to just 24). The Academy has also presented 19 certificates of achievement to the teams to celebrate reaching significant milestones. Ward 9 became the first ward in the region to achieve a Diamond level certificate after achieved a staggering 333 days without a HAPU.

The project has recruited 5 volunteers from the Trust's Quality and Safety Team who will be supported by the Academy to become huddles coaches. They will be supporting teams to implement and embed huddles so that we can spread the project across the Trust.

PRASE (Patient Reporting and Action for a Safe Environment)

Over the past two years the Trust has been participating alongside Bradford Teaching Hospitals NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust in the PRASE project, which has been funded by the Health Foundation.

PRASE is an intervention that helps patients to provide useful feedback about the safety of the care they receive. We use volunteers, who are trained to use an electronic patient safety questionnaire, to collate information from patients about factors that contribute to patient safety, such as equipment, communication, and delays.

This year the funding for the project has ended and we held a celebration event for all of the Trusts involved. Two of our volunteers, Graham Gedney and Ray Dove (pictured right), received certificates for their invaluable contribution to the project. With their continued support, combined with the Trust's Patient Experience Team, PRASE will be spread to other wards within the Trust over the coming year.

Timed Action Plans for Patients (TAPPs)

The Academy has been working with frontline teams to develop and test a new intervention. Timed Action Plans for Patients (TAPPs) is a tool which improves quality and safety through supporting the delivery of consistent and reliable patient care. When patients get what they need, when they need it, they spend less time waiting and a measureable outcome for this is a reduction in length of stay. Through reducing delays, patients are less likely to come to harm through acquiring a hospital acquired infection, or suffer deterioration associated with a hospital stay for frail, elderly patients.

Since we started developing and testing TAPPs we have been evaluating its impact. Early results show a sustained reduction in length of stay, saving an estimated 3562 bed days. There has been a corresponding increase in the number of admissions and discharges, allowing the team to treat an extra 348 patients.
In November Sister Kay Brighton, Dr Jacqueline Smithson and Dr Fiona Thomson from the Trust presented this project at the Science of Improvement Conference. This has generated interest from other Trusts around the region who hope to join the project and beginning to test TAPPs within their ward environments.

TAPPs is being implemented on 3 wards within the Trust and we plan to spread further following evaluation.

What is the Improvement Academy?

The Improvement Academy is a team of improvement scientists, patient safety experts and clinicians who are committed to working with frontline services, patients and the public to deliver real and lasting change for the people of our region. Their aim is to use evidence and practical support to help organisations to become high reliability organisations for safety, improving care 'bottom-up from the top.'

NHS Staff Survey Results – KF26 and KF21

Hull and East Yorkshire Hospitals NHS Trust undertook the NHS National Staff Survey 2016 between October and December for full census of its staff.

The response rate for the Trust was 44% (3,508 staff), against a national average of 43%. Of these completed survey questionnaires, 0.23% were paper questionnaires and 99.77% were online. This is the largest number of staff to respond to the staff survey in the past ten years with staff groups represented proportionately.

In the 2016 report there are 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 on 07 March 2017.

In 2016 the Trust is above average for 13 of the 32 key findings:
KF1. % appraised in the last year
KF20. % experiencing discrimination at work
KF21. % believing the organisation provides equal opportunities
KF28. % witnessing potentially harmful errors
KF30. Fairness and effectiveness of procedures for reporting errors
KF31. Staff confidence and security in reporting unsafe clinical practice
KF18. % attending work despite feeling unwell
KF15. % satisfied with flexible working opportunities
KF16. % working extra hours
KF14. Satisfaction with resourcing and support
KF2. Satisfaction with quality of work they are able to deliver
KF22. % experiencing physical violence from patients or the public
KF25. % experiencing harassment, bullying or abuse from patients or the public

The Trust is deemed to have improved significantly against these findings:
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
KF11. Percentage of staff appraised in last 12 months

The Trust has not seen deterioration in any of the key findings in the staff survey. The overall score for engagement, where five is the highest score possible, has also improved: 3.77

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

Staff Survey Question	Ranking compared with Acute Trusts in 2015	Ranking compared with Acute Trusts in 2016
KF26 - % of staff experiencing harassment, bullying or abuse from staff in last 12 months	38% Highest (worst) 20%	31% Highest (worst) 20%
KF21 - % of staff believing that the Trust provides equal opportunities for career progression or promotion	85% Below (worse than) average	88% Top 20% (higher than average)

Three objectives have been approved by the Trust Board:

- Objective 1 - Trust performance in the National Staff Survey will be in the top 20% of Trusts in the United Kingdom by February 2019, on publication of the 2018 survey results. The overall score for engagement will be the key performance indicator in this respect.
- Objective 2 - Medical and dental engagement will be in the top 20% Trusts by February 2020 on publication of the 2019 results.

- Objective 3 - Scores for non-clinical staff (including Corporate and Estates, Facilities and Development will be comparable to those of the best performing Health Group by publication of the 2018 results.

In order to achieve the objectives set out above, a Staff Survey Working Group has been established. This includes membership from all Health Groups and Directorates, and has been extended to include medical and nursing members. The Head of Therapies has also been invited to join the group in an effort to learn from areas of excellent practice and shift at some focus on to best practice. A standing agenda item for the group will be 'learning from excellence'. The group will meet monthly and report to the Workforce Transformation Committee. An action plan has been agreed and will be continuously updated following further discussions with specific areas of the workforce. These discussions will include "all staff" focus groups, workshops with our disabled workforce, a focus on good practice in therapies and specific interventions for the medical and dental workforce as well as the Estates, Facilities and Development directorate.

Senior manager briefing sessions will be held throughout May and August 2017 for the 800 band 7+ managers we employ. These will set out our intended objective and expectations of managers in all areas to deliver the objective.

A separate group focusing specifically on medical engagement and accountability has been established with medical membership from all Health Groups. The first meeting of this group was held in March 2017. The discussion built upon feedback from a workshop with triumvirates and clinical directors held in December 2016, with five clear themes emerging:

1: Basic needs: Car parking, office accommodation, admin/secretarial support, training and development, organisational respect, SPA time
2: Clarity of roles: Job descriptions, appraisals, job planning/team planning
3: Structures: Sharing the workload, clinical hierarchy
4: Relationships: Secretaries, business/service managers, networking, consultants' forum, team working
5: Accountability: Empowerment and authorisation, removal of centralised unilateral decision-making, hand back control over waiting lists

The group, led by the Chief Medical Officer and Director of Workforce and Organisational Development, will continue to meet monthly to develop a robust plan of action, based on the five themes. The action plan will be discussed by and approved at both the LNC and Trust Board.

Part 4: Statements of Assurance from the Board

This section includes:

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

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

Statements of Assurance from the Board

Review of services

During 2016/17 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 2016/17 represents 100% of the total income generated from the provision of NHS services by the Hull and East Yorkshire Hospitals for 2016/17.

Participation in clinical audits

During 2016/17, 42 national clinical audits and 5 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 100% 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 2016/17. 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%
Children		
Paediatric Intensive Care (Paediatric Intensive Care Audit Network - PICANet)	Yes	100%
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	Yes	100%
UK Cystic Fibrosis Registry (children)	Yes	100%
Blood and Transplant		
Audit of Patient Blood Management in Scheduled Surgery (Oct 2016 re-audit)	Yes	100%
National Comparative Audit of Lower Gastrointestinal Bleeding and the Use of Blood	Yes	100%
Acute care		
National Emergency Laparotomy Audit (NELA)	Yes	36%
Adult Critical Care (Case Mix Programme – ICNARC)	Yes	100% (April – Dec 2016)
Adult Asthma	Yes	100%
Severe Sepsis and Septic Shock in Emergency Departments	Yes	100%
Asthma (paediatric and adult) Care in Emergency Departments	Yes	100%
Long term conditions		

Audit:	Participated	% of Cases Submitted
Diabetes (National Adult Diabetes Audit)	Yes	100%
Diabetes in Pregnancy Audit	Yes	100% (Jan – Dec 2016)
Diabetes Footcare Audit	Yes	80%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Ulcerative Colitis and Crohn's disease (National Inflammatory Bowel Disease - IBD Audit)	Yes	
UK Cystic Fibrosis Registry (adults)	Yes	100%
Endocrine and Thyroid National Audit	Yes	100%
National Chronic Obstructure Pulmonary Disease (COPD) Audit	Yes	100%
National Dementia Audit	Yes	100%
Stress Urinary Incontinence Audit	Yes	100%
Elective procedures		
Hip, Knee, Ankle, Elbow and Shoulder Replacements, Implant Performance, Hospital Performance and Surgeon Performance (National Joint Registry)	Yes	100%
Coronary Angioplasty (National Institute for Clinical Outcome Research - NICOR Adult Cardiac Interventions audit)	Yes	99%
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	Yes	100%
Percutaneous Nephrolithotomy (PCNL)	Yes	100%
Radical Prostatectomy Audit	Yes	100%
Heart		
Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	Yes	100%
Heart Failure (Heart Failure Audit)	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Arrest Audit (NCCA)	Yes	100%
Renal disease		
Renal Replacement Therapy (Renal Registry)	Yes	100%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Oesophago-gastric Cancer (National OG Cancer Audit)	Yes	71-80%
Head and Neck Cancer audit	Yes	100%
National Prostate Cancer audit	Yes	100%
Trauma		
Major Trauma (Trauma and Audit Research Network)	Yes	100%
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) – including the Hip Fracture Database (NHFD)	Yes	100%

Audit:	Participated	% of Cases Submitted
Acute Stroke (Sentinel Stroke National Audit Programme - SSNAP)	Yes	94%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Non-invasive Ventilation (NIV)	Yes	100%
Mental Health in General Hospitals	Yes	71%
Chronic Neurodisability	Yes	100%
Young People and Mental Health	Yes	80%
Maternal Infant and Perinatal Programme (MBRRACE-UK)	Yes	100%

The reports of 25 national clinical audits were reviewed by provider in 2016/17 and Hull and East Yorkshire Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Audit	Proposed actions
Neonatal Intensive and Special Care (National Neonatal Audit Programme - NNAP)	• To review the process for documentation of first consultation with parents
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
National Bowel Cancer Audit	• To undertake a review of 2 year mortality data • To review the recording of American Society of Anaesthesiologists (classification system)
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
Heart Failure (Heart Failure Audit)	• To appoint a Heart Failure consultant, to assist with achieving the Best Practice Tariff.
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
National Pregnancy in Diabetes Audit	• To discuss the results of the audit with the Diabetes Network Board. • To carry out a local audit of glucose control. • To further analyse the data on pre-pregnancy folic acid use and glucose control, in order to identify any potential trends by age group. • To contact Public Health, Clinical Commissioning Groups and Family Planning clinics to discuss potential further actions.
National Diabetes Footcare Audit	• To clarify the definition of ‘ischemia’ with the national audit team, to

Audit	Proposed actions
	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
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
National Diabetes Audit	• No further action required as standards met
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
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.
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
National Audit of Percutaneous Coronary Interventions (PCI)	• No further action required as standards met
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

Audit	Proposed actions
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
PICANET (Paediatric Intensive Care Audit Network)	• To discuss a business case for providing family psychological support at the Paediatric Governance meeting. • To organise for the Paediatric Nurse Educator to provide a critical education session.
End of Life Care Audit	• To include a section in the End of Life 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
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.
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
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
National Prostate Cancer Audit	• No further action required as standards met
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
National Oesophago-Gastric Cancer Audit	• No further action required as standards met
UK Cystic Fibrosis Registry - Paediatric	• To review azithromycin usage to date Review cystic fibrosis guidelines with new commissioning arrangements
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	
Acute Pancreatitis	• No further action required as standards met
Other Enquiries/Reviews	
MBRRACE-UK	• To review ultrasound capacity, parental education on fetal movement and smoking cessation as part of the national Growth Assessment

Audit	Proposed actions
	Protocol (GAP) project

An update regarding the implementation of the proposed actions identified as a result of a national clinical audit reports published in the 2015/16 Quality Account is provided below to demonstrate the improvements made to quality. Actions taken in response to reports published in 2016/17 will be included in the Quality Account for 2017/18.

Audit	Proposed actions	Progress
National audit		
Neonatal Intensive and Special Care (National Neonatal Audit Programme - NNAP)	• To implement a process to ensure 2 year follow-up information is submitted at point of clinic attendance • To undertake regular review of 2 year follow-up data completeness through continued audit of BadgerNet (the neonatal database)	• A process for monitoring 2 year follow-up has been implemented • A regular review of 2 year follow-up is undertaken through BadgerNet
National Chronic Obstructive Pulmonary Disease Audit (COPD)	• To raise awareness amongst medical and nursing staff of the need to document ceiling of care escalation plan for all patients, via a departmental training session • To raise awareness of the need to refer to pulmonary rehabilitation via a departmental training session • Senior Nurses to remind staff to refer to pulmonary rehabilitation prior to discharge	• Presentations have been delivered at the grand round and to the acute medicine department on COPD and related issues, such as escalation of care and referral to pulmonary rehabilitation. These are also addressed during the Respiratory attachment that junior doctors undertake. • Work is currently underway with the Emergency Department to improve pathways and facilitate referrals for patients attending ED. • The Acute Respiratory Assessment Service has raised the issue of referral to pulmonary discharge with the respiratory ward teams. This is also a part of the British Thoracic Society discharge bundle, which is completed for all COPD patients.
Lung Cancer (National Lung Cancer Audit)	• To obtain more in-depth data – specifically data for resection rate for localised (stage I/II) lung cancer • To undertake an audit of biopsy proven cancer	• In-depth data was obtained through data.gov.uk, including resection rates for localised (stage I/II) cancer • An audit on biopsy proven cancer was undertaken by cellular pathology
Adult Community Acquired Pneumonia Audit	• To hold a training session to reiterate the importance of good record keeping, including the CURB65 score	• The importance of good record keeping (including the CURB65 score) is emphasised as part of departmental teaching
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	• To appoint dedicated administrative clerk for robust data capture on the Twinkle database • To establish a pathology link with Twinkle to ensure a true reflection of annual screening in this audit • To establish a dedicated structured education session for children and families to improve engagement in diabetes management and improving the mean HbA1C levels	• Administrative Clerk appointed to manage Twinkle database • Ongoing work with the Pathology team to establish a link between systems • Unsuccessful implementation of structured education following multiple attempts, with poor uptake of patients. Alternative methods of implementation are being explored

National Pregnancy in Diabetes Audit	• To focus on health promotion in the outpatient clinic, in order to raise awareness of the issues associated with diabetes in pregnancy • To discuss the promotion of pre-pregnancy planning at the Diabetes Network Board meeting	• This is currently ongoing – work between dietetics, outpatient diabetes staff and diabetes specialist midwife • This information was discussed at the Diabetes Network Board in April 2016
National Inpatient Falls Audit	• To audit the availability of call bells in all inpatient areas to ensure they are within reach of the patient	• Call bell availability has been audited three times over the past 12 months with a further audit scheduled for April 2017
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 • Undertake a snapshot audit of patients transferred from the acute admissions unit to assess if treatment escalation plans are clearly documented on the post take ward round	• The NCAA data set is discussed quarterly at the Resuscitation and Deteriorating Patient Committee. Areas of good practice and areas requiring attention are highlighted and escalated to Health Groups and the Operational Quality Committee. This information is also included in Consultant mandatory training sessions • Snapshot audits have been undertake in the Acute Medical Unit and Elderly Assessment Unit and the results shared with the Medicine Health Groups governance meeting. Both audits showed limited documentation and decision making around DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) and ceilings of care
Initial Management of the Fitting Child (College of Emergency Medicine)	• To plan a training session, to include all nursing staff • To produce a patient information leaflet, as per the recommendations made by the College of Emergency Medicine	• Training sessions are given on an ongoing basis • Patient information leaflet for discharge from Emergency Department has been written and is currently awaiting approval from the relevant committee
Asthma in Children (College of Emergency Medicine)	• To educate staff regarding the importance of recording all vital signs • To remind staff to record the discharge prescription for oral prednisolone	• The importance of recording all vital signs has been re-iterated a number of times • Staff are reminded to document this, as standard (FP10) prescription forms are given to patients that are discharged out of hours
Severe Sepsis and Sepsis Shock (College of Emergency Medicine)	• To audit antibiotic use during severe sepsis / septic shock • To educate staff regarding the importance of recording all vital signs (including urine output measurement)	• A number of audits on antibiotic use and the management of sepsis have been carried out since this national audit, which suggest that a number of aspects of sepsis management have improved over this time • The importance of recording all vital signs has been re-emphasised following the subsequent audits • A sepsis nursing competency is to be launched before Summer 2017
Paracetamol Overdose in Adults (College of Emergency Medicine)	• To feedback to all doctors and nurses the importance of beginning treatment with N-acetylcysteine as	• Junior doctors receive a teaching session on toxicology, which covers the physiology and treatment of paracetamol

	soon as possible and within 8 hours of ingestion if the patient presents early enough • To educate nurses that the use of N-acetylcysteine should be discussed with a senior doctor in patients where the overdose is staggered and in those cases where ingestion was over 8 hours ago	overdose • Toxicology is part of the junior doctor's Emergency Department induction, which highlights the guidance available via the Trust intranet and Toxbase.org • Up-to-date N-acetylcysteine pathways are on the Trust intranet site • Study sessions have been carried out for nursing staff, and a competency based on paracetamol is to be introduced
Mental Health in the Emergency Department (College of Emergency Medicine)	• To continue work on creating a new Immediate Discharge Sheet, incorporating College of Emergency Medicine guidance regarding referral or follow-up arrangements • To continue working towards a dedicated assessment room for mental health and to work towards the standards as set out by the Psychiatric Liaison Accreditation Network (PLAN)	• One of the consultants is now working on improving the system of creating Immediate Discharge Sheets – this work will incorporate mandatory coding, in order to ensure more accurate details are provided, in order to facilitate referral/ follow-up arrangements • While a PLAN accredited mental health assessment room was part of the initial plans for restructuring the Emergency Care Area, this was lost as plans were modified during the process – this will be reconsidered during the next phase of restructuring work
Assessing Cognitive Impairment of Older People (College of Emergency Medicine)	• To educate staff regarding the importance of documenting the Early Warning Score • To incorporate the 4 As Test (for delirium and cognitive impairment) into nursing forms, in order to improve the record keeping of cognitive assessment	• Staff education undertaken at the Emergency Department governance meeting • The 4 As Test has been incorporated into nursing documentation
Sentinel Stroke National Audit Programme (SSNAP)	• To ring-fence stroke beds in order to minimise outliers • To undertake a root cause analysis in all cases where no pre-alert occurs • To improve identification of communication issues by referring all patients that are at all disarthric • To improve the implementation of mood and cognition screening through the use of an appropriate tool • To ensure that the use of mood and cognition screening is properly documented • To look at the possibility of having a social worker working with the multidisciplinary team	• The department have been unable to ring-fence beds for a number of reasons (bed pressures within the organisation) and so this has now been placed on the risk register • All thrombolised patients are discussed on a regular basis, including any issues • Better identification of communication issues has been addressed through an increase in referrals to Speech and Language Therapy (SLT). The Trust is currently working on a business plan to fund further SLT input. • Mood and cognition screening has vastly improved [from 20% to almost 80%] in the past year • Data quality has improved through the submission of higher levels of data over the last year: • A social worker is still not part of the multi-disciplinary team as there are no available Social Workers
National Emergency Laparotomy Audit (NELA)	• To implement the new laparotomy pathway	• The guideline for emergency laparotomy was published in May 2016

National Hip Fracture Database	• To encourage Trauma Co-ordinators to provide nerve block to patients on admission where appropriate • To ensure a weekly meeting takes place to discuss the resources for extra theatre sessions as difficulties are experienced in staffing these extra sessions	• Trauma Co-ordinators can now provide nerve blocks • A weekly performance meeting for Theatres has been established
National Vascular Registry	• To review the waiting time for lower limb angiogram with the Radiology team • To arrange a joint meeting with Stroke Medicine to discuss the performance of symptom to procedure for Carotid Endarterectomy	• The waiting time is reducing but will not be altered in a major way until the final room refurbishment is finished in April/May 2017 • The performance of symptom to procedure for Carotid Endarterectomy Second was discussed at the Getting it Right First Time review – the Trust is within national guidance
MBRRACE-UK	• To undertake a local stillbirth audit to identify any factors which may be responsible for the high rate of stillbirths in Hull • To implement the use of customised growth charts and the West Midlands Perinatal Institute maternity hand held records to ensure a co-ordinated approach to the management of reduced fetal growth • To implement a new patient information leaflet regarding fetal movements and count kicks towards an agreed approach to the management of reduced or altered movements • To implement K2 CTG interpretation training to ensure midwives and medical staff are using the NICE guidance correctly including assessment and escalation • To continue to undertake a review of all stillbirths via the maternity case review, to consider implementing the National Patient Safety Agency (NPSA) toolkit to review these as an added measure and to replicate what is being done across the region	• A stillbirth audit to be undertaken in 2017 • Customised growth charts and the West Midlands Perinatal Institute maternity hand held records have been implemented • A 'Your Baby's Movements in Pregnancy' leaflet has been developed and is given at 16weeks • K2 package CTG interpretation training is ongoing • All stillbirths are reviewed at the maternity case review meeting. The NPSA toolkit is not yet in use but is to be reviewed and used with any adjustments made accordingly.

The reports of 278 local clinical audits were reviewed by Hull and East Yorkshire Hospitals NHS Trust in 2016/17. For an update on the progress of the actions identified as a result of local clinical audits completed in 2016/17 and proposed actions for 2017/18, 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 & East Yorkshire Hospitals NHS Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 10,322.

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 177 clinical research studies of which 133 commenced during the reporting period 2016/17. This compares with 156 new submissions and 120 commencing in 2015/16.
The Trust used national systems to manage the studies in proportion to risk. Of the 133 studies given permission to start, 91 were National Institute for Health Research (NIHR) portfolio adopted.

The Trust has 171 studies actively reporting accruals (patient recruitment) under the NIHR Clinical Research Network (CRN) Portfolio, as compared to 173 portfolio studies reporting accruals for the period 2015/16.

The number of recruits into the Trust portfolio studies for the periods 2015/16 and 2016/17 was 2,300 and 8,996 respectively. A target of more than 6,000 patient accruals has been set for 2017/18. The largest topic area of portfolio adopted studies across 2016/17 is Oncology (Cancer) and Haematology with 48 studies between them. The top five therapeutic areas of Trust research in 2016-17 (based on portfolio recruiting studies) were:

1) Oncology and Haematology
2) Cardiovascular
3) Renal Disorders
4) Gastroenterology
5) Diabetes and Endocrinology

77% of commercial portfolio studies completed in 2016/17 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 100 publications, abstracts and book chapters have resulted from our involvement in portfolio and non-portfolio research across six specialty areas (Vascular Surgery, Radiation Physics, Respiratory Medicine, Diabetes, Haematology and Emergency Medicine). 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:
The Trust was the top recruiter in Yorkshire and Humber for the 'Yorkshire Health Study' with over 3,000 participants in 2016/17. The study will run for another two years 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 findings will support relevant parties to further deliver effective, service user driven care within Hull to suit type 2 diabetes service users' needs in conjunction with delivering national and local standards of care. This reflects the aims of the Hull CCG 2020 programme which states, "people will be supported by services that fit their needs and lifestyle, designed in partnership with them" – an aim which will support a healthier city. The study report and dissemination for the studies will occur over the summer of 2017 and is expected to have a high impact.

Alongside the large cohort studies, the team have continued to be successful in the small number of commercial clinical trials available and are the preferred UK site for Novo Nordisk studies.

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 and delivers clinical trials to time and target.

Gastroenterology and Hepatology (non-IBD) department:
The Trust is one of only 2 sites in the UK to look at Non-Alcoholic Fatty Liver Disease (NAFLD) and how it is managed by both GP and liver specialists. In the COMMANDS-02 trial, we designed a NAFLD Integrated Care Pathway (NAFLD e-ICP) for GPs to standardise care for patients in primary care and ensures that GPs complete a full liver assessment. Standard care is haphazard and inconsistent resulting in poor referral decision making and poor patient management and outcomes. HEY Trust has helped set up the e-consult clinic element of the research trial and both East Riding of Yorkshire and Hull CGGs have part-funded the research.

Interim data analysis shows a significant increase in complete GP liver assessments, improved patient diagnosis, improved referral decisions, appropriate use of the e-consult clinic option, reduced secondary care referral rates and high patient and GP satisfaction feedback. Interim data analysis suggests Health Care Professional and public awareness of NAFLD is poor and we aim to examine this in self-generated portfolio research trials due to start recruiting in 2017/18.

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 particular, in conjunction with Chemistry Hull Uni, the department received £140k from cancer research UK to develop a new therapeutic approach for acute leukaemia called Bioimprinting which was devised by Prof Paunov in Hull Uni. This study has been adopted onto the portfolio and the first patients will be recruited in early 2017/18. https://paunovgroup.org/news-2/

Working with the University of Newcastle they have developed a large cohort of chronic lymphocytic leukaemia patients who have undergone genomic analysis. We are in the process of demonstrating that some people are predisposed to have disease that progresses quicker than others and have found novel genetic markers predicting this. This work will be published later this year.

One of our portfolio studies (NIHR BPD study) has offered whole genome sequencing to patients with rare and previously undiagnosed disorders. One such patient with an immunological disorder, who unfortunately died, was diagnosed through this study with positive consequences for her family. They reported their experiences to the Hull

Daily Mail. http://www.hulldailymail.co.uk/tributes-to-one-of-a-kind-lyndsey-borman-after-death-at-just-33/story-30121698-detail/whatson/story.html

The team have also become an affiliated member of the Trials Acceleration Programme (TAP). TAP is an initiative set up by the Bloodwise Charity to deliver promising treatments to more patients, more quickly. Through this collaborative work it is hoped that more trials infrastructure, ideas and delivery personnel can be utilised to share a common goal of ensuring researchers get the support they need to make their trials happen.

The department also contributed to the 'Patient perceptions on the symptomatic and economic burden of Myeloproliferative Neoplasms (MPN)' study. The MPNs LANDMARK survey is a multi-country cross-sectional survey of MPN patients and treating physicians and provided valuable data on the patients' disease burden including how it affect patients' work productivity, and impacts them financially.

Respiratory Research Department:
The department's research on the neuronal mechanisms has radically altered our understanding leading to the concept of cough hypersensitivity. This has been translated through randomised controlled trials in man demonstrating novel tussive pathways (TRPA1) and therapeutic advances (opiates and P2X3 antagonists). This paradigm shift in the clinical management is disseminated through the NHS by extensive publication, invited lectures, and seminars at both national and international meetings. The immense social and economic morbidity of cough has been revealed in epidemiology studies. Whilst overlapping with other respiratory disease, it is now recognised as a distinct condition (the cough hypersensitivity syndrome) which is stimulating the burgeoning pharmacological developments in the field.

Professor Alyn Morice has pioneered investigation into the epidemiology, diagnosis and therapeutics of cough culminating in the production of national and international guidelines.
The molecular study of irritant (TRP) receptors suggested novel therapeutic directions. We were the top global recruiter in the phase 2B study of AF219, the first highly effective antitussive. Our study of its effect on cough reflex hypersensitivity was required by the FDA for the pivotal phase 3 study.

Vascular Surgery Research Department:
The Academic Vascular Surgery Unit (AVSU) has led on significant impactful research in 2016-17. In particular, the department is cited 3 times in the current NICE Guidelines (CG168) for Varicose veins: diagnosis and management and also cited 3 times in the current NICE Guidelines for PAD (CG147) Peripheral arterial disease: diagnosis and management.

Through Professor Chetter's role on the RCS Education Committee, he has developed and introduced the Specialist Trainee year 5 course which is delivered in Hull (this follows on from the successful development of ST3 course which was also piloted in Hull). The AVSU have cultivated a number of awards nominees and winners in 2016-17. At the recent Vascular Society Annual Scientific Meeting:

- Panos Souroullous was the winner of the British Journal of Surgery BJS Prize for presenting his work on the ASSIT trial; results so far have been impressive and suggest that 5 day prophylactic antibiotics are more effective than 24hrs for the prevention of surgical site infection following major amputation.
- Thomas Cayton was nominated for the BJS prize for his presentation of the work on extracorporeal shockwave therapy as a novel non-invasive treatment for claudication.
- Clement Leung was nominated for the Sol Cohen Prize session for his presentation for the LAMA trial - a randomised controlled trial comparing endovenous laser ablation versus mechanochemical ablation in the treatment of superficial venous incompetence.
- Joshua Totty was the winner of the first ever Dragons Den session – this inaugural Dragon's Den session saw 5 trainees pitch their research proposals to 5 Dragon Professors to win their support, funding, and the backing of the Vascular and Endovascular Research Network to take the proposal to a multi-centre trial. He won for his proposal; 'A randomised controlled trial to assess the clinical and cost effectiveness of Dialkylcarbamoylchloride (DACC) coated post- operative dressings versus standard care in the prevention of Surgical Site Infection in clean or clean-contaminated, vascular surgery'.
- Jordan Green a 2nd year medical student at Hull York Medical School (HYMS) who is currently working in the AVSRU has been awarded the Royal College of Surgeons Intercalated Bachelor of Science Degree in Surgery Award 2017.

The AVSU have led research in 2016-17 within the following areas and the impact/findings have been categorised as follows:

Varicose veins
- higher disease specific QoL benefit in our patients undergoing endothermal ablation than national PROMS data
- increasing PH of local anaesthetic solution reduces pain during endothermal ablation
- mechanochemical ablation is less painful than endothermal ablation
- recurrence rates after endothermal ablation are lower than after surgery at 5 years
- local anaesthetic reduces post op pain in patients undergoing surgery under GA
- patients with recurrent veins have significantly more symptoms

Peripheral Arterial Disease (PAD)
- higher than national uptake rates for Supervised Exercise Programme
- lower than national withdrawal rates for Supervised Exercise Programme
- in terms of improvements in walking distances, Extracorporeal Shock Wave Therapy as good as Supervised Exercise Programme or Percutaneous Transluminal Angioplasty
- Surgical Site Infections reduced with "active" dressings in vascular patients

Wounds
- surgical wounds healing by secondary intention common following emergency surgery
- surgical wounds healing by secondary intention take on average 3 months to heal
- Negative Pressure Wound Therapy for SWHSI may delay wound healing and is thus unlikely to be cost effective

Abdominal Aortic Aneurysm (AAA)
- angiotensin converting enzyme (ACE) inhibitors ineffective in reducing expansion rates
- pre habilitation improve fitness and reduces post op complications in patients undergoing AAA repair

Fistulas
- routine pre op duplex does not improve patency rates

NMS
- improves venous return in patients with varicose veins
- improves capillary blood flow in patients with PAD
- may protect against DVT

Emergency and Acute Medicine:
The development of a multi-centre trial looking at a clinical decision tool for radiographing elbow injury is in progress and relevant submissions will be finalised in 2017. It is hoped that the appointment of academic posts in 2017-18 will support the development and delivery of a portfolio of studies looking at patients presenting with head injuries. Links between specialties and wider agencies have continued to be forged via research involvement and close links to pre-hospital care expanded.

Radiation physics:
The radiation physics research team have undertaken work this year that has led to changes in the radiology and radiotherapy departments. All work has demonstrated excellent collaboration between the Radiation Physics Department and the Radiology & Radiotherapy Departments and shows that science can be used for patient benefit. A few examples:

- The Automatic Exposure Control (AEC) devices in our hospital Trust were up until a short while ago calibrated for film-screen; given we are now using digital imaging this was not optimum. To correct this, a collaborative research study was carried out between the Radiology and Radiation Physics departments, led by Craig Moore. Following this study an optimised calibration curve was identified which has been programmed into all x-ray systems in the Trust, providing improved patient care. This research has been published in the journal Physics in Medicine & Biology (Phys. Med. Biol. **61** (2016) N551–N564).
- The use of anti-scatter grids was not routine in clinical practice for digital chest radiography in our Trust. We examined the possibility of using these grids to improve image quality using computer simulated chest x-rays. Four experienced image evaluators graded images with a grid. These were scored against corresponding images

reconstructed without a grid. For all virtual patients, diagnostic image quality improved with the use of a grid, *without* the need to increase patient dose. We therefore showed it is possible to improve image quality by utilising grids for chest radiography with digital x-ray systems without increasing patient exposure. We have potentially improved the care of 1000s of patients per year. This research has been published in the British Journal of Radiology (Br J Radiol 2015; 88:20140613.)

- We have also translated experimental work on CT scanners and cone beam CT scanners on radiotherapy linacs to optimise patient radiation dose. Again, all collaborative work with Radiology, Radiotherapy and ourselves putting science at the heart of patient benefit. This work published in the Journal of Radiological Protection (*J. Radiol. Prot. 35 495 (2015) and British Journal of Radiology (BJR* 2015; 88: 20150364.)

Radiotherapy Research:
Locally, research has impacted in the Radiotherapy (RT) department in the following ways:

- Currently 10 Planning Physicists, 3 Dosimetrists and 14 Therapy Radiographers have undertaken Good Clinical Practice Training. A number of these are on the delegation log for RT trials and this has helped facilitate screening (particularly for the PEARL and PRAIS trials). This training has helped build the skills of the staff and is helping to build a culture where trials and research are an inherent part of RT treatment.
- Identification of patients who are on RT trials has improved through the use of the electronic patient management form and trial specific planning protocols. These (along with the use of tasks to improve workflow in the ARIA database) have helped to ensure adherence to trial protocols and facilitate prompt and efficient collection of data.
- Involvement in research is expected by patients *(NHS Constitution, 2013).* Staff, visitors and patients can see slides on the screens in our department promoting clinical trials in radiotherapy.
- Presentations on new trials and updates on RT Trials by the Research Radiographer and Physicist have helped improve the awareness of RT trials to staff in the department, reducing protocol violations and improving quality for patients.
- The Radiation Physics R&D Forum (monthly) and Radiotherapy R&D Forum (quarterly) provide a platform forum to support and discuss new projects to encourage a research culture and pursue scientific publication. Both departments are recording the post-graduate work and publications (see attached for Radiotherapy Publications). As well as locally there is national collaboration through Research and Clinical Trials Radiographers meetings quarterly (the October meeting is due to be held at CHH).
- Working with R&D the 'Departmental Position Statements for the Secondary use of Retrospective Patient Data' have helped facilitate service development:
    - Individual immobilisation for head and neck patients to ensure patient comfort, stability and treatment accuracy.
    - Retrospective analysis of images to optimise imaging exposure and protocols to ensure patients treatment is accurate and reduce con-comitant dose.
    - Cross-fertilisation with other departments (eg. retrospective analysis of abdomen images taken during treatment will help to quantify weight loss to help inform the Dietic service to these patients).
- Trial protocols (eg. SCALOP2 and Aristotle) have led to changes in pre-treatment preparation with regards to the use of contrast and breath-hold scans which allows the Clinician to better localise the RT treatment. This directly benefits patients (even those not in trials) as it improves treatment quality.
- The on-going local trust-sponsored PEARL trial is helping to integrate research into practice in the RT department. It will also help to optimise the patient experience.

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 2016/17 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.

The National Schemes only apply to the 2016/17 Clinical Commissioning Groups (CCG) contract. These include an extension to the Sepsis scheme from 2015/16 which included inpatients. There were new schemes which included; Health and Wellbeing initiatives; a reduction in sugary food, increase flu uptake and Antimicrobial Resistance reduction (AMR). The value of these schemes was £3.8m. The Trust has achieved all of these schemes with the exception of the required AMR 1% reduction in the antibiotics required. This is a cost to the Trust of approximately £150,000. A partial Sepsis achievement in quarter one 2016/17cost the Trust £48,000. This is a total loss of approximately £200,000.

Clinical Commissioning Groups - Local CCG schemes agreed with services across the Trust with a financial value of £4.8m. These included the continuation for a further year for the maternity safety thermometer and patient experience.

There were a number of new local CQUIN schemes for 2016/17;

1. Appropriate diagnostics for 2 week waits in upper and lower GI cases
2. Fast track hip and knee replacement
3. Johns campaign for dementia
4. Nutritional and hydration audit
5. ECIP frailty pathway.

All schemes have achieved their scheme requirement and achieved the full CQUIN value.

NHS England Specialised Services included a mandatory Clinical Utilisation Review (CUR) Scheme, Spinal network with data input to spinal register, Adult Critical Care timely discharge, Hep C for the Operational delivery network which HEYHT are responsible for ensuring the governance and partnership working across the Hep C network. The Trust agreed not to pursue the Clinical Utilisation scheme as outlined by NHS England (NHSE) but have offered to use in house tools to deliver the same information, this is still in discussion. The Trust has built into its financial plan that it will receive no funding for this scheme (£0.4m) in 2016/17.

NHSE are linking £235,000 CQUIN to supporting QiPP delivery in 2016/17.

NHSE local schemes - There are further local schemes from the NHSE specialised portfolio that HEYT have agreed to deliver in 2016/17 include:

- HIV: Patient activation survey
- Palliative care: enhanced supportive care
- Haemophilia: patient reporting tool
- Cardiology: optimisation of cardiac device usage

The Trust continues to achieve the NHSE CQUIN schemes outlined above with a potential under achievement the Hep C schemes which will not be identified until first quarter of 2017/18 as this is under a national programme.

The Trust has worked closely with all commissioners to develop a programme of CQUIN quality indicators for 2017/18. There are no local CCG schemes as there are several National CQUIN schemes mandated to all Trust to deliver in2017/18 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): 0.5% engagement with the STP In effect, this will be a cost free indicator for providers with clear scope for earning the full amount and 0.5% of the local CCG 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

NHS England Specialised Services (NHSE) - The Trust receives a CQUIN value of 2.8%. 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.

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 new CQC Operating Model introduced from 1 October 2014 focuses on eight core services. These are:
- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Maternity and Gynaecology
- Services for Children and Young People
- End of Life Care
- Outpatients and Diagnostic Imaging

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 has also introduced the use of ratings into their Operating Model; they are an important element of their 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 2016/17.

Hull and East Yorkshire Hospitals NHS Trust has participated in any special reviews or investigations by the CQC during the reporting period. The review considered services for looked after children and safeguarding in Hull. The results of this review have not yet been published by the CQC. Following publication an appropriate action plan will be developed

if there are any areas for improvement noted for the Trust.

The Care Quality Commission rates Hull and East Yorkshire Hospitals NHS Trust as 'Requires Improvement' – June 2016

The Care Quality Commission (CQC) undertook a full comprehensive inspection between 28 June and 01st July 2016. The inspection covered all core services across all sites the Trust operates from including Hull Royal Infirmary, the Castle Hill Hospital and the minor injuries unit at the Beverley Community Hospital.

A breakdown of the Trust's ratings from the June 2016 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	Requires Improvement	Good	Requires Improvement	Requires Improvement
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	Requires Improvement	Good	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Intensive and Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity	Requires Improvement	Good	Good	Good*	Requires Improvement	Requires Improvement
Children and Young People	Requires Improvement	Good	Good	Good	Good	Good
Outpatients	Requires Improvement	Inspected but not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life Care	Good	Good	Good	Good	Good	Good
Overall for HRI	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Table 3 – Ratings for Castle Hill Hospital (CHH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Intensive and Critical Care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Outpatients	Requires Improvement	Inspected but not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life Care	Good	Good	Good	Good	Good	Good
Overall for CHH	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Areas for improvement

The Trust accepted all of the 32 recommendations made by the CQC following the inspection in June 2016. 22 of the recommendations were 'must do' actions and 10 were 'should do' actions. Areas of improvement included:

- Ensure that the planning and delivering care meets the national standards for A&E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits
- Review the process for categorising incidents, including safeguarding incidents, relating to children, to ensure effective investigation and lessons learnt
- Ensure that staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns
- Ensure learning from never events is further disseminated and lessons learnt are embedded.
- Ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness
- Ensure that staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services.
- Ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- Ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E.
- Ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.
- Ensure that records of the management of controlled drugs are accurately maintained and audited within A&E.
- Ensure the Trust continues to work actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services.
- Ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- Ensure that staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.
- Ensure antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement the Growth Assessment Protocol (GAP).
- Ensure the effective use and auditing of best practice guidance such as the "Five steps to safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts.
- Ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- Review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- Ensure outpatient services have timely and effective governance processes in place which identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
- Ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient and maternity services.
- Ensure that there are at all times sufficient numbers (including junior doctors) of suitability skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).
- Continue to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to

one care in labour.
- Take further steps to improve the facilities for young people on the 13th floor of HRI.

Good practice
Ares of outstanding practice were identified during the CQC inspection in June 2016 including:

- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The critical care teacher trainers had been shortlisted for a national nursing award and had been asked to write an article for a national nursing journal about their training courses.
- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health needs.
- Recreational co-ordinators had been introduced in medical elderly wards. Their role was to provide patients with activities and stimulation whilst in hospital.
- The responsiveness of the Specialist Palliative Care team (SPCT) in relation to acting on referrals. For example, we saw that the SPCT was prepared to see patients without having received a referral and 98% of patients referred to the team were seen within one working day.
- The bereavement initiative of providing cards for relatives to write messages to their loved ones
- The International Glaucoma Association had awarded the ophthalmology department an innovation award for their glaucoma monitoring work.
- Radiology at the trust was an exemplar site for the BSIR (British Society of Interventional Radiology) IQ programme for interventional radiology.
- The ultrasound department was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in threedimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit carried out vacuum assisted biopsies. This one-stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient and saving on resources.

Quality Improvement Plan

The Quality Improvement Plan (QIP) is a high level plan which defines the improvement goals the Trust is working towards. It is an overarching plan 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, 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 2016/17 and those that are linked to the pledges.
Key

Colour	Meaning
Green	Improvements achieved – objectives achieved and or project closed or re-open for 2017/18 with new objectives
Amber	Improvement made compared to last year. Project carried forward onto the 2017/18 plan for further monitoring
Red	No improvements made. Project carried forward onto the 2017/18 plan for further action and monitoring

Ref	QIP Project	Aim	Source	Status
QIP01	Risk and incident management	The aim of this project is to confirm that there are effective systems and processes in place to ensure incidents, serious incidents and risks managed both effectively and timely.	Sign up to safety and CQC	
QIP02	Learning Lessons	The aim of this project is to improve learning from Serious Incidents and Never Events so that the organisation understands the root causes that contributed to those incidents and what improvements have been made as a result. This should be visible through the implementation of sustainable changes and improvements	Sign up to safety and Quality Account	
QIP03	Staffing	The aim of this project is to ensure the Trust provides at least the minimum safe staffing levels at all times and to ensure continued compliance with the National Quality Board requirements for Safer Staffing (the 10 expectations)	CQC	
QIP04	Safeguarding	The aim of this project is to implement the new safeguarding care plan to further improve the documentation in relation to vulnerable adults and children and to improve the process for 1 to 1 patient watch and restraint.	CQC	
QIP05	Medication Safety	The aim of this project is to ensure a multi-disciplinary, person centred approach to ensuring patients receive the right medicines, the right dose and at the right time	Sign up to safety, Quality Account and CQC	
QIP06	Deteriorating Patient (Adult)	The aim of this project is to ensure early identification of a patient's deterioration, to identify which patients require end of life support and to ensure treatment and escalation plans and the end of life care plans are documented.	Sign up to safety and Quality Account	
QIP08	Infection Control	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)	CQC	
QIP09	Falls	The aim of this project is to build on the significant improvements made during 2015/16 by focusing on improving compliance with assessment documentation increasing education, awareness and lesson learnt and increasing the roll out of tested interventions.	Sign up to safety and Quality Account	
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 for every patient.	Sign up to safety and Quality Account	
QIP11	Maternity Services	The aim of this project is to address the immediate areas of improvement identified in the initial feedback from the CQC following the June 2016 comprehensive inspection.	CQC	
QIP12	Children and Young People with Mental Health Needs	The aim of this project is to the management of children and young people who have been admitted who are at risk of self-harm and suicidal intent.	CQC	
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	
QIP15	Sepsis	The aim of this project is to continue the implementation of the sepsis pathway across the organisation.	Quality Account and CQC Mortality Outlier Alerts	

QIP16	Resuscitation Equipment	This project will also ensure that further improvements are made on the completion of the daily and monthly resuscitation equipment trolley checks.	CQC	
QIP20	Duty of Candour	The aim of this project is to ensure the Duty of Candour process is embedded across the organisation and all incidents reported as moderate or above including those where the patient required a moderate increase in treatment, comply with the Duty of Candour requirements.	CQC	
QIP22	Nutrition and Hydration	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.	Sign up to safety, Quality Accounts and CQC	
QIP23	Dementia	The aim of this project is to provide safe, high quality, effective care for every person with dementia delivered as an integrated pathway across acute, primary and community care settings in line with the Royal College of Nursing SPACE principles of Dementia care.	CQUIN and CQC	
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	
QIP26	Health Records	The Trust is required to improve the content, storage and confidentiality of its patient's records. The aim of this project is to ensure the Trust has accurate and well maintained patient records, which are available at all times and to ensure patient's confidentiality is maintained.	CQC	
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. The project will also aim to improve the standard of information provided to our patients to ensure they are receive all of the relevant information and are able to make informed decisions.	Sign up to safety, Quality Account and CQC	
QIP29	Missed and Delayed Diagnosis	Missed and delayed diagnosis is the failure to diagnose a condition early enough to effect a cure or achieves maximum survival.	Sign up to safety, Quality Account and CQC	
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	
QIP31	Care for Older People	The aim of this project is to have better case management of the frail elderly person in conjunction with health care partners, particularly in relation to the emergency acute pathway.	Sign up to safety and Quality Account	
QIP32	Care for People with Mental Health Needs	The aim of this project is to develop mental health patient pathways in conjunction with partner organisations and agencies to ensure the needs of patients attending the Emergency Department with mental health needs are met.	Sign up to safety and Quality Account	
QIP33	Handover Arrangements	The aim of this project is to ensure that patients have management plans and EDD reviewed daily to ensure that progress to discharge is managed effectively.	Sign up to safety and Quality Account	
QIP34	Critical Care	The aim of this project is to ensure that the Critical Care Service provides high quality, fit for purpose facility.	CQC	

QIP35	Checklist Compliance	The aim of this project is to review the application, consistency and effectiveness of the checklist within the organisation, including WHO.	CQC	
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	

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 fortnightly 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 2016/17 Quality Improvement Plan were due to be improved by the end of March 2017. All improvement areas that achieved the improvement goals and targets were closed and signed off at the April 2017 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 36).

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 2017/18 Quality Improvement Plan. Further information on the 2017/18 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.

During 2016/17 the duty of candour processes were clarified and further embedded across the Trust, through additional support to clinical teams in undertaking the compliance provided by the Quality and Risk Teams.

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

Following the CQC comprehensive inspection in June 2016 the CQC did not highlight any areas of concern or non-compliance against the Duty of Candour requirements. The CQC reported that the Trust had included the Duty of Candour requirements into the relevant Trust policy, used an electronic incident reporting system (DATIX) and had raised staff awareness through Duty of Candour training. Staff understood their responsibilities and the requirements of Duty of Candour and the incidents reviewed by the CQC demonstrated that Duty of Candour was consistently applied. The Trust is compliant with CQC Regulation 20: Duty of Candour.

The Trust has an audit programme in place to monitor Duty of Candour compliance on a monthly basis through the DATIX incident reporting system. Compliance is reported to the Health Groups Governance Committee, Performance

Meetings and the Operational Quality Committee. Compliance on each stage of the duty of candour process has increased steadily throughout the year. This demonstrates that duty of candour is becoming embedded across the Trust.

Chart 1: Duty of Candour compliance rates April 2016 to March 2017

Data Quality

NHS number and general practice code validity

Hull and East Yorkshire Hospitals NHS Trust submitted records during 2016/17 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:

99.87% for admitted patient care;
99.95% for outpatient care; and
99.18% for accident and emergency care.

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

100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care.

Information Governance Toolkit

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

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

Hull and East Yorkshire Hospitals NHS Trust's Information Governance Assessment Report overall score for 2016/17 was 71%. Thirteen standards were reaching Level 2 and above, but further evidence was required for two standards. Action plans are in place for all of these.

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

Clinical Coding Error Rate

Hull and East Yorkshire Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission. The recommendations below are drawn from the internal specialty audits performed during 2015/16. The following information provides an update on the implementation of the recommendations.

Recommendation	Priority	Progress Update	Status
R1 - Engagement should be encouraged with clinicians across all specialties with examples of good coding and bad coding to highlight where any problems are occurring and why, and the impact this has coding outcomes	High	Concentrate on surgical specialties and increasing the number of coding validation sessions being done. The number of validation sessions has remained steady however more clinicians are keen to assist and be contacted on an ad hoc basis.	Ongoing
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	Casenote 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.	Ongoing
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.	Ongoing
R7 – Ensure coders are maintaining standards and receive regular audit feedback	Medium	Regular feedback post audit	Ongoing
R8 – Histology results should be checked in a timely fashion.	Medium	Encouraged to make better use of daily histology report.	Continue to monitor
R9 - Adjust proforma in preparation for HRG4+	Medium		Ongoing

Part 5: Looking forward – our plans for the future

This section includes:

- Information on how the Trust consulted on the 2017/18 quality and safety improvement 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 for escalation and/or assurance

Our Plans for the Future – Consultation

For 2017/18 the Trust has put together a long list of potential quality improvement priorities by:

- Evaluating our performance against our quality and safety priorities for 2016/17
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2016/17
- Inclusion of the Trust's three main priorities for 2016/17 as detailed in the Operational Plan for 2016/17
- 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 2017/18 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 2016/17 Quality Account and to consult on the 2017/18 priorities. This year 91 people completed the online survey in February 2017.
- Relevant committees were also asked for their comments and ideas:
    - Health Group Governance Committees for their suggestions on what priorities should be consulted on and whether any local clinical priorities should be included
    - Operational Quality Committee for consultation on all priorities and approval of the 2017/18 priorities
    - Quality Committee for approval of the 2017/18 priorities
    - Trust Board for ratification of the 2017/18 priorities

The Trust has identified these quality improvement priorities for 2017/18 because they are important to our staff, patients and stakeholders:

Quality and Safety Improvement Priorities for 2017/18

1. Avoidable Hospital Acquired Infections
2. Avoidable Hospital Acquired Pressure Ulcers
3. Nutrition and Hydration
4. Venous Thromboembolism (VTE)
5. Avoidable Patient Falls
6. Medication Safety
7. Deteriorating Patient
8. Sepsis
9. Resuscitation Equipment and Checklists Compliance
10. Compliance with National Standards for Interventional Procedure Checklists
11. Avoidable Mortality
12. Learning Lessons

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

1. Avoidable Hospital Acquired Infections

What do we want to achieve?

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.

How will we measure this priority?

- 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

How will we monitor and report on progress?

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

2. Avoidable Hospital Acquired Pressure ulcers

What do we want to achieve?

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.

How will we measure this priority?

- 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

How will we monitor and report on progress?

This project will be monitored via the Wound Management Committee with leadership from Tissue Viability Team.

3. Nutrition and Hydration

What do we want to achieve?

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.

How will we measure this priority?

- 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

How will we monitor and report on progress?

This project will be monitored via the Nutrition Steering Group Committee with leadership from the Senior Nursing Team, Surgery Health Group and Head of Dietetics.

4. VTE

What do we want to achieve?

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.

How will we measure this priority?

- 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

How will we monitor and report on progress?

This project will be monitored by the Thrombosis Committee with leadership from the Deputy Medical Director for the Surgery Health Group.

5. Avoidable Patient Falls

What do we want to achieve?

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.

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
- 50% of clinical staff to have completed the falls prevention e-learning by the end of March 2018

How will we monitor and report on progress?

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

6. Medication Safety

What do we want to achieve?

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.

How will we measure this priority?

- Achieve reconciliation of medicines on admissions to hospitals for 70% of our patients within 24 hrs
- 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

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.

7. Deteriorating Patient

What do we want to achieve?

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.

How will we measure this priority?

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

How will we monitor and report on progress?

The project will be monitored by the Operational Quality Committee with leadership from the Deputy Chief Medical Officer.

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

Better Outcomes (Effective, Safe and Caring)

1. 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 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.

How will we measure this priority?

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

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. Resuscitation Equipment and Checklists Compliance

What do we want to achieve?

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

How will we measure this priority?

- Achieve 95% compliance with the completion of the daily resuscitation equipment checks
- Achieve 95% compliance with the completion of the monthly resuscitation equipment checks

It has been agreed that there will not be any performance targets in relation to compliance with the NatSSIPs project until the project is embedded within the Trust. Baseline data will be gathered once the project is established at the end of 2017/18.

How will we monitor and report on progress?

This project will be monitored through the Resuscitation Committee with leadership from the Resuscitation Manager.

The project will be monitored by the Senior Nursing Team with leadership from the Nurse Director for the Surgery Health Group and the Resuscitation Manager.

3. Compliance with National Standards for Interventional Procedure Checklists

What do we want to achieve?

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).

How will we measure this priority?

- Achieve full implementation of the improvement project

How will we monitor and report on progress?

The project will be monitored by the Senior Nursing Team with leadership from the Nurse Director for the Surgery Health Group.

4. 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?

- 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.

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.

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

Improved Experience (Caring, Responsive and Well-led)

1. Learning Lessons

What do we want to achieve?

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

How will we measure this priority?

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

How will we monitor and report on progress?

This project will be monitored through the Operational Quality Committee with leadership from the Risk Manager.

2. 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?

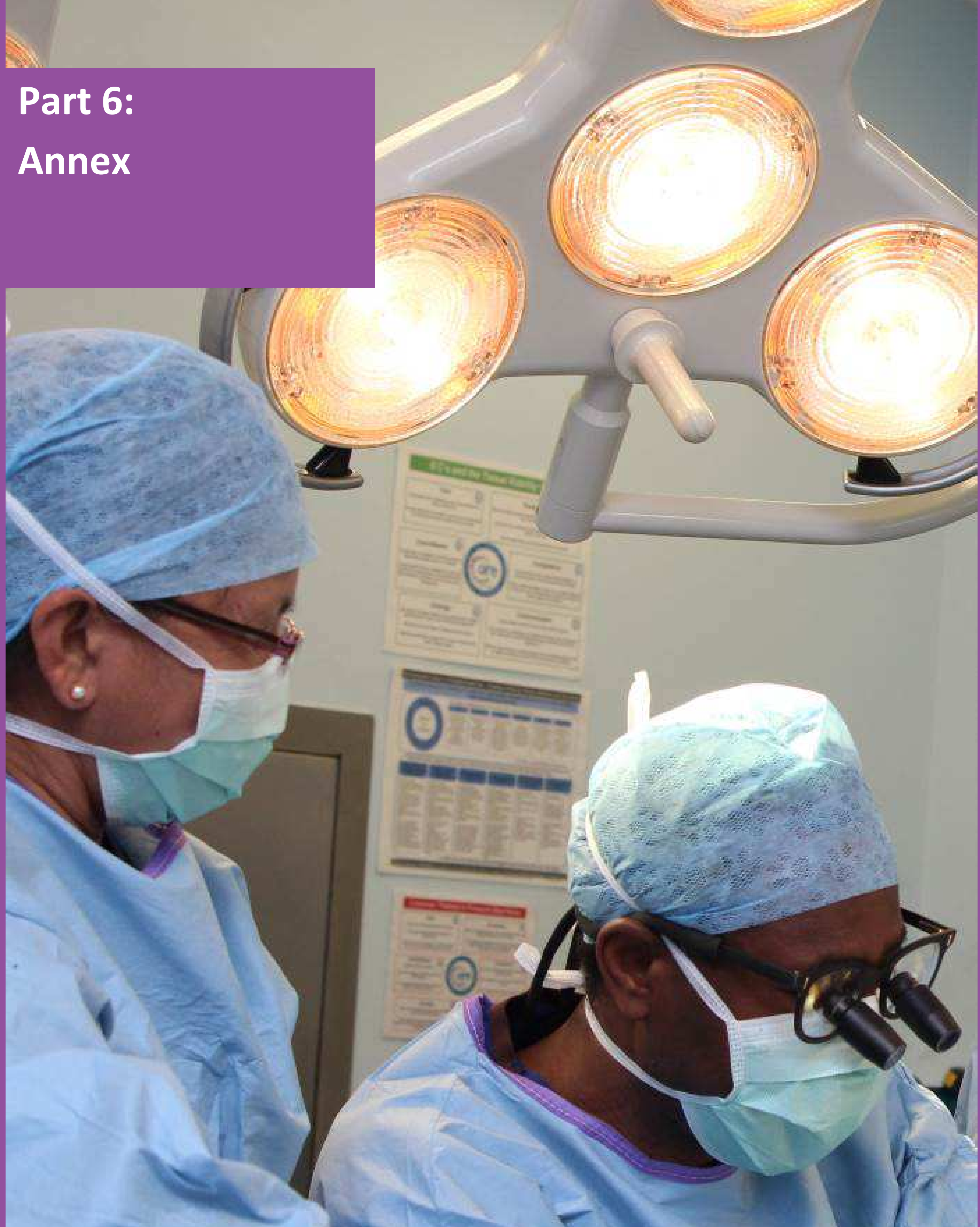
- Achieve 85% of formal complaints closed within the 40 day target and actions recorded where appropriate

How will we monitor and report on progress?

This project will be monitored by the Patient Engagement and Experience Forum with leadership from the Deputy Director of Quality Governance and Assurance/ Assistant Chief Nurse.

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

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 first draft of the Trust's 2016/17 Quality Account was forwarded to key stakeholders on the 03 May 2017 with a request for statements of no more than 500 words to be received before the 01 June 2017. The key stakeholders are:

- NHS Hull Clinical Commissioning Group
- 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

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

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

The Local Healthwatch and the Overview and Scrutiny Committees were asked to consider:
- Whether the Quality Account is representative
- Whether is gives a comprehensive coverage of the provider's services
- Whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to the Quality Account

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

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

NHS Hull and NHS East Riding of Yorkshire Clinical Commissioning Groups welcome the opportunity to review and comment on the Hull and East Yorkshire Hospitals NHS Trust Quality Accounts for 2016/17. The report illustrates a focus on improving the quality of patient care in 2016/17 and the actions taken.

We are pleased to see the improvements around patient safety, which includes medicine reconciliation and the work around avoidable hospital acquired pressure ulcers. We note the medicine reconciliation on admission to hospital within 24 hours has not been achieved but we are assured to see the actions being taken to address this, including the recruitment of additional staff and the ward medicines management reviews.

The Trust has undertaken a significant amount of work to standardise mortality reviews ensuring robust systems and processes are in place. The Trust is working with commissioners to progress this in line with the National Quality Board Learning from Deaths Guidance. It is acknowledged that this has been highlighted by the Trust as a key priority for 2017/18. However, it is disappointing to see that the work to better case manage the frail elderly person did not meet its

target for 2016/17, however the Trust has acknowledged the limitations and are pursuing further work to introduce frailty screening and rapid access clinics.

We are pleased to note that the ''missed and delayed diagnosis'' has been identified as a priority for 2017/18 as we remain concerned with this element from the information we have received from Serious Incidents.

It is encouraging to see the continued good work in relation to reporting of incidents including the learning. We note the reduction in the number of never events and on the numbers of recurrent serious incidents. The introduction of learning groups and improved communication has focused the trust's attention on embedding the learning.

We note the year on year improvements in Friends and Family Test for Accident and Emergency and the further work planned for 2017/18.

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

The CQC inspection conducted in June 2016 is acknowledged within the report. The commissioners note the vast amount of work undertaken by the Trust in response to the inspection and the subsequent quality improvement plan to address the areas deemed as requiring improvement. The commissioners look forward to working with the Trust to ensure the actions are taken forward. We were pleased to see the acknowledgment of the "good" rating in relation to end of life care.

Finally, we confirm that to the best of our knowledge, the information contained in the report is accurate against which has been shared with commissioners on quality of care.

The commissioners remain committed to working with the Trust and its regulators to improve the quality of services available for our population and look forward to working with the Trust to continue to deliver better outcomes for all of our patients.

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

Whilst there remain some areas for improvement, the Trust appears to be well on the way to identifying where improvements can be made, and working on ways to do so. The Trust appears to be taking the recommendations made in the latest CQC report very seriously, and has developed a strategy to make good on the recommendations made.

It is encouraging to see that strides have been made to treat patients who present at hospital with mental and physical health co-morbidities jointly, rather than separately. According to Healthwatch Kingston upon Hull's 'Your View Counts' survey (2017), Mental Health provision is one of the main areas of interest/concern for local people.

The Quality Account is relatively easy to read, and there is ample evidence that a concerted effort has been made to involve patients and members of the public in the decisions being made about the design of future services. In an ever

changing world, continuing communication with patients and service users is vital to understanding which service areas need to be adapted or improved, to make sure they continue to be fit for purpose.

Healthwatch East Riding of Yorkshire

Healthwatch East Riding of Yorkshire (HWERY) are enthused by the continued commitment to service improvement by HEYHT. Service provision and range of provision does appear to be a priority moving forward and is reflected in the report. Healthwatch East Riding of Yorkshire will work alongside HEYHT to make sure that the public have a voice regarding service provision and improvement.

Hull City Council Overview and Scrutiny Committee

No statement was received for the 2016/17 Quality Accounts.

East Riding of Yorkshire Overview and Scrutiny Committee

Hull and East Yorkshire Hospitals NHS Trust has engaged with the Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee throughout its work programme 2016/17 and will continue its joint scrutiny alongside Hull City Council's Health and Social Well-Being Commission during 2017/18.

The Draft Quality Accounts are set out in a clear and easy to understand format, with the progress made against previous year priorities clear to see. The Sub-Committee welcome the transparency of the Draft Quality Accounts, with the relevant evidence and data provided to support the outcomes. It is disappointing, however, to see that a large majority of the 2016/17 priorities have not been met. In particular, the Sub-Committee feel that, whilst none of the markers for the priority 'Care for Older People' have been met during 2016/17, this should be continued as a priority for 2017/18. The Sub-Committee do, however, congratulate the Trust on its improvements made in diagnosing and treating sepsis during 2016/17.

The Sub-Committee welcome the majority of the priorities set for 2017/18, particularly the continuing education and increasing awareness amongst staff within the Trust around sepsis and the management of patients with sepsis. The Sub-Committee does, however, feel that the priority 'Checklists' does not bear the same weighting as the other priorities and that the 2016/17 priority 'Care for Older People' should instead take its place as it feels this is an important area that warrants further improvement by the Trust.

It is hoped that the improvements made since the latest CQC inspection continue to be sustained and that further improvements can be made in order for the Trust to aspire to achieving a 'Good' rating in its next inspection.

Trust Response to the Statements

The Trust would like to thank all stakeholders for their comments on the 2016/17 Quality Account. We are pleased that the statements from our stakeholders demonstrate the collaborative commitment we share in improving the quality of services we provide and the outcomes for our patients and that stakeholders are in agreement that the quality and safety improvement priorities for 2017/18 are the right ones.

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

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

East Riding of Yorkshire Council Overview and Scrutiny Committee	
In particular, the Sub-Committee feel that, whilst none of the markers for the priority 'Care for Older People' have been met during 2016/17, this should be continued as a priority for 2017/18.	The Trust is assured by the systems and processes implemented and the improvement work undertaken during 2016/17 for the 'Care for Older People'. Following consultation with staff, stakeholders and patients, this was also not identified as a priority for improvement for 2017/18. As noted on page 31, there will however be further improvement work undertaken through the existing monitoring arrangements in place within the Medicine Health Group rather than through a 'quality improvement project'.
The Sub-Committee does, however, feel that the priority 'Checklists' does not bear the same weighting as the other priorities and that the 2016/17 priority 'Care for Older People' should instead take its place as it feels this is an important area that warrants further improvement by the Trust.	The 'Checklist' priority for improvement was included as a priority for 2017/18 because the Trust was not achieving compliance against the completion of the WHO checklist and the completion of the resuscitation equipment checks. These issues were also identified by the CQC as an area for improvement and were reported as compliance actions which led to breaches in regulations. The Trust therefore decided to place more of a focus on these areas and agreed that they would be priorities for improvement during 2017/18. The aim of this improvement work is to improve the completion of the relevant checks, improve compliance and to remove the breaches in regulations. As a result of this the Trust also decided to split the 'Checklists' priority into two. These are now included as 'Resuscitation Equipment and Checklists Compliance' and 'Compliance with National Standards for Interventional Procedural Checklists'. More information on these projects can be found on page 82.

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

26.06.17 ....Chair

26.06.17 ....Chief Executive

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required 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 2017 ("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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

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

Respective responsibilities of the Directors and the auditor

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the 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 ("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 to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- joint feedback from the Hull and East Riding Commissioners dated 02/6/2017;

- feedback from Local Healthwatch groups dated 02/06/2017;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the latest national patient survey for 2016 dated 31/05/2017;
- the latest national staff survey for 2016 dated 07/03/2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated March 2017;
- the annual governance statement dated 25/05/2017; and
- the Care Quality Commission's Quality Report dated 15/02/2017.

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

This report, including the conclusion, is made solely to the Board of Directors of 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 save 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;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to 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 which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 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.

KPMG LLP

KPMG LLP
Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds LS1 4DA

26 June 2017

Abbreviations and definitions

3G Audit	All wards in the Trust are audited by the 3G (Great Ward, Great Staff, Great Care) assessment process. The 3G audits assess all wards against a number of quality and safety standards
AAU	Acute Assessment Unit
AKI	Acute Kidney Injury
Aria	An electronic prescribing system
Care Bundle	Care bundles help us to deliver safe and reliable care. They are research based actions for delivering care to certain patients. They are designed to ensure we deliver safe and reliable care to our patients at a certain point in their care e.g. on discharging, prescribing antibiotics, and preventing certain infections
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
COPD	Chronic obstructive pulmonary disease - 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
CQC	Care Quality Commission – the organisation that regulates and monitors the Trust's standards of quality and safety
CQUIN	Commissioning for Quality & Innovation – 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
Deteriorating Patient	A patient whose observations indicate that their condition is getting worse
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
e-Learning Package	A training programme that individuals or groups can complete online
ED	Emergency Department
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
Hospital Episode Statistics (HES)	HES is a data warehouse containing details of all admissions into NHS hospitals in England
HRI	Hull Royal Infirmary Hospital
HSCIC	Health & Social Care Information Centre
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
Medication Errors	An incorrect or wrongful administration of a medication, e.g. a mistake in the dosage of medication
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
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'
NEWS	The National Early Warning Score has been developed to provide a single, standardised early warning system across the NHS which should help to identify patients most at risk and enable their care to be escalated appropriately in order to prevent further deterioration and possible respiratory or cardiopulmonary arrest.
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 Hull CCG	NHS Hull Clinical Commissioning Group
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
Outliers	Patients who have been in the wrong speciality bed, for a non-clinical reason. For example, a Medial Elderly patient on a Gynaecology ward.

PaCT	Professionalism and Culture Transformation
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
PAWS	Paediatric Advanced Warning Score. An early warning scoring system for the initial assessment of children in the emergency department
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
Quality Account	The Quality Account is a report based upon the quality of the service provided and is used to highlight key areas to the local communities and stakeholders
QIP	Quality Improvement Plan
RAMI	Risk Adjusted Mortality Indicator
Root Cause Analysis	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
Skin Care Bundle	The SKIN bundle must be applied/used in conjunction with the Pressure Ulcer Prevention and/or Pressure Ulcer Treatment Care Plan for every patient who is assessed as at risk from pressure ulceration or has existing damage.
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.
TBC	To Be Confirmed
Trust Board	The Trust's Board of Directors, made up of Executive and Non-Executive Directors
Vital Signs	Vital signs are measures of various physiological statistics and are an essential part of care. Vital signs are normally the recording of body temperature, pulse rate (or heart rate), blood pressure, and respiratory rate
VTE	Venous Thromboembolism – a blood clot within a vein

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:

The Compliance Team
Quality Governance and Assurance Department
Suite 19
Castle Hill Hospital
Cottingham
HU16 5JQ