



Great Staff - Great Care - Great Future

**Quality Account
2015/16**

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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 30th June 2016. 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 2015/16 Quality Account please contact:
The Compliance Team on 01482 605271 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 2015/16

Statement on Quality from the Chief Executive

Welcome to Hull and East Yorkshire Hospitals NHS Trust's 2015/16 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 2016/17. 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 67 to 73) we set out the quality and safety improvement priorities for 2016/17. 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)

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

Better Outcomes (Clinical Effectiveness)

- Sepsis
- Missed and Delayed Diagnosis
- Avoidable Mortality
- Care for Older People
- Care for People with Mental Health needs
- Handover Arrangements

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 75 to 77). We welcome involvement and engagement from all staff and stakeholders because their comments help us acknowledge achievements made and identify further improvements to be made.







I can confirm that the Board of Directors has reviewed the 2015/16 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 2015/16 – Celebrating Success

The following table provides an overview of our successes during 2015/16. Some of the year’s highlights include:

April 2015	<p>New Emergency Department Hull Royal Infirmary opened the doors to its new Emergency Department. The new facility allows staff to treat patients in state of the art facilities. This was the culmination of seven years’ of design, development and construction work, and at a total cost of some £12 million.</p>	
	<p>Be clear on cancer As part of Bowel Cancer Awareness Month, Sally Wood and her colleagues from the screening team hosted an information stand in St Stephen’s Shopping Centre, Hull. Members of the public were met by friendly faces, along with information on bowel cancer and the national screening programme, and advice on how to reduce your risk of developing the disease.</p>	
May 2015	<p>Clinical research: Help shape the future of healthcare Wednesday 20th May marked the International Clinical Trials Day, when both academics and health professionals in East Yorkshire celebrated years of research and raising awareness of the importance of clinical trials. Hull and East Yorkshire Hospitals NHS Trust has an excellent record for recruiting people into clinical research, with around 4,000 participants recruited to National Institute Health Research (NIHR) studies each year.</p>	
June 2015	<p>International recognition for Haemophilia Centre The Haemophilia Centre, based within the Queen’s Centre for Oncology and Haematology at Castle Hill Hospital, was awarded ‘European Haemophilia Treatment Centre’ status by the European Haemophilia Network. More than 300 people with acquired or inherited bleeding disorders, including Haemophilia, are currently under the care of the Haemophilia Centre’s 10-strong team.</p>	
	<p>Diaries help special care babies keep in touch Having a baby who needs intensive care from day one can be agonising for the parents, but it can also be a confusing time for younger siblings who were expecting a new brother or sister to take home and take care of. To help reassure families and keep them in touch, the Neonatal Intensive Care Unit team created a short ‘diary style’ booklet for each family, telling them what baby has been up to and what’s been happening each day. The team also put baby’s hand and footprints in the booklet.</p>	
	<p>New IT system installed to improve care for patients In June 2015, Hull and East Yorkshire Hospitals NHS Trust introduced a new IT system, called Lorenzo. This is an electronic system for patient records. It has been an enormous task to prepare staff to use the new software and to ensure it ‘talks’ to the other clinical systems.</p>	

<p>August 2015</p>	<p>Celebrating our staff – recognition for long service More than 30 members of hospital staff who have collectively served more than 900 years in the NHS were celebrated at a special ceremony. Staff from departments as diverse as Portering, Pharmacy, Intensive Care and Accounts were each recognised for their long service of 25 years or more. Stealing the limelight, however, was Jean Walker, who has recently retired after spending 56 years in the NHS. Jean started as a Buttercup (cadet nurse) in 1959, working on the children’s wards at the old Princess Royal Hospital, but spent the majority of her career as a staff nurse within Hull Royal Infirmary’s Emergency Department.</p>	
	<p>Thank you for saving my husband’s life The mother of a one-year-old and a four-year-old from East Yorkshire thanked hospital staff for saving her husband’s life and keeping her family together. Gill Osgerby was told four times to expect the worst after her husband, Will, contracted pneumonia and Streptococcus A skin infection which sent his body septic. He experienced multiple organ failure, spending three weeks unconscious in intensive care. Will spent a total of seven weeks in hospital between April and June this year, both at Hull Royal Infirmary and Castle Hill Hospital in Cottingham. He returned home and continued his recovery. Gill wants to use her very unique experience to help others who find themselves in a similar position.</p>	
<p>September 2015</p>	<p>Full of life In September 2015 health professionals from Hull and East Yorkshire Hospitals NHS Trust contributed to a week-long programme of events designed to increase awareness of older people’s issues and celebrate the contribution they make to our community. Older People’s Week in Hull incorporated UK Older People’s Day on Thursday 1st October. It was kicked off with a presentation on dementia care from Consultant in Elderly Care, Dr Dan Harman. The talk covered various aspects of hospital-based dementia care, including recent moves to bring older people’s services together in one place, and efforts to improve the experience of patients with dementia during their stay in hospital.</p>	
<p>September 2015</p>	<p>Pilot scheme launched to help reduce stillbirth Pregnant women in Hull and East Yorkshire were amongst the first in the country to benefit from a new project aimed at reducing the number of UK stillbirths. Pregnancy charity, the MAMA Academy, chose Hull and East Yorkshire Hospitals NHS Trust as one of just 16 organisations across the country to receive free Wellbeing Wallets to give to women receiving antenatal care. Each Wellbeing Wallet will be used by pregnant women to store their handheld antenatal notes, which they are expected to keep with them as their pregnancy progresses. Crucially, however, the wallets provide information and advice on the health of mum and baby, including when and how to monitor baby’s movements, foods to avoid, and suggestions for staying active during pregnancy.</p>	
<p>October 2015</p>	<p>Anglers donate to help poorly children A group of 12 bus drivers with a keen interest in angling raised £400 to help care for poorly children. Bus driver, Garry Barwick, said: “We are a bunch of mates who enjoy fishing, so we formed our club 16 years ago to add a little friendly rivalry to our sport. We have a competition every year to raise funds for local charities, and this year we chose the Children’s Emergency Department at Hull Royal Infirmary”.</p>	

<p>November 2015</p>	<p>Hospital staff gear up to help the homeless Hospital staff collected items to help the homeless in memory of a much loved colleague. Former Hull Royal Infirmary Stroke Coordinator, Dyson Stubbins, was a keen supporter of homeless charities until he sadly, and unexpectedly, passed away in July 2015. In his memory, and to help the scores of local people who find themselves without a roof over their heads, staff supported Humbercare’s Winter Shoebox Appeal. Members of the public and hospital employees donated shoe boxes filled with goods such as toiletries and sweets to help make life that little bit more comfortable.</p>	
	<p>Project tackles issues affecting older people’s well-being More than 800 older people signed up to a project which aims to improve health and reduce isolation in the space of just eight weeks. Patients aged 75 or over who are registered with Manor House Surgery, Practice 2 Medical Centre, and Dr Harris & Partners (Practice 3) in Bridlington took part in the EASYcare Pathfinder Project. The project aims to identify needs or concerns affecting older people which may not necessarily be medical, but which may impact on their overall health and well-being.</p>	
<p>December 2015</p>	<p>Allam Robotics Centre helps almost 100 patients in under a year In December 2014, Dr Allam announced that he would be personally donating £1.4 million to bring the new Da Vinci Robotic Surgery System to Castle Hill Hospital in Cottingham and enable patients to benefit from ‘state of the art’ minimal invasive surgery undertaken locally. The Da Vinci robot cuts tissue in the same way as a surgeon would when carrying out open surgery and replicates the range of movements of a surgeon’s hand. But unlike open surgery, the robot does this through tiny holes, a technique known as minimally invasive surgery. By the end of March 2016, over 100 people had benefited from this potentially life-saving surgery, thanks to the generosity of Dr Assem Allam and his family.</p>	
	<p>“Be A Hero” campaign launched to save more lives in Hull and East Yorkshire People across Hull and East Yorkshire were encouraged to get on board with a life-saving campaign during the “Be A Hero Campaign.” Hull and East Yorkshire Hospitals NHS Trust launched the campaign to raise awareness of the number of people waiting for transplants in the region and encouraged more people to sign the donor register.</p>	
<p>January 2016</p>	<p>All hands on deck! Hull and East Yorkshire Hospitals NHS Trust’s Patient Experience Team launched the ‘Hands on Deck’ programme, after being inundated with offers of help. Under the Hands on Deck programme, staff gave up either their own time or, with their line manager’s permission, up to an hour of their working day, to assist in the areas which are under most pressure. One of the areas which benefited was the Oncology department. The ‘winter pressures ward’ also benefitted from the programme, which opened to create extra bed capacity.</p>	
<p>March 2016</p>	<p>Apprenticeship awards celebrate local hospitals’ rising stars Staff at Hull and East Yorkshire Hospitals NHS Trust celebrated after receiving five award nominations for work to develop local apprenticeships. Alex Bampton, won the ‘Intermediate Non Clinical Apprentice of the Year’, Jamiee-Leigh Lister was the “Advanced Non-Clinical Apprentice of the Year” and HEY and HYA Training won “Partnership of the Yea” at the Health Education Yorkshire and the Humber ‘Talent for Care’ Awards on Friday 18th March.</p>	

National Apprenticeship Week: Hull mortuary worker to be recognised at Ministerial event in London

Jordan Burn, a Trainee Anatomical Pathology Technologist (ATP) with Hull and East Yorkshire Hospitals NHS Trust, was the country's first Mortuary Apprentice, and is one of just a handful of people invited to London to attend the special event. Jordan was recognised by Ministers as part of the National Apprentice Week celebrations.



All eyes on Hull as ophthalmic unit is judged number one by its patients, and international charity agrees

An international award arrived in the Ophthalmic Unit after local people under the care of Hull and East Yorkshire Eye Hospital showed their support for the service. The International Glaucoma Association (IGA) launched its search for the 'ophthalmic unit most appreciated by patients for quality of service' back in late 2015. Members of the Hull and East Riding Glaucoma Group responded by nominating Hull Royal Infirmary's Ophthalmic Unit for the IGA 'Ophthalmic Unit of the Year 2015/16' award. The unit has been recognised not only for its clinical skill and expertise, but also for the all-round support it offers to patients who are vulnerable to sight loss or impairments. Over the past decade, the unit has increased its capacity and has been leading the way in terms of treatment, by using some of the latest surgical and laser techniques. A new technique has even been named after the city, and the unit now boasts a dedicated team of staff who, in the words of one patient, "don't just go the extra mile, they run a marathon".



Part 2: Review of our Quality Achievements



This section includes:

- An overview of the 2015/16 Quality and Safety improvement priorities
- A detailed update on the performance, achievements and further improvements against the 2015/16 priorities

Overview of 2015/16 – Performance against Priorities

The following table provides an overview of performance against all targets during 2015/16. We recognise that not all of our quality and safety improvement priorities for 2015/16 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 2016/17.

Key

✓ Goal achieved

✗↑ Goal not achieved but performance improving

✗↓ Goal not achieved

✗↔ Goal not achieved, performance remained the same

* These targets do not have a status because the data was collected during 2015/16 to establish the baselines for monitoring during 2016/17.

Quality and Safety Improvement Priority	Target	Status
Medication Safety	Achieve reconciliation of medicines on admissions to hospitals for 85% of our patients at any time	✗↑
	Achieve 75% reconciliation of medicines on admissions to hospital for our patients within 24 hours	✗↑
	Reduce the number of patients who have missed a dose of the high risk medicine: anticoagulants by 20% by March 2017	*
	Reduce the number of patients who have missed a dose of the high risk medicine: opioids by 20% by March 2017	*
	Reduce the number of patients who have missed a dose of the high risk medicine: anti-infectives by 20% by March 2017	*
	Reduce the number of patients who have missed a dose of the high risk medicine: insulin by 20% by March 2017	*
	Implementation of Aria electronic prescribing for 80% of chemotherapy prescriptions	✗↑
Deteriorating Patient – Adult	Evaluate the pilot of Electronic Observations (E-OBS)	✓
	Achieve 95% compliance with the completion of observations (NEWS) and actioned appropriately	✓
	Achieve 80% correct completion of the DNACPR orders on the documentation of discussions with the patient and/or their relatives including best interest discussions	✓
Deteriorating Patient - Children	Infant mortality (NHS Outcomes Framework Indicator) – Achieve the value of 3.8 or below, per 1,000 births	✓
	Achieve 95% compliance with the completion of Paediatric Advanced Warning Score (PAWS)	✗↑
VTE	Maintain 95% compliance with the VTE Risk Assessment	✗**
	No VTE Serious Incidents	✓
Nutrition and Hydration	Achieve >89% completion rate of food charts as measured by the 3G audits	✗↑
	Identify and introduce a hydration assessment process	✓
Falls	Deliver the falls action plan	✓
	Reduce by 25% the number of avoidable patient falls per 1000 bed days	✗↑
	Reduce by 40% the number of avoidable falls rated moderate incident and above	✓
	Falls with harm below England average	✓
Avoidable Pressure Ulcers	Reduce the number of Serious Incidents resulting in fractured neck of femur or other injury	✓
	To have no avoidable Hospital acquired pressure ulcers – Grade 3	✗↑
	To have no avoidable Hospital acquired pressure ulcers – Grade 4	✗↓

	Reduce the number of avoidable Hospital acquired pressure ulcers (Stage 2 and above)	✓
	To have no avoidable Hospital acquired pressure ulcers – unstageable	✗↑
	Achieve 95% compliance with the implementation of the Skin Care Bundle (taken from HEY Safer Care audit)	✓
Sepsis	Audit the implementation of the Sepsis Six bundle in AAU and ED to ensure compliance – completion of the audit	✓
	Percentage correctly screened – improve from baseline	✓
Missed & Delayed Diagnosis	Reduce to <=1% of patients waiting over 6 weeks for diagnostic test	✓
	Reduce the number of missed and delayed diagnosis Serious Incidents	✗↓
Acute Medical Pathway	Reduce the number of medical outliers	✓
	Reduce the number of avoidable in-patient transfers – patients who are moved 2 or more times	✓
	Improve patient length of stay	✗ ↔
Learning Lessons	Conduct a review of the Serious Incident process and implement changes	✓
	Never Events – to have no repeat Never Events	✗↑
	Reduce the number of overdue Serious Incident actions	✓
	Reduce the number of overdue Serious Incident investigations	✓
	Reduction in the severity of incidents reported	✓
	Serious Incidents discussed at Health Group Governance meetings	✓
	Monthly summary of completed Serious Incidents circulated by Risk team	✓
Patient Experience – listening to patients and acting on their feedback	90% of formal complaints to be closed within 40 days and actions recorded where appropriate	✗↑
	To increase the number of volunteer recruits in the Trust, to benefit patients in clinical areas to 350 volunteers	✓
	Achieve 95% of patients who would recommend the Trust to their friends or family	✗↑

** The performance position is reflective of data capture issues between the paper system and the electronic system, Lorenzo. Information from the safety thermometer monthly audit demonstrates that performance is better than recorded on Lorenzo.

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 2015/16:

The aims of the medication safety priority were to improve the following:

- To provide a multi-disciplinary, person-centred approach to ensuring our patients receive the right medicines, 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 within 24 hours of admission (process to ensure the medications patients are taking while at home are received in hospital along with any other medications that may be prescribed during admission). This will remove the potential for harm and the delivery of a safe and effective medication process for our patients.
- 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 implement Aria electronic prescribing for 80% of chemotherapy prescriptions
- To improve the storage, security, recording and administration of medicines on Medical wards
- To ensure controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within the Emergency Department and Children Services
- Record and monitor daily temperatures of fridges used for storage of medicines within the Emergency Department

Actual outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Achieve reconciliation of medicines on admissions to hospitals for 85% of our patients at any one time	70%	78.6%	✗↑
Achieve 75% reconciliation of medicines on admissions to hospital for our patients within 24 hrs	35%	41%	✗↑
Reduce the number of patients who have missed a dose of the high risk medicine: anticoagulants by 20% by March 2017	Not collected – baselines established in 2015/16	51 (0.48%) patients missed a dose	*
Reduce the number of patients who have missed a dose of the high risk medicine: opioids by 20% by March 2017		17 (0.16%) patients missed a dose	*
Reduce the number of patients who have missed a dose of the high risk medicine: anti-infectives by 20% by March 2017		57 (0.53%) patients missed a dose	*
Reduce the number of patients who have missed a dose of the high risk medicine: insulin by 20% by March 2017		15 (0.14%) patients missed a dose	*
Implementation of Aria electronic prescribing for 80% of chemotherapy prescriptions		64.9%	✗↑

*These targets do not have a status because the data was collected during 2015/16 to establish the baselines for monitoring during 2016/17.

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

Improvements achieved:

- Recruitment into the Pharmacy Service to further improve the Pharmacy support across the organisation included an additional 5 Pharmacists and 3 Technicians
- Communication campaigns undertaken to launch and raise awareness of the revised Drug Policy and to improve the storage and administration of medicines and the management of controlled drugs across the organisation

- Pharmacy support has increased to the Family and Women's Health Group improving the clinical service provided to this area
- Paediatrics and the Emergency Department were identified for particular focus to improve the management of controlled drugs. Improvement work has been undertaken by increasing Pharmacy support
- Pharmacy technicians provided more regular monitoring of the management of controlled drugs and worked with ward staff to improve documentation. Improvements have been demonstrated in Paediatrics and monitoring has returned to 6 monthly
- Pharmacy safety briefings were implemented. Each morning, all pharmacy staff meet in the dispensary for a safety briefing led by a different member of staff every day. These briefings cover all aspects of daily operational work, and include feedback to staff from Trust strategic command and relevant Trust meetings so staff are aware of ongoing activity. There is also a daily clinical briefing for pharmacists and medicines management technicians so that resources can be directed to support patient safety and experience, including medicines reconciliation and discharge planning
- An online prescribing assessment module for Foundation Year 1 (FY1) doctors was implemented to ensure all junior doctors were competent in prescribing. It provides additional training if a Junior Doctor requires further awareness and refresher training
- Pharmacy assisted drug administration rounds were piloted between September 2015 and March 2016 to gather information on how pharmacy can assist the medication rounds on the wards and identify which interventions can be made to improve medication safety. Pharmacists identified where they were able to have a positive impact on the medication rounds going forward and also challenged a number of administration practices, improving the safety and effectiveness of the process for the patients
- Electronic-prescribing on Lorenzo has been developed with a successful pilot on discharge for cardiology patients
- Internal Pharmacy medicines management inspection process was revised. These inspections are undertaken to look at all aspects of medicines management on a ward and the resulting report is sent to the charge nurse and then to the health group governance meeting to agree actions required and monitor progress
- 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, one of which is a medicine management standard. Between April 2015 and March 2016 54 wards have been assessed against the medicine management standards; 4 wards were rated as outstanding, 14 wards were rated as good, 32 wards were rated as requires improvement and 4 wards were rated as inadequate. The wards which were rated as requires improvement and inadequate developed an action plan to address the areas for improvement and will be re-assessed during 2016/17

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 2016/17 (see page 68) 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 60.

The focus for further improvements will be:

- Further improvement work will be undertaken to continue to improve the safe storage, security, recording and administration of medicines
- Increasing the number of Pharmacy non-medical prescribers to assist with the prescribing process and to contribute to the reduction of prescribing errors
- Work on maximising the patient benefits of electronic prescribing and administration including the continued implementation of Aria electronic prescribing for chemotherapy prescriptions and the use of Lorenzo
- Further improvement work will also be undertaken on the monitoring and management of controlled drugs to ensure they are accurately maintained and audited
- Continued monitoring of the missed doses and use of the specific high risk medicines through the safety thermometer audit
- Increased learning from medicine management incidents and the introduction of learning sessions

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 2015/16:

The aim of the deteriorating patient (adult) priority was to ensure the early identification of a patient’s deterioration through the use of observations to identify which patients require end of life care plans. These should be documented and include a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order form to avoid inappropriate attempts to be resuscitated.

This priority aimed to achieve the following specific targets by the end of March 2016:

- Evaluate the pilot of Electronic Observations (E-OBS)
- Achieve 95% compliance with the completion of observations (NEWS) and actioned appropriately
- Achieve 80% correct completion of the DNACPR orders on the documentation of discussions with the patient and/or their relatives including best interest discussions

Actual outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Evaluate the pilot of E-OBS	Pilot not in place	Evaluated	✓
Achieve 95% compliance with the completion of observations (NEWS) and actioned appropriately	97%	99.1%	✓
Achieve 80% correct completion of the DNACPR orders on the documentation of discussions with the patient and/or their relatives including best interest discussions	70%	80%	✓

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 use of E-Obs was piloted on wards 11 and 110 at Hull Royal Infirmary, and wards 14 and 15 at the Castle Hill Hospital. The review of the trial demonstrated improvements in the number of observations completed correctly and more information is available to the clinicians involved in the patient care. Deteriorating patients were also escalated in a timely manner. It also had a positive impact on staff experience
- A process for the identification and escalation of deteriorating patient concerns from a Serious Incident was agreed and implemented. This ensures the involvement from the relevant team, e.g. Resuscitation or Outreach in the Serious Incident investigations, developing of the subsequent action plan and disseminating lessons learned across the organisation
- A review of all themes from Serious Incidents reported with failure to escalate deteriorating patient was completed by the Risk Team. Main themes identified were: communication between staffing groups, documentation of DNACPR, inadequate documentation and failure to follow up. These themes were disseminated as lessons learned in the Trust’s Learning Lessons newsletter
- The Outreach Team introduced an internal spot check audit process against the completion of the NEWS charts. 6 wards received a spot check inspection and The Yorkshire and Humber Improvement Academy has been jointly working with the Trust and the Acute Medical Unit to identify what the barriers were in completing the NEWS charts and then forming a treatment and escalation care plan for patients who score a NEWS of >5. The improvement work has included specialised cultural change surveys, workshops and assessments to address the behaviours to change with the nurses and doctors and to implement a process for completing the NEWS charts along with a treatment and escalation plan which is fit for purpose and meaningful for the Acute Medical Unit

- A monthly spot check, which audits against the completion of the NEWS charts, was implemented by the Outreach Team. 10 forms were audited on a monthly basis from December 2015. Between December 2015 and February 2016 the following wards were audited at HRI 4, 44, 110, 12 and 12 and at CHH 33. Results and action required was immediately fed back to the ward for improvement
- A new process was implemented to ensure all new starters to the Trust complete the e-learning package for DNACPR as part of their induction to improve awareness and understanding of the Trust's Resuscitation Policy and the process to follow for completing a DNACPR order

Further improvements identified:

It has been identified that further improvements on the management of deteriorating patient are required and it is therefore a quality and safety priority for 2016/17 (see page 68) 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 60.

The focus for further improvements will be:

- Further improvement work to be undertaken in the Acute Medical Unit on the completion of observations, culture changes and the implementation of the multidisciplinary safety huddles
- Themes, trends and lessons to learn from any deteriorating patient Serious Incidents identified and actioned accordingly
- Continue to explore funding options for the further roll out of E-OBS
- Completion of the daily and monthly resuscitation equipment checks on all ward areas
- Further monitoring and identification of lessons to learn when completing the DNACPR order forms and documenting discussions with the patients and /or their relatives or advocates
- Reviewing the frequency of observations and escalation of the deteriorating patient and ensuring the policy is correctly implemented

Deteriorating Patient – Children

Deterioration in infants, children and young people requires rapid intervention to ensure a life can be saved. Early recognition of the signs that a child is deteriorating and listening to parents concerns is crucial to ensuring the appropriate planning of care, action and escalation of care is undertaken.

What we aimed to achieve in 2015/16:

The aim of the deteriorating patient (children) priority was to ensure the early identification of a child's deterioration through the use of observations and the Paediatric Advance Warning Score (PAWS) to identify the requirement of a prompt intervention or treatment and to prevent avoidable deterioration.

This priority aimed to achieve the following specific targets by the end of March 2016:

- Infant mortality (NHS Outcomes Framework Indicator) – Achieve the value of 3.8 or below, per 1,000 births
- Achieve 95% compliance with the completion of Paediatric Advance Warning Score (PAWS)

Actual outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Infant mortality (NHS Outcomes Framework Indicator) – Achieve the value of 3.8 or below, per 1,000 births	4.0	1.9	✓
Achieve 95% compliance with the completion of Paediatric Advance Warning Score (PAWS)	Not collected – baselines established in 2015/16	72%	✗↑

*This target does not have a status because the data was collected during 2015/16 to establish the baselines for monitoring during 2016/17.

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

Improvements achieved:

- A Baseline audit for the compliance with PAWS (Paediatric Advance Warning Score) was completed, the results are broken down below:
 - 100% of charts used were the correct form and appropriate for age
 - Frequency of observations stated on 86% of forms
 - 84% charts included temperature, pulse and respiratory rate with O2 stats, care and treatment reviews and alert, voice, pain, unresponsive scores
 - 96% of charts included blood pressure
 - 94% of entries were initialled
 - 72% of charts had the PAWS score calculated; 90% of those were correctly calculated
 - 70% of charts had the graded responses recorded
 - 81.8% of staff stated the charts were available when required

Further improvements identified:

- Refresher training against the completion of the PAWS chart to be provided to staff on the Paediatric Wards to ensure all staff remain competent and up to date with their training
- To implement the recording of the child's blood pressure on admission
- Continue to monitor compliance against the completion of the PAWS chart and ensure compliance through the Family and Women's Health Group clinical audit plan during 2016/17. Any actions and lessons to learn will be identified and delivered through the internal governance arrangements

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 2015/16:

The aim of the VTE priority was to continue to achieve the 95% of patients assessed for VTE within 24 hours of admission.

This priority aimed to achieve the following specific targets by the end of March 2016:

- Maintain 95% compliance with the VTE Risk Assessment
- No VTE Serious Incidents

Actual outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Maintain 95% compliance with the VTE Risk Assessment	95.39%	Q4 – 77.95%	✘*
No VTE Serious Incidents	4	0	✓

* The performance position is reflective of data capture issues between the paper system and the electronic system, Lorenzo. The Trust knows from the Safety Thermometer results that performance against the VTE target is better than reported against the national target included in this report.

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 number of staff completing the VTE e-learning module increased from 173 during 2014/15, to 398 during 2015/16
- The Trust has reduced the number of VTE Serious Incidents from 4 to 0 during 2015/16
- The Trust has implemented an electronic patient record system called Lorenzo. One of the aims of this project was to implement an electronic VTE patient risk assessment form for completion within 24 hours of admission. The implementation of the electronic records has resulted in an increase in the completion of the full patient VTE risk assessment form which ensures a full and robust assessment of the patient and an informed plan of care

Further improvements identified:

It has been identified that further improvements on VTE are required and it is therefore a quality and safety priority for 2016/17 (see page 70) 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 60.

The focus for further improvements will be:

- Implementation of the VTE e-learning module as a mandatory requirement for all senior doctors
- Further improvement work will be completed on Lorenzo to increase the completion of the VTE risk assessments
- Improvements in the compliance against the VTE risk assessment target of 95%
- Delivery of the NICE Guidance CG92 (Venous Thromboembolism in adults admitted to hospital; reducing the risk)

Nutrition and Hydration

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

What we aimed to achieve in 2015/16:

The aim of the nutrition and hydration 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 2016:

- Achieve >89% completion rate of food charts as measured by the 3G audits (ward nursing audit – Great ward, Great staff, Great care)
- Identify and introduce a hydration assessment process

Actual outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Achieve >89% completion rate of food charts as measured by the 3G audits	Not collected -baseline established in 2015/16	33.60%	✗↑
Identify and introduce a hydration assessment process	Not collected	Achieved	✓

*This target does not have a status because the data was collected during 2015/16 to establish the baselines for monitoring during 2016/17.

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

Improvements achieved:

- Over the year, performance against the target in relation to completion of food charts was escalated as it was not meeting the trajectory. Work was undertaken to assess the root cause of this underachievement and from this a significant review of all nutrition and hydration documentation was completed. This has resulted in the development and implementation of a hydration assessment and tool and the implementation of a revised food record chart and process. The auditing of nutrition and hydration care on wards has been reviewed and a new audit programme rolled out.
- The development of a new oral hygiene assessment tool was agreed and implemented across relevant wards
- A review of all 'red top' systems (including red tray, red top and red jug) and corresponding guidance completed (Red top water jug/tray system to identify patients that are on fluid balance management/nutritional management)

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 2016/17 (see page 69) 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 60.

The focus for further improvements will be:

- Embedding the 'red top' systems and guidance across the Trust
- Monitoring the new nutrition and hydration assessment tool
- The Trust will also focus on supporting those wards that are underachieving, based on the audit programme results, to improve the nutrition and hydration of patients on those wards

Falls

A fall is defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of the cause. A patient falling in hospital is 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 2015/16:

The aim of the falls priority was to reduce the number of falls that happen in the organisation. The project also aimed to reduce the level of harm caused from falls. The project intended to achieve this aim by undertaking a number of improvement projects across the Trust as well as increasing awareness of ways to prevent falls.

This priority aimed to achieve the following specific targets by the end of March 2016:

- Deliver the falls action plan
- 25% reduction in the number of avoidable patient falls per 1000 bed days
- 40% reduction in the number of avoidable patient falls rated moderate or above
- Falls with harm below England average
- Reduce the number of Serious Incidents resulting in fractured neck of femur or other injury

Actual Outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Deliver falls action plan	Action plan not in place during 2014/15	On-track	✓
Reduce by 25% the number of avoidable patient falls/per 1000 bed days – reduce to 5.2 to achieve this target	6.94	6.81 patient falls per 1000 bed days	✗↑
Reduce by 40% the number of avoidable patient falls rated moderate incident and above – reduce to 47 to achieve this target	78	42 avoidable falls	✓
Falls with harm below England average	Below	Below	✓
Reduce the number of Serious Incidents resulting in fractured neck of femur or other injury	31	17	✓

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

Improvements achieved:

The Trust set itself a target of reducing the number of falls rated moderate and above (i.e. the falls that cause the most harm to patients) by 40% during 2015/16. In addition, the Trust wanted to be below the England average for falls with harm and reduce the number of Serious Incidents. This has been achieved by putting in place a number of initiatives:

- The Trust has worked closely with the Yorkshire and Humber Improvement Academy to pilot safety huddles on a number of wards. Safety huddles allow for a multi-disciplinary team to meet at the start of a shift to discuss those patients who are at most risk. This allows for additional measures to be put in place and it has seen a reduction in the number of falls. Focus groups and reviews were held after each pilot to help improve the systems for when they were rolled out onto new wards.
- Enhanced training has been developed with an e-learning package launched. This has led to increased awareness of potential risks to patients and measures put in place to reduce the risk of falls happening

- Alert systems have been put in place in key areas including piloting a visual alert (yellow wrist bands) to help staff easily identify patients at risk of falling and funding has been secured for the purchase of sensory alarms following successful trials
- A new assessment tool and revised documentation was introduced to help staff to identify measures that will reduce a patient's risk of falling

Further improvements identified:

The falls priority has been identified as a quality and safety priority for 2016/17 (see page 69) 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 60.

The Trust has seen a significant decrease in the number of falls with the most significant harm to patients. The overall number of falls has not however reduced. This in part will be due to increase awareness and greater reporting of falls, however, work will need to continue to improve the overall figure and sustain the good progress that has been made during 2015/16.

The focus for further improvements will be:

- Improving the completion of initial assessment documentation
- Increasing education and awareness as well as learning lessons from incidents of falls
- The project will also build on the interventions that were tested and piloted during 2015/16 and increase the roll out across the Trust

Avoidable 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 2015/16:

The aim of the avoidable pressure ulcers priority was to reduce the number of patients who acquire avoidable hospital pressure ulcers. It focused on ensuring the appropriate risk assessments were completed for patients who were at risk of developing pressure ulcers.

This priority aimed to achieve the following specific targets by the end of March 2016:

- Reduce the number of avoidable Hospital acquired grade 3 and grade 4 pressure ulcers
- Achieve 95% compliance with the implementation of the Skin Care Bundle
- Reduce the number of avoidable Hospital acquired unstageable pressure ulcers

Actual Outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
To have no avoidable hospital acquired pressure ulcers – Grade 3	2	1	✗↑
To have no avoidable hospital acquired pressure ulcers – Grade 4	4	6	✗↓
Reduce the number of avoidable hospital acquired pressure ulcers (Stage 2 and above)	172	112	✓
To have no avoidable Hospital acquired pressure ulcers – unstageable	21	16	✗↑
Achieve 95% compliance with the implementation of the Skin Care Bundle(taken from HEY Safer Care audit)	Not collected	96.40%	✓

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:

- To reduce the number of avoidable hospital acquired pressure ulcers the Trust decided that the Skin Care Bundle (i.e. the different types of treatment and care we provide) be reviewed, revised and re-launched. This included reviewing the lessons learnt from previous Serious Incidents.
- To help test staff's knowledge of the identification of potential risks to patients, as well as the care and treatment required, a bedside assessment tool was developed. This was to review key areas of compliance and non-compliance, increase awareness as well as targeting key areas for improvement.
- To raise awareness a bespoke communication plan was launched that included the revised Skin Care Bundle. This was promoted through formal communication from the Chief Nurse during briefing sessions, the nurse conference and formal emails addressing issues at a corporate level.

Further improvements identified:

The Trust had more Grade 4 and unstageable Pressure Ulcers during 2015/16 than was acceptable. The avoidable pressure ulcer priority has been identified as a quality and safety priority for 2016/17 (see page 69) 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 60.

The focus for further improvements will be:

- All clinical areas will have a validated bedside assessment tool
- Develop and implement a quarterly HEY Skin matters bulletin / newsletter to raise awareness of pressure ulcer issues and lessons to learn
- Embed the pressure ulcer prevention cares with Hull University student nurses and midwives
- Develop non-registered Tissue Viability Link Nurse (TVLN) associate champion role
- Tissue Viability service to develop a joint primary and secondary care pressure ulcer focus campaign plan for 2016/17
- Tissue Viability Service to embed pressure ulcer prevention cares with Hull University student nurses and midwives
- Introduce a rolling programme of Serious Incidents lessons learnt review undertaken by Tissue Viability Service

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 one 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 2015/16:

The aim of this project was to raise awareness of the Sepsis Six Bundle, implement the revised sepsis care bundle and improve coding of patients.

This priority aimed to achieve the following specific targets by the end of March 2016:

- Audit the implementation of the Sepsis Six bundle in the Acute Assessment Unit (AAU) and the Emergency Department (ED) to ensure compliance
- Percentage correctly screened – improve from baseline*

*additional target put into place during the further development of the sepsis project for the Quality Improvement Plan.

Actual Outcome:

The following table provides performance data against the targets:

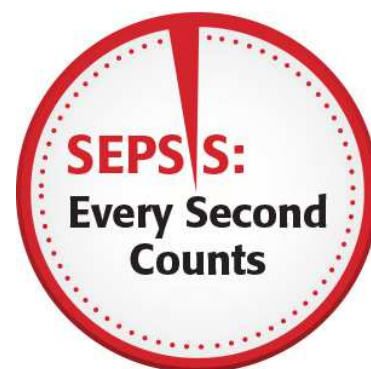
Target	Baseline 2014/15	Performance 2015/16	Status
Audit the implementation of the Sepsis Six bundle in AAU and ED to ensure compliance – completion of the audit	Not collected	74%	✓
Percentage correctly screened – improve from baseline	25%	74%	✓

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 now has two dedicated leads for Sepsis, a consultant and a nurse. The work completed by this team has led to the increased compliance with the sepsis bundle, improved coding of patients as well as improved outcomes for patients. In order to achieve this, the following improvements were made during the course of the project:

- Training took place in emergency care teams. This has led to greater awareness of patients presenting with sepsis as well as the optimising treatment and care. This has led to an increase in the number of patients correctly assessed for sepsis in the Emergency Department.
- To understand the risks to patients and to learn lessons from previous incidents, a monthly multi-disciplinary meeting has been established to not only discuss individual treatment plans but also to learn from analysis of patients who have severe sepsis or septic shock.
- A Sepsis Nurse has been appointed and commenced in post
- Sepsis training was delivered to the Surgical Admissions Wards (6th Floor), Paediatrics, ED and AAU staff
- Screening tool was introduced in the Emergency Department and Acute Assessment Unit, as well as the implementation of the sepsis stickers

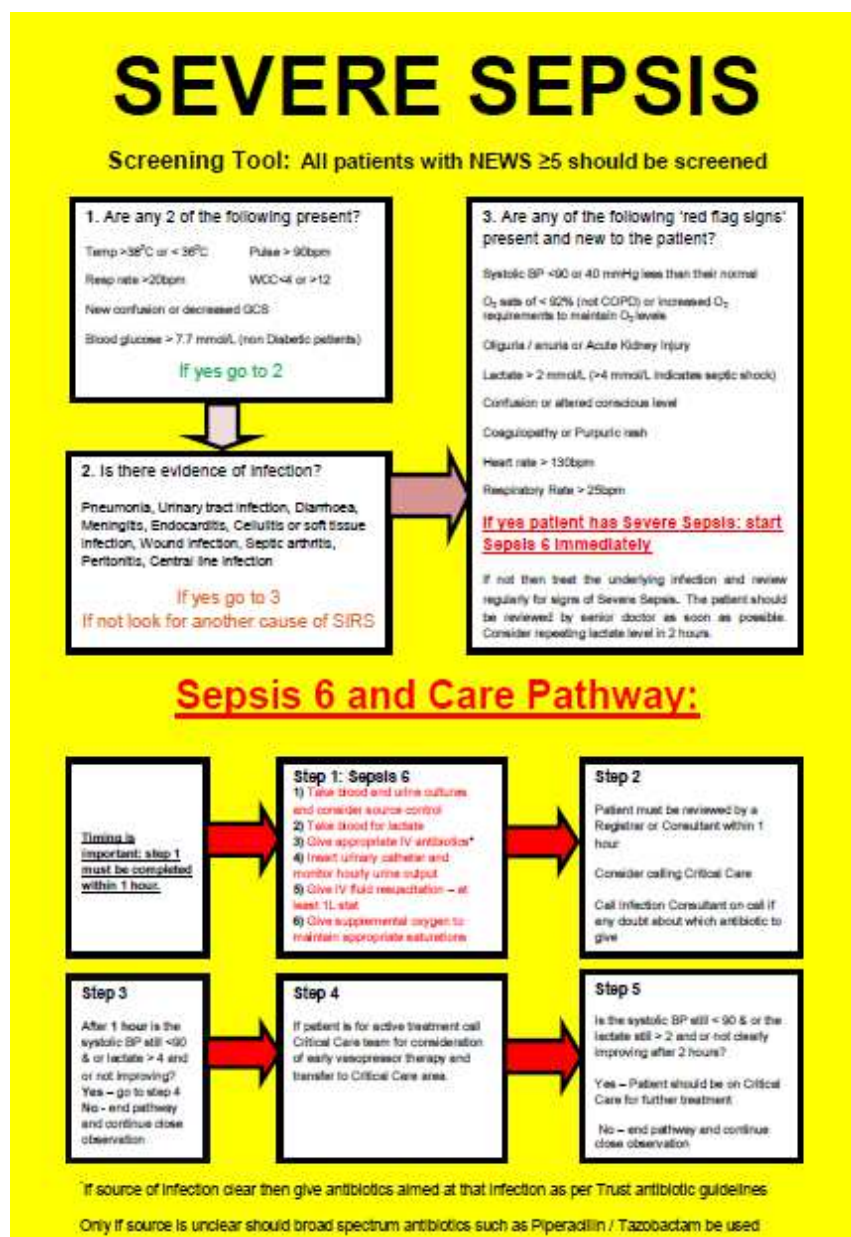


Further improvements identified:

It has been identified that further improvements on sepsis are required and it is therefore a quality and safety priority for 2016/17 (see page 71) 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 60.

The focus for further improvements will be:

- A sepsis link nurse to be introduced on all wards to improve awareness and progressive treatment and care plans
- Further communication tools developed including an intranet site
- Sepsis screening pathway rolled out to key areas of the Trust during 2016/17
- Process embedded for monthly root cause analysis
- Paediatric pathways developed to mirror adult pathways



Missed and Delayed Diagnosis

Missed and delayed diagnosis is the failure to diagnose a condition early enough to effect a cure or achieve maximum survival. The aim of this priority is to reduce the number of missed and delayed diagnosis Serious Incidents and to improve patient safety.

What we aimed to achieve in 2015/16:

The aim of this priority was to reduce the number of missed and delayed diagnosis Serious Incidents and to improve patient safety.

This priority aimed to achieve the following specific targets by the end of March 2016:

- Reduce the number of missed and delayed diagnosis Serious Incidents
- Reduce to $\leq 1\%$ of patients waiting over 6 weeks for diagnostic test

Actual Outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Reduce the number of missed and delayed diagnosis Serious Incidents	10	14	✘↓
Reduce to $\leq 1\%$ of patients waiting over 6 weeks for diagnostic test	0.24%	0.7%	✓

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:

Whilst the target to reduce the number of missed and delayed diagnosis Serious Incidents was not achieved, a significant review was completed on all missed and delayed diagnosis Serious Incidents from 2014 to the end of 2015 which identified themes.

Further improvements identified:

The missed and delayed diagnosis priority has been identified as a quality and safety priority for 2016/17 (see page 71) 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 60.

Following on from the review of themes of missed and delayed diagnosis Serious Incidents the focus for further improvements will be to reduce the time from plain film performing to reporting. This will ensure that clinicians have access to patients' results quicker. A flag system will be introduced to ensure that all urgent and/or unexpected test results are acted on for all HEY patients ensuring that all urgent and/or unexpected test results are acted upon quickly.

Acute Medical Pathway

Emergency Department (ED) attendances and unplanned medical admissions are continuing to increase, both locally and nationally. Although action has been taken to increase service capacity and improve service arrangements, many acute hospitals are struggling to cope effectively with the increasing emergency workloads. Demographic changes are also affecting the complexity of the acute medical caseload. Nationally, nearly two thirds of patients admitted to hospital are over 65 years of age and around 25% of hospital inpatients have a diagnosis of dementia. As a consequence comorbidities, levels of acuity and complexity of illness are increasing.

What we aimed to achieve in 2015/16:

The aim of this priority was to continue implementing the acute medical pathway transformation programme to deliver new and improved models of care for emergency/unplanned admissions, improve patient flow across the organisation and to streamline and standardise discharge processes.

The priority aimed to achieve the following specific targets by the end of March 2016:

- Reduce the number of medical outliers
- Reduce the number of avoidable inpatient transfers – patients who are moved two or more times
- Improve patient length of stay

Actual Outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Reduce the number of medical outliers	5596	1223	✓
Reduce the number of avoidable inpatient transfers – patients who are moved two or more times	4978	4536	✓
Improve patient length of stay (greater than 0 and less than 49) in days (source CHKS)	5.1	5.1*	✗ ↔

* Whilst length of stay overall has remained the same as baseline, there have been improvements made in medicine for example Hull Royal Infirmary on Ward 500, Ward 80 and Ward 90, this work will continue in 2016-17.

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

Improvements achieved:

The Trust, in conjunction with key partners developed the Urgent and Emergency Care Improvement Programme. This is a 5 project plan, which includes a project on the emergency pathway. The work is ongoing into the 2016/17 programme. The work during 2015/16 has focused on:

- Developing a performance dashboard to closely monitor activity
- Reviewed the self check-in system (Clarity) in the emergency department
- The roll-out of the RAT (Rapid Assessment and Treatment) model has started Monday to Friday

Further improvements identified:

- Ambulance handover targets to be achieved, including ensuring timely, appropriate and high quality handover.
- Ensure timely triage of all patients attending the Emergency Department, Initial Assessment and Emergency Care
- Rapid access to senior surgical, medical or specialist opinion as required
- Development of nurse led assessment, treatment and criteria led discharge
- Review the pathway for ambulatory care

Learning Lessons

The aim of this priority 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. The learning from these events should be visible through the implementation of sustainable changes and improvements.

What we aimed to achieve in 2015/16:

The priority aimed to achieve the following specific targets by the end of March 2016:

- Conduct a review of the Serious Incident process and implement changes
- Never Events – to have no repeat Never Events
- Reduction in the severity of incidents reported*
- Reduction in the number of overdue SI actions*
- Reduction in the number of overdue SI investigations*
- Serious Incidents discussed at Health Group Governance meetings*
- Monthly summary of completed Serious Incidents circulated by Risk team*

*additional targets put into place during the further development of the learning lessons project for the Quality Improvement Plan.

Actual outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
Conduct a review of the Serious Incident process and implement changes	Review not in place	Completed	✓
Never Events – to have no repeat Never Events	5	3*	✗↑
Reduction in the severity of incidents reported	8 Deaths 18 Severe 169 Moderate	3 Deaths 15 Severe 122 Moderate	✓
Reduction in the number of overdue SI actions	126	58	✓
Reduction in the number of overdue SI investigations	Not collected	0	✓
Serious Incidents discussed at Health Group Governance meetings	Process not in place	Process in place	✓
Monthly summary of completed Serious Incidents circulated by Risk team	Process not in place	Circulated	✓

* Four Never Events were reported in 2015-16, however one of the Never Events occurred in 2013.

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:

To provide clear focus to this project a working group was established led by a senior nurse and consultant. The working group initially focused on reviewing how the Trust overall, as well as individual Health Groups shared learning from key events such as Serious Incidents. To support this review analysis of key trends, learning and delivery was undertaken. This has now been expanded to the CIRCLE Group (Clinical Incident Review Creating a Learning Environment) which meets monthly to share themes, issues and inform learning process and events.

To help members of staff understand the need for learning lessons and what methods of communication could be used events were held. Such as:

- A claims workshop with the emergency department, breast services and anaesthetic staff
- The Lessons Learnt bulletin and quality and safety bulletin were launched and are now available at the monthly chief executive briefings to all staff
- The learning lessons intranet site has been expanded
- A leadership fellow has been appointed and work has started on deteriorating patient reviews
- Learning events have also been developed and will be launched during 2016-17
- A Plan, Do, Study, Act (PDSA) learning cycle was trialled in Family and Women's Health Group. This approach focuses on:
 - Plan – the change to be tested or implemented
 - Do – carry out the test or change
 - Study – data before and after the change and reflect on what was learned
 - Act – plan the next change cycle or fully implement

Further improvements identified:

The learning lessons priority has been identified as a quality and safety priority for 2016/17 (see page 73) 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 60.

The focus for further improvements will be:

- Greater emphasis will be placed on communicating lessons learnt and review evidence, including auditing, to determine the impact this is having on issues such as repeat Serious Incidents
- Undertaking work with clinical teams after a Serious Incident has occurred

LESSONS LEARNED Hull and East Yorkshire Hospitals NHS Trust

June 2016

Cessation of faxing from radiology and critical result acknowledgement

There have been some important changes to the way Consultants and clinical staff are notified about serious, unexpected or urgent findings in radiology recently.

In 2014, the Trust had eight Serious Incidents where communication of radiology findings was found to be an issue. Unfortunately this included cases containing serious findings (i.e. new cancers) that were faxed to the referring clinician but not acted upon. Faxing of urgent findings is clearly suboptimal, so the Radiology Department has replaced this with an electronic system through which the results must be acknowledged. Other organisations, including York, have mandated consultant result acknowledgement of all results.

With effect from Monday 22nd May 2016 the Radiology Department turned off faxing from radiology for all internal HEY referrers (GPs will follow shortly). Instead of sending a fax, the Radiology Department will send the abnormal result directly to the consultant by email. This email will contain a link to acknowledge that the result has been received, and confirm whether or not it requires action. It should only take a few seconds to acknowledge each result, and this can be done by webmail from any site or on a mobile phone.

You can see a brief demonstration of the system on this 2 minute YouTube video: <https://youtu.be/XY8ZMuCAYNw>

These serious / urgent results will still appear in e-results, but will go to the top of the list, in case the consultant or their secretary wishes to print them. They will be denoted with yellow (serious / unexpected), orange (urgent) or red (critical) codes. It has been agreed that result acknowledgement is a consultant-only task that cannot be delegated to secretary / admin teams.

The system will automatically send reminders at 1, 4, 7, 14 and 21 days until the result has been acknowledged by a consultant. The Radiology Department will contact the consultant's secretary at day 4 in case of absence/leave.

We have agreed with our commissioners that 95% of flagged results will be acknowledged within 14 days, and 100% will be acknowledged within 28 days. We hope that you agree that this will deliver a measurable safety benefit to our patients. The flagged results will replace the previous faxed system which has been found wanting, as highlighted by recent Serious Incidents and delayed diagnosis cases.

If you have any questions or concerns, please feel free to contact Tony Goldstone, Clinical Director, Imaging Department: tony.goldstone@hey.nhs.uk

Falls within the Hospital

The Trust Falls Prevention Committee review all completed investigations into Serious Incidents relating to in-hospital falls. Any fall which resulted in serious harm (such as a fractured neck of femur) may be declared as a Serious Incident.

From reviewing recent investigations, the committee has highlighted how important it is to ensure that patients are welcomed and orientated to the ward and their bed area, and also, if at risk of falls, reminded not to mobilise alone. It is also important that intentional rounding is completed. There have been recent incidents when patients have fallen after mobilising alone, including for trips to the bathroom or reaching for their belongings.

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Transfusion second sample information

What you need to know

The national recommendation for blood and blood products transfusion is that patients should have two samples for blood transfusion to ensure that there are no mistakes in blood cross matching which can be fatal.

Therefore, from May 2016 the Transfusion Laboratory will not be compatibility testing on samples where the patient has not been tested before. Patients without historical transfusion record will require a second sample to be taken on a separate occasion before blood components will be issued.

Please ensure all staff in your area are aware, especially consultant colleagues as they will lead for outpatient sampling.

If you would like more information regarding transfusion second samples please contact the Transfusion Laboratory on 607731 or speak to a member of the Transfusion Practitioner team on 607763

Hull and East Yorkshire Hospitals NHS Trust

Why is it important?

Wrong blood transfusion can be fatal.

Apart from causing serious harm to the patient, wrong blood transfusion is a Never Event.

What You Can Do

Staff must:

In an emergency situation where a second sample is not available, Group O blood will be provided (uncross matched) until a second sample is received.

For elective patients, blood sample should be taken for group and save at the outpatient department after seeing the consultant with a decision to operate to ensure that we already have a blood group in the system. All clinical areas preparing patients for surgery (pre-assessment and wards) must check that patients have two samples in the system. If patients do not have two samples in the system, areas must ensure that another sample is taken and sent to the lab.

It is critically important that staff do not take the 2 samples simultaneously, if there is any suspicion that this has occurred, both samples will be rejected.

18 May 2016

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 and relatives and carers is crucial to learn lessons and 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 2015/16:

The aim of this priority was to seek and act on feedback from patients, relatives and carers. This would allow the Trust to learn what is working well and what requires further improvement. Feedback would inform required changes to ensure our services are responsive to our service users.

Initially this priority aimed to achieve the following specific targets by the end of March 2016:

- Measure the level of satisfaction of the complaints process using the post complaint survey
- Improve the analysis of themes and trends and reporting lessons learned by the Health Groups to the Patient Engagement and Experience Forum. This was a piece of work that was carried out and improvements made but was not deemed to be a measurable target.

On review, it was considered that the following targets were more relevant to track performance:

- 90% of formal complaints to be closed within 40 days and actions recorded where appropriate
- To increase the number of volunteer recruits in the Trust to 350 volunteers, to benefit patients in clinical areas
- Achieve 95% of patients who would recommend the Trust to their friends or family

Actual Outcome:

The following table provides performance data against the targets:

Target	Baseline 2014/15	Performance 2015/16	Status
90% of formal complaints to be closed within 40 days and actions recorded where appropriate	Not collected - baseline established in 2015/16	Q4 – 76%	✗↑
To increase the number of volunteer recruits in the Trust, to benefit patients in clinical areas to 350 volunteers	210	376	✓
Achieve 95% of patients who would recommend the Trust to their friends or family	94%	94.59%	✗↑
Improve the analysis of themes and trends and reporting lessons learned by the Health Groups to the Patient Engagement and Experience Forum	Not reported to Patient Engagement and Experience Forum	Achieved-reported to Patient Engagement and Experience Forum	✓

*This target does not have a status because the data was collected during 2015/16 to establish the baselines for monitoring during 2016/17.

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

Improvements achieved:

- An additional 166 volunteers were recruited during 2015/16, increasing the number of volunteers to 376. Every ward in the Trust now has dedicated volunteers supporting with nutrition and hydration, patient conversations and

reading, helping visitors and providing support to staff

- Volunteers were assigned to the Emergency Department to provide patients with Friends and Family forms for completion to increase the response rate for the area and also provide refreshment rounds
- All Health Groups now submit a monthly report which includes analysing themes and trends and reporting lessons learned to the Patient Engagement and Experience Forum
- Information from the 'You Said We Did' boards was implemented. These boards are used to inform patients what action has been taken by the ward following their feedback or suggestions. Examples of some of the improvements made include:
 - The Acute Medical Unit now has a Medical Elderly consultant on the unit at all times and physiotherapists are also available so that patients are not waiting
 - Discharges are now smoother and safer for patients from the Acute Medical Unit as there has been a reduction in delays in medications being provided for patients to take home, as there is now a dedicated Pharmacist

Further improvements identified:

The patient experience priority has been identified as a quality and safety priority for 2016/17 (see page 73) 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 60.

The focus for further improvements will be:

- Improving the information provided to patients on the care and treatment they are receiving and the services they are accessing to ensure they have all the relevant information to make informed decisions
- Review the national patient survey results and identify any areas which required additional focus by the Trust
- The development and roll out of a patient experience dashboard across the Health Groups which will show themes and trends from PALS and complaints and to inform changes and improvements to services provided to our patients
- Continue to improve the Trust response times to complaints and work to achieving response times within 40 days
- Further increase the number of volunteers based in clinical areas to provide support



*Making a
difference through
the Voice of the
Patient*

Part 3: Review of our Quality Performance



This section includes:

- Trust performance for 2014/15 and 2015/16 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 2015/16
- 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	2014/15	2015/16	National Average	Best performer	Worst performer
<ul style="list-style-type: none"> • the value of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period* 	106.4	110	100	65.2	117.7
<ul style="list-style-type: none"> • the banding of the SHMI for the Trust for the reporting period* 	2	1	2	1	3
<ul style="list-style-type: none"> • the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period* 	23.5%	22.8%	26.6%	11.7%	53.5%

*Most recent data on HSCIC for period October 2014 to September 2015, published in March 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 improvement priority for 2016/17. The aim of this priority is to aid the organisation in the delivery of the national objective of a standardised approach to review of hospital mortality. The priority 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. 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	2014/15	2015/16	National Average	Best performer	Worst performer
• groin hernia surgery	79.3	64.6	50.6	100	0
• varicose vein surgery	82.6	85.7	83.4	100	50
• hip replacement surgery	67.7	100	84.1	100	0
• knee replacement surgery	70.5	100	77.6	100	0

* Most recent data on HSCIC for period April 2015 to September 2015

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:

- Development of new technologies, including the application for robotic surgery to other services
- With Public Health and other provider partners, deployment of an 'Every contact counts' plan focussed on staff providing advice and signposting to prevention services for smoking, obesity and alcohol abuse
- Working with partners, delivery of a programme of long-term condition service redesign to create integrated services across primary, community and secondary care
- Leadership and support to our specialist services to meet the National Service Specifications and achieve upper quartile performance in their Peer Reviews
- Aim to meet all Best Practice Tariffs and PROMs for relevant surgical services

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

Prescribed Information	2014/15	2015/16	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	6.5%	8.1%	8.8%	0%	17.2%
• the percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	6.1%	6.5%	6.4%	3.1%	9.2%

* Taken from CHKS for period April 2015 to January (December for HES Peer) 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:

- 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	2014/15	2015/16	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.	67.3	67	68.9	86.1	59.1

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 improvement priority again for 2016/17. 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. This will help shape services to ensure they are responsive to our patient's needs. 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	2014/15	2015/16	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.	52%	69.7%	78.7%	100%	45.2%

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 improvement priority again for 2016/17. 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. This will help shape services to ensure they are responsive to our patients' needs. 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	2014/15	2015/16	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.	95%	80.6%	95.7%	100%	80.6%

* Quarter 1 – Quarter 3 2015/16 Aggregated from NHS England

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 improvement priority again for 2016/17. The aim of this priority 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. 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	2014/15	2015/16	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 100,000 bed days of cases of C difficile infection	16.1	16.4	15.1	0	62.2

Prescribed Information	2014/15	2015/16	National Average	Best performer	Worst performer
reported within the Trust amongst patients aged 2 or over during the reporting period.					

*Most recent data April 2014 to March 2015 (Year lag)

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 Acquired Infections as a quality and safety improvement priority for 2016/17. The aim of this priority is to ensure compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) which will then reduce the number of avoidable hospital acquired infections. 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	2014/15	2015/16	National Average	Best performer	Worst performer
<ul style="list-style-type: none"> the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, 	29.44	30.33	37.15	82.21	3.57
<ul style="list-style-type: none"> the number and percentage of such patient safety incidents that resulted in severe harm or death 	0.4%	0.4%	0.5%	0.05%	5.2%

*The data above is for the reporting period October 2014 – March 2015 from NRLS

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 improvement priority again for 2016/17. The aim of this priority 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. Further information on actions taken and achievements will be reported 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	2014/15	2015/16	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)	74%	77.1%	87.4%	98.6%	65.3%
Inpatients	93%	96.2%	95.7%	99.7%	67.1%

* Most recent data is for April 2015 to February 2016 aggregated ** April for February Data

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:

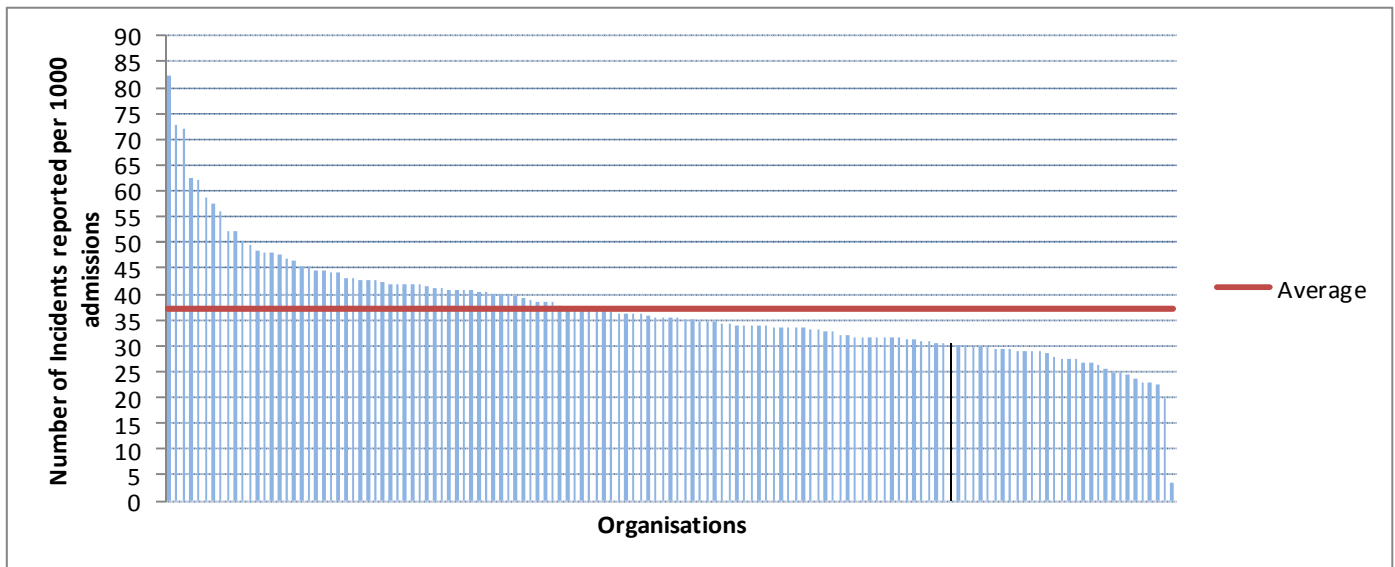
- Identifying Patient Experience as a quality and safety improvement priority again for 2016/17. The aim of this priority is to seek and act on feedback from our patients their relatives and carers. This will enable us to learn what is working well and what requires further improvement and to use the feedback to inform those required services changes. This will help shape services to ensure they are responsive to our patients' needs. 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 is taken from the latest National Patient Safety Agency National Reporting and Learning Service (NRLS) data report published September 2015 and shows the Trust to be below average for reporting of patient safety incidents.

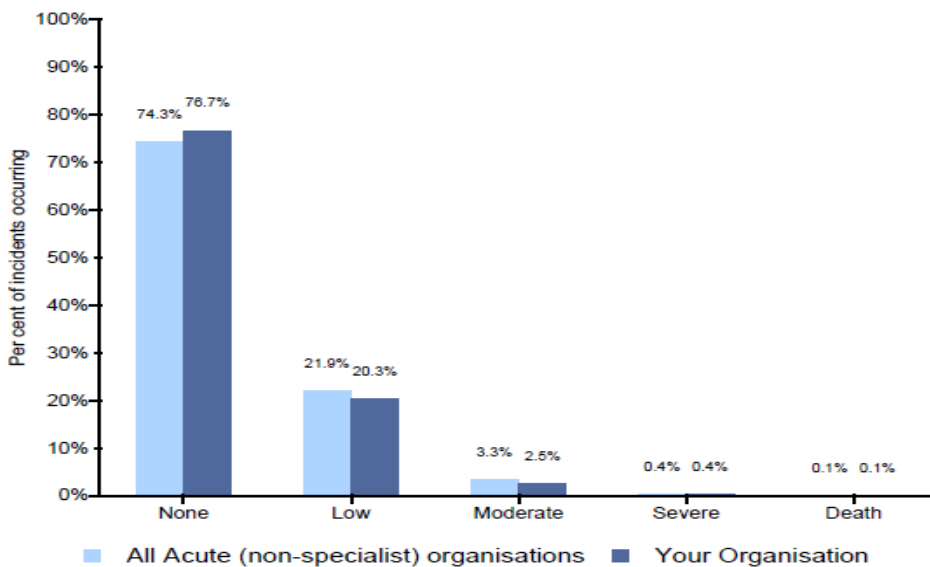
Figure 1: Patient safety incidents per 1000 admissions for the period of 1 October 2014 to 31 March 2015



*Hull and East Yorkshire Hospitals NHS Trust is highlighted above in black
The latest report covers the 6 months between October 2014 and March 2015.

Figure 2 shows the incidents reported by degree of harm, comparing Trust performance with that of Acute (non-specialist) organisations and is taken from the latest National Patient Safety Agency National Reporting and Learning Service (NRLS) data report to September 2015.

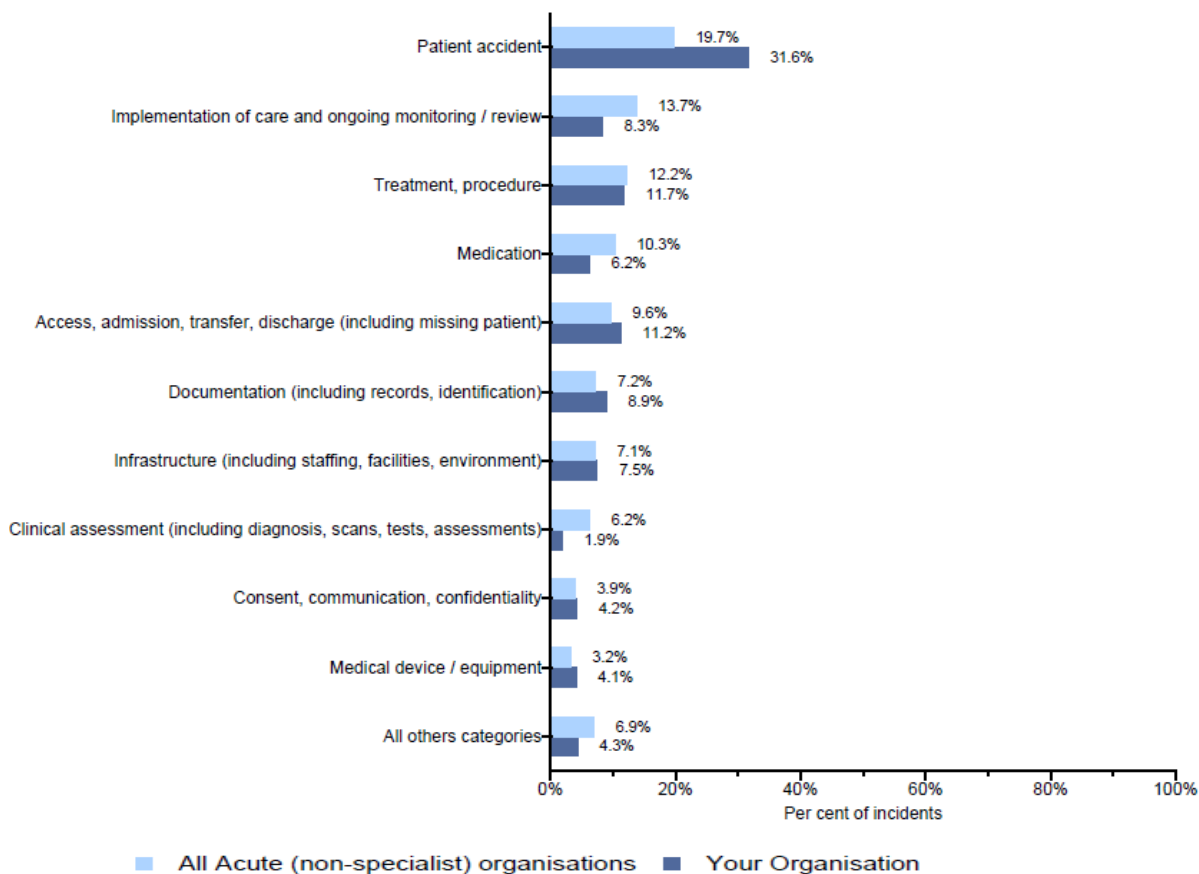
Figure 2: Incidents reported by degree of harm for Large Acute organisations for the period from October 2015 to March 2015



The Trust appears to be reporting in line with the cluster on degree of harm. The top 10 types of patient safety incident reported between October 2014 and March 2015 are detailed in **Figure 3** below.

Figure 3 shows the top 10 types of incidents reported within our reporting cluster compared against the number reported by the Trust. The Trust profile does appear different from the cluster and the variance is attributed to the way our incident coding structure has been mapped to the NRLS codes (i.e. how we matched our type, category and sub-category codes to the NRLS). This variance has been resolved from 1 April 2016 as we have adopted the DATIX classification codes.

Figure 3: Top patient safety incidents reported by %



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

A number of actions have been undertaken to improve staff awareness of incident reporting procedures, openness of reporting and to increase the number of incidents reported including:

- From April 2016 the Trust implemented a new process for reporting incidents, asking reporters to report either an actual incident which caused harm or a concern/near miss/no harm incident. This new process has been implemented through training sessions open to all staff which encourages incident reporting and has raised awareness of incident reporting generally
- Further developments of the incident reporting system to make the incident report form easier and more intuitive to complete
- The adoption from the 1 April 2016 of the DATIX CCS2 codes. These replace the Trust’s existing categorisation codes (see figure 3) and will align the organisation with national reporting codes
- Further development of communication of Lessons Learned. The Lessons Learned Bulletin continues to be produced on a monthly basis, and is sent out to staff. A Quality and Safety Bulletin has been developed which is a method for sending out key messages to staff, and this is produced on a monthly basis.
- Both bulletins are available on the Trust Lessons Learned intranet site, which has been further developed to include more information and to be more accessible to staff
- Development of a learning group (CIRCLE – Clinical Incident Review Creating a Learning Environment) which meets on a monthly basis to review the learning from incidents, of claims and complaints

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:

	2011/12	2012/13	2013/14	2014/15	2015/16
Total Never Events declared	4	3	4	5	4**
Total Serious Incidents declared	10	8	32	88*	107***
Total	14	11	36	93*	111***

*excludes 3 Serious Incidents which were downgraded following investigation.

** 4 Never Events were declared in 2015-16 however one occurred in 2013

***excludes 9 Serious Incidents which were downgraded following investigation

Types of Serious Incident and Never Events declared during 2014/15 and 2015/16

Serious Incident type	2014/15	2015/16
Treatment Delay	3	19
Patient Fall	31	18
Delayed Diagnosis	10	17
Pressure Ulcer (3 or 4)	4	11
Surgical/Invasive Procedure incident	1	10
Sub-optimal care of the deteriorating patient	3	9
12 hour ED trolley breaches	9	7
Drug Incident	7	3
Unexpected Death	9	3
HCAI/Infection Control Incident	1	2
Intrapartum Death	0	2
Never Event – Retained Foreign Object	1	2
Never Event – Wrong Site Surgery	3	2
Retained dressing (not a Never Event)	0	2
Retained foreign object (not a Never Event)	0	1
Wrong Site Surgery (not a Never Event)	0	1
Unplanned maternal NICU admission	2	0
Others	9	2
Totals	93	111

The Trust has reported more Serious Incidents in 2015/16 than in any previous year. The Trust acknowledges the increased number of Serious Incidents, and considers that this demonstrates continued openness, transparency and honesty when errors have been made.

The Trust has undertaken significant work during 2015/16 to ensure that Serious Incident investigations are completed on time, and actions arising from these investigations are also implemented within the timescales agreed. This can be demonstrated in the Learning Lessons quality and safety priority performance update provided on page 27:

- The Trust has implemented a weekly Serious Incident update meeting, led by Chief Nurse and Chief Medical Officer, for the chairs of investigations to report on progress
- The Trust has invested in training for those involved in serious incident investigations; training has been delivered on Root Cause Analysis awareness, Human Factors and Systematic Incident Investigations.
- A monthly summary of Serious Incidents completed are sent out widely to assist staff in the sharing and dissemination of this information. Summary information is added to the Trust Lessons Learned intranet site

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 2015/16 and the Trust's progress

Reference	Alert Title	Issue Date	Deadline	Trust Response
NHS/PSA/RE/2015/008	Supporting the Introduction of the National Safety Standards for Invasive Procedures	14-Sep-15	14-Sep-16	Action is necessary: on-going
NHS/PSA/Re/2015/007	Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme	18-Aug-15	31-Mar-16	Action complete and matter resolved
NHS/PSA/W/2015/006	Harm from delayed updates to ambulance dispatch and satellite navigation systems	09-Jul-15	20-Aug-15	No action is required
NHS/PSA/W/2015/005	Risk of death or severe harm due to inadvertent injection of skin preparation solution	26-May-15	07-Jul-15	Action complete and matter resolved
NHS/PSA/Re/2015/009	Support to minimise the risk of distress and death from inappropriate doses of naloxone	26-Oct-15	26-Apr-16	Action complete and matter resolved
NHS/PSA/W/2015/010	Risk of death and serious harm by falling from hoist	28-Oct-15	09-Dec-15	Action complete and matter resolved
NHS/PSA/W/2015/011	The importance of vital signs during and after restrictive interventions/manual restraint	03-Dec-15	21-Jan-16	Action complete and matter resolved
NHS/PSA/W/2015/012	Risk of using different airway humidification devices simultaneously	16-Dec-15	02-Feb-16	Action complete and matter resolved
NHS/PSA/W/2016/001	Risk Of Severe Harm Or Death When Desmopressin Is Omitted Or Delayed In Patients With Cranial Diabetes Insipidus	08-Feb-16	21-Mar-16	Action complete and matter resolved
NHS/PSA/W/2016/002	Risk of death from failure to prioritise home visits in general practice	30-Mar-16	04-May-16	No action is required

Working with the Improvement Academy

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



Huddling up for Safer Healthcare









The Academy is leading a project within the Trust which supports teams to introduce safety huddles. Huddles are a daily, short (5 – 10 minutes) discussion involving all members of the team, which focus on 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.

This project starts with a safety culture assessment which allows the ward team to reflect on how they work together and how they can enhance team working. The team is then introduced to improvement tools, such as the Model for Improvement which supports small scale testing of evidence based interventions to build reliable processes which ensure that each patient gets what they need when they need it, to keep them safe from harm. The project uses the Measurement for Improvement technique to help teams to regularly monitor their progress and to celebrate their successes.

Safety huddles were first tested on Ward 9, a Medical Elderly ward at Hull Royal Infirmary, that has reached 25 days without a fall and have reduced the number of falls by 41%. The team uses their daily safety huddle to identify which patients have a high risk of falls and identify a plan for each patient to keep them safe. Later during the day they check back to see if the prescribed interventions are in place. The Team is currently reassessing the safety culture on the ward to see if the project has also improved staff morale and teamwork.

The project is part of a wider programme being implemented across the region. The Trust is now looking at how we can share learning from this programme within the Trust and increase capacity in order to support more teams to improve patient safety. Here are our achievements so far:

Team	Achievement (Number of times previously achieved)		Date Achieved (most recent)
Ward 9	 Silver (x 1)	20 days without a fall (achieved 25 days in total)	24/10/2015
	 Bronze (x 5)	10 days without a fall	27/01/2015
	 Silver (x 1)	100 days without a hospital acquired pressure ulcer (achieved 145 days in total)	27/01/2015
Ward 80	 Silver (x 1)	100 days without a hospital acquired pressure ulcer (achieved 104 days and counting)	18/03/2016
	 Bronze (x 1)	50 days without a hospital acquired pressure ulcer	27/01/2016
Ward 90	 Bronze (x 1)	50 days without a hospital acquired pressure ulcer (achieved 71 days in total)	01/03/2016

Giving Patients a Voice to Improve the Safety of their Care

PRASE (Patient Reporting and Action for a Safe Environment) is an intervention that helps patients to provide useful feedback about the safety of the care they receive.



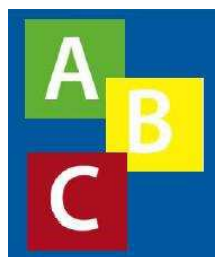
The project uses volunteers, who are trained to use an electronic patient safety questionnaire to collate information from patients about factors that contribute to patient safety, such as equipment, communication, and delays. This information is then used by frontline teams to make improvements at ward level.

Ward 50 at HRI was the first area to be involved in the project. Our PRASE Volunteers have helped 47 of their patients to complete the questionnaire. The ward received lots of positive feedback, but there were a couple of issues raised, such as knowing who their Consultant was and delays in getting their medication. The team is now looking to make improvements in these areas.

In January, the project was introduced to Wards 6 and 60, where our volunteers have been working hard, surveying a further 129 patients.

This project is being funded by the Health Foundation and the Trust is participating alongside Bradford Teaching Hospitals NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust. The project is currently being independently evaluated by the Bradford Institute for Health Research.

Achieving Behaviour Change (ABC) for Patient Safety



The Academy is supporting a team from the Acute Medical Unit (AMU) to improve the recognition and management of the deteriorating patient.

Implementing best practice to improve patient safety often requires NHS staff to change their behaviour. It is often assumed that this is easy – tell people what to do and they will do it, but we recognise that behaviour change can be difficult to achieve.

The AMU team is using the Academy's ABC Toolkit which aims to help healthcare teams Achieve Behaviour Change by applying theories from Psychology. This involves assessing barriers and levers to ideal practice, tailoring implementation strategies according to these and basing these on behaviour change theory.

So far, they have gained feedback from 45 doctors about what gets in the way to completing escalation plans for patients whose condition is deteriorating. The next step is to look at the interventions that could be implemented to reduce the biggest barriers that they have reported.

Mortality Review Programme

The Academy has developed a systematic, evidence-based mortality review programme which aims to drive improvement in the quality and safety of patient care. This methodology allows trained reviewers to identify and describe the quality of care received and in doing so create a score of that quality. The use of a standardised method of case note review helps to highlight good quality, provide feedback to teams and spread good practice to other areas. Also emergent patient safety themes can be acted on by supporting teams with improvement techniques.

So far the Academy has trained 37 reviewers from the Trust through this programme, which will support the development of a robust mortality and morbidity review system across the Trust and shared learning with the wider region.

Building Capacity & Capability of Quality & Safety Improvement

Five members of staff from the Trust have attended the Academy's Gold level Quality Improvement Training. This competency-based 'Train the Trainer' programme is designed to provide trainees with the knowledge and materials to deliver the Academy's one-day Silver Level Quality Improvement Training for individuals, and skills to mentor and support staff who have chosen to undertake an improvement project. These individuals will be used to develop capacity within the organisation to support future improvement projects.





The Academy also employs Implementation Manager, Liz Watson, who is based at Hull Royal Infirmary to support frontline teams to improve patient safety. In July, Liz became one of 10 from our region to participate in the founding cohort of, and contribute to the design of Q. Q is an initiative, led by the Health Foundation and is supported and co-funded by NHS England, connecting people skilled in improvement across the UK in order to accelerate improvements to the quality of care.

The Academy has also helped to connect leaders at the Trust with the wider region through hosting roundtable events and conferences on topics such as falls, patient flow and sepsis. The Trust also has 7 clinicians that are supported as Improvement Fellows with the Academy, with many of these leading improvements with their teams on the projects listed above.

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.'

The Improvement Academy is part of the Yorkshire and Humber Academic Health Science Network.



YORKSHIRE & HUMBER
ACADEMIC HEALTH SCIENCE NETWORK

NHS Staff Survey Results – KF26 and KF21

The Trust undertook the NHS National Staff Survey 2015 between October and December 2015. This has shown an improvement in many areas. The response rate for the Trust was 36% (295 staff), against a national average of 41%.

In 2015 the Trust is above average for the following key findings:

- Recognition and value of staff by managers and the organisation
- Quality of non-mandatory training, learning or development
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (positive result)
- Percentage of staff satisfied with the opportunities for flexible working patterns
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents

Against 10 of the 32 key findings the Trust's score has improved. Furthermore the Trust is deemed to have improved significantly against these findings:

- Staff recommending the organisation as a place to work or receive treatment
- Staff motivation at work
- Support from immediate managers
- Staff confidence and security in reporting unsafe clinical practice
- Effective use of patient / service user feedback

The overall score for engagement, where five is the highest score possible, has also improved significantly:

- 2014 - Hull and East Yorkshire Hospitals NHS Trust 3.54
- 2015 - Hull and East Yorkshire Hospitals NHS Trust 3.74
- 2015 - Average for acute and specialist trusts 3.79

Other highlights include:

- 94% of staff said they definitely or to some extent were aware of the Trust's values
- 89% said that managers always, often or sometimes demonstrated the Trust's values
- 94% said that other colleagues always, often or sometimes demonstrated the Trust's values

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

Staff Survey Question	Change since 2014 survey	Ranking compared with Acute Trusts in 2015
KF26 - % of staff experiencing harassment, bullying or abuse from staff in last 12 months	No change	38% Highest (worst) 20%
KF21 - % of staff believing that the Trust provides equal opportunities for career progression or promotion	No change	85% Below (worse than) average

A Professionalism and Cultural Transformation (PaCT) steering group, chaired by the Chief Executive was established to develop and implement an approach to Transforming the Culture of the Trust and monitor the cultural transformation programme. A significant amount of improvement work has been carried out, including:

- New Trust values developed: CARE, HONESTY and ACCOUNTABILITY
- Work to appoint to vacancies successful in a number of key areas including the Emergency Department
- A confidential Staff Advice Line (SALs) launched for staff to raise concerns
- Over 700 managers attended mandatory briefing sessions, outlining what is expected of a HEY leader
- 5000 staff attended PaCT training
- Six key goals have been communicated widely across the Trust
- Quarterly Performance Reviews require Health Groups and Directorates to report on progress against staff engagement and culture
- The Organisational Development and Education teams are developing a revised leadership programme
- The Pioneer Team Academy has been re-launched

- Work to reduce bureaucracy at all levels and commit to modernising non-clinical support services is underway as part of our Back Office Modernisation programme.
- Feedback provided to staff who report errors and incidents has improved with the launch of a new Datix system and a communications campaign.

The Trust has identified that further improvement work is required to continue changing the culture of the organisation. A PaCT action plan has been developed and sets out the key milestones to progress the cultural transformation work, which began in 2015. The goal is to create a culture, characterised by specific values, which our workforce believes will enable us to deliver Great Care. These values are: ACCOUNTABILITY, CARE, and HONESTY.

The PaCT action plan is closely connected to the Trust's People Strategy which identifies seven key workstreams that will enable the delivery of our desired working culture and it will focus on the following areas:

- Improving team-working
- Creating a greater sense of pride in our work
- Engagement of the medical workforce
- Leadership development
- Having a greater patient perspective on our work
- Encouraging innovation and creativity
- Improving behaviours
- Reward and recognition

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 2015/16 the Hull and East Yorkshire Hospitals NHS Trust provided 43 NHS services within 4 Health Groups and 10 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 2015/16 represents 100% of the total income generated from the provision of NHS services by the Hull and East Yorkshire Hospitals for 2015/16.

Participation in clinical audits

During 2015/16, 45 national clinical audits and 3 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 2015/16. For those national clinical audits and national confidential enquiries that Hull and East Yorkshire Hospitals NHS Trust participated in, and for which data collection was completed during 2015/16, 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		
Vital Signs in Children (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
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%
Paediatric Asthma	Yes	100%
Blood and Transplant		
Audit of Patient Blood Management in Scheduled Surgery	Yes	100%
Audit of the Use of Blood in Lower GI bleeding	Yes	100%
Audit of the Use of Blood in Haematology	Yes	100%
Acute care		
National Emergency Laparotomy Audit (NELA)	Yes	21%
Adult Critical Care (Case Mix Programme – ICNARC)	Yes	100%

Audit:	Participated	% of Cases Submitted
National Complicated Diverticulitis Audit (CAD)	Yes	100%
Emergency Use of Oxygen	Yes	100%
Procedural Sedation in Adults (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
VTE Risk in Lower Limb Immobilisation (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	100%
Diabetes in Pregnancy Audit	Yes	75%
Diabetes Footcare Audit	Yes	Data collection due to be completed in July 2016
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Ulcerative Colitis and Crohn's disease (National Inflammatory Bowel Disease - IBD Audit)	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Yes	16%
UK Cystic Fibrosis Registry	Yes	100%
Elective procedures		
Hip, Knee, Ankle, Elbow and Shoulder Replacements, Implant Performance, Hospital Performance and Surgeon Performance (National Joint Registry)	Yes	100%
National Vascular Registry (elements include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)	Yes	100%
Adult Cardiac Surgery Audit (ACS)	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%
National Percutaneous Coronary Intervention (PCI) Audit	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Arrest Audit (NCCA)	Yes	100%
Renal disease		
Renal Replacement Therapy (Renal Registry)	Yes	100%
Cancer		
Lung Cancer (National Lung Cancer Audit)	Yes	100%
Bowel Cancer (National Bowel Cancer Audit Programme)	Yes	100%
Oesophago-gastric Cancer (National O-G Cancer Audit)	Yes	100%
National Prostate Cancer audit	Yes	100%
Trauma		
Major Trauma (Trauma and Audit Research Network)	Yes	62%
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) – including the hip fracture database (NHFD)	Yes	100%

Audit:	Participated	% of Cases Submitted
UK Parkinson's Audit (physiotherapy)	Yes	100%
Acute Stroke (Sentinel Stroke National Audit Programme - SSNAP)	Yes	96%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Acute Pancreatitis	Yes	57%
Mental Health in General Hospitals	Yes	62.5%
Chronic Neurodisability	Yes	Data collection due to complete in late 2016
Young People's Mental Health	Yes	Data collection due to complete in late 2016
Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBBRACE – UK)		
Maternal Infant and Perinatal Programme (MBBRACE-UK)	Yes	100%

The reports of 26 national clinical audits were reviewed by provider in 2015/16 and Hull and East Yorkshire Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Audit	Proposed actions
National audit	
Neonatal intensive and special care (National Neonatal Audit Programme - NNAP)	<ul style="list-style-type: none"> 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)
National Chronic Obstructive Pulmonary Disease Audit	<ul style="list-style-type: none"> 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
Lung cancer (National Lung Cancer Audit)	<ul style="list-style-type: none"> To obtain more in-depth data – specifically data for resection rates for localised (stage I/II) lung cancer To undertake an audit of biopsy proven cancer
Cardiac arrhythmia (CRM)	<ul style="list-style-type: none"> No further action required as the results met the standards
Adult Community Acquired Pneumonia Audit	<ul style="list-style-type: none"> To continue working with the Acute Medical Unit on validation work for the pneumonia care bundle To hold a training session to reiterate the importance of good record keeping, including the CURB65 score
Heart failure (Heart Failure Audit)	<ul style="list-style-type: none"> No further action required as the results met the standards
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	<ul style="list-style-type: none"> 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
National Pregnancy in Diabetes Audit	<ul style="list-style-type: none"> To focus on health promotion in the outpatient clinic, in order to raise

Audit	Proposed actions
	<p>awareness of the issues associated with pregnancy in diabetes</p> <ul style="list-style-type: none"> To discuss the promotion of pre-pregnancy planning at the Diabetes Network Board meeting
National Inpatient Falls Audit	<ul style="list-style-type: none"> To audit the availability of call bells in all inpatient areas to ensure they are within reach of the patient To ensure that all staff within the Elderly Medical inpatient areas participate in continence care training To implement the pilot of the continence care plan on all Elderly Medicine inpatient areas
National Cardiac Arrest Audit (NCCA)	<ul style="list-style-type: none"> 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
Initial Management of the Fitting Child (College of Emergency Medicine)	<ul style="list-style-type: none"> 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
Asthma in Children (College of Emergency Medicine)	<ul style="list-style-type: none"> To educate staff regarding the importance of recording all vital signs To remind staff to record the discharge prescription for oral prednisolone
Severe Sepsis and Sepsis Shock (College of Emergency Medicine)	<ul style="list-style-type: none"> To audit antibiotic use during severe sepsis / septic shock To educate staff regarding the importance of recording all vital signs (including urine output measurement) To feedback to all medical and nursing staff about the importance of prescribing oxygen To continue with the severe sepsis training
Paracetamol Overdose in Adults (College of Emergency Medicine)	<ul style="list-style-type: none"> To feedback to all doctors and nurses the importance of beginning treatment with N-acetylcysteine as 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
Mental Health in the Emergency Department (College of Emergency Medicine)	<ul style="list-style-type: none"> To create and pilot a mental health risk assessment proforma, in collaboration with the mental health team 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
Assessing Cognitive Impairment of Older People (College of Emergency Medicine)	<ul style="list-style-type: none"> 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
Sentinel Stroke National Audit Programme (SSNAP)	<ul style="list-style-type: none"> To improve education and awareness of Stroke in the Emergency Department by carrying out extra training 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

Audit	Proposed actions
	<p>patients that are at all disarthric</p> <ul style="list-style-type: none"> • 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 • To enter all data on Cayder (electronic ward board), in order to improve data quality
National Emergency Laparotomy Audit (NELA)	<ul style="list-style-type: none"> • To implement the new laparotomy pathway
National Hip Fracture Database	<ul style="list-style-type: none"> • 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
National Prostate Cancer Audit	<ul style="list-style-type: none"> • Local data has been analysed with the introduction of the Da Vinci robot which has shown a reduction in length of stay. To re-audit to ensure this practice is embedded.
National Vascular Registry	<ul style="list-style-type: none"> • 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 • To hold discussions with Anaesthetics regarding Consultant Vascular Anaesthetist cover in theatre • To review the resources required to improve data collection
National Oesophago-Gastric Cancer Audit	<ul style="list-style-type: none"> • Cardiopulmonary Exercise Testing has been introduced to ensure that an accurate measure of the patients' fitness for surgery is taken. This has led to an improved method of patient selection for surgery and a reduction in the mortality rate. This reduced mortality rate will be reflected in future national reports
UK Cystic Fibrosis Registry	<ul style="list-style-type: none"> • The results from this audit are being considered alongside the findings of a peer review
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	
Gastrointestinal Haemorrhage	<ul style="list-style-type: none"> • Compliant with the recommendations therefore no actions required
Other Enquiries/Reviews	
MBRRACE-UK	<ul style="list-style-type: none"> • 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 NPSA toolkit to review these as an

Audit	Proposed actions
	added measure and to replicate what is being done across the region

An update regarding the implementation of the proposed actions identified as a result of a national clinical audit reports published in the 2014/15 Quality Account is provided below to demonstrate the improvements made to quality. Actions taken in response to reports published in 2015/16 will be included in the Quality Account for 2016/17.

Audit	Proposed actions	Progress
National audit		
National Pleural Procedures Audit	<ul style="list-style-type: none"> To perform pleural procedures in a designated procedure room To perform all pleural procedures under direct ultrasound guidance 	<ul style="list-style-type: none"> The majority of pleural procedures are now done in a designated procedure room The majority of pleural procedures are now done under ultrasound guidance
MINAP (Myocardial Ischaemia National Audit Project)	<ul style="list-style-type: none"> To communicate with the National Institute for Cardiovascular Outcomes Research (NICOR) in regards to having HRI and CHH reported as a single Hospital Trust 	<ul style="list-style-type: none"> This is an ongoing effort in order to increase the quality of data provided by our Trust
SSNAP – (Stroke National Audit Programme)	<ul style="list-style-type: none"> To ensure the National Institute of Health Stroke Scale (NIHSS) is available on the first Stroke Team contact To design a sticker to prompt Stroke Team members to complete the NIHSS To increase the awareness of NIHSS with junior doctors 	<ul style="list-style-type: none"> The National Institute of Health Stroke Scale (NIHSS) has been made available Stickers are now available Awareness has been increased with the junior doctors through training
National Care of the Dying Audit for Hospitals	<ul style="list-style-type: none"> The Specialist Palliative Care Service to undertake a scoping exercise to look at the feasibility of providing a 9-5, 7 day a week face to face service To develop a guideline for the assessment and delivery of mouth care To liaise with the chaplaincy team regarding spiritual care and documentation of chaplaincy input To develop a nursing care plan to ensure appropriate documentation of care after death 	<ul style="list-style-type: none"> The scoping exercise has been carried out and additional clinical nurse specialists have been recruited in preparation for 7 day working. A pilot project for oral care has been carried out in 5 wards across the Trust in Feb-March 2016 – Trust-wide policy to be finalised following this Chaplaincy keep a database of patients that they see, which can be consulted by the palliative care team The newly-developed nursing care plans incorporate this
National Joint Registry	<ul style="list-style-type: none"> To discuss the issue of consent for inclusion in the audit for both elective and acute patients 	<ul style="list-style-type: none"> This issue was raised within specialty and is being monitored by the Trauma Co-ordinators. The consent rate has now risen to 83%
Epilepsy 12 National Audit Round 2	<ul style="list-style-type: none"> To include a diagnosis section with seizure and syndrome type on clinic letters; document unclassified where unable to classify To evidence communication regarding water safety in the clinic letter and Patient Information Folders. 	<ul style="list-style-type: none"> As standard practice the service adheres to both actions when relevant
National Review of Asthma Deaths (NRAD)	<ul style="list-style-type: none"> To raise awareness of the smoking cessation services offered by City 	<ul style="list-style-type: none"> Referrals to the smoking cessation services are made, where required. In

	<p>Healthcare Partnership (CHCP) within asthma clinics</p> <ul style="list-style-type: none"> To promote the importance of the correct inhaler technique within the local healthcare body via local audit 	<p>addition, leaflets for the City Healthcare Partnership smoking cessation service are available on the ward</p> <ul style="list-style-type: none"> This audit was completed in 2015 and, as a result, regular training on correct inhaler technique is conducted at respiratory departmental teachings
National Audit of Inpatient Falls (pilot)	<ul style="list-style-type: none"> To implement the new falls tool within the Trust To develop an educational and training package to support the implementation of the new falls tool To implement the falls information leaflet within the Trust 	<ul style="list-style-type: none"> The new falls tool has been implemented 'Falls: Assessment and Intervention' course is available to all staff members via the online learning portal at HEY247.net 'Staying Safe in Hospital (Falls Prevention)' is now available within the Trust, or via the Trust's internet site

The reports of 193 local clinical audits were reviewed by Hull and East Yorkshire Hospitals NHS Trust in 2015/16. For an update on the progress of the actions identified as a result of local clinical audits completed in 2015/16 and proposed actions for 2016/17, 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 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 2715.

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 156 clinical research studies of which 120 commenced during the reporting period 2015/16. This compares with 184 new submissions and 151 commencing in 2014/15.

The Trust used national systems to manage the studies in proportion to risk. Of the 120 studies given permission to start, 95 were National Institute for Health Research (NIHR) portfolio adopted and 80% (76) of these were given permission by an authorised person in 15 days or less following receipt of a valid application.

The Trust has 173 studies actively reporting accruals (patient recruitment) under the NIHR Clinical Research Network (CRN) Portfolio, as compared to 174 portfolio studies reporting accruals for the period 2014/15.

The number of recruits into the Trust portfolio studies for the periods 2014/15 and 2015/16 was 3,800 and 2,300 respectively. A target of more than 3,500 patient accruals is expected to be set for 2016/17. The largest topic area of

portfolio adopted studies across 2015/16 is Oncology (Cancer) and Haematology with 55 studies between them. The top five therapeutic areas of Trust research in 2015/16 were:

- 1) Oncology and Haematology
- 2) Cardiology
- 3) Diabetes and Endocrinology
- 4) Gastroenterology
- 5) Renal and Respiratory (joint fifth)

In the last year, over 50 publications have resulted from our involvement in portfolio and non-portfolio research across four specialty areas. 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 for the population we serve is still a significant challenge to be overcome by all NHS organisations. However, 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:

Paediatrics:

- The Trust is assisting in the collation of 10 years data regarding growth hormone use in children (Nordinet) which is showing useful trends with the use and effect of growth hormone. In participating in this work the Trust has benefited from the use of an online database for managing all our endocrine patients, not just the ones taking part in the study. This has become an indispensable tool for our clinical service and we are hoping to continue using it after the study finishes.
- A second similar study (ECOS) has completed data collection and analysis will start soon. This study used an electronic drug delivery system to see how much growth hormone was used over a given time and if it correlated with growth outcomes. Historically studies relied on patient's reporting missed doses (recall) which can be unreliable. This device is the first one to give us accurate data about drug use. Again, this system will be available to clinicians to monitor adherence, which is particularly important with expensive long term treatments, providing another benefit to the local service.

Vascular Surgery:

- Laser surgery developed by researchers in Hull means that sufferers of varicose veins no longer need to have invasive open surgery. The Academic Vascular Surgery Unit pioneered a 'walk-in, walk-out' treatment performed under local anaesthetic utilising laser technology. Instead of being removed, veins are destroyed using laser-generated heat delivered from within the vein itself. This results in the vein being reabsorbed by the body. Patients showed a quicker recovery, reduced recurrence rate and fewer complications when compared with traditional open surgery. NICE now recommends this as a first line treatment.

Diabetes:

- The Trust was the first and only site in the UK to recruit patients into the VITAL growth hormone deficiency study and Harmony10, an insulin based study for type 2 Diabetics.

Breast Care:

- The Trust contributed to research impact directly showing the drug Anastrozole effectively reduces the incidence of breast cancer in high-risk postmenopausal women. Indirectly this work demonstrates an ability to provide a good follow-up framework that undoubtedly provides reassurance to these women.

Imaging:

- A £10m investment from the local community, Trust and the University of Hull in a PET-CT Centre represents a truly exciting opportunity for research development in Hull and will undoubtedly be a crucial foundation on which to build a clinical trials unit putting Hull at the forefront of research in this area.

Microfluidics:

- The Trust is helping to support the University of Hull undertake pioneering research in the use of scaled down systems to analyse or study various tissues such as blood and tumour biopsies, with the aim of predicting certain features of behavioural qualities of the tissue (microfluidics). This work has many practical spin-offs. The work in Hull has attracted funding in excess of £4 million with successful grants from institutions including EPSRC and the Home Office.

Ophthalmology:

- Ophthalmic research continues to develop with a big impact on patient care. Examples include a UK wide study looking at reducing the burden of injection therapies into the eye for diabetic eye disease. Injections into the eye are now a common treatment in Ophthalmology and whilst patients tolerate the injections well they find the constant cycle of treatment with injections sometimes every month for several years onerous. Any reduction in the number of injections needed by combining them with laser would therefore be welcome to this patient group.
- Another potentially important international study observes the progression of one of the commonest diseases causing blindness (dry age-related macular degeneration) which is currently untreatable. This study looks for a previously proven genetic pre-disposition and has proven popular with patients who appreciate the six monthly monitoring in the study which is not usually offered within standard NHS care. Treatments for this disease are in phase III studies at present but will only be effective in certain sub-types of patients so this study is increasing the knowledge of local Ophthalmologists as to how to identify the patients who may in the future benefit most from new therapies.
- Usman Mahmood one of our Consultant Ophthalmologists has also designed a study in collaboration with the University of York looking at the development of amblyopia in young children and how brain activity changes during therapy for amblyopia. Amblyopia or a "lazy eye" is a common cause of unilateral visual loss in childhood and generates a huge screening and intervention programme for the NHS - any better understanding of how the brain responds during amblyopia therapy may therefore have a big impact.

Critical Care:

- The Critical Care units at Hull Royal Infirmary recently started to participate in a research study called POPPI (<https://www.icnarc.org/Our-Research/Studies/Poppi/About>). Critical Care units can be stressful area for patients and families due to a patient's condition, the noise of alarms and the unusual environment. As a result there is evidence that patients who spend extended periods in Intensive Care Units suffer longer term psychological problems. The POPPI study is looking at helping by providing psychological support to patients after their admission to critical care in attempt to reduce these problems.
- Participating in this study has enabled three members of critical care nursing staff (non-research) to be trained in providing psychological support for critical care patients during their hospital stay. Alongside this an eLearning training package for all the critical care staff has been provided to improve staff awareness of the psychological impact on patients and facilitate improvements in the clinical environment. With only 11 other hospitals sites able to access this bespoke training, this study offers local critical care patients the opportunity to access care otherwise not available in a majority of NHS Trusts. It also begins to help address compliance with NICE guidance 83 and the recent Guidelines for Provision of Intensive Care Services (GPICS).

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 2015/16 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 potential financial value for 2015/16 was £10.5m of which £7.6m was Clinical Commission Groups (CCGs) and

£2.9m NHS England services. Of the NHS England schemes the Trust did not deliver on 2 schemes, the installation of the clinical utilisation tool (£130k) and the rheumatology network scheme in quarters 3 and 4 (£70k). Thus 93% of the NHS England target was achieved.

The Trust achieved all the local CCG schemes but did not deliver against all of the national schemes. The Trust made significant improvements in the roll out of the new 2015-16 national schemes Acute Kidney Injury (AKI) and Sepsis which started from a zero position and improved to 49% and 75% respectively. Unfortunately the Trust was not awarded the full 100% achievement for either of these improvements and lost £780k due to the scaling methodology used for achievements. Sepsis therefore was only awarded 10% in Q4 and no payment achieved for AKI. The Trust also did not deliver 50% improvement in Q4 for the recording of Mental Health in Emergency departments which was worth £300k. Thus the Trust delivered 85% of the CCG schemes.

The Trust has worked closely with all commissioners to develop a programme of CQUIN quality indicators for 2016/17.

The Trust has finalised and signed off all CQUIN schemes for 2016/17.

There are a small number of local CCGs CQUIN schemes being carried forward for a further year in 2016/17.

Local 2 year CCG schemes are:

- Maternity Safety Thermometer
- Patient experience for trauma orthopaedic admissions

Local CCG Schemes include:

- Appropriate diagnostics for 2 week waits in upper and lower GI cases
- Fast track hip and knee replacement
- John's campaign for dementia
- Nutritional and hydration audit
- Emergency Care Improvement Programme (ECIP) frailty pathway

National CQUIN schemes for CCGs include:

These include an extension to the Sepsis scheme from 2015/16 with the expansion into the inpatient setting. There are new schemes which include;

- Health and Wellbeing initiatives;
- a reduction in sugary food for staff and visitors ,
- increase flu vaccination uptake
- Antimicrobial Resistance reduction

NHS England Specialised Services (NHSE) include mandatory schemes:

- Clinical Utilisation Review (CUR) Scheme,
- Spinal network with data input to spinal register,
- Adult Critical Care timely discharge,
- Hepatitis C for the Operational delivery network which HEYHT is responsible for ensuring the governance and partnership working across the Hepatitis C network

The Trust has agreed not to pursue the Clinical Utilisation scheme as outlined by NHS England but have offered to use in house tools to deliver the same information, this is still in discussion. NHS England is linking £235k CQUIN to Quality, Innovation, Productivity and Prevention Programme (QiPP) delivery in 2016/17.

NHS England specialised commissioned local schemes:

There are further local schemes from the NHSE specialised portfolio that Hull and East Yorkshire Hospitals NHS Trust has 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

Further details of the agreed goals for 2016/17 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 2015/16.

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

The Care Quality Commission rates Hull and East Yorkshire Hospitals NHS Trust as 'Requires Improvement' – May 2015

The Care Quality Commission (CQC) undertook a re-inspection against the Chief Inspector of Hospitals action plan from February 2014 in May 2015 and provided an overall rating of 'Requires Improvement'.

The re-inspection took place between 19th and 21st May 2015 and covered all areas that were rated as 'Requires Improvement', including Surgery, Medical Care, Urgent and Emergency Care, Children and Young People and Outpatients. The CQC also assessed the staffing element of the Maternity Services during the inspection, although they

were rated as a 'Good' following the February 2014 inspection.

A breakdown of the Trust's ratings from the May 2015 re-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	Inadequate	Requires Improvement
Overall Trust rating	Requires Improvement				

Table 2 – Ratings for Hull Royal Infirmary (HRI)

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

*these ratings were from the February 2014 Chief of Hospitals inspection because they were rated as good, they were not fully re-inspected in the May 2015 inspection and therefore the ratings remain in place as good.

Table 3 – Ratings for Castle Hill Hospital (CHH)

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

*these ratings were from the February 2014 Chief of Hospitals inspection because they were rated as good, they weren't fully re-

inspected in the May 2015 inspection and therefore the ratings remain in place as good.

Areas for improvement

The Trust accepted all of the 47 recommendations made by the CQC following the re-inspection in May 2015. 20 of the recommendations were 'must do' actions and 27 were 'should do' actions. Areas of improvement included:

- Address the breaches to the national targets for the Emergency Department and referral-to-treatment times to protect patients from the risks of delayed treatment and care
- Improve the reporting of performance of Histopathologist service
- Ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly on the elderly care wards, consultant and nursing cover within the Emergency Department; Histopathologist, Echocardiography Team and surgical wards
- Ensure that all incidents are investigated in a timely manner, that lessons are learnt and that duty of candour requirements are effectively acted upon and audited
- Ensure that there is a policy and procedures in place to ensure that there is effective transition for young people to adult services
- Ensure appropriate arrangements are in place to respond to major trauma and incidents within the Emergency Department
- Ensure that there is an effective and timely system in place, which operates to, responds to, and acts on, complaints
- Ensure that there are robust processes in place for the checking of equipment particularly resuscitation equipment on the medical wards
- Take actions to protect children and young people from the risk of self-harm and/or injury by ensuring that on the 13th floor the ligature and anchor points on the ward are addressed, and that there is an appropriate "safe room" for the use of children and young people with mental health problems
- Ensure that patients' nutrition and hydration is maintained in a timely manner
- Ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards.
- Ensure that controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within the Emergency Department and children's services
- Ensure that call bells are within reach of the patient at all times
- Ensure that appropriate procedures are in place to obtain consent for hysteroscopy within outpatients

Good practice

Examples of good practice were identified during the CQC re-inspection in May 2015 including:

- The CQC identified the Radiology discrepancies peer review process as an outstanding example of governance. The peer review process focussed on openness and learning and displayed a sensible application of legislation
- The Plastics team, based in outpatients, had developed a one stop service for patients to attend the department and be immediately listed for Theatre when appropriate
- The Trust had responded to previous concerns regarding staffing and was actively recruiting
- The Trust had rectified concerns previously raised in relation to governance of safeguarding arrangements
- There had been a positive change to the culture of the organisation and the appointment of anti-bullying tsar
- The opening of the new Emergency Department represented a substantial improvement in the facilities for the Trust in that emergency care and treatment was provided in a suitable environment
- Overall the CQC observed positive, kind and caring interactions between staff and patients
- Most patients the CQC spoke with felt they were emotionally supported
- Work had been introduced to improve the experience for dementia patients and further work was planned including changing the menu, introducing new visiting times and the use of dining companions
- Physiotherapists had introduced a neon wristband on the elderly care wards to alert staff if patients needed assistance with mobilising or required a walking aid
- The development of extended roles and the exploration of technical apprenticeships along with the glaucoma monitoring scheme and the introduction of nurse practitioners and virtual clinic were improving the management of increasing demand as well as dealing with historical waiting lists

In response to the recommendations from the CQC a Quality Improvement Plan was developed to address all areas which required improvement and services that were rated as inadequate.

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, 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 2015/16 and those that are linked to the pledges.

Key

- ✓ Improvements achieved – project closed
- ☑ Improvement made compared to last year. Project carried forward onto the 2016/17 plan for further monitoring
- ✗ No improvements made

Ref	QIP Project	Aim	Source	Status 2015/16
QIP01	Risk and incident management	The aim of this project is to ensure there are effective systems and processes in place to ensure incidents and serious incidents are investigated in a timely manner and lessons are learnt and disseminated	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 maintain compliance with CQC Regulation 13: Safeguarding and to improve the processes for 1 to 1 patient watch and restraint, documentation of potential vulnerable children in ED and compliance with safeguarding children level 3 training	CQC	☑
QIP05	Medication Safety	The aim of this project is to provide 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 through the use of observations to identify which patients require end of life support and to ensure end of life care plans are documented and include a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order form to avoid inappropriate attempts at resuscitation	Sign up to safety and Quality Account	<input checked="" type="checkbox"/>
QIP07	Deteriorating Patient (Children)	The aim of this priority is to ensure early identification of a child's deterioration through the use of observations and the Paediatric Advance Warning System (PAWS) to identify the requirement of prompt intervention or treatment and to prevent avoidable deterioration	Sign up to safety and Quality Account	<input checked="" type="checkbox"/>
QIP08	Infection Control	The aim of this project is to ensure compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015)	CQC	<input checked="" type="checkbox"/>
QIP09	Falls	The aim of this project is to reduce the number of falls and the level of harm caused from falls by undertaking falls improvement work to understand the root causes of falls and to implement prevention measures to raise awareness of falls and improve the assessment of risk	Sign up to safety and Quality Account	<input checked="" type="checkbox"/>
QIP10	Avoidable Pressure Ulcers	The aim of this project is to reduce the number of patients who acquire avoidable hospital acquired grade 3, 4 or unstageable pressure ulcers. To ensure the appropriate risk assessments are undertaken to identify patients who are at risk of developing pressure ulcers and the implementation of the Skin Care Bundle	Sign up to safety and Quality Account	<input checked="" type="checkbox"/>
QIP11	Maternity Services	The aim of this project is to monitor Midwifery and Consultant staffing establishments and to undertake a review against the Kirkup Morecambe Bay report to ensure the Maternity Services provided are safe and lessons are learned from external reviews	CQC	<input checked="" type="checkbox"/>
QIP12	Children and Young People with Mental Health Needs	The aim of this project is to improve access to the local Child and Adolescent Mental Health Services (CAMHS) for Children and Young People within the Children's Emergency Department and to improve the facilities on the 13th floor and support provided to the vulnerable Children and Young People admitted	CQC	<input checked="" type="checkbox"/>
QIP13	Environment (Theatres and General Clinical Areas)	The aim of this project is to remedy the immediate issues identified during the CQC inspection in May 2015 and to ensure Theatres are fit for purpose to meet all legislative requirements	CQC	<input checked="" type="checkbox"/>
QIP14	VTE	The aim of this project is to continue to achieve the 95% of patients assessed for VTE within 24 hours of admission	Sign up to safety and Quality Account	<input checked="" type="checkbox"/>
QIP15	Sepsis	The aim of this project is to raise awareness of the Sepsis Six, implement the Sepsis care bundle and reduce death from Sepsis. In addition approximately 50% of patients coded with sepsis attending ED do not have it. The project intends to improve coding of this condition	Quality Account and CQC Mortality Outlier Alerts	<input checked="" type="checkbox"/>
QIP16	Resuscitation Equipment	The aim of this project is to ensure that all resuscitation equipment trolleys checking procedures are completed in accordance with the Trust's policy	CQC	<input checked="" type="checkbox"/>
QIP17	Hysteroscopy Consent	The aim of this project is to implement patient consent for women undergoing a hysteroscopy and adherence to the WHO checklist within outpatients	CQC	<input checked="" type="checkbox"/>

QIP18	Histopathology	The aim of this project is to improve the staffing numbers of suitably skilled and qualified staff in line with best practice (5 out of 13 consultant posts vacant) and to improve performance against the reporting of cell pathology test results	CQC	✓
QIP19	Governance	The aim of this project is to ensure there are systems established and operated effectively to ensure the Trust is able to assess, monitor and ensure compliance with all aspects of quality and safety	Sign up to safety and 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 missed and delayed diagnosis comply with the duty of candour requirements	CQC	☑
QIP21	Training, Appraisal and Supervision	The aim of the project is to ensure that all Trust staff have access to and are provided with statutory, mandatory and developmental training and learning that all staff receive regular and constructive appraisal and supervision	CQC	✓
QIP22	Nutrition and Hydration	The aim of this project is to ensure patients have 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 ensure that staff who are involved in caring for patients living with dementia are suitably trained, for example portering staff and that only staff who are involved in caring duties, including dealing with patients exhibiting challenging behaviour due to mental health illness or dementia, support patients	CQUIN and CQC	☑
QIP24	Children and Young People Services	The aim of this project is to continue to improve facilities for children, young people and their parents on the 13th floor and to ensure the service is responsive to the needs of its service users	CQC	☑
QIP25	Major Trauma	The aim of this project is to improve the communication and availability of its Major Incident Plan and provide adequate training to ensure staff are able to respond appropriately. Equipment must also be checked frequently and fit for purpose	CQC	✓
QIP26	Health 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 confidentiality is maintained	CQC	☑
QIP27	Patient Communication	The aim of this project is to improve escalation and information to the Trust Board relating to PALS and Complaints to ensure all Trust Board members have an understanding of the patient stories and experiences across the Trust	CQC	✓
QIP28	Patient Experience	The aim of this project is to seek and act on feedback from our patients their relatives and carers. This will enable us to learn what is working well and what requires further improvement and to use the feedback to inform those required changes. This will ensure the services are responsive to our service users	Sign up to safety, Quality Account and CQC	☑
QIP29	Missed and Delayed Diagnosis	The aim of this project is to reduce the number of missed and delayed diagnosis Serious Incidents and to improve patient safety	Sign up to safety, Quality Account 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 2015/16 Quality Improvement Plan were due to be improved by the end of March 2016. All improvement areas that achieved the improvement goals and targets were closed and signed off at the April 2016 Operational Quality Committee. Achievements made against the Quality Account priorities in the plan are all detailed in this Quality Account report (pages 10 to 29).

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 2016/17 Quality Improvement Plan. Further information on the 2016/17 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/>

The Care Quality Commission comprehensive inspection of Hull and East Yorkshire Hospitals NHS Trust – June 2016

The Care Quality Commission is undertaking a full comprehensive inspection in June 2016.

The comprehensive inspection is taking place between 28 June and 01 July 2016 and covers 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.

The inspection was taking place at the time of publication of the Quality Account; therefore further information on the inspection, hospital ratings and recommendations for improvement will be included in the next year's Quality Account.

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 Trust has established a number of processes to support staff in delivering the Duty of Candour requirements. The Trust has recently refreshed its values which are Care, Honesty and Accountability and has encouraged all staff, at all levels, to be open and transparent when things go wrong with care and treatment.

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.

The following support and guidance has been provided to staff:

- A definition of when Duty of Candour applies, providing staff with more information to assist in their understanding and application of the Duty
- The Trust's Being Open Policy has been updated to include Duty of Candour requirements

- A flow chart has been produced which sets out the steps that staff need to follow
- The Trust Duty of Candour staff intranet site has been refreshed and now includes clinical examples of when the Duty needs to be applied as well as the policy, process, definition and awareness and training information
- Duty of Candour awareness and training sessions have been provided by the Risk Team
- The Trust solicitor presented at the Medical Grand Round from a legal perspective of the Duty of Candour. This covered when the Duty should be applied, how the Duty should be applied and also reiterated that the provision of an apology is not an admission of liability
- The Duty of Candour definition and processes to be followed are discussed with staff during the internal 3G ward inspections
- Audit of the compliance with the Duty of Candour has been undertaken. The initial audits identified that the process needed to be streamlined and made easier for staff to follow, which has now been done.

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

The Care Quality Commission assessed the Trust in May 2015 against the Duty of Candour requirements. The CQC found that staff were aware of their responsibilities under the Duty of Candour requirements. The Trust is compliant with CQC Regulation 20: Duty of Candour.

The Trust 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.

Data Quality

NHS number and general practice code validity

Hull and East Yorkshire Hospitals NHS Trust submitted records during 2015/16 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:

99.89% for admitted patient care;
99.86% for outpatient care; and
99.86% 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 is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It is fundamental to the secure storage, transfer, sharing and destruction of data both within the organisations and between organisations.

Hull and East Yorkshire Hospitals NHS Trust's Information Governance Assessment Report overall score for 2015/16 was 68%. Seven standards were reaching Level 2 and above, but further evidence was required for eight standards. Action plans are in place for all of these.

Clinical Coding Error Rate

Hull and East Yorkshire Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2015/16 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. Possible areas; UGI Maxillofacial / Oral Surgery ENT	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	Improve timeliness of day-to-day coding.	Ongoing
R4 - Improve case note quality by monitoring the state of the case notes and assessing the availability of information and report any issues.	Medium	Assess case notes through routine audits and issues are regularly reported to the patient records committee (PRC).	Ongoing
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

Part 5: Looking forward – our plans for the future



This section includes:

- Information on how the Trust consulted on the 2016/17 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 2016/17 the Trust has put together a long list of potential quality improvement priorities by:

- Evaluating our performance against our quality and safety priorities for 2015/16
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2015/16
- 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 2016/17 the following actions were undertaken:

- An online survey was developed and circulated to all Trust staff and patient members and stakeholders, for their feedback. This year 151 people completed the online survey in February 2016
- A stakeholder event was held on the 22 February 2016 where Health & Well Being Boards, Healthwatch and Clinical Commissioning Groups from Hull and East Riding attended to receive feedback on achievements against the 2015/16 quality and safety improvement priorities and to consult on the content of the 2015/16 Quality Account and the 2016/17 priorities
- 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 2016/17 priorities
 - Quality Committee for approval of the 2016/17 priorities
 - Trust Board for ratification of the 2016/17 priorities

The Trust has identified these quality improvement priorities for 2016/17 because they are important to our staff, patients and stakeholders:

Quality and Safety Improvement Priorities for 2016/17

1. Medication Safety
2. Deteriorating Patient – Adult
3. Avoidable Hospital Acquired Pressure Ulcers
4. Nutrition and Hydration
5. Avoidable Patient Falls
6. Venous Thromboembolism (VTE)
7. Avoidable Hospital Acquired Infections
8. Sepsis
9. Missed and Delayed Diagnosis
10. Avoidable Mortality
11. Care for Older People
12. Care for people with Mental Health needs
13. Handover Arrangements
14. Learning Lessons
15. Patient Experience

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

1. Medication Safety

What do we want to achieve?

The aim of this priority 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 patients.

The specific aims of this project are:

- 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

How will we measure this priority?

- 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%

*This measurement may be reviewed depending on the Trust's continuation with the national Medication Safety Thermometer measuring tool

How will we monitor and report on progress?

This priority will be monitored at the Safer Medication Practice Committee with leadership from the Chief Pharmacist.

2. Deteriorating Patient (Adult)

What do we want to achieve?

The aim of this priority 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 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.

How will we measure this priority?

- 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 $\geq 95\%$ compliance with the completion of the monthly resuscitation equipment checks

How will we monitor and report on progress?

This priority will be monitored at the Resuscitation and Deteriorating Patient Committee with leadership from the Resuscitation Manager.

3. Avoidable Hospital Acquired Pressure ulcers

What do we want to achieve?

The aim of this priority is to prevent any patient developing avoidable hospital acquired pressure ulcers. This project will also aim 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.

How will we measure this priority?

- 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

How will we monitor and report on progress?

This priority will be monitored by the Nurse Director team with support and leadership from the Tissue Viability Team.

4. Nutrition and Hydration

What do we want to achieve?

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.

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?

- 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

How will we monitor and report on progress?

This priority will be monitored at the Nutrition Steering Group with leadership from the Nurse Director for the Surgery Health Group.

5. Avoidable Patient Falls

What do we want to achieve?

The aim of this priority is 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 will build on this work. The focus will be 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 will 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.

How will we measure this priority?

- 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

How will we monitor and report on progress?

This priority will be monitored at the Falls Committee. The lead for this project will be the Surgery Health Group Falls Lead.

6. Venous Thromboembolism (VTE)

What do we want to achieve?

The aim of this priority 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
- Maintain 0 VTE Serious Incidents

How will we monitor and report on progress?

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

7. Avoidable Hospital Acquired Infections

What do we want to achieve?

The aim of this priority is to ensure compliance with the updated Health & Social Act (2008): code of practice on the prevention and control of infections and related guidance (2015) which will then reduce the number of avoidable hospital acquired infections.

How will we measure this priority?

- 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

How will we monitor and report on progress?

This priority will be monitored at the Infection Control and Prevention Committee with leadership from the Director of Infection Control and Lead Nurse for Infection Control.

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 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?

- 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)

How will we monitor and report on progress?

This priority will be monitored at the Mortality Committee with leadership for the lead Consultant and Nurse for Sepsis within the Trust.

2. Missed and Delayed Diagnosis

What do we want to achieve?

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

The aim of this priority is 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.

How will we measure this priority?

- 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

How will we monitor and report on progress?

This priority will be monitored at the Radiology Department Monthly Governance Committee with leadership from the Clinical Directors for Radiology (Dr Oliver Byass and Dr Tony Goldstone).

3. Avoidable Mortality

What do we want to achieve?

The aim of this priority 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?

- 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)

How will we monitor and report on progress?

This priority will be monitored at the Mortality Committee with leadership from the Chief Medical Officer.

4. Care for Older People

What do we want to achieve?

The aim of this priority 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. This project will also look to develop, in partnership with other providers further end of life care planning and management of the community management of the frail elderly.

How will we measure this priority?

- 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

How will we monitor and report on progress?

This priority will be monitored through the Urgent and Emergency Care Portfolio with leadership from the Chief Operating Officer.

5. Care for People with Mental Health needs

What do we want to achieve?

The aim of this priority 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.

How will we measure this priority?

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

How will we monitor and report on progress?

This priority will be monitored through the Urgent and Emergency Care Portfolio with leadership from the Chief Operating Officer.

6. Handover Arrangements

What do we want to achieve?

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

How will we measure this priority?

- 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)

How will we monitor and report on progress?

This priority will be monitored through the Urgent and Emergency Care Portfolio with leadership from the Chief Operating 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.

Improved Experience (Caring, Responsive and Well-led)

1. Learning Lessons

What do we want to achieve?

The aim of this priority 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.

How will we measure this priority?

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

How will we monitor and report on progress?

This priority will be monitored at 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 patients, relatives and carers. This will enable the Trust to learn what is working well and what requires further improvement and to use feedback to inform required service changes. The project will aim to improve the standard of information provided to patients to ensure they receive relevant information and are able to make informed decisions.

This will ensure the services we provide are more responsive to patients.

How will we measure this priority?

- Achieve 95% of patients who would recommend the Trust to their friends or 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

How will we monitor and report on progress?

This priority will be monitored at the Patient Engagement and Experience Forum with leadership from the Assistant Chief Nurse (Patient Experience).

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 2015/16 Quality Account was forwarded to key stakeholders on the 06 May 2016 with a request for statements of no more than 500 words to be received before the 03 June 2016. 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 it 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

*This statement has also benefitted from a review by NHS North Lincolnshire Clinical Commissioning Group and NHS North East Lincolnshire 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 2015/16. The report illustrates a focus on improving the quality of patient care in 2015/16 and the progress still to make.

We recognise that there are new performance indicators for monitoring quality for 2015-16 which has been included in the report. The CCG feel that the report could better reflect what has and has not been achieved in 2015-16, as some of the measures show as achievement when they are below target or do not compare with the baseline position.

The CCG welcomes the significant work on Learning Lessons from incidents included in the report. We wish to encourage the continued recognition and reporting of all incidents as opportunities to identify improvements. The Trust remains around the level of the lowest quartile on patient incident reporting rates compared with National Reporting and

Learning System (NRLS) data therefore we encourage the Trust to continue its work on staff culture and openness in reporting, particularly as the level of harm reported by the Trust is in keeping with national trends. It is a concern that the target for reducing repeated types of Never Event has not been met. We feel that this continues the need to still effectively embed lessons learned and that this report demonstrates that this is not yet in place, despite this being a theme for the last two Quality Account reports. This continues to be a priority identified by the Trust for 2016-17, which we support in this context.


As highlighted by the report, considerable work has been undertaken to complete Serious Incident investigations within timescales, and also to complete action plans resulting from Serious Incident investigations. We acknowledge the hard work of the Trust to undertake this work. Therefore in the context of lessons learned work still to do as noted above, we wish to see this position maintained and improved in 2016-17.

In relation to the Trust's identified priorities for 2016-17, these reflect commissioner priority areas as well and the information that has been shared in 2015-16; in particular commissioners want to see improved outcomes for frail, elderly patients, in sepsis, and in deteriorating patients, as these have been repeated concerns in Serious Incidents in 2015-16. All the priorities identified by the Trust for 2016-17 are appropriate, including further work on areas that have been not been fully achieved in 2015-16 – from a patient point of view, continued improvement is vital so that all patients benefit from better practice, processes and experience.

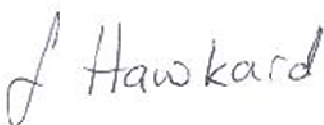
The research section details the level of recruitment into portfolio clinical trials that the Trust have made, particularly in specific topic areas and in maintaining the NIHR portfolio infrastructure, although there appears to have been a reduction in numbers of clinical trials from 2014/15 to 2015/16. The area that is not as clear is what non-portfolio work has been established and there are no examples of what impact the research has made for patient outcomes and what this has meant in practice areas. There is a positive example of how the Trust have been involved in the NIHR "OK to Ask" campaign and there are good examples of how the Trust are working with the improvement Academy as part of the Yorkshire and Humber Academic Health Science Network to make improvements in patient safety.

Finally, notwithstanding the missing year end data for some elements of the report, we confirm that to the best of our knowledge, the information contained in the report is accurate against that which has been shared with commissioners on quality of care through contract management arrangements with Hull and East Yorkshire Hospitals NHS Trust in 2015-16. We reflect again as to how the Trust conveys improvement in the data measures used in the report, particularly where targets have not been fully met but are reported as an improvement; whilst we agree that an improvement has been seen in most areas, we want to support continued interrogation of the data and the room for improvement that is evident in this report. Furthermore, there are some cross-cutting themes on quality relating to the Trust's current performance on national waiting time standards and access targets that commissioners have continuously raised in 2015-16, which we would be remiss not to reference.

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 Hawcard
Chief Officer
NHS East Riding of Yorkshire Clinical Commissioning Group

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

We believe that the Quality Accounts are representative and give a comprehensive coverage of the services that the Hull and East Yorkshire Hospitals NHS Trust provides.

We are happy with the progress that has been made in the Performance against Priorities and are satisfied that the ongoing areas will be completed in due course, as well as recognising that some improvement has been made in all areas. We commend the Trust's commitment to further improvement, even in areas where targets have been achieved, and for working in partnership with the Improvement Academy. We further commend the Trusts commitment to clinical audits.

It is clear that the Trust has learned lessons from its last CQC inspection of 'Requires Improvement' and we are satisfied that the areas for improvement highlighted by the CQC in the Quality Improvement Plan have been improved or are in ongoing improvements and we hope to see the results of this in the most recent inspection.

Whilst we are pleased that the number of so called 'Never Events' remains low, we are concerned that there has been an increase in the number of 'Serious Incidents' reported. We recognise that action has obviously been taken in regards to patient's falls since 2014/2015 and we hope that similar improvements will be made in other areas. We also recognise that this increase could be, in part, due to greater transparency.

We would like to take this opportunity to thank all the staff members of the Trust for their hard work and dedication.

Hull City Council Overview and Scrutiny Committee

The Trust provided an update on its Quality Accounts and Quality Improvement Programme to Hull City Council's Health and Wellbeing Overview and Scrutiny Commission on Thursday, 24 March, 2016. The Commission supported the joined up approach outlined by the Trust and the measures being taken to address weaknesses and improve service delivery across the organisation. The Commission hopes this year's Quality Accounts, combined with the Quality Improvement Programme, will help the Trust to attain an improved CQC rating.

East Riding of Yorkshire Overview and Scrutiny Committee

The 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 2015/16. This has included monitoring performance against the Trust's current priorities and previous CQC inspection outcomes, through joint scrutiny meetings with Hull City Council. The Sub-Committee also welcomed the opportunity to participate and comment on the development of the 2015/16 Quality Accounts through a stakeholder event and were pleased to see that comments raised at that stakeholder event have been taken into account.

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.

The Sub-committee welcome the priorities set for 2016/17, particularly the continuing priority surrounding missed and delayed diagnosis and learning lesson, two priorities that are vital for both patient satisfaction and Trust improvement.

It is hoped that the improvements made since the latest CQC continue to be sustained and that these stand the Trust in good stead in light of the next impending inspection.

Trust Response to the Statements

The Trust would like to thank all stakeholders for their comments on the 2015/16 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 2016/17 are the right ones.

A number of suggestions were also noted from the formal stakeholder statements. The Trust would like to respond to these via this section of the Quality Account.

Healthwatch Kingston upon Hull and Healthwatch East Riding of Yorkshire	
<p><i>Whilst we are pleased that the number of so called 'Never Events' remains low, we are concerned that there has been an increase in the number of 'Serious Incidents' reported. We recognise that action has obviously been taken in regards to patient's falls since 2014/2015 and we hope that similar improvements will be made in other areas. We also recognise that this increase could be, in part, due to greater transparency.</i></p>	<p>During 2015/16 a significant amount of work has been undertaken to improve the management and learning from Serious Incidents. Some of these include:</p> <ul style="list-style-type: none"> • The codes in DATIX have been reviewed and aligned to national codes to ensure the Trust is able to make direct comparisons with peer groups and identify themes, trends and learning from other organisations • Learning lesson video has been produced following a retained swab to focus on that type of Never Event and to raise awareness of these errors and how to avoid them re-occurring • The Radiology Department identified an incident theme of failure to complete all of the relevant checks. The department has produced various information for patients and staff to raise awareness of the incidents and what actions have been taken as a result and guidance to ensure all of the checks are completed correctly • Improvement work also continues on reducing the number of hospital acquired pressure ulcers as this was highlighted as an area for improvement and also is one of the top 5 patient safety incidents reported • Analysis of other incident themes includes outpatient appointments and transfer for care (discharges). Improvement work for these areas is being carried out through the Outpatient Transformation Project and the Emergency Department action plan <p>The improvement work linked to incidents, Serious Incidents and Never Events will continue during 2016/17 and will be reported in next year's Quality Account.</p>

NHS Hull Clinical Commissioning Group and East Riding of Yorkshire Clinical Commissioning Group	
<p><i>The CCG feel that the report could better reflect what has and has not been achieved in 2015-16, as some of the measures show as achievement when they are below target or do not compare with the baseline position</i></p>	<p>The performance data tables have been updated to reflect the correct achievement status following the clarification of some of the targets and data.</p>
<p><i>The area that is not as clear is what non-portfolio work has been established and there are no examples of what impact the research has made for patient outcomes and</i></p>	<p>The participation in clinical research statement has been further updated since the draft Quality Account was shared with the Stakeholders. The statement now</p>

<p><i>what this has meant in practice areas. There is a positive example of how the Trust have been involved in the NIHR “OK to Ask” campaign and there are good examples of how the Trust are working with the improvement Academy as part of the Yorkshire and Humber Academic Health Science Network to make improvements in patient safety.</i></p>	<p>includes more information on the impact the research has made on patient outcomes in a number of areas across the organisation. This information can be found on pages 54 to 55.</p>
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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

28.06.16Chair

28.06.16Chief Financial Officer on behalf of the
Chief Executive

Independent Auditor's Report

INDEPENDENT AUDITOR'S 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 2016 ("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 2016 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 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 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;

- joint feedback from the four local Commissioners dated 03/06/2016;
- feedback from Local Healthwatch groups dated 03/06/2016;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the latest national patient survey for 2015 dated 08/06/2016;
- the latest national staff survey for 2015 dated 22/03/2016;
- the Head of Internal Audit's annual opinion over the Trust's control environment for 2015/16 dated May 2016;
- the annual governance statement dated 26/05/2016;
- the Care Quality Commission's three Quality Reports dated 13/10/2015; and
- the Trust's QIP progress report dated February 2016.

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.

Basis for qualified conclusion

We sample tested the indicator for the percentage of patients risk-assessed for venous thromboembolism (VTE). The results showed 6 out of 24 cases where the patient's records included their risk assessment but the Lorenzo administration system did not show that their assessment had been undertaken. As overall VTE reporting used data from the Lorenzo system, this significantly understated the Trust's performance and suggested that the dimensions of data quality for reliability and validity had not been met. Consequently we are unable to give limited assurance on the Percentage of patients risk-assessed for venous thromboembolism (VTE) Indicator included in the Quality Account for the year ended 31 March 2016.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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 indicator in the Quality Account subject to limited assurance (Rate of clostridium difficile infections) has 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.

A handwritten signature in black ink that reads "KPMG LLP". The signature is written in a cursive, slightly slanted style. It is positioned on a light blue rectangular background.

KPMG LLP
1 Sovereign Square
Sovereign Street
Leeds LS1 4DA

28 June 2016

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 <u>Central Alerting System</u> 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 Indicator - 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
Governance and Assurance Department
4th Floor, Alderson House
Hull Royal Infirmary
Anlaby Road
Hull
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