NHS

York Teaching Hospital

NHS Foundation Trust

# Quality Report 2019-20



# Contents

## Part One – Statement on quality from the Chief Executive

As new Chief Executive having joined the Trust in August 2019, it gives me great pleasure to introduce the annual Quality Account and share with you our achievements, challenges and successes over the past year and identify areas for continued improvement.

In June 2019 the Care Quality Commission (CQC) visited the Trust as part of its planned inspection programme, focusing on Scarborough and Bridlington hospitals. They also carried out a well led review and a use of resources assessment. Taking account of all of these elements, the overall rating of the Trust remains as 'Requires Improvement'.

The report includes many positive examples of the services we are providing, and it is encouraging to see the efforts of our staff being acknowledged by the CQC, with every service rated as 'Good' for caring, without exception.

Areas of outstanding practice have been highlighted, including the creation of the same day emergency care (SDEC) centre in Scarborough's emergency department, and the introduction of day case hip replacements in Bridlington.

It is also positive to see that that Scarborough's maternity services and Bridlington Hospital achieved a rating of 'Good' overall, demonstrating improvement since the last inspection. However, the inspection team raised a number of concerns about safety, and these are reflected in the overall safety rating for Scarborough Hospital. These concerns relate in the main to staffing levels for nursing and medical staff, and our ability to meet key access targets - which remains a key priority for us.

We recognise the CQC's concerns regarding acute and emergency care in Scarborough, and we know that these services are facing significant pressures which make it difficult to achieve key access targets. Nonetheless, the CQC acknowledge that patient safety is prioritised and that patients are quickly risk assessed in the department, and that staff act rapidly upon patients at risk of deterioration. Risk is actively managed in order to keep patients safe.

Following the inspection we responded positively to the CQC's concerns and took immediate action. This includes increasing medical staffing overnight and extra nursing staff to cover shifts on key medical wards. We have also reintroduced Hospital at Night, and have bolstered the medical leadership team in Scarborough to help with senior decision making.

In addition to these immediate actions following the inspections, there are a number of longer-term pieces of work already underway which are starting to make an impact.

In February 2020, the COVID-19 pandemic began and has seen our staff face unprecedented challenges on a daily basis. As Chief Executive I have been astounded and incredibly proud of the incredible care that I have seen our staff provide. I would also like to take the opportunity to thank the local communities for the fantastic support that they have given our staff during this period. As we write the Quality Account, the pandemic is continuing and we are learning daily how best to treat this disease. The next Quality Account will undoubtedly focus on our continuing efforts to return to a new normal and address the backlog of elective surgery and outpatient appointments while ensuring we minimise the risk of COVID-19 infection.

As we look ahead to the coming year it is important to recognise the financial challenges that we, like many trusts, will continue to experience. However, with our commitment to achieving both efficiencies and quality improvements through our quality improvement approach, we are confident that we can meet our financial targets and continue to provide high quality and effective care.

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

Simon Morritt
Chief Executive

14 December 2020

## Part Two – Priorities for improvement

### 2.1 Priorities for the Trust 2020-21

Following the launch of the National Patient Safety Strategy (July 2019) and the corresponding Trust Patient Safety Strategy, there will be a requirement to redesign our patient safety system utilizing a patient-centred approach and the national patient safety curriculum to do this. This will be a significant focus for 2020-21 although it is anticipated that there may be some delay associated with responding to the current pandemic. It will include implementation of a revised Serious Incident process, renaming adverse patient experiences as Patient Safety Incidents and using Patient Safety Investigations as a way of looking into the situation.

**PATIENT SAFETY**

**SAFER care bundle**

To embed principles of the SAFER care bundle across all inpatient wards

- All patients to have a senior review before midday (to be evidenced on Core Patient Database – CPD);
- Every patient to have a discharge status set (and recorded on CPD);
- All downstream wards who received pts from an assessment area to have discharged or transferred at least one patient by 10am (this is the golden patient);
- 33% of all discharges or transfers to have occurred by midday and Time of day of discharge/ transfer to earlier in the day (discharge curve);
- 33% reduction in super stranded pts, evidenced through CPD and the long length of stay review meeting.

**Antimicrobial prescribing**

- Further reduction in volume of antimicrobials -2% embedded in the national contract;
- OPAT Improving the percentage of patients on self-care pathway ( 75% for April);
- The Antibiotic Kit Review (ARK) will be rolled out Trust-wide and added to statutory and mandatory training to improve compliance.

**Recognition of the deteriorating patient**

- Educate all relevant staff in relation to the importance of recognition, early escalation and treatment;
- All Inpatients to have a Ceiling of Care (CoC) recorded on the Core Patient Database (CPD) ideally within 24hours of admission with regular reviews carried out and a review following change in the patient's condition. The CoC can state that all treatment is appropriate;
- 90% of all clinical observations and NEWS/MEWS/PAWS scores to be recorded within an hour of the due time;
- Implementation of the Out of Hours team bleep filtering/ task allocation system

- the aim of this system is for all clinicians working out of hours to work as part of a team instead of in their specialties. This includes an expansion of the Critical Care Outreach team to include a Clinical Support Worker. A new electronic "task" request system will be implemented on the wards including information about level of urgency. The tasks will then be allocated to the most appropriate available staff member instead of all going directly to the Medical Registrar on shift;
- Achieve requirements of CQUIN to commence from September 2020 - achieving 60% for the recording of NEWS 2 score, escalation time and response time for unplanned critical care admissions from non-critical care wards of patients aged 18 years and over;
- The enhanced critical care outreach team will adopt a proactive approach using an interactive whiteboard to identify patients at risk of deterioration.

**Sepsis**

- Implement and embed the Maternity Sepsis screening tool with an agreed audit programme to provide assurance;
- Implement the Paediatric sepsis screening tool from the UK Sepsis Trust with an agreed audit programme to provide assurance.

**Infection Prevention & Control**

- To further embed IPC in Care Groups including through governance structures, monitoring of good clinical practice, education and continuous improvement;
    - Care group records demonstrate evidence that planned continuing professional development and education activities focused on the prevention of infection reaches all staff over the course of the year at a rate of 25% per quarter;
- To continue work on reducing GNBSI bacteraemia by 25%.

**Safeguarding**

- Deprivation of Liberty Safeguards - Safeguarding Adults team to monitor national and local development/roll out direction of the Liberty Protection Scheme (LPS) to ensure compliance with the Deprivation of Liberty Safeguards replacement process.

N.B. We are awaiting government release of the consultation of the code of practice which is currently on hold. On its release, a response will be formulated as an organization within the nationally determined time frame and follow the national implementation time frames for embedding the legislation in Trust processes.

**Ambulance turnaround**

- The Trust will continue to focus on reducing ambulance handover times on both the York and Scarborough sites - 55% reduction in 60mins delays compared to last year.

## CLINICAL EFFECTIVENESS

### 7 Day Services Standards

- To continue the on-going work towards improving performance against the 7 day standards (trajectory of 90%); this will be tracked on CPD with feedback to Care Groups being monitored through governance meetings.

### Falls

- 10% reduction in the average number of falls per 1000 bed days (based on the last 12 months data);
- A baseline assessment will be undertaken for falls with moderate harm or above, where lapses in care are identified; an improvement plan will then be designed and implemented and monitored via the Falls Improvement Group;
- To improve the accuracy of reporting a trajectory has been set of a 50% reduction in falls with no level of harm documented.

### Pressure Ulcers

- A 50% reduction in medical device related injuries by April 2021;
- A baseline audit of heel damage will be undertaken; an improvement plan will then be designed and implemented and monitored via the Pressure Ulcer Improvement Group;
- Elimination of all Category 4 pressure ulcers, with lapses in care, by December 2020.

## PATIENT EXPERIENCE

### Complaints & PALS

**Improve the timeliness of complaint responses**

- 90% trajectory: <10 days for PALS, <30 days complaints.

**Improve the quality of complaint responses**

- Design a process to learn from reopened complaints and demonstrate actions taken to improve the quality of complaint responses;
- All investigating officers to have attended in-house complaints management training.

### Learning from patient experience

- Patients will know the name or names of the people who are looking after them;
- Improvement trajectories to be agreed in response to feedback from National Surveys and complaints, e.g. experience of waiting in ED; food quality; hygiene care; discharge; attitude of staff (linked to ‘Clever Together’).

The Governors have chosen to monitor 14-hour senior review as their 2020-21 indicator.

The quality priorities suggested for 2020-21 are largely generated from a review of outstanding priority outcomes from 2019-20 or they are stretch targets based on driving further improvements. The trajectories (where set) have been developed based on anticipated 'business as usual' activity however they do not necessarily reflect the change in nature of current activity due to the current pandemic. The priorities do provide a broad base to frame quality improvement activities for the year ahead. Any variance due to the Covid-19 pandemic will be reflected in future reports.

Some priorities have been continued from 2019-20 to 2020-21 to allow further improvements to be made and work to be embedded. Some indicators do change according to the priority given to different areas which require improvement. Priorities are finalised with the agreement of the Quality Committee. Progress against these priorities will be monitored through updates to the Quality Committee.

### 2.1.1. A Just Culture of Safety

The 'Just Approach'

The 2018 Staff Survey demonstrated that the organisation is below average for its safety culture. The Trust scored below average in all questions relating to this theme. The Trust scored below average for staff feeling secure raising concerns, being confident that the organisation would address them and feeling that the organisation acts on those concerns.

The Just Culture Steering Group was established in March 2019 and is a work stream of the Patient Safety Strategy 2019 – 2024 and the Workforce and OD Strategy 2019-2024. The aim is to promote a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. The Trust will continue to encourage reporting of errors and incidents in order to learn, and to promote positive reinforcement rather than blame or punishment.

It is intended that the Just Culture work will be complimentary to the engagement work undertaken in partnership with Clever Together. It is anticipated that the Clever Together initiative will allow a greater launch pad to roll out a Just approach to a wider audience.

The importance of training on what a just and learning culture is and how this can be implemented when it comes to HR practices is an important and initial step on a long journey of cultural change. Just Culture workshops have taken place whereby the HR Team, Staff Side colleagues and key managers came together to learn more about how the Just approach differs to the organisations traditional approach, particularly in relation to Employee Relations matters. The workshops focussed on how to ensure learning is a priority and discussed how to remove the punitive / sanctions oriented nature Employee Relations cases can take.

The current language used in both SI and Employee Relations investigations can add to the feeling of a punitive / blame oriented approach. ‘Incidents’, ‘witnesses’, ‘sanction’ and ‘interview’ all conjure the images of a negative and almost criminal approach. To shift the approach to one of restoration and learning some of these key terms must also be shifted. ‘Incidents’ may become ‘events’, ‘witnesses’ may become ‘observers’. Work needs to be undertaken to look at the language currently used, identify inappropriate phrases and collectively look at what alternatives may be more appropriate.

A key part of a Just approach is to ensure learning is central to any incident or event. As such a key objective for the steering group was to switch on the feedback function within Datix. This also links to a key objective on the Corporate Staff Survey Action Plan. This feedback mechanism went live in January 2020.

Patient Safety Walkrounds

Patient safety walk rounds provide an opportunity for executive and non-executive board members to visit clinical teams and seek assurance on patient safety issues. Speaking to staff, patients and families enables triangulation with other data and information to provide a full picture on quality, safety and experience.

In the last 12 months, 24 Patient Safety Walk rounds have taken place across the various sites. The main themes identified and being addressed were staffing, Infection Prevention Control and Information technology systems. Walkrounds will continue during the next year with Executive, Non-Executive and Governor engagement.

**Leadership and Quality Improvement (QI)**

QI strategy

Our quality strategy lays out our commitment to improve the quality of care for our patients. It describes our long-term ambitions in terms of how staff can be supported to deliver improvements, with an aim to create a culture of continuous improvement, focused on the needs of our patients and community. Our plans are to strengthen professional leadership, using quality improvement (QI) methodology, to deliver sustained improvements across our organisation.

Care of the Deteriorating Patient

2019 saw the implementation of NEWS2; an early warning score that now includes identification of new confusion as a trigger for escalation and provides clarity on oxygen saturation target levels. Compliance with the identification of new confusion and 4AT screening remains a challenge; this assessment (4AT) helps clinicians to recognise what may be causing the new confusion and generates a pathway of interventions.

Learning from events, it is known that the Trust continues to see cases where patient deterioration fails to result in adequate escalation. In order to better understand the barriers and challenges to robust escalation, the Trust commissioned a small study,

seeking the views of a range of staff through semi-structured interviews. The findings of the study are awaited.

Over the last 18 months a group of clinicians from York hospital have been involved in a working group rewriting the START course. A deteriorating patient course intended for FY1 doctors to be rolled out nationally. This course has successfully run twice for the new F1 Doctors with positive feedback in York.

There has been successful running of AIRA (Acute Illness Recognition and Assessment) course to the nursing/healthcare staff at both York and Scarborough. The course continues to be a success with very positive feedback.

In situ training and simulation at both Endoscopy units in Scarborough and York: co-ordinated MDT teaching and scenario simulation to improve deteriorating patient recognition and care, review equipment and processes, enhance escalation and management of deteriorating patient, and develop team work/communication.

Deteriorating Patient workshops were hosted in February 2020; the topics covered, were recognising and dealing with deterioration and DNACPR decisions and discussions. Further workshops are planned.

There is ongoing QI work focussing on implementing ways to improve decision making for all inpatients and recording Ceiling of Care decisions on the electronic Core Patient Database. The intention is that by improving Ceiling of Care decision and documentation, this will reduce the amount of inappropriate cardiac arrest calls and outreach visits. Patients who deteriorate out of hours will also have a clearer plan which makes it easier for on call staff and in turn will hopefully improve patient and family experience and satisfaction.

A paper based adult sepsis screening tool was introduced to the Trust in August 2019. The pathway uses the International definitions of sepsis and the sepsis 6 pathway recommended by the UK Sepsis Trust. Further department specific pathways have been introduced for the community in-patient units, Bridlington Hospital and the community nursing team. Work is ongoing to develop pathways for use in maternity, paediatrics and the satellite renal dialysis units.

<u>Pressure Ulcers and falls</u>

The Trust continues to focus on reducing the incidence of Category 3 and 4 pressure ulcers, which develop or deteriorate in our care. The Pressure Ulcer Steering Group has focused much of its work during this last year on analysis, accuracy, presentation and the sharing of data across the Trust.

The TVN team aims to focus on early recognition of pressure damage, and part of this work includes the new risk assessment which categorises patients into ‘at risk’ or ‘not at risk’. Following the success of this in community areas, the plan is to roll out this work, as part of the new nursing documentation.

Targeted training by the Tissue Viability team continues in areas with increased reporting of areas of concern. Improvement trajectories have been agreed as:

- A 50% reduction in medical device related injuries by April 2021;
- A 20% reduction in all categories of heel ulcers in inpatient settings by April 2021;
- Elimination of all Category 4 pressure ulcers, with lapses in care, by December 2020.

The Trust continues to focus on reducing harm from in-patient falls. The Trust falls, slips and trips policy has been updated with improvements in falls risk assessments and the post falls pathway. Work has been ongoing to introduce the three key falls prevention actions identified in the CQUIN bundle.

Improvement trajectories have been agreed as:

- A10% reduction in falls per 1000 bed days by the end of December 2020;
- A 10% reduction in falls with moderate harm or above where lapses in care are identified, by the end of December 2020;
- A 50% reduction in falls with no documented level of harm, by the end of December 2020.

**Patient and Carer Engagement**

Duty of candour

The Trust reviewed its processes for the management of Duty of Candour during 2019/20. This includes the development of a policy and supporting guideline and the development and implementation of Duty of Candour dashboards that run on a live basis at Care Group level. This means that Care Groups can see at any one time the patients for which Duty of Candour must be addressed.

Compliance with Duty of Candour is recorded on Datix, the organisations Risk Management System, and this is supported by the relevant evidence. Compliance is reported on a weekly basis to the Quality and Safety Meeting and monthly to both Quality Committee and the Board of Directors. At the point of writing compliance for the year is 85.2%.

Patient and Family Involvement in serious incident investigation Research study

The Trust is one of 4 Trusts participating in a research study to co-design processes and resources to guide the role of patients and families in serious incident investigations at a national and local level. This involves testing these processes to understand their impact upon experience, learning and likelihood of seeking legal recourse.

The study is expected to take 40 months and will involve exploration of psychological trauma to patients and families following serious incidents, as well as engaging service users to build trust as partners in care.

## Continuous Learning and Improvement

Patient Safety Matters

This newsletter has been produced on a regular basis since 2016, and while it was originally produced for junior doctors, it has gradually gained a broader reader base. The newsletter is now contributed to and distributed to a wider multi-disciplinary group. The principle of the newsletter has been shared nationally through the Health Foundation. The newsletter continues to present content related to patient safety and quality improvement, and where ever possible, be contributed to by frontline staff. The newsletter has a multidisciplinary editorial group and is now produced bi-monthly.

Nevermore

Nevermore is a publication by the Patient Safety Team which aims to share learning from Serious Incidents within the Trust. The current audience for the publication includes executives, non-executives, clinicians, care group directors and managers. The case studies included in Nevermore incorporate findings from Serious Incidents, with recommendations, links to service improvements and new policies or procedures.

Last year there were three publications. One edition focused on two key areas, the development of a pressure ulcer from a medical device and a Structured Judgement Case note Review (SJCR). The second focused on Never Events or near misses within the Trust. The most recent Nevermore focused on the value of the lactate and other blood gas measures in deteriorating patients.

Learning Policy

In response to the need to formalise the process of learning from events of all types, the organisation has developed a Learning from Events Policy. This aims to ensure that all staff within the organisation understands the roles, responsibilities and various mechanisms for the sharing of learning within the organisation. This has been supported by the commencement of automatic feedback to reporters of events once investigations have been completed. This commenced from January 2020. The Learning Policy was formally approved by the Executive Committee in March 2020.

Never Events

Never Events are defined as serious incidents that are wholly preventable. Since April 2019, the Trust has declared 3 such incidents.

A patient was listed for a left sided procedure. 20ml of 0.25% Levobupivacaine (anaesthetic) was injected. When changing syringes to infuse a further 20mls, the Operating Department Practitioner realised that the wrong side was being anaesthetised. This incident is still under investigation.

A guidewire from a peripherally inserted central catheter line was retained within a patient, resulting in their transfer from Scarborough to York for endovascular removal of the guidewire by the interventional radiology team. The learning resulted in the aspiration to develop a formal lines service as well as creating standard operating procedures.

An oral medication was administered via an intravenous cannula. The error was recognised by the staff member administering the medication. There was no harm caused to the patient. The learning identified a training requirement as well as a need to standardise procurement of syringes across the Trust. A re-launch of the policy was undertaken.

Root Cause Analysis Training

As described in the patient safety strategy, the Trust aims to develop capability to undertake good quality investigations. With this in mind, 41 senior Nurses have participated in root cause analysis training, with further training planned during 2020. Furthermore, 43 staff has completed Serious Incident investigation training.

Learning from Death

Around 50% of people die in hospital and research has shown that in 3-5% of cases the death was preventable if optimal care had been provided

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). In February 2017, the CQC set out new requirements for the investigation of deaths for all Trusts to run alongside the local existing processes. The Trust has investigated deaths since 2013 through the use of a structured proforma, in addition to the formal investigation of deaths reported through the incident management process.

We have a consistent and coordinated approach to undertaking mortality reviews, and reporting on findings, with implementation of identified actions. Completion of timely and proportionate mortality also enable the Trust to identify recurring and emerging issues and allow for a quick response to any questions raised by external organisations, in relation to mortality trends.

In addition, deaths which occur under the following circumstances are automatically reviewed; elective admission, patient had learning difficulties/under section of mental health act/transfer from psychiatric hospital, next of kin raised concerns about care or coroner's inquest being held.

The Learning from deaths process is ever evolving. The Introduction of a Medical Examiner role from the 1st April 2019 has, as expected, seen an increase in the number of SJCR's commissioned from 130 between April 2018-March 2019, to 196 from April 2019-March 2020, an increase of 34%.

The learning from deaths process is managed within each care group to ensure ownership following completion of the Structured Judgement Case Review (SJCR); findings are discussed at Governance Meetings and a Quarterly report submitted for discussion at the Mortality Steering Group. Governance meetings monitor completion of actions and ensure learning is shared.

Further training has been delivered in the SJCR process thus increasing the number of reviewers.

**Learning from deaths mandatory reporting requirements:**

Item 27.1 - During April 2019 – March 2020, 2237 of York Teaching Hospital NHS Foundation Trust patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

497 in the first quarter (April 2019 – June 2019);
508 in the second quarter (July 2019 – September 2019);
597 in the third quarter (October 2019 – December 2019);
365 in the fourth quarter (January 2020 – March 2020).

Item 27.2 - By 31 March 2020, 1568 case record reviews and 177 SJCR investigations have been carried out in relation to 2237 of the deaths included in item 27.1.

In 1568 cases a death was subjected to both a case record review and / or an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

410 in the first quarter (April 2019 – June 2019);
401 in the second quarter (July 2019 – September 2019);
422 in the third quarter (October 2019 – December 2019);
335 in the fourth quarter (January 2019 – March 2020).

Item 27.3 - One representing 0.07% 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:

1 representing 0.2% for the first quarter (April 2019 – June 2019);
0 representing 0% for the second quarter (July 2019 – September 2019);
0 representing 0% for the third quarter (October 2019 – December 2019);
0 representing 0% for the third quarter (January 2020 – March 2020)

These numbers have been estimated using several methods; structured judgement case note review (SJCR), serious investigations (SI's).

Item 27.4 - One case has been reported as avoidable.

*Case 1* – death from haemopericardium caused by dissection of the ascending aorta.

Learning:

- Continued and frequently updated teaching, training and communication on aortic dissection in order to ensure high levels of awareness of this condition amongst all ED staff.
- Improved communication of key messages to all staff including bank and locum medical staff with more frequent safety briefings.
- Improved medical documentation and documentation of repeat observations and pain scores.
- Reflection for the staff involved given the tragic outcome in this case

Item 27.5 - A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period in consequence of what the provider has learnt during the reporting period for item 27.4.

The key learning was:

Case 1 - Improve awareness of this rare diagnosis among all ED staff through ongoing teaching sessions and safety briefings.
Ensure all medical staff are aware of the need to accurately record clinical findings including important negatives.
Ensure the right level of senior medical staff assess patients with high risk presenting complaints.

Item 27.6 - An assessment of the impact of actions described in item 27.5 which were taken by the provider during the reporting period
The action is robust but teaching of all new ED staff at the beginning of the rotation must continue to include high risk conditions like this to look out for with guidance on where to seek advice on management 24/7.

The Mortality Steering Group will continue to monitor for recurrent similar events or the same errors in particular clinical areas.
Communication of safety messages with all staff is shared via Patient safety matters newsletter, Nevermore newsletter and screen savers

Item 27.7 - 162 case record reviews and 69 investigations completed after 1st April 2019 which related to deaths which took place before the start of the reporting period.

Item 27.8 - 0 representing 0% 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 several methods; structured judgement case note review (SJCR), serious investigations (SI's)

Item 27.9 - 0 representing 0% of the patient deaths during the previous reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

<u>WHO assurance visits</u>

As part of the quality schedule within the contract, it was agreed that auditing of the quality of WHO checklists would take place during 2019/20.

Observations were undertaken in a range of theatres, to assess WHO checklist compliance during the Safety Briefing, Pre-Anaesthetic “Stop, look and listen”, Pre-Incision “Stop, look and listen” and the sign out.

In the majority of cases, theatre staff carried out the WHO checklist appropriately, within policy and to a high standard. There were some exceptions which were noted as areas for improvement and shared with the relevant Care Groups.

Learning from NPSA alerts

Autonomic Dysreflexia (AD) is a potentially life threatening condition that can occur in patients with spinal cord injury at or above the sixth thoracic vertebra (T6).
It is the term used to describe the paralysed body’s autonomic response to a painful stimulus below the level of injury which can cause severe, sudden hypertension (raised blood pressure) and if left untreated can lead to a stroke, epileptic fit or even death and for this reason should always be treated as a medical emergency.

A NPSA alert was issued in July 2018 highlighting the risk to patients of staff not being aware of how to prevent AD and how to treat episodes that occur. In response a Trust task and finish group was set up with input from the Spinal Injuries unit in Pinderfields Hospital.

The spinal injury units in Pinderfields and Hull were able to provide a list of patients living in our region that are high risk for having AD episodes. An alert has been added to the Trust’s Core Patient Database and on the front of the medical notes for each of these patients. Prevention pathways and treatment guidelines have been placed in the front of each of these patients’ notes. An e-learning package has been devised and is available on the Trust learning hub. Communication has also been sent to the GP for each of the patients to ensure the risk is added to the GP records. Community nurse team will ensure that alerts are set up for newly identified patients.

A NPSA alert was issued in December 2018 highlighting concerns about inconsistent temporary identification systems being used when patients are brought to the hospital with an unknown identity. The alert recommended changing the way names and dates of birth are allocated to unknown patients.
A process has now been implemented that conforms to the advice on the alert and also meets the requirements for blood transfusion and radiology. The identification of patients’ policy has been updated.

### 2.1.2. Seven Day Services

In 2013 a group chaired by Sir Bruce Keogh agreed a series of clinical standards for seven-day hospital services. The standards were founded on published evidence and on the Academy of Medical Royal Colleges (AoMRC) position in relation to

consultant-delivered acute care. Ten standards were agreed for adoption in acute in-patient hospitals.

Four of the 10 standards were identified as priority clinical standards on the basis of their potential to positively impact patient outcomes. These shown below:

| | |
|---|---|
| Standard 2 | Time to first consultant review and (more recently extended to include) the overall proportion of patients made aware of diagnosis, management plan and prognosis within 48 hours of admission; |
| Standard 5 | Access to diagnostic tests |
| Standard 6 | Access to consultant-directed interventions |
| Standard 8 | Daily review by consultant; twice daily if high dependency |

All acute trusts in England are required to undertake self-assessment surveys to measure compliance with the four priority standards for seven-day services. Audits were completed as part of the self-assessment in April and October 2019 and reported through to Board. Performance in relation to 14-hour post take review is monitored monthly by the Board via the Trust Integrated Board report.

**Clinical Standard 2**

National compliance for this standard is 90% for weekdays and weekends. The most recent audit in October 2019, demonstrated that the Trust is not currently meeting the national standard, with overall performance at 69.5%.

**October 2019 Overall Trust performance**

| | |
|---|---|
| Trust weekday | 72.4% |
| Trust weekend | 60.1% |
| OVERALL | 69.5% |

Post take performance data is taken from the Trust electronic patient record (CPD) and it has been established that a number of reporting errors are potentially influencing the data. Firstly, it appears that consultants are not always selecting the tick box option in CPD to record that the review has taken in place and the approach to consultant allocation in CPD, does not always accurately reflect the actual consultant caring for the patient , therefore the data is inaccurate. These reporting issues are being addressed through ongoing work across the care groups and job plans continue to be reviewed to ensure consultants are able to fulfil their review requirements.

**Clinical standard 5**

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The standards require that Hospital in patients must have scheduled seven day access to diagnostic services, typically ultrasound, computerized tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant directed diagnostic tests and completed reporting will be available seven days a week:

Within 1 hour for critical patients

Within 12 hours for urgent patients
Within 24 hours for non-urgent patients

- Radiology- Currently, neither York or Scarborough sites seven day access for MRI. However there is network agreement with Hull for out of hours

- .Microbiology- Main service gap is failure to incubate blood cultures bottles within 4 hours of them being taken overnight. Clinical advice is available 24/7 on a category A on-call rota.

- Echocardiography-There is a 9-5 service Monday – Friday provided by the cardio-respiratory department, at all other times patients requiring urgent echocardiography are seen by the on call consultant cardiologist.

- Endoscopy/ ERCP services. Saturday/Sunday - Critical acute bleed patients at Scarborough are transferred to York (formal networked arrangement) after discussion between the referring doctor and the on call York Gastroenterologist. This means there is provision for critical patients over the weekend however there is currently no provision of inpatient endoscopy for Urgent/Routine patients.

**Clinical Standard 6**

Hospital in patients must have 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear written protocols.

The Trust has determined that it is compliant with this standard.

**Clinical Standard 8**

Based on the most recent audits the trust is assured that it is meeting the required standard of performance above 90%. The latest audit data is shown below:

| | |
|---|---|
| Trust Weekday once daily reviews | 94% |
| Trust Weekend once daily reviews | 100% |
| Trust Weekday twice daily reviews | 94% |
| Trust Weekend twice daily review | 91% |

**Further Action**

In order to continue improving the Trust performance in relation to the delivery of 7-day service, the following actions have been agreed with Care group directors

- To agree improvement trajectories with directorate teams
- Establish mechanisms at directorate level to monitor compliance with standard 2 and establish escalation processes if the standard is not being met

- Establish robust assurance processes to ensure compliance and improvement as part of care group governance
- Ensure workforce requirements meet the expectations of delivery of 7 day services

### 2.1.3. Freedom to Speak Up

Our Trust is committed to the principles of the Freedom to Speak Up review and its vision for raising concerns. The 'raising concerns/whistleblowing' policy is in line with national best practice and details routes of escalation for staff who wish to raise concerns about **risk, malpractice or wrongdoing** Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care;
- unsafe working conditions;
- inadequate induction or training for staff;
- lack of, or poor, response to a reported patient safety incident;
- suspicions of fraud (which can also be reported to our local counter-fraud team);
- a bullying culture (across a team or organisation rather than individual instances of bullying).

We are committed to listening to our staff, learning lessons and improving patient care. Concerns received by the Freedom to Speak Up Guardian are recorded on a highly confidential database and staff receive an acknowledgement within two working days. The Guardian records the date the concern was received, whether confidentiality has been requested, a summary of the concerns and dates when staff have been given updates or feedback. The Freedom to Speak Up Guardian will also carry out a 3-month well-being check as appropriate to ensure the member of staff has suffered no detriment as a result of raising a concern.

**Ways in which staff can speak up**

- Through their line manager/tutor/senior clinician;
- Through HR drop in sessions;
- Through Fairness Champions;
- Through the FTSU Guardian;
- Through listening exercises;
- Through Datix.

**Ensuring No Detriment -** Every 'speak up' receives a follow up questionnaire which includes:

- Did you feel your concern was addressed appropriately by the Freedom to Speak up Guardian?
- Is there anything else you would have liked the Guardian to have done for you?
- Have you suffered any detriment as a result of speaking up?

The Trust Board receives a full report form the FTSU Guardian bi-annually which details the numbers, themes and lessons learnt form staff who have raised concerns.

### 2.1.4 Information about the Guardian of Safer Working – Rota Gaps

The 2016 national contract for junior doctors encouraged stronger safeguards to prevent doctors working excessive hours with the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors.

Junior doctors can complete online exception reports highlighting variations from their work schedule. This includes working extra hours to ensure patient safety, missed teaching or training sessions and missed breaks. Exception reports are primarily managed by their supervisors with oversight by the guardian.

Outcomes for the individual can be closure with no further action, allocation of payment for the extra hours worked or time owing in lieu.

Exception reports can also lead to the host department being fined by the Guardian as well as review of staffing and rostering to tackle any systemic factors that may be contributing to the breach in terms.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The work of the guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

The Role of the Guardian is to:

- Champion safe working hours;
- Oversee safety related exception reports and monitor compliance;
- Escalate issues for action where not addressed locally;
- Require work schedule reviews to be undertaken where necessary;
- Intervene to mitigate safety risks;
- Intervene where issues are not being resolved satisfactorily;
- Distribute monies received as a result of fines for safety breaches;
- Give assurance to the Board that doctors are rostered and working safe hours;
- Identify to the Board any areas where there are current difficulties maintaining safe working hours;
- Outline to the Board any plans already in place to address these;
- Highlight to the Board any areas of persistent concern which may require a wider, system solution.

The Board receives a quarterly report from the Guardian, which will include any details of fines for breaches of safe working:

| Month | Care Group | Reason | Guardian portion | Doctor portion | Total fine amount |
|---|---|---|---|---|---|
| September 2019 | 2 | More than average 48 hour working week over 11 week reference period | £108.45 | £66.36 | £174.81 |
| September 2019 | 4 | More than average 48 hour working week over 7 week reference period | £48.68 | £29.79 | £78.47 |
| November 2019 | 3 | Unable to achieve more than 75% of their breaks over three, four week reference periods | £120.03 | N/A | £120.03 |
| November 2019 | 2 | More than average 48 hour working week over 11 week reference period | £19.86 | £12.15 | £32.02 |
| December 2019 | 3 | Worked a shift of more than 13 hours in duration | £7.20 | £6.08 | £13.28 |
| December 2019 | 3 | Unable to achieve 11 hours rest between shifts | £39.72 | £24.30 | £64.02 |
| December 2019 | 6 | Unable to achieve 5 hours uninterrupted rest between the hours of 22:00 and 07:00 | £34.47 | £21.10 | £55.57 |
| January 2020 | 6 | Unable to achieve 5 hours uninterrupted rest between the hours of 22:00 and 07:00 | £141.69 | £85.02 | £226.71 |
| January 2020 | 6 | Unable to achieve 5 hours uninterrupted rest between the hours of 22:00 and 07:00 | £188.92 | £113.36 | £302.28 |
| February 2020 | 6 | Unable to achieve 5 hours uninterrupted rest between the hours of 22:00 and 07:00 | £118.08 | £70.85 | £188.93 |

**Rota Gaps**

Schedule 6, paragraph 11b of the *Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016* requires “a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account”.

The Trust is working to reduce rota gaps through a host of recruitment and retention initiatives:

- The Patchwork pilot scheme was successful and we have now fully procured the software to help fill bank locum shifts. Since implementation bank fill rates have improved by 10%;

- The east coast recruitment project has continued to have a positive impact with further reduction in medical vacancy rates in Scarborough. These are down to 10.6% overall (from 21.3%) and 4% for junior doctors;

- The government’s decision to review the Resident Labour Market Test requirements has made it easier to employ doctors from overseas and

medical staffing continue to streamline recruitment processes for all applicants;

- The Trust continues to work with Hull York Medical School to establish Teaching Fellowships in order to attract doctors into the organisation;

- Ongoing recruitment and training of Advanced Clinical Practitioners across York and Scarborough is creating a permanent workforce of highly skilled professionals capable of working at the level expected of a junior doctor;

- The Junior Doctor Forum action plan is aimed at improving working conditions for junior doctors. It is hoped that this will encourage trainees to return to the organisation in substantive posts and Trust Grade/SAS doctors to remain.

## 2.2 Statement of Assurance from the Board of Directors

### 2.2.1 The Regulations

The Government introduced a specific set of regulations that Foundation Trusts are required to address as part of the Quality Report. These requirements are included in the assurance statements made by the Board of Directors.

### 2.2.2 Assurance from the Board

During 2019-20 the York Teaching Hospital NHS Foundation Trust provided and/or sub-contracted 36 relevant health services.

The York Teaching Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in 36 of these relevant health services. The income generated by the relevant health services reviewed in 2019-20 represents 100 per cent of the total income generated from the provision of relevant health services by York Teaching Hospital NHS Foundation Trust for 2019-20. The income generated has been received from services commissioned by Clinical Commissioning Groups, NHS England, and the Local Authorities.

### 2.2.3 Clinical Audit

During 2019-20, **48** Quality Account audits; **26** National clinical audits and **2** national confidential enquiries covered relevant health services that York Teaching Hospital NHS Foundation Trust provides.

During that period York Teaching Hospital NHS Foundation Trust participated in **47** (**98%**) national clinical audits and **2** (**100%**) national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that York Teaching Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2019-20, are listed in Table 1 below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

**National Audit & Enquiry Activity** (Table 1)

| National Clinical Audits York Teaching Hospital NHS Foundation Trust were eligible for and participated in 2019-20 | Care Group Participating | Data Collection Undertaken 2019-20 | Data Collection Completed % | |
|---|---|---|---|---|
| | | | YTH | SGH |
| **RCEM** Assessing Cognitive Impairment in Older People (Care in Emergency Departments) | 1 & 2 | Yes | Audit provider analysing data | |
| BAUS Urology Audit - **Female Stress Urinary Incontinence (SUI)** | 3 | Yes | 100 | N/A |
| BAUS Urology Audit - **Nephrectomy** | 3 | Yes | 100 | |
| BAUS Urology Audit - **Percutaneous Nephrolithotomy (PCNL)** | 3 | Yes | 100 | |
| **RCEM** Care of Children in Emergency Departments | 1 & 2 | Yes | Audit provider analysing data | |
| ICNARC Case Mix Programme **(CMP)** | 3 | Yes | 100% | |
| Elective Surgery (National **PROMs** Programme) - **Hernia/Varicose Veins/Hip/Knee** | 3 | Yes | 100 | |
| British Association of Endocrine and Thyroid Surgeons **(BAETS)** - **Endocrine and Thyroid National Audit** | 3 & 6 | Yes | 100 | |
| Falls and Fragility Fractures Audit Programme **(FFFAP)**<br>- **National Hip Fracture Database**<br>- **National Audit of Inpatient Falls** | 1, 2 & 3 | Yes | 100<br>Audit provider analysing data | |
| Child Health Clinical Outcome Review Programme **(NCEPOD)** – Young People's Mental Health | 5 | No | N/A | |
| Inflammatory Bowel Disease **(IBD)** Registry | 3 | Yes | 0 | |
| Major Trauma Audit **(TARN)** | 1, 2 & 3 | Yes | 100 | |
| Public Health England **(PHE)** Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection | Corporate | Yes | 100 | |
| Maternal, Newborn and Infant Clinical Outcome Review Programme **(MBRRACE)** - multiple work streams | 5 | Yes | 100 | |
| Medical and Surgical Clinical Outcome Review Programme **(NCEPOD)**<br>- **Pulmonary Embolism**<br>- **Acute Bowel Obstruction**<br>- **Dysphagia in Parkinson's Disease**<br>- **In Hospital Management of Out of Hospital Cardiac Arrests** | 1 & 2 | <br>No<br>No<br>Yes<br>Yes | <br>N/A<br>N/A<br>100<br>100 | |
| **RCEM** Mental Health (Care in Emergency Departments) | 1 & 2 | Yes | Audit provider analysing data | |
| National Asthma and COPD Audit Programme **(NACAP)**<br>- **COPD Secondary Care** | 1, 2 & 5 | Yes | Audit provider | |

| National Clinical Audits York Teaching Hospital NHS Foundation Trust were eligible for and participated in 2019-20 | Care Group Participating | Data Collection Undertaken 2019-20 | Data Collection Completed % | |
|---|---|---|---|---|
| | | | YTH | SGH |
| - **Adult Asthma Secondary Care**<br>- **Pulmonary Rehabilitation**<br>- **Paediatric Asthma Secondary Care** | | | analysing data<br>Collecting data<br>Collecting data<br>Collecting data | |
| National Audit of Breast Cancer in Older People **(NABCOP)** | 4 | Yes | 100 | N/A |
| National Audit of Cardiac Rehabilitation **(NACR)** | 1 | Yes | 100 | N/A |
| National Audit of Care at the End of Life **(NACEL)** | 1 & 2 | Yes | Audit provider analysing data | |
| National Audit of Dementia **(NAD)** - care in general hospitals | 1 & 2 | No | N/A | |
| National Audit of Seizure Management in Hospitals **(NASH3)** | 6 | Yes | Audit provider analysing data | |
| National Audit of Seizures and Epilepsies in Children and Young People **(Epilepsy12)** | 5 | Yes | Audit provider analysing data | |
| National Bariatric Surgery Registry **(NBSR)** | 3 | Yes | 100 | |
| National Cardiac Arrest Audit **(NCAA)** | 3 | Yes | 100 | |
| National Cardiac Audit Programme **(NCAP)**<br>- **Myocardial Ischaemia National Audit Project**<br>- **National Heart Failure Audit**<br>- **National Audit of Percutaneous Coronary Interventions**<br>- **National Cardiac Rhythm Management Audit** | 1 & 2 | Yes | 100<br>66<br>100<br>100% | N/A |
| National Diabetes Audit **(NDA)**<br>- **National Diabetes Inpatient Audit**<br>- **National Pregnancy in Diabetes Audit**<br>- **National Diabetes Foot Care Audit**<br>- **National Core Diabetes Audit** | 5 & 6 | Yes | 100<br>100<br>100<br>Audit provider analysing data | |
| National Clinical Audit of Specialist Rheumatoid and Early Inflammatory Arthritis (NCAREIA) - **National Early Inflammatory Arthritis Audit (NEIAA)** | 6 | Yes | Audit provider analysing data | |
| National Emergency Laparotomy Audit **(NELA)** | 3 | Yes | 100 | |
| National Gastro-intestinal Cancer Programme<br>- **National Oesophago-Gastric Cancer Audit**<br>- **National Bowel Cancer Audit** | 1, 2 & 3 | Yes | 81-90<br>97 | 109 |
| National Joint Registry **(NJR)** | 3 | Yes | 97 | |

| National Clinical Audits York Teaching Hospital NHS Foundation Trust were eligible for and participated in 2019-20 | Care Group Participating | Data Collection Undertaken 2019-20 | Data Collection Completed % | |
|---|---|---|---|---|
| | | | YTH | SGH |
| National Lung Cancer Audit **(NLCA)** | 4 | Yes | Audit provider analysing data | |
| National Maternity and Perinatal Audit **(NMPA)** | 5 | Yes | 100 | |
| National Neonatal Audit Programme **(NNAP)** | 5 | Yes | 65-97 | |
| National Ophthalmology Audit **(NOA)** - Adult Cataract Surgery **(ACS)** | 3 & 6 | Yes | Audit provider analysing data | |
| National Paediatric Diabetes Audit **(NPDA)** | | Yes | Audit provider analysing data | |
| National Prostate Cancer Audit **(NPCA)** | 4 | Yes | 82-97 | |
| **BTS** National Smoking Cessation Audit | Corporate | Yes | 90 | N/A |
| National Vascular Registry **(NVR)** | 3 | Yes | 100 | |
| Perioperative Quality Improvement Programme **(PQIP)** | 3 | Yes | Collecting data | |
| Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)<br>- **Antibiotic Consumption**<br>- **Antimicrobial Stewardship** | Corporate | Yes | <br>100<br>100 | |
| Sentinel Stroke National Audit Programme **(SSNAP)** | 1 & 2 | Yes | 82-96 | |
| Serious Hazards of Transfusion (SHOT): **UK National Haemovigilance Scheme** | | Yes | 100 | |
| Society for Acute Medicine's Benchmarking Audit **(SAMBA)** | 1 & 2 | Yes | Audit provider analysing data | |
| Surgical Site Infection Surveillance Service **(SSISS)** | 3 & 6 | Yes | 100 | |
| UK Cystic Fibrosis Registry (Adult & Paediatric) | 1 | Yes | 100 | N/A |
| UK Parkinson's Audit | 1 & 2 | Yes | 100 | |

## National Audits Published During 2019/20

There have been **26** National Audit reports published in 2019-20, of which **19 (73%)** have been reviewed by the provider, and 7 are still in the process of review.

## Outlier Status

Of the 26 published National Audit Reports, the Trust was identified as having Outlier Status in two. The summaries below reflect the findings, recommendations and the Trusts' response and supporting actions.

**NEIAA National Early Inflammatory Arthritis Audit - Project no. QA2018-008R**
This report was published in October 2019 for 2018-19 data.

| **NATIONAL FINDINGS & RECOMMENDATIONS** |
| --- |
| The Key Findings from this NEIAA Report 2019 identified for a typical rheumatology unit, fourteen patients with suspected inflammatory arthritis were enrolled into the NEIAA each month. Although referral from primary care is frequently delayed, with only 41% meeting the three-day NICE target, performance has improved significantly since the last phase of this audit.<br><br>There are variations across Trusts/Health Boards in staffing ratios. NICE recommended access to specialist allied health professional (AHP) services and early inflammatory arthritis (EIA) pathways. Those with EIA pathways are more likely to have access to specialist AHP services. Secondary care units take an average of 28 days to achieve first assessment, with performance against the three-week target poorest in Wales.<br><br>Since the start of the last phase of this audit in 2014, there have been significant reductions in treatment delay, but disease-modifying anti-rheumatic drug (cDMARD) treatment is still only initiated within six weeks of referral in 54% of patients.<br><br>By three months of care there is evidence of clinically meaningful improvement, both in clinician- and patient-reported measures for some patients.<br>Whilst provision of telephone helplines for patients is high (92%), only 50% of Trusts/ Health Boards report on the annual survey of their service structure that they offer emergency access to rheumatology advice within 24 hours.<br><br>Patients presenting with inflammatory arthritis have a significant burden of disease, both in terms of physical and mental health. Access to psychology services is limited across all regions.<br><br>Clinician-reported patient education is provided for 93% of patients. Data collected directly from patients suggested a lower frequency of educational provision of 81%.<br><br>In some regions the gap between patient- and clinician-reported education was greater (over 20% discrepancy in the West Midlands).<br><br>Patients with axial Spondyloarthritis (axial SpA) tended to have substantially greater symptom duration prior to assessment, and low levels of referrals from gastroenterology, ophthalmology and dermatology suggest a failure to consider and investigate inflammatory spine disease. Nearly a third of patients reported significant work impairment at presentation due to their symptoms. This improved over the first three months of care. |

| TRUST FINDINGS |
|---|
| The NEIAA has identified our Trust as an Outlier for QS2 QS3 and QS6 between May 2018 and May 2019. Unfortunately, due to a number of challenges during this period which have made it difficult to achieve the desired targets.<br><br>In response to this, we have already implemented changes within our department and have further considerations planned for the future to improve on our performance.<br><br>The Trust performance against QS 2 is anticipated to show significant since the addition of a rotational physician associate in the York team and 3 additional weekly RAPID slots for patients with suspected early inflammatory arthritis which were introduced in February 2019 at York Hospital.<br><br>A new specialist nurse has also been recruited at York hospital in October 2019 (replacement post) improving staffing levels at this site and a new consultant (replacement post) is expected to join the team in April 2020. In Scarborough, as of May 2019, there has been an additional alternate weekly RAPID slot and plans are in place to have a further alternate weekly RAPID slot added. Also a weekly RAPID slot is also being introduced in Bridlington Hospital. These actions are intended to help reduce delays in initial assessment of patients with suspected inflammatory arthritis.<br><br>The Trust performance against QS 3 is also anticipated to significantly improve as in order to reduce time to DMARD initiation a pharmacist-led DMARD initiation clinic was introduced in March 2019 at York Hospital. There has also been an increase in nurse capacity at Scarborough Hospital and in June 2019, group clinics were launched with the aim of starting DMARD therapy earlier, as well as providing education to patients from different allied health professionals. Additional group clinics are planned for when the stadium is open.<br><br>Trust performance against QS6, is unclear, as to why the Trust were flagged as outlier as all our patients have access to the advice line, therefore check are being made with the data inputted for further clarification. |

| TRUST ACTIONS | |
|---|---|
| **Summary of Issues** | **Actions** |
| Delay for initial assessment | Additional RAPID slot capacity |
| Delay in initiating DMARD therapy | Pharmacist led DMARD initiation clinics; group clinic; improvement in nursing staffing levels |
| Delay in initiating DMARD therapy | Additional group clinics once transferred to stadium |

**NJR National Joint Registry - Project no. 1384**
This report was published in September 2019 for 2017-18 data.

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| The Registry reports that hip surgeons are performing an average of 60 joint replacements per year. This year's report confirms the increasing trend for hybrid hip replacement over the last five years.<br><br>Three and five year revision rates have reduced over the last ten years, after the peak of metal-on-metal, and the introduction of NJR clinician feedback since 2008. |

Young women form the group that are most likely to be revised. Reassuringly the numbers of revisions performed each year has decreased since 2012 despite higher numbers of primaries. For those joints that are revised, the longer the primary lasts, the lower the chance of re-revision.

There are over one million knee replacement procedures contributing to the registry and we add to it with over 100,000 new cases per year. Surgeons are performing around 40 cases per year on average. The results show the lowest revision rates for cemented unconstrained fixed bearing TKR and cemented TKR with monobloc polyethylene tibias. The revision rates in cemented TKRs that are posterior stabilised and those that have mobile bearings remain higher. The revision rates for UKRs remain substantially higher than for TKR, this is most marked in the patellofemoral replacement group.

This year's report showcases an increasing dataset in both the shoulder and elbow registries with both revision and perioperative mortality being included.

More elective humeral hemiarthroplasties are being revised earlier and while it can be argued this revision is an easier operation to perform, the PROMs data in this report does suggest lower change scores are being achieved in the specific patient groups that receive a hemiarthroplasty.

We now have over 5,000 ankle operations recorded on the registry, the majority of which are un-cemented implants. There is a cumulative percentage of revision at seven years following a primary ankle replacement of 8.51%, but there is a belief that not all revisions are being entered, and both the British Orthopaedic Foot and Ankle Society (BOFAS) and the NJR encourage surgeons to complete forms for all revisions, conversion of an ankle replacement to an arthrodesis, and amputations, which are mandatory requirements.

**TRUST FINDINGS**

The Trust received Outlier notification that the York Hospital results from primary knee replacement surgery were above the upper 99.8% control limit (approx. 3SDs) for revision/re-operation since 2009 and we were asked to look at potential reasons for this deterioration in performance. The cases in question were all types of primary knee replacement including uni-compartmental, patello-femoral and total knee replacement. It did not include revision knee replacement.

There does appear to be a greater proportion of high BMI patients who have undergone re-operation, suggesting a contribution of high BMI to the cause for failure in some. 46% had a BMI over 35. With current threshold restrictions it would be rare to operate on patients in this BMI bracket now.

There are three causes that account for over 61% of the total; infection in 17/73 cases, progression of OA in 18/73 cases and instability in 10/73 cases.

We are aware that over the last five years there has been an increased rate of infections in the unit, and this has been the subject of a comprehensive multi-disciplinary internal review and action plan leading to many improvements and changes in practice. Work with this is ongoing, but we have seen a reduction in infections of primary arthroplasty cases in the last few years. What we can see is that despite a peak in 2017, infection has now dropped off as a cause, but the last few years have seen higher volumes of cases revised due to progression of OA.

| TRUST ACTIONS | |
|---|---|
| **Summary of Issues** | **Actions** |
| Outlier Notification for Trust Received | Maintain 6 monthly NJR outcome data meetings. This report to be discussed at the next meeting on 18th March 2020 (which is a cross-site meeting). |
| | All knee replacement procedures to be discussed at a regular arthroplasty governance meeting. All hip cases are currently discussed weekly as well as knee replacements performed by lower limb arthroplasty surgeons. |
| | A group discussion about the indications for patella resurfacing to ensure best practice is being adopted. Protocol to be produced following the group consensus. |
| | All surgeons to demonstrate adoption of the recommended measures for infection prevention (to be audited once Ward 29 re-opens for inpatient elective care). |

However, there is learning to be gained from most published National Audits and the following section identifies the issues raised in each report and the organisations response, including any actions which are agreed and owned by the relevant Care Group(s). Actions are subsequently monitored via the relevant Care Group(s) Quality Committee.

The report findings and agreed actions are identified below.

**NACEL National Audit of Care at the End of Life - Project No. C3244**
Published in May 2019, the report covers the outcomes for the 2018-19 data submitted.

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| The NACEL Report 2019 identified the following key themes:<br><br>**Recognising the possibility that death may be imminent -** Compliance with documenting that a person may die within the next few hours or days is high. However, for around half of patients, they are recognised to be dying less than one and a half days before they die, leaving a limited amount of time to discuss and implement an individual plan of care.<br><br>**Communication with the dying person -** Recording of discussions with the dying person could be improved. In around one third of cases, a discussion with the patient about the plan of care, and discussions about medication, hydration and nutrition had not been recorded.<br><br>**Communication with families and others -** As would be expected given the timing of recognition of death, discussions about the plan of care were more likely to be held, and documented, with families and others than with the dying patient. Discussions about medication, hydration and nutrition could be better recorded. Involvement in decision making and in the majority of cases, discussions with the patient and with the family/others about life-sustaining treatments and cardiopulmonary resuscitation (CPR) were held and documented or reasons recorded as to why the discussion did not take place.<br><br>Although the use of advance care planning has increased (in place in 7% of cases) compared to the 2016 the Audit result (4%, England, acute trusts only), there remains scope for improvement. |

**Needs of families and others** - There is documented evidence that the needs of the family were asked about in just over half of cases, a result which is in line with low compliance highlighted in this area in the previous audit (End of Life Care Audit – Dying in Hospital, 2016).
**Individual plan of care -** The evidence overall from the audit suggests there remains a gap in the development and documentation of an individual plan of care for every dying person. There was documented evidence of the existence of an end of life care plan in 62% of cases.

**Governance -** Compliance with appropriate policies is generally high and the majority of organisations have action plans to promote improvements in end of life care. However, the results from other themes of the audit suggest further work needs to be done on the implementation of policies and action plans.

**Workforce/specialist palliative care -** Just over half of hospitals have specialist palliative care nurses available 7 days a week for face-to-face contacts (as recommended in One Chance To Get It Right).

**TRUST FINDINGS**

Since the previous annual report in April 2018, End of Life Care work continues to progress on the following areas:

- Advance care planning and the Care Plan for the Last Days of Life
- Fair access to care
- Public engagement
- Education of staff

Since the previous report in 2018 work has progressed by the Trust to ensure:

- Completion of the advance care plan documentation, education and the introduction of a systems and network alert
- Completion of a new Last Days of Life documentation and pilot of its introduction
- Continued discussions on the challenges and availability of fast track care particularly within the Vale of York and City of York.
- An animation to encourage public discussion of End of Life Care.
- A concise education programme in End of Life Care for all staff
- Bereaved feedback used to improve service

**TRUST ACTIONS**

| Summary of Issue | Actions |
|---|---|
| Advance Care Plan documentation | Launching the new documentation for the Last Days of Life Care Plan with an education programme (April 2019). |
| Fair Access | Working with other stakeholders to improve access to fast track care in the last weeks of life |
| | Working with other stakeholders to improve interoperability across IT systems and develop an Electronic Palliative care coordination system |

**NDFA National Diabetes Foot Care Audit - Project No. A7031**
Published in May 2019, the report covers the outcomes for the 2017-18 data submitted.

**NATIONAL FINDINGS & RECOMMENDATIONS**

Since the first survey in 2015, the NDFA has found that the basic framework for effective

prevention and management of diabetic foot disease often seems to be missing and since starting in 2014, the NDFA has firmly established the relationships between time to first expert assessment and ulcer severity, healing outcomes and hospital admissions.

In the 2019 Report the NDFA make recommendations that Service Providers should:

- Use the audit findings to encourage commissioners and service managers to ensure a NICE-recommended diabetes foot care service is in place.
- Create simple and rapid referral pathways.
- Participate in the NDFA to collaborate in this nationwide drive to improve the outcomes for diabetic foot disease.

**TRUST FINDINGS**

Patients presented with lower numbers of severe ulcers than nationally (SINBAD score 3 or over) 30.9% vs 45.6%.

Time from first presentation with ulceration to podiatry assessment was faster than nationally with 65.7% presenting directly to podiatry vs 29.9% nationally. The numbers not seen for 2 months or more was lower than nationally 3% vs 8.6%.

The numbers of patients alive and ulcer free at 12 weeks was higher than nationally 52.6% vs 44.8% and the numbers of patients alive and ulcer free at 24 weeks was higher than nationally 74% vs 58.3%.

The numbers of patients with persistent ulceration at 24 weeks was lower than nationally 19.7% vs 23.2%.

98.7% of all patients entered into the audit had an outcome recorded at 12 weeks (92% nationally and 98.2% of all patients entered into the audit had an outcome recorded at 24 weeks (88% nationally).

There are still issues across the service in decreasing minor amputation rates however and until this report is linked to HES data for this we cannot ascertain whether ulceration resulted in a healed ulceration or a healed minor amputation wound.

**TRUST ACTIONS**

| Summary of Issue | Actions |
|---|---|
| Amputation Rates | The process of root cause analysis for minor and major amputation will continue in order to identify areas for improvement and learning. |

**BTS CAP Adult Community Acquired Pneumonia - Project no. QA2018-021**
Published in June 2019, the report covers the outcomes for the 2018-19 data submitted.

**NATIONAL FINDINGS & RECOMMENDATIONS**

No overall National Report is published for this Quality Account, with instead each participating hospital site being provided with a report which outlines the hospitals performance against the National findings.

However from the National figures provided for both Scarborough and York Hospitals the management of CAP nationally appears somewhat discouraging.

| TRUST FINDINGS |
|---|
| **York Hospital**<br><br>This audit suggests that in York Hospital a lot of well patients who were admitted with CAP – with no critical care input at all, very low IV antibiotics use, and very early oral switch compared with national. We identified that even though patients had CXR performed and antibiotics prescribed they were not administered in time – on discussion with ED consultants this is a known problem and is largely due to lack of band 5 nurses who are able to administer IV antibiotics.<br><br>We also noticed that a significant number of pneumonia patients in York Hospital did not have any follow up arranged. We also need to investigate this matter in more detail and identify the reasons. BTS guidelines suggest a 6 week follow up with CXR in patients with ongoing signs or symptoms or those at higher risk of underlying malignancy.<br><br>**Scarborough Hospital**<br><br>Against the key results reported in the National Report Scarborough were in line with the national outcomes. However, Scarborough's results were not always in line with the national average across the whole audit.<br><br>There have been discussions of the results locally and we are going to try and develop a more robust pathway through the SDEC (Same Day Emergency Care) for the fitter patients at least. |

| TRUST ACTIONS | |
|---|---|
| **Summary of Issue** | **Actions** |
| Compliance with national guidelines (Scarborough Hospital Site only). | We are going to try and develop a more robust pathway through SDEC for the fitter patients (at least). |
| Delay from admission to first antibiotic dose. | Review of the staffing level in A&E with increased presence of Band 5 nursing in all areas especially at Sepsis Trolley and resus. |
| Inadequate capacity in ED and delayed downstream patient flow. | Ongoing work within Care Groups to optimise ED capacity and downstream patient flow. |
| Inadequate middle grade cover on-call to review patients who could be transferred to wards, outlier or discharged and maintain patient flow. | Consider a second medical registrar/ SHO. |

**RCEM Feverish Children - Care in Emergency Departments - Project no. QA2018-002**
Published July 2019 for 2018-19 data

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| Almost all (97%) EDs reported to be using an early warning score for feverish children which demonstrated good practice. This was an encouraging improvement as the 2015/16 RCEM audit recommended that all EDs adopt a vital signs scoring system such as a PEWS (or an equivalent early warning score).<br><br>Most departments (91%) reported using a tool to identify children at risk of sepsis, however this |

was not reflected in the patient-level weekly data, suggesting consistent implementation of such a tool was challenging.

Furthermore, the data revealed that 92% of EDs use a clinical management tool having identified children as high risk for sepsis.

Finally, data revealed that there was good use of safety net advice, with most units having a written leaflet for families to refer to.

Key recommendations

1. EDs should look at ways to improve timely initial assessment consistently at times of pressure and peak activity, ensuring all parameters are checked and recorded to give a comprehensive assessment of febrile children within 15 minutes.
2. EDs should work closely with management teams to ensure adequate senior decision maker cover at peak times of activity to ensure safe assessment and management of the acutely unwell febrile child.
3. EDs should adopt or develop a tool to stratify risk of sepsis for feverish children so that they receive appropriate escalation or de-escalation of treatment and senior review.
4. Adequate training should be in place for all staff managing children less than 5 years presenting with fever. Training should enable complete sets of observations to be performed and responded to, with recognition of risk regarding serious bacterial illness or sepsis, and appropriate treatment instigated.

**TRUST FINDINGS**

**York -** Room for improvement was identified in all standards, but specific improvements required as below:

- Observations within 15 minutes require improvement and are likely due to high workload at front desk and this may improve automatically with introduction of SDEC model.
- Sepsis stratification tool is a paper copy only and not available in ED. No current electronic trigger.
- NICE guidance being utilised in fever without apparent source – performing at national average.
- Senior review for key patients at 35% is poor but should have improved already with introduction of senior sign off sheet. Automatic prompts for senior review on CPD have disappeared.
- Discharging patients with safety netting will be hard to capture data on as variably documented. Significant room for improvement.
- Training clinicians - likely performing better with juniors than seniors. Interestingly York data exactly matches Scarborough data.

**Scarborough -** There is room for improvement across all standards, but specifically:

- Observations within 15 minutes which require improvement – lack of achievement is likely due to high workload and this may improve automatically with introduction of the SDEC model.
- NICE guidance does not appear to be utilised in fever – performing below national average.
- Training clinicians - likely performing better with juniors than seniors.

The results reported for York Teaching Hospitals NHS Trust identified no outliers data at either York or Scarborough Hospital sites for the period reported.

| Summary of Issue | Actions |
|---|---|
| **Scarborough Hospital** | |
| Use of Nice guidance | Introduction of traffic light system for fever – through shop floor teaching and Wednesday afternoon teaching |
| Simulation training | Attendance at EPALs and Crumpet |
| Use of Nice guidance | Ensuring safeguarding training and e-learning is completed |
| **York Hospital** | |
| Too few patients have observations within 15 minutes | Review staffing on front desk/navigation |
| Sepsis risk not being assessed | Highlight current paper version of Paediatric Sepsis Screening Tool and encourage use |
| Too few senior reviews done | Ensure CPD prompt is in place for children under 1<br>Remind clinicians of indications for senior review |

**RCEM Vital Signs in Adults - Care in Emergency Departments - Project No. QA2018-003**
Published July 2019 for 2018-19 data

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| The report shares evidence that since the previous audit, there has been significant improvement in the repeat measurement of vital signs and of appropriate actions taken. It is clear that departments are using newly developed tools and rising to the challenges of crowding and ever increasing attendances by identifying and prioritising patients who have deteriorated. It also represents the difficult nature of effecting change in busy departments and during a period which has seen particular challenges of crowding and poor hospital flow.<br><br>Key recommendations<br>1. Departments struggling to meet the challenge of measuring a complete set of vital signs within 15 minutes of arrival should review their processes and consider how they can learn from higher performing Trusts.<br>2. Departments are encouraged to use the QI platform to support their QI activities.<br>3. Departments not achieving repeat vital signs within 60 minutes, should review their results and consider how to effect improvement |
| **TRUST FINDINGS** |
| The results in the report did not identify any outliers' data for the period reported on in the Trust. However there are improvements to made in:<br><br>• Monitoring vital signs within 15 minutes of arrival or triage (whichever is the earliest) and again at 60 minutes.<br><br>• Ensuring patients have all aspects of the standards monitored - pulse, BP, oxygen saturation, respiratory rate and temperature and that these are documented. |

| TRUST ACTIONS | |
|---|---|
| **Summary of Issue** | **Actions** |
| NEWS within 15minutes of arrival | Corridor nurse for when ambulance handover >15minutes |
| NEWS every 60 minutes in NEWS >5 | Undertake observation round every hour in majors |
| Documentation of patient reviews | Ensure NEWS >5 has clear documentation in notes |

**SSNAP Sentinel Stroke National Audit Programme - Project No. 1885**
Published July 2019 for 2013-18 data

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| Teams were expected to achieve an A or B SSNAP rating.<br><br>Such scores are indicative of first class quality of care and a good or excellent service in many aspects respectively. A SSNAP rating of a C or less would suggest that some or several areas of care require improvement, whilst a SSNAP rating of D or E would indicate that several areas require significant improvement.<br><br>Proportion of teams achieving an A rating<br>- July – September 2013 (First Quarter): 0%<br>- January – March 2019 (Final Quarter): 22%<br>Proportion of teams achieving an E rating<br>- July – September 2013 (First Quarter): 43%<br>- January – March 2019 (Final Quarter): 1% |
| **TRUST FINDINGS** |
| The SSNAP record starts when patient is admitted (the first inpatient ward) which at York is the Acute Stroke Unit (ASU), therefore SSNAP classify York site as a Routinely Admitting Team. In Scarborough, the Stroke Team run a triage system utilising a Treat and Transfer model; therefore Scarborough is classified as a Non-Routinely Admitting Team and resulting in York starting the SSNAP record for the majority of stroke patients admitted from both York and Scarborough sites.<br><br>The majority of patients from Scarborough ED are transferred to York ASU for acute stroke care following initial treatment. A significant proportion of these Scarborough patients are then directly discharged from York ASU, with the remainder being transferred back to Scarborough Stroke Unit (STU) at some point during their hospital stay to continue their rehabilitation.<br><br>**York -** has performed well in the SSNAP audit, achieving either higher than or comparable with national percentages across all except one of the audit criteria as below:<br>• C7.36 Number of social service visits is known – York achieved 63.6% against the national average of 73.3 %<br><br>**Scarborough -** has performed reasonably well in the SSNAP audit, achieving either higher than or comparable with national percentages across all except two of the audit criteria as below:<br>• C4.8 Patients who were recorded as discharged with either ESD or CRT and transferred to an ESD or CRT on the web tool – Scarborough achieved 56.2% against the national average of 78.3%<br>• C7.36 Number of social service visits is known – Scarborough achieved 58.4% against |

the national average of 73.3 %

The decline in performance was felt to be due to the funding being removed by our commissioners for an Early Supported Discharge (ESD) Team at Scarborough and it is unclear at present if this will be re-instated.

| **TRUST ACTIONS** | |
|---|---|
| **Summary of Issue** | **Actions** |
| Post 72-hours compliance | The Stroke Pathway paperwork to be updated. |
| Section C7 – specific compliance issues | Send an email to Stroke Therapists to complete the therapy discharge page in Stroke Pathway paperwork with full details of patients discharge package of care.<br>Complete monthly pathway audit to check compliance. |
| General staff awareness | Share concluded report with stroke leads at Scarborough and York including published electronic annual SSNAP report. |

**BTS NIV Adult Non-Invasive Ventilation Audit - Project no. QA2018-027**
Published August 2019 for 2018-19 data

| **NATIONAL FINDINGS & RECOMMENDATIONS** |
|---|
| No overall National Report is published for this Quality Account, with instead each participating hospital site being provided with a report which outlines the hospitals performance against the National findings. |
| **TRUST FINDINGS** |
| **Scarborough Hospital**<br><br>NIV results are broadly comparable with national data.<br>There is a high rate of NIV success and delivery within 60 minutes of last blood gas having been taken than achieved nationally.<br>Time to specialist review is similar to national data.<br>There is a high rate of discharge from hospital off NIV with low mortality but length of stay is longer than nationally.<br>There is more frequent use of higher range oxygen saturation target and lower pre-NIV CO2 levels suggesting a lower threshold for NIV in mild hypercapnia. This may reflect the higher rate of usage in patients with 'other' respiratory diagnoses.<br><br>**York Hospital**<br><br>Achieved 100% for blood gas measurement repeated after starting NIV, which is higher than achieved nationally.<br>Higher than average mortality for this patient group compared with nationally, with 75% of those who died whilst an in-patient not having a case review/ M&M meeting documented as held.<br>0% of patients receiving NIV within 1 hour of ABG demonstrating requirement for the treatment which is significantly lower than the 50% achieved nationally.<br>There is a delay until review by NIV specialist at York.<br>York has a higher % of patients admitted 'out of hours' than admitted during hours. |

| **TRUST ACTIONS** | |
|---|---|
| **Summary of Issue** | **Actions** |

| Scarborough Hospital Site Only | |
|---|---|
| CQC recommendation/ feedback regarding a dedicated NIV area | Dedicated NIV area has been created on the Respiratory ward with increased staffing in response to feedback from CQC inspection.<br>Monitoring equipment is being procured. |
| Staff education and training | Education has been provided to Medical and ICU teams regarding appropriate use of NIV in non-COPD conditions through a case review process as part of clinical governance activity. |
| Oxygen prescribing | Oxygen prescribing and appropriate target setting is being actively promoted by Respiratory Specialist Nurses and Senior Ward Nurses. |
| **Trust wide** | |
| • Higher than average mortality for this patient group compared with nationally<br>• Patients not receiving NIV within 1 hour of ABG demonstrating requirement for the treatment<br>• Delay until review by NIV specialist | Investment in NIV service – will need consultant time, trained nursing workforce and equipment. |
| Low number of referrals for NIV during audit period | Improve awareness in acute areas of need to identify and promptly manage patients with type 2 respiratory failure through education and training. |

**NCAP HFA National Heart Failure Audit - Project no. 1340**
Published September for 2017-18 data

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| Specialist input, irrespective of the place of admission, is associated with higher rates (92%) of echocardiography. There is however considerable variation in the use of this essential diagnostic tool across institutions, leaving room for improvement.<br><br>Irrespective of the place of admission, 50% of patients with HFrEF, seen by a member of the specialist HF team as an inpatient, were prescribed all three disease modifying medications, which is a key performance indicator (KPI). This has improved from 47% last year. The number of patients seen by HF specialists has also increased to over 82% this year. This is important as specialist care improves survival.<br><br>The mortality of patients hospitalised with heart failure remains high overall at 10.1%. Whilst some attrition is inevitable in an elderly population, with no new treatments for acute heart failure for over 20 years, the variation in care suggests these figures can be improved.<br>Those admitted to cardiology wards had an in-patient mortality of 7.1% and those who saw specialists (no matter where they were) had an 8.6% mortality rate in hospital. Out-reach specialist care and/or an increase in access to cardiology or specialist HF beds should be further promoted.<br><br>• Post-discharge mortality rates at one year are substantially, and significantly, lower for those admitted to cardiology wards, those accessing cardiology follow-up, those offered cardiac rehabilitation and those discharged on the key disease-modifying medicines for HFrEF. |
| **TRUST FINDINGS** |

This year's audit report results have shown improvement from 2016/17 results. However the data relates to 2017/18 and at this time we were in the process of setting-up the Heart Failure Service, therefore its anticipated that improvements will be seen in future audits.

Since 2017/18 in York we have recruited an additional Heart Failure Nurse (we now have two), an admin support and we are achieving the 70% reporting target. In Scarborough there is now also a Heart Failure Nurse and data from the following year has improved, too.

Unfortunately, we still have no Cardiac Rehab in heart failure or agreement to fund it. The small number of patients who have received it is an achievement – by using goodwill and any spare capacity. Unless funding is agreed this is unlikely to improve.

The numbers of patients continue to increase and our Heart Failure Nurse Team is stretched leaving ongoing success in the balance unless we receive further resource.

We are unable to manage most patients on cardiac wards due to space and shortage of heart failure consultants.

| **TRUST ACTIONS** | |
|---|---|
| **Summary of Issue** | **Actions** |
| Not fully compliant with required standards | • Present/ discuss the above results with relevant colleagues/ forum<br>• Devise a suitable plan of action to further improve the service |

**NCAP MINAP Myocardial Ischaemia National Audit - Project no. 920**
Published in September 2019 for 2017-18 data

| **NATIONAL FINDINGS & RECOMMENDATIONS** |
|---|
| This report focuses on three broad quality improvement (QI) themes:<br>• Timely care – are patients receiving care quickly enough to obtain the greatest possible benefit?<br>• Specialist care – is treatment provided by those who are best trained to deliver the relevant care?<br>• Evidence-based care delivered to a uniformly high standard – how well are local services providing care against current standards?<br><br>The report provides a reassuring overall picture with many such improvements. However, there are some areas where either an overall deterioration in the quality of services or considerable unwarranted variation in the delivery of services between hospitals has been found. |
| **TRUST FINDINGS** |
| The audit findings reflect that overall we perform well in most areas measured by the MINAP data.<br><br>One of our main issues remains admitting patients to a Cardiac Ward for care for the first 24 hours.<br><br>Also, part of the BPT is measured on the number of patients that have a coronary angiogram within 72 hours, and it is anticipated that the Trust figures will improve when the new Vascular Imaging labs are built and our capacity is increased. |
| **TRUST ACTIONS** |

| Summary of Issue | Actions |
|---|---|
| Not fully compliant with required standards | Discuss this report with relevant leads to ensure that Cardiology Team work with the Bed Management Team to get cardiac patients on to our Cardiology Ward as soon as possible after admission. |
| | Await the new Vascular Imaging labs to increase our angiogram capacity and so reduce waiting times. |

**NCAP PCI National Audit of Percutaneous Coronary Interventions - Project No. 1864**
Published in September 2019 for 2017-18 data

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| There is no report published for this National Audit. Instead, data is submitted about all percutaneous coronary intervention procedures performed and then each participating hospital is provided with an annual summary of its performance. |

| TRUST FINDINGS |
|---|
| **NAPCI 1**: Number of cases per hospital should be >400. The Trust achieves 200.<br>Our centre has never been close to reaching this standard primarily due to the low resources available. We should have 2 Cath Labs, rather than 1. This was to be addressed with the new VIU build but this has again been delayed. Following this, we will need further medical appointments but this standard is not likely to be met for some years.<br>**NAPCI 4**: Access via the radial artery route for PCI should be >85%. Trust data above shows 89.18%. Criteria met.<br>**NAPCI 5:** Day case PCI should be >85%. Trust data shows 70%. Criteria not met – see action plan recommendations.<br>**QS68 4**: Unstable patients undergo PCI within 24 hours Specific audit data not collected on this population, but this standard likely to be met as patient transfer to Castle Hill in Hull and is generally rapid when instability occurs. York Hospital has its own facility to intervene on unstable patients and daily access Monday to Friday is easily achieved. |

| TRUST ACTIONS | |
|---|---|
| **Actions** | |
| Patients waiting too long for PCI for NSTEMI. | Formally inform ODN Working Group of issue. Resolution lies outside of York Trust. |
| Patients wait too long for urgent CABG | Undertake an audit – to be assigned/ to be confirmed |

**NMPA National Maternity and Perinatal Audit - Project No. C3133**
This report was published in September 2019 for 2016-17 data.

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| This second clinical report from the NMPA demonstrates overall stability in the availability of data. It is positive that the completeness of the data received by the NMPA has increased, both in terms of births captured and of individual data items. This suggests that electronic maternity records are being used more widely and effectively.<br><br>This report gives a national picture of services in 2016/17 and builds on the NMPA's previous report from 2015/16. |

It is not possible to speak of trends based on just two years, but the report highlights areas that require monitoring, in particular around induction of labour, timing of birth and timely delivery of babies that are small for gestational age.

**TRUST FINDINGS**

Levels of vaginal birth are higher for the Trust than the national mean; and caesarean and instrumental rates are lower.

Work is ongoing to improve neonatal outcomes.

York site continues to have a higher than expected rate of PPH. Work is ongoing and each case is reviewed independently.

We are currently considering implementation of the Wales pathway.

**TRUST ACTIONS**

| Summary of Issues | Actions |
|---|---|
| Improving baby outcome | • Implement SBLv2<br>• Continue to implement ATAIN<br>• Continue MatNeo work<br>• Increase and develop transitional care |
| Improve outcomes and experiences in pregnancy and birth | • Implement Continuity of Carer to 35% by March 2020 and 51% by March 2021 |
| PPH above 1500mls | • Audit and individual review of all cases<br>• Consider introducing the Wales Pathway tool |

**NOD National Ophthalmology Audit - Adult Cataract Surgery - Project no. D9136**
This report was published in September 2019 for 2017-18 data.

**NATIONAL FINDINGS & RECOMMENDATIONS**

Since the original proof of concept of a national cataract audit in 2010, there has been a 38% reduction in PCR complications in cataract surgery, equating to approximately 3,400 fewer complications annually across the NHS.

Overall, the audit findings are favourable indicating high quality surgery is being delivered to NHS patients. Specifically, among the contributors, no outlying centres or surgeons have been identified.

For all surgeons, 1.2% of operations were affected by PCR, slightly above the current consultant only based average rate of 1.1% used for risk adjustment.

A ‘good’ postoperative VA of 0.30 LogMAR (=6/12, required to drive) or better was achieved in 90.6% of eyes overall, 95.8% of eyes with no ocular co-pathology and 83.8% of eyes with a recorded co-pathology. The median preoperative VA was 0.50 LogMAR units (6/19 Snellen Equivalent); the median postoperative VA was 0.10 LogMAR units (6/7.5 Snellen); and the median change in VA was a 0.36 LogMAR gain.

Overall the VA Loss rate was 0.7%, close to the 0.9% rate used for risk adjustment and approximately 37% lower than in 2010. The samples used for the VA Loss results are smaller than those used for the PCR results due to missing presenting (pre-) and / or postoperative VA measurements as well as a shorter time period of 10 months to cater for postoperative

recovery and VA reporting.

**TRUST FINDINGS**

Previous data sent to the NOD was not reported for visual loss as the criteria for inclusion included a shortened time between vision testing and surgery than our current waiting time, which resulted in most of the Trust data not being included and hence our results not being reportable.

Following consultation with the NOD statisticians it was agreed to give more generous time limits for recording of pre-operative and post-operative recording of VA and hence for the first time all data submitted by the Trust was included. Unfortunately this uncovered an error in our data reporting where the best vision recorded was not being submitted hence skewing our results to give a very poor reported visual outcome compared to other centres. This issue has now been resolved however not in time for the final report or online public area.

The results however show that the Trust is not an outlier and has a better than average percent of patients who loose vision as a result of cataract surgery with results well within the national guidelines.

**TRUST ACTIONS**

| Summary of Issues | Actions |
|---|---|
| Possibility of submitting spurious data to NOD national database | Check data before submission against what we believe to be our outcomes |
| Expansion of NOD into other clinical areas will require collection of data and submission | Employing a third party EPR to manage data collection and submission |
| Cost implication of NOD | Ensure Trust budgets for future funding as required |

**MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Project no. 1378**

This report was published in October 2019 for 2016-18 data.

**NATIONAL FINDINGS & RECOMMENDATIONS**

There has been a reduction in the rate of extended perinatal mortality in the UK:

5.40 per 1,000 total births for babies born at 24+0 weeks gestational age or later compared with 5.64 in 2016. This represents a 12% reduction in extended perinatal mortality since 2013, equivalent to nearly 500 fewer deaths in 2017.

The stillbirth rate for the UK has reduced to 3.74 per 1,000 total births from 4.20 in 2013, which represents 350 fewer stillbirths.

The rate of neonatal mortality for babies born at 24 weeks gestational age or later in the UK continues to show a steady decline over the period 2013 to 2017 from 1.84 to 1.67 deaths per 1,000 live births. This represents a 10% reduction in neonatal mortality over the last five years. There has been an increase in the completeness of carbon monoxide monitoring data for both stillbirths and neonatal deaths over the period 2015 to 2017: from 36.4% to 48.3% for stillbirths and 31.4% to 44.5% for neonatal deaths. This improvement is clearly linked to the Saving Babies' Lives Care Bundle

**TRUST FINDINGS**

MBRRACE set out a number of recommendations for all Trusts to ensure that improves are continued Nationally.

Below are the outcomes for the Trust:

1. Implementing existing national initiatives to reduce stillbirths and continue the slow but steady decline in neonatal mortality rates observed since 2013. Particular emphasis should be placed on reducing preterm birth.
   **The Trust requires actions to achieve compliance**
2. Mechanisms for timely notification should be incorporated into local processes, and must have adequate staff, time allocation and resources. Trusts and Health Boards should aim for completion of all surveillance data within 90 days in order to facilitate data sharing with the PMRT and aid discussions with parents at follow-up appointments.
   **The Trust is compliant**
3. Use of the MBRRACE-UK real time data monitoring tool to monitor the completeness of their data. Particular emphasis should be placed on carbon monoxide monitoring and other data items feeding into national initiatives such as the Saving Babies' Lives Care Bundle version 2.
   **The Trust is compliant**
4. Commissioning organisations should review both their crude and stabilised mortality rates alongside their high risk population characteristics (e.g. deprivation and ethnicity) to facilitate the development of public health initiatives and to target focused interventions, such as the continued rollout of continuity of carer as recommended by Better Births, with a particular focus on women in high-risk ethnic groups and those living in areas of high deprivation.
   **The Trust requires actions to achieve compliance**
5. Trusts and Health Boards with a stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate that falls into the red or amber band should carry out an initial investigation of their data quality and possible contributing local factors. Organisations should review their performance against national outcome measures with a view to understanding where improvement may be required.
   **The Trust requires actions to achieve compliance**
6. Trust and Health Boards should use Perinatal Mortality Review Tool multidisciplinary meetings to improve the quality of cause of death coding.
   **The Trust is compliant**
7. Trusts and Health Boards should review their policies to ensure that the parents of ALL babies who die are provided with unbiased counselling for post-mortem to enable them to make an informed decision.
   **The Trust is compliant and relevant staff training already in place**
8. Trusts and Health Boards should work to implement fully the National Bereavement Care Pathway to ensure that all parents are offered high quality, individualised bereavement care after the loss of their baby.
   **The Trust is currently working towards compliance**

**TRUST ACTIONS**

| **Summary of Issues** | **Actions** |
|---|---|
| Staff awareness | Present findings at Clinical Governance sessions |
| Efforts need to be focused on implementing existing national initiatives to reduce stillbirths and continue the slow but steady decline in neonatal mortality rates observed since 2013. Particular emphasis should be placed on reducing preterm birth. | Saving Babies Lives 2 work ongoing |

| Summary of Issues | Actions |
|---|---|
| Commissioning organisations should review both their crude and stabilised mortality rates alongside their high risk population characteristics (e.g. deprivation and ethnicity) to facilitate the development of public health initiatives and to target focused interventions, such as the continued rollout of continuity of carer as recommended by Better Births, with a particular focus on women in high-risk ethnic groups and those living in areas of high deprivation. | COC being introduced, MatNeo work |
| Trusts and Health Boards with a stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate that falls into the red or amber band should carry out an initial investigation of their data quality and possible contributing local factors. Organisations should review their performance against national outcome measures with a view to understanding where improvement may be required. | Amber for extended perinatal death and stillbirth – unsure how we investigate data quality. Discuss with relevant leads |
| Trusts and Health Boards should work to implement fully the National Bereavement Care Pathway to ensure that all parents are offered high quality, individualised bereavement care after the loss of their baby. | Currently compliant with the NBCP other than providing continuity of care |

**NCA National Comparative Audit of Blood Transfusion Programme and NCA National Comparative Re-Audit of the Usage of O RhD Negative Blood - Project no. NA2018-014R**

These National Audit outcomes were combined into one report by the NCA which was published in October 2019 for 2018-19 data.

| NATIONAL FINDINGS & RECOMMENDATIONS |
|---|
| This re-audit established the following National information regarding performance against the identified standards:<br><br>• 59.3% (2946/4970) of O D negative red cells are transfused to O D negative patients<br>• 10.8% (538/4970) of O D negative red cells were transfused as a substitution made by hospital laboratories. Approximately half (5%, 247/4908) of those needs could have been met by suitable O D positive red cells<br>• 10% (504/4970) of O D negative units of red cells were transfused to women aged over 50 years of age and adult males<br>• Median O D negative red cell stock was 13%<br>• 5% (252/5343) of the fated units were wasted due to either time expiry (143/252) or out of temperature control (109/252)<br>• 12.6% O D negative red cells were transfused to avoid wastage due to time expiry<br><br>As a result of the National findings the following recommendations have been made: |

Hospitals should review:

- Local transfusion policies and ensure they include recommendations for the use of O D positive red cells for unknown/O D negative adult male patients and female patients of non-childbearing potential in an emergency.
- The number of days stock held before transfusion (Issuable Stock Index - ISI): aim for an ISI for O D negative of 3-4 days.
- Use of O D negative red cells in emergencies (including (air) ambulance): Appropriate use and wastage of red cells should be audited regularly. The number of units carried in pre-hospital care boxes should be adjusted accordingly.
- Use of O D negative red cells held in satellite fridges: consider reducing the number of units held. O D negative red cells kept in satellite fridges must be rotated to avoid wastage.
- Use of O D negative red cells held in remote issue fridges: regularly review the stocks of O D negative red cells in each fridge. All stock held in remote fridges should be rotated back into stock with enough shelf life remaining to allow the units to be used appropriately before time expiry. Adequate number of O D positive red cells must be kept to avoid unnecessary use of O D negative as a substitution.

**TRUST FINDINGS**

- Nationally 59.3% of O D negative red cell was transfused to O D negative patients in the 2018 audit; Scarborough site achieved 54.8% and York site 91.3%.
- Nationally 10% of O D negative was transfused to adult males (>18years old) and females over 50 years of age as an emergency; Scarborough used 3.2% and York site used 4.3%.
- 12.6% of O D negative was transfused to avoid time expiry; Scarborough recorded 29% and York 0%.
- Nationally 5% of O D negative was wasted; Scarborough wasted 6.5% and York wasted 4.3%.
- The number of sites reported nationally where O D negative stockholding is greater than 12.5% has increased to 64% in 2018. Compared to the target of 12.5% Scarborough held 21% and York held 8%.

The audit also found that nationally 10.8% of O D negative red cells were used as a substitute by hospital laboratories and approximately half of those needs could have been met by suitable O D positive red cells.

It is recommended that the Trust gives consideration to the stock holding levels for OD Negative at each of its sites in line with the national recommendations.

**TRUST ACTIONS**

| **Summary of Issues** | **Actions** |
|---|---|
| Emergency Transfusion Policy | To discuss with Transfusion Laboratory the recommendation for a policy to provide O D positive red cells in an emergency to unknown females over 50 years old and unknown adult males. |
| Stockholding | a. To discuss with transfusion laboratory the amount of O D negative held at SGH site to see if stockholding level can be brought to nearer 12.5% from 21% during the audit period. |
| | b. To discuss with clinical staff whether the number of O negative units at BDH could be reduced to 4 from 6. |

| | |
|---|---|
| Laboratory Information Management System (LIMS) | To discuss with Transfusion Team to determine how the data can be made readily available for RTC sharing. |

**NPID National Pregnancy in Diabetes Audit - Project no. 2626**
This report was published in October 2019 for 2017-18 data.

| **NATIONAL FINDINGS & RECOMMENDATIONS** |
|---|
| This National Audit Report identified that neonatal death, stillbirth, congenital anomaly, large and small for dates babies and neonatal unit admission all remain very high by comparison with non-diabetic pregnancies and so are of considerable concern. Seven in eight women did not achieve NICE recommended, risk reducing, pregnancy preparation. These results are unchanged over 5 years.<br><br>After case-mix adjustment, analysis of unit-to-unit variation suggests that all services are experiencing similar challenges. Improvement is therefore likely to require universal changes to systems and/or treatment technologies.<br><br>Some system wide changes that may help include:<br>• increased use of continuous glucose monitoring for women with Type 1 diabetes (planned for England starting 2020) and other technologies as evidence emerges<br>• targeted and improved patient education and support around contraception and pregnancy preparation with a focus on identifying and supporting those at highest risk<br>• greater empowerment of women to make routine diabetes self-management decisions<br>• increased awareness and training for all healthcare professionals<br>• development and implementation of new pathways for identification, referral and treatment |
| **TRUST FINDINGS** |
| **York Site -** The results for York showed that the care was well above average regionally and nationally. The only aspect not met was routinely repeating HbA1c in the third trimester. This is as a result of following NICE guidance that clearly advises not to request an HbA1c routinely however the NPID Team insists to include this in their auditable standards. We have recently started requesting this test routinely on all women with pre-existing diabetes (this has no direct impact on management of patients and has not been linked to improved outcomes).<br><br>**Scarborough Site -** The results for Scarborough identify issues with admission to SCBU and also pre-conceptual care; therefore there has been a review all pre-existing diabetic women from 2016 to look at the figures and reasons for admission to SCBU and socioeconomic aspects such as planning pregnancies / smoking/ occupation etc. So far it suggests that our demographics play a big part in our outcomes as we have a lot of unplanned pregnancies that have no record in notes whether patients are not on folic acid 5mg until pregnancy commences, however our folic acid record is very good.<br><br>Many of the Scarborough patients are poor attenders; with poor compliance and start off with high HBA1C (a large percentage of our type 1 diabetics are not as compliant pre or post pregnancy). To address this our Diabetic Nurses are setting-up a clinic and addressing the GP information as they have more access to young women with pre-existing diabetes and to educate them on pre-conceptual care and the Diabetes Team is working on getting the message across to GPs as well as providing education/ training in the community/ GP services with flyers and teaching sessions.<br><br>In 2018 the Trust implemented a change in the guideline for intrapartum VRIII following JBDS guidelines so neonatal admission is being closely monitored as is the number of preterm |

| | |
|---|---|
| deliveries. We also now provide transitional care which should reduce the number of babies being admitted to SCBU. | |
| **TRUST ACTIONS** | |
| **Summary of Issues** | **Actions** |
| Various issues re. compliance with NPID standards | (i) Start the Pre- conception Clinics |
| | (ii) Education/ Training |
| Guideline for intrapartum VRIII | Implement change following JBDS guidelines |

**NNAP National Neonatal Audit Programme - Project no. 1678**
This report was published in December 2019 for 2018 data.

| **NATIONAL FINDINGS & RECOMMENDATIONS** |
|---|
| The NNAP National Audit Report 2019 does not provide a summary of National findings, but instead provides a number of recommendations to specific services from the results, dependant on their own Trust's results. |
| **TRUST FINDINGS** |
| Results for York Teaching Hospitals NHS Foundation Trust benchmarked against the national average indicated that the Trust performs well either exceeding or equalling the National average against the following standards audited:<br>• Antenatal Steroids<br>• Consultation with Parents<br>• Parents on Ward Rounds<br>• Retinopathy of Prematurity (ROP) Screening: On Time<br>• Minimising Separation – Term<br><br>However there are 4 standards were the Trust does not achieve the National average and therefore needs to make improvements:<br>• Magnesium Sulphate<br>• Temperature on admission<br>• Two-year Follow-up<br>• Sufficient Nursing Staff |

| **TRUST ACTIONS** | |
|---|---|
| **Summary of Issues** | **Actions** |
| **Magnesium Sulphate** | This has been highlighted to the obstetrics and midwifery teams who are responsible for administering this prior to the birth of the baby. Precept midwives in post who are involved with education/training and to review all missed cases. |
| **Temperature** – all babies should have a normal temperature on admission | This is an area of focus for maternity and paediatrics already as part of the MatNeo QI programme. Work is being undertaken to ensure babies are kept warm on the labour ward and postnatal ward as well as during transfer between areas.<br>Scarborough application of MatNeo. |
| **Consultation with Parents** | There has been an improvement in this area compared to last year (85%). We are continuing to encourage senior clinicians to update parents and document on the yellow communication form within 24 hours of |

| | |
|---|---|
| | admission.<br>Scarborough was 100% need to maintain. |
| **Minimising Separation – Late Preterm** – Babies are separated from their mothers when admitted to the neonatal unit | Discussions are currently ongoing about development of a transitional care facility. This would enable us to reduce the amount of time that late preterm babies are being kept separated from their mothers. We are also involved with Family Integrated Care.<br>Scarborough – further development of transitional care with improved data capture of transitional care on SCBU site. |
| **Nurse Staffing** | There have been staffing difficulties with uncovered maternity leave and some long- term sickness. This will improve in the new year and should see the unit fully staffed by the spring. We currently have 64% QIS trained nurses (as per the dinning tool) with one further nurse undertaking the course, currently. It is recognised that there is significant issues |
| **2-year Follow-up** | Scarborough Guideline for follow-up process and pathways in draft to be published on intranet (Staff Room) to improve understanding of the importance of these which can lead to better follow-up attendance. Review of PARCA questionnaire to support 2-year follow-up assessment. Unclear whether Paediatric service to Bridlington needs to be addressed. |

**NACAP National Asthma and COPD Audit Programme - Adult Asthma Secondary Care - Project no. QA2018-010R**
This report was published December 2019 for 2018-19 data.

| **NATIONAL FINDINGS & RECOMMENDATIONS** |
|---|
| This National Audit report summarised the key National findings as being:<br>• 72.6% of patients had a PEF measurement recorded during their hospital admission. Guidelines require measurement of PEF as part of severity assessment.<br>• 76.8% of patients were reviewed by a respiratory specialist during their admission<br>• 87.7% of patients were administered systemic steroids following arrival at hospital. |
| **TRUST FINDINGS** |
| **Scarborough Hospital** – the report identified poor PEFR on admission and which have been discussed with senior management. The availability of the PEFR meters in Emergency Department has come up as an issue as not enough is being ordered. We are trying to introduce the Trust wide Asthma Management Plan (already in use in York ED but not in Scarborough).<br><br>Poor results are also reported for the Six Elements of Good Practice which is surprising as every asthma patient seen will have had a bundle – therefore work is being undertaken to establish what is missing from the bundle and whether there are issues with data entry.<br>The smoking cessation element (although rated as being Amber by the report) is a success and will continue to improve with the planned changes to local service and their provision. It is also noted that there is not an NACAP option to say that patients have declined smoking cessation; hence we cannot say that smoking dependency has been addressed but declined.<br><br>**York Hospital – the** Respiratory Nursing Team have performed well against the National Medians for the 3 benchmarked key indicators and missed the target for performance of PEF |

| by only 1%. | |
|---|---|
| **Summary of Issues** | **Actions** |
| **Scarborough Site** | |
| Availability of PEFR meters in Scarborough ED | Discuss to look at ways to improve availability |
| Scarborough not fully compliant with local guidelines | Introduce the Trust wide Asthma Management Plan |
| Lack of clarity re. NACAP key indicator 1st PEF | Query sent to NACAP colleagues – awaiting response |
| Not fully complaint with NACAP key indicator six elements of good practice care | Query with Data Administrator what are missing from our bundle |
| **York Site** | |
| Improve the number of Asthma patients having PEF taken within the first hour of arrival at hospital | • Additional education for staff in ED, AMU, AMB & Care of the Elderly regarding the importance of obtaining initial PEF reading and the implications for the patient if this is not done. Rolling programme every 3 months.<br>• Mission statement to clinical areas re. Prompt performance of PEF.<br>• Include performance of PEF in the Safety Briefing to ED, AMU, AMB and Care of the Elderly. |
| Improve the number of Asthma patients who are current smokers having their Tobacco dependency addressed at discharge | Improve the overall number of patients entered onto the Asthma Audit by increasing the number of referrals to the Respiratory Nursing Team from ED and all ward areas by proactively screening for asthma patients and providing the education and prompts as detailed above. |

**National Audit of Dementia - 4th Round - Project no. QA2018-001R**
This report was published in August 2019 for 2018-19 data.

| **NATIONAL FINDINGS & RECOMMENDATIONS** |
|---|
| The 2019 report presents the Round 4 results of the National Audit of Dementia.<br><br>And reports that there are several areas where improvement has been made:<br>• 96% of hospitals in England and Wales now have a system in place for more flexible family visiting;<br>• 88% of carers (and/or patients) receive a copy of the discharge plan;<br>• More staff report being able to access finger food or snacks for patients with dementia.<br><br>It is identified that although a higher proportion of staff reported they had received training in dementia, it is disappointing that many hospitals seem to have no formal record of staff who have received this training.<br><br>The most concerning aspect identified by the National Report 2019 is the low rate of screening for delirium. People with dementia are particularly susceptible to delirium. This is a frequent cause of acute admission to hospital and a contributory factor in falls and prolonged lengths of stay. Yet in Round 4 only 58% of people with dementia were assessed for possible delirium. This is an area which needs urgent action. |

The audit also highlights variations between specialities and routes of admission. Delirium assessments for patients on orthopaedic wards with a hip fracture were amongst the highest. This is most likely due to the inclusion of routine delirium screening into fracture neck of femur pathways/clerking proformas.

**TRUST FINDINGS**

The main themes that stand out for the Trust from this reports are around the following:

- **Delirium Screening**. The audit period preceded the implementation of NEWS2 by the Trust and therefore the requirement to screen all patients for new confusion (including those with a pre-existing dementia diagnosis). The NEWS2 implementation has been linked to the 4AT delirium screening pathway, and so our rates of delirium screening will improve for future audits.
- **'This is About Me'** document needs addressing as a matter of urgency to ensure it is meaningful and also user-friendly for staff and families to complete and this will be a priority.
- **Discharge Documentation** requires review and we are considering a discharge working group but need to work out the remit of the group and get a sense of what its aim will be but a discharge checklist is required and we are trialling a new version on a ward in York. We would also need external teams also to be involved such as social care and ensure that other projects that are going on such as the 'red bag' project run by the CCG for care homes links with this.

The Trust has also updated the action plan for the CQC which sits alongside the strategy and will be outlining our priorities for 2020.

**TRUST ACTIONS**

| **Summary of Issues** | **Actions** |
|---|---|
| Lack of delirium screening | The 4-AT has been embedded in Scarborough as part of delirium screening now (required for NEWS2 roll-out). Therefore delirium screening rates should improve considerably for the next round of NAD. |
| Collection of Information about patient's with dementia | I have emailed the ward sisters on the elderly wards in Scarborough to remind the ward nurses to complete the 'This is Me' booklet for patients with dementia.<br>Review the 'this is about me' document as a matter of urgency to ensure it is meaningful and also user-friendly for staff and families to complete and this will be a priority.<br>Also we have looked at using a board above each patient's bed called 'what matters to me?' which has been used successfully in other organisations and also covers every patient group not just with dementia - it is easy to see and simple. |
| Inadequate discharge documentation of patient's with dementia | I have emailed the medical director to see if we can get the social workers to document discharge plans, and who they have been discussed with, and capacity assessments etc. in the medical notes (they currently keep their own separate notes that we can't access)<br>Review the discharge documentation and consider a discharge working group. Also external teams need to be involved such as social care to ensure that other ongoing projects such as the 'red bag' project run by the CCG for care homes links with this. |

**Reports Still to be Published**

There were **7** National Audits which were published in 2019-20 or which were due to be published but as yet have not been but have not yet been reported on and these are shown below:

- **RCEM VTE Risk in Lower Limb Immobilisation - Care in Emergency Departments.** Project No. QA2018-004. Report has not yet been yet published

- **NCA National Comparative Audit of Blood Transfusion Programme - Management of massive (major) haemorrhage.** Project QA2018-015. Report has not yet been yet published.

- **UK Parkinson's Audit 2019 - inc. OT, SaLT, Physio, Elderly.** Project No QA2019-001R. Awaiting report from Trust Lead.

- **SSNAP Sentinel Stroke National Audit Programme - Organisational Audit.** Project No 1885. Awaiting report from Trust Lead.

- **BTS National Smoking Cessation Audit 2019.** Project No QA2019-008. Awaiting report from Trust Lead.

- **NACR National Audit of Cardiac Rehabilitation.** Project No 1142. Awaiting report from Trust Lead.

- **NVR National Vascular Registry.** Project No 1370. Awaiting report from Trust Lead.

**National Confidential Enquiries**

During 2019/20 there **2** national confidential enquiries commenced. Both cover health services that York Teaching Hospital NHS Foundation Trust provides and the organisation participated in both. These are identified in Table 1 above as both NCEPOD studies were Quality Accounts.

There have been **3** NCEPOD Self-Assessment Checklists published in 2019/20

- Mental Healthcare for Young People and Young Adults
- Know the Score – the quality of care provided for people with pulmonary embolism.
- Acute Bowel Obstruction - Delay in Transit

The above Self-Assessments have been sent to the NCEPOD Leads are to review the recommendations made.

## Local Clinical Audit

A total of **238** clinical audits where identified as priorities at the start of 2019/20, and as a result of the on-going engagement with Care Groups a further **131** clinical audit topics, were identified as being priorities, over the course of 2019/20.

Therefore a total of **369** Clinical Audits were identified as priority audits and included on the Trust Annual Audit Programme 2019/20.

Table 3 below, provides information on the categories of the **369** Clinical Audits identified as priority audits between 01 April 2019 and 31 March 2020, including how many were registered with and had audit reports returned to the Clinical Effectiveness Team.

**Table 3**

| TYPE | AAP TOTAL | REGISTERED | COMPLETED |
|---|---|---|---|
| Quality Account | 48 | 48 | 0 |
| Compliance with NICE | 9 | 2 | 1 |
| Local Clinical Audit | 185 | 139 | 33 |
| Re-Audit | 96 | 31 | 12 |
| New Procedure Audit | 1 | 0 | 0 |
| NPSA Audit | 4 | 1 | 1 |
| National Audit | 26 | 24 | 1 |
| **Total** | **369** | **245** | **48** |

An entirety of **245** Clinical Audits has been registered with the Clinical Effectiveness Team; this is a total of **66%** of the **369** clinical audits identified as priority has been registered with the Clinical Effectiveness Team.

The addition of **131** audits to the Annual Audit Programme 2019/20 have resulted from the ongoing engagement by the Clinical Effectiveness Team throughout the year, with the various Care Groups to ensure that both the audits initially identified as priority for the year have remain so and that any newly developed priorities are reflected.

Of the **245** Clinical Audits on the Annual Audit Programme, which were registered with the Clinical Effectiveness Team, Trust wide only **20%** of these audits had reports submitted back to the Clinical Effectiveness Team and therefore were completed in 2019/20.

Although 20% is a relatively low percentage of audits having been completed, it is normal for both Quality Account and National Audits to take up to 24 months before reporting is completed; with data submission taking place in one financial year, then data analysis in the following financial year and then finally the National Report to be published.

With regard to local clinical audits, previous years inform us, that many of those registered in the 3rd and 4th Quarters of 2019/20 will finally be completed in the following financial year.

Table 4 below shows the progress against the Annual Audit Programme 2019/20, by Care Group, showing the number of priority Clinical Audits identified by the Care Group and the number of these which have been registered with the Clinical Effectiveness Team and those which have had audit reports returned to the Clinical Effectiveness Team

**Table 4**

| CARE GROUP | AAP TOTAL | REGISTERED | COMPLETED |
|---|---|---|---|
| **Care Group 1** | 59 | 33 (56%) | 4 (12%) |
| **Care Group 2** | 143 | 29 (20%) | 8 (27%) |
| **Care Group 3** | 145 | 94 (65%) | 21 (22%) |
| **Care Group 4** | 26 | 15 (58%) | 6 (40%) |
| **Care Group 5** | 59 | 47 (80%) | 5 (11%) |
| **Care Group 6** | 27 | 17 (63%) | 4 (24%) |
| **Corporate** | 21 | 10 (48%) | 0 (0%) |

The reports of **101** local clinical audits were reviewed in 2019/20 and as a result actions have been identified to improve the quality of healthcare provided as a result of audit outcomes.

Of the actions arising from local audits that will have beneficial outcomes on patient care, a selection is described below:

**Oxygen Prescribing In Medical Wards - Project No. 2019-0001**

Oxygen is an important and one of the most commonly used drugs. It is an inexpensive, painless, and easily applied therapy.

This audit looked patient care on Trust medical wards to establish whether practice was in line with the BTS guidelines for oxygen use in adults in healthcare and emergency settings and set the following targets for performance in the Trust:

1. Oxygen should be prescribed to achieve target saturations of 94-98% for most acutely ill patients or 88-92% for those at risk of hypercapnia respiratory failure – for 100% of all patients.
2. The target saturations should be ringed on the drug chart or prescribed electronically for 100%.of all patients.
3. Oxygen saturations with delivery device codes should be recorded on the monitoring charts for 100%.of all patients.

Face to face discussion with doctors, nurses and other staff and making them realize how important it is to have oxygen prescribed in correct manner including target saturation
The major barrier was that traditionally oxygen is not considered a drug and so people do not feel it is important to prescribe it on EPMA.

The audit made recommendation that the Trust needs to continue interventions until 100% of the patients are prescribed oxygen correctly as per BTS guidelines and as a result the following actions have been put in place to improve patient care and safety in the Trust:

| Summary of Issue | Actions |
|---|---|
| Oxygen not prescribed for 100% of all patients who require it as per BTS Guidance | Continue interventions until 100% of the patients are prescribed oxygen correctly as per BTS guidelines. |
| | Continued face to face discussion with doctors, nurses and other staff and making them realize how important it is to have oxygen prescribed in correct manner including target saturations. |

**Audit Into Patients Dietary Instructions for Acute Admissions to Surgical Wards**
**Project No. 2019-006**

Dietary instructions are one of the most fundamental aspects of clinical care on surgical wards. Dietary restrictions are important for therapeutic reasons or for pre-op optimisation; however these are not always required, for example keeping a patient nil by mouth (NBM) or on clear fluids can be unpleasant and/or unnecessary.

This audit was undertaken to investigate whether nursing staff are informed about patient's dietary instructions and also to establish whether patient are aware of their dietary instructions

The audit found that there was a high rate of nurses being aware of the dietary instructions for patients; however this did not meet the 100% target set out by the audit.

There was poor documentation of dietary instruction in patient notes by both junior to senior doctors.

Also there was poor involvement of the patient and poor communication with the patient about dietary instructions

This audit established that the Trust is currently doing poorly on the documentation of dietary instructions for acutely admitted surgical patients. Moreover, nurses and patients are often unclear on these decisions.

This should not be the case in our patient-care-driven health system and therefore the following actions have been put in place to improve patient care and safety in the Trust:

| Summary of Issue | Actions |
|---|---|
| Poor documentation of dietary instructions. | Education of staff involved in the clerking and management of acutely admitted surgical patients through an initial presentation and then reminder with leaflets. |
| Poor involvement of patients in dietary planning | |
| Poor communication to patients of their dietary instructions | |

**Re-Audit of the Use of DOACs in Patients with Impaired Renal Function - Project No. 2019-010(R)**

An audit of the use of direct oral anticoagulants (DOACs) in patients with impaired renal function was previously undertaken in October 2018. The study consisted of identifying patients on Elderly Wards in Scarborough Hospital who were taking DOACs, and verifying if they were prescribed the correct dose according to their creatinine clearance (CrCl) levels. Results in that audit revealed that although standards were being met at a relatively high level, there was a general lack of awareness amongst doctors regarding the utilisation of CrCl as an indicator of renal function in drug dosing regimens in DOACs, as opposed to using estimated glomerular filtration rate (eGFR).

This re-audit specifically compares the results in the 2nd cycle with the 1st cycle, in order to validate the effectiveness of the actions implemented to bring about improvements.

Over the 4 week re-audit period, all patients were found to be at the correct dose of DOACs with respect to their CrCl levels, achieving a 100% compliance with established standards.
It was also found that dose reduction on EPMA was correctly and appropriately performed by 9 doctors and 1 pharmacist, this equates to 90% of dose reduction being picked up by doctors. This is in contrast to a 33% rate in the previous audit.

Hence this equates to a three-fold increase in accuracy of doctors noticing the need for dose-reduction in patients with renal impairment, compared to the previous audit. Results of this re-audit indicate that the actions implemented following the initial audit have resulted in improvement with regards to the percentage compliance to established standards.

Furthermore, it was evident that more doctors were aware with regards to using CrCl levels for dose reduction, as there was a 3-fold increase in doctors initiating dose reduction in this cycle (2nd cycle), compared to the previous cycle (1st cycle).

In conclusion, this re- audit confirms that actions implemented from the previous audit were effective and no further actions to make improvements are required at this time

**Familial Hypercholesterolaemia in York Hospital (Re-Audit) - Project no. 2019-012(R)**

The purpose of this audit was to re-evaluate the clinical management of patients with Familial Hypercholesterolaemia (FH) at the metabolic clinic following the introduction of a dedicated FH service in York Teaching Hospital NHS Foundation Trust.

The audit in summary found that the FH service has led to improved identification and genotyping of patients with suspected FH. More than 70% patients achieved LDL reduction targets compared to 48% patients in 2015.

Gene testing was offered to all eligible patients who fulfilled DLCN criteria.
Family members of almost all gene positive index patients were offered DNA-based cascade testing for FH.

There is marked improvement in LDL reduction in patients (40% patients to 70% patients)
Although improvements have been identified by this re-audit, if we consider the approximate population served by YTHT as 500000, there are still >1700 (>85%) patients with FH not known to the FH service.

| Summary of Issue | Actions |
|---|---|
| Case finding of new FH patients in primary care | Add comment on high cholesterol laboratory reports to refer to lipid clinic.<br>Arrange CPD meeting for GPs. |
| Optimisation of LDL reduction in FH patients | Develop a pathway for primary and secondary care to help them refer to lipid clinic. |

**Management of Diabetic Ketoacidosis as per Local Protocol based on Joint British Diabetes Society (JBDS) Guidelines - Project No. 2019-0013**

Diabetic ketoacidosis (DKA) is a life-threatening medical emergency and a common complication of Type 1 diabetes. DKA is preventable if all necessary steps are thoroughly followed. However, mismanagement of DKA could be associated with significant morbidity and mortality.

This audit was undertaken to assess adherence to DKA guidelines in patients managed according to DKA prescription chart and to improve the standard of care and management of DKA.

The trust did well in diagnosing DKA with 97% of the patients who were treated for DKA met all 3 diagnostic criteria.

All 29 patients audited had correct insulin prescription on DKA chart and were reviewed by dedicated Diabetes team.

Only 24% of patients had K+ added to the 2nd litre of normal saline as per guidelines.

Lack of monitoring of electrolytes of patients on DKA pathway with 31% of patients did not receive the recommended monitoring.

From this audit the following areas were identified for improvements:

- Monitoring of electrolytes and adding of K to the 2nd bag of normal saline
- Fluids management
- Long acting insulin prescription along FRII
- Ketones monitoring
- Switch from FRII to VRII

The following actions have been put in place to improve patient care and safety in the Trust:

| Summary of Issue | Actions |
|---|---|
| Improve Staff Education | Provide teaching sessions regarding DKA |
| Stakeholder Awareness | Ensure stakeholder awareness through discussion of this audit report at Clinical Governance Meetings |
| DKA awareness | Developing Posters for clinical areas |
| | Liaise with IT team regarding the possibility of an automatic warning on CPD |

**Foetal Fibronectin Audit - Project Number 2019-0015**

Foetal fibronectin is a point of care test used to predict the risk of delivery within 14 days when pregnant women present with threatened preterm labour. The test uses a vaginal swab from which quantitative analysis of foetal fibronectin is performed.

The aim of this audit was to assess the performance of this test in York and that York guideline standards (adopted from the manufacturer, literature, NICE and EMBRACE regional recommendation) are met.

- Quality check once daily: (Standard = 100%)
  Audit finding = 90.23% (11 month average)
- Offer admission if positive result (Standard = 100%)
  Audit findings: 20/21 patients admitted (95%) 1 offered but declined (100%)
- Give steroid +/- tocolysis (Standard = 100%)
  Audit findings: 50% in 200 – 499 group (50% had steroids but no tocolysis)
  100% in >500 group.

It was difficult to ascertain if quality control was done on daily basis as recommended by manufacturer. Data (stickers) provided to Trust POC Co-ordinator suggested there were many missing days (90% average over 11 months). However, the equipment gives a visual reminder and does not analyse if quality control has not been done in the last 24 hours. This suggests quality control was always done but not always recorded.

There was good compliance for offering hospital admission and giving steroids. However there was inconsistent use of tocolysis in the group with test results 200 – 499.

The following actions have been put in place to improve patient care and safety in the Trust:

| Summary of Issue | Actions |
|---|---|
| Inconsistent documentation of daily quality check | Better documentation of daily QA |
| Standard not met for giving tocolysis | Tighten tocolysis administration |
| Review of compliance | Repeat audit |

**Provision and Accessibility of Hand Hygiene Facilities in General Surgery - Project No. 2019-0026 (R)**

Effective hand hygiene is fundamental to patient safety. The hands are the most common vehicle for the spread of infection. The aim of hand hygiene is to remove contamination and/or to reduce the level of organisms on the hands.

The aim of this audit was to analyse the hand hygiene facilities on the acute and elective surgical ward; specifically to establish:

1) Is there alcohol gel at the end of every bed?
2) Is there liquid soap at every hand-wash sink?
3) Are there paper towels at every hand-wash sink?

The standard was expected to be 100% compliance for each of the above areas
In the first audit performed in January 2019, Ward 14 provided alcohol gel at 58% of bed spaces and had liquid soap and paper towels at 100% of hand-wash sinks.

Ward 16 provided alcohol gel at 50% of bed spaces, had liquid soap at 100% of hand-wash sinks and paper towels at 90% of hand-wash sinks.

At this re-audit (performed in June 2019) Ward 14 had improved the provision of alcohol gel to 86% of bed spaces and Ward 16 had improved it to 87% of bed spaces.

100% provision of liquid soap at all hand-wash facilities. Improvement of alcohol gel provision after discussion with ward sisters.

Overall, the general surgery wards have good hand hygiene facilities. The hand-wash sinks are well stocked with liquid soap and paper towels. However there is room for improvement to ensure that all bed spaces have alcohol gel available.

The following actions have been put in place to improve patient care and safety in the Trust:

| Summary of Issue | Actions |
|---|---|
| Ensure standards are maintained | Hand hygiene facilities will be re-audited later in the year with the new intake of trainees. |

**Timescale from Referral to Start Of Treatment for New – Onset Wet AMD Patients - Project No. 2019-0043(R)**

Age related degeneration (AMD) is the leading cause of irreversible blindness in developed countries.
The aim of the audit was to determine the time taken to treat new – onset Wet AMD patients from the initial referral.

Delay in appointments booking into URC or treatment clinic after the initial diagnosis was identified as the most common cause (56.25%) for delay in initiating treatment.

In 12.5% FFA prior to treatment was cause of delay, while combination of both was identified as cause of delay in 31.25%.

Median number of days to FFA from URC was 7.937 (0 – 19) & from FFA to treatment 6.5 (0 – 19).

We were able to partially achieve the desirable targets. Majority patients (> 72.0%) received treatment within 3 weeks of referral or 2 weeks after seen in URC. Improvement is definitely required to speed up the time from URC clinic appointments to treatment initiation in designated AMD treatment clinics.

The following actions have been put in place to improve patient care and safety in the Trust:

| Summary of Issue | Actions |
|---|---|
| FFA prior to treatment is a cause of delay | Create additional FFA clinics in Scarborough Hospital |
| Improvement is required to speed up the time from URC clinic appointments to treatment initiation in designated AMD treatment clinics | Dedicated email address for all urgent wet AMD referrals by optoms for same day triaging by retinal specialist consultants |

**Correct Prescribing Of Opioid Medicines and Kidney Failure - Project No. 2019-0169**

The aim of the audit was to establish whether the Trust policy is being adhered too when prescribing opioids in renal impairment.

Out of seven patients with an EGFR< 30ml/min four was rightly prescribed Oxycodone (57%).

The remaining three patients two of those were wrongly prescribed Morphine (28%) and the other patient had no opioids prescribed.

Out of twelve patients with an EGFR >30ml/min four patients were wrongly prescribed Oxycodone (33%) and eight patients were rightly prescribed morphine (67%).

Out of the eight patient's prescribed Oxycodone five patients PRN doses were too high (66%). The remaining three one of those was prescribed correctly, one had no

range and used a decimal point and the remaining one was prescribed the correct range but using decimal points.

Over half of the patients with EGFR <30ml/min were prescribed the correct medication. Out of the twenty patients only two was incorrectly prescribed Morphine (10%).

Despite the majority of patients been prescribed the correct opioids for their renal function this audit has highlighted inconsistences with regards to the range and the use of decimal points when prescribing medication.

This audit has highlighted that even in the specialist palliative care team there is a lack of consistency regarding at what level the EGFR is before switching opioid.

The following actions have been put in place to improve patient care and safety in the Trust:

| Summary of Issue | Actions |
|---|---|
| No continuity of switch between SPPC | Palliative care consultant to provide training session |
| To ensure correct opioid, range and dose is prescribed by non-specialist palliative care health care professionals. | F1 teaching<br>Ad hoc teaching to medics on the wards.<br>Training to be given to ward staff at EOL study days. |

**Use of Nottingham Hip Score in Hip Fracture Patients - Project No. 2018-0067 (R)**

The aim of this re-audit was to assess if we are using NHFS for risk of mortality within 30 days of surgery for hip fracture patients and to establish whether or not the actions from the initial audit have bought about improvements.

In the first part of the audit, we collected data for 56 patients. There were 24 males and 32 females, and the average age was 83 years.

We found that none of these patients had NHFS recorded in their notes.

In the second part of the audit we collected data for 30 patients. There were 13 males and 17 female patients. The average was 80 years.

Although all the patients had NHFS stickers in the notes, the scores were recorded for 15 patients only.

This re-audit shows that we have achieved a 50 % documentation rate with NHFS. The following actions have been put in place to continue to improve NHFS documentation in the Trust:

| Summary of Issue | Actions |
|---|---|
| Documentation of NHFS for patients with hip fractures | Incorporation of NHFS in clerking booklets and educating the admitting doctors to complete these |

| | |
|---|---|
| | on admission. |

**Audit of eDN letters for Elderly Care Team - Project Number: 2019-0028**

Every patient who is admitted to the care of the elderly wards within the hospital, will have an electronic discharge note (eDN) compiled as part of their discharge process. These eDNs are copied to both the patients GP and the patient; they should give a summary of the episode of care during the admission

The aim of the audit was to ensure that the eDNs produced by the medical team within the care of the elderly service are of a high quality and meet the national standards set by the Royal College of Physicians and AoMRC for the information received by the patient / carer and the Primary care medical team.

This audit was able to demonstrate that the majority of the eDNs that were compiled via the elderly care service were of an acceptable standard, and gave the basic amount of information regarding the individuals concerned, to the professionals who were receiving this information.

It was noted that a number of the standards that the audit identified where automatically included within the eDN by the computerized clinical system used within the hospital, therefore these areas were seen as a hundred percent compliant within the standard.
However there were a number of elements within the standards that fell short of acceptability, the main areas for these were:-

1. The admission method- there was no identification in the majority of the admissions of where the patient was actually admitted from i.e. elective, emergency or transfer from another healthcare provider.
2. The identification of any procedures that were carried out as part of the admission, however as these were medical patients the number of procedures was a small limited amount, which appeared to skew the overall final percentages within this standard.
3. The summary of the patient's admission appeared limited in the majority of the electronic discharge notes however in 73% of the patients audited there was a summary; however the quality of this summary was seen to be lacking in detail for the majority of the cases.

The following actions have been put in place to continue to improve P3NP testing in the Trust:

| Summary of Issue | Actions |
|---|---|
| Lack of knowledge of the required standards for eDNs by the Junior medical staff | To be included as part of the education programme for the Junior medical staff in Care of the Elderly. |
| The lack of implementation of the identified standards | Presentation of the results at the weekly journal meeting of the audit to the Care of the elderly team, identifying the shortfalls identified in the eDNs. |
| To ensure compliance to the standards as an ongoing process | To regularly re-audit the eDNs produced by the Care of the Elderly team, to ensure high stand of eDNs. |

## Improvement Resulting from Local Clinical Audit

Where re-audits have been undertaken during 2019-20 the Trust is able to identify and demonstrate a range of improvements for services, as a result of actions identified by the original audits, which include but are not limited to:

- The majority patients (> 72.0%) with Age Related Degeneration (AMD) are now receiving treatment within 3 weeks of referral.

- Improvement in the availability of alcohol gel at bed spaces and all hand wash sinks there was both liquid soap and paper towels provided.

- Familial Hypercholesterolaemia (FH) service has improved identification and genotyping of patients with suspected FH.

- The knowledge of and compliance with standards regarding the use of direct oral anticoagulants (DOACs) in patients with impaired renal function, has significantly improved with the re-audit showing achievement of 100% compliance with established standards and a three-fold increase in accuracy of doctors noticing the need for dose-reduction in patients with renal impairment, compared to the previous audit.

- Use of Nottingham Hip Score for patients with Hip Fracture has improved by 50% since the original audit, although further improvements are identified by the re-audit

### National Institute for Health & Care Excellence (NICE)

NICE's role is to improve outcomes for people using the NHS and other public health and social care services. They do this by:

- Producing evidence-based guidance and advice for health, public health and social care practitioners;

- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services;

- Providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.

The maintenance of an up-to-date NICE Guidance database continues to enable each piece of guidance to be tracked to ensure successful implementation within specified timescales. Any risk issues are escalated to the Clinical Effectiveness Group.

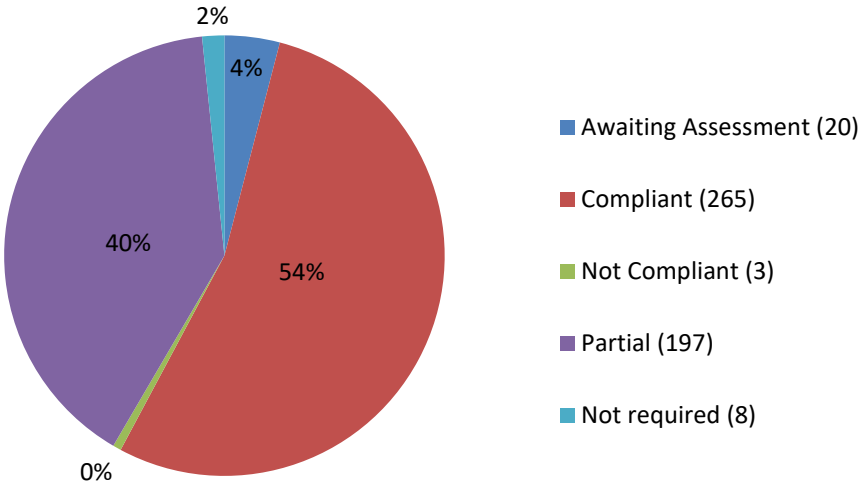
There were a total of **129** NICE Guidance published in 2019/20 (Appendix 1) of which **119** were relevant to the Trust. The categories of these applicable guidance are summarised in table 5 below:

**Table 5: Categories of Applicable NICE Guidance**

| Code | Type | Number |
|---|---|---|
| **CG** | [Updated] Clinical Guidelines | **11** |
| **DG** | Diagnostics Guidance | **5** |
| **IPG** | Interventional Procedure Guidance | **28** |
| **MTG** | Medical Technologies Guidance | **10** |
| **NG** | NICE Clinical Guidelines | **47** |
| **QS** | Quality Standards | **18** |
| **Total** | | **119** |

## NICE Compliance

At the end of the financial year the Trust NICE Guidance database contained a total of **1126** pieces of current NICE guidance. **633** were reported as not relevant, or not applicable, to the Trust. Of the **493** guidance applicable the current progress towards demonstrating compliance is summarised in figure 1. (excluding Drug TAs which are reviewed by Pharmacy).




Those marked as ‘Compliant’ have a completed baseline assessment and evidence to support this status. For those which are ‘Partial’, this status has either been agreed by the Clinical Effectiveness Group, or has an action plan to achieve compliance. Guidance which is documented as ‘awaiting assessment’ covers all guidance which has not, at this stage, had a baseline assessment completed and returned to the Clinical Effectiveness Team. Additionally, for 2019/20, those marked ‘Not required’ are guidance which are applicable to the Trust but baseline assessments are not required, for example NICE Rapid Guidelines for COVID-19.

## NICE Guidance by Care Group

In order to establish the Trust’s compliance with NICE guidance, clinical leads are identified in each Trust Care Group for which the guidance has relevance. Where guidance is relevant to more than one Care Group, the one with the most relevance would be the lead and will coordinate with others in the assessment. As CG1 and

CG2 have similar services, York & Scarborough sites respectively, some guidance is split equally between both.

**Table 6**

| | CG1 | CG1: CG2 | CG3 | CG4 | CG5 | CG6 | Corporate | Total |
|---|---|---|---|---|---|---|---|---|
| Awaiting Assessment | 0 | 6 | 4 | 2 | 4 | 3 | 1 | 20 |
| Compliant | 3 | 61 | 79 | 18 | 68 | 14 | 22 | 265 |
| Not compliant | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| Partial | 7 | 56 | 36 | 14 | 42 | 17 | 25 | 197 |
| Not required | 0 | 1 | 2 | 2 | 1 | 2 | 0 | 8 |
| **Total** | **10** | **127** | **121** | **36** | **115** | **36** | **48** | **493** |

**Table 6** shows the number of NICE guidance assigned to each Care Group and their progress toward establishing compliance with these.

## New Procedures

The Clinical Effectiveness Team facilitates the process for the proposals of new procedures to ensure correct approval from Finance and Clinical Directors. This responsibility has been assumed post the dissolution of the New Procedures Committee.

The new procedure process applies to all clinical staff wishing to make significant changes to practice, or to introduce a new procedure or technique; it does not apply to minor incremental changes or developments.

The new procedure process does not apply to the introduction of new drugs, which is dealt with separately by the Drugs & Therapeutics Committee.

If individual clinical staff are in doubt as to whether a new procedure or technique falls within the remit of the policy they should seek advice from their Clinical Director if they are medical staff or their Directorate Manager if they are non-medical staff – please see Introducing New Clinical Procedures or Techniques Policy on staff room.

All new applications (proposals) are considered and approved by the New Procedures Group (NPG). The group meets on a quarterly basis and reports to the Clinical Standards Group.

There were no new procedures were registered with the Trust in 2019/20.

## Care Group Governance Structures

Care Group Governance structures require Clinical Effectiveness issues to be considered and discussed at Care Group Quality Committees. During 2020/2021 a new Clinical Effectiveness Group will be established to cover Audit, Effectiveness and CQC Compliance.

### 2.2.4 Research and Development

The aim of clinical trials is to increase knowledge about treatments to ensure we are treating based on the best possible evidence. Research offers participants the opportunity to be involved in research which may or may not be of benefit to them.

Yorkshire & Humber (Y&H) is one of 15 regions that form part of the Clinical Research Network (CRN). Every CRN is targeted with a figure by the National Institute for Health (NIHR) on the number of patients entered into a clinical trial in a given financial year. As Y&H is 10 % of the national population, we are expected to represent 10% of the national NIHR target, which puts our regional annual target at 65,000.

This annual target is divided between the 22 partner organizations, of which we are one. To reach the 65,000 the Y&H CRN requires our hospital to set a stretching target of 3800 patients accrued into clinical trials in our Trust from 1 April 2019 to 31 March 2020. It's important that we meet this target as this will determine our money flow into the Trust next financial year, which pays for all the research staff we have.

Currently we have approximately 100 research studies open to recruitment. The number of patients receiving relevant health services provided or sub-contracted by York Teaching Hospitals in the period 1 April 2019 to 31 March 2020 that were recruited during that period to participate in research approved by a research ethics committee is 4359.

These patients were recruited across a wide range of specialties as most of our hospital now recruits patients into clinical trials. Some areas where we have performed really well are as follows:

- The Rheumatology clinical team and our Physiotherapists really supported the WORK PROMS Study. This study looked at patient reported outcome measures (PROMS) in people with rheumatoid arthritis, osteoarthritis, ankylosing spondylitis or fibromyalgia in the UK. It is known that working people with these conditions can find that they have difficulties doing their job because of their arthritis. The Work PROMS study is adapting and testing seven work assessments that were originally developed in Canada to be used in the UK. This testing procedure hopes to identify if the measures are relevant to use in the UK.

- The Cardiology Research team has been working on an exciting new study. The ORION-4 trial is studying the effects of the investigational cholesterol lowering drug inclisiran in participants with atherosclerotic cardiovascular disease. The University of Oxford is working in collaboration with Novartis and NHS Digital to invite potentially eligible participants to attend screening appointments at local sites. This has led the way in a streamlined new approach to research where the research teams have been able to screen large numbers of potential participants. The UK Government, NHS England, and Novartis have proposed that the yet to be approved drug inclisiran also be studied in UK patients to prevent them from having their first vascular event (primary prevention) as part of a large-scale NHS clinical trial.

- The Microbiologists, led by Dr Mawer, have successfully been implementing the ARK-hospital project over the past 2 years which incorporates antimicrobial stewardship, internet-based training and support packages. In our Trust it is showing an increase in antibiotic stoppage rates which have been successfully sustained over more than a year now. This not only has a positive benefit to the patient but a profound cost saving. The Microbiologists are now looking at using the protocols in other areas outside of the acute wards.

- The Renal Research Team has successfully opened HB-101-Hookipa trial; the Trusts first ever study using a Genetically Modified Organism (GMO). This was an excellent example of collaboration between the Renal Specialty, Study Sponsor, Pharmacy, Laboratory Medicine, the University of York and our R&D department.

- Our Trusts Gastroenterology research teams are set to end the year as the top recruiting Trust in the country with 1915 patients recruited to date; 800 more than the nearest Trust. This will be the 2nd time we have achieved this in the last 3 years after also achieving this in 17/18.

- The Hepatology research team is currently the 3rd highest recruiter in the country to Hepatology research studies with 658 recruits to date.

- Our two Respiratory Cystic Fibrosis (CF) Physiotherapists successfully completed their CF Health Hub research study which ran across the CF service both here and in Hull Trust. They have now continued to go onto run the CF Health Hub Data Observatory with them progressing well with.

- The Trust has a Trial Management team available to support our researchers. The team currently manages 22 Trust Sponsored studies, including 5 multi-site studies, for which they take on sponsor responsibilities. They deal with all aspects of some very complex studies, from study concept and design, getting research approvals, set up and delivery across all sites, through to data analysis and study reporting.

- Over the last year the Trust has been delivering The Bridlington Eye Assessment Project (BEAP). The project started in April at Bridlington Hospital recruiting 278 volunteers from the local community. The project has since moved to recruiting patients with Age-related Macular Degeneration at York and Bridlington Eye Clinics with an additional 310 participants recruited.

As well as the many clinical trials we support our Hospital has been involved in different aspects of research. Under UK rules all clinical trial results must be reported within one year. A 2018 report from the Commons Science and Technology Committee declared that ‘failing to publish data from clinical trials presents risk to human health’ and called on the UK Government to bring in measures to ensure all trials have reported results. As a result, all UK trial sponsors (Universities, NHS Trusts and companies) were given 6 months from January 2019 to increase the reporting of their trials.

In the subsequent update report by the House of Commons Science and Technology Committee in October 2019, whilst a third of all trials still remain unreported, York Teaching Hospital was named as one of only five NHS Trusts that had reported 100% of its trial data.

Due to the increasing demand in external grant awards being written by our staff R&D have appointed a Grant Development Officer to join the R&D Team. Dr Marthe Ludtmann is experienced in writing and securing fellowships/grants from various funding bodies and is working with our staff to help them develop their grant applications and make them aware of research funding calls. We are already witnessing an increase in grant applications that can start to bring in new research monies into the Trust to support our researchers own ideas.

Finally, our relationships with our two local universities continue to grow from strength to strength with an increasing number of collaborations and joint grants submissions being developed this year.

Yet again 2019-2020 has been a great year for us, we are very proud of our staff and the amazing achievements from this year.

### 2.2.5 Commissioning for Quality and Innovation Payment Framework

The majority of York Teaching Hospital NHS Foundation Trust's income in 2019-20 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the monies attached to CQUIN were incorporated into the Aligned Incentive Contract signed with the Trust's main Commissioners. For services that are directly commissioned by NHS England approximately £0.2m income was conditional on achievement.

The CQUIN goals are managed through our internal processes and cover a significant number of areas. They fall into two areas:

**National** – Reducing Anti-microbial resistance, Staff Flu vaccinations, preventing hospital falls, six month reviews for Stroke survivors and Same Day Emergency Care (SDEC) for patients presenting with Pulmonary Embolus, Tachycardia with Atrial Fibrillation and Community Acquired Pneumonia.

**Specialist** – Cystic Fibrosis supporting Self-care.

At the time of writing this report the Trust had agreed payment with the Commissioners for CQUINs. Please note that due to the COVID-19 pandemic CQUINs were suspended for quarter four of 2019-20 and for the entirety of 2020-21.

### 2.2.6 Care Quality Commission

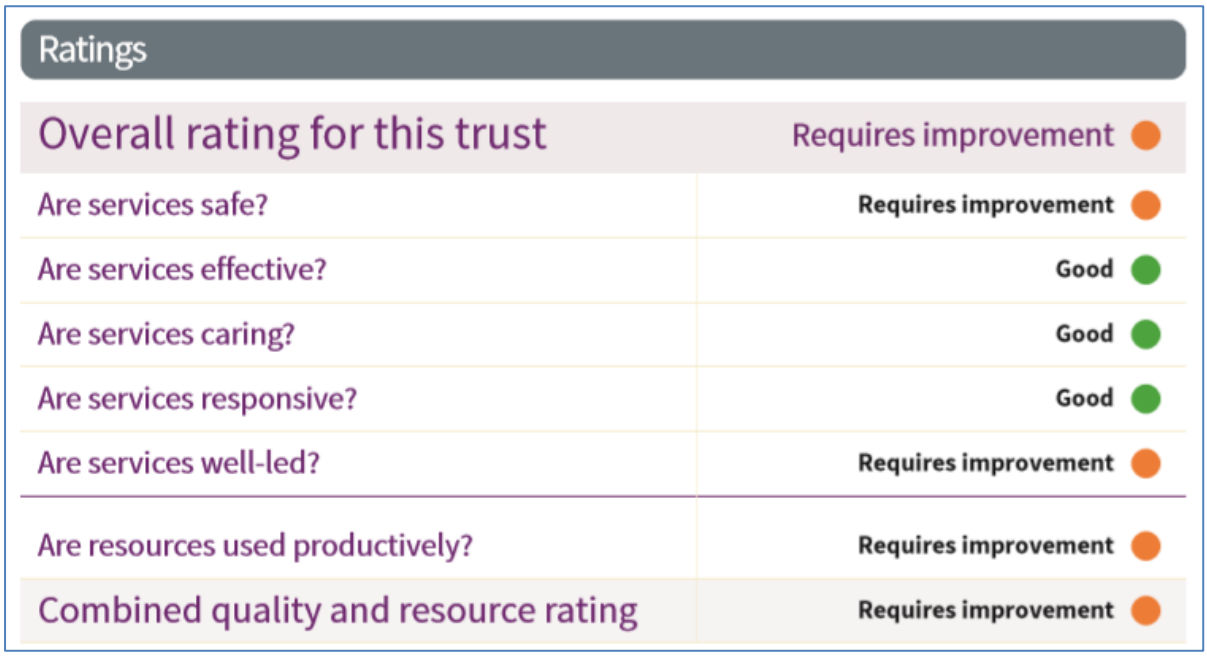
York Teaching Hospital NHS Foundation Trust is required to register with the CQC and its current registration status is registered with conditions attached to its

registration. Throughout 2019-20, the trust has received 3 unannounced inspections and 1 announced inspection.

**18-20 June 2019:** Unannounced inspection at Scarborough Hospital of Urgent and Emergency Care, Medicine, Surgery and Outpatients. In addition the inspection also covered Surgery and Outpatients at Bridlington Hospital.

**16-18 July 2019:** Unannounced inspection at Scarborough Hospital of Maternity services, Community Maternity services and the Medical Service at Scarborough.

The Trust has been subject to a number of inspections during 2019-20 and as a result of the inspections during June and July 2019, the report published in October 2019 gave the Trust an overall rating of **Requires Improvement.** Areas of outstanding practice and areas for improvement were identified by the CQC.




**Outstanding Practice**

Areas of outstanding practice were identified during the June-July 2019 inspection and are noted below:

- The Service had created and opened the same day emergency care centre (SDEC) department in December 2019, this area was well utilised and was helping to manage capacity and flow problems to some degree.
- The introduction of a clinical educator for the department had resulted in there being a positive impact on nursing staff's mandatory training compliance which had improved significantly.
- The department had a box containing products to support relatives of dying patients; this included an information leaflet, a blanket and a pillow, toiletries, a bottle of water and tissues.
- A senior nurse had been nominated by a patient for a 'star-award'. The senior nurse had suggested to the executive team that all the staff in the department

deserved the award and therefore the whole team had been awarded the recognition.

- Scarborough hospital was selected to be a pilot site for Transanal Total Mesorectal Excision (TATME) surgery, as one of only five hospitals in the country.
- Bridlington had become one of the few hospitals in the country able to provide hip replacements for selected day case patients.

**Areas for Improvement**

Areas for improvement were identified during the June-July 2019 inspection and **26** 'must-do' actions were noted to be required in order to comply with legal requirements. In addition a further **50** 'should-do' actions were noted to be required to improve the services delivered within the Trust.

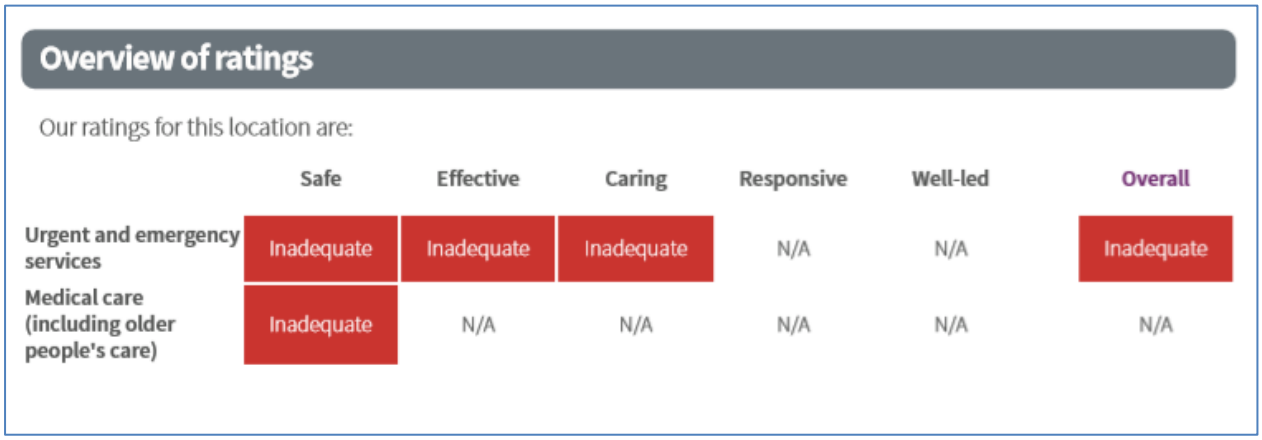
**13-14 January 2020**: Unannounced focused inspection at York Hospital in the Emergency Department. The report published in March 2020 gave an overall rating of **Inadequate** for York Hospital Urgent & Emergency Services.

**Overview of ratings**

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate | Inadequate | Inadequate | N/A | N/A | Inadequate |

**13-14 January 2020:** Unannounced focused inspection at Scarborough Hospital in the Emergency Department. The report published in March 2020 gave an overall rating of **Inadequate** for Scarborough Hospital Urgent & Emergency Services and **Inadequate** for Safety in Scarborough Medical Care.



**Overview of ratings**

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate | Inadequate | Inadequate | N/A | N/A | Inadequate |
| Medical care (including older people's care) | Inadequate | N/A | N/A | N/A | N/A | N/A |

York Teaching Hospital NHS Foundation Trust has the following conditions on registration which are detailed below. The CQC has not taken enforcement action against York Teaching Hospital NHS Foundation Trust during 2019-20.

An urgent notice of decision to impose conditions on registration was sent to the trust on 17th January 2020. The conditions were as follows:

- The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.
- The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.
- The registered provider must by 20 January 2020 ensure there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.

In addition to the conditions imposed, a Section 29A Warning notice was received on 21st January 2020. The warning notice serves to notify the trust that the CQC have formed the view that the quality of healthcare provided by the trust requires significant improvement. Significant improvements were required for the following reasons:

- Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).
- Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.
- Neither emergency department were meeting the standards from the Facing the future: standards for children in emergency settings.
- Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.
- Not all incidents were being reported and investigated to identify mitigating actions to prevent reoccurrence and reduce the risks to patients.
- We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.

**Areas for Improvement**

- Areas for improvement were identified during the January 2020 inspection and **13** 'must-do' actions were noted to be required in order to comply with legal requirements. In addition a further **5** 'should-do' actions were noted to be required to improve the services delivered within the Trust.

**Immediate Actions**

A CQC Programme Group was established to ensure that progress against actions is monitored on a fortnightly basis. The Quality Committee and Board receive a monthly summary improvement plan which details the current status and RAG rating of each of the actions. Significant progress has been made in addressing the actions, and some of the key immediate actions taken were as follows:

- Assessment of the environment in both Emergency Departments for patients who present with Mental Health conditions, in line with national guidance. This was used to progress specialist anti-ligature rooms. The anti-ligature rooms were delayed due to the COVID pandemic.
- Mental Health risk assessments were created and implemented within the Emergency Departments to safely identify patients at risk, and mitigate the risks as far as reasonably possible.
- Collaborative working with stakeholders to increase the Mental Health service provision for the population of Scarborough and the East Coast.
- Immediate implementation of Paediatric Nurses within both of the Trusts' Emergency Departments; utilising agency and banks staff whilst recruitment plans were put in place.
- Immediately after the CQC Inspection, before the warning notices were received, staffing levels for Scarborough medical wards were increased utilising agency and bank staff whilst establishment reviews were carried out.
- A review of nursing documentation within the trust was carried out with actions taken to standardise this.

**18-19 February 2020:** Announced Inspection of the York Child Sexual Assault Assessment Service at York Hospital. The CQC were advised during the visit that the Trust had served notice on the contract for the service and would no longer be providing it. In April 2020 a report was received which highlighted some key findings and areas for improvement. The Service was not subject to a rating but did require action to ensure legal requirements were met. York Teaching Hospital NHS Foundation Trust no longer deliver this service at the time of writing this report.

**Next Steps**

In response to the Covid 19 pandemic, both hospital sites have undergone significant reconfiguration of service provision, which will impact on some of the actions which are required. Despite this, over the course of 2020-21, it is anticipated that the conditions associated with the trusts registration will be lifted following the submission of evidence to the CQC. All actions identified during the inspections, highlighted in this report, will be addressed with evidence to demonstrate

compliance. Following this an assurance programme will be developed with an aim of delivering an overall “good” rating.

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

### 2.2.7 Data Quality

York Teaching Hospital NHS Foundation Trust submitted records during 2019-20 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;
99.94% 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;
100% for accident and emergency care.

### 2.2.8 Information Governance

York Teaching Hospital NHS Foundation Trust Information Governance risks are managed in accordance with compliance with the standards contained within the DSP Toolkit, and, where appropriate, recorded on the Corporate Risk Register. The submission of the DSP Toolkit for 2019-20 has been delayed until 30 September 2020 due to the Covid-19 pandemic. Where any standard is not fully met, an action plan that indicates how the organisation will work towards compliance will be submitted.

### 2.2.9 Payment by Results

York Teaching Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019-20 by the Audit Commission.

## 2.3 Reporting against Core Indicators

Trust performance against the set of core indicators mandated for inclusion in the Quality Report by the Department of Health is shown below.

For each indicator, the number, percentage value, score or rate (as applicable) for the last two reporting periods is shown. Where this data has been published by NHS Digital (*also some from NHS England and the Staff survey results*), the lowest and highest values and national average for each indicator for the latest reporting period is also shown.

| Summary Hospital-level Mortality Indicator (SHMI) and Banding | Trust Apr 18 – Mar 19 | Trust Apr 19 – Mar 20 | NHS Average Apr 19 – Mar 20 |
|---|---|---|---|
| Trust score (lower value is better) | 1.00* | 0.99** | 1.00 |
| Banding | As expected | As expected | As expected |

*Rounded up from 0.997
** Rounded up from 0.986

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge.

The SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- Information on the Summary Hospital-level Mortality Indicator (SHMI) is reported to and scrutinised by the Executive Committee, Quality Committee and Board of Directors when published. The above data is consistent with locally reported data
- We continue to audit the quality of our clinically coded data for deceased patients as part of our mortality reviews to ensure it is an accurate reflection of the patient's diagnoses and procedures. All clinicians are required to validate the clinical coding of patients who died in hospital to ensure it accurately reflects the main conditions for which the patient was treated and investigated, and that all co-morbidities have been recorded.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:**

- Ensuring that all in-patient deaths are reviewed by a consultant within four weeks of the death occurring
- Promoting discussion of learning from mortality review at department governance meetings
- Providing a quarterly report on learning from mortality reviews
- Expanding the terms of reference of the Trust Mortality Review Group to provide an emphasis on identification, review and learning from avoidable mortality.
- The Trust is now reporting a new avoidable mortality score and training is underway to conduct the new style mortality reviews with a selected number of clinicians.
- A new Quality and Safety Dashboard includes number of deaths, unadjusted mortality rate by site, age band and discharging ward or specialty. It also includes reliability with ceiling of care decision making, recording of observations, compliance with 14hr post take review and daily senior review. This should allow closure targeting of areas non-compliant with processes defined in national guidance for 7 day service.

**We will:**

- Continue with our mortality review programme including consultant mortality reviews and development of in-depth review of avoidable mortality.

| Palliative Care Coding | Trust Apr 18 – Mar 19 | Trust Apr 19 – Mar 20 | *NHS Average Apr 19 – Mar 20 | Highest Trust Apr 19 – Mar 20 | Lowest Trust Apr 19 – Mar 20 |
|---|---|---|---|---|---|
| % Deceased patients with palliative care coded | 24 | 30 | 37 | 58 | 9 |

*Average for England is 37%

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- This data is consistent with the data reported on the monthly Integrated Business Report presented to the Board of Directors.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:**

- Monitoring the quality of our clinically coded data for deceased patients as part of our mortality reviews to ensure it is an accurate reflection of the patient's diagnoses and procedures. In addition, the Clinical Coding Team receives weekly information on any patients who have had palliative care or contact with the Palliative Care Team, so that this can be reflected in the clinical coding.

**We will:**

- Continue with our mortality review programme and ensure we continue to validate the clinical coding of deceased patients as part of the mortality reviews undertaken by consultants.
- The Trust is now a new avoidable mortality score and training is underway to conduct the new style mortality reviews with a selected number of clinicians.

| Patient Reported Outcome Measures (EQ-5D Index, Percentage of Patients Improving scores) | Trust Apr 18 – Mar 19 | *Trust Apr 19 – Mar 20 | *England Apr 19 – Mar 20 | Highest Trust Apr 19 – Mar 20 | Lowest Trust Apr 19 – Mar 20 |
|---|---|---|---|---|---|
| Hip replacement (Primary) | 88.1 | 88.4 | 90.8 | Not available | |
| Knee replacement (Primary) | 88.2 | 85.0 | 83.6 | Not available | |
| Groin Hernia | Not available | Not available | Not available | Not available | |
| varicose vein surgery | Not available | Not available | Not available | Not available | |

*Provisional data

Note: Patients undergoing elective inpatient surgery for the above elective procedures funded by the English NHS are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves. As participation is voluntary, patients can choose not to participate. The percentage of patients reporting improvement after a procedure is only available at individual Trust level and at national level, therefore it is not possible to determine the highest and lowest score for Trusts.

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- This data is consistent with locally reported data. This performance information is benchmarked against other Trusts in the Yorkshire and Humber region with Trust performance being within the expected range for all procedures.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve these scores, and so the quality of its services by:**

- Ensuring that relevant staff attend regional PROMs workshops which facilitates networking with colleagues from other Trusts and allows sharing of best practice.

**We will:**

- Continue to ensure that the Trust Executive Committee and Board of Directors receive PROMs outcome and participation rates so that we can ensure that any areas of performance where the Trust may be an outlier are acted upon.

| Readmissions within 28 Days of Discharge | Trust 2011-12 | Trust 2012-13 | NHS Average 2012-13 | Highest Trust 2012-13 | Lowest Trust 2012-13 |
|---|---|---|---|---|---|
| Percentage of Readmissions aged 0 to 15 | 9.7% York (10.0%) SGH | Not available | Not available | Not available | Not available |
| Percentage of readmissions aged 16 and Over | 10.6% York (9.8%) SGH | Not available | Not available | Not available | Not available |

Note: This data is based readmissions for hospitals categorised as medium acute hospitals only. The lower the percentage the better the performance.

Monitoring on readmissions within 30 days of discharge is included in the monthly Integrated Business Report to the Board of Directors.

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- The data is consistent with that reported locally on the Trust's electronic performance monitoring system.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by:**

- Continuing with the weekly Quality and Safety briefings to consistently address any issues raised. The meetings are chaired by the Medical Director and are attended by the Director of Nursing, Deputy Director of Patient Safety, Deputy Director of Healthcare Governance and Assistant Director of Nursing
- The agenda of these meetings includes emergency readmissions and other quality and safety issues.

**We will:**

- Continue to hold our weekly quality and safety briefings and take action to address any issues raised
- Continue to monitor readmission rates as part of our contract monitoring process with our commissioners and take remedial action if the rate is exceeded.

| Responsiveness to personal needs of patients | *Trust 2018-19 | **Trust 2019-20 | **NHS average 2019-20 | **Highest Trust 2019-20 | **Lowest Trust 2019-20 |
|---|---|---|---|---|---|
| Responsiveness to inpatients personal needs | 67.2 | 65.8 | 67.1 | 84.2 | 59.5 |

*Data collected is from hospital stay: 1 July 2018 to 31 July 2018; Survey collected 1 August 2018 to 31 January 2019
**Data collected is from hospital stay: 1 July 2019 to 31 July 2019; Survey collected 1 August 2019 to 31 January 2020

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- All feedback from patient surveys is reported to and scrutinised by the Trust's Quality Committee, and by Board of Directors
- Feedback from the Friends and Family test is also reported to the Patient Experience Steering Group, Quality Committee and Board of Directors.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by:**

- Introducing a new role, Patient Services Operative, to assist patients further on elderly wards
- Reviewing all nursing documentation used on the wards and launching a new set of documentation
- Implementing Perfect Ward as a more thorough and trackable way of auditing on wards
- Developing a new easy-read menu after a number of patients reported difficulties reading the menu choices
- Working with Care Group Leads to develop new monthly patient experience reports, which provide qualitative and quantitative data for each ward about the experiences their patients have reported. This in turn makes it easier to identify themes and trends and action areas to focus on.
- Ran a workshop after the publication of the National Inpatient Survey results to discuss areas of particular concern, including patient getting more help to keep themselves clean while in our care.

**We will**

- Launch Always Events across the Trust, including piloting an Always Event around helping patients to be clean while in our care.
- Refresh the "Hello my name is" campaign across the Trust which aims to improve communication between patients and staff, breaking down a potential barrier of patients not feeling confident asking for help with their personal needs
- Continue to triangulate all types of patient experience feedback to provide meaningful information to Care Groups in order for them to plan action for improvement

| Staff recommending the Trust to family and friends | Trust 2018 | Trust 2019 | NHS Staff Survey Average Score 2019 | NHS Staff Survey Highest 2019 | NHS Staff Survey Lowest 2019 |
|---|---|---|---|---|---|
| Percentage of staff who would be happy with the standard of care provided by the organisation | 66.6% | 64.7% | 71.0% | 90.5% | 48.8% |

These results are presented in the context of the best, average and worst results for similar organisations taken from the 2019 NHS Staff Survey. The question asked is:
*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.*

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- The data published by the Information Centre is consistent with the staff survey results received by the Directorate of Workforce & Organisational Development for staff surveys. The results of the annual staff survey are reported to the Board of Directors

The results of the 2020 survey will be used to fully evaluate the actions which were taken in response to the 2019 survey.

- Staff and Patient suggestions will be used to inform decisions
- Feedback will be provided about how staff and patient suggestions have been used, particularly through the COVID pandemic.
- Incident reporting procedures are and should be seen to be fair and effective.

**We will:**

- Continue to encourage all of our staff to complete the Staff Friends and Family Test when this is available. This will give valuable feedback which we will use to improve outcomes for our patients
- Continue to roll out the just culture framework so individuals feel able to safely raise concerns for everyone to be able to learn from to improve the care delivered to patients.

| Patients admitted and risk assessed for venous thromboembolism *(Acute Trusts)* | Trust Oct – Dec 2018 | Trust Oct - Dec 2019 | *NHS Average Oct - Dec 2019 | Highest Trust Oct – Dec 2019 | Lowest Trust Oct – Dec 2019 |
|---|---|---|---|---|---|
| Percentage of patients risk assessed | 97.84 | 96.35 | 95.04 | 100.00 | 71.59 |

*Average total for England was 95.33%

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- Compliance with venous thromboembolism (VTE) assessments is reported monthly to the Board of Directors as part of the Integrated Board Report. Compliance is also reported on Signal, the Trust's electronic activity and performance monitoring dashboard. The above data is consistent with locally reported data.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by:**

- Continuing to measure and report compliance with VTE risk assessments as described above.

**We will:**

- Continue to monitor and report compliance with VTE assessments as described above to ensure that performance continues to meet and exceed the required standards.

| Clostridium difficile infection (for patients aged 2 and over) | Trust 2017-18 | Trust 2018-19 | NHS average 2018-19 | Highest Trust 2018-19 | Lowest Trust 2018-19 |
|---|---|---|---|---|---|
| Trust apportioned cases - rate per 100,000 bed days (HO Hospital Onset) | 13.4 | 12.4 | 11.7 | 79.7 | 0.0 |

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- Clostridium difficile Infection incidence is reviewed and discussed at the Trust Infection Prevention Steering Group TIPSG), Quality and Safety briefing and at Post Infection Reviews (PIR).
- Incidence of all Healthcare Associated Infection (HCAI) is reported to the Quality Committee and the Trust Board via the quarterly Director of Infection Prevention and Control report that aims to assure the Board of action and mitigation in relation to HCAI and infection prevention performance.
- HCAI are discussed and actions agreed at the Care Group Quality meetings. Overall figures, themes and trends for the trust are reviewed at TIPSG (chaired by the DIPC). .

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services by:**

- Continuing to monitor progress against trajectory through multi-disciplinary Post Infection Review (PIR) of all cases
- Through PIR and case follow up, continually and critically monitoring and auditing infection prevention practices to ensure they reflect best practice and enhance patient safety
- Establish a monthly C. difficile Control Group to monitor and address the high infection rate in the trust's east coast sites.
- Audit and monitoring of antibiotic prescribing remains a key priority for the Trust's Antimicrobial Stewardship Team. Compliance with antibiotic prescribing is reported to the Quality Committee via the TIPSG and to the Board of Directors. Audit results are also disseminated for information and action.
- Ward based training and education sessions are delivered to staff in high incidence areas to address and raise awareness of PIR outcome and best practice in line with Trust IP polices/guidelines with subsequent dissemination at PNLF, Senior Nurse meetings and Medical Staff training. PIR outcomes and lessons learnt are also disseminated via staffroom and case studies are developed to assist understanding and learning
- Scrutinise PIR outcomes with local commissioners (Vale of York and Scarborough & Ryedale CCGs) at a monthly Joint HCAI Review Meeting that has independent oversight

(chaired by a nurse consultant in public health at the City of York Council)

**We will:**

- Continue with PIR and dissemination to staff of lessons learnt to inspire and generate improvement. Audit of compliance with best practice and antimicrobial stewardship will continue together with seeking new initiatives to reduce incidence.
- Continue to report progress to the Quality Committee and the Board of Directors in the Director of Infection Prevention and Control quarterly report which as previously described, provides assurance to the Board of Directors that initiatives continue to be developed aimed at achieving sustainable reduction in HCAI.
- Continue to discuss incidence and risk at weekly quality and safety briefings to identify and agree action required.

| **Patient safety incidents and the number of incidents resulting in severe harm or death** | **Trust Oct 18 – Mar 19** | **Trust Apr - Sep19** | **Average Apr – Sep 19** | **Highest Trust Apr - Sep 19** | **Lowest Trust Apr – Sep 19** |
|---|---|---|---|---|---|
| Rate of patient safety incidents | 39.4 | 36.6 | 49.8 | 103.8 | 26.3 |
| *Number of incidents resulting in severe harm or death | 22 | 25 | 19 | 95 | 0 |
| % of incidents resulting in severe harm or death | 0.33 | 0.39 | 0.35 | 1.60 | 0.0 |

Note – data represents acute non specialist trusts only.

***Not all Trusts reported over a 6 month period *(I have not included the overall numbers for incidents for this reason)***

The rate of patient safety incidents is based on per 1,000 bed days. The data is taken from information reported to the National Learning and Reporting System (NLRS).

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- All incidents of severe harm or death are validated by the Deputy Director of Patient Safety and Governance prior to being reported to the National Patient Safety Agency.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this rate, number and percentage, and so the quality of its services by:**

- Holding weekly quality and safety briefings and ensuring that appropriate action is taken in response to any issues raised. These meetings between the Medical Director, Director of Nursing, Deputy Director of Patient Safety and Governance and Assistant Director of Nursing are held to discuss quality and safety issues, which includes deaths, serious incidents, critical incidents, adverse incidents, and safety alerts.
- Information on numbers of patient safety incidents and those resulting in severe harm or death are reported monthly to the Quality Committee and the Board of Directors as part of the Integrated Board Report.

**We will:**

- Continue to hold our weekly quality and safety briefings and take action to address any issues raised, and continue to validate all incidents of severe harm and death.

| Family and friends test score (patient element) | Trust Feb 2019 | Trust – Feb 2020 | NHS average - Feb 2020 | Highest Trust – Feb 2020 | Lowest Trust – Feb 2020 |
|---|---|---|---|---|---|
| *Inpatient % recommend | 96% | 97% | 96% | 100% | 73% |
| **A&E % recommend | 88% | 79% | 86% | 99% | 40% |

Note – data for NHS Trusts only.

*Total for England was 96%
**Total for England was 85%

**The York Teaching Hospital NHS Foundation Trust considers that this data is as described for the following reasons:**

- Inpatient, Outpatient and Maternity results continue to be very positive across the Trust.
- Emergency Department performance remains a challenge, particularly York ED.
- The main cause of ED dissatisfaction is linked to waiting times and poor communication.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:**

- Results and themes of comments are reported each month to senior Care Group representatives for their response and action.
- The Emergency Department has implemented the following improvements to improve response rates:-
  - Patient Assurance Document now prompts a discharge checklist at hour 4.
  - The Safe discharge checklist process includes handing out a FFT form to the patient and/or relatives.
  - The Ready for Discharge button on CPD also prompts the discharge checklist as further capture opportunity.
  - Improved signage in all cubicles and waiting room.
  - Each individual cubicle now has access to FFT cards with appropriate stationary.
  - Display board in the waiting room with all responses from the previous month to increase visibility and transparency of the results.

**We will:**

- Continue to seek meaningful feedback from patients which we can celebrate and act on
- Continue to make FFT reports available on the shared drive
- Continue to create bespoke monthly Care Group reports about patient experience performance, including FFT results.

| Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months | Trust 2018 | Trust 2019 | NHS Staff Survey Average 2019 | NHS Staff Survey Highest (Worst) Trust 2019 | NHS Staff Survey Lowest (Best) Trust 2019 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months – Managers* | 11.3% | 11.9% | 11.8% | 18.0% | 7.2% |
| Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months – Other colleagues* | 20.4% | 19.0% | 18.0% | 24.9% | 11.7% |

*These results are presented in the context of the best, average and worst results for similar organisations taken from the 2019 NHS Staff Survey.

Relates to percentage of staff saying they experienced at least one incident of bullying, harassment or abuse.

***Question is split now between managers and other staff and is based on at least one incident. Comment from last year***

The results of the annual staff survey are reported to the Board of Directors. The data is consistent with that reported to the Board of Directors.

**The York Teaching Hospital NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by:**

Agreeing new values and behaviours for the organisation through feedback from employees.

**We will:**
The new values and behaviours will be rolled out across the organisation and work will commence to embed these into every day working life. Training will be available to staff members to enable them to safely challenge when a colleague is not demonstrating the agreed values and behaviours.

Work will continue to publicise the Fairness Champions within the organisation.

| ***Percentage of staff believing that the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?*** | ***Trust 2018*** | ***Trust 2019*** | ***NHS Staff Survey average 2019*** | ***NHS Staff Survey Highest Trust 2019*** | ***NHS Staff Survey Lowest Trust 2019*** |
|---|---|---|---|---|---|
| ***Percentage of staff believing that the organisation acts fairly with regard to career progression / promotion, regardless*** | 87.9% | 86.7% | 85.6% | 95.3% | 71.6% |

| | | | | | |
|---|---|---|---|---|---|
| ***of ethnic background, gender, religion, sexual orientation, disability or age?**** | | | | | |

*These results are presented in the context of the best, average and worst results for similar organisations taken from the 2019 NHS Staff Survey.

*(Number for 2018 has been updated since last year was 87.8)*

The results of the annual staff survey are reported to the Board of Directors. The data is consistent with that reported to the Board of Directors.

**The York Teaching Hospital NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by:**

The results of the 2020 survey will be used to fully evaluate the actions which were taken in response to the 2019 survey.

**We will:**
The Trust is in the process of setting up a Race Equality Network and will set up a Disability network within the next 12 months.

An Equality Action plan is being produced following submission of the Workforce Race Equality Standard and the Workforce Disability Equality Standard, this action plan will include reviewing training, such as recruitment and leadership development, to ensure unconscious bias is embedded, reviewing the availability of mentors and reviewing opportunities for diversity within interview panels.

## Part Three – Review of Quality Performance

### 3.1 Quality Priorities set in 2018-19 which were measured in 2019-20

| **Patient Safety** |
|---|
| **By the End of March 2020, we will ensure that:** |
| **SAFER patient bundle** - We will implement the SAFER patient bundle throughout our adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients by:<br>• **Effective ward and board rounds;**<br>• **Ensuring that all patients have an estimated date of discharge;**<br>• **Ensuring early in the day flow from assessment units;**<br>• **Ensuring that patients are discharged early in the day;**<br>• **Proactive review of patients with a long length of stay.**<br><br>**Measures**<br>• All patients to have a senior review before midday;<br>• Every patient to have a discharge status set;<br>• Number of Discharges/transfers before 10am (including transfer of patients to a downstream ward from admission /assessment units).<br>• All downstream wards who received patients from an assessment area to have discharged or transferred at least one patient by 10am (this is the golden patient);<br>• 33% of all discharges or transfers to have occurred by midday and Time of day of discharge/ transfer to earlier in the day (discharge curve);<br>• The national target is a 25% (this target has now moved to a 40% reduction in super stranded pts) reduction in length of stay for patients with a length of stay of over 21 days from our current base line. |
| **Update:** Progress has been delayed across the Trust, with the Strategic SAFER Group not meeting in March or April due to emergency preparedness for COVID-19. Operational actions taken in response to the pandemic are helping to embed SAFER principles and promote early discharge.<br><br>York site:<br>• The roles of Patient Flow Manager, Bed Managers and Discharge Liaison Officers in delivering SAFER refreshed and relaunched on York site.<br><br>Scarborough site:<br>• Where best next' Workshops held in collaboration with ECIST<br>• Monthly SAFER Task & Finish (T&F) Group established Jan 2020<br>• Data and information has been collected for all wards to evaluate how well all SAFER principles and processes have been embedded and inform further improvement planning<br>• LLOS – reduction in number of stranded patients; the target if a 40% reduction |

by the end of March 2020 has been achieved
- Established YAS Locality Managers' regular attendance in ED providing training on the current diversionary pathways, challenging inappropriate ambulance referrals and picking up any actions to support the full utilisation of existing pathway services

**Early identification of the deteriorating patient and reducing the impact of antimicrobial resistance** - Early identification of the deteriorating patient (National Early Warning System (NEWS) of 5 or more) and reducing the impact of the antimicrobial resistance by *(CQUIN):*

**Timely identification of patients with sepsis in emergency departments and acute inpatient settings;**
**Timely treatment of sepsis in emergency departments and acute inpatient settings;**
**Clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours;**
**Reduction in antibiotic consumption per 1,000 admissions;**

**Measures** - All reported as part of the contract:
- Number of unplanned admissions to ITU;
- Compliance with observations within hour of prescribed time;
- Number of crash calls.

**Update:**
- NEWS within 1 hour across both sites remains within target at 90%
- Reduced calls to Critical Care Outreach teams at both Scarborough and York sites at the end of quarter 4 are representative of fewer patients admitted into hospital in the Green/Cold side. There were an improved number of ceiling of care decisions and again reduced admissions highlighted in low cardiac arrest calls
- The roll out of ARK trial in Scarborough has been further postponed due to Covid. Recommencement date not identified yet.
- UTI CQUIN achieved goal of staff education by January and can be closed down
- Colorectal CQUIN achieved target of 90% (actual 94%) by the end of January can be closed down. This was from a base of 75%
- Volume of antibiotics consumption (-13.8%) target -2% by the end of JAN therefore target achieved
- Compliance with sepsis screening in the in-patient wards has decreased from 71% to 68% but the administration of antibiotics within the hour has improved from 57% to 59%

**Ceiling of care (CoC):** There is a big variation amongst specialties and wards for % of patients having a CoC completed. Elderly care consistently performs top at both sites and general medicine in YDH also commonly performs well. Surgical specialities across both sites routinely have low percentages of completed CoC for their inpatients. It must be noted however that some of the surgical data includes acute admission beds so some patients may have only been an inpatient for a short period of time and not yet been reviewed by a senior/consultant. A QI project looking at implementing ways to

improve decision making and recording CoC on CPD was commenced in October 2019. As of March 2020 yet there has only been a statistically significant improvement on one ward in percentage of patients with a CoC filled out. Further PDSA cycles were planned however due to the current situation with Covid 19 the QIP has been suspended.

Deteriorating patient workshops have been run for staff including guidance on DNACPR decisions which will hopefully encourage staff to prompt doctors to have discussions and make CoC decisions for more patients.

Since mid-March there have been significant changes in the trust related to Covid -19. This included number of inpatients, type of inpatient, where these patients are nursed and who is responsible for them. Senior review and involvement has been much greater and there has been a big drive to think about CoC for all patients on admission and document this decision. As a consequence of this CoC for the trust currently sits at 79% and had been above 70% for the whole of April. Some of the confirmed CoVID-19 positive wards have had weeks with 100% completion.

**Cardiac arrests:** There has been a definite improvement in rates of cardiac arrest since the function to record CoC was introduced. In 2016 pre electronic recording there were 137 cardiac arrests in the trust This number has reduced to 77 in 2019.

**Infection, Prevention & Control -** To embed IP in Care Groups ensuring a named IPC lead in each Care Group.

- Q1 – identify Care Group responsibilities within the team, and contact Directorates;
- 2 Care Groups to have key performance indicators agreed Q2;
- 4 Care Groups Q3, and;
- all by the end of Q4, by which time they should be starting to come through the PSQ-PAM process.

**Improvement Measures**

- Having experienced significant viral infections in 2018-19 which has affected people and services, the Trust will lead a piece of system wide work to develop a system wide escalation document to improve the management of a viral infection outbreak. This will result in a reduction of lost capacity through beds and ward closures in the winter of 2019-20;
- The Trust will focus on E.coli bacteraemias. The Trust will demonstrate system wide working and will aim to reduce E.coli bacteraemias by 10%.

In accordance with the E.coli bacteraemia quality priority, the Trust will aim to improve the management of urinary tract infections in older people. A specific piece of work to deliver better catheter insertion decision making; insertion technique and management and indwelling catheter review will be introduced.

**Update**: Since the last quarterly report the context of care has changed significantly as a result of COVID-19 which has resulted in extraordinary pressure on the IPC Team. Consequently, it will be necessary to review the extent that a previous effort to align the IPC team to the Care Groups has been sustained.

Infection Prevention Guideline: Management and Control of Outbreaks does include Appendix 7 Viral gastroenteritis – Systems Partners Guidance

Due to a combination of the very high rate of Clostridium difficile infections across the trust this financial year and Covid-19 planning since mid-January there has been limited work on addressing E. coli bacteraemias.

A clinically led multidisciplinary QI project focussing on the diagnosis and management of urinary tract infection in the elderly. The CQUIN for UTIs achieved its target for staff education in January 20.

**Improvement in Safeguarding -** To ensure a robust process for completion and sign off of actions arising from safeguarding adult investigations.

**Measures**:
Q1 – Approval of action plan and fixed agenda item by
Safeguarding Adults Strategic Governance Group(SAGG);
Q2 onward – Progress Report to SAGG through fixed agenda item;
Q4 – annual report to include Trends and actions.

**Deprivation of Liberty Safeguards** - Safeguarding Adults team to monitor national and local development/roll out direction of the Liberty Protection Scheme (LPS) to ensure compliance with the Deprivation of Liberty Safeguards replacement process.

**Measures**:
Q1 onwards– update report to SAGG (minutes);
Dependant on national progress the action plan, progress and reports will be submitted either by exception or direct to SAGG.

**Update:** This Quality Standard has been addressed. There are processes in place for completion; sign off and assurance of actions arising from safeguarding investigation process as follows:

- Standing item on Safeguarding Adults Governance Group agenda
- Bi monthly meetings with Heads of Nursing to support and sign off actions from Safeguarding enquiries and ensure actions arising are monitored/implemented.
- Shared investigations with departments involved and the safeguarding adults team and monthly review and follow-up of actions by Named Nurse for safeguarding adults.

This needs to remain as a priority as although there is a significant delay in the release of the draft code of practice, once released and subsequently approved there will be an intensive drive to roll the process out. This will have a major impact on the work the Trust needs to engage with. The Care Groups will be required to give consideration to establish teams of individuals at clinical level designated to approve liberty protection applications. The Safeguarding Adults team will be pivotal in assisting the Trust with implementation.

It is not clear at this time the scale of the impact, but with a general expected increased demand planning will be required, which may require more capacity in the SGA team. What that looks like and what specific measures are required is uncertain but will be

reported on in depth through this system and on a quarterly basis through the Safeguarding Adults Governance Group.

**Ambulance Turnaround -** For 2019-20 the Trust will place a strong focus on reducing ambulance handover times on both the York and Scarborough sites. This will be guided by an approach that ensures that when a patient arrives at an ED they become the immediate responsibility of the Trust's teams. To support this approach we will:

- Strengthen the streaming step at the ambulance front door to enable rapid handover on arrival;
- Remove any barriers to accessing current alternatives to ED. This will reduce either the need for ambulance conveyance to ED by improving direct access to community teams, or, if already at the acute site, will improve direct ambulance access to areas other than ED e.g. ambulatory care, paediatric assessment units, Urgent Treatment Centre etc. This will include working with Yorkshire Ambulance Service to improve self-handover and ensure that patients can be directed to the most appropriate place to meet their needs.

**The trajectories** referenced below will be submitted to NHSI in April 2019 for approval so may subsequently change.

As part of our 2019-20 operational plan the Trust has submitted trajectories to NHS Improvement that predict the following by the end of March 2020:

- A 20% reduction in the number of ambulance handovers taking between 15 and 30 minutes;
- A 50% reduction in the number of ambulance handovers taking between 30 and 60 minutes;
- A 90% reduction in the number of ambulance handovers taking more than 60 minutes.

**Update**: Progress has been delayed across the Trust, with the Strategic SAFER Group not meeting in March or April due to emergency preparedness for COVID-19.

York Site:

- Review of medical model in ED to include requirements for AAA Trial of senior decision maker medic rostered to be based in AAA, trailed for X1 week on hold due to COVID-19 preparations.
- Budget review and diary exercise for ED admin team to review admin establishment required to staff Ambulance Handover area. In changing of admin rota patterns – we now have the AAA staffed by admin team member 24/7 to ensure timely handover.
- Planning started for joint YAS / York ED / community Education event: There is a clear gap in knowledge / availability of alterative pathways or end disposition offered to frontline paramedics, and perhaps other services such as GP's and 111. Patients that are conveyed to the York could have been managed by some other pathways or referral in the community. 'Open Day' Education Event for both York and YAS teams is in the early planning stage to re-launch what services / pathways are available to them to prevent ED attendance. Utilisation

of alternative pathways during COVID-19 is much improved – early data suggests that 20% of ambulance attendances have been avoided because of use of these pathways. To be reviewed over coming weeks to ensure that utilisation does not drop off.

- Self – Handover process: Now standing item agenda at bimonthly meeting – YAS to update on utilisation of self-handover process. Meeting will discuss patient level clinical risk & discussions around where governance lies.
- Low Acuity Chest Pain Pathway: There are large numbers of low acuity chest pain patients who arrive at the front door via various avenues including 111, 999 and GPs. These patients should be part of a front door steam away from ED into SDEC. ED to SDEC pathway drafted – put on hold during COVID-19. To be reviewed over coming weeks.

Scarborough site:

- Commenced work with YAS on direct handover processes to Same Day Emergency Care & Home First Units.
- Displayed information "Fit to Sit" banners in ED ambulance corridor, empowering Ambulance Co-Ordinator to embed "Fit to Sit" as the norm for ambulance crews offloading patients.
- Established YAS Locality Managers regular attendance in ED providing training on the current diversionary pathways, challenging inappropriate ambulance referrals and picking up any actions to support the full utilisation of existing pathway services.
- Restructured the TCSL group into a Pre Hospital Delivery group (PHDG) which will report into the Health and Care Resilience board.

Trust ambulance handover times (number of patients) compared to 2019-20 Trajectory and to previous year Q4 are presented in the table below:

*ED in March 2020 experienced a 31% reduction in attendances at our two main EDs.

| | 15-30 Mins | | | 30-60 Mins | | | 60+ Mins | | |
|---|---|---|---|---|---|---|---|---|---|
| Q4 | Actual 2018-19 | Trajectory 2019-20 | Actual 2019-20 | Actual 2018-19 | Trajectory 2019-20 | Actual 2019-20 | Actual 2018-19 | Trajectory 2019-20 | Actual 2019-20 |
| Jan | 935 | **685** | 1035 | 470 | **288** | 625 | 380 | **127** | 554 |
| Feb | 893 | **681** | 943 | 556 | **256** | 465 | 477 | **101** | 263 |
| Mar* | 915 | **677** | 799 | 484 | **225** | 324 | 397 | **76** | 176 |

**Clinical Effectiveness and Outcomes**

**By the End of March 2020, we will ensure that:**

**7 Day Services -** The four priority clinical standards for seven day services in hospitals are achieved by:

- ensuring a review of patients within 14 hours of admission to hospital;

- ensuring timely access to diagnostics;
- access to consultant delivered interventions;
- On-going consultant directed review.

**Measures**
The following standards will be assessed twice a year via a national 7 day working audit which will be reported to NHS England. The Trust will be required to split the measures below out this year by weekend and weekday:

- CS2 –(time to first consultant review);
- CS5 –(access to diagnostics) CS6 –(access to interventions);
- CS8 – (ongoing reviews).

**Update:** IT colleagues have developed a dashboard showing which patients are outstanding for a senior review by consultant / speciality and ward; these dashboards are refreshed every morning. It is the responsibility of each care group director/manager to review and escalate where necessary. Although there has been a slight improvement with senior review through Q4 there is some variation across sites, specialties and day of review. Improvements to this are being supported by the SAFER bundle, handover and board round programmes. Full bi-annual audits will continue during 2020/21, with bespoke reviews as required. As part of the audit process a focus will be placed on % deaths, discharges and senior review on both weekdays and weekends by care group, speciality and ward.

There continues to be monitoring and improvement within the care groups in relation to access to diagnostics and interventions.

There is a need to standardise what ongoing review looks like. Review of job plans is being addressed and a focus on clear plans of care in relation to appropriate review, presence at board rounds and appropriate escalation when required. The recording of senior review within CPD continues to be explored.

**Falls -** The Trust has undertaken a comprehensive review into falls management and has agreed a programme of work. The two specific priorities that the Trust will work towards are:

The **two specific priorities** that the Trust will work towards are:

- Achieve a 10% reduction in all in patient falls;
- Achieve a 20% reduction in in patient falls that result in moderate harm or above.

**Update**: Previous improvement trajectories were set and recorded according to calendar year.
The improvement trajectory for 2019 were:
10% reduction in inpatient falls
20% reduction in falls with moderate harm or above
- both trajectories have been achieved.

In 2019-2020 Falls prevention is a CQUIN - 80% of all admissions to an inpatient unit aged 65 or over must have:
1. Lying & standing blood pressure to be recorded within 24hours of admission or the reason why not is documented
2. Medication review to be carried out with risk assessment of prescribing hypnotics, anxiolytics and antipsychotics versus the increased risk of falls
3. Mobility assessment to be carried out within 24 hours of admission and a walking aid provided within 24hours if needed Good progress has been made towards achieving the standards required for this CQUIN. As predicted, the Trust has achieved above 80% compliance with recording of lying & standing blood pressures.

95% of patients had a mobility assessment documented within 6hrs of admission however of these only 79% of those needing a walking aid were recorded as having one issued within 24hours. Education is being provided to staff to raise awareness of the importance of recording when mobility aids are provided and communication of what mobility aid a patient needs.

All patients have a medication reconciliation carried out on admission however this is not specific to falls risk. Compliance of 80% for medication reviews has not been achieved and further work needs to be undertaken to establish how medication reviews can be facilitated and the impact monitored.

**Pressure Ulcers -** The Trust is undertaking a root and branch review which will be reported to the Quality Committee in May. When the review is available further measures will be added below which will be reported on quarterly:

**Measures** will be added once further work has been carried out.

**Update**: Q4 2019/20 has identified areas for improvement to ensure improved accuracy of Pressure Ulcer incidence data reported. This improvement will include removal of inaccurate Datix reports from quarterly data including;
Moisture associated skin damage.

- Any other wounds reported that are not pressure related.
- Increased scrutiny of duplicated Datix reports,
- Implementation in Emergency Departments and re-introduction in Inpatient areas, of the 'Pink Sticker' to identify patients with pressure damage on admission and document the Datix number when reported, therefore preventing duplication on transfer into other areas.

6 Category 3 and 4 pressure ulcers were reported in Q4 and presented at Pressure Ulcer Panel. These included 2 category 4 and 4 category 3 pressure ulcers. 2 of these cases were noted to have no lapses in care and warranted no further action and were appropriately de-logged. This applied to both Category 4 pressure ulcers. The additional 4 cases were reported as Serious Investigations and identified issues in relation to pressure ulcer risk assessments, care plan documentation, and repositioning frequency, as common themes in each, when identifying lapses in care.

Organisationally, to address this ongoing issue, adoption of the evidence based Risk Assessment Tool, PURPOS T, which guides the user into a Care Pathway and interlinks the Intentional Rounding Tool, (replacing COMFE Tool), is to be launched.

Recommendations are for this to be rolled out, initially into Inpatient areas and then throughout the Organisation in Q1 2020-21.

**Patient Experience**

**By the End of March 2020, we will ensure that:**

**Complaints**

Objectives: Deliver improvements to policy and provide staff with the tools to confidently undertake complaints management

Outcome: Improved complaints management **Indicators**: Increase in cases closed within target, reduction in complaints about Directorate complaints management and positive survey results.

In 2018-19 the Patient Experience Team developed and piloted a complaint satisfaction survey to obtain feedback from people who have made complaints to the Trust and received a response. The introduction of the survey will remain a key priority for the coming year and results will help identify improvement priorities for complaints management. (Quarterly).

The Concerns and Complaints Policy will be reviewed following the organisational restructure. The Patient Experience Team will undertake engagement events with the new Care Group teams to inform revisions to the policy and processes, ensuring that they are fit for purpose. (Quarter 3).

**Update**: The Concerns and Complaints Policy was approved by the Patient Experience Steering Group in April 2020 and is available on staff room.

The in-house training programme has been put on hold at present due to the Covid-10 pandemic but dates will be available to book via Learning Hub once training is resumed.

140 complaint cases were closed in Q4. On average 47% (up from 42% Q3) of these met the Trust's 30 day response target.

Overall this year, on average 46% of closed cases met the target compared to 36% in 2018-19. This improvement is due to the targeted work that care groups have undertaken, where indicated, to address the timeliness of complaint responses.

The patient experience team has introduced new care group specific monthly reports this quarter to assist in highlighting areas for improvement. These reports complement the care group management dashboards and have been well received.

**Lessons Learnt** - Feedback from both the national surveys and from when people complain about our services are the stimulus for the following two quality priorities.

- Patients will know the name or names of the people who are looking after them. The Trust will measure this by a reduction in complaints that have a communication element and by an improvement in the inpatient survey results in

response to this question.

- Patients will be given clear written or printed information about their medicines. Working with pharmacy and the Discharge Lounges the Trust will measure this by an improvement in the inpatient survey in relation to the question: Were you given clear written or printed information about your medicines?

**Update**: The Patient Experience Team was asked to lead a piece of work relaunching "hello my name is" in order to ensure more patients know the name of the person looking after them. Staff and patient surveys were undertaken however the work was put on hold to allow Clever Together to complete their staff engagement exercise.

A Project Manager within the Patient Experience Team has been leading a project group in looking at what more can be done to ensure patients leave our care with clear information about their medication. The group includes Pharmacy and Medicines Management representatives and is ongoing. The scope has widened to address other linked questions in the National Patient Experience Survey. We hope to see an increase in positive responses to the 2020 survey, results available November 2020.

**Volunteering –** The Volunteering Team will continue with the work on the York Emergency Department (ED) volunteering model and will expand this work to Scarborough ED.

Quarter 1: Introduce two volunteers to the Scarborough ED team;
Quarter 2: Gain feedback from volunteers and staff to inform further recruitment;
Quarter 3: Engagement / promotion work, including at local colleges;
Quarter 4: Open recruitment for ED volunteers, recruit at least four more volunteers for Scarborough ED.

The Volunteering Team will undertake a specific audit on the impact of volunteers, focused in one area:

Quarter 1: Set up a process for measuring the hours contributed, through rota collation and input into Harlequin;
Quarter 2: Design a suite of short surveys to measure satisfaction of volunteers and staff with the volunteering contributions;
Quarter 3: Add questions to FFT asking patients if they were helped by a volunteer, and if so what value they got from their volunteer;
Quarter 4: Collate results into a report outlining the value of volunteers.

**Update**: The Trust now has volunteers in both Emergency Departments (active until the Covid 19 pandemic). Volunteers link regularly with each other and with the volunteering service team to share best practice and provide feedback.

No promotion work is required at local colleges; we found we had enough people coming forward to volunteer.

It is no longer viable to use Harlequin to measure hours contributed, however the annual volunteer survey went out in October 2019 and 106 volunteers responded (57 responses in 2018). The survey included wide-ranging questions, but relating to the hours contributed, the results are as follows:

42% volunteer 1-2 hours per week
39% volunteer 3-4 hours per week
18% volunteer 5 or more hours per week

We will measure this again in October 2021.

The following question was added to FFT text messages in November 2019: Were you assisted by a volunteer? If so, please provide any comments you have.

Early indications - fewer than 10% of patients were assisted by a volunteer and a wide-ranging set of comments from very positive “he was very polite” to comments about how volunteers should not be required in the NHS.

All volunteering has temporarily paused and staff have been redeployed. Given the uncertainty of how many volunteers will return to their posts, it does not feel appropriate to report on the impact of volunteering at this time.

### 3.2 Trust Performance against National Quality Indicators

| Indicator | 2018-19 | Target 2019-20 | Q1 2019-20 | Q2 2019-20 | Q3 2019-20 | Q4 2019-20 | Total 2019-20 |
|---|---|---|---|---|---|---|---|
| Total time in ED under 4 hours – national* | 87.69% | 95% | 81.86% | 80.27% | 77.10% | 79.88% | 79.78% |
| *The Trust is monitored on the total for the Trust (type 1) and (type 3) the minor injuries units Type 1 attendances at the main Emergency Departments only, compliance for 2019-20 was 65.86% | | | | | | | |
| Referral to treatment time, 18 weeks in aggregate, incomplete pathways | 82.8% | 92% | 79.6% | 76.7% | 75.1% | 72.5% | 75.9% |
| Cancer 2 week wait (all) | 90.5% | 93% | 84.9% | 88.7% | 93.7% | 92.6% | 89.9% |
| Cancer 2 week wait Breast Symptomatic | 94.9% | 93% | 87.8% | 96.8% | 98.0% | 97.4% | 94.9% |
| Cancer 31 days from diagnosis to first treatment | 98.1% | 96% | 98.0% | 98.7% | 97.8% | 97.7% | 98.0% |
| Cancer 31 days for second or subsequent treatment – surgery | 95.4% | 94% | 95.4% | 92.6% | 94.3% | 88.2% | 92.5% |
| Cancer 31 days for second or subsequent treatment – drug treatment | 100% | 98% | 100.0% | 100.0% | 99.1% | 100.0% | 99.8% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Cancer 62 day wait for first treatment (urgent GP) | 79.5% | 85% | 81.9% | 80.3% | 77.7% | 78.0% | 79.5% |
| Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service) | 91.1% | 90% | 97.1% | 96.2% | 93.4% | 94.1% | 95.1% |
| Cancer 28 day Faster Diagnosis Standard **(*Target 2020-21)** | | 75%* | 65.3% | 61.0% | 68.0% | 68.1% | 65.5% |
| Diagnostics – 6 week wait referral to test | 94.2% | 99% | 87.6% | 84.0% | 83.4% | 81.3% | 84.0% |

# Appendices

## Statements from Key Stakeholders

## Statement from the Trust's Council of Governors

This is an in-depth report which highlights the issues addressed and to be addressed within the Trust. It shows how issues have been dealt with and what needs to happen in the future.

With the increase in the number of patients with dementia it is important that patients are assessed. As governors it is an important issue that will be kept under review. The NEDs will be asked what assurance they get to ensure this happens across the organisation.

The safety and well-being of patients is always a concern for the Trust as a whole but also of the governors and this report highlights some of the issues where the Trust fails to achieve the response it desires and what actions are being taken to address these failings. The governors look forward to hearing about the progress being made.

Margaret Jackson, Lead Governor
On behalf of Governor Colleagues

## Statement from the Chairman of the North Yorkshire County Council Scrutiny of Health Committee

Over the past 12 months and despite the disruption caused by the pandemic, the North Yorkshire Scrutiny of Health committee has worked with the Trust to review proposed and actual changes to some specialist services at Scarborough Hospital as part of the 'East Coast Review'. The committee has also been able to review plans for the development of Scarborough Hospital and the action plan that has been put in place in response to the unannounced inspection of the Emergency Department at Scarborough Hospital carried out by the Care Quality Commission on 13 and 14 January 2020, which resulted in an overall rating of 'inadequate'.

Throughout, members of the Trust have provided the committee with timely and detailed updates on progress with key pieces of work and also positively responded to requests for greater engagement with local County Councillors in the Scarborough area.

I look forward to continuing to work with members of the Trust over the next year as we review the developments at Scarborough Hospital and learn more about the

response of the NHS to the pandemic and the way that it has changed how services are commissioned and provided.

John Ennis, Chairman
North Yorkshire County Council Scrutiny of Health Committee

## Statement from Vale of York Clinical Commissioning Group

On behalf of NHS North Yorkshire CCG, NHS East Riding of Yorkshire CCG, NHS Vale of York CCG is pleased to provide comments on York Teaching Hospital NHS Foundation Trust's Quality Report for 2019/20.

The past twelve months have seen unprecedented challenge across the whole of the health and social care system including a pandemic that could not have been foreseen and has pushed each and every one of us into unchartered waters. We recognise the impact this has had upon the completion of the 2019/20 quality priorities.

Following the Care Quality Commission (CQC) visit in June 2019 as part of a planned inspection which focused on Scarborough and Bridlington hospitals the CCGs have worked closely to support the Trust in responding to actions arising from elements of the report. Whilst the overall rating of the Trust is currently 'Requires Improvement', system partners recognise the incredible amount of progress that has been made following inspection and the positive outcomes that are demonstrated in the annual report.

Notable improvements at the Scarborough site includes increasing medical staffing overnight and extra nursing staff to cover shifts on key medical wards. The reintroduction of Hospital at Night, and bolstered medical leadership team in Scarborough has strengthened senior decision making which will be of benefit to patient safety. This has been further strengthened by collaborative working with system partners to increase the provision of mental health support into the emergency department.

The CQC have noted the creation of the same day emergency care (SDEC) centre in Scarborough's emergency department which helps facilitate flow and access and ultimately improve patients' experience. The creation of a discharge command centre and hub has enabled more effective and appropriate discharges to be facilitated and is helping reduce delayed transfers of care. A huge amount of work has been focussed on improving the quality and patient experience of discharge pathways and this is recognised. There are recognised environmental issues at Scarborough Hospital site and again the CCGs recognise the limitations and risks this poses. The trust has clear plans in place to offer assurance regarding progress and we recognise that the Board are sighted on these plans.

The effort of staff was reflected by the CQC inspection report with every service rated as 'Good' for caring, without exception which demonstrates a positive culture across the organisation which the Trust are focusing on.

Scarborough's maternity services and Bridlington Hospital achieved a rating of 'Good' overall which is a positive improvement since the last inspection. A number of concerns were identified relating to workforce and access targets which the Trust remain focused upon.

The Trust also continues to work on the seven day standard service to improve patient safety and patient experience.

In February 2020, the COVID-19 pandemic began in earnest and has changed the way in which all systems have had to respond and work. The Trust has demonstrated focus and resilience under novel conditions. As this letter is written the pandemic continues into the traditional 'winter pressures period'. The effort of all staff to ensure the continuity of services whilst minimising the risk of infection from Covid19 is recognised. The Trust continues to care for those who are acutely unwell whilst addressing the backlog of elective surgery and outpatient appointments and this will remain a challenge for some time to come.

Shortages in workforce across both the medical and nursing workforce continue as a key challenge for the organisation. In response the Trust continue to successfully lead on the training and recruitment of innovative workforce models such as Advance Clinical Practitioners, Nurse Associates and Associate Practitioners. We commend your commitment to ensure systems and processes are in place to ensure patients are kept safe (such as SAFER and senior review) in order to help mitigate reduced numbers of staff.

Patient flow continues to be a challenge and high numbers of 12 hour trolley waits have been reported. This is improved from last year partly due to the pandemic but remains an area of concern which is being mitigated and work continues with system partners to support admission avoidance where possible and transformation of urgent care.

We are pleased to be working in close partnership with the Trust to improve the quality and safety of patient services. We are especially pleased to note the following achievements:-

- Our continued contribution at the Falls and Pressure Ulcer panels. There is evidence of embedded learning and improvements to practice and the Trust has seen a further reduction in the numbers of incidents. We know the Trust remains committed to further improvements in this area and note the ambitious plan for no category 4 ulcers (with lapses in care) which we commend.
- Our attendance at post infection reviews continues to provide assurance of robust processes and embedding of adherence to revised infection prevention practices resulting in a reduction in preventable cases of Clostridium difficile infection. The commitment the Trust has shown in its participation with both national and local audits is welcomed. Clostridium difficile remains a concern and the Trust has demonstrated clear action plans for supporting reduction.
- We particularly welcome the opportunity to continue to work in partnership with the Trust, specifically to improve learning from Never Events and Serious Incidents and are closely involved in the current Quality Improvement work being undertaken in partnership with colleagues.

- We welcome your drive to ensure Just Culture underpins all your patient safety work and supports staff to speak out where improvements can be made.
- We welcome that the National Patient Safety Strategy and the corresponding Trust Patient Safety Strategy will be of significant focus in 2021 showing the Trusts desire in improving patient safety.

It is important that we continue to work collaboratively to achieve positive outcomes across all services. We understand that you are committed to your priorities for 2020/21 and commend your continued focus on patient quality and safety. We recognise the impact that the pandemic has had on the quality improvement work and are pleased that the Trust has continued to work towards its improvement journey,

As lead commissioner for York Teaching Hospital NHS Foundation Trust, NHS Vale for York CCG would like to commend the work of the Trust in 2019/20. We can confirm that with NHS North Yorkshire CCG and NHS East Riding of Yorkshire CCG, NHS Vale of York CCG are satisfied with the accuracy of this Quality Report.

The CCGs look forward to working collaboratively with York Teaching Hospital NHS Foundation Trust in 2020/21.

Michelle Carrington, Executive Director Quality and Nursing, NHS Vale of York Clinical Commissioning Group
Sue Peckitt, Director of Nursing and Quality, NHS North Yorkshire CCG
Paula South, Interim Chief Operating Officer / Director of Quality / Executive Nurse NHS East Riding CCG

## Statement from Healthwatch York

Healthwatch York welcome the opportunity to review and comment on the York Teaching Hospital Quality Accounts 2019-20. We feel that the priorities for improvement reflect a number of the priorities for people living in York.
We welcome the continued focus on implementing the SAFER patient bundle. We have previously recommended that discharge planning begins at admission, so are very pleased to see the measure of all patients having a discharge status set. We are also pleased to see reducing pressure ulcers remains a priority, and when seen alongside the care home work supported by NHS Vale of York CCG shows a system focus on preventing serious risks to health.

We acknowledge the CQC inspections of the Emergency Department and the concerns raised. We welcome details of the Trust's improvement plans, and are pleased to see the planned improvements will address concerns previously raised with us.

It is good to see the focus on patient experience, both through the #HelloMyNameIs work, and through improving the timeliness and quality of complaint responses. We welcome the inclusion of patient stories and feedback about when things went well and when they didn't go so well. We also recognise the unprecedented challenges facing healthcare at this time, and hospitals in particular. We have continued to hear

of exceptional care and support being offered by staff at the hospital to people experiencing the most difficult time of their life. On behalf of everyone who shared their positive stories with us, we want to finish by saying “thank you” to these everyday heroes.

Sian Balsom
Manager

## Statement of Directors' Responsibilities in respect of 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 2019-20 and supporting guidance Detailed requirements for quality reports 2019-20.

- 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 2019 to 26 May 2020;
    - papers relating to quality reported to the board over the period April 2019 to 26 May 2020;
    - feedback from commissioners dated 24 November 2020;
    - feedback from governors dated 26 November 2020;
    - feedback from local Healthwatch organisations dated 1 December 2020;
    - feedback from North Yorkshire County Council Scrutiny of Health Committee dated 30 November 2020;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27 May 2020;
    - the latest national patient survey 2 July 2020;
    - the latest national staff survey 31 January 2020;

- 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 NHS Improvement'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

14 December 2020 .....Chair

14 December 2020 .....Chief Executive

## Glossary

**Board of Directors -** Individuals appointed by the Council of Governors and Non-Executive Directors. The Board of Directors assumes legal responsibility for the strategic direction and management of the Trust.

**Clostridium Difficile (C Diff) -** Clostridium difficile is a species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora are wiped out by antibiotics.

**Care Quality Commission (CQC) -** The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations. They aim to make sure better care is provided for everyone – in hospitals, care homes and people's own homes. They also seek to protect the interests of people whose rights are restricted under the Mental Health Act.

**Commissioning for Quality and Innovation (CQUIN) Payment Framework -** The CQUIN scheme was announced in *High Quality Care for All* (2008) and introduced through the new standard NHS contracts and the NHS Operating Framework for 2009-10. It is a key element of the NHS Quality Framework, introducing an approach to incentivising quality improvement. CQUIN schemes were mandated for acute contracts from 2009-10.

**Ceiling of Care (CoC) –** is the course of treatment considered to be the predetermined highest level of intervention deemed appropriate by a medical team, aligning with patient and family wishes, values and beliefs. These crucial early decisions aim to improve the quality of care for patients in whom they are deemed appropriate.

**Council of Governors (CoG) -** Every NHS Foundation Trust is required to establish a Council of Governors. The main role of the Council of Governors is threefold:

- **Advisory** – to advise the Board of Directors on decisions about the strategic direction of the organisation and hold the Board to account.
- **Strategic** – to inform the development of the future strategy for the organisation.
- **Guardianship** – to act as guardian of the NHS Foundation Trust for the local community.

The Chair of the Council of Governors is also the Chair of the NHS Foundation Trust. The Council of Governors does not ‘run’ the Trust, or get involved in operational issues.

**Department of Health and Social Care (DHSC) -** The Department of Health and Social Care is a government department with responsibility for government policy for health and social care matters and for the (NHS) in England. It is led by the Secretary of State for Health.

**Deteriorating Patient -** Sometimes, the health of a patient in hospital may get worse suddenly. There are certain times when this is more likely, for example following an emergency admission to hospital, after surgery and after leaving critical care. However, it can happen at any stage of an illness. It increases the patient's risk of needing to stay longer in hospital, not recovering fully or dying. Monitoring patients regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

**Family and Friends Test -** From April 2013, all patients will be asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. The results of this friends and family test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback.

**Infection Prevention & Control (IPC) -** Infection prevention is a top priority for everyone at the Trust and widespread activity takes place to reduce infections and make the environment in wards and clinics as safe as possible for patients, focusing on prevention, practices and procedures.

**Methicillin-resistant Staphylococcus aureus (MRSA) -** MRSA is a bacterium responsible for several difficult-to-treat infections in humans. It may also be called multi-drug-resistant Staphylococcus aureus or oxacillin-resistant Staphylococcus aureus (ORSA). MRSA is, by definition, any strain of Staphylococcus aureus that has developed resistance to certain antibiotics.

**NHS Improvement -** NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. They offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, they help the NHS to meet its short-term challenges and secure its future.

**National Clinical Audits -** The National Clinical Audit and Patient Outcomes Programme (NCAPOP) is a set of centrally-funded national projects that provide local Trusts with a common format by which to collect audit data. The projects analyse the data centrally and feedback comparative findings to help participants identify necessary improvements for patients. Most of these projects involve services in England and Wales; some also include services from Scotland and Northern Ireland.

**National Confidential Enquiry into Patient Outcome and Death (NCEPOD) -** NCEPOD promote improvements in healthcare and support hospitals and doctors to ensure that the highest possible quality of safe patient care is delivered. NCEPOD use critical senior and appropriately chosen specialists to critically examine what has actually happened to the patients.

**National Early Warning System (NEWS) -** NEWS is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. The more the measurements vary from what would have been expected (either higher or lower), the higher the score. The six scores are then aggregated to produce an overall score which, if high, will alert the nursing or medical team of the need to escalate the care of the patient.

**National Institute for Clinical Excellence (NICE) quality standards -** National Institute for Clinical Excellence (NICE) quality standards are a set of specific, concise statements that act as markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.
Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with the NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

**National Patient Safety Agency (NPSA) alerts –** NHS England routinely process and review patient safety incident reports and, where appropriate, use this information to identify actions that organisations can take to reduce risks. This information is sent to the Trust in the form of a NPSA alert.

**Oxygen Saturation -** Oxygen saturation is a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry.

**Patient Advice & Liaison Service (PALS) –** this service offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

**Patient Reported Outcome Measures (PROMS) -** Patient Reported Outcome Measures are questionnaires that ask patients about their health before and after an operation. This helps to measure the results or outcome of the operation from the patient's point of view. This outcome is known as the 'health gain'. All NHS patients undergoing planned hip replacement, knee replacement, varicose vein or groin hernia surgery procedures are invited to fill in PROMs questionnaires.

**Pulse -** Measurement of a pulse is the equivalent of measuring the heart rate, or how many time the heart beats per minute. Your heart rate can vary depending on what you're doing. For example, it will be slower if you're sleeping and faster if you're exercising.

**Pressure Ulcers -** Pressure ulcers or decubitus ulcers, are lesions caused by many factors such as: unrelieved pressure; friction; humidity; shearing forces; temperature; age; continence and medication; to any part of the body, especially portions over bony or cartilaginous areas such as sacrum, elbows, knees, and ankles.

Pressure ulcers are graded from 1 to 4 as follows:

- Grade 1 – no breakdown to the skin surface
- Grade 2 – present as partial thickness wounds with damage to the epidermis and/or dermis. Skin can be cracked, blistered and broken
- Grade 3 – develop to full thickness wounds involving necrosis of the epidermis/dermis and extend into the subcutaneous tissues
- Grade 4 – present as full thickness wounds penetrating through the subcutaneous tissue.

**Respiratory Rate -** The number of breaths over a set period of time. In practice, the respiratory rate is usually determined by counting the number of times the chest rises or falls per minute. The aim of measuring respiratory rate is to determine whether the respirations are normal, abnormally fast, abnormally slow or non-existent.

**Same Day Emergency Care -** is one of the many ways the Trust is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and unnecessary hospital admissions.

**Secondary Uses Service (SUS) -** The SUS is a service which is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development. The service is provided by the Health and Social Care Information Centre.

**Structured Judgement Case Review (SJCR) –** This is a process that reviews the care received by patients who have died. This will in turn allow learning and support the development of quality improvement initiatives when problems in care are identified.

**Summary Hospital-level Mortality Indicator (SHMI) -** The SHMI is a measure of deaths following hospital treatment based on all conditions, which occur in or out of hospital within 30 days following discharge from a hospital admission. It is reported at Trust level across the NHS in England using standard methodology.

**Supported Discharge -** Supported Discharge describes pathways of care for people transferred out of a hospital environment to continue a period of rehabilitation and recuperation at a similar level of intensity and delivered by staff with the same level of expertise as they would have received in hospital.

**Venous thromboembolism (VTE) -** VTE is a condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vein can be limited by the clot, and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT). An embolism occurs if all or a part of the clot breaks off from the site where it forms and travels through the venous system. If the clot lodges in the lung a potentially serious and sometimes fatal condition, pulmonary embolism (PE) occurs.

Venous thrombosis can occur in any part of the venous system. However, DVT and PE are the commonest manifestations of venous thrombosis. The term VTE embraces both the acute conditions of DVT and PE, and also the chronic conditions which may arise after acute VTE, such as post thrombotic syndrome and pulmonary hypertension, both problems being associated with significant ill-health and disability.

**World Health Organisation (WHO) Surgical Safety Checklist -** The aim of the WHO checklist is to ensure that all conditions are optimum for patient safety, that all hospital staff present are identifiable and accountable, and that errors in patient identity, site and type of procedure are avoided. By following a few critical steps, healthcare professionals can minimise the most common and avoidable risks endangering the lives and well-being of surgical patients.