



Quality Account 2013/14



Great Staff - Great Care - Great Future

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If you require any further information about the 2013/14 Quality Account please contact:
The Compliance Team on 01482 604305 or e-mail us at quality.accounts@hey.nhs.uk

Part 1: Introducing our Quality Account



Statement on Quality from the Chief Executive

Welcome to Hull and East Yorkshire Hospitals NHS Trust's 2013/14 Quality Account.....

I am pleased to present Hull and East Yorkshire Hospitals NHS Trust fifth 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 2014/15. It demonstrates our commitment to continue to improve and provide high quality safe 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 to further improve patient safety, care and experience.



In part 2 of this report (pages 33-35) we set out the quality and safety improvement priorities for 2014/15 which were identified through consultation with patients, staff, Foundation Trust members, Health and Wellbeing Boards, Healthwatch and the local community, during which 598 responses were received. As a result of the very good consultation the following quality and safety improvements priorities were identified because they are important to our staff, patients and stakeholders:

1. Deteriorating Patient

We want to improve the early recognition of patients who require support for their end of life care through the use of vital observations. Early recognition of patients will ensure their end of life care plans are agreed, appropriately documented and acted upon including the decisions and documentation relating to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders to avoid inappropriate attempts at resuscitation and to ensure that the patient's wishes are met.

2. Medication Safety

We want to improve patient safety issues relating to medicines. We want to increase the level of medicine reconciliation being undertaken across the organisation to ensure patient's current medications are documented in their medical notes on admission, reduce the number of missed doses and to improve the safety of the use of high risk medicines such as anticoagulants, opioids, injectable sedatives and insulin.

3. Dementia

The Trust has recognised that dementia remains an emerging issue; therefore it was identified as a priority for 2014/15. We want to improve the dementia training packages available for all staff (clinical and non-clinical) to increase the number of staff attending the training. This will ensure that we have an adequately trained workforce that is able to meet the specific needs of patients with dementia.

4. Learning Lessons

Learning lessons from incidents has been identified as a high priority for the Trust during 2014/15. It was identified as a quality and safety improvement priority by our staff, patients and stakeholders during the Quality Account consultation period and it was also identified as an area for improvement following the Care Quality Commission (CQC) Chief Inspector of Hospitals inspection in February 2014.

We want to improve our learning from Serious Incidents (SIs) and Never Events so that we can understand the root causes that have contributed to the incidents and what changes and improvements can be made as a result. This will ensure lessons are learned, sustainable improvements are made and similar incidents are prevented from reoccurring.

5. Sepsis

We want to improve the implementation rate of the sepsis care bundle in the Emergency Department (ED) and in the Acute Assessment Unit (AAU). The sepsis care bundle is a documented care bundle which includes three specific

treatments and three specific investigations which must be completed within one hour of identifying sepsis. It is essential that these key interventions are performed to improve the chance of survival. We want to increase the number of patients identified and commenced on the sepsis care bundle as well as the overall management of sepsis.

We have seen a number of improvements and achievements during 2013/14 as also set out in part 2 of this report (pages 6-32). The Trust has achieved continuous improvement over the past three years on reducing our Hospital Standardised Mortality Rate (HSMR) from 118.45 in 2011/12 to 89.8 in 2013/14. This improvement is also recognised in the Dr Foster 'My Guide to Hospitals' report which identifies Hull and East Yorkshire Hospitals NHS Trust as outperforming many other Trust's when it comes to HSMR. The Trust has also seen further improvements in reducing the number of avoidable MRSA and C.difficile infections, improving the number of patients receiving harm free care as well as reducing the number of avoidable stage 2 and unstageable pressure ulcers.

The Trust experienced its first inspection from the Care Quality Commission (CQC) Chief Inspector of Hospitals inspection in February 2014, which was an intense period for all. The Chief of Hospitals inspection was welcomed by the Trust Board and all Trust staff as an opportunity to show the quality of care provided at HEYHT and to learn and further develop our services. The CQC identified a number of good practices, for example the excellent End of Life service provided by the Palliative Care Team and the introduction of the Pioneering Teams. The CQC also identified a number of areas for improvement, in particular the Acute Medical Pathway, Nurse staffing, Junior Doctor staffing, Outpatient cancellations and learning lessons from incidents. We are now working with stakeholders to finalise a quality improvement plan to address all areas of improvement within the next 12 months. Further information on these work-streams can be found throughout this report. The approved action plan and updates against work-streams will be published on the Trust's website during 2014/15.

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 4 of this report (pages 59-62). 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 with their support.

I can confirm that the Board of Directors has reviewed the 2013/14 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate fair account of our performance.

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



John Saxby
Interim Chief Executive



Part 2: Our Commitment to Quality



Reducing all avoidable deaths

Hospital mortality refers to the number of patients who die whilst in and soon after leaving hospital. Mortality ratios are just one of the ways Trusts can detect potential quality issues in their organisations and should be treated as ‘smoke detectors’ in that they highlight potential problems that need investigating and possible opportunities for improvement.

The Trust uses a number of measures such as our actual rate of deaths within the hospital (crude mortality) and risk adjusted measures (such as Hospital Standardised Mortality Rate and Summary Hospital-level Mortality Indicator) which are used to compare hospitals as they take into account the impact of individual risk factors such as age, severity of illness and other medical problems that can put some patients at greater risk of death than others.

What we aimed to achieve by March 2014:

To reduce our Hospitals Standardised Mortality Rate (HSMR) to 90

To reduce our Summary Hospital-level Mortality Indicator (SHMI) to 104

To reduce our crude mortality rate to 1.4%

Actual outcome:

Our HSMR for April 2013 to December 2013 is 89.8 – ✓ **Goal achieved**

Our SHMI for April 2013 to November 2014* is 95.5 – ✓ **Goal achieved**

Our crude mortality rate is 1.47% – ☑ **Improvement made compared to last year**

What is Hospital Standardised Mortality Rate (HSMR)?

HSMR is the ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths. It is a scoring system that works by taking a hospital’s crude mortality rate and adjusting it for a wide variety of factors, such as population size, age profile, level of poverty, range of treatments and operations provided.

What is Summary Hospital-level Mortality Indicator (SHMI)?

SHMI is a similar scoring system to HSMR, but it does not just look at the number of patients that die whilst in hospital. It also includes patients who died soon after (within 30 days) leaving hospital.

What does this data tell us?

A hospital scoring below 100 (HSMR and SHMI) would be described as having a ‘lower than expected’ number of deaths. It is important to remember that this figure does not represent actual deaths – it is just a baseline number that statisticians use to compare performance.

When Sir Bruce Keogh reviewed 14 hospitals with high mortality rates during 2013, he found that understanding mortality (and concepts such as excess and avoidable deaths) is much more complex than studying a single hospital-level indicator. There are many different causes of high mortality and no ‘magic bullet’ for preventing it.

There are factors not related to the quality of care patients receive that can, and do, affect our scores:

- The quality of the clinical coding – every clinical procedure undertaken in the NHS has its own unique code and unless these are used properly on our computer records, this can have a direct effect on the resulting HSMR score.
- Where a patient dies – compared to other parts of the country, Hull has fewer hospice beds and community-based services that help people to be with their families and loved ones when they die. As a result, we have more people who die in our hospitals when that doesn’t need to happen, or they wish to die elsewhere. Again this can affect our HSMR score.

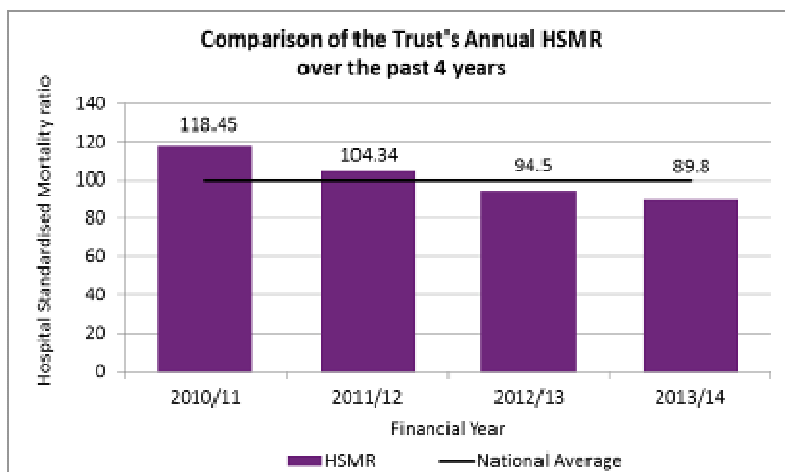
*Unvalidated HED Publication data. Validated IC publication data is only available for Q1 which is 99.5.

In 2010/11 the Trust's HSMR score was 118 which was 'higher than expected' and therefore prompted an investigation to see if this related to the quality of care being provided to our patients. What we found was a problem that the clinical codes recorded on our electronic system did not always accurately reflect the clinical reasons why patients came into hospital or why they died. The quality of our clinical coding has greatly improved due to actions taken following this investigation.

Although this work did not directly influence clinical care received by our patients, it has allowed us to see any areas where our HSMR was higher than it should have been and therefore should be investigated. For example, the 2013 Hospital Guide identified a potential problem with patients with complex illness following surgical procedures. Initial investigations suggest that half of these deaths occurred in patients who were undergoing medical procedures rather than actual surgery under anaesthetic and many of these patients were already critically ill. Firstly this shows a problem with the quality of information recorded on our systems. Secondly, that we intervene and carry out procedures on patients to give them the best possible chance of survival, even if they are really poorly.

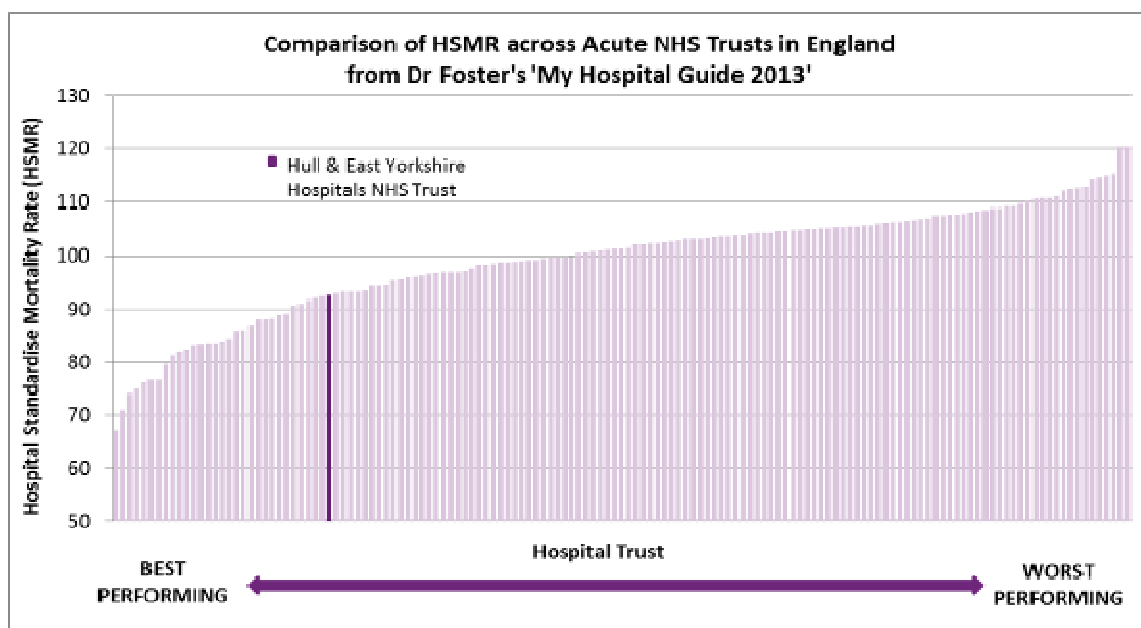
We have also been working closely with our commissioners to look at avoiding inappropriate admissions from nursing homes for end of life care. We have also increased support available to people who want to die in their own homes and this includes funding a palliative care consultant who works in the community.

The graph opposite shows that we have improved our HSMR for the past three years. During this time we have also seen a decrease in our crude mortality from 1.6% in 2011/12 to 1.47% in 2013/14. This confirms that we have seen a decrease in the number of patients dying in hospital.



How do we compare?

Each year Dr Foster Intelligence (a provider of healthcare information to monitor the performance of the NHS) publishes its 'My Hospital Guide' which provides information to the public about mortality within the NHS. In their latest guide for 2013 it shows the Trust as outperforming many other Trusts when it comes to HSMR.



Further improvements identified:

We will continue to investigate all incidences of higher than expected mortality rates and work with our partners within the community to improve services, therefore reducing the need for patients to be admitted to hospital to die.

Deteriorating patient

Patients, families and carers have a right to believe that when they are admitted to hospital they will receive the best possible care. They should feel confident that, should their condition deteriorate, they are in the best place for prompt and effective treatment.

Research shows that some patients who are, or become acutely unwell in hospital may not receive good care. A large proportion of patients who suffer a cardio-respiratory arrest in hospital have recognisable changes in routine observations during the preceding 24 hours. Action taken during these early stages can prevent deterioration progressing to cardiac arrest. Therefore we need to ensure that patients have all their observations taken on time, any early signs of deterioration are recognised and communicated, so that appropriate action can be taken to prevent cardiac arrest.

What we aimed to achieve in 2013/14:

To reduce cardiac arrest calls to 200

To sustain 95% compliance with vital sign observations

Actual outcome:

There were 289 cardiac arrests calls –

☑ **Improvement made compared to last year**

95.3% compliance with vital sign observations –

✓ **Goal achieved**

Improvements achieved:

The Trust uses a Root Cause Analysis (RCA) tool to investigate when a patient has had a cardiac arrest on a ward* and we have attempted to resuscitate them. RCA is a tool to help identify problems and improve systems of care. Through this process we have found that the Early Warning Score (EWS) that we use was not sensitive enough to provide early detection of deterioration; therefore, following a successful pilot, the Trust implemented the National Early Warning Score (NEWS) in September 2013.

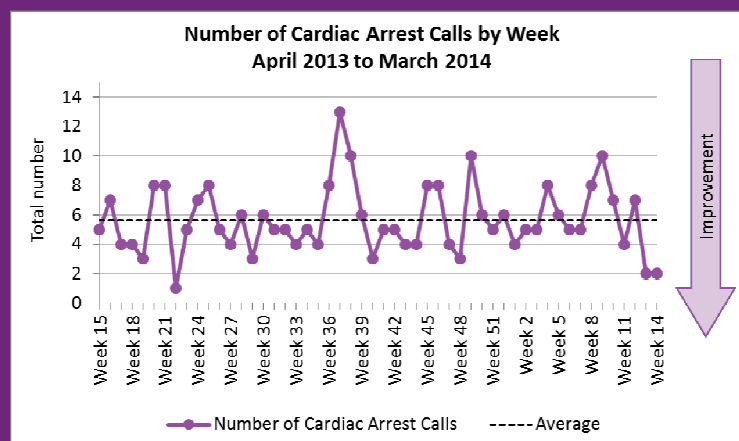
NEWS has been developed and recommended by the Royal College of Physicians[†] to provide a single, standardised early warning system across the NHS which should help to identify patients most at risk and enable their care to be escalated appropriately in order to prevent further deterioration and possible respiratory or cardiopulmonary arrest.

Following the introduction of NEWS, an audit of 781 patients from 38 wards across the Trust was conducted by the Critical Care Outreach team which showed compliance with vital signs or observations' being completed at 96%. Calls to escalate concerns about deteriorating patients to the Critical Care Outreach team have increased following the introduction of NEWS and the team has delivered training aimed to empower the nurse in charge to decide whether a call to the Critical Care Outreach team is required.

*Please note that this does not include patients in intensive care areas or patients with heart disease.

[†]Royal College of Physicians. National Early Warning Score (NEWS): Standardising the assessment of acute illness severity in the NHS. Report of a working party. London: RCP, 2012.

Although we have not met our target for 2013/14, we have seen a 16% reduction in the number of cardiac arrest calls being made compared to 2012/13.



Our weekly monitoring tool which looks at 5 observation charts on each ward shows the percentage of observation charts been completed with all vital signs (respiratory rate, oxygen saturations, temperature, systolic blood pressure, heart rate and level of consciousness).

We aim to improve our monitoring over the next year through replacing this system with a monthly point prevalence audit which will look at every patient's observation chart.

Our Improvement Story

Medical Elderly Ward 70, Hull Royal Infirmary

The NEWS was initially introduced on Ward 70 at HRI. A team of consultants, nurses and junior doctors tested small scale changes until they designed a process that ensured that patients had all of their vital signs or observations completed.



The NEWS is more sensitive than our current system and incorporates the fact that not all patients should be escalated. This highlighted the need for each patient to have a documented plan in the event of deterioration in their clinical condition to help ensure that the entire team is aware of the situation and understands the escalation plan for the patient.

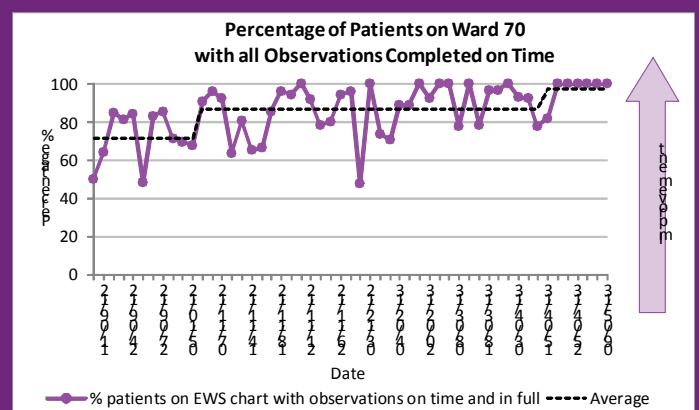
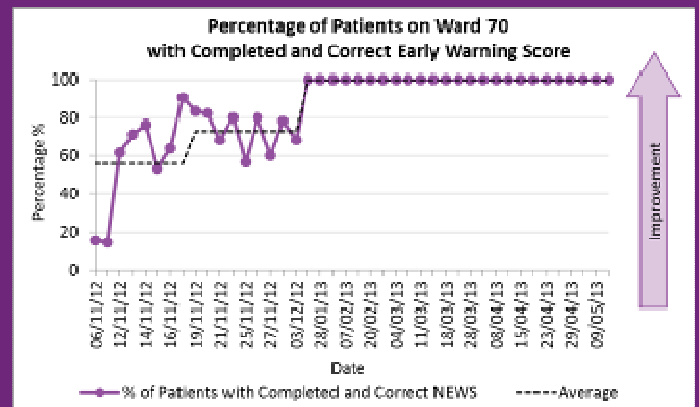
The team also improved culture on the ward through:

- Introducing daily team Safety Briefings, this helped staff become more aware of the patients who were at risk of deterioration. The briefings allow all members of the team to have up to date information about each patient and work more efficiently to promote early discharge and reduced length of stay. The safety briefings also help to highlight other patient safety issues such as falls, hospital acquired infections and pressure ulcers.
- Undertaking skills training with all the team.
- Completing a Pulse Check and a Big Conversation to help engage staff and give them the opportunity to voice their ideas to improve nutrition and the ward environment. Achievements to date include the development of an A La Carte Menu with the support of the catering team, a welcome desk at the entrance to the ward and a new nurse call system which allows an emergency bell to be used should a patient's condition deteriorate.
- The Chief Executive also visited the ward as part of the Trust Board's Leadership Walkrounds.

The team achieved a real shift in culture. Before the project started cardiac arrest calls were just a generally accepted occurrence on the ward. The nurses now feel empowered to act on and escalate their concerns to medical staff and by working together the team is able to prevent further deterioration or act in the patient's best interests if it is not appropriate to escalate care.

Results of the Pilot

- The longest spell between cardiac arrest calls was 91 days.
- The average number of days between cardiac arrests calls increased from 5 days to 44 days (an increase of 780%).
- The ward has reduced the number of cardiac arrest calls made by 75%.
- Compliance with patient's observations completed on time and in full rose from 72% to 97%.
- Compliance with a completed and correct early warning score rose from 56% to 100%.



The project was led by Consultant Dr Fiona Thomson and Sister Gill Martin. Their leadership engaged all levels of Medical and Nursing staff on the ward. This project has been recognised through the Nursing and Golden Hearts, and was nominated for a national patient safety award.

Further improvements identified:

Over the coming year the Trust will be introducing an Electronic Observations Decisions Support System [EODS]. This is a recommendation from the Francis Report.

EODS is a medical system using hand-held mobile technology that enables clinicians and nurses to collect vital signs observations on admission and throughout the patient's stay. Combined with data from patient administration, pathology, microbiology and radiology systems, EODS identifies high risk and deteriorating patients and immediately alerts a doctor. EODS addresses the fundamental question of "who, where and how is my patient?" so that interventions can be started earlier, reducing complications and potentially preventing cardiac arrests. Consultants and senior nurses can therefore check, at any time, that their patients are being monitored appropriately and their care promptly escalated when needed.

We have also identified that we need to improve with regards to deciding and documenting individual plans for patients about how their care should be escalated if their condition deteriorates. The Trust has highlighted the deteriorating patient improvement project to continue to be a priority for 2014/15.



Infection prevention and control

Methicillin-resistant Staphylococcus aureus (MRSA) is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections. It is particularly troublesome in hospitals as patients with open wounds, invasive devices (such as urinary catheters) and weakened immune systems are at greater risk of infection than the general public.

A Clostridium difficile infection (C.difficile) is a type of bacteria which may live in the bowel and can produce a toxin that can affect the digestive system.

Infection prevention and control is the responsibility of everyone because the failure to control healthcare acquired infections such as MRSA and C.difficile can have devastating effects for patients and are a common cause of harm and mortality.

What we aimed to achieve in 2013/14:

To have no avoidable MRSA

To reduce avoidable C.difficile infections to 54

55 wards (97%) have not had a case of MRSA in over a year.

31 wards (54%) have not had a case of C.Difficile in over a year.

Actual outcome:

We had 2 cases of MRSA – Improvement made compared to last year

We had 57 cases of C.difficile – Improvement made compared to last year

Improvements achieved:

Many patients who develop C difficile diarrhoea can be identified in advance as being at high risk, especially people who have had previous infection documented. In July 2013 the Trust introduced a C. difficile passport in partnership with City Healthcare Partnership Hull to identify any patient who is at risk or has previously been C difficile positive. An alert has also been placed on our electronic system 'Patient Centre' to alert any member of staff providing care for the patient.

The Trust has reviewed the cleaning materials it uses, which has resulted in changing from hypochlorite based disinfectant to chlorine dioxide across the Trust from 31st March 2014.

The Trust has increased the size of its monitoring team to ensure that all of the National Specification for Cleanliness in NHS frequencies is met in all risk areas. The Trust Facilities team now report weekly to the Divisional Nurse Managers so that immediate action can be taken. We currently exceed the expected minimum standards and improvements have been made to improve our scores in relation to the cleaning of ward equipment. An electronic tracking system is now used to track beds and mattresses. All beds have an identification tag (barcode) and all cleaning dates are logged to ensure that our decontamination processes are being followed.

Another key area that the Infection Prevention and Control team has focussed on is Urinary Tract Infections (UTI). These are one of the most common infections acquired in hospitals and studies show that the risk of bacteriuria increases by 5% for each day that a urinary catheter is in situ, the risk of a UTI is therefore significantly increased following the insertion of a urinary catheter. These types of infection are also associated with bacteraemia, increased mortality and may lead to complicated infections of the urinary tract. Data from the NHS Safety Thermometer (see page 15 for more information) shows that the Trust is higher than the national average for patients that have a urinary catheter.

A Catheter Steering Group was set up in September 2013 to co-ordinate both on-going and current work to facilitate further improvements to catheter care and reduce urinary catheter related infections. They undertook a point prevalence audit of pre-connected urinary catheters in October 2013. The results showed that the number of catheters being inserted had reduced and there had been an increase in appropriate selection of catheter type and size.

A pilot project has been undertaken on a number of wards, (Elderly Short Stay Unit, Ward 70, Cedar Ward, Intensive Care Unit and General High Dependency Unit at HRI, and Ward 21 at CHH) to review the process for urinary catheter insertion and removal. In these areas posters are used to prompt clinical staff to review the need for the urinary catheter before it is inserted and to review the continuing need for the catheter so that it can be removed as soon as possible therefore reducing the risk of infection. Information posters explaining the maximum duration for long and short term urinary catheters and the appropriate duration of urinary catheter drainage bags have also been developed.

The data from the Safety Thermometer shows that 18.4% of our patients have an indwelling urethral urinary catheter. This is a 2% reduction in urinary catheters since 2012/13, but further improvements are required to meet the national average of 16.7%. The last five months of 2013/14 have also seen a reduction in catheter related urinary tract infections from an average of 6 per month between April and October 2013 to 2 per month between November 2013 and March 2014.

Further improvements identified:

The Trust will continue to monitor cases of MRSA and C.difficile and take any actions identified through root cause analysis. Our C.difficile action plan has been updated for 2014-15 and progress against it will continue to be monitored through the Infection Prevention and Control Committee. The Committee will also be focusing on actions to reduce cases of Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia and E.Coli bloodstream infections.

The UTI pilot project (described above) will be introduced more widely across the Trust. Posters and pocket sized prompt cards will be produced to support this initiative.

It has been identified that continuity of care for catheterised patients when they are discharged into the community is extremely important. Therefore, we are planning to introduce a Urinary Catheter Passport during April 2014 to ensure that there is a comprehensive handover of care that is necessary for these patients.

Our Improvement Story Urinary Catheter Infections (UTIs) Ward 21, Castle Hill Hospital

Ward 21 started the project in December 2013. It included raising consciousness about patients that have an indwelling catheter and a regular review to check if the patient still needs to have the catheter so that it can be removed as quickly as possible. The project helped to empower the nursing staff to challenge the Medical staff regarding the clinical need for the patient to have the catheter. Within 4 weeks the average length of catheter days reduced from 7.8 to 3.8 days.

The team also tested the use of intermittent catheters in conjunction with the use of bladder scanners. An intermittent urinary catheter is inserted just long enough to drain your bladder before being removed, therefore reducing the risk of infection to the patient. In total ten intermittent catheters were inserted and both patients and nurses gave positive feedback about their use.

A heightened awareness by both medical and nursing staff meant that bladder scanning was undertaken on more patients which allowed them to identify patients with urinary retention. This allowed them to focus on bowel care for the patient to avoid constipation and therefore urinary retention, reducing their need for catheterisation.

Pneumonia

Pneumonia is inflammation (swelling) of the tissue in one or both lungs. It is usually caused by an infection. For people with other health conditions, Pneumonia can be severe and may need to be treated in hospital.

Community acquired Pneumonia is the fourth leading cause of death in the UK and some of these deaths are avoidable through the use of the recommended care bundle 'COST'. A care bundle is a set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes. COST stands for Chest x-ray, Oxygen assessment, Severity score and Treatment and by ensuring that patients needing admission to hospital with Pneumonia receive all of these elements of care we can reduce their risk of death and the length of time they need to stay in hospital.

What we aimed to achieve in 2013/14:

To reduce the number of deaths with a diagnosis of Pneumonia to 500

Actual outcome:

534 patients died in hospital from Pneumonia –

✔ **Improvement made compared to last year**

Improvements achieved:

Although we have not met our improvement target for 2013/14, the number of patients who died in hospital from pneumonia has reduced by 23% since 2012/13.

A Registrar led improvement project has been undertaken in the Emergency Department to improve compliance with the COST care bundle to reduce mortality and length of stay for patients needing admission to hospital due to pneumonia. Please see the improvement story opposite.

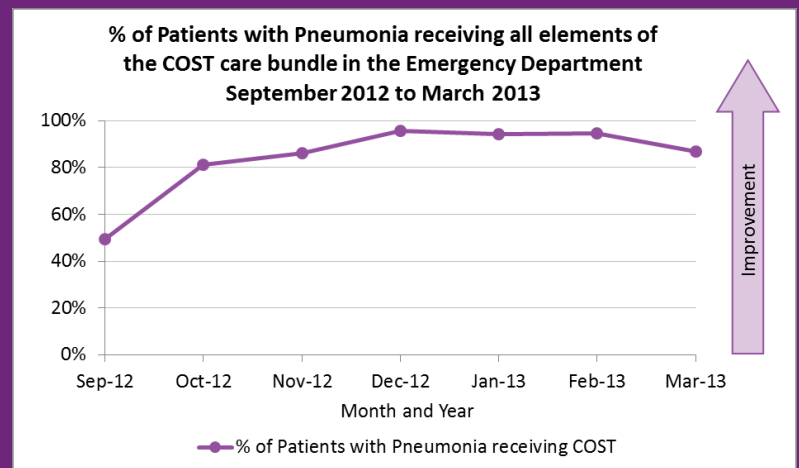
Further improvements identified:

Our compliance with the COST care bundle across the Trust requires improvement; therefore this has been continued as a local priority for improvement with our commissioners under the CQUIN scheme.

Our Improvement Story Emergency Department (ED)

An initial audit showed 40% of patients with pneumonia received all the elements of the COST care bundle in the Emergency Department.

Clinicians and nurses were given educational sessions to increase their awareness and highlight the importance of the bundle but this showed little improvement. Following feedback from the staff, regular face to face teaching was undertaken and a checklist was designed to prompt clinicians. After testing they found that the checklist worked when it was re-designed as a sticker on the front page of the patients' notes.



Compliance improved to 90% within the first three months of this project and continued to be sustained.

Reducing all avoidable harm

As part of the Trust's patient safety pledge, it is our aim to provide patient care that is safe, effective and of a high quality. Patients do not expect to be harmed when receiving care. It is the Trust's duty to protect patients from all avoidable harm.

What we aimed to achieve by March 2014:

95% of patients to receive "harm free" care as measured by the Department of Health Safety Thermometer

Actual outcome:

95% of patients received 'harm free' care in March 2014 – ✓ **Goal achieved**

What is the NHS Safety Thermometer?

The NHS Safety Thermometer is a point of care survey that is carried out on 100% of in-patients on one day each month and is one of the largest patient safety data collection of its kind in the world. It provides a 'temperature check' on harm and looks at the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE).

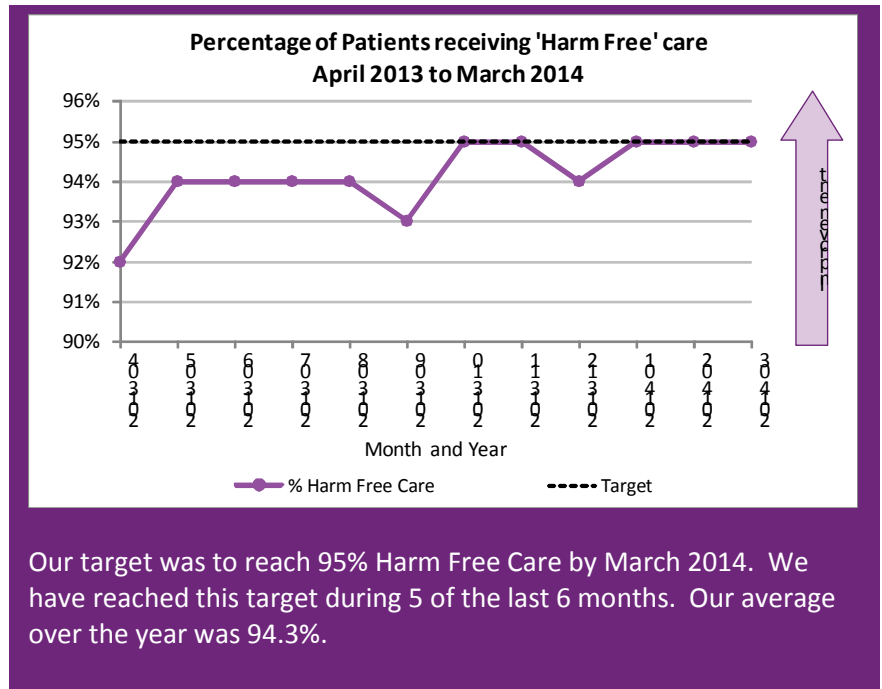
How does it define harm?

Pressures ulcers – It identifies pressure ulcers that were either present when the patient came under our care, or developed after the patient was admitted to hospital.

Falls – It identifies falls (an unplanned or unintentional descent to the floor), with or without injury, regardless of cause (slip, trip, fall from a bed or chair) that the patient has experienced within 72 hours of the survey taking place.

Catheter and urinary tract infections (UTI) – It identifies patients that have a urinary catheter in place within 72 hours of the survey taking place and any patient being treated for a UTI either before the patient came under our care or after the patient was admitted to hospital.

Venous thromboembolism (VTE) – It identifies patients that are being treated for a deep vein thrombosis, pulmonary embolism, or other recognised type of VTE with appropriate therapy such as anticoagulants, starting either before or after the patient was admitted.



How does our performance compare?

The table below shows our performance against each of the harm indicators from the Safety Thermometer for March 2013 to February 2014:

Harm Indicator:	Hull and East Yorkshire Hospitals	Average for Acute (non-specialist) Trusts in England	How do we Compare?
Patient with any Pressure Ulcer	4.1%	4.8%	✓
Patient with a New Pressure Ulcer	0.7%	1.1%	✓
Falls with Harm	0.3%	0.7%	✓
Patients with a Catheter	18.4%	16.7%	✗
Patients with a Catheter and UTI	0.8%	1.2%	✓
Patients with a New VTE	0.6%	0.6%	✓
Patients with Harm Free Care	94.4%	93%	✓
Patients with Harm Free Care (New Harm Only)	98%	97.1%	✓

We have performed well over the past year in all but one indicator. The number of patients with a catheter remains above the national average although we have seen an overall reduction by 2% compared with 2012/13.

Further improvements identified:

Improvements that have been identified regarding reducing the number of patients with a urinary catheter are detailed on page 11.

The Trust has signed up to NHS QUEST. This is a network of Trusts aspiring to levels of quality and safety beyond current expectation. The network focuses on four key priority areas: leadership, measurement, building capability and improvement programmes. This includes improving the 'harms' identified through the Safety Thermometer.

Medication errors

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.

Dispensing errors are just one specific measure of medication incidents.

What we aimed to achieve in 2013/14:

To reduce the number of dispensing errors that leave Pharmacy to 179

Actual outcome:

There were 171 dispensing errors that left the Pharmacy department – ✓ **Goal achieved**
There was also a 2% increase in the number of medicines dispensed during this period.

Improvements achieved:

In October 2013 the CQC judged the Trust as non-compliant against Management of Medicines regarding the safe and secure storage of medicines. This was an opportunity to review and improve all aspects of medicines use. As a result, a comprehensive action plan was developed by the Chief Pharmacist and some of the improvements made are detailed below:

- Implementation of the pharmacy waste bins on all wards across the Trust – these pharmacy waste bins ensure that all used medicines are disposed of safely and appropriately.
- The Chief Pharmacist has made unannounced visits to wards to monitor how medicines are used and stored. Patients and relatives are also asked for their views and experiences. Feedback is given to the senior nurses at the end of the visit and action plans are agreed if necessary and monitored for progress.

New processes have been introduced to help patients manage their medicines when they leave hospital including compliance aids, the introduction of new documentation to help carers ensure medicines are given safely and closer worker with colleagues outside the hospital.

Our Improvement Story

The pharmacy team have developed an outreach service in conjunction with City Health Care Partnership to all care homes in Hull. This has been developed following an investigation into an incident which highlighted the need for a 'gold standard' service for patients who reside in care homes, as this group of patients are vulnerable to harm due their complex medication needs.

A referral system has been put in place for care homes to notify us that one of their residents has been admitted. This allows the pharmacy service to clinically review these patients' medications to ensure that any medications that are no longer needed to be taken are stopped. This focus is to reduce the number of unnecessary drugs the patient is taking, therefore reducing their risk of harm, and ensuring that the care home is made aware of any changes. Through this 'gold standard' service we have helped to reduce the number of patents with dementia taking antipsychotic drugs and also helped patients that have a higher risk of falls due to the side effects of medication being taken.

After the patient is sent home, we contact the care home within 7 days to ensure that they have all the medications and information they need to ensure there is no room for error.



Increased seven day working has been introduced in Pharmacy. The department is open 365 days a year and a clinical pharmacy service at weekends has been introduced to target vulnerable patients and those on high risk medications. This also supports a safer and more efficient discharge 7 days a week.

A review of pharmacy cover on the wards was undertaken leading to an increase in support for the Acute Assessment Unit. Pharmacists can check prescriptions on admission and any medication required is supplied in a timelier manner.

An electronic 'virtual ward' has been developed in pharmacy which helps staff to identify patients ready for discharge or those requiring specific help with medication issues.

The Trust has introduced an electronic prescribing system for chemotherapy (ARIA). This will improve patient safety as this system has built in safeguards and checks.

The Pharmacy team at CHH have developed a service to collect and deliver prescriptions to the wards throughout the day. The new service has reduced the time that patients have to wait to receive their medicines.

Further improvements identified:

The pharmacy team at the Queen's Centre has developed a process for reporting and providing feedback to doctors about any errors they make when prescribing medications. This has helped to identify common themes and identifies any training needs. It is planned to implement this system across the Trust.

We are currently looking at the possibility of a contract with a pharmacy outside the Trust to further improve our service to outpatients.

In February 2014 the CQC undertook an inspection of HEYH. They wanted us to increase the number of medicines reconciliations for our patients, and also to increase the pharmacy teams out on the wards. Medicines Reconciliation is the process of identifying the medications that the patient is currently taking and ensuring these are accurately prescribed in hospital, if appropriate. The Trust will seek to increase the percentage of medicine reconciliations undertaken on admission and ensure this key patient safety work is undertaken in a timely fashion. The Chief Pharmacist will review the level of Pharmacy support on the wards, especially in high risk areas.

Pressure ulcers

Pressure ulcers are a type of injury that causes skin and underlying tissue to breakdown. They are caused when an area of skin is placed under pressure. They are also sometimes known as ‘bedsores’ or ‘pressure sores’. Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. They can be painful and debilitating and, if left untreated, can lead to serious harm or death.

Research shows that between 80% and 95% of pressure ulcers are preventable through providing good care.

The Trust has adopted a zero tolerance approach to all hospital acquired avoidable pressure ulcers and uses the SSKIN care bundle, which is a tool that helps our nurses deliver best practice care to their patients who are at risk of developing pressure ulcer.

What we aimed to achieve in 2013/14:

- No stage 1* or 2 pressure ulcers
- No stage 3 or 4 pressure ulcers
- 50 unstageable[†] pressure ulcers

Actual outcome:

227 stage 2 hospital acquired pressure ulcers –

✓ **Improvement made compared to last year**

- 2 stage 3 hospital acquired pressure ulcers
- 3 stage 4 hospital acquired pressure ulcer
- 38 unstageable** pressure ulcers – ✓ **Goal achieved**

Improvements achieved:

The Trust is part of the of the Transparency Project which encourages organisations to be open and transparent about how they are doing in areas of patient safety and quality of care. This includes reporting the number of patients who have developed a stage 2, 3 and 4 pressure ulcer whilst in our care. We have also chosen to report the number of suspected deep tissue injuries and un-stageable pressure ulcers to this project.

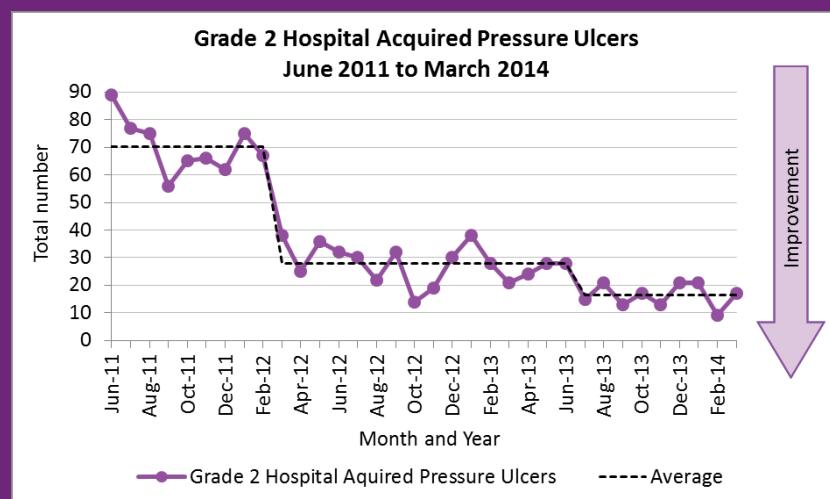
The Trust uses a root cause analysis (RCA) tool to learn lessons from all hospital acquired pressure ulcers. Through the RCA we determine whether the pressure ulcer was avoidable, i.e. we failed to do one of the following: evaluate the patient’s clinical condition and risk of developing a pressure ulcer; plan and provide individualised care for that patient to recognised standards of practise; monitor and evaluate the impact of the care received by the patient; or take further actions as appropriate. Where all of these aspects of care have taken place and yet the patient still develops a pressure ulcer, this is classed as unavoidable.

* Please note that our current policy does not include the mandatory reporting of stage 1 pressure ulcers.

[†] Unstageable pressure ulcers are a wound covered with a fluid or scab which prevents the depth of the wound from being determined. Once the pressure ulcer becomes stageable it is recorded within our information systems.

Our Improvement Story

Although we have not met our target for grade 2 pressure ulcers, the Trust has seen a reduction for a second year. The graph below shows that since June 2011 and with the introduction of the SSKIN care bundle, the number of grade 2 pressure ulcers has fallen from 67 per month in 2011/12 to 19 per month in 2013/14. This represents a 66% reduction overall.



The Trust also captures information about pressure ulcers through the NHS Safety Thermometer. During 2013/14 the percentage of patients with a new pressure ulcer was 0.7%. This is lower than the national average which stands at 1.1%.

The nursing teams use a validating skin injury poster to ensure the correct cause of the wound is documented. This enables the nursing team to correctly treat and evaluate the skin injury. The Tissue Viability team confirm and photograph all stage 3, 4, suspected deep tissue injury and un-stageable pressure ulcers. All hospital acquired stage 3 and 4 pressure ulcers are declared and investigated as a Serious Incident (SI) and the patient is referred to the Safeguarding Adult Team.

A Tissue Viability Wound Management Committee has been created in order to share lessons from root cause analysis and results from audits (including Setting the Standard) and evidence of good practice to improve patient outcomes.

A new database has been developed to record all hospital acquired un-stageable and suspected deep tissue injury pressure ulcers. The staging of the potentially severe pressure ulcers cannot be achieved until the depth of the wound bed is revealed. If the outcome is known before the patient is discharged this is recorded on the database and the Tissue Viability protocol is followed. Following the RCA process, all hospital acquired un-stageable pressure ulcers are discussed at nurse director level and a decision is made whether further actions are required.

The Tissue Viability team is working closely with the ward and senior nursing teams to ensure that the workforce has the knowledge and skills to correctly identify the category of pressure ulcer. The team is also working closely with the podiatrists and ostomy nurses to improve cross speciality working, share knowledge and good practice to improve patient outcomes.

Further improvements identified:

Over the next year we aim to reduce all avoidable hospital acquired pressure ulcers.

We have highlighted that there is an issue relating to education. Competency based training for tissue viability and wound management will be rolled out across the organisation by the end of 2014. This will promote a skilled, competent and confident workforce in wound management, pressure ulcer prevention and their treatment and care. This training will become mandatory. All registered and non-registered nurses will attend a study day once every 3 years; this will be supported with an e-learning package and bedside training. Competencies will be assessed by key trainers and recorded in the tissue viability learning passport. This will be implemented across the Trust during 2014.

The reporting of pressure ulcers within the wider Yorkshire and Humber health community has been agreed with our commissioners as a goal for improvement. Part of this will involve working with our health partners over the coming year on developing a process for tracking or following patients with pressure ulcers, regardless of where the pressure ulcer developed in order to improve the continuity of their care.

Venous thromboembolism (VTE)

Venous Thrombosis is a blood clot within a blood 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 or DVT) or can move to the lungs causing a blockage that could lead to death (this is known as pulmonary embolism or PE). Patients in hospital have a greater risk due to a number of reasons including being immobile or having a major operation. This risk can be greatly reduced through assessing every patient when they are admitted to hospital so that appropriate treatment can be given to prevent a VTE from occurring.

What we aimed to achieve in 2013/14:

95% of all patients admitted to hospital to undergo a VTE risk assessment.

Actual outcome:

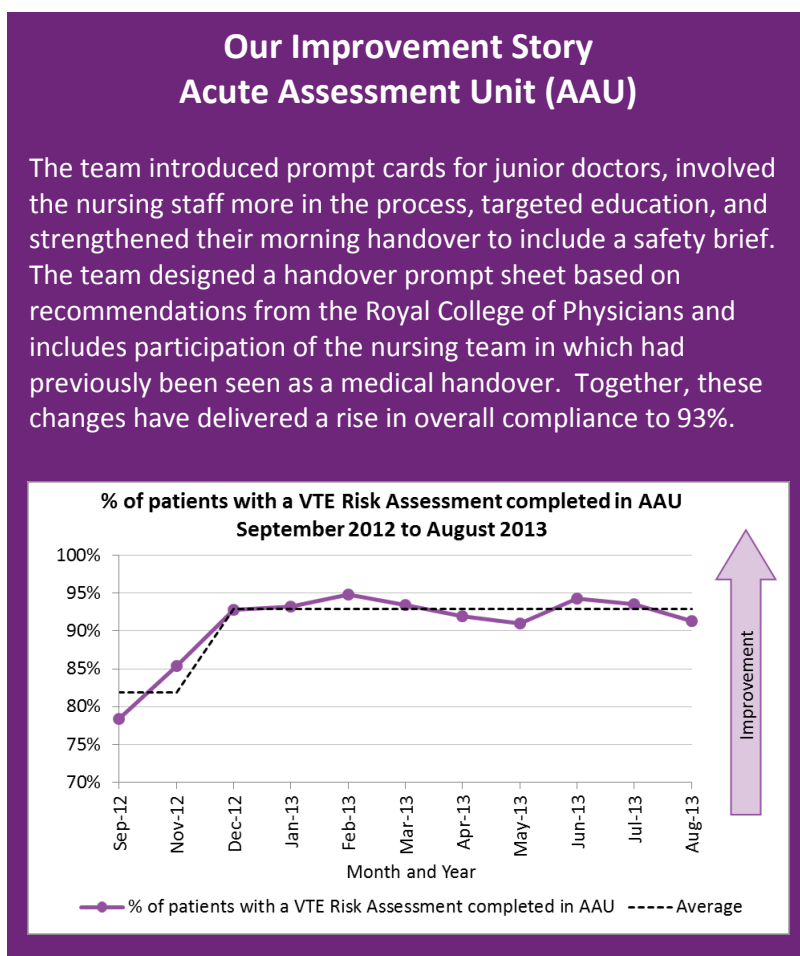
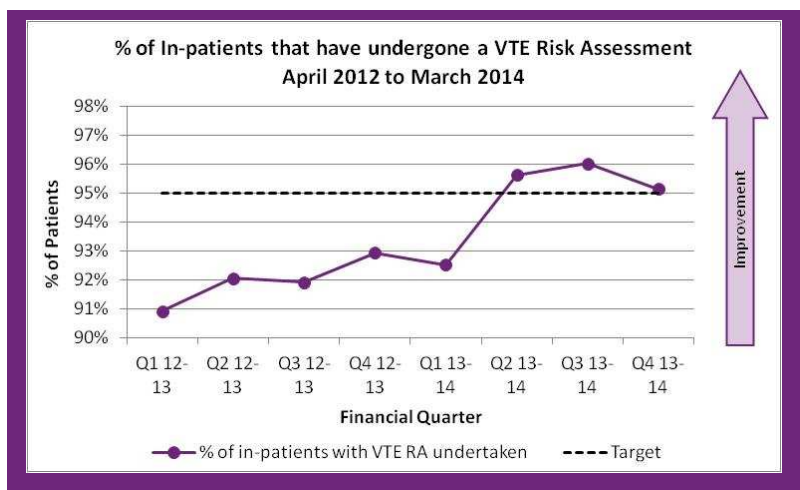
94.8% of patients admitted to the Trust had a VTE risk assessment undertaken – **Improvement made compared to last year**

Improvements achieved:

Although we have not met our target over all, during the last three quarters we have exceeded the 95% target.

A project to improve compliance with patients who are admitted to hospital receiving a VTE risk assessment has been completed on our Acute Assessment Unit (AAU), Hull Royal Infirmary. This was a particular issue due to the number of patients admitted on a daily basis; the unit has around 500 admissions a week and has a high rotation of junior doctors.

A team of nurses from Ward 7 have been supported through the Trust's Pioneer Teams to improve the system in place for ensuring that patients get a clinic appointment to check their international normalisation ratio (INR) and medication following discharge from hospital. The INR is a laboratory measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants on the clotting system. The current system is time consuming for staff and can cause delays in discharging patients from hospital. The project involves working with our partners in the community to look at the possibility of developing an electronic system. They plan to use our new Electronic Patient Record system, Lorenzo, to make electronic referrals to the Anticoagulation team in Hull from December 2014 and hope to also introduce this system for patients within the East Riding.



Further improvements identified:

All patients highlighted by the NHS Safety Thermometer as developing a VTE following hospital admission have a root cause analysis completed in order to learn lessons to improve patient care. We would like to improve this system; therefore we are currently developing a database to identify every inpatient VTE episode.

The Trust also plans to increase the number of patients that receive verbal counselling on signs and symptoms for VTE before they are discharged from hospital.

The INR Pioneer Team will be looking at introducing INR Link Nurses at ward level to advise staff and patients regarding anticoagulation therapy and monitoring.

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 is the most common patient safety incident reported to the National Reporting and Learning System (NRLS). Although 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 2013/14:

To reduce falls to 2245

Actual outcome:

2649 patient falls in 2013/14 – **Improvement made compared to last year**

Improvements achieved:

The Trust has introduced Intentional Rounding on all wards from December 2013. This is a tool that aims to help nurses deliver a reliable standard of care to every patient. What is important is that it is patient rather than task-focused: every hour, nurse checks with the patient, to find out if they are comfortable and if there is anything they need. The idea of hourly rounds has been promoted by the Prime Minister and endorsed and encouraged by the Chief Nursing Officer at the Department of Health as there is evidence to show that Intentional Rounding can reduce adverse events such as falls and pressure ulcers, improve patients' experience of care and provide much needed comfort and reassurance to the patient.

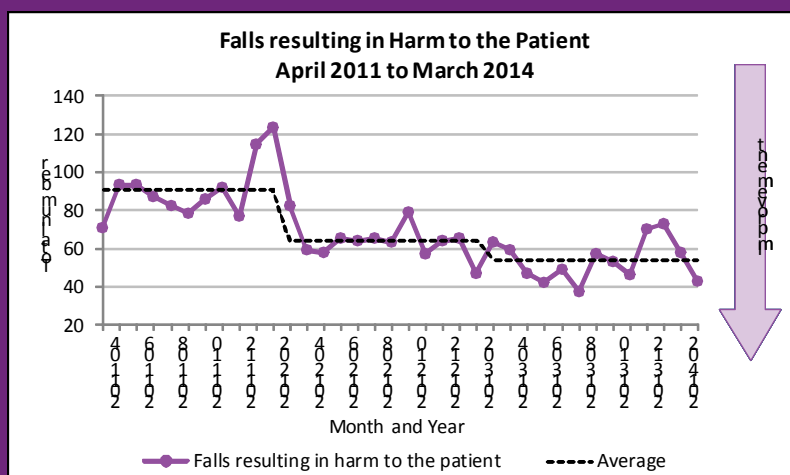
We have also introduced a Root Cause Analysis (RCA) tool which looks at the reasons why a patient has fallen. This tool is used as part of the Transparency Project that the Trust is part of alongside other Trusts in the north of England. After being tested successfully on the Elderly Short Stay Ward (ESSU) at Hull Royal Infirmary the questions from the tool have been added to our electronic incident form (DATIX) so that root causes of all patient falls can be identified at the time of the incident.

Open visiting has also been introduced within some of our wards (Elderly Short Stay Ward, Ward 70 and Ward 100 at Hull Royal Infirmary, and Ward 21 and Ward 19 at Castle Hill Hospital) which has shown an overall reduction in the number of falls within the elderly care areas.

In January 2014, the Trust started to report all incidents where a patient fell and suffered a fractured hip as Serious Incidents (SIs). Since then 9 incidents have or are currently being investigated as a serious incident. A common theme that we have found from looking at these incidents is that the current risk assessment we use does not always correctly

Our Improvement Story

Although the overall number of patient falls reported in 2013/14 has only fallen by 6% compared with last year, the Trust has seen a significant reduction in the number of falls resulting in harm (patient falls reported with a severity of minor, moderate, major and catastrophic) to the patient. The graph below shows that since April 2011 the number of falls causing harm to the patient has reduced from 90 per month in 2011/12 to 53 per month in 2013/14. This represents a 41% reduction overall.



The number of falls reported that were 'near misses' or did not cause any harm to the patient have remained static over the past 3 years. This supports the fact that the Trust has an open reporting culture for falls.

The Trust also captures information about patient falls through the NHS Safety Thermometer. During 2013/14 the percentage of patients admitted to the Trust who experienced a fall that caused harm was 0.3%. This is lower than the national average which stands at 0.7%.

identify patients who have a higher risk of falling. There is currently no national tool that can be used across all specialities; therefore we have developed a new tool that is being tested within the Trust. It involves a scoring system that looks at all risk factors such as medication the patient is receiving, specific medical conditions the patient may have, how frail the patient is and the environment in which they are being cared for.

The Trust has also introduced daily Safety Briefings across all wards. The ward team come together to discuss patient safety issues such as the number of patients that have a high risk of falling, the dependency of patients on the ward and any staffing issues. These are then escalated to the Patient Safety Meeting which takes place twice a day with representation from a Nursing Director so that issues can be acted upon promptly.

Further improvements identified:

Although Intentional Rounding has been introduced, there are still improvements to be made to ensure that all patients receive these checks every time. This process will be monitored as part of 'Setting the Standard' where all wards are reviewed by senior nurses on standards of nursing care. See page 56 for more details.

Over the coming year the new falls risk assessment will be introduced across the Trust. It will be accompanied by a new care plan which is currently being developed. The care plan will identify what actions should be taken in response to which factors have been assessed as causing a high risk to the patient. This will encourage care to be individualised to each patient.

Other improvements that are planned for 2014/15 include introducing visibility zones in all clinical areas, the development of guidance for patients with confusion, and possible introduction of open visiting to other wards following evaluation of the pilot.

A Falls Prevention Committee has also been established and it will meet on a monthly basis during 2014/15 to drive and monitor these improvements.

Dementia

Dementia is not a single illness but a group of symptoms caused by damage to the brain. These symptoms include memory loss, mood changes and problems with communication and reasoning.

Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with dementia. Their length of stay is longer than patients without dementia and they are often subject to delays in discharge when leaving hospital. Patients with dementia are also more likely to come to harm than patients without dementia.

What we aimed to achieve in 2013/14:

90% compliance with Dementia Screening

Actual outcome:

90.87% of patients received Dementia screening – ✓ **Goal achieved**

Improvements achieved:

Over the past year the Trust has continued to implement Dementia screening for all patients, with 90% of our patients being screened. The FAIR process (Find, Assess, Investigate and Refer) is helping to identify people with undiagnosed Dementia, allowing them to be referred onto the appropriate community services for further assessment and treatment.

There is a national drive to reduce the use of antipsychotics in managing 'behaviour that challenges' in people with dementia. The Trust has been working closely with our liaison psychiatry team to reduce our prescribing rates. A regional audit completed in 2013 shows that we now have one of the lowest antipsychotic prescribing rates in the region.

In April 2013 we established a multidisciplinary Dementia Programme Board to ensure we deliver high standards of care for people with dementia and their carers. It has membership from health, social care, carer and voluntary organisations and is therefore truly representative of the needs of people with dementia.

The Trust has appointed a Dementia Care Lead consultant, a nurse trainer and

Our Improvement Story Elderly Short Stay Unit (ESSU)

Through listening to our patients, their relatives and carers we have made a number of improvements in response to the issues they identified and to make the ward a better environment for our patients that suffer with dementia.

- We have introduced open visiting between 9am and 7pm
- We have bought picture signage to help our patients find the toilets on the ward
- We have increased our number of Dining Companions (these are volunteers who assist patients at meal times)



We have also introduced coloured crockery to help our patients eat and drink independently. People suffering from dementia often experience visual problems including not being able to distinguish between different colours. Studies have found that this can be a problem at mealtimes if the crockery is a similar colour to the food being served as a person with dementia may not be able to see the contrast and recognise the food that is on their plate.

We also now offer digital reminiscence therapy to our patients. This uses prompts, such as photos from the past, to encourage the patient to talk about earlier memories, which people with dementia tend to retain best. By talking about who they are, people with dementia can help others focus on them, and not their dementia. We are currently recruiting and training volunteers to deliver this on our wards.

dementia champions across the Trust not only in nursing and medical teams, but also in therapies, catering, security and volunteer teams.



We have continued to implement the Butterfly Scheme across the Trust. It is a tool to enable staff to provide person centred care to our patients with dementia. With the patient's consent a symbol of a butterfly is placed above the patient's bed and staff are taught skills to allow them to care for these patients. Patients with dementia are also now identified on the Trust's CAYDER board using a butterfly symbol. This helps to minimise the transfer of patients with dementia when bed pressures occur.

We have created a database which looks at the health care outcomes for patients with dementia across the Trust. This allows us to identify issues relating to length of stay, readmission to hospital, falls, in hospital mortality and pressure ulcers for patients with dementia.

We have introduced a carer survey in July 2013 within our elderly care areas to help us to address the needs of carers for people with dementia. This has prompted us to develop a patient and carer leaflet in order to highlight support services that exist both within the Trust and community based services.

Further improvements identified:

We are one of only a few acute hospital Trusts to use dementia mapping in our wards to understand the deficiencies in our service from the patient's perspective. Hull's local Dementia Academy has supported us with this project and we plan to use dementia mapping in all our environments in which people with dementia are cared for.

A Trust wide training package has been developed for staff, which includes an awareness module for all staff and more detailed training for dementia champions, but the uptake remains low. We need to ensure that we have an adequately trained workforce to meet the needs of patients with dementia. This concern was also highlighted when the CQC undertook the Chief of Hospitals Inspection in February 2014 and stated that the Trust must ensure that staff employed for caring duties, including dealing with patients exhibiting challenging behaviour due to mental health illness or dementia, appropriately support patients. The dementia awareness training programme will be rolled out to all clinical and non-clinical staff. Although non-clinical staff e.g. Porters do not care for patients, they do come into contact with patients and therefore it is important that they are also able to respond to challenging behaviour and appropriately support patients.

We plan to continue to refurbish the Elderly Short Stay Ward (ESSU) to enhance the healing environment and to meet the specific needs of patients with dementia.

Perioperative Care

Perioperative care is the care that is given before, during and after surgery. This period is used to prepare the patient both physically and psychologically for the surgical procedure and after surgery.

Having surgery increases a patient's risk of serious harm. Never Events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. These incidents include surgery performed on the wrong site (for example wrong knee, wrong eye, wrong patient, wrong limb, or wrong organ) and retained instruments (where an instrument or a swab is left inside a patient during surgery).

During 2012/13 the Trust had 3 such Never Events. These incidents are unacceptable and preventable.

What we aimed to achieve in 2013/14:

To have no Perioperative (surgical) Never Events.

Actual outcome:

4 Perioperative (surgical) Never Events were reported – ✗ **Goal not achieved**

Improvements achieved:

During the past year the Trust has declared 4 perioperative Never Events. All of these incidents have been investigated as a Serious Incident using root cause analysis techniques in order to learn lessons and put in place action to reduce the risk of similar incidents happening in the future.

The Surgery Health Group and the theatres team have introduced a new policy regarding needles and swabs. This includes a new escalation process that must be followed if it is suspected that a needle or swab has been misplaced during surgery. This involves stopping surgery to perform an x-ray to ensure that the needle or swab is not retained inside the patient.

Incident reporting training has been provided to senior nurses (Band 6 and 7) and a weekly senior nurse team meeting has been introduced which allows the opportunity to learn lessons from incidents.

Further improvements identified:

Through the investigation of these incidents and other incidents within theatres it has been identified that the safety briefing that takes place prior to each theatre list could be improved. The Theatre Team is currently reviewing their safety brief prompt to include more complex questions in order to improve the quality of information discussed to improve patient safety and efficiency.

Learning lessons from Serious Incidents and Never Events has been identified as a key priority for the Trust over the coming year. Please see page 35. The CQC undertook the Chief of Hospitals Inspection in February 2014 and stated that the Trust must ensure that staff receive feedback and learn lessons from incidents reported including Never Events being disseminated Trust wide.



Planned admission to discharge from hospital

We aim to ensure that every patient receiving the right care in the right place and at the right time. It is appropriate to admit a patient to an acute admission area for preliminary assessment and treatment before transferring them to another specialty or service for their on-going care, where this is indicated for clinical reasons. However patients have been moved from one ward to another for reasons that do not relate to their specific care or condition. Such patient transfers not only impact on the patient experience but have also been found to increase the potential safety risks to patients as a result of fragmented care. This can also extend a patient's length of stay in hospital unnecessarily. If a patient does not receive the right care in the right place at the right time, this can result in delayed discharge or unplanned re-admission to hospital.

Planned admission to discharge from hospital is the process of patients being sent home as they no longer require acute medical care or the patient's care is handed over to another health care organisation in a more appropriate setting i.e. to a residential or nursing home, intermediate care facility or community hospital.

What we aimed to achieve in 2013/14:

To reduce in patient readmissions to hospital after 28 days to 4.4%

To reduce the number of patients on the delayed discharge list to 1904

To reduce the total numbers of patients with a length of stay greater than 50 days to 635

Actual outcome:

6.7% of patients were readmitted to hospital after 28 days – ✗ **Goal not achieved**

4191 patients were on the delayed discharge list between April 2013 and March 2014 – ✗ **Goal not achieved**

538 patients had a length of stay greater than 50 days in 2013/14 – ✓ **Goal achieved**

Improvements achieved:

A multi-disciplinary 'PREDICT' team has been established to develop and implement effective patient management planning process to improve core patient management, planning processes and discharge arrangements and patient experience when going home. The aims of the Predict Team is to revise ward rounds to 'make every ward round count' and to ensure they are the key vehicle for planning patient care and discharge, improve communication ensuring the patient is at the centre, ensure the Expected Date of Discharge is planned early and informs the timeliness of care and interventions and promote pro-active and collaborative working towards a safe, timely and effective discharge.

Further improvements identified:

In February 2014 the CQC undertook the Chief of Hospitals Inspection and judged that the Trust was non-compliant with Outcome 4 (Regulation 9) Care and Welfare. The CQC Chief of Hospitals Inspection identified patient pathways into and out of hospital as one of the reasons why the Trust was non-compliant with regulation 9. The review of the Acute Medical Pathway (including patient transfers in and out of hospital) has been identified as one of the Trust's top six priorities following the Chief of Hospitals Inspection. A Transformation Programme will be led by the Chief Medical Officer and the Medical Director for the Medicine Health Group to review the Acute Medical Pathway to ensure the Trust and its stakeholders have robust and effective patient pathways into and out of hospital.

PREDICT Methodology

Plan

Review

Engage/Educate

Discharge

Inform

Communicate

Transfer

PREDICT

*working towards
your ticket home*

Patient pathways / inpatient transfers

Inpatient transfers are the transfer of a patient from one ward to another including transfers between the Hull Royal Infirmary and Castle Hill Hospital sites. An example of an avoidable transfer is the internal transfer of a patient between 10.00pm and 6.00am; this transfer should be avoided unless their clinical condition requires specialist support within other units of the Trust.

The Trust's aim is to ensure that all patients are treated on the most appropriate care pathway for their condition and are treated in the right place at the right time for their clinical care needs to be met.

What we aimed to achieve in 2013/14:

To reduce avoidable inpatient transfers, in particular for patients moved more than 2 times, to 375

To reduce the number of patients transferred after 10pm for non-clinical reasons to 1461

Actual outcome:

499 patients were transferred more than 2 times; this includes avoidable and unavoidable transfers – **× Goal not achieved**

2035 patients were transferred after 10pm; this includes patient transferred for both clinical and non-clinical reasons – **✓ Improvement made compared to last year**

Improvements achieved:

Each of the Health Group has a system in place to investigate incidences of transfers occurring between 10pm and 6am, and when a patient is transferred more than twice. The aim is to find out if the transfer took place for reasons relating to the clinical care of the patient (i.e. unavoidable) or for non-clinical reasons, such as relating to bed capacity (i.e. avoidable) and report their findings to safety briefing meeting in order to share and learn lessons. The investigations and lessons learned are reported in the corporate performance report to the Trust Board on a monthly basis.

This review of transfers shows that:

- some transfer times were recorded incorrectly on our system and actually occurred before 10pm or after 6am
- some patients were transferred to and from Critical Care areas which would be appropriate for the patient
- some patients were transferred within the same ward or speciality – this was to ensure that they were cared for with other patients of the same sex
- some patients were transferred due to clinical need, but pathways, such as having a Hickman line inserted should be reviewed to minimise the number of transfers required
- some patients that are moved do not have a clinical need to be in hospital, but are waiting for access to community services
- one transfer was due to a specific request by the patient

Of the 166 transfers that were reviewed between December 2013 and March 2014, 85 (51%) patients were transferred for non-clinical reasons. This is an unacceptable number and further improvements have been identified.

Further improvements identified:

In February 2014 the CQC undertook the Chief of Hospitals Inspection and judged that the Trust was non-compliant with Outcome 4 (Regulation 9) Care and Welfare. One of the reasons why the Trust was non-compliant with regulation 9 was because patients experienced multiple moves around the hospital and across sites. The CQC felt that the multiple moves were putting patients at risk of delayed assessment and inconsistent treatment. The Trust's Chief Medical Officer will review the current patient flow within and across hospitals sites and implement a revised process to significantly reduce the number of patient transfers for non-clinical reasons including multiple moves and moves during the night. The Trust is currently looking at how the wards could be better located to minimise the need for transfers to

take place between the two hospital sites.

The CQC Chief of Hospitals Inspection also identified patient pathways into hospital, in particular attendance at the Emergency Department (ED) and admission to the Acute Assessment Unit (AAU) or other hospital wards as well as the quality and consistency of the documentation as another reason why the Trust was non-compliant with Outcome 4 (Regulation 9) Care and Welfare. A Transformation Programme will be led by the Chief Medical Officer and the Medical Director for the Medicine Health Group to review the Acute Medical Pathway to ensure patients are assessed and treated appropriately to meet their needs and that patients are admitted to the appropriate ward for their clinical condition. The Transformation Programme will also review the current handover arrangements to improve communication among clinicians across the organisation.

The Transformation Programme will work in conjunction with the Clinical Commissioning Groups and Local Authorities to improve patient pathways into the Emergency Department. This will include reviewing ambulance criteria for attendance at the Emergency Department to ensure patients are admitted to the most appropriate place to meet their needs and also to monitor the GP referrals into the Acute Assessment Unit (AAU).

Patient experience

Our vision is to provide great care. To achieve this it is essential to listen to the needs, concerns and suggestions from our patients about how we can improve care, quality and experience. We are committed to learning from and acting on patient feedback to improve the aspects of quality that matter most to our patients.

What we aimed to achieve in 2013/14:

To reduce complaints to 2.2 per 1000 in patient Finished Consultant Episodes (FCEs)

To reduce complaints & PALS concerns regarding staff attitude to 180

Outcome:

We received 5.1 per 1000 in patient Finished Consultant Episodes FCE's – **✗ Goal not achieved**

242 complaints & PALS concerns were received regarding staff attitude – **✗ Goal not achieved**

In October 2013 a report, commissioned by the Prime Minister, called 'Putting Patients Back in the Picture' was published. The report highlights the need to make improvements to the complaints process to make it more accessible and responsive. The review panel writing this report heard from people who had not complained because they felt the process was too confusing or they feared for their future care. This is supported by a survey completed by Healthwatch England which identified that 54% of people who had a problem with health or social care in the past three years did not report it.

What this information means is that the Trust needs to adopt an entirely new approach towards complaints and as a result we need to find different ways to monitor patient experience. In successfully implementing the recommendations from this report to make our complaints process more accessible, we would hope to see more people feeling able to raise concerns. Therefore it is too simple to have our aim as reducing the number of complaints we receive and our aim should be to encourage patients to report their concerns.

Improvements achieved:

Over the past year the Trust has made significant steps to actively gain information from patients about the services we provide and also learn from the feedback we have received.

The Trust hosted a 'Big Conversation' in September 2013 as part of the Trust Innovation Day, which was well attended, inviting patients and relatives to share their experiences of the care received whilst in hospital.

The Chief Nurse has also introduced Patient Story sessions for staff to help us better understand the quality of care we provide and the impact we have on people's lives. The monthly sessions enable all staff to hear directly from patients about their experiences, both good and bad, and ask questions to help us to better understand what we do well and how we might improve care for future patients.



Friends and Family Test

Since we introduced it in March 2013, the NHS Friends and Family Test has been helping us to review the care we provide across our wards, outpatient clinics and urgent care services and to look for ways of improving based on direct feedback from the people who have used our services.

Over the past year we have also introduced the Friends and Family test to cover our Maternity and Paediatric services.

The Friends and Family Test is a great way of capturing patients' thoughts, experiences, criticisms and compliments whilst they're still fresh in their minds. Patients are asked to rate the care they have received, usually at or near to the point they are discharged. There is one key question; how likely are you to recommend this ward/department to friends and family if they needed similar care or treatment?

The results enable us to learn from patients' comments and suggestions and to make improvements to their care. Over the past year the Trust has seen many fantastic examples of our staff taking initiative from their patients to make changes for the benefit of future patients. These include:

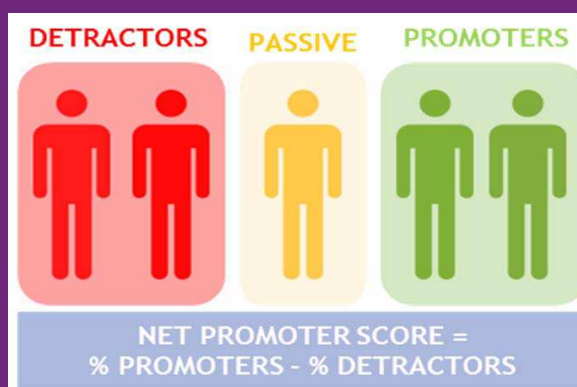
- Ward 26 at Castle Hill Hospital, where delivery times were changed after a patient complained of the disturbance created by a lorry delivering goods during the night.
- The introduction of a special Sister's Surgery on Ward 9 at Hull Royal Infirmary to help patients and their relatives better understand the patient's plan of care and discharge arrangements.
- A daily nutritional assessment of patients on Ward 110 at Hull Royal Infirmary, to ensure those at risk of malnutrition are regularly eating enough for their requirements.
- The Fracture and Orthopaedic clinic staff are currently looking at how they can reduce waiting times within the department following feedback from patients.
- The Emergency Department has devised a new one way system to change the flow of patients after then have had their initial assessment so that patients do not return to the waiting room and feel that they have been forgotten about.
- Ward 8 at Castle Hill Hospital has developed a welcome pack which is being used in the admission lounge following a comment from a patient about the lack of information available about the ward.
- The Eye Clinic has introduced weekend clinics and a new 'scan van' for Wet AMD (Lucentis) patients to improve waiting times.
- Ward 9 at Castle Hill Hospital reduced delays in discharge due to patients waiting for their take home medications. They have worked with the junior doctors and the pharmacists to devise a way to ensure that medications are prescribed the day before so that patients do not have to wait on the day of their discharge.

In March 2014 the Trust scored 80 for the Friends and Family Test*

To measure patient and staff experience we use a Net Promoter Score. The idea is simple: if you like using a certain product or doing business with a particular company you like to share this experience with others. From the answers given 3 groups of people can be distinguished:

- Detractors - people who would probably not recommend you based on their experience, or couldn't say.
- Passive - people who may recommend you but not strongly.
- Promoters - people who have had an experience which they would definitely recommend to others.

This gives a score of between -100 and +100, with +100 being the best possible result. The average score for NHS Hospitals in England for March 2014 was 72.



*This is based on 1679 responses. Please note that this result may have changed since publication, for the latest score please visit: <http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/>

- Ward 10 at Hull Royal Infirmary has changed their ward routine so that the medicines round starts earlier as patients had commented about getting their medicines late in a morning.

Further improvements identified:

An action plan has been developed to implement the recommendations from the 'Putting Patients Back in the Picture' report. This includes:

- Providing basic information to patients about what they need to know about the ward that they are being treated on
- Helping patients to understand their treatment
- Utilising volunteers to help patients to express any concerns they may have
- Training for staff on how to respond to a complaint
- Improving the way complaints are handled
- Sharing both positive and negative feedback from patients
- Review of our policy and procedure to ensure that we offer a truly independent review of complaints.

The Trust also is launching the #hello my name is campaign on Friday 25th April 2014 at our Nursing Conference. "Hello, my name is..." is a small gesture, but one that really makes a difference.

Hull and East Yorkshire Hospitals NHS Trust

You said...

"I now hold a 'Sister's Surgery' and go around the ward whenever I'm clinically working to see the patients and relatives."

"This has helped to reduce complaints and helped patients and relatives to understand the plan of care and discharge process."

"We also try and make each ward round count and I always ask if they have any further questions for the doctor".

Sister Anne Broadhurst, Ward 9, Hull Royal Infirmary

We did

Great Staff - Great Care - Great Future

Help us to improve. Give us your feedback. Contact the Friends and Family Team on 01482 675189 or PALS on 01482 623065. Visit us online at www.hey.nhs.uk/fft

#hello my name is...

During 2013 Dr Kate Granger, a senior registrar specialising in the care of older people, and who is also terminally ill, was an in-patient in NHS care and noticed that only some members of the healthcare team looking after her introduced themselves. Kate wondered why this fundamental element of good communication (the introduction) seemed to have failed. She noted how members of healthcare staff know so much about the patients in their care but that this is not always reciprocated and she pointed out that this tends to push the balance of power in favour of the healthcare worker. Given that people receiving treatment and care often feel vulnerable already, this imbalance creates an unhelpful and unfortunate gap.

Kate shared her views via twitter and suggested that getting to know people's names is the first rung on the ladder towards providing compassionate care. It is getting the simple things right that means that the more complex things follow more easily and naturally. As a result, the idea of #hellomynameis was born.

Our Plans for the Future

This year the Trust has put together a long list of potential quality improvement priorities by:

- Evaluating our performance against our priorities for 2013/14;
- 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).
- Considering recommendations made in reports such as the Francis inquiry, the Keogh mortality review and the Berwick review into patient safety.
- Looking at what our regulators have identified as priorities, such as compliance with the CQC Essential Standards of Quality and Safety.

The Trust also asked patients, staff, Foundation Trust members, Health & Well Being Boards, Healthwatch and the local community what they thought the priorities should be for 2014/15.

This year 598 people completed an online survey in March 2014, including 420 staff members, 51 Foundation Trust members and 127 members of the public.

The results of the survey were discussed by the Clinical Quality Committee. The third most important issue identified by the respondents of our survey was Infection Prevention and Control. The Committee felt that we have made many significant achievements in this area over the past few years and felt that Dementia was still an emerging issue and should be given more of a focus. The Trust has good systems in place for monitoring and responding to issues relating to Infection Prevention and Control and the previous section details the work we are continuing in this area.

We have identified these quality improvement priorities for 2014/15 because they are important to our staff, patients and stakeholders:



Quality Improvement Priorities 2014/15

- Deteriorating Patient
- Medication Safety
- Dementia
- Learning Lessons
- Sepsis

These priorities are part of a number of projects we will be focussing our attentions during 2014/15.

Quality Improvement Priorities 2014/15

1. Deteriorating patient

What do we want to achieve?

Early recognition of patients who require support for end of life care and to ensure the end of life care plans are documented including a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order form to avoid inappropriate attempts at resuscitation.

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

Implementation of electronic observations.

How will we measure this priority?

Root cause analysis of cardiac arrests is undertaken, as recommended by the NCEPOD's Time to Intervene study and the Resuscitation Council. We aim to reduce avoidable cardiac arrests (i.e. futile attempts and failure to rescue). A baseline of compliance against the implementation of the NEWS score and the electronic observations is to be established. The Trust will then aim to improve compliance throughout 2014/15.

How will we monitor and report on progress?

Root cause analyses of cardiac arrests are undertaken and learning is monitored monthly by the Resuscitation and Deteriorating Patient Committee. Monthly escalation reports are also received by the Clinical Quality Committee. The Clinical Quality Committee will also receive a bi-monthly report detailing progress against the quality improvement priorities to monitor improvements and identify gaps in assurance for further action.

2. Medication safety

What do we want to achieve?

To improve patient safety related to medicines by increasing medicines reconciliation (identifying the most accurate list of a patient's current medicines), decreasing the number of missed doses and improving safety on the use of specific high risk medications (anticoagulants, opioids, injectable sedatives and insulin).

How will we measure this priority?

This will be monitored through the Trust's local Medications Safety Thermometer and incident reporting. Medicines reconciliation will be monitored using the electronic 'Cayder' board.

How will we monitor and report on progress?

The Safer Medication Practice Committee will monitor this quarterly. Escalation reports are also received by the Clinical Quality Committee. The Clinical Quality Committee will also receive a bi-monthly report detailing progress against the quality improvement priorities to monitor improvements and identify gaps in assurance for further action.

Improvements against medication reconciliation will also be monitored through the CQC Chief Inspector of Hospitals' action plans.



3. Dementia

What do we want to achieve?

We need to ensure that we have an adequately trained workforce to meet the needs of patients with dementia.

How will we measure this priority?

This will be monitored through the number of staff attending training. A baseline will be identified and the Trust will then aim to improve compliance throughout 2014/15.

How will we monitor and report on progress?

The Dementia Programme Board will monitor this monthly. Monthly escalation reports are also received by the Clinical Quality Committee. The Clinical Quality Committee will also receive a bi-monthly report detailing progress against the quality improvement priorities to monitor improvements and identify gaps in assurance for further action. Improvements against dementia training will also be monitored through the CQC Chief Inspector of Hospitals' action plans.

4. Learning lessons

What do we want to achieve?

To improve learning from Serious Incidents and Never Events so that the organisation understand 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 and the delivery of the learning lessons trust-wide communication plan.

How will we measure this priority?

This will be measured through the staff survey, compliance with the learning lessons trust-wide communication plan including debriefs, newsletters, events and lesson of the month. A number of short pulse checks will also be undertaken to evaluate the dissemination of lessons and the knowledge of workers at the front line and to set a target for improvement following a baseline assessment.

How will we monitor and report on progress?

To be monitored monthly by the Clinical Quality Committee. The Clinical Quality Committee will also receive a bi-monthly report detailing progress against the quality improvement priorities to monitor improvements and identify gaps in assurance for further action. Improvements against learning lessons will also be monitored through the CQC Chief Inspector of Hospitals' action plans.

5. Sepsis

What do we want to achieve?

Implementation of the Sepsis care bundle in the Emergency Department (ED) and the Acute Assessment Unit (AAU). The care bundle is 3 treatments and 3 investigations that should be completed within one hour of identifying sepsis. These key interventions if performed reliably, will improve survival.

How will we measure this priority?

This will be monitored through the number of patients identified and commenced on the Sepsis care bundle and the improved management of Sepsis. A baseline of compliance against the implementation of the bundle is to be established. The Trust will then aim to improve compliance throughout 2014/15.

How will we monitor and report on progress?

Resuscitation and Deteriorating Patient Committee will monitor this monthly. Monthly escalation reports are also received by the Clinical Quality Committee. The Clinical Quality Committee will also receive a bi-monthly report detailing progress against the quality improvement priorities to monitor improvements and identify gaps in assurance for further action.

Statements of Assurance from the Board

Review of services

During 2013/14 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 2013/14 represents 100% of the total income generated from the provision of NHS services by the Hull and East Yorkshire Hospitals for 2013/14.

Participation in clinical audit

During 2013/14, 37 national clinical audits and 5 national confidential enquiries covered NHS services that Hull and East Yorkshire Hospitals NHS Trust provides.

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

The table below details the national clinical audits and national confidential enquiries that Hull and East Yorkshire Hospitals NHS Trust was eligible to participate in and those which we participated in during 2013/14. 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 2013/14, the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry are listed in the last column:

Audit:	Participated	% of Cases Submitted
Peri- and Neonatal		
Neonatal intensive and special care (National Neonatal Audit Programme - NNAP)	Yes	100%
Children		
Paediatric asthma (British Thoracic Society)	Yes	100%
Moderate or severe asthma in children (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
Childhood epilepsy (Epilepsy 12 RCPH National Childhood Epilepsy Audit)	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%
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	100%
National audit of seizure management (NASH)	Yes	100%
National emergency laparotomy audit (NELA)	Yes	59% Hull Royal Infirmary 100% Castle Hill Hospital
Adult critical care (Case Mix Programme – ICNARC)	Yes	100%

Audit:	Participated	% of Cases Submitted
Paracetamol overdose (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
Severe sepsis and septic shock (care provided in Emergency Departments - College of Emergency Medicine)	Yes	100%
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	100%
National Inpatient Diabetes Audit (NADIA)	Yes	100%
Ulcerative colitis and Crohn's disease (National Inflammatory Bowel Disease - IBD Audit, includes Paediatric IBD Services)	Yes	Casenote audit 1% Organisational audit (Biologics Audit 100%)
Chronic Obstructive Pulmonary Disease (COPD)	Yes	100%
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	100%
Elective surgery (National Patient Reported Outcome Measures Programme - PROMs)	Yes	Unilateral Hip Replacement 99% Unilateral Knee Replacement 98% Groin Hernia Surgery 90% Varicose Vein surgery 44%
Coronary angioplasty (National Institute for Clinical Outcome Research - NICOR Adult cardiac interventions audit)	Yes	100%
National Vascular Registry (elements include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)	Yes	Endovascular and open operations for abdominal aortic aneurysm 100% Above and below knee amputations 20% for 2013. 100% for 2014. Fem-Pop bypasses 20% for 2013. 100% for 2014.
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	Data due to be submitted in July 2014
Cardiac arrhythmia (HRM)	Yes	96%
National cardiac arrest audit (NCCA)	Yes	100%
Renal disease		
Renal replacement therapy (Renal Registry)	Yes	100%
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	97%
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	100%
Head and neck cancer (Data for Head and Neck Oncology - DAHNO)	Yes	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	100%
Trauma		
Severe trauma (Trauma and Audit Research Network)	Yes	100%
Blood transfusion		
Audit of the use of Anti-D (National Comparative Audit of Blood Transfusion)	Yes	100%

Audit:	Participated	% of Cases Submitted
Audit of the management of patients in Neuro Critical Care Units (National Comparative Audit of Blood Transfusion)	Yes	100%
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) - including the hip fracture database (NHFD)	Yes	100%
Acute stroke (Sentinel Stroke National Audit Programme - SSNAP)	Yes	Quarter 2 80 – 89% Quarter 90+% Quarter 4 Data to be submitted by 27 May 2014
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study		
Tracheostomy (i) Ward questionnaires (ii) Clinical questionnaires	Yes	100% 90%
Lower Limb Amputation	Yes	100%
National Review of Asthma Deaths	Yes	100%
Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBBRACE – UK)		
Maternal infant and perinatal programme (MBBRACE-UK)	Yes	100%
Other Enquiries/Reviews		
Child Health (CHR – UK)	Yes	100%

The reports of 27 national clinical audits were reviewed by the provider in 2013/14 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 revise the Trust antenatal steroid policy (as part of Clinical Guideline 133) to comply with national guidance To train neonatal junior staff at induction onto the Neonatal Unit (and subsequent monitoring of practice) regarding recording of data items in the database To develop and implement a system for capturing and recording of 2 year outcome data obtained at outpatient follow up of babies born at <30 weeks gestation in BadgerNet database To audit 'missed' antenatal steroid cases identified to determine accuracy and reasons for missed opportunities
Chronic pain (National Pain Audit)	<ul style="list-style-type: none"> Ensure full participation in future national audits Review patient questionnaire at first appointment
Bowel cancer (National Bowel Cancer Audit Programme)	The audit results showed the Trust is consistently performing over the 90% threshold for all the performance indicators.
Head and neck cancer (Data for Head and Neck Oncology - DAHNO)	<p>Pathway measures summary and percentage of pathway indicators met:</p> <ol style="list-style-type: none"> 1.4% Pre-treatment seen by Clinical Nurse Specialist 26.4% Pre-treatment nutritional assessment 9.3% Pre-treatment speech and language therapy (SALT) assessment 44.3% Pre-treatment dental assessment 52.9% Pre-treatment chest CT/CXR 100% Discussed at multi-disciplinary team meeting 72.9% Resective pathology discussed at multi-disciplinary team meeting

Audit	Proposed actions
	<p>As the data within the report is from 2011/12, a number of changes have already been put into place. Of the indicators above, points 1, 2, 3, 5 and 7 are outside expected anecdotal experience in the Multi-disciplinary team.</p> <p>The Clinical Nurse Specialist now uploads information directly to the national database therefore improvements should be seen in the next report. The Trust has appointed a Consultant within the Head and Neck Max Fax Department who will be providing pre-treatment dental assessment.</p>
Lung cancer (National Lung Cancer Audit)	<ul style="list-style-type: none"> • To undertake a service review based around the histological diagnosis and CT before bronchoscopy results. • To undertake an investigation into the lung biopsies and lung cancer not otherwise specified results. • To discuss with colleagues the availability of nurse specialists at appropriate clinics.
Oesophago-gastric cancer (National O-G Cancer Audit)	The key recommendations of the audit report were reviewed and circulated to multi-disciplinary team meeting members. The multi-disciplinary team meeting comply with key recommendations and continue to audit outcomes by annual participation in the national audit.
Heavy Menstrual Bleeding	The audit results showed compliance with the NICE guidelines therefore no actions were felt necessary.
Paediatric Fever (College of Emergency Medicine)	<ul style="list-style-type: none"> • To increase the awareness of blood pressure measurements within the nursing team. • To include the College of Emergency Medicine standards within the training of new staff members.
National dementia audit (NAD)	<ul style="list-style-type: none"> • Establish Dementia care Lead in Clinician, Nursing and Managerial teams. • Work in partnership with the Education team and the Dementia Academy to design a training package for the Trust. • Deliver basic dementia awareness training to all working with older people. • Deliver higher dementia training to all Dementia Champions. • Develop a Dementia Programme board with representation from all key partners. • Ensure the Trust is represented at local, regional and national networks. • Implement a monthly dementia carer survey within the Trust • Develop a Dementia screening tool for all patients admitted to our organisation. • Audit the screening tool to ensure improvements in patient care. • Develop a web-based patient tracker tool to assist in patient placement and assessment. • Implement the “Butterfly Scheme” trust wide. • Appoint Dementia Champions in all clinical and non-clinical team. • Reduce the use of antipsychotics in the management of BPSD. • Use Dementia Mapping in our wards to understand delivery of care from the patient’s perspective. • Develop trust guidance on the management of Delirium. • Introduce Digital Reminiscence Therapy for patients in the Trust. • Develop a Dementia Dashboard to report on healthcare outcomes for patients with Dementia. • Refurbishment of ward environments to enhance the healing environment for people with dementia.
Cardiac arrhythmia (HRM)	<ul style="list-style-type: none"> • To improve the education received by junior doctors within the Acute Assessment Unit for this condition. • To increase the presence of cardiology physicians on the Acute Assessment Unit
Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	<ul style="list-style-type: none"> • To hold bi-monthly meetings to review compliance with targets. • To meet the clinical leads from the emergency departments of referring hospitals regarding the timely transfer of patients. • Ongoing audit of pre-alert acceptance rates against criteria. • To review the training needs of paramedic ambulance providers.
Heart failure (Heart Failure Audit)	<ul style="list-style-type: none"> • To increase the availability of specialist heart failure cover for Hull Royal Infirmary • To have NHS rather than academic heart failure service • To recruit to the heart failure nurse post • To configure an inpatient heart failure service with specialist nurse and consultant cover
Coronary angioplasty (National Institute for	<ul style="list-style-type: none"> • No further action required as the results met the standards.

Audit	Proposed actions												
Clinical Outcome Research - NICOR Adult cardiac interventions audit)													
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	<ul style="list-style-type: none"> To aim to reduce mean HbA1C by 0.5% with measures such as intensive insulin regimen, more frequent follow up and psychology input as indicated 												
Diabetes (National Adult Diabetes Audit)	<ul style="list-style-type: none"> To continue to work with local commissioners and health care providers to continuously improve the quality of diabetes care for the local population. At this time specific actions are delayed pending the publication of the final reports by Health and Social Care Information Centre for Hull and East Riding due to data quality issues 												
National Inpatient Diabetes Audit (NADIA)	<ul style="list-style-type: none"> To increase the frequency of foot risk assessments undertaken during inpatient episodes For patients admitted with foot disease to be seen by MDT within 24 hours To reduce the number of insulin errors To increase the awareness of diabetes through an e-learning package 												
Hip, knee and ankle replacements (National Joint Registry)	Currently under review.												
National cardiac arrest audit (NCCA)	<ul style="list-style-type: none"> To write ceilings of care for all acute admissions with altered NEWS To improve documentation for advanced care planning in the Trust To review the resuscitation policy 												
Fractured neck of femur (College of Emergency Medicine)	<ul style="list-style-type: none"> To use information from the report to feed into new working practices in new Emergency Department e.g. Controlled drugs available at interventional triage New emergency care record to have pain scoring 												
Renal Colic (College of Emergency Medicine)	<ul style="list-style-type: none"> To use information from the report to feed into new working practices in new Emergency Department e.g. Controlled drugs available at interventional triage New emergency care record to have pain scoring 												
Carotid interventions (Carotid Intervention Audit)	<ul style="list-style-type: none"> No further action required as the results met the standards. 												
Hip fracture (National Hip Fracture Database)	Currently under review.												
Adult critical care (Case Mix Programme)	<p>Hospital Standardized Mortality ratio for HRI has reduced from 1.4 to 0.97 (2010 – 2013), our mortality is now below the national average. The database helped us identify areas which needed improving. The following patient group mortalities were reduced as follows:</p> <table border="1" data-bbox="400 1402 751 1541"> <thead> <tr> <th></th> <th>2010</th> <th>2013</th> </tr> </thead> <tbody> <tr> <td>Sepsis</td> <td>65%</td> <td>36%</td> </tr> <tr> <td>Pneumonia</td> <td>76%</td> <td>38%</td> </tr> <tr> <td>Emerg. Surg.</td> <td>58%</td> <td>20%</td> </tr> </tbody> </table> <p>It was therefore agreed that no actions were deemed necessary.</p>		2010	2013	Sepsis	65%	36%	Pneumonia	76%	38%	Emerg. Surg.	58%	20%
	2010	2013											
Sepsis	65%	36%											
Pneumonia	76%	38%											
Emerg. Surg.	58%	20%											
Severe trauma (Trauma and Audit Research Network)	Currently under review.												
Adult asthma (British Thoracic Society)	<ul style="list-style-type: none"> To undertake an inhaler technique review and an educational audit in healthcare professionals to be started in 2014/15. To promote the importance of Peak Flow monitoring. To increase the awareness of smoking cessation services in asthmatics. 												
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study													
Subarachnoid Hemorrhage	<ul style="list-style-type: none"> To provide education to local district hospitals regarding the management of Subarachnoid Haemorrhage patients. 												
Alcohol Related Liver Disease	<ul style="list-style-type: none"> To develop guidelines for the 'Identification of Alcohol Misuse' and 'Management of Alcohol Withdrawal' 												

Audit	Proposed actions
Other Enquiries/Reviews	
Child Health (CHR – UK)	<ul style="list-style-type: none"> • To revise the way in which deaths are reviewed in the health group governance meetings. • To discuss with the neonatologists on how to revise the perinatal and older children's deaths internal reviews.

The reports of 123 local clinical audits were reviewed by the provider in 2013/14 and Hull and East Yorkshire Hospitals. For a full list of the proposed actions Hull and East Yorkshire Hospitals NHS Trust intends to take following local audits reviewed during 2013/14, please see the Clinical Audit Annual Report. This can be requested via the Quality Accounts email address: quality.accounts@hey.nhs.uk or reviewed online via the Quality Accounts page at: www.hey.nhs.uk/qualityaccounts

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Hull & East Yorkshire Hospitals NHS Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 6,192.

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. The Trust continues to demonstrate strong partnership and collaborative working with all key stakeholders. Furthermore, in the period 2013/14, the Trust has continued to strengthen current systems and processes to ensure that it can demonstrate the best standards in research governance and delivery.

The Trust was involved in processing 187 clinical research studies of which 147 commenced during the reporting period 2013/14. This compares with 210 new submissions and 148 commencing in 2012/13.

The Trust used national systems to manage the studies in proportion to risk. Of the 147 studies given permission to start, 93 were National Institute for Health Research (NIHR) portfolio adopted and 77% of these were given permission by an authorised person less than 30 days from receipt of a valid application.

The Trust has 172 studies actively reporting accruals (patient recruitment) under the NIHR Comprehensive Local Research Network (CLRN) Portfolio as compared to 142 portfolio studies reporting accruals for the period 2012/13. This represents a growth of 21% for active portfolio studies compared to 2012/13.

The number of recruits into HEYHT portfolio studies for the periods 2012/13 and 2013/14 was 3743 and 4,190 respectively. This demonstrates an overall level of recruitment is being maintained across the two years with a 12% increase overall compared with last year. A target of more than 5,500 patient accruals is expected to be set for 2014/15. The largest topic area of portfolio adopted studies across 2013/14 is Oncology (Cancer) and Haematology with 25 studies between them. In the last year, 235 publications have resulted from our involvement in portfolio and non-portfolio research across 16 specialty areas, which show our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

The North East Yorkshire and Northern Lincolnshire Comprehensive Local Research Network (NEYNL CLRN) maintained its funding of staff participating in research across many topic and specialty areas in the Trust in 2013/14. The support infrastructure provided by the NEYNL CLRN continued to help the Trust maintain an increased volume of research activity and patient recruitment, ensuring that established studies are continuously supported throughout their life. This has helped to develop productive working relationships and has encouraged staff to actively support trial recruitment.

Goals agreed with our commissioners

The Commissioning for Quality and Innovation (CQUIN) framework is all about improving the quality of healthcare. Our Commissioners reward excellence by linking a proportion of our income to the achievement of locally set and agreed improvement goals. These goals are then embedded into our contract 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 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Hull and East Yorkshire Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

The total contract value of the CQUIN indicators, including the Specialist Commissioning Group indicators, is £10.8 million for 2013/14. At the end of quarter 3 the Trust had successfully achieved all but one of the requirements for the 2013/14 CQUIN programme. We did not achieve our target in quarter 3 for the Pneumonia indicator which represents a financial sanction of approximately £60,000. This indicator has been reviewed with our commissioners and has been changed to reflect quality outcomes rather than a percentage target. The Trust expects to achieve all the requirements in quarter 4 and therefore, should receive 99.3% of the total contract value.

The Trust has worked closely with local commissioners to develop a programme of CQUIN quality indicators for 2014/15. While some topics have been carried forward, there are also some new additions.

National CQUIN Goals:

- Friends and Family Test – where commissioners will be empowered to incentivise high performing providers
- Improvement against the NHS Safety Thermometer, particularly pressure ulcers
- Improving dementia and delirium care, including sustained improvement in Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR)
- Improving diagnosis in mental health – where providers will be rewarded for better assessing and treating the mental and physical needs of their service users

Local CQUIN Goals:

- I Want Great Care - Use of patient feedback to drive continuous improvement
- Working with bereaved carers to improve support
- Transparency Programme - Improve accountability and reduce harm to patients
- To develop acuity monitoring and staffing plans
- Continuous improvement from reviewing end of life care cases
- Improving compliance with the pneumonia care bundle
- Better identification and support to patients with learning disabilities
- Reporting of pressure ulcers within the wider Yorkshire Humber health community

Specialist CQUIN Goals

- Implementing new quality dashboards
- Improving the clinical data collection of patient receiving pulmonary hypertension drug therapies
- Improving registration and communication with GPs about care of the HIV patient
- Increase the percentage of patients enrolled in clinical trials
- Improving access to breast milk for preterm infants

Further details of the agreed goals for 2013/14 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

The Care Quality Commission regulates and inspects health and social care services in England. It checks that services meet the government's standards or rules about care. If it feels that an organisation provides good, safe care it registers it without conditions.

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 2013/14.

Hull and East Yorkshire Hospitals NHS Trust has participated in one special review or investigations by the CQC during the reporting period. The review considered services for looked after children and safeguarding in the East Riding of Yorkshire. The result of this review has not yet been published by the CQC. Following publication an appropriate action plan will be developed if there are any areas of improvement noted for the Trust.

The CQC undertook two compliance inspections at Hull and East Yorkshire Hospitals NHS Trust during the reporting period (June and October 2013). The areas of non-compliance for Hull and East Yorkshire Hospitals NHS Trust following these two inspections are detailed below:

Outcome	Reasons for non-compliance
Outcome 4 – Care and welfare of people who use services	The CQC felt that patients were not protected against the risks of receiving care or treatment that is inappropriate or unsafe because the planning and delivery of care and where appropriate, treatment, did not meet the patient's individual needs or ensure the welfare and safety of the patient.
Outcome 7 – Safeguarding people who use services from abuse (This was a review of safeguarding adults only. Safeguarding children is assessed separately via the looked after children and safeguarding review described above)	The CQC felt that patients (adults) were not safeguarded against the risk of abuse. This is because the hospital did not take reasonable steps to identify the possibility of abuse and prevent it before it occurred or respond appropriately to allegations of abuse.
Outcome 9 – Management of Medicines	The CQC felt that patients were not protected against the risks associated with medicines because the arrangements in place to manage medicines safely were not adhered to consistently and that patients were not protected against the risks associated with medicines because the hospital did not have appropriate arrangements to obtain and store medicines.

The Trust has developed a comprehensive action plan to address all areas of non-compliance and improvement from both the June and October 2013 compliance inspections. The Trust has responded to the CQC outlining how it intends to make the improvements and maintain compliance with the Essential Standards of Quality and Safety. The action plans are being monitored to ensure that actions are implemented and that the concerns have been addressed. Examples of actions taken to improve include:

- The development of a central database for recording safeguarding adult concerns/referrals received externally and raised internally. This database also records the number of Deprivation of Liberty applications to the relevant Safeguarding Adult Team and the number of approved Independent Mental Capacity Advocate.
- Reviewed the safeguarding adult training content to ensure the signs of abuse are clear and staff understands how to recognise abuse.
- Revised the Trust's Tissue Viability Assessment and Management Protocol to include a trigger point for potential safeguarding adult incidents and an escalation processes for staff.
- Developed a policy for the prevention and management of delirium or behavioural and psychological symptoms of dementia (BPSD).
- Included training sessions on the Junior Doctor training and corporate induction regarding medicine management.
- Included medicine management audits into the Setting the Standard audit programme led by the Chief Nurse in

conjunction with the Medicines Management Nurse.

- The Chief Pharmacist became a member of the board Quality, Effectiveness and Safety (QUEST) Committee to ensure important issues relating to medicines management are escalated from Ward to Board and acted upon.

The Trust was selected as one of the healthcare providers to be inspected during wave two of the Chief of Inspector of Hospitals Inspection programme because it is an aspiring Foundation Trust. The inspection took place on the 4 and 5 February 2014 at Hull Royal Infirmary and the Castle Hill Hospital. The reports from this inspection have been published by the CQC and are available on the CQC website. The Quality Summit meeting led by the CQC and the NTDA (NHS Trust Development Authority) took place on 2 May 2014 with relevant stakeholders present to review the findings of the inspection, respond to the final reports and commence action planning. The Trust is currently developing a sustainable action plan to address all areas of non-compliance and other areas for improvement. The Trust is working in partnership with all stakeholders in developing the action plan to ensure the right support is in place to help improve the services provided. The Trust's Chief of Hospitals Inspection action plan will be published on the hospitals internet site following approval by the Trust Board in June 2014.

The overall rating for Hull and East Yorkshire Hospitals NHS Trust is – Requires Improvement. A breakdown of the overall rating is detailed in the table below.

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

Data quality

NHS number and general practice code validity

Hull and East Yorkshire Hospitals NHS Trust submitted records during 2013/14 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:

99.8% for admitted patient care;
 99.9% for out patient care; and
 99.1% for accident and emergency care.

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

100% for admitted patient care;
 100% for out patient 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 score overall score for 2013/14 was 71% and was graded green.

Clinical coding error rate

Hull and East Yorkshire Hospitals NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatments coding (clinical coding) were:

10.8% primary diagnosis incorrect

14.6% secondary diagnosis incorrect

5.4% primary procedures incorrect

15.6 % secondary procedures incorrect

The data above and the recommendations rated as a high priority detailed below are drawn from the Audit Commission external audit review of Payment by Results (PbR) coding for the year ended 31 March 2013. The audit was conducted by the Audit Commission's business partner, Capita Business Services Limited.

Hull and East Yorkshire Hospitals NHS Trust will be taking the following actions to improve data quality:

Recommendation	Priority	Progress update
<p>Recommendation 1 All errors found through the audit should be fed back to the coding staff and any required training provided to ensure they are aware of the common coder errors found such as:</p> <ul style="list-style-type: none"> • extraction, indexing and sequencing of codes; • coding of symptoms of diagnosed conditions; • primary diagnosis definition; and coding of mandatory comorbidities 	High	All staff was made aware of the general findings in the November 2013 coding meeting. Each individual error was also discussed with the coder responsible and the correct coding was agreed.
<p>Recommendation 2 Ensure coding staff are up to date with national guidance and coding standards.</p>	High	Regular internal training is provided to all coders, the last session was in January 2014 on External Cause codes. At present all coders are up to date with their refresher training. It is also a specification in all coders Personal Development Review's that their coding reference books are up to date and these are regularly checked at internal training sessions.
<p>Recommendation 3 Improve the standard of information included in the immediate discharge letters, particularly around the coding of mandatory co morbidities.</p>	High	<p>Due to the missing information on the Immediate Discharge Letters in Acute Assessment Unit it had already been decided to refer back to case notes. Currently the business manager for medicine is looking for office space on or close to AAU so the coder can code work from there.</p> <p>The coding manager has also requested that complex ENT/MaxFax operation notes are typed out rather than hand written but at present there is insufficient secretarial support to provide this.</p> <p>All Health Groups have been asked to improve on the quality of the Immediate Discharge Letters when they are expected to be used for coding purposes.</p>

Part 3:
Looking back over
the past year



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.

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 previous section.

Prescribed Information	2012/13	2013/14	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—					
<ul style="list-style-type: none"> • the value of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period 	102.5	102.6	99.9	65.2	117
<ul style="list-style-type: none"> • the banding of the SHMI for the trust for the reporting period 	2	2	NA	3	1
<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. *The palliative care indicator is a contextual indicator. 	25.1%	NA	21.3%	0.0%	44.9%

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 and improvements identified are part of our quality improvement project for mortality which is detailed on pages 6-7.
- Work commenced in January 2014 to remove the use of the Liverpool Care Pathway from the Trust, in line with national guidance. The Liverpool Care Pathway was replaced with Trust developed guidelines on personalised management planning for the dying patient, symptom management and palliative rapid discharge pathways. Work will continue to embed the new Trust guidelines and working towards national gold standards of best practice.

Prescribed Information	2012/13	2013/14	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 patient reported outcome measures scores during the reporting period for—					
<ul style="list-style-type: none"> • groin hernia surgery 	50.9	54.7	50.2	100	14.3
<ul style="list-style-type: none"> • varicose vein surgery 	56.1	54.5	52.7	88	14.3
<ul style="list-style-type: none"> • hip replacement surgery 	83.2	84.4	87.8	100	70.6

Prescribed Information	2012/13	2013/14	National Average	Best performer	Worst performer
<ul style="list-style-type: none"> knee replacement surgery 	80.1	84.1	81	100	35.7

Notes on data:

Most recent data on HSCIC is for period 01/04/2013 – 31/12/13

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

- The Trust does have a higher than average percentage of revisions for both Knee and Hip which can affect outcomes. Data is now available split between primary and revision and this data is being used alongside the following to investigate our results.
- The Trust has begun to look at the issues with the hip replacement outcomes scores in greater detail in particular those patients who had a negative outcome. The latest data has seen a significant improvement in our outcomes for Hip primary.
- Patient level data is being analysed to look at the outliers and their impact on the overall scores by our orthopaedic surgeon team and to understand how we can improve overall.

Prescribed Information	2012/13	2013/14	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 during the reporting period with regard to –					
<ul style="list-style-type: none"> the percentage of patients aged 0 to 14 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period 	7.4%	6.9%	7.8%	1.4%	28.6%
<ul style="list-style-type: none"> the percentage of patients aged 15 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 	6.7%	6.6%	7.5%	0%	30.0%

Notes on data:

The data presented in the 2012/13 Quality Account was for the % of patients aged 0 to 17 and the % of patients aged 18 or over, in line with the reporting arrangements. The reporting arrangements have changed for 2013/14 to the requirements above therefore the data for 2012/13 has changed from the Quality Account published last year.

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 and improvements identified are part of our quality improvement project for discharge which is detailed on page 27.

Prescribed Information	2012/13	2013/14	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.	70.4	75.1	76.9	87	67.1

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:

- The Chief Nurse will lead on the implementation of #hellomynameis campaign to improve communication between nursing and medical staff and patients.

- A number of initiatives at ward level to improve the patient experience, Setting the standard, the 6C's and using the real time feedback from the inpatient Friends and Family Test to drive improvement at a ward and service level – using You said we did.

Prescribed Information	2012/13	2013/14	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.	92.1%	94.73%	96%	100%	80.2%

Notes on data:

For 2013/14 only quarters 1 -3 are fully reported on NHS England stats website

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 and improvements identified are part of our quality improvement project for venous thromboembolism (VTE) which is detailed on pages 20-21.

Prescribed Information	2012/13	2013/14	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 reported within the trust amongst patients aged 2 or over during the reporting period.	26.5	15.9	14.41	0	30.8

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 and improvements identified are part of our quality improvement project for infection prevention and control which is detailed on pages 11-12.

Prescribed Information	2012/13	2013/14	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 -					
<ul style="list-style-type: none"> • the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, 	6.9	6.96	7.94	12.84	4.87
<ul style="list-style-type: none"> • the number and percentage of such patient safety incidents that resulted in severe harm or death 	0.3%	0.3%	0.3%	0.1%	0.9%

Notes on data:

The data above is for the reporting period 01/04/13 – 30/09/2013 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:

- The actions and improvements identified are detailed on pages 51-54. Learning lessons from Serious Incidents (SIs) and Never Events has been identified as a priority for 2014/15, which is detailed on page 35.

Prescribed Information	2013/14	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 ‘If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation’ for each Acute and Acute Specialist Trust who took part in the survey	52.94*	52.57**	93.92	39.57

Notes on data:

The Trust implemented the staff Friends and Family Test in April 2014 and therefore does not have any data for the reporting period of 2013/14.

This information is taken from the National NHS Staff Survey as provided by HSCIC for inclusion

*This result puts the Trust in the 1st quartile (lowest performing Trusts). Trusts in the 4th quartile are top performers

**National average for Trust’s in the 1st quartile

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:

- A programme of focus groups are to take place led by the Communications and Engagement team between March and November 2014 as well as summer engagement events planned for staff to focus on this issue.
- Hold Big Conversation session with Ophthalmology and Paediatrics as well as five focus group sessions with staff in maternity and breast care to work on engagement and morale.

Prescribed Information	2013/14	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)	75	64	NA	NA

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

- The Trust already has rolled out the Friends and Family Test to all outpatient areas and day case services ahead of national requirements after demand from services to help understand patient experience and what patients are saying about the service to help improvement.
- Implement the consultant Friends and Family Test.

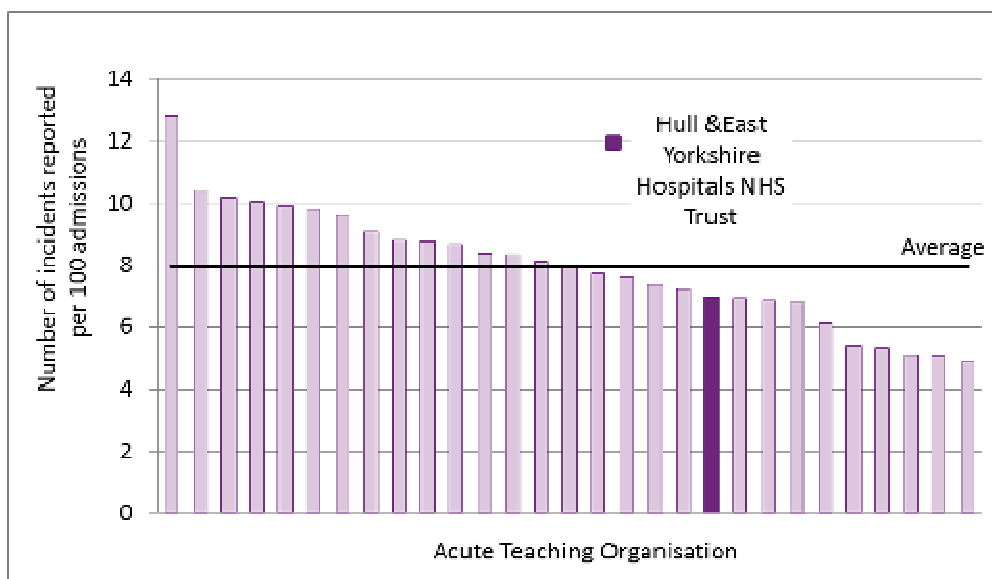
Patient Safety Incidents

Patient safety is identified as the organisation's number one priority. The Trust aims to provide care that is safe, effective and high quality for all patients and service users. One of our priorities is 'To Reduce all Avoidable Harm' with the aim of 95% of patients receiving harm free care, it is our duty to protect patients from all avoidable harm and 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 recurrence.

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 May 2014 and shows the Trust to be below average for reporting of patient safety incidents.

Figure 1: Patient safety incidents per 100 admissions for the period of 01 April 2013 to 30 September 2013



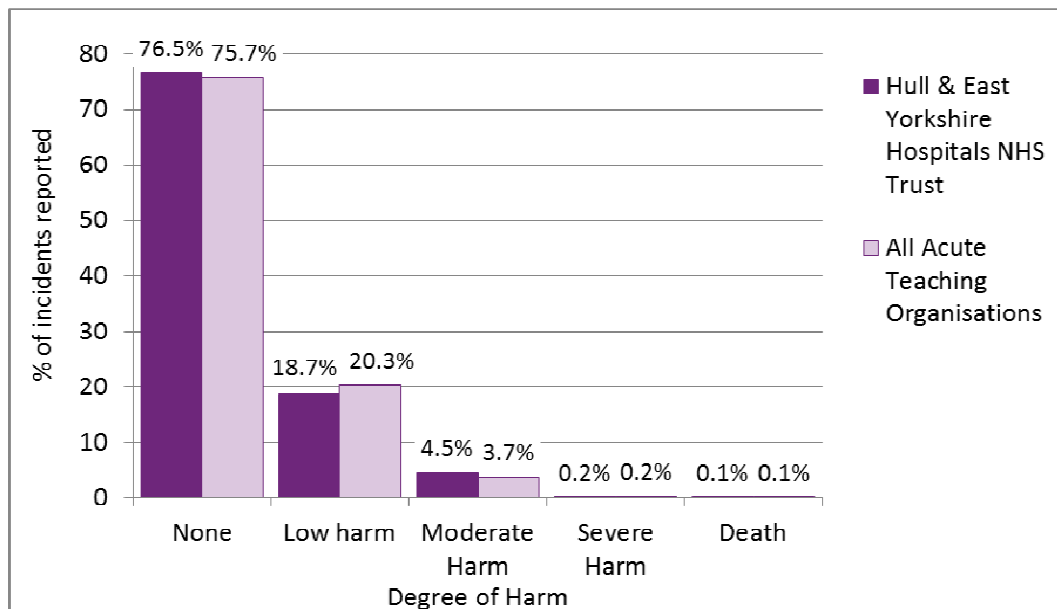
The latest report covers 6 months in 2013. At this point in time the Trust had identified a drop in incident reporting through receiving feedback from staff, including responses in the staff survey, and from previous NRLS reports.

In response to this the Trust held an Incident Reporting Big Conversation in October 2013, which resulted in an action plan being developed by the Risk Team to address the issues raised. The actions taken so far include:

- Working with the Communications Team to include an incident reporting button on the intranet front page
- Review of the incident form to make it quicker and easier to complete
- On-line training package produced for How to Report Incidents
- Development of Newsletters to raise awareness of incident reporting and lessons learned
- Work with individual teams to look at their specific issues around incident reporting and how to resolve them (i.e. Tissue Viability and Transport Incidents)

Figure 2 shows the incidents reported by degree of harm comparing Trust performance with that of Acute Teaching Hospitals and is taken from the latest National Patient Safety Agency National Reporting and Learning Service data report published May 2014.

Figure 2: Incidents reported by degree of harm for Acute Teaching organisations for the period of 01 April 2013 to 30 September 2014



The Trust appears to be reporting in line with the cluster on degree of harm. This would indicate that the severity ratings for incidents are generally correct.

The top six patient safety incidents reported during 01 April 2013 to 30 September 2014 are detailed in Figure 3 below.

Figure 3: Top six patient safety incidents reported by %

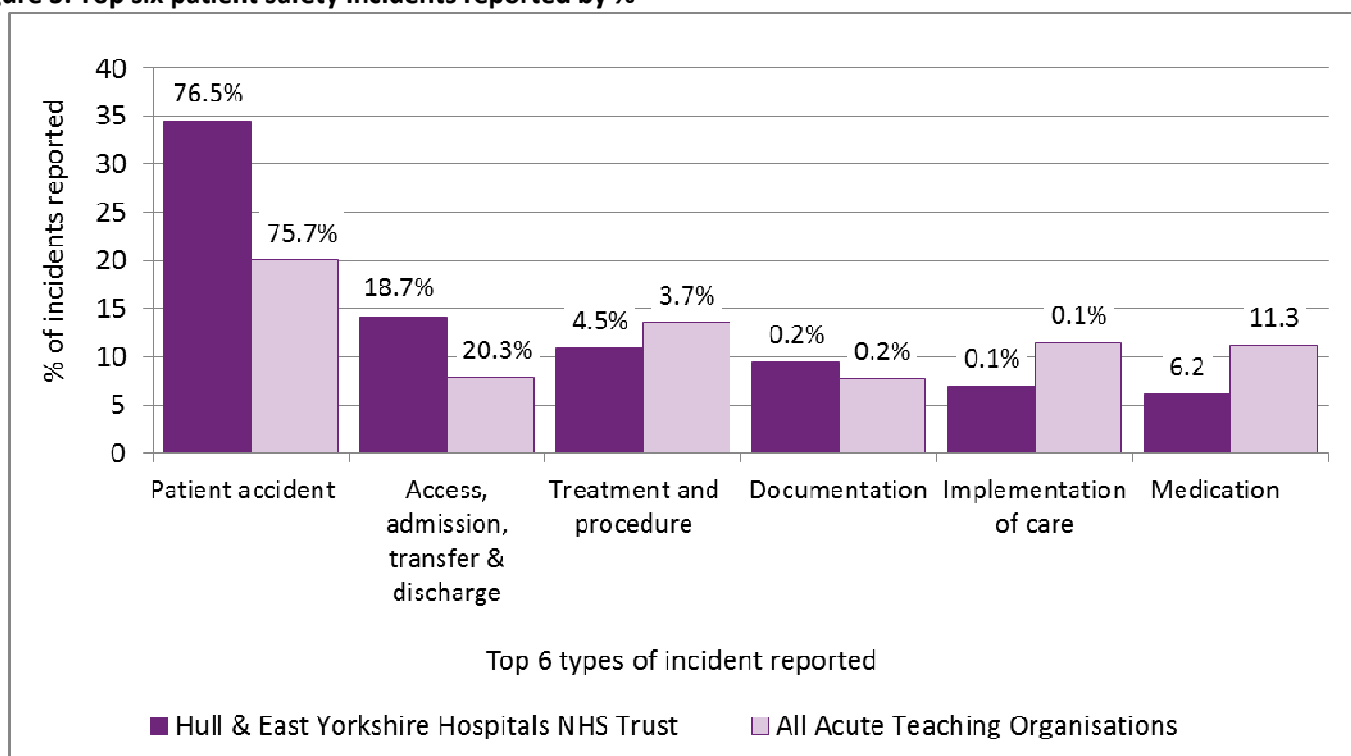


Figure 3 shows our top 10 types of incidents reported against the cluster. Our profile does look different from the cluster, and the differences could be attributed to the way our mapping codes have been mapped to the NRLS codes (i.e. how we matched our Type, Category and sub-category codes to the NRLS) or due to possible high risk areas within incidents. The Risk Team have sent over the Trust mapping to the NRLS team to check how our codes have mapped.

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

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 falls into the category of an incident that must be reported to the local Commissioning agencies.

The Trust was informed that it may be an outlier in the number of reported Serious Incidents being declared when compared to its peers. The Trust was reporting significantly less SIs than the peer group average. A review was therefore undertaken of the 71 incidents which had been identified as Critical Incidents to determine whether they had been correctly categorised. The incidents had occurred between April 2011 and August 2013.

The review commenced in November 2013 and was undertaken by the Chief Medical Officer, Chief Operating Officer, Chief Nurse and Deputy Director of Governance and was completed in December 2013.

The review determined that 26 of the 71 Critical Incidents should have been reported as Serious Incidents.

Of the 26, it was agreed that those that had occurred after to 1 April 2013 would be declared as Serious Incidents and have been investigated accordingly. Of the remaining 21, 20 are been reported retrospectively as Serious Incidents by this Trust and 1 by another Trust. The approved Critical Incident reports are being shared with the commissioners.

This work led to a review of the declaration and escalation arrangements for potential Critical Incidents, Serious Incidents and Never Events, with a more robust process put in place in January 2013/14. Critical Incidents have now been removed as a category.

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

	2011/12	2012/13	2013/14
Total Never Events declared	4	3	4
Total Serious Incidents declared	10	8	32
Total	14	11	36

Top three types of Serious Incident and Never Events declared during 2013/14

Serious Incident	
Type of incident	Number
Fall resulting in fractured neck of femur or other injury	8
Unexpected death of patient	8
Avoidable Hospital Acquired G3 and G4 Pressure Ulcer (G3 = 2 and G4 = 3)	5

Never Events	
Type of incident	Number
Retained Foreign Object (<i>Never Event</i>)	2
Wrong Site Surgery (<i>Never Event</i>)	1
Surgical Error (<i>Never Event</i>)	1

An investigation is undertaken for each SI and Never Event declared, and from the investigation lessons learned are identified and recommendations made. During the final quarter of 2013/14 a new Lessons Learned Newsletter was developed which shares the learning identified from Serious Incident investigations. The content is agreed at the Clinical Quality Committee.

The information included in the newsletter covered:

- Staff awareness of a recent Patient Safety Alert
- Tissue viability training now being mandatory for all clinical staff which has led to a higher confidence in looking for and monitoring pressure ulcers
- Providing feedback from the CQC in October 2013 relating to pressure ulcer care and details of further audits and mock inspections that took place, including improvements demonstrated regarding better completion of assessments and recording of pressure ulcers
- Detailing work undertaken by the Tissue viability team to examine protocols and which has led to an increased awareness of the link between pressure ulcers and safeguarding
- Staff awareness of roles and responsibilities relating to the Data Protection Act and staff duties when accessing patients records
- Staff awareness regarding reporting all medical device and medications incidents through the Trust reporting system
- Staff awareness of ensuring security guards have been given a brief handover of the patient if a patient requires a 'bedwatch'. This ensures that the security guard and patient are not put at risk
- Information regarding the implementation of the new Restraint Policy to ensure patients who are restrained are done so appropriately with no detrimental impact on the patient, there is full documentation in their notes and that their needs are still met
- Providing feedback from the CQC regarding Safeguarding and the action taken in response. Improvements included:
 - Introduction of an internal Trust Safeguarding adult telephone advice line
 - The development of a central database for recording safeguarding adult concerns/referrals received externally and raised internally. This database records the number of Deprivation of Liberty applications to the relevant Safeguarding Adult Team and the number of approved Independent Mental Capacity Advocate
 - Bespoke safeguarding training for senior nurses and midwives introduced
 - Commencement of Mental Capacity Assessments, Best Interests and Deprivation of Liberty Standards training for senior managers and clinicians
 - Development of a central safeguarding adult database which now records the number and reason for contact with the Learning Disabilities Nurse and whether a safeguarding referral is required
 - Feedback being provided to the reporters of safeguarding adult concerns to ensure they understand why a concern was not escalated to a formal concern and outcomes following investigations undertaken internally or by the Local Authorities
 - A significant increase in the awareness of the different types of abuse and reporting of safeguarding adult concerns.



Setting the Standard for Hospital Care

Patients and visitors can now tell at a glance how well our hospital wards are performing. The Trust has implemented its 'Setting the Standard' initiative across all wards at Hull Royal Infirmary and Castle Hill Hospital to publicly demonstrate how well we're looking after our patients.

Setting the Standard is essentially a rating system whereby each ward is awarded either a Red, Bronze, Silver, Gold or Platinum rating based on its performance in 12 key standards of care. Following a successful pilot on six wards during June and July 2013, the Senior Nursing team has assessed every ward based on performance in areas such as patient nutrition, respect and dignity, and infection control and awarded a rating.

Amanda Pye, Chief Nurse, says:

"The Mid Staffs Inquiry and the subsequent Francis Report clearly demonstrate the need for us as health professionals to be more open and up-front with our patients, and to be accountable for the quality of care we provide. Setting the Standard is a scheme we've chosen to introduce locally which will enable anyone visiting a ward at either Hull Royal Infirmary or Castle Hill Hospital to see how that ward is performing at any given time. We feel this will offer patients and the public reassurance that the care being provided meets core standards in respect of quality and safety."

Each ward's rating will be displayed prominently at its entrance, and quarterly unannounced reviews, which take into account the views of patients, will determine whether a ward's rating changes or stays the same.

Within one week of review, every ward must produce an action plan designed to address any notable areas of concern, and performance against these plans will be tracked through regular ward team meetings.

Improvements achieved:

- New process were introduced across the organisation and the nutrition risk assessment and care plans was revised and reformatted
- Further embedding of the intentional rounding process
- Introduced daily Safety Briefings across all wards. The ward team comes together to discuss patient safety issues such as the number of patients that have a high risk of falling, the dependency of patients on the ward and any staffing issues. These are then escalated to the Patient Safety Meeting
- Introduction of the Patient Safety Meeting which takes place twice a day with representation from a Nursing Director so that issues can be acted upon promptly
- Standardised student booklets across all clinical areas

Further improvements identified:

- Mandate specific link nurse roles across the organisation with defined responsibilities
- Review the ward round documentation and process
- Undertake large scale testing of revised nursing and inpatient risk assessment documentation and include a section on infection control admission risk
- Introduce the Setting the Standard review process to incorporate other clinical areas such as Theatres and the Emergency Department

The 12 Key Standards

- ✓ Patient safety; Organisation and management of the clinical area
- ✓ Staffing
- ✓ Culture
- ✓ Respect and dignity
- ✓ Leadership
- ✓ Clinical Safety
- ✓ Communication
- ✓ Record keeping
- ✓ Safeguarding
- ✓ Medicines management
- ✓ Nutrition and hydration
- ✓ Pressure ulcers

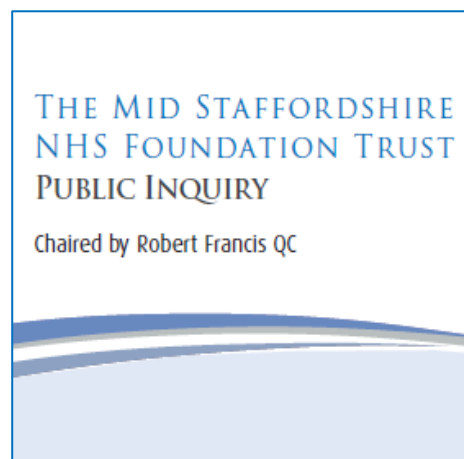
Responding to the Francis Report

The Francis Report was published nationally in February 2013. Following the publication a number of actions occurred within the Trust including:

- The Senior Team met to discuss the 290 recommendations, and agreed that there were 27 key recommendations to take forward, 11 of which were prioritised.
- A steering committee was set up to review and deliver the recommendations as agreed by the Trust Board, this meeting was chaired by the Chief Executive.

As a result five task and finish groups have been set up and they each have a set of recommendations to consider:

- Openness, Transparency & Candour
- Information
- Leadership & Foundation Trust
- Care & Compassion
- Values & Standards



These groups meet monthly to review and progress their action plan. Every month the task and finish groups report to the Francis Committee on their progress with particular reference to the Top 27 and specifically progress made against the top 11 recommendations. A member of the Francis Committee also sits on the Francis 2 Programme Board. The purpose of the Francis 2 Programme Board is to provide seamless appropriate quality care when a patient journey spans more than one organisation and is made up of all the relevant stakeholders including, Hull and East Yorkshire Hospitals NHS Trust, NHS Hull Clinical Commissioning Group, NHS East Riding of Yorkshire Clinical Commissioning Group, Humber NHS Foundation Trust, City Health Care Partnership, Spire Hospital – Hull and East Riding, Hull City Council, East Riding of Yorkshire Council and NHS Yorkshire and Humber Commissioning Support Unit.

Improvements achieved:

- 225 staff have signed up and become Dementia Champions
- Great Leaders Programme, which is a middle management leadership programme introduced Trust-wide in October 13
- Speak Out Safely: Supports the Nursing Times speak out safely campaign
- Hospital Control Team Helpline: Phone line to report any urgent issues or concerns relating to patient safety
- Staffing levels are now published on the Quality and Safety Boards on each ward across the Trust
- Using 6Cs to demonstrate issues & learning from patient harm; tissue viability posters
- Relative Clinics were successfully tested on one ward; wide scale test to commence in the Surgery Health Group during May 2014
- Open & Honest Care: Driving Improvement: Since November 2013 we have been one of sixteen Acute Trust boards in the North of England who have published data on safety, effectiveness and experience with the overall aim of driving improvements in practice and culture. These reports are published on our public facing website

Further improvements identified:

Our "IWantGreatCare" results tell us that our patients rate, very highly, the care we provide. Sometimes, though, our staff don't see things in the same way. Staff underestimates the excellent care they provide and forget the amazing things they do every day. Therefore we plan to hold a series of Big Conversations where we will encourage staff to talk about their stories. We want the staff to talk about the great work that is being done and help to bring to life the five domains that the report identified as above.

Implementing the Six C's for Nursing

In late 2012, the Chief Nursing Officer launched 'Compassion in Practice', a three year-strategy for developing a culture of compassionate care throughout the NHS and social care.

For all nurses, the 'Six Cs' are not new, but serve as a useful reminder of the basic skills and values we should be demonstrating towards our patients every day. They are:

Care	Our core business of providing patient centred, tailored care at any and every stage of a person's life
Compassion	Showing empathy, dignity and respect, which are often central to how people view their care overall
Competence	Having the ability to understand an individual's health and social care needs, as well as the expertise and clinical knowledge to deliver effective care and treatment
Communication	This is the key to generating a healthy workplace and central to successful caring relationships which benefit patients and staff alike. Listening becomes as important as the things we say, and this is essential for "no decision about me without me"
Courage	Having the personal strength and vision to innovate, to embrace change, and to do the right thing on behalf of those we care for
Commitment	Taking our commitment to our patients and our population and building on it by improving the patient experience and tackling challenges head on

In order to really make these values come alive within our Trust, a piece of work will be undertaken to demonstrate how the Six Cs will be delivered trust-wide. More specifically, one of the Cs will be a focus every other month, using roadshows and other methods, and work with nursing and midwifery staff to ensure these values are embedded and staff are consistently delivering the care and quality our patients rightly expect.

In the wake of the Francis Report, it is vital that the Trust along with many other healthcare professionals up and down the country show that we remain committed to delivering on these basic but vital principles of care.



Part 4:
Annex



Statements from Key Stakeholders

The first draft of the Trust's 2013/14 Quality Account was forwarded to key stakeholders on the 8 May 2014 with a request for statements of no more than 500 words to be received before the 7 June 2014. The key stakeholders are:

- NHS Hull Clinical Commissioning Group
- NHS East Riding of Yorkshire Clinical Commissioning Group
- Healthwatch 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 Quality Accounts

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

NHS Hull Clinical Commissioning Group

NHS Hull Clinical Commissioning Group welcomes the opportunity to review and comment on the Hull and East Yorkshire Hospitals Trust Annual Quality Accounts 2013-14.

The report clearly demonstrates the progress made and challenges encountered by Hull and East Yorkshire Hospitals NHS Trust in 2013-14.

NHS Hull Clinical Commissioning Group recognises the Trust's ongoing commitment to clinical audit and research and confirms the research section in the Quality Account is accurate, representative, and appropriate and gives a satisfactory coverage of the activities provided in this domain.

As Commissioners, we are pleased to note the work undertaken relating to the Nursing 6 C's strategy and the Francis 2 recommendations, however a greater level of detail on the outcomes of the work streams would be beneficial. We recognise the participation of the Trust in the multi-stakeholder Francis 2 Partnership board and it is good to see examples of ward to board/board to ward leadership within the Quality Accounts.

The draft report does not yet provide the data for Patient Safety Incidents or the Key Performance Indicators & National Targets, however commissioners are aware that there have been significant difficulties and underachievement of some national targets and anticipate that the final report will accurately reflect these challenges and the actions being taken to address the shortfall.

With regards to Patient Safety, Commissioners remain concerned with the Trust's current ability to recognise and escalate incidents that require investigation and reporting under the Significant Incident and Never Events framework and this is an area which we expect to feature comprehensively in the Trust's action plan and response to the CQC Chief Inspector of Hospitals Inspection report.

We are pleased to note the inclusion of Deteriorating Patient, Medication Errors, Sepsis and Learning Lessons in the Trust's priorities for improvement in the coming year and will continue to support the Trust in this endeavour. NHS Hull Clinical Commissioning Group anticipate that the Learning Lessons area will draw not only on individual learning but also the cross cutting theme/trend learning to prevent repetition in other areas of the Trust, particularly in relation to key risk areas such as Peri-operative harms, Pressure Ulcers and Falls.

Finally, we note that notwithstanding the missing updated year end data for some areas of the report, we confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by Hull and East Yorkshire Hospitals Trust and that the data and information contained in the report is accurate.

NHS Hull Clinical Commissioning Group remains committed to continuing to work with the Trust and its regulators to improve the quality of services available for our population in order to improve patient outcomes.



Emma Latimer
Chief Officer
NHS Hull Clinical Commissioning Group

NHS East Riding of Yorkshire Clinical Commissioning Group

East Riding of Yorkshire Clinical Commissioning Group is pleased to be given the opportunity to review and feedback on Hull and East Yorkshire NHS Trusts' Quality Accounts for 2013/14. Overall the report is well presented and the information included provides a balanced view. Areas where further improvement in care delivery is required have been identified with the focus on patient experience and outcomes, which is pleasing.

The Trust's continued achievement in reducing mortality rates is noted along with the focus on investigating all incidences of higher than expected mortality rates. The on-going work to reduce infection rates is also encouraging; however it is disappointing to see that the C-Difficile trajectory was breached by the Trust this year.

It is encouraging to see that the Trust has acknowledged themselves as an outlier in reporting incidents and serious incidents in comparison to its peers. The Trust has reviewed its serious incident policy and the reporting of serious incidents and work is being undertaken to improve this, ensuring staff are competent and have the skills and knowledge to provide safe, effective patient care.

We are supportive of the areas identified by the Trust for further improvement, which clearly identify with the three elements of quality; patient safety, clinical effectiveness and patient experience and also include recommendations from the Francis Report. The focus on dementia care is positive, although achievements have been made over the past few years; dementia is still seen as an emerging issue and requires further focus which has been acknowledged.

The information in relation to clinical audits and research is positive, however it would have been beneficial to have an overview of the outcomes of the audits that have been completed, and the impact the outcomes have had on patient care and service delivery.

The recent CQC inspections have been acknowledged within the report by the Trust and the action plan that has been developed as a result to address the issues of non-compliance. Further expansion on the actions for improvement regarding patient safety would have been of benefit and provided a more detailed account.

The Trust has demonstrated improvement across the majority of the CQUIN indicators for 2013/14 supporting innovation and quality improvement. The CCG has worked in partnership with the Trust to agree the CQUIN schemes for 2014/15 with particular focus on pressure ulcer care and medication errors.

We confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by Hull and East Yorkshire Hospital Trust and that the data and information contained in the report is accurate. The Clinical Commissioning Group is looking forward to working with the Trust in the future to improve the quality of services available for our patients and continually improve patient outcomes.



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

Healthwatch Kingston upon Hull

Healthwatch Kingston upon Hull are focussing their resources on other work connected to the Trust's services following the Care Quality Commission (CQC) Chief Inspector of Hospitals Inspection report and therefore will not be submitting a statement for inclusion in the 2013/14 Quality Account. However colleagues from Healthwatch Kingston upon Hull were involved in the quality and safety priorities consultation process and have liaised with the Compliance Team on the development of the Quality Account regarding readability of the document.

Hull City Council Overview and Scrutiny Committee

Hull City Council's Health and Wellbeing Overview and Scrutiny Commission has continued to be involved in the development of the Hospital Trust's Quality Accounts and was last consulted in April 2014. The Commission welcomed the proposal to reduce the number of key priorities and recommended that patient care and staff numbers should be reflected in the 2014/15 priorities.

East Riding of Yorkshire Overview and Scrutiny Committee

The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee would like to thank the Trust for the opportunity to comment on its Quality Accounts 2013-14.

The Sub-Committee found the new style used in the accounts to be very clear in the presentation of information. The use of improvement story boxes which are clearly laid out also provide a different way of understanding the information being presented in a format that it is felt will be far more user friendly to members of the public.

The Sub-Committee was pleased to see that the Trust had come in just under target with regard to the number of medication errors made but would also like to see more information on what the Trust is doing to reduce delayed discharges due to the long waits for prescriptions to be filled.

The reduction in the number of falls causing the patient harm is a good news story and the Sub-Committee looks forward to similar reductions in the number of actual falls occurring throughout the Trust. The new tool that has been developed by the Trust to identify patients who have a higher risk of falling is welcomed by the Sub-Committee and it is hoped that this leads to no new patients breaking a hip through falling.

The results of the family and friends test are extremely positive and the Sub-Committee welcomes these.

The Sub-Committee notes with concern the outcomes of the Care Quality Commission inspection earlier this year and very much looks forward to seeing improvements arising from implementing the recommendations which will of course benefit East Riding residents.

The Care Quality Commission judged that the Trust was non-compliant with Outcome 4 (Regulation 9) Care and Welfare. One of the reasons why the Trust was non-compliant with regulation 9 was because patients experienced multiple moves around the hospital and across sites. It is hoped that the Trust will look at this as a matter of urgency to ensure that numbers are reduced.

Although the advances made with regard to dementia are a positive step, the Sub-Committee remains concerned following the recent inspection by the Care Quality Commission which indicated that not all staff had received training in the butterfly scheme.

Although overall, the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee supports the Trust's priorities for 2014/15 and hope that these can be achieved, members would also have liked to have seen additional priorities added to reflect the most important issues raised by the Care Quality Commission, for example around staffing levels, demand in the Accident and Emergency Department and the number of cancelled procedures and appointments.

In the past, engagement with the Sub-Committee had been patchy; however, we are confident that with the recent changes at senior level within the Trust, much closer relationships will develop between the Trust and scrutiny.

Trust Response to the Statements

The Trust would like to thank all stakeholders for their comments on the 2013/14 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 2014/15 are the right ones.

As a result of the formal stakeholder statements and additional comments and suggestions received to further improve the information in the Quality Account, the Trust has made the following amendments since the first draft send to the stakeholders:

- All the data for the full financial year is now included in the workstream updates in part 2 and performance review updates in part 3 of the Quality Account
- Achievements and areas for further improvement have been added to the planned admission to discharge section
- Amended the Serious Incidents and Never Events section to ensure the number of Serious Incidents and Never Events reported each year are correct

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

NHS Hull Clinical Commissioning Group	
As Commissioners, we are pleased to note the work undertaken relating to the Nursing 6 C's strategy and the Francis 2 recommendations, however a greater level of detail on the outcomes of the work streams would be beneficial	More information has been included on pages 56-57 to provide feedback on actions undertaken by the workstreams and improvements that have been made.
The draft report does not yet provide the data for Patient Safety Incidents or the Key Performance Indicators & National Targets	The data for the patient safety indicators and the key performance indicators was not available at the time of sending the draft Quality Account to stakeholders. All data for the financial year is now included. The performance against the national targets has now been removed from the Quality Account and is included in the Trust's annual report instead.
With regards to Patient Safety, Commissioners remain concerned with the Trust's current ability to recognise and escalate incidents that require investigation and reporting under the Significant Incident and Never Events framework and this is an area which we expect to feature comprehensively in the Trust's action plan and response to the CQC Chief Inspector of Hospitals Inspection report	The concerns relating to incident reporting including the reporting of Serious Incidents and Never Events and learning lessons from incidents will be addressed through the Trust's Chief Inspector of Hospitals Inspection action plan.

NHS East Riding of Yorkshire Clinical Commissioning Group	
The information in relation to clinical audits and research is positive, however it would have been beneficial to have an overview of the outcomes of the audits that have been completed, and the impact the outcomes have had on patient care and service delivery	The Trust will include outcomes and actions from internal audits in the clinical audit section of the Quality Accounts from 2014/15.

<p>The recent CQC inspections have been acknowledged within the report by the Trust and the action plan that has been developed as a result to address the issues of non-compliance. Further expansion on the actions for improvement regarding patient safety would have been of benefit and provided a more detailed account</p>	<p>Missing information has been added to the 'What others say about us (CQC) section to ensure the involvement and support from stakeholders during the development of the Chief Inspector of Hospitals Inspection action plan is recognised and to include some information regarding the recommendations and actions following the compliance inspections in June and October 2013</p>
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East Riding of Yorkshire Overview and Scrutiny Committee	
<p>The Care Quality Commission judged that the Trust was non-compliant with Outcome 4 (Regulation 9) Care and Welfare. One of the reasons why the Trust was non-compliant with regulation 9 was because patients experienced multiple moves around the hospital and across sites. It is hoped that the Trust will look at this as a matter of urgency to ensure that numbers are reduced</p>	<p>The concerns relating to the Acute Medical Pathway has been identified as one of the top six priorities for the Trust following the Chief of Hospitals Inspection in February 2014. Further improvements on this area of concern can be found on pages 28-29 of this document.</p>
<p>Although the advances made with regard to dementia are a positive step, the Sub-Committee remains concerned following the recent inspection by the Care Quality Commission which indicated that not all staff had received training in the butterfly scheme</p>	<p>The concerns relating to the completion of Dementia training was identified by the CQC during the Chief of Hospitals Inspection and the Trust has included this in the Chief of Hospitals Inspection action plan to be addressed as well as identified it as an area for further improvement in this document.</p>
<p>Although overall, the Health, Care and Wellbeing Overview and Scrutiny Sub-Committee supports the Trust's priorities for 2014/15 and hope that these can be achieved, members would also have liked to have seen additional priorities added to reflect the most important issues raised by the Care Quality Commission, for example around staffing levels, demand in the Accident and Emergency Department and the number of cancelled procedures and appointments.</p>	<p>The concerns relating to the Accident and Emergency, Staffing levels and cancellation of appointments have all be identified in the Trust's top six priorities following the Chief of Hospitals Inspection in February 2014 and included on the Trust's action plan. These work-streams will be closely monitored by the Trust Board. Information on progress against these priorities will be included in the 2014/15 Quality Account.</p>

Statement of Directors' Responsibility

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011)).

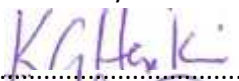
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

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

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

NB: sign and date in any colour ink except black

26.06.14 Chair

26.06.14 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 by the Audit Commission 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 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act").

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) Amended Regulations 2011 and the National Health Service (Quality Account) Amended Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2014 are subject to limited assurance consist of the following indicators:

- Friends and family test (Patient element score)
- Patient safety incidents resulting in severe harm or death

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

Respective responsibilities of Directors and auditors

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 the 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, confirms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- 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 2013/14 issued by the Audit Commission on 17 February 2014 (“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.
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulation 2009;
- the latest national patient survey dated 2013;
- the latest national staff survey dated 2013;
- the Health of Internal Audit’s annual opinion over the Trust’s control environment dated June 2014;
- the annual governance statement dated 3/6/2014;
- Care Quality Commission quality and risk profiles/intelligence monitoring dated October 2013 and March 2014; and
- The results from the Payments by Results coding review dated October 2013.
- 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 in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. 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 with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of our appointment under the Audit Commission Act 1998 and in accordance with the Audit Commission’s 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 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 are unable to confirm that the indicators in the Quality Account subject to limited assurance (Friends and Family Test patient element score and Patient Safety Incidents Resulting in Severe Harm or Death) have been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We are unable to confirm the accuracy, validity and reliability of the Patient Safety Incidents Resulting in Severe Harm or Death indicator due to the difficulty of auditing the clinical judgements made in grading the severity of incidents and cannot confirm the completeness of the dataset as it is not possible to obtain assurance that all incidents have been recorded.

We are unable to confirm the accuracy, validity, reliability and completeness of the Friends and Family Test patient element score as completed questionnaires are processed by a third party and prime documentation is held off site.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter(s) 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 2014:

- 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.



John Graham Prentice for, and on behalf of, KPMG LLP Statutory Auditor
Chartered Accountants
1 The Embankment
Leeds
LS1 4DW

26 June 2014

Abbreviations and definitions

AAU	Acute Assessment Unit
Avoidable Deaths	Deaths that could have been avoided given a different course of action
Avoidable Harm	Harm of patients that could have been avoided given a different course of action
Care Bundle	Care bundles help us to deliver safe and reliable care. They are research based actions for delivering care to certain patients. They are designed to ensure we deliver safe and reliable care to our patients at a certain point in their care e.g. on discharging, prescribing antibiotics, and preventing certain infections
Care Pathways	This is an anticipated care plan that a patient will follow, in an anticipated time frame and is agreed by a multi-disciplinary team
Cayder Boards	Cayder boards are an electronic ward information board which enables us to ensure that the right patient is in the right bed at the right time. The use of the Cayder Boards will help us reduce the amount of time patients spend in hospital and in turn will help save lives
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, devises and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease
CLRN	Clinical Research Network
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
COST Bundle	Chest x-ray, Oxygen assessment, Severity score and Treatment
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
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

EODS	The Electronic Observations Decisions Support System is a medical system using hand-held mobile technology that enables clinicians and nurses to collect vital signs observations on admission and throughout the patient's stay
ESSU	Elderly Short Stay Unit
FCE	Final Consultant Episode
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
Harm Free Care	Harm free care is aimed at ensuring that no patient is unnecessarily harmed as a result of the care they receive whilst being a patient of ours
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
IDL	Immediate Discharge Letters – these are letters that summaries a patient's hospital stay
Intentional Rounding	Intentional rounding is a process that involves carrying out regular checks with individual patients as set intervals. This approach helps nurses to focus on clear, measurable aims and expected outcomes and can reduce adverse events, improve patients' experience of care and provide much needed comfort and reassurance
MDT	Multi-disciplinary team – a team composed of staff from different professional groups, e.g. doctors, nurses, physiotherapists and pharmacists
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) develop 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
NHS QUEST	NHS QUEST is the first member-convened network for Foundation Trusts who wish to focus relentlessly on improving quality and safety.
NHS Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care
NRLS	National Reporting and Learning Service
NTDA	NHS Trust Development Authority
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
Patient Safety Pledge	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
Re-admissions	There are two types of re-admission. The first is following planned treatment or care and the second is following emergency treatment or care. When a patient is discharged after completing their treatment or care, the Trust would not expect them to be readmitted unless it was for a different condition
Root Cause Analysis	RCA is a method of problem solving that tries to identify the root causes of faults or problems
SDTI	Suspected Deep Tissue Injury
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 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
Sskin Care Bundle	The SSKIN 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.
Trust Board	The Trust's Board of Directors, made up of Executive and Non-Executive Directors

Urgent Care	Urgent care is the treatment of patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department
UTI	Urinary Tract Infection
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
YTD	Year To Date

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
HU3 2JZ