Humber Teaching
NHS Foundation Trust

2017-18
Quality Account

'The Improvement Journey'

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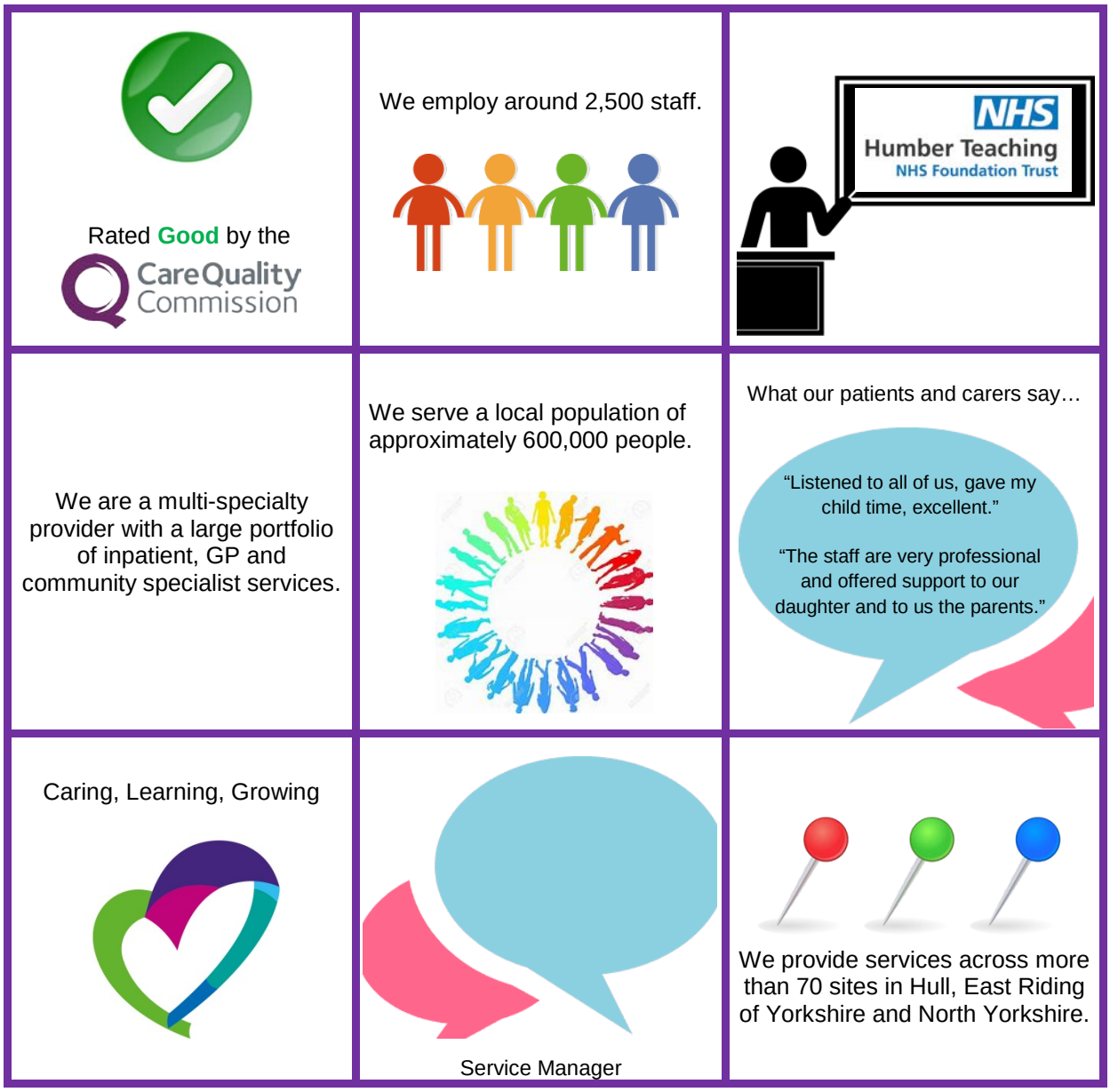


Our Vision

We aim to be a leading provider of integrated health services, recognised for the care compassion and commitment of our staff and known as a great employer and a valued partner.

About the Trust:

Our Values

CARING	Caring for people while ensuring they are always at the heart of everything we do
LEARNING	Learning and using proven research as a basis for delivering safe, effective, integrated care
GROWING	Growing our reputation for being a provider of high-quality services and a great place to work

These values shape the behaviour of our staff and are the foundation of our determination to:

- Foster a culture in which safe, high-quality care is tailored to each person's needs and which guarantees their dignity and respect;
- Achieve excellent results for people and communities;
- Improve expertise while stimulating innovation, raising morale and supporting good decision-making;
- Unify and focus our services on early intervention, recovery and rehabilitation;
- Engage with and listen to our patients, carers, families and partners so they can help shape the development and delivery of our healthcare;
- Work with accountability, integrity and honesty; and
- Nurture close and productive working relationships with other providers and our partners.

Our Strategic Goals

For further information on our strategic goals, please see Annex 4.

The Areas We Serve

We provide a broad range of community and inpatient mental health services, community services (including therapies), learning disability services, healthy lifestyle support and addictions services to people living in Hull and the East Riding of Yorkshire.

The Trust also provides specialist services for children, including physiotherapy, speech and language therapy and support for children and young people and their families who are experiencing emotional or mental health difficulties.

Our specialist services, such as forensic support and offender health, support patients from the wider Yorkshire and Humber area and from further afield.

The Trust also manages Whitby Community Hospital in providing inpatient, outpatient and community services to Whitby and the surrounding area. In addition, the Trust established Humber Primary Care Ltd. (a private limited company) to enable Humber to hold the General Medical Services (GMS) contract for Peeler House, Hessle, one of six GP practices across Hull, Hessle, Cottingham, Market Weighton and Bridlington. Humber Teaching NHS Foundation Trust is the registered provider with the Care Quality Commission (CQC) for all six GP practices.

What are Quality Accounts?

The purpose of Quality Accounts is to enable:

- **Patients and their carers to make better informed choices**
- **Boards of providers to focus on quality improvement**
- **The public to hold providers to account for the quality of NHS Healthcare services they provide**

In order to provide patients with the assurance that they are receiving the very best quality of care all providers of healthcare services for or on behalf of the NHS are asked to prepare a Quality Account annually.

The requirements for the Quality Account are set nationally by NHS Improvement. Providers are required to ensure they receive external assurance on the quality of the report.

1.1 Chief Executive Statement

It gives me great pleasure to introduce the Quality Account for Humber Teaching NHS Foundation Trust, my second as Chief Executive of the organisation. The report showcases our achievements regarding the quality of our services throughout 2017-18; achieved by our staff who are committed to working in partnership with patients, carers, other providers of health and social care and those who commission our services.

During 2017 the Trust refreshed its Mission, Vision and Strategy which sets out our ambition to be a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff and known as a great employer and a valued partner.

As a Trust we collectively strive to achieve excellence and refuse to be complacent. We are an organisation that learns from our mistakes, responds to constructive feedback about quality and safety, and ensures our patients and carers are at the centre of everything we do.

In the last 12 months we have made significant improvements to the quality and effectiveness of our services during a time in which resources are increasingly scarce and demand is higher than ever. The following are some notable examples of achievements this year:

- During 2017 we were inspected by our regulator the CQC. The inspection involved unannounced inspections of our services, interviews with our staff, patients and carers and examination of information in relation to our performance. I am delighted to report that following the inspection we achieved a rating of 'Good' which is down to the work and commitment of our staff. However, we were rated as 'requires improvement' for the Safe domain, which was an improved position from our 2016-17 inspection. The quality improvement initiatives across the Trust have seen rapid improvements in areas such as use of restrictive interventions and self-harm. Further work continues to improve the systems and processes in relation to the management, investigation and learning from patient safety incidents.

- In May we were proud to host our very first research conference, 'Developing a City of Research 2017', a reference to Hull's designation as the current UK City of Culture. The event was open to staff, commissioners, NHS partners, GPs, social services teams, academics, charities, media and the public, providing a great opportunity for speakers from a range of specialties and organisations to showcase the ground breaking research they are involved in with our Trust. All 140 places were quickly taken and we were delighted that the delegates representing at least 20 organisations praised "the incredible work" and the "passion", "positivity and energy in the Trust". As well as hearing from national and international experts we were delighted to hear from people who access our services and take part in our studies. Following the incredible success of this inaugural research conference this will be an annual event.

- In line with the national picture, safer staffing levels remain a high priority area for the Trust. We are continuing to use innovative methods to promote recruitment and retention. We have strengthened our processes around the escalation of staffing shortfalls in order to ensure that our units are safely staffed and supported from a senior level. We face a number of challenges at a national level in terms of the ability to recruit to medical and clinical roles and this is further compounded by the financial pressures facing NHS organisations. Within the Trust, the challenge is recruiting to future vacancies which will arise as a result of an ageing workforce, with retirement accounting for the highest reason for employees leaving the nursing profession and the potential for the Trust to lose over 200 qualified nurses over the next five years due to age retirement. The Trust is looking at opportunities to retain staff who are due to retire and already has in place a "retire and return" scheme. To address future vacancies, the Trust is working with the universities across its geographical area to offer placements and to offer employment opportunities to newly-qualified nurses. The Trust is looking to fund nursing opportunities through the apprenticeship levy, giving opportunities to existing non-qualified staff to gain a degree to become a registered nurse. Work is also underway to look at new roles to support our services, including the new role of Nursing Associate, and the Trust is already piloting this scheme and hopes to be able to expand this further in the 2018-19 academic year. The Trust already offers career pathways and is in discussion with the university to expand learning opportunities and exploring the option of a university-accredited preceptorship scheme. The Trust is working with local schools and colleges to promote roles within the Trust and the wider NHS through career events and the Trust has a successful work experience scheme in place for sixth form students wishing to pursue a career in medicine.

- The challenges around recruitment and retention of a medical workforce in primary care and mental health services are a national problem to which Humber has not been immune. However, the Medical Directorate has developed a plan over the past six months which focuses on not just recruitment and retention, but also exploring alternative models of care which can use the skills and strengths of other health care professionals to do work traditionally overseen by doctors. This has been successfully rolled out in our primary care services. In primary care, we are working closely with our Clinical Commissioning Group (CCG) partners and are actively supporting their international workforce recruitment agenda. In addition, our Primary Care Directorate will be seeking to build on the Humber Teaching brand, encouraging GPs from outside the area to see us as a forward thinking and ambitious organisation that is keen to support and develop their personal and professional ambitions. We firmly believe that we can offer a career which offers the opportunity to practice patient-centred care within an organisation that can support academic research, teaching and opportunities to work in other clinical services as part of a portfolio. We have placed a strong emphasis on enhancing our substantive consultant workforce so that we can reduce our reliance on agency staff. We are working to support transition from training to consultant posts over the next 18 months. In addition, we have developed a bespoke recruitment campaign to develop the concept of the Trust as an aspiring organisation which is seeking talented colleagues to join us with a bespoke offer based on their career point and ambitions.

- We continue to invest in our staff and launched a leadership programme in 2017 to ensure our workforce has leaders who are able to work across our services acting as advocates for our patients and staff as we go forward on our improvement journey. The second cohort of the programme will undertake a review of future delivery models working with the NHS Leadership Academy to inform service development in the Trust.

- The Trust continues to develop the portfolio of services that it delivers. This has resulted in further GP surgery contracts being acquired by Humber FT, in addition to the renewal of the Field House Surgery contract. In October 2017, Humber NHS FT established Humber Primary Care Ltd. (a private limited company) to enable Humber to hold General Medical Services (GMS) contracts with the practices. We will continue to deliver the objectives outlined in the Primary Care Strategy (2017-19).

- In April 2017, the East Riding Community Services contract was moved to another provider, which required a safe and comprehensive handover of services through a robust demobilisation project. In addition, Pocklington Community Mental Health and Child and Adolescent Mental Health Services (CAMHS) services were transferred to Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) in January 2018, again requiring a robust demobilisation project. The planned transfer of all services was completed in a timely and safe manner.

- On behalf of our patients and service users we are taking an active role in the Sustainability and Transformation Partnerships (STP) programme which aims to develop shared proposals to improve health and care across health and social care systems. The Trust has representation across all work programmes with a particular focus on the mental health work stream where I am the Senior Responsible Officer (SRO). The priorities agreed in 2017-18 will continue to be developed in 2018-19 with a key focus on partnership working with patients, carers and other stakeholders and improved clinical engagement.

- Our CAMHS services have successfully aligned their service model to ‘Thrive’, a national model for delivering focused support to young people and their families. This has seen significant quality changes to the composition of teams and the development of robust pathways to deliver care including Self-harm, Depression, Anxiety, Trauma Psychosis; Attention Deficit Hyperactivity Disorder (ADHD) and conduct.

- Our CAMHS service has also recently launched a safe space for young people aged 14 years and over who require support during a crisis. The service is working with the local authorities, CCGs and third sector organisations to offer an alternative to Accident and Emergency (A&E). Evidence is already emerging to show that access to CAMHS inpatient pathways is being avoided and children are being supported close to home.

- A dedicated eating disorder service was launched in 2017 for children living in Hull and East Riding. This enables children to receive high quality specialist community-based care when they need it, reducing the need for admission to specialist placements away from home.

- The Trust has successfully achieved planning permission to build a flagship inpatient service for children and their families to access within their local community. This will further support our approach to providing high quality service for children and families. It is anticipated that the building of the unit will commence in the 2018-19 financial year.

- The Trust name will change on 1st April 2018 to Humber Teaching NHS Foundation Trust following approval by the Council of Governors and Trust Board. This will further progress our strategic aim to be recognised as a world-class specialist education and teaching provider. This will be an important strategic development in the year ahead and will emphasise our commitment to delivering excellent services to our patients and carers, development opportunities for staff and to continue to work with our academic partners to nurture the future generation of doctors, nurses and other health care professionals.

The Quality Account showcases further examples of quality improvements achieved across all of our services during 2017-18. I am immensely proud of everything we have achieved in the last year and this is testament to the hard work and dedication of our staff. As we look ahead to the coming year it is important to recognise the significant financial challenges that we, like many trusts, continue to experience. However, with our commitment to achieving both efficiencies and quality improvements through a quality improvement approach, we are confident that we can meet our financial targets and continue to provide high quality services. We look forward to another year and building on our success and keeping quality at the heart of everything we do.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Michele Moran
Chief Executive, Humber Teaching NHS Foundation Trust

1.2 Edith's Journey – A Patient Story

Edith first became involved with the Neighbourhood Care Team following a referral for a mobility assessment. Staff visited Edith and found her on the floor having fallen two days previously. Edith attended the emergency department at a local hospital and was discharged home with antibiotics and diagnosis of a urine infection with no care package in place.

Edith was admitted to the Neighbourhood Care Team's 'hub' bed at a local residential home where she received physiotherapy, occupational therapy and nursing input to improve her mobility, progress her independence with meal preparation and assess her continence needs and pressure area care. Upon discharge Edith was referred to Red Cross services and Social Services for aids and adaptations and ongoing care.

A few months later, Edith became involved with the Neighbourhood Care Team once more following a fall at home. Edith had cancelled her daily calls through Social Services and at this point was referred for physiotherapy and occupational therapy for falls prevention but wanted to cancel these visits also. Staff agreed to visit her for assessment anyway. Edith was found on the sofa where she had been for around 48 hours, unable to weight bear due to pain. Following discussion between Edith's physiotherapist and the duty GP at her surgery, Edith's physiotherapist arranged for her to attend A&E for assessment and she was subsequently readmitted to the hub beds where she received physiotherapy and occupational therapy, a nursing assessment and Social Services assessment. Edith progressed well in the hub and was able to mobilise independently with an aid and complete her own personal care with supervision on discharge.

Edith was able to return home once more with three calls a week through the intermediate care team.

During the Neighbourhood Care Team intervention, weekly meetings were held with Edith's GP and Social Services to help Edith identify when her health is deteriorating and to ensure a minimum care package of one call per day is maintained in the long term to enable Edith to manage better at home.

Through close working with the GP, onward referrals have been made to mental health services and urology.

Edith continues to receive support from the Long-Term Conditions Nurse and also the Neighbourhood Care Team. She also continues to receive physiotherapy and occupational therapy to improve her independence and allow her to return to outdoor mobility which Edith is keen to do.

When telling her story, Edith told us that the staff always have her best interests at heart. She said, "The services and support I have had have been extremely good and I can't fault any of them. I feel very well looked after. Sometimes I think to myself, I have all these people coming in, helping and doing things for me, I think I'm the Queen of Sheba!"

Part Two: Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement

In part two of our Quality Account we outline our planned quality improvement priorities for 2017-18 and provide a series of statements of assurance from the Board on mandated items, as outlined in the 'Detailed requirements for quality reports 2017-18' (https://improvement.nhs.uk).

In this section we will also review the progress we have made in relation to the quality priorities we set ourselves in the 2016-17 Quality Account.

2.2 Our Approach to Quality Improvement and Quality Governance

2.2.1 Quality Improvement

Our executive lead for quality improvement is the Medical Director. Over the coming year we will focus on developing the capacity, capability and culture of continuous quality improvement.

Capacity for quality improvement activities will be realised from within existing teams in addition to ensuring that all individuals have sufficient time to undertake annual appraisal, mandatory and required training and team quality and safety meetings. We see these activities as being a fundamental part of our collective day to day work both in clinical and corporate support services. We acknowledge that 'freeing up time' will be a challenge; however we are certain that in the long run it will benefit both patients and staff.

We will develop our capability to support Quality Improvement (QI) by working with quality improvement bodies to support individual and staff training in acquiring the required technical skills. We will identify and support staff who already have the technical QI skills but are not currently using them. We demonstrated through our Reducing Restrictive intervention and Suicide and Self harm work that we have the capability to deliver successful improvement and we will seek to scale up this work and encourage local initiatives right across the breadth of our services. We have concluded that we will not be prescriptive regarding the methodology to be used as many of them have similar underlying philosophies. To focus on one methodology may limit our ability to realise the diversity of QI skills already present in our workforce.

We will develop a culture of continuous quality improvement at all levels. The Board has recently started to develop its own capabilities in terms of quality improvement and will develop a pledge to support others to also participate in similar initiatives. We will encourage an approach whereby service user involvement is considered central to our work, and over time, co-production of service developments and improvement with service users will become a cultural norm. We understand developing the culture of continuous quality improvement will take time, effort and persistence.

QI capacity and capability will be supported and monitored through the Quality Committee with every care group required to provide updates on a regular basis on the improvement and innovation that is taking place in their service.

In developing the Quality Improvement Plan (QIP) we have taken into account:

- National and local commissioning priorities
- Trust quality goals
- Existing quality concerns and plans to address them
- Key risks to quality and how these will be managed
- The content of the Sustainable Transformation Partnership Plans.

The QIP supports our quality priorities which will be further developed during 2018-19.

2.2.2 Quality Governance

In May 2017 the Quality Committee was established in order to strengthen the Board's oversight of quality. The Quality Committee is chaired by a Non-Executive Director and is a sub-committee of the Board. The purpose of the Quality Committee is to:

- Oversee and support quality improvement to support the journey of taking the Trust to becoming a 'high performing organisation' that delivers excellence in patient care
- Assure the Trust Board that appropriate processes are in place to give confidence that:
    - Quality, patient safety performance and associated risks are monitored effectively and that appropriate actions are taken to address any deviation from accepted standards and to manage identified risks
    - Ensure performance in relation to information governance and research and development requirements is monitored effectively with appropriate actions being taken to address any performance issues and risks.

Each care group has a Quality and Safety Group with responsibility to ensure that robust quality governance arrangements address the key elements of quality and safety. Each care group is required to provide assurance to the Quality Committee against its QIPs.

The Trust has embedded a range of QI approaches to support effective quality governance and improvement. These are as follows:

- Perfect Ward App. This is an iPad-enabled, in the moment clinical audit tool which clinicians use to audit their practice and care environment. Results are immediate ensuring any improvements required can be immediately taken
- Electronic Risk Registers – this approach ensures teams capture, manage and escalate risks
- Staff Training and Development opportunities supported by our learning centre and an in house skills laboratory
- Leadership and organisational learning and sharing events and newsletter
- A range of approaches to gather patient/service user and carer real time feedback and engagement
- The use of an app based tool (HealthAssure) to support the dissemination of evidence based practice and the delivery of clinical audits.

2.3 Looking Back: Review of the Quality Priorities in 2017-18

As part of our 2016-17 Quality Account following consultation with our stakeholders, the Board of Directors agreed three quality priorities to be addressed via the Quality Account during 2017-18 as follows:

Priority One: We will work with partners to reduce the stigma of mental illness by delivering a recovery focussed approach to achieve social inclusion.

Why this is important:

In mental health, recovery does not always refer to the process of complete recovery from a mental health problem in the way that we may recover from a physical health problem. The term recovery is most frequently used to describe the personal journeys experienced by people with mental health problems as they work towards living more meaningful and satisfying lives. The continued existence of 'symptoms' is not considered a weakness to achieving these goals. Recovery takes into account the obstacles that people face in their daily lives and focuses on building the resilience of people and not just treating or managing their problems. Recovery helps people rebuild their life and as a result, find meaning in what has happened and a new sense of self and purpose.

What we did in 2017-18:

The following is a summary of the key actions that we have completed in 2017-18:

What we said we would do	What we did
We will ensure patients, carers and families play a key role in the planning and delivery of our services.	• Launched a Patient and Carer Experience and Engagement forum to bring lived experiences and individual perspectives to inform our service developments. • Involved our young people in the planning and development of the CAMHS inpatient facility. • Strengthened our working relationships with community groups to ensure we are working in partnership with everyone who uses our services. • Working together with patient representatives we have implemented an e-Consult consultation service in our GP Practices to improve access to primary care.
We will empower people to work with us so they can manage their own health and social care needs.	• Commenced roll out of our Mental Health Rehabilitation strategy. • Launched the social prescribing pilot in the East Riding delivered by our Health Trainers service. • Launched the young people's safe space in partnership working in partnership with Humbercare.
We will deliver responsive care that improves health and reduces health inequalities. Developing an ambitious prevention and recovery strategy.	• Refreshed and commenced roll out of the Trust Suicide and Self-Harm Mitigation Strategic Plan 2017-2019. • Continued to develop the My Health Guide app so that people with a learning disability can better manage their own health and care needs. • Improved the delivery of primary care services for people with a learning disability through our GP practices.

Priority Two: We will implement the Trust Organisational Development Plan to support staff with their development, health and wellbeing.

We will implement the Trust Organisational Development Plan to support staff with their development, health and wellbeing.

Why this is important:

A high-performing organisation recognises the need to invest in its workforce as vital to its success. The 2017-2022 Workforce and Organisational Development (OD) Strategy is a key document that draws together all that the Trust does to attract, retain, support and reward its staff to meet our strategic priorities. We recognise that many of our staff "go that extra mile" every day to deliver high quality services, and we are committed to making Humber Teaching NHS Foundation Trust a great place to work where staff feel empowered to make a difference to the outcomes for their patients.

What we did in 2017-18:

The following is a summary of the key actions that we have completed in 2017-18:

What we said we would do	What we did
Develop a healthy organisational culture.	• Developed a revised Staff Charter demonstrating our commitment to our staff and what is expected of them. • Increased the uptake of the flu vaccine across our staff groups. • Invested in our leaders through a bespoke leadership module and regular leadership forums. • Improved our support for staff who may find themselves needing addition support following a patient safety incident.
Invest in teams to deliver clinically excellent and responsive services.	• Developed and implemented Suicide Awareness and Self-Harm training (SASH) together with an expert by experience. • Implemented training on Clinical Risk Assessment Tools to support our

What we said we would do	What we did
	staff in clinical decision making. • Commenced safety huddles in teams to support them to deliver safe care and raise awareness of patient safety. • Achieved over 80% compliance against a suite of safeguarding training across our services.
Enable transformation and organisational development through shared leadership.	• Transformed the Mental Health Response Service, Mental Health Liaison Service, Specialist Public Health Nursing and CAMHS working with service users and our commissioners.

Priority Three: We will work with our staff, patients, carers and the public to co-design improvements to the Trust's inpatient facilities

Why this is important:

As a Trust with Caring, Learning and Sharing at the heart of our values, it is crucial that when evaluating and designing improvements to our services we are able to hear the voice of our staff, patients and carers.

Developing a culture of involvement and meaningful engagement, will lead to sustained improvements in the care that we deliver and a workforce that feels engaged and valued.

What we said we would do	What we did
Co-design improvements to the Trust's inpatient facilities.	• Our staff have worked proactively with patients to reduce restrictive interventions in our mental health in inpatient units. • We have worked with patients to ensure they have access to the internet. • Refurbishment of Maister Lodge, our older people's unit, is underway with improvements informed by staff, patients and carers. • We are using feedback from surveys, e.g. the Friends and Family Test to gather experience to inform improvements. • Young people have worked with us on the design of the proposed CAMHS Unit.
Give patients and carers a key role in the recruitment of our staff and the reviews of our services.	• Stakeholder panels which include patients/carers are used for senior appointments. • Many teams routinely use service users in their recruitment for all staff posts.
Capture carers' stories to inform our service improvements.	• A patient and carer stories framework has been developed with stories reported monthly to the Board. • We have introduced the use of patient stories at the Commissioner Clinical Quality Forum to inform the commission of our services.
Develop patient and carer experience targets.	• Targets for patient and carer experience are identified in each Care Group's QIP capturing initiatives for improved patient and carer engagement and patient communication and information.

2.4 Looking Forward: Our 2018-19 Quality Priorities

The Trust is committed to continuous quality improvement and uses a range of initiatives to drive improvement in all of the services it provides. Throughout 2018-19 the Trust will continue to drive forward the priorities identified in 2017-18 whilst focussing on three key priority areas informed by our staff in consultation with patients, carers and our partners.

How we identified our priorities for 2018-19:

Information from Trust quality improvement systems was collated and presented to our staff, patients, carers and our partners via a well-attended workshop in February 2018. Facilitated table discussions held throughout the day were designed around the Trust strategic objectives. The themes of the discussions were captured and developed into quality priorities. The quality priorities were presented to the Board with the following three being agreed by the Board at its meeting held in public in February 2018.

Priority 1 Ensure we have meaningful conversations with patients/carers to develop therapeutic relationships and engagement in service delivery	**Strategic Goal 1** Innovating quality and patient safety **Strategic Goal 2** Enhancing prevention, wellbeing and recovery **Strategic Goal 5** Fostering integration, partnerships and alliances
Priority 2 Ensure that quality improvement is a part of every staff member's role to maximise patient safety across all of our services	**Strategic Goal 1** Innovating quality and patient safety **Strategic Goal 3** Developing an effective and empowered workforce
Priority 3 Embed best available evidence in practice utilising patient reported and clinical reported outcome measures (PROMS, CROMS) Enhancing prevention, wellbeing and recovery	**Strategic Goal 1** Innovating quality and patient safety **Strategic Goal 2** Maximising an efficient and sustainable organisation **Strategic Goal 6** Enhancing prevention, wellbeing and recovery

Priority One: Ensure we have meaningful conversations with patients/carers to develop therapeutic relationships and engagement in service delivery.

Why this is important:

Meaningful conversations are fundamental to the delivery of excellence in health care. Unless we listen and engage, we cannot be certain that we are meeting the needs of the communities we serve. A genuine culture of involvement will enable the Trust to learn and grow in line with our values.

In order to be meaningful engagement needs to be genuine, not tokenistic and ensure that all members of the community have an equal opportunity to be heard.

In line with the principles of the Triangle of Care staff need to feel empowered to involve patients and carers in decisions about care and to feel supported to listen to feedback both positive and negative. Likewise, patients' carers and families need to trust that their views are heard and respected. Without a culture of genuine openness to involve and learn the Trust will not reach its aspiration to be an outstanding provider of health care.

What we will do in 2018-19:

We will:

- Always ask you who you want us to share your information with
- Ensure our staff are empowered to involve you
- Ensure that our methods of engagement are accessible and adapted to meet the needs of our community, using a range of communication methods
- Always involve you in the planning of your care

How will we know we are making a difference?

In order to demonstrate that we are making progress against this priority we will:

- Audit clinical records to capture evidence of a discussion regarding information sharing and patient involvement in care planning
- Refresh our Equality and Diversity and our Service User and Carer Involvement Strategies to include these priorities. Our annual report for 2018-19 will describe improvements and achievements

Priority Two: Ensure that quality improvement is a part of every staff member's role to maximise patient safety across all of our services.

Why this is important:

Quality Improvement is about making health care safe, effective, timely, patient centred, efficient and equitable. As a Trust we continually strive to improve and learn.

As a Trust we collect a wide range of information to enable us to continuously assess the quality and safety of our services. Our regulators, the CQC and our commissioners also identify areas of good practice and areas we can improve upon. A quality improvement approach helps to develop a culture of openness to change through the involvement of staff, patients and carers to achieve systematic sustainable change.

What we will do in 2018-19:

We will:

- Develop a leadership style that encourages new ideas and develops a culture of continual quality improvement underpinned by developing our approach to quality improvement
- Develop the skills of our staff in relation to quality improvement and the use of technology
- Embed a culture of asking ourselves "what have we done that has made a difference to our patients and carers" by utilising feedback from patients and carers in our clinical staff appraisal process
- Develop a meaningful and effective approach to learning from incidents, compliments, complaints and feedback with our staff, patients and carers
- Reduce harm to our patients through taking action to reduce the incidence of pressure ulcers acquired in our care
- Enhance our focus on patient safety incidents by supporting our staff to identify, report and learn from patient safety incidents.

How will we know we are making a difference?

In order to demonstrate that we are making progress against this priority we will:

- Describe our approach to rolling out quality improvement at scale and report on improvements through our quality dashboard and annual reports

- Increase the number of staff trained in improvement methodology
- Further reduce the number of pressure ulcers acquired in our care
- Include feedback from service users and carers (either service/Trust level feedback or individual where available) in our appraisal process.

Priority 3: Embed best available evidence in practice utilising patient reported and clinician reported outcome measures (PROMS, CROMS)

Why this is important:

It is important that we measure outcomes to determine whether the care we deliver is effective. There are a range of outcome measures available. PROMS capture a person's perception of their health and CROMS capture the clinician's perception. On an individual level these measures help us to detect improvements or worsening of symptoms and direct the choice of appropriate treatment. At a Trust level the use of outcome measure helps us to determine how effective our services are.

By developing and implementing standardised, evidence based metrics that incorporate National Institute for Health and Care Excellence (NICE) standards there should be more effective and comprehensive assessment of the care provided to patients to inform improvement in services and ensure equity of access to high quality care.

What we will do in 2018-19:

We will:
• Implement the NICE guidance informed depression pathway across our Adult Mental Health Services • Roll out PROMS and CROMS across identified services within Adult Mental Health • Evaluate the effectiveness of our services using the agreed outcome measures.

How will we know we are making a difference?

In order to demonstrate that we are making progress against this priority we will:

- Utilise the NICE Guidance informed pathway for depression across Adult Mental Health Services with a focus on all Community Mental Health Teams (CMHTs) as a minimum having implemented the pathway
- Identify a suite of CROMS and PROMS and implemented across all CMHTs as a minimum
- Include CMHT CROMS and PROMS data reports in the Integrated Quality and Performance Tracker (IQPT) by quarter three 2018-19.

2.5 Statements of Assurance from the Trust

Review of Services

Humber Teaching NHS Foundation Trust held a number of contracts for the services delivered by the Trust and for services delivered for the Trust by other providers.

Working with our commissioners, during 2017-18 Humber Teaching NHS Foundation Trust provided 87 and sub-contracted 49 relevant health services. The most significant contracts agreed were as follows:

- NHS ERY CCG – Mental Health, Learning Disability, Primary Care and Community Services
- NHS Hull CCG – Mental Health, Learning Disability, Primary Care and Community Services
- NHS Vale of York CCG – Community Services
- Tees Esk and Wear Valleys NHS Foundation Trust – Mental Health Services (York Locality)
- NHS England – Medium and Low Secure Mental Health Services, Child Health Information Service, Primary Care Services and School Age Vaccination & Immunisation Services
- Hull City Council – Mental Health and Learning Disability Services
- East Riding of Yorkshire Council – Mental Health and Learning Disability Services, Substance Misuse Services, Community Services and Integrated Public Health Nursing Services
- City Health Care Partnership CIC – Mental Health Services, Community Services and Corporate Services
- NHS Hambleton, Richmond and Whitby CCG – Whitby Community Services.

The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2017-18 represents 97.44% of the total income generated from the provision of relevant health services by Humber Teaching NHS Foundation Trust for 2017-18.

Improving Care through Clinical Audit

We have a well-developed and extensive clinical audit programme for the Trust informed by our staff, patients and national requirements. During 2017-18, seven national clinical audits and one national confidential enquiry covered relevant health services that Humber Teaching NHS Foundation Trust provides. During that period Humber Teaching NHS Foundation Trust participated in 90% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Humber Teaching NHS Foundation Trust was eligible to participate in during 2017-18 are as follows:

National Clinical Audits

National Pulmonary Rehabilitation Audit
National Diabetes Foot Care Audit
National Audit of Inpatient Falls (NAIF) Round 2
The Sentinel Stroke National Audit Programme (SSNAP)
National Clinical Audit of Psychosis
National Audit of Intermediate Care (NAIC)
Learning Disability Mortality Review Programme (LeDeR)
Prescribing Observatory for Mental Health (UK) (POMH-UK) – Topic 15b Prescribing Valproate for Bipolar Disorder
Prescribing Observatory for Mental Health (UK) (POMH-UK) – Topic 17a Use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention

National Confidential Enquiries

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The national clinical audits and national confidential enquiries that Humber Teaching NHS Foundation Trust participated in, and for which data collection was completed during 2017-18, 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 Clinical Audits 2017-18	Cases Required	Cases Submitted	%
National Baby Feeding Initiative	No minimum requirement	TBC	
National Diabetes Foot Care Audit (April-July 2017)	No minimum requirement	433	
National Clinical Audit of Psychosis (NCAP)	No more than 100	96	100%
National Pulmonary Rehabilitation Audit	No minimum requirement	TBC	
National Audit of Inpatient Falls (NAIF) Round 2	No minimum requirement	60	
The Sentinel Stroke National Audit Programme (SSNAP) (April-July 2017)	No minimum requirement	283	
Learning Disability Mortality Review Programme (LeDeR)	No minimum requirement	10	-
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	N/A	12	
POMH-UK – Topic 15b Prescribing Valproate for Bipolar Disorder	No minimum requirement	29	-
(POMH-UK) – Topic 17a Use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention	No minimum requirement	31	-
Prescribing Observatory for Mental Health (UK) (POMH-UK) – Topic 1g & 3d Prescribing high-dose and combined antipsychotics	No minimum requirement	90	-

The reports of 11 national clinical audits were reviewed by the provider in 2017-18 and Humber Teaching NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (please see Annex 5)

The reports of 48 local clinical audits were reviewed by the provider in 2017-18 and Humber Teaching NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (please see Annex 5).

Research

We recognise the importance of investing in research; enabling our staff to learn and grow and our community to participate in healthcare improvement. As there is evidence that people tend to do better in organisations that do research we view this as core business and as such are committed to working with key local, national and international experts, to increase opportunities for our community to take part in studies. Our growth and delivery of research in the Trust contributes to the wider evidence base for better health, increased opportunities for our community to shape services and improvements in the quality of our care locally.

We are immensely proud of our research activity. Based on the size of the population the Trust covers it recruits a significantly larger proportion of people into Portfolio studies than other trusts across the country which provide similar services. National league tables published August 2017 by the National Institute for Health Research (NIHR) for research activity in 2016-17 listed the Trust in the top 50% of mental health trusts (www.nihr.ac.uk/research-and-impact/nhs-research-performance/league-tables, accessed 15 February 2018).

As a relatively small Trust in comparison to many others, this is really something to be proud of. It shows our commitment to research and the importance we place on our community having the chance to contribute to high quality research that will shape future innovation and delivery of services.

Consultant Psychiatrist (and former Medical Director)
Humber NHS Foundation Trust

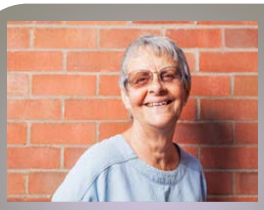
The number of patients receiving relevant health services provided or sub-contracted by Humber Teaching NHS Foundation Trust in 2017-18 that were recruited during that period to participate in research approved by a research ethics committee was 1655.

1129 patients were recruited to the NIHR Portfolio studies and 526 were recruited to local studies. In total, there were 45 Portfolio studies and 25 (non-Portfolio) local studies running in the Trust in 2017-18. The Trust exceeded its target of 660 for recruitment to Portfolio studies in 2017-18 and for the fourth year running has increased the numbers of Portfolio studies taking place in the Trust and the numbers recruited into them. It was also the first NHS site to open, the first to recruit and the first to reach its recruitment target on a number of national Portfolio studies. Patients accessing Trust services are offered a breadth of research opportunities spanning numerous health conditions and many types of study design; approximately a quarter of Portfolio studies involved the evaluation of novel treatment interventions.

In 2017-18 the Trust continued to provide core funding for a small number of key research posts, demonstrating its commitment to grow research, provide increased opportunities for patients to take part in good quality research studies and contribute to the national evidence base for future healthcare delivery.

As the Trust is a partner organisation in the Yorkshire and Humber NIHR Clinical Research Network (CRN), an additional £297k of CRN funding was provided specifically to support research delivery in 2017-18, with a further £16k for specialty leads with Trust contracts, one for dementia and the other for mental health, to champion research across Yorkshire and Humber. Extra CRN funding was also provided for a Trust researcher who has taken on the additional role of a regional research trainer across Yorkshire and Humber, illustrating the quality of experience the Trust has within Research and Development (R&D). In addition the Trust received almost £35k Research Capability Funding from the Department of Health and Social Care (DHSC).

A two-year research strategy for 2017-19 ‘Reaching out with Innovation and Ambition’ was launched at the Trust’s inaugural research conference in May 2017, replacing the previous 2015-17 strategy. As well as the Chief Executive the Research Strategy also included a foreword from the Trust’s Patient Research Ambassador.



Wendy Mitchell
Patient Research Ambassador

‘When you’re given a diagnosis, whatever that condition might be, you might feel like your life is falling apart, feel worthless and of no use to anyone anymore. Participation in research can offer people hope for the future. Being involved makes you feel valued as you’re contributing to possible new developments – you could be helping future generations. I have Alzheimer’s disease, for which there is currently no cure, and without willing volunteers to test new theories there will continue to be no cure or knowledge of how best to live with dementia. We have to normalise involvement in research, but to do this we must have the backing of all healthcare professionals, as talking about research has to be normalised too. Promoting research doesn’t have to eat into anyone’s budget. The NHS can’t move forward without research and research can’t move forward without willing volunteers. Without research we can’t change the future!’

Seven aspirational objectives (below) have been identified in the strategy and during 2017-18 good progress has been made against these.

Wendy Mitchell

Objectives of Research Strategy 2017-19

1. Embed research as core business
2. Increase participation in research
3. Maximise research income
4. Develop new partnerships for applied research
5. Increase capacity and capability for research
6. Strive for excellence in the quality, safety and governance of research
7. Translate research into practice

As part of the national Health Research Authority (HRA) assessment process for research which was implemented in March 2016, the R&D department 'assess, arrange and confirm local capacity and capability' to deliver each new study. Internal R&D procedures have been adapted during 2017-18 to better utilise the local performance management system, EDGE, some elements of which now communicate automatically with the national central system for reporting research performance information.

Each quarter the Trust has published its performance in initiating and delivering (PID) research, a DHSC national benchmark. The PID data in relation to eligible studies (NIHR Portfolio intervention trials) have been posted on the R&D pages of the Trust's website as well as submitted centrally. For quarters one, two and three the NIHR confirmed that the benchmark was met, once any valid exceptions were allowed for (N.B. quarter four had not been published at the time of writing).

Humber has consistently provided excellent help. Recruitment is always a major challenge for work in our area, but Humber has always surpassed recruitment targets. A main reason for this is the team's ability to quickly identify potential barriers and then work creatively to overcome them. We have been particularly impressed with the team's willingness to share their knowledge of how to maximise recruitment with other similar services.

Chief Investigator, University of York and Hull York Medical School

Research performance data has been reported to the Board on a monthly basis, with a more detailed report provided quarterly, helping ensure research has remained high on the Trust's agenda. The R&D Group, chaired by the Medical Director, has met quarterly to ensure appropriate research management, governance, participation in quality research and strengthening of the research culture. The Assistant Director R&D has continued to represent the Trust at various stakeholder meetings, including the CRN Partnership Group.

It is always important for research to have patient and public involvement (PPI) and throughout 2017-18 there have been many examples of how the Trust has achieved this, including:

- Trust Patient Research Ambassador, someone living with dementia, has helped promote research. For example, she presented at the monthly staff induction programme and to the local University of the Third Age, participated in the video for the Annual Members' Meeting, promoted 'Join Dementia Research' as a way for more patients and their supporters to get involved in research and been an active member of the Trust's R&D Group. Her valued contribution culminated in her being awarded Trust Volunteer of the Year in December 2017
- Research participants, including someone with a learning disability, were involved in presentations at the research conference in May 2017, for which the Trust received very positive feedback
- As part of World Alzheimer's Month a couple that has participated in research took part in a national research promotion campaign by the NIHR. This was facilitated via the Trust's research team
- PPI group was established to inform a potential external research grant application
- First Recovery College workshop took place on 'Living with dementia and hope from research' and included a person living with dementia delivering the workshop with the Assistant Director R&D.

Made us think outside the box for a few things…a great learning experience. Brilliant that someone living with/experiencing dementia came to tell their side. Love it.

Workshop Participants

During 2017-18 the R&D department developed new principal investigators and opened studies in services and with professions not previously involved in research. Work continued to establish stronger relationships with higher educational institutions, locally and nationally, and other key stakeholders to ensure as many research opportunities as possible for those accessing Trust services. Collaborating with Chief Investigators not previously worked with resulted in new research studies being opened in the Trust, including from the Collaboration for Leadership in Applied Health Research and Care for Yorkshire and Humber, Sheffield Health and Social Care NHS Foundation Trust, Sussex Community NHS Foundation Trust and the Universities of Oxford, Sussex and York.

The inaugural research conference in May 2017 provided the opportunity to celebrate the Trust's contribution to research and to raise awareness locally. Entitled 'Developing a City of Research 2017' – a reference to Hull's designation as the UK City of Culture – guest speakers included, amongst others, Barry Wright, Professor of Child Mental Health at the University of York, Allan House, Professor of Liaison Psychiatry at the University of Leeds and Julie Jomeen, Professor of Midwifery at the University of Hull. Everyone who completed an evaluation form on the day rated it either 'excellent' or 'good' and for a first event it was a fantastic to have delegates from at least 20 organisations attend.

During 2017-18 new innovative healthcare interventions have continued to be evaluated as part of research in the Trust. For example, one is testing a web-based application for people with memory problems and their supporters in the European-funded study led in the UK by the University of Hull, for which the Trust was the first country to recruit into it. Another is testing a treatment for children with phobias, and again the Trust was the first nationally to recruit to this. Other important research taking place includes studies exploring the genetics of a number of health conditions.

'More has been learned about the genetic basis of these conditions in the last five years than in the 100 years before and we are discovering novel insights which should lead to improved treatments with fewer side effects. These advances are largely thanks to the staff, clinicians and patients who dedicate their time and support to the project and Humber has been a lead centre in this respect so we thank them for all they've done.'

Trial Manager, University of Cardiff (genetics study in psychosis and schizophrenia)

Research has continued to be promoted within the Trust and out in the community, including via social media, at public events such as Hull Memory Walk, Beverley Food Festival and the Tour de Yorkshire, in libraries and general practices, at Clinical Commissioning Group and Council events, via local radio interviews and in voluntary groups. A quarterly research newsletter has been circulated within and outside of the Trust and is available on the Trust's website. The R&D team has also promoted the NIHR's 'I Am Research' campaign. A number of research papers including authors from within the Trust have been published in 2017-18, a list of which is included on the Trust's website. These add to the jigsaw of evidence that will contribute to the enhancement of healthcare in the future.

Commissioning for Quality and Innovation (CQUINs)

CQUIN is an annual scheme where commissioners and providers agree on which areas need more focus for improvement and payments are made for evidencing those improvements. The scheme is refreshed every 12 months and each scheme may be different from preceding years.

A proportion of Humber Teaching NHS Foundation Trust's income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between Humber Teaching NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The values for 2017/18 CQUIN schemes were:

- East Riding/Hull CCGs: CQUINs £880042.80 (1.5% contract value), STP £293347.60 (0.5%),Risk Reserve £293347.60 (0.5%).
- Hambleton, Richmondshire and Whitby CCG: CQUINs £93658.54 (1.5%), STP £31219.51 (0.5%), Risk Reserve £31219.51 (0.5%)
- NHS England: CQUINs £320412.00 (2.5%)

Further details of the agreed goals for 2017-18 and for the following 12-month period are available in the table below and electronically at http://www.humber.nhs.uk/about-our-trust/cquin-scheme-201718.htm

Agreed CQUIN Goals 2017-18

East Riding/Hull Mental Health Services

Indicator Name	Indicator Description
Health & Wellbeing – Improvement of health and wellbeing of NHS Staff	Initiatives for staff health and wellbeing including providing stress management and sleep hygiene training, encouraging outdoor activities and team events
Health & Wellbeing – Healthy food for NHS staff, visitors and patients	Reduction in salt, sugar, fat and sugar sweetened beverages in all food contracts for the Trust's food outlets
Health & Wellbeing – Improving the uptake of flu vaccinations for front line	Flu vaccine target of 70% for front line clinical staff
Physical Health – Cardio metabolic assessment and treatment for patients with psychoses	Physical health checks and interventions for all patients with a diagnosis of psychosis
Physical Health – Collaboration with primary care clinicians	Improve communication and establish closer working between primary and secondary care regarding physical health for patients with serious mental illness
Improving services for people with mental health needs who present to A&E	Mental health and acute care providers to work with other partners (primary care, police, social care) to meet patients' mental health needs more effectively and reduce mental health related attendances at A&E
Transition out of Children and Young People's Mental Health services	Improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health services
Preventing ill health by risky behaviours – alcohol and tobacco	Adult patients in mental health inpatient services are screened for, and offered appropriate interventions to reduce, alcohol and tobacco use

Forensic Secure Services

Indicator Name	Indicator Description
Recovery College	Implement a Recovery College for patients in secure settings, encouraging co-production and co-delivery of training courses
Reducing Restrictive Practice	The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, in order to improve service user experience whilst maintaining safe services

NHS England – Immunisation and Nursing

Indicator Name	Indicator Description
Promoting equality and reducing health inequalities in school delivered Vaccination and Immunisation services in the East Riding	To undertake a Health Inequalities Impact Assessment, assess the findings and develop an action plan for work to be delivered throughout 2018-19.

Whitby Community Services

Indicator Name	Indicator Description
Health & Wellbeing – Improvement of health and wellbeing of NHS Staff	Initiatives for staff health and wellbeing including providing stress management and sleep hygiene training, encouraging outdoor activities and team events
Health & Wellbeing – healthy food for NHS staff, visitor and patients	Reduction in salt, sugar, fat and sugar sweetened beverages in all food contracts for the Trust's food outlets
Health & Wellbeing – Improving the uptake of flu vaccinations for front line	Flu Vaccine target of 70% for front line clinical staff
Supporting safe and proactive discharge	Monitor and reduce delayed discharges for community inpatients
Preventing ill health by risky behaviours – alcohol and tobacco	Adult patients attending the Minor Injuries Unit are screened for, and offered appropriate interventions to reduce, alcohol and tobacco use
Improving the assessment of wounds	Increase the number of chronic wounds that receive a full assessment within four weeks
Personalised care and support planning	Provide personalised care to community patients with long term conditions enabling them to proactively manage their illness

Care Quality Commission (CQC)

Humber Teaching NHS Foundation Trust is required to register with the CQC and its current registration status is registered to provide services. The Trust has no conditions on registration. The CQC has not taken enforcement action against the Trust during 2017-18.

Humber Teaching NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

An announced scheduled 'well-led' inspection was carried out by the CQC in 2017, from 16th-18th October 2017. This was preceded by a number of unannounced inspections across eight core services and substance misuse services.

The overall rating of the Trust improved from the previous inspection to **Good**. The CQC rated the effective, caring and well-led domains as good. The safe domain was rated as requires improvement, although this was an improvement from the 2016 inspection when safe was rated as inadequate.

"Patients and carers had opportunities to give feedback about the care and treatment the service provided. This was through surveys, comment cards, and regular meetings."

Outstanding Practice

Areas of outstanding practice were identified within our learning disability services. These were as follows:

- There was a culture of development and improvement at the learning disability service
- We saw examples of staff who were striving for excellence
- Some members of the team had published research in relation to learning disabilities
- Other team members had received national awards for good practice and leadership skills
- Many members of the staff team had undertaken additional training courses to enhance their practice and improve patient care
- The learning disability service was undertaking innovative practices to support the discharge of patients into their local community. This included working closely with the commissioners of the service to set up new community provision for current inpatients.

"We observed that staff working within services were exceptionally caring, kind and compassionate. All levels of staff took the time to get to know patients and communicate with them."
CQC Inspector 2018

Areas for Improvement

The CQC identified 15 actions that the Trust must take in order to comply with legal obligations. These included the following themes:

- Ensuring staff receive supervision, mandatory training and appraisals
- Ensuring that there are sufficient staff to meet safe staffing levels
- Ensuring that accurate complete and contemporaneous records are maintained
- Ensuring that patients have an up to date risk assessment and management plan in place
- Ensuring that the rooms used by the Mental Health Response Service are properly maintained
- Ensure that all staff know what the Freedom to Speak Up Guardian is and who they are
- Ensuring that audit schedules are in place for the mental health crisis and health-based place of safety services
- Ensuring that governance systems and processes are in place across all community health services
- Ensuring that recovery plans are regularly reviewed in line with Trust policy and best practice
- Ensuring that patients receive regular clinic reviews in line with policy and best practice.

"There was a culture of openness and transparency and good team support among the managers and staff."
CQC Inspector 2018

In addition to the areas the Trust must improve, the CQC identified a number of areas that the Trust should take action to address. A comprehensive Improvement Plan was developed to address the concerns raised via 'must' and 'should' do actions that were detailed in the final inspection reports. The 'must do' Improvement Plan was presented to the Trust Board in February 2018. A Quality and Regulations Governance (QRG) Group has been introduced in order to monitor and drive the delivery of the must and should do actions. The QRG group, report through the Executive Management Team (EMT), the Quality and Patient Safety Group (QPaS) and the Quality Committee to the Board.

"Staff focused on the needs and the experiences of people who used the services and behaved in a way that was consistent with their vision and values."
CQC Inspector 2018

GP Surgery Inspections

During 2017-18 five of our six GP surgeries were inspected by the CQC (Field House, Chestnut, Peeler House, Market Weighton and Hallgate surgeries). All five received a rating of good. Our Field House surgery which was taken over by the Trust from another provider in January 2017 had improved from needs improvement in the last inspection to Good.

Areas for Improvement

A number of areas for improvement were identified by the inspectors. These are as follows:

- Ensuring that all incidents are reported and actioned appropriately
- Ensuring up to date with appropriate safeguarding training
- Ensure policies and procedures in place for the management of high risk medicines
- Implement a process for recording that actions agreed at multi-disciplinary team (MDT) meetings have been followed up
- Review the process for informing patients of blood results by the receptionists
- Implement a process to gain regular feedback from patients and staff regarding the DrFirst triage system
- Continue to improve the Quality Outcome Framework (QOF) scores
- Continue to improve access to appointments.

"There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on."

CQC Inspector 2017

Our Overall Ratings

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community health services for adults	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Requires improvement	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Requires improvement	Good	Good
Forensic inpatient/secure wards	Requires improvement	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Specialist community mental health services for children and young people	Good	Good	Good	Requires improvement	Good	Good
Substance misuse services	Good	Requires improvement	Good	Good	Good	Good
Urgent care services	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Requires improvement	Good	Outstanding ☆	Outstanding ☆	Good	Good
End of life care	Good	Good	Good	Good	Good	Good

Data Quality and Coding

Humber Teaching NHS Foundation Trust submitted records during April 2017 to March 2018 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 99.8% for admitted patient care
  - 100% for outpatient care
  - 98.6% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 97.9% for accident and emergency care.

Clinical Coding Error Rate

Humber Teaching NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017-18 by the Audit Commission.

Information Governance Assessment Report

Information Governance (IG) refers to the way in which organisations process or handle information in a secure and confidential manner. It covers personal information relating to our service users and employees and corporate information, for example finance and accounting records.

Humber Teaching NHS Foundation Trust's Information Governance Assessment Report overall score for 2017-18 at quarter four is 80% Satisfactory. The IG Toolkit was audited and assessed achieving Significant Assurance.

IG provides a framework in which the Trust is able to deal consistently with, and adhere to, the regulations, codes of practice and law on how information is handled, for example the Data Protection Act 1998, the Freedom of Information Act 2000 and the Confidentiality NHS Code of Practice.

The way in which the Trust measures its performance is via the IG Toolkit. The IG Toolkit is a performance tool produced by DHSC, which draws together the legal rules and guidance referred to above as a set of requirements.

In the current version (Version 14.1) there are 45 requirements relevant to this Trust. Each requirement has an attainment level from level 0 (no compliance) to level 3 (full compliance). Trusts must score a minimum of level 2 or above in all requirements to achieve an overall rating of Satisfactory. If any one of the 45 requirements is assessed at level 0 or 1, the Trust will be rated Unsatisfactory.

The Trust's submission for version 14.1 of the IG Toolkit is as follows:

Level 0	No requirements rated at this level
Level 1	No requirements rated at this level
Level 2	26 requirements rated at this level
Level 3	18 requirements rated at this level
Not relevant	1 requirement assessed as not relevant

Key areas of development in the year 2017/2018 have been:

Changes to Data Protection Legislation

The IG Team has reviewed guidance issued by the Information Commissioners Office and the EU Working Party. They have attended external agency provided workshops as part of the Trust's preparations for the introduction of the General Data Protection Regulation. This has informed an Action Plan with timescales on how we will implement this as a Trust. The Plan has been reviewed and approved by the Trust's IG Group and the Quality Committee which is attended by the Executive and Non-Executive Directors and the Chief Executive.

Progress on the Action Plan is monitored through the Trust's IG Group.

Changes to the IG Toolkit

The IG Toolkit will be replaced in April 2018 with the Data Security Protection Toolkit. The IG Team has reviewed and identified changes to Board reporting requirements and evidence to meet the new requirements. Reports and updates on the changes have been provided to the IG Group.

'Spot Check' Audits

To provide assurance that information governance practices are compliant with Trust policy, legal and regulatory requirements and are embedded in the Trust culture, a programme of random 'spot check' audits are conducted throughout the Trust. This ensures that information governance policies, processes and operational activities are effective on the ground and compliant with IG Toolkit requirements and CQC outcomes 2 and 21. If this is not the case, corrective action is recommended by the IG Team. The results of these audits confirm that IG practices are well established and are compliant with Trust policy, legal and regulatory requirements.

Information Assets

The Trust has reviewed its information assets. Its key information assets have been identified and approved by the IG Committee this year. Each key asset has an Information Asset Owner assigned. Each asset has been updated in the Information Asset Register.

The Information Asset Register has been reviewed and amended. The Register has been approved by the IG Committee.

New Systems/Privacy Impact Assessment (PIA)

When new services begin, new information processing systems are introduced or there are significant changes to existing information processing involving personal confidential information, the Trust ensures that it remains complaint with legislation and NHS requirements. This process is a mandated requirement on the IG Toolkit and will be a significant part of 'Privacy by Design and Default' at the change of data protection legislation.

The PIA process has been reviewed this year to ensure it continues to provide a robust assessment ensuring that privacy concerns have been considered and actioned to safeguard the security and confidentiality of personal confidential information, whilst supporting innovation in patient care.

Information Sharing Agreements

This good work has continued in 2017-18 with the development of information sharing agreements between the Trust and partner organisations across the Humber region. This work has enabled the Trust and its local partners to support patient care in the following:

- End of Life and Overnight Nursing Service
- Musculoskeletal Paediatric Podiatry
- Continuity of Care for Whitby Community between Health, Social and Out of Hours providers
- Access to appropriate tailored services for patients who repeatedly attend the A&E Service
- Headstart Hull
- Transfer of patient care to Tees, Esk and Wear Valleys NHS Foundation Trust
- Provide joined up care for children and young people across the Hull and East Riding area
- Facilitating GP access to Whitby Minor Injuries Unit.

Policies

Lawful and correct treatment of personal data is important. During 2017-18 a number of IG Policies were reviewed. All policies have been mapped to identify key policies and which should become standard operating procedures or guidance notes. The mapping helped to ensure that robust information governance is in place to ensure information is lawfully and effectively managed.

Data Quality

Data quality checks are undertaken to provide assurance that data is accurate and ready for migration to national systems. An action plan had been identified to improve data quality.

The Trust has established a Data Quality Group which provides a forum to consider performance against data quality standards, audits and ad hoc requirements across a range of Trust activities. The Data Quality

Group co-ordinates action plans and reports progress to the IGC and Audit Committee (in respect of audits).

A clinical coding audit was performed on discharged patient records in 2017-18. The results from the audit were good. The percentage of records that had a correctly coded primary and secondary episode were:

Overall:
- 90.0% primary
- 77.3% secondary.

This means the Trust can claim a level 2 on standard 514 and level 3 on standard 516 of the IG Toolkit.

Humber Teaching NHS Foundation Trust will be taking the following actions to improve data quality:

- Target relevant Teams where ethnicity recording is on or below the national average to update the ethnicity field in the electronic patient record to enrich future reports and data sets that require this data item
- Circulate ethnicity recording guidance to all teams to remind staff of the correct procedure to follow
- Target the relevant teams where NHS number recording is on or below the national average to update NHS number recording in the electronic patient record
- Monitor improvement in ethnicity and NHS number recording through the Data Quality Group and IG Group.

Freedom of Information (FOI)

The Trust supports the principle that openness and not secrecy should be the norm in public life and wants to create a climate of openness. The Freedom of Information Act 2000 provides individuals with a general right to access all types of recorded information by public authorities. The right is subject to certain exemptions. The aim of the Act is to promote openness and accountability within the public sector.

The Trust responded to 279 requests for information under the Freedom of Information Act, this is a rise of 9%. 114 requests (40%) were not answered within the statutory 20 day timescale due to delays in the information being supplied and a delay in the authorisation process. The FOI process is under review.

Registration Authority (RA)

Humber Teaching NHS Foundation Trust is established as a Registration Authority. The Registration Authority for the Trust's employed staff moved to the Informatics Team. The RA team works closely with Human Resources and IG, together with other relevant organisations externally. For other staff requiring a Smartcard the relevant ID checks are undertaken by either the HR RA staff, the RA Officer or, as necessary, an RA Manager. Once a member of staff's identity is confirmed they are issued with a Smartcard and a pass code.

Staff have to use their Smartcard and pass code each time they log on to access and use information in systems such as SystmOne, Lorenzo or the NLMS e-learning platform.

The Trust has in place an RA Policy and Procedures which has just undergone a review to reflect national RA policy, procedures and guidance.

The RA Officer introduced audit checks to ensure staff have followed registration procedures for identity checks and that the correct role is assigned. The audits also ensure that when someone leaves the organisation their role is removed from the Smartcard.

How We Measure Performance – Meeting NHS Improvement Targets

Humber Teaching NHS Foundation Trust reports to NHS Improvement (NHSI) and NHS Digital. Key indicators are mapped via the IQPT to the NHSI Single Oversight Framework (SOF) (formerly Risk Assessment Framework).

Our Trust uses a 'traffic Light' or 'RAG rating' system to report on performance and quality against our selected priorities and Key Performance Indicators (KPIs), e.g. Red = Weak, Amber = Fair and Green = Good. This is translated to reflect the organisation's performance on the selected priorities and initiatives.

Our internal reporting is split into three levels:

Level 1: Monthly and quarterly performance reports to the Trust Board via the IQPT
Level 2: Monthly Care Group and Service Line Reports via a Dashboard to the Operational Care Groups and their Directors
Level 3: Monthly performance reports at team level to Directors, Service Managers and Team Leaders
We also report externally to our Commissioners via:

Contract Activity Report (CAR)

This is completed on monthly basis by the Business Intelligence Department (BI Hub). The BI Hub was formed during the year to provide a more joined up working approach which improves fluidity and enhances cohesiveness.

This system ensures that we can:

- Monitor critical clinical processes and activities using measures of clinical and corporate performance that trigger alerts when potential problems arise.
- Analyse the root cause of problems by exploring relevant and timely information from different sources and at various levels of detail.
- Manage people and processes to improve decisions, be more effective, enhance performance, and steer the organisation in the right direction.

Meetings are held regularly with Commissioners, Board Members, Care Group Directors, Service Managers and with Team Leaders and their teams.

Internal and external audits are undertaken to ensure our methods of calculation and delivery meet the national and local guidelines.

Performance Indicator returns (PIs)

All SOF and CQC indicators are reported in the IQPT and in Care Group Dashboards. KPIs that are failing to either meet a target or are showing a continued downward trajectory (subsequently at risk of breaching a target) are reported by exception on PIs. PIs are discussed with operational staff to understand the issues and problems and current action plans are agreed that would support the development of services and make improvements that will enable the Trust to meet its contractual obligations.

Benchmarking

Each year the Trust participates in the national benchmarking data collections projects, this consists of Adult and Older People's Mental Health Service, Community Services (Physical Health), CAMHS, Corporate Services and Perinatal to name a few.

The benchmarking projects allows for comprehensive benchmarking of activity, finance, workforce and quality metrics. Service quality, safety and outcomes against the rest of the NHS can be explored within the toolkit, which is the largest set of physical and mental health intelligence available in the NHS, including a dataset of over 5,000 indicators provided by each statutory provider in England and Wales and a number of large independent sector providers.

The Trust utilises a number of outputs from the data collection, such as:

- Access to the benchmarking toolkit, allowing you to compare your service nationally across several thousand metrics
- A high level bespoke report tailored to our organisation, outlining key messages and metrics
- The opportunity to attend the various conference to hear from national speakers and member good practice sites

The findings are shared with the respective Care Groups for their consideration and action. Any identical indicators in the Trust's IQPT will also include the national benchmarking results for a direct comparison.

2.6 Core Quality Indicators

A national core set of quality indicators was jointly proposed by the Department of Health and Monitor for inclusion in trusts' Quality Accounts from 2012-13. Further information about these indicators can be found on the HSCIC website www.hscic.gov.uk.

Seven-Day Follow Up

The National Suicide Prevention Strategy for England recognises that anyone discharged from inpatient care under the Care Programme Approach (CPA) should be contacted by a mental health professional within seven days of discharge. The Trust has set a local performance standard that all patients should be seen face to face. However, phone contact is acceptable where face to face is either not geographically viable or safe.

Our aim is to ensure everyone discharged under the CPA process from a mental health inpatient unit is followed up within the criteria. Our goal is to ensure at least 95% of all patients are contacted within seven days of discharge each quarter. Exceptions to the national target are:

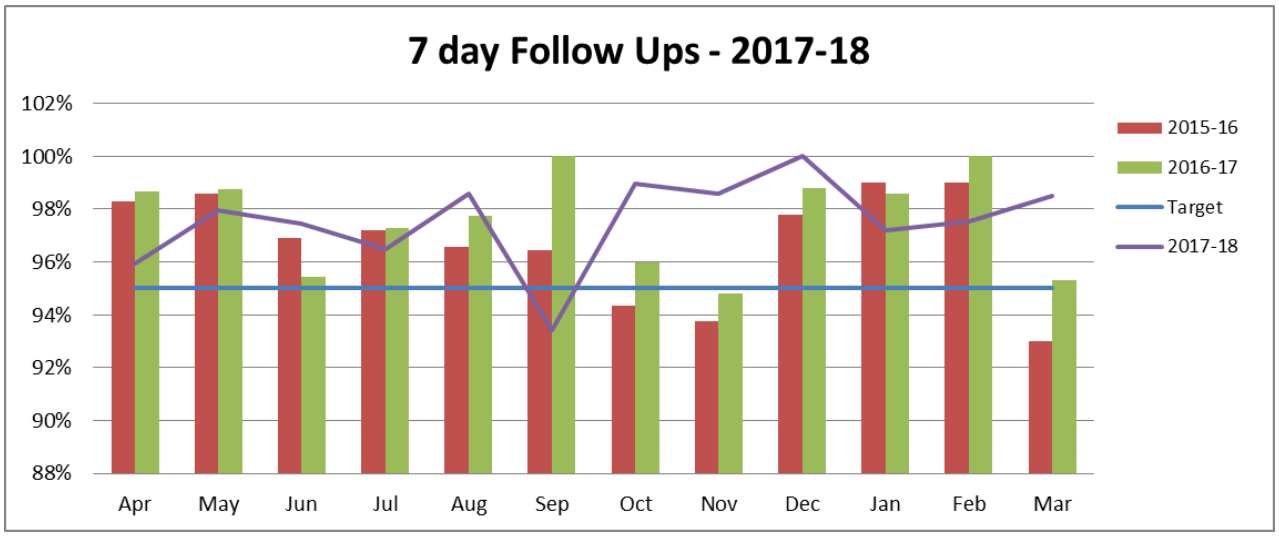
- People who die within seven days of discharge
- Transfers to other psychiatric units
- Where legal precedence has forced the removal of a patient from the country
- Patients discharged or transferred to other NHS hospitals for psychiatric treatment

Summary of Progress

As at year end, 23 patients were not seen within the seven-day follow up period. This is just one additional breach compared to 2016-17. Each follow up breach is reported as an adverse incident and reviewed with the Care Group and overall responsible to CRMG (Clinical Risk Management Group).

The Trust has retained an average 97.5% across the year with and achieved its quarterly targets despite having a dip in September to 93.6%. This equates to 912 patients seen out of the 935 discharges. All incidents are investigated and reported on the Trust Datix system. Appropriate actions and resolutions sought for individual cases.

Graph



Humber Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- This indicator is a national target (95%) and is closely monitored and audited on a daily basis. The data is recorded and reported from the Trust's patient administration system (Lorenzo) and is governed by standard national definitions.
- It is reported to the Trust Board as part of the Integrated Quality and Performance Tracker. It is also reported to Clinical Directors and team leaders at individual team level.

- It is also reported externally to our commissioners on a monthly basis and to DHSC on a quarterly basis via the Mental Health Provider Commission return.

Humber Teaching NHS Foundation Trust has taken the following actions to improve this % and the quality of its service by:

- Reporting on patients who are discharged out of the area for continuing community care.
- Teams are notified of each discharge via email as an additional reminder of their obligations to carry out a seven-day follow up contact.
- The role of the assessment unit is reviewed to ensure there is a robust procedure in place for assigning patients to the Care Programme Approach as part of the discharge process and continued future treatment.
- The Performance team actively monitor the seven-day follow up procedure at team and senior operational level. The Trust Care Group Directors and Service Managers receive a daily Potential Breach Report which identifies those patients who are at risk of not being seen within timescale.
- This key performance indicator will become a zero event from 1st April 2018 and further initiatives are being developed to improve compliance.

*The table below benchmarks the Trust's achievements against the national average submitted to DHSC. Figures may differ slightly on occasion due to timing of submission and refresh of data.

Indicator	NHS Outcomes Framework Domain	Health & Social Care Information Centre Performance Data (2017-2018)				
Percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period	Preventing people from dying prematurely Enhancing quality of life for people with long-term conditions		**Q1**	**Q2**	**Q3**	**Q4**
		Humber	97.2%	96.1%	99.2%	97.7%
		National average	96.7%	96.7%	95.4%	95.5%
		National best score	100.0%	100.0%	100%	100%
		National worst score	71.4%	87.5%	69.2%	68.8%

Gatekeeping

A mental health inpatient admission is said to have been gate-kept if the patient has been assessed by the Mental Health Response Service (previously called crisis and home treatment team) or intensive home treatment team within 48 hours prior to their admission and if they were involved in the decision-making process which resulted in the admission. Every referral for admission is assessed to ensure the most appropriate method of care is provided. Only when a patient's care and treatment cannot be best met in their own home is an admission made.

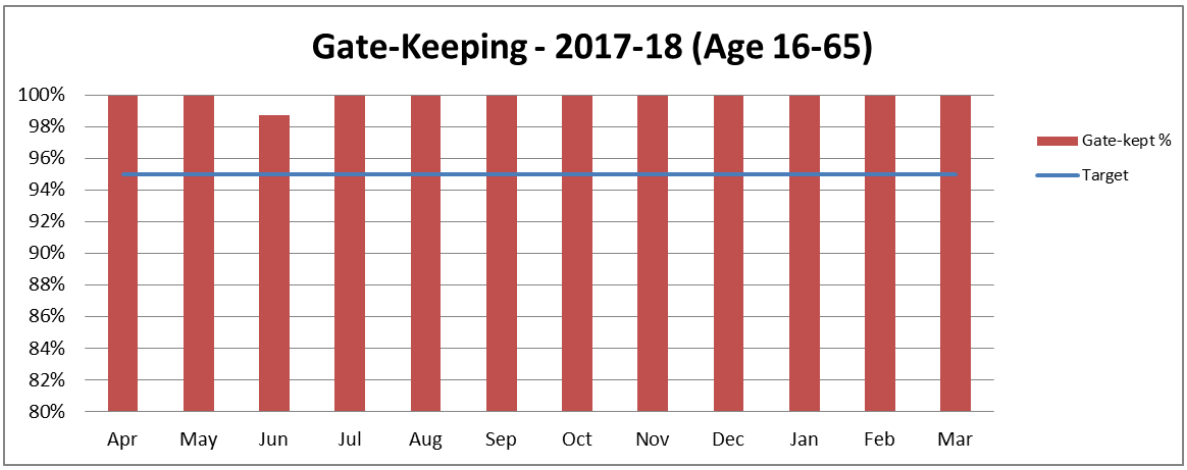
Summary of Progress

As per the SOF guidelines, only adults aged 16-65 are gate-kept prior to admission. During 2017-18 there were a total of 731 admissions in this age group. All except one of these admissions being gate-kept giving a compliance rate of 99.9% for the year (see Graph 1).

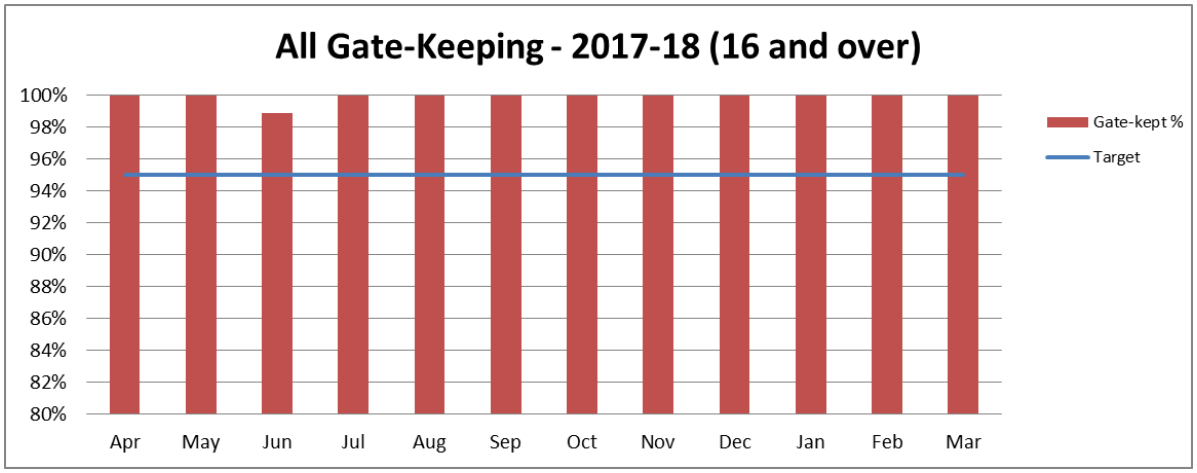
The Trust also reports to the DHSC Unify Submission. The guidelines require that all patients aged 16 and over are gate-kept and these are benchmarked against other Trusts. There were a total of 1033 patients aged 16 and over admitted to Trust units and 99.9% were gate-kept for the same period (see Graph 2).

The data below does not include admissions to the Trust's Psychiatric Intensive Care Unit, Learning Disability or Forensic units and does not include transfers in from other hospital wards.

Graph 1



Graph 2



Humber Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- All gatekeeping is recorded on the Trust's patient administration system (Lorenzo) and is adopted across both Hull and East Riding.
- Patients aged 16-65 are reported to the Trust Board as per Single Oversight Framework guidelines (see Graph 1). However, by way of good practice this process continues to be in place for all patients aged 16 and over (see Graph 2) and is reported to the DHSC.
- Gatekeeping is monitored weekly to ensure consistency and accuracy of data and is subject to regular refresh.

The Trust has not had to take any actions to improve the percentage but will maintain its good practice and quality of service and continue to strive for excellence. The table below benchmarks the Trust's achievements against the national average based on all patients aged over 16.

Indicator	NHS Outcomes Framework Domain	Health & Social Care Information Centre Performance Data (2017-2018)				
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	Enhancing quality of life for people with long-term conditions		Q1	Q2	Q3	Q4
		Humber	99.6	100	100	100
		National average	98.7	98.6	98.5	98.7
		National best score	100	100	100	100
		National worst score	88.9	94.0	84.3	88.7

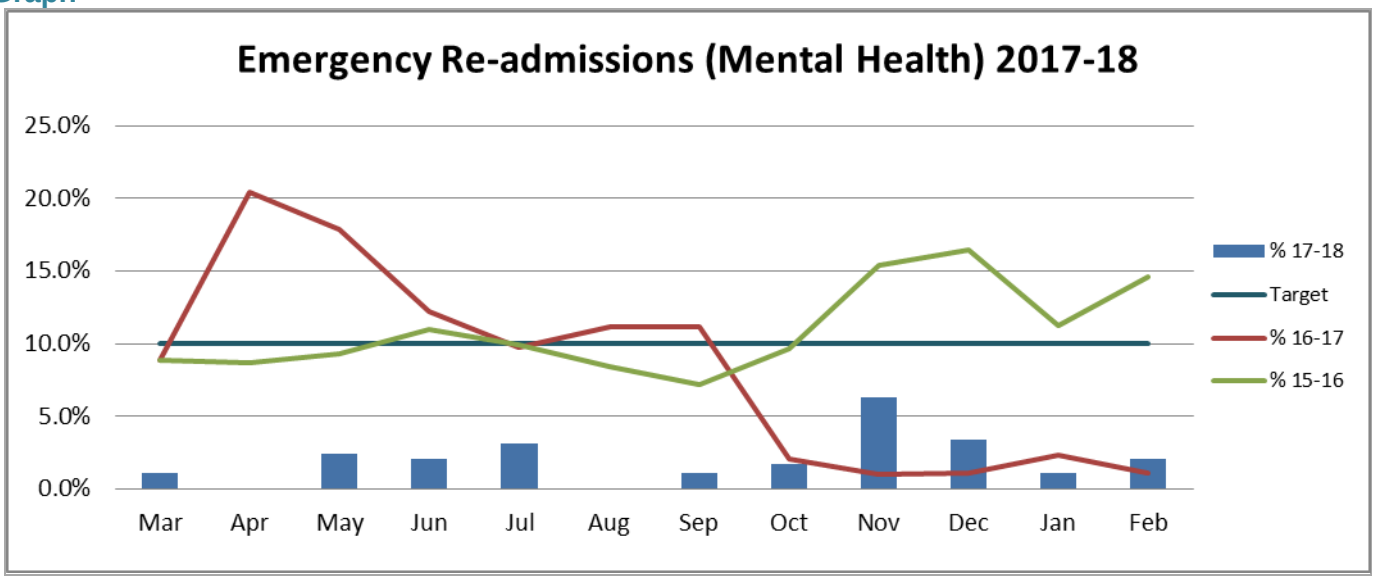
Emergency Readmissions (Mental Health)

The Trust monitors emergency readmissions where patients have been readmitted within 30 days of discharge. Although there is no national target apportioned, the Trust has set an internal threshold of 10%.

The calculation for Mental Health is based on the number of patients who were readmitted within 30 days of their previous discharge. Therefore the report is based one month in arrears and will show discharges from March 2017 to February 2018.

Not all patients who are readmitted are classified as an emergency. Some patients are recalled as part of their treatment. Patients may also be discharged earlier as part of their home treatment and care plan with a view to them being readmitted if the patient and care co-ordinator feel it is more beneficial to their overall recovery. For 2017-18 there were a total of 24 readmissions.

Graph



Humber Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- Patients who have been transferred from another Mental Health bed are not included.
- It does not include patients who have been recalled under a Community Treatment Order (CTO).
- Patients who return to hospital as part of their on-going care plan are not included as these are not classified as emergency.

The Trust has taken the following actions to improve this percentage and the quality of its service by:

- Monitoring on a weekly basis to ensure community beds are available when required by the patient(s).
- Liaising with Service Leads to investigate each admission on an individual basis.

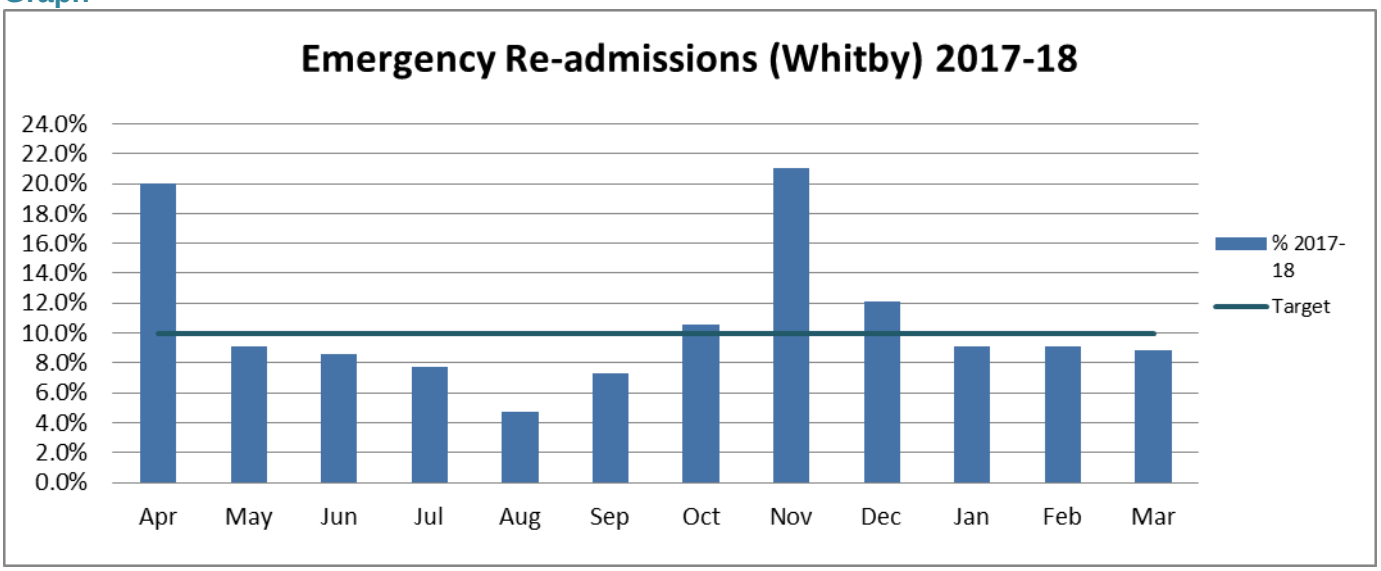
Emergency Readmissions (Community Hospital)

Currently the Trust has one Community Hospital site in Whitby for which the following chart and narrative relates to.

This is the first year that the Trust has reported on this indicator for Whitby. For 2017-18 there were 386 discharges. There were 39 patients who were readmitted within 30 days of their previous discharge which equates to 9.1%.

The calculation for Community Hospitals is based on the number of readmissions within a month divided by the number of discharges within the same month.

Graph



Humber Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- A community bed provides short term (usually no longer than three weeks) 24 hour clinical care and rehabilitation for individuals whose clinical care needs cannot be supported at home but do not require acute level care.
- Evidence suggests that patient outcomes are enhanced by robust delivery of community care, including a step up and step down approach to the management of individual episodes of need and long-term conditions. This, together with flexible and accessible community beds, within community hospitals have been shown nationwide to deliver beneficial outcomes for patients.

The Trust has taken the following actions to improve this percentage and the quality of its service by monitoring on a monthly basis to ensure community beds are available when required by the patient(s).

This indicator is being removed in 2018-19 due to the fact that there is no national validated metric available.

The NHS Community Mental Health Users Survey

Each year, a national study takes place across the NHS to gather patients' experiences of using community-based mental health services. The Trust was pleased that the percentage response rate was 27% and slightly higher than the national average of 26%. The results demonstrate that whilst there are always opportunities to learn and improve, the services we provide are consistent in delivering evidence-based quality care.

Section Descriptor	Score 2017 (Compared with other Trusts)
Health and social care workers	Better
Organising Care	Better
Planning Care	Same
Reviewing Care	Better
Changes in who people see	Same
Crisis Care	Same
Treatments	Same
Support and Wellbeing	Better
Overall views of care and services	Same
Overall Experience	Same

The Trust is one of only three in the country where patients experience care is 'better than expected'. The Trust was congratulated in a letter from Paul Lelliott, CQC Deputy Chief Inspector of Hospitals, on the progress and improvements that have been made since the 2016 survey. The Trust recognises the challenge to build on and maintain these improvements and the Clinical Care Director for the Mental Health care group is working with the Clinical Network to address the recommendations made by Quality Health.

Learning from Deaths

Humber Teaching NHS Foundation Trust is committed to embedding a culture of continuous learning. The approach introduced in 2016 to learning from deaths that do not meet the threshold for a serious incident investigation has continued to be strengthened throughout 2017-18. In quarter four, a daily (Monday to Friday) patient safety huddle was introduced by the Risk and Quality team. This huddle ensures that patient safety incidents (including deaths) reported within the previous 24 hours (72 hours on Mondays) are reviewed and action is taken accordingly.

The serious incident investigation process has been fully reviewed in collaboration with the Clinical Commissioning Group. The aim has been to strengthen the process to ensure high quality timely reviews are undertaken and the questions and views of the family and carers are addressed within the investigation. A programme of Root Cause Analysis training has been introduced to ensure that investigators have the skills necessary to undertake high quality investigations.

The Trust continues to work closely with other trusts and organisations to develop the approach to learning from deaths that do not meet the serious incident threshold. The Mortality Governance Group, chaired by the Medical Director oversees the process and the dissemination of learning.

A bi-monthly Quality Newsletter has been introduced and alongside a twice-yearly Learning the Lessons Conference, is one of the vehicles by which learning from deaths is disseminated across the organisation.

During April 2017 to March 2018, 291 of Humber Teaching NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 62 in the first quarter
- 76 in the second quarter
- 76 in the third quarter
- 77 in the fourth quarter.

By 31st March 2018, 14 case record reviews and 36 investigations had been carried out in relation to 48 of the deaths included above. In one case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 22 in the first quarter
- 13 in the second quarter
- 9 in the third quarter
- 6 in the fourth quarter.

Zero representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 0 representing 0% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the structured judgement methodology and root cause analysis methods.

The following learning, whilst not causal, has been collated from the investigations above:

- Teams are providing good quality care that meets people's needs and liaise well with other health professionals.
- Some inconsistencies with assessing risk have been found. To ensure a consistent evidence based approach to risk assessment the Trust continues to roll out specifically developed suicide and self-harm and clinical risk training to support staff to continuously develop skills and expertise in the management of risk.
- Some individuals are not consistently adhering to the required standards of defensible documentation.
- The Trust needs to ensure that when new operational policies are implemented consideration needs to be given to how staff will be supported to familiarise themselves with the changes.
- The need to address physical health alongside a person's mental health and improving the application and understanding of National Early Warning Score (NEWS) in line with national guidance and Trust policy.
- Ongoing discussions and review is required with the Clinical Commissioning Groups regarding Assertive Outreach for people with Addictions in line with national policy and guidance.

The actions which the Trust has taken in the reporting period, and those proposed to take following the reporting period, in consequence of the Trust's learning are as follows:

- Optimisation of electronic records systems continues and promotes improvements in record keeping and documentation standards. This provides greater opportunities for improvements in communication with and about patients.
- The structured judgement methodology has been introduced to undertake quality and safety reviews as a qualitative record keeping audit. This methodology allows services to review practice and make judgements on the quality of care provided to people who are have used our services.
- The Clinical Risk Management Policy has been refreshed and a scenario based package of training rolled out across the Trust. Prior to registration for training staff complete the e-learning package before the half-day clinical risk management training. They are then signposted to formulation, suicide and self-harm, training. The completion of clinical risk and SASH training is being closely monitored against a trajectory to 80% qualified staff trained by October 2018. The Functional Analysis of Care Environments (FACE) risk assessment tool has been implemented in Adult Mental Health and Older Adult Mental Health teams.
- The Physical Health and Care of the Deteriorating Patient Policy has been updated to support the escalation and management of the deteriorating patient and implementation of NEWS2 in quarter four. The policy promotes the review of physical health at point of referral/admission though to discharge, ensuring effective communication with primary care and the GP. All registered nurses are undertaking physical health and sepsis awareness training. The management of patients within the first 48 hours of admission is monitored via an iPad-enabled audit and quality improvement tool known as the Perfect Ward app. This allows instant feedback and action planning.

The impact of the actions outlined above is as follows:

- Trustwide implementation of the electronic patient record and mobile working solutions allows immediate access to relevant patient information at the point of care.
- The SASH and Clinical Risk Training programme is showing improvements in the quality of assessments and resultant decisions and management plans.
- The implementation of close assurance systems such as the Perfect Ward app has led to demonstrable and rapid improvements across the inpatient units. This approach is being rolled out to the community to achieve similar results.
- The introduction of regular qualitative record keeping audits ensures direct feedback is given to clinicians, and addresses record keeping issues more responsively to ensure a culture of continuous learning.

Deaths in 2016-17

There were five case record reviews and ten investigations completed after 31st March 2017 which related to deaths which took place in 2015/16 before the start of the reporting period.

One representing 1.3 % of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the structured judgement methodology and root cause analysis methods.

Two representing 2.6% of the patient deaths during 2016-2017 are judged to be more likely than not to have been due to problems in the care provided to the patient.

It is not possible to accurately compare the 2016-17 and 2017-18 data in relation to deaths as new systems for reporting and learning were introduced during 2016-17. All deaths within our mental health and community services (including expected natural deaths) are now reported via Datix using the Mazars LLP criteria (below), therefore the data available for 2017-18 is now an accurate picture of the number of deaths that have occurred.

Mazars LLP

Mazars LLP is the UK firm of Mazars, an international advisory and accountancy organisation. Mazars was commissioned by NHS England to review the deaths of people with a learning disability or mental health issues. The criteria they introduced for categorising deaths is as follows:

- **Expected natural death – (EN1)** A death that occurred in an expected time frame
- **Expected natural death – (EN2)** A death that was expected but was not expected to happen in the timeframe
- **Expected unnatural death – (EU)** A death that was expected but not from the cause expected, or timescale
- **Unexpected natural death – (UN1)** Any unexpected death from a natural cause e.g. a sudden cardiac condition or stroke
- **Unexpected natural death – (UN2)** An unexpected death from a natural cause but that did not need to have resulted in death
- **Unexpected unnatural death – (UU)** An unexpected death from unnatural causes e.g. suicide, homicide, abuse, neglect.

Working with Adult and Children's Safeguarding Boards

Safeguarding Children Boards – learning and dissemination

The Humber safeguarding service works alongside the safeguarding children boards throughout the Safeguarding Children Review (SCR) process and a SCR panel is established for each review. This process identifies learning for Humber (and other agencies). Action plans are devised and shared within the panel that reflect the all of the required learning objectives. These are also governed within the safeguarding forum so assurances can be provided regarding completion. The safeguarding team are involved in all related SCR meetings and are part of the agency review process throughout the SCR. The safeguarding team attend relevant sub groups and are involved in strategic work.

The Hull safeguarding children Board have recently started to disseminate briefings following the completion of SCRs; these are shared across the organisation.

Key issues that are identified in the initial chronology process are shared with the service area managers immediately if there is specific learning or action required.

Learning from SCRs is shared via:

- Development sessions – operational and managers levels
- Training
- Supervision
- Newsletters
- Five-minute focus bulletins
- Safeguarding working lunches
- Six-monthly Lessons Learned conferences
- SCR/SAR tables with themes and trends identified in the quarterly reports disseminated to staff
- Specific planned work shop sessions in clinical areas affected which inform, train and develop staff knowledge.

Safeguarding Adult Boards – learning and dissemination

The safeguarding service is closely involved with the adult safeguarding boards and is represented at board meetings and strategic sub groups. Attendance at the Safeguarding Adult Review (SAR) panel meetings ensures involvement with the process and there have been shared learning sessions with multi agency groups which examine themes and trends and reviews action plans.

The themes and issues from previous SAR have been disseminated trustwide and specific actions implemented. This has been reviewed by the relevant local authority via a variety of methods which include self-assessment, panel interview to review actions of the trust, self-declarations and work shop style feedback.

The Humber safeguarding service works closely with local authority's boards with co-development of strategic plans, strategies for self-neglect, Vulnerable Adult Risk Management Meeting Process (VARM) and Domestic Homicide Reviews (DHR). Learning from SAR is shared via:

- Clinical governance groups
- Clinical network groups
- MDT meetings
- Lessons learned conferences
- Development sessions (operational and managerial)
- Clinical work shops
- Supervision
- Training
- Practice Notes
- Newsletters
- Five-minute focus bulletins
- SCR/SAR/DHR/LLR reports disseminated to staff in quarterly reports identifying themes and trends.

Patient Safety Incidents

The National Patient Safety Agency (NPSA) reports nationally on all incidents relating to patient safety. Within these figures, the national median rate for incident reporting from their last six-monthly report, which was published in September 2017, was 45.9 per 1,000 bed days. Humber Teaching NHS Foundation Trust's reporting rate was 88.2 incidents per 1,000 bed days which was the highest number of incidents per 1,000 bed days.

	Total Incidents 2016-17	Total Incidents 2017-18	Severe/ Death 2016-17	Severe/ Death 2017-18	Serious Incidents 2016-17	Serious Incidents 2017-18
1 April-30 June	1,246	1,184	17	15	10	10
1 July-30 September	1,362	1,208	17	10	5	5
1 October-31 December	1,473	1,064	10	7	6	6
1 January-31 March	1,519	1,040	24	13	10	4

Healthcare Associated Infections

Healthcare associated infections (HCAI) remain one of the major causes of patient harm and although nationally there continues to be a reduction in the number of patients developing serious infections such as Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridium difficile (C. diff) in health care settings, the rates of other HCAI have risen due to an emergence of resistant organisms. It is therefore vital that the reduction of HCAI remains a high priority on the patient safety agenda within the Trust and indeed in any other NHS organisation.

The Trust has a proven track record of performing well against the contractually agreed targets for HCAI and this year has been no exception. Our performance against agreed key performance indicators are outlined below.

Clostridium difficile Infection (CDI) Measure

Whilst the Trust continually strives to ensure we have no CDI the target on this nationally set key performance indicator is currently:

- Not to exceed four cases within the Trust's Hull and East Riding of Yorkshire inpatient units (Hull and East Riding of Yorkshire Clinical Commissioning Group CCG)
- Not to exceed four cases for Whitby Community Hospital inpatient unit (Hambleton, Richmondshire and Whitby CCG)

Summary of Progress

During Q1 to Q4, 2017-18, it is noted there have been two CDI cases apportioned to the Trust. Both cases were in Whitby Hospital Inpatient Unit. This position remains unchanged compared to the same period last year, where two cases were reported.

2017-18	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year End
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0
Whitby Hospital	0	0	1	0	0	0	0	0	1	0	0	0	2
Trustwide	0	0	1	0	0	0	0	0	1	0	0	0	2

Humber Teaching NHS Foundation Trust considers that this data is as described for the following reasons: a CDI Policy is available on the Trust Intranet for all staff. It is expected that staff manage any suspected cases as per Trust policy. The diagnosis of CDI is based upon the presence of the C. diff toxin. In some instances people are referred to as being a C. diff carrier as they have the C. diff bacteria present within their gut but no toxin production.

Only CDI cases were the sample is obtained after four days from admission are included in the quality data reporting. Any cases that occur prior to this are not deemed attributable to the Trust.

When the laboratories detect C. diff toxin in a sample, there is a notification process in place to ensure both the clinical area and infection prevention and control team are informed.

The Trust has taken the following actions to improve this percentage and so the quality of its service:

- Identifying any areas of learning using root cause analysis and whether the case of CDI could have been avoided.
- Ensuring antibiotics were prescribed and administered in accordance with the respective locally agreed antibiotic guidelines.
- Increase the opportunities to work collaboratively across the health economy to prevent and control CDIs.
- Identifying and eliminating (where applicable) any potential risks of cross contamination and other possible risk factors.
- Provision of staff educational workshops with specific focus i.e. C. diff.
- The applicable Care Group Clinical Governance Network for Trust apportioned cases monitoring the actions identified from the investigation.

Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia Measure
For the financial year 2017-18, quarter one to quarter four, it is noted there have been zero MRSA Bacteraemia cases apportioned to the Trust.

Escherichia coli (E. coli) **Bacteraemia**
For the financial year 2017-18, quarter one to quarter four, it is noted there have been zero E. coli Bacteraemia cases apportioned to the Trust.

Medicine-Related Incidents

The Governors of Humber Teaching NHS FT chose medicines incidents as the local indicator for the Quality Account as there has been an increased focus on medicines errors nationally. Most of the medicine-related incidents in 2017-18 occurred during administration. This category has, therefore, been chosen as the quality indicator for medicine-related incidents. There were 217 drug administration incidents all of which had resulted in either no harm (193) or minimal harm (24) (i.e. required extra observations or minor treatment). The data included in this indicator will be subject to external audit.

Humber Teaching NHS FT has clear systems and processes in place for the reporting and investigation of medicine-related incidents. These incidents include errors and non-errors (e.g. rapid tranquilisation) and they are reported via Datix and reviewed by the Medicines Safety Officer.

The top two subcategories were inter-related – the non-annotation of administration boxes and the failure to give medication as prescribed. Following the implementation of various initiatives, including the reviewing of medicines administration record (MAR) charts at handover, the “Pot and Dot Scheme” etc., this has now improved. However, incidents still occurred when medication was not ordered in a timely manner and some depot medications had also been missed when staff overlooked the Periodic Injection section of the MAR charts. The remaining incidents within these subcategories resulted from a mixture of causes, e.g. family not bringing in sufficient amount of medications on admission; staff were distracted/disturbed by alarms or unexpected incidents half way through administration; items prescribed on multiple charts and some medicines were overlooked etc.

The third highest subcategory was the administration of incorrect doses. A third of these involved “when required” medications, e.g. the total amount administered exceeded the prescribed maximum dose. Another third occurred when doses were changed or when medications were being titrated.

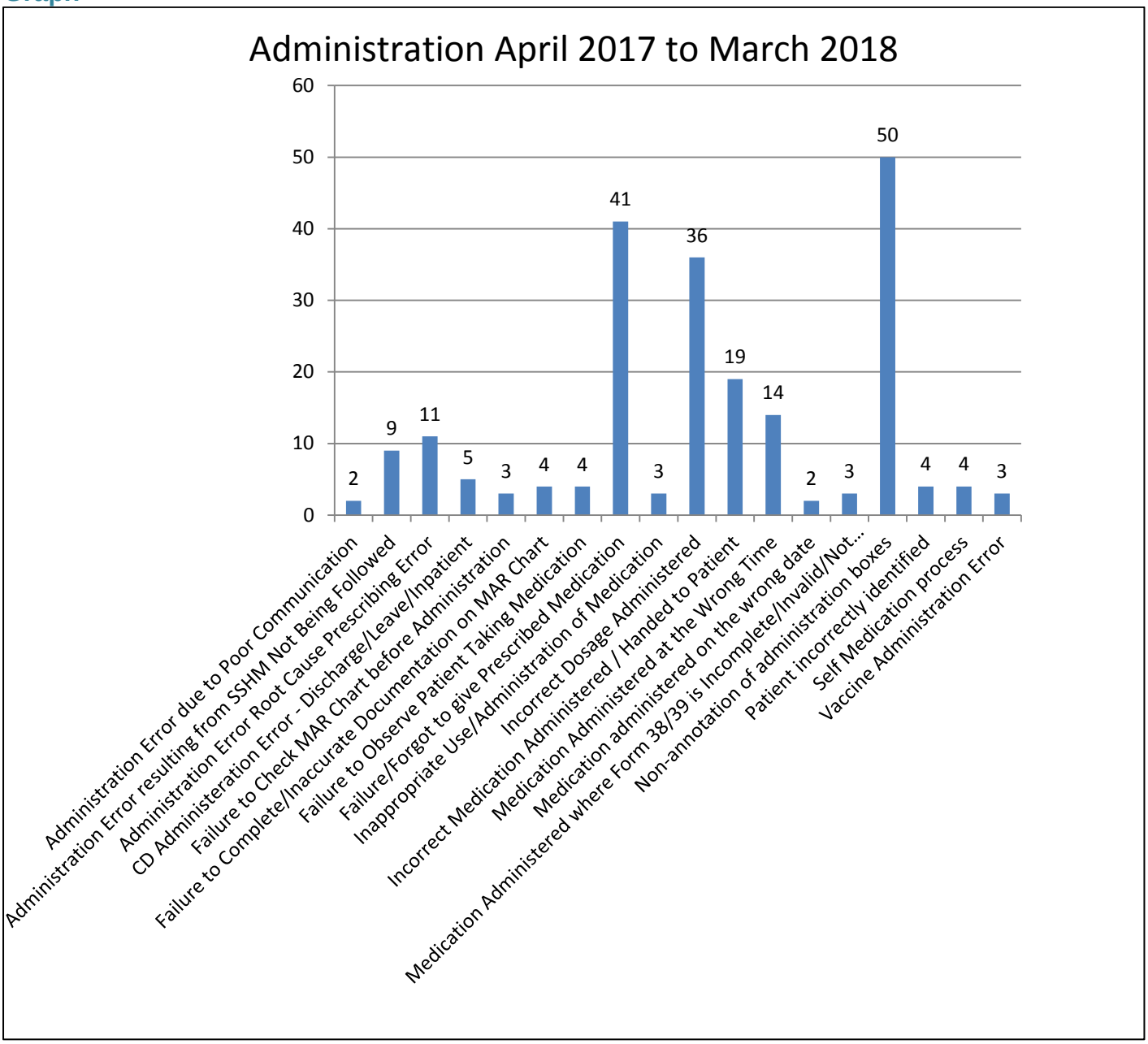
The fourth highest subcategory was the administration or supply of an incorrect medicine. These include the selection errors between plain and modified release formulation of the same medicine; wrong route (e.g. injection was prescribed but oral medication of the same drug was administered); administration of a medicine that was recently cancelled by a prescriber; dispensing error by a community pharmacy; administration of a medicine dispensed for another patient because of medicine shortage (non-error).

Amongst the other subcategories, there were four incidents where the patient was incorrectly identified. Two of them occurred because the patients had identified themselves as another patient; one was an antihistamine given to another patient with the same first name and the last one was a calcium tablet given to a wrong patient by a healthcare assistant.

Three incidents were reported under the subcategory of “Inappropriate Use/Administration of Medicines”. One was the application of three transdermal patches in order to make up the prescribed dose when the product licence stated that no more than two patches should be applied at the same time; the other two related to injection technique.

The Lead Medicines Optimisation Nurse, Medicines Safety Officer and the wider pharmacy team are working with the Link Practitioners to discuss medicine-related incidents and establish ways to prevent similar incidents from occurring again. Moreover, “Medicines Optimisation Work-Based Competency Programme” is currently being rolled out to improve and maintain standards. From October 2017, pharmacy technicians are linked with individual wards and teams to establish and support good practice.

Graph


Administration April 2017 to March 2018
60
50
40
30
20
10
0
2
9
11
5
3
4
4
41
3
36
19
14
2
3
50
4
4
3
Administration Error due to Poor Communication
Administration Error resulting from SSHM Not Being Followed
Administration Error Root Cause Prescribing Error
Administration Error - Discharge/Leave/Inpatient
CD Administeration Error - Failure to Check MAR Chart before Administration
Failure to Complete/Inaccurate Documentation on MAR Chart
Failure to Observe Patient Taking Medication
Failure/Forgot to give Prescribed Medication
Inappropriate Use/Administration of Medication
Incorrect Dosage Administered / Handed to Patient
Incorrect Medication Administered at the Wrong Time
Medication Administered on the wrong date
Medication administered/ Incomplete/Invalid/Not...
Medication Administered where Form 38/39 is
Non-annotation of administration boxes
Patient incorrectly identified
Self Medication process
Vaccine Administration Error

2.7 Key National Indicators

There are three domains which the Key National Priorities fall under that the Trust has reported on in Section 3.This is explained in the table below (please note that some of these indicators have already been included in Part Two of the report; where this is the case, reference is made to Part Two).

The Three Domains for Key National Indicators

Domain	Indicator
Patient Safety	Immunisation Rate for Human Papillomavirus (HPV)
	Seven day follow up (**Part Two**)
	Clostridium Difficile (**Part Two**)
	Admissions of Under 18s to Adult Facilities
Clinical Effectiveness	Mental Health Delayed Transfers of Care
	Percentage of Patients Seen for Treatment within 14 Days of Referral
	Gatekeeping (**Part Two**)
	Percentage of Children Measured for Height/Weight in Reception
	Cardio Metabolic Assessments
Patient Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability
	Attrition (Drop-Off) Rate of Breastfeeding Prevalence between Ten Days and Six Weeks
	Four-hour waits – MIU
	Percentage of Patients Seen for Treatment within six and 18 Weeks of Referral

Immunisation Rate for Human Papilloma Virus (HPV)

Immunisation against Human Papillomavirus (HPV) highlights an area of national and international concern to end the transmission of preventable life-threatening infectious diseases. Vaccines prevent infectious disease and can dramatically reduce disease and complications in early childhood, as well as mortality rates.

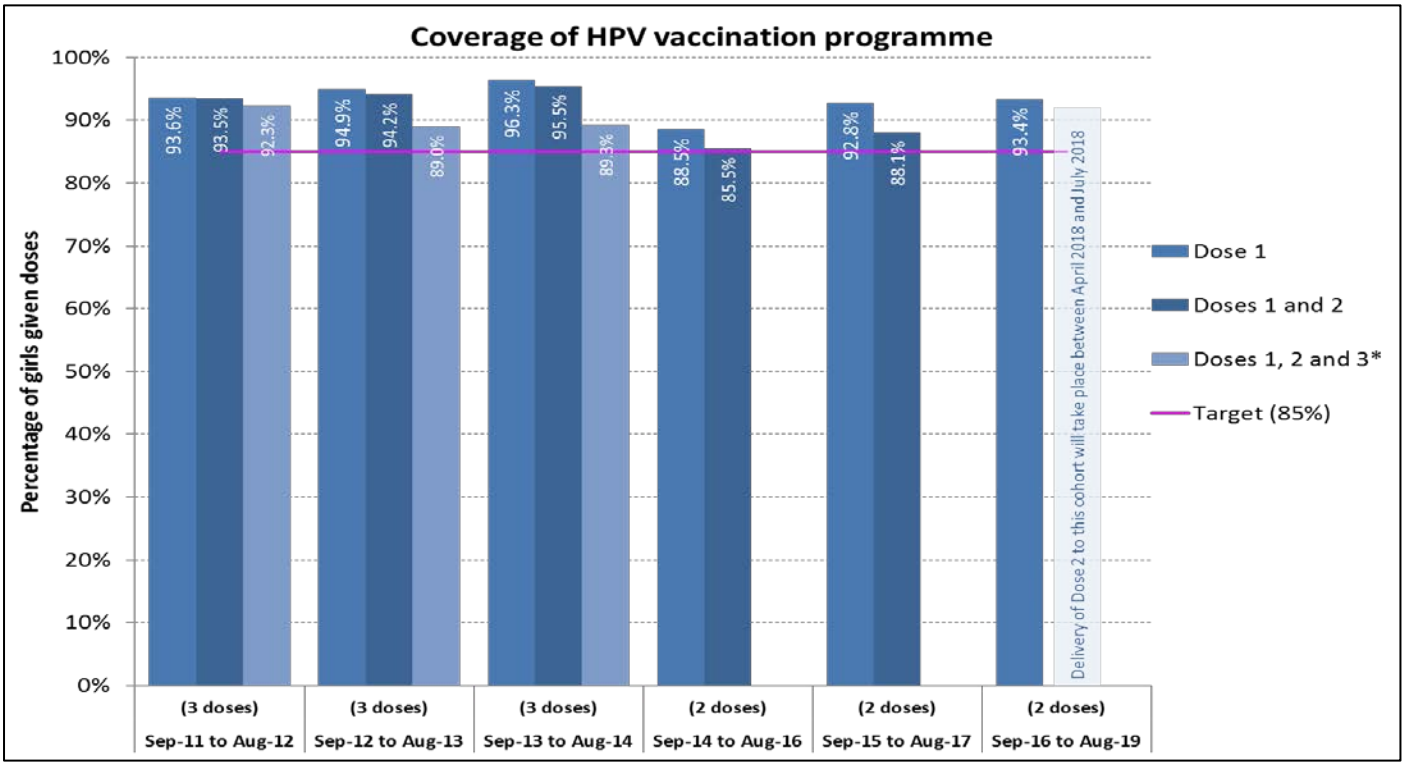
The HPV vaccine is delivered in two separate doses. Delivery of the two doses has to be spread out over at least a six month period to work properly, and to fit this around the academic school year and deliver it efficiently it is delivered across two academic years.

Due to the difference between the financial year we are describing in this report (April 2017 to March 2018) and the academic year that dictates the delivery timings of the vaccination doses (September 2017 to July 2018), we are reporting on vaccinations completed between April 2017 and August 2017, the 2016-17 academic year.

Between April 2017 and August 2017 the Trust delivered the second dose of the HPV immunisation to 85.5% of girls in Year 9 in East Riding Schools, against a target of 85%.

Between April 2017 and July 2017 the Trust also delivered the first dose of the HPV immunisation to 88.1% of girls in Year 8. This allows a drop-out rate of 3.1% between Dose 1 and Dose 2 to achieve the target of 85% receiving both doses by the end of August 2018.

Graph



* From September 2014 onwards those receiving the new vaccine require two doses given one year apart, delivery is split across two academic years. Those who received their vaccination prior to September 2014 were given three doses (of the old vaccine) spread out across a single academic year.

Mental Health Delayed Transfers of Care (DToC)

This indicator measures the impact of community-based care in facilitating timely discharge from a hospital and the mechanisms in place to support this. The aim is to ensure people receive the right care, in the right place, at the right time.

The target is to show less than 7.5% of delayed transfers. This figure compares the number of days delayed with the number of occupied bed days (OBDs). In accordance with NHSI, the Trust only records mental health inpatient delayed discharges for patients aged 18 and over.

Summary of Progress

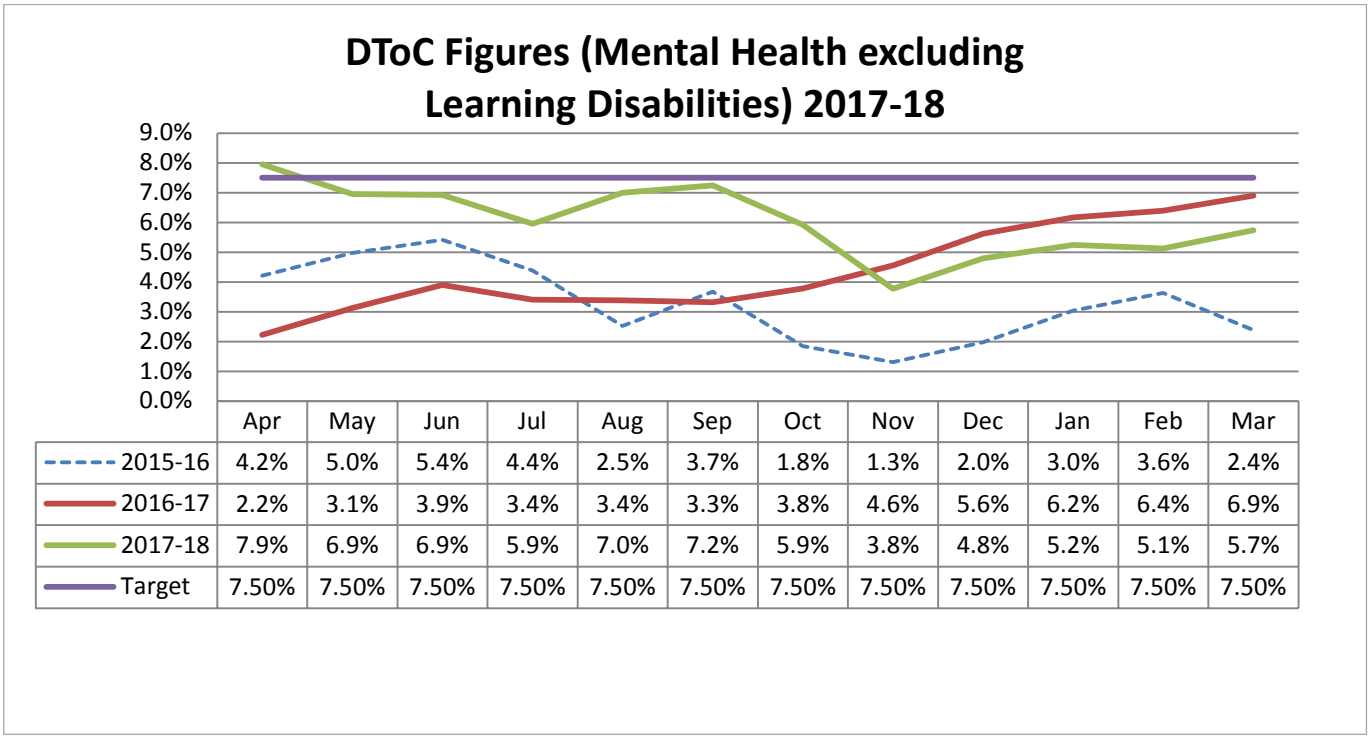
For the whole of 2017-18, the Trust reported a percentage of 6.11% delayed transfers which although an increase on last year is still within the measure. From Q3 however, there has seen a steady improvement and the units are seeing a reduction in the number of delays.

The number of occupied bed days is reported through the Trust's patient administration system (Lorenzo). The number of patients affected and the number of days delayed by are monitored via weekly system updates. The data is governed by standard national definitions. The OBDs are subject to constant refresh.

Delayed Transfers of Care are also reported to the Department of Health and Social Care. This return (SitReps) looks at the count of all patients (community hospitals, learning disabilities and mental health) who were delayed during the month. It does not compare against Occupied Bed Days.

A project group was set up during Q4 of 2016-17 to move all delayed transfers of care onto Lorenzo. This has now been achieved for all mental health and learning disability units. Work is underway within the Care Group to facilitate the move across from manual recording to electronic reporting for Community Hospitals.

Graph



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	4.2%	5.0%	5.4%	4.4%	2.5%	3.7%	1.8%	1.3%	2.0%	3.0%	3.6%	2.4%
2016-17	2.2%	3.1%	3.9%	3.4%	3.4%	3.3%	3.8%	4.6%	5.6%	6.2%	6.4%	6.9%
2017-18	7.9%	6.9%	6.9%	5.9%	7.0%	7.2%	5.9%	3.8%	4.8%	5.2%	5.1%	5.7%
Target	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%

The graph above compares three years data by month up to 2017-18.

The table below highlights the number of occupied bed days and the number of patients delayed days per month.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
OBDs	**5348**	**5468**	**5016**	**5313**	**5131**	**4970**	**4799**	**4568**	**4529**	**4542**	**4237**	**4830**
Delayed Days	425	380	347	316	359	360	284	172	217	238	217	277

Humber Teaching NHS Foundation Trust considers that this data is as described for the following reasons; Both the CQC and NHSI measure delayed discharges for patients whose transfer of care was delayed due to factors which were the responsibility of Social Care/NHS or both.

The Trust has taken the following actions to improve this percentage and so the quality of its service by:

- Holding weekly operational meetings to identify problem areas and seek to plan early, appropriate discharge more effectively.
- Delayed Transfer of Care within Mental Health are routinely raised at a fortnightly patient flow and escalation meeting which is attended by East Riding of Yorkshire Council and both CCGs. Equally all other delays are raised via the daily system wide meetings.
- Liaising with families, carers and housing providers. Regular liaison also takes place with residential homes to give support/advice and ensure patients settle in well.
- Validation meetings to cross-reference electronic recording and reporting.
- Weekly and monthly automated reports to senior clinical leads identifying current patient delays.
- Project team set up to review the process and adopt within community hospital wards.

Percentage of Patients Seen for Treatment within six and 18 Weeks of Referral

Improving Access to Psychological Therapies (IAPT) Access Times/Goal

The waiting time standard requires that 75% of people with common mental health conditions referred to the IAPT programme will be treated within six weeks of referral, and 95% will be treated within 18 weeks of referral. The standard applies to adults.

Summary of progress

The IAPT team has been measured against this standard for the East Riding catchment area throughout 2017-18. Both the six and 18 week target have been achieved each month throughout the year

Trustwide Total Proportion of Treatments Commenced within the Timescales set out (NHSI Target)					
Month	**Number of treatments commenced**	**Number of Treatments within six weeks of Referral**	**Proportion of Treatments Commenced within six weeks of Referral**	**Number of Treatments within 18 weeks of Referral**	**Proportion of Treatments Commenced within 18 weeks of Referral**
Apr 17	187	181	97%	187	100%
May 17	246	238	97%	245	100%
Jun 17	209	205	98%	209	100%
Jul 17	185	178	96%	185	100%
Aug 17	240	234	98%	240	100%
Sep 17	230	224	97%	230	100%
Oct 17	309	305	99%	309	100%
Nov 17	265	260	98%	265	100%
Dec 17	170	168	99%	170	100%
Jan 18	216	210	97%	215	100%
Feb 18	164	164	100%	164	100%
Mar 18	175	171	98%	175	100%

	Number of treatments commenced	**Number of Treatments within six weeks of Referral**	**Proportion of Treatments Commenced within six weeks of Referral**	**Number of Treatments within 18 weeks of Referral**	**Proportion of Treatments Commenced within 18 weeks of Referral**
Q1 17-18	642	624	97%	641	100%
Q2 17-18	655	636	97%	655	100%
Q3 17-18	744	733	99%	744	100%
Q4 17-18	555	545	98%	554	100%

The Trust considers that this data is as described for the following reason:

Monthly reporting from the Trust's PCMIS system.

Percentage of Patients Seen for Treatment within 14 Days of Referral

From April 2016 NHS England (NHSE) introduced a series of standards for Early Intervention for Psychosis (EIP) Teams to meet in the delivery and shaping of services with these being measured and Teams working towards achieving national accreditation. The access and waiting time standard for EIP services requires that from 1st April 2016 more than 50% of people experiencing first episode psychosis will be treated with a NICE-approved care package within two weeks of referral. The standard is targeted at people aged 14-65.

Summary of progress

From April 2016, the Psychosis Service for Young People in Hull and East Riding (PSYPHER) team has been measured against this standard. During 2017-18 the service has increased the age range in which for patients and now work with patients between 14 and 65. The year to date performance of 74% is greater than the nationally mandated target of 50%. All data for 2017-18 has been audited by the Trust's external auditors.

14 day First Treatments – 2017-18	Treated	Within 14 days	%
Quarter One	53	38	72%
Quarter Two	47	17	36%
Quarter Three	57	52	91%
Quarter Four	46	44	96%

Humber Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- Fortnightly reporting from the Trust Lorenzo system
- Weekly MDT meeting for feedback on assessments in progress
- Daily morning meeting where referrals are discussed and allocated.

The Trust has taken the following actions to improve this percentage and so the quality of its service by increasing caseloads for each clinician resulting in prompt waiting times. Performance has increased from Q2 and is above the nationally mandated target.

Percentage of Children measured for Height/Weight in Reception

*Results for this report are shown based on an academic year, not financial year and relate to February to April 2016. This report looks at the financial year and therefore shows the full year achievement for 2015-16.

Good nutrition is essential for the healthy development of children, with long-term effects on health for the whole of a person's life. Collecting data about childhood obesity and under-nourishment provides parents with important health information about their children. Health service commissioners at both local and national level need the information to make decisions about the services required now and in the future. The Trust is commissioned to deliver the National Child Measurement Programme (NCMP) in East Riding Schools by East Riding of Yorkshire Council.

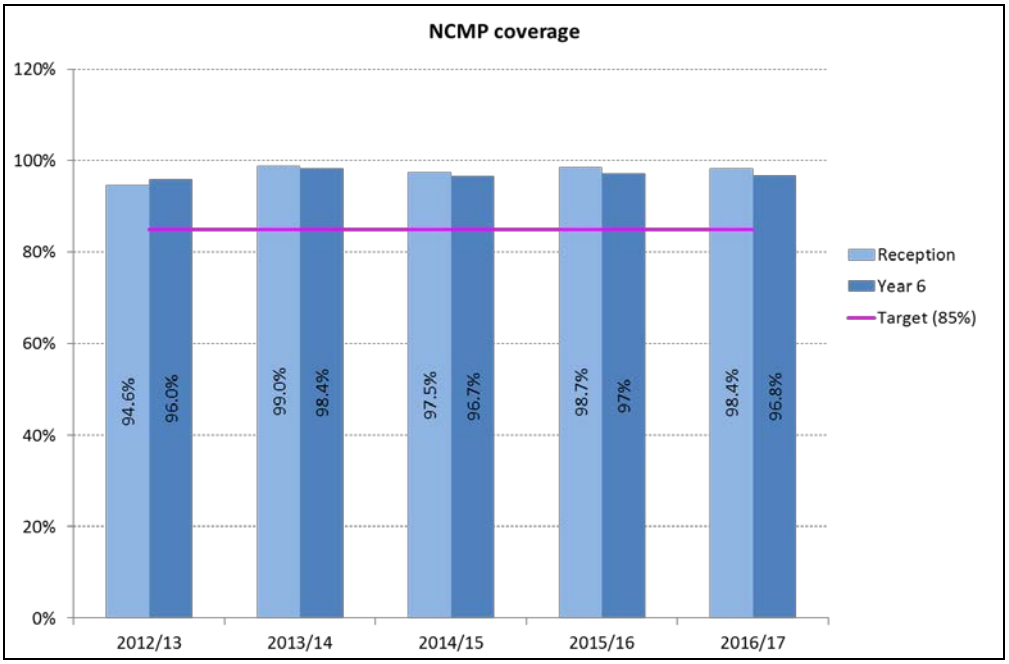
This is a nationally mandated indicator with a target of 85% coverage. Every school child is measured for height and weight in Reception (age 5-6 years old), and again in Year 6 (age 10-11 years old). In the East Riding this is done by School Nurses, between February and May.

The data is used to calculate the Body Mass Index (BMI) for each child. Parents receive a letter explaining their child's BMI to raise awareness of the health risks for over or under weight children. The data is also used for Public Health planning.

Summary of progress

In 2017 Nurses from the Integrated Public Health Nursing Service recorded the height and weight for 98.4% of children in Reception and 96.8% of children in Year 6. The children in the 2017-18 academic year will be measured between February 2018 and April 2018 and shown in the 2018-19 Quality Report and Accounts.

Graph



The Trust considers that this data is as described for the following reasons: the target is to measure and weigh at least 85% of children in Reception (age 5-6 years old), and again in Year 6 (age 10-11 years old). The NCMP programme is recorded against the record of each child individually on SystmOne (our electronic clinical record system) and compared with a master list of all eligible children. We are therefore able to accurately identify the overall percentage coverage.

The 2017-18 planned programme commences in March 2018 following the half term, and will finish in May 2018. Any children missed in the first rollout will be identified from the master list. They will be weighed and measured during catch-up sessions, as school nurses visit the schools regularly. We expect coverage to reach similar levels to last year, well above target.

Cardio-metabolic assessment and treatment for people with psychosis

The Trust should ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:

- Inpatient wards
- EIP
- Community Mental Health Services (CPA clients).

People with severe mental illness (SMI) are at increased risk of poor physical health, and their life-expectancy is reduced by an average of 15-20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital receive the recommended assessment of cardiovascular risk in the previous 12 months.

Physical health assessments for patients with SMI are a CQUIN in 2017-18. Patients with SMI for the purpose of this CQUIN are all patients with psychosis, including schizophrenia, in all types of inpatient units and community settings commissioned from all sectors.

CQUIN performance for community and inpatient services is measured by the National Clinical Audit of Psychosis. EIP performance is measured by the EIP Self-Assessment Audit. Results for both audits will be published mid-2018.

The following figures are a snapshot of the current position at 31st March 2018. It should be noted that these figures do not include those assessments that were completed on paper prior to the development of the electronic form and so are not directly reportable. As such these figures will underestimate the true performance as would be measured according to the CQUIN guidelines.

Service	Target	% of patients with complete electronic Health Improvement Plan
Inpatient	90%	75.0%
Community (non-EIP)	65%	48.74%
EIP	90%	64.36%

Data is recorded and reported from the Trust's Lorenzo patient administration system and is governed by the definitions in the national CQUIN guidance.

The Trust has taken the following actions to improve the quality of its service:

- Developed the electronic record so the assessment can be entered directly into the system.
- To ensure the electronic assessment has been fully adopted a local audit will be carried out in quarter one of 2018-19 as required by the CQUIN.
- Online reports detailing the current state for each team have been published.
- Weekly updates highlighting areas for improvement are emailed to team leaders and responsible Assistant Directors.
- The CQUIN monitoring team attends regular Operations team meetings to discuss and rectify any issues with data collection and/or reporting.
- The Trust has participated in all national audits required by the CQUIN and will carefully consider any actions that result from the audit findings.

Admissions of Under 18s to Adult Facilities

Inpatient CAMHS General Adolescent Services deliver tertiary level care and treatment to young people with severe and/or complex mental disorders (12 and 18 years) associated with significant impairment and/or significant risk to themselves or others such that their needs cannot be safely and adequately met by community CAMHS. This includes young people with mild learning disability and Autism Spectrum Disorders who do not require Inpatient CAMHS Learning Disability Services. There is currently no provision within the Trust for mental health inpatient services for this age group.

In the event that a young person needs an immediate admission for their safety or that of others, it is acknowledged that a CAMHS inpatient unit is normally the preferred environment for a person under age 18. There are occasions when a bed or other CAMHS alternatives are not available.

The revised Code of Practice (2015) states if a young person is admitted in crisis it should be for the briefest time possible.

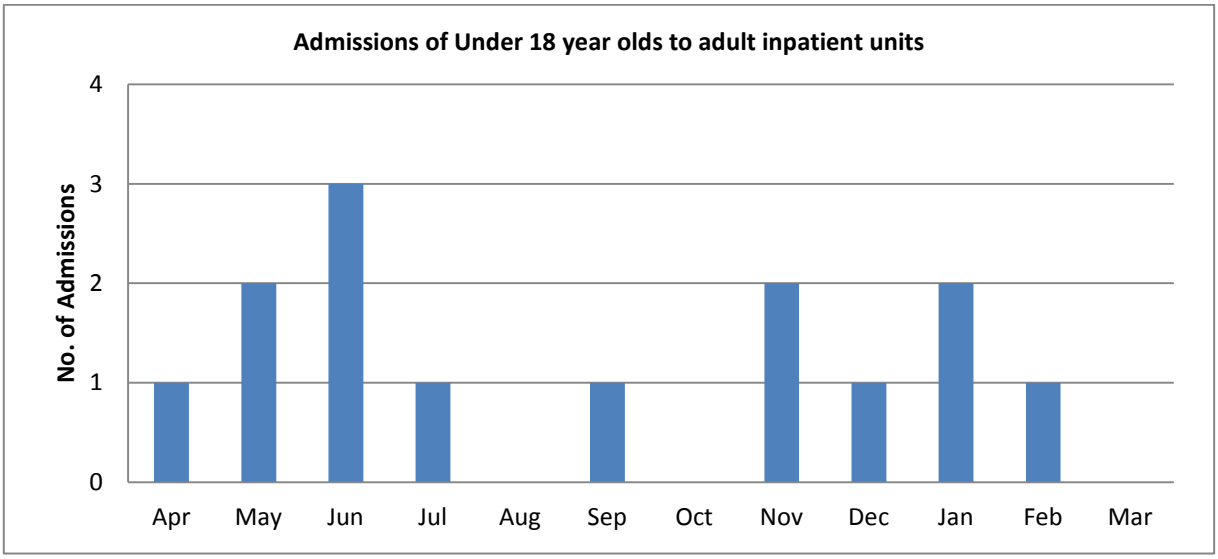
There are also some 17 year olds who prefer to engage with adult mental health services and have a preference for being admitted to an adult ward environment when the need arises. However, even in these circumstances there is still an obligation to ensure that safeguards are in place for an under 18 year old in line with their status as a minor.

Summary of progress

There is no national target set for this indicator but the aim is to have no admissions of children into adult wards. The Trust has two designated wards to accept emergency admissions for children where appropriate placements are not available: Westlands for female patients and Mill View Court for male patients. The average length of stay for patients aged under 18 in this time period was 2.6 days.

During 2017-18 there were 14 admissions of under 18's.

Graph



Humber Teaching NHS Foundation Trust considers that this data is as described for the following reasons:

- Currently CAMHS inpatient beds are commissioned by NHSE and there is a very clear protocol for CAMHS services needing to access those beds. It is nationally accepted that there is a current shortage of beds. Young people are admitted to adult wards due to the lack of accessible and available beds CAMHS specific beds.
- As described the exception is the young person admitted two days before their eighteenth birthday as the adult ward was deemed the most clinically appropriate space.

The Trust has taken the following actions to improve this percentage and the quality of its service by:

- The Trust has been commissioned by NHSE to provide a 13 bedded CAMHS Inpatient Unit, this will comprise of four PICU Beds and nine General Adolescent beds. NHSE has specifically commissioned this number of beds based on an audit of the regional usage. The new service will support young people from Hull, East Yorkshire, North and North East Lincolnshire. The unit will be a state of the art new build and will be located on Walker Street in Hull. The new service will offer a shift from the traditional approach to CAMHS inpatient provision to one that supports the ongoing transformation of Young people's Mental Health services locally, where access to services is key.
- As part of the Local Transformation of young people's mental Health services, the Trust has launched a pilot supported by STP Funding to open a Safe Space for young people experiencing a mental health crisis. This will allow young people to step out of their crisis to a safe place where they will be supported by experienced clinicians to develop new coping strategies. The safe space will offer a real alternative to inpatient admission.
- Both the new inpatient service and the safe space will enhance current provision and will reduce the need for lengthy out of area admissions, keeping young people close to the systems of support that aid recovery.

Out of Area Placements

Definitions

Out of Area Placement – this is when a patient with assessed acute mental health needs who requires non-specialised inpatient care (CCG commissioned), is admitted to a unit that does not form part of the usual local network of services. This includes inpatient units that:

a) are not run by the patient's home mental health care provider, regardless of distance travelled or whether the admitting unit is run by an NHS or Independent Sector Provider (ISP);

b) are not intended to admit people living in the catchment of the person's local community mental health team (CMHT);

c) are located in a place where the person cannot be visited regularly by their care coordinator to ensure continuity of care and effective discharge planning.

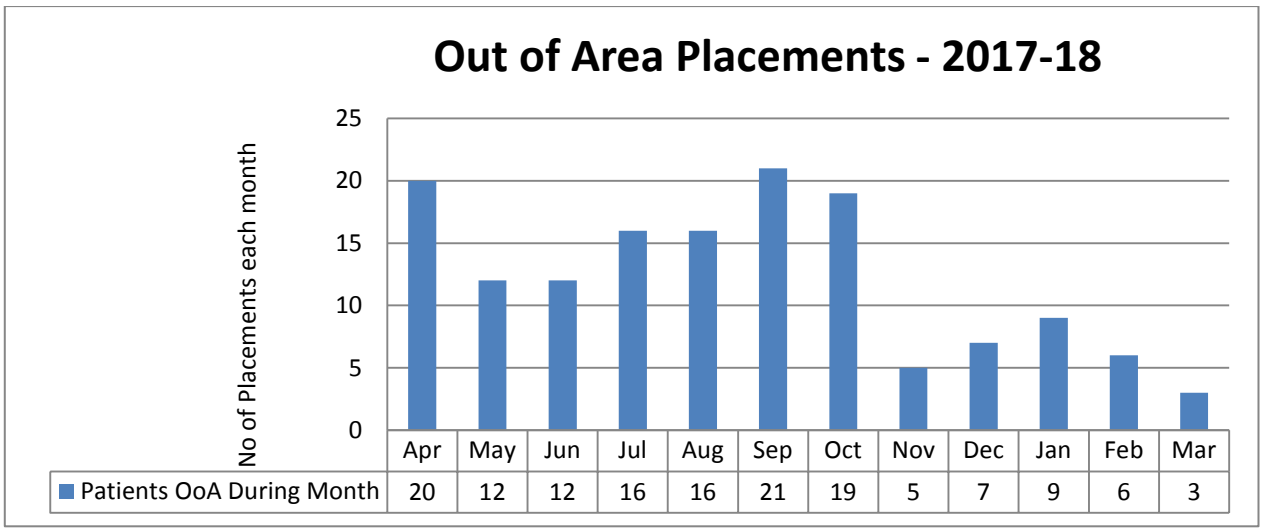
Summary

From quarter four 2017-18, the results of Out of Area Placements are documented in the Integrated Quality and Performance Report (IQPT). The graph below shows the number of patients who were in an out of area placement per month. It is the Trust's intention that there will be zero inappropriate out of area placements by 2020. For quarter four there were nine patients who were admitted. This equates to a total of 310 days. As per the Single Oversight Framework, this indicator was newly included from 1st January 2018. Quarter 4 data has been audited by the Trust's external auditors.

Progress

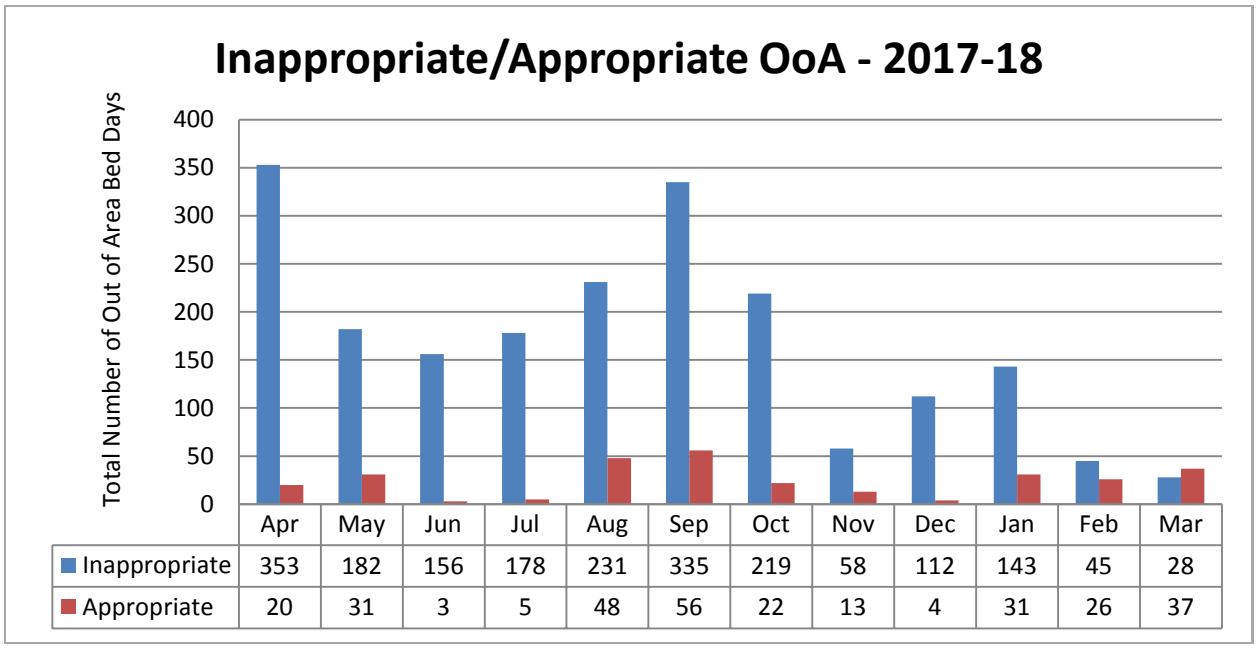
Over the quarter, significant work has commenced to address the large number of working age adult out of area placements. New reporting mechanisms are being finalised to ensure the best care is received and that the service user is returned as safely and quickly as capacity allows. One of the STP priorities for the year ahead is to look at how capacity can be managed better in the region, looking at regional bed management and reducing the need for any service user to go far from home when admitted out of their home area. The closer someone is to their home Trust, the more beneficial this is for family and enable on-going care needs to be met.

Graph1



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patients OoA During Month	20	12	12	16	16	21	19	5	7	9	6	3

Graph 2



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Inappropriate	353	182	156	178	231	335	219	58	112	143	45	28
Appropriate	20	31	3	5	48	56	22	13	4	31	26	37

Humber NHS Foundation Trust considers that this data is as described for the following reasons:

- Total number of out of area placements within each month
- Total number of patients placed out of area and the number of days away from 'home trust'

- Split of inappropriate and appropriate placements
- There are no interim percentage targets set and the results are based on the number of placements and days out of area
- The local community mental health team is the Trust catchment area (Hull, East Riding and North Yorkshire)
- Quarter four data has been audited and validated by the Trust's external auditors

Humber NHS Foundation Trust has taken the following actions to improve this outcome and the quality of its service by:

- Introduction of new beds on Mill View Court
- Agreement to extend the crisis pad hours
- Recommissioning of the crisis pad service for a further 12 months
- Securing of five step-down beds within MIND accommodation to support earlier discharge when housing needs may create a delay around discharge.
- Creation of a new bed management team to support the management of capacity
- Showing the division between working age, Psychiatric Intensive Care Unit and older people placement for 2018-19
- Validation and escalation process to be initiated with Care Group Directors on a monthly basis

CAMHS Eating Disorders

Percentage of children and young people with an eating disorder seen for treatment within target timescales

From April 2016 NHSE introduced a requirement for all CAMHS providers to provide a dedicated Eating Disorder team. National access time targets for children and young people with an eating disorder (CYP ED). The indicators look at the number of children and young people who have accessed, or are waiting for treatment following a routine or urgent referral for a suspected eating disorder. Eating disorders present both an immediate risk to life and long terms health risks due to the pressure placed on internal organs by a severely restricted diet. For this reason the access time targets for CYP ED are tighter than most other mental health conditions.

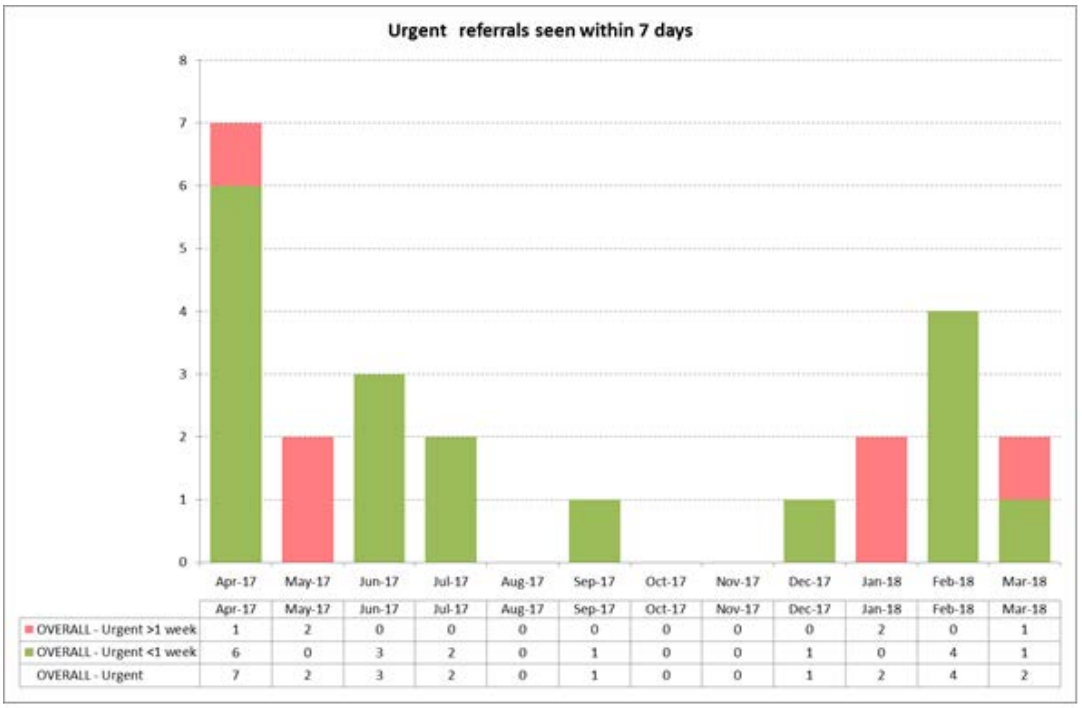
Children and young people (up to the age of 19) referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case. The standard includes all children and young people up to the age of 19 years in whatever setting (community or inpatients) the young person is receiving care.

The national data collection is still experimental, with a focus on data quality and completion.

Summary of progress

The Trust was already providing treatment for eating disorders within its core CAMHS service but we did not have a dedicated team in place. We began recruiting to a dedicated team covering the Hull and East Riding 0-19 populations from April 2016 and the team became operational in October 2016. We have been monitoring performance against the ED access time indicators since April 2016.

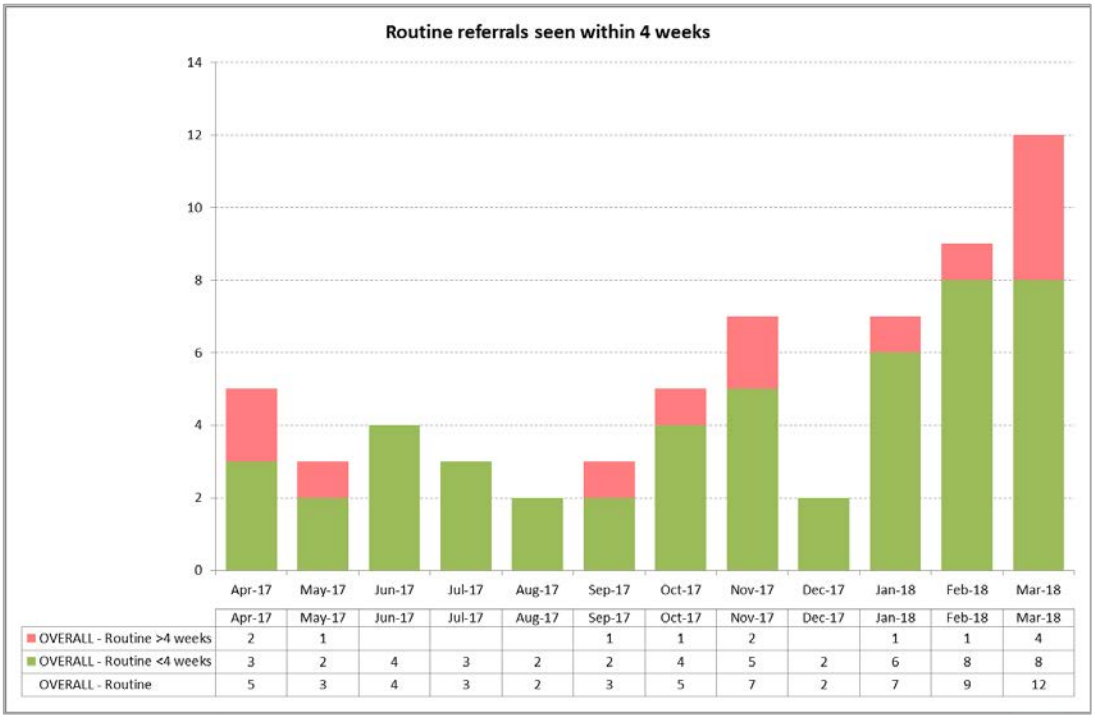
Graph 1



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
OVERALL - Urgent >1 week	1	2	0	0	0	0	0	0	0	2	0	1
OVERALL - Urgent <1 week	6	0	3	2	0	1	0	0	1	0	4	1
OVERALL - Urgent	7	2	3	2	0	1	0	0	1	2	4	2

As at 31st March 2018 25 children and young people started treatment following an urgent referral for a suspected eating disorder, of which 18 (68%) did so within one week of referral. Urgent referrals are prioritised and the service investigates each breach of this target; we can confirm that in the majority of cases this was due to circumstances beyond the control of the service, such as the child not being brought to the appointment, or the family cancelling it. The breaches in January and March 2018 were due to the high volume of referrals.

Graph 2



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
OVERALL - Routine >4 weeks	2	1				1	1	2		1	1	4
OVERALL - Routine <4 weeks	3	2	4	3	2	2	4	5	2	6	8	8
OVERALL - Routine	5	3	4	3	2	3	5	7	2	7	9	12

As at 31st March 2018, 62 children and young people started treatment following a routine referral for a suspected eating disorder, of which 49 (67.7%) did so within four weeks of referral. In most cases where the first contact happened later than four weeks this was due to reasons beyond the control of the service, such as the child not being brought to the appointment, or the family cancelling it. In two instances it was to the comparatively high referral rate in that month.

Numbers of referrals are small compared with other pathways such as anxiety, but patients with eating disorders tend to remain on the caseload for longer (often up to two years) and require more intensive/frequent intervention that other conditions. Because of the intensity of intervention, especially at the start of the pathway, the volatility of the referral rate presents a challenge as even a five or six more referrals than usual places a much greater demand on the team.

The Trust considers that this data is as described for the following reasons:

- Weekly reporting from the Trust Lorenzo system
- Weekly team meeting for caseload management
- Daily morning meeting where referrals are discussed and allocated.

The Trust has taken the following actions to improve this percentage and so the quality of its service by:

- Close monitoring of referral numbers and access times, and recruitment to vacancies.

Certification of Compliance with Requirements Regarding Access to Healthcare for People with a Learning Disability

Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (Department of Health, 2008).

NHS Foundation Trust Boards are required to certify that their Trust meets requirements at the annual plan stage and in each quarter.

Summary of Progress

This key indicator has also being monitored closely at the monthly Trust board meetings via the IQPT.

	Q3	Q4	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Activity	met	met	met			met			met			met
Target/Plan	met	met	met			met			met			met
Variance to plan												

Question	CQC Questions
1	Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?
2	Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria?: a) Treatment, b) complaints procedures and c) appointments
3	Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning Disabilities?
4	Does the NHS foundation trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?
5	Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?
6	Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?

The Trust can confirm that each of the six criteria have been achieved for 2017-18.

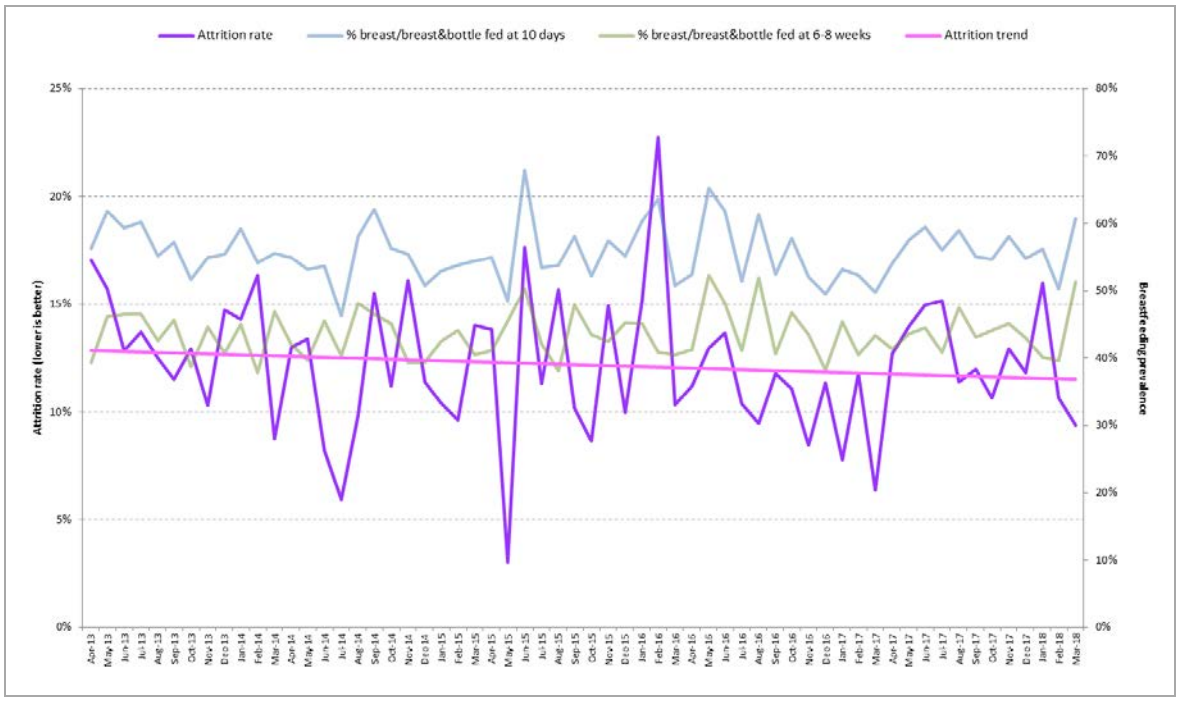
Attrition (Drop-Off) Rate of Breastfeeding Prevalence between Ten Days and Six Weeks

There is clear evidence that breastfeeding has positive health benefits for both mother and baby in the short and longer-term. Breastmilk is the best form of nutrition for infants and exclusive breastfeeding is recommended for the first six months of an infant's life.

The key indicator for measuring our performance on supporting breastfeeding is the attrition rate (drop off). Comparing the breastfeeding status of each child at ten days and six weeks is the most meaningful way to measure how effective the Health Visitors are at supporting mothers who are breastfeeding to continue doing so in the early weeks of the baby's life.

The attrition rate fluctuates considerably from month to month, but comparing longer periods gives a more useful indication of progress. A lower attrition rate indicates good performance, as it indicates that a greater proportion of the mothers who were breastfeeding at ten days have been supported to continue breastfeeding until at least six weeks. The graph below illustrates that the long-term trend shows a clear reduction (improvement) in the attrition rate.

Graph



The average attrition rate for 2017-18 was 12.7%, compared with 11.1% in 2016-17, a deterioration of 1.6%.

The proportion of babies who are breastfed at ten days increased (improved) to 55.8% in 2016-17 and has further increased to 56.3% in 2017-18. The proportion of babies who are breastfed at six weeks remained the same at 43% in 2014-15 and 2015-16, increased (improved) to 44.7% in 2016-17 but has dropped back to 43% in 2017-18. The attrition rate increased (improved) from 11.85% in 2014-15 to 11.7% in 2015-16, and improved again in 2016-17 to 11.1%, but has increased (deteriorated) to 12.7% in 2017-18.

The Trust's Children Services Management team is committed to and very supportive of the United Nations Children's Fund Baby Friendly Initiative (UNICEF BFI) and is proud to have achieved Level 3 of the UNICEF BFI accreditation scheme in 2015 and maintained Level 3 accreditation in 2016 and 2017.

The Trust continues to work closely with Children's Centres to increase the amount of antenatal (pre-birth) contact pregnant women receive to help them make informed and healthy choices about breastfeeding.

During 2016-17 commissioners funded a pilot scheme to promote earlier contact by Health Visitors in order to further reduce (improve) the breastfeeding attrition rate and this was embedded in the new contract from April 2017. Health Visitors are obtaining permission to contact mothers by text (or other means if there is no text option) to offer earlier support for infant feeding.

Percentage of Patients Seen and discharged/transferred within four hours for Minor Injuries Units

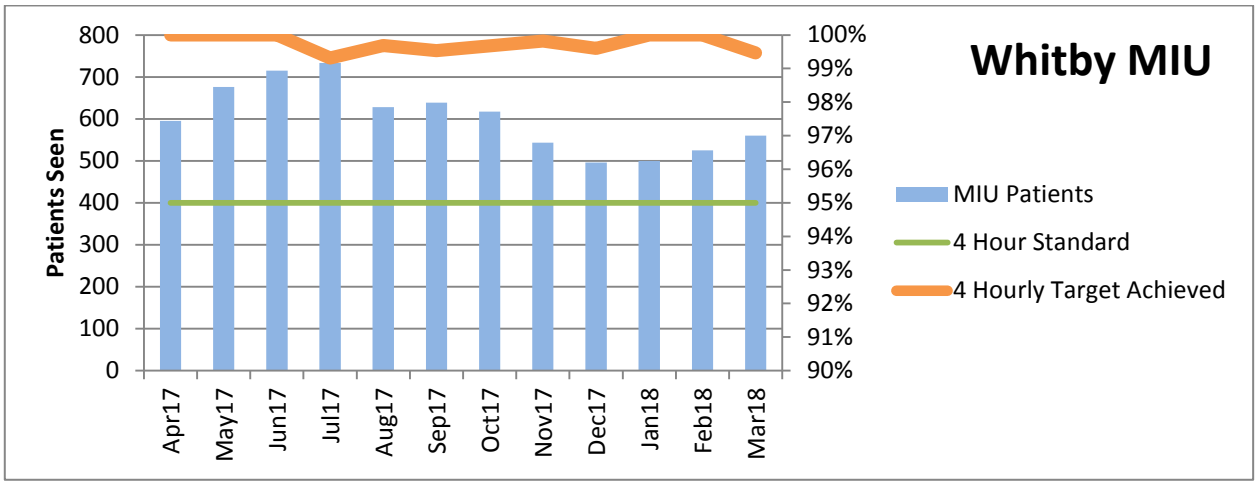
The national target for other A&E departments including Urgent Care Centre/Minor Injury Units is for at least 95% of patients attending to have a total time in the service less than four hours from arrival to discharge or transfer.

Underlying of the four-hour target is the principle that patients should receive excellent care without unnecessary delay. The target focuses on patients requiring treatment which can be accessed without an appointment for treatment as a minor injury or illness. In order to be a part of the reporting, the service has to have an average weekly attendance of more than 50 people, which is calculated over a quarter.

The Trust provides one Minor Injuries Unit (MIU) in Whitby. The MIU saw 7,227 patients from April 2017 to March 2018, an average of 140 patients a week.

The National Standard requires that a minimum of 95% of patients attending an A&E department should be admitted, transferred or discharged within four hours of their arrival. We can report an achievement of 99.8% for April 2017 to March 2018 at Whitby MIU. Data is sourced via the SystmOne patient administration system.

Graph



Part Three

Complaints and Patient Advice and Liaison Service (PALS)

All complaints data is sourced from Datix. The Complaints and PALS Department records and responds to complaints, concerns, comments and compliments received from all areas of the Trust. The Trust ensures that all potential complainants have the option to have their concerns dealt with informally via the PALS service or formally via the NHS Complaints Procedure. Offering both services through one department allows the Trust to monitor all concerns raised, whether formally or informally, to see if there are any trends and to provide a consistent approach for patients, carers and the public.

Formal complaints

For the period 1st April 2017 to 31st March 2018, the Trust received 192 formal complaints which compares to 238 for 2016-17 and 164 for 2015-16.

Each complaint is treated individually, as although the issues raised may be similar to others, the circumstances are often different for the individual concerned. The Trust aims to respond to formal complaints within 30, 40 or 60 working days, dependent on the complexity and number of issues raised. If the timescale cannot be achieved, the complainant is informed of when they may expect their response.

It is important to note that not all formal complaints are the result of a Trust failing or poor service. For example, a complainant may not be happy with the service provided because they consider their needs are different to what the Trust has assessed them as needing. At the outset of each complaint staff try to determine the complainant's desired outcome from making the complaint, however it is not always possible to give people what they seek.

For the period 1st April 2017 to 31st December 2017, the Trust has responded to 185 formal complaints (which compares to 234 for 2016-17). The primary subjects for these complaints are as follows:

Communications	40
Patient Care	36
Admissions/discharge	19
Appointments	18
Values and behaviours of staff	15
Clinical treatment	14
Trust admin/policies/procedures	13
Access to treatment or drugs	11
Prescribing	10
Other	5
Consent	1
All aspects of restraint	1
Privacy and dignity	1
Facilities	1

Of the 185 responded to, one complainant has taken their case to the Parliamentary and Health Service Ombudsman.

The following are some examples of actions/learning from complaints responded to between 1st April 2017 and 31st March 2018; patient specific actions have been excluded.

- Adult Mental Health Community – To ensure that client related telephone calls are recorded to ensure that practice is defensible.
- Adult Mental Health, Inpatient – Remind team to be mindful as patients are admitted daily, staff may lose sight of new experience for patients/carers. Ensure welcome book given and information gathering at point of admission if possible. If high patient activity, inform and apologise to patient/carers so they understand the reasons for delay.
- Legal Services – When case files are reproduced for legal purposes, e.g. claims and inquests, the clinician who screens the records will be asked to sign a form to say that the records and been thoroughly checked and there are no documents filed relating to other patients. The current form will be adapted.

- Paediatric Speech and Language Therapy – To review Special School care pathway, including assessment and to review Education and Health Care plan reports submitted within Special Schools.
- Addictions – Ensure any one due for admission to a detox unit for treatment regarding dependence on alcohol and/or substances is fully informed re: environment and reasons for security etc.
- Emotional Wellbeing Service – Ensure administration processes are developed and implemented in relation to – access rights to service email accounts to be reviewed and amended as necessary; use of different email accounts within the service; telephone script describing the content of the 45 assessment process; patient template letters on PCMIS are reviewed to ensure these are appropriate for all eventualities.
- CAMHS – Non-attendance at multi-agency meetings communication with families ensure they are aware. A reminder will be sent to the teams to ensure that when they are a critical member of a meeting and expected by the family that their non-attendance is communicated with the family to avoid the family feeling let down.

The actions for complaints are monitored by the Complaints department and for each action, and confirmation and evidence is requested from the lead person identified for that action that the action has been completed by the specified time. Once this has been received, the action plans are signed off by the relevant Care Group Director. An action plan tracker to cover all actions identified from formal complaints is currently being developed.

Patient Advice and Liaison Service (PALS)

For the period 1st April 2017 to 31st March 2018, the Trust responded to 431 PALS contacts which compares to 655 for the previous year. NB: compliments are no longer recorded on the PALS database.

Of the 431 contacts, 176 were referrals to other Trusts and therefore there were 255 concerns, queries or comments for this Trust.

Priorities for 2017-18

To continue to manage and respond to complaints, concerns, comments and compliments for all our services. To ensure that staff aim to resolve issues as they arise as close to the delivery of the service as possible, however, if a formal complaint is raised, to ensure staff are aware of the importance of a professional, open, honest and informative response to patients and carers when they raise a concern or complaint.

Feedback Tree, Child and Adolescent Mental Health Services
Rivendell House, Driffield

Below are examples of a few of the compliments which have been received:

Husband of a patient expressed his gratitude for the care his wife had received whilst an inpatient. He stated he always felt supported by staff and when he rang staff were always able to give him an accurate update of his wife's progress and if a nurse is not available to speak to him, somebody always calls him back in a timely manner. He also stated that even though his wife's appetite was not great she praised the food and fluid options available on the unit and states that the food is 'beautiful'.
Adult Mental Health, Inpatient

"My heartfelt thanks to everyone. You will be in my heart for always. Thanks."
Older People's Mental Health, Inpatient

"My father-in-law has been given excellent and timely treatment by conscientious and courteous GPs. In addition, the support staff are also extremely helpful and courteous."
GP surgery

A patient from the Home Based Treatment Team commented on the excellent service she had received. She particularly mentioned three members of the team who she felt had offered her the time and support she required at that time. She remarked on the excellent care they offered to her and she wanted to express her thanks to them.
Mental Health Response Service

"Thank you so much for all your never-ending care and love given to the patient over the years. We would not have managed without your support 24 hours, seven days a week. You are truly amazing."
Community Hospital

A card was received expressing gratitude for the service that had been provided to a mother and her children. The Health Visitor was also complimented for her practical advice as well as being helpful and kind.
Health Visiting

Patient and Carer Experience

In June 2017 a Head of Patient and Carer Experience and Engagement was appointed to the Trust. Since then, there have been a number of positive developments toward improving patient and carer experience processes. Some of the improved processes are as follows:

Forums

Two forums have been created to give our patients, carers and staff a voice and the chance to be involved in Trust business. These are:

Patient and Carer Experience Forum (PaCE) – Our patients and their carers are invited to attend this forum to provide them with a public voice by bringing lived experiences and individual perspectives. We also have representatives from patient and carer support groups on the forum.

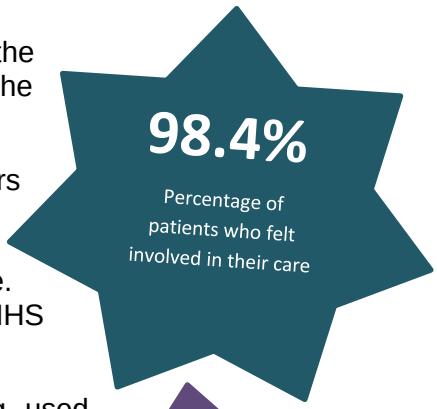
Staff Champions of Patient Experience (SCoPE) – Staff (Champions) attend this forum to share best practice and provide a voice of experience on behalf of their teams. The forum also reviews survey findings and complaints to identify key themes to help inform the Patient Experience Team's work plan.

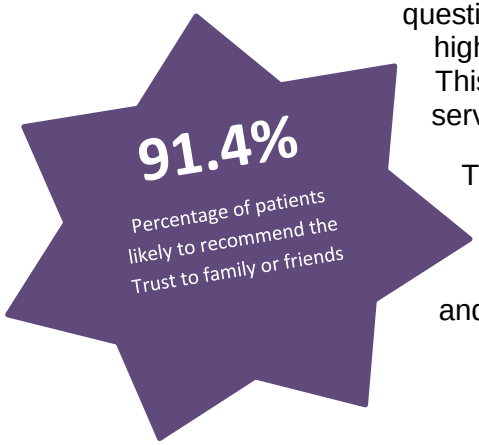
Friends and Family Test

The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to feedback on their experience.

The survey asks people if they would recommend the service to others and offers a range of response options. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.

There are a range of different surveys being used throughout the Trust including Child, Parent, Inpatient, Community, LD Inpatient, LD Community, Forensic Secure, Crisis, Carer and the Short FFT.





Sharing our Achievements

Adult and Older People's Mental Health Services

The Hull Integrated Care Team for Older People has planned, implemented and evaluated a new model of care for people in care homes with mental health needs. It supports and educates care staff and provides in-reach care and treatment. The approach is helping to provide people with early response and improved outcomes.

The Adult Community Mental Health Services in Hull has trialled a new approach to help people waiting for services gain quicker access to care through the delivery of group-based intervention. The group supports people in recognising and managing symptoms as well as building personal strategies and approaches to recovery.

Maister Lodge has commenced a programme of refurbishment designed to improve the environment of care for people living with the later stages of dementia. The programme is due to complete and the team has supported patients to settle into temporary accommodation at Dove House while planning and preparing for a new environment and developing the clinical approach to highly personalised and individual care.

Complex Care Coordinators have been appointed to support a new and developing model for the care of people with complex need arising from a personality disorder. This new addition to the service will work with colleagues providing specialist psychotherapy and traumatic stress services to coordinate help to those with highly complex needs across community and hospital services, providing much needed continuity and coordination.

The Goole Older People's Mental Health Team has been supported by the Bromhead Charity to deliver a service to people in Ward 3 at Goole Hospital and those in care homes with dementia in planning for end of life plans and providing support and advice for carers and families.

The Adult Mental Health Acute Care Pathway has been extensively remodelled over the year. Working in partnership with Mind and Humbercare we have introduced a crisis pad to support people who may otherwise be at risk or be admitted to hospital and a small number of step-down beds to help people who do not have a secure tenancy to leave hospital and find suitable long-term accommodation.

Granville Court – Celebration of Life

Granville Court is a specialist nursing care home for people with a profound learning disability and associated complex healthcare needs which are such that, it is not possible to sustain and stabilise wellness and wellbeing in the wider community. The home has two specialist respite care beds. Despite intensive health monitoring, the focus of our service is very much that we provide a home environment for our patients for the duration of their stay, however their journey may unfold. With effective support and bespoke planning, a person can enjoy opportunities to enhance their life. This includes the individual's and family's wishes when their life journey, or that of their loved one, is drawing to a close.

Our nurses are highly trained and skilled in palliative and end of life care, enhanced by a caring and compassionate care team. The home has all the necessary equipment and knowledge to ensure an individual's final days are spent with the people they love, friends, carers and have the opportunity to make precious memories for their loved ones.

Throughout a person's final days, the priority is to ensure that their death is dignified, pain free and without fear, surrounded by things important to them in their own home.

At the end of life, the verification of expected death is undertaken by nurses in the home who have been trained in this field, meaning that the nurse who verifies the death will be someone who has been known to the individual. This is a great comfort to families before the person is taking to their final resting place.

After the funeral, we hold a celebration of life in memory of the person, celebrating with the family, memories of a life well-loved and lived. Despite the sadness this is an opportunity for families and staff to say goodbye in a befitting way. In closure, we release biodegradable balloons, plant a tree or flower and write goodbyes onto a memory tree, the celebration is as unique as the person we are remembering.

Young people's mental health film project celebration event

Young people from Hull created a film as part of a project which explores emotions and mental health. The film, 'Surviving Thriving', premiered on 23rd March 2018 at the Octagon in Hull. Combining film and dance, the premiere brought together local services, practitioners, young people and their families to celebrate their achievements around promoting and supporting young people's emotional resilience and mental health.

The project was a joint partnership between Humber Teaching NHS Foundation Trust's SMASH programme and the Cornerhouse Young People's Peer Mentor Project, with funding from the HeadStart Hull 'Big Lottery Fund'.

The project involved a group of young people creating a bid that focused on reducing the stigma surrounding mental health, learning about emotional and mental wellbeing and making it everybody's business. The bidding process was unique as the funding was granted by a panel of young people.

The group engaged in emotional and mental health sessions and had a two-night residential trip to Melton Lodge, where they were encouraged to get back to nature. They explored how to improve their emotional resilience and mental wellbeing, learn independent life skills and embrace peer-to-peer support. The young people transformed their learning in to a piece of contemporary dance and the whole process was filmed.

SMASH Programme Manager, Emma Train-Sullivan said: "I have delivered early intervention for young people's emotional resilience and mental health for 16 years. I have seen young people flourish through accessing the right support at the right time. I have to say with confidence that this young person co-produced project has completely blown me away. They are truly inspirational and I feel blessed to have watched them grow and see them not only survive, but 'thrive'.

Estelle Parker, Project Co-ordinator, Young People's Peer Mentoring at Cornerhouse, explains; "For me, it was really nice to see the young people participating in various activities that can improve emotional wellbeing, such as getting outside and taking walks, learning new skills and coming together as a group to support each other. What particularly stood out for me was that none of the group used their mobile phones and instead had face to face conversations with each other and staff. I feel that the residential trip enabled them to have the opportunity to be away from social media, which is sometimes needed for this generation."

Some of the young people who were involved in the project said:

"My journey on this has been nice, I felt like no one left me out. I've been happy and really want it to continue." Jess

(The project) "Made us understand each other and ourselves better." Joe

"I would totally go again!" Lucy

"Everybody has a different story: Don't judge somebody else because you don't know theirs." Emily

Head of Transformation at Humber Teaching NHS Foundation Trust, Peter Flanagan said: "I had the privilege of spending some time with these young people at Melton and was struck by how quickly they had become a cohesive group. They have already given us a commitment as a group to their central role in co-designing our future Thrive-like support for local young people with emotional mental health needs. I am convinced their experiences and views will be a huge asset to us."

HeadStart Hull Programme Manager, Gail Teasdale said: "HeadStart Hull aims to enable children and young people to have positive mental health and wellbeing, thrive in 'their communities' and to 'bounce back' from life's challenges.

"We are pleased to support projects such as this which gives young people a voice and supports them to raise awareness of issues which matter to them, challenging stigma on the issue of mental health in a creative way."

Watch the short film here at **https://vimeo.com/252564687**

Stopping Over-medication of People with a Learning Disability, Autism or Both (STOMP)

The Community Learning Disability Services (CTLD) submitted a bid and were successful to be included in a national pledge to stop the over medication of people with a learning disability. Current research suggests that between 30,000 and 35,000 adults with a learning disability are taking prescribed antipsychotic or

antidepressants on a daily basis without clear clinical indications. A large proportion of these people can safely have their drugs reduced or withdrawn altogether. The aims of STOMP which we are aiming to embed in our practice are to:

- Improve the quality of life of people who are prescribed these drugs
- Make sure that people only receive these drugs for the right reason in the right amount
- To improve understanding of these drugs and when they should and should not be used
- To improve understanding of non-drug approaches to support with behavioural difficulties and to ensure full MDT involvement in making changes
- To empower people with a learning disability with the right support and information.

Staff Awards

Outstanding Team of the Year

In what could not have been a more appropriate end to a glittering event at Willerby Manor Hotel, Julie Jomeen, Professor of Midwifery and Dean of the Faculty of Health Sciences at the University of Hull, presented the team with their second award.

The achievement, acclaimed by an audience of 130 guests including sponsors, commissioners and fellow prize-winners, capped an emotional evening featuring excellent entertainment from Thomas Payne, a talented singer-songwriter from the PSYPHER service, who performed three of his own songs, and the Staff Choir, who impressed with a medley of hits including Coldplay's 'Fix You'.

Winners

Mental Health Team of the Year – The Perinatal Mental Health Team

Outstanding Team of the Year – The Perinatal Mental Health Team

Specialist Services Team of the Year – Road to Recovery Academy

Primary Care, Community, Learning Disabilities and Children's Services team of the Year – Field House Surgery

Corporate Services Team of the Year – Communications Team

Outstanding Care Award – Dave Reade, Changes Project

DXC Technology Inspiration Award – Victoria Dunn, Children's Occupational Therapist

Chief Executive's Rising Star Award – Hollie Wilkinson

Health Stars Sparkle Award – Vicky Oxbury

Konica Minolta Mentor of the Year Award – Catherine West

Smile Foundation Volunteer Award – Michael Cohen and Wendy Mitchell

Gosschalks Solicitors Patient Choice Award – Haltemprice Adult Community Mental Health Team

KCOM Apprentice of the Year – Trevor Lusiola

Chairman's Award – Ruth Edwards and Siobhan Ward

National success

Perinatal Mental Health team scoops prestigious award

Our Perinatal Mental Health team won Team of the Year at the British Journal of Midwifery Practice Awards.

The award recognises collaborative working and innovation and is given to the team which has demonstrated an exceptional contribution to midwifery.

The Trust team was shortlisted for its commitment to resolving everyday challenges in perinatal mental health, such as poor attendance and the need to improve prediction, diagnosis and referral rates.

Trust Nurse crowned General Practice Nurse of the Year

Charlene Sargeant, a practice nurse at Field House Surgery in Bridlington, was crowned Yorkshire's General Practice Nurse of the Year at the General Practice Nursing Awards on 21st March 2018.

The awards were held by the Yorkshire and Humber General Practice Nursing Awards Committee to recognise the skills, expertise and dedication of practice nurses in our area.

The Committee hosted the awards ceremony after NHSE's Chief Nursing Officer, Professor Jane Cummings, launched a ten-point action plan to recognise and develop the role general practice nurses have in transforming care and helping deliver the plan to make the NHS fit for the future.

The regional success followed Charlene being crowned Practice Nurse of the Year for the Humber, Coast and Vale sustainability and transformation partnership area on 28th February 2018.

Externally, we also had our successes with Trust Mental Health Nurse Andrew Barker being nominated in the Edith Cavell Outstanding British Army Reserve of the Year Award. The award recognised his provision of welfare support to service personnel at the height of the 2007 Ebola crisis in the West African state of Sierra Leone.

We are proud of our internal and external award submissions which demonstrate the quality of our services and our staff. To be nominated, shortlisted or to win is an achievement to be celebrated.

To learn more about the winners go to http://www.humber.nhs.uk/about-our-trust/staff-award-winners-2017.htm

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2017-2018

Humber Teaching NHS Foundation Trust has undertaken a self-assessment against required areas of the NHSE Core Standards for EPRR in 2017-18. The Trust self-assessed itself as demonstrating the Substantial compliance level against the core standards maintaining the same level as 2016-17. This was agreed by the Trust Board on 27th September 2017 and submitted to NHSE on 3rd October 2017.

Annex 1: Statement from Commissioners, Local Healthwatch Organisations and Overview and Scrutiny Committees

NHS East Riding of Yorkshire Clinical Commissioning Group and Hull Clinical Commissioning Group are pleased to be given the opportunity to review and comment on Humber NHS Foundation Trust's Quality Report for 2017-18. The Quality Account provides Commissioners with a useful overview of progress made and the challenges encountered by the Trust during 2017-18 to achieve its goals.

The unannounced Care Quality Commission (CQC) inspection undertaken in October 2017 was reported as positive and Commissioners note the Trust's overall rating following this inspection was upgraded by the CQC from Requires Improvement to Good. However, we note the 'requires improvement' for the Safe domain and acknowledge that the Trust is working across all care groups to improve this position. We are aware of the improvement work undertaken by the Trust in respect of reducing Restrictive Interventions and in respect of Suicide and self-harm. It is duly noted, the excellent work within the Learning Disability services, being reported as 'outstanding' practice by the CQC.

The Trust launched their first research conference in May 2017, which was well received and included speakers locally and nationally. We support the aim to make this an annual event and the possibility of making this a wider partnership event to include other Providers I Stakeholders. Commissioners welcome the work undertaken by the research and development department, particularly the involvement of the patients and public, acknowledging the positive feedback received. The introduction of a web-based application for people with memory problems and their supporters is seen as a positive new innovation in healthcare. It would have been helpful to have been made aware of any engagement work initiated with Primary Care and if the Trust have linked into the 'OK to Ask Campaign'.

Commissioners recognise the Trust's strong clinical audit programme, both nationally and locally, and the actions taken to improve quality standards, patient outcomes, learning materials, training and development.

Staffing remains an area of concern and the challenges the Trust is facing in the recruitment and retention of staff. However, there does not appear to be any significant detail on how the Trust is going to approach this in the future, although it is acknowledged this is also a national problem. We are aware the investment made in the leadership programme for staff improvement and look forward to seeing the outcome of this during 2018-19.

We require the Trust to significantly improve their response rate to requests for information under the Freedom of Information Act by the end of 2018-19. It is acknowledged that the Trust is reviewing the FOI process.

The Trust has embedded systems to enable it to learn from patient death reviews and has strengthened its processes taking views of the family and carers within the investigation. We note the learning that the Trust is taking forward to improve investigations, the methodology, risk management training and a review of policies and procedures. Commissioners would like to see improvements and outcomes in the management and monitoring of case reviews, as well as working in partnership with the local Mortality Steering Group. We note the significant amount of work which has been undertaken to strengthen the Trust's approach to the identification, management and learning from Serious Incidents.

We recognise the use of the Perfect Ward App in enabling audit and quality improvement, but the Trust does not provide sufficient detail on the Apps innovation, efficiency in reporting and assurance. However Commissioners are aware of the benefits this has had in clinical practice.

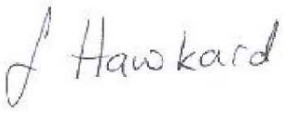
The 2018-19 Quality Priorities detail the commitment the Trust is placing in continuously improving quality in all services. The workshop in February 2018 was representative of the Trust's value on staff, patients, carers and partners, with three key priorities being agreed by the Board.

We would welcome more documented assurance on the Trusts safeguarding responsibilities, partnership working or how the Trust is working with the Safeguarding Boards for children and adults and particularly no identification and learning from Serious Case Reviews.

The draft report reflects an accurate picture of the Trust based on data included to date which in some areas is awaiting year end data. Taking that into account and the comments noted above, we can confirm that to the best of our knowledge, that the report is a true and accurate reflection of the quality of care

delivered by Humber NHS Foundation Trust and that the data and information contained in the report is accurate.

NHS East Riding of Yorkshire Clinical Commissioning Group and Hull Clinical Commissioning Group look forward to partnership working with the Trust to continue to improve the quality, safety and effectiveness of services for patients and improve patient outcomes.



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

Emma Latimer
Chief Officer
NHS Hull Clinical Commissioning Group

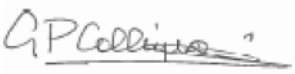
Having begun commissioning community services for the Whitby locality in April 2017, the CCG welcomes the opportunity to provide feedback on HFT Quality Account for 2017/18.

In so far as we are able to comment on the services commissioned for Whitby, HRW CCG feels this Quality Account is representative and provides a comprehensive coverage of services provided by HFT.

The CCG was pleased to note the trust's focus on improving patient safety in 2017/18 by supporting the team to deliver safe care and welcomes the continued commitment to continuously improve the systems and processes in relation to the management, investigation and learning from patient safety incidents.

The CCG supports the priorities identified for 2018/19; the emphasis on developing a culture of continuous quality improvement through engagement with patients and carers to develop services and creating conditions to ensure quality is integral to every persons role to maximise patient safety, aligns closely with the CCG' s strategy and values. The CCG is looking forward to working with the Trust in 2018 to design new and integrated whole system solutions to cater for the needs of people in the Whitby community, including ensuring all available community bed capacity is utilised to its full potential and patient flow is proactively managed.

Yours sincerely



Gill Collinson
Chief Nurse
Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Healthwatch East Riding of Yorkshire accepts the quality accounts and would like to commend the Trust on the work they have been doing. This work is reflected in the accounts and although there are still steps to take, the Trust are demonstrating a commitment to continued improvement and providing the best service they can for the public. It also a good indication of the trusts intentions with the well placed priorities that they have selected to focus on this year and Healthwatch will offer any support to help achieve these in the best interests of the public.

Healthwatch East Riding of Yorkshire

Hull City Council Health and Wellbeing Overview and Scrutiny Commission continues to support the work of the Humber NHS Foundation Trust. The Commission welcomes the production of the Trust's 2017/18 Quality Accounts, and the three priorities identified, with a view to strengthening service delivery and improving patient care.

Hull City Council Health and Wellbeing Overview and Scrutiny Commission

Humber Teaching NHS Foundation Trust has engaged with the Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee throughout its work programme 2017/18. The Sub-Committee welcomes the open and honest nature of the Quality Account and the opportunity to comment on this draft.

The Sub-Committee was pleased with the CQC inspection outcome of 'good' during 2017 for Humber Teaching NHS Foundation Trust and the rapid improvements with regard to the reduction of self-harm and the use of restrictive interventions. The Sub-Committee was also glad to read that safe staffing levels, recruitment and retention are a priority and the organisational culture of the Trust seems to reflect a keen understanding of the fact that its staff will be the people who affect the improvements outlined in the Quality Account. That the Trust continues to safely manage an increasing number of GP surgeries across East Riding is reassuring.

The Sub-Committee was pleased to see that the Trust had achieved highly in relation to its 2017/18 priorities, particularly with regard to reducing stigmas associated with mental illness by working on inclusive approaches. The Trust's keen involvement in research is to be applauded and the outcomes of this involvement are clear to see.

According to the most recent CQC inspection, safety requires improvement but the Sub-Committee was encouraged to read that the Trust had incorporated this into its priorities and strategic goals for 2018/19.

East Riding of Yorkshire Council Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

Annex 2: Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to May 2018
  - papers relating to quality reported to the board over the period April 2017 to May 2018
  - feedback from commissioners dated 1st May 2018
  - feedback from governors. The draft Quality Report was circulated to Governors, no comments were received however, they were involved in the development of the report.
  - feedback from local Healthwatch organisations dated 2nd May 2018
  - feedback from Overview and Scrutiny Committee dated 27th April 2018
  - summative data from the Trust's quarterly complaints report to provide annual data relating to complaints received within the Trust. The annual complaints report published under regulation of the Local Authority Social Services and NHS Complaints Regulations 2009 will be submitted to the July Board
  - the national patient survey 4th August 2017
  - the national staff survey 2017
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 11th May 2018
  - CQC inspection report dated 1st February 2018
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHSI's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

23rd May 2018.....Chairman

23rd May 2018.....Chief Executive

Annex 3: Independent auditors report to the Council of Governors of Humber Teaching NHS Foundation Trust on the Quality Report

Independent auditor's report to the Council of Governors of Humber Teaching NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Humber Teaching NHS Foundation Trust to perform an independent assurance engagement in respect of Humber Teaching NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'quality report') and certain performance indicators contained therein.
This report, including the conclusion, has been prepared solely for the Council of Governors of Humber Teaching NHS Foundation Trust as a body, to assist the Council of Governors in reporting Humber Teaching NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Humber Teaching NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral;
- inappropriate out-of-area placements for adult mental health services.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' issued by NHS Improvement.
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in here; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from Commissioners, dated 1st May 2018;
- feedback from governors, the draft Quality Report was circulated to Governors but no comments were received;
- feedback from local Healthwatch organisations, dated 2nd May 2018;
- feedback from Overview and Scrutiny Committee dated 27th April 2018;
- summative data from the Trust's quarterly complaints report to provide annual data relating to complaints received within the Trust. The annual complaints report published under regulation of the Local Authority Social Services and NHS Complaints Regulations 2009 will be submitted to the July Board;
- the national patient survey, dated 4th August 2017;
- the national staff survey 2017;
- CQC inspection report dated 1st February 2018;

- the Head of Internal Audit's annual opinion over the Trust's control environment, dated 11 May 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.
We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'.
The scope of our assurance work has not included testing of indicators other than the selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual';
- the quality report is not consistent in all material respects with the sources specified in here; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance.

Deloitte LLP

Deloitte LLP
Newcastle Upon Tyne
24 May 2018

Annex 4: Our Strategic Goals

Innovating quality and patient safety

We will:

- Deliver high-quality, responsive care by strengthening our patient safety culture;
- Demonstrate that we listen, respond and learn;
- Achieve excellent clinical practice and services;
- Capitalise on our research and development;
- Exceed CQC and other regulatory requirements.

We will demonstrate we have achieved our goal by:

- An 'outstanding' CQC rating;
- Timely access to safe services delivered by excellent clinical staff;
- National recognition for best practice through specialist research and benchmarking.

Enhancing prevention, wellbeing and recovery

We will:

- Ensure patients, carers and families play a key role in the planning and delivery of our services;
- Empower people to work with us so they can manage their own health and social care needs;
- Deliver responsive care that improves health and reduces health inequalities;
- Develop an ambitious prevention and recovery strategy.

We will demonstrate we have achieved our goal by:

- Pioneering innovation that promotes access, patient/carer engagement, empowerment, self-management and peer support;
- A zero suicide death rate in our inpatient services;
- A jointly managed transformation of services based on people's needs;
- Nationally recognised leadership demonstrated across all health and social care pathways.

Fostering integration, partnership and alliances

We will:

- Be a leader in delivering Sustainability and Transformation Partnership plans;
- Foster innovation to develop new health and social care service delivery models;
- Strive to maximise our research-based approach through education and teaching initiatives;
- Build trusted alliances with voluntary, statutory/non-statutory agencies and the private sector.

We will demonstrate we have achieved our goal by:

- System-wide solutions to long-term problems with our partners;
- Recognition of the Trust as a world-class specialist education and teaching provider;
- Joint ventures that enhance our ability to deliver excellent services.

Developing an effective and empowered workforce

We will:

- Develop a healthy organisational culture;
- Invest in teams to deliver clinically excellent and responsive services;
- Enable transformation and organisational development through shared leadership.

We will demonstrate we have achieved our goal by:

- Teams built around their members and which deliver services tailored to individual needs;
- Staff who are nationally recognised as excellent leaders;
- Motivated staff influencing decision-making and delivering change.

Maximising an efficient and sustainable organisation

We will:

- Be a flexible organisation that responds positively to business opportunities;
- Be a leading provider of integrated services;
- Exceed requirements set by NHS Improvement regarding financial sustainability;
- Build state-of-the-art care facilities.

We will demonstrate we have achieved our goal by:

- Business growth that exceeds £30 million;
- A physically and financially efficient business built on sound integrated models of care.

Promoting people, communities and social values

We will:

- Apply the principles outlined in the Social Value Act (2013);
- Ensure our human resource priorities and services have a measurable social impact;
- Improve recruitment and apprenticeship schemes and promote career opportunities;
- 'Make every contact count' via an integrated approach designed to make communities healthier.

We will demonstrate we have achieved our goal by:

- A robust social values policy implemented across the organisation;
- Social impact measures as core performance measures for all services;
- A clear demonstration of the social impact return on investment for apprenticeship schemes;
- Reduced demand for services.

Annex 5: Clinical Audit Actions

Local Audits

Audit Ref	Audit Title	Actions
UNICEF	National Baby Feeding Initiative	Audit complete. Full accreditation maintained.
NDFA	National Diabetes Foot Care Audit (April-July 2017)	The service that was audited transferred to City Health Care Partnership (CHCP) on 1st August 2017 so it is now responsible for action plan development.
NCAP	National Clinical Audit of Psychosis	Report and action plan to be completed when outcomes received from NCAP in June 2018.
MHAD278	National Pulmonary Rehabilitation Audit (East Riding Pulmonary Rehab Programme)	Report received (Winter 2017-18). This service transferred to CHCP so it is responsible for any audit actions.
NAIF	National Audit of Inpatient Falls (NAIF) Round 2	This audit informed the new Trust Falls Policy. A re-audit of the policy will take place in quarter one 2018.
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP) (April-July 2017)	The service that was audited transferred to CHCP on 1st August 2017 so it is now responsible for action plan development.
LeDeR	Learning Disability Mortality Review Programme	This audit informed the new Trust Physical Health Policy and management of sudden death in epilepsy.
NCISH	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	SASH training is now in place in the Trust.
POMH-UK	Topic 1g & 3d Prescribing high-dose and combined antipsychotics	a) Raise awareness of standards with Trust prescribers: • Circulate presentation to Consultant Psychiatrists • Presentation of audit at doctors teaching morning • Inclusion in medicine management newsletter. b) Disseminate results through clinical networks particularly forensic and adult: Represent at Forensic and Adult clinical networks. c) Monitor completion of high-dose antipsychotic form: Completed through local audit and/or yearly POMH audit in addition to pharmacy technician checks. d) Monitor physical health checks: Completed through local audit and/or yearly POMH in addition to pharmacy/MDT checks on monitoring forms where used.
POMH-UK Topic 15b	Prescribing Valproate for Bipolar Disorder	Report completed. Action plan in development.
POMH-UK Topic 17a	Use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention	Report completed. Action plan in development.

Quarter One

Audit Ref	Audit Title	Actions
MHA9	Mental Health Act (MHA) Inspection Audits via Perfect Ward	Reports available on Perfect Ward.
OPMH3	Older Persons Fellowship Programme (Service Evaluation in conjunction with Hull University)	Report overdue – waiting for academic lead at Hull University to provide their data.
LD	Inpatient experience in Learning Disability Services	Report completed.
MH12	Occupational & Educational Needs in PSYPHER	Report overdue – audit lead on maternity leave. Audit supervisor to advise on completion.
SI 2015-23632	Audit of observation levels, risk assessment and leave arrangements of informal patients	a) Develop a leaflet that describes the new engagement and observation policy and procedure and what this will mean to them as an informal patient.

	(Westlands)	b) Engagement and observation is described within the information booklets for all inpatient units to ensure that all patients have an understanding of what this means to them as an individual. c) Consent is sort from the patient (who is informal) to agree to this level of observation. d) A summary of the patient and plans for leave as part of their recovery journey is discussed in the handover and documented within the records. e) Leave is clearly documented as part of the recovery meetings and safety plan to ensure that all staff working on the unit are clear on the leave arrangements for each patient. f) Leave stamp is used across all services to enable staff to easily identify discussions regarding leave within the records. g) Pro forma for risk assessment is developed to enable all staff to clearly articulate the process of risk assessment prior to any patient leaving the unit and or returning from leave. h) Review the audit tool and audit across all the inpatient services to review the level of enhanced observations and leave taken for both informal and detained patients. i) Audit of NEWS within inpatient mental health services to ensure that all staff are aware of the escalation needed when a patient scores a 3.
SI 2014-24579	Audit against the policy and procedures related to the management of self-ligature and the use of ligature cutters	a) Re-audit of compliance with new policy. b) Target of 100% completion (or attempts to complete) NEWS post restraint. c) Target of 95% or above for all staff to be trained in ligature removal at all times on units. d) Qualitative review of management plans.
SI 2014-24579	Audit against the policy and procedures related to prone restraint	a) Audit of compliance with new policy to be undertaken. b) Target of 100% medic attendance post restraint. c) Target of 95% or above for all staff to be trained in Management of Actual or Potential Aggression (MAPA) at all times on the units. d) Recording of restraint should include details of MAPA trained staff and numbers of bank/agency involved in restraints. e) Future audit could include other service areas including learning disabilities and episodes occurring in 136 suite.
CORP1	Audit of inpatient clinical equipment at Humber Teaching NHS Foundation Trust	a) Review electrocardiogram (ECG) training for junior doctors b) Review forensic inpatient equipment and provision – review with modern matron to discuss provision of on call box of medical equipment.

Quarter Two

Audit Ref	Audit Title	Actions
NICE NG15	NICE NG15 Antimicrobial stewardship	Report completed.
NICE NG10	NICE NG10 Violence & Aggression	Report completed.
NICE CG191	NICE CG191 Pneumonia	Report completed.
NICE CG179	NICE CG179: Pressure Ulcer Prevention and Management	a) Learning materials to support further training: a poster (Prevention, Discovery, Reporting, Safeguard and Investigation of Pressure Ulcers) has been shared with the Neighbourhood Care Teams and the Community Hospital. b) All pressure ulcers developed in our care are reviewed by the Lead Tissue Viability Nurse and reviewed using structured judgement methodology, which is reported within the IQPT.
CAMH1	Audit of Assessing the practice of prescribing Stimulants for ADHD within the CAMHS treatment units	a) Present the audit in clinical focus group and in Drug and Therapeutic Committee meeting. b) Continue current practice. c) Re-audit in 12 months' time. d) The audit tool used for this audit could be attached to all patients' notes.
PC1	Holderness Care Navigator Project	Report to be completed by 24th May 2018.

	(Service Evaluation in conjunction with Hull University)	
CN3	Investigating routine use of Patient Outcome Measures in a Community Mental Health Team (Service Evaluation)	Audit ongoing. Report due September 2018.
LD2	Gastrointestinal disorders in patients with mental illness and learning disability	Report to be completed by 31st May 2018.
MH13	Audit of General Liaison MDT sheets	a) To update the MDT sheets to include a 'completed by:' heading. b) To include a risk assessment column in the new referral table to indicate if risk has been considered and if it reflects the positioning on the waiting list, or if there are any further additional considerations, before adding to the waiting list. c) To include a heading on the individual patients' MDT record to reflect consideration and documentation of capacity and risk, if relevant. d) To be re-audited in 12 months.

Quarter Three

Audit Ref	Audit Title	Actions
MH12	Audit of General Liaison MDT sheets (September 2017)	a) To update the MDT sheets to include a 'completed by' heading. This recommendation has been agreed by the general liaison MDT. b) To include a risk assessment column in the new referral table to indicate if risk has been considered and if it reflects the positioning on the waiting list, or if there are any further additional considerations, before adding to the waiting list. c) To include a heading on the individual patients' MDT record to reflect consideration and documentation of capacity and risk, if relevant. This recommendation has been agreed by the general liaison MDT. d) To re-audit in 12 months.
NICE QS138	NICE QS138 Blood Transfusion (October 2017)	a) Process for the administration of blood and blood products to be adhered to as per policy. Bedside check documented. Transfusion start/stop times documented on protocol. Vital signs as per protocol. b) Care of patients receiving transfusion: observations recorded pre transfusion; 15 mins (+/-5 min) after starting; hourly (+/-15 min). Allow small delay as acceptable deviation. c) Organisation expectations in relation to staff training, as identified in the training needs analysis. To obtain training figures for transfusion safety training. Expectation of 90% of staff involved in transfusion process trained. Continue competency based training and assessment for all staff involved in the relevant sections of the transfusion. d) Process for monitoring compliance with all the above: adverse incidents related to blood component transfusion are reported via Datix and investigated. Matron to ensure all staff involved in the transfusion process have undertaken update training every three years. Ensure staff practice corresponds with Trust policy. Being aware of transfusion errors within the directorate and ensure changes in practice have been implemented to avoid reoccurrence.
SSA1	Service Evaluation: Effectiveness of Opioid Overdose and Take-home Naloxone training for staff (October 2017)	a) All new staff starting with the service to have opioid overdose and take home Naloxone training. b) Arrange a refresher training session once a year for all East Riding Partnership (ERP) staff. c) Record numbers of staff, carers and patients trained following initial training in March 2017.
NICE Gap Analysis	Service Gap Analysis of NICE CG178, CG133, CG185, CG90 &	a) Feedback to staff involved in the audit. b) Establish within the clinical pathways action plan when it

Audit Ref	Audit Title	Actions
	CG120 (October 2017)	would be appropriate to repeat the audits.
SSF1	Re-audit of completion of discharge letters – Forensics	a) To present the audit in Clinical network meeting. b) Highlight the concerns and recommendations from the re-audit of completion of discharge letters to all relevant staff members who are involved in patient care and follow up. c) To devise a checklist of discharge packs which would include compliance with recommended standards, such as dispatching an immediate discharge letter within 24 hours, discharge summary within seven days of discharge and documentation of physical health monitoring and relevant investigations. This checklist to be included in the full discharge summary template.
NICE NG11	NICE NG11 Challenging Behaviour & Learning Disabilities	a) Review the service's care pathways for challenging behaviour to improve the stepped care model and ensure that the service offers joined up assessments and interventions. b) Review the training needs of staff in light of the revised care pathways. c) Develop a flowchart and written description about how the service responds to challenging behaviour to help clarify the process for staff and service users. d) Include more structured checklists within the pathway to help guide assessment processes and to act as screening tools for onward referrals. e) Ensure that interventions and support plans follow from a clear statement regarding the hypothesised function of the behaviour and have clear targets, methods and review dates. f) Ensure appropriate risk assessments are completed. g) Ensure that information regarding PALS and the right to a second opinion are provided during the initial assessment.
NICE NG28	NICE NG28 Type 2 diabetes in adults: management – Dr Clive Henderson	a) Consideration should be given to an additional retrospective audit (over the past two years) audit of all in last two years with HbA1C equal to or greater than 42 but less than 48. This cohort should be coded as "At Risk of Diabetes" and a recall to offer the patient an annual re-test. b) If future coding issues occur regarding this audit then this can be addressed with the relevant clinician. c) Repeat audit in six months to ensure changes are embedded in to practice.
SSF2	Service Evaluation – Recovery College in Forensic Charlotte Nicholls	To increase the length and complexity of some of the courses on offer to patients/students of the Recovery College.
MHA8	MCA Mental Capacity Act: Knowledge of Staff	a) Article in Midweek Mail to coincide with the relaunch of the updated policies and procedures. b) To continue Midweek Mail when new updates are available or when any internal issues need addressing. c) Best Interests Assessors (BIA) list to be updated d) Two drop-in sessions to discuss what was learnt from the audit and to discuss the updated polices and a drop-in session at the end for general MCA 2005 and DoLS questions. e) Performance and Development Review to include additional training and learning for MCA 2005 and DoLS f) Qualitative audit (dip sampling) within specific work areas: Ullswater ward is considering a specific audit. g) Next MCA 2005 and DoLS audit September 2018. h) BIA role review: long-term plans put in place when the replacement system for DoLS has been approved.
NICE CG50	NICE CG50 (NEWS) audit	a) Ensure staff use A3 formatted coloured NEWS charts. b) Registered staff to complete NEWS charts within the appropriate guidance. c) Staff to receive updated NEWS training based upon findings from this audit report.
NICE QS9	NICE QS9 Heart Failure in Adults	a) To review and improve read coding for Chronic Heart Failure patients who are currently on the Heart Failure Register.

Audit Ref	Audit Title	Actions
		b) To improve and comply with the diagnosis, assessment and management of Chronic Heart Failure for older adults. To review medication and titrated to optimum treatment dose.
NICE CG53	NICE CG53 Chronic Fatigue	a) To ensure all blood results are received and checked prior to acceptance for an assessment. b) To alter MDT so as to enable staff to meet immediately following clinic to complete decision-making process. This is working and all MDT sheets are now being signed off. c) To put a tick box on the assessment form so staff can indicate whether the DVD has been given.
NICE NG16	NICE NG16 Dementia, disability and frailty in later life	a) Ensure programmes to prevent non-communicable chronic diseases share resources and expertise nationally and locally to maximise coverage and impact (see NICE's pathways on preventing type 2 diabetes: population and community interventions and behaviour change: individual approaches). Health Improvement Plan (HIP) assessments offered to those in clusters 10-17. Advice given as per CQUIN 3a 2017-18 pathway. b) Work together to deliver services that address the needs of people with multiple risk factors as well as for those with single risk factors: GP, Health Trainers, mental health assessment includes consideration of physical health. Occupational therapy and physiotherapy are part of the MDT. c) Emphasise the need for, and help people to maintain, healthy behaviours throughout life (such as stopping smoking, being physically active, drinking less alcohol, eating healthily and being a healthy weight): HIP assessments offered to those in clusters 10-17. Advice given as per CQUIN 3a 2017-18 pathway. AUDIT (Alcohol Use Disorders Identification Test) and DAST (Drug Abuse Screening Test) carried out at initial assessment and advice given/referral to specialist services if necessary and consented to. d) Help people identify and address their personal barriers that prevent them from making changes to improve their health: mental health barriers. e) Make information and services available to all (see the Equality Act 2010). Additionally, target these towards those with the greatest need whenever possible: physical health. f) Commissioners and providers of local services should work with local communities to understand the range of services that they need to reduce the risks of dementia, disability and frailty: Health Trainers g) Commissioners and providers of local services should provide information in a range of languages and culturally acceptable styles and offer translation and interpretation facilities if appropriate: this is available. h) Public and third sector providers (such as local authorities, leisure services, emergency services and health and social care providers) should use routine appointments and contacts to identify people at risk of dementia, disability and frailty (for example, appointments with a GP or practice nurse, when attending leisure centre classes, or visiting a community pharmacy): physical health is part of the mental health assessment process. Physical Health Policy and Procedure Incorporating Care of the Deteriorating Patient P028 is implemented Trustwide. i) Local authorities and third sector organisations with a responsibility for, or who support, public health services should encourage both recreational activities and active travel (for example, walking, cycling) for local journeys: Cycle To Work scheme.
CQUIN2	CQUIN audit of Lorenzo records	Report completed.
SEA 2017-08	SEA 2017-08 Lairgate SMS Open Access Service	Removed from audit plan. The audit was not completed as the service closed.

Quarter Four

Audit Ref	Audit Title	Actions
POMH Topic 17a	POMH Topic 17a : Use of depot/long acting antipsychotic injections for relapse prevention	Report completed. Action plan in development.
MH14	Recovery-Focused Practice at Bridlington Driffield Mental Health Team	a) To provide multimedia examples of success stories from other service users, which can inspire hope. b) To involve service users in recruitment, training and service development forums. c) To support local facilities (e.g. leisure, education, employers) to understand and accommodate mental health challenges. d) To provide information on available interventions (e.g. therapies), which enables clients to make choices. e) To link service users with peers who can act as support, within which service users can develop recovery plans. f) To develop recovery plans (how to keep well, not just what to do if unwell). g) To provide/facilitate recovery education. h) To have a recovery framework in supervision. i) To prioritise service user recovery instead of administration. j) To write notes and documents collaboratively. h) To make advance directives and crisis plans.
NPRH	National Pulmonary Rehabilitation audit (Winter 2017-18)	Report completed. Action plan in development.
SG1	Safeguarding – Mental Capacity Act: Knowledge of Staff	a) Article to be published in Midweek Mail to cover the updated policies, areas requiring clarification raised from the survey, how to access the Introduction to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) booklet, how to access the MCA 2005 code of practice and the MCA 2005 DoLS code of practice. b) Drop-in sessions to go through what was learnt from the audit, to discuss the updated policies and have an opportunity for general MCA 2005 and DoLS queries (x2). c) How to access a copy of the MCA 2005 and DoLS Code of Practice. This will be via a link in Midweek Mail.
NICE NG16	NICE NG16 Dementia, disability and frailty in later life	Report completed. Action plan in development.
NICE QS138	NICE QS138 Blood Transfusion	a) Bedside check documented. b) Transfusion start/stop times documented on protocol. c) Vital signs as per protocol. d) Observations recorded pre transfusion; 15 mins (+/-5 min) after starting; hourly (+/-15 min). Allow small delay as acceptable deviation – the audit shows improvement with this. e) To obtain training figures for transfusion safety training. Expectation of 90% of staff involved in transfusion process trained. Continue competency-based training and assessment for all staff involved in the relevant sections of the transfusion. f) Adverse incidents related to blood component transfusion are reported via Datix and investigated. g) Matron to ensure all staff involved in the transfusion process have undertaken update training every three years. h) Ensure staff practice corresponds with Trust Policy.
MH15	Driving Risk Assessment at Newbridges	a) Posters around all adult psychiatric inpatient units. b) Patient information leaflets with useful contact information (Driver and Vehicle Licensing Agency (DVLA)). c) Driving assessment tool. d) Re-audit on regular basis. e) Raise awareness of responsibility of healthcare professionals. f) General Medical Council (GMC) guidance and DVLA rules and regulation.
NICE CG53	NICE CG53 Chronic Fatigue	a) To ensure all blood results are received and checked prior to

Audit Ref	Audit Title	Actions
		acceptance for an assessment. b) To alter MDT so as to enable staff to meet immediately following clinic to complete decision making process. This is working and all MDT sheets are now being signed off. Action complete. c) To put a tick box on assessment form so staff can indicate whether the DVD has been given.
SG2	Safeguarding – Children's Records in Whitby MIU	a) Defensible documentation teaching sessions will be provided to staff, addressing the need for robust and comprehensive record keeping as per Nursing and Midwifery Council guidelines and Trust policy. b) A meeting with the Service Manager has been arranged for 23rd February 2018 to discuss this review and the learning outcomes. c) A meeting will be arranged with the MIU team to feed back this information and ensure the actions required are understood by all staff. d) A further review will take place to measure the achievement of the above actions in July 2018.
SG3	Safeguarding – Think child, think parent, think family (Holderness CMHT)	a) Safeguarding Link staff should maintain up to date information on staff notice boards. b) The use of the consideration log should be used consistently to facilitate multi-disciplinary discussion and provide evidence of this taking place. c) Ensure staff are aware of the referral processes for safeguarding children and adults. d) Ensure that all staff working with families are compliant with level 3 safeguarding children training. e) Ensure that all staff are compliant with the required safeguarding adult training. f) Ensure that all staff have access to safeguarding children supervision on a three-monthly basis to discuss cases where there are safeguarding concerns present. g) Ensure that all link and supervisors access development days four times per year as per policy.
SG4	Safeguarding – Think child, think parent, think family (Westlands)	a) Ensure all staff are compliant with relevant safeguarding training. b) Maintain records of safeguarding children supervision in patient files if relevant. Guidance can be found in the Trust safeguarding supervision guidance document (2017). c) Ensure that any safeguarding information is maintained by the Link staff and reviewed on a regular basis. d) Encourage staff attendance at the Trust's Defensible Documentation training to develop record keeping skills and understanding of the detail required in patients' records.
SG5	Safeguarding – Think child, think parent, think family (Rapid Response Service)	a) Support to be provided to the Rapid Response team from the Safeguarding team to assess appropriate models of safeguarding supervision that would meet their needs. b) Link staff to attend the development sessions four times per year. c) Safeguarding children supervisors to attend four development sessions per year. d) Team lead/manager to attend the appropriate development session. e) Team lead manager to ensure all staff are compliant with required levels of training. The Safeguarding Children team is able to provide flexible access to the training. f) Safeguarding team to provide information relating to historical allegations of abuse and defensible documentation if required. This will be clarified with the team lead/manager.
SSA2	Service Evaluation to assess the prevalence of patients prescribed drugs of abuse by their GP in addition to opioid substitution treatment by the specialist Addictions Service	a) Ensure all patients have a record of prescribed medications from the summary care record via the spine – action completed. b) Present this data to GPs via the Hull and East Riding Prescribing Committee.
MH16	Driving Risk Assessment of Mental Health Patients on admission	a) Posters around all adult psychiatric inpatient units. b) Patient information leaflets with useful contact information (DVLA). c) Driving assessment tool.

Audit Ref	Audit Title	Actions
		d) Re-audit on regular basis. e) Raise awareness of responsibility of healthcare professionals. f) GMC guidance and DVLA rules and regulation.
NICE NG10	NICE NG10 Violence and aggression: short-term management in mental health	a) Establishment of service user group will need funding and significant support in order to meet the objectives and be meaningful for those involved. Cost implications to be drafted. b) Mandatory tab on Lorenzo to allow access to update information regarding debrief. Discussion at the Reducing Restrictive Interventions group and recommendation to Lorenzo implementation group.
NICE CG191	NICE CG191 Pneumonia	a) To review and improve the quality of read coding for pneumonia within primary care. b) To request the inclusion of the CRB65 Mortality Risk Assessment Score to be uploaded onto SystmOne to determine the severity. c) To review the potential benefit and cost implications towards the implementation of C-reactive protein testing for community-acquired pneumonia in primary care

Annex 6: Glossary and Further Information

136 Suite	A registered health-based place of safety where Police can take an individual under a Section 136 of the Mental Health Act for their own safety
BIA – Best Interests Assessor	Best Interests Assessors are responsible for ascertaining that the person is 18 or older. They are solely responsible for assessing whether there are any lawful decision-makers who object to what is proposed. If qualified also as Approved Mental Health Professionals, they are able to carry out an eligibility assessment, to decide whether a person's rights should be protected by the use of the MHA or the MCA, via the Safeguards.
BMI – Body Mass Index	A measure of body fat based on height and weight.
C. Diff – Clostridium difficile	A type of bacterial infection affecting the digestive system.
Care Co-ordinators	A health care worker who is assigned a caseload of patients and is responsible for organising the care provided to them.
Care Plan	A document which plans a patient's care and can be personalised and standardised.
CCG – Clinical Commissioning Group	NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Community Hospital	The Trust has two Community wards providing short term 24-hour clinical care and rehabilitation – Whitby Community Hospital and Fitzwilliam Ward, Malton Community Hospital
CPA – Care Programme Approach	A multi-agency system used to assess, plan and co-ordinate care for a patients receiving mental health services.
CQC – Care Quality Commission	The independent regulator of health and social care services in England. The CQC monitors services by way of setting standards and carrying out inspections.
CQUIN – Commissioning for Quality and Innovation	A framework rewarding excellence in healthcare by linking achievement with income.
CROMS – Clinical Reported Outcome Measures	Assess the quality of care delivered to NHS patients from the clinical perspective.
CTO – Community Treatment Order	A legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.
Datix	Datix Limited is a patient safety organization that produces web-based incident reporting and risk management software for healthcare and social care organisations.
DHSC – Department of Health and Social Care	Responsible for Government policy on health and social care in England.
DoLS – Deprivation of Liberty Safeguards	Part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.
E. coli – Escherichia coli	*Escherichia coli* (abbreviated as *E. coli*) are bacteria found in the environment, foods, and intestines of people and animals. *E. coli* are a large and diverse

	group of bacteria.
EDGE	Clinical Research Management System
FACE – Functional Analysis of Care Environments	The FACE risk profile is part of the toolkits for calculating risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people, and in perinatal services.
FFT – Friends and Family Test	A patient feedback survey used throughout the NHS asking whether patients would recommend services to their friends and family.
Freedom to Speak Up Guardian	Freedom to Speak Up (FTSU) guardians in NHS trusts were recommended by Sir Robert Francis, following his review and subsequent report into the failings in Mid-Staffordshire. FTSU guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled.
KPI – Key Performance Indicator	Indicators which help an organisation to measure progress towards goals.
LeDeR – Learning Disability Mortality Review Programme	The programme aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere.
Lorenzo	An electronic health record for patient records.
MCA – Mental Capacity Act	Designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.
MDT – Multi-disciplinary Team	A group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, etc.), each providing specific services to the patient.
MHA – Mental Health Act	The main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
Midweek Mail	A communication email sent weekly to Humber Teaching NHS Foundation Trust.
MRSA – Methicillin-resistant Staphylococcus aureus	A bacterial infection, resistant to a number of anti-biotics.
NHSE – NHS England	NHS England is an executive non-departmental public body of the Department of Health and Social Care.
NHSI – NHS Improvement	Supports foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NICE – National Institute for Health and Care Excellence	Produces evidence-based guidance and advice for health, public health and social care practitioners. Develops quality standards and performance metrics for those providing and commissioning health, public health and social care services. Provides a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.
NIHR – National Institute for Health Research	Funds health and care research and translate discoveries into practical products, treatments, devices and procedures, involving patients and the

	public in all our work.
NPSA – National Patient Safety Agency	Lead and contribute to improved, safe patient care by informing and supporting organisations and people working in the health sector.
PALS – Patient Advice and Liaison Service	Offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.
Perfect Ward	An app-based, real time inspection and reporting tool for healthcare inspections. It eliminates administration by capturing results directly and provides automated reporting.
POMH-UK – Prescribing Observatory for Mental Health (UK)	Helps clinical services maintain and improve the safety and quality of their prescribing practice, reducing the risks associated with medicines management.
PROMS – Patient Reported Outcome Measures	Assess the quality of care delivered to NHS patients from the patient perspective.
QOF – Quality Outcome Framework	Part of the General Medical Services contract for general practices and was introduced on 1st April 2004. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.
SEA – Significant Event Analysis	A qualitative method of clinical audit which highlights and reviews events in a non-threatening meaningful way; involving a range of people to review the issues, to gain a collective understanding of what happened, why it happened and identify areas for learning and or areas for change or improvement to reduce the likelihood or prevent recurrence.
SitReps – Situation Report	A report on the current situation to inform of any issues within services at that time.
SOF – Single Oversight Framework	Sets out how NHSI oversees NHS trusts and NHS foundation trusts, helping to determine the level of support they need.
STP – Sustainability and Transformation Partnerships	The purpose of Sustainability and Transformation Partnerships is to help ensure health and social care services in England are built around the needs of local populations.
SystmOne	An electronic health record for patient records.