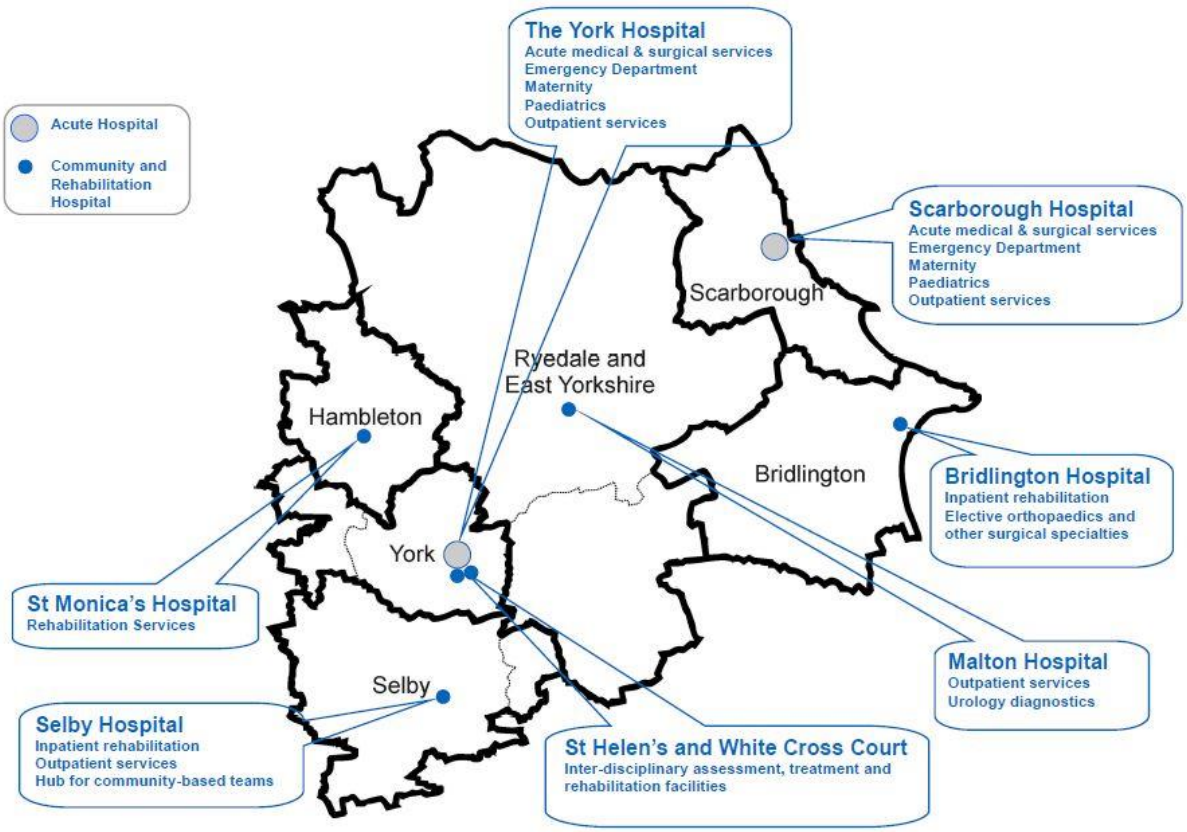
York Teaching Hospital
NHS Foundation Trust

Quality Report 2020/21

About the Trust

York Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale – an area covering 3,400 square miles. Our annual turnover is over £0.5bn and we manage eight hospital sites through a workforce of over 9,000 staff working across our hospitals and in the community. Our values are kindness, openness and excellence.

We are a NHS Foundation Trust. Foundation Trusts operate independently of the Department of Health, but remain part of the National Health Service. This gives us greater freedom and more formal links with patients and staff. We are accountable to them through an elected and appointed Council of Governors.



Our Values

Our colleagues, co-created, challenged and agreed that collectively, above all else we should value being kind, open and excellent. These are the powerful principles which people said should guide everything we do at the trust, without which we'll be unable to achieve our shared vision. Under each of these values sit three key behaviours which provide clarity and direction about how everyone who work in our Trust should act. Our agreed values and behaviours framework is as follows:

We are KIND meaning we:

- Respect and value each other
- Treat each other fairly
- Are helpful and seek help when we need it

We are OPEN meaning we:

- Listen, making sure we truly understand the point of view of others
- Work collaboratively, to deliver the best possible outcomes
- Are inclusive, demonstrating that everyone's voice matters

We pursue EXCELLENCE meaning we:

- Are professional and take pride in our work, always seeking to do our best
- Demonstrate integrity, always seeking to do the right thing
- Are ambitious, we suggest new ideas and find ways to take them forward, and we support others to do the same

Contents

Part One – Statement on Quality from the Chief Executive

As Chief Executive, it gives me great pleasure to introduce the annual Quality Account and share with you our achievements, challenges and successes throughout what has been an unprecedented year for the Trust and the NHS as a whole.

We began the year in the midst of the COVID-19 pandemic and I have been immensely proud of our staff who have worked tirelessly to deliver care to our patients. The welfare of our staff throughout the pandemic and beyond has been a key priority and we have ensured that a number of initiatives are in place to support their wellbeing.

The community response to the NHS and locally our Trust was overwhelming and extremely gratefully received. It was truly humbling to see the Thursday Clap for the NHS and receive the generous gifts from the community to support our staff, ranging from PPE to skin care products. Thank you to every business, educational establishment and individual who extended their support to us at such a challenging time it made a huge difference.

During the first wave of the pandemic the NHS as a whole was unable to carry out elective surgery and many non-emergency consultations. This has resulted in increased waiting lists and delays to patients receiving elective procedures.

Despite being in the midst of a pandemic, it remained important that we maintained a focus on tour improvement journey. As we described in our last Quality Account the Care Quality Commission (CQC) visited the Trust in June 2019 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'. Following the inspection we responded positively to the CQC's concerns and took immediate action. As a result we have applied for the conditions of our registration to be lifted. We await formal feedback from the CQC at time of writing this report.

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 both 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

May 2021

Emily's story – respect & kindness

March 2021

York and Scarborough Teaching Hospitals
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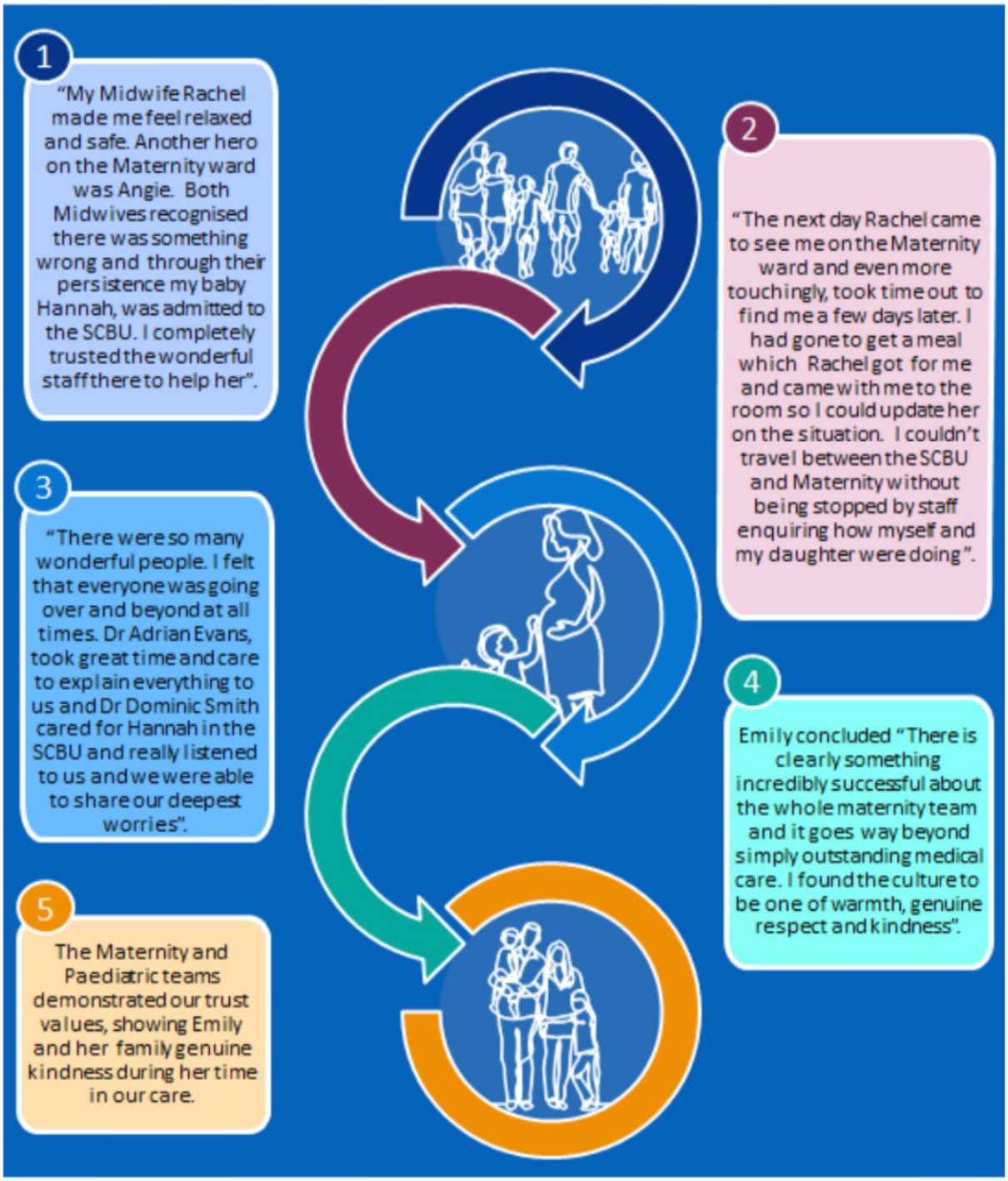


Emily's Story – further information

Emily's maternity care was transferred to York as she didn't want to be cut off from her family during the national lockdown. Emily said, "being transferred to York was the best decisions I have ever made, there were so many wonderful people to support me."

Emily told her midwife, Rachel, that when she was a baby she had experienced problems with her mouth that led her not being able to feed when she was born. However, Emily said that she was not expecting any similar issues with her own baby. After the birth, Rachel and her colleague Angie recognised that Hannah, Emily's baby was not feeding properly and they wanted Hannah to be properly assessed by a paediatrician. Angie and Rachel's persistence led to Hannah being admitted to the SCBU for further assessment. Due to their actions, both mother and baby are now home and doing well.

Michala Little, Deputy Head of Midwifery, said "we are delighted that Emily and baby Hannah had such a positive experience. As a service, we strive to always provide high standards of care for all the families accessing our services, especially at such a challenging time. It's lovely to be able to feedback to staff that their kindness and professionalism was recognised and made a real difference."

Looking Back on 2020/21

In this last year our work has been dominated by COVID-19.

Covid-19 has presented the NHS with the greatest challenge it has faced since its creation. However, our health service - through our skilled and dedicated staff - is renowned for the professional, flexible and resilient way that it responds to adversity and as an entire Trust we have pulled together, as one, in a coordinated effort.

As a Trust we are incredibly proud and thankful for everything our staff have done, and continue to do, in the face of pressure and challenges of the global pandemic.

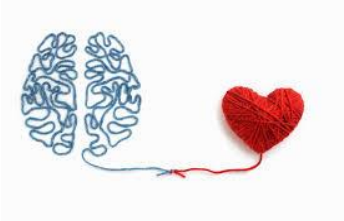
We are humbled by their strength, resilience and tenacity.

April 2020

Keeping patients and their families connected

In April technology provided vital communication in the most difficult of circumstances for patients suffering from Covid-19 when visiting was not allowed on hospital wards, with the introduction of iPads, mobile phones and virtual visiting. These new ways of visiting helped ensure families could stay in touch with loved ones when they needed them most.

Knitted hearts also kept patients connected. With one small gesture patients and families could stay connected by giving them a small knitted heart - one for the patient and one for the family. The heart stayed with the patient throughout their time in hospital, hopefully to be reunited with their family when they recovered.



May 2020

Long service rewarded

A new commemorative badge was launched for our staff who have completed ten years' service with the Trust.

Staff are already being recognised for completing 25 and 40 years' service and their commitment to the NHS. This new badge reflects appreciation for ten dedicated years of service, which represents a significant milestone in anyone's career.

Long Service AWARDS

June 2020

A week of reflection

A week of reflection was held across the Trust from Monday 29 June to mark the loss of the first patient to Covid-19, and to mark the courage and endurance of NHS staff in response to the pandemic. Staff were invited to look 'behind the mask' and take time out to reflect on the effect of Covid-19 on their working and personal lives. During the week, staff were offered extra team support and drop-in psychological wellbeing sessions, and there was a reflective art exhibition in the hospital corridors.

Members of the public were invited to join staff for a two minutes silence during the week, which was accompanied by an online service of reflection conducted by the chaplaincy team.

New equipment for Selby Hospital

In June new high-tech equipment was donated to Selby Hospital, meaning that more patients from Selby and the surrounding area are now able to have their operations and treatment locally.

The Friends of The New Selby War Memorial Hospital and York Teaching Hospital Charity donated over thirty thousand pounds for the hospital to buy an extra operating theatre table. The Friends also funded a diathermy machine, which helps people with muscle and joint conditions.

July 2020

Blue lights for NHS

In July York's skies turned blue to salute one of the country's most iconic institutions, the NHS as it turned 72 years old on the 5 July. York Hospital joined the City Walls and Clifford's Tower in lighting up blue around the city, along with national landmarks, as part of a collective memorial across the country.

There is no doubt that 2020 was the most challenging year in NHS history. Lighting up our hospital gave the Trust the perfect opportunity to reflect on everything our communities have endured, stand in solidarity to mourn losses, and thank those who continue to risk so much to keep us safe.

August 2020

Smoke Free Site

In order to help reduce the number of people who smoke and the serious illnesses associated with smoking, the Trust went smoke free on all its hospital and community sites from 1 August 2020.

Going smoke free means a much safer and fresher environment for our patients, visitors and staff, and brings significant benefits for the health and wellbeing of everyone in our hospitals and those using our services.

September 2020

Organ donation

This year's Organ Donation week, a week-long celebration of organ donation across the UK began on 7 September and the Trust backed the campaign to help raise awareness.

Earlier in the year the law around organ donation in England, known as Max and Keira's Law, moved to an opt-out system to allow more people to save more lives.

All adults in England will be considered as willing to donate when they die, unless they have recorded a decision not to donate, are in one of the excluded groups, or have told their family they don't wish to donate.

October 2020

A Royal visit

In October Her Royal Highness The Princess Royal paid a visit to Scarborough Hospital to see first-hand how the NHS has risen to the challenges of the Covid and to thank staff.

Her Royal Highness was met by Her Majesty's Lord-Lieutenant of North Yorkshire, Mrs Johanna Ropner, Dr Ed Smith, Clinical Director at Scarborough Hospital and Susan Symington, Chair of the Trust.

During the visit The Princess Royal conducted the official opening of the Willow Eye Unit where Her Royal Highness heard how the new unit had seen significant investment in brand new diagnostic equipment and clinical, nursing and technical staff - which has allowed services to expand to meet the demand of the local population.

Bedside lockers

Also in this month the Trust started an eight month roll out of new bedside lockers starting with New Selby War Memorial Hospital, thanks to funding from York Teaching Hospital Charity. The bespoke lockers have been designed with soft close doors and drawers, and in addition, the colour chosen to be dementia and sight impairment friendly.

The new lockers are more secure for personal belongings, which mean they are suitable for patients to keep their own medication with them. The design has incorporated a high depth medicine drawer built to house the tallest medicine bottle standing up, preventing leakages and mess.

November 2020

#hello my name is…

In November, we reaffirmed our commitment to the "Hello My Name Is…" campaign.

The campaign was started by Dr Kate Granger in 2015, a hospital consultant in Leeds whose terminal cancer diagnosis led her to campaign for a more compassionate NHS. The simple "Hello my name is..." campaign calls for all staff, not only to introduce themselves to patients at every occasion, but to ask patients what they would like to be called.

Putting patients at the centre of what we do is key to our organisation's values and taking the simple step of introducing ourselves to patients by name can make all the difference in building relationships.

December 2020

National 'Elf' Service

In December people were once again invited to join the National 'Elf' Service.

This was a Christmas like no other, so our charity supporters had to get creative as the usual traditional fundraising was difficult - but they did not disappoint! It was a fantastic month full of lots of brilliant festive events which helped raise spirits during difficult times and raised more than £5,000.

The charity helps to funds the extras to improve our healthcare facilities above and beyond the NHS, making patients feel better. They support staff in our hospitals to make the hospital experience the best it can be for all who visit and stay there.

January 2021

Covid-19 vaccines delivered

In January Scarborough and York hospitals joined the national effort to protect people most at risk from Covid-19 by starting to vaccinate frontline NHS staff.

Vulnerable staff and those who were shielding were prioritised, along with patient-facing frontline healthcare workers because of their heightened risk of exposure to the virus.

By early February, the rapid uptake meant that the Trust had vaccinated nearly 17,000 NHS staff, other health and social care organisations, hospices, health students and several hundred primary and social care organisations. This is a tremendous achievement, of which we are very proud.

February 2021

Trust name change

During February, following an engagement exercise with our key stakeholders, the public and extensive staff engagement on the matter, we communicated that the Trust would be changing its name from 1 April 2021 to 'York and Scarborough Teaching Hospitals NHS Foundation Trust'.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

The change will help us be more inclusive for our staff and to move forward as a single organisation. We also believe having a name that better reflects our organisation's purpose will help us with some of our strategic challenges, provide a more honest description of the Trust and improve our connections with all of the communities we serve.

March 2021

Innovative digital hub launched

In March a new digital health hub was launched at Bridlington Customer Service Centre, designed to help more people access their appointments virtually, and save them making unnecessary trips to hospital.

The hub is a 12 month pilot scheme agreed between the Trust, East Riding of Yorkshire Council and East Riding CCG, which enables people to swap their hospital appointments for a virtual one if they are suitable.

During the Covid-19 pandemic many hospital services had to react quickly to offer patients virtual appointments in order to reduce the footfall onto hospital sites and keep people safe.

The pilot will be fully evaluated to understand lessons learned to offer a blueprint to expand the service to primary care, other organisations, services and locations.

Part Two – Priorities for Improvement

2.1 Looking Back: Progress with Our Quality Priorities for 2020/21

Following the launch of the National Patient Safety Strategy in July 2019 and development of the corresponding Trust Patient Safety Strategy, the 2020/21 quality priorities were largely patient safety focussed. The delivery of some of the priorities was impacted by COVID-19 pandemic and it is important that this is taken into account when reading the report. However, despite this we have made considerable progress. In this section we provide an update on progress to date.

Our Effectiveness Priority for 2020/21

We said we would:

Improve Performance 7 Day Services Standards
➢ Continue the on-going work towards improving performance against the 7 day standards (trajectory of 90%); this will be tracked on the electronic care record (CPD) with feedback to Care Groups being monitored through governance meetings.

What we have achieved:

A series of clinical standards for seven-day hospital services 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.

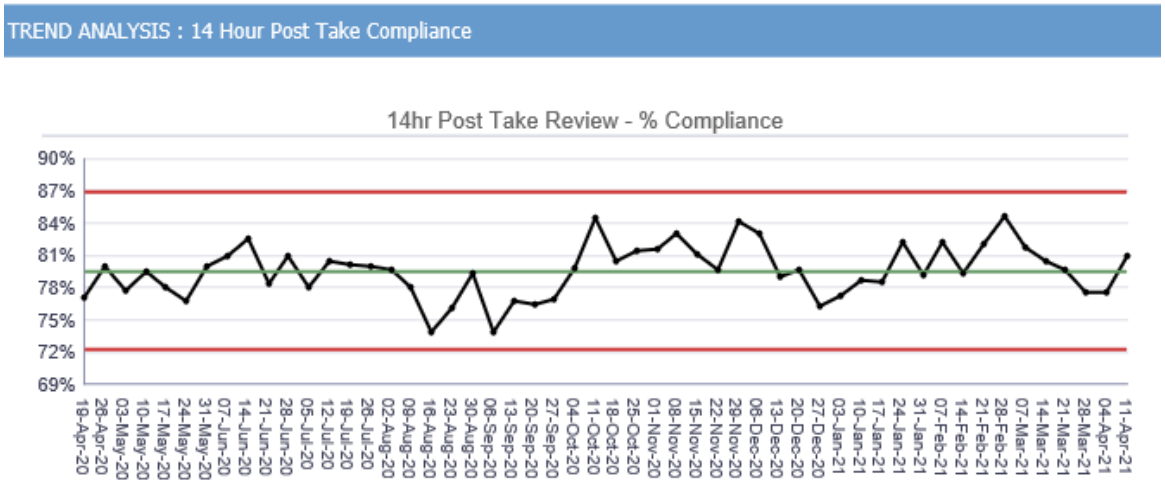
Four of the 10 standards were identified as priority clinical standards on the basis of their potential to positively impact patient outcomes. These shown below:

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. Due to the Covid pandemic the external reporting was suspended however, performance in relation to 14-hour post take review and daily senior review is monitored monthly by the Board via the Trust Integrated Board report.

Clinical Standard 2: Time to first consultant review and (more recently extended to include) the overall proportion of patients made aware of diagnosis

National compliance for this standard is 90% for weekdays and weekends.



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 at times 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: Access to diagnostic tests

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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 nor 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.

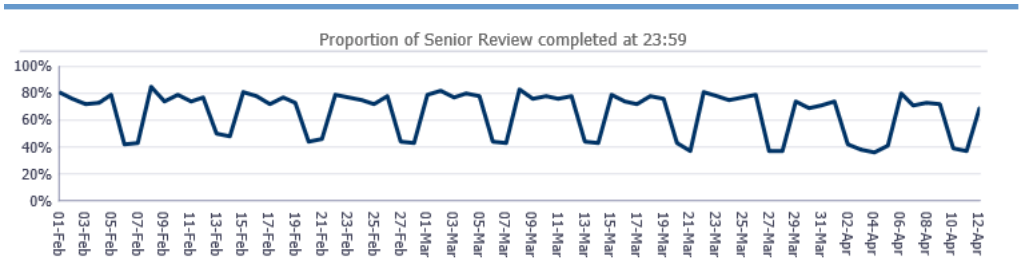
Clinical Standard 6: Access to consultant-directed interventions

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: Daily review by consultant; twice daily if high dependency

National compliance for this standard is 90% for weekdays and weekends. The most recent data shows an 80% compliance rate during the week Monday-Friday however this drops significantly to 40% compliance over a weekend. This is 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.



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

Our Patient Safety Priorities 2020/21

Priority One: Embed the SAFER Care Bundle

As part of the Patient Safety Strategy the Trust has committed to delivering the SAFER patient flow bundle. SAFER is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity).The SAFER bundle blends five elements of best practice (box 1). NHSI (2017) assert that it is important to implement all five elements together to achieve cumulative benefits. When followed consistently, length of stay reduces and patient flow and safety improves.

Box 1: The SAFER patient flow bundle

The SAFER patient flow bundle
S - Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A – All patients will have an Expected Discharge Date (EDD) and Clinical Criteria for Discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting.
F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am.
E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
R – Review. A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7days – also known as 'stranded patients') with a clear 'home first' mind set.

We said we would:

Embed the 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 patients from an assessment area to have discharged or transferred at least one patient by 10am (this is the golden

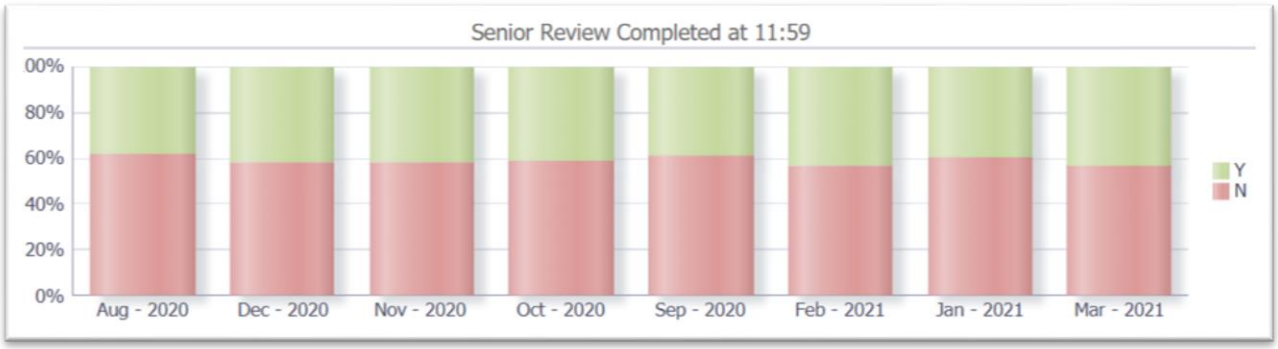
patient);

- 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.

What we have achieved:

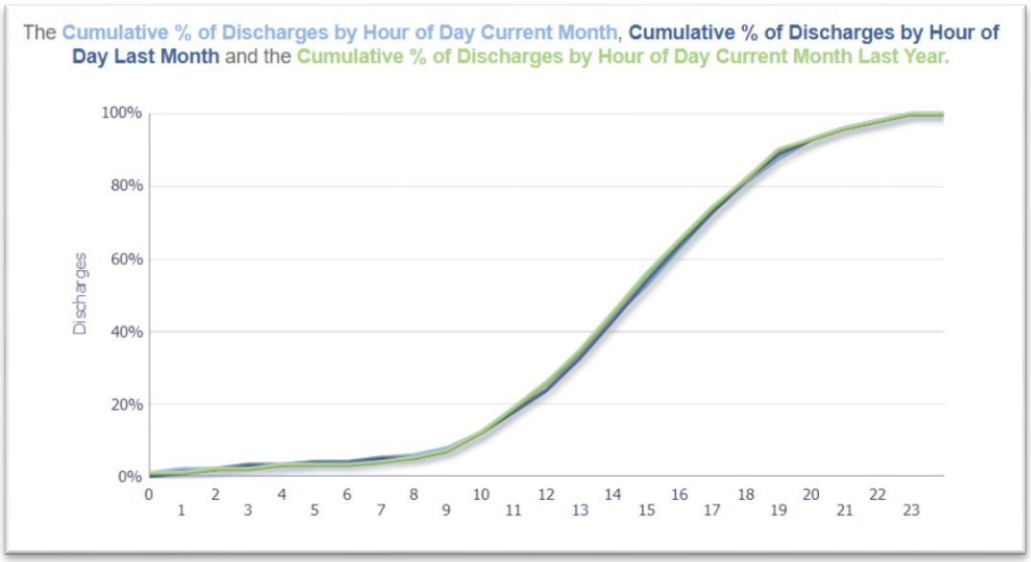
Senior Review before Midday

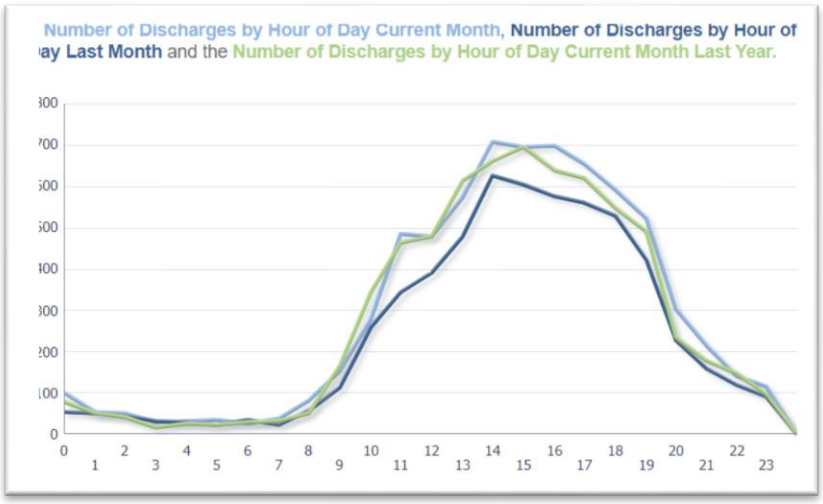
The aspiration for all senor reviews to take place before midday has not been achieved within 2020/21. As can be seen around 60% of all reviews are completed by midday. It is not possible to compare figures from the previous year as the data set only came on line from August 2020. Work continues through our SAFER steering group to understand the reasons for this not being achieved. It is likely that 100% compliance with this will not be achieved due to variance in the clinical activity of some consultants.



33% of all discharges or transfers to have occurred by midday

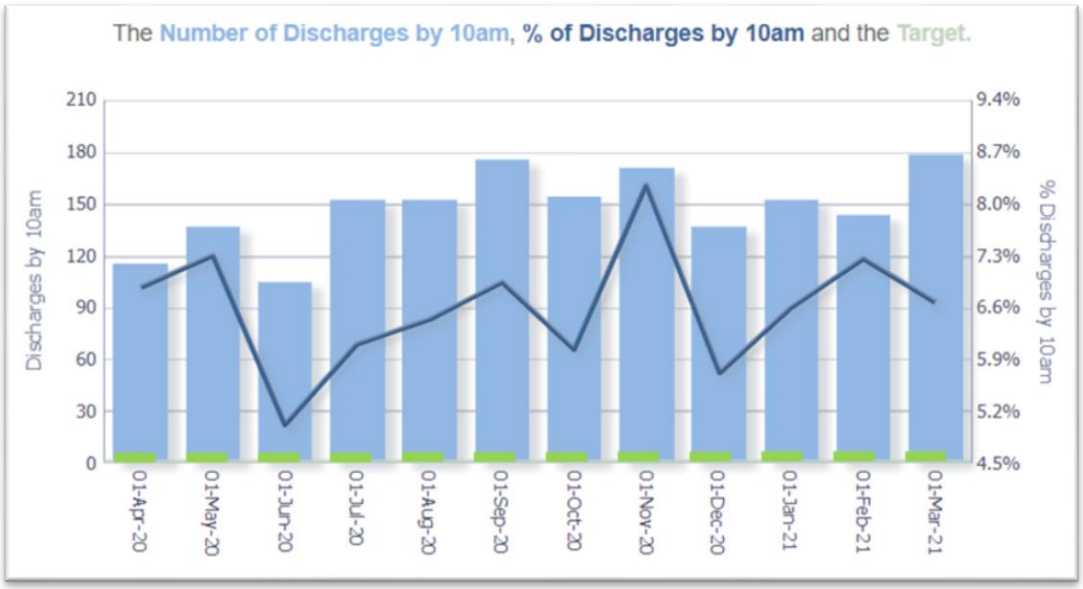
The graphs below show that limited progress has been achieved against this priority over the last year as the curve remains largely unchanged from 2019/20. The peak time for discharge is around 4pm with quite a large number occurring in the early evening. This has been impacted on during the pandemic due to waits for swab results. From a patient experience and flow perspective this is not ideal. The SAFER group are exploring barriers to achieving earlier discharge and focus is on the effectiveness of the Board Round in planning for discharge.





The Golden Patient

Focus continues to be placed on the ‘golden patients’, i.e. those who can be discharged before 10am. Progress is positive in relation to this metric, as the number of discharges before 10am, consistently exceeds the target.

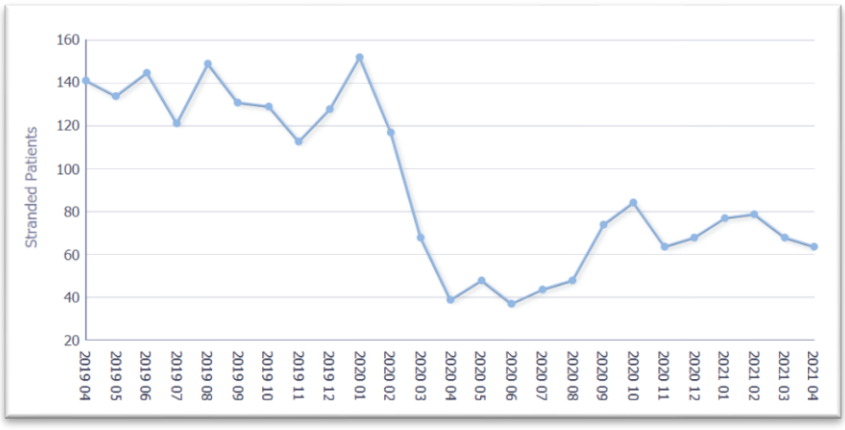


Super Stranded Patients

Super stranded patients are those who are significantly delayed in their discharge, often due to awaiting care provision outside of the hospital setting.

As can be seen in the graph below positive progress against this metric has been made and interestingly performance was at its highest during the peak of the pandemic, but is still maintained as an improvement compared to the last financial year. Further work is underway to understand the learning from the pandemic that impacted positively on performance.

Graph number of super stranded patients



What we will do to ensure we improve over 2020/21.

The SAFER group is currently evaluating the approach we have taken to date; which has not achieved the traction we anticipated, notwithstanding the fact that performance must be viewed in the context of the pandemic. Care Group one (Acute medicine and elderly medicine – York) have seen some positive progress through taking a different approach and it has been agreed that other areas will pilot the approach. The approach works with wards individually and focusses on optimising the ward routine with a particular focus on the following key areas:

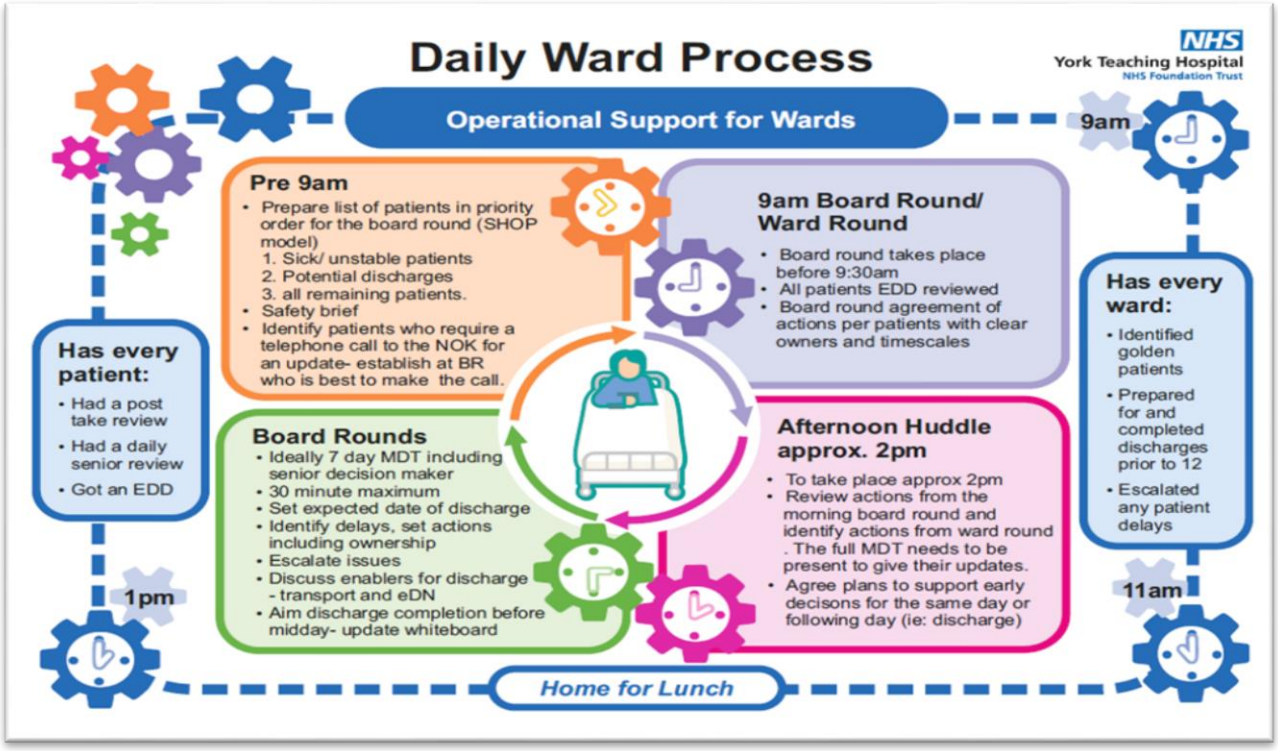
- Maximising discharges before lunch
- Ensuring concise/ action focussed board rounds
- Planning tomorrows discharges today (re-focus golden patients)
- Reviewing stranded patients
- Transport issues impacting on time of discharge

In addition it was agreed that relatives would be kept updated and involved in discharges for the following reasons:

- There have been a number of complaints relating to next of kin (NOK) not being informed of medical plans and discharge plans causing distress for them
- Because of NOK are up to date with plans, the discharge reduces the risk of being delayed and is a smoother process with clear expectations set.

To support discussions at ward level around the principles of an effective ward routine the poster on the next page was developed. At Board round it was agreed that the following four questions would be used to structure discussions:

- **Does this patient need to be in hospital?**
- If they do, what is the reason?
- And if they don't, what are they waiting for and what needs to happen?
- WHEN to do we expect this to happen?



Priority Two: Improve antimicrobial prescribing practice

Antimicrobial resistance (AMR) poses a significant threat to public health. Antimicrobial-resistant infections result in at least 700,000 deaths worldwide each year. Therefore, it is essential that antibiotic prescribing practice ensures that antimicrobials remain effective treatments for managing infections.

We said we would:

Improve Antimicrobial Prescribing Practice
➢ Further reduce the 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.

What we have achieved:

- Total consumption of antimicrobials has reduced by -4.6% against a target of -2%
- Percentage of patients on self-care pathway 50% against a target of 33%
- Implementation of ARK a “decision aid” tool which assists prescribers in the stopping of unnecessary antibiotics shown positive progress at York prior to the pandemic. Scarborough has not yet implemented ARK.

Priority Three: Recognition of the Deteriorating Patient

Early recognition of the deteriorating patient and prevention of cardiac arrest is the first link in the chain of survival. Once cardiac arrest occurs, fewer than 20% of patients having an in-hospital cardiac arrest will survive to go home.

We said we would:

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.

What we have achieved:

- The routine recording of observations and the completion of NEWS2 has improved considerably over 2020/21 and by March 2021 performance had reached 92.87%. PAWS performance by March 2021 had reached 96.3%.
- The ceiling of care data has shown consistent improvement over the last 3-4 years and a more marked improvement once the first wave of COVID-19 arrived.
- Crash call rates shown below 4 on the wards in both hospitals are at historically low levels (this would be consequent of Ceiling of Care decision making, appropriate treatment of the deteriorating patient, and regular and early senior review (not DNACPR decisions alone)).

Priority Four: Infection Prevention & Control

The COVID-19 global pandemic posed a significant challenge to the Trust in relation to infection prevention control (IPC). While significant focus has understandably been given to managing the and preventing the transmission of CVOVID 19, work has continued to reduce other Healthcare Associated Infections such as *Clostridium difficile*-associated diarrhoea, *Methicillin Resistant Staphylococcus aureus* (MRSA) and *Methicillin Sensitive Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to three Gram negative bacteria *(Escherichia coli* (*E.coli*)), *Klebsiella* species and *Pseudomonas aeruginosa)* and other important healthcare-associated infections.

We said we would:

Infection Prevention and Control
➢ 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%.

What we have achieved:

- The IPC team continues to integrate into Care Groups to improve engagement with clinical teams and improve outcomes for reducing HCAIs; in particular *C.difficile* and blood stream infections.
- The IPC nurses have been allocated to each Care Group to ensure attendance at Quality Committee meetings to provide feedback on HCAIs data within Care Groups and offer support with training.
- The IPC team has developed cleaning competency tools with a focus on commode and bed cleaning as a *C.difficile* reduction strategy. These are being rolled out into Care Groups through the IPC links and ward managers.
- A process of reviewing and conducting Post Infection Reviews (PIRs) through Care Groups has been developed in conjunction with the DATIX team. It is intended that his process will highlight action plans on Care Group dashboards, enhance learning from PIR outcomes and sustain improvement in practice.

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2022/2023. In March 2021, the Trust reported a total of 63 cases of the three GNBS organisms which are part of national surveillance. Of these, 20 cases were classed as trust-apportioned as defined by the Department of Health (*E. coli 17; Klebsiella sp. 3; Pseudomonas aeruginosa* 0). In the 12 months of 2020/21 there have been a total of 688 GNBS organisms reported across the organization of which 512 were *E. coli*, 132 *Klebsiella* and 44 *Pseudomonas aeruginosa.* The trust was seeing small reductions in the incidence of hospital-associated *E.coli* bacteraemia in the first 6 months of 2020/21 but there has been an increase in the *E.coli* incidence from October 2020. This could be related to the fact that the trust also saw a reduction in bed occupancy from the start of the financial year due to the COVID-19 pandemic compared with last year for the same period. The trust's GNBSI annual plan for 2020/21 aims to continue ongoing reduction of healthcare associated GNBSI and includes introducing initiatives around promotion of hydration, urethral catheter care audits and training and education for staff. However, it has been challenging to undertake these initiatives due to competing priorities of managing the COVID-19 pandemic.

Priority Five: **Safeguarding**

We said we would:

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.

What we have achieved.

Liberty Protection Safeguards (LPS) is due to come into full force in April 2022 (was October 2020), replacing the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty.

The Department of Health National Steering Group for Liberty Protection Safeguards (LPS) continue to develop he updated MCA Code of Practice which includes the draft of the proposed Code of Practice for LPS – this was due April 2021.

Before LPS is implemented, the safeguards provided by the DoLS still apply. Legal duties to determine if someone is, or will be, deprived of their liberty as a result of the arrangements for their care and treatment, remain. If this is the case, then legal authorisation is required and it is important that decision-makers comply with their existing legal requirements for this. For adults residing in a care home or hospital, this would usually be provided by the DoLS. If the person is aged 16-17, or residing in any other settings, then an application to the Court of Protection should be considered.

As these new safeguards are going to alter who can authorise the deprivation of liberty, it is essential that Liberty Protection Safeguards leads, advisors and senior managers understand the new legal framework and begin their preparation, training and strategies for these changes coming into full force in April 2022. The Trust Safeguarding Adult team receive monthly Bulletins with updates and continue to escalate dependent on the urgency.

Priority six: Ambulance turnaround

We said we would:

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.

What we have achieved:

The trust has sustained Improvements through 2020/21, although it must be noted that this again was in the context of reduced attendances through the peaks of the pandemic. Both sites have implemented revised handover processes, with a dedicated nurse to support handover which has supported improvements. The comparative annual position: there were 411 ambulance handover delays in 2020/21, compared to 5817 in 2019/20, a reduction of 93%. The Trust is committed to sustaining the improved level of long wait handovers and this is monitored through Care Group performance meetings.

Priority Seven: Falls

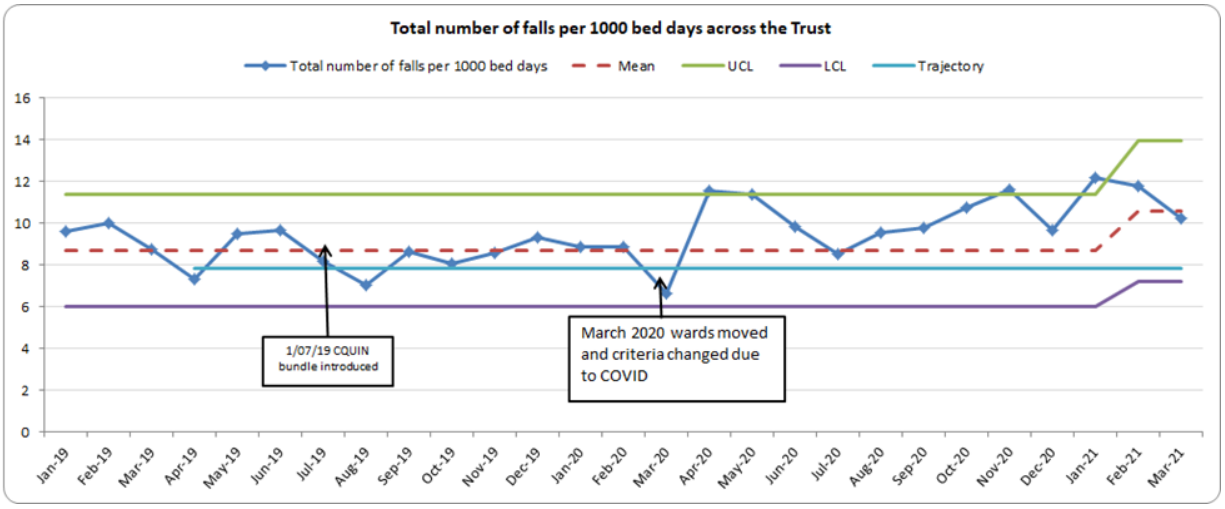
We said we would:

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.

What we have achieved:

The Trust is committed to reducing the incidence of patient falls in hospital and has progressed a number of initiatives over the last year. Regrettably the COVID-19 pandemic has had a significant impact, the pattern of falls incidents apparently tracking the pattern of activity, i.e. the incidence increased during Wave 1, started to improve over the summer and then started to increase again from autumn onwards. The overall trajectory for reducing incidence by 10% was not achieved.

Priority 1: 10% reduction in the average number of falls per 1000 bed days (based on the last 12 months data)



Note:

***UCL** on the graph means Upper Control limit - The **upper control limit** is used to mark the point beyond which a sample value is considered a special cause of variation*

*L**CL** on the graph means lower Control Limit - The **lower control limit** is used to mark the point beyond which a sample value is considered a special cause of variation*

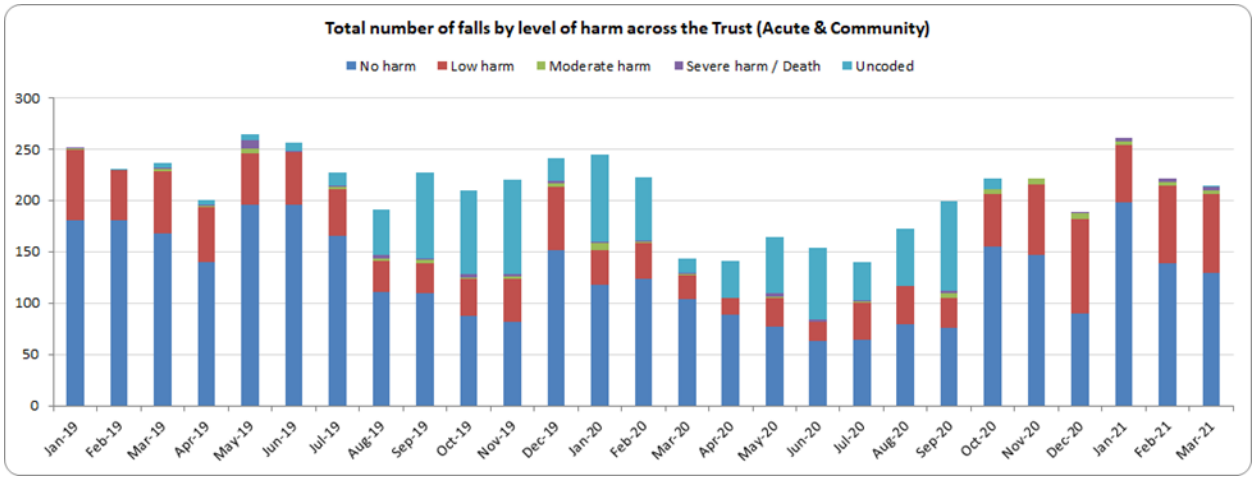
A number of factors contributed to this position

- Inpatient wards have changed specialties as we have had to separate wards for patients who have tested positive to Covid-19 and for those who are negative, e.g. no designated ward for patients living with dementia means that these patients have been spread through a number of wards and therefore have not had the same access to nursing and medical staff with specific skills and expertise
- To reduce the risk of cross infection, more patients have been cared for in single cubicles where, prior to COVID-19, several high risk patients may be cared for in a bay making it easy to offer enhanced supervision
- Patient acuity has been higher for those in hospital

A number of actions have been progressed over the last year including:

- Appointment of a dedicated Falls Clinical Specialist to support staff, to ensure best practice is promoted and to deliver some face to face training
- New documentation to make it easier for staff to identify patients at risk and to put the preventative steps in place and document the care given
- Strengthened our reporting of incidents which are reviewed daily

Priority 2: 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

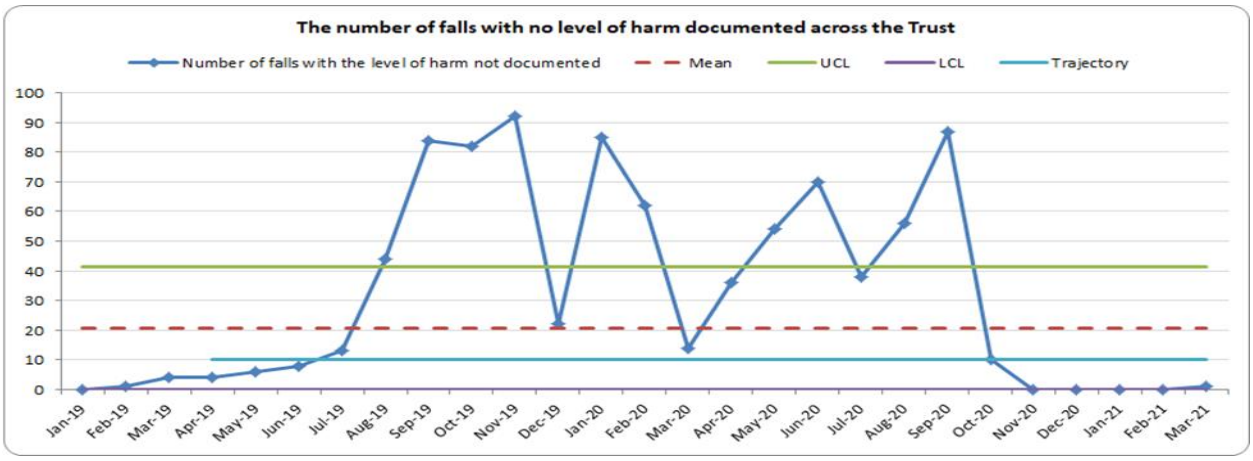


Data is captured on a monthly basis and reviewed by the Falls Improvement Group.

Investigations into falls incidents causing moderate or severe harm are reviewed by a multi-disciplinary Falls Learning Panel to identify themes and trends so we can support further action; this is an area we wish to strengthen further so we maximise the opportunity to learn from when patients have fallen and come to harm but also want to share the good practice between wards and departments.

An improvement plan is in place which aims to respond to identified themes from investigations.

Priority 3: To improve the accuracy of reporting a trajectory has been set of a 50% reduction in falls with no level of harm documented.



The degree of harm was made mandatory for completion by the reporter at the beginning of December 2020 so this priority is now demonstrating compliance.

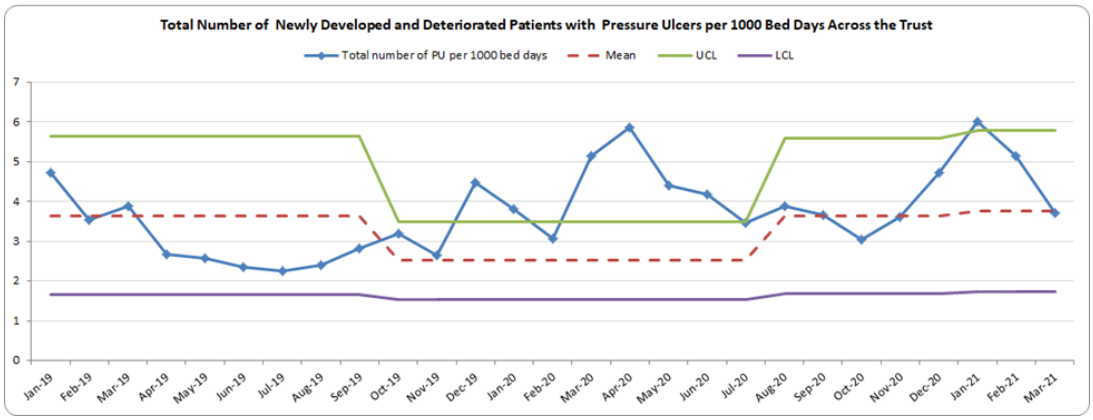
Priority Eight: Pressure Ulcers

We said we would:

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.

What we have achieved:

Priority 1: A 50% reduction in medical device related injuries by April 2021



This trajectory was agreed prior to the pandemic and subsequently the Trust saw an increase in the use of medical devices due to the surge of patients being cared for in critical care units, e.g. oxygen masks, ventilator tubing, urinary catheters etc. We saw a significant increase in Wave 1 as a result, similar to many Trusts, despite proactive training being delivered to front-line staff in both ITUs where the majority of device related incidents are reported. Our Tissue Viability Nurses anticipated the problems with skin integrity that patients who were poorly with COVID-19 might face, including being nursed for prolonged periods of time in the proned position, for the purpose of improving their breathing, etc. and therefore delivered bespoke training as well as increasing visits to these areas daily. They also produced pictorial guidance for staff to refer to.

This had a positive effect and we have seen that the incidence reduced over time until October 2020 when we for the first month achieved our planned reduction. Regrettably as we moved into the 2nd wave of COVID-19 in Nov/December the incidence began to rise again until the peak in January.

Our understanding of the causation of device related issues has rapidly improved in relation to contemporary clinical practice. An improvement plan is in place working with ICU Nurse Managers, Continence Team, Respiratory Team, and Clinical Educators to drive further improvements.

Priority 2: 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

Data has been collected to understand the extent of the issue. The Tissue Viability Nurses have been working closely with podiatry colleagues to ensure appropriate prevention and treatment strategies are in place.

Priority 3: Elimination of all Category 4 pressure ulcers, with lapses in care, by December 2020.

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21		
Number Cat 4 PU	0	2	0	0	1	1	0	0	0	1	0	0	0	2	0	0	1	1	2	2	1		
Trajectory for lapses in care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Lapses in care	0	1	0	0	0	1	0	0	0	0	0	0	0	2	0	0	1	0	0	0	0		

We have made some good progress in relation to the elimination of Category 4 pressure ulcers where lapses in care have been identified. This has not been fully eliminated (3 over the year) and will continue to feature as a priority in 2021-22.

The majority of areas that have seen an increase in pressure damage are those that have been caring for COVID-19 positive patients. Positioning of patients has been a factor in that many patients who are breathless prefer to sit upright to aid their symptoms so were reluctant to move onto their side – this increased the risk of pressure damage to the sacral area.

A number of improvement actions have been progressed in the last year including:

- Introduction of a new risk assessment tool to help identify the patient's degree of risk with developing pressure damage that begins when the patient presents at the Emergency departments, rather than just on admission to the ward
- Clear pathways of care to follow depending on the degree of risk with improved documentation to record when a patient is supported to change position
- Increased focus on the contribution of good nutrition to the prevention and management of pressure ulcers, including identification of risk, the use of oral supplements and referral to a dietician
- Sharing patient stories and their accounts of their experience to promote the importance of good pressure area care
- Focused ward based training sessions in addition to innovative virtual training sessions
- Launch of pressure ulcer advocates, individuals identified at ward level who have an interest in tissue viability who can receive additional training and support best practice in their area

Although not a quality priority, the Trust recognised quite quickly that we had a responsibility to support our staff to reduce the risk of pressure damage from the prolonged use of PPE, i.e. face masks and goggles. We worked with occupational health and pharmacy to develop guidelines for staff and provided access to suitable products including moisturisers and protective dressings.

Our Patient Experience Priorities 2020/21

Priority One: Complaints and PALS

We said we would:

Complaints and 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.

What we have achieved:

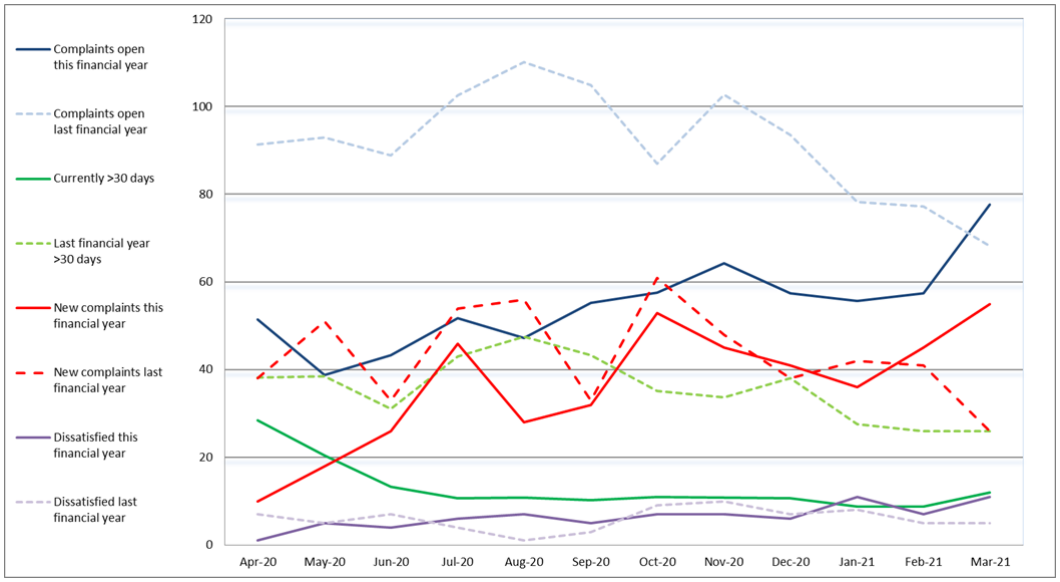
The best way to improve care is to listen to what patients and their families tell us. We do receive a vast amount of positive responses and compliments about the fantastic care the majority of patients receive however we don't get it right 100% of the time. All feedback is a valuable opportunity to learn from past experiences and we need to demonstrate this by showing what has changed as a result.

Improve the timeliness of complaint responses 90% trajectory: <10 days for PALS, <30 days complaints

Complaint responses within target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of cases closed	33	18	27	35	37	26	62	35	60	33	42	56
Closed within 30 days	11	6	15	21	21	13	36	25	39	20	34	36
%	33%	33 %	56%	60%	57%	50%	58%	71%	65%	61%	81%	64%
Average quarterly %	41%			56%			65%			69%		

PALS responses within target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of cases closed	64	82	113	134	144	161	160	115	97	94	111	148
Closed within 10 days	44	56	91	103	107	122	114	79	71	72	96	105
%	69%	68 %	81%	77%	74 %	76 %	71%	69 %	73 %	77%	86 %	71 %
Average quarterly %	73%			76%			71%			78%		

There has been a notable reduction in the number of open complaints since 2019 due to the fact that complaints management is a Trust priority this year and Care Groups are responding to complaints in a more timely way. The number of cases over 30 days has improved since 2019 and this is a great achievement given the challenges of the pandemic. Although we have not achieved the very challenging 90% response rate target that we set ourselves (within 30 days for formal complaints and 10 days for PALS), we have seen steady improvements over the year and this should be recognised and celebrated.



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.

There is a need to differentiate between a complainant who is dissatisfied with the investigation and one who wishes to raise new issues or questions as a result of our initial response. We actively encourage complainants to contact us if they have further questions or require more clarity. Dissatisfied complaints are reported quarterly to the Quality & Patient Safety group through the Patient Experience Steering Group report. Themes are highlighted to Care Groups in monthly reports, to enable them to focus improvement

activity in areas that will improve the patient experience. Care Groups are asked to report back to the Patient Experience Team about actions taken.

All investigating officers to have attended in-house complaints management training.

The Complaints Manager has reviewed the training offer and has delivered a number of training sessions. Work is now underway in collaboration with the Patient Safety Team to review the training for all officers undertaking investigations, related to an incident or a complaint.

Priority Two: Learning from Patient Experience

We said we would:

Complaints and PALS
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').

What we have achieved:

Patients will know the name or names of the people who are looking after them

This priority was chosen due to a low scoring question in the national inpatient survey. "Did you know which nurse was in charge of looking after you?" scored only 55% which put the Trust in the bottom 20% nationally. It was felt that improving the response to this question would also boost other elements of patient experience, for which we scored in the bottom 20%, including:

- Did you find someone on the hospital staff to talk to about your worries and fears? 49%
- Were you involved as much as you wanted to be in decisions about your care and treatment? 70%

With communication issues being a common theme among concerns and complaints, it was hoped that the Hello My Name Is campaign would improve relationships and communication between staff and patients (and their loved ones).

Hello My Name Is was relaunched in October 2020. Each Care Group had an action plan for promoting the campaign.

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 Patient Experience Steering Group reviewed national surveys and local surveys and identified a number of themes where the Trust needed to improve. Some of these related to what could be termed fundamental aspects of care such as good discharge planning, providing support at meal times and good pain management. Care Groups have established their own quality priorities, using triangulated data, to drive relevant improvement action. A Trust-wide group is leading on improving the patient experience of discharge and reporting into the wider health-care system. The supported mealtimes guideline has been revised and an audit undertake, providing some assurance regarding how well are patients are supported with nutrition and hydration.

The Trust has taken the opportunity to register with NHSE/I for support in introducing an improvement methodology called Always Events so an oversight group has been established to lead the implementation. Always Events can be simply described as things that should always happen, i.e. all staff should introduce themselves by name to a patient. They should focus on the things that matter most to patients and therefore should be developed, agreed and the solutions co-designed with service users. The Trust has received regular coaching calls with NHSE/I and although this work is in its infancy, it is hoped that this methodology will help empower front-line staff to take ownership of issues affecting the patient's experience going forward. Pilot units have been identified and supportive educational materials are under development.

Patient Experience of COVID-19

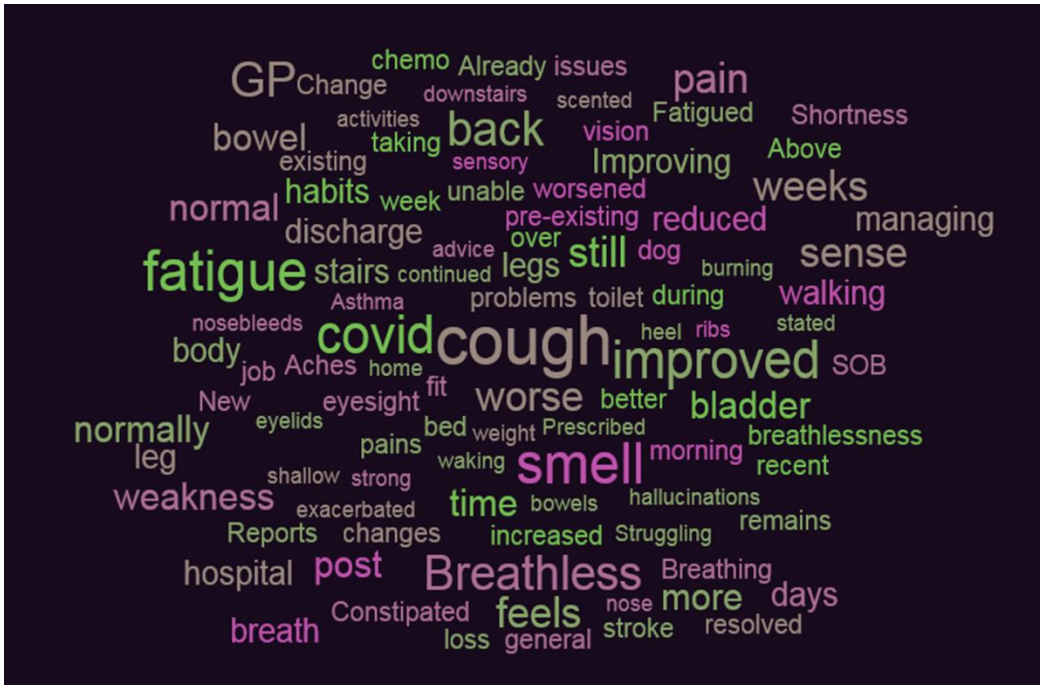
2 key pieces of work have been undertaken that were pertinent to our patient's experience during the pandemic:

a) Patients discharged from York Teaching Hospital NHS Foundation Trust a following a positive COVID-19 diagnosis

A retrospective audit was undertaken to look at the first 233 patients discharged from the Trust that had a positive COVID-19 test. Patients were contacted by telephone and offered a 10-15 minute discussion/questionnaire. The vast majority of patients contacted were extremely keen to discuss their recovery phase, return to daily activities and the relationship between any ongoing symptoms and impact on function. We were particularly struck by the positivity of feedback about the care received and the positive feedback we received about the positive approach we had as a Trust to learn about this new disease and our efforts to make the experience for patients as good as possible in uncertain times.

Patient shared with us the ongoing issues and symptoms of having COVID-19 and the impact on them both physically and mentally. Area for improvement were shared with Care

Groups, including difficulties communicating with staff wearing face masks and discharge feeling rushed.



Actions were taken to improve general discharge planning, with the development of an information booklet incorporating support knowledge, self-help strategies and what patients are likely to expect on discharge.

A temporary Principal Clinical Psychologist offered a psychological service to the COVID-19 survivors of ICU.

b) Patient and clinician's experience of virtual outpatient consultations

As part of supporting effective social distancing, the majority of outpatient appointments were delivered via telephone or video-consultation, where it was safe to do so. An evaluation of this service was undertaken and the findings included:

- 80% patients found online appointment as good as or better than a face-to-face appointment
- 60% clinicians got everything they needed from the online appointment
- The main barrier to both patients and clinicians was WiFi connection issues
- Some services found that Virtual consultations and appointments didn't work well for them for example, Physiotherapy

Colleagues are using this feedback to consider other innovative solutions in terms of supporting patients to use technology and improve their experience.

2.2 Looking Forward: Our Quality Priorities for 2021-22

In order to develop our priorities a virtual event was held on 2nd February 2021 with Members and Governors. This event chaired by the Trust Chair Sue Symington and was the first occasion that the trust has worked to co-produce the quality priorities with lay members.

The event consisted of 3 presentations covering the three domains of quality (Effectiveness/improvement, patient safety and experience) and each presentation was followed by breakout rooms to discuss priorities. This report details recommended quality priorities for each domain, which were identified during this event.

The priorities were presented to the Trust Governors who have chosen the Clinical effectiveness and improvement priorities as their Governor led indicators for 2021-22. Quarterly updates will be provided to the Governors. These priorities are in addition to those from 2020/21 which we will continue to work on.

Our Clinical Effectiveness and Improvement Priorities

Why this is important

In their review of hospital Trusts the CQC (2018) found that where a culture of quality improvement (QI) is embedded trusts 'feel' different; staff are engaged, they are focused on the quality of patient care, and they are confident in their ability to improve. This was also reflected in surveys of staff and patient satisfaction. As a trust we do not currently have a quality improvement culture, supported by an embedded strategy and access to coaching and support for staff wishing to undertake QI. While we have an established programme of audits and NICE guidance baseline reviews, we do not routinely use QI methodology to address gaps. Developing and aligning our QI and Effectiveness strategies, supported by the involvement of patients and carers will support the Trust in ensuring the provision of high quality safe care.

Effectiveness and Improvement: **Priority One**

Develop a culture of QI and Effectiveness being everyone's business through the development of aligned strategies for Clinical Effectiveness and Quality Improvement with engagement from staff, patients and carers.

What we will do in 2021/22

We will:
➢ Ensure the aligned strategies are developed for implementation by November 2021; ➢ Ensure all key stakeholders (including patients, carers and staff) are fully consulted with in the development for the strategy.

Effectiveness and Improvement: Priority Two

Enable staff, patients, and carers to participate in improvement and effectiveness by providing the required support, tools and resource.

What we will do in 2021/22

We will:
➢ Refocus the role of the improvement– team to provide a wider expert level of support across the organisation through the use of QI coaching, training for staff undertaking improvement projects; ➢ Develop and implement a training programme for QI coaches; ➢ Enhance the QI skills training materials and workshops available to staff; ➢ Ensure staff, patients and carers are enabled to participate in improvement and effectiveness by providing the required support, tools and resources; ➢ Further enhance sharing mechanisms to celebrate learning and achievements which are meaningful for patients and staff.

Effectiveness and Improvement: Priority Three

To further enhance sharing mechanisms to celebrate learning and achievements which are meaningful for patients and staff.

What we will do in 2021/22

We will:
➢ Consult with Patients, carers and staff to determine the most effective mechanisms for sharing learning and best practice; ➢ Develop and embed QI charters; ➢ To use the safety spotlight in staff matters to share learning; ➢ To implement ICS wide shared learning virtual conferences.

Our Patient Safety Priorities

Why this is important

Patient safety is fundamental to the provision of high quality services and is defined by NHS England and NHS Improvement (2018) as 'maximising the things that go right and minimising the things that go wrong for people experiencing healthcare'. The impact of patient harm is felt widely; by patients themselves, families, and the teams delivering care.

Adverse incidents will and do occur but with a strong safety and learning culture the impact in terms of harm and recurrence will reduce. All staff must feel safe to report patient safety issues without fear of retribution, and be empowered to act swiftly to address risk. During

the engagement exercise with our members they told us that we need to do more to support and care for our staff to enable them to feel safe to report incidents and learn.

Patients and families also must feel part of serious incident investigations to ensure their questions are answered and to ultimately ensure we achieve optimal learning. This is an area that our members were clear needed considerable improvement and asserted that they need to be involved and heard as patients and families.

Patient Safety: Priority One

To ensure effective communication with patients and families during serious incident investigations.

What we will do in 2021/22

We will:
➢ Develop the serious incident processes to ensure patients and or their families are involved in setting the terms of reference for serious incident investigations to ensure their questions are answered; ➢ Ensure patients and families are involved, supported and kept informed throughout the investigation process.

Patient Safety: Priority Two

To develop a culture of safety at all levels of the organisation

What we will do in 2021/22

We will:
➢ Reintroduce non-executive led safety walkrounds to provide opportunity for patient safety orientated discussion and challenge at ward/team level; ➢ To develop the Patient Safety Specialist role within the Trust through participation in the NHSE/I national programme; ➢ To improve the incident reporting culture to be within the upper quartile for reporting of no harm/low harm incidents nationally, through timely feedback and the embedding of a just culture where incidents can be reported and learned from without fear of reprisal; ➢ To ensure patient safety related data available in an accessible and easily understood format at all levels of the organisation; ➢ To ensure robust processes are in place for learning from incidents and good practice; ➢ To introduce call for concern, a facility for relatives to raise concerns to a critical care outreach nurse about their loved one during visits; ➢ Increase patient involvement in the review of patient safety incidents through the introduction of the Patient Safety Partner role; ➢ Ensure appropriate education and training is in place for new members of staff and

We will:
additional training is targeted to areas with high incidence of patient safety events; ➢ Embed quality improvement methodology for addressing patient safety concerns.

Patient Safety: Priority Three

To achieve a 10% reduction in the average number of falls per 1000 bed days (based on the last 12 months data)

What we will do in 2021/22

We will:
➢ Involve Patients, carers and loved ones in the investigation of falls; ➢ Ensure effective assessment of risk and appropriate preventative measures are in place for patients from the moment they enter our care; ➢ To strengthen the investigation processes to ensure that contributory factors are better understood and inform improvement initiatives; ➢ To ensure learning is more widely shared across the organisation through safety briefings; ➢ Use improvement methodology to develop, implement and evaluate evidence-based practice in falls prevention and management; ➢ Safely staff our wards.

Patient Safety: Priority Four

To reduce the incidence of patients developing device-related pressure damage and eliminate all category 4 pressure ulcers where lapses in care have been identified for patients in our care

What we will do in 2021/22

We will:
➢ Involve Patients, carers and loved ones in the investigation of pressure ulcers; ➢ Ensure effective assessment of risk and appropriate preventative measures are in place for patients from the moment they enter our care; ➢ To strengthen the investigation processes to ensure that contributory factors are better understood and inform improvement initiatives; ➢ To ensure learning is more widely shared across the organisation through safety briefings; ➢ Use improvement methodology to develop, implement and evaluate evidence-based practice in falls prevention and management.

Our Patient Experience Priorities

Why this is important

As a Trust we are committed to ensuring that our patients and carers have the best possible experience of our care. However, there are times when this experience will not be of the standard that we or the patient and their family would expect to have. It is therefore important that we have an embedded culture of valuing and listening to the experience of those who access our services.

Improving patient experience is not simple as it requires effective leadership and culture receptive to hearing feedback. Such feedback is crucial if we are to learn and continuously improve. Our engagement event attendees told us that we could do more to communicate and listen.

Patient Experience: **Priority One**

Hear the voice of those patients who are seldom heard

What we will do in 2021/22

We will:
➢ We will increase the variety of opportunities to hear the views of patients, carers and public, including those with underlying health problems and sensory impairments; ➢ We will actively listen to patients and their carers, involving them in decisions about their care, promoting the attitude of 'doing with' rather than 'doing to'; ➢ We will improve how we communicate with both patients and carers, whether the person is an inpatient, outpatient or accessing care in the community setting – this will build on the foundations laid last year from the Hello My name Is…. Campaign and will incorporate specific projects, i.e. communication with carers who are unable to visit.

Patient Experience: **Priority Two**

Foster a culture of co-production to improve the patient experience

What we will do in 2021/22

We will:
➢ We will work to improve fundamental standards of care, including nutrition and hydration, assistance with hygiene, timely discharge – this will include the use of Always Events improvement methodology to co-design solutions to improve the

patient experience;

- We will involve patients, families and carers in quality improvement work;
- We will ensure we meaningfully capture and share patient feedback.

2.3 Mandatory Reporting Requirements

2.3.1 Learning from Deaths

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 managed within each Care Group to ensure actions are agreed from the recommendations made on completion of the Structured Judgement Case Review (SJCR). These are discussed at Care Group Governance Meetings and then presented at the End of Life/Learning from deaths group to a wider audience for discussion/assurance. The Care Group Governance meetings monitor completion of actions and ensure learning is shared.

Learning from deaths mandatory reporting requirements:

Item 27.1 - During April 2020 – March 2021, 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:

547 in the first quarter (April 2020 – June 2020);
383 in the second quarter (July 2020 – September 2020);
582 in the third quarter (October 2020 – December 2020);
699 in the fourth quarter (January 2021- March 2021)

Item 27.2 - By 31 March 2021, 1207 case record reviews and 113 SJCR investigations have been carried out in relation to 2211 of the deaths included in item 27.1.

In 1207 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:

324 in the first quarter (April 2020 – June 2020);
234 in the second quarter (July 2020 – September 2020);
310 in the third quarter (October 2020 – December 2020);
339 in the fourth quarter (January 2021-March 2021);

Item 27.3 - 16 representing 1.05% 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, however on review of these cases this did not impact on the outcome for the patient.

In relation to each quarter, this consisted of:

6 representing 1.09% for the first quarter (April 2020 – June 2020);
5 representing 1.31% for the second quarter (July 2020 – September 2020);
8 representing 1.37% for the third quarter (October 2020 – December 2020);
1 representing 0.14% for the fourth quarter (January 2021-March 2021);

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

Item 27.4 - No cases have been reported as avoidable.

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 themes and learning have been captured with a robust action plan to support Quality Improvement and Learning.

- Timely Senior/review and decision making
- Recognition of the deteriorating patient
- Appropriate end of life care Ceiling of care and DNACPR decision making
- Reduction of Healthcare associated infection

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/actions are:

- Monitoring of Post Take Ward Round (PTWR) performance through the Signal Quality and Safety dashboard.

- Mobile devices for nurses to input observations at bedside

- Tasking App for automated escalation of alerts to nurse in charge , responsible team and Critical Care Outreach Team where the National early warning score (NEWS 7 or more)
- Artificial Intelligence work on Computer Aided Risk of Mortality (CARM) & Computer Aided Risk of Sepsis (CARS). Implementation of Covid-19 version of Calculated Mortality Risk Score for staff working in Covid19 clinical areas
- Palliative care expansion and support across both sites
- Revision of Last Days of Life documentation
- Revision and update of Ceiling of care section in Integrated Care Record to include last days of life
- Electronic Palliative Care Coordination system (EPACCs) link to ED and In-patient Care record
- Practising good antimicrobial stewardship promoting the use of START SMART Then FOCUS and the use of the Antibiotic Review Kit (ARK) system.
- Where antimicrobial treatment is indicated that the correct agent/s is promptly prescribed and administered to reduce harm from sepsis.
- Ensuring that decisions involving the use of antimicrobials are underpinned by the appropriate samples, diagnostic tests, clinical decision support and clinical data.
- Providing clear and accessible information on formulary choices by the use of posters, the intranet, EPMA and the Ignaz app. Education for antimicrobials.
- Responding to incidents involving antimicrobials and developing systems to engineer out failures.

The End of Life/learning from deaths Group will continue to monitor for recurrent similar events in particular clinical areas.
Communication of safety messages with all staff is shared via Patient safety spotlight newsletter, and screen savers

Item 27.7 – 151 case record reviews and 13 investigations completed after 1st April 2020 which related to deaths which took place before the start of the reporting period.

Item 27.8 – 6 representing 0.95% 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) however on review of these cases this did not impact on the outcome for the patient.

Item 27.9 - 6 representing 0.95% 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 however on review of these cases this did not impact on the outcome for the patient.

2.3.2. Seven Day Services

A series of clinical standards for seven-day hospital services 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:

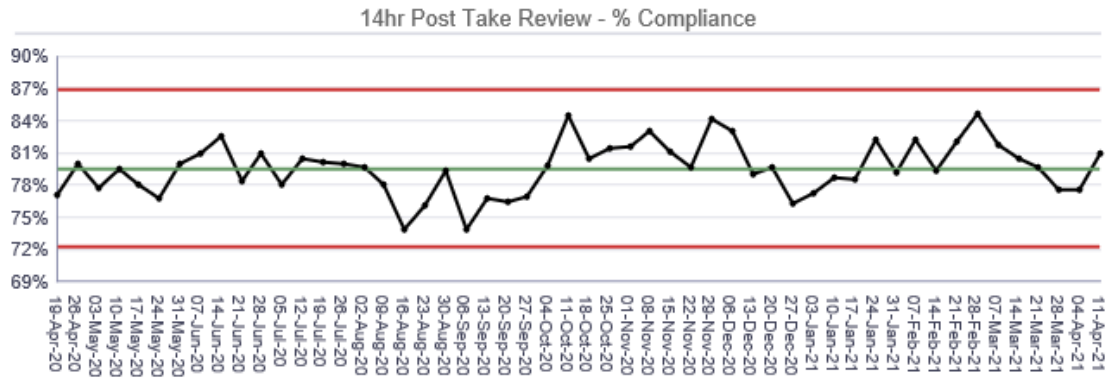
Standard 2	Time to first consultant review and (more recently extended to include) the overall proportion of patients made aware of diagnosis, management plan and prognosis within 48 hours of admission;
Standard 5	Access to diagnostic tests
Standard 6	Access to consultant-directed interventions
Standard 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. Due to the COVID-19 pandemic the external reporting was suspended however, performance in relation to 14-hour post take review and daily senior review is monitored monthly by the Board via the Trust Integrated Board report.

Clinical 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

National compliance for this standard is 90% for weekdays and weekends.

TREND ANALYSIS : 14 Hour Post Take Compliance



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 at times 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: Access to diagnostic tests

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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 nor 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 and 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.

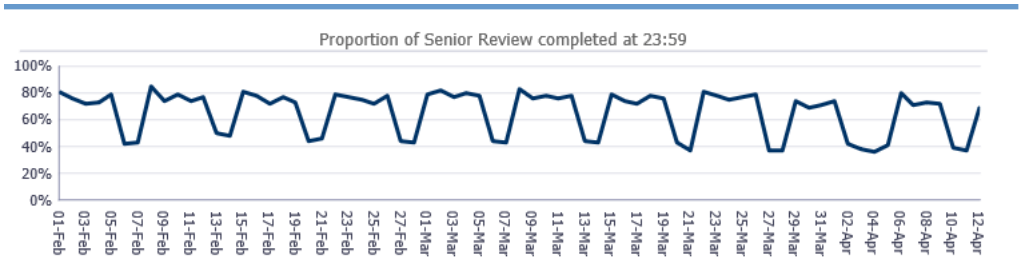
Clinical Standard 6: Access to consultant-directed interventions

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: Daily review by consultant; twice daily if high dependency

National compliance for this standard is 90% for weekdays and weekends. The most recent data shows an 80% compliance rate during the week Monday-Friday however this drops significantly to 40% compliance over a weekend. This is 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.



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

2.3.3. 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).

NHSE/I are expected to confirm in Q1 2021-22 whether they will be updating the national FTSU policy this year. The Trust Raising Concern/ Whistleblowing policy will subsequently be reviewed once the outcome of the NHSE/I consultation outcome is known.

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 four 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.

2.3.4 Information about the Guardian of Safer Working Hours

The 2016 national contract for junior doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came 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 the junior doctor's supervisor with oversight by the Guardian, although this was altered during the height of the COVID-19 pandemic to reduce administrative work for senior clinicians.

Outcomes for each report can be closure with no further action (in terms of compensation), the allocation of payment for 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 initiating a review of staffing and rostering to tackle any systemic factors that may be contributing to the breach in contractual terms.

Reports highlighting problems with teaching or training are shared with the Director of Medical Education.

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 the Trust. The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by Health Education England (HEE) who oversee the quality of training. These measures should ensure the safety of doctors and therefore of patients.

During the first wave of COVID-19 the British Medical Association (BMA) and NHS Employers negotiated temporary terms acknowledging the possibility of breaching working hour regulations to maintain services and safety. The Trust remained committed to avoiding this as much as possible. The only contractual rules that were breached were:

1. Frequency of weekend working (maximum 1 in 3)
2. Notice period for rostering changes (minimum 6 weeks)

We saw a dramatic reduction in exception reporting during the first wave. The re-deployment of doctors allowing for enhanced staffing levels compared to normal coupled with reduced acute admissions are likely to be key reasons for this.

Periods of self-isolation and shielding together with the reduction in elective surgery, outpatient activity and delivery of training sessions also altered the pattern of reporting this year.

Since the BMA withdrew from the agreement with NHS Employers, rosters have been managed in line with the current (2016) terms and conditions.

The resumption of planned care, teaching sessions and increased acute admissions has coincided with a gradual increase in exception reporting, although levels remain low compared to previous years.

Key metrics for this reporting period are highlighted below:

Exception reports received by site (for financial year 2020/21)

Site	Number of exception reports
Scarborough Hospital	43
York Hospital	50
Total exception reports received	**93**

Types of reports received (for financial year 2020/21)

Nature	Type	Number of exception reports	Percentage of total reports*
Hours and rest	Additional hours worked	83	83.87%
	Missed breaks	34	36.55%
Education and training	Missed education and training	12	12.9%

** Percentage does not add up to 100% as reporters are allowed to select more than one reason for each submission.*

Hours and rest outcomes

Outcome type	Number of exception reports	Hours claimed	Value of hours claimed
Payment for additional hours worked	59	108.75	£1,787.11
Time off in Lieu	26	50	£0
Other action	8	0	£0
Still open (pending decision)	0	0	£0

Guardian fines for levied for contractual breaches of safe working hours: £443.58.

Rostering Gaps

Health Education England manages the national training numbers and regional distribution of doctors accepted into the different programs (grades and specialties).
Due to challenges with national recruitment not all of these posts are filled and the organisation aims to employ Trust Grade/Locally Employed doctors to cover these vacancies.

As the number of trainee posts allocated to the organisation as a whole isn't sufficient to deliver the level of care and service required, the Trust has recruited to a number of non-training posts that have been created over the years.

The number of vacancies in each category is in a constant state of flux for a variety of reasons, including:

- Training posts are often unfilled. The gaps are 'shared' across the region
- Trainees rotate between hospitals as well as primary and secondary care at various points throughout the year
- Non-training posts are often used as a temporary break from the national training pathway. There is no guarantee these doctors will remain in the organisation once they return to training.

Vacancies in non-training posts have been consistently close to 10% in York since December 2019. In Scarborough there was a significant improvement from approximately

22% in December 2019 to a similarly stable figure of approximately 10% since early-mid 2020.

Trainee vacancies have varied from 4-9% over the same period.

The organisation continues to use a variety of methods to recruit doctors and mitigate these gaps. This includes:

- Development of innovative posts that combine clinical and non-clinical activities such as research or teaching
- International recruitment drives
- Increasing numbers of Advanced Clinical Practitioners
- Improving the experience that medical students and junior doctors have in the organisation thereby making us a regional employer of choice. This is being achieved in a number of ways, for example, providing extra annual leave on top of the statutory minimum, improving rest facilities, hosting annual Junior Doctor Awards, a paired learning programme and providing a voice via the Junior Doctors' Forum.

2.4 Statement of Assurance from the Board of Directors

2.4.1 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.

2.4.2 Assurance from the Board

During 2020/21 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 2020/21 represents 100 per cent of the total income generated from the provision of relevant health services by York Teaching Hospital NHS Foundation Trust for 2020/21. The income generated has been received from services commissioned by Clinical Commissioning Groups, NHS England, and the Local Authorities.

2.4.3 Participation in National Clinical Audits and National Confidential Enquiries

During 2020/21, 61 national clinical audits and 2 national confidential enquiry reports / review outcome programmes (NCEPOD) covered relevant health services that York Teaching Hospital NHS Foundation Trust provides.

During that period York Teaching Hospital NHS Foundation Trust participated in 55 (90%) of the national clinical audits and 2 (100%) of the NCEPODs. Participation did not occur for

4 (7%) national clinical audits due to the COVID pandemic and subsequent deferral from national providers. This renders the Trust 97% compliant with participation for all eligible listings within the Quality Accounts.

The national clinical audits and national confidential enquiries that York Teaching Hospital NHS Foundation Trust was eligible to participate in during 2020/21 are as follows:

National Clinical Audits			National Confidential Enquiries
PHE Antenatal and Newborn National Audit Protocol 2019 to 2021	NACAP National Asthma and COPD Audit Programme - COPD Secondary Care	GICAP National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	*NCEPOD Medical and Surgical Clinical Outcome Review Programme - Dysphagia in People with Parkinson's Disease*
BAUS Urology Audits - Nephrectomy	NACAP National Asthma and COPD Audit Programme - Pulmonary Rehabilitation	NJR National Joint Registry	*NCEPOD Medical and Surgical Clinical Outcome Review Programme - Physical Health in Mental Health Hospitals*
BAUS Urology Audits - Female Stress Urinary Incontinence	NABCOP National Audit of Breast Cancer in Older People	NLCA National Lung Cancer Audit	
BAUS Urology Audits - Renal Colic	NACR National Audit of Cardiac Rehabilitation	NMPA National Maternity and Perinatal Audit	
ICNARC CMP Case Mix Programme	NACEL National Audit of Care at the End of Life	NNAP National Neonatal Audit Programme	
Elective Surgery - National PROMs Programme	NAD National Audit of Dementia - Care in General Hospitals	NOD National Ophthalmology Database Audit - Adult Cataract Surgery	
RCEM Fractured Neck of Femur (Care in EDs)	Epilepsy12 National Audit of Seizures and Epilepsies in Children and Young People	NPDA National Paediatric Diabetes Audit	
RCEM Pain in Children (Care in EDs)	NSBR National Bariatric Surgery Registry	NPCA National Prostate Cancer Audit	
RCEM Infection Control (Care in EDs)	NCAA National Cardiac Arrest Audit	NVR National Vascular Registry	
FFFAP Falls and Fragility Fractures Audit Programme - National Audit of Inpatient Falls	NCAP National Cardiac Audit Programme - National Cardiac Rhythm Management	PHE NHS provider interventions with suspected/confirmed carbpenease producing Gram negative colonisations / infections	
FFFAP Falls and Fragility Fractures Audit Programme -	NCAP National Cardiac Audit Programme - Myocardial Ischaemia	PQIP Perioperative Quality Improvement Programme	

National Clinical Audits			National Confidential Enquiries
National Hip Fracture Database	National Audit Project		
IBD Inflammatory Bowel Disease Service Standards	NCAP National Cardiac Audit Programme - Percutaneous Coronary Interventions	SSNAP Sentinel Stroke National Audit Programme	
IBD Inflammatory Bowel Disease Biological Therapies Audit	NCAP National Cardiac Audit Programme - Heart Failure Audit	SHOT Serious Hazards of Transfusion: UK National Haemovigilance Scheme	
LeDeR Learning Disability Mortality Review Programme	NDA National Diabetes Audit - Adults - National Diabetes Foot Care Audit	SAMBA Society for Acute Medicine's Benchmarking Audit	
PHE Mandatory Surveillance of HCAI	NDA National Diabetes Audit - Adults - National Diabetes Inpatient Audit	SSISS Surgical Site Infection Surveillance Service	
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	NDA National Diabetes Audit - Adults - Harms - reporting on diabetic inpatient harms in England	TARN Major Trauma Audit	
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal morbidity and mortality confidential enquiries	NDA National Diabetes Audit - Adults - National Core Diabetes Audit	CFR UK Cystic Fibrosis Registry (Adult & Paediatric)	
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality surveillance and mortality confidential enquiries	NDA National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	UK Registry of Endocrine and Thyroid Surgery	
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries	NEIAA National Early Inflammatory Arthritis Audit	UK Renal Registry	
NACAP National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care	NELA National Emergency Laparotomy Audit		
NACAP National Asthma and COPD Audit Programme - Adult Asthma Secondary Care	GICAP National Gastro-intestinal Cancer Programme - Oesophago-Gastric Cancer		

The national clinical audits and national confidential enquiries that York Teaching Hospital NHS Foundation Trust participated in during 2020/21 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Audit Topic	What is the Audit about?	Trust Participation in 2020/21	Data Completion %	Outcome
PHE Antenatal and Newborn National Audit Protocol 2019 to 2021	The audit looks at the time to intervention from screen positive report for HIV, hepatitis B or syphilis being received by the Screening Team from the laboratory or the known positive status being communicated to the Screening Team.	Yes	100%	Action plan in place and completed in relation to data collection.
BAUS Urology Audits - Nephrectomy	This audit includes nephrectomies, nephroureterectomies & partial nephrectomies carried out either through a conventional open incision or through several keyhole incisions (laparoscopic or robotic assisted laparoscopic).	Yes	100%	National report expected 2022
BAUS Urology Audits - Female Stress Urinary Incontinence	This audit includes all surgical treatments for both primary and recurrent stress urinary incontinence.	Yes	100%	2020 data is not being analysed or published
BAUS Urology Audits - Renal Colic	This audit will collect baseline data on the assessment and management of patients presenting with renal colic.	Yes	Data collection ending March 2021	National report expected June 2021
ICNARC CMP Case Mix Programme	This audit looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	Yes	Continuous data collection	National report expected March 2021
Elective Surgery - National PROMs Programme	This audit looks at patient reported outcome measures in NHS funded patients eligible for hip or knee replacement.	Yes	Continuous data collection	National report expected August 2021
RCEM Fractured Neck of Femur (Care in EDs)	This QIP will identify current performance in EDs against nationally agreed clinical standards to improve the care provided to adult patients in the ED who have a diagnosis of fractured neck of femur.	Yes	Data collection 3 Nov 2020 - 9 Apr 2021	National report expected Summer 2021
RCEM Pain in Children (Care in EDs)	This QIP will identify current performance in EDs against nationally agreed clinical standards to improve the care provided to paediatric patients in the ED who present in moderate or severe pain with a limb fracture.	Yes	Data Collection 3 Nov 2020 - 3 Oct 2021	National report expected Summer 2021
RCEM Infection Control (Care in EDs)	This QIP will identify current performance in EDs against nationally agreed clinical standards to improve patient safety and quality of care as well as, workspace safety through sufficient measurement to track change but with a rigorous focus on action to improve.	Yes	Data collection 3 Nov 2020 - 9 Apr 2021	National report expected Summer 2021
FFFAP Falls and	The audit provides the first comprehensive	Yes	Continuous	Action plan in place,

National Audit Topic	What is the Audit about?	Trust Participation in 2020/21	Data Completion %	Outcome
Fragility Fractures Audit Programme - National Audit of Inpatient Falls	data sets on the quality of falls prevention practice in acute hospitals.		data collection	to be completed June 2021
FFFAP Falls and Fragility Fractures Audit Programme - National Hip Fracture Database	The audit measures quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform.	Yes	Continuous data collection	Action plan currently being developed
IBD Inflammatory Bowel Disease Service Standards	The IBD Standards say what high-quality care should look like at every point of a patient's journey – from first symptoms, to diagnosis, treatment, and ongoing care.	No	The Trust did not participate in the audit due to local IT infrastructure issues. Action plan currently being developed for consideration	
IBD Inflammatory Bowel Disease Biological Therapies Audit	The IBD Registry biological therapies audit collected data on all patients of all ages diagnosed with the ICD-10 codes and receiving biological therapy at any time during the year. The data was requested at three time points: initiation, post-induction review and 12-month review.	No	The Trust did not participate in the audit due to local IT infrastructure issues. Action plan currently being developed for consideration	
LeDeR Learning Disability Mortality Review Programme	The learning from deaths of people with a learning disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities.	Yes	Continuous data collection	National report expected May 2021
PHE Mandatory Surveillance of HCAI	Mandatory HCAI surveillance outputs are used to monitor progress on controlling key health care associated infections and for providing epidemiological evidence to inform action to reduce them.	Yes	Continuous data collection	Reports published as national statistics, on Monthly, Quarterly and Annual basis
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	The study addresses late foetal losses – baby delivered between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred. Terminations of pregnancy - resulting in a pregnancy outcome from 22+0 weeks gestation onwards. Stillbirths – baby delivered from 24+0 weeks gestation showing no signs of life. Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth. Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.	Yes	Continuous data collection	No publication date yet identified
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review	This enquiry concerns intrapartum stillbirths and intrapartum related neonatal deaths in multiple births.	Yes	Continuous data collection	No publication date yet identified

National Audit Topic	What is the Audit about?	Trust Participation in 2020/21	Data Completion %	Outcome
Programme - Perinatal morbidity and mortality confidential enquiries				
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality surveillance and mortality confidential enquiries	All deaths of women who die during pregnancy or up to one year after the end of the pregnancy regardless of how the pregnancy ended or the cause of death.	Yes	Continuous data collection	No publication date yet identified
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity confidential enquiries	The aim is to identify avoidable illness and deaths so the lessons learned can be used to prevent similar cases in the future.	Yes	Continuous data collection	No publication date yet identified
NACAP National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care	The audit looks at the care children and young people with asthma get when they are admitted to hospital because of an asthma attack.	Yes	Continuous data collection	No publication date yet identified
NACAP National Asthma and COPD Audit Programme - Adult Asthma Secondary Care	The audit looks at the care of people admitted to hospital adult services with asthma attacks.	Yes	Continuous data collection	No publication date yet identified
NACAP National Asthma and COPD Audit Programme - COPD Secondary Care	The aim of the audit is to drive improvements in the quality of care and services provided for COPD patients.	Yes	Continuous data collection	No publication date yet identified
NACAP National Asthma and COPD Audit Programme - Pulmonary Rehabilitation	This audit looks at the care people with COPD get in pulmonary rehabilitation services.	Yes	Continuous data collection	No publication date yet identified
NABCOP National Audit of Breast Cancer in Older People	This audit evaluates the quality of care provided to women aged 70 years and older by breast cancer services in England and Wales.	Yes	Continuous data collection	No publication date yet identified
NACR National Audit of Cardiac Rehabilitation	The audit aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.	Yes	Continuous data collection	National report expected November 2021
NACEL National Audit of Care at the End of Life	The aim of the audit is to improve the quality of care of people at the end of their life for people receiving NHS funded care in England, Wales and Northern Ireland.	N/A	No data collection for 2020/21	
NAD National Audit of Dementia - Care in General Hospitals	The audit measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital.	N/A	No data collection for 2020/21	
Epilepsy12 National	The audit aims to address the care of	Yes	Continuous	No publication date

National Audit Topic	What is the Audit about?	Trust Participation in 2020/21	Data Completion %	Outcome
Audit of Seizures and Epilepsies in Children and Young People	children and young people with suspected epilepsy who receive a first paediatric assessment from April 2018 within acute, community and tertiary paediatric services.		data collection	yet identified
NSBR National Bariatric Surgery Registry	The National Bariatric Surgery Register is a comprehensive, prospective, nationwide analysis of outcomes from bariatric surgery in the United Kingdom and Ireland. It contains pooled national outcome data for bariatric and metabolic surgery in the United Kingdom.	Yes	Continuous data collection	No publication date yet identified
NCAA National Cardiac Arrest Audit	The project audits cardiac arrests attended to by in-hospital resuscitation teams.	Yes	Continuous data collection	National report expected March 2022
NCAP National Cardiac Audit Programme - National Cardiac Rhythm Management	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	Yes	Continuous data collection	No publication date yet identified
NCAP National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 in response to the National Service Framework (NSF) for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.	Yes	Continuous data collection	No publication date yet identified
NCAP National Cardiac Audit Programme - Percutaneous Coronary Interventions	This project looks at percutaneous coronary intervention (PCI) procedures performed in the UK. The audit collects and analyses data on the nature and outcome of PCI procedures, who performs them and the general health of patients. The audit utilises the Central Cardiac Audit Database (CCAD) which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.	Yes	Continuous data collection	No publication date yet identified
NCAP National Cardiac Audit Programme - Heart Failure Audit	The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.	Yes	Continuous data collection	No publication date yet identified
NDA National Diabetes Audit - Adults - National Diabetes Foot Care Audit	Patients referred to specialist diabetes footcare services for an expert assessment on a new diabetic foot ulcer.	Yes	Continuous data collection	No publication date yet identified
NDA National Diabetes Audit - Adults - National Diabetes Inpatient Audit	The National Diabetes Inpatient Audit (NaDIA) is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical wards. NaDIA allows hospitals to benchmark hospital diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and	Yes	Continuous data collection	No publication date yet identified

National Audit Topic	What is the Audit about?	Trust Participation in 2020/21	Data Completion %	Outcome
	outcomes.			
NDA National Diabetes Audit - Adults - Harms - reporting on diabetic inpatient harms in England	The National Diabetes Inpatient Audit - Harms (NaDIA-Harms) is a continuous collection of four diabetic harms which can occur during an inpatient stay.	Yes	Continuous data collection	No publication date yet identified
NDA National Diabetes Audit - Adults - National Core Diabetes Audit	National Diabetes Audit collects information on people with diabetes and whether they have received their annual care checks and achieved their treatment targets as set out by NICE guidelines.	Yes	Continuous data collection	No publication date yet identified
NDA National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	The audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	Yes	Continuous data collection	National report expected October 2021
NEIAA National Early Inflammatory Arthritis Audit	The audit aims to improve the quality of care for people living with inflammatory arthritis.	Yes	Continuous data collection	No publication date yet identified
NELA National Emergency Laparotomy Audit	NELA aims to look at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	Yes	Continuous data collection	Action plan currently being developed
GICAP National Gastro-intestinal Cancer Programme - Oesophago-Gastric Cancer	The oesophago-gastric (stomach) cancer audit aims to examine the quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all O-G cancer patients, both curative and palliative.	Yes	Continuous data collection	Action plan currently being developed
GICAP National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	Colorectal (large bowel) cancer is the most common cancer in nonsmokers and second most common cause of death from cancer in England and Wales. Each year over 30,000 new cases are diagnosed, and bowel cancer is registered as the underlying cause of death in half of this number.	Yes	Continuous data collection	Action plan currently being developed
NJR National Joint Registry	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.	Yes	Continuous data collection	Action plan in place, completion date delayed due to COVID pandemic
NLCA National Lung Cancer Audit	Lung cancer has the highest mortality rate of all forms of cancer in the western world and there is evidence that the UK's survival rates compare poorly with those in the rest of Europe. There is also evidence that, in the UK, standards of care differ widely. The audit was set up to monitor the introduction and effectiveness of cancer services.	Yes	Continuous data collection	Action plan delayed due to COVID pandemic
NMPA National Maternity	A new large scale audit of NHS maternity services across England, Scotland and	Yes	Data collection is	National report publication delayed

National Audit Topic	What is the Audit about?	Trust Participation in 2020/21	Data Completion %	Outcome
and Perinatal Audit	Wales, collecting data on all registrable births delivered under NHS care.		via the NHS Digital Maternity Services Dataset	due to COVID pandemic
NNAP National Neonatal Audit Programme	To assess whether babies requiring specialist neonatal care receive consistent high quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	Yes	Continuous data collection	Action plan in place, to be completed December 2021
NOD National Ophthalmology Database Audit - Adult Cataract Surgery	The project aims to prospectively collect, collate and analyse a standardised, nationally agreed cataract surgery dataset from all centres providing NHS cataract surgery in England & Wales to update benchmark standards of care and provide a powerful quality improvement tool. In addition to cataract surgery, electronic ophthalmology feasibility audits will be undertaken for glaucoma, retinal detachment surgery and agerelated macular degeneration (AMD).	Yes	Continuous data collection	No publication date yet identified
NPDA National Paediatric Diabetes Audit	The audit covers registrations, complications, care process and treatment targets.	Yes	Continuous data collection	National report expected May 2021
NPCA National Prostate Cancer Audit	The National Prostate Cancer Audit is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	Yes	Continuous data collection	Action plan currently being developed
NVR National Vascular Registry	The National Vascular Registry collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.	Yes	Data collection April 2020 – March 2021	Action plan currently being developed
PHE NHS provider interventions with suspected/confirmed carbpenease producing Gram negative colonisations / infections	An improvement resource to help health and social care economies reduce the number of GNBSIs.	N/A	Although included on QA List 2020/21 - project has currently closed as of 10th March 2020 due to capacity redirection to COVID-19.	
PQIP Perioperative Quality Improvement Programme	This programme aims to improve the care and treatment of patients undergoing major surgery in the UK.	Yes	Continuous data collection	No publication date yet identified
SSNAP Sentinel Stroke National Audit Programme	The audit collects data on all patients with a primary diagnosis of stroke, including any patients not on a stroke ward. Each incidence of new stroke is collected.	Yes	Continuous data collection	Action plan currently being developed
SHOT Serious Hazards of Transfusion: UK National Haemovigilance Scheme	The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.	Yes	Continuous data collection	National report expected July 2021

National Audit Topic	What is the Audit about?	Trust Participation in 2020/21	Data Completion %	Outcome
SAMBA Society for Acute Medicine's Benchmarking Audit	The SAMBA is a national benchmark audit of acute medical care. The aim is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national average.	N/A	Data collection delayed due to COVID-19, due to pressure on clinical teams. All participating units are acute medicine units, therefore data collection delayed to avoid increasing pressure on these services.	
SSISS Surgical Site Infection Surveillance Service	The aim of the national surveillance program is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.	Yes	Continuous data collection	National report expected December 2021
TARN Major Trauma Audit	TARN is working towards improving emergency health care systems by collating and analysing trauma care.	Yes	Continuous data collection	No publication date yet identified
CFR UK Cystic Fibrosis Registry (Adult & Paediatric)	This audit looks at the care of people with a diagnosis of cystic fibrosis under the care of the NHS in the UK.	Yes	Continuous data collection – submitted as part of the Leeds Network	Data reported as part of the Leeds Network
UK Registry of Endocrine and Thyroid Surgery	The Registry collects data on all patients undergoing thyroid surgery performed by any surgeon registered with the audit.	Yes	Continuous data collection	No publication date yet identified
UK Renal Registry	Data collected by the Renal Association are used to conduct a wide range of audit and research work to improve the lives of people with kidney disease.	Yes	Continuous data collection	National report expected June 2022
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Dysphagia in People with Parkinson's Disease	This study aims to examine the pathway of care of patients with Parkinson's disease (PD) who are admitted to hospital when acutely unwell. In particular, to identify and explore multidisciplinary care and review organisational factors in the process of identifying, screening, assessing, treating and monitoring the ability to swallow.	Yes	100%	National report expected Summer 2021
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Physical Health in Mental Health Hospitals	This study aims to identify and explore remediable factors in the physical healthcare of adult patients admitted to an inpatient mental health facility.	Yes	100%	National report expected Summer 2021

The reports of 41 national clinical audits were reviewed by the provider in 2020/21 and York Teaching Hospital NHS FT intends to take the following actions to improve the quality of healthcare provided:

- A Clinical Effectiveness Officer will be allocated to each Quality Account as a link person for the audit lead; they will meet on a minimum quarterly basis to determine progress with data submission, ascertain any red-flags from data submission so far, and develop a good working relationship to enhance effective communication.
- Upon receipt of a national audit report, a Clinical Effectiveness Officer will arrange an MDT meeting with the audit lead and any relevant stakeholders to discuss the findings, share learning, determine how the results will be shared, develop an action plan where required, and benchmark against the report recommendations.
- The Clinical Effectiveness Team will contact and request support from the Quality Improvement Team for audits which have metrics demonstrating reduced compliance when compared nationally.
- Upon receipt of national audit reports, they will be added to the weekly Quality & Safety meeting agenda for sharing across the organisation to ensure early stakeholder oversight. Any immediate risks will be determined and shared through the weekly Q&S meeting.
- An improvement work-stream is required over the next 6 months to enable effective use of the Trust Intranet and Website to promote the findings from Quality Accounts.

The reports of 117 local clinical audits were reviewed by the provider in 2020/21 and York Teaching Hospital NHS FT intends to take the following actions to improve the quality of healthcare provided:

- Q-Pulse will be utilised within each Care Group to capture and record local clinical audit.
- Local clinical audit will be managed within each individual Care Group with coordination from Clinical Governance Co-ordinators & Clinical Governance Facilitators.
- Approval and ownership will be the responsibility of Care Group governance teams and will allow for approval in line with Care Group / department priorities.
- All audit activity will be captured on Q-Pulse and will enable Care Groups and Corporate teams to have oversight of the activity, with learning captured in one place.

2.4.4 Research and Development

The aim of clinical trials is to increase knowledge about treatments to ensure treatments are 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 2020 to 31 March 2021 that were recruited during that period to participate in research approved by a research ethics committee is 4760.

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 Trust recruited approximately 1700 participants into phase 4 of the FAST TRACK study during the COVID-19 pandemic. This study compares two stool tests in patients presenting to primary care with bowel symptoms at low risk for colorectal cancer to determine the point of optimal transition from Faecal Calprotectin to FIT for this group of patients.

- York Teaching Hospitals NHS Foundation Trust has been at the forefront of recruitment of patient recruitment into the Recovery Trial, the Trust recruited 221 patients into this trial and remains open to recruitment. The trial has had two major findings so far; it has demonstrated how dexamethasone was the first drug which could reduce mortality from COVID-19, and also how an anti-inflammatory treatment called tocilizumab reduced the risk of death seen in patients hospitalized with severe COVID-19. The study also highlighted how tocilizumab shortens the required in-patient time and reduces the need for mechanical ventilation so patients can be successfully discharged from hospitals sooner. It is currently the largest global trial of treatments for COVID-19.

- The Trust recruited 29 patients in the REMAP-CAP trial which showed how arthritis drugs helped to reduce mortality and time spent in ICU for those suffering with more severe COVID-19. It has both an innovative and adaptive design to mirror the unpredictable nature of the virus and patients can be randomised into a number of different treatment choices simultaneously. This study randomized patients into multiple arms with the ‘treatment group’ receiving the trial drug and standard care and the ‘control group’ receiving standard care. This is a global initiative with 315 hospital sites taking part and so far the findings have shown tocilizumab, and a second drug called Sariluma, both types of immune modulators called IL-6 receptor antagonists used to treat arthritis have significant impact on patient survival rates, reducing mortality by 8.5%. Equally significant, the findings have also highlighted a number of treatments which have been shown to be ineffective, which is as also helpful and a key part of running a drug trial.

- The R&D department enrolled 361 members of Trust staff into the urgent Public Health England study SIREN which is looking at immunity and reinfection rates within the NHS Staff population. The study has been a huge success and is being used to evidence the effectiveness of the Pfizer vaccine rollout which has supported the UK Government’s COVID strategy and England’s pathway out of Lockdown.

- The Trust has been actively participating in the Urgent Public Health Study; Clinical Characterisation Protocol for Severe Emerging Infections (CCP) since the beginning of the COVID-19 pandemic, and has recruited 1789 patients so far. It aims to inform clinical practice and management of the pandemic through globally collecting patient data on various markers such as the clinical features of COVID-19, patient symptoms and responses to treatments. It has provided one of the largest databanks of information on the virus so far.

- The SSHeW trial has shown clear evidence how the 5* GRIP-rated, slip-resistant shoes provided by the study reduced the number of slips NHS staff had at work. Staff who were provided with these shoes had fewer slips than those staff members who wore their own shoes at work

- So far, the Trust has recruited 119 patients into the Urgent Public Health Study, Genetics of Mortality in Critical Care (GenOMICC). The study collects DNA samples of patients severely unwell in ICU with conditions, such as COVID-19, in the hope genes can be analysed and identified which may provide insight as to why some people become more severely unwell than others and why people react differently to different infections.

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 2020/21 has been a great year for us, we are very proud of our staff and the amazing achievements from this year.

2.4.5 Commissioning for Quality and Innovation Payment Framework

Due to the COVID-19 pandemic CQUINs were suspended for quarter four of 2019-20 and for the entirety of 2020/21. At the time of writing there has not been any guidance received regarding CQUIN schemes for 2021-22.

2.4.6 Care Quality Commission

York Teaching Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is ‘Registered with Conditions’. The CQC took enforcement action against York Teaching Hospital Trust in 2019/2020 and during 2020/21 the following conditions on registration remained in place:

York Hospital

1. 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.

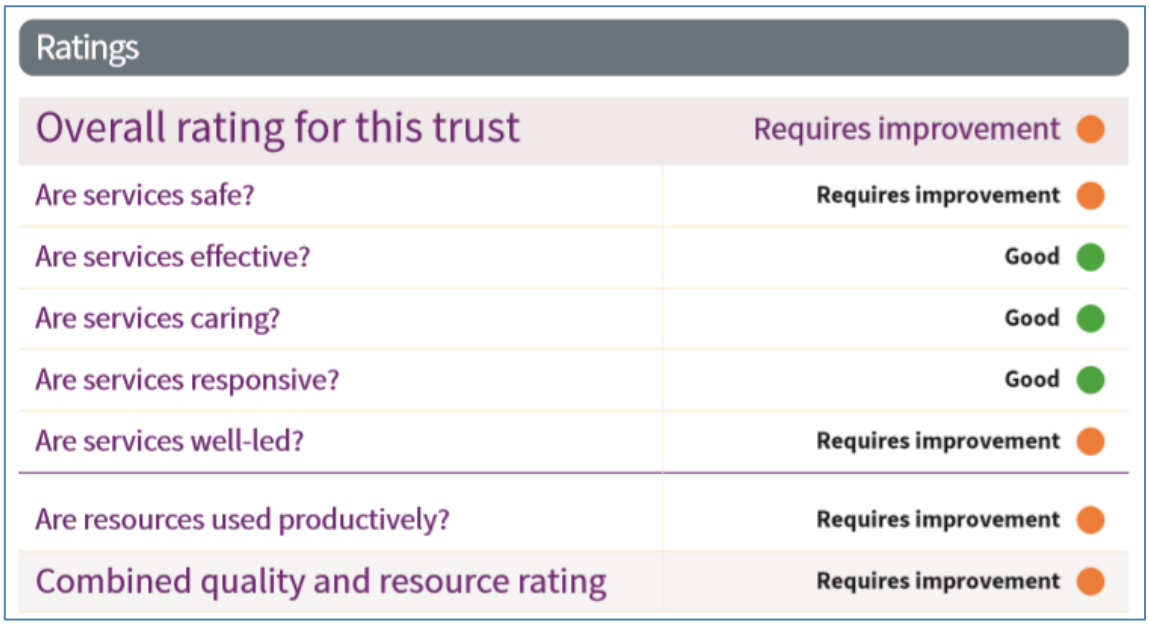
2. The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.
3. The registered provider must by 20 January 2020; 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.

Scarborough Hospital

1. The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at Scarborough Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.
2. 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 department at Scarborough Hospital is safe for its intended purpose, specifically in relation to patients with mental health conditions.
3. The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at Scarborough Hospital, twenty-four hours a day, seven days a week.
4. The registered provider must ensure that there are sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff at all times to meet the needs of patients within all medical wards at Scarborough Hospital.

The Care Quality Commission has not taken enforcement action against York & Teaching Hospitals NHS Foundation Trust during the reporting period. York Teaching Hospitals NHS FT has not participated in any special review or investigations by the CQC during the reporting period.

York Teaching Hospitals NHS Foundation Trust last received a full inspection in July 2019 with an overall Trust rating of ‘Requires Improvement’. Following the last CQC inspections, York Teaching Hospitals NHS Foundation Trust developed a comprehensive action plan. Since the inception of the action plan, significant actions have been taken to improve safety. The improvements can be described under three key themes:



Mental Health Care – Mental Health risk assessments were successfully standardised and implemented across the Trust which allows for the early identification of risk and appropriate care delivery. In addition both of the Trusts emergency departments host a mental health assessment suite, both of which meet national standards and expectations. In order to strengthen the priority of Mental Health within the Trust, steering groups were established in both of the Trusts Emergency Departments; to oversee these groups a Mental Health Strategic Group was established. The groups will ensure mental health standards and considered and implemented and set the strategic direction of mental health care within the Trust, including training and education requirements.

Paediatric Emergency Care – Both Emergency Departments have seen a significant investment including the recruitment of Senior Registered Children's Nurses. Whilst the recruitment was underway, ward staff and agency nurses were utilised to ensure children were seen by specially trained staff within the Emergency Departments. Environmental assessments were undertaken with initial improvement work completed enabling Children to wait and be cared for in dedicated Children areas.

Staffing – Increases in staffing establishments took place across medical wards at Scarborough Hospital. Daily management of staffing is overseen by Senior Nurses within the Hospital and a significant improvement in covering shifts has been demonstrated over the last 12 months. Further staffing establishments are being reviewed across the Trust.

In addition to the key themes highlighted above, the CQC action plan includes other a range of other recommendations. Excellent progress has been demonstrated with the CQC action plan and further improvement work has commenced with oversight from the Quality Committee. On 12th February 2021, 7 notifications were submitted to the CQC on behalf of the organisation. The 7 notifications were to request the removal of the 3 conditions associated with registration for York Hospital and 4 conditions associated with registration for Scarborough Hospital, with effect from 1st March 2021. Through regular engagement meetings with the CQC, the Trust has bee notified that 5 of the 7 conditions associated with registration will be removed. This demonstrates significant improvements in safe care delivery. Written notification is awaited from the CQC following their internal

processes. This will demonstrate that the Trust has 2 conditions associated with registration as follows:

York Hospital

1. 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.

Scarborough Hospital

1. The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at Scarborough Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.

The CQC ascertained that improvements have been made in relation to the 2 conditions, and will review the appropriateness of removing these following further audits to provide assurance that the practice is embedded.

2.4.7 Data Quality

York Teaching Hospital NHS Foundation Trust submitted records during 2020/21 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:
99.9% for admitted patient care;
99.7% for outpatient care;
99.6% 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.

2.4.8 Information Governance

Information Governance is how the trust handles and uses information, both personal information (such as patient and employee records) and corporate information (such as financial records).

In the NHS, information is essential for the clinical management of individual patients and the efficient provision of services and resources.

Information Governance provides a framework to ensure that patient information is fairly obtained, securely handled, properly maintained, and readily accessible to staff with a legitimate reason to access it, to facilitate the provision of high quality healthcare services.

Our commitment to the fundamental principles of data protection, confidentiality and privacy means our patients can be assured that their information will be handled legally and appropriately at all times.

The Trust uses the Information Commissioners Accountability Framework to monitor progress and provide assurance on compliance with the requirements of the Data Security and Protection Toolkit. This is broken down to 10 domains and performance across these areas is detailed below.

1. Leadership and Oversight
2. Policies and Procedures
3. Training and Awareness
4. Individuals' Rights
5. Transparency
6. Record of Processing Activities (ROPA) and Lawful Basis
7. Contracts & Data Sharing
8. Risks and Data Protection Impact Assessments (DPIA)
9. Records Management
10. Breach Response and Monitor

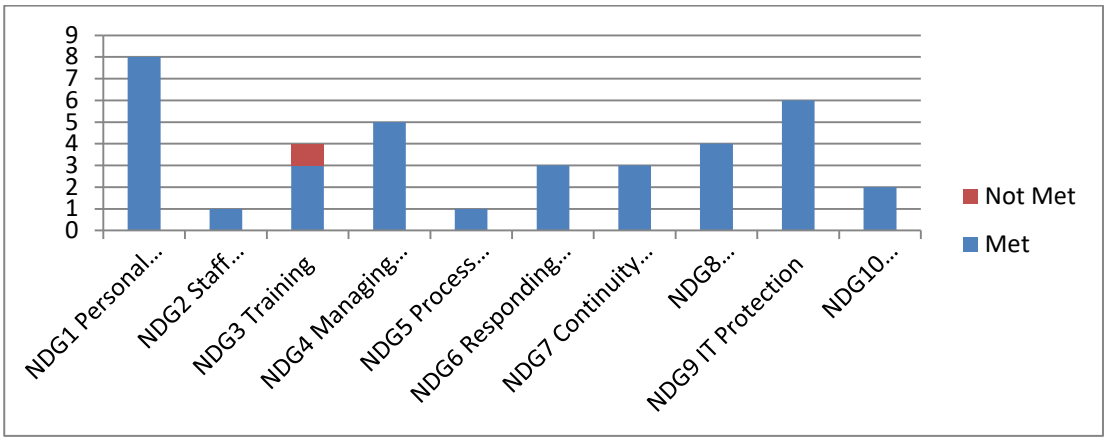
Fulling meeting our expectation	30%
Partially meeting our expectation	39%
Not meeting our expectation	20%
Not applicable	3%

Data Security and Protection Toolkit

The Trust measures its performance against the Data Security and Protection Toolkit which is a set of standards set by the National Data Guardian (NDG) and the Department of Health and Social Care (DHSC).

The current toolkit has 42 assertions that the Trust is required to assess itself against and provide 110 pieces of mandatory evidence items.

The Trust's current submission status is that all but 1 mandatory assertion are "met". The mandatory assertion where the standard is "not met" is where the requirement is for 95% of staff to have completed their annual Information Governance statutory and mandatory training. The current compliance rate is 87%. Work will continue by the Information Governance Team to improve compliance rates but it is not anticipated that by the 30 June 2021 submission date that this standard will be "met".



Compliance Information Governance Spot Checks

To assure compliance with IG requirements across the Trust against relevant policies, a programme of compliance spot checks is undertaken on a rolling basis.

During the COVID-19 pandemic the scope of these checks has had to be narrowed but additional checks were made in non-clinical areas.

The checks undertaken assessed compliance with IG policies and operational practices in line with the Data Security and Protection toolkit requirements and CQC outcomes 2 and 21. Where issues were identified corrective action was recommended by the Information Governance Team. Outcomes from the compliance spot checks are reported to the Information Governance Executive Group on a bi-monthly basis.

Information Sharing Agreements

Work has continued on an ongoing basis to develop Information Sharing Agreements between the Trust and partner organisations in the region. These agreements have enabled the Trust to improve healthcare and its partners.

Some of the Information Sharing Agreements that have been developed are:

- Bridlington Digital Hub where patients who do not have internet access at home can attend virtual outpatient appointments in a safe and confidential environment.
- City Health Care Partnerships to manage efficient patient flow through the management of referrals for treatment
- St Leonards Hospice for the treatment of end of life patients and patients for palliation

Data Quality

The Trust aims to always have the most accurate information available in order to provide high quality healthcare. The Trust has a dedicated Data Quality Team who quickly and efficiently responds to the identification of data quality issues. The Data Quality Team works closely with the Information Governance Team to provide assurance to the Information Governance Executive Group on all data quality matters.

On an annual basis the Clinical Coding Services have an audit undertaken on Finished Consultant Episodes (FCE) and the findings of the 2020/21 audit achieved significant assurance on its findings.

Freedom of Information

The Trust is committed to a culture of openness and transparency in its operation. We recognise the importance of the public seeing how decisions are made and where money is spent.

In 2019 the trust responded to 343 requests for information under the Freedom of Information Act. 85% of these requests were responded to within the 20 day statutory timeframe.

In 2020 The Trust received a total of 273 requests for information and responded to 74% of these within the timeframe.

2.4.9 Payment by Results

York Teaching Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission.

2.5 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, with the exception of the Summary Hospital-Level Mortality Indicator (SHMI).

Summary Hospital-level Mortality Indicator (SHMI) and Banding	Trust Nov 19 – Oct 20	Trust Dec 19 – Nov 20	NHS (England) Dec 19 – Nov 20
Trust score (lower value is better)*	0.96*	0.95*	1.00
Banding	As Expected	As Expected	As Expected

We will:

- Continue to strengthen our approach to the triangulation of themes and learning from mortality reviews, complaints, claims inquests and serious incidents to identify quality improvement initiatives.
- Continue to strengthen the quality of action plans arising from reviews and investigations and ensure robust governance of delivery.

Palliative Care Coding	Trust Nov 19 – Oct 20	Trust – Dec 19 – Nov 20	*NHS Average (England) Dec 19 – Nov 20	Highest Trust Dec 19 – Nov 20	Lowest Trust Dec 19 – Nov 20
% Deceased patients with palliative care coded	25.0	24.0	36.0	59.0	8.0

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

- We monitor 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.

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 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.

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	90.2	100.0	75.8
Knee replacement (Primary)	88.2	85.0	83.0	94.3	61.8

Provisional data, and is the most recent PROMs data, published in August 2020. Data for the highest and lowest performing Trusts for April 2019 to March 2020 (which was not available in the last Quality Report), is now available and is included above. The England value for primary knee replacements in Apr 19 – Mar 20 has been updated from 83.6 to 83.0.

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.

Emergency Readmissions within 30 Days of Discharge	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
Percentage of Readmissions aged 0 to 15	13.1	13.7	11.6	18.5	4.3*
Percentage of readmissions aged 16 and Over	13.3	13.5	13.6	17.5	9.2

Note: The lower the percentage, the better the performance. The above data is based on Emergency readmissions to hospital within 30 days of discharge for acute hospital Trusts. As the NHS Digital data does not identify acute Trusts as a separate category in their published data, acute Trusts were identified using the Trust's Healthcare Evaluation Data (HED) system ED, and the data was mapped to the nationally published data. NHS Digital published their readmission data in February 2021, therefore it was not available for inclusion in the Quality Account.

* The lowest Trust has a caution note attached to the NHS Digital data indicating the numbers of patients discharged were too small for meaningful comparison.

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

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

- A quality improvement initiative has been established to improve the quality and safety of discharge processes
- All reported incidents including those related to discharge are reviewed daily and those of concern are further investigated using 72-hour report methodology. The 72-hour reviews are presented and discussed at the weekly Quality and Safety group to ensure the appropriate action is taken to address any issues raised. The group is chaired by the Deputy Director of Governance and is attended by the Medical Director Chief Nurse, Deputy Medical Director, Deputy Chief Pharmacist/Medicines Safety Officer, Senior Care Group representation and appropriate clinicians related to the incidents discussed.

We will:

- Continue to hold our weekly quality and safety group 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	**Trust 2019	**NHS (England) 2019	**Highest Trust 2019	**Lowest Trust 2019
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.
Data collection for patients who were inpatients at the Trust in November 2020 is currently live, and the results of the survey are expected to be published in Autumn 2021.

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 and Patient Safety 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:

- Care Group 1 have Introduced a new role, Patient Services Operative, to assist patients further on elderly wards
- Reviewed all nursing documentation used on the wards and launched a new set of documentation. Work continues to develop an integrated care record.
- Implemented Perfect Ward as a more thorough and trackable way of auditing on wards. This is now being evaluated and revised based on feedback.
- Developing a new easy-read menu after a number of patients reported difficulties reading the menu choices
- Implemented 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.

We will

- Continue to utilise Always Events© methodology across the Trust to ensure our patients are involved in improving care.
- Continue to work with the Improvement Academy to embed the use of the Patient Experience plus toolkit.
- 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 2019	Trust 2020	NHS Staff Survey Average Score 2020	NHS Staff Survey Highest 2020	NHS Staff Survey Lowest 2020
Percentage of staff who would be happy with the standard of care provided by the organisation	64.6%	66.9%	74.3	91.7	49.7

These results are presented in the context of the best, average and worst results for similar organisations taken from the 2020 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 2019 value has been updated from 64.7% to 64.6%.

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-19 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
- Develop our Quality Improvement (QI) Strategy in consultation with our staff and embed QI at team level to ensure staff are empowered to improve care and identify areas for improvement.
- 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 (England*) Oct - Dec 2019**	**Highest Trust Oct – Dec 2019**	**Lowest Trust Oct – Dec 2019**
Percentage of patients risk assessed	97.84	96.35	95.33	100.00	71.59

*Data is for Acute Trusts only. National VTE data collection and publication is currently paused to release NHS capacity to support the response to Coronavirus, so the above data is the most recently published national data. This indicator is monitored locally, with reported performance being 94.86% for October – December 2020, and 94.40% for January to March 2021.

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.

*Data is for Acute Trusts only. National VTE data collection and publication is currently paused to release NHS capacity to support the response to Coronavirus, so the above data is the most recently published national data. This indicator is monitored locally, with reported performance being 94.86% for October – December 2020, and 94.40% for January to March 2021.

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 2018/19	Trust 2019/20	NHS average 2019/20	Highest Trust 2019/20	Lowest Trust 2019/20
Trust apportioned cases - rate per 100,000 bed days (HO Hospital Onset)	12.3*	22.5	13.2	51.0	0.0

The Trust's 2018-19 value has been updated from 12.4 to 12.3.

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 Apr-Sep 19	Trust Oct 19 – Mar 20	Average Oct 19 – Mar 20	Highest Trust Oct 19 - Mar 20	Lowest Trust Oct – Mar 20
Rate of patient safety incidents	36.6	41.9	50.7	110.2	15.7
*Number of incidents resulting in severe harm or death	25	23	20	93	0
% of incidents resulting in severe harm or death	0.38	0.34	0.33	1.49	0.00

Note – data represents acute non specialist trusts only, which is the Peer Group the Trust is benchmarked against for this indicator. The Trust % of incidents resulting in serious harm or death for Apr-Sep 19 was previously published as 0.39%.

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 Patient Safety and Governance team with clinical specialists prior to being reported to the National Patient Safety Agency.

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 Patient Safety and Governance team with clinical specialists 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:

- All incidents of all level of severity are reviewed daily to ensure appropriate action is taken and to ensure the severity rating is appropriately assigned
- The weekly Quality and Safety group chaired by the Deputy Director of Governance and Patient safety and attended by the Medical Director, Deputy Medical Director, Chief Nurse, Deputy Chief Pharmacist/ Medicines Safety Officer, senior Care Group representatives and relevant clinical representation (for specific incidents) ensures robust scrutiny of clinical incidents and that appropriate action is taken in response to any issues raised.
- Information on numbers of patient safety incidents, themes, trends and those resulting in severe harm or death are reported monthly to the Quality and Patient Safety Group through a detailed report and to the Quality Committee and the Board of Directors as part of the Integrated Board Report.

We will:

- Continue to hold the weekly Quality and Safety group chaired by the Deputy Director of Governance and Patient safety and take action to address any issues raised, and continue to validate all incidents of severe harm and death.
- Continue to work with frontline staff to ensure they feel safe to report incidents and sue the data from incidents to inform quality improvement.

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. Data submission and publication for the Friends and Family Test was paused during the response to the pandemic, and restarted for acute and community providers from December 2020. Data for December 2020 to February 2021 was due for publication in April 2021, but the most recent published data still relates to February 2020.

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 2019	Trust 2020	NHS Staff Survey Average 2020	NHS Staff Survey Highest (Worst) Trust 2020	NHS Staff Survey Lowest (Best) Trust 2020
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months from Managers*	12.1 %	13.1 %	12.6%	23.7%	6.2%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months from other colleagues*	19.2 %	20.1 %	19.8%	26.3%	12.2%

*These results are presented in the context of the best, average and worst results for similar organisations taken from the 2020 NHS Staff Survey. Relates to percentage of staff saying they experienced at least one incident of bullying, harassment or abuse. The Trust values for 2019 have been updated from 11.9% to 12.1% (managers) and from 19.0% to 19.2% (other colleagues) to reflect the data published in the most recent staff survey.

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

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 2019	Trust 2020	NHS Staff Survey average 2020	NHS Staff Survey Highest Trust 2020	NHS Staff Survey Lowest Trust 2020
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?*	86.7 %	85.7 %	84.9 %	94.3 %	66.5 %

*These results are presented in the context of the best, average and worst results for similar organisations taken from the 2020 NHS Staff Survey.

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

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

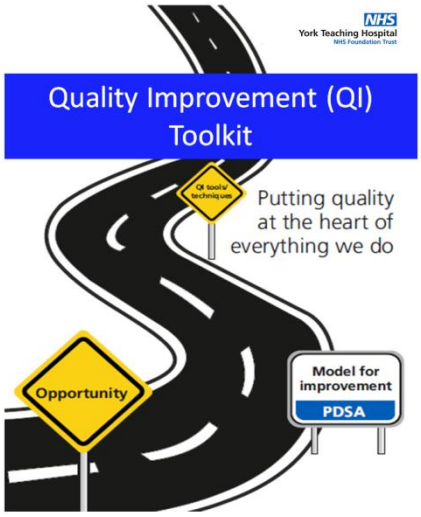
3.1 Trust Performance against National Quality Indicators

Indicator	2019-20	Target 2020-21	Q1 2020-21	Q2 2020-21	Q3 2020-21	Q4 2020-21	Total 2020-21
Total time in ED under 4 hours – national*	79.78%	95%	93.65%	87.05%	80.64%	78.85%	84.74%
*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 2020-21 was 77.78%							
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	75.9%	92%	50.0%	51.9%	66.5%	63.8%	58.4%
Cancer 2 week wait (all)	89.9%	93%	94.0%	92.5%	93.7%*	91.3%*	92.8%*
Cancer 2 week wait Breast Symptomatic	94.9%	93%	96.1%	95.6%	93.3%*	88.8%*	92.7%*
Cancer 31 days from diagnosis to first treatment	98.0%	96%	98.6%	97.1%	97.6%*	97.2%*	97.5%*
Cancer 31 days for second or subsequent treatment – surgery	92.5%	94%	81.4%	87.2%	89.2%*	90.7%*	87.0%*
Cancer 31 days for second or subsequent treatment – drug treatment	99.8%	98%	100%	99.5%	100%*	100%*	99.9%*
Cancer 62 day wait for first treatment (urgent GP)	79.7%	85%	79.4%	78.5%	75.1%*	72.4%*	76.1%*
Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service)	95.1%	90%	92.7%	-	89.5%*	88.4%*	88.6%*
Cancer 28 day Faster Diagnosis Standard	65.5%	75%	61.9%	64.0%	63.1%*	62.1%*	62.8%*
Diagnostics – 6 week wait referral to test	84.0%	99%	27.2%	48.7%	63.5%	65.6%	51.8%

* Cancer figures for Q3, Q4 and Total 2020-21 are provisional only.

3.2 Our Quality Improvement Journey

Our vision is to embed a culture of continuous improvement, whereby staff are empowered in collaboration with patients and carers to make on-going improvements in their everyday work to ensure the delivery of the highest standards of care. The embedding of a safety culture from board to ward, where improving safety is seen as everyone's business, and implementing a systematic approach to quality improvement across the organisation will support the delivery of the Trust's vision.



Quality improvement is the use of a systematic method to involve those closest to the quality issue in discovering solutions to a complex problem. Educating and enabling staff to use Quality Improvement methodology will be key to support the delivery of the clinical strategy.

In order to embed a culture of QI we will publish our QI strategy by the end of September 2021.

Development of the Quality Improvement Strategy

A QI strategy group has been created to develop our trust-wide systematic and effective approach for QI. In addition to the expertise within the strategy group which includes a lay member, staff engagement sessions are planned to enable staff to contribute to the development of the strategy.

QI educational resources

In order to support teams to lead their own quality improvement projects the improvement team will be developing the following in 2021/22

- Finalise the 6 simple steps to improvement (based on Model for Improvement)
- Amend our QI toolkit to reflect the above
- Development of a QI website with key aspects of QI information and templates.
- Development of an QI adult learning platform for self-directed study
- Provision of expert quality improvement advice and support for teams in running rapid improvement events and process mapping events, for example.

Development of a QI Coaching Programme

In order to enhance and grow the QI coaching resource and ethos, the Trust has recently partnered with Central London Community NHS Trust who have developed a QI coaching training package through the support of a Q Exchange grant (Health Foundation). The 'QI Coach training package' is free of charge to use and it is envisaged that this will form a key enabler to creating an embedded culture of QI across the Trust, commencing in Q3 2021/22

Quality Councils

Within the Family Health Care Group a pilot has been underway of a Quality Council approach. This approach enables front line staff to identify quality improvement projects that are supported to flourish through QI methodology coaching provided by the Improvement team. This enables teams to own their improvements and gain practical skills in QI.

Appendices

Statements from Key Stakeholders

Statements from the Trust's Council of Governors

Sheila Miller – Elected Governor

A very long and complex document. Good to see improvements being made and good to know how well staff coped during the pandemic and the excellent care given.

Concern that "Hello my name is.." has had to be re-introduced as this was first introduced a few years ago! Concern that 7 day service is still not up and running as it was hoped for; discharging patients by 10am is still not compliant ; good that the issue of listening to patients and their families is improving; comments I receive from patients is that they receive excellent care whilst they are seriously ill but then they seem to be ignored!

Pleased that Scarborough Hospital is now included in the name of the Trust.

I am hopeful that patient Safety Priorities will be implemented quickly.

Michael Reakes – Elected Governor

Expedite actions to meet Clinical Standard 5 to provide 7-day services; especially by enhancing diagnostic services such as CT/MRI on weekends.

Statement from City of York Council Scrutiny Services

Not received

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

The North Yorkshire County Council Scrutiny of Health Committee has been in regular contact with the York Teaching Hospitals NHS Foundation Trust throughout 2020/21 and has appreciated the open and constructive dialogue that has been maintained. In particular, as services at Scarborough Hospital have gone through a number of changes. We have seen the development of a different approach to the management of hyper acute stroke services, which has brought it into line with other hospitals in the

region, and detailed plans for the redevelopment of the Emergency and Urgent Care Department, having secured £47million in capital funding. The committee and local elected members have welcomed the renewed focus upon Scarborough Hospital, something that has been reflected in its change of name of the Foundation Trust to include Scarborough.

The Foundation Trust has kept the committee fully informed of how it has adapted to working during the pandemic and what measures it has put in place to enable services to continue in a safe manor and in a way that is open and accessible to people who need ongoing treatment and who need assessment, diagnosis and treatment. The committee has welcomed the work that the Foundation Trust has done, as part of a national push, to address the backlog in cancer assessment, diagnosis and treatment and to reduce waiting times for elective surgery. It is recognised that reductions in waiting times will itself take time as the Foundation Trust continues to respond to the pandemic and manage a workforce that has been working at pace for over 16 months. The committee has also been impressed with the innovative work being done to address some of the issues arising from workforce shortages in the east of the county.

Over the past year, the committee has been in dialogue with the Foundation Trust concerning the response to the CQC inspection in January 2020, which highlighted some issues with the quality of patient care at Scarborough Hospital. The action plan and its implementation has been tracked and the regular meetings held with the CEO and clinical leads and will continue to be tracked over the next year.

County Councillor John Ennis

Chairman, North Yorkshire County Council Scrutiny of Health Committee.

14 June 2021.

Statement from Vale of York, East Riding and North Yorkshire Clinical Commissioning Groups

NHS
Vale of York
Clinical Commissioning Group

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YO1 6GA
Tel: 01904 555870
RNID typetalk: prefix-18001
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Website: www.valeofyorkccg.nhs.uk

14th June 2021

Mr Simon Morritt
Chief Executive
York and Scarborough Teaching Hospitals NHS Foundation Trust
Wigginton Road
YORK

Dear Mr Morritt,

RE YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST QUALITY REPORT 2020/21

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 2020/21.

Firstly, we would like to take this opportunity to thank all staff at York and Scarborough Teaching Hospital for their hard work and dedication during the COVID19 pandemic that has been ongoing for a significant period of time. The efforts taken in responding to this health crisis have been truly impressive across the health system. We would like to extend our gratitude and appreciation to you all, for your part in the local NHS and wider system response.

The report illustrates a focus and commitment to continuous improvement in the quality of patient care in 2020/21, with a particular focus on the work undertaken in research in relation to Covid both understanding it better, treatments and participation in clinical trials for the vaccine.

We would like to take this opportunity to welcome and reflect on the importance of the name change for the Trust and the impact that this will have to be more inclusive for staff and of how it will help it to become a single organisation.

We enjoyed reading about what has happened in the past 12 months at the Trust, including the introduction of the 10-year long service award, the ways in which staff aimed to keep patients connected with their families despite the challenges of Covid and the success of the National Elf Service in December in raising funds for the Trust and the impressive roll out of the covid vaccine.

We note the work that has been undertaken in order to improve the performance against the clinical standards for seven-day hospital services out of the ten standards that were agreed for acute trusts. We note the further actions that the Trust has identified in order to continue its improvement journey.

The Trust set out to achieve eight priorities for patient safety and two priorities for patient experience. We appreciate that due to the impact of Covid varying levels of progress have been made against these priorities.

- **Embed- the safer care bundle-** There has been limited progress made in this priority due in part to the pandemic, we note the approach that has been taken in care group one that appears to be more successful and welcome the decision to pilot this approach across the Trust. In addition to the work undertaken, we welcome an increased focus upon quality of discharges to ensure positive patient experience, safety, and continuity when care is transferred from hospital to home (usual or new residence i.e., care home)

- **Improve anti-microbial prescribing-** we note the achievements that have been made in this despite the pandemic and are keen to understand when the Antibiotic Review Kit (ARK) is to be implemented at Scarborough.

- **Recognition of the deteriorating patient-** we note the significant improvements have been made in the use of NEWS 2 and PAWS, with a marked reduction in the number of crash calls to wards showing that appropriate escalation of the deteriorating patient is happening.

- **Infection Prevention and Control (IPC)** - we would like to particularly highlight the excellent progress that has been made in IPC. Whilst Covid -19 has created the greatest challenges, work to reduce the number of gram-negative blood stream infections (GNBSI) and *C. difficile* remains a priority. We welcome the opportunity to participate in case reviews and consider opportunities for system wide learning to ensure continued action to reduce these infections.

- **Safeguarding**- we would value more information regarding the Trust's plans for implementing the new Liberty Protection Safeguards from April 2022 and any work undertaken with the Local Authorities in preparation and in advance of implementation. This will be a significant change in practice and will require a robust supporting training strategy.

- **Ambulance turnaround**- The Trust has acknowledged that the pandemic has had a positive impact on ambulance turnaround times due to a significant reduction in ambulance attendance at ED especially during the first lockdown in early 2020. We understand this cannot be used as a comparator for previous performance, but we welcome the improvements in turnaround times and the Trust's on-going commitment to sustain this improvement moving forward.

- **Falls**- we note the introduction of a dedicated Falls Clinical Specialist is a positive step towards improving patient safety and improving the work around falls prevention.

- **Pressure Ulcers**- we acknowledged that the priority of reducing pressure ulcers by 50% would be challenging and commend the attainment of this in October 2020. The increase in device related pressure ulcers is also noted, particularly in relation to the impact of covid and the rapid resultant learning that has taken place. We also note the important work to reduce pressure damage in staff wearing PPE which also shows the value the Trust places upon staff wellbeing.

In addition to the above priorities, we would like to note the collaborative working that has taken place between ourselves as commissioners and the Trust's patient safety team. We have welcomed the opportunity to work together in the redesign of Serious Incident processes and inclusivity within Trust Serious Incident, Falls and Pressure Ulcer panels.

Learning from Patient Experience the Quality Report shows positive progress in learning from patient experience, including improvements in timeliness and quality of complaint investigations to proactive work to understand the lived experience of patients and how improvements are made as a result.

In recognition of an extremely challenging year, we see that patient feedback from their experience at the Trust remained positive and appreciative of the kindness and care provided by the staff.

The trajectory of reducing the timescale of responding to complaints and PALS by 90% was not achieved in this year but there was an improvement in every quarter until March 2021 reaching 69% and 78% respectively.

The 'Hello my Name Is' campaign relaunch in October 2020, the work of the Patient Experience Steering Group and oversight group to lead the implementation of the 'Always Events' to help focus on what matters to patients are all recognised to improve and enhance patient experience.

Whilst understanding the impact the pandemic had on patient experience such as communication issues and rapid discharges, the Trust must be commended for their hard work and dedication to their patients and for introducing innovative ideas to help enhance patient wellbeing such as the introduction of the clinical psychologist for Covid survivors and the successful implementation of IT platforms to enhance patient experience during online consultations to reduce hospital visits.

In addition to the quality priorities above, we also recognise the significant work that has taken place arising from the Care Quality Commission (CQC) inspections in 2019. We are in support of the Trust submitting an application to have conditions of registration lifted and look forward to continued joint working for continuing and sustained improvement.

We note the quality priorities for 2021-22 that have been identified by the Trust with involvement from Lay members and fully support the decisions that have been made, particularly surrounding the introduction of a quality improvement culture and methodologies to support this. As we move towards a 'Just culture', the Trust may wish to review terminology utilised within incident investigation i.e., 'lapses in care' to refocus upon learning and the journey towards a 'Just Culture'. Further to this we would welcome hearing more regarding the Trust's plans for implementation of the anticipated Patient Safety Incident Response Framework in Spring 2022.

The Trust has shown consistently that it values its' staff and patients, and this is a theme that emerges from the choices that have been made for these quality priorities.

It is important that we continue to work collaboratively to achieve positive outcomes across all services, particularly in our work to address the consequences of the pandemic and continued recovery.

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 2020/21. 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 and consider it to be a fair reflection of the Trust's performance and acknowledges the

NHS
Vale of York
Clinical Commissioning Group

progress made to improve patient safety culture, outcomes and experience despite the challenges brought about by the ongoing pandemic. The key successes and challenges are reflected in the Quality Report.

The CCGs look forward to continuing to work collaboratively with York and Scarborough Teaching Hospital NHS Foundation Trust in 2021/22.

Yours sincerely

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 and

Paula South, Interim Chief Operating Officer / Director of Quality / Executive Nurse

NHS East Riding CCG

Statement from Healthwatch York

Not received

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 2020 to 26 May 2021;
    - papers relating to quality reported to the board over the period April 2020 to 26 May 2021;
    - feedback from Commissioners dated 15 June 2021;
    - feedback from Governors dated May 2021;
    - feedback from Local Healthwatch organisations dated May/June 2021;
    - feedback from Overview and Scrutiny Committee dated 14 June 2021;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27 May 2021;
    - the latest national patient survey 2 July 2020;
    - the latest national staff survey

- 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

28 June 2021 .....Chair

28 June 2021 .....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)
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)
PALS 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
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.