Quality Improvement Overview Plan 2019-20

Hull University Teaching Hospitals NHS Trust

Introduction

The purpose of this plan is to define, at a high level; the overall continuing quality improvement journey the Trust is making and the improvement goals that the trust will work towards over the next 12 months. The plan includes all of the MUST DO and SHOULD DO recommendations in the CQC Quality Reports and detailed plans are being developed for each project/work area. However, the plan is broader than those actions and includes longer-term pieces of work that the trust is pursuing to improve overall quality and responsiveness across the organisation, for example in relation to Quality Accounts.

The plan outlines the trust's overall ambition to meets its vision of Great Staff, Great Care, Great Future. It is therefore not the intention that the improvement goals will all be achieved by March 2020 but rather significant progress can be demonstrated against all of them. The plan includes a number of key milestones and these will be reported on at the monthly Operational Quality Committee. The milestone dates are all the end of the month unless a specific date is recorded. The plan will be reviewed and refreshed at the end of the financial year.

A separate monthly progress report will be produced to demonstrate progress against milestones and improvement goals.

No	Quality Improvement Project	Problem	Performance Indicators	Baseline From 2018/19	Regulatory Influences	Sponsor	Clinical / Project Lead	1-4 Months Milestones (April – July)	5-9 Months Milestones (Aug - Dec)	10+ Months Milestones (Jan - March)
QIP05	**Medicines Optimisation** The aim of this project is to improve key aspects of the medicine management discharge process. Three focused projects will be completed to achieve this – increased referrals to the Transfer of Care Around Medicines Scheme will improve the process Trust wide. Two focused pilot projects will be completed to improve turnaround times of dispensing discharge prescriptions for the patient lounge and improved timeliness of IDS from Boots to Queens Centre. The intention would be to use the pilot to then launch trust wide in the 2020-21 programme	Medication provision at the point of discharge is not optimal.	70% of discharge prescriptions dispensed within an hour for patient lounge by March 2020 50% >126increase in referrals to "Transfer of Care Around Medicines Scheme" by March 2020	53% annual 84 annual	CQC Inspection 2018 – The trust must ensure that registered nurses follow the correct steps when administering medicines in line with their nurse policy and NMC regulations and sign medication charts after it has been given to patients. CQC Inspection 2016 – The trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E. CQC Inspection 2016 – The trust must ensure that records of the management of controlled drugs are accurately maintained and audited within A & E. CQC Inspection 2015 – The Trust should record and monitor daily temperatures of fridges used for storage of medicines within A & E CQC Inspection 2015 – Ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards. In addition the Trust must ensure that controlled	David Corral, Chief Pharmacist	Simon Gaines, Clinical Governance Pharmacist	Review of medication processes on discharge completed - **May-19** Improve turnaround times of dispensing discharge prescriptions for the patient lounge: Introduce medicines management assistant into the pharmacy discharge lounge team to improve turnaround times of dispensing discharge prescriptions - **May-19** Increase referrals to 'Transfer of Care Around Medicines' scheme: Face to face training sessions to the wider pharmacy department delivered to ensure that all rotational staff are able to complete electronic referrals and associated paperwork - J**un-19** Increase referrals to 'Transfer of Care Around Medicines' scheme: Launch event held for community pharmacists on the "Transfer of Care Around Medicines" referral Scheme - **Jun-19** Improve accessibility of SIP feeds on discharge: Review stock lists - **Jun-19** Increase referrals to 'Transfer of Care Around Medicines' scheme: A user guide for community pharmacists will be produced in conjunction	Increase referrals to 'Transfer of Care Around Medicines' scheme: Patient information leaflets about the Transfer of Care Around Medicines' referral scheme will be updated - **Aug-19** Improve timeliness of transfer of completed IDSs from Boots to QCOH wards: Analysis of data collection from bleep trial undertaken and corresponding action plan produced - **Aug-19** Improve accessibility of SIP feeds on discharge: Produce an educational poster for wards **Aug-19** Improve accessibility of SIP feeds on discharge: Produce an educational poster for pharmacy departments - **Aug-19** Improve turnaround times of dispensing discharge prescriptions for the patient lounge: Audit data produced on Tracker system for review to improve turnaround times of dispensing discharge prescriptions - **Sep-19** Completion of look back exercise against improvement activity in 2018/19 - **Oct-19** Improve turnaround times of dispensing discharge prescriptions for the patient lounge: Action plan created based on analysis of tracker to target specific areas for improvement if identified - **Oct-19**	

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					drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within A & E and children's services. Linked to regulation breach – Regulation 12 Safe Care and Treatment. These have been addressed and closed by the Trust as sufficient actions have been put in place however the Trust has not yet been re-assessed as compliant by the CQC.			with the Local Pharmaceutical Committee and will be circulated to community pharmacies in the region - **Jul-19** Improve turnaround times of dispensing discharge prescriptions for the patient lounge: Introduce new prescription tracker system into patient lounge service to improve turnaround times of dispensing discharge prescriptions - **Jul-19** Improve timeliness of transfer of completed IDSs from Boots to QCOH wards: Trial of ward discharge assistants and trust pharmacy staff holding designated bleep - **Jul-19** Improve accessibility of SIP feeds on discharge: Amend stock list to improve stock holding - **Jul-19**	Increase referrals to 'Transfer of Care Around Medicines' scheme: Scoping exercise completed to identify further wards appropriate to undertake the 'Transfer of Care Around Medicines' referral scheme - **Nov-19**	
QIP06	**Deteriorating Patient** To ensure all patients with an elevated NEWs to be escalated in line with Trust Policy (which incorporates NEWS2)	Patients are not always escalated in line with Trust Policy	90% of patients that have a NEWS Score above 1 have evaluation states actions taken or escalation documented	Baseline to be established for 2019-20	CQC Inspection 2018 – The Trust must ensure that patients are escalated for medical reviews in line with the trust policy when the trigger is altered when using the National Early Warning Scores (NEWS). CQC Inspection 2016 – The trust must ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Maternity and obstetrics early warning score (MOEWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness. Linked to regulation breach – Regulation 12	Beverley Geary, Chief Nurse	Jo Ledger, Deputy Chief Nurse	Completion of look back exercise against improvement activity between 2017 and 2019 **– May 2019** Next steps identified following look back exercise **– May 2019**	Development of Fundamental Standard – Recognise and Respond **– September 2019**	

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					Safe Care and Treatment					
QIP10	**Pressure Ulcers** To be open and transparent skin damage reporters, improving safety and patient experience through robust assessment, care planning and evaluation by sharing best practice from areas with low reported incidents and to improve understanding of key themes and trends from all reported incidents.	Patients at risk of developing hospital acquired pressure ulcers and moisture associated skin damage	100% completion of RCA in 14 days	81.3%	NHS Improvement	Jo Ledger, Deputy Chief Nurse	Karen Harrison, Tissue Viability Nurse	Completion of look back exercise against improvement activity between 2017 and 2019 - **May-19** Next steps identified following look back exercise - **May-19** Trust communication on new NHS I recommendations: Communication Strategy to be developed - **Jun-19** Trust communication on new NHS I recommendations: All key policies and guidelines amended as required - **Jun-19** Trust communication on new NHS I recommendations: Training amended as required - **Jun-19** Strategic overview by Ward developed - **Jun-19** YCFF used as the tool for review of all PU Sis - **Jun-19** Non-registered bespoke training package investigated - **Jul-19** Contribute to collaborative PILs - **Jul-19**	Digital / electronic wound photography rolled out and implemented - **Aug-19** Trust communication on new NHS I recommendations: Auditing arrangements to be developed - **Aug-19** Review census actions and add any relevant actions onto QIP and look back - **Aug-19**	Identification of Themes and trends from Category 2 Pressure Ulcers and MASD (moisture associated skin damage) - **Jan-20** Review of Sskin care bundle **Mar-20**
QIP22	**Nutrition** • To ensure patient's nutrition and hydration needs are risk assessed in accordance with Trust Policy (CP335) • To ensure patients are weighed in accordance with Trust Policy (CP335) • To ensure that patients are fasted pre-operatively in accordance with policy	Patients are at risk of not being assessed correctly in relation to nutrition and hydration.	95% of patients weighed within 24hrs of admission 90% of patients weighed every 72hrs 95% of weighs plotted on weight graph 90% of weight recorded on Drug Chart 95% of daily Nutrition Risk Assessments 95% of appropriate	84.5% 74.3% 74.4% 88.3% 92.4% 92.6%	CQC Inspection 2018 – The Trust must ensure that patients are fasted pre-operatively in line with best practice recommendations The Trust must ensure that patient risk assessments are completed to determine if patients are at risk of malnutrition The Trust should ensure that all patients have weights record in their record Linked to regulation	Beverley Geary, Chief Nurse	Jo Ledger, Deputy Chief Nurse	Completion of look back exercise against improvement activity between 2017 and 2019 - **May-19** Next steps identified following look back exercise - **May-19** Review commenced actions taken to mitigate against Dietician Risk Register - **May-19** Task and Finish Group set up to develop programme	Enhance current training provision with the non-registered nurses - **Aug-19** Review commenced into the links between the Trust Nutrition QIP and the system wide Nutrition QIP - **Aug-19**	

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			referral to Dietician 95% of care plan states "low, Medium or High Risk" 80% of hydration charts completed	 77.4% 45.8%	breach – Regulation 12 Safe Care and Treatment CQC Inspection 2016 – The trust must ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients. CQC Inspection 2015 – Ensure that patients' nutrition and hydration is maintained in a timely manner; including the effective use of the 'red top' water jug system across all medical wards and the accurate recording of fluid balance and food charts for patients (**This has been addressed and closed by the Trust as sufficient actions have been put in place however the Trust has not yet been re-assessed as compliant by the CQC)** Linked to regulation breach – 14 Meeting nutritional and hydration needs.			of work for DME wards in relation to the number of patients requiring support - **Jun-19** Review completed of the Pre-Operative Fasting of Adults, Infants and Children for GA procedure - **Jun-19** Nutrition Census completed - **Jun-19**		
QIP23	**Dementia** The aim of this project is to ensure that the dementia bundle is embedded, all identified and relevant staff are trained in Dementia to the appropriate level and dementia documentation is consistently completed to the appropriate level.	Staff in relevant wards may not be fully trained in dementia and the associated documentation which means that compliance with dementia documentation is inadequate and could result in the wrong care being delivered.	75% of Dementia / delirium screening pathway completed in the medical document 75% of Online dementia/delirium screening tool completed 75% of Diagnosis documented in the medical notes 75% of Butterfly displayed at the bedside 75% of Butterfly icon in place on cayder 75% of Reach Out To Me document at the bedside 75% of members of staff able to articulate the	85.7% 76.2% 100% 66.7% 100% 40.9% 77.8%	CQC Inspection 2018 - The trust should continue to develop and embed the documentation in relation to dementia care.	Dr Purva, Chief Medical Officer	Lead Consultant (Dr Yoghini Nagandran) and Lead Dementia Nurse (Kay Brighton)	Training review against national targets completed to agree Tier 1 and Tier 2 and Tier 3 staff that are required to complete dementia training - **May-19** Pilot of non-verbal pain score tool on wards H60 and DME and Orthopaedics - **May-19** Training gap analysis complete to assess whether appropriate for relevant tier and is compliant with National Dementia Guidance for training - **May-19** Existing or amended Dementia training re-launched - **Jun-19** John's Campaign and Butterfly Scheme re-launched trustwide - **Jun-19** Action plan from 2018/19 Dementia Audit developed -	NAD Action: To establish dementia champions using a formalised network - **Aug-19** abbreviated mental test scores for patients over 75 who have been in hospital for longer than 72 hours - **Sep-19** NAD Action: Nutrition- finger food availability is trust-wide, to be communicated with all trust staff - **Sep-19** Dementia care bundle embedded into practice on elderly care wards - **Oct-19** Discharge communication improved through linking dementia screening to the IDL via Lorenzo - **Oct-19** NAD Action: Dementia and delirium information leaflet	NAD Action: 4AT to be introduced Trust wide as part of delirium assessment - **Jan-20** NAD Action: 4AT to be incorporated into the medical clerking booklet alongside the SQiD - **Jan-20** NAD Action: Key principles of environment work such as signage to become trust standard for dementia friendly signage - **Jan-20** NAD Action: To establish a direct referral route to dementia lead nurse in order to provide support to patients/carers & staff - **Jan-20**

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			meaning of "Johns Campaign & Butterfly Scheme 75% of Clinical area displaying poster re: Johns Campaign 75% of Clinical area displaying poster re: Butterfly Scheme 30% of Trust Tier 1 staff have completed the relevant dementia training 30% of Trust Tier 2 staff have completed the relevant dementia training 30% of Trust Tier 3 staff have completed the relevant dementia training	 75% 66.7% (June 2019 data) No baseline No baseline No baseline				**Jul-19** Review of milestones achieved in 2018/19 to ensure embedded completed - **Jul-19**	developed to be implemented - **Oct-19** NAD Action: Amend business intelligence to reflect falls, delays in discharge and reasons for readmissions for patients with dementia - **Nov-19** NAD Action: To look at feasibility of an 'indoor' garden within HRI - **Dec-19**	
QIP28	**Patient Experience** Reduce the number of re-opened complaints due to dissatisfaction and facilitate a process to address all recommendations from the NHS Patient Survey 2018 and Mersey Internal Audit Agency Complaints Management Review	Improvements are required on the number of re-opened complaints due to dissatisfaction	Reduce the number of reopened complaints due to dissatisfaction by 10% - 73.8	82	CQC Inspection 2015 – Ensure that there is an effective and timely system in place, which operates to respond to, and act on, complaints. Linked to regulation breach – Regulation 16 Receiving and acting on complaints. **This has been addressed and closed by the Trust as sufficient actions have been put in place and assurance was received from the February 2018 CQC inspection "People using services felt they could raise concerns and complaints and they would be listened to."**	Beverley Geary, Chief Nurse	Head Of Patient Experience and Engagement (Louise Beedle)	Working group for each HG established to review results from NHS Inpatient Survey 2018 PICKER survey - **Jun-18** NHS Inpatient Survey 2018 PICKER report results poster displayed in key areas around the trust - **Jul-19**	Action plan from each working group developed from NHS Inpatient Survey 2018 PICKER survey - **Aug-18** Action plan for NHS Inpatient Survey 2018 included in PEF reports - **Aug-18** Recommendations from MIAA – Agreement for regular report for submission to Operational Quality Committee - **Sep-19** Recommendations from MIAA – to include the performance against the 25-day and 40-day targets of complaint completion in the report to Operational Quality Committee - **Sep-19** Recommendations from MIAA – Process for recording, monitoring and escalation of lessons learned outcomes for all closed complaints reviewed - **Oct-19** Completion of look back exercise against improvement activity in 2018/19 - **Oct-19**	
QIP39	**Outpatients**	Learning tools are	90% of OP areas rated	92.3% March	CQC Inspection 2018 -	Beverley	Head of	Baseline (Quarter 1) patient	Friends and Family Test Scores	Quarter 4 re-audit waiting

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	To use learning tools such as complaint and survey data to improve the outpatient service. To improve the availability of data on wait times in clinics	not always fully utilised. Data is not always available consistently on wait times in clinics.	green or blue Patient Experience Fundamental Standard 90% of OP areas rated green or blue Staff Experience Fundamental Standard Outpatient Governance Committee held monthly Friends and Family Test Scores for Outpatients above 95% Increase in positive compliments or comments on NHS Choices Improved waiting times at clinics	2019 data 92.5% March 2019 data achieved 98% April 2019 data 41 annual to be agreed following initial audit in May 2019	The trust should ensure they develop processes to formally monitor patient waiting times	Geary, Chief Nurse and Dr Purva, Chief Medical Officer	Outpatient Services (Eileen Henderson)	waiting times audit completed - **May-19** Staff experience survey developed for permanent outpatient staff members not included in the Fundamental Standard Inspection cohort, including medical staff, allied Health Professional and specialist nursing staff which focusses on environment, clinic times etc - **May-19** staff experience survey developed for staff members attending outpatient areas to deliver clinics including medical staff, allied Health Professional and specialist nursing staff which focusses on environment, clinic times etc. - **May-19** staff experience survey approved by Outpatient Governance Committee for permanent outpatient staff members not included in the Fundamental Standard Inspection cohort, including medical staff, allied Health Professional and specialist nursing staff - **Jun-19** staff experience approved by Outpatient Governance Committee for staff members attending outpatient areas to deliver clinics including medical staff, allied Health Professional and specialist nursing staff - **Jun-19** Agree a process to obtain regular reports from Datix that captures all accurate and appropriately assigned Outpatient Clinical Area PALs and complaints - **Jun-19** Baseline from PALs and Complaints reported in 2018/19 following agreement of process	and comments reported at Outpatient Governance Committee as part of the agenda on quarterly basis - **Aug-19** Quarter 2 re-audit waiting times audit completed - **Aug-19** Outpatient specific SOPs / guidance section live on Pattie - **Sep-19** PALs and Complaints reported as per agreed process at Outpatient Governance Committee as part of the agenda on quarterly basis - **Sep-19** 6 monthly report of Patient Experience Fundamental Standards Inspection results focussing on negative and positive themes presented at Outpatient Governance Committee - **Oct-19** Completion of look back exercise against improvement activity in 2018/19 - **Oct-19** Quarter 3 re-audit waiting times audit completed - **Nov-19** Patient information for Outpatients on external HUTH website improved - **Dec-19**	times audit completed - **Feb-20**

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								presented at Outpatient Governance Committee - **Jun-19** Patient engagement programme developed for targeted areas based on the 2018/19 PALs and Complaints report - **Jul-19** Pattie webpage or workspace for Outpatient staff developed - **Jul-19**		
QIP47	**Acute Kidney Injury** The project aims to increase compliance specifically with the following Quality Statements from NICE Quality Standard 76: • Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition. • Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level ... monitored. • Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected. This will be a short-term project to support the completion of the outstanding work from the 2018/19 QIP.	The Trust's care of patients at risk of acute kidney injury does not fully comply with NICE Quality Standard 76	Quality statement 2: People who present with an illness with no clear acute component and 1 or more indications or risk factors for acute kidney injury are assessed for this condition Quality statement 3: People in hospital who are at risk of acute kidney injury have their serum creatinine level ... monitored Quality statement 4: People have a urine dipstick test performed as soon as acute kidney injury is suspected or detected.	not compliant not compliant partially compliant	None	Prof Sunil Bhandari, Dr Martin Chanayireh, Consultant Nephrologists	Dr Sofia Sofroniado, Consultant Nephrologists	AKI re-audit report completed including agreed next steps - **Jun-19** Formal assessment of NICE Quality Standard 76 - **Jun-19** Completion of look back exercise against improvement activity in 2018/19 - **Jun-19** Next steps following re-audit agreed - **Jul-19**		
QIP48	**Mental Health** • To improve the sharing of patient information between the Acute Trust and Mental Health services both internally and externally • To ensure that all children with Mental Health needs have an individual care plan appropriate to their needs and risk assessments undertaken to eliminate potential self-harm • To ensure that all mental health training is recorded centrally • To ensure the SLA (Adults) with Humber is monitored and delivered via the specific Mental Health Committee	Information and governance arrangements are not as robust as the Trust requires.	Quarterly operational working group with CAMHs leads and HUTH Children's Service held 95% compliance quarterly with the completion of the individual Risk Assessments for Children and Young People at risk of self-harm 95% compliance with paediatric relevant staff trained in CAMHS Established bi-monthly Mental Health Committee held	No baseline 100% No baseline No baseline	CQC Inspection 2016 - Regulation 12 – Safe Care and Treatment - The trust must ensure it works actively with others internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services. CQC Inspection 2018 - Regulation 12 - Safe Care and Treatment - The trust must ensure that patient risk assessments are completed, in particular… mental capacity assessments.	Beverley Geary, Chief Nurse	Assistant Chief Nurse (Kate Rudston)	Completed review of all improvement work undertaken in 2018/19 to ensure they are embedded - **May-19** Review of existing SLA with Humber MH to ensure that monthly reports on the numbers of detainees and holds are received as per agreement - **May-19** Workshop for external agencies and Trust representatives to scope Terms of Reference for a Mental Health Committee - **May-19** Q1 2019/20 audit of the individual self-harm risk assessments completed,	Q2 2019/20 audit of the individual self-harm risk assessments completed, compliance assessed and any learning identified - **Sep-19** Terms of Reference for a Mental Health Committee agreed by appropriate Trust committee such as Operational Quality Committee - **Nov-18** Q3 2019/20 audit of the individual self-harm risk assessments completed, compliance assessed and any learning identified - **Dec-19**	Mental Health Committee commenced - **Jan-19** Patient Experience process for Mental Health patients scoped - **Feb-19** Q4 2019/20 audit of the individual self-harm risk assessments completed, compliance assessed and any learning identified - **Mar-20**

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								compliance assessed and any learning identified - **Jun-19** Training Needs Analysis based on the review of Mental Health, Learning Disabilities and Autism training requirements for front facing staff completed in 2018 approved at relevant committee such as the Mental Health Committee or Safeguarding Committee - **Jun-19** Develop SLA for CAMHS to include data collection requirements of referrals - **Jun-19** Training Needs Analysis developed based on the review of Mental Health, Learning Disabilities and Autism training requirements for front facing staff completed in 2018 for front facing staff - **Jun-19** All datix incidents related to children are reviewed by the Safeguarding Children's Team - **Jul-19** Training matched with HEY24/7 for both paediatrics and adults - **Jul-19** Training plan based on the review of Mental Health, Learning Disabilities and Autism training requirements for front facing staff completed in 2018 developed for implementation - **Jul-19**		