Hull and East Yorkshire Hospitals NHS Trust

Quality Accounts 2011/12

Great Staff - Great Care - Great Future

Going for Gold

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نسخه از این برگه را می‌خواهید لطفا با شماره تلفن ۴ ۵ ۷ ۴۰۵ ۲۶ ۴۸ ۰۱ تماس حاصل فرمایید.

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تريد وأنت الأولى اللغة يستل الانكليزية لديكم كان وإذا .الكبيرة الطباعة ,برايل بلغة
هاتف رجاء ,الوثيقة هذه ترجمة 01482 674054

Contents

Introduction

Welcome to the third set of Quality Accounts for Hull and East Yorkshire Hospitals NHS Trust.

Hull and East Yorkshire Hospitals NHS Trust was established in October 1999 through the merger of the Royal Hull Hospitals NHS Trust and East Yorkshire Hospitals NHS Trust. The Trust operates from two main sites: Castle Hill Hospital and Hull Royal Infirmary.

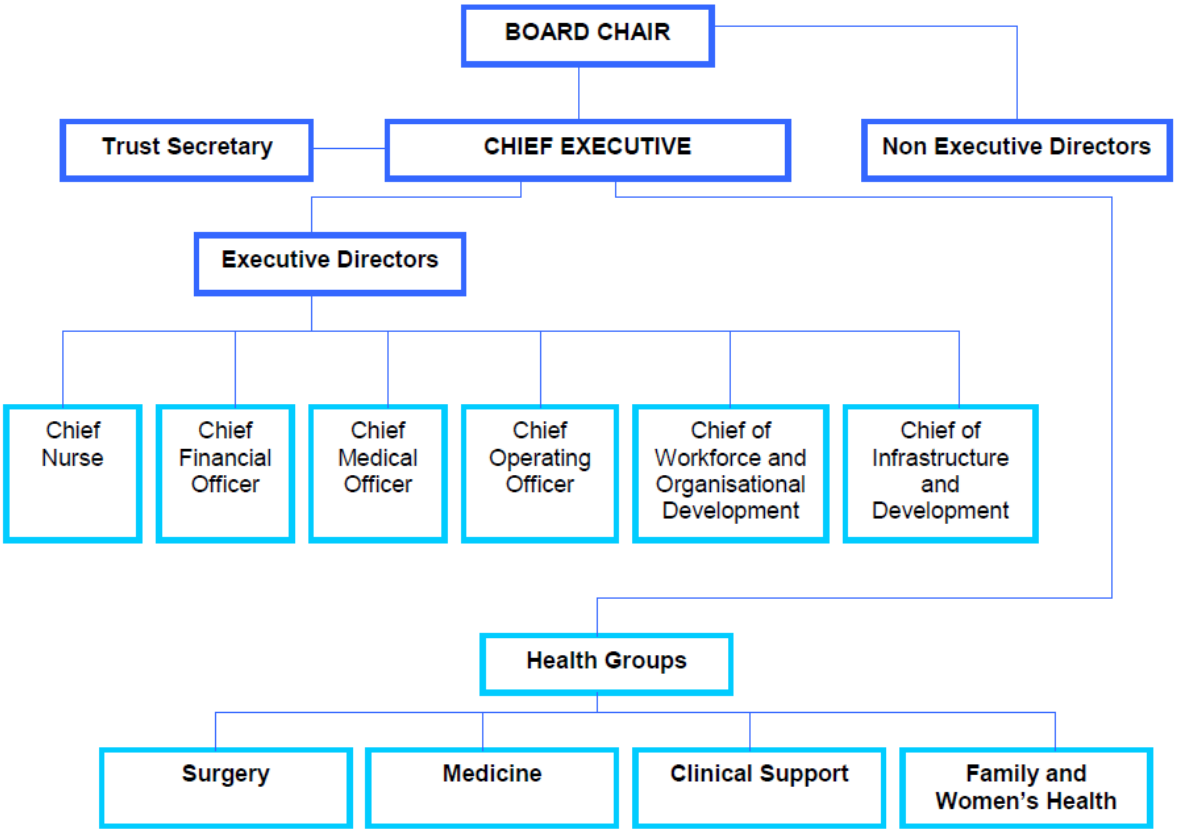
A full range of NHS hospital services are provided to almost 600,000 people in the Hull and East Yorkshire area. In addition the Trust's staff provide specialist/tertiary services (including neurosciences, cardiology, cardiothoracic surgery and trauma) and cancer services to a catchment population of up to 1.25 million people in a broader geographical area extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in Lincolnshire. The only services not provided locally are transplant surgery, burns and some specialist paediatric surgery.

These Quality Accounts are presented in three parts[1]:

- Part 1 is a statement from the Chief Executive of the Trust.
- Part 2 sets out the organisation's priorities for quality for 2012/13. It also includes a series of statements about the organisation in areas such as clinical audit, research and data quality.
- Part 3 reviews the last twelve months in terms of patient safety, quality and effectiveness and uses some of the indicators the Trust Board has used to monitor progress throughout the year and states whether the Trust has met the planned target outcomes.

[1] The format and sequencing of this document are in accordance with the National Health Service (Quality Accounts) Regulations 2010 and Department of Health (DoH) Quality Accounts Toolkit 2010/2011.

Trust Organisational Structure



Quality Accounts 2011/12

Part 1

Statement from the Chief Executive

Hull and East Yorkshire Hospitals NHS Trust is proud to present this year's Quality Accounts.

This year has seen many improvements at the Trust including a significant restructure within the organisation. The Trust has moved from having 7 Business Units to 4 Health Groups. It has been a challenging time for the Trust, but staff have worked hard to implement the changes as efficiently and effectively as possible. The Trust has also seen changes at a senior management level with Mrs. Jayne Adamson appointed as our Chief of Workforce and Organisational Development and Dr Yvette Oade appointed as our Chief Medical Officer. Mr. Rob Deri also became the Trust's new Chairman during the year.

The Trust has also seen significant upgrading of its facilities. In May 2011 the Clinical Skills, Dermatology and Ophthalmology Facility was opened. This £7m building provides Dermatology and Ophthalmology outpatient clinics as well as a state of the art Clinical Skills centre for education, training and assessment of healthcare students, foundation and specialty trainees and staff from all disciplines at the Trust. A £7.3m major scheme to significantly improve our Emergency Department is also well underway. Major construction work has already begun on site and once complete will transform the way we see and treat patients who attend as emergencies. The Department will separate Paediatrics, minor and major injuries enabling radical improvements in terms of privacy and dignity.

During the year the Care Quality Commission has visited the Trust on a number of occasions. The Trust maintained compliance with all Essential Standards during the year. The CQC visited for a number of purposes including to review our compliance against Essential Standards as well as a joint visit with Ofsted to review our safeguarding practices. As a result of a visit from the CQC the Trust reviewed its strategy for maternity services. The Jubilee Birth Centre was closed as a result of the review to ensure that the Trust continued to provide safe and effective care for our patients.

We continue to believe our staff are key to ensuring that as a Trust we deliver high quality care. During the year "I Will" statements were adopted across the organisation to bring our values to life:

Value - *Intentionality*
I will look to continually improve the way my service is delivered

Value - *Identity*
I will look for ways we can, rather than reasons we can't

Value - *Inclusion*
I will listen to and value the opinions of others and treat everyone as I wish to be treated myself

Value - *Inspiration*
I will always look for things to inspire me and remember to say "well done" and "thank you"

Value - *It's all about you*
I will make a difference to patient care, quality and safety every day

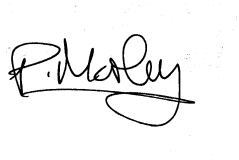
The Trust continues on the journey to becoming a Foundation Trust. This year the organisation made the decision to change the way in which we recruit our staff as members. In previous years this has been through an opt-out process, now staff have to sign up to become a member. This is intended to give greater ownership of the Foundation Trust process to the whole of the Trust. Over 3,000 members of staff have now signed up to become a member.

Mortality rates are a major issue for all Acute Hospital Trusts. This year the Trust has undertaken a review of all deaths that have happened in the hospital. We have also begun to improve the way in which we record which patients are coming into hospital and the true acuity (how sick a patient is) or illness of our population. The patient safety work streams in our Quality Accounts are essential to ensuring a sustainable reduction in mortality rates. The Trust has begun to see a reduction within the last year; however, there is still work to do.

This report reviews our planned target outcomes for 2011/12 and details how we want to go further for 2012/13.

The Quality Accounts demonstrate our commitment to providing excellence in Healthcare and creating an organisation of which we are proud.

I can confirm that to the best of my knowledge the information contained within this document is accurate and has received full approval of the Trust Board.



Phil Morley
Chief Executive

Quality Accounts 2011/12

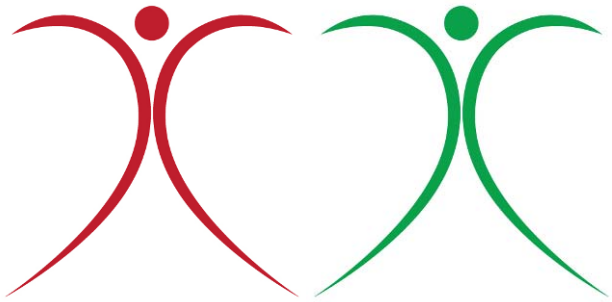
Part 2

Priorities for improvement: Safety

Patient Safety is the organisation's number one priority. The Trust Board in January 2011 made the following Patient Safety Pledge:

"We aim to provide patient care that is safe, effective and high quality for all patients and service users. This is care where we reduce all avoidable deaths and all avoidable harm caused until we have eliminated all avoidable deaths and all avoidable harm altogether"

Our priorities for Safety are:



To Reduce All Avoidable Death

To Reduce All Avoidable Harm

In order to achieve the priority to reduce all avoidable death, the Trust will continue its work on reducing mortality, the deteriorating patient work-stream as well as on infection, prevention and control.

In order to achieve the priority to reduce all avoidable harm, the Trust will continue to work on improving medicines management, prevention of falls, as well as working towards the eradication of pressure ulcers.

Trust Board – An Explanation

The Trust Board is the Board of Directors of the Trust, who is collectively accountable for the Trust. The Trust Board sets the strategic direction (the 'direction of travel') for the Trust over the coming years and ensures that the Trust has high standards in clinical care, financial stewardship as well as responding to the health needs of the population it serves.

Our Trust Board comprises 12 Board members with voting rights and 3 additional Directors. Every Trust Board is required to have a Chairman and a mix of Non-Executive and Executive Directors. The Non-Executive Directors, who make up the majority of the Trust Board, give an independent voice to the Trust Board and provide a high level of scrutiny to all aspects of the Trust. They bring to the Board a wide range of professional and business experience.

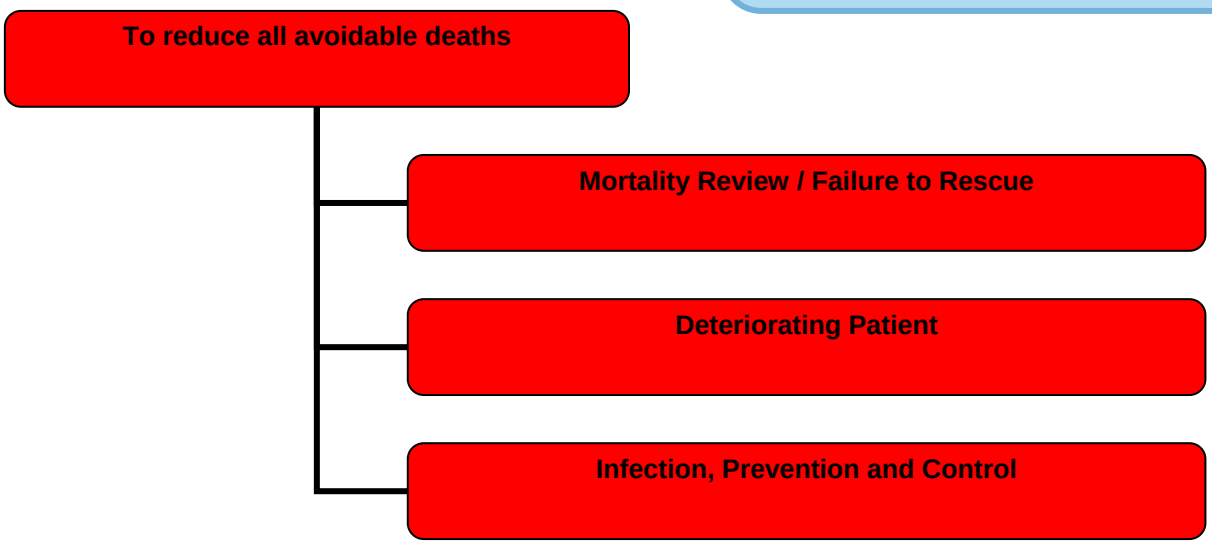
To reduce all avoidable deaths

Avoidable Death – An Explanation

This is a death that could have been avoided if a different course of action was undertaken.

Goal

To reduce all avoidable deaths with the goal of achieving and sustaining a Hospital Standardised Mortality Ratio (HSMR) of 80 by 2016.



Why?

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.

Who?

- Mortality Reduction Committee led by the Chief Medical Officer
- The Trust Board
- Infection Prevention & Control Committee
- Infection Reduction Committee
- Patient Safety Committee
- Director of Patient Safety & Quality Improvement
- All Health Group Medical Directors
- All Health Group Nurse Directors
- Infection Prevention & Control Team
- All clinical staff
- Corporate Nursing

How?

- Continuation of the deteriorating patient work-streams with particular focus on communication (Situation Background Assessment Recommendation – SBAR) techniques, vital sign observation charts and fluid balance charts.
- Continuation of the infection, prevention and control work-streams with focus on all avoidable hospital-acquired bacteraemias, public campaigns, hand hygiene and establishing a Vascular Access Team.
- Continued programme of ward decontamination and deep cleaning.
- Improved hand hygiene, through increased hygiene training as well as the use of water and not gel. The Trust has also allocated £250,000 for the installation of more wash hand basins.

When?

Evidence of an improving hospital standardised mortality ratio (HSMR) started from 2011/12, with a year on year reduction expected in both HSMR and Summary Hospital Mortality Indicator (SHMI).

Summary Hospital Mortality Indicator (SHMI) – An Explanation

SHMI is a measure of whether mortality linked to being in hospital is at a level that would be expected for the services we provide and for the people that use them.

Planned target outcomes

These include:

- Reduction in mortality against an agreed trajectory with the aim of a maintained HSMR of at least 30 points less than our starting position of 116 (2010/11).
- Reduction in crude mortality rates.
- Sustain 95% compliance with vital sign observations (completion and appropriate action).
- Monitoring of fluid balance chart with the overall aim of 95% compliance by the end of 2016 (2011/12 – 85, 2012-13 – 90).
- Achieve a 50% reduction in cardiac arrest calls.

Hospital Standardised Mortality Ratio (HSMR) Re-basing – An Explanation

HSMR data is rebased every year by Dr Foster. What this means is that as the average for all hospitals gets better every year, the Trust's benchmarked position & HSMR changes.

Monitoring arrangements

Each Health Group will be monitored via their regular performance meetings with directors.

The Mortality Reduction Committee will ensure that sufficient working groups are in place to meet all safety implementation plans and receive updates no less than 4 times a year.

The Quality, Effectiveness and Safety Committee (QuESt) will seek assurance on behalf of the Trust Board that all implementation plan milestones are achieved and that outcomes are monitored against agreed trajectories.

Accountable Officer

The Chief Medical Officer is accountable to the Trust Board for delivery of this priority. The Health Group Medical Directors will be accountable for delivery of this priority within their Health Group.

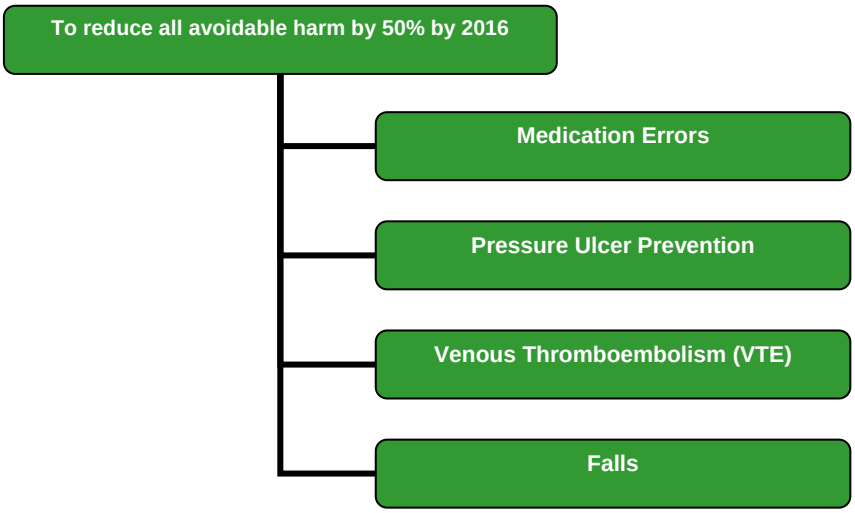
Non Executive Director Sponsor

The Non Executive Director Sponsor for this priority is Dr Keith Hopkins.

To reduce all avoidable harm by 50% by 2016

Goal

To increase the number of patients receiving “harm free” care.



Why?

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.

Who?

- Patient Safety Committee led by the Chief Medical Officer
- Senior Nursing & Midwifery Forum led by the Chief Nurse
- Safer Medications Practice Committee
- Thrombosis Committee
- Director of Patient Safety & Quality Improvement
- All Health Group Medical Directors
- All Health Group Nurse Directors
- Pharmacy
- Tissue Viability Nurses
- Quality Governance & Assurance Department
- Corporate Nursing
- Information Department
- All clinical staff

Harm Free Care – An Explanation

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.

This year there are new measures nationally to monitor the care we provide. The measures we are using – Medication errors, Pressure Ulcers, VTE and Falls will all be used in this new way of monitoring.

How?

- Establish baseline data and improvement trajectory for the Safety Thermometer.
- Continued development and implementation of Medicine Reconciliation Work-stream.
- Improve compliance with the Skin Care Bundle.
- Ensure no patients acquire an avoidable Grade 3 and 4 Pressure Ulcer whilst in hospital.
- Implementation of the Safety Thermometer in all areas.

- "Improvement Capacity" will be increased through:
    - Leading Improvement in Patient Safety (LIPS) course.
    - Clinical teams attending the Training and Action for Patient Safety (TAPS) training.
- Target high risk patients for the "falls" care bundle.
- The Trust achieved the 90% target of all patients being risked assessed for VTE on admission to hospital. The Trust will undertake further work to measure episodes of VTE.
- Finalise the policy for Falls Prevention.
- Monitor through the Falls Prevention Group.
- Quality and Safety Managers introduced.

When?

Reduce harm year on year from 2011 levels including a reduction in patient safety incidents rated above moderate and a decrease in cardiac arrest calls.

Planned Target Outcomes

These include:

- Establish baseline data and improvement trajectory for the Safety Thermometer during 2012-13.
- Remain in the upper quartile for patient safety incident reporting with a ratio of patient safety incidents reported: 100 admissions of >7 as reported by the National Reporting Learning System.
- Maintain a higher proportion (>1% higher) of no harm risks than other large acute trusts as reported by the National Reporting Learning System.
- Following successful implementation of the skin care bundle in 2011/12, the Trust achieved 90% compliance. The planned target outcome for 2012/13 is to maintain 90% compliance and to aim for no avoidable grade 3 or 4 pressure ulcers.
- Implementation of a falls bundle, root cause analysis of all falls causing harm of any severity and a zero tolerance to falls causing severe harm or death.
- Continue to achieve the national Commissioning for Quality & Innovation (CQUIN) requirement of 90% of all patients admitted to hospital to undergo a VTE risk assessment. Obtain baseline data for subsequent actions following the VTE risk assessment and agree a trajectory with the ultimate aim of 95% compliance by 2014/15 (85% 2012/13, 90% 2013/14).

Monitoring arrangements

Each Health Group will be monitored via their regular performance meetings with directors.

The Patient Safety Committee will ensure that sufficient working groups are in place to meet all safety implementation plans and receive updates no less than 4 times a year.

The Quality, Effectiveness and Safety Committee will seek assurance on behalf of the Trust Board that all implementation plan milestones are achieved and that outcomes are monitored against agreed trajectories.

Accountable Officer

The Chief Medical Officer is accountable to the Trust Board for delivery of this priority. The Health Group Medical Directors will be accountable for delivery of this priority within their Health Group.

Non Executive Director Sponsor

The Non Executive Director Sponsor for this priority is Mr. John Hattam.

Priorities for improvement: Effectiveness

To be able to provide safe care and improve the overall patient experience. The care the Trust provides must be evidence based and achieve the optimum clinical outcomes.

Our priorities for Effectiveness are:

To ensure that the Trust always treats the right patient, in the right place at the right time

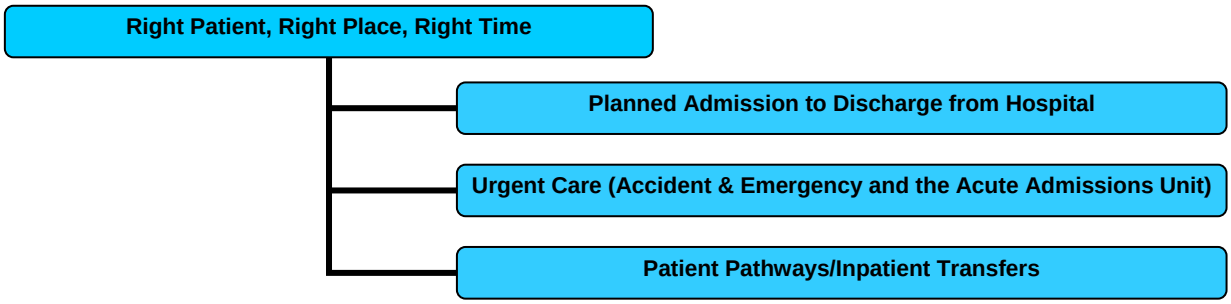
To aspire to achieve the best clinical outcomes

There have been a number of schemes implemented in the last 12 months to improve clinical outcomes. Further work is required to ensure that our patients are treated on the most appropriate care pathway and to ensure that we deliver the best clinical outcomes for our patients.

To ensure the Trust always treats the right patient, in the right place, at the right time.

Goal

To reduce the number of unnecessary inpatient transfers and unplanned patient readmissions to hospital



Why?

Clinical Governance centres on the right 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 ongoing care, where this is indicated for clinical reasons. However, all too frequently and particularly at peak emergency activity times, many 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.

The Trust's aim is to ensure that all patients are treated on the most appropriate care pathway for their condition and individual needs.

Who?

- The Operational Delivery Group led by the Chief Operating Officer
- All Health Group Medical Directors
- All Health Group Nurse Directors
- All Health Group Operation Directors
- Information Department

How?

- Continuation of the discharge from hospital work-stream.
- Continuation of the urgent care work-stream.
- Monitoring and analysis of patient transfers to identify further development of appropriate patient pathways.
- Aim for achieving trauma centre status.
- Monitoring discharges from hospital to home occurring after midnight.

When?

The majority of this work commenced in 2010. Evidence of improved patient experience of discharge, inpatient care, outpatient clinics and emergency care and a reduction of unplanned re-admissions is expected on an annual basis.

Planned target outcomes

These include:

- Reduction in patient readmissions to hospital with the aim of matching peer performance in 2011/12 and higher than peer by the 2016.
- Reduction in inpatient transfers, in particular for patients moved more than 2 times (10% reduction year on year from baseline).
- Reduction in inpatient transfers after 10pm for non-clinical reasons (10% reduction year on year from outturn).
- Reduction in the number of patients on the delayed discharge list (10% reduction year on year from baseline).
- Reduction in the number of patients with a length of stay greater than 50 days (10% reduction year on year from baseline).

Monitoring arrangements

Each Health Group will be monitored via their regular performance meetings with directors.

The Operational Delivery Group will ensure that sufficient working groups are in place to meet all effectiveness implementation plans and receive updates no less than 10 times a year.

The Performance and Finance Committee will monitor the planned target outcomes and escalate concerns where appropriate.

The Quality, Effectiveness and Safety Committee (QuESt) will seek assurance on behalf of the Trust Board that all implementation plan milestones are achieved and that outcomes are monitored against agreed trajectories.

Accountable Officer

The Chief Operating Officer is accountable to the Trust Board for delivery of this priority. The Health Group Operations Directors will be accountable for delivery of this priority within their Health Group.

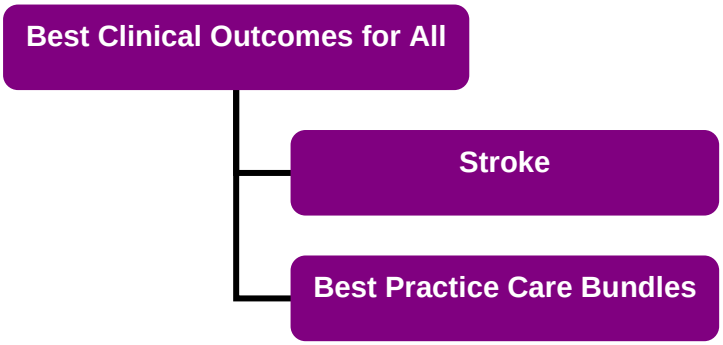
Non Executive Director Sponsor

The Non Executive Director Sponsor for this priority is Mrs. Mary Wride.

To aspire to achieve the best clinical outcomes for all

Goal

To be in the upper quartile (best performing trusts) for the National Sentinel Stroke Audit and to identify other areas where best practice care bundles could increase the quality and effectiveness of care.



Why?

The care and management of people who have had a stroke is a national, regional and local priority. Stroke is the highest cause of adult disability in the UK. If identified and treated in line with best practice guidance, the survival of patients can be increased greatly and the risk of disability lowered.

Care Bundles – An Explanation

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 discharge, prescribing antibiotics, and preventing certain infections.

The Trust is committed to implementing systems that demonstrate continuous improvement for patients who have had a stroke and ongoing compliance with best practice guidance.

A number of 'best practice care bundles' have been developed to support clinicians in providing care that is evidence based and known to provide the best results. The bundles are also measurable in terms of the care provided and the clinical outcomes.

The Trust is keen to identify other best practice bundles for use within the Trust that could improve clinical outcomes for patients.

Who?

- The Patient Safety Committee led by the Chief Medical Officer
- Director of Patient Safety & Quality Improvement
- Health Group Medical Director
- Health Group Nurse Director
- Health Group Operations Director
- Information Department
- Quality Governance & Assurance Department

How?

- Continuation of the continuous monitoring system & pathway work in Stroke services.
- Improvement in Cardiac, Respiratory and Colorectal care pathways & clinical outcomes.
- Identification of additional best practice bundles for other clinical conditions including Pneumonia, Chronic Obstructive Pulmonary Disease (COPD) and Sepsis.

When?

Continuous improvements in compliance with Stroke standards are expected to be made. The percentage improvements have been be set against an agreed trajectory with the overall aim to be 95% compliant on all elements of best practice by 2016. For 2011/12 the Trust achieved 90.9% compliance.

Similar continuous monitoring systems will now be introduced for other clinical pathways and best practice care bundles will be evaluated

Planned target outcomes

These include:

- Reduction in acute Cerebral Disease standardised mortality ratios.
- Implementation of the Stroke 90:10 care bundle with continued 90% compliance by 2016.
- To be in the upper quartile of the National Sentinel Stroke Audit.
- Reduction in Heart Failure standardised mortality ratios, length of stay and readmission rates.
- Reduction in Myocardial Infarction standardised mortality ratios, length of stay and readmission rates.
- Reduction in Colorectal standardised mortality ratios, length of stay and readmission rates.
- Achievement of the best clinical outcomes for all patients.

Monitoring arrangements

The Medicine Health Group will be monitored for the stroke indicators via its regular performance meetings with directors. The other Health Groups will be asked to identify best practice care bundles in their areas.

The Quality, Effectiveness and Safety Committee (QuESt) and the Patient Safety Committee will seek assurance on behalf of the Trust Board that all implementation plan milestones are achieved and that outcomes are monitored against agreed trajectories.

Accountable Officer

The Chief Executive is accountable to the Trust Board for delivery of this priority.
The Health Group Medical Directors will be accountable for delivery of this priority within their Health Group.

Non Executive Director Sponsor

The Non Executive Director Sponsor for this priority is Mr. Duncan Ross

Priorities for improvement: Experience

We understand that each patient experience is affected by every element of that patient's journey and we need to listen to patient views, and use their experiences to improve care overall for all service users.

Our priority for Experience is:

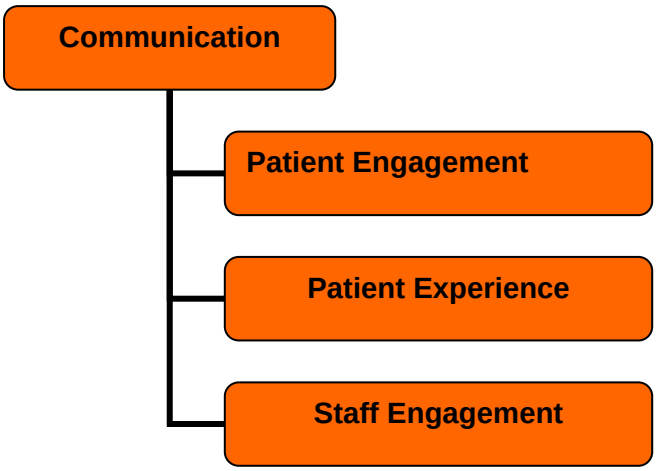
To improve communication through patient & staff engagement

To improve the experience our patients have we will continue to learn from the views of patients, carers and visitors. We know that staff who work in a positive culture are more likely to deliver high quality care. That is why our vision is "Great Staff, Great Care, Great Future". Engaging with our staff is key to developing high quality services for our patients.

To improve communication through patient & staff engagement

Goal

To be described as one of the best performing trusts (top 20%) in the Care Quality Commission's (CQC) national inpatient survey and national staff survey.



Why?

The Trust is committed to ensuring that every patient receives high quality care and treatment and as a result has the best possible experience of hospital services. To achieve this, the Trust needs to understand fully the aspects of care that matter to patients and affect their experience. This is why patient engagement and learning from the views of patients, carers and visitors is essential.

It is recognised widely that staff who work in a positive culture with opportunities to be developed and supported fully by their managers are more likely to deliver high quality health care. This is why the Trust's vision is 'Great Staff, Great Care, Great Future'. Staff engagement is key to shaping the future of services and delivering services to meet the expectations of patients.

Who?

- The Patient Experience Forum led by the Chief Nurse
- Workforce Transformation Group led by the Chief of Workforce and Organisational Development
- Denison focus groups
- Head of Patient Experience
- Health Group Medical Directors
- Health Group Nurse Directors
- Human Resource Managers

Engagement – An Explanation

This is the use of all of the resources available to us to work with staff, patients and visitors to gain knowledge and understanding to help develop patient pathways. It means involving all of our key stakeholders in every step of the process to help us to provide high quality care.

How?

- The Trust will introduce Patient Panels to gather further insights into patients' experience.
- An end of life care survey adapted from the Southampton Voices will be used.

- An Engagement Strategy will be developed to provide clear direction on how, when and why patients will be engaged with.
- Engagement will be improved with user groups, especially with “hard to reach” groups.
- The Trust will continue to use Denison to understand the culture of the organisation.
- The Leadership Strategy will continue to be implemented.
- The Workforce Strategy will continue to be implemented.
- More staff events will be arranged including Consultant and Therapies conferences.
- Staff will use interactive voting to have their say on key issues facing the Trust
- The Trust’s membership scheme will be developed further.

When?

Some improvement has been seen in the national surveys following actions taken during 2011. However, the Trust still has a great deal to do to improve further. Local monitoring systems have been introduced for patients, which have demonstrated improvements. Local staff satisfaction and feedback mechanisms were also introduced during 2011. It is expected that annual improvements will be demonstrated by the national surveys with the Trust being reported as being in the top 20% for overall patient experience, patient engagement and staff engagement by 2015. This position should then be maintained.

Planned target outcomes

These include:

- Improved patient experience measured by surveys (locally & nationally – overall care question).
- Reduction in complaints overall or as a proportion of activity.
- Reduction in complaints & PALS concerns regarding staff attitude.
- Improved staff engagement measured by surveys (locally & nationally – Staff engagement section & staff who would recommend the Trust – K34).
- Improvements in the annual cultural survey results (Dennison survey undertaken for the first time in 2011).
- Implementation of the Leadership Strategy.

Monitoring arrangements

Each Health Group will be monitored via the quarterly performance review.

The Patient Experience Forum will monitor the elements relating to patient experience and patient engagement and ensure that working groups are in place to continuously improve patient experience and patient engagement.

The Quality, Effectiveness and Safety Committee (QuESt) will seek assurance on behalf of the Trust Board that all implementation plan milestones are achieved and that outcomes are monitored against agreed trajectories.

Accountable Officer

The Chief Nurse is accountable to the Trust Board for delivery of this priority. The Health Group Nurse Directors will be accountable for delivery of this priority within their Health Group.

Non Executive Director Sponsor

The Non Executive Director Sponsor for this priority is Mrs. Vanessa Walker.

Review of services

During 2011/12 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 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by the Hull and East Yorkshire Hospitals for 2011/12.

Hull and East Yorkshire Hospitals NHS Trust reviews data on all services via its quality governance reporting framework and performance management framework. Every service produces a service integrated governance report, which is used to populate a divisional integrated governance report on a quarterly basis in line with the Performance Strategy. Monthly performance data for all elements of quality (safety, effectiveness and experience) is used to monitor the Health Groups as part of their performance review and is summarised for the Trust Board.

Participation in clinical audit

During 2011/12, 47 national clinical audits and 4 national confidential enquiries covered NHS services that Hull and East Yorkshire Hospitals NHS Trust provides.

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

Clinical Audit – An Explanation

Clinical Audit is a quality improvement process that seeks to improve patient care. Elements of care are selected and evaluated against a specific set of criteria. Where required, changes are made to improve care.

The national clinical audits and national confidential enquiries that Hull and East Yorkshire Hospitals NHS Trust participated in during 2011/12 are as follows:

National audit

Peri- and Neonatal
Perinatal mortality (Centre for Maternal and Child Enquiries - CMACE):
Neonatal intensive and special care (National Neonatal Audit Programme - NNAP)

Children
Paediatric pneumonia (British Thoracic Society)
Paediatric asthma (British Thoracic Society)
Pain management (College of Emergency Medicine)
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)
Paediatric intensive care (Paediatric Intensive Care Audit Network - PICANet)
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)

Acute care
Emergency use of oxygen (British Thoracic Society)
Adult community acquired pneumonia (British Thoracic Society)
Non invasive ventilation (NIV) – adults (British Thoracic Society)
Pleural procedures (British Thoracic Society)
Severe sepsis and septic shock (College of Emergency Medicine)
Adult critical care (Case Mix Programme)
Potential donor audit (NHS Blood and Transplant)
Seizure management (National Audit of Seizure Management)

Long term conditions
Diabetes (National Adult Diabetes Audit)
National inpatient diabetes Audit (NaDIA)
Heavy menstrual bleeding (HMB) (Royal College of Obstetrics and Gynaecologists - RCOG National Audit of Heavy Menstrual Bleeding)
Chronic pain (National Pain Audit)

Ulcerative colitis and Crohn's disease (National Inflammatory Bowel Disease - IBD Audit)
Parkinson's disease (National Parkinson's Audit)
Chronic obstructive pulmonary disease (British Thoracic Society/European Audit)
Adult asthma (British Thoracic Society)
Bronchiectasis (British Thoracic Society)

Elective procedures
Hip, knee and ankle replacements (National Joint Registry)
Elective surgery (National Patient Reported Outcome Measures Programme)
Coronary angioplasty (National Institute for Clinical Outcome Research – NICOR Adult cardiac interventions audit)
Peripheral vascular surgery (Vascular Society of Great Britain and Ireland Vascular Surgery Database)
Carotid interventions (Carotid Intervention Audit)
Coronary artery bypass graft and Valvular surgery (Adult cardiac surgery audit)

Cardiovascular disease
Acute myocardial infarction and other acute coronary syndrome (Myocardial Ischaemia National Audit Project)
Heart failure (Heart Failure Audit)
Acute stroke (Stroke Improvement National Audit Programme)
Stroke care (National Sentinel Stroke Audit)
Cardiac arrhythmia (Cardiac Rhythm Management Audit)

Renal disease
Renal replacement therapy (Renal Registry)

Cancer
Lung cancer (National Lung Cancer Audit)
Bowel cancer (National Bowel Cancer Audit Programme)
Head and neck cancer (Data for Head and Neck Oncology – DAHNO)
Oesophago-gastric cancer (National Oesophago-gastric Cancer Audit)

Trauma
Hip fracture (National Hip Fracture Database)
Severe trauma (Trauma and Audit Research Network)
Falls and non-hip fractures (National Falls and Bone Health Audit)

Blood transfusion
Bedside transfusion (National Comparative Audit of Blood Transfusion)
Medical use of blood (National Comparative Audit of Blood Transfusion)

End of life
Care of dying in hospital (National Care of the Dying Audit – Hospitals NCDAH)

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study
Cardiac Arrest Study

Bariatric Surgery
Alcohol Related Liver Disease
Subarachnoid Haemorrhage Study

The Trust did not participate in the following national audits during 2011/12:

National audit	
Cardiac arrest (National Cardiac Arrest Audit)	The Trust has signed up to commence the audit on 1 April 2012
Risk factors (National Health Promotion in Hospitals Audit)	The Trust will participate in the next round of the audit in 2012

The 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 2011/12, are listed below alongside 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.

National audit	**Participation (Yes/No)**	**% cases submitted**
Peri- and Neonatal		
Perinatal mortality (Centre for Maternal and Child Enquiries – CMACE)	Yes	100%
Neonatal intensive and special care (National Neonatal Audit Programme – NNAP)	Yes	100%
Children		
Paediatric asthma (British Thoracic Society)	Yes	100%
Pain management (College of Emergency Medicine)	Yes	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	100%
Paediatric intensive care Audit (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%
Pleural procedures (British Thoracic Society)	Yes	100%
Severe sepsis and septic shock (College of Emergency Medicine)	Yes	100%
Adult critical care (Case Mix Programme)	Yes	100%
Potential donor audit (NHS Blood and Transplant)	Yes	100%
Seizure management (National Audit of Seizure Management)	Yes	100%
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	100%

National inpatient diabetes Audit (NaDIA)	Yes	100%
Heavy menstrual bleeding (HMB) (Royal College of Obstetrics and Gynaecologists - RCOG National Audit of Heavy Menstrual Bleeding)	Yes	21%[2]
Chronic pain (National Pain Audit)	Yes	Unknown [3]
Ulcerative colitis and Crohn's disease (National Inflammatory Bowel Disease - IBD Audit)	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Yes	75%
Chronic obstructive pulmonary disease (COPD) (British Thoracic Society/European Audit)	Yes	100%
Adult asthma (British Thoracic Society)	Yes	100%
Bronchiectasis (British Thoracic Society)	Yes	100%

Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	100%
Elective surgery (National Patient Reported Outcome Measures Programme – PROMs) Unilateral Hip Replacement Unilateral Knee Replacement Groin Hernia Surgery Varicose Vein surgery	Yes	 88% 89% 89% 86%
Coronary angioplasty (National Institute for Clinical Outcome Research – NICOR Adult cardiac interventions audit)	Yes	99%
Peripheral vascular surgery (Vascular Society of Great Britain and Ireland Vascular Surgery Database – VSGBI VSD)	Yes	97%
Carotid interventions (Carotid Intervention Audit)	Yes	100%
Coronary Artery Bypass Graft (CABG) and Valvular surgery (Adult cardiac surgery audit)	Yes	100%

Cardiovascular disease		
Acute Myocardial Infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	Yes	100%
Heart failure (Heart Failure Audit)	Yes	100%
Acute stroke (Stroke Improvement National Audit Programme - SINAP)	Yes	100%

Renal disease		
Renal replacement therapy (Renal Registry)	Yes	100%

[2] The number in this audit was limited due to patient choice as to whether to be included in the audit which involved completing a large questionnaire

[3] Data submission was for a three month period in 2011. It was a patient questionnaire which the Trust has delivered to the relevant patients. The Trust has not received any feedback about the return rate or quality of responses.

Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	99%
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	99%
Head and neck cancer (Data for Head and Neck Oncology – DAHNO)	Yes	100%
Oesophago-gastric cancer (National Oesophago-gastric Cancer Audit)	Yes	94%

Trauma		
Hip fracture (National Hip Fracture Database)	Yes	100%
Severe trauma (Trauma and Audit Research Network)	Yes	100%
Falls and non-hip fractures (National Falls and Bone Health Audit)	Yes	100%

Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	100%
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	100%

End of life		
Care of dying in hospital (National Care of the Dying Audit – Hospitals NCDAH)	Yes	70%[4]

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	Participation (Yes/No)	% cases submitted
Cardiac Arrest Study	Yes	100%

Centre for Maternal and Child Enquiries (CMACE) study	Participation (Yes/No)	% cases submitted
Perinatal Mortality	Yes	100%

The reports of 33 national clinical audits were reviewed by the provider in 2011/12 and Hull and East Yorkshire Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National audits	Proposed actions
Neonatal intensive and special care (National Neonatal Audit Programme - NNAP)	Recommendations are being formulated by the Yorkshire Neonatal Network Board. These will be disseminated and implemented across all the networks within the Yorkshire region.
Paediatric pneumonia (British Thoracic Society)	1. To review the pneumonia guidelines to include: › Admission criteria › Investigations › Antibiotic choice › Management & investigation of complications › Follow-up

[4] The minimum requirement for this audit was for 10 completed pathways. The Trust only identified 7 completed pathways during the audit period. This is being addressed for future audits in this area through the recruitment of an End of Life Facilitator.

National audits	Proposed actions
Paediatric asthma (British Thoracic Society)	1. To revise the current asthma pathway and documentation. 2. To ensure staff are aware of the new pathway and documentation to be completed. 3. To re-audit when asthma pathway has been adapted and fully implemented.
Paediatric intensive care Audit (Paediatric Intensive Care Audit Network - PICANet)	1. To develop written information for parents regarding the service.
Diabetes (Royal College of Paediatrics and Child Health - RCPCH National Paediatric Diabetes Audit)	1. To develop a system of automated text reminders 48 hours prior to appointment. 2. The Multi-Disciplinary Team and Retinal screening service to monitor and enrol in the screening programme. 3. To re-establish the 24 hour telephone support service for children and families. 4. To aim to extend current support to all children in the care of the Paediatric Diabetes team. 5. To develop collaborative networking with teams in Yorkshire and aim to attend 80% of meetings. 6. To establish regular education programme for children and parents. 7. To hold regular teaching / training sessions for ward staff and junior doctors. 8. A parent representative to attend multi-disciplinary team meetings. 9. To collect information from 80% of service users about the current provision of the service.
Emergency use of oxygen (British Thoracic Society)	1. To change the position of the pre-printed oxygen prescription on the drug card 2. To ensure staff receive ongoing training 3. To continue the Quality Monitoring Programme which will look at the implementation of changes
Non invasive ventilation – adults (British Thoracic Society)	1. To improve documentation around the mode of ventilation 2. To issue oxygen alert cards for patients with type 2 respiratory failure. 3. To look at levels of oxygen given to patients prior to hospital admission, excess oxygen being a contributory factor in respiratory failure
Adult critical care (Case Mix Programme) *No annual report - service receives quarterly reports per ward HICU GICU1, GICU2.	1. To undertake a local audit using Case Mix Programme Database to identify management issues of Sepsis and Ventilator Associated Pneumonia in relation to the Standardised Mortality Ratio score for Hull Royal Infirmary and Castle Hill Hospital. 2. To escalate feedback regarding the increasing figure of delayed discharges to senior management and planners. 3. To undertake a local audit to assess staff knowledge of Critical Care Minimum Data Set definitions in order to create an education programme to support achievement of maximum funding.

National audits	Proposed actions
Potential donor audit (NHS Blood and Transplant)	1. To continue to address education needs, and disseminate guidance and policies, update hospital policies to achieve 100% referral rate and 100% brain stem death testing rate. 2. To update all guidance and policies relating to organ and tissue donation.
Seizure management (National Audit of Seizure Management)	1. To produce a guideline and a proforma for patients presenting to the Acute Assessment Unit (AAU) and Emergency Department with a seizure.
Diabetes (National Adult Diabetes Audit)	1. The diabetes specialist team will continue to work with commissioners both existing, and emerging Clinical Commissioning Groups, through the Hull & East Riding Diabetes Network to support commissioners in the planning of service design and delivery to meet the increasing prevalence recognising that over 90% of diabetes contacts for adult services occur within primary care. 2. The diabetes specialist team will review the pathway for individuals with Type 1 diabetes who repeatedly fail to attend outpatient appointments and have not engaged with diabetes services as they are a group at very high risk of poor outcome. 3. To develop initiatives to investigate the high rate of amputations, understand the underlying causes and work to reduce amputations by: › Root cause analysis of major amputations › Competency assessment of podiatry services › Launch of e-learning package on foot examination supported by Yorkshire & Humber Strategic Health Authority including risk assessment in accordance with the National Institute for Health and Clinical Excellence (NICE) and appropriate referral to foot protection team launched April 2012 as joint work of specialist diabetes podiatrists employed by Humber Mental Health Trust and the Trust's diabetes team.
National Inpatient Diabetes Audit (NaDIA)	1. To raise the profile of foot examinations in hospital 2. To improve staff education in relation to the management of inpatients with diabetes 3. To develop an insulin prescription chart to be used throughout the Trust
Heavy menstrual bleeding (Royal College of Obstetrics and Gynaecologists National Audit of Heavy Menstrual Bleeding)	1. To devise a guideline on menorrhagia in line with NICE guidance 2. To devise a patient information leaflet
Chronic pain (National Pain Audit)	There were no actions from the Phase 1 report required. The Trust continues to take part in the national project. The Phase 2 report is awaited.

National audits	Proposed actions
Ulcerative colitis and Crohn's disease (National Inflammatory Bowel Disease Audit)	1. To devise a business case to remedy the shortage of Inflammatory Bowel Disease Specialist Nurses provision 2. To ensure a dedicated pharmacy support to help in streamlining use of drugs which will have potential cost savings. 3. To devise a business case for a dietetic lead for the celiac service.
Parkinson's disease (National Parkinson's Audit)	1. To review the level of occupational therapy and speech and language therapy resource available to patients with Parkinson's disease.
Adult asthma (British Thoracic Society)	1. To improve documentation 2. To improve the standard of record keeping
Bronchiectasis (British Thoracic Society)	1. To improve access to respiratory physiotherapy 2. To implement annual spirometry
Dementia (National Audit of Dementia)	1. To develop dementia care pathway 2. To develop policy relating to governing the use of interventions for violent or challenging behaviour, aggression and extreme agitation which is suitable for use in patients with dementia who present with behavioural or psychological symptoms 3. To involve carers or relatives in the care of patients with dementia 4. To recommend additions and amendments to admission pack, which include recording information 5. To provide mandatory training of dementia awareness to doctors and all acute health care staffs involved in the care of people with dementia or who may have dementia 6. To include structural imaging audit in the Medicine Health Group Audit Plan. Re-audit of organisational audit due to significant anecdotal evidence that current practice and organisational structure would provide increased compliance with standards 7. To ensure an assessment of functioning using a standardized assessment tool is carried out e.g. Barthel ADL Functioning Assessment Scale
Hip, knee and ankle replacements (National Joint Registry)	**Total Hip Replacements** 1. As per report recommendations the Trust is showing a growing trend within the Elective Orthopaedic Department for Cemented Hip Replacements being performed on men and women over 70 years of age. This will be discussed and encouraged further in Clinical Governance meetings. **Data Inputting** 1. As per a new requirement of the National Joint Registry, the Trust will begin to input all the Shoulder Replacements performed.

National audits	Proposed actions
Carotid interventions (Carotid Intervention Audit)	A recent visit to the Stroke Service resulted in the following actions:- 1. To continue to provide acute strokelysis/acute carotid surgery and image predominantly through duplex rather than MRA. 2. To ensure all patients will be seen by a dedicated stroke physician following pathways of care. 3. To ensure dedicated daily sessions for duplex in this will be provided for the Transient Ischemic Attack (TIA)service. 4. To ensure quality assurance process for imaging in place.
Acute myocardial infarction and other Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project)	1. To review the management of patients with ST Segment Elevation Myocardial Infarction (STEMI) who initially present to Hull Royal Infirmary. 2. To develop a pathway with emergency medicine to ensure prompt management of patients with STEMI who are not directly transferred for primary angioplasty.
Heart failure (Heart Failure Audit)	1. To review the provision of the heart failure service as part of a strategic review of cardiac services.
Acute stroke (Stroke Improvement National Audit Programme)	1. To educate all staff, work on the Trust pathway and produce posters for awareness that all stroke patients should be directly admitted to a stroke unit which is equipped to manage acute stroke patients. 2. To ensure patients receive the same standard of care whether admission to hospital is in or out of hours. There is a 24/7 on call for stroke service and Thrombolysis. 3. To improve co-ordination of care to reduce the delays within hospital control. On arrival, patients to be triaged rapidly to a specialist stroke team, undergo brain scanning, be thrombolysed where appropriate and be admitted to a stroke bed in a designated stroke unit. 4. To improve education across the Trust regarding stroke symptoms and how to contact the stroke team. This will reduce the current unacceptable delays. 5. To ensure that all stroke patients have access to a stroke service that can deliver Thrombolysis safely and effectively. Any patients who are eligible for Thrombolysis should receive it. 6. To place all incontinent patients onto a clear plan for continence management within 72 hours of admission. 7. To regularly maintain public awareness campaigns to reinforce the message that stroke needs to be treated as a medical emergency. The Act F.A.S.T campaign has been suggested to the PCT.

National audits	Proposed actions
Stroke care (National Sentinel Stroke Audit)	1. The direct stroke unit admission policy has been extended to direct admissions 24/ 7. To ensure the Resident Medical Officer reviews the patients after midnight and that transfers to the stroke unit are safe. 2. To produce a business case for dedicated in-reach neuropsychology support and a dedicated discharge liaison support worker 3. Nursing staff, occupational therapy assistants and physiotherapy assistants have been appointed and a business case will be put forward for further positions.
Renal replacement therapy (Renal Registry)	1. To continue to supply data on all Renal Replacement Therapy patients as per the Renal Registry
Lung cancer (National Lung Cancer Audit)	1. To ensure CT scan performed first/ pre-booking, to streamline diagnostic cancer pathway 2. To ensure specialist nurse is present at diagnosis 3. To consolidate patient flow through specialist multi-professional clinic
Bowel cancer (National Bowel Cancer Audit Programme)	1. To review data during in May 2012. At present there are no current existing actions.
Head and neck cancer (Data for Head and Neck Oncology - DAHNO)	1. To increase input from allied specialties to the Somerset database and thus to DAHNO. 2. The multi-disciplinary team manager is to meet monthly with Consultants, Speech and Language Therapists and Dieticians to input patients into DAHNO. 3. To review whether additional resources are required to ensure the following national targets are met - 100% newly diagnosed patients should have been assessed by 1) Clinical Nurse Specialist 2) Dietician 3) Speech and Language Therapist before their treatment starts. Also, 85% of histopathology reports for suspected cancer should be reported within 7 days.
Hip fracture (National Hip Fracture Database)	1. Through discussion with the Yorkshire Ambulance Service, a protocol will be put in place to provide an early warning of hip fracture patients to ensure prioritisation of bed and theatre slots 2. To write a business case for the recruitment of a Nurse Practitioner to be prepared to early optimise patients for theatre 3. To increase investment to orthogeriatrician cover of wards, particularly at weekends and holiday periods 4. To increase flexibility of theatre sessions through peak times to ensure timely management of patients.
Falls and non-hip fractures (National Falls and Bone Health Audit)	1. To ensure orthogeriatricians undertake falls assessments and treat underlying causes. 2. To ensure nurses, physiotherapists and occupational therapists undertake falls assessment. 3. For Osteoporosis assessments to be done by orthogeriatricians and to provide secondary prophylaxis of osteoporosis.

National audits	Proposed actions
Bedside transfusion (National Comparative Audit of Blood Transfusion)	1. Provide results to Nurse Directors and Medical Directors with a requirement for each Nurse Director to provide reassurances to the Hospital Transfusion Committee as to how they will action the findings. 2. Transfusion Nurse Specialist to attend Nurse Directors meeting in March 2012, for feedback on Health Group response to the audit. 3. Recommend that each Health Group undertakes a 5 patient mini-audit to identify if compliance has improved. 4. Hospital Transfusion Committee to review the Transfusion policy in relation to the recording of observations for demonstrating compliance regarding forthcoming NHS Litigation Authority assessment. 5. Re-audit as per national comparative audit plan.
Care of dying in hospital (National Care of the Dying Audit – Hospitals NCDAH)	1. To roll out training in care of the dying for all staff. 2. To recruit an End of Life Facilitator to support education and training.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study	Proposed actions
Paediatric Surgery	1. To develop specialty specific operational policies regarding who can operate on and anaesthetise children for elective and emergency surgery 2. To introduce leaflets for children and parents about anaesthesia at pre-operative assessment 3. To increase staffing to ensure theatre 8 is open at all times 4. To implement the Paediatric Advanced Warning Score
Peri-operative Care	1. To identify a process to identify the high risk patient (both emergency and elective) 2. Revise and extend the critical care booking form for pre-assessment to all patients and use to identify those who would require a High Observation Bay.

The reports of 92 local clinical audits were reviewed by the provider in 2011/12. Example of actions Hull and East Yorkshire Hospitals NHS Trust intends to take to improve the quality of healthcare provided are detailed below:

- To make dedicated clinic spaces available for Ocularplastic patients
- To make a video for patients undergoing a peripheral nerve block as part of multimodal analgesia for day surgery upper limb procedures
- To issue an information leaflet about illness and treatment being offered to patients being treated for Psoriatic Arthritis after failure of 1 Anti TNF inhibitor and to document in the patient notes that patients have been provided with the information leaflet

For a full list of the proposed actions Hull and East Yorkshire Hospitals NHS Trust intends to take following local audits reviewed during 2011/12, please see the Clinical Audit Annual Report. This can be requested via the Quality Accounts email address: quality.accounts@hey.nhs.uk.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Hull & East Yorkshire Hospitals NHS Trust in 2011/12, that were recruited during that period to participate in research approved by a research ethics committee was 4052.

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. It 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 2011/12, the Trust has continued to strengthen systems and processes to ensure that it can demonstrate the best standards in research governance and delivery.

Clinical Research – An Explanation

Clinical Research is a branch of medical science that determines the safety and effectiveness of medication, diagnostics products, devises and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.

The Trust was involved in processing 187 clinical research studies of which 117 commenced during the reporting period 2011/12. This compares with 195 new submissions and 75 commencing in 2010/11.

The Trust used national systems to manage the studies in proportion to risk. Of the 117 studies given permission to start, 74% were given permission by an authorised person less than 40 days from receipt of a valid complete application. In 2011/12 the National Institute for Health Research (NIHR) supported 49 of these studies through its research networks.

The Trust had 132 studies actively reporting accruals (patient recruitment) under the National Institute for Health Research Comprehensive Local Research Network (NIHR CLRN) Portfolio as compared to 123 portfolio studies reporting accruals for the period April 10 – March 2011. This represents a growth of 7% for active portfolio studies compared to 2010/11.

The number of recruits into the Trust's portfolio studies for the periods 2010/11 and 2011/12 (as at 15/03/12) was 5,575 and 3,629 respectively[5]. This demonstrates an overall decrease in patient recruitment compared to 2010/11 that can be explained by the increase in complex, low-target recruiting studies that commenced during 2011/12. A target of more than 5,000 patient accruals is expected to be set for 2012/13. The largest topic area of portfolio adopted studies across 2011/12 is Oncology with 48 studies.

[5] Caution must be taken with the interpretation of these figures as they do not factor-in study type, complexity, involvement of external partners and any delays encountered in receiving information from applicants.

In the last year, 243 publications [6] have resulted from our involvement in portfolio and non-portfolio research across 11 specialty areas, which shows 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 2011/12. The support infrastructure provided by the NEYNL CLRN continues 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.

Research at Hull and East Yorkshire Hospitals NHS Trust:

Gastroenterology:

In 2011/12, the second full year of conducting Gastroenterology and Hepatology research in the Trust, the team has successfully established themselves as a sought after location for conducting high quality, Gastroenterology and Hepatology research. The team now has 18 studies on going covering a range of drug, genetic, observational and service improvement trials. To date, they have recruited almost 600 patients with Chrons disease, Ulcerative colitis, Hepatitis B and C, Barretts Oesophagus and Autoimmune liver diseases into research trials.

The team is over the 100% recruitment target for 6 studies and on target to achieve 100% in 8 more as well as being nationally recognised as the top recruiter for three prestigious trials (CONSTRUCT, SOLUTION, and 5-ASA) and have attracted the interest of more established sites across the UK. In addition, in recent months, the department has been approached independently by 3 different industry companies to participate in their research trials. This reflects the significant progress that has been made over the last 2 years in raising the department and Trust profile as an active and enthusiastic research site. It is also a crucial step towards achieving our self funding strategic objective by 2015.

In 2011/12 the team has submitted several grant applications for funding Trust sponsored trials focusing on Inflammatory Bowel Disease, Coeliac Disease and Fatty Liver Disease. We are currently awaiting feedback from these submissions. The Trust sponsored, Department of Health funded, COMMANDs pilot study (Medipex Award Finalist 2011) is now recruiting in the community. Initially recruiting from just 3 GP practices, it is now opened up to 9 more practices across NHS Hull and East Riding, as a result of GP interest and requests to become involved. This is a very exciting development and is generating a great deal of interest regionally and nationally.

One key priority for the department in 2012/2013 is to consolidate progress made to date by promoting effective and productive relationships with industry, academia and regional partners. As a department, plans are in place to broaden the range of research activities that they currently conduct including a drive to increase participation in industry-supported studies, provide evidence for service delivery improvements within the Gastroenterology department, and develop and conduct investigator-led research studies in collaboration with our major stakeholders, such as The University of Hull, Primary Care Trusts, York Clinical Trials Unit, Yorkshire and Humber Inflammatory Bowel Disease Network and other Trust departments such as immunology, endocrinology, oncology.

[6] As at 15/03/12 and based on returns from 11 research active specialties including; Renal, Cardiology, Respiratory, Dermatology, Critical Care and Theatres, Ophthalmology, Gastroenterology, Head and Neck cancer, Oncology, Emergency Medicine and Reproductive Medicine.

Paediatrics and Reproductive Health:
The Reproductive Health and Paediatric Research Teams have demonstrated that midwifery- lead research is positive and viable research option within the Trust and wider region with the continuous improvement to paediatric evidenced based healthcare through rigorous research.

The first midwifery-led portfolio research 'the Vignette Study: Will the Introduction of Non Invasive Prenatal Diagnosis (NIPD) Influence Informed Choice? A Study of Providers and users of Maternity Services' reached its annual recruitment target in just eight weeks, recruiting 70 participants. The research teams have exceeded the participant target set for the DECIDE study and are well on target for delivering recruitment to target for the EPIC study with the recruitment of 28 patients in a three month duration. This work is the first stepping stone in acquiring and supporting further fully midwife-led studies within the Trust and the ambition of increasing the number of National Institute for Health Research (NIHR) portfolio studies with the potential of employing a new research midwife.

Oncology:
In 2011/12 the Oncology Research Team has recruited the first patient in the UK into a phase I/II haematology trial (AML18) and have been top national recruiters in several other major trials across various tumour sites.

The Oncology portfolio of research has diversified and is now able to offer trials in specialties that previously had nothing available including neurosurgery, mesothelioma and head and neck surgery. This has enabled a wider group of patients to be offered access to new and innovative treatments, and in some cases treatment when no other options would be available. This can have a significant saving to the NHS for drug treatment costs as these are often funded or supplied free for trial patients. Furthermore, the team has successfully expanded the radiotherapy trials portfolio and anticipates that this growth will continue over the next financial year.

The team now have an extensive malignant haematology portfolio of trials and is able to offer the benefit of participating in a clinical trial to almost all haematology patients. Developments in non-malignant haematology mean that the team has opened its first studies in this field.

Support and infrastructure has been increased 2011/12 with the medical research 'leads' for the specialist tumour sites now in post. The Oncology team have also collaborated with other teams to support trials in set-up including the cardiology 'Home Oxygen Therapy' trial, helping to ensure skills and expertise are shared across the research arena.

In 2012/13 the team hope to further pursue the goal of developing the oncology research department so that it becomes a paradigm of quality research and governance within the Trust. This will be achieved by continuing to develop Trust-led grant applications and run trials in the department with the long term aim of becoming part of a fully functional Clinical Trials Unit to help to ensure and progress the long term future success of research at the Trust. Creating and offering a collaborative training programme for principal investigators to improve the success of grant applications, improve the quality of our research and provide support and information for new researchers. Work will also commence on partnership research with Primary Care services such as collaborating with NHS Hull to look at developing a joint project to devise a Patient Concerns Inventory for use in Oncology outpatients and in Primary Care using the latest tablet technology.

Laboratory (Head and Neck):
Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques. One major success story has been demonstration of the efficacy of the micro-fluidic based systems for

maintaining and testing tissue biopsies with grants awarded by Yorkshire Cancer Research and NC3Rs. The research portfolio encompasses studies on head & neck cancer, colorectal cancer and heart disease. These projects are built on a strong collaboration between the Postgraduate Medical Institute (PGMI), Department of Chemistry and Hull and East Yorkshire Hospitals NHS Trust, and the aim for the forthcoming years is to develop proof of concept devices into fully functional clinical devices.

The main aim of the forthcoming year is to develop close collaborative links with staff soon to be working in the new Allam building and associated radiochemistry unit on the main University campus. The state of the art research Positron Emission Tomography (PET) / computerised tomography (CT) scanners will offer many new opportunities in terms of targeting tumours and imaging cardiac dysfunction. With the imminent installation of clinical PET/CT on the Castle Hill Hospital site the combination of units will offer a centre of excellence for translational imaging work.

Ophthalmology:
The Academic Unit of Ophthalmology has continued to expand with the initiation of a further portfolio study in this financial year and the appointment of a Clinical Trials Assistant. The unit has also become involved in industry sponsored Clinical Trials and demonstrated a firm commitment to multi-disciplinary research working in collaboration with other specialities including Ophthalmology researchers becoming co-investigators for PREDNOS, initiated with Paediatrics, and also undertaking ophthalmic examinations to support the REMOVAL study initiated in Endocrinology.

In 2011/12 the team has acted as a trial centre for 6 portfolio studies; 2 of which involved Investigational Medicinal Products (IMPs) allowing patients to participate in trials researching new therapies for diabetic retinopathy and wet age related macular degeneration. The team were the leading recruiter for one of these studies; MERLOT; achieving recruitment ahead of the rest of the UK.

Targets for the forthcoming financial year include timely recruitment for the new portfolio study initiated recently (LUMINOUS) and the initiation of 2 further IMP portfolio studies researching the effects of a modified treatment regime using Lucentis for retinal vein occlusions (CRYSTAL, BRIGHTER). This additional industry funded activity will increase income leading to the long-term aim of recruitment of more research staff, ultimately increasing novel research within the unit.

Critical Care:
The uptake of studies and consistent patient recruitment has enabled the Critical Care Research Team to obtain further CLRN support to recruit patients outside of office hours. Work in 2011/12 has focused on assessing capacity for complex trials in this specialty. One work-stream to look at this involved incorporating a log of patients who are recruited into critical care research studies in to the ongoing ICNARC registry of critical care patients within the Trust. This allows the team to assess what proportion of patients admitted to critical care participate in critical care research studies subsequently allowing them to plan participation in future studies.

For 2012-2013 the priority is to work on providing a consistent service across both Trust sites in both Anaesthesia and Critical Care with the ability to enable improvements in patient recruitment.

Emergency Medicine:
In 2011/12 the Emergency Department Research Team became the winner of the '3Mg *Golden Inhaler Award'* for most improved site having the highest recruiting department 2 months running.

The Emergency Department Research Nurse has been instrumental in organising regular Research Nurse meetings to promote a collaborative approach to working. These sessions provide a forum for sharing skills, experience and expertise in an informal environment with support from the Central Research and Development Office.

The team continues to collaborate with many research units, often being the 'gatekeeper' aiding recruitment to many trials. In particular, the team has been collaborating with Critical Care and Theatres recruiting extra members of staff, training them in varying studies and expanding the screening of patients beyond office hours to maximize recruitment and the potential patient benefits from participation in research.

Dermatology:
Dr Shernaz Walton, Consultant Dermatologist, was awarded the Investigator Award for 2011 for the BADBIR Study by the British Association of Dermatologists Scientific Committee in June 2011. This was awarded in recognition of Dr Walton's innovative ways of improving recruitment to the British Association of Dermatologists Biologics Intervention Register (BADBIR) and outstanding recruitment.

Peter Jones, Research Nurse, was awarded the Quarterly Award (March 2011- July 2011) for the Blister Study in recognition for efforts made to recruitment. The team were also awarded the Quarterly Award (Sep 2011- Dec 2011) for the Stop Gap trial in recognition of their efforts.

Over the next year the department has aspirations of developing its relationship with the Faculty of Health at the University of Hull. It is their aim to undertake more collaborative work with academic partners over the next 12 months to try and produce some more academic research in the field of Dermatology, specifically looking at issues such as patients self care of skin diseases.

Renal:
In 2011/12 Michelle Cooke, Renal Anaemia Nurse Practitioner, and colleagues became the winners of the Medipex NHS Innovation Awards & Showcase 2011 in the Acute and Secondary Care Category for their work on 'A QIPP approach to Intravenous Iron administration in the community a shared patient focused approach'.

In December, 2011, The Yorkshire and Humber Renal Research Day took place for the first time at the Hull Royal Infirmary in the East Riding Medical Education Centre organised by the Renal Research Unit.

The event was split up into two sections consisting of 'shared knowledge exhibits' and 'plenary and research sessions' with the 'Tsar' of Renal Medicine as a guest speaker.

The aim of the 'Mini Exhibition' was, in effect, telling the story of clinical research within the hospital and industrial arenas. This was captured by the attendance of personnel who are pivotal players in the diverse roles that make a clinical research study a reality, from initiation to end, including a previous patient participant of a clinical study to deliver her thoughts and personal emotion of becoming a participant, along with her experiences and concerns throughout her study visits.

The Renal Research Unit at the Hull Royal Infirmary has continued to demonstrate high recruitment in research after reaching their recruitment target of 20 patients for the MIRCERA trial, making them the joint top recruiters out of the 23 UK sites.

Throughout 2011/12, the Renal Research Unit has run a number of teaching sessions within the renal service to maximize the awareness and importance of research to staff.

Cardiology and Respiratory:
The Cardiology Research team have secured a number of research grants in 2011/12 with Professor Cleland securing an NIHR Senior Faculty award and being appointed to the NIHR Experimental Medicine Review Board. He has also secured a new FP7 grant (Semantic HealthNet) and several commercial grants (Philips, BRAHMS-Thermofisher, Vifor, Amgen).

The prestigious NIHR Health Technology Assessment (HTA) grant award (Clopidogrel compared to Aspirin in Chronic Heart Failure (CACHE)) was finally launched in September 2011. This has a radical new efficient trial design that endeavours to deliver a cost-effective outcome study which will be led from Hull and delivered nationally.

The development of Telehealth services and research continues across Cardiology and Respiratory research with successful funding having been awarded via HEIF 5, Semantic HealthNet and the HeartCycle Home Telemonitoring studies. The continued development of Telehealth services in Respiratory Medicine, particularly around chronic obstructive pulmonary disease, continued with successful funding having been awarded via HEIF 5 and Philips.

The key priority for the following 12 months for Cardiology and Respiratory will be the continued contribution to the development of a Clinical Trials Unit in Hull to maximise opportunities for researchers and patients alike by increasing the number of studies designed locally and delivered nationally.

Surgical Research:
Surgical research in the Trust has seen an expansion over the last year with activity from colorectal surgery significantly increasing. Work includes an observational pilot study to investigate the relationship between patient body weight and the complications of ileostomy formation, an observational pilot study to assess the potential of a microfluidic tissue culture model to predict rectal cancer response to neo-adjuvant therapy and a retrospective study of the incidence of invasive carcinoma in panproctocolectomy specimens excised following the detection of a dysplasia-associated lesion or mass. Colorectal researchers are also participating in national research on polyp prevention during colonoscopic surveillance in the NHS Bowel Cancer Screening Programme.

HYMS Active Research Programme
Hull and East Yorkshire Hospitals NHS Trust is significantly involved in partnership research undertaken by the Centre for Cardiovascular and Metabolic Research (a partnership between Hull and East Yorkshire Hospitals NHS Trust (as part of the Hull York Medical School – HYMS). The centre brings together research expertise to tackle heart failure, diabetes and blood-related disorders, and is lead by Professor Khalid Naseem. The Centre focuses particularly on treatments that can be translated from the laboratory bench to the bedside, with a real impact on patient care and consists of the following research groups:

- Cardiovascular Biology and Medicine

Cardiovascular diseases remain a major cause of mortality worldwide and represent several disorders that result in failure of the heart. This area of research includes a number of major clinical problems from heart failure to peripheral arterial disease. We have a number of internationally competitive research programmes that stretches from the study of basic mechanisms of cardiovascular function through to clinical practice.

- Diabetes and Metabolic Health

Research in this area focuses on Metabolic Syndrome that comprises of a number of disorders that together increase the risk of cardiovascular disease and associated diabetes. The main research thrust is insulin resistance and the interface between polycystic ovarian syndrome (PCOS), impaired glucose tolerance and type 2 diabetes, and their relationship to metabolic syndrome and cardiovascular risk factors.

- Haemostasis, Thrombosis and Inflammation

Research projects in this area are focused on the regulation of platelet function and their contribution to a number of diseases and inflammatory states.

Overall research priorities for 2012/13:
Many of the research active areas within the Trust have set a priority for 2012-2013 to increase their involvement in commercial/ income generating research studies and as such generate a sustainable income stream, to complement the support received from the North and East Yorkshire and Northern Lincolnshire Comprehensive Local Research Network. This, it is hoped will pave the way for more Trust-led research that builds upon the successful NIHR grants already received.

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of Hull and East Yorkshire Hospitals NHS Trust income in 2011/12 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.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available on request from the following email address: quality.accounts@hey.nhs.uk.

The following key applies to Table 1:

✘	Improvement not demonstrated
☑	Goal not achieved but improvements made
✓	Goal achieved

Table 1: CQUIN Indicators agreed with Commissioners

National / Local	Scheme	Indicator	Definition	Q4 Target	Q4 Status	Key
National	1	VTE Prevention	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool	90%	91.34%	✓
National	2	Patient Experience - Personal Needs	Composite indicator on responsiveness to personal needs from the adult inpatient survey	69.0	69.2	✓
Local	3a	End of Life Care	Number of people on the Liverpool Care Pathway	30%	30.9%	✓
	3b		Number of people with a recorded preferred priority of care	30%	11.4%	☑
Local	4	Pressure Ulcers	The number of Quality Assurance audits fully completed at Health Group level	90%	90%	✓
			Grade III avoidable pressure ulcers	<2 per year	0	✓
			Grade IV avoidable pressure ulcers	<2 per year	0	✓
Local	5a	Mortality	Number of hospital deaths reviewed by a consultant within 1 calendar month of their death	90%	96.1%	✓
	5b		Reduction in HSMR by 10 points by 1st April 2012	10 point reduction	108[7]	☑

[7] Estimated year-end position, validated March 12 data unavailable at time of publication.

National / Local	Scheme	Indicator	Definition	Q4 Target	Q4 Status	Key
Local	6a	Deteriorating Patient	Number of observation charts audited which are fully completed as per the Trust Policy and NICE Guidance	95%	98.1%	✓
	6b		Number of fluid balance charts audited which are fully completed as per Trust guidance	90%	90%	✓
Local	7a	Patient Experience	Dignity - Index-based score reflecting positive responses to the 4 questions within the composite indicator	88.4	8.8[8]	✓
	7b		Understanding - Index-based score reflecting positive responses to the 4 questions within the composite indicator	75	7.7	✓
Local	8	Improving Hospital Discharge	Increased use of Expected Discharge Date (EDD) to promote effective timely discharge	35%	61.3%	✓
Local	9	Patient Experience of Hospital Discharge	Improve patient satisfaction of hospital discharge with an increase in am discharges	25%	19.3%	✗
Local	10	Criteria Led Discharge	% of patients discharged using criteria led discharge - Elective Chemotherapy	60%	87%	✓
			% of patients discharged using criteria led discharge - Elective Hip & Knee Replacement	60%	71%	✓
			% of patients discharged using criteria led discharge - ERAS - Major Colorectal Surgery	25%	0%	✗
			% of patients discharged using criteria led discharge - Elective Cardiology Procedures	70%	86%	✓
			% of patients discharged using criteria led discharge - Coronary Artery Bypass Graft	25%	26%	✓
Local	11a	Improving Patient Flow	Number of patients staying on AAU for more than 24 hours	12%	12.5%	✓
	11b		Number of patients nursed on a trolley in the corridor		0	✓
	11c		Number of hospital transfers from the SSW to another acute ward	10%	15.7%	✗
	11d		Number of patients staying on SSW for more than 72 hours	27%	34.7%	✗
Local	12	Promoting Seamless Care	Improve the interface between Secondary Care and Community Services	47%	48.4%	✓
SCG	13a	Neonatal ICU	Temperature recorded within one hour of birth	98%	100%	✓

[8] The Care Quality Commission amended the Patient Experience scores in 2011/12 from a measure out of 100 to a measure out of 10.

National / Local	Scheme	Indicator	Definition	Q4 Target	Q4 Status	Key
	13b		Out of network or region transfers	5%	0%	✓
SCG	14	Paediatric ICU	Out of network or region transfers		n/a	n/a
SCG	15a	Renal	Number of inpatient bed days where admission was solely due to the need for routine dialysis	0%	0%	✓
	15b		100% of patients referred to transplant service (or decision not to refer) for transplant / live donor within 180 days of commencing dialysis	100%	100%	✓
SCG	16a	Disease Modifying Therapies	Number of all patients who are prescribed DMT for multiple sclerosis who receive an annual review	90%	100%	✓
	16b		Number of all patients who are prescribed DMT for multiple sclerosis who meet the regionally agreed treatment cessation criteria and whose DMT treatment is therefore stopped	95%	100%	✓
SCG	17a	Haemophilia	Proportion of haemophilia A patients on home treatment with concentrate, with systematic recording of bleeds and treatments	75%	100%	✓
	17b		Recording of days lost from school / work due to complications of haemophilia	90%	100%	✓

Further details of the agreed goals for 2011/12 and for the following 12 month period are available on request from the following email address: quality.accounts@hey.nhs.uk.

The total contract value of the CQUIN indicators, including the Specialist Commissioning Group indicators, is £6,271,958 million. The Trust received £5,512.473 million of this money.

The Trust will continue to work closely with its commissioners and the evolving GP Commissioning Consortia to ensure that patient safety and service quality continue to be a primary focus.

What others say about the Hull and East Yorkshire Hospitals NHS Trust

Hull and East Yorkshire Hospitals NHS Trust is registered with the Care Quality Commission (CQC) and its current registration status is unconditional.

The Care Quality Commission has not taken any enforcement action against Hull and East Yorkshire Hospitals NHS Trust since initial registration in 2010.

Hull and East Yorkshire Hospitals NHS Trust is subject to periodic compliance reviews by the Care Quality Commission and in 2011/12 there were six reviews and visits to the Trust.

The Care Quality Commission (CQC) – An Explanation

The CQC is an independent regulator of all health care in England. Their job is to make sure that all organisations providing health care meet recognised government standards. They have the power to visit organisations and view the services and care they provide, make recommendations to improve standards and issue enforcement notices where required.

Two of the visits were undertaken by CQC and Ofsted to look at the Hull and East Yorkshire Hospitals NHS Trust element of safeguarding children and looked after children at both Hull City Council and East Riding of Yorkshire Council. Some recommendations were made to improve the timeliness of Health Assessments for looked after children and improve supervision arrangements for staff holding safeguarding children case loads. Overall the Trust's safeguarding arrangements for children were found to be good.

The Trust had a review of its Maternity services in June 2011 and was found to be compliant overall. However, the CQC found there to be major concerns with outcome 13 – staffing. This was in respect of services provided at the Jubilee Birth Centre based at Castle Hill Hospital. The Trust has since undertaken a review of Maternity services and has closed the Jubilee Birth Centre and transferred the service to the Women's and Childrens Hospital. The Trust is now fully compliant.

The Trust had another compliance check in October 2011 against three outcome areas and CQC found no areas of non compliance and made only one improvement action. This was related to governance arrangements for escalating staffing concerns; this has been addressed in full.

In February 2012 the Trust was subject to a further compliance review to the Castle Hill Hospital. The review looked at Outcome areas 2, 4, 8, 13 and 16 and found no areas of non compliance. However two areas of improvements were noted; consent practices need to be improved, particularly in relation to ensuring patients understand what they are consenting to and are fully informed and contemporaneous notes need to be made of all aspects of a patients' care. The Trust is in the process of addressing these improvement actions and improving practice in these areas.

In March 2011 the Trust was reviewed for its termination of pregnancy services. All Trusts providing such services were reviewed and no action was taken against the Trust as a result of the visit.

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

Data quality

Hull and East Yorkshire Hospitals NHS Trust submitted records during 2011/12 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:

- 99.80% for admitted patient care;
- 99.85% for out patient care; and
- 98.85% 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.

Hull and East Yorkshire Hospitals NHS Trust's score for 2011/12 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 71% (satisfactory).

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:

- 14.5% primary diagnosis incorrect
- 20% secondary diagnosis incorrect
- 8.7% primary procedures incorrect
- 10.6% secondary procedures incorrect

Work to further improve this position is ongoing and monitored via internal coding audits.

Data Quality Assurance

Hull and East Yorkshire Hospitals will be taking the following actions to improve data quality.

The Trust has introduced a Data Quality Strategy that is based on the principle of 'getting the data right first time' to give assurance that the data meets the six dimensions of data quality as set out in the Audit Commission document 'Improving Information to Support Decision Making: Standards for 'Better Data Quality'.(2007) These dimensions are:

- Accuracy
- Validity
- Reliability
- Timeliness
- Relevance
- Completeness

The Trust has implemented a Data Quality Assurance matrix for a number of key datasets and performance indicators that assess on the above dimensions, identifies risks and highlights areas of improvements. The self assessments undertaken so far have covered:

- Inpatients dataset (including clinical coding)
- Outpatients dataset
- A&E dataset
- 18 weeks
- Cancer waiting times
- Stroke indicators
- Maternity indicators
- Diabetic retinopathy

Of the above, external assurance has also been given for inpatients, outpatients and A&E (through the Secondary Users Services Data Quality dashboard where overall, the Trust has a higher data quality score than national average)

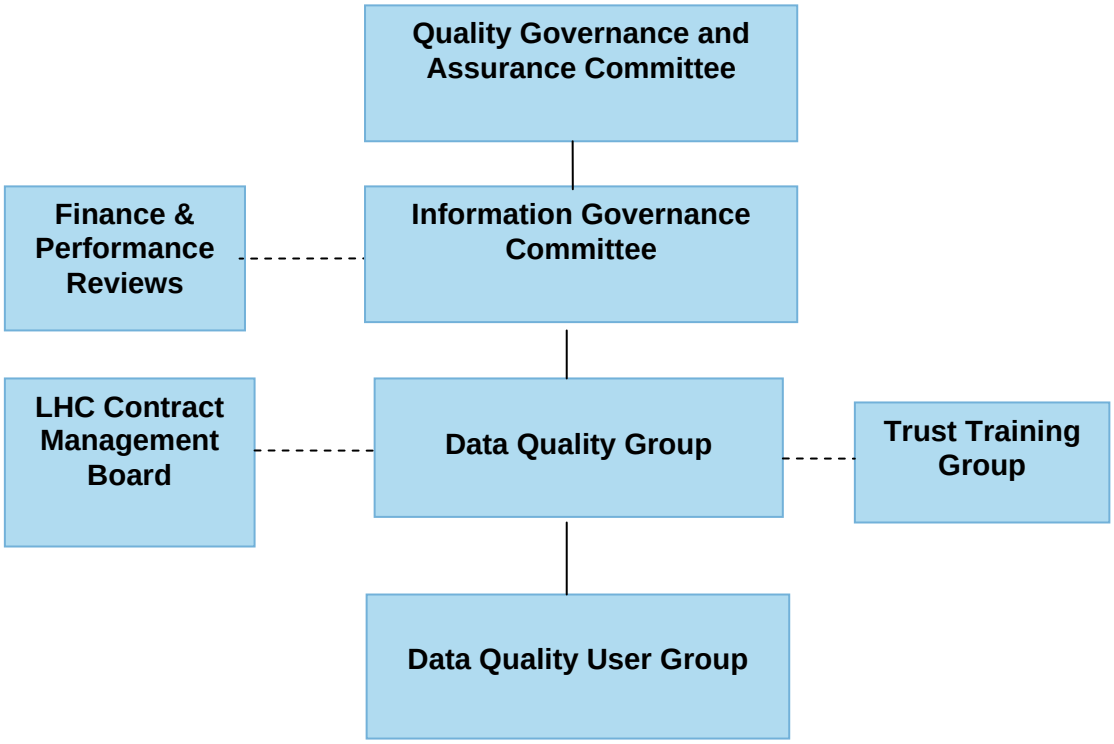
Where data quality issues have been identified in the above assessments, a data quality improvement plan has been put in place to address these.

The Data Quality Strategy also sets out the importance of all staff being aware that data quality is everyone's responsibility, and sets out the need to ensure everyone is made aware and has training on the importance of data quality and its impact on patients.

The Trust has a dedicated Data Quality Team who:

- Undertake routine audits
- Produce weekly, monthly and quarterly data quality reports
- Produce guides/leaflets to help front line staff with data collection
- Meet regularly with staff groups to discuss data quality issues and take corrective action

The Data Quality Strategy also sets out the reporting structure for the policy on data quality how data quality issues can be escalated to the appropriate committees.



Quality Accounts 2011/12

Part 3

Review of performance: Safety

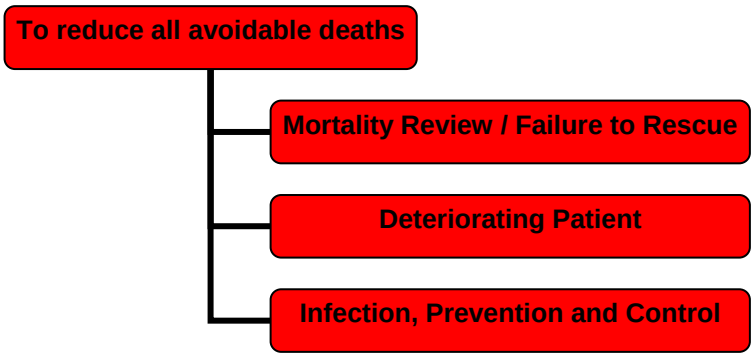
To reduce all avoidable Death

Background

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.

Goal

To reduce all avoidable deaths with the goal of achieving and sustaining a Hospital Standardised Mortality Ratio (HSMR) of 80 by 2016.



Planned Target Outcomes

Table 2: Planned Target Outcomes – To reduce all avoidable Death

Outcomes	Baseline	Planned Target Outcome	Year End Figure	Achieved
Reduction in mortality against an agreed trajectory with the aim of reducing HSMR of 80 by March 2016	118.9	Less than or equal to 100	108* (* Note: Estimated year-end position, validated March 12 data unavailable at time of publication)	☑
Reduction in crude mortality rates	1.7%	Less than 1.7%	1.6%	✓
Achieve 95% compliance with vital sign observations (completion and appropriate action) by the end of 2011 and sustain this standard	84%	95% or higher	98%	✓
Implement fluid balance chart monitoring with the overall aim of 95% compliance by the end of 2013 (2011/12 85%)	56.8%	85% or higher	90%	✓
Achieve a 50% reduction in cardiac arrest calls.	653	326 or lower	234	✓

Outcomes	Baseline	Planned Target Outcome	Year End Figure	Achieved
Achieve less than 60 cases of Clostridium Difficile (C.Difficile)*	60	No more than 60	105	✘
Achieve less than 9 acute acquired cases of MRSA Bacteraemia	9	No more than 9	8	✓
Trust Board Patient Safety Priorities	Quality and Safety Strategy approved and implemented			✓

* The Trust recognises the importance of reducing C Difficile infections and as a result of the failure to achieve the targeted reduction in both hospital and community acquired cases actions have been taken to cohort the care for affected patients. This means nursing patients with C Difficile in a dedicated ward. This has improved care for infected patients but also protects patients in other environments by reducing the risk of cross contamination. The Trust has also made significant improvements to the hospital environment by increasing wash hand basins, increasing deep cleaning and use of technology such as Hydrogen Peroxide Vapour.

Please see appendix one for more detailed information on the workstream updates by planned target outcomes.

Summary of Key Achievements

- Mortality has reduced month on month since August 2011 as measured by the Hospital Standardised Mortality Ratio (HSMR).
- The Mortality Reduction Committee has been established to ensure the success of mortality review projects.
- There is greater understanding of mortality data and potential issues within the Trust and health community.
- Improved reliability of recording patient observation charts by implementing measures to improve handover communication. This is critical to patient safety by ensuring appropriate coordination of care between health care professionals as well as continuity of care. As part of this improved communication an e-learning package has been introduced. Health care professionals undertake the learning to gain greater understand of practices relating to handover of care, early warning scores to indicate when a patient is deteriorating and the recording of clinical observations.
- A sepsis working group has been developed so that the Trust can focus on improving sepsis related deterioration
- Continuation of the Infection, Prevention and Control work-streams with focus on all avoidable hospital-acquired bacteraemia, public campaigns, hand hygiene and establishing a Vascular Access Team.
- Implementation of the Quality and Safety Strategy.
- Achieved less than 9 MRSA Bacteraemias.
- Introduction of zero tolerance on bare below the elbow and hand washing in all clinical areas.
- Greater understanding of mortality and identified patient groups.
- Improved depth of coding.
- Improved HSMR for Stroke.

Depth of Coding – An Explanation

When a patient receives treatment and care within the Trust their diagnosis and treatment are recorded. This is then given a code that we use to monitor the care we are providing.

It is important that we record as much information as possible in our patient's notes so that when their diagnosis and treatment are given a code it is as accurate as possible. This helps us to make sure we are providing the best care we can.

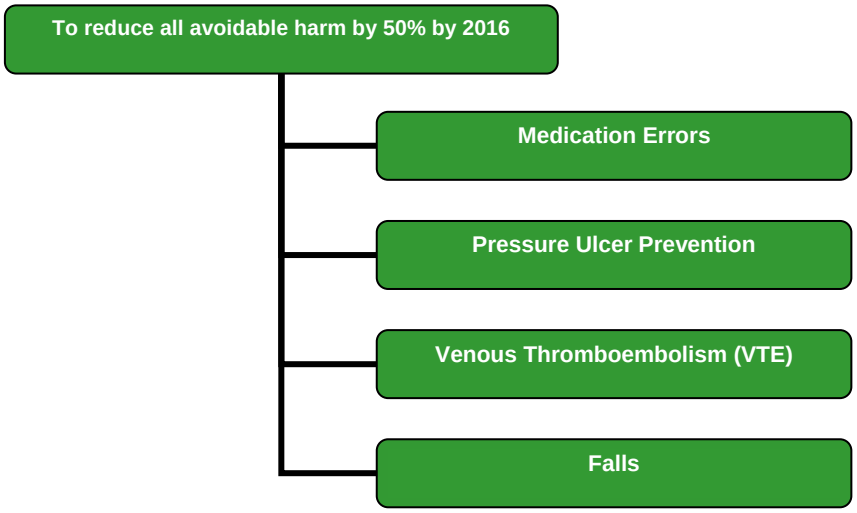
To reduce all avoidable Harm

Background

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.

Goal

To reduce all avoidable harm to patients by a minimum of 10% (as measured by the global trigger tool) per year in each Health Group.



Planned Target Outcomes

Table 3: Planned Target Outcomes – To Reduce All Avoidable Harm

Outcomes	Baseline	Planned Target Outcome	Year End Figure	Achieved
Remain in the upper quartile for patient safety incident reporting with a ratio of patient safety incidents reported/100 admissions of >7 as reported by the National Reporting Learning System	7.42	7 or higher	8.7 [9]	✓
Maintain a higher proportion (>1% higher) of no harm risks than other large acute trusts as reported by the National Reporting Learning System.	>1% higher than other large acute trusts	At least 1% higher than other large acute trusts	2.6% greater than other large acute trusts [10]	✓
Compliance with the best practice skin-care bundle, following implementation, of 95% by 2015/16	Data collection started 2011/12	Data collection to establish baseline undertaken		✓
No avoidable grade 3 or 4 pressure ulcers	4	0	0	✓

[9] Data taken from the national dataset from the National Reporting Learning System March 2012
[10] Data taken from the national dataset from the National Reporting Learning System March 2012

Outcomes	Baseline	Planned Target Outcome	Year End Figure	Achieved
Achieve the national Commissioning for Quality & Innovation (CQUIN) requirements of 90% of all patients admitted to hospital undergo a VTE risk assessment. Aim of 95% compliance by 2014/15 (85% 2012/13, 90% 2013/14)	82.5%	90%	90.5%	✓

Overall goal of reduction of patient harm as measured by the global trigger tool will be changed when the Quality & Safety Strategy undergoes its annual review. This will reflect 'harm free care' as measured by the Safety Thermometer. This is a national requirement.

Please see appendix one for more detailed information on the workstream updates by planned target outcomes.

Summary of Achievements

Pressure Ulcers – An Explanation

These are open wounds that form when there has been prolonged pressure applied to skin covering bony areas of the body. Patients who are unable to get out of bed are prone to pressure ulcers. The ulcers are graded by their severity.

- New Drug Chart rolled out across the Trust in December 2011.
- Increased Medicine Management training, including Critical Medicines study day.
- Chemotherapy e-prescribing started to reduce medication errors.
- Compliant with all relevant National Patient Safety Agency alerts. These alerts are issued to provide advice to health organisations relating to the safety of patient care.
- A pilot of the skin care bundle took place in April 2011 on 6 wards. Following the pilot a review was carried out and the package altered accordingly. Once the review had been completed rapid implementation occurred across the Trust between May and July. At the present time the Trust is monitoring compliance with the skin care bundle as part of weekly audit checks. Monthly meetings are held with Nurse Directors from each of the Health Groups to discuss the pressure ulcer reports. The aim of these meetings is to highlight best practice, problems areas and methods for improvement.
- A significant decrease has been demonstrated in Grade 2 pressure ulcers, as a result of the work under this work stream.
- The Trust had no avoidable Grade 3 pressure ulcers during the year.
- The Trust also had no avoidable Grade 4 pressure ulcers during the year.
- The target through the National Commissioning for Quality & Innovation Scheme (CQUIN) was for 90% of patients to be risk assessed for Venous Thromboembolism (VTE) on admission to hospital. The Trust achieved this target consistently throughout the year.
- A Falls Working Group has been developed with support from the National Patient Safety Agency.
- Falls data is analysed and reviewed by the Health, Safety and Security Committee to consider trends and corresponding actions.
- Work was undertaken to comply with the National Patient Safety Alert "Essential Care After An Inpatient Falls".

Patient Safety Quality Indicators

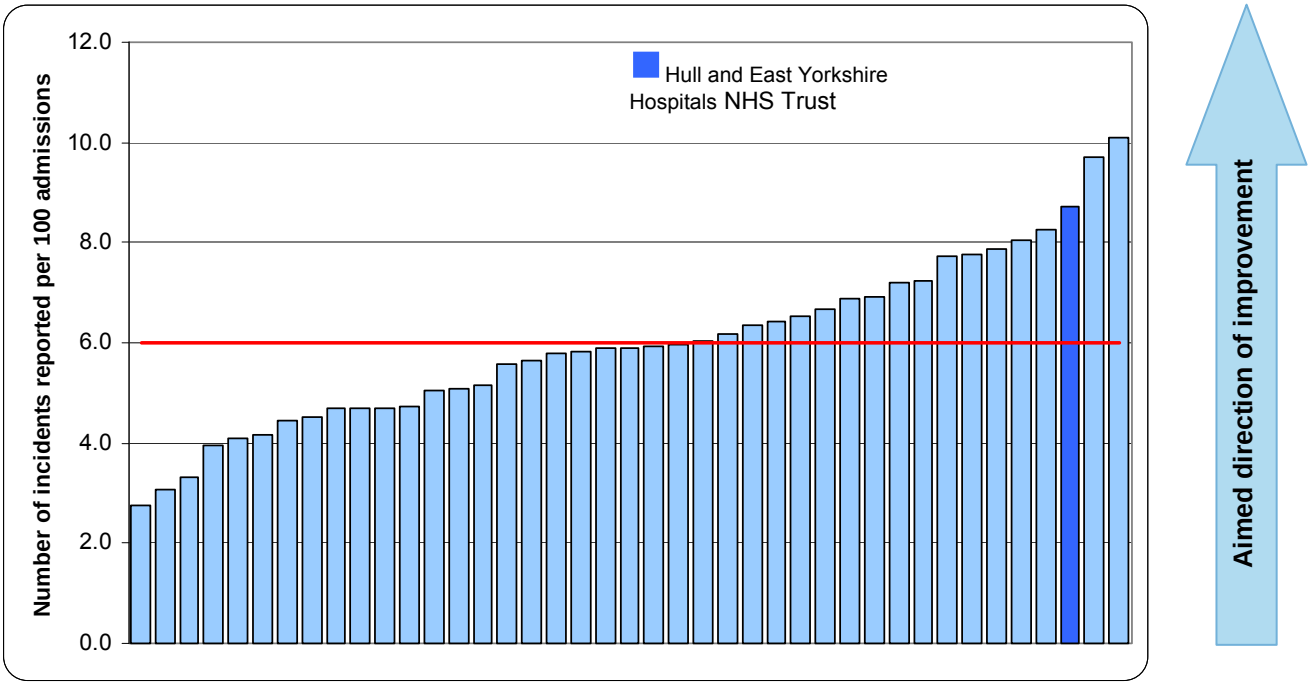
Hull and East Yorkshire Hospitals NHS Trust is following the proposed changes made by the National Quality Board to strengthen the Quality Accounts through the introduction of mandatory reporting against a small, core set of quality indicators. The core set of quality indicators are aligned closely with the NHS Outcomes Framework and are all based on data that Trusts already report on nationally.

The Trust Board has also monitored some of the core quality indicators throughout the 2011/12 period.

Patient Safety Incidents

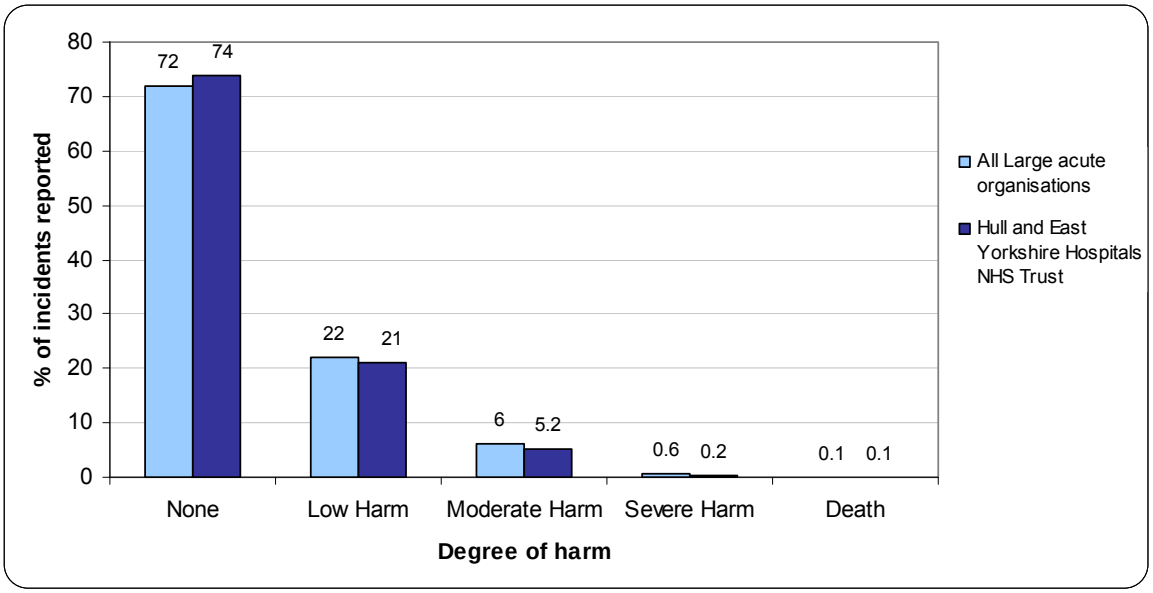
A strong incident reporting culture is an indicator of a good patient safety culture. The Trust has continued to improve in this area over the last 12 months and maintained its positive reporting culture. Figure 1 is taken from the latest National Patient Safety Agency National Reporting and Learning Service data report March 2012 and shows that the Trust is in the top 25% of reporters. The Trust is reporting 8.7 incidents per 100 admissions compared to an average of 5.9 per 100 admissions for other Trusts.

Figure 1: Patient Safety Incidents per 100 admissions for the period 1 April 2011 to September 2011



Source: National Patient Safety Agency National Reporting and Learning Service organisation feedback report for all large acute trusts.

Figure 2: Incidents reported by degree of harm for large acute organisations for the period 1 April 2011 to 30 September 2011



Source: National Patient Safety Agency National Reporting and Learning Service organisation feedback report for all large acute trusts.

A strong incident reporting culture is an indicator of a good patient safety culture. We would like to see a high level of reporting for incidents. Figure 1 indicates that the Trust is a high reporter and above the national average. We would also like to see a low level of reporting for incidents that have resulted in death or been given a rating of severe level of harm. Figure 2 shows that the Trust has a lower percentage of "moderate" and "severe" incidents in comparison to other large acute Trusts and indicates that less than 0.3% of all incidents have results in death or severe harm.

Domain 5 of the NHS Outcomes Framework for 2012/13 includes the rate of patient safety incidents reported and the proportion of these resulting in severe harm or death, as a measure of the willingness to report incidents and learn from them, and therefore reduce the number of incidents that cause serious harm. The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, whilst the numbers of incidents resulting in severe harm or death should reduce.

Understanding Harm – An Explanation

Nationally, 68 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult. Organisations should record actual harm to patients rather than potential degree of harm.

Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.

The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. Depending on the SHMI value the Trust is banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared with other Trusts.

The SHMI value for Hull and East Yorkshire Hospitals NHS Trust is 1.1738 indicating the Trust's SHMI band as a 1 which is high compared to other Trusts.

Table 4: SHMI Data

Outcomes	Baseline	Planned Target Outcome	Year end figure
Summary Hospital Mortality Index (SHMI)	116.36	This is a new measure and the Trust does not currently have a planned target outcome. This will be defined during 2012-13	116
Percentage of patients admitted whose treatment included Palliative Care	0.5%	This is a new measure and the Trust does not currently have a planned target outcome. This will be defined during 2012-13	1
Percentage of patients admitted who died and treatment included Palliative Care	29.7%	This is a new measure and the Trust does not currently have a planned target outcome. This will be defined during 2012-13	29.7%

Domain 1 of the NHS Outcomes Framework for 2012/13 requires the NHS to reduce the number of people dying prematurely. To support this, the NHS Operating Framework for 2012/13 sets out an expectation that all Trusts examine, understand and explain their SHMI and identify and act where improvements are needed.

Rate of Clostridium Difficile (C.Difficile)

Clostridium Difficile can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel. Hospital-asscíated C.Difficile can be preventable.

Table 5: Clostridium Difficile Data

Outcomes	Baseline	Planned Target Outcome	Year end Figure	Achieved
Rate of Clostridium Difficile (C.Difficile) per 1000 bed days (Hospital Acquired)	0.155	0.155	0.245	✘

The national average for rate of Clostridium Difficile per 1000 bed days (Hospital Acquired) is 0.158.

Domain 5 of the NHS Outcomes Framework for 2012/13 includes incidence of Clostridium Difficile as an important indicator of improvement in protecting patients from avoidable harm, as does the NHS Operating Framework for 2012/13, which sets out a "zero tolerance" approach to infections acquired in healthcare settings.

Venous Thromboembolism (VTE)

Venous Thromboembolism (VTE) is a blood clot that can develop in the deep veins of the body, most often the leg. This can remain in the leg and cause pain and swelling of the leg or can move to the lungs causing breathlessness or chest pain.

Table 6: Venous Thromboembolism (VTE) Data

Outcomes	Baseline	Planned Target Outcome	Year end Figure	Achieved
Percentage of patients who were risk assessed for Venous Thromboembolism	82.5%	90% or higher	91.3%	✓

The national average for the percentage of patients who were risk assessed for Venous Thromboembolism was 90% for the period of January to December 2011.

Domain 5 of the NHS Outcomes Framework for 2012/13 includes incidence of VTE as an important indicator of improvement in protecting patients from avoidable harm, and the NHS Operating Framework for 2012/13 sets out an expectation that patients will be risk assessed for hospital-related VTE.

Serious Untoward Incidents (SUIs) 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 SUI 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 believe to be worthy of investigation by an Independent Panel and/or falls into the category of an incident that must be reported to the Strategic Health Authority.

Never Event – An Explanation

A Never Event is a type of SUI. 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'.

During 2011-12, 12 SUIs were reported in the Trust of which 3 were classed as Never Events. Two Never Events were retained swabs and one Never Event was a wrong site surgery.

Table 7: Details of recommendations made from the Never Events declared in 2011/12

Never Event Recommendations	Complete
Review all written procedures relating to swab, needle and instrument counts at all births (including perineal suturing). Where possible and appropriate, these should be consolidated into one document. They should also include information pertaining to the role of lead professionals (midwives and obstetricians) in undertaking a correct swab, needle and instrument count.	✓
Education and training of the revised procedures and policies should be undertaken with every midwife and obstetrician, to include ensuring that each is aware of his/her accountability for documenting the completed counts and results noted in the woman's health record. In addition, all staff are to be reminded that a retained swab is a reportable incident and a 'Never Event'.	✓
Following the introduction of any revised policies, procedures and documentation, an audit of swab count practices should be undertaken in all birthing areas to ensure on-going compliance with them.	✓
The content of the Trust's delivery packs should be reviewed to include taped and x-ray detectable swabs only (remove all untapped swabs).	✓
The Labour Partograms must be revised to ensure that the full swab, needle and instrument checking procedure has been carried out by the lead practitioner and, also, been verified by a second practitioner before any clinical waste is disposed of. The revised document should be unambiguous and explicit and allow for each practitioner to sign clearly that this procedure has been undertaken fully and correctly.	✓
The procedure for safeguarding swabs, needles and instruments from other clinical waste must be reviewed to enable accurate counts to be undertaken safely and in a way that minimises the risks to staff and patients and that is not dependent upon a single yellow clinical waste bag.	✓
The National Patient Safety Agency Rapid Response Report (NPSA/2010/RRR012) - "Reducing the risk of retained swabs after vaginal birth and perineal suturing" should be copied to every midwife and obstetrician. The use of the associated clinical briefing sheet is to be encouraged.	✓
Consideration should be given as to whether it is necessary for all women with perineal tears or post-episiotomy to have a perineum examination on day 1 post delivery. At this stage, the swab, needle and instrument check could also be verified by way of an additional safety check.	✓

Review of Performance: Effectiveness

Right Patient, Right Place, Right Time

Background

Clinical Governance centres on the right 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 ongoing care, where this is indicated for clinical reasons. However, all too frequently and particularly at peak emergency activity times, many 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.

The Trust's aim is to ensure that all patients are treated on the most appropriate care pathway for their condition and individual needs.

Re-admissions – An Explanation

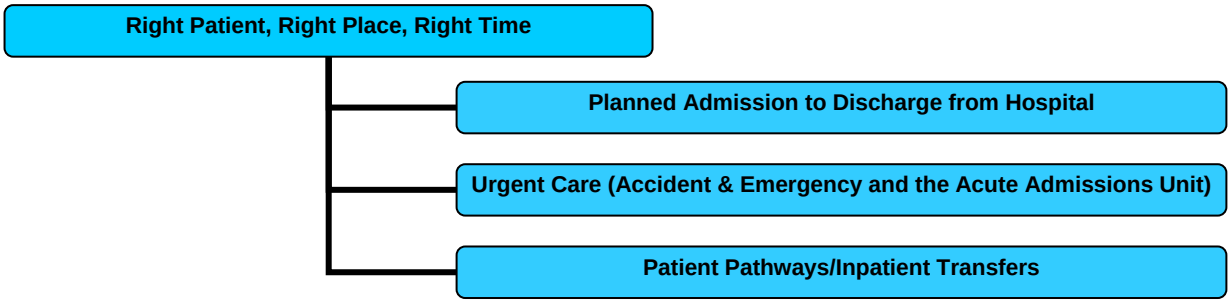
There are two types of readmission. The first is following planned treatment or care and the second is following emergency treatment or care

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.

When the Trust measures the number of people being re-admitted the figure includes patients that have come back to us for any reason, not just for the same condition.

Goal

To reduce the number of unnecessary inpatient transfers and unplanned patient readmissions to hospital.



Planned Target Outcomes

Table 8: Planned Target Outcomes – Right Patient, Right Place, Right Time

Outcomes	Baseline	Planned Target Outcome	Year end Figure	Achieved
Reduction in patients being readmitted to hospital within 28 days with the aim of matching peer performance in 2011/12 and having lower readmission rates compared to peer by 2016	6.7%*	6.5 % or lower	6.9	✘
10% reduction in avoidable inpatient transfers, in particular for patients moved more than 2 times (data currently being validated)	515	464	475	☑
10% reduction in avoidable in inpatient transfers after 10pm (data currently being validated)	3114	2803	2473	✓
10% reduction in the number of patients on the delayed discharge list	Baseline data collection undertaken during 2011/2012		2,350	✓
10% reduction in the number of patients with a length of stay greater than 50 days	871	784	707	✓

**This was initially set for a reduction of unplanned readmissions within 14 days with a baseline of 4.7%. No improvement has been demonstrated. The Trust now measures 28 days readmissions in line with latest guidance for Quality Accounts.*

Please see appendix two for more detailed information on the workstream updates by planned target outcomes.

Summary of Achievements

- Achievement of the majority of performance targets including all Cancer indicators
- The Minor Injuries department has moved to the former discharge lounge and chapel. This has created additional treatment facilities and reduced waiting times both for triage and treatment.
- A temporary Medical Ambulatory Care Unit was created during the winter months to improve efficiency.
- The number of initial assessment bays has been increased, providing improved privacy and dignity for our patients.
- A range of winter alleviation work created additional facilities for the department to help them manage through the winter months.
- Demolition of the vacated fracture clinic space has begun to enable the new Emergency Care Unit and the Children's Emergency Department to be constructed
- Demolition has commenced on a number of redundant buildings behind the current department to allow for the new extension to be built.
- A process for monitoring the number of patient moves has been developed.
- Delayed discharge process improved.
- Greater understanding and confidence in data systems to monitor the planned target outcomes associated with this domain.
- Development and introduction of an e-learning module for 'Simple Discharge Planning' package.
- Significant improvements in immediate discharge letters in terms of timeliness and quality (this is the information provided to GPs when a patient is discharged).

To aspire to achieve the best clinical outcomes for all

Background

The care and management of people who have had a stroke is a national, regional and local priority. Stroke is the highest cause of adult disability in the UK. If identified and treated in line with best practice guidance, the survival of patients can be increased greatly and the risk of disability lowered.

The Trust has demonstrated improvements over the last year in meeting some of the national stroke targets and contract quality improvements. In 2011 the Trust was accredited as a Level 1 hyper acute stroke unit.

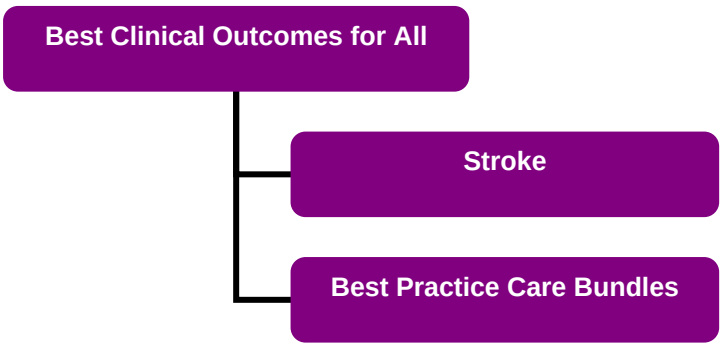
The Trust is committed to implementing systems that demonstrate continuous improvement for patients who have had a stroke and ongoing compliance with best practice guidance.

A number of 'best practice care bundles' have been developed to support clinicians in providing care that is evidence based and known to provide the best results. The bundles are also measurable in terms of the care provided and the clinical outcomes.

Over the last two years, the Trust has consistently achieved high levels of compliance (95-100% for all elements) with best practice care bundles in hip and knee surgery and in the treatment of Acute Myocardial Infarction. The systems to continuously monitor this compliance are in place and will continue. The Trust is keen to identify other best practice bundles for use within the Trust that could improve clinical outcomes for patients.

Goal

To be in the upper quartile (best performing trusts) for the National Sentinel Stroke Audit and to identify other areas where best practice care bundles could increase the quality and effectiveness of care.



Planned Target Outcomes

Table 9: Planned Target Outcome – Best Clinical Outcomes for All

Outcomes	Baseline	Planned Target Outcome	Year end Figure	Achieved
Stroke Care Bundle measures 12 (Overall compliance with NICE quality standards stroke indicators)	64.1%	80% or higher	90.9%	✓
To be in the upper quartile of the National Sentinel Stroke Audit / Stroke Improvement National Audit Programme	Lower Quartile	Upper Quartile	Upper Quartile	✓
Acute Cerebrovascular Disease (ACD): Reduction in HSMR of one point per year	97	96 or lower	88*	✓
Congestive Heart Failure (CHF): Reduction in HSMR of one point per year	106	105 or lower	108*	✗
Congestive Heart Failure (CHF): 10% reduction in Length of Stay	11.6	10.4 or lower	11	☑
Congestive Heart Failure (CHF): 10% reduction in Emergency Readmissions	0.15	0.14 or lower	0.14	✓
Acute Myocardial Infarction (AMI): Reduction in HSMR of one point per year	168	167 or lower	137*	✓
Acute Myocardial Infarction (AMI): 10% reduction in Length of Stay	6.2	5.5 or lower	5.8	✗
Acute Myocardial Infarction (AMI): 10% reduction in Emergency Readmissions	0.13	0.12 or lower	0.04	✓
Colorectal Surgery: Reduction in HSMR of one point per year	162	161 or lower	107*	✓
Colorectal Surgery: 10% reduction in Length of Stay	9.9	8.9 or lower	7.2	✓
Colorectal Surgery: 10% reduction in Emergency Readmissions	0.03	0.03 or lower	0.04	✓

*Note: (Estimated year-end position, validated March 12 data unavailable at time of publication)

Please see appendix two for more detailed information on the workstream updates by planned target outcomes.

Summary of Achievements

- Following submission of Stroke Improvement National Audit Programme Data, it has been confirmed that the results for the Trust are in the Upper Quartile.
- The Trust has seen weekly improvements in the Stroke Care Bundle, with Care Bundle one achieving nearly 100% every week.
- The Trust is compliant with all the standards for Myocardial Ischaemia National Audit Project (MINAP) Care Bundles.
- Trust was accredited as a Level 1 hyper acute stroke unit.

- Identification of further care bundles for ventilator associated pneumonia, central line insertion, sepsis, skin care and falls.
- Significant improvement in mortality rates in patients admitted with acute myocardial infarction.
- Reduction in emergency re-admissions for patients admitted with acute myocardial infarction.
- Significant reduction in mortality rates for patients undergoing colorectal surgery.

Effectiveness Quality Indicators

Hull and East Yorkshire Hospitals NHS Trust is following the proposed changes made by the National Quality Board to strengthen the Quality Accounts through the introduction of mandatory reporting against a small, core set of quality indicators. The core set of quality indicators are aligned closely with the NHS Outcomes Framework and are all based on data that Trusts already report on nationally.

The Trust Board has also monitored some of the core quality indicators throughout the 2011/12 period.

Emergency readmission to Hospital within 28 days of Discharge

Whilst some emergency readmissions following discharge from hospital are unavoidable consequence of the original treatment, others could potentially be avoided through ensuring the delivery of opitmal treatment according to each patient's needs, careful planning and support for self-care.

Table 10: Emergency Readmissions

Outcomes	Baseline	Planned Target Outcome	Year end Figure	Achieved
Emergency Readmission to Hospital within 28 days as % of all discharges	6.7%	6.5 % or lower	6.6*	✘

** Figure of Jan '12 year to date. The 2012/2013 year end position is not available until July 2012*

The national average for emergency Readmission to Hospital within 28 days as % of all discharges is 6.5%.

Domain 3 of the NHS Outcomes Framework for 2012/13 includes emergency readmissions within 30 days of discharge from hospital as an important measure of how far the NHS is helping people to recover from ill health or following injury. It is accepted that Trusts report on admissions within 28 days of discharge, which is the measure included in this set of Quality Accounts.

Performance Indicators

The table below details the Trust's performance against key indicators and national targets, comparing 2010/2011 with 2011/2012.

Table 11: Performance targets for 2010/2011 and 2011/2012

		2010/2011	Target		2011/2012	Target
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancers		94.2%	93%		94.8%	≥93%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers		96.7%	96%		98.5%	≥96%
Maximum waiting time of 31 days for subsequent treatments for cancer	Surgery	97.0%	94%		97.7%	≥94%
	Drugs	99.3%	98%		99.6%	≥98%
Cancer – Breast Symptomatic					95.8%	≥93%
Maximum waiting time of 62 days from referral to treatment for all cancers	All cancers	80.4%	85%		89.3%	≥85%
	Screening referral	80.0%	90%		90.1%	≥90%
18 weeks admitted pathways – 95th percentile					19 weeks	≤ 23 weeks
18 weeks non-admitted pathways – 95th percentile					15 weeks	≤ 18.3 weeks
18 weeks incomplete pathways – 95th percentile					18 weeks	≤ 28 weeks
A&E Operational Standard					98.1%	≥95%
A&E Patient Impact					1 out of 2	1 out of 2
A&E Timeliness					1 out of 3	1 out of 3
Methicillin-sensitive Staphylococcus Aureus (MSSA) Bacteraemia					43	≤110
Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteraemia		13	≤10		8	≤9
Clostridium Difficile		68	≤187		105	≤60
Cancelled Procedures (% of activity)					0.7%	≤0.8%
Stroke – 90% of time on a stroke ward (acute pathway)					81%	≥80%
Stroke – 90% of time on a stroke ward (combined pathway)					81%	≥80%
Transient Ischemic Attack (TIA) – high risk patients having a brain scan within 24 hours					93%	≥60%

	2010/2011	Target		2011/2012	Target
TIA – low/moderate patients having a brain scan within 7 days				100%	≥95%
Immediate Discharge Letters (Timeliness)				100%	≥98%
Immediate Discharge Letters (Quality)				96%	≥90%
Venous Thromboembolism				91%	≥90%
Appointment Slot Issues				0.2	≤0.1
Diagnostic 6 week breaches				0.14%	≤1.0%

Summary of Achievements

- All of the Cancer waiting time targets were achieved for the first time as an organisation.
- Referral to Treatment waiting times have been achieved consistently for admitted and non-admitted pathways for the percentage of patients treated in less than 18 weeks, median wait and 95th percentile waits.
- The Accident and Emergency operational standard was achieved and the previous national standard of 98% was maintained.
- The number of hospital acquired MRSA Bacteraemias were under the threshold set
- All of the stroke and TIA indicators were delivered.
- There has been an improvement in the number cancelled procedures on the day of admission for non-clinical reasons.
- Significant improvements in immediate discharge letters in terms of timeliness and quality (this is the information provided to GPs when a patient is discharged).
- There has been a reduction in the number of patients waiting over 6 weeks for a diagnostic test and a reduction in the number of avoidable breaches.

Summary of Under-Achievements

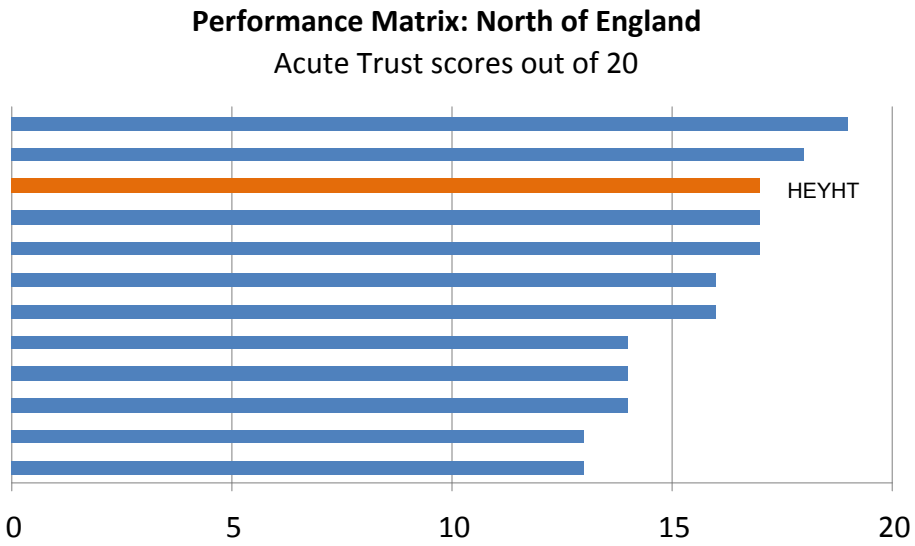
- At the end of March there were 105 acute-acquired Clostridium Difficile Infections (CDIs) year to date against a trajectory of 60 and this equates to a rate of 1.21 CDIs per 1,000 ordinary admissions year to date.
- The contract indicator for sufficient slots to be provided on the Choose and Book system was not achieved at 0.20 appointment slot issues per direct booking.

New Targets for 2012/13

- Referral to Treatment Incomplete pathways measure of ≤92%.
- Referral to Treatment delivery at specialty level against 90% admitted and 95% non-admitted indicators.

How do we compare?

Against a range of 21 performance indicators comparing Hull and East Yorkshire Hospitals NHS Trust to other Acute Hospitals in the North of England, the Trust has been awarded the 3rd highest score which reflects the Trust's record of strong performance in 2011/12.



A&E

- Four hour maximum wait in A&E

Healthcare Associated Infections

- MRSA performance year to date
- Clostridium Difficile performance year to date

2 week Cancer

- 2 weeks GP referral to 1st outpatient
- 2 weeks GP referral to 1st outpatient-breast symptoms

31 day Cancer

- 31 day second or subsequent treatment-surgery
- 31 day second or subsequent treatment-drug
- 31 day diagnosis to treatment for all cancers
- 31 day second or subsequent treatment-radiotherapy

Referral to Treatment

- Admitted 95th Percentile
- Non-admitted 95th Percentile
- Incomplete 95th Percentile
- Admitted 90% within 18 weeks
- Non-admitted 95% in 18 weeks
- Incomplete 92% in 18 weeks

62 day Cancer

- 62 day referral to treatment from consultant screening
- 62 day referral to treatment consultant upgrade
- 62 day urgent GP referral to treatment of all cancers

Diagnostics

- Patients waiting no longer than 6 weeks for a diagnostic test

Mixed Sex Accommodation

- Number of Mixed Sex Accommodation Breaches
- Rate of Mixed Sec Accommodation per 1000 FCE's

Review of performance: Experience

To improve communication through patient and staff engagement

Background

The Trust is committed to ensuring that every patient receives high quality care and treatment and as a result has the best possible experience of hospital services. To achieve this, the Trust needs to understand fully the aspects of care that matter to patients and affect their experience. This is why patient engagement and learning from the views of patients, carers and visitors is essential.

It is recognised widely that staff who work in a positive culture with opportunities to be developed and supported fully by their managers are more likely to deliver high quality health care. This is why the Trust's vision is 'Great Staff, Great Care, Great Future'. Staff engagement is key to shaping the future of services and delivering services to meet the expectations of patients.

Goal

To be described as one of the best performing Trusts (top 20%) in the Care Quality Commission's national inpatient survey and national staff survey.

Planned Target Outcomes

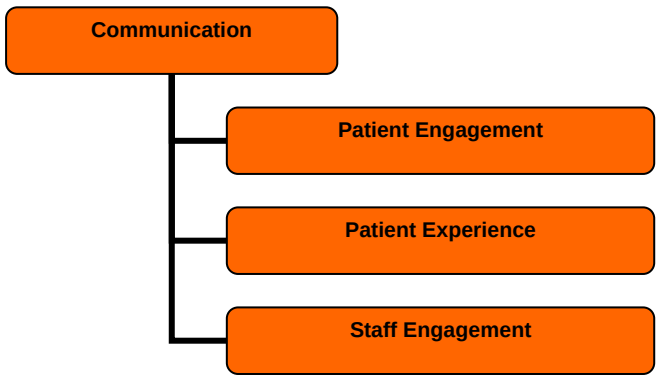


Table 12: Planned Target Outcomes – Communication

Outcomes	Baseline	Planned Target Outcome	Year end Figure	Achieved
Improved patient experience measured using overall care question from National Patient Survey	7.7	7.8 or higher	7.9	✓
Reduction in number of complaints	497	5% reduction	521*	✗
Reduction in complaints & PALS concerns regarding staff attitude	208	5% reduction	197	✓

Outcomes	Baseline	Planned Target Outcome	Year end Figure	Achieved
**Improved staff engagement measured by surveys (locally & nationally – Staff engagement section & Staff who would recommend the Trust – K34)	3.38 (Score between 1 – 5)	Above 3.38	3.35	✘
Improvements in the annual cultural survey results (Denison survey undertaken for the first time in 2011)	To Be Confirmed	Not applicable – will be measured in June 2012		

**The complaint increases have been matched in claims received by the Trust by the same complainants. This increased significantly in Quarter 4 with 30 claims received that were also in the complaints process.*

****Improved Staff Engagement – An Explanation**
The Trust is given a score between 1 and 5. 1 means that staff are unlikely to recommend the Trust to others and 5 means staff are likely to recommend the Trust to others.

Please see appendix three for more detailed information on the workstream updates by planned target outcomes.

Summary of Achievements

- The Patient Experience Forum has been established and a work-plan has been devised to focus efforts on key areas of development.
- The Meridian system has now been implemented. This is a tool that captures real time patient experience through surveys that can be completed online, through paper version and by using a tablet computer. A team of volunteers have been recruited to gather patient experience. This system was launched in November 2011.
- Customer service training has now been implemented and has been extremely popular with the course becoming over subscribed.
- In order to help the organisation understand its culture, in April 2011 the first Denison survey was carried out. Workshops were held in August 2011 to identify staff agents as well as focus groups in Health Groups and in the Corporate Directorates to gain further information. The Trust will re-survey in September 2012 to establish whether the culture of the organisation has changed

Denison Survey – An Explanation

This is a survey linked to organisational culture, leadership and performance. The aim of the survey is to help align an organisations culture to ensure that its goals and ambitions are achieved and reached. It helps build accountability into the organisation in order to help manage change, which is key to our success in such challenging and ever changing times.

- Leadership programmes have been introduced. The Advisory Board 3 Year programme commenced in October 2011. The aim of the programme is to "provide the opportunity for our leaders to gain the right knowledge, skills, values, attitudes and motivation". The senior Health Group Management Team has already completed a number of sessions, the Trust Board and Middle Management Teams are due to complete it throughout 2012. The Achieve Breakthrough programme has also been implemented.
- The Trust introduced a Golden Hearts scheme. Each year we aim to recognise significant achievements and the outstanding contributions being made towards improved care, and making our Trust a better organisation for patients, staff and visitors. Teams and individuals are nominated for awards by their colleagues in a number of categories including 'Outstanding Team of the Year', 'Outstanding Customer Focus' and Outstanding Partnership Working'. The awards are presented at an Oscar's style evening ceremony. The nominees have their work promoted

widely across the Trust to enable us to learn from best practice. The nominations have more than doubled from last year, with over 200 nominations for staff received.

- During the year the Trust made the decision to ask staff to be Foundation Trust members. The majority of Trusts automatically make staff members with the right to opt out where they wanted to. This was a bold decision for the Trust as 93% of all other Trusts use the opt out method. The Trust wanted our staff to be more engaged in the process and a number of member events and promotions have already taken place. By the end of March 2012, over 3,000 members of staff had signed up to become a member.
- In April 2011 all staff was asked to submit "I Will" statements to engage staff on which behaviours matter to us as an organisation. Staff then voted on their top five, which have now become our Trust's behaviours
    - I Will look to continually improve the way my service is delivered
    - I Will look for ways we can, rather than reasons we can't
    - I Will listen to and value the opinions of others and treat everyone as I wish to be treated myself
    - I Will always look for things to inspire me and remember to say 'well done' and 'thank you'
    - I Will make a difference to patient care, quality and safety every day

Experience Quality Indicators

Hull and East Yorkshire Hospitals NHS Trust is following the proposed changes made by the National Quality Board to strengthen the Quality Accounts through the introduction of mandatory reporting against a small, core set of quality indicators. The core set of quality indicators are aligned closely with the NHS Outcomes Framework and are all based on data that Trusts already report on nationally.

The Trust Board has also monitored some of the core quality indicators throughout the 2011/12 period.

Patient Reported Outcome Measures (PROMs)

PROMs measure a patient's health status or health-related quality of life from the patient's perspective, typically based on information gathered from a questionnaire that patients complete before and after surgery.

"An excellent surgeon who explained my procedure before the operation and who followed up with timely and informative discussions."

Table 13: PROMs scores April to June 2011

Procedure	Trust PROMs Score	England Average	Achieved
Hip replacement surgery	79.3%	72.5%	✓
Knee replacement surgery	85.4%	78.9%	✓
Groin Hernia surgery	74.7%	72.5%	✓
Varicose Veins surgery	67.3%	62.3%	✓

The NHS Outcomes Framework for 2012/13 includes PROMs scores as an important means of capturing the extent of patients improvement in health following ill health or injury.

Staff Views on Standards of Care

How members of staff rate the care that their employer organisation provides can be a meaningful indication of the quality of care and a helpful measure of improvement over time.

In the 2011 national NHS Staff Survey 54% of staff who responded, agreed or strongly agreed that if a friend or relative needed treatment, they would be happy with the standard of care provided by the Trust. This has increased slightly from 52% in the 2010 national NHS Staff Survey.

The national average for acute Trusts is 62% of staff agreed or strongly agreed that if a friend or relative needed treatment, they would be happy with the standard of care provided by the Trust.

Responsiveness to Inpatient's Needs

Patient experience is a key measure of the quality of care. The NHS should continually strive to be more responsive to the needs of those using its services, including needs for privacy, information and involvement in decisions. The NHS Outcomes Framework for 2012/13 includes an organisation's responsiveness to patients needs as a key indication of the quality of patient experience.

The annual national NHS Inpatient Survey undertaken by the Care Quality Commission is published on the Care Quality Commission's website.

In previous Quality Accounts the Trust has reported its results as a comparison of each year since 2004. This year the CQC has changed the way the data is reported. In previous years the Trust has been given the number of questions where we were in the 20% worst performing Trusts, where we were in the 20% best performing Trusts and where we were in the middle. This year the CQC provided us with information on where we have performed worse or better than expected, as well as where we have performed as they would have expected us to. This year the Trust performed better than expected on two questions. The first was on receiving written information on discharge and the second was patients being told who to contact on discharge if they were worried about anything. The Trust performed worse than expected in two areas. The first was being given enough privacy and dignity in A&E and the second was that patients had some where to put their personal belongings.

The CQC rate the Trust against all other Trusts. The score received is based on answers to five questions in the CQC inpatient survey:

- Q41 - Were you involved as much as you wanted to be in decisions about your care and treatment?
- Q44 - Did you find someone on the hospital staff to talk about your worries and fears?
- Q45 - Were you given enough privacy when discussing your condition or treatment?
- Q64 - Did a member of staff tell you about medication side effects to watch for when you went home?
- Q69 - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

"Good communication from doctors & nurses, always pleasant and helpful and efficient. I had total confidence in them."

Table 14: Comparison of Results 2009-2011 (inclusive)

Year	National Average	Overall	Q41	Q44	Q45	Q64	Q69
2009	66.7	63.2	64.9	53.9	75.8	37.7	83.7
2010	67.3	67.2	67.8	55.3	79.8	46.1	87.3
2011	67.4	69.2	70.3	58.8	81.0	46.9	89.3

The 2011 regional average for the above score based on the CQC national inpatient survey, for their responsiveness to patient's needs is 67.6.

Summary

Hull and East Yorkshire Hospitals NHS Trust recognises that, whilst most patients get safe, effective and high quality care, there are still many issues for it to address to ensure that all patients and service users receive the same high standard of safety, treatment and care. The Trust will progress the work described in section two to improve the safety and quality of its services further. To support this, the Trust will continue to implement the Quality and Safety Strategy (2011-2016) which sets the strategic direction for the Trust's Quality and Safety priorities going forward.

Engagement of key stakeholders

As outlined in previous Quality Accounts the Trust aimed to carry out a wider range of consultation exercises to help inform the Quality Accounts 2011/12 than had taken place for the previous years Accounts.

Stakeholder Events
Two stakeholder events were held in December 2011 and in February 2012. Stakeholders were invited to attend from a wide sphere of the community and included representatives from Local Involvement Networks, Overview and Scrutiny Committees, GPs, Trust members and Trust staff. All stakeholders were represented at both events.

The stakeholder events provided the Trust with a valuable opportunity to engage with key members of the community. Engagement with these organisations and individuals is vital to the success of the Quality Accounts. These events gave the Trust the opportunity to demonstrate the improvements the Trust has made as well as ensuring the Trust's priorities are shaped by our community. At the events, stakeholders took part in an interactive voting session as well as two workshops to help shape not only the priorities of this year's Quality Accounts but also the style of the document.

Feedback included:
- Approximately three quarters of attendees understood the priorities for Safety, Effectiveness and Experience
- 94% felt that the glossary of terms was useful
- 91% felt that the Quality Achievements document was useful
- 96% felt there was a good mix of visual and text information.
- 89% wanted an organisational chart included in the document so they would know who the key individuals are

In response to this feedback, the Trust has:
- Expanded the glossary of terms
- Will continue to produced a summary version of the Accounts entitled 'Quality Achievements'
- Insert text boxes with explanations of terms used
- Continue to use a mix of visual and text information to ensure that the information that is provided is easier to understand
- Organisation chart included in the introduction

Suggestions for additional work-streams were put forward as part of these events. They included outpatients, customer service and patient transport. It has been agreed that the Patient Experience Forum will focus on these areas as part of their work-plan and report on these under the work-stream 'Patient Experience'.

Staff and Public members
This year the Trust asked all Foundation Trust members, including staff, patient and public members to provide the Trust with their views on the Quality Accounts. A number of members responded to the consultation as well as attending the two stakeholder events where they could discuss their views in more detail.

Overview and Scrutiny Committees & Local Involvement Networks
In addition, the Trust has attended meetings at local Overview and Scrutiny Committees to present the draft Quality Account priorities and gain their views. The Trust plans on liaising with the local involvement networks to finalise the Quality Achievements document in a similar way to last year.

Statements from key stakeholders

The first draft of the Trust's Quality Accounts was discussed by the Hull and East Yorkshire Hospitals Trust Board on the 10th April 2012 and approved at Quality, Safety and Effectiveness Committee on 25th April 2012 on behalf of the Trust Board. This was the first opportunity to approve a draft for the financial year of 2011/12. The accounts were then forwarded to the key stakeholders on the 30th April 2012 with a request for statements of no more than 500 words to be received before the 31st May 2012. The key stakeholders are as follows:

- NHS Hull (lead commissioner)
- NHS East Riding of Yorkshire (commissioner)
- Hull Local Involvement Network
- East Riding of Yorkshire Local Involvement Network
- Hull City Council Overview and Scrutiny Committee
- East Riding of Yorkshire Overview and Scrutiny Committee

As per 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 to it 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 Involvement Networks and the Overview and Scrutiny Committees were asked to consider:

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

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

NHS Hull

NHS Hull welcomes the opportunity to provide commentary on the Hull and East Yorkshire Hospitals Trust annual Quality Accounts

NHS Hull welcomes the continued commitment to patient safety which is demonstrable within the Quality Account through the setting of challenging targets. NHS Hull has collaboratively worked with and supported the Trust in 2011/2012 on the priorities identified in the Quality Accounts, specifically understanding and reducing mortality and the joint health community approach to reducing Clostridium Difficile infections. NHS Hull is encouraged by the in year reduction in mortality and encourages this continued reduction in 2012/13. There is significant challenge for the Trust and health community in

reducing Clostridium Difficile for 2012/13 and looks forward to working together. NHS Hull would like to praise the Trust on its achievement of zero avoidable grade 3 or 4 pressure ulcers. This is a commendable achievement.

NHS Hull was impressed with the clear commitment to research as a driver for improving the quality of care and patient experience.

The results from the National Inpatient Survey show some improvement, however the increased number of patient complaints indicate that the Trust has more work to do in relation to improving the patient experience in some areas. NHS Hull would particularly like to see a focus on activities which will result in more staff recommending the trust which should, in turn, impact positively on an improved patient experience.

NHS Hull looks forward to the continued concerted working to improve quality patient outcomes and subsequently improve the patient experience. NHS Hull can conclude that the information presented in the Quality Accounts is accurate and fairly presented.

NHS East Riding of Yorkshire

NHS East Riding of Yorkshire (NHSERY) welcomes the opportunity to comment on the annual Quality Account for Hull & East Yorkshire Hospitals NHS Trust which we feel is well presented in a public facing format. NHSERY has worked with and supported the Trust throughout 2011-12 on the priorities identified in the accounts, specifically in relation to improving patient flow and discharge, reducing clostridium difficile infections and reducing hospital mortality.

We note that the Trust held two stakeholder events to facilitate and encourage services users, commissioners and other stakeholders to identify and agree the areas for improvement in 2012-13. We welcome this approach as we feel it confirms the Trust's commitment to work in partnership with key stakeholders to improve the patient experience, safety and effectiveness of services.

NHSERY are pleased that ensuring patient safety remains a top priority for the Trust. Specific quality improvements of note are that the Trust has a high incidence of reporting and a low incidence of reported patient harm. When a serious incident does occur, the quality of the investigation report is excellent and evidence suggests that the learning is shared with actions being tracked centrally to ensure they are implemented. Also of particular note is the reported zero incidence of grade III and grade IV pressure ulcers since the introduction of the Skin Care Bundle which is a commendable achievement.

The results from the National Patient Survey and the increased number of patient complaints indicate that the Trust has more work to do in relation to improving the patient experience in some areas. We are disappointed to see an increase in patient complaints and that 54% of staff would recommend the Trust to relatives /friends against a national average of 62%. We would particularly like to see a focus on activities which result in more staff recommending the trust which should in turn impact positively on an improved patient experience.

We particularly support the planned target outcomes of reducing inpatient transfers which if achieved should have a positive impact on patient safety and experience and improved patient outcomes.

It is noted that the Trust did not meet the trajectory with regard to the number of patients who are on the End of Life pathway. It is encouraging to see that the Trust has put emphasis on this for 2012/13 and intends to roll out a training programme in care of the dying to support staff and improve patient care.

C Difficile is reported as 'not met' in terms of the reduction target. Given its high profile as a quality target we would have liked to see some indication of the steps being taken by the Trust to ensure the target (which is more challenging for 2012/13) is achieved.

The Trust has made good progress with all of the CQUIN indicators during 2011-12 in particular in relation to recognising the deteriorating patient, improving patient flow through AAU, undertaking VTE assessment and reducing the HSMR. NHSERY supports the Trust priority of improving discharge with planned improvement outcomes. It was however disappointing that our suggestions for inclusion in the 2012/13 CQUIN scheme in relation to improving discharge were declined by the Trust in terms of being part of the quality incentive scheme. It is however noted that the Trust has plans to develop and introduce an e-learning module for 'Simple Discharge Planning'. We look forward to seeing the reported improvement outcomes from this initiative.

NHSERY endorses the proposed quality programme and looks forward to continued working with the Trust to meet our joint aim of ensuring services that are provided to our residents are of high quality in that they are safe, effective and provide a positive experience for patients.

We feel that to the best of our knowledge the Quality Account represents a comprehensive and balanced description of the quality of services provided by HEYHT during 2011-12.

Hull Local Involvement Network (LINk)

People involved in Hull LINk have welcomed the opportunity to be pro-actively involved in the development of the Quality Accounts, for example by participating in the stakeholder events. The priority themes for improvement (safety, effectiveness, experience) are all appropriate areas for development and have all been raised by people involved in the LINk as worthy of consideration.

In the effectiveness domain, issues including re-admissions, transfers and delayed discharge have previously been examined by the LINk in our Hospital Discharge report and we will be reviewing this in the coming year.

The document is quite lengthy and includes a lot of material so we support the decision to publish a summary version again this year. One of the challenges of the Quality Accounts process is to communicate the findings to patients and the public in an effective way and we would welcome opportunities to support this.

We are encouraged to see recognition of the value of patient and staff experience as a means of continuing to develop safe, effective and high quality services and look forward to developing further opportunities for pro-active patient and public engagement in the future.

East Riding Local Involvement Network (LINk)

ERYLINk welcomed the opportunity to be involved with the stakeholder event consultation workshops, providing an opportunity to influence priorities and also understand the progress that had been made to date. It was also an opportunity to meet staff, ask questions and see first hand some of the innovative schemes being implemented.

From the information received by ERYLINk from the local community and the project work undertaken, it would agree that the areas that have been prioritised for the Quality Accounts are appropriate. We also note that those areas that were raised during

stakeholder discussions have not been lost but have been included in the work plan for the Patient Experience Forum.

The organisational diagram is a useful response to previous comments and the introduction of 'HealthGroups' as opposed to the previous 'Business Units' is welcomed.

The Quality Accounts could have been an opportunity to identify and emphasise the role of other agencies in achieving planned target outcomes for example Adult Social Care Services supporting appropriate discharge and the move to 'transfer of care'.

The Chief Executive's 'I will' statements are positive and encouraging but also reflect an honesty regarding work still to do. Targeting particular areas where improvement continues to be slow, for example C Difficile and re-admission rates and identifying specific posts that are responsible for implementation, including Non Executive Directors shows the involvement at all levels of the organisation.

The summary of National Audits which also itemises the proposed actions for each and the summary of CQC activity and responses, shows an increased transparency and clear approach to improving practices.

The increased commitment to research elevates the reputation of the Trust and should be promoted locally.

The CQUIN summary is easy to follow helped by the simple key and identifies those areas that have been brought forward for further attention as part of the Quality Account.

Document structure – although this is in part determined by the Department of Health it would have been more beneficial to the reader if the achievements could directly follow the target outcomes for the previous year.

The blue explanation boxes are an extremely useful way of providing technical detail in a simplified manner.

The Trust must be congratulated on the many achievements identified in the target outcomes. It is unfortunate that several critical areas continue to raise concern and have not reached their target but we are pleased to see that these areas continue to have a focus from the Trust and have clearly identified actions which include all levels of the organisation (everyone's responsibility).

The Quality Account's would appear to be a much more open, self critical and improvement focused document balanced with achievements and a positive raised profile, this should be commended.

Hull City Council Health and Well-being Overview and Scrutiny Committee

Hull City Council's Health and Social Well-Being Overview and Scrutiny Commission welcomed the opportunity to feed into the quality accounts process and received briefings to the October 2011 and February 2012 meetings. The briefings also included updates on the Quality Matters programme, which enabled the Commission to review service performance in conjunction with the development of the 2011/12 Quality Accounts. In supporting the consultation process, and 2011/12 Quality Accounts, the Commission has also sought to review the type of performance data submitted to the Commission, in order to support the scrutiny and quality accounts process in future years.

The East Riding of Yorkshire Council NHS Overview and Scrutiny Committee

The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee at East Riding of Yorkshire Council thanks the Trust for this opportunity to respond to its Quality Accounts 2011/2012.

Of particular note is the amount of detailed information that the Trust has provided in the accounts, which the Sub-Committee found useful. The explanations in blue boxes were useful as was the glossary of terms at the end of the accounts, but this could have been extended to cover additional technical terms.

The Sub-Committee notes with concern that mortality figures remain high, with the Trust regrettably having been scored in the highest band for the Summary Hospital-Level Mortality Indicator (SHMI). However, the work of the Trust to put suitable action plans into place to address this is commended by the Sub-Committee and the Sub-Committee also acknowledges that this is a problem experienced by all of the local trusts and requires the joined up efforts of both community health services and the acute trusts to rectify.

The accounts state that no improvement has been demonstrated by the Trust in the numbers of patients readmitted within 28 days and the Trust is yet to meet the performance of peer trusts. The Sub-Committee hopes that improvements are made in this outcome in the coming year.

The section on clinical audits provided an interesting list of actions that the Trust intends to take to improve the quality of healthcare it provides and the Sub-Committee noted with particular interest the proposed actions around stroke and care of the dying in hospital following review panels on these topics carried out by the Council.

The Sub-Committee strongly supports the capital build work being undertaken to improve Hull Royal Infirmary's Accident and Emergency (A&E) Department, together with the establishment of a separate children's and young people's department in the A&E.

The Trust has amply engaged with key stakeholders in the production of these quality accounts as well as staff and public members of the Trust. However, the Sub-Committee is unsure to what extent the Trust has engaged with the general public.

Over the coming year, the Sub-Committee would like to forge closer working relationships with the Trust and looks forward to the Trust's presence at its meetings in order to participate in matters important to the residents of the East Riding.

The Trust's Response to the Statements

The Trust is 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. The stakeholder consultation events have been successful in facilitating these discussions, sharing plans and shaping these priorities together. This is also evident in the way that our CQUIN indicators are developed with commissioners and help us to achieve the quality improvement priorities detailed in this document and our Quality & Safety Strategy. We look forward to this continued partnership working and further developing the relationships we have.

In addition to the published statements, our stakeholders have provided additional comments/suggestions to improve the Quality Accounts. The Trust has made the following amendments since the first draft:

- All data for the full financial year has now been included
- An explanation has been provided for all clinical audits with less than an 80% recruitment rate.
- Additional information has been included about local clinical audits conducted throughout 2011/2012.
- The current Stroke compliance with best practice has been included alongside the planned target outcome.
- An overview of the actions being taken to reduce Clostridium Difficile has been included.

Statement of directors' responsibilities in respect of the Quality Account

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).

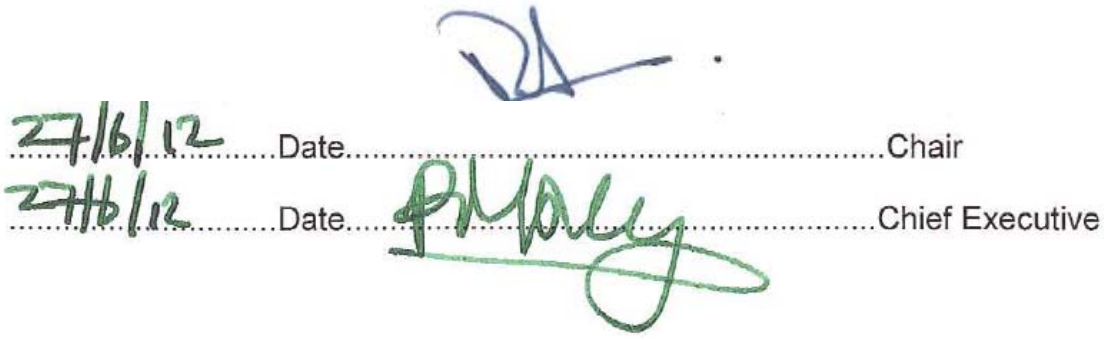
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- 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



Independent auditor's limited assurance report to the Directors of Hull and East Yorkshire Hospitals NHS Trust on the Quality Accounts

I am 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 2012 ("the Quality Account") as part of my 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 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

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

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.
I read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for our report if I become aware of any inconsistencies.

Audit Commission External assurance on NHS trust Quality Accounts 28
This report 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.

Assurance work performed
I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. Our limited assurance procedures included:

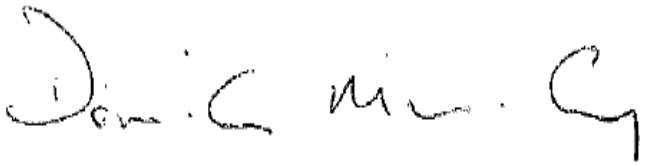
- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

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
The scope of our assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived. 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. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion
Based on the results of our procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.



Damian Murray
Engagement Lead
27 June 2012

How to provide feedback on the account

Hull and East Yorkshire Hospitals NHS Trust hopes that you have found this Quality Account interesting and informative. If you have any comments on the Accounts or areas you think should be considered for future quality priorities, please send these to the following email address:

Quality.Accounts@hey.nhs.uk

Trust membership

Developing a representative membership is very important to the organisation. The Trust's members will help to develop its future plans. Please sign up as a member and become part of the future of the Trust.

If you sign up to become a member the main benefits are:

- Showing your support for your local hospitals
- Keeping in touch with what is happening at your local hospitals by receiving a regular newsletter
- Giving you the chance to give your views and influence decisions
- Giving you a vote on who you would like to represent you on the Council of Governors or for you to stand as a Governor

Membership is free and members can be involved by receiving the member's newsletter. Some members may want to be more involved by taking part in consultation exercises or attending events. In addition, some members will become Governors and represent members at the highest level of the organisation. Membership can take up as little or as much time as you wish. It is a way for you to be more informed, give your views and for the Trust to become much closer to the community it serves.

If you would like further information on membership or our foundation trust application please contact Liz Thomas, Trust Secretary on (01482) 675165 or email foundation.trust@hey.nhs.uk.

Glossary of Terms:

A&E	Accident and Emergency Department
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 Bundles	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 eg 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-discipline team (i.e. a team made up of individuals responsible for different aspects of a patient's care).
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 Governance	This is an approach to maintaining and improving the quality of patient care
COPD	Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used, but are now included within the COPD diagnosis. COPD is not simply a "smoker's cough" but an under-diagnosed, life-threatening lung disease.
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
Deteriorating Patient	A patient whose observations indicate that their condition is getting worse
e-Learning Package	Training programme that individuals or groups can complete online.
HEYHT	Hull and East Yorkshire Hospitals NHS Trust
Hospital Episode Statistics	Is a data warehouse containing details of all admissions into NHS hospitals in England.

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
Medication Errors	An incorrect or wrongful administration of a medication, such as a mistake in the dosage of medication
National Patient Safety Agency Alerts	Through analysis of reports of patient safety incidents, and safety information from other sources, the National Reporting and Learning Service (NRLS) develops advice for the NHS that can help to ensure the safety of patients. Advice is issued to the NHS as and when issues arise, via the Central Alerting System in England and directly to NHS organisations in Wales. Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices.
NEYNL CLRN	Northern Lincolnshire Comprehensive Local Research Network – this organisation provides support for research trials
Never Event	A Never Event is a type of SUI. 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*'.
NIHR	National Institute for Health Research – this organisation commissions and funds research in the NHS and in social care
NHS	National Health Service
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.
NPSA	National Patient Safety Agency – this is an arms length body of the Department of Health that leads on improving patient safety and care
PALS	Patient Advice and Liaison service
Patient Safety Pledge	The Pledge made by the Trust to reduce all avoidable deaths and avoidable harm
PCT	Primary Care Trust – there are two main local Primary Care Trusts that the organisation works with: NHS Hull and NHS East Riding. These are the organisations that commission services from the Trust
PDSA	Plan, Do, Study, Act Cycles – An approach to managing change
PGMI	Hull University Postgraduate Medical Institute

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
SBAR	Situation Background Assessment Recommendation – a communication technique
Secondary Users Service	The Secondary Users Service Programme supports the NHS and its partners by providing a single source of comprehensive data on planning, commissioning, management, research, audit, public health and payment by results
Sepsis	Is a medical condition that is characterised by a whole body inflammatory state and the presence of a known infection.
SHMI	SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.
Serious Untoward Incident (SUI)	A SUI 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.
TIA	Transient Ischemic Attack – an interruption of the blood supply to the part of the brain that causes a temporary impairment of vision, speech or movement
Trust Board	The Trust's Board of Directors, made up of Executive and Non Executive Directors
VTE	Venous Thromboembolism

Index

Appendix One – Safety Domain

The following key applies to all figures included in Appendix One:

✘	Improvement not demonstrated
☑	Goal not achieved but improvements made
✓	Goal achieved

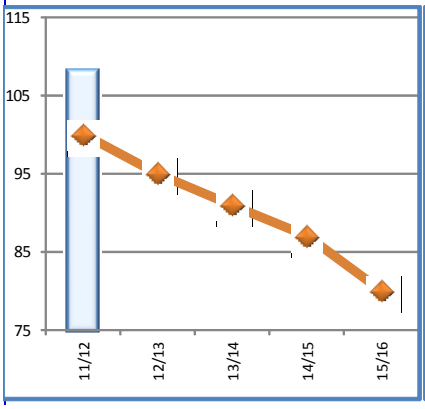
Work-stream updates

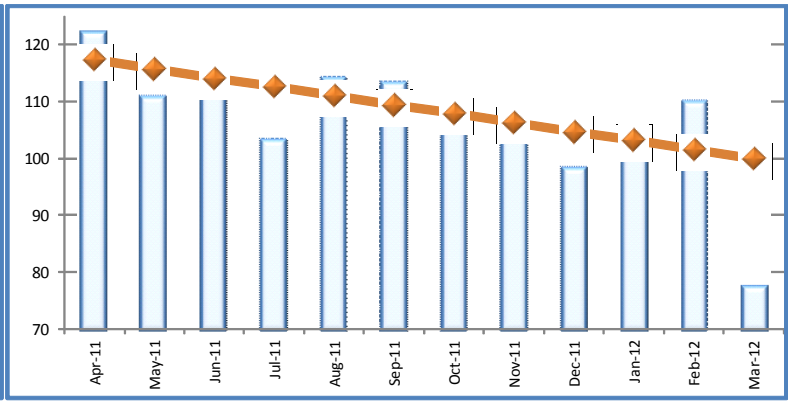
Below are the detailed graphs for the 4 key work-streams relating to the safety priority for improvement - to reduce all avoidable deaths.

Mortality Review / Failure to Rescue

Figure 1.1: Reduction in mortality against an agreed trajectory with the aim of a maintained HSMR of 80 by 2016.

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
118.9	100.0	121.0	114.0	103.0	97.083	95.0	80	☑



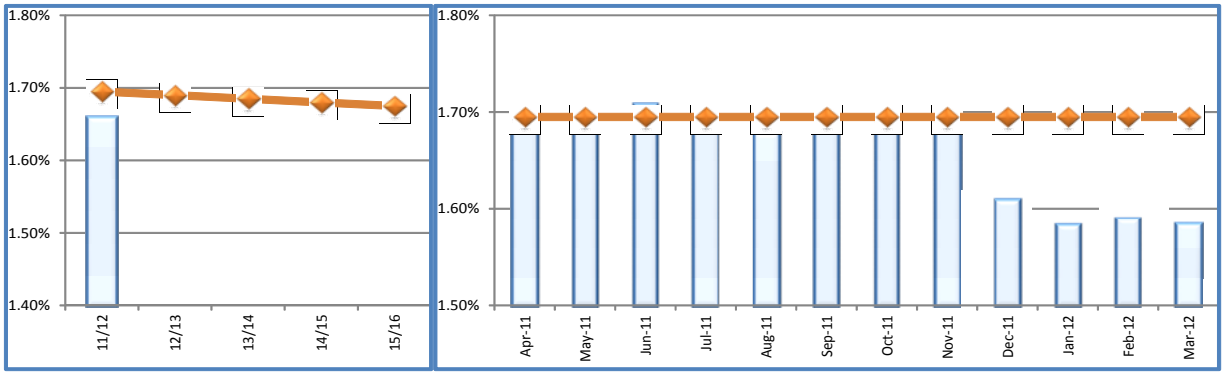


The position measure and shown is the Trust's monthly HSMR which is rebased on a monthly basis (datasource = HED).

There has been a month on month reduction since August 2011. The March 2012 figure is 108 *Note (Estimated year-end position, validated March 12 data unavailable at time of publication).

Figure 1.2: Reduction in crude mortality rates

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
1.7%	1.70%	1.70%	1.69%	1.67%	1.59%	1.69%	1.675%	✓

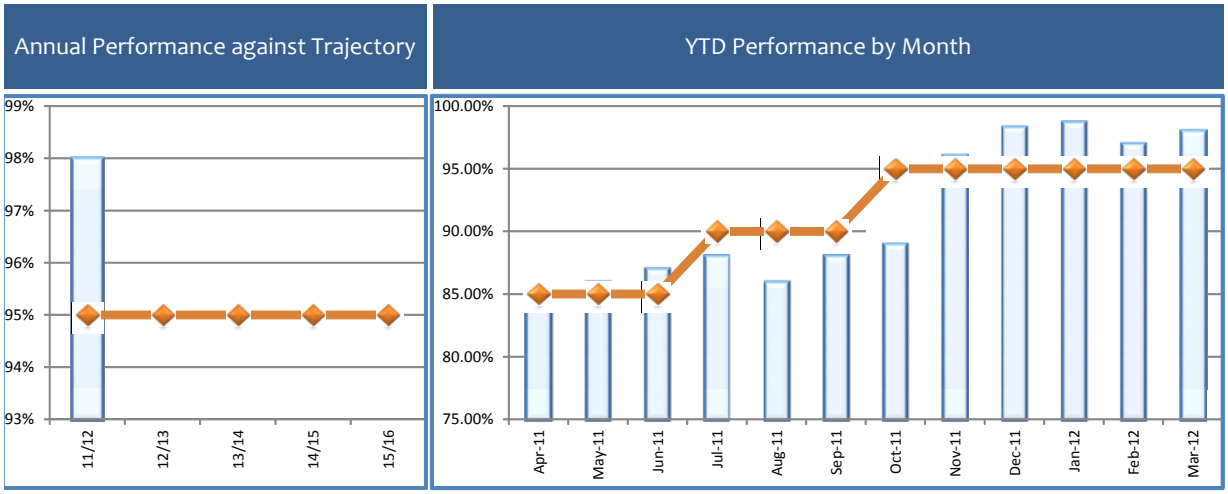


The position measured and shown is the Trust's Moving Annual Total crude mortality; this is the position when measured across the previous 12 months. Annual trajectory shows gradual downwards trend per year.

Deteriorating Patient

Figure 1.3: Compliance with vital sign observations, achieve 95% compliance and sustain by the end of 2011.

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
April '11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'12	Mar '16	
84.0%	95.0%	87.0%	88.0%	98.3%	98%	95%	95%	✓



The trajectories shown for 12/13-15/16 are for the maintenance of 95% compliance.

Figure 1.4: Implementation of the fluid balance chart monitoring with overall aim of 95% compliance by the end of 2013.

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
April '11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
56.8%	85%	61.8%	69.1%	85.1%	84.3%	90%	95%	☑

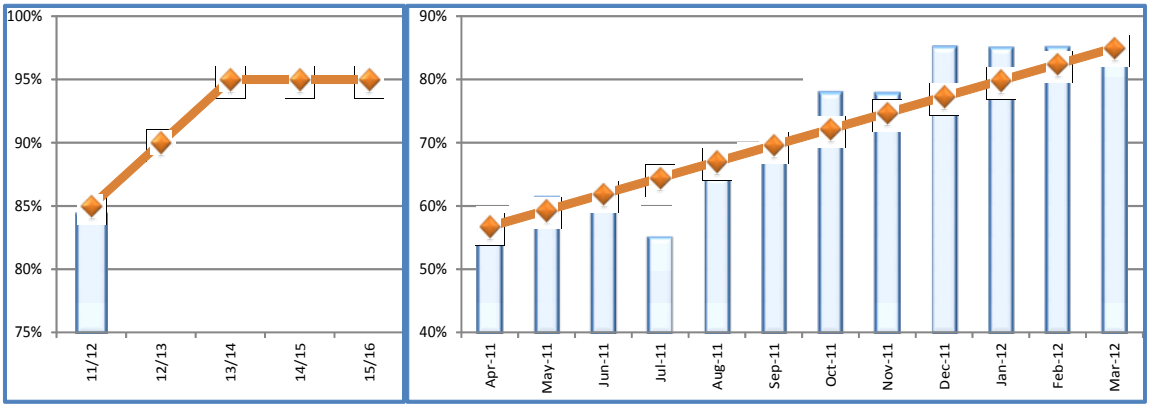
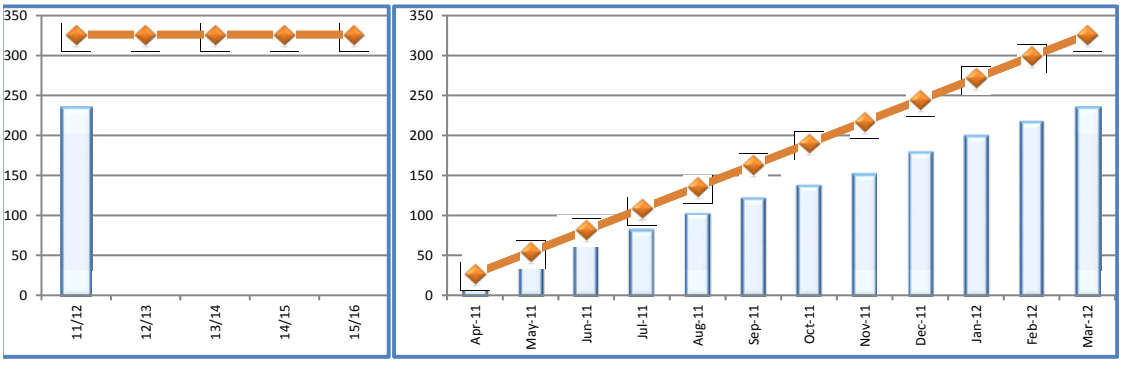


Figure 1.5: To achieve a 50% reduction in cardiac arrest calls

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
653	326	68	52	59	55	326	326	✓



The 11/12 trajectory is a 50% reduction from the 2010/11 baseline of 653; trajectories shown for 12/13-15/16 are to maintain this.

The quarterly totals detailed above show the actual number of calls received in each quarter whereas the graph shows the cumulative number of calls over the year by month. As at the end of March 2012 there had been 234 calls which are significantly below trajectory, equating to good performance.

Infection, Prevention and Control

Figure 1.6: Incidence of Methicillin-resistant Staphylococcus Aureus (MRSA) Hospital Acquired

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
Apr '11	2011/12	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
1	9	2	2	2	2	Target not set	Target not set	✓

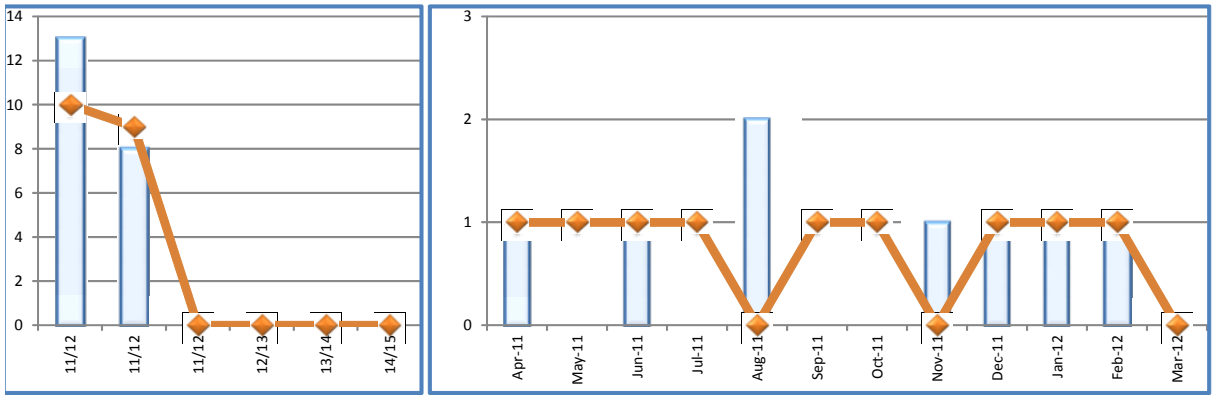
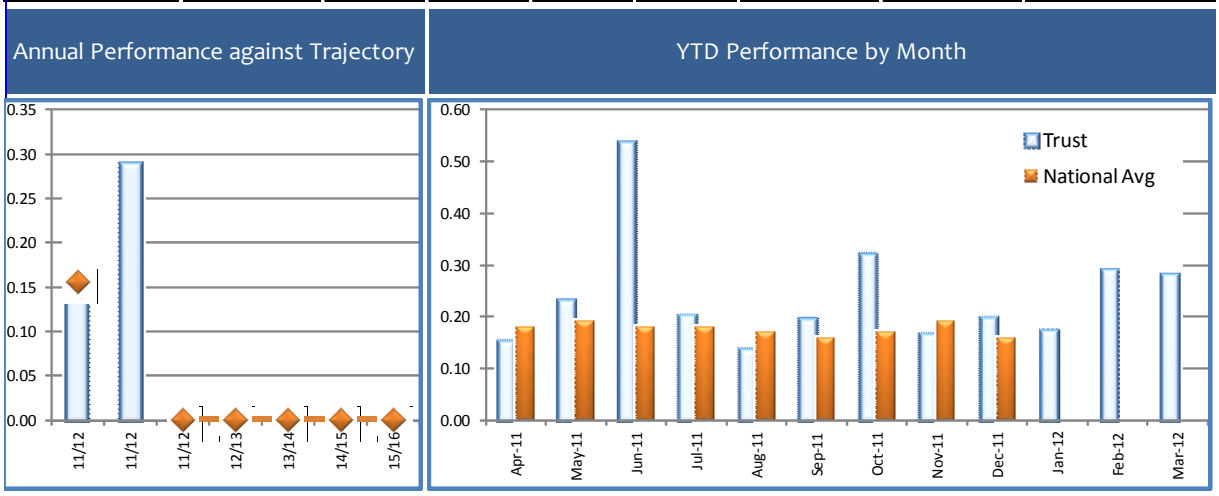


Figure 1.7: Rate of Clostridium Difficile (C.Diff) per 1000 bed days (Hospital Acquired)

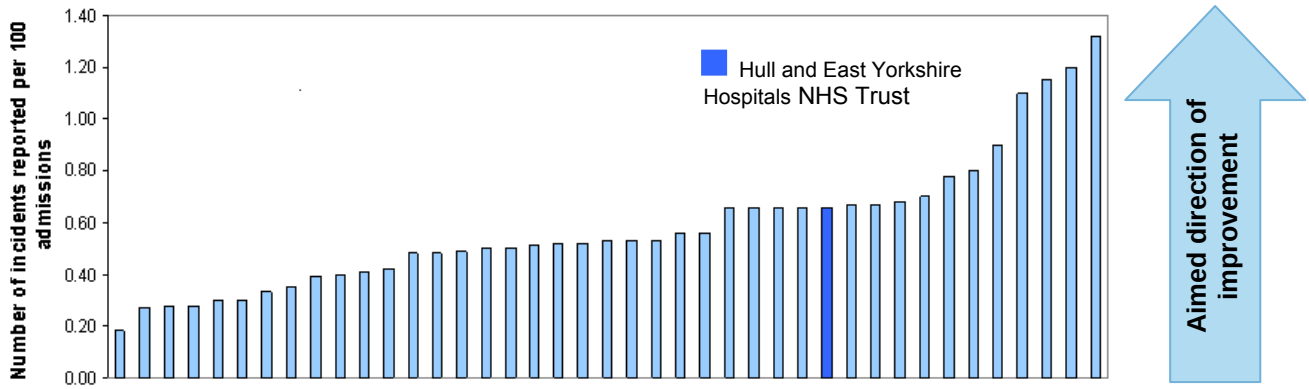
What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
Apr '11	2011/12	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
0.155	0.198	0.533	0.196	0.198	0.245	0.00	0.00	✗



Below are the detailed graphs and tables relating to the 4 key work-streams relating to the safety priority for improvement - to reduce all avoidable harm by 50% by 2016.

Medication Errors

Figure 1.8: Medication Incident rate per 100 admissions for the period 01st April 2011 to 30th September 2011



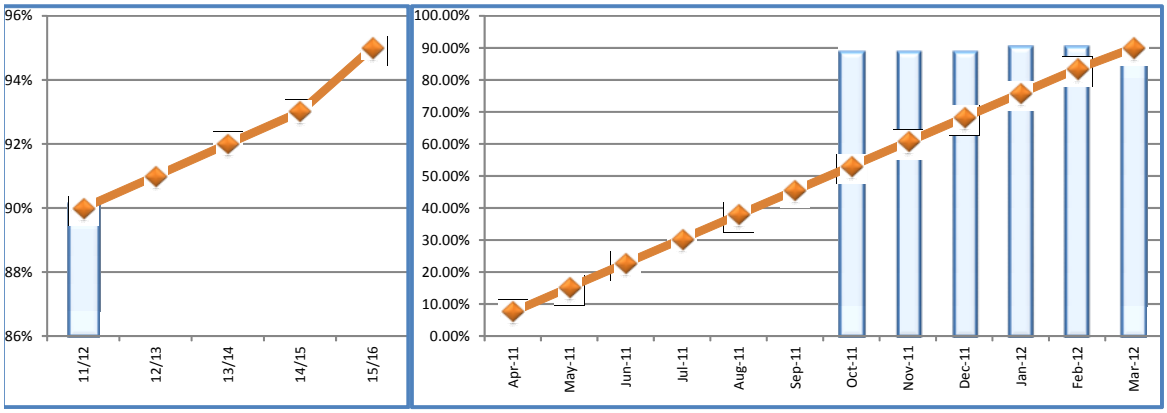
Source: Patient Safety incident reports successfully submitted to theNational Reporting and Learning Service organisation (NRLS).

Hull and East Yorkshire Hospitals NHS Trust reporting rate is 0.66 per 100 admissions which is an increase from 0.61 per 100 admissions in 2010.

Pressure Ulcer Prevention

Figure 1.9: Compliance of best practice SSKIN Care Bundle: to avoid all grade 3 and 4 pressure ulcers

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
Q3 11/12	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
88.5%	implementation	-	-	88.5%	90.1%	91%	95%	✓



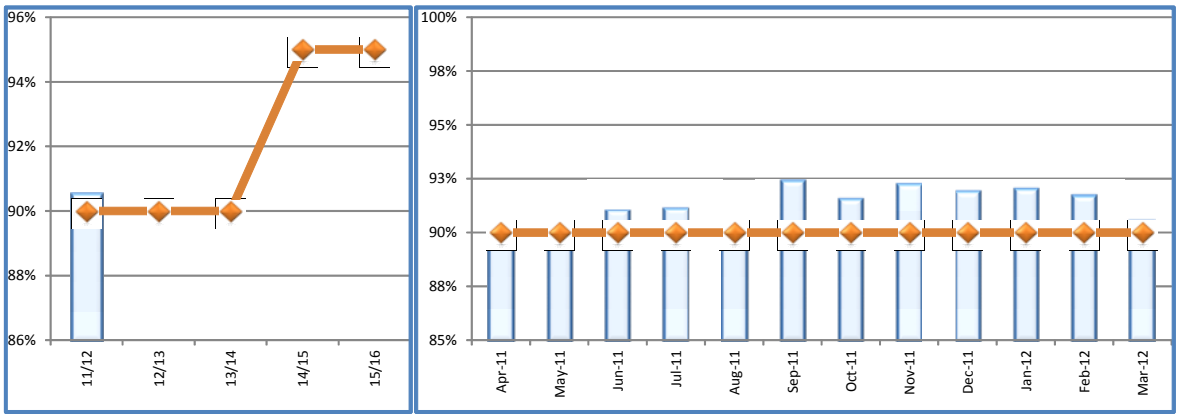
Data collection commenced Q3 11/12, annual trajectory set to show progress required to ensure 95% compliance by March 2016.

Implementation target was 70 for 12/13, the Trust will surpass this target and will therefore aim to maintain 90% compliance, rising to 95% for 13/14.

Venous Thromboembolism (VTE)

Figure 1.10: Undertake VTE risk assessments on at least 95% of patients by 2014/15

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
82.5%	90.0%	91.0%	92.4%	91.9%	90.5%	90%	95%	✓



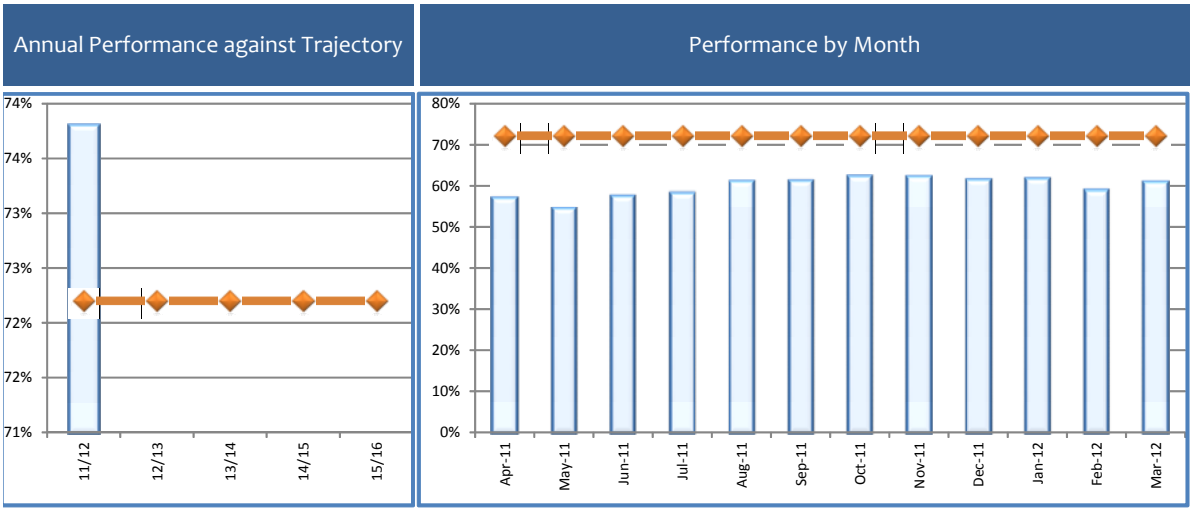
Patient Safety Incident Reporting

Figure 1.11: Remain in the upper quartile for patient safety incident reporting, with a reported rate of at least 7 incidents per 100 admissions

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
7.42	>7	8.6	9.1	8.5	8.6	>7	>7	✓

Figure 1.12: Maintain a higher proportion of no harm risks compared to peer (at least +1%)

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
April '11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
7.42	61.4%	56.4%	60.1%	61.9%	60.4%	>1% above peer	>1% above peer	✓



Monthly data shown is unvalidated Trust data and the 11/12 position shown for the Trust and trajectory (peer) is validated national data from the National Patient Safety Agency.

NRLS data is 2.6% higher than the peer average.

Appendix Two – Effectiveness Domain

The following key applies to all figures included in Appendix Two:

✘	Improvement not demonstrated
☑	Goal not achieved but improvements made
✓	Goal achieved

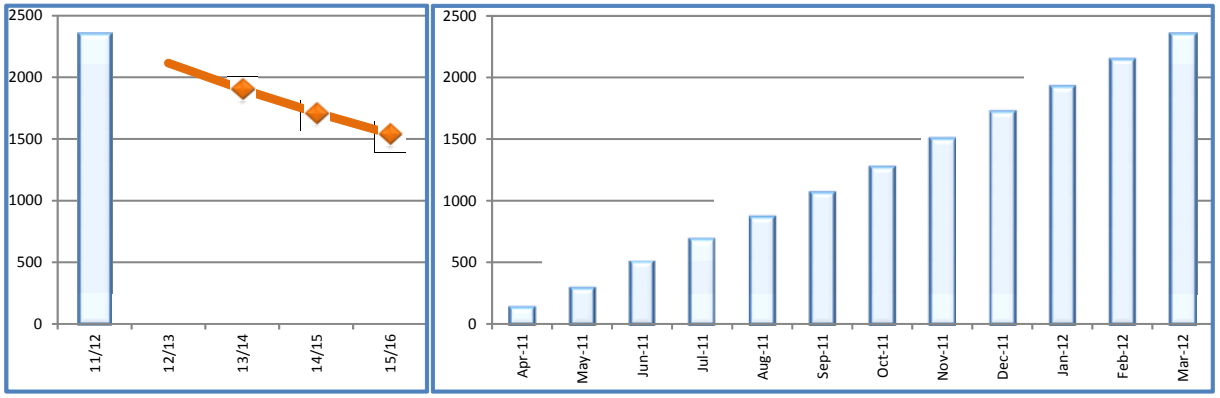
Work-stream updates

Below are the detailed graphs for the 3 key work-streams relating to the effectiveness priority for improvement - to ensure the Trust always treats the right patient, in the right place at the right time.

Planned Admission to Discharge from Hospital

Figure 2.1: Reduce the number of patients on the delayed discharge list

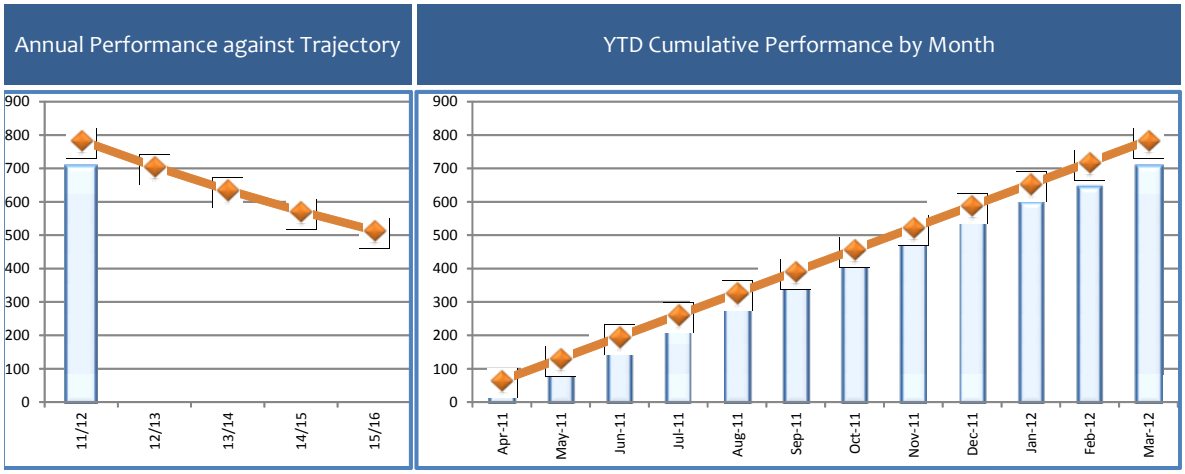
What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
10/11 data unavailable	Implement monitoring	507	557	657	629	2115	1542	✓



Trajectories for 12/13 – 15/16 based on a 10% reduction on the 11/12 baseline position of 2,350.

Figure 2.2: Reduce the number of patients with a length of stay greater than 50 days

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
April '11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'12	Mar '16	
871	784	182	183	193	149	706	514	✓

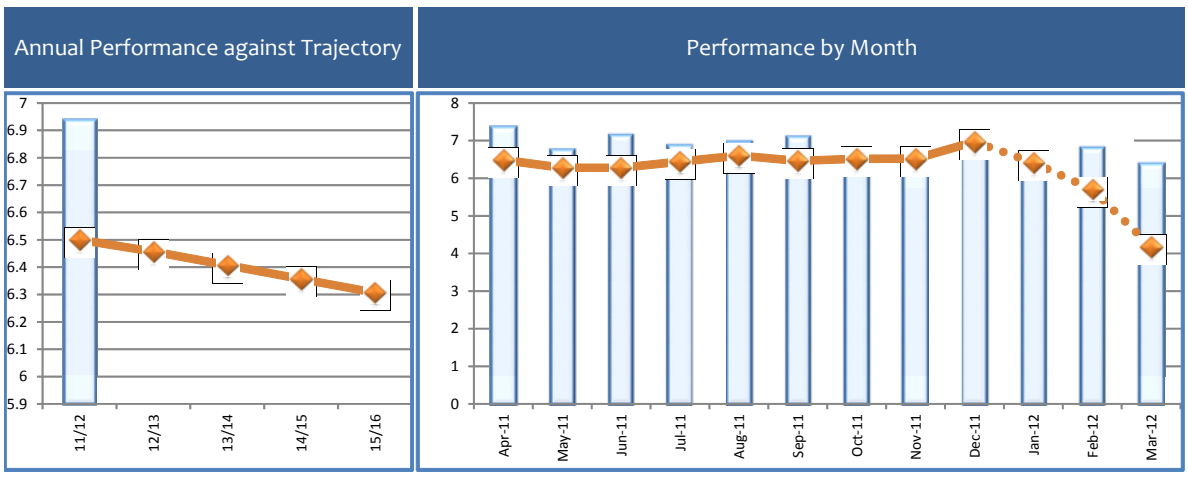


Annual trajectory set to 10% reduction per annum (where trajectories for 12/13-15/16 are calculated as a 10% reduction on the previous year's trajectory.

Urgent Care (Accident and Emergency and the Acute Assessment Unit)

Figure 2.3: 28-Day readmission rate – Trust against Peers

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
6.7%	6.5%	7.1%	7.1%	7.0%	6.6%	6.5%	6.3%	✗



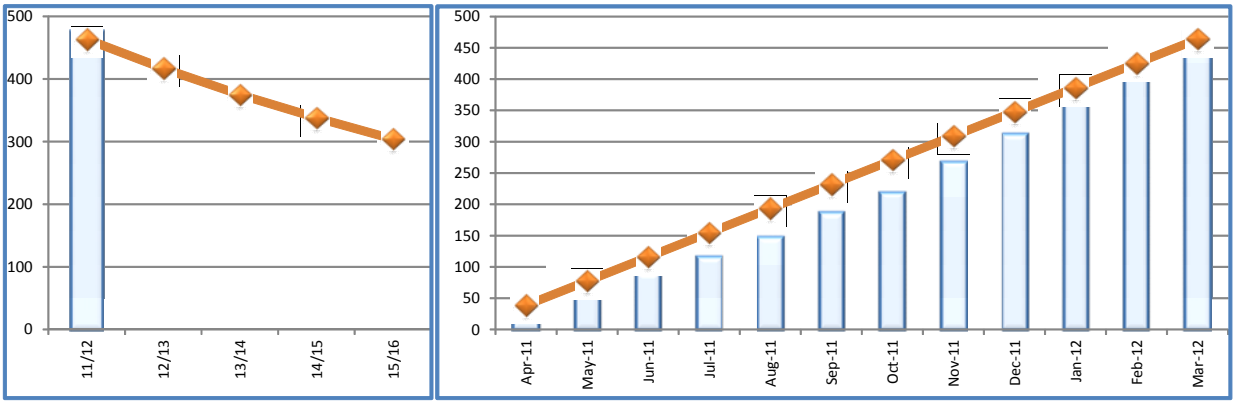
Readmissions data are taken from the CHKS benchmarking system (no exclusions have been made). Annual trajectory set to 0.5 percentage-point reductions from 10/11 peer position 6.7%.

This indicator has been reviewed since publication of the 10/11 Quality Accounts and data used for publication has been extracted from the CHKS national benchmarking system to ensure reliable measurement against peer organisations. As a result the Trust's position and targets have been refreshed since the 10/11 Quality Accounts publication. The original baseline was 4.7% for the planned target outcome of the reduction in avoidable patient 14 day readmissions with the aim of matching peer performance of 4.4%. The Trust did not achieve this target.

Patient Pathways / Inpatient Transfers

Figure 2.4: Reduce avoidable inpatient transfers, in particular patients who are moved more than 2 times

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
515	464	90	96	125	164	417	304	☑

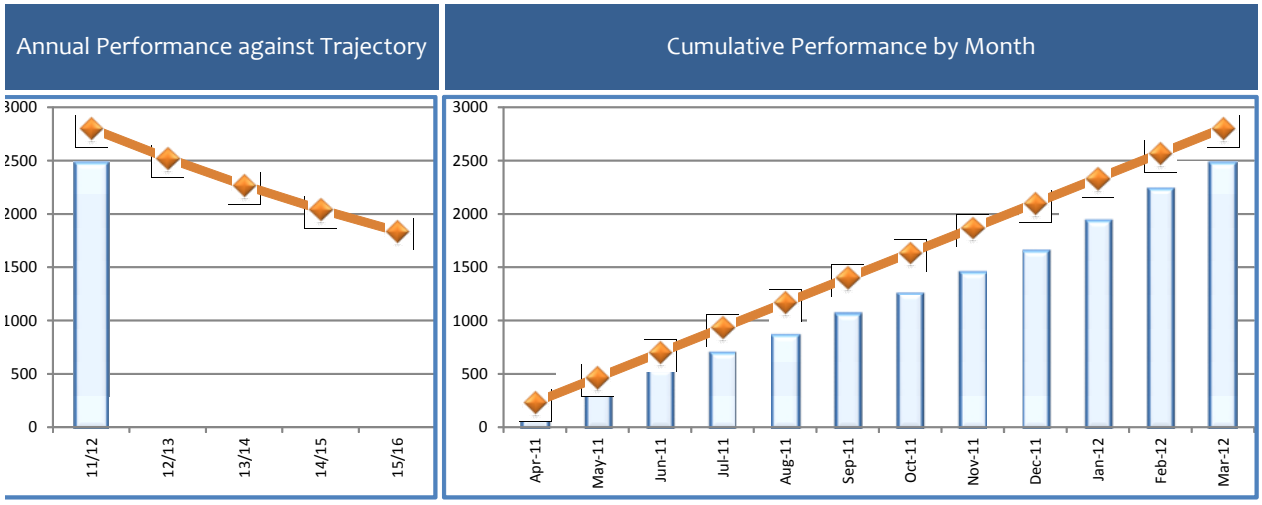


Annual trajectory set to 10% reduction per annum (where trajectories for 12/13-15/16 are calculated as a 10% reduction on the previous trajectory.

The quarterly totals detailed in the above table show the actual number of transfers each quarter whereas the graph shows the cumulative number of transfers over the year by month. During 11/12 475 patients were transferred more than 2 times against a target of 464.

Figure 2.5: Reduce avoidable inpatient transfers after 10.00pm

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
3114	2803	537	525	589	822	2226	2102	✓



Annual trajectory set to 10% reduction per annum (where trajectories for 12/13-15/16 are calculated as a 10% reduction on the previous trajectory.

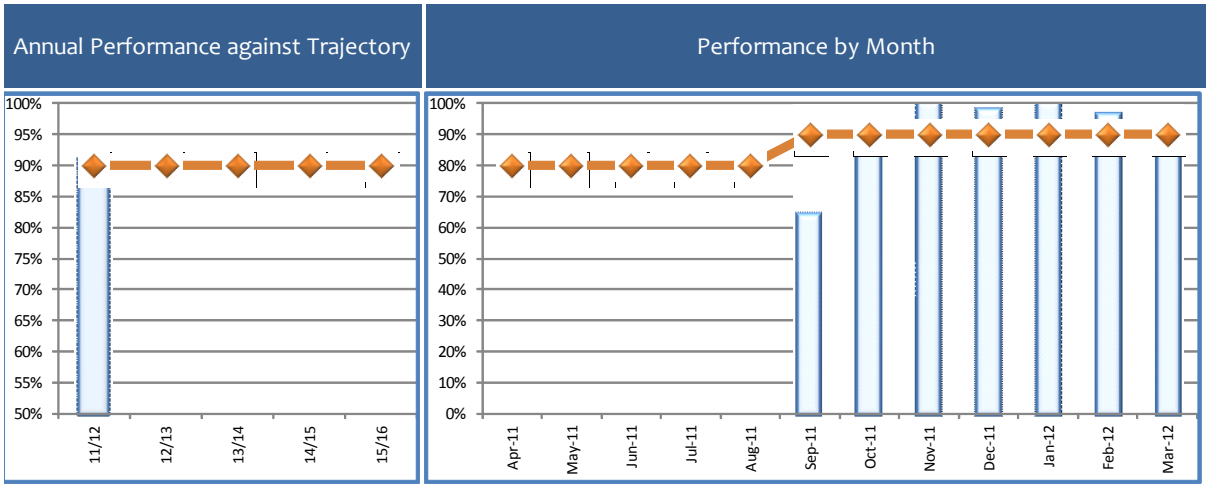
The quarterly totals detailed in the above table show the actual number of transfers each quarter whereas the graph shows the cumulative number of transfers over the year by month. During 11/12 2,743 patients were transferred after 10pm against a target of 2,803.

Below are the detailed graphs for the 2 key work-streams relating to the effectiveness priority for improvement – to aspire to achieve the best clinical outcomes for all.

Stroke

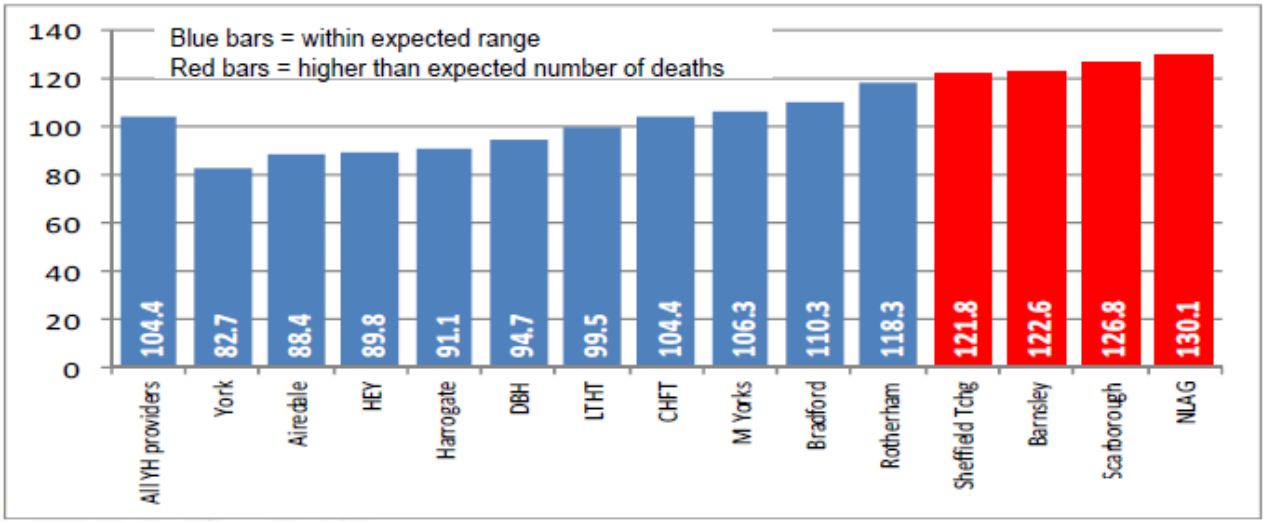
Figure 2.6: Overall compliance with NICE quality standards – Stroke indicators

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
Sep '11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
64.1%	90%	No data	64.1%	97.5%	90.9%	90.0%	90.0%	✓



The lack of completed dataset for 11/12 is due to new data collection being established. Quarter-end and year-end positions are the relevant month – i.e. the 11/12 year-end position shown is for March 2012.

Figure 2.7: Stroke HSMR by Provider

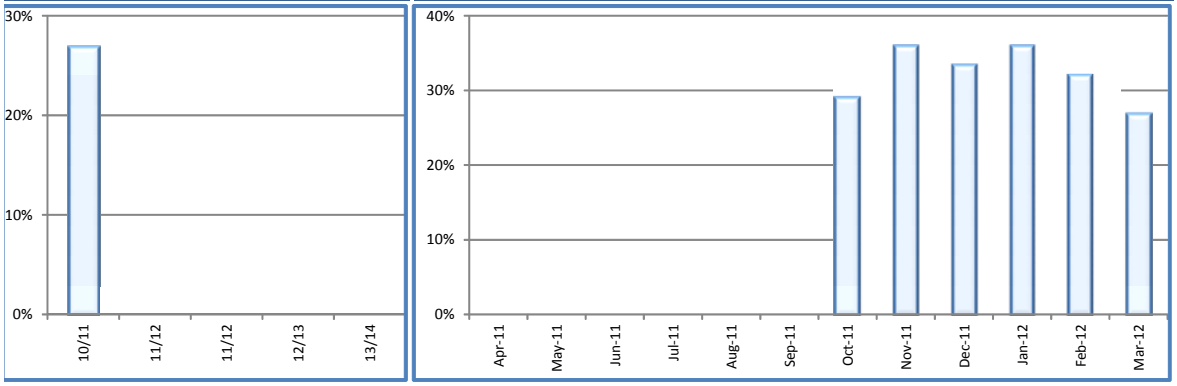


This chart shows the variation in the HSMR by Yorkshire and Humber (Y&H) providers for non-elective patients. The data covers the last 12 months and the HSMRs have been re-based to the national average of 100.

Best Practice Care Bundles / Clinical Outcomes

Figure 2.8: Increase the overall Care Bundle score for Stroke

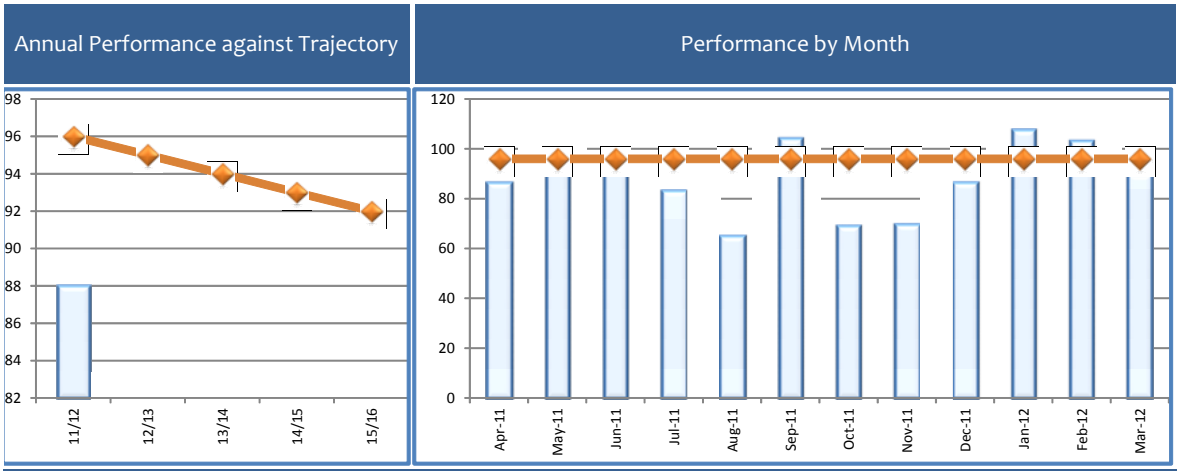
What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
Sep '11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
0.0%	No target set	No data	0.0%	33.4%	26.8%	No target set	No target set	✓



The lack of completed dataset for 11/12 is due to new data collection being established. Quarter-end and year-end positions are the relevant month – i.e. the 11/12 year-end position shown is for March 2012.

Figure 2.9: Reduce HSMR for patients diagnosed with Acute Cereberal Disease (ACD)

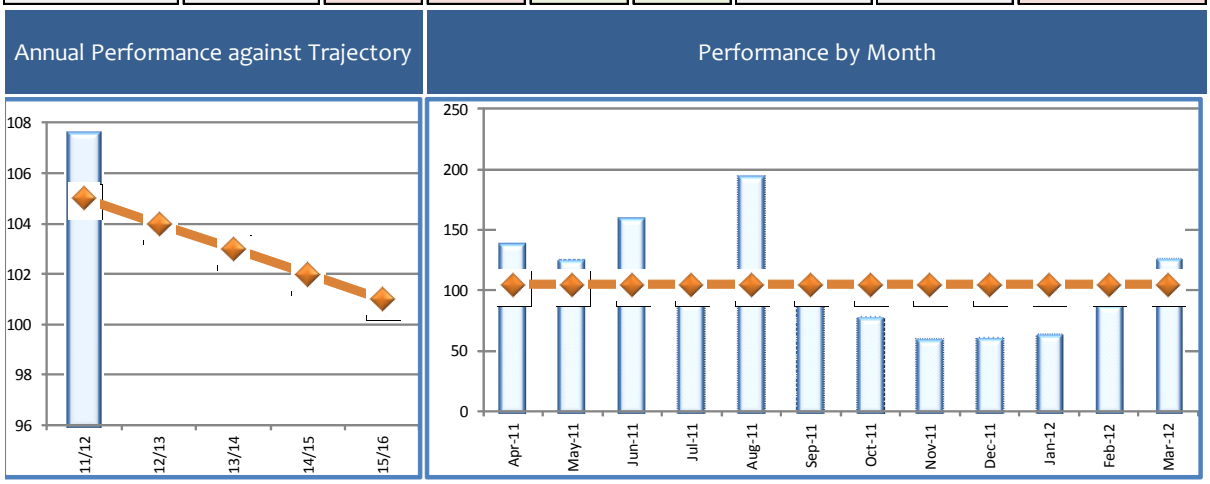
What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
97	96	93	84	75	100	95	92	✓



Annual trajectory set to a 1-point reduction in HSMR per year. The March 2012 figure is 88*Note (Estimated year-end position, validated March 12 data unavailable at time of publication).

Figure 2.10: Reduce Congestive Heart Failure (CHF) HSMR

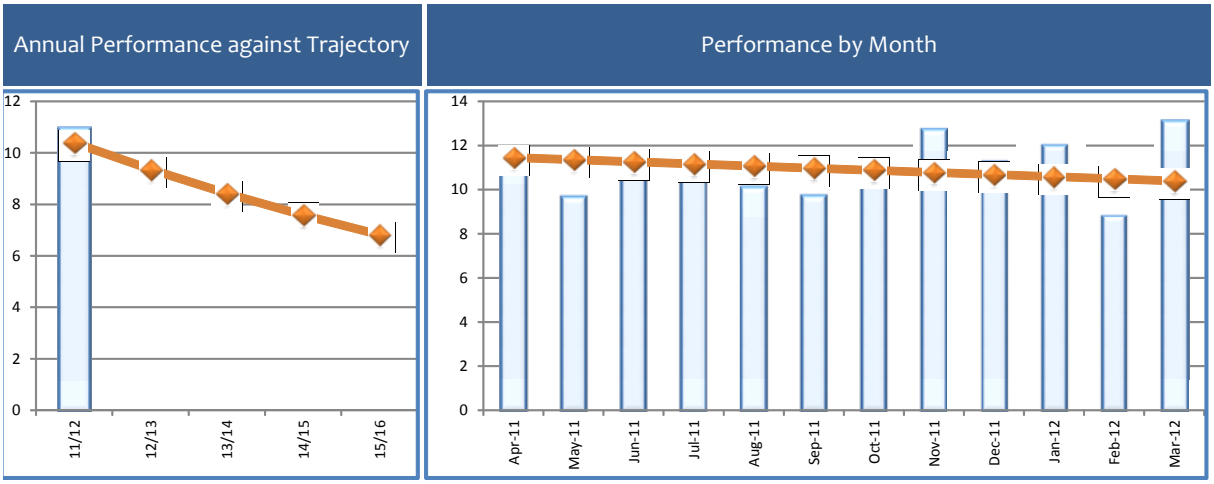
What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
106	105	140	132.36	66	92	104	101	✗



Annual trajectory set to a 1-point reduction in HSMR per year. The March 2012 figure is 108*Note (Estimated year-end position, validated March 12 data unavailable at time of publication).

Figure 2.11: Reduce Congestive Heart Failure (CHF) length of stay

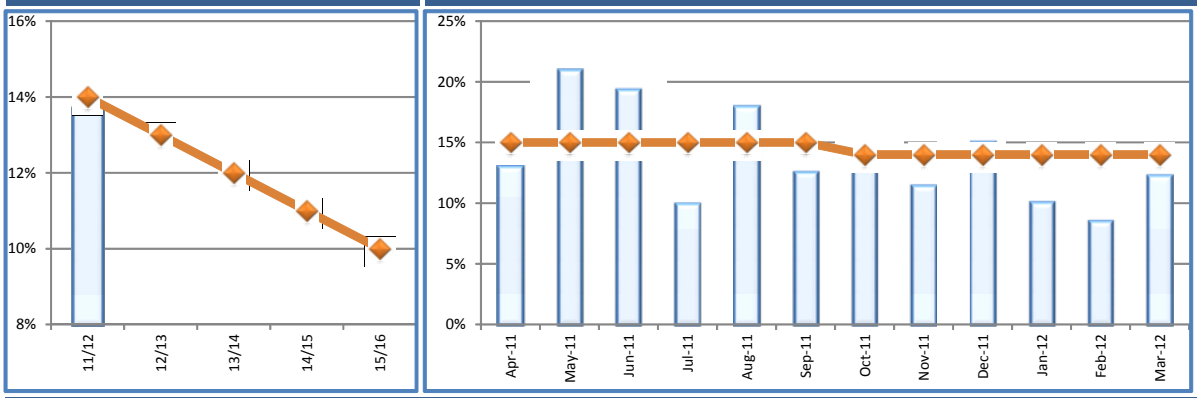
What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
11.6	10.4	10.8	10.2	11.5	11.3	9.4	6.8	☑



Annual trajectory set to a 10% reduction per year.

Figure 2.12: Reduce Congestive Heart Failure (CHF) emergency readmissions

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
0.15	0.14	0.18	0.13	0.13	0.10	0.13	0.10	✓

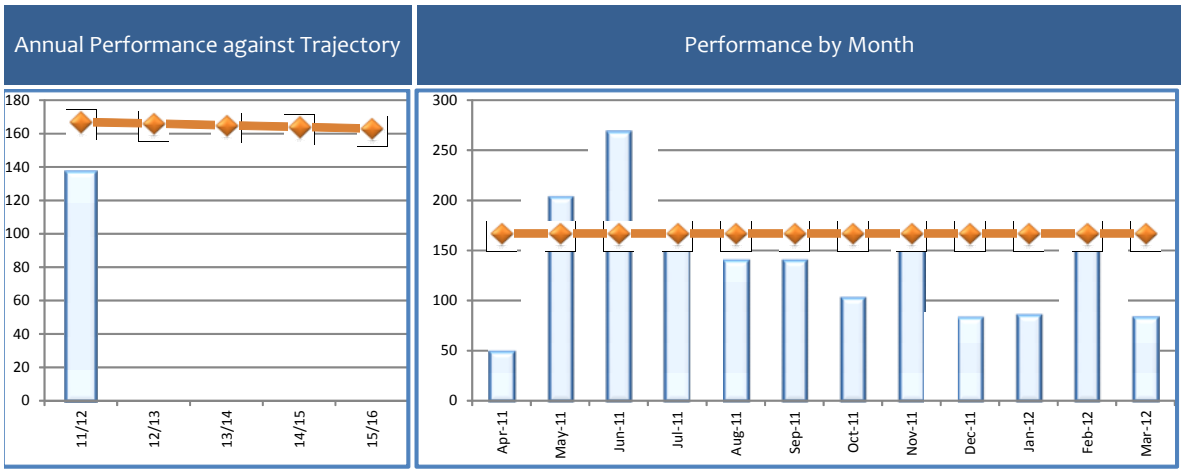


Annual trajectory set to a 10% reduction per year.

Data from quarters 2, 3 and 4 show improvements in performance against this indicator; therefore the Trust achieved this target.

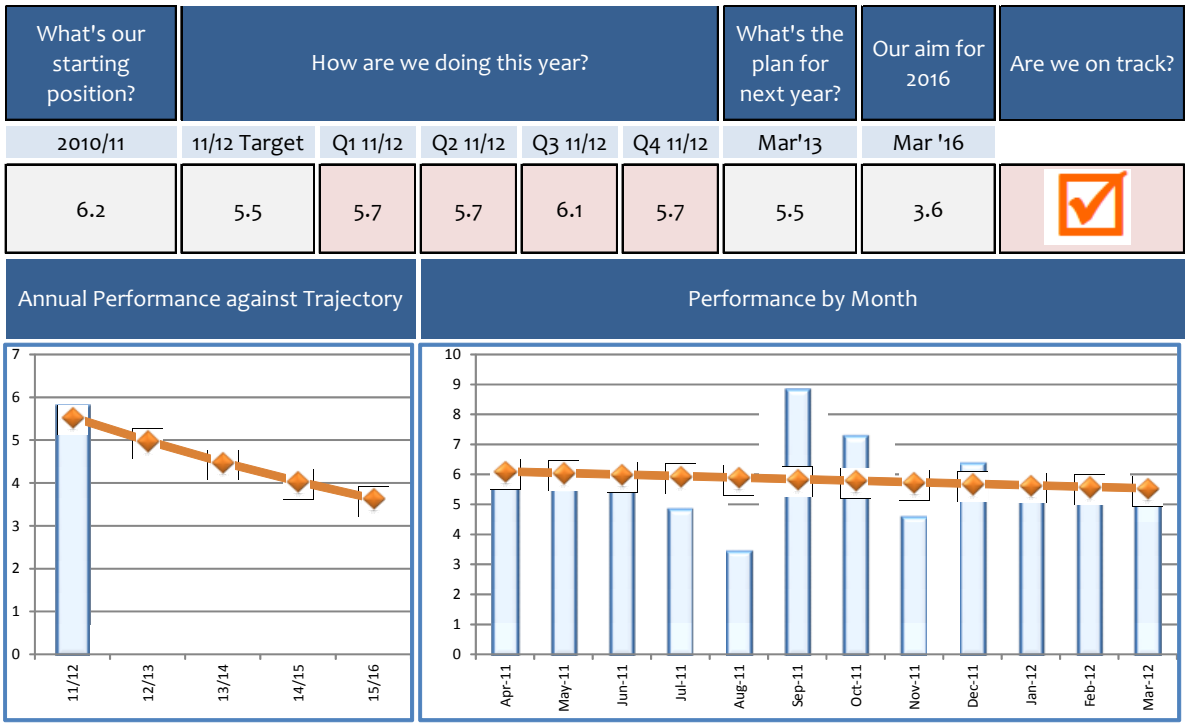
Figure 2.13: Reduce Acute Myocardial Infarction (AMI) HSMR

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
168	167	172.9	144.7	117.87	110.73	166	163	✓



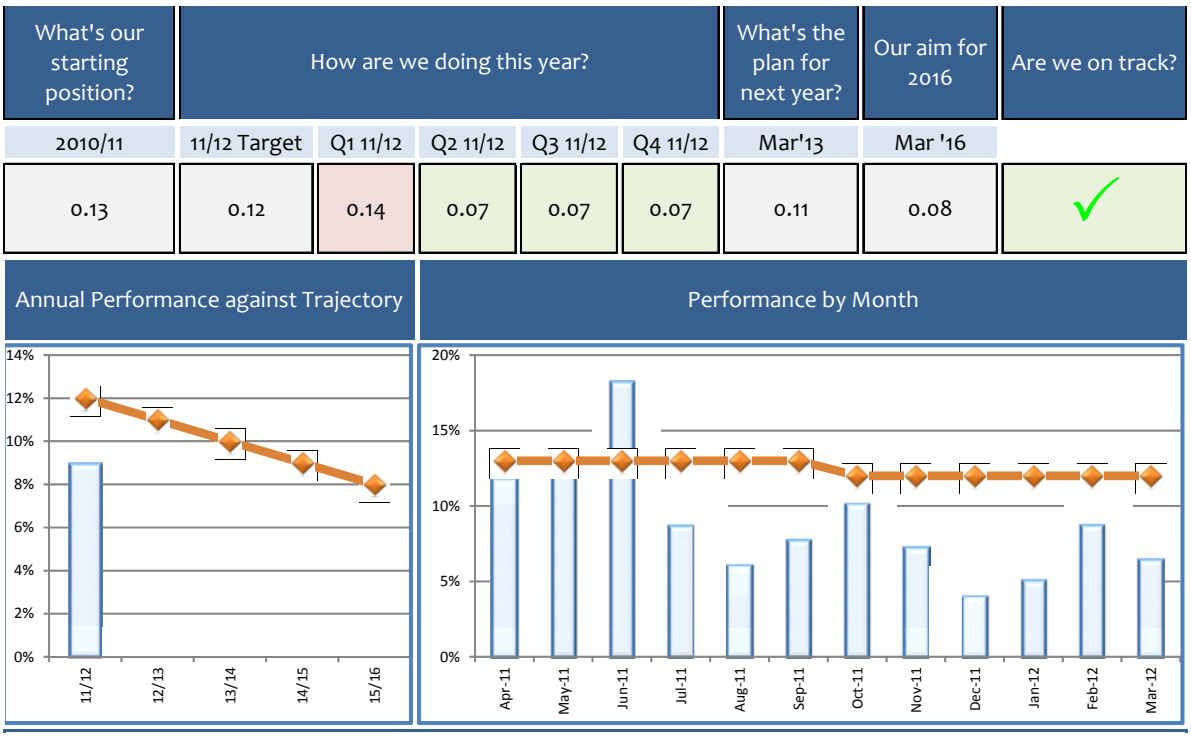
Annual trajectory set to a 1-point reduction in HSMR per year. The March 2012 figure is 137*Note (Estimated year-end position, validated March 12 data unavailable at time of publication).

Figure 2.14: Reduce Acute Myocardial Infarction (AMI) length of stay



Annual trajectory set to a 10% reduction per year.

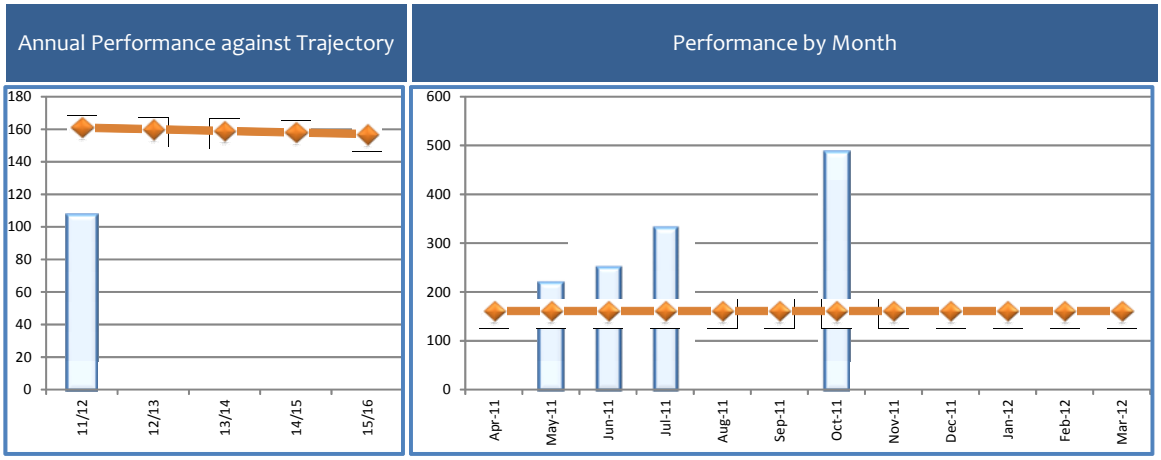
Figure 2.15: Reduce Acute Myocardial Infarction (AMI) emergency readmissions



Annual trajectory set to a 10% reduction per year.

Figure 2.16: Reduce Colorectal Surgery HSMR

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
162	161	156.4	110	161.95	0	160	157	✓



Annual trajectory set to a 1-point reduction in HSMR per year. The March 2012 figure is 107*Note (Estimated year-end position, validated March 12 data unavailable at time of publication).

Low numbers of deaths for the colorectal surgery service mean that the HSMR value fluctuates, where there are no deaths recorded for any month then the HSMR value will be zero.

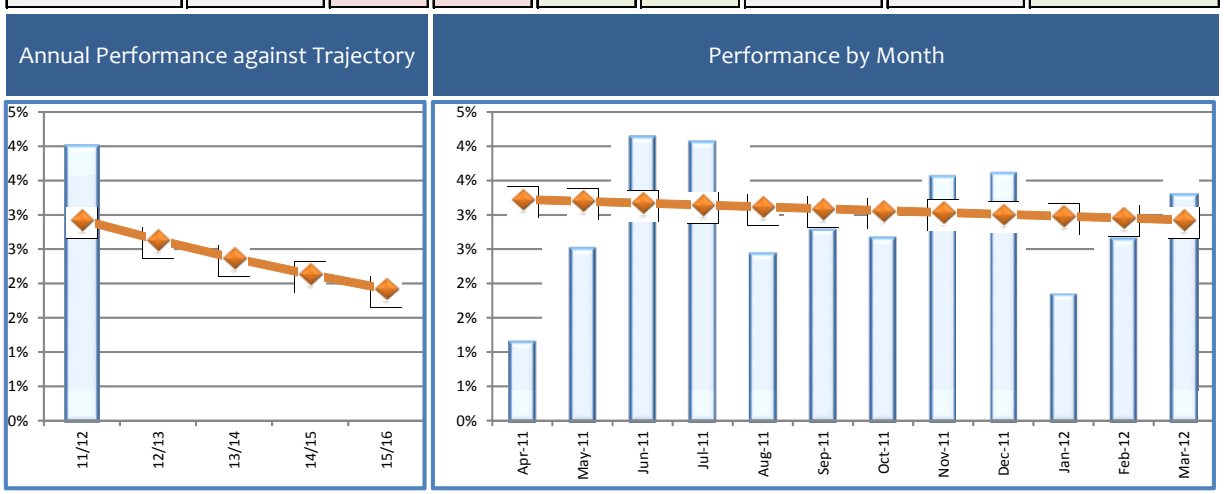
Figure 2.17: Reduce Colorectal Surgery length of stay

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
9.9	8.9	6.3	7.4	7.3	7.9	8.0	5.8	✗

Annual trajectory set to a 10% reduction per year.

Figure 2.18: Reduce Colorectal Surgery emergency readmissions

What's our starting position?	How are we doing this year?					What's the plan for next year?	Our aim for 2016	Are we on track?
2010/11	11/12 Target	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Mar'13	Mar '16	
0.03	0.03	0.04	0.03	0.04	0.03	0.03	0.02	✓



Annual trajectory set to a 10% reduction per year.

Appendix Three – Experience Domain

The following key applies to all figures included in Appendix Three:

✘	Improvement not demonstrated
☑	Goal not achieved but improvements made
✓	Goal achieved

Work-stream updates

Below are the detailed graphs and tables for the 3 key work-streams relating to the experience priority for improvement – to improve communication through patient and staff engagement.

Patient Engagement

The Trust engages with patients via paper based surveys and an increased use of technology called Meridian to identify key priority themes to inform actions to be taken to improve patient experience.

Table 3.1: Local Inpatient Survey Results (April 2011 to March 2012).

Subject	2010/2011 Results	2011/2012 Results Paper Based
Privacy & Dignity	99% of patients said they were always given enough privacy when being examined or treated. 18% of patients reported that on admission they shared a sleeping area with patients of the opposite sex Of those patients required to share a sleeping area on admission, 30% reported that this was of some level of concern to them 3.2% (16) of all formal complaints raised were regarding patient's privacy and dignity not being respected. 0.99% (21) of all PALS concerns raised were regarding patients' privacy and dignity not being respected.	98% of patients said they were always given enough privacy when being examined or treated. 12% of patients reported that on admission they shared a sleeping area with patients of the opposite sex Of those patients required to share a sleeping area on admission, 42 %reported that this was of some level of concern to them 2.49% (13) of all formal complaints raised were regarding patient's privacy and dignity not being respected. 1.36% (29) of all PALS concerns raised were regarding patients' privacy and dignity not being respected.

Subject	2010/2011 Results	2011/2012 Results Paper Based
Cleanliness	92% of patients rated their ward/department as very clean. 0.2% (1) of all formal complaints raised was regarding the cleanliness of the patient's ward/department. 0.4% (9) of all PALS concerns raised was raised regarding the cleanliness of the patient's ward/department.	81% of patients rated their ward/department as very clean. 2.49% (13) of all formal complaints raised was regarding the cleanliness of the patient's ward/department. 0.33% (7) of all PALS concerns raised was raised regarding the cleanliness of the patient's ward/department.
Attitude	84% of patients said that the doctors who treated them did not talk over them as if they weren't there. 96% of patients said that the nurses who treated them did not talk over them as if they weren't there. 99% of patients had confidence and trust in the nurses treating them 98% of patients had confidence and trust in the doctors treating them 7.8% (39) of all formal complaints raised were regarding unprofessional or inappropriate attitude by the staff treating them. 4.1% (88) of all PALS concerns raised were regarding unprofessional or inappropriate attitude by the staff treating them.	90% of patients said that the doctors who treated them did not talk over them as if they weren't there. 93% of patients said that the nurses who treated them did not talk over them as if they weren't there. 99% of patients had confidence and trust in the nurses treating them 98% of patients had confidence and trust in the doctors treating them 7.48% (39) of all formal complaints raised were regarding unprofessional or inappropriate attitude by the staff treating them. 4.33% (92) of all PALS concerns raised were regarding unprofessional or inappropriate attitude by the staff treating them.
Care & Comfort	97% of patients said that If required, they received enough help from staff to eat their meals. 2.8% (14) of all formal complaints raised were regarding lack of assistance with food/fluids. 0.6% (13) of all PALS concerns raised was regarding were regarding lack of assistance with food/fluids.	98% of patients said that If required, they received enough help from staff to eat their meals. 4.22% (22) of all formal complaints raised were regarding lack of assistance with food/fluids. 0.84% (18) of all PALS concerns raised was regarding were regarding lack of assistance with food/fluids.

Patient Experience

Complaints and Patient Advice Liaison Service (PALS)

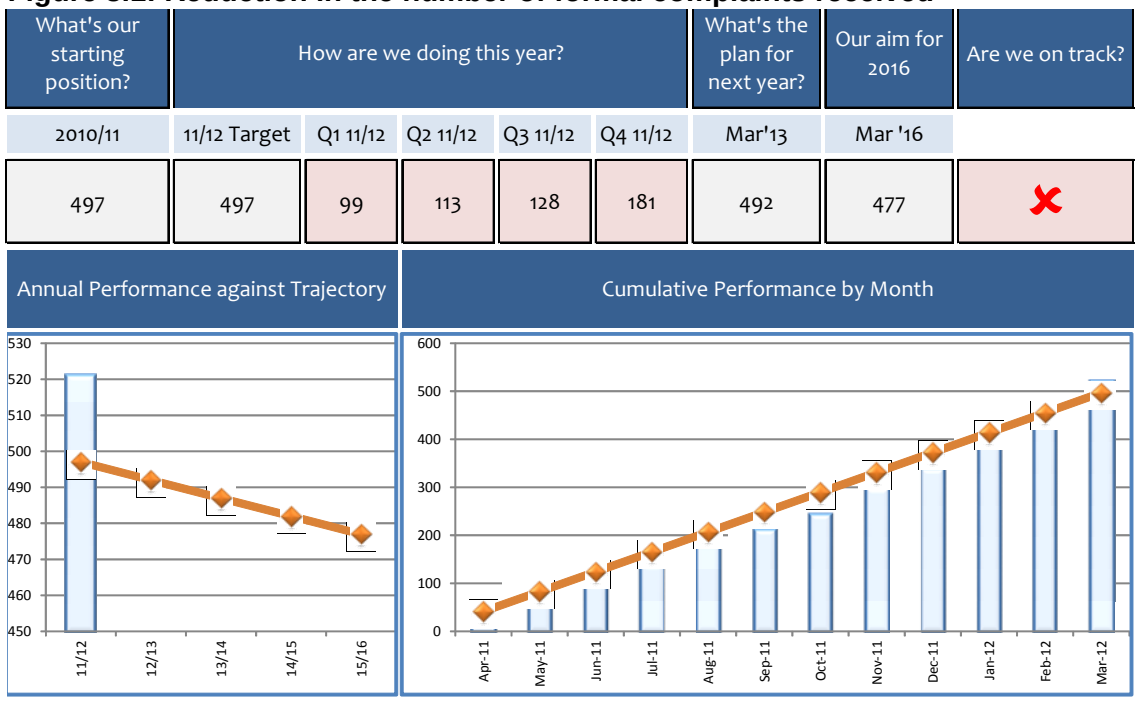
The Trust currently reviews patient experience in a number of ways. The most reported measures to the Trust Board continue to be PALS and Complaints information. Patient surveys, complaints and PALS are discussed regularly at the Trust's Patient Experience Forum along with the actions taken in response to both individual concerns and identified themes to improve patient experience and reduce the number of complaints received.

Table 3.2: The ratio of formal complaints to activity for the period 1 January 2011 to March 2012

		Jan / Mar 11	Apr / Jun 11	Jul / Sept 11	Oct/ Dec 11	Jan/Mar 12
Inpatients	FCEs*	47020	45551	33874	45098	47320
	Complaints	71	80	67	89	112
	Rate/1000 FCEs	1.5	1.75	1.97	2.00	2.36
Outpatients	Appointment	254688	261149	189529	253836	256578
	Complaints	25	45	29	28	49
	Rate/1000 Appointments	0.09	0.17	0.15	0.11	0.19
A & E	Attendances	34260	29099	27017	31812	31265
	Complaints	13	14	17	19	17
	Rate/1000 Attendances	0.37	0.48	0.62	0.60	0.54

**FCE: finished consultant episode which denotes the time spent by a patient under the continuous care of a consultant*

Figure 3.1: Reduction in the number of formal complaints received



Complaints increases have been matched against claims received by the Trust by the same complainants. This increased significantly in quarter 4 with 30 claims received that were also in the complaints process. The annual report on complaints and PALS is in the process of being developed and will be taken through the Patient Experience Forum and QuESt.

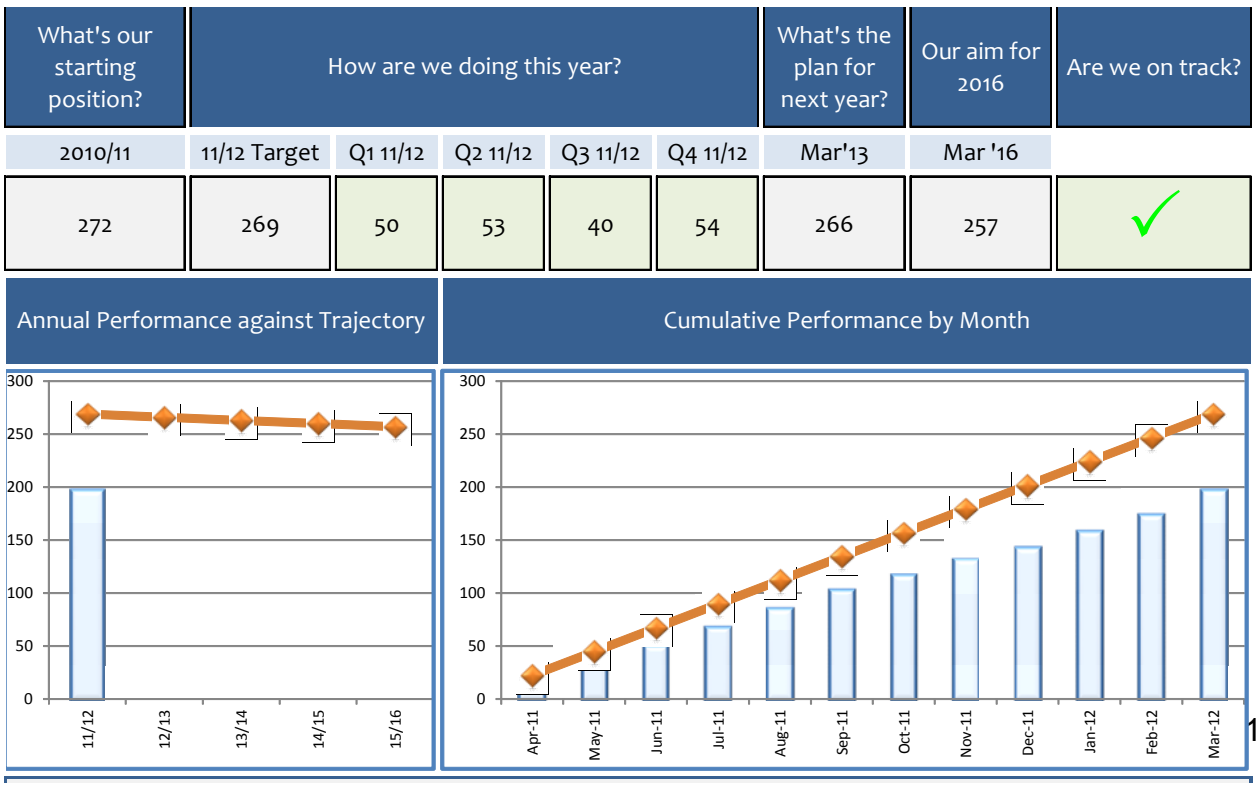
Table 3.3: Top 5 subjects raised in formal Complaints received during 2010/11 and 2011/12. (Please note that each complaint may contain several issues)

Subject of formal complaint	Number of formal complaints raised	% of all formal complaints raised	Number of formal complaints raised	% of all formal complaints raised
	2010/2011		2011/2012	
Treatment	393	52%	66	59%
Discharge			12	11%
Delays, waiting times and cancellations	80	10%	10	9%
Care and comfort including privacy and dignity	84	11%	9	8%
Attitude	64	8%	7	6%
Communication/Record Keeping	67	8%		

Table 3.4: Top 5 subjects of PALS concerns received during 2010/11 and 2011/12
(Please note that each concern may contain several issues)

Subject of PALS concern	Number of PALS concerns received	% of all PALS concerns received	Number of PALS concerns received	% of all PALS concerns received
	2010/2011		2011/2012	
Delays, waiting times and cancellations	698	34%	95	26%
General Advice			85	23%
Communication/Record Keeping	397	19%	55	15%
Treatment	353	17%	51	14%
Attitude	209	10%	25	7%
Care and Comfort including privacy and dignity	111	5%		

Figure 3.2: Reduction in formal complaints and PALS concerns regarding staff attitude



Continuous Learning from Complaints and Patient Advice Liaison Service (PALS)

You Said, We Did…….

We aim to respond to all complainants to let them know what actions we have taken. It is vital that the Trust learns from the complaints and PALS that are received. As a result of some of the contact we have had with our patients and visitors we have made many changes to our services.

These include:

- Following confusion caused by administrative error in transcription, a review of the systems and processes for transcription is to be undertaken.
- New Trust wide documentation implemented to follow a patient from admission to discharge, which will eliminate the need for duplication of information gathering.
- New medical ambulatory care service implemented which will prevent poor experiences in the future.
- Following a complaint the actions arising included a change of visiting times, an increase in staff numbers and the introduction of dining companions. It was agreed that the complaint would be shared with staff to raise awareness.
- Staff have been reminded of the necessity to inform relatives of falls. Relative's surgeries introduced to improve communication.
- New pathway instigated in Oncology which will ensure that patients are booked for the procedure prior to admission, which will reduce delays and improve the patient pathway.

Staff Engagement

National NHS Staff Survey

The Care Quality Commission National Staff Survey 2011 demonstrated some improvements in staff satisfaction and experience. These are detailed below:

- The percentage of staff suffering work-related injury in the last 12 months. This has decreased from 21% in 2010 to 12% in 2011 (the lower the score the better). The national average is 16%.

- The impact on health and well-being on ability to perform work or daily activities. This score has reduced from 1.68 in 2010 to 1.51 in 2011 (the lower the score the better). The national average is 1.56.

- Staff job satisfaction. This score has increased from 3.41 in 2010 to 3.53 in 2011 (the higher the score the better). The national average is 2.59.

- On a score of 1-5 with 5 being the best result, the Trust scored 3.60 for support from immediate managers (the higher the score the better). This was an increase from 3.50 in 2009 and 3.55 in 2010 but still below the national average of 3.61.

- Staff that would recommend the Trust as a place to work or receive treatment has increased from a score of 3.30 in 2009 and 3.36 in 2010 to 3.38 in 2011 (the higher the score the better). The national average score for this question is 3.50.

Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ

Tel: (01482) 875875
Web: www.hey.nhs.uk

Castle Hill Hospital
Castle Road
Cottingham
HU16 5JQ