Notice of a public meeting of

Health Overview & Scrutiny Committee

To: Councillors Funnell (Chair), Doughty (Vice-Chair), Riches, Hodgson, Fraser, Richardson and Cuthbertson

Date: Wednesday, 20 February 2013

Time: 5.30 pm

Venue: The Guildhall, York

A G E N D A

1. Declarations of Interest (Pages 3 - 4)
At this point in the meeting, Members are asked to declare:

- any personal interests not included on the Register of Interests
- any prejudicial interests or
- any disclosable pecuniary interests

which they may have in respect of business on this agenda.

2. Minutes (Pages 5 - 22)
To approve and sign the minutes of the meetings held on 19 December 2012 and 16 January 2013.

3. Public Participation
At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **Tuesday 19 February 2013** at **5:00 pm**.

4. Update on the North Yorkshire and York Clinical Services Review (Pages 23 - 48)

The Chief Executive from NHS North Yorkshire and York will be in attendance at the meeting to present the next phase of the North Yorkshire and York Clinical Services Review. Also in attendance to join the debate will be representatives from York Teaching Hospital NHS Foundation Trust and the Vale of York Clinical Commissioning Group.

5. Final Report on End of Life Care Review (Pages 49 - 160)

This is the draft final report arising from the Committee's work on their 'End of Life Care Review – The Use and Effectiveness of DNACPR Forms'. Members are asked to identify any amendments they may wish to make prior to the report and associated recommendations being presented to Cabinet for consideration.

6. Update Report on the Annual Carer's Strategy and Update on the implementation of outstanding recommendations arising from the Carer's Scrutiny Review (Pages 161 - 216)

The Health Overview and Scrutiny Committee (HOSC) completed a Carer's Review in 2010/11. The Committee recommended that the Cabinet Member for Health Housing and Adult Social Services should receive an annual report on the Carer's Strategy and that the same report should be submitted to the Health Overview and Scrutiny Committee. This is the second annual review to be submitted.

7. Update on the Implementation of NHS 111 Service (Pages 217 - 220)

The Commissioning Manager from NHS North Yorkshire and York will be in attendance at the meeting to present the report and answer any questions the Committee might have.

8. Update from Leeds & York Partnership NHS Foundation Trust (Access to Talking Therapies/Improving Access for Psychological Therapy (IAPT)) (Pages 221 - 228)

In June 2012 Leeds and York Partnership NHS Foundation Trust (LYPFT) presented a paper to York Health Overview and Scrutiny Committee which set out the issues faced regarding waiting times for talking therapies. It described plans to improve access to talking therapies, including the implementation of a programme of service transformation to deliver better, simpler and more efficient services. This paper updates the Committee on progress to date.

The Associate Director, North Yorkshire and York Services , the Improving Access to Psychological Therapy (IAPT) Service Manager and the Acting Chief Operating Officer and Chief Nurse from Leeds and York Partnership NHS Foundation Trust will be in attendance at the meeting to present the report and answer any questions the Committee might have.

9. Work Plan (Pages 229 - 230)

Members are asked to consider the Committee's work plan for the municipal year.

10. Urgent Business

Any other business which the Chair considers urgent.

Democracy Officer:

Name- Judith Betts
Telephone – 01904 551078
E-mail- judith.betts@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting:

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- Business on the agenda
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Contact details are set out above.

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Agenda Annex

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Further information about what's being discussed at this meeting
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Scrutiny Committees

The purpose of all scrutiny and ad-hoc scrutiny committees appointed by the Council is to:

- Monitor the performance and effectiveness of services;
- Review existing policies and assist in the development of new ones, as necessary; and
- Monitor best value continuous service improvement plans

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Agenda Item 1

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Agenda item 1: Declarations of interest.

Please state any amendments you have to your declarations of interest:

Councillor Doughty	Volunteers for York and District Mind and partner also works for this charity. Member of York NHS Foundation Teaching Trust.
Councillor Fraser	Retired Member of UNISON and Unite (TGWU/ACTS sections).
Councillor Funnell	Member of the General Pharmaceutical Council Trustee of York CVS
Councillor Hodgson	Previously worked at York Hospital Member of UNISON
Councillor Richardson	Frequent user of Yorkshire Ambulance Service due to ongoing treatment at Leeds Pain Management Unit. Member of Haxby Medical Centre Niece works as a staff district nurse for NHS North Yorkshire and York.
Councillor Riches	Council appointee to the governing body of York Hospital Member of UNITE

City of York Council Committee Minutes

MEETING	HEALTH OVERVIEW & SCRUTINY COMMITTEE
DATE	19 DECEMBER 2012
PRESENT	COUNCILLORS FUNNELL (CHAIR), DOUGHTY (VICE-CHAIR), RICHES, HODGSON, FRASER, RICHARDSON AND CUTHBERTSON

47. DECLARATIONS OF INTEREST

At this point in the meeting Members were invited to declare any personal, prejudicial or disclosable pecuniary interests, other than their standing interests attached to the agenda that they might have had in the business on the agenda.

Councillor Funnell declared a personal interest in Agenda Item 5 (Local HealthWatch York: Progress Update) as a Board Member of York CVS, who had been successful in obtaining the contract to establish Local HealthWatch York.

Councillor Fraser declared a personal interest in the business on the agenda as a retired member of UNISON and Unite (TGWU/ACTS sections).

Councillor Hodgson declared a personal interest in Agenda Item 8 (2012 Local Account for Adult Social Care) as Yorkcraft, which was mentioned in the Officer's report, was situated in his ward.

No other interests were declared.

48. PUBLIC PARTICIPATION

It was reported that there had been one registration to speak under the Council's Public Participation Scheme.

Graham Purdy, who was a Public Governor of Leeds and York Partnership NHS Foundation Trust spoke regarding Agenda Item 3 (Results of Consultation on Proposed Closure of Mill Lodge). He supported the proposal to close Mill Lodge Community Unit for the Elderly.

He stated that although the use of the building as a Community Unit for the Elderly (CUE) would cease, he felt that there was flexibility to provide other services in the building and that the service provided by the CUE would not be lost through the closure of the building. He added that the closure might also raise a question of how treatment of dementia could be addressed through the independent care sector, rather than within inpatient care.

David Smith from York Mind was in attendance at the meeting, he spoke following permission from the Chair. He stated that the organisation was in support of moving patients from hospital into community care, provided that a clear package for how this would be carried out was properly resourced.

49. RESULTS OF CONSULTATION ON PROPOSED CLOSURE OF MILL LODGE

Members received a paper which provided them with an update on Leeds and York Partnership NHS Foundation Trust's proposals to redesign the way that older people's mental health services are provided in York, Selby and Tadcaster.

The two authors of the paper, Melanie Hird (Associate Director of York and North Yorkshire Services) and Lynn Parkinson (Deputy Director of Leeds and York Partnership NHS Foundation Trust) were in attendance to present their report and to answer Members' questions.

In response to a question from a Member about when care would cease at Mill Lodge, it was reported that a definite date had not yet been fixed. In addition, for those still under care at Mill Lodge, the Trust would try to avoid disruption and not transfer current patients at Mill Lodge until a clear transition point had been reached.

Further questions from Members included;

- Where would the nursing staff needed for the Community Mental Health Teams come from?
- How will the care offered by the CUE's be replaced?
- How would the closure of one CUE (Mill Lodge) impact on wider social care services in the city?

- What the monthly discharge rate of patients from Mill Lodge, of 20.5%, as detailed in the report, related to. Did it relate to occupied or non occupied bed spaces?

Leeds and York Partnership NHS Foundation Trust felt that the closure would not have a major impact on current social care services that were provided within the city. They added that they felt that a community care setting would be better for those with dementia rather than an inpatient one, as transitions from different inpatient facilities to others were disruptive and confusing for dementia sufferers. It was also reported that the discharge percentage referred to in the report related to those who had been discharged from currently occupied beds.

Further discussion ensued and concerns and questions were raised such as;

- Whether there were enough resources to provide services to a growing older population in the city.
- How could it be ensured that a new service configuration would have sufficient resources for it to work
- That future use of the Mill Lodge building as a NHS used facility or whether it would be available to other service providers.

Chris Butler, the Chief Executive of Leeds and York Partnership NHS Foundation Trust explained that old NHS properties would either transfer to the new providers of the previously provided services or transfer to a new organisation called NHS Prop Co. For those NHS bodies who wished to continue to use old NHS facilities, they would then enter into a lease with the Prop Co. Further to this, current Government policy dictated that NHS bodies would not be able to pick and choose which buildings to use for their services. They would either have to take on leases for all of the buildings or none at all.

Members requested that a report be brought to the Committee at a later date on the progress of the transition from clinical to community care, what resources were currently being used and which ones would be used in the future. This report should also include information about partnership working.

Councillor Fraser asked if the work of Doctor Peter Kennedy, the former Chief Executive of York Health Trust be recorded in the minutes of the meeting in recognition of his contribution to the understanding of psychiatric needs of mental health patients in the city.

RESOLVED: (i) That the update be noted.

(ii) That a progress report on the reconfiguration of services for older people's Mental Health be considered by the Committee at a later date.

REASON: To keep the Committee informed of the Leeds and York Partnership NHS Foundation Trust proposals to redesign the way that older people's mental health services are provided in York, Selby and Tadcaster.

50. VERBAL REPORT FROM LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST (MENTAL HEALTH SERVICES)

The Chief Executive from Leeds and York Partnership NHS Foundation Trust (Mental Health Services), Chris Butler, attended the meeting and gave a short verbal update on the current work of the Trust.

He explained to Members how the Trust provided Mental Health Services at a large number of sites across the North Yorkshire and York area, and currently had 3,000 people using their services, which were mostly provided in or around communities. It was noted that approximately £180 million pounds per annum was spent by the Trust in providing these services.

He reported that the Trust also had a number of objectives for improving meaningful patient engagement. These included;

- The need to campaign on further social inclusion.
- To move services away from a focus on treatment to that of recovery.
- To provide efficient and good value for money services for the community.

Members asked questions about efficiency savings that the Trust needed to make. They asked if the necessary savings could be achieved and if further cuts would be examined in the future.

In response, the Committee were informed that the Trust anticipated a 45%-50% saving could be made in clinical services. This had been as a result of being more assertive in examining management infrastructure within the Trust's services. It was also noted, that any future savings would be as part of a balanced programme and would not concentrate costs on one specific service area.

RESOLVED: That the verbal update be noted and a further report be provided to the Committee on an annual basis

REASON: In order to keep the Committee updated on the work of the Leeds and York Partnership NHS Foundation Trust in relation to Mental Health Services in the city.

51. LOCAL HEALTHWATCH YORK: PROGRESS UPDATE

Members received a report which updated them on the progression from LINKs (Local Involvement Networks) to Local HealthWatch by April 2013.

Members requested that Local HealthWatch might wish to share their work plan with the Committee once it had been produced in order to avoid duplication of work and so that the work of the Committee could also complement it. It was also noted that the start up costs for Local HealthWatch, as detailed in the Officer's report, would be for the current financial year.

The Chair suggested that the regular progress update reports on Local HealthWatch be removed from the Committee's work plan.

RESOLVED: (i) That the report and latest progress towards the establishment of Health Watch be noted.

(ii) That future progress reports be removed from the Committee's work plan.

REASON: To oversee the transition from LINks to HealthWatch is identified as a priority in the Health Overview and Scrutiny Work Plan.

52. 2012/13 SECOND QUARTER FINANCIAL & PERFORMANCE MONITORING REPORT- ADULT SOCIAL SERVICES

Members considered a report which analysed the latest performance for 2012/13 and forecasted the financial outturn position by reference to the service plan and budgets for all the relevant services falling under responsibility of the Director of Adults, Children and Education.

In relation to the report Members had the following queries;

- Why had there been an overspend in patient transport and vacancies in small day services?
- What were the reasons for targets not being reached in regards to adults with learning disabilities in settled accommodation and timeliness of social care assessments (i.e. Commencement of Assessment within 2 weeks and completion of Assessment in 6 weeks)?

Officers responded that targets had not been achieved in patient transport and vacancies in small day services due to demographic pressures of young people using the system with complex issues. It was reported that work was ongoing to reduce the number of patient escorts and ways of reducing the cost of patient transport vehicles. Members were also informed that a review was underway to look at small day services.

In response to a Member's question about timeliness of social care assessments, Officers responded that social care reviews were profiled across the year and that due to a change in criteria, the Council now had to review those with moderate care needs.

RESOLVED: That the report be noted.

REASON: To update the Committee on the latest financial and performance position for 2012/13.

53. UPDATE REPORT: RE PROVISION OF THE TRAVELLERS AND HOMELESS MEDICAL SERVICE IN THE CITY OF YORK

Members received an update report regarding the recommissioning of the Primary Medical Services (PMS) Homeless Service in York. John Keith from NHS North Yorkshire and York was in attendance to present the report and answer Members' questions.

Members raised a number of questions about the report which included;

- What were the shortfalls in the robustness of current service that were referred to?
- How would homeless people and travellers find out about a change in the provision of services, would it be signposted clearly and who would carry out this signposting?
- How would the new service provider ensure that potential homeless or traveller patients did not miss the opportunity to register with a GP?
- How would the new service deal with capacity issues such as an increase in patients who had sudden lifestyle changes, and ensure that those who needed to access the service would do so?

In response to the question about the shortfalls in the robust nature of the existing service, Members were informed that this referred to the current situation. If a member of the PMS team, such as a Practice Nurse was unavailable, then a replacement could often not be found. This would then mean that tasks such as dealing with patients' dressings would not be carried out.

Regarding the question about information provided to patients about the commissioning changes it was reported that the GP service would now provide information to homeless people and travellers, through directing them to their nearest GP practice. It was reiterated that existing services would not be taken away, but that the proposals were to change the method of delivery for these services.

It was highlighted however, that many GP surgeries would not take on new patients without a fixed registered address, which meant that homeless and traveller patients had difficulties registering with a practice.

In relation to a question about capacity to take on new patients, Members were informed that there would be a greater amount of capacity as under the new proposals, the specific services for homeless people and travellers would not be located in solely in one GP practice.

Reference was made to a recommendation arising from a previous scrutiny review into the PMS service, in that it should continue and be strengthened. It was felt that the provision of medical services to travellers and the homeless population continued to raise concerns, and that further monitoring should take place.

Other Members agreed and suggested that a report be brought to the Committee by the Director of Public Health, which looked at how medical services had been provided in the past, identified what issues had arisen and were still existing. They added that the report should contain a plan to monitor progress and issues around provision of the Travellers and Homeless Medical Service. The Chair suggested that this report be brought to the Committee in either March or April 2013.

RESOLVED: (i) That the report be noted.

(ii) That a report from the Director of Public Health evaluating and monitoring the provision of travellers and homeless medical services be considered by Members at a future meeting in March or April 2013.

REASON: In order to keep the Committee informed of the provision of medical services for the traveller and homeless communities in York.

54. THE LOCAL ACCOUNT FOR ADULT SOCIAL CARE

Members received a report which introduced them to the contents of the Local Account for Adult Social Care 2012.

Officers reported that a number of the areas of improvement highlighted by the Local Account would not be solved by spending more money on them, but by working more efficiently.

Questions from Members to Officers related to;

- The reduction in waiting lists for carers assessments
- Supporting those in the sheltered employment service at Yorkcraft to get jobs in the wider economy.
- Methods of increasing independent living for adults in contact with Learning Disabilities and those receiving secondary mental health services.

Members were informed that Officers had talked with carer's groups regarding the reduction of Self Directed Support and it was noted that an additional body would carry out assessments.

Officers also felt that it needed to be recognised that some elderly residents would be reluctant to take on direct payments, but that the Personalisation Scrutiny Review could help examine this.

Members were also informed that a report on Yorkcraft would be considered at a future meeting of the Economic and City Development Overview and Scrutiny Committee.

RESOLVED: That the report be noted.

REASON: To update the Committee on the Local Account for Social Care.

55. REMIT - SCRUTINY REVIEW INTO PERSONALISATION

Members considered a report which presented them with work undertaken by the Task Group appointed to the Personalisation Review. The report included a draft remit for the Task Group's work for the Committee to agree.

The Scrutiny Officer updated Members in relation to Paragraph 12, which referred to a proposed planning meeting with the Task Group and various invited organisations that would take place on 17 January 2013. It was reported that an independent facilitator had been sourced to assist with this review.

RESOLVED: (i) That the report be noted.

(ii) That Option 1, to agree to the remit and key objectives for the review as outlined in the report at Paragraph 10 be approved.

REASON: To enable the Task Group to commence the review.

56. UPDATE REPORT ON PROPOSED CHANGES TO CHILDREN'S CARDIAC SERVICES AND FORMATION OF A JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE TO RESPOND TO A NATIONAL CONSULTATION ON ADULT CARDIOLOGY SERVICES

Members received a report which updated them on the outcomes of the Review of the Children's Congenital Heart Services, the proposed changes and the work undertaken by the regionally formed Joint Health Overview and Scrutiny Committee (Joint HOSC) around this. It also updated them on the continuing work of the Joint HOSC around the implementation phase of the review.

Further to this, Members were also informed about a proposed national consultation on services for adults living with congenital heart disease and were asked to approve the formation of a further Joint HOSC to consider the proposals and implications for Yorkshire and the Humber patients arising from this proposed review.

The Committee were informed that the proposed review into adults living with congenital heart disease was currently scheduled to take place in 2013-14 and that it was unclear as to whether the current Joint HOSC would continue in its present form, or reform with new terms of reference to reflect a new review.

RESOLVED: (i) That report and update be noted.

(ii) That the Chair (with the Vice Chair acting as substitute)be nominated to any further Joint HOSC established to consider the proposed review into Adults with Congenital Heart Disease.

REASON: To keep the Committee informed of the work of the Joint HOSC.

57. WORK PLAN

Members considered the Committee's updated work plan for the municipal year 2013.

RESOLVED: That the updated work plan be noted and the following items be added and amended to the workplan[1];

- A progress report on the reconfiguration of services for Older People's Mental Health Services, including information on partnership working (June 2013).
- A report from the Director of Public Health evaluating and monitoring the provision of travellers and homeless medical services (March 2013).
- To slip the update report from Leeds & York Partnership Foundation Trust (Access to Talking Therapies/Improving Access to Psychological Therapy (IAPT)) from the January 2013 meeting to the February 2013 meeting.
- The removal of further Local Health Watch update reports from the Committee's workplan.

REASON: In order to keep the Committee's work plan up to date.

Action Required

1. To update the Committee's work plan TW

CLLR C FUNNELL, Chair

[The meeting started at 5.00 pm and finished at 7.20 pm].

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City of York Council	Committee Minutes
MEETING	HEALTH OVERVIEW & SCRUTINY COMMITTEE
DATE	16 JANUARY 2013
PRESENT	COUNCILLORS FUNNELL (CHAIR), DOUGHTY (VICE-CHAIR), FRASER, RICHARDSON, CUTHBERTSON, BOYCE (SUBSTITUTE FOR COUNCILLOR RICHES) AND BURTON (SUBSTITUTE FOR COUNCILLOR HODGSON)
APOLOGIES	COUNCILLORS HODGSON & RICHES

58. DECLARATIONS OF INTEREST

At this point in the meeting, Members were invited to declare any personal, prejudicial or pecuniary interests, other than their standing interests attached to the agenda, that they might have had in the business on the agenda.

None were declared.

59. MINUTES

RESOLVED: That the minutes of the meeting of the Health Overview and Scrutiny Committee held on 11 December 2012 be approved and signed by the Chair.

60. PUBLIC PARTICIPATION

It was reported that there had been no registrations to speak under the Council's Public Participation Scheme.

61. SAFEGUARDING VULNERABLE ADULTS ASSURANCE REPORT

Members received a report which provided them with an update on the Safeguarding Adults activity and improvement work within the city.

Questions from Members to Officers focused on several areas, these included;

- Vulnerable Adult Safeguarding referrals that had not been determined or had been deemed as being inconclusive.
- Recording of these safeguarding investigations.
- Who had the responsibility of carrying out the safeguarding investigations?
- Why the performance indicator from April 2011 to November 2012 (as shown in Annex A to the report) of the percentage of initial assessments being sent for comment within 2 days of alert had reduced.
- Why there was no information shown in Annex A which related to the number of adults at risk with key information missing.

Members were informed that York's performance was better than comparator authorities, with lower numbers being concluded in this way. Some of the reasons why investigations were not determined or inconclusive were: where Officers had not been able to establish whether the referral related to a safeguarding issue, or when a conclusion on an action that needed to be taken in response had not yet been reached.

On recording safeguarding alerts from health partners, Members were informed that Officers recognised that a technical issue had prevented them from being able to record whether action had been taken or not. This is being addressed. It was noted that this often relied on both health partners and Officers working together. Safeguarding has to remain everybody's business, and the Council does not have the resources, or any additional funding from other partners, to undertake all investigations within the city. There is a protocol between agencies about who will lead on an investigation. The outstanding work is to ensure that we can register the health investigations and include them in the data in future.

In response to the question about percentage reduction in initial assessments being sent for comment within 2 days of alert, Members were informed that this is currently under investigation and will be reviewed at the next 'performance clinic' for the Adults Assessment and Safeguarding Teams in the Council.

Regarding the missing information about adults at risk from the Council's Safeguarding Performance table in Annex A to the report, it was noted that there are times when information is shared but details such as name and address of the adults at risk were not available. This can make it more difficult for an assessment to take place, and could explain some of the longer assessment times. Therefore the amount of missing information could not be counted and included in the figures. It was also noted that whistleblowers who alerted the Council to cases at risk may not wish to give out certain personal details, which could reveal their identity.

Members requested that a further amount of information be included in a further safeguarding vulnerable adults assurance report from Officers, such as the number of Protection Plans in place in the city, and implications from national reports such as the Winterbourne View Review and the Francis Report.

RESOLVED: That the report be noted and a further report be scheduled into the Committee's work plan for June 2013 on the 'Annual Assurance in terms of Governance Arrangements'.

REASON: In order to keep the Committee informed of the arrangements for Adult Safeguarding within the Council.

62. QUALITY MONITORING-RESIDENTIAL, NURSING & HOMECARE SERVICES

Members received a report which provided them with an overview of the processes in place to monitor the quality of services delivered by Residential/Nursing Care and Home Care in York.

It also provided them with a summary of the current performance of providers against Care Quality Commission (CQC) Standards and the Council's own standards for performance and quality.

Officers were also asked whether the new providers of Home Care in York had obtained CQC accreditation and whether the Council was referring to these providers, placing customers with the new providers or signposting them towards their services.

In response to Members' concerns on the usage of CQC validation, Officers reported that the Council itself carried out exhaustive assessments on all Residential/Nursing Care and Home Care providers and used this information alongside the inspection detail from CQC. Officers confirmed that they did not simply rely on CQC inspection detail for monitoring and performance managing of services.

It was also noted that if a provider continued to fail to make urgent improvements to care then the Council would immediately suspend business with them. If no action was taken by the provider, the Council would offer customers the opportunity to move to another provider. It was highlighted that some customers chose to stay with a provider that was under investigation because they felt the service, or rather the specific carers working for the provider, personally offered a good standard of care to them.

Further questions from Members were raised relating to how service user surveys were carried out. Officers reported that these often took place over the telephone and also gave users a chance to talk about life in general. Comments from these surveys were then cross referenced with a Council database, so that Officers knew how to make the most appropriate contact in the future.

Officers informed the Committee that a new framework for monitoring Quality standards in Nursing Care and Residential and Home Care services in the city would be introduced later on in the year.

Members suggested that Officers involve lay members when consultation took place on the new framework. They also added that a focus on night care in Care Homes also be a significant part of the framework.

RESOLVED: (i) That the report be noted.

(ii) That a shortened version of the report be received and considered by the Committee on a six monthly basis to consider the performance and standards of provision across care services in York.

REASON: To inform Members of the quality of provision across Residential and Home Care Services in York.

63. VERBAL UPDATE FROM CHAIR-PROPOSED CHANGES TO CHILDREN'S CARDIAC SERVICES

The Chair gave Members a verbal update regarding the proposed changes to Children's Cardiac Services in the region. The Chair commented that she had been in contact with colleagues in Leeds.

RESOLVED: That the update be noted.

REASON: In order to keep Members informed of current developments in regards to changes to Children's Cardiac Services.

64. WORK PLAN 2012-13

Members considered the Committee's updated Work Plan for 2012-13.

Discussion on the work plan took place regarding the item on the North Yorkshire Review, which was due to be considered at the Committee's meeting in February. It was suggested that representatives from York Hospital, NHS North Yorkshire and York and the Vale of York Clinical Commissioning Group be requested to attend.

RESOLVED: That the following changes be made to the Committee's work plan[1];

(i) June 2013 - Annual Assurance in terms of Governance Arrangements'.

(ii) June 2013 – Quality Monitoring of Residential, Nursing and Homecare Services

(iii) That representatives from York Hospital, NHS North Yorkshire and York and the Vale of York Clinical Commissioning Group be invited to attend the Committee's meeting in February.

REASON: In order to keep the Committee's work plan up to date.

Action Required

1. To update the Committee's Work Plan. TW

Councillor C Funnell, Chair

[The meeting started at 5.30 pm and finished at 6.45 pm].

Agenda Item 4

Item Number: 7

NHS NORTH YORKSHIRE AND YORK CLUSTER **BOARD MEETING**	NHS North Yorkshire and York
Meeting Date: 22 January 2013	
Report's Sponsoring Director: Chris Long Chief Executive	**Report Author:** Sherry Hirst Communications and Engagement Programme Director, North Yorkshire

1. Title of Paper: North Yorkshire and York Clinical Services Review Report

2. Strategic Objectives supported by this paper:

Goal 1, 5 and 6: To support and receive assurance from the North Yorkshire and York Clinical Commissioning Groups in commissioning high quality, safe, effective patient care, seeking to improve the quality of care wherever possible

Goal 4: To support and receive assurance from the NYY CCGs in delivering a clinically and financially sustainable healthcare system through delivery of the Quality, Innovation, Productivity and Prevention Programme (QIPP) and North Yorkshire Review Programme to meet the needs of the people of North Yorkshire and York

3. Executive Summary

In 2011, an independent review of North Yorkshire and York was published. As the next phase of this work, in July 2012, the North Yorkshire health community (NHS North Yorkshire and York, the five North Yorkshire CCGs, Harrogate and District NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust, Airedale NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, Yorkshire Ambulance Service NHS Trust) tendered for support to take the 2011 North Yorkshire Review, to the next level of analysis.

The health community worked together to examine the current pattern and cost of services and to identify opportunities to restructure services across the system to maintain or ideally improve the service offering, but at lower overall cost to the system. KPMG have been supporting the health community in this work.

The review ensured views from across the healthcare system have been captured, including over 150 clinicians and managers, and the system leaders. Potential options were considered against a framework of stages. Key enablers to ensure delivery were identified.

The report which will be presented to the Board on 22 January provides further detail around the emerging themes from the review to be taken forward in further phases.

4. Risks relating to proposals in this paper

Failure to take forward the next steps and critical path outlined in the report would lead to significant financial and quality failures in the duty to provide safe and effective healthcare for North Yorkshire residents.

5. Summary of any finance / resource implications

All financial implications in relation to items mentioned in this report are being actively managed and monitored by the appropriate department/group.

6. Any statutory / regulatory / legal / NHS Constitution implications

In line with statutory processes.

7. Equality Impact Assessment

Documentation made available in additional formats on request.

8. Any related work with stakeholders or communications plan

Paper is available on the internet and is shared with stakeholders. Further work will be required to develop a communications and engagement strategy.

9. Recommendations / Action Required

The Board is asked to:

- Note the process outlined in this paper to deliver this phase of the North Yorkshire and York Clinical Services Review.
- Approve the North Yorkshire and York Clinical Services Review report.

10. Assurance

The Board will be provided with a regular updates and from 1 April updates will be made through the CCG governing bodies in conjunction with the NHS CB Local Area Team.

For further information please contact 01423 859616

NHS NORTH YORKSHIRE AND YORK CLUSTER

Board Meeting: 22 January 2013

North Yorkshire and York Clinical Services Review

1. Introduction

1.1 The purpose of this paper is to inform the Board about the process that has been undertaken to deliver the North Yorkshire and York (NYY) Clinical Services Review, the next phase in a series of the North Yorkshire and York independent review.

1.2 The full report outlining the context around the case for change and the high level strategy, plus the next steps and critical path to be taken forward in further phases of the review, will be presented at the Board meeting on 22 January.

2. Background

2.1 In August 2011, an independent review of North Yorkshire and York, chaired by Professor Hugo Mascie-Taylor was published. This made several recommendations regarding the shifting of care to community settings and the reduction of 200 or more inpatient beds as well as the introduction of strategic planning for integration between the different elements of the care sector.

2.2 In July 2012, the NYY health community (NHS North Yorkshire and York, the five North Yorkshire CCGs, Harrogate and District NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust, Airedale NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, Yorkshire Ambulance Service NHS Trust) tendered for support to take the 2011 North Yorkshire Review, to the next level of analysis. Specifically this next stage of the review sought to understand NYY's forecast financial position by 2016/17, the size of the potential deficit based on the current pattern of provision and the increased demand as well as to identify new models of care that could potentially meet these significant challenges.

2.3 The NYY health community worked together from September to December 2012 to examine the current pattern and cost of services and to identify opportunities to restructure services across the system to maintain or ideally improve the service offering, but at lower overall cost to the system. KPMG have been supporting the health community in this work.

3. Approach and methodology for the review

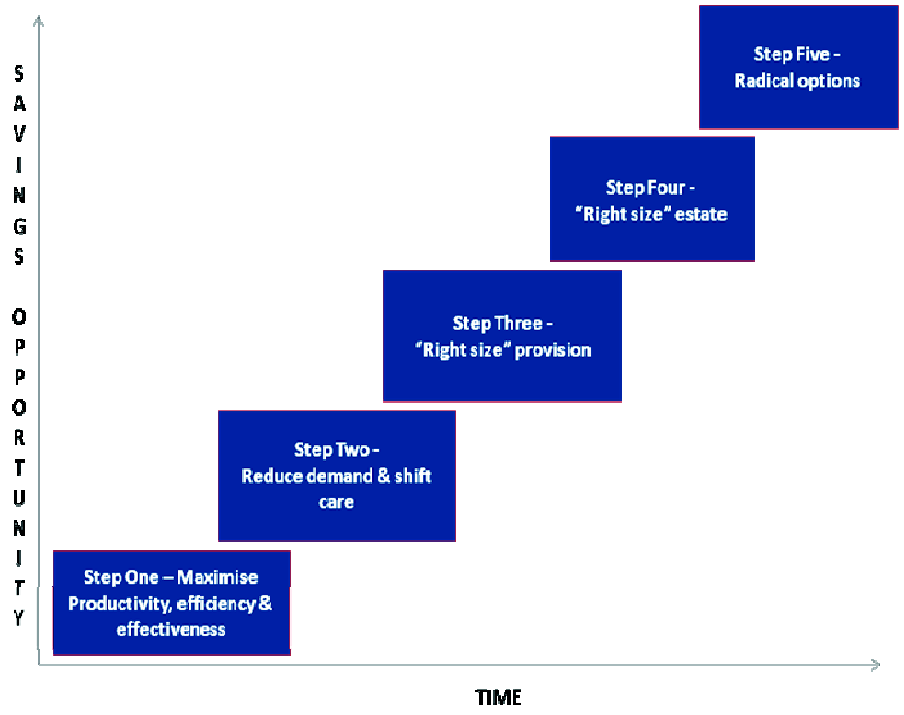
Background to the Approach

3.1 The approach was facilitated by KPMG, who supported the clinicians and managers to develop a series of potential high level options that could maintain or improve the quality of services within the level of resources available.

3.2 The approach was both "bottom up" – working with the clinicians in the locality clinical working groups – and "top down" – with a panel of experts facilitated by KPMG to provide examples from elsewhere to bring further challenge to the system leaders. This approach ensured that the views across the healthcare system have been captured and enabled over 150 clinicians and managers across all sectors with the opportunity to contribute

Framework to consider options

3.3 A five stage or 'staircase' of stages provided the framework for potential options to be considered. The five steps are shown in the diagram below and then each of them is explained subsequently in more detail:



Step One - Maximise productivity, efficiency and effectiveness

- Examined size of the opportunity if the providers move to the top 25% performing providers in the country (upper quartile) and/or the top 10% performing providers (upper decile) across a range of productivity and efficiency indicators

- Examined potential size of opportunity generated through centralising and/or outsourcing back office and/or clinical support services
- Examined economies of scale generated through joint commissioning with the local authority

Step Two - Reduce demand and shift care

- Considered and quantified opportunities to shift care to a lower level of acuity (for instance, from a hospital setting into the community or primary care)
- Examined different options to reduce elective demand and also move more care into primary and/ or community care utilising enablers such as assistive technology where appropriate

Step Three - "Right size" provision

- Considered how care can be reconfigured across acute sites and across community hospital sites to "right size" hospital care
- Examined opportunities for potential centralisation of services across a range of specialities

Step Four - "Right size" estate

- Considered where there were opportunities to reconfigure or rationalise estate, based on exploration of steps one - three. Estate requirements are driven by the clinical strategy and service provision model and once services are centralised or demand reduced, then estate requirements change in line with the new requirements
- Examined the community hospital infrastructure and the role of the community hospitals within a pathway of care

Step Five - Radical options

- Considered any further more radical options that could be undertaken

Methodology

3.4 A number of workshops were held with a wide range of stakeholders, to shape the high level strategy and emerging strategic themes. For instance, to ensure strong frontline clinical input, a number of clinical working groups were run in each of the CCG locality areas. These generated options which broadly fell into the categories for steps 1 -3 in the majority of cases.

3.5 To generate more radical thinking, a challenge session with the system leadership was held, facilitated by KPMG, to develop ideas for steps four and five.

3.6 From these sessions, a number of enablers for change to support delivery of the strategy were also identified; for instance, increased use of assistive technology and local tariff.

3.7 The report which will be presented to the Board on 22 January provides further detail around the emerging themes to be taken forward in further phases of the review.

4. Recommendations

The Board is asked to:

4.1 Note the process outlined in this paper to deliver this phase of the North Yorkshire and York Clinical Services Review.

4.2 Approve the North Yorkshire and York Clinical Services Review report.

North Yorkshire and York clinical services review

The next phase of the North Yorkshire and York independent review

North Yorkshire and York health community

22 January 2013

Report outlining the process for developing high level strategic direction to support the North Yorkshire and York health community to achieve financial balance by 2016/ 17. The report contains the high level emerging strategic themes and recommendations for the next steps.

1 Introduction

1.1. North Yorkshire and York (NYY) health economy has, for the past six years, not been able to maintain financial balance without either support from the Strategic Health Authority or by overspending its budget.

1.2. The UK's economic position and specifically the new commissioning arrangements mean that this support will no longer be available from April 2013. NYY also faces burgeoning health demands from its ageing and articulate population. The lack of ongoing financial support coupled with the forecast increased demand meant that the current pattern of healthcare provision across NYY needed to be urgently examined.

1.3. In August 2011, an independent review of North Yorkshire and York, chaired by Professor Hugo Mascie-Taylor[1] was published. This made several recommendations regarding the shifting of care to community settings and the reduction of 200 or more inpatient beds as well as the introduction of strategic planning for integration between the different elements of the care sector.

1.4. In July 2012, the NYY health community (NHS North Yorkshire and York, the five North Yorkshire CCGs, Harrogate and District NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust, Airedale NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, Yorkshire Ambulance Service NHS Trust) tendered for support to take the 2011 North Yorkshire Review, to the next level of analysis. Specifically this next stage of the review sought to understand NYY's forecast financial position by 2016/17, the size of the potential deficit based on the current pattern of provision and the increased demand as well as to identify new models of care that could potentially meet these significant challenges.

1.5. The NYY health community worked together from September to December 2012 to examine the current pattern and cost of services and to identify opportunities to restructure services across the system to maintain or ideally improve the service offering, but at lower overall cost to the system. KPMG have been supporting the health community in this work.

1.6 This report is a summary of the work to date. It must be recognised from the outset, however, that this report is still very much a staging point which sets out the agreements and vision for services in the future as envisaged in January 2013, recognising the constantly and rapidly changing environment

[1] Independent Review of Health Services in North Yorkshire and York; Report of the Independent Commission, 2 August 2011

1.7 The outputs from this stage of the review are being taken forward by the system as a whole but the driver in the future will not be the PCT (which will not exist from April 2013) but primarily will be the constituent CCGs. The way in which this is envisaged is set out later in this report.

2 National Context – case for change

2.1 The NHS is undergoing unprecedented levels of change informed by the following:

- System reform (Health and Social Care Act 2012)
- Economic decline (£15-20bn Quality, Innovation, Productivity and Prevention challenge across the NHS in England)
- Acute Trusts face a current net tariff deflation of 1.5% as the 4% efficiency targets are embedded into the provider contracts off-setting modest inflation assumptions
- This level of efficiency is predicted to continue in the medium term with Monitor predicting efficiency requirements for 2013 to 2016/17 of 4.2% - 5% (base case) or 5%-5.5% (downside case) to ensure that Trusts maintain their Financial Risk Ratings
- The King's Fund has predicted that the NHS saving target could rise to £50bn by 2019/20 because of the UK economic outlook
- The second Francis report, which is scheduled for publication in early 2013, is widely predicted to lead to a sea-change in service provision with further focus on quality and safety which may have additional cost and system implications for the NHS

2.2 The Autumn Statement on the 5 December 2012 announced:

- Pay freeze lifted with 1% pay rise for the public sector and abandonment of the proposed introduction of regional pay
- Health budget to receive "relative protection" from government spending cuts to 2015/16
- Next generation of Private Finance Initiative (PFI) deals will exclude soft facilities such as cleaning and catering
- The Office for Budget Responsibility (OBR) has revised the Gross Domestic Product (GDP) deflator for 2013-14 to 2016-17 downwards since the 2012 budget from 2.5% to 2%. The GDP deflator is the measure of inflation used to uprate the NHS budget. This could affect the potential deficit range for North Yorkshire (outlined in point 2.3 below)
- The need for a sustainable funding solution for social care was not addressed and a further reduction in local government spending of £445m in 2014/15 could put further pressure on social care and therefore into the health and social care economy overall.

2.3 There are also national guidelines which have recently been published to which all health economies are responding. Examples of these include the national guidelines for Stroke (revised September 2012)[2] and the proposals from the Royal College of Obstetricians and Gynaecologists Expert Advisory Group. Their report on High Quality Women's Healthcare (June 2011)[3] focuses on a network and life course approach to maternity services and promotion of births outside the hospital setting and if accepted may impact on the way services are delivered across the localities.

2.4 The NHS Commissioning Board published 'Everyone Counts' in December 2012 which highlighted the key objectives for the NHS over the next 12 months. The main areas offered locally to CCGs as priorities and solutions to be addressed as part of commissioning discussions include:

- NHS services available 7 days a week
- More transparency, more choice
- Listening to patients and increasing participation
- Better data – informed commissioning, better outcomes
- Higher standards, safer care
- Prevent people dying prematurely
- Enhancing quality of life for patients with LTC
- Recovery from episodes of ill health
- Positive experience of care
- Safe environment and protect from avoidable harm

These objectives and priorities are very much tied in with a set of key strategic enablers which have been devised to progress the outcomes of this Review (See section 4 for further details).

2.5 There are several national workforce drivers that will also affect the way services are delivered in NYY such as the Shape of the Medical Workforce (February 2012)[4] and the Seven Day Consultant Present Care (December 2012)[5] which will impact across all aspects of health and social care and are likely to have significant organisational and resource implications.

[2] National Clinical Guideline for Stroke, 4th Edition; 2012
[3] High Quality Women's Healthcare; Royal College of Obstetricians and Gynaecologists, June 2011
[4] Shape of the Medical Workforce – starting the debate on the future consultant workforce – a discussion document for Leaders; Centre for Workforce Intelligence, February 2012
[5] Seven Day Consultant Present Care; Academy of Medical Royal Colleges; December 2012

2.6 Current national negotiations on the GP contract will also have implications for the potential models of care as primary care is seen as a key enabler to the delivery of a significant amount of the reduction in demand for hospitals and shift in care away from secondary care that is necessary.

3 Local context - case for change

3.1 As outlined above, the NHS is facing an unprecedented level of change and NYY, like other health economies, needs to proactively respond to this change to ensure that they can provide a long term clinically sustainable and financially viable health and social care system for their local population. As well as the financial implications, there have been several national drivers for change such as the first Francis report[6] on Mid-Staffordshire which highlighted the need for a significant improvement in quality and safety in the NHS. The second Francis report is due to be published in January 2013 and it is anticipated that the outcome of this report will have far reaching implications for the future delivery of services within the NHS.

3.2 NHS North Yorkshire and York (NHS NYY) has had a structural deficit for the past six years and despite additional efforts by the commissioners to rectify this, they have been unable to return to financial balance without support. In 2011/12 this amounted to approximately £15m[7].

3.3 The aim of the Commissioners is to return to financial balance in 2014 which will require paying off the remaining underlying deficit. Under the allocation formula used to allocate monies to PCTs, there was an acknowledgement that NHS NYY received approximately £17m less than the allocation should provide for their local population demographics as this is phased in over time. With the change to the new system in 2013, allocations are being made to CCGs for most secondary care services and to the National Commissioning Board for primary care and specialised services. Allocations have been made for 13/14 without reference to any target formula but by a straight uplift on the historical allocations. As this is nationally determined, it is recognised that it is outside the control of the health economy and therefore beyond the scope of this review. However the resources are allocated, the CCGs have a statutory duty to live within their allotted sums.

3.4 Based on the current funding and allocation assumptions, KPMG worked with the Directors of Finance across the health economy to overlay demographic predictions of demand and activity assumptions. It is predicted that by 2016/17, the health economy may be facing a potential overall deficit in the range of £93m to £156m. These figures do not include the current structural deficit figure so if this is not paid off by 2014, then the total figure could be significantly higher.

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[6] Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009, Volume I, The Mid Staffordshire NHS Foundation Trust Inquiry Chaired by Robert Francis QC, 24 February 2010

0[7] NHS North Yorkshire and York Finance Department

3.5 During the course of this work, the resource allocations and NHS Operating Framework have been published for 2013/14 (Everyone Counts: Planning for Patients 2013/14). Since the CCGs and Foundation Trusts are currently assessing the implications of this framework and are preparing their plans for 2013/14, it has not been possible to factor in any assessment of the impact of this in this report. The report is therefore based on the situation and information available just prior to Everyone Counts.

3.6 At the time of this review, Hambleton, Richmondshire and Whitby CCG, in partnership with South Tees Hospitals NHS Foundation Trust were leading a consultation on the proposed clinical reconfiguration of maternity and paediatric services on the grounds of clinical safety and viability.

3.7 Under the Transforming Community Services agenda (TCS), in April 2011, each of the acute trusts were awarded the community services provision at different levels including the community hospital provision in their locality. As part of this process, Harrogate and District NHS Foundation Trust (FT) became the main provider for a number of regional services including the Out of Hours GP provision (excluding Scarborough). This should allow the development of seamless “end to end” patient pathways

3.8 It is clear that the local health system across North Yorkshire needs to respond to the national challenges facing the NHS, as well as the local challenges. Hence this work was commissioned as the next phase in designing the detail (following the recommendations set out in Professor Hugo Mascie-Taylor’s independent review) for the clinical strategy for reconfiguring the provision of healthcare across the region to ensure a viable future. The CCGs (Vale of York CCG, Hambleton, Richmondshire and Whitby CCG, Scarborough and Ryedale CCG, Harrogate and Rural District CCG, Airedale, Wharfedale and Craven CCG) have been at the forefront of leading this phase of work, along with the Chief Executives of the acute trusts (Harrogate and District NHS FT, York Teaching Hospital NHS FT, South Tees Hospitals NHS FT, Airedale NHS Foundation Trust), Yorkshire Ambulance Service NHS Trust, and NHS North Yorkshire and York. The Governing Bodies of the five CCGs and the four acute trusts are committed to working together to address the financial and service demand challenges faced by the health economy.

4 High level strategy and road map

4.1 To inform development of the high level strategy, a series of clinical workshops were held with clinicians from across the localities. Feedback from this was subsequently discussed at a wider stakeholder event, where key emerging strategic were identified to be taken forward. The approach and process followed as part of this review is set out in detail in Appendix 2 to this report.

4.2 The stakeholder event also agreed a list of enablers which all organisations thought to be important and which need to be taken forward as part of the next phase of work. It should be noted that these enablers are critical to the successful delivery of the strategy. If these enablers are not capable of being delivered, then this could put at risk implementation of one or more of the strategic themes set out below. These enablers are as follows:

- Seven day working across all health and social care sectors. It is recognised that it might be a challenge in some areas, such as primary care, where there is a national contract.
- Increased use of assistive technology and, where appropriate, shared care records.
- Strategic collaborative commissioning across the NYY footprint for areas such as frail elderly, to have a single approach (eg Comprehensive Geriatric Assessment to support community teams).
- New medical and nursing workforce models, including new specialist roles working across acute and community, Enhanced Care Practitioner, and create roles such as Home Care Workers to care for ventilated and stoma care patients.
- Local tariffs (eg year of life tariff for certain specialties /conditions).
- Enhanced capacity and capability in primary care.
- Opportunity to manage urgent care. The Directory of Services within the new urgent care 111 number (from March 2013) provides an opportunity to manage urgent care needs closer to home and reduce the need for a hospital attendance.
- Development of mental health urgent care liaison model (RAID) in both acute A&E and community hospitals to support the early discharge of patients with dementia and other mental health diagnosis (as part of the urgent care strategy and to reduce length of stay).

4.3 The work to date has led to the development of a high level clinical strategy and emerging strategic themes under a range of clinical areas. These are summarised in the chart at Appendix 1 and are as follows:

a) <u>Primary care</u>

- Primary care has a significant enabling role in the delivery and implementation of new models of care. North Yorkshire needs to ensure it maximises value for money by preventing patients from being admitted to hospital and facilitating earlier discharge
- Primary care transformation needs to focus on keeping people in their own homes – key enablers to support this such as assistive technology and near patient testing need to be defined
- Explore models to maximise impact primary care can have in rural areas
- Undertake risk stratification & establish Multi-Disciplinary Teams (MDTs) to more effectively manage long term conditions

- Review out of hours provision and move to 7 day working
- Establish virtual clinics and use telemedicine to seek specialist opinion to reduce outpatient referrals
- Develop an End of Life Care strategy

b) Community care

- Reassess entire community services provision in conjunction with CCG and local acute trust to properly define service needs locally and improve efficient use
- Move appropriate acute services into the community such as specialist care supporting long term conditions and frail elderly services
- Develop integrated health and social care community teams
- Adopt a model with primary care and the acute sector to support patients through the system to enable appropriate discharge
- Focus on dementia care in line with the national strategy

c) Frail elderly

- Develop an overarching clinical strategy for the care of the frail elderly
- Link with the urgent community, social and primary care plans
- Develop support for nursing and residential homes and link to telemedicine

d) Social care

- Integrated health and social care supporting across the system to keep people well and out of hospital and to support patients through the system to enable appropriate discharge once in hospital.

e) Planned Care

- Manage demand through use of clinical thresholds, shared decision making and patient decision aids
- Review further opportunities to collaborate across the acute trusts to develop joint clinical networks and alliances, or where feasible create centres of excellence
- Use enhanced recovery to reduce elective length of stay
- Use assistive technology to support more community based follow up care

f) Maternity and Paediatrics

- Consultant led maternity services are to be sited on at least the three sites of Harrogate, York and Scarborough. Provision at Northallerton is still to be determined
- Review the provision of Midwifery Led Birthing Units
- Assess whether community infrastructure is appropriate to reduce ante-natal admissions
- Review the provision of paediatric inpatients in line with maternity services
- Integrated strategy for paediatrics across acute and primary care to reduce inpatient admissions

g) Urgent care

- In line with national and college guidance and existing clinical networks, review the provision of urgent care across NYY including the number of Minor Injuries Units and the effectiveness of out of hours primary care provision
- Review the provision of emergency surgery and define the optimum model for quality and productivity in line with national guidance
- Review the role of the ambulance trust in supporting the optimum models for urgent care. Review opportunities arising from '111'
- Examine the potential for A&E departments to implement an integrated model of care, for example a GP practice at the front door of A&E to reduce attendances
- Examine new workforce models such as the clinician in the ambulance control room and use of Emergency Care Practitioners
- Develop stroke services in line with national guidance considering role of local clinical networks
- Consider the impact of any changes above on the trauma network

h) Mental health

- Mental health to support on a system wide perspective particularly in integrated community teams and the urgent care review
- Review patients who at present are placed out of North Yorkshire with a view to providing their care closer to home

4.4 Key to supporting this work is the role of mental health and social care services. Collaboration with mental health services is important to support a reduction in length of stay and A&E admissions through the development of models such as Rapid Assessment Interface and Discharge (RAID) in A&E and on the wards. This model of care has a strong evidence base for the reduction in length of stay and improvement in patient experience[8,9]. This area will be picked up in the urgent care clinical work-stream.

4.5 Social care have an integral role in the development of integrated community teams and services that work as part of an end to end pathway to prevent elderly patients and people with long term conditions from being admitted to hospital and for supporting early discharge if they are admitted. The relevant clinical work-streams will work with social care colleagues to ensure they are included where relevant in the detailed plans.

4.6 Included in this work is also the review of the role of the community hospitals and the role they play in preventing admissions or facilitating earlier discharge. The plans will ensure that they include the community hospitals role in relevant pathway redesigns to ensure that they are used most effectively and most likely for patients requiring either step up/ step down care or rehabilitation.

4.7 The role of nursing and residential homes will also be examined as part of this strategy, including the development of an end of life strategy that aims to keep people in their own home (including where this is a nursing or residential home) if this is their wish. This includes support to the care homes from primary and community care to reduce admissions and building on the evidence from the Airedale Collaborative Community Team of the reduction in A&E admissions through the use of telemedicine in care homes.

5 Next steps

5.1 The next stage of the work is for each of the NYY CCGs to consider the outputs from this review and map them against their existing strategic plans. Much of what is contained in this review here already exists within the local CCG plans but new themes identified need to be considered within the local context of the individual CCG and if appropriate added to the locality plans.

5.2 The urgency of delivery of new schemes must be judged alongside existing priority areas, to produce an overarching plan including key collaboration partners, timescales, milestones and outcomes.

5.3 The new combined CCG plans will describe the overarching strategic direction of North Yorkshire articulating clearly the diversity of locality, geography and clinical alliances that exist across the county.

[8] Birmingham and Solihull presentation by Professor George Tadros (RAID Lead Clinician, Birmingham http://www.dementiauk.org/assets/files/what_we_do/networks/liaison/RAID_Faculty_of_Old_Age_Psychiatry_17.3.111.pdf as accessed on 6 December 2012

[9] Economic evaluation of a liaison psychiatry service; Michael Parsonage and Matt Fossey, Centre for Mental Health

5.4 County wide co-operation will exist on projects which span more than a single CCG: this will be particularly important on issues which affect or include strategic partners such as North Yorkshire County Council, Yorkshire Ambulance Service NHS Trust and local mental health Foundation Trusts.

5.5 Local and county wide plans will need to determine if the strategic themes and detailed pieces of work require any investment or pump priming.

5.6 An important aspect of the future work programme will concern closer collaboration between York and Harrogate NHS Foundation Trusts. York and Harrogate NHS Foundation Trusts already have well established Clinical Alliances in place across a number of clinical specialities. This has enabled local expertise to be maintained in North Yorkshire and a full range of services to be provided between the two providers with commissioner support for service models developed. In order to take this work forward, both organisations are committed to continuing to use this approach to deliver service change. This will enable further opportunities to maximise efficiencies and deliver changes in the way services are delivered to the population of North Yorkshire. Over the next 6 months a detailed work programme will be agreed and work streams identified to take forward key actions.

5.7 This programme will be regularly monitored through the Clinical Alliance Board which has Chief Executive, Executive Director and Clinical Director representation across both provider organisations and which will also in the future liaise with local CCGs. In addition, both Provider Trusts will continue to work in partnership with commissioners on whole system activities, for example the future role of the community hospitals, use of telemedicine and patient decision aids. Existing Provider discussions with neighbouring Commissioners and Providers in Leeds and Hull will also inform the work agenda.

5.8 The initiatives described in this review work will help address the forecast deficit and will help restore financial balance to the community. The schemes will deliver financial savings to commissioners and will deliver financial efficiencies for service providers. This is entirely consistent with the national efficiency requirements currently faced by the NHS.

5.9 As highlighted in the context to this report, there are a range of issues which are very current and which need to be fully assessed and worked through as part of the next stage of this work. The most significant ones are as follows:

- The latest financial allocations to CCGs for 2013/14.
- The impact of the planning assumptions and framework in ‘Everyone Counts’.
- The impact of the second Francis report due imminently – this in particular may set out recommendations for quality which may have profound implications on the way services can be reconfigured for the future. It may also have significant resource implications.
- The financial position and residual issues inherited by the CCGs from the PCT on 1 April 2013.

- The agreement of activity levels between commissioners and providers over the medium term to enable providers to plan for and ensure long term capacity.

5.10 While the vision and proposals in this report have the support of all the relevant participating NHS organisations, all of whom are committed to taking forward the relevant schemes for their locality, there is a considerable degree of interdependency. Hence the ability of FTs to remodel services, for example, depends in part on the ability of GPs and the CCGs to remodel primary and community services to manage patient demand more effectively. Similarly the ability of CCGs to invest further in community services which need to form a major plank of the strategy, depends on the ability to release costs from the acute hospitals through having a lower bed base.

6 Programme governance structure

6.1 A robust governance structure is required to ensure pace and delivery of this work. This will be led by the Chief Executives forum that commissioned and approved this report.

6.2 The operational delivery of the majority of the work will be at local CCG level. Therefore the governance structures need to reflect this and enable autonomy whilst ensuring oversight of the programme.

6.3 Each CCG will establish a Local Delivery Board to include local providers of health and social care and other stakeholders to oversee and drive forward the delivery of the plans.

6.4 An overarching NYY wide group with membership from all commissioning and provider organisations of health and social care will be established.

6.5 The Chief Executives Forum will be responsible for providing oversight and support as well as focus and ensuring progress. There may be additional groups providing support and capacity on finance and communications/ engagement at both a county-wide and local level.

6.6 Some work may involve several CCGs and providers. It is suggested that a series of smaller task-focused multiagency delivery groups will be established where appropriate and will include membership from the commissioners and providers involved in the specific initiative. These groups will report jointly to the local Delivery Boards of the localities involved. Alternatively, the existing York/Scarborough and York/Harrogate Clinical Alliance Boards will be used, with senior management and clinical involvement from CCGs to drive the work.

6.7 The local office of the NHS Commissioning Board, the North Yorkshire and the Humber Area Team, will have two key roles. They are a major health commissioner in North Yorkshire for primary care and specialist services and will be included in delivery of the primary care elements of the review. They are also responsible for ensuring that local CCG plans are coherent and will sign off CCG operational plans. They also provide an assurance role in holding CCGs to account for the delivery of their plans.

7 Proposed timescales

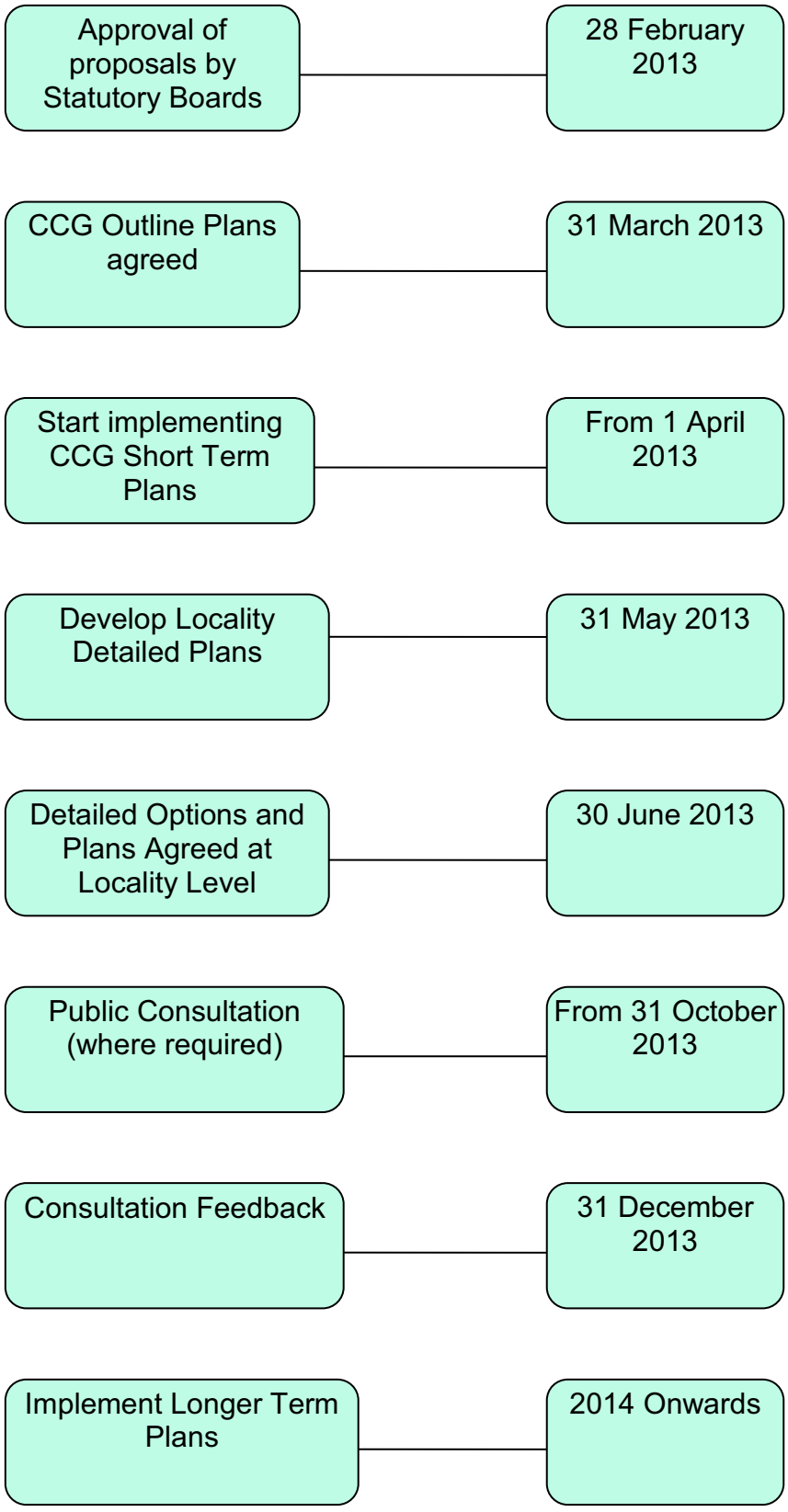
7.1 At this stage it is not possible to finalise a detailed timetable or confirm a critical path for all the actions that will be needed to ensure that this strategy is taken forward with the overall objective of getting the system into financial balance by 2014.

7.2 Where there is a possibility of a major service change, formal consultation will of course need to take place. Ideally consultation would need to take place later in 2013 if change is to be implemented during 2014. There are a series of milestones that need to be reached between January and November 2013 in order for the delivery of the service reconfigurations to be successful and the clinical and financial benefits to be realised within these timescales.

7.3 The first step is of course to get the agreement formally of all the Boards to the way forward set out in this paper. The PCT Board on 22 January is on the critical path. The second target date is to ensure that any public consultations that may need to be undertaken can take place in the autumn (possibly October to December 2013). There is a significant amount of analysis and development of clinical models to be undertaken during the next six month window if this is to be achieved.

7.4 The dates outlined in the critical path below are the indicative milestone completion dates for the next phases of work assuming this overall timeline is to be achieved.

Proposed Timescales



8 Conclusion

The work undertaken over the past few months, supported by KPMG, has set out a broad strategy across a wide range of areas. However, more detailed work is required over the next few weeks to turn these proposals into specific plans for change with timescales and costings. Some proposals may require formal public consultation before final plans can be firmed up. Others may be a continuation of existing plans which can be taken forward immediately as part of the operational plans of CCGs in the forthcoming financial year. All this work will now need to be taken forward by the new NHS structures post March 2013.

Primary Care Trust:

Chris Long, Chief Executive, NHS North Yorkshire and York

CCGs:

Amanda Bloor, Accountable Officer, Harrogate and Rural District CCG

Simon Cox, Accountable Officer, Scarborough and Ryedale CCG

Dr Mark Hayes, Clinical Chief Officer, Vale of York CCG

Dr Vicky Pleydell, Clinical Chief Officer, Hambleton, Richmondshire and Whitby CCG

Dr Philip Pue, Chief Clinical Officer, Airedale, Wharfedale and Craven CCG

Foundation Trusts:

Patrick Crowley, Chief Executive, York Teaching Hospital NHS Foundation Trust

Bridget Fletcher, Chief Executive, Airedale NHS Foundation Trust

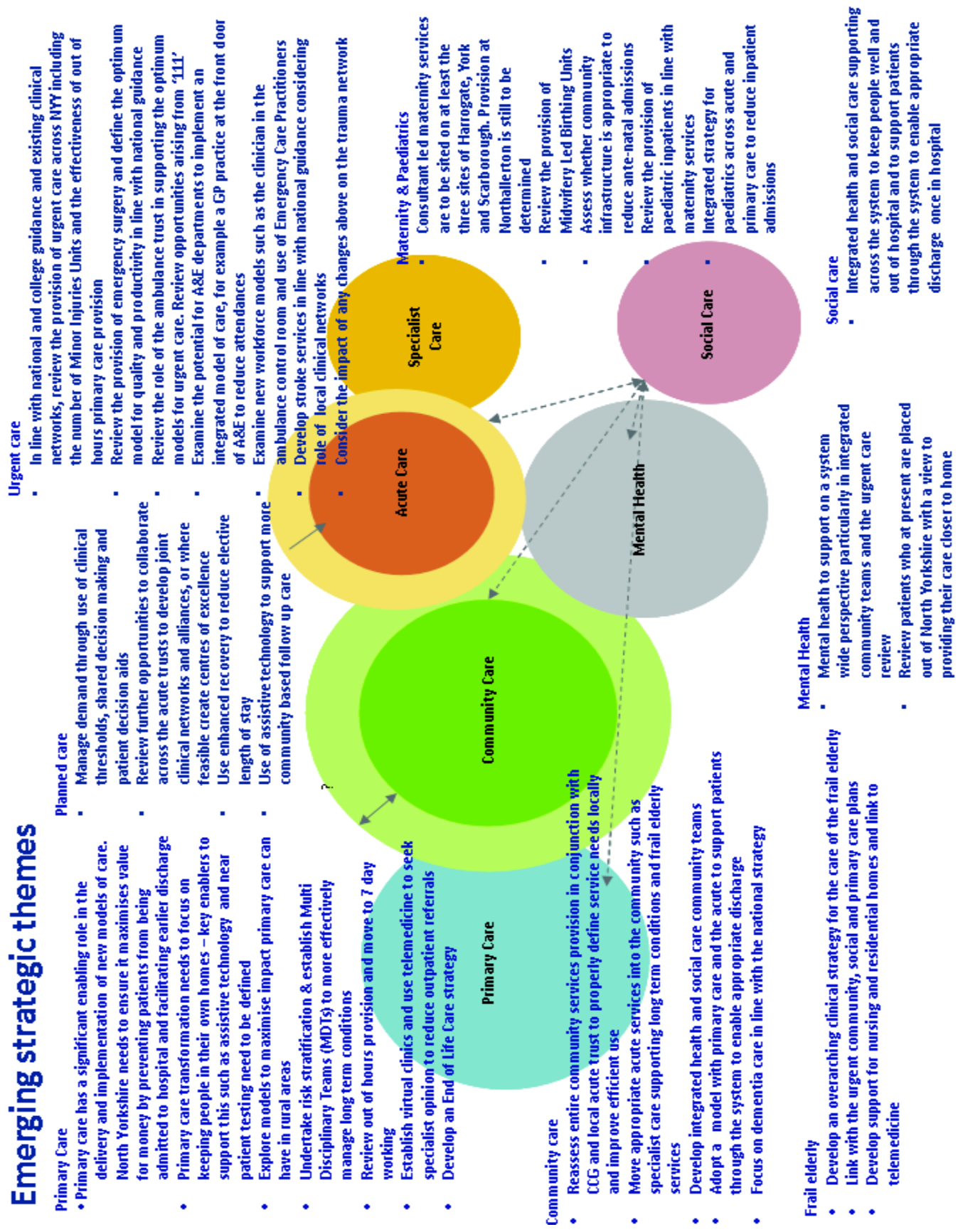
Professor Tricia Hart, Chief Executive, South Tees Hospitals NHS Foundation Trust

Richard Ord, Chief Executive, Harrogate and District NHS Foundation Trust

Ambulance Trust:

David Whiting, Chief Executive, Yorkshire Ambulance Service NHS Trust

APPENDIX 1 – Emerging Strategic Themes



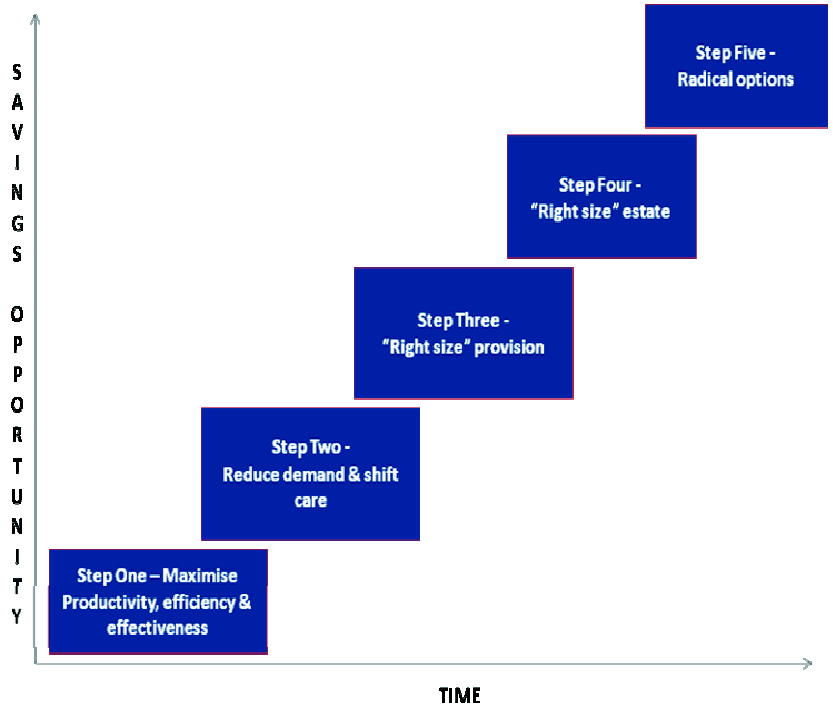
APPENDIX 2 - Summary of approach

1. The approach was facilitated by KPMG, who were commissioned by the health community to work in collaboration with them to support the understanding of the current pattern of service provision and the future financial impact of this by 2016/17. KPMG facilitated the clinicians and managers to develop a series of potential high level options that could maintain or improve the quality of services within the level of resources available.

2. For this process to be successful, the approach was both "bottom up" – working with the clinicians in the locality clinical working groups – and "top down" – with a panel of experts facilitated by KPMG to provide examples from elsewhere to bring further challenge to the system leaders. This approach ensured that the views across the healthcare system have been captured and enabled over 150 clinicians and managers across all sectors with the opportunity to contribute.

3. Stepped Approach

3.1 A five stage or 'staircase' of stages provided the framework for potential options to be considered. The five steps are shown in the diagram below and then each of them is explained subsequently in more detail below:



3.2 Maximise productivity, efficiency and effectiveness

The first step examined the size of the opportunity if the providers move to the top 25% performing providers in the country (upper quartile) and/or the top 10% performing providers (upper decile) across a range of productivity and efficiency indicators. This also examines the potential size of the opportunity generated through centralising and/or outsourcing back office and/or clinical support services and maintaining a better grip on outgoings such as rent. It also examines the economies of scale generated through joint commissioning with the local authority.

3.3 Reduce demand and shift care

Step two considered and quantified the opportunities to shift care to a lower level of acuity (i.e. shift care out of acute hospital setting into community or primary care). This step examined the different options to reduce elective demand and also move more care into primary and/ or community care utilising enablers such as assisted technology where appropriate.

3.4 "Right size" provision

The third step then considered how care can be reconfigured across acute sites and across community hospital sites to "right size" hospital care. In NYY, as in many other health economies, there are elements of duplication and fragmentation across the provision of acute services. In line with national best practise guidance there is emerging evidence[9 10] that greater volumes of activity result in better quality and safety outcomes. This step considered these opportunities. In addition to quality improvements, economies of scale can also be achieved through the centralisation of services. This step examined opportunities in maternity, urgent care, stroke, community services and planned care across a range of specialities.

3.5 "Right size" estate

On the back of steps one, two and three, step four then considered where there were opportunities to reconfigure or rationalise the estate across NYY. The estate requirements are driven by the clinical strategy and service provision model and once services are centralised or demand reduced, then the estate requirements change in line with the new requirements. This step also examined the community hospital infrastructure and the role of the community hospitals within a pathway of care.

3.6 Radical options

This final step is a catch all and considered any further more radical options that could be undertaken such as a radical reduction in the acute bed base based on techniques such as telemedicine and also "bed-less" hospital

models such as in Washington USA or the Abingdon model in Oxford[10], and the Germantown Maryland stand-alone Emergency Room (which saw 22,000 patients with no inpatient beds the year it opened in August 2006 with 95% of all patients being seen, treated and discharged).[11] Also, where the clinical working groups generated really radical options such as build a new hospital, these were also included under this step.

4. Process

4.1 A number of workshops were held with a wide range of stakeholders, to shape the high level strategy and emerging strategic themes. For instance, to ensure strong frontline clinical input, a number of clinical working groups were run in each of the CCG locality areas. These generated options which broadly fell into the categories for steps 1 -3 in the majority of cases.

4.2 To generate more radical thinking, the KPMG Expert Panel (Professor Nigel Edwards, Professor Marc Berg, Professor Hilary Thomas and Andrew Hine from KPMG) held a challenge session with the system leadership to increase the thinking around more radical options.

4.3 The outcome of all the engagement activity was the generation of the clinical services strategy and the emerging themes to take forward. A number of enablers to ensure delivery of the work were also identified, as outlined below:

- Seven day working across all health and social care sectors. It is recognised that it might be a challenge in some areas, such as primary care, where there is a national contract.
- Increased use of assistive technology and where appropriate, shared care records.
- Strategic collaborative commissioning across the NYY footprint for areas such as frail elderly, to have a single approach (eg Comprehensive Geriatric Assessment to support community teams).
- New medical and nursing workforce models, including new specialist roles working across acute and community, Enhanced Care Practitioner, and create roles such as Home Care Workers to care for ventilated and stoma care patients
- Local tariffs (eg year of life tariff for certain specialties /conditions)
- Enhanced capacity and capability in primary care
- The Directory of Services within the new urgent care 111 number (from March 2013) which provides an opportunity to manage urgent care needs closer to home and reduce the need for a hospital attendance.
- Development of mental health urgent care liaison model (RAID) in both acute A&E and community hospitals to support the early discharge of patients with dementia and other mental health diagnosis (as part of the urgent care strategy and to reduce length of stay).

[10] Professor Nigel Edwards Expert Panel presentation 25 October 2012
[11] Report on the operations, utilization and financing of freestanding medical facilities; Maryland Healthcare Commission, 18 February 2010

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Health Overview & Scrutiny Committee **20th February 2013**

Report of the Assistant Director Governance & ICT

Draft Final Report - End of Life Care Review – *'The Use & Effectiveness of DNACPR Forms[1]'*

Summary

1. This is the draft final report arising from the Committee's work on their 'End of Life Care Review – The Use and Effectiveness of DNACPR Forms'. Members are asked to identify any amendments they may wish to make prior to the report and associated recommendations being presented to Cabinet for consideration.

Background

2. At a scrutiny work planning event held on 25th July 2011 it was agreed that the Health Overview and Scrutiny Committee would do some review work around End of Life Care. This led to a workshop being held on 31st August 2011 between Members of the Committee and a variety of stakeholders to agree a specific focus for the review. Discussions led to this being agreed as the 'use and effectiveness of DNACPR forms'.

3. At a further informal meeting of the Committee held on 13th October 2011 it was agreed that the main ambition for the review was:

   To ensure that patients'[2] wishes and instructions are acted upon by health professionals and carers at the end of life, especially in terms of ensuring that instructions in relation to information on DNACPR forms is up to date and adhered to when required.

[1] Do Not Attempt Cardiopulmonary Resuscitation
[2] Adults aged 16 and over

4. In October 2011 the Care Quality Commission (CQC) published a 'Review of Compliance'[3] for York Teaching Hospital NHS Foundation Trust which highlighted major concerns in relation to 'consent to care and treatment'. During their site visit CQC looked closely at 22 patients' care records across eight wards, within these they found that patient information details, in relation to consent, were not always fully completed. One of the standards reviewed by the CQC was 'Outcome 02: Before people are given any examination, care, treatment or support they should be asked to agree to it' and they said of this:

   'People we spoke to about consent to treatment told us they had been consulted and given full explanations about what to expect and this was evident within the records we looked at. However, documentation relating to the serious matter of whether a patient should be resuscitated or not, was not being completed correctly or reviewed as required by the hospital's own guidelines. This could mean that some patients may have an instruction in place, which is out of date, incorrect or is no longer in their best interests.'

5. With this in mind the Committee discussed some potential themes that they wanted to receive information on in the first instance, namely:

   - Clarity on what the DNACPR form is, how the form works and who recognises the form
   - Clarification on the difference between a DNACPR form and a living will
   - An understanding of what variants there are to the DNACPR form, if any
   - To understand how the form came into being
   - To understand what is happening now and why it is happening
   - To understand how clearly the scheme is set up
   - To understand the opinions/guidance and advice of professional organisations in relation to this form
   - To investigate how things can be improved and who can help with any suggested improvements

6. The Committee also discussed who they might like to speak to during the course of the review and began to complete the Scrutiny Topic Assessment Form attached at **Annex A** to this report.

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[3] The full report is available on the CQC website and can be accessed via the following link:
http://www.cqc.org.uk/directory/rcb00

Information Received During the Review

7. This subsequently led to the briefing note on DNACPR forms at **Annex B** to this report being submitted to the Committee by NHS North Yorkshire & York which included a copy of the latest version of the DNACPR form.

8. This annex details key information on what Cardiopulmonary Resuscitation (CPR) is, potential outcomes of CPR, the post CPR period, when to consider making a DNCAPR decision, what a DNACPR form is, variants of DNACPR forms, the Yorkshire and Humber Regional DNACPR form, roll out of the regional DNACPR form, how the regional DNACPR form works, who recognises the regional DNACPR form and the differences between a DNACPR form and a Living Will.

9. The information in **Annex B** was discussed at an informal meeting of the Committee held on 21st December 2011 where three Committee Members and a representative of NHS North Yorkshire & York were in attendance. From this annex Members gained a greater understanding of the background to DNACPR forms, in particular the form currently in place across Yorkshire and the Humber. They also gained a greater understanding around how the form worked and how the form should move with patients between care settings.

10. Discussion of this document led to the representative of NHS North Yorkshire and York indicating that Yorkshire Ambulance Service (YAS) had some time ago reported that the DNACPR form was not working as well as it could within their organisation. However it appeared that most of the problems YAS had experienced with Version 11 of the form had been addressed with the introduction of Version 12.

11. Members also heard and discussed some anecdotal evidence around the fact that DNACPR forms had not been accompanying patients when they were discharged from hospital, with good practice stating that the form should travel with the patient and be reviewed on a regular basis. Whilst the CQC report of October 2011 mentions concerns around the review of DNACPR forms it does not specifically mention the issue of forms not travelling with patients between care settings so the Task Group were unable to substantiate this evidence at this point in the review.

12. Further discussion highlighted another anecdote around potential problems with the Out of Hours Service (OOH); however at this stage of the review this appeared to be around patients towards the end of life being admitted to hospital from care settings (at times which were felt to be inappropriate by staff and family), rather than specifically being

connected to issues related to DNACPR forms. It was not known whether the anecdote concerned patients who had a valid DNACPR in place.

13. And finally, the different levels and provision of training/support around DNACPR and CPR across health organisations was highlighted as a potential issue by NHS North Yorkshire and York. A more in-depth summary of the discussion from the 21st December meeting is at **Annex C** to this report.

14. On consideration of the briefing paper at **Annex B** and the discussions (as set out in **Annex C**) the Committee identified the following as areas that they wanted to receive further information on from key health providers across the city:

    i. What training is provided and to whom
    ii. Are discussions around DNACPR documented in a patient's case notes/how many clinicians are having conversations with patients
    iii. How is the form used within each organisation
    iv. How is the form audited
    v. Have there been any problems with the form
    vi. Is the use of the form written into each organisation's policies
    vii. Evidence that all staff have been trained
    viii. Do YAS, in particular, have any problems with using the form
    ix. What do organisations do if the form doesn't work? How do they address the problems and learn from them

15. In addition to the information provided at **Annex B** the representative from NHS North Yorkshire and York circulated the results of an online staff survey that had been undertaken between January and July 2011 in relation to the use of DNACPR forms. NHS Bradford & Airedale led on this project and the survey was widely disseminated to as many health organisations as possible (including hospitals, GPs, nursing homes and other primary care trusts) across the Yorkshire and Humber Region. Of those that responded 59% were nurses, 26.6% hospital doctors, 4.5% hospice doctors, 4.8% were GPs and 5.1% stated their profession as 'other'. In total there were 441 responses to the survey and 94 of these were provided by the North Yorkshire and York area. Below is a brief summary of the findings from the survey in relation to the responses from staff across North Yorkshire and York:

    - The majority found the overall experience of using the new form 'satisfactory' or 'good', however 9.1 % found it 'fair' and 8.3% found it 'poor'

- The majority of staff found their experience of completing the new form 'satisfactory' or 'good', similarly a small number did find it 'fair' or 'poor'
- 46% found their experience of understanding completed DNACPR forms in patients' records 'good' and 11% rated this as 'excellent'
- When asked to rate how you found your experience of discussing the new DNACPR forms with patients, 22% stated that this was 'not applicable' and only 6.6% said that this was 'excellent'.
- When asked to explain what they found helpful about the new regional DNACPR forms the following responses were given:
  - Ease of use
  - Patient feels in control
  - transfer of information across services easier
  - improved clarity of decision making

- When asked to explain what they found difficult/unhelpful about the new regional DNACPR forms the following responses were given:
  - Form not accepted in South Tees after North Yorkshire Primary Care Trust (PCT) split
  - Unsure who can sign/counter sign the form
  - Not all staff fully trained in using the new form
  - Non-coloured form

- 61% of respondents had received training on how to use/complete the form

16. At the meeting held on 21st December 2011 Members suggested that the above survey might be repeated in 6 months time after the form had been in place for a little longer and more people were used to using it.

17. Members were informed that Yorkshire Ambulance Service completed a different set of questions and are not, therefore, included in the overall figures above.[4] However, to summarise the outcomes of the survey, 67 members of staff responded and the responses are summarised below:

    - 83.6% indicated that they were not always informed of the existence of the new regional DNACPR form before attending a patient in a community or acute organisation

[4] Copies of both surveys are available as background papers to this review and are also published in the Health Overview and Scrutiny Committee papers of 6th August 2012 available via by clicking here

- 53.7% did not feel that the new regional DNACPR form was easy to find in a patients' medical records whilst 46.3% felt it was

- 59.7% responded that they were informed of the DNACPR form when attending a patient in their own home. However 68.7% said that the form was not easy to find in patients homes with 70.1% responding that relatives were not always aware of a DNACPR decision being in place for a patient.

- When asked whether the new DNACPR form was easy to understand 87.5% of respondents said yes, however, only 48 out of 67 responded to this particular question with 10.4% (of the 48 respondents) saying that they had attempted CPR despite the existence of a DNACPR form.

18. However, Members did acknowledge that this information was now out of date and improvements had been made within YAS in relation to DNACPR forms since the survey was undertaken.

19. After consideration of all of the information received at the meeting on 21st December 2011 the Scrutiny Officer wrote (on behalf of the Committee) to six key health organisations asking them to respond to 11 specific questions. In addition to this the letter was sent to various other partners across the city and responses were invited.

20. A table containing all the responses received is attached at **Annex D** to this report with the following paragraphs very briefly summarising some of the key points raised in the responses:

    i. <u>Is your organisation using this form? If not why not? Are all the relevant members of staff aware of its existence?</u>

    YAS, Leeds & York Partnership NHS Foundation Trust (LYPFT) and York Teaching Hospital NHS Foundation Trust (YTHFT) all use the form. Whilst the form requires clinical/medical completion staff in care settings, on the whole, are aware of its existence.

    ii. <u>Can you give the Committee some positive examples of the way your organisation has used the DNACPR form?</u>

    Both YTHFT and NHS North Yorkshire and York mentioned the fact that the Out of Hours (OOH) handover forms from GPs to OOH had been redesigned to include information on DNACPR status, ensuring good sharing of information. NHS North Yorkshire and York, whilst not using the forms specifically but being involved with implementation and roll

out of the forms, had an identified project lead who is a member of the Regional DNACPR Project Board.

iii. What training has your organisation provided in relation to competing and using the form? What percentage of staff has your organisation trained? When will the remainder be trained? Can you evidence how staff are trained? In addition to this do you offer refresher training and routinely offer training to all new member of staff on how to use the form?

YAS said that all existing staff will receive training on DNACPR and as at February 2012 82.37% staff had been trained. Both LYPFT and YTHFT train their staff on the use and rationale of the form. Training for CYC care staff and care staff working in the independent care sector is not mandatory; whilst some have had training others have not.

iv. How has the use of the form been integrated into your own policies? Is it written into your own policies?

YAS, LYPFT, YTHFT and NHS North Yorkshire & York all have the form integrated into their own policies; however, most care homes do not.

v. Do you audit the use of the form? If so, how?

YTHFT and LYPFT have audit processes in place.

vi. In relation to the DNACPR form – have you received any complaints from families after a relative has passed away? If so, what lessons have you learned from this?

YAS cited two examples of inappropriate resuscitation which appeared to have involved crew members who had not, at that point in time, been trained on the DNACPR process. YTHFT had had 2 or 3 complaints around communications with family members. St. Leonard's Hospice had feedback from a family who had a relative at home with a DNACPR form in place where YAS had attempted CPR.

vii. Are there any barriers to your organisation using the form? If so, what are these and what action have you taken to try and resolve this?

There were no specific barriers to any of the organisations using the form. However it was acknowledged that further training was needed in using the form.

viii. Has your organisation had any experience of the form not working? If so what were these experiences and what course of action was taken to try and resolve the problem?

YAS highlighted three main issues; the first around a document being refused as it did not have a red border, the second around the non-acceptance of a form as it was not thought to be an original document and the third around non-acceptance of the form as it was thought that the review date had expired. This appeared to be a training/educational issue. One care home said that a GP had refused to sign a form.

ix. Has your organisation had any experience of patients being given CPR even though there has been a DNACPR form in place? What were the circumstances that overruled the DNACPR decision?

NHS North Yorkshire and York responded detailing a situation where a patient had been given CPR by YAS. The ambulance crew had not received training around DNACPR and therefore would not accept the form. YTHFT cited two instances where there had been problems; one with an out of date form that YAS would not accept and the other a situation where a patient was given CPR.[5]

x. Is there anything further that you think the Committee should be aware of in relation to the use and effectiveness of DNACPR forms (either generally or within your organisation)?

YTHFT mentioned that there were several issues regarding embedding the form in a community setting. Responses from representatives at independent care homes highlighted a need to provide more publicity around the form, the need for GPs to have more conversations with patients whilst a person has capacity to make a decision and the need to be made aware when a new version of the form was released.

xi. If a DNACPR form was not accepted by Yorkshire Ambulance Service when transporting a patient, why was it not accepted?

YAS have responded to this at question viii but there were four main reasons that forms had not been accepted, these being; the form should have red borders, the form was a copy, the crew felt the form was several months old and there were no instructions for ambulance crews.

[5] These appear to be a repetition of incidents previously highlighted.

21. This information was discussed at a further informal meeting held on 29th February 2012 with the following in attendance to join the debate:

- 4 Members of the Health Overview & Scrutiny Committee
- Representative of Yorkshire Ambulance Service
- Representatives from York Teaching Hospital NHS Foundation Trust (Medical Director and Palliative medicine Consultant)
- Representatives from NHS North Yorkshire & York
- A GP from Strensall Medical Group
- Representative from North Yorkshire Police
- Representative from York Council for Voluntary Service (CVS)
- Representative from York Local Involvement Network (LINk)
- 1 renal social worker and 1 hospital social worker
- Representatives from City of York Council
- Representative from St Leonard's Hospice
- Representative from Macmillan Cancer Support

22. A detailed summary of the discussion is attached at **Annex D1** to this report but briefly this includes the implementation of training courses at the hospital to increase awareness of the form, other practices at the hospital leading to improvements and an increased awareness of what a patient's wishes were around DNACPR, a training programme being run by Yorkshire Cancer Network and the Out of Hours Service.

23. To put the information received to date and the discussions had in relation to this into context the Committee felt at this stage, that it was necessary to identify some areas where either improvements needed to be made or further information was needed, not forgetting to acknowledge there were areas of good practice. In the first instance it was important to understand and reiterate that DNACPR was just one element of the end of life care process and advanced decisions/plans about life saving should be in the context of a patient's deteriorating condition. However, this review was around the use and effectiveness of DNACPR forms and any recommendations arising would be in the context of this.

24. Some of the anecdotes heard, along with several of the points raised in discussions, illustrated that some of the information given to families had been poor and some of the experiences traumatic. Information, in the future, needed to be joined up and about the whole end of life care pathway. Good experiences should not be disease specific (at the moment cancer patients nearing the end of their life appeared to be offered a better 'service' than others) and good practice should be rolled

out to all services to allow all patients nearing the end of their life to be treated with dignity.

25. At this stage in the review Members sought further clarity on the following:

26. The form itself - On several occasions throughout the review concerns had been raised, including in **Annex D** to this report, about whether photocopies and/or black and white copies of the form could be accepted. The representative from NHS North Yorkshire & York confirmed that the form with the red borders was the preferable one but as long as the form was 'original' with appropriate and original signatures then black and white was acceptable. He also confirmed that at the moment Version 11 of the form was acceptable however, older forms should be reviewed and the current Version, Version 12 should really be used. In the Acute Trust Version 12 is now the only form in use. The Committee felt that this was an issue that could be addressed by further training on how to use the form.

27. The Out of Hours Service (OOH) – The Chair wrote to the OOH Service outlining the issues that had been raised in the papers received and the associated discussions. The Chair was also aware that to date, the Committee had only heard one side of the story and much of the information that had been received about the OOH Service was anecdotal. It was therefore felt that clarity on much of what had been said needed to be sought from OOH.

28. Training and Support on the DNACPR form – This had been a recurring theme running through the evidence received as part of this review and training now appeared to be in place for all hospital and YAS staff. However, whilst DNACPR forms were, in the main, completed by clinicians it was felt that it was still important for staff in all care homes across the city to have a good understanding of how and why DNACPR forms were put in place. Members felt that there should be adequate support mechanisms in place to allow for this, specifically to reduce the amount of avoidable hospital admissions for those at the end of life.

29. At a further meeting held on 6th August 2012 the Clinical Director of Unscheduled Care and the Director of Partnerships and Innovation from Harrogate and District Foundation Trust (who had the contract to run the York and Selby Out of Hours Service) attended a meeting of the

Committee, alongside key partners[6]. They submitted written evidence to the meeting and this is at **Annex E**, to this report [7]

30. This set out information on the pathway by which DNACPR forms are received into the OOH service, an overview of the difficult issues relating to the use of the forms, the verification of death process, evidence supporting the use of DNACPR forms in the OOH period and current action.

31. A summary of the discussions had at the meeting held on 6th August 2012 is at **Annex F** to this report. However some of the issues raised at the 6th August 2012 meeting went beyond the scope of this review but included issues around Living Wills and Advanced Decisions along with their role in ensuring good end of life care and giving patients control over key decisions in their life.

32. These discussions further identified areas of concern and where improvements could be made. The York Hospital Medical Director identified four possible areas where he felt tangible outcomes could be made namely:

- Working better in partnership
- Working towards the Gold Standards Framework[8]
- Working towards consistency in nursing homes
- Improving practices overall

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[6] Representatives of Yorkshire Ambulance Service, York Mental Health Forum, York Local Involvement Network, St. Leonard's Hospice, NHS North Yorkshire & York, York Teaching Hospital NHS Foundation Trust, Harrogate and District Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Vale of York Clinical Commissioning Group, York Branch Royal College of Nursing, Independent Care Group, York Carer's Forum, York Council for Voluntary Service, York Older People's Assembly, North Yorkshire Police and City of York Council.

[7] Further supporting papers were submitted by the OOH and these were published in the health Overview and Scrutiny Committee agenda of 6th August 2012 and can be accessed here

[8] The Gold Standards Framework (GSF) is a systematic evidence based approach to optimising the care for patients nearing the end of life delivered by generalist providers. It is concerned with helping people to live well until the end of life and includes care in the final years of life for people with any end stage illness in any setting.

33. In addition to this Members also felt that the following could be improved:

- Training/support on DNACPR forms
- Publicity of the DNACPR form and end of life care issues in general
- Partnership working
- Ensuring that reviews of existing DNACPR forms already in place are done in a systematic way

Consultation

34. Various key partners have been consulted during the course of this review and are referenced in the annexes and background papers associated with this report, as well as in the report itself

Options

35. There are no specific options for Members arising from the draft final report. However, Members are asked to identify any amendments they might wish to make to the body of the report or the recommendations contained within it prior to it being presented to Cabinet for consideration.

Analysis

36. It would be appropriate to mention again at this stage that the remit of this review was specifically:

To ensure that patients' wishes and instructions are acted upon by health professionals and carers at the end of life, especially in terms of ensuring that instructions in relation to information on DNACPR forms is up to date and adhered to when required.

37. It has been very difficult for the Committee not to, on occasion, stray from this very specific focus in light of the enormous amount of information they have received which has spanned across much wider issues around end of life care. In spite of this, the recommendations arising from the review are, however, focussed around the agreed remit.

38. The Committee had originally started this review after a CQC report had identified issues around the completion and review of DNACPR forms at York Teaching Hospital NHS Foundation Trust in October 2011. Since this report the Committee are pleased to acknowledge that significant improvements have been made and that the CQC had re-inspected the hospital in February 2012 and now considered them compliant. The short paragraph below is an extract from the CQC's report:

'In July 2011 we carried out a review and found that improvements were needed to documentation relating to the serious matter of whether a patient should be resuscitated or not. This was not being completed correctly or being reviewed as required. Over the course of this most recent visit we found that the trust and their staff had worked hard to make sure improvements had been made. New practices had been introduced and staff, including doctors and consultants, had received appropriate training and information relating to the trust's policy on this matter. We reviewed, in total, 12 'do not attempt resuscitation' (DNAR) forms across the wards we visited. All of these had been completed on the correct forms and all the information required was present.'

39. However, despite this positive move forward and the relatively low numbers of complaints and incidents that can be evidenced in relation to DNACPR forms, the Committee still felt there were further improvements that could be made to improve their use and effectiveness. Whilst there was no evidence that a large number of people within the city were having a poor death, in the few instances where things had gone wrong it had obviously, from the evidence received, caused distress to all parts of the system and this needed to be avoided if at all possible.

Conclusions

40. Having considered all the information received over the course of the review the Committee identified several areas where they thought improvements needed to be made namely:

- Raising awareness with the general public about the DNACPR form and end of life care choices more generally
- Ensuring that once DNACPR forms have been completed the right people know they are in place
- Ensuring that everyone knows what to do with the form once it has been completed and co-ordinates and shares it appropriately
- Ensuring that staff in care homes are supported to respond to and respect the clear wishes of residents as set out in a DNACPR agreement
- Ensuring that any DNACPR forms in place are reviewed in a timely and systematic way

These themes are expanded upon in the paragraphs below:

41. Public information and public awareness – The general underlying context of the review as set out in the first part of the remit set was *'to ensure that patients' wishes and instructions were acted upon by health professionals and carers at the end of life ...*'. Whilst the main focus of the review was around the use and effectiveness of DNACPR forms ensuring that end of life care was good in much wider terms was also implicit throughout the whole review.

42. As can be seen from the various annexes and background papers associated with this report, several times during the review, including in the initial workshop held in August 2011, mention was made of there not being enough understanding of end of life care choices. It was accepted that it was a difficult subject to raise with discussions around it needing to be treated sensitively. There was also little public profile of such matters

43. The Committee believed that better press and publicity around the existence of DNACPR orders and also end of life care issues in general would lead to an increased public awareness and willingness to have conversations around this subject. It could also lead to more people asking to have a DNACPR order put in place towards the end of their life.

44. Representatives from York Carer's Forum spoke at the meeting held on 6th August 2012 and said that community meetings could provide a chance for discussion and input into the successful use of the DNACPR form. This was felt to be a positive move, especially if it gave residents confidence to start discussions with their GPs.

45. these considerations led to the Committee making the following recommendation:

    Recommendation 1 – that key health partners, namely York Teaching Hospital NHS Foundation Trust, NHS North Yorkshire and York[9], Yorkshire Ambulance Service, Independent Care Group, York GPs and the Vale of York Clinical Commissioning Group look at ways of better publicising the existence of DNACPR forms and in doing this they make use of the wealth of experience and knowledge that already exists within voluntary organisations such as the Carer's Forum' and LINks[10] (soon to be HealthWatch) to assist them with holding public events

46. Information Sharing - Evidence received throughout the review also highlighted room for improvement in relation to information sharing between key health partners and that further work needed to be done to

[9] Up until April 2013
[10] Local Involvement Networks

allow the Out of Hours Service to better access a patient's GP/hospital record to see whether a DNACPR order was in place.

47. Information given by both York Hospital and NHS North Yorkshire and York in response to question 2 at **Annex D** to this report stated that the Out of Hours handover forms from GPs to doctors at the Out of Hours Service had been re-designed to include information on DNACPR status and to ensure good sharing of information. However the Committee felt that more still needed to be done around this in light of the information submitted by the OOH Service and the discussions around this that took place at the meeting on 6th August 2012 (**Annex E** refers).

    Recommendation 2 - That key health partners (Vale of York Clinical Commissioning Group, York Teaching Hospital NHS Foundation Trust, NHS North Yorkshire and York, Yorkshire Ambulance Service, Independent Care Group, York GPs and the Out of Hours Service) review whether the redesigned handover forms for the OOH Service GPs have improved the sharing of information around end of life care wishes (including DNACPR forms) and explore whether there are further improvements that can be made in relation to information sharing.

48. Partnership Working – This was highlighted on several occasions throughout the review where it was acknowledged that there needed to be improvements to partnership working between all health agencies in relation to the health needs of the city's residents. New Neighbourhood Care Teams were being developed within the Vale of York Clinical Commissioning Group's area and it was hoped that these teams would offer a more holistic view and be able to plan more proactively for the health and support needs of individuals, including having discussion around end of life care choices. It was hoped that the new Neighbourhood Care Teams could also take the lead role in co-ordinating plans in response to people's individual end of life care choices.

    Recommendation 3 – That key health partners ensure that there are appropriate co-ordination arrangements in place to ensure that patients can discuss their end of life care wishes and those wishes are enacted. The Neighbourhood Care Teams should play a pivotal role in responding to this recommendation, in particular in terms of identifying patients most at risk of health problems and looking at ways of talking to patients about their End of Life Care needs, including DNACPR orders.

49. Support for Care Home Staff – As can be seen from the evidence given in the annexes attached to this report mention has been made on several occasions that a significant proportion of avoidable admissions to hospital

at end of life were coming from care homes (both Council run and independently run). Members felt that it was important that care homes had a greater understanding around their role at end of life and felt supported and part of any end of life care plan in place for their residents.

Recommendation 4 – That the Multi-Agency Workforce Development Group within the city be asked to consider how they can support all care homes within the city to achieve this.

50. Review of Existing DNACPR Forms - At various stages throughout the review concerns were raised about how existing DNACPR orders were reviewed and whether they were always up to date. The Committee felt that any reviews should be done in a systematic way. It was noted that when NHS North Yorkshire and York had given a copy of the current DNACPR form to all health providers across the region this was accompanied by a best practice guide. However, this was only a guide and each individual organisation had its own policy around resuscitation which could complicate matters.

Recommendation 5 – That once a DNACPR form is in place:

i. there is a known protocol setting out who will undertake the review of the form and when

ii. the review date should be clearly stated on the front of the form

iii. there are processes in place within key health partners' internal policies to identify which forms are due for review and how these will be undertaken

iv.it is ensured that the completion of planned reviews is monitored.

Council Plan 2011-2015

51. This review is linked with the 'protecting vulnerable people' element of the Council Plan 2011-2015; specifically the theme of 'safeguarding adults and promoting independence'. Two of the key outcomes of this theme are 'more people will live for longer in their own homes' and 'there will be a focus on independence and greater choice and control over their lives for vulnerable people'.

Comments from Key Health Partners

52. All organisations involved in this review were asked if there were any further comments they wished to make on the recommendations arising from this review. All responses received are set out below:

53. NHS North Yorkshire and York is reviewing the Yorkshire and Humber wide DNACPR form, and this review is due to be completed by June 2013, with a new version of the form being released shortly after. As a result of this the Yorkshire Cancer Network have taken the opportunity to review the current position across the Yorkshire and Humber by way of a 'DNACPR Education Questionnaire'; this asks questions around what changes should be made to any new version produced, what education in relation to DNACPR has been implemented in individual localities, any issues that should be raised with a DNACPR Working Group, any complaints about the DNACPR form or any areas of good practice that should be shared.

54. NHS North Yorkshire and York also confirmed that they would cease to exist as of 1st April 2013. However most of the recommendations arising from this review refer to health partners working together, improving communication, sharing information, training and protocols to be in pace which are fair and necessary. The review of the document will be managed by Yorkshire and Humber Strategic Working Group who met on 12th November and will be meeting again in January, York Teaching Hospital NHS Foundation Trust have representation on this group.

55. The Directorate Manager for Specialist Medicine at York Hospital said that we agree with the recommendations that have been made and they fit well with our own strategy. I do not foresee any major obstacles to progression and there are no implications that I feel need to be raised at this stage. There will be challenges in areas such as patient information, consent and getting systems to talk to each other; however we will work through these issues with other key health partners.

56. Coincidently York Hospital have already started looking at a number of work streams which fit well with the recommendations that have been made, as follows:

- A new York Hospital internal End of Life Care Forum has been formed with internal hospital and community representation.
- From the Forum, a new End of Life Care Strategy and Workplan are being developed to ensure progress against a number of initiatives in end of life care (this includes a specific item on DNACPR)
- The York and Scarborough End of Life Care Board has also recently formed and met. This is a multi-agency provider collaborative to aid working across care settings.

- A Lead Nurse for End of Life Care starts on 2nd January 2013 appointed jointly by the Acute Trust and St. Leonards Hospice to give

greater emphasis to End of Life Care issues and give a dedicated voice and ears to these issues. The Lead Nurse will also lead our education programme and work closely with volunteer and partner organisations.

57. The Vice-Chair of York Local Medical Committee (YORLMC) indicated that YORLMC welcomed this report and its findings. However, it did feel that all local GPs needed to have a clearer understanding of what was expected of them, in relation to implementing the recommendations.

58. YORLMC also advised that NHS North Yorkshire and York had given notice on the current specification for the Gold Standards for Palliative Care Local Enhanced Service, with the termination date for this being 31st January 2013. This effectively means that funding will be withdrawn to support this service and this will impact on capacity within general practice from February 2013. To explain this further part of the Gold Standard around palliative care was for all those involved in palliative care to have regular meetings together, this would include (for example) GPs, palliative care nurses and district nurses to discuss all patients on the palliative care register. The Primary Care Trust introduced a service (with funding) to allow this to happen. This service and the regular monthly meetings with all involved flagged up areas of good practice, new services on offer, and overall better communication between all those involved. A report writing template was introduced and this was completed for every patient on the palliative care register, making it easier to spot what help might be needed at an early stage for individual patients as well as increasing awareness around palliative care in general.

59. When the funding for the formalised meetings is withdrawn in 2013 good practice is still likely to be followed by GPs, however the requirement to follow the Gold Standard is removed. The regular and more formalised meetings may well cease (although this will be dependent on the capacity of each individual GP surgery) and information will be shared in a more informal and ad hoc way; especially as the formalised meetings can take up quite a lot of clinical time. This could mean that those involved with palliative care do not get to look at issues with colleagues in such a holistic way as they did when the meetings were more formalised and everyone was present in the same room.

60. A representative of Yorkshire Ambulance Service responded that they were happy to support, where possible, such initiatives as those raised in the recommendations in association with other key health partners.

61. The Chief Executive from the Independent Care Group (ICG) has confirmed that she has put an item in the weekly ICG update reminding

people about the DNACPR form and where to find it on the NHS website. She also confirmed that on the occasions when a new version of the form is issued she lets people know that this has happened.

62. In relation to the recommendation around supporting care homes; if training could be sourced, even potentially through City of York Council's Workforce Development Unit then the ICG would be happy to promote this.

Implications

63. **Financial** – It is recognised that improvements to the processes and protocols will need to be delivered within the existing resources of all partners. Providing better information so that people can die in the settings they choose, and other than a hospital, will help reduce unnecessary hospital admissions.

64. In relation to recommendation 4 the Multi-Agency Workforce Development would be happy to receive this recommendation and consider the evidence of need for training alongside identifying how solutions may be implemented to meet this need. Development and implementation of solutions is likely to include consideration of: how much of the care sector workforce need the training, the costs of providing the training and how this will be funded, methods for assessing and evaluating impact and outcomes. If agreed the Strategy Group is likely to require partnership contributions to implement this.

65. **Human Resources** - There are no specific implications for staffing. Support and training for staff, including those in care homes will require multi agency collaboration. This could be progressed through the multi agency workforce development strategy group.

66. **Other** – There are no other implications associated with the recommendations within this report.

67. **Implications for health partners** – The implications set out above are directly for City of York Council and not for any of our key health partners that have been involved in this review. It will be for those health partners to identify any support or contributions, in kind or otherwise, to assist in the delivery of the recommendations.

Risk Management

68. In compliance with the Council's risk management strategy there are no high risks associated with the recommendations within this report.

However if no action is taken then end of life care may not be as effectively planned as it could be, and this will increase risks in respect of finances within the health care system.

Recommendations

69. Members are asked to consider the draft final report and the associated recommendations arising from this scrutiny review which are listed below:

70. Recommendation 1 – that key health partners, namely York Teaching Hospital NHS Foundation Trust, NHS North Yorkshire and York, Yorkshire Ambulance Service, Independent Care Group, York GPs and the Vale of York Clinical Commissioning Group look at ways of better publicising the existence of DNACPR forms and in doing this they make use of the wealth of experience and knowledge that already exists within voluntary organisations such as the Carer's Forum' and LINks (soon to be HealthWatch) to assist them with holding public events.

71. Recommendation 2 - That key health partners (Vale of York Clinical Commissioning Group, York Teaching Hospital NHS Foundation Trust, NHS North Yorkshire and York, Yorkshire Ambulance Service, Independent Care Group, York GPs and the Out of Hours Service) review whether the redesigned handover forms for the OOH Service GPs have improved the sharing of information around end of life care wishes (including DNACPR forms) and explore whether there are further improvements that can be made in relation to information sharing.

72. Recommendation 3 – That key health partners ensure that there are appropriate co-ordination arrangements in place to ensure that patients can discuss their end of life care wishes and those wishes are enacted. The Neighbourhood Care Teams should play a pivotal role in responding to this recommendation, in particular in terms of identifying patients most at risk of health problems and looking at ways of talking to patients about their End of Life Care needs, including DNACPR orders.

73. Recommendation 4 – That the Multi-Agency Workforce Development Group within the city be asked to consider how they can support all care homes within the city to achieve this.

74. Recommendation 5 – That once a DNACPR form is in place:

    i. there is a known protocol setting out who will undertake the review of the form and when
    ii. the review date should be clearly stated on the front of the form

iii. there are processes in place within key health partners' internal policies to identify which forms are due for review and how these will be undertaken
iv. it is ensured that the completion of planned reviews is monitored.

Reason: In order to complete this scrutiny review.

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For further information please contact the author of the report

Background Papers:
(all apart from 7) attached to Agenda Item 3: Interim Report- End of Life Care Review 'The Use and Effectiveness of DNACPR forms'- http://modgov.york.gov.uk/ieListDocuments.aspx?CId=671&MId=7338&Ver=4

1. Care Quality Commission Review of Compliance (October 2011)
2. Results of online staff survey undertaken by NHS Bradford and Airedale
3. Survey Results Undertaken by YAS Staff
4. Letter to Key Health Organisations
5. 'What Happens if my Heart Stops' Leaflet
6. Supporting Documents submitted by OOH
7. Care Quality Commission Review of Compliance (March 2012)

Annexes

Annex A Topic Assessment Form (Online Only)

Annex B NHS North Yorkshire & York Briefing Note on DNACPR Forms (Online Only)

Annex C Summary of Discussion – 21.12.2011 (Online Only)

Annex D Responses from Key Health Organisations (Online Only)

Annex D1 Summary of Discussion – 29.02.2012 (Online Only)

Annex E Written Evidence from the Clinical Director of Unscheduled Care (Online Only)

Annex F Summary of Discussion – 06.08.2012 (Online Only)

Annex A

SCRUTINY TOPIC ASSESSMENT FORM FOR COUNCILLORS
'ONE PAGE STRATEGY'

What is the broad topic area?

End of Life Care

What is the specific topic area?
I.e. what should be included & excluded from the topic? what are the driver behind the topic?

Do Not Resuscitate (DNACPR) Forms – their use and effectiveness

Ambitions for the review:
i.e. what is the review trying to achieve & why e.g. financial / efficiency savings and/or performance improvements? what will be different as a result of the review?

To try and ensure that patients wishes and instructions are acted upon by health professionals and carers at the end of life.

(For completion by the relevant Overview & Scrutiny Committee)

Does it have a potential impact on one or more sections of the population? **Yes**	**x**	**No**	
Is it a corporate priority or concern to the council's partners? **Yes**	**x**	**No**	
Will the review add value? and lead to effective outcomes? **Yes**	**x**	**No**	
Will the review duplicate other work? **Yes**		**No**	**x**
Is it timely, and do we have the resources? **Yes**	**x**	**No**	

If the answer is 'Yes' to the above questions, then the Committee may decide to proceed with the review. To decide how best to carry out the review, the Committee will need to agree the following:

Annex A

1) Who and how shall we consult?
i.e. who do we need to consult and why? is there already any feedback from customers and/or other consultation groups that we need to take account of?

Who: Key Health Partners (NHS North Yorkshire & York, Yorkshire Ambulance Service, York Hospital, St Leonard's Hospice, Adult Social Care at CYC, Independent Care Group,)
York Link, the Police, Funeral Directors, public, families

How: Informal meetings, briefing papers, discussions

2) Do we need any experts/specialists? (internal/external)
I.e. is the review dependent on specific teams, departments or external bodies? What impact will the review have on the work of any of these?

Will need technical support from those listed above, what a DNACPR form is, how they work, background information, good practice, examples of when they have worked well and examples of when they haven't worked.

Evidence of how the form is used and whether the forms are recognised by the Police, Hospital & Ambulance Service – for example

3) What other help do we need? E.g. training/development/resources
I.e. does this review relate to any other ongoing projects or depend on them for anything?
What information do we need and who will provide it? What do we need to undertake this review e.g. specific resources, events, meetings etc?

LINks have already undertaken a review on 'End of Life Care' Review however this has no specific recommendations linked with the use of DNACPR form but is focussed around wider issues associated with End of Life Care.

4) How long should it take?
i.e. does the timings of completion of the review need to coincide with any other ongoing or planned work

Annex B

Briefing Paper on DNACPR Form prepared by NHS North Yorkshire and York

1. Introduction

The purpose of this paper is to provide the Health Overview and Scrutiny Committee with some background information regarding Cardiopulmonary Resuscitation (CPR), the Regional Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Form including its implementation and Living Wills to help them with their review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and their use and effectiveness.

2. Cardiopulmonary Resuscitation (CPR) – What it is and what it is not

"When someone suffers sudden cardiac or respiratory arrest, CPR attempts to restart their heart or breathing and restore their circulation. CPR interventions are invasive and include chest compressions, electric shock by an external or implanted defibrillator, injection of drugs and ventilation"[1]. The level and speed of interventions given will depend on the patient's location at the time of cardiac or respiratory arrest.

CPR measures do not include analgesia, antibiotics, drugs for symptom control, feeding or hydration (by any route), investigation and treatment of a reversible condition, seizure control, suction, or treatment for choking.

3. Potential Outcome of CPR

"In reality, the survival rate after cardiorespiratory arrest and CPR is relatively low. After CPR for cardiorespiratory arrest that occurs in hospital, the chances of surviving to hospital discharge are at best about 15-20%. Where cardiac arrest occurs out of hospital, the survival rate is lower, at best 5-10%. The probability of success depends on factors including the cause of the arrest, how soon after the arrest CPR is started, and the equipment and staff available to deliver it. Attempting CPR carries a risk of significant adverse effects such as rib or sternal fractures, hepatic or splenic rupture, or prolonged treatment in an

[1] Treatment and care towards the end of life, General Medical Council, 2010

intensive care unit (ICU), possibly including prolonged artificial ventilation"[2].

4. Post CPR Period

"In the immediate post-CPR period most patients require at least a brief period of observation and treatment in an ICU or a coronary care unit (CCU) or both. Some patients will require treatments such as artificial ventilation, renal dialysis or haemofiltration, and circulatory support with inotropic drugs and/or an intra-aortic balloon pump. It is not uncommon for difficult decisions about CPR to arise in respect of patients for whom it may be possible to re-start the heart after cardiac arrest but for who admission to an ICU for continued organ support would be clinically inappropriate because they would be unlikely to survive their admission to the ICU.

There is also a risk that the patient will be left with brain damage and resulting disability, especially if there is delay between cardiorespiratory arrest and the initiation of the CPR. Some CPR attempts may be traumatic, meaning that death occurs in a manner that the patient and people close to the patient would not have wished"[3].

5. When to consider making a DNACPR decision

The General Medical Council supports the use of a DNACPR decision if:

- The decision is based on the circumstances of the individual patient
- It is the patient wish/choice not to have CPR
- Cardiac or respiratory arrest is an expected part of the dying process and CPR will not be successful
- It will help to ensure that the patient dies in a dignified and peaceful manner
- The potential outcome of CPR may be successful but the benefits of prolonging life is outweighed by the burdens and risks

In situations whereby the patient requests CPR in spite of a small chance of success or the judgement that it would be clinically inappropriate, the General Medical Council provides advice on how this should be handled and concludes that "when the benefits, burdens and risks are finely

[2] Decisions relating to cardiopulmonary resuscitation, A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 2007
[3] Decisions relating to cardiopulmonary resuscitation, A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 2007

balanced, the patients request will usually be the deciding factor." However, "the medic is not obliged to agree to attempt CPR if it is considered not to be clinically appropriate"[4]

6. What is a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form?

The DNACPR form is a means of communicating a DNACPR decision (an advanced decision specific to CPR) that has been made by a senior doctor (e.g. Consultant, GP) who has responsibility for the patient or a health care professional who has undertaken the necessary training to make the DNACPR decision or by the patient, to those who may encounter the patient in the event of a cardiopulmonary arrest.

The presence or absence of a DNACPR form should not override clinical judgement about what will be of benefit to the patient in an emergency (e.g. choking, anaphylaxis, sepsis etc).

7. Variants of DNACPR forms

Unlike Scotland, England doesn't have a national DNACPR Policy, DNACPR form or Website. In England DNACPR policies are created locally by the care provider and this has led to a number of variants of the DNACPR form. Historically these forms were only valid in the care facility that issued it and did not travel with the patient.

Therefore care providers in Yorkshire and Humber have been working on an approved DNACPR form which will be the agreed form for recording the DNACPR decision, within the Yorkshire and the Humber region.

8. Yorkshire and the Humber Regional DNACPR Form

The aim of the initiative was to establish a common form and protocol to be used across the region to ensure that DNACPR decisions made for a patient, or by the patient, are documented and communicated effectively.

Work had already commenced at Airedale General Hospital (AGH) in 2009 to review their Do Not Attempt Resuscitation (DNAR) form against the one developed by NHS Lothian. The reason the NHS Lothian template was used as the model form was because its design took into

[4] Treatment and care towards the end of life, General Medical Council, 2010

consideration the need to ensure that the form was transferable across care settings.

AGH then engaged with NHS Bradford and Airedale with the aim of agreeing a joint policy to support the transferable form and a local working group was formed to achieve that.

In August of 2009, as a result of feedback given at NHS Bradford and Airedale's Clinical Review Group meeting with Yorkshire Ambulance Service (YAS), it was decided that the issue of the multiplicity of DNAR forms within Yorkshire and the Humber needed to be addressed in order to resolve some of the problems it presented to YAS.

As lead commissioner for YAS, NHS Bradford and Airedale took ownership of the proposal and a bid was submitted to NHS Yorkshire and the Humber to secure financial support from the Regional Innovation Fund.

Once the regional working group was established the DNACPR form now in use across NHS Bradford and Airedale was reviewed against the template recommended by the Resuscitation Council (UK).

The feedback from clinicians regarding the Resuscitation Council template was as follows:

- It didn't request an explanation as to why CPR would be inappropriate
- It was interpreted as a record of a decision being made by the patient
- It didn't include any guidance
- Section 2 did not distinguish between inappropriate, unsuccessful or not in the patients best interests
- The design of the form did not facilitate its transferability of use to patient transfer services or to other care settings

It was agreed that the current NHS Bradford and Airedale model had been tried and tested and therefore was selected as the template from which the regional DNACPR form would evolve.

The regional DNACPR form is:

- Applicable to adults over 16 years old
- Transferable from one care setting to another

- Consistent with the
    - Decisions relating to Cardiopulmonary Resuscitation. A joint statement from the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN) 2007
    - Treatment and care towards the end of life: good practice in decision making. General Medical Council (GMC) Guidance July 2010
    - Advice statement on resuscitation Nursing and Midwifery Council (NMC) May 2008
- To be in accordance with mental capacity act, safeguarding adults/children

An example of the latest version of the Yorkshire and Humber regional DNACPR form is at the end of this annex.

9. Roll out of the Regional DNACPR Form

NHS Bradford and Airedale set up a Regional DNACPR Project Board and Regional DNACPR Strategic Working Group which had representation from partner organisations across the Yorkshire and Humber region. Representation on these groups included the Lead Resuscitation Officer from York Teaching Hospitals NHS Foundation Trust and Community and Mental Health Services, NHS North Yorkshire and York, as well as a Commissioning Manager from NHS North Yorkshire and York.

Prior to roll out of the regional DNACPR form, NHS North Yorkshire and York had discussions with and/or wrote to its care provider colleagues. These included:

- Chief Executives of Acute Hospitals
- Managing Director of Community and Mental Health Services, NHS North Yorkshire and York
- Local Medical Council
- Local Authorities
- Hospices
- Independent Care Group
- End of Life Locality Groups
- Cancer Locality Boards

Annex B

Just prior to the roll out of the regional DNACPR form, care provider colleagues were also invited to a meeting to:

- Understand the current arrangements
- Understand the proposed arrangements
- To finalise the NHSNYY's roll out plan
- To address any outstanding concerns or issues

NHS North Yorkshire and York started rolling out a new single 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Form v11 in September 2010'. This was quickly adopted within Community and Mental Health Services (including Out of Hours Services) and GPs, Hospices, Local Authorities, and Independent Care Homes but was more problematic in some acute settings.

To overcome concerns in the acute setting staff were invited to a workshop and contributed to discussions on how the form could be amended to make it more user friendly in an acute setting and this lead to version 12 of the form being published in July 2011.

An education package was compiled by members of the Strategic Working Group and consisted of:

- PowerPoint training presentations
- DVD/webcast of doctor to doctor and doctor patient/simulated DNACPR conversations
- CPR Patient information leaflet

These implementation aides and training tools were provided to all organisations to assist with their implementation programme. However, each organisation managed their implementation in accordance with their own project plan and time table.

As roll out progressed staff were given the opportunity to participate in an online survey regarding the roll out of the regional DNACPR form. The results show this opportunity was well received by staff within the NHS North Yorkshire and York patch.

During the introduction of the regional DNACPR form there have been a small number of cases reported across the region where the form was not adhered to. Reported incidents have been investigated and all necessary action taken which includes cascading any lessons learnt

from the incident to relevant staff groups to prevent the problem arising again.

10. How does the Regional DNACPR form work?

The regional DNACPR form is adopted by the care provider and incorporated into their DNACPR policy.

The regional DNACPR form is completed using the guidance provided on the reverse of the form, a framework for making a CPR decision from the care provider's local DNACPR policy and/or at the patient's request. Other guidance such as treatment and care towards the end of life (General Medical Council, 2010) and decisions relating to cardiopulmonary resuscitation (A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 2007) is available to staff when considering a DNACPR decision.

It is the responsibility of the healthcare professional completing the form to ensure that the DNACPR decision is communicated to all who need to know.

Whilst the patient is in hospital, the DNACPR form should remain in front of the case notes or kept in accordance with local hospital policy.

In all other care settings the DNACPR form should be located in the front of the care record/nursing record or kept in accordance with the care providers DNACPR policy.

If no nursing record exists in the home, the patient/family/carer will determine the best place to store it, and communicate this to the health care professionals.

As patients move between care settings, the DNACPR form moves with the patient in a clearly marked envelope. Ambulance control should be informed that a DNACPR form exists at the time of booking a patient transport services (PTS) ambulance or when requesting an emergency ambulance.

11. Who recognises the regional DNACPR form?

The regional DNACPR form is recognised by all health care providers and Yorkshire Ambulance Service in the Yorkshire and Humber region.

Annex B

12. What is the difference between a DNACPR form and a Living Will?

DNACPR Form

A DNACPR form is an approved document used by care providers to record an advanced decision. The document is limited to the withholding of one treatment only i.e. Cardiopulmonary Resuscitation.

Validating a Regional DNACPR form

Having one regional DNACPR form makes it easier for staff to validate the form quickly. For the form to be validated it must be:

- Completed correctly
- Current i.e. not exceeded any review date set by the person making the DNACPR decision or in accordance with local DNACPR policy if a review date hasn't been set
- Signed by an appropriate person
- An original form with an ink signature

Living Will

A Living Will (also known as Advance Decision in England and Advanced Directive in Scotland) is a document which sets out the future medical wishes of an individual should they become terminally ill or require medical treatment at a time when they do not have the full mental capacity to make those relevant decisions.

The term 'Living Will' can be divided into two categories, Advanced Statement and an Advanced Decision. An Advanced Statement is purely informative and must be fully respected by health care professionals, it outlines the extent of medical intervention that the individual would like whereas an Advanced Decision is legally binding and details the individual's right to refuse any form of treatment from antibiotic medication to intravenous feeding and resuscitation.

In England, Wales and Scotland a Living Will is considered to be a legally binding document which must be respected by all medical professionals. However, this is not the case in Northern Ireland.

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A Living Will will only be valid (accepted legally and by health care professionals) if the document has met a number of criteria which include that the individual:

- Was 18 or over and had capacity when they made it
- Has set out exactly which treatments they don't want in future (if they don't want life-saving treatment, their decision must be signed and witnessed)
- Has explained the circumstances under which they would want to refuse this treatment
- Has made the advance decision without any harassment by, or under the influence of, anyone else
- Hasn't said or done something that would contradict the advance decision since it was made

Because of the potential complexity of a Living Will, it is anticipated that individuals may have sought advice and have discussed their Living Will with their GP, or other treating health care professionals while they have the capacity to do so.

To ensure compliance to the Living Will all care providers will need to be aware of the Living Will and would have to have satisfied their selves of its validity.

Validating a Living Will

This can be difficult as there is no set format for a Living Will. If the person providing treatment is aware of a Living Will, they must then consider whether it is valid and applicable to the particular circumstances.

When deciding whether a Living Will is valid, the person providing the treatment should try to find out if the patient has:

- Withdrawn the decision since they made it, at a time when they had the mental capacity to do so
- Done anything which is inconsistent with the decision and suggests that it no longer represents their wishes or
- Made a Lasting Power of Attorney, giving someone else the authority to make the decision consenting to or refusing the particular treatment

Annex B

When deciding whether a Living Will is applicable to the particular circumstances, the person providing the treatment must also:

- Assess whether the patient actually still haves the mental capacity to make the particular decision about their treatment at the time it has to be made (they must start from the assumption that you have capacity and the advance decision will only be relevant if there is evidence that this is not the case)
- Check that the treatment and circumstances are the same as those referred to in the decision
- Consider whether there are any new developments that the patient didn't anticipate when they made their decision, which could have affected their decision; for example new developments in medical treatment, or changes in their personal circumstances.

Professionals providing medical treatment are protected from liability for not providing treatment if they reasonably believe there is a valid and applicable Living Will.

Health Care Professionals can provide treatment if they are in doubt over the existence, validity or applicability of a Living Will, and they are again protected from liability.

13. Further Reading

This paper only briefly touches on Living Wills and due to the complexity it is recommended that the Health and Overview Scrutiny Committee may wish to seek further advice to ensure clarity over the legal standing of this type of documentation. A number of useful websites/documents are as follows:

National End of Life Care Programme
www.endoflifecareforadults.nhs.uk/publications/pubadrtguide

Directgov UK
www.direct.gov.uk/en/Governmentcitizensandrights/Death/Preparation/DG_10029429

AgeUK
www.ageuk.org.uk/money-matters/legal-issues/living-wills/

Many of the quotes made in this paper have been taken from the following documents:

Annex B

Decisions relating to Cardiopulmonary Resuscitation. A joint statement from the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN) 2007.
www.rcn.org.uk/__data/assets/pdf_file/0004/108337/003206.pdf

Treatment and care towards the end of life: good practice in decision making. General Medical Council (GMC) Guidance July 2010
www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

12 December 2011

Annex B

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over v12 June 2011

In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.

NHS No	Hospital No	Next of Kin / Emergency Contact
Name		
Address		Relationship
Postcode	Date of Birth	Tel Number

Section 1 Reason for DNACPR: Select as appropriate from A - D (see reverse)

Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient's notes.

A. ☐ **CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision.**

B. ☐ **CPR is against the wishes of the patient as recorded in a valid advance decision**
The right to refuse CPR in an Advance Decision only applies from the age of 18.

C. ☐ **The outcome of CPR would not be of overall benefit to the patient and:**
i) They lack the capacity to make the decision ☐ **or**
ii) They have declined to discuss the decision ☐
This must be discussed with relevant others wherever possible (details overleaf)
This **has** been discussed with ..... (name) Relationship to patient:.....

D. ☐ **CPR would be of no clinical benefit because of the following medical conditions:**
.....
Even in situations in which CPR is not expected to be successful, it is still good practice to explain to the patient and/or relevant others why CPR will not be attempted.
This **has** been discussed with the patient ☐
This **has not** been discussed with the patient because it would cause them unnecessary distress ☐
This **has** been discussed with ..... (name) Relationship to patient:.....

Section 2 Healthcare professionals completing DNACPR form (see reverse)

Name & Designation	Name & Designation (Counter Signature if required)
Organisation	Organisation
Signature Date	Signature Date

Section 3 Review of DNACPR decision (if appropriate)

This order is to be reviewed by: Date: .....

Review Date	Full Name and Designation	Signature	Still applies	Next Review Date
			☐ (tick)	
			☐ (tick)	

AMBULANCE CREW INSTRUCTIONS

If Cardiopulmonary Arrest occurs, please do not attempt CPR. All other appropriate treatment should be given.
Any other specific instructions: .....

Annex B

These guidelines are based on an agreement within the Yorkshire and Humber region.
For more details refer to your local policy relating to DNACPR.
This is not a legally binding document; the decision may change according to clinical circumstances

Section 1 Guidance (*Please write legibly and with black ink*)

Option A

Record details in the patient's notes, including the assessment of the patient's mental capacity to make this decision.

Option B

The Mental Capacity Act (2005) confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

1. The decision is in writing, signed, witnessed and the patient is aged 18 or over;
2. It includes a statement that the advance decision is to apply even if the patient's life is at risk;
3. The advance decision has not been withdrawn;
4. The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
5. The patient has not done anything clearly inconsistent with its terms; and
6. The circumstances that have arisen match those envisaged in the advance decision.

16 and 17-year-olds: *Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility*

Option C

1. The term "*overall benefit*" is used in the context defined by GMC Guidance 2010 (Treatment & Care towards the End of Life; pg. 40-46; paragraphs 6, 13) and takes into account "*best interests*" as defined by the Mental Capacity Act, 2005.
2. This situation **must** be discussed with relevant others where possible. Record details of your discussion in the patient's notes.
3. The term "*relevant others*" is used to describe a patient's relatives, carers, representatives, people with lasting power of attorney, independent mental capacity advocates (IMCAs), advocates, and court appointed deputies (refer to Mental Capacity Act) http://www.dh.gov.uk

Option D

Record underlying condition/s eg poor Left Ventricular function, end stage obstructive airway disease, disseminated malignancy with poor performance status.

Section 2 Authorisation

Responsibility for making the DNACPR decision lies with a senior doctor (e.g. Consultant, GP) who has responsibility for the patient. In some localities, other healthcare professionals who have undertaken the necessary training may make the DNACPR decision.

If junior medical staff or other authorised professionals have been instructed to sign the form by a senior clinician, the form should be countersigned by the senior doctor, as soon as possible or as per local policy.

Section 3 Review – In accordance with your local Policy.

It is considered good practice to review DNACPR status in the following circumstances:

- At the consultant ward round, MDT or Gold Standards Framework meeting;
- On transfer of medical responsibility (eg hospital to community or vice versa); or
- Whenever there are significant changes in a patient's condition.

When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form, writing **CANCELLED** in large capitals and adding your signature and date. It should then be filed in the patient's notes.

COMMUNICATING DNACPR DECISIONS

It is the responsibility of the healthcare professional completing the form to ensure that the DNACPR status is communicated to all who need to know.

For patients being transferred between different care settings, it is essential that all professionals including Out of Hours (OOH) and Ambulance (e.g. Yorkshire Ambulance Service) are made aware of this DNACPR order

1. Send the **original form** with the patient.
2. A photocopy should only be retained in the patient's notes for audit, marked with the words '**COPY**' in large capitals, signed and dated.
3. In circumstances where patients are being transferred to community: the DNACPR status should be communicated to patient (if appropriate) and *'relevant others'*. They may prefer the form to be placed in a clearly marked envelope.
4. For discharges to community settings: communicate to the GP, Out of Hours service, and any other relevant services as appropriate e.g. Hospice.

v12 June 2011
Regional Review Date: June 2013
Regional Lead Contact: Palliative Medicine Consultant
Airedale NHS Foundation Trust, West Yorkshire

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Annex C

Summary of discussions from the meeting held on 21st December 2011

1. The present version of the form is Version 12; this currently meets the needs of all the health providers across the Yorkshire and Humber region [including Yorkshire Ambulance Service (YAS)] and has been approved for use. It is hoped that all health providers, in all locations across Yorkshire and Humber will have adopted the form by the end of 2012. The form is already live across York and North Yorkshire. Members commended NHS North Yorkshire and York for getting agreement for the use of the form from all parties.

2. In York the hospital started using the form in June 2011 and other health commissioners in the city throughout 2011.

3. YAS had, sometime ago, reported to NHS North Yorkshire and York that the form had not been working as well as it could have done within the organisation, this was due to several reasons, one of which was having to implement a huge staff training programme based around the use of the form. Also with the introduction of Version 12 the form had been standardised (with clinical input) and made transferable across health organisations and sites which had made it much more practical for YAS to use.

4. In the first instance it is usually the lead clinician and/or the patient that broaches the subject of DNACPR. The involvement of family is dependent on the patient's wishes (where the patient has the capacity to make their own decision). Sometimes the patient asks that the matter is not discussed with the family. It was noted that conversations around this subject matter were of a very sensitive nature but despite this, they still needed to happen.

5. The public were becoming more aware of the existence of the form. This was a positive note as it meant that patients could, if they wished to, start conversations with their GPs about their 'End of Life Care' wishes.

6. NHS North Yorkshire and York have given a copy of the form to all health providers across the region along with a best practice guide. However, this is only a guide and each individual organisation has its own policy on resuscitation which is where things can become complicated.

Annex C

7. The representative of NHS North Yorkshire and York had anecdotal evidence that DNACPR forms had not been accompanying patients and were being cancelled on discharge from hospital. Good practice says that the form should travel with the patient but be reviewed on a regular basis. It was noted at this point that it was hard to act upon anecdotal evidence.

8. It was noted that there was still work to be done to improve the use of the form and to encourage all organisations to use the form in a consistent way.

9. There was a training issue within certain organisations around the use and completion of the form. Some organisations provided better training than others. Some organisations provided regular resuscitation training but there was a lot to cover within these sessions and they were not solely dedicated to the use, completion and validity of the DNACPR form.

10. Anecdotal comments highlighted that there may be potential problems with the GP Out of Hours Service (OOH). For instance, where a nursing home contacted the OOH, usually for clinical support (such as pain control/breathing changes) towards the end of a patient's life there had been times when an ambulance had been called and the patient taken to hospital unnecessarily.

Health Overview & Scrutiny Committee End of Life care Review (Use & Effectiveness of DNACPR[1] Forms)
Responses to questions asked

1. **Is your organisation using this form? If not, why not? Are all the relevant members of staff aware of its existence?**

Organisation	Response
Yorkshire Ambulance Service (YAS)	Yes YAS is a sitting member of the DNACPR Strategic Working Group and has worked closely with all 12 PCTs across the Yorkshire & Humber Strategic Health Authority (SHA) region since the inception of the project. All operational staff are aware of the existence of the new form and associated processes, although it needs to be noted that not all staff in the North Yorkshire area of YAS are yet formally trained (please see YAS answer to question 3)
Leeds & York Partnership Foundation Trust	Yes, the form is included in the Trust's *Do not attempt cardiopulmonary resuscitation (CPR) policy* All staff were briefed on the updated policy and it is available to access from the NHS North Yorkshire & York intranet
NHS North Yorkshire & York (NHSNYY)	NHSNYY does not use the form but does require the use of the form in secondary care provision and promotes the use of this form by all care providers

[1] Do Not Attempt Cardio Pulmonary Resuscitation

Organisation	**Response**
York Teaching Hospital NHS Foundation Trust (YTHFT)	Yes Everyone in the organisation is using Version 12 of the Strategic Health Authority (SHA) form. This has been rigorously implemented across Acute and Community Hospitals, along with the roll out of the new DNACPR policy from December 2011. Discussions are underway with GPs about encouraging the use of the forms and also with Nursing Home Forum in Selby and York locality to encourage the use of the forms.
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	This form requires clinical medical completion. Our social work/care managers are aware of its existence. The staff in CYC residential homes work with their GPs to ensure this form is completed when appropriate.
Independent Care Group[2] – Home 1	Yes, we are all using the form
Independent Care Group – Home 2	Yes all trained staff are aware of the form
Independent Care Group – Home 3	Yes, we are using the form
Independent Care Group – Home 4	Yes

[2] The Independent Care Group received responses from several residential homes and nursing homes across the city – each response has been included in this document individually

Organisation	**Response**
Independent Care Group – Home 5	Yes, our organisation is using the DNACPR form, senior staff do know of their existence, however most of our new clients have had the form completed before admission, which makes the process easier for us
Independent Care Group – Home 6	Yes
Independent Care Group – Home 7	Yes
Independent Care Group – Home 8	Yes, we are using the form and all the RNs are aware of it
St Leonard's Hospice	Yes, we are utilising the DNACPR form
Macmillan Cancer Support (MCS)	MCS does not employ the Macmillan professionals directly however we do advocate the use of the DNACPR form and are aware that palliative care teams are actively working together on the development and utilisation of the form. The aim being to improve quality of care, informing patients and families and involving timely, active discussions with patients/carers and the wider health care teams about proactive plans and advocating patient choice about treatment plans for End of Life Care. The DNACPR form is part of the discussions about patient choice, active involvement in discussions about preferred place of care and what support practically, emotionally, socially and psychologically is required by the patient and family. The essential component within this is not only the discussions

Organisation	Response
	taking place but more importantly that the specialist and wider generalist teams have the skills, competence and confidence to discuss end of life care issues in a timely and supportive way.

2. Can you give the Committee some positive examples of the way your organisation has used the DNACPR form?

Organisation	Response
Yorkshire Ambulance Service (YAS)	The pre-dominant object of the regional DNACPR process is to offer a robust method of communicating the resuscitation status of a patient in cardiac arrest to all health professionals who may come into contact with the patient along their care pathway. Ultimately this objective is to support a dignified death and to negate inappropriate and futile resuscitation efforts that would be contradictory to the views of the medical team of the patient. Across YAS and certainly one example within the North Yorkshire area, trained crews have been presented with a valid regional DNACPR form on arrival at the scene of a patient in cardiac arrest. This then has rightly led to no further clinical intervention but equally importantly the instigation of an element of pastoral care for the relatives who were present at the time of death.

Organisation	Response
Leeds & York Partnership Foundation Trust	The Older People's service ensures that discharged patients to nursing homes have their form retained in the records that are kept by the nursing home. This prevents nursing homes from raising the issue again with patients and/or their families
NHS North Yorkshire & York (NHSNYY)	NHSNYY has an identified project lead who is a member of the Regional DNACPR Project Board and Strategic Working Group. The project lead has been involved in the roll out and implementation of the form across North Yorkshire Information on the project has been cascaded to providers and NHSNYY has a web page on their intranet The Out of Hours handover forms from GPs to Out of Hours (OOH) doctors has been re-designed to include information on DNACPR status, ensuring good sharing of information
York Teaching Hospital NHS Foundation Trust (YTHFT)	Julie Dale (Specialist Palliative Care Nurse, YTHFT), is able to present an example of a gentleman from Ward 32 who went home for end of life care. It was clear to all involved - ward staff, ambulance crew, community district nursing, hospice, at home and out of hours GP that the patient had a DNACPR order and had expressed a wish for a natural peaceful death that was achieved. Out of Hours handover forms from GPs to OOH

Organisation	Response
	doctors have been re-designed to include information on DNACPR status, ensuring good sharing of information.
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	N/A as we do not lead in using the form
Independent Care Group – Home 1	It prevents admission into hospital when not appropriate
Independent Care Group – Home 2	We are speaking to all our residents/or their families to ensure they understand why we want these forms in place and it is part of the discussions we have about end of life care so we understand our residents/families wishes
Independent Care Group – Home 3	No
Independent Care Group – Home 4	When the service user moves to Hospital or Nursing home, clear information for staff
Independent Care Group – Home 5	We always send our completed DNACPR form with our resident if admitted to hospital, none have been put into action yet
Independent Care Group – Home 6	All new admissions are assessed and the family are involved with this process and it is care planned if DNACPR is in place. The family sign to say they are agreeing to the plan, also a red sticker is on the resident's file to say DNACPR.

Organisation	**Response**
Independent Care Group – Home 7	If we know the person does not want to be resuscitated we have managed to talk to them and their family. Sometimes doctor slow in signing the form
Independent Care Group – Home 8	Our GPs are using the forms and are happy to complete them. Our Company (Mimosa Healthcare) like the forms as they are in line with the MCA
St Leonard's Hospice	We ensure that patients are discharged from the Hospice with either a DNACPR, if appropriate, or a documented conversation that it had been discussed.
Macmillan Cancer Support (MCS)	As per question 1 – there is discussion with the teams about the use of DNACPR forms and the part that this has in quality of care and management of patients. No operational examples available at this time, however MCS is aware of the core part that this form has in active patient management and involving patients and families in choices related to actively taking part in decision making.

3. What training has your organisation provided in relation to completing and using the form? What percentage of staff has your organisation trained? When will the remainder be trained? Can you evidence how staff are trained? In addition to this do you offer refresher training and routinely offer training to all new members of staff on how to use the form?

Organisation	Response
Yorkshire Ambulance Service (YAS)	All existing staff receive a module session on DNACPR which is incorporated with their mandatory Resuscitation Guidance Update training programmes – as at 13th February North Yorkshire A/E staff training compliance is 82.37% (327). It may be noted that the reason for DNACPR training to be added to other mandatory training is that there is no specific funding available to support DNACPR education to any area of the health economy within the Yorkshire & the Humber region. It naturally applies therefore that this lack of financial support slows the process of training and education to all professionals. It can be further confirmed that all new staff are provided with DNACPR training within their formal education programme and refresher training is also accounted for within the future mandatory Resuscitation Guidance updates. Seventy A/E frontline staff are yet to receive formal DNACPR training and based on the on-month training progression it would not be unrealistic to

Organisation	Response
	suggest that completion of this programme in North Yorkshire may be completed by around May/June of this year.
Leeds & York Partnership Foundation Trust	The use and rationale of the form is covered in the Basic Life Support (BLS) presentation. The Intermediate Life Support (ILS)Training is being modified to cover the use of the form 29%of staff have received BLS training for the first 7 months of this financial year 95% of staff identified as requiring ILS training have been trained in the same timeframe Additional training is in place to the end of this financial year
NHS North Yorkshire & York (NHSNYY)	Staff do not require formal training but there is information regarding the form and training materials on the intranet if required. The project lead is also available to provide training/briefings in-house
York Teaching Hospital NHS Foundation Trust (YTHFT)	Basic Life Support training is delivered annually to all staff who have patient contact and this training includes information about DNACPR and the form. 1,789 acute and community staff have had this annual mandatory basic life support training. This training from 2011 has included information about the DNACPR form, and an awareness about its use. This will be repeated annually for all staff who are in

Organisation	Response
	patient contact. Training DVD and information also given to GP & dental practices who access our training (recently Copmanthorpe, South Milford, dentist at Orthokind, York, Pickering, Sherburn) DVD on form completion & difficult conversations shown to new doctors on Induction Programme in PGME (Post Graduate Medical Education) (first week in February & August) DVD & Question & Answer sessions with Band 6 and higher nurses and therapists facilitated by Resuscitation Officers. Planned to repeat for Community staff new to the Trust across Scarborough, Whitby and Ryedale. Additional Training by Hempsons, solicitors for medical staff and senior nurses in January 2012 on form completion and difficult scenarios. (this information supplied by Resuscitation Officer and Corporate Learning & Development Team)
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	No specific training to care management staff

Organisation	**Response**
Independent Care Group – Home 1	Only nurses complete the form, would only train everyone else if this is a requirement
Independent Care Group – Home 2	We are a small Nursing Home so at present it has been the manager or her deputy who have dealt with the forms
Independent Care Group – Home 3	The form is of constant discussion at our nurses meetings for the difficulty in getting GPs to sign the form and the families and resident not wanting to enter into conversation about it. All the nurses have been trained on them. Staff were trained by the General Manager who attended a meeting with a representative from the PCT who came along and explained the need and how to use the form effectively. The form is constantly on care file audits we complete as General Managers. New staff are shown the form as part of their documentation training on induction.
Independent Care Group – Home 4	None, the organisation speaks to the GP in relation to completing and using the form and at the moment the GP does all the form filling We are residential care
Independent Care Group – Home 5	We have attended meetings about the form but no official training has been given yet
Independent Care Group – Home 6	I have been advised that all staff are aware in the use of the DNACPR paperwork

Organisation	**Response**
Independent Care Group – Home 7	All our trained staff have been trained to use the form. We have included the topic in staff meetings. If the form changes in any way staff are updated
Independent Care Group – Home 8	Staff have not been trained on the form itself
St Leonard's Hospice	The training has been informal and via a cascade approach in team meetings. I have not been able to gain evidence of who has been trained at this point.
Macmillan Cancer Support (MCS)	MCS provides education and learning grants for Macmillan professionals which they can access on an individual basis or as part of the team. The grants could potentially be used in this area for improving the knowledge, competence and skills of teams if this was requested.

4. How has the use of the form been integrated into your own policies? Is it written into your own policies?

Organisation	Response
Yorkshire Ambulance Service (YAS)	Yes. YAS not only has integrated the DNACPR regional form and processes into its Resuscitation Policy but also now has a specific Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Policy and Procedure that outlines the processes for both the A/E and PTS elements of the trust when treating and/or transporting patients with a DNACPR decision in place. This policy at the time of writing was circulated to all PCTs via the DNACPR Strategic Working Group to inform and assist with the newly adopted processes within both the community and acute setting to ensure alignment of services.
Leeds & York Partnership Foundation Trust	Yes, the form is included in the Trust's *Do not attempt cardiopulmonary resuscitation (CPR) policy*
NHS North Yorkshire & York (NHSNYY)	The form has been fully integrated into our policy
York Teaching Hospital NHS Foundation Trust (YTHFT)	Yes. It is integral to our DNACPR policy and has been rolled out across the organisation and is available for all staff on the Intranet. It has been the focus of much work post CQC inspection and is high profile within the organisation.
CYC – Adults Children's Education (ACE)	N/A

Organisation	**Response**
Directorate – Assessment & Safeguarding	
Independent Care Group – Home 1	Yes, and now kept in residents' files
Independent Care Group – Home 2	We are trying to ensure that we ask all our residents their wishes but find we have to pick the appropriate moment. We are currently deciding what our time scale for doing this will be and then we will include it in our policies
Independent Care Group – Home 3	The form has not been written into our policies being a national company all PCT areas are not working with these
Independent Care Group – Home 4	Work in progress
Independent Care Group – Home 5	No, this has not been incorporate into our policies and procedures
Independent Care Group – Home 6	No comment provided
Independent Care Group – Home 7	We already had end of life wishes integrated into our documentation/policies
Independent Care Group – Home 8	The forms are used in conjunction with the end of life section of our care plans and policy
St Leonard's Hospice	It is not integral to any of our policy currently but we have our end of life pathway review ongoing
Macmillan Cancer Support (MCS)	The education and learning grants offer opportunities for the Macmillan teams to identify education and learning needs and devise their own bespoke education programme, which the grant could support. MCS also has 'Learn Zone' which is a resource available to anyone whether they are a Macmillan

Organisation	Response
	professional, health or social care professional or member of the public. This is free and only requires registration. There are already many resources available including specific resources e.g. Out of Hours toolkit, palliative care education modules which are highly relevant to the delivery of specialist and generalist palliative care and have been devised with the involvement of MacMillan GPs and Macmillan Clinical Nurse Specialists. www.macmillan.org.uk/learnzone

5. Do you audit the use of the form? If so, how?

Organisation	Response
Yorkshire Ambulance Service (YAS)	At this juncture there is no formal audit in place for DNACPR within the trust annual audit cycle. However within the YAS Patient Report Form (PRF) all DNACPR patients are recorded irrespective of clinical intervention or otherwise as it needs to be remembered that YAS may attend DNACPR patients with an acute episode of illness or injury. This facility will therefore allow for future planning to include any audit relating to the new process.
Leeds & York Partnership Foundation Trust	Yes, after completion of a DNACPR form, staff must complete and submit a DNACPR completion form to the Governance Manager
NHS North Yorkshire & York (NHSNYY)	Audits have been completed as part of the Regional Project. The audit has focussed on questions relating to the implementation of the form, training received and quality checks on completeness of forms
York Teaching Hospital NHS Foundation Trust (YTHFT)	Yes. The Trust's Compliance Unit regularly audit the completion of DNR/CPR forms and feeding this back to Ward Sisters, Consultants and the Corporate Directors. Any errors identified are addressed. (Information supplied by Compliance Unit)
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	N/A

Organisation	**Response**
Independent Care Group – Home 1	No
Independent Care Group – Home 2	Not yet
Independent Care Group – Home 3	The form is audited in the care file audit process in the home
Independent Care Group – Home 4	Work in progress- we have just started to look at the audit
Independent Care Group – Home 5	We include the form in discussion with the family and GP when need arises i.e. review or change in a persons health needs
Independent Care Group – Home 6	It is audited when the care file is audited which is done in a planned way
Independent Care Group – Home 7	No we haven't up to now
Independent Care Group – Home 8	No
St Leonard's Hospice	There is currently no audit, but our audit process is currently under review
Macmillan Cancer Support (MCS)	Macmillan services undergo service reviews which involve the Macmillan Development Manager, the Macmillan team and their managers. The review will include looking at the evidence which demonstrates quality issues around impact and added value which the specialist teams provide. Involvement with DNACPR forms will be an operational issue which may be discussed at the review together with appropriate tools e.g. Gold Standards Framework, Liverpool Care Pathway. The service review provides opportunity to acknowledge best practice

Organisation	Response
	and to share good practice from other areas as appropriate.

6. In relation to the DNACPR form - have you received any complaints from families after a relative has passed away? If so, what lessons have you learned from this?

Organisation	Response
Yorkshire Ambulance Service (YAS)	YAS is aware of two examples of inappropriate resuscitation each of which appears to have involved crews who were not trained on the new DNACPR process.
Leeds & York Partnership Foundation Trust	There have been no complaints
NHS North Yorkshire & York (NHSNYY)	No complaints from families/carers
York Teaching Hospital NHS Foundation Trust (YTHFT)	In the last year there have been 2 or 3 complaints. These have focussed on the issue of communication with family members. In light of these complaints the policy has been reviewed regarding communication and a training programme put in place for all medical staff and appropriate senior nursing staff. See other comments from YTHFT (Information supplied by Complaints team)
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	No
Independent Care Group – Home 1	No complaints received
Independent Care Group – Home 2	No
Independent Care Group – Home 3	No complaints
Independent Care Group – Home 4	No
Independent Care Group – Home 5	We have not used one yet
Independent Care Group – Home 6	No
Independent Care Group – Home 7	We have not received any complaints

Organisation	Response
Independent Care Group – Home 8	No complaints about the form, but have brought up the subject at the recent relatives meeting so all are aware of it
St Leonard's Hospice	We have had feedback from a family who had a relative at home that had a DNACPR form and was at the end of life. At the point where the patient stopped breathing the family called 999 and an ambulance crew attended the house and attempted to resuscitate the patient despite being aware of a DNACPR. The issues for us were relating to our communication to families on what to do and who to call when a patient dies to prevent 999 calls in the future. This information was fed back to YAS at the time by the previous Director of Clinical Services for the Hospice
Macmillan Cancer Support (MCS)	I have no information related to this area. If MCS receives a complaint about patient care or experience we have a complaints procedure to follow and would discuss with the appropriate employer/organisation.

7. Are there any barriers to your organisation using the form? If so, what are these and what action have you taken to try and resolve this?

Organisation	Response
Yorkshire Ambulance Service (YAS)	There does not appear to be any specific barriers other than the educational issues as described in our answer to question 6
Leeds & York Partnership Foundation Trust	We have found no barriers in using the form
NHS North Yorkshire & York (NHSNYY)	No
York Teaching Hospital NHS Foundation Trust (YTHFT)	All staff to be using the most current version of the form and to be aware of its use and developing the skills in having difficult conversations around end of life care. Feedback regarding the form itself has been given to the SHA project group to say that the design of the form and the flow of information within the form is not intuitive and the information could flow better DNACPR task group started at end of 2011 to prioritise issue, new policy, training and education.
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	N/A
Independent Care Group – Home 1	No
Independent Care Group – Home 2	Not really – some GPs are sometimes reluctant to have them in place unless the resident is terminally ill
Independent Care Group – Home 3	No
Independent Care Group – Home 4	Too early to say

Organisation	**Response**
Independent Care Group – Home 5	We do feel that these could be used inappropriately if everyone was not in agreement as to the person's capacity and general health status
Independent Care Group – Home 6	No barriers
Independent Care Group – Home 7	No, not once all were on board
Independent Care Group – Home 8	Only that most staff leave this subject to deal with at a later date and then forget about it
St Leonard's Hospice	No barriers to using the form, our difficulty is around the timing of the conversations with patients and their expectation when they are admitted. The area has often not been discussed prior to a patient coming into the Hospice
Macmillan Cancer Support (MCS)	MCS has a role in negotiating with teams, their managers and employers and using opportunities to influence from a local, regional or national level. MCS advocates working to develop and improve DNACPR and End of Life Care.

8. Has your organisation had any experience of the form not working? If so what were these experiences and what course of action was taken to try and resolve the problem?

Organisation	Response
Yorkshire Ambulance Service (YAS)	A number of issues have been raised via the DNACPR Lead for the PCT to YAS all of which in the main have related to three specific areas of concern: 1. YAS crews not accepting a document which does not have a red border. This remains very much an educational issue within YAS and relates to the agreement by the DNACPR Strategic Working Group that a document can either have a red or black border as long as it is the original document. It may be noted that this decision was agreed to accommodate the desires of GP practices across all PCT areas who argued that they did not have colour printers in their surgeries not the budget to replace or upgrade. YAS is continuing to work hard both inside the trust and with colleagues from the PCTs to address this issue 2. YAS crews not accepting forms as they were concerned that the form was not an original as agreed within the original process. At the most recent meeting of the Strategic

Organisation	Response
	Working Group - is now agreed that crews no longer are required to obtain assurance that the document is the original but may act upon the document provided and as long as they are satisfied that the DNACPR decision relates to the patient in their care and that it is both in date and fully signed by an appropriate clinician. 3. YAS crews not accepting the form as they are under the belief that the review date of the form has expired. This appears to be a further educational issue probably based on staff's previous understanding of the time limitations of the old DNAR style forms Once again YAS is working hard to ensure that staff are fully aware that the form is valid if the review date is in date (and this period can be anything up to six months) or alternatively if there is no review date included (but is signed) that the form can be deemed as valid for an indefinite period.
Leeds & York Partnership Foundation Trust	We have had no experience of the form not working
NHS North Yorkshire & York (NHSNYY)	• Yes: • Ambulance Crew call to transport patient from home to hospice. Crew stated DNACPR

Organisation	Response
	form was out of date and refused to transfer the patient with the DNACPR form at the house. The crew wanted the form updating and also the section regarding ambulance crew guidance completed. • GP was contacted to complete another DNACPR form. • Ambulance crews have stated it was not a valid document because: • The form should have red borders • The form is a copy • The crew felt the form needed reviewing as the form was several months old (i.e. more than 3 but less than 6 months) • There are no instructions for ambulance crews • Not always resolved at the time but reported to Yorkshire Ambulance Service (YAS) as the forms were valid at the time of the incident
York Teaching Hospital NHS Foundation Trust (YTHFT)	The form itself works well. See other answers for issues that are raised
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	No
Independent Care Group – Home 1	No
Independent Care Group – Home 2	No
Independent Care Group – Home 3	Where residents and relatives have agreed their decisions then the GP has refused to sign them, the

Organisation	Response
	resident was then part of an unexpected death procedure in the home and the resident had been dead a matter of minutes before they were found. The ambulance came blue light after being told it is not an emergency as the person was dead (confirmed by a registered nurse) and they carried out CPR
Independent Care Group – Home 4	Received forms from York Hospital not filled in correctly – family not signing the form and do not know anything about it
Independent Care Group – Home 5	No
Independent Care Group – Home 6	No
Independent Care Group – Home 7	No
Independent Care Group – Home 8	No, Ii think it is a good form and has saved us having to create another ;best interest' decision form of our own
St Leonard's Hospice	See Hospice response to question 6
Macmillan Cancer Support (MCS)	I have no specific information or examples of this, although there have been general discussions related to the management of patient care when a patient's condition has deteriorated and yet the family have relayed that the patient did not wish to be resuscitated and admitted, but procedure/policy led to this happening.

9. Has your organisation had any experience of patients being given CPR even though there has been a DNACPR form in place? What were the circumstances which overruled the DNACPR decision?

Organisation	Response
Yorkshire Ambulance Service (YAS)	Please see YAS's response to question 6
Leeds & York Partnership Foundation Trust	This has not occurred
NHS North Yorkshire & York (NHSNYY)	Yes Rapidly deteriorating patient discharged, to fulfil his wish to go home to die DNACPR in place and discussed with patient, the family, the ambulance crew taking him home and the hospice team –agreed what to do if he died during the journey home The GP OOH's Palliative Care Handover Form was completed and faxed When he died his carer rang 999 and a crew was dispatched who went on to attempt CPR This was unsuccessful and the police and the coroner were then involved The ambulance crew had not received their training and therefore wouldn't accept the form
York Teaching Hospital NHS Foundation Trust (YTHFT)	On occasion an out of hours phone call made by family to alert OOH to an unexpected death have resulted in the despatch of paramedic responders and police and telephone advice about starting resuscitation. This is not about compliance with

Organisation	Response
	DNACPR form but the appropriate triaging of such phone calls. Across the SHA commissioners are doing a piece of work with YAS about this and are collating information. The feedback from commissioning is as follows: There have been very few problems in the City of York area that have been brought to the commissioners' attention: • June 2011 – Ambulance crew stated DNACPR form was out of date and refused to transfer the patient with the DNACPR form at the house. They wanted it update and also the section regarding ambulance crew guidance completed • November 2011 – the Director of Clinical Services, St Leonard's Hospice informed the project lead of an incident in November 2011. The patient was also known to the Specialist Palliative Care Team who also raised this as a concern. Rapidly deteriorating patient discharged, to fulfil his wish to go home to die. DNACPR in place and discussed with patient, the family, the ambulance crew taking him home and the hospice team – agreed what to do if he died

Organisation	Response
	during the journey home. The GP Out of Hour's Palliative Care Handover Form was completed and faxed When he died his wife, as family members do, rang 999 and a crew was dispatched who went on to attempt CPR. This was unsuccessful and the police and coroner were then involved. The ambulance crew had not received their training and therefore won't accept the form Across North Yorkshire the main problems have been related to ambulance crews stating the DNACPR form was not a valid document because: 1. The form should have red borders – this is an issue for GPs and nursing homes if they download forms rather than using pre-printed forms, as few offices have colour printers. Discussions underway about GPs using/accessing the printed forms 2. The form is a copy 3. The crew felt the form needed reviewing as the form was several months old (i.e. more than 3 but less than 6 months)
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	No

Organisation	**Response**
Independent Care Group – Home 1	A photocopy of the form was given to ambulance men, but they wouldn't accept it so we spoke to our GP
Independent Care Group – Home 2	No
Independent Care Group – Home 3	See answer given to question 8 And GP refusal to sign
Independent Care Group – Home 4	No
Independent Care Group – Home 5	CPR has not been attempted on anyone in this care setting
Independent Care Group – Home 6	No
Independent Care Group – Home 7	No
Independent Care Group – Home 8	No
St Leonard's Hospice	See Hospice answer to question 6
Macmillan Cancer Support (MCS)	I have no information related to this

10. Is there anything further that you think the Committee should be aware of in relation to the use and effectiveness of DNACPR forms (either generally or within your organisation)?

Organisation	Response
Yorkshire Ambulance Service (YAS)	No
Leeds & York Partnership Foundation Trust	In our experience the main issue for end of life care is not whether resuscitation is provided when someone arrests but whether active treatment e.g. intravenous infusions or admission to a general hospital, should be given when a patient is dying. We believe the emphasis should be on maintaining comfort and dignity for the dying person. This may mean that active treatment is not appropriate. Raising awareness of the use of Advance Directives would assist in this
NHS North Yorkshire & York (NHSNYY)	No
York Teaching Hospital NHS Foundation Trust (YTHFT)	After discussion with social services colleagues and the community matron who works in nursing homes there are several issues regarding embedding the use of the form in a community setting. Nursing homes are trying to use them, (and community matron has taken forms to nursing homes), and get them signed by visiting GPs, however when a patient comes into hospital the form seems to get lost en route/in ED (Emergency Department) and rarely returns to the nursing

Organisation	Response
	homes. This causes them more work as they then have to start again requesting the form to be completed by a non-resident doctor. An awareness raising exercise in the importance of returning the original form after a hospital admission/appointment needs to be ongoing. Social services residential home managers would after discussion only feel comfortable using a DNACPR form completed by a doctor where it can be evidenced that a discussion has taken place with family, carers or a best interest decision is clearly documented. Whilst acknowledging best practice is to have this conversation, there are occasions when they are signed by the doctor without discussion, and there are concerns expressed by social service colleagues about the appropriateness of this. This reflects a lay assumption that family or patient has to consent to the DNACPR being in place. This will need to be followed up with further discussions of all parties. After discussion at dementia workshops etc social services staff have proactively completed DNACPR

Organisation	Response
	forms with all appropriate new residents and are now considering retrospectively doing the same for existing residents. Further joint working on this issue will be very positive
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	We are uncertain how far the requirements of the Mental Capacity Act are embedded in clinical practice to inform judgements around DNACPR
Independent Care Group – Home 1	No
Independent Care Group – Home 2	We had a resident who was discharged from York Hospital who had a form with him on his return to the Nursing Home, however despite the fact that he had capacity it had not been discussed with him or his family
Independent Care Group – Home 3	Provide more publicity to the public. Have discussions with GPs and perhaps have an appeal process to go through when GPs refuse to sign
Independent Care Group – Home 4	When a form comes back with a service user after being in hospital and it is not filled in correctly what to do and how long does it last, the GP thought 6 months then he would need to speak to the service user and family to do another one

Organisation	Response
Independent Care Group – Home 5	We feel that DNACPR wishes should be made while the person has capacity to make the decision for themselves. We find the forms a little worrying as people's emotional state changes especially at the loss of a loved one and then start to express feelings of guilt which can lead to recriminations
Independent Care Group – Home 6	No
Independent Care Group – Home 7	We do need to know when a new version has come out
Independent Care Group – Home 8	No comment provided
St Leonard's Hospice	Our Hospice at Home Team (H & H) have cared for a patient in the community who was at the end of life and died over a night time. The H & H Team were not present at the time of death however the family had been informed to contact the out of hours GP team when the patient died. At the time of death the family called 999 rather than the out of hours team and an ambulance attended. The patient did not have a DNACPR form and the ambulance crew attempted to resuscitate. The family intervened and removed the crew from the house and were obviously distressed by the situation. The ambulance crew contacted the police as they had been removed from the property and the police then attended. The family were traumatised by the situation.

Organisation	Response
	The concern is that the H & H Team were called to support the patient at the very end of life and the patient had no other prior contact with the Hospice Team. The DNACPR form had not been completed by health professionals involved with the patient's care. It is vital that all health professionals are aware of their responsibility to have the difficult conversations with patients and their loved ones in a timely manner to avoid situations such as this one
Macmillan Cancer Support (MCS)	MCS is in agreement that the development and use of DNACPR forms is essential for quality of life and quality of death and should be core in all patient pathways.

11. If a DNACPR form was not accepted by Yorkshire Ambulance Service when transporting a patient, why was it not accepted?

Organisation	Response
Yorkshire Ambulance Service (YAS)	See YAS's answer to question 8
Leeds & York Partnership Foundation Trust	We have no experience of this
NHS North Yorkshire & York (NHSNYY)	Yes Ambulance crews have stated it was not a valid document because: • The form should have red borders • The form is a copy • The crew felt the form needed reviewing as the form was several months old (i.e. more than 3 but less than 6 months) • There are no instructions for ambulance crews
York Teaching Hospital NHS Foundation Trust (YTHFT)	Anecdotal evidence, although may be able to ascertain more information from commissioners who are doing a piece of work with YAS about this and are collating information. See other comments from YTHFT
CYC – Adults Children's Education (ACE) Directorate – Assessment & Safeguarding	N/A
Independent Care Group – Home 1	Because it was a photocopy, not the original
Independent Care Group – Home 2	No comment provided
Independent Care Group – Home 3	In the early stages the ambulance crew were not aware of them so we did have a couple of instances of CPR given when the person had been dead for

Organisation	**Response**
	many minutes
Independent Care Group – Home 4	No
Independent Care Group – Home 5	No comment provided
Independent Care Group – Home 6	No comment provided
Independent Care Group – Home 7	Because it was not an up to date version
Independent Care Group – Home 8	Very recently a member of the YAS reluctantly agreed to use it after complaining that it wasn't outlined in red (it was just a black and white version)
St Leonard's Hospice	As per answer 6 from the Hospice, I do not know why it is not accepted. There has been no feedback to me. However, I have only recently come into post at St Leonard's
Macmillan Cancer Support (MCS)	No information related to this operational issue.

Other Information/Comments

Comment from LINKs – The following comment was received as part of e-mail correspondence regarding today's meeting

'We don't use the form but have received several complaints from relatives of people who had the form but were still actively treated - possibly not CPR but the effect is the same as life is prolonged' (Annie Thompson; Links Partnership Co-ordinator)

Comment from York Teaching hospital NHS Foundation Trust – The following comment was received as part of e-mail correspondence regarding today's meeting

'We are pleased to be able to feedback to you about a large amount of work that has been undertaken in the Trust recently with the launch of our new policy and ongoing training for staff.
Looking forward there remains a great deal of work to do around this area of end of life care, and one of the issues it would be interesting to explore collaboratively is how to influence the culture of the general population to engage in discussions about their end of life wishes and plans, whilst they are well and able to discuss these things with families and friends. It would be ideal if the general social acceptance of sex education by the general population could be replicated in similar education about death and dying, and this would lead to a very helpful public airing of these issues and help support development of this work.' (Elizabeth McManus; Chief Nurse)

Information from the Chief Executive of the Independent Care Group

York Health Overview & Scrutiny Committee - DNACPR Forms

I am very sorry not to be able to attend the meeting. I would like to make one or two points.

Background

I think any discussion on CPR should begin by looking at the subject objectively.
The General Medical Council says:
'CPR has a reasonable success rate in some circumstances. Generally, however, CPR has a very low success rate and the burdens and risks of CPR include harmful side effects such as rib fracture and damage to internal organs; adverse clinical outcomes such as hypoxic brain damage; and other consequences for the patient such as increased physical disability. If the use of CPR is not successful in restarting the heart or breathing, and in restoring circulation, it may mean that the patient dies in an undignified and traumatic manner.'

I think it's important not to forget this. One of the reasons why we have worked to have a Do Not Resuscitate Form is because the Ambulance Service has been (historically) obliged to perform CPR and this has caused distress to everyone where a client is at the end of their life or is frail and has no wish to be resuscitated.

In the past care homes who telephone for advice and support for a client whose condition has worsened have on occasion inadvertently triggered an Ambulance. The person who is at the end of their life and their relatives would not want CPR to be performed but once the ambulance arrived there was no choice.

From talking to Independent Care Group members (care homes in York) and from the forms I have received back I think the following points should be addressed.

The Form

The DNACPR Form has been designed with a red border. Most care homes do not have a colour printer. We have been told that forms do not have to have a red border but there still seems to be a problem with the Ambulance Service accepting this.

GPs being willing to sign forms on the wishes of the patient

Some homes have a very good relationship with the numerous GP practices with whom they work. However, I do still get reports of homes having difficulty engaging GPs in getting the forms signed.

The validity of the Form

If a patient in hospital has a DNACPR Form put into place there remains confusion over what happens to it when the patient is discharged. We need guidance on this. I have been told that the DNACPR Form is location specific – but is this true. If the form has not been discussed in hospital with the person and their relatives then it needs to be discussed by their GP if they are discharged with a DNACPR Form.

People with dementia

Homes which look after people with dementia would like more guidance. Often relatives will say that they do not want their loved ones to undergo resuscitation. This places the home in a difficult position as DNACPR would have to be agreed with the person who lacks capacity.

Annex D1

Summary of discussions from the meeting held on 29th February 2012

1. It was acknowledged very early on in the meeting that the discussions around and the completion of a DNACPR form were only a small part of establishing an End of Life Care pathway; however DNACPR was the chosen focus for this review

2. The Commissioning Manager, Specialist Commissioning, from NHS North Yorkshire & York said that there had only been a couple of incidences in York where the form had not been used properly and he was aware of these

3. In relation to the Acute Trust (the hospital) concerns had been raised by the Care Quality Commission (CQC) about the use of the form. The Medical Director from the Acute Trust acknowledged that there had been times when the form had not been correctly used within the hospital environment. Training programmes in relation to the use and completion of the form had now been implemented and there had been a shift in practice and more importantly a shift and increase in awareness of the form and its purpose. The CQC had visited the hospital again recently and had noticed a real change in practice and now regarded them as being compliant in the use of the DNACPR form

4. The Chair of the Health Overview & Scrutiny Committee acknowledged that the focus for this review had been partly triggered by the CQC report and it was excellent to know that improvements had been made and concerns addressed within the hospital environment

5. The Medical Director from the Acute Trust said that he sits down with staff every week to review all deaths that have taken place in the hospital over the past 7 days. They look at factors such as age, length of time in hospital and anything that could have been managed differently. He gave an example of an elderly person having been admitted to the hospital; she was very poorly, had dementia and heart disease and was admitted acutely to the hospital from a nursing home; She died 2 hours later. DNACPR was discussed with the patient and they chose not to be resuscitated. However, this was an unnecessary admission to hospital resulting in an undignified death in a place the patient did not want to be.

The process could have been made simpler and more dignified for the patient had DNACPR been discussed within the nursing home, especially as in this case the death would have been foreseen

6. It was acknowledged that some nursing homes do a fantastic job in relation to all aspects of End of Life Care; however there were others where improvements needed to be made. Yorkshire Cancer Network was rolling out a process to enable access to a training programme for staff in nursing homes across the city.

7. A local GP also raised concerns as to why the above mentioned patient was admitted to hospital in the first instance. He said that often admissions like those above happened when the Out of Hours Service (OOH) admitted a patient, however in the instance stated above the patient was *not* admitted by OOH and neither was there any evidence that DNACPR had ever been discussed with the patient

8. A representative of North Yorkshire Police also raised concerns about the OOH service and suggested that the improvements being made to the way DNACPR forms were dealt with were being undermined by inconsistent practice within the OOH service, and a failure to identify patients where death was expected from those in need of urgent medical attention, and consequently the failure to deliver support to the services caring for a patient whose death was expected. Representatives from York Hospital agreed that there had been issues where the Police have been called to expected deaths. If the death is expected with a DNACPR form in place then there is no need to inform the Police. There needs to be more joined up working with the OOH providers and Yorkshire Ambulance Service around these issues along with more education and more robust pathways put in place.

9. A Social Worker told a story of a patient in a nursing home who had a DNACPR in place; the nursing home telephoned the OOH service but instead of coming out to visit the patient they had sent a paramedic, the patient subsequently died and this led to the Police becoming involved which was distressing for the family

10. The Chair of the Committee commented that the OOH service was being mentioned with regularity in what appeared to be a negative light.

The OOH had not been invited to the meeting on 29th February but it was clear that the Committee would need to speak to them in the future and include them in any further discussions. To date, it was acknowledged that all comments received about the OOH were anecdotal and these were only one part of the jigsaw.

11. The Committee indicated that they would like to know more about how the OOH dealt with these situations, such as: If a GP was aware that death was imminent for a particular patient was there a process in place that could alert OOH to this and thus avoid YAS and/or the Police being called? The GP present at the meeting on 29th February was confident that this was the case if the patient was dying from cancer as robust end of life care pathways were usually in place. However, this was not always the case if the person was just elderly and/or in a care home rather than suffering from cancer

12. He felt that OOH should be asking 'is this an expected death' and if the answer is yes then there would be no need to call YAS. If the death occurs in a nursing home then a registered nurse, who has completed the appropriate training, can verify[1] death. An unexpected death would be handled in a different way. However when a telephone call comes through to OOH electronic systems should provide them with all information they need whether the death is expected or not. The GP confirmed that, internally, they were being asked to be more aware of which patients had a DNACPR form in place

13. A representative from a residential care home raised the point that in residential care homes there was not always a registered nurse on the premises. Therefore if someone does die there is not always someone on site to verify death. It had sometimes been a struggle for them to get a GP to attend to verify death, especially an OOH GP. There had been an instance in the past when there had been an expected death in a residential home and the GP would not attend, instead advising the nursing home to ring YAS and the Police. This unfortunately ended up in the Coroner's Court which was distressing for all concerned.

[1] Verification of death is when the death is confirmed by a staff member who is trained in verification. Certification of death is when a Doctor documents the cause of death on a death certificate. This is a legal document required by the informant to be able to register the death at the Registrar's office.

This is an area that needs to be looked at further as residential homes do not always have registered nurses that can verify a death.

14. A consultant in palliative medicine from York Hospital mentioned that a GP did not have to be present to verify a death that was expected. However, there may be issues around this process that needed to be made clearer and more widely understood. It was important that people had a dignified death and distressing situations, such as the unnecessary involvement of YAS and/or the Police, needed to be avoided at all costs. It was therefore acknowledged that there was work to be done around managing the 'verification of death' process in both residential care homes and some nursing homes.

15. It was acknowledged that some GPs still had their own OOH service but only very few. The current, main OOH service was commissioned by NHS North Yorkshire & York. It was not clear from discussions at this meeting what policies and guidelines were in place for the OOH service in relation to DNACPR forms; however it was generally understood that they would be aware of them but clarity needed to be sought at a future meeting. Neither was it known what training they had had in relation to DNACPR forms. The Committee asked that further information be provided on this for a future meeting, especially in relation to what training is provided to the OOH GPs in relation to DNACPR forms. However it was stated that discussion around and completion of the DNACPR form should take place 'in hours' with patients, families and appropriate medical staff. The 'paperwork' should be in place by the time a death occurs. It was noted that commissioning of this service would be moved from NHS North Yorkshire & York to the Vale of York GP Commissioning Consortium and they should be involved in further discussions around this.

16. Representatives from York Hospital said that 25% of deaths are from cancer and 75% are from a non-cancer related illness. 60% of all deaths happen in hospital and only 20% of deaths will have a palliative care pathway in place with their GP. The Hospital representatives were very supportive of DNACPR forms being embedded across the community to allow all a dignified death. Of the 60% mentioned above many would have preferred to die at home so there is still work to be done and it is clear that we aren't getting things completely right yet.

17. It also appeared that in some instances communication in relation to end of life care was breaking down when a patient left the hospital. There had been instances when the DNACPR form had not left the hospital with the patient, with the hospital saying that the form belonged to them.

    The Medical Director said that this was unlikely to happen now as issues around DNACPR forms had been addressed and staff had been provided with training and thus had a much better understanding of how the form was used. It was now known that when a patient left hospital with a DNACPR form, their form should go with them. The electronic discharge notice issued to a patient's GP should include information on any current DNACPR form so they are aware of a patient's wishes.

18. In the past some DNACPR forms had not clearly shown whether there had been any consultation with the patient and/or their family. Whilst the subject matter being discussed was acknowledged as being sensitive, patients were often very happy to discuss it with medical staff and were keen to be involved in making decisions about their own death. The Medical Director at the Acute Trust said that it was good practice to discuss end of life issues with a patient. If patients are competent they can refuse cardiopulmonary resuscitation (CPR); if patients who lack capacity have a valid advance decision to refuse treatment which includes 'not for CPR', these patients will not be resuscitated and will have a DNACPR order put in place. A patient has a right to make a decision on whether they want to be resuscitated or not after being fully appraised of their medical condition around quality of life issues. (The CPR may well be successful but the outcome following CPR may be that the patient has a very poor functional state.)The patient understanding this may wish, on quality of life grounds to be resuscitated. However, if resuscitating the patient were considered to be medically futile then the decision on whether to resuscitate or not would be made by a clinician. Patients can also change their minds about DNACPR; if a competent patient had previously made a decision to not be resuscitated, but then changed their mind, providing it is not deemed a medically futile treatment then the patient would be resuscitated; but if CPR is deemed to be medically futile and not in the patient's best interest the DNACPR order will remain in place.

19. Sometimes there may be evidence of discussions around DNACPR in a patient's care notes – it was important that these were clearly documented on the DNACPR form. Improvements needed to be made around documentation, although indications show that this is now happening.

    The Acute Trust had a leaflet produced by the Strategic Health Authority entitled 'What happens if my heart stops' and this could be used to provide information to and prompt discussion with patients and their families.

20. A Service Manager at one of York's Residential Care Homes said that there was tangible evidence to show that DNACPR forms had generally been used in an excellent way and there were only a few instances where things had gone wrong, however it was still very important to address these.

21. A representative of YAS acknowledged that there had been some training and staffing issues which were being addressed; however there had been a vast improvement and a quantum leap with this. The procedures and protocols used within the Ambulance Service around DNACPR were becoming stronger and stronger and bad experiences were occurring less and less. There had been a noticeable improvement within the last 2 or 3 years. He also acknowledged that unnecessarily calling YAS and/or the Police to a death was not only distressing for families but also for staff within YAS as well who wanted to do the best for the patient and their family.

Annex H

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NHS Foundation Trust

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24th July 2012

Dear Councilor Funnell,

Many thanks for your letter dated the 2nd July and for the copy of your interim report of the End of Life Care Review with a focus on the Use and Effectiveness of DNACPR forms. The report clearly raises some very important issues and I am very happy to contribute to this process. I am slightly disappointed that the comments about the Out of Hours Service in the report, at this stage, seem to be based largely on anecdotal evidence and lack any real data to support them. I must also express disappointment that the OOH service has not been asked to contribute earlier in the process. That having been said, I fully understand the need to get this process right and I hope the OOH service can contribute to a positive conclusion.

In addressing the issues I thought it would be useful to try to break things down and present opinion and evidence under the following headings;
1. The pathway by which DNACPR forms are received into our service and communicated to our staff.
2. An overview of the difficult issues relating to the use of the forms
3. The Verification of Death Process
4. Evidence supporting the use of DNACPR forms in the OOH period
5. Current Action

1. Pathway;

Currently information relating to patients that are approaching the end of life is sent in to the OOH service from GPs via our YAS call handling service. They process the information and it is attached electronically to

a patients OOH computer record on the Adastra System (Adastra is the IT system used by the OOH service). There is a proforma designed for this purpose and all practices have it. It can be faxed and some practices have the ability to send the information electronically. Once the information is on the system it is visible to a clinician when they open the clinical record prior to contacting or consulting with a patient.

If this process is not completed by the in-hours clinicians responsible for a patient's care then the information will not be available to the OOH clinicians at all.

One of the difficulties of the OOH system is that the clinicians working in our service do not (usually) have any prior knowledge of the patients accessing the service. It is therefore very difficult for them to actually put a DNACPR order in place if it has not been done and the feeling is that it is not particularly appropriate. We have considered the need for this and the attached letter sent out in May 2010 is provided as evidence for this (**Annex H1**), however the responsibility for this process must lie either with the patient's GP practice or indeed a Hospital team if the patient has recently been in hospital. We currently do not receive communication from Hospitals – the information would go back to the GP and then it would be forwarded to OOH – perhaps this is something that could be improved upon. I will present data re the number of forms received into the service in section 4.

2. Difficult Issues;

- Following on from the last section the OOH service uses the Adastra IT platform which currently does not allow the OOH clinicians to view the patients GP or Hospital records. At some of our sites (including York Primary Care Centre (PCC)) we are able to view the Hospital record, however this is not available when the clinician is out in one of our mobile units. **Improvement in IT and access to the in-hours GP record would in my opinion enhance the care that is given to patients.**
- Sometimes when carers or care home staff call into the service and they are assessed via the call handlers algorithms the presenting complaint can trigger an inappropriate response – ie an ambulance is called – when often they just want to talk to a clinician. I realize that I too am bordering on anecdotal but there is a paucity of robust evidence for how often this is happening. **Introduction of a pathway enabling algorithms to be bypassed would improve the management of this group of patients.**
- DNACPR orders do not mean Do Not Treat. It is difficult for clinicians who have no prior knowledge of patients to refuse all treatment. If the

treatment recommended by the OOH GP for example for conditions such as a UTI or a chest infection constitutes a course of IV antibiotics then are there not occasions when a short admission to hospital may not be appropriate (as things stand currently – as IV treatment is not really possible in the community at present). **Development of protocols for administering IV antibiotics in the community may help in this situation.**

- The OOH service is supported by a District Nurse Service provided by York Hospital Foundation Trust in the Selby and York Area – it is worth stating that HDFT provide the nurses in the Harrogate area. Recently the service in York has faced staffing difficulties and this has resulted in many District Nursing shifts being unfilled – this has resulted in a lack of support for palliative patients during the overnight period and may have contributed to some of the issues. **More robust staffing would be ideal – perhaps even developing a dedicated OOH palliative care team.**
- There is an issue of care homes taking responsibility for their patients – particularly in residential homes. If a patient deteriorates there can be a perceived pressure that because the staff aren't 'trained' they are not appropriate to look after the patient and therefore the patient should be moved – it is unclear the exact origin of this pressure but it is felt that it is related to fear of retribution or litigation if something untoward were to happen to a patient. **We need to work closely with the care homes to develop treatment pathways that give staff the confidence/support to continue to look after patients if they deteriorate. We also need to look at staffing levels and consider innovative ways to augment staffing levels when patients require more intensive input.**
- Of course we must consider resources/finances. Whilst it is easy to hide behind this it cannot be ignored. My feeling is that the OOH service as it currently stands is under resourced. It has faced budgetary cuts annually for at least the last 4 years, the activity is increasing year on year (9% increase in 2010-2011), there are fewer clinicians working in the service and there has been an increase in skill mix ie less qualified staff. The morale is low as further change is on the way – NHS111 is coming in 2013 and this will reduce the clinician's control over the workload and it is feared that the workload will increase as a result with, of course, no increase in resources. In my opinion this is a serious issue and one that cannot be ignored – the PCT have already suggested there will be a procurement process in the near future which will introduce yet more uncertainty and, possibly, yet another provider – in my opinion a huge issue. **Pressure must be put on commissioners to give stability and adequate resource to the service by ensuring the commissioned service is**

reviewed against its budget enabling the creation of a fit for purpose, sustainable service for the future.

3. Verification of Death;

This has been a topic of much debate for many years within the OOH service particularly whether a GP is required to visit a patient, who has been seen recently by their own GP and is 'expected' to die, in order to confirm death. The feeling and current guidance is that it does not need to be a GP that visits. In reality this can cause some problems as your anecdotes reveal. Usually it is not a simple decision, not always black and white – each decision is different and needs to be put into context. However as a general rule if there is an expected death in a nursing home we would ask the staff if they are able to confirm death and if so then the GP would not visit. If the death occurred in a non-nursing home environment then there would be an expectation that a health care professional needs to confirm the death. We have worked with our District Nursing Service and developed a policy that provided governance for them to confirm death under particular circumstances including expected deaths. The policy is attached (**Annex H2**). Whilst the OOH service and the DN service were under the same provider the system was working well, however since the services now have different providers and are experiencing the staffing pressures as described above the District Nurses are no longer confirming death on a reliable basis. This has put further pressure on the OOH service and whilst I absolutely would expect GPs to behave appropriately and sensitively when faced with the situation I do understand why there is a reluctance to visit when the guidance is clear that there is no legal requirement for the Dr to do this. However I must make it clear that if needed I would expect a GP working in our service to visit to confirm death.

I think the circumstances that necessitate reporting a death to the coroner are very clear and I would expect all GPs working within the service to be aware of this. Some of the anecdotes in your report do sound alarming however I can assure you this is not a common occurrence and if the source of the anecdote would like to provide me with more information I would be happy to investigate individual cases.

4. Evidence;

In order to demonstrate some of the issues I have discussed I can provide some evidence;
We record the outcome of all our patient encounters and are able to tell how many deaths have been reported to the service and of those how many were expected or unexpected. I accept that this will only 'capture'

those deaths that occurred in the patients' homes so the overall total number of patients that died following contact with our service will be slightly higher. In addition we have a record of the number of DNACPR that are in place for those patients who have died expectedly. This data is captured by the YAS algorithm for expected death. As you can see from the data DNACPR forms/orders were in place for less than half of these patients (43%). Whether or not this figure should be 100% (or close to it) is a point that we should debate.

Deaths in OOH period from July 2011-June2012	Total Number	% of all calls
Died - Expected	968	0.87%
Died - Unexpected	34	0.03%

Expected Deaths Jan - June 2012	No of expected deaths	DNACPR in place	%
January	40	17	42.5
February	32	15	47
March	48	18	37.5
April	39	14	36
May	35	19	54
June	28	12	43
Mean			43

5. Action;

I absolutely concur with the paragraph in your report quoting the York Hospital Medical Director that suggested where tangible outcomes could be achieved;

- Working better in partnership
- Working towards the Gold Standards Framework
- Working towards consistency in nursing homes
- Improving practices overall

At HDFT we are already working very hard with partners to try to improve this situation. We are working with Harrogate and Rural District Clinical Commissioning Group and YAS looking at reducing avoidable admissions from Care Homes and part of this work is to recognise that patients with DNACPR orders in place need to be managed in a different way – we are trying to develop a pathway with YAS to bypass the current algorithms and give staff direct access to speak to a clinician in order to make a patient centred decision rather than a protocol driven one. We are gathering data on all of these issues and I have attached some of the data that has been collected so far – I accept that much of it is unrelated to DNACPR forms however it shows what we are looking at and how this is, as always in the modern NHS, linked to making savings and using resources more efficiently (**Annex H3**). I have also attached a presentation given to this group by YAS – this is really to show that the issue of DNACPR forms and End of Life Pathways is something that we are looking at as part of this wider piece of work (**Annex H4**).

I hope this information informs your future discussions and can contribute to the improvement of the effectiveness of DNACPR forms for this group of patients.

Yours Sincerely,

Mike Holmes

Dr M A Holmes

Clinical Director, Unscheduled Care, Harrogate and District Foundation Trust
Chair, Locality Management Group, GP OOH, Selby and York
GP Partner, Haxby Group, York

Annex F

Summary of Discussion from the Meeting held on 6th August 2012

1. Acknowledged early on that patients and close relatives would be at their most vulnerable if they were in a situation when they had to decide whether or not to allow for CPR to be performed.

2. In reference to **Annex G** (NHS leaflet – 'What happens if my heart stops') it was felt that the publicity and availability of the leaflet had a very high value and it could prompt discussions between patients and GPs around a very sensitive subject.

3. The representatives from the Out of Hours Service (OOH) run by Harrogate and District Foundation Trust raised concerns that much of the evidence received to date around the OOH had been anecdotal. They raised concerns that these comments were taken out of context in relation to the way the service was operated.

    i. The OOH Service saw approximately 130, 000 patients a year and provided a range of different services for a range of different people. Much of the time everything ran very smoothly, however when dealing with this many patients occasionally the service would not get everything right.

    ii. Clarity was given by the Clinical Director of Unscheduled Care that the OOH Service didn't play any part in putting DNACPR orders in place, this was the responsibility of the 'In-hours' Service as they worked with patients on a regular basis and had access to medical records and a greater understanding of a patient's medical history. It was also highlighted both within **Annex H** and at this meeting that if the 'in-hours' clinicians had not completed the process correctly then the information around a patient's end of life care would not be available to the OOH service.

    iii. There were difficulties around the different IT systems in place, not all of which were compatible with each other.

As highlighted in point 2 of **Annex H** the OOH service used the Adastra IT platform which currently does not allow the OOH clinicians to view a patient's GP or hospital records. At some sites (including York Primary Care Centre) we can view a patient's hospital record, however this is not available when the clinician is out in one of the mobile units.

iv. The OOH call handling service (operated by Yorkshire Ambulance Service) can sometimes trigger an ambulance response; especially if a patient or their carer/relative telephones in distress.

v. DNACPR does not mean do not treat. It is sometimes appropriate to admit a patient to hospital, even if they are nearing the end of their life and have a DNACPR order in place.

vi. The OOH Service is provided by Harrogate and District Foundation Trust but the District Nurses are provided by York Teaching Hospital NHS Foundation Trust and this can lead to gaps in service and conflicting priorities. The two organisations had slightly different agendas and were slightly less joined up than when one organisation had responsibility for both.

vii. The District Nursing service in York has faced staffing difficulties recently which has resulted in a lack of support for palliative patients during the night.

viii. We need to work closely with care homes to develop treatment pathways that give staff the confidence/support to continue to look after patients if they deteriorate.

ix. The OOH does have budgetary constraints and is under resourced. It has faced budget cuts for at least the last four years yet the activity increases year on year. We are uncertain of the impact that NHS 111 will have on the OOH Service but fear that it may increase their workload even more with no extra resource allocation

4. Various questions were asked around access to medical records and whether there were any ongoing projects to improve continuity and information sharing between key health partners. The Director of Partnerships and Innovation at Harrogate and District Foundation Trust said that some parts of were now standardised but interfaces between different IT systems still presented difficulties. There was an ongoing national project around this but there were no indicative timescales for completion.

5. In North Yorkshire there was no active work happening around this issue; however the NHS were committed to working in partnership and trying to improve systems across the region.

6. Further discussion took place around the new NHS 111 Service and how the OOH Service would work with this and what some of the challenges might be. There was apprehension around how the NHS 111 Service's software would identify if a patient needed to receive telephone triage, see a GP or be admitted to hospital. There were concerns that the percentage of telephone triage would reduce and the OOH Service would be expected to see more patients face to face without having any extra resources to manage this and any further capacity to respond. As far as the OOH Service were aware there were no plans to increase the number of clinicians. There were currently very few OOH clinicians to cover a large geographical area covering York and North Yorkshire. For example, there was only one OOH doctor for the York and Selby area.

7. Referring to the figures in **Annex H** discussion was had around the low number of DNACPR forms that appeared to be in place for those with expected deaths. It was felt that more robust policies needed to be in place to ensure that the OOH service were aware of DNACPR orders that were in place. The Medical Director at York Hospital highlighted the importance of sharing information as much as possible and said that most GPs could access hospital records for a patient and vice-versa; however this did not currently stretch to the OOH service.

There was also a need to be mindful of only sharing information about a patient with those who needed it and there were regulations around this that had to be adhered to.

8. It was difficult to store DNACPR forms electronically as they were essentially ‘live’ documents that required review at frequent intervals. The form also needed to travel with the patient and not be kept by the GP or the hospital.

9. Further discussion ensued around ‘how we can do something together with the public around the delicate subject of End of Life Care’ and how awareness could be raised around this sensitive issue as a whole.

10. A representative from York Carer’s Forum felt that community meetings could provide a chance for discussion and input into the successful use of the DNACPR form and believed that people would welcome the opportunity to have an input into this debate.

11. A representative from the Independent Care Group felt that whilst we had come a long way in improving communication and information sharing stronger connections needed to be made between GPs, OOH Service, Yorkshire Ambulance Service and Care Homes.

12. The representative from the Independent Care Group also spoke about how some patients with neurological problems in care homes had an Advanced Decision in place. An Advanced Decision was a legally binding contract which allowed the patient to refuse treatment. In comparison to a DNACPR it could also be interpreted differently, for example if a patient had a DNACPR order in place there were circumstances where a medical practitioner might override this and resuscitate a patient, this could not happen if the patient had made an Advance Decision.

Annex F

13. Discussion moved on to identify some possible areas where recommendations might be made namely;

- Better press and publicity around End of Life Care issues in general, leading to increased public awareness and willingness to have conversations around this subject.

- Improvements to information sharing between the different agencies involved

- Improvements to IT systems

- Partnership working between the Vale of York Clinical Commissioning Group and City of York Council (using the Neighbourhood Care Teams)

- Ensuring that reviews of existing DNACPR forms already in place are done in a systematic way

- Further work on Advanced Decisions and DNACPR orders and how these can be used side by side.

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Review of compliance

York Teaching Hospital NHS Foundation Trust The York Hospital	
Region:	Yorkshire & Humberside
Location address:	Wigginton Road York North Yorkshire YO31 8HE
Type of service:	Acute services with overnight beds Rehabilitation services Long term conditions services
Date of Publication:	March 2012
Overview of the service:	The York Teaching Hospital NHS Foundation Trust provides most of its health care services from The York Hospital. Acute hospital services are provided for around 350,000 people living in and around the York area. There are also a range of specialist services, which are spread over a wider

	area of North Yorkshire, serving a total of approximately 500,000 people.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The York Hospital was meeting all the essential standards of quality and safety.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether The York Hospital had made improvements in relation to:

Outcome 02 - Consent to care and treatment
Outcome 05 - Meeting nutritional needs
Outcome 09 - Management of medicines

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 27 February 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

Patients told us they were 'more than happy' with their care in the hospital. They said they can 'voice their views' about their treatment and care and that staff included them in whatever decisions were being made. Nurses were described as 'lovely, really nice.' One patient told us that staff 'go the extra mile to make sure we are looked after properly.' One patient told us, "Nurses are lovely, especially in intensive care. They don't get enough credit." One patient told us about the discussion she had had with the doctors and they had taken her views into account and changed the treatment being given. The patient said she had felt 'listened to and treated with respect.' Another patient told us about the way nurses had been supportive when the patient had been 'frightened' about the future and the treatment they were having. The patient also said [the staff had] 'been very clear about their condition and treatment and the prognosis.' They said staff have been 'clear and understanding.'

Some people were not able to share their views with us about their experiences of care on the ward. However, during our observations we judged that peoples' needs were being well met. Those who did comment said, "Don't worry, we are well looked after in here." Another patient said, "They are very very good" when referring to the staff on the ward.

What we found about the standards we reviewed and how well The York

Hospital was meeting them

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Patients were able to make choices and decisions about their care and treatment, and staff supported them in this process. Overall we found that the service was meeting this essential standard.

Outcome 05: Food and drink should meet people's individual dietary needs

Patients using the service were supported to have adequate fluids, this was monitored and steps were being taken where patients were at risk. Overall we found that the service was meeting this essential standard.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Patients had their medicines when they need them and they were given in a safe way. Overall we found that the service was meeting this essential standard.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

The provider is compliant with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
Patients told us they were 'more than happy' with their care in the hospital. They said they can 'voice their views' about their treatment and care and that staff included them in whatever decisions were being made. Nurses were described as 'lovely, really nice.' One patient told us that staff 'go the extra mile to make sure we are looked after properly.' One patient told us, "Nurses are lovely, especially in intensive care. They don't get enough credit." One patient told us about the discussion she had had with the doctors and they had taken her views into account and changed the treatment being given. The patient said she had felt 'listened to and treated with respect.' Another patient told us about the way nurses had been supportive when the patient had been 'frightened' about the future and the treatment they were having. The patient also said [the staff had] 'been very clear about their condition and treatment and the prognosis.' They said staff have been 'clear and understanding.'

Other evidence
In July 2011 we carried out a review and found that improvements were needed to documentation relating to the serious matter of whether a patient should be resuscitated or not. This was not being completed correctly or being reviewed as required. Over the course of this most recent visit we found that the trust and their staff had worked hard to make sure improvements had been made. New practices had been introduced and staff, including doctors and consultants, had received appropriate

training and information relating to the trusts policy on this matter.

We reviewed, in total, 12 'do not attempt resuscitation' (DNAR) forms across the wards we visited. All of these had been completed on the correct forms and all the information required was present.

Where patients could make their own decisions in this matter, this was recorded on the form and supplementary information was also included in the patient's medical notes detailing the disussions and decisions made. Where patient's lacked capacity or were too distressed to enter into discussions about this, their next of kin had been consulted and again this was clearly documented. Where patients could make their own decisions in this matter, this was recorded on the form and supplementary information was also included in the patient's medical notes detailing the disussions and decisions made. Where patient's lacked capacity or were too distressed to enter into discussions about this, their next of kin had been consulted and again this was clearly documented.

We saw one example where attempts had been made to involve an advocate who could represent a patient, who was unable to make major or potentially life changing decisions due to a lack of capacity and had no known next of kin. These advocates are called IMCA's, which stands for Independent Mental Capacity Advocates. Decision makers in the NHS and in local authorities (for example doctors and social workers) have a duty to consult an IMCA for the most vulnerable people. An IMCA will not be the decision-maker, but the decision-maker will have a duty to take into account the information given by the IMCA. In this example, a best interests meeting had been held and the patient's social worker and psychiatrist had assisted in the process. This is further evidence to demonstrate that the correct procedures were being followed.

Where DNAR instructions were in place, it was evident that these were being reviewed every week by the consultants and doctors involved. If the instruction remained in place this was recorded on the form and in the patients medical notes if necessary. Staff on the ward said they had noted a significant improvement in the way the decisions were being made and that procedures had been 'tightened' up to make sure good practice was being followed.

We spoke with two consultants during our visits to the wards. They confirmed the action the trust had taken to address any inconsistencies in practice and they were clear about the policies in place. One ward sister highlighted the issue from another perspective, in particular when patients came into hospital with a DNAR instruction in place and whether these had been reviewed or completed in accordance with NHS guidelines and who by. This matter was to be discussed with the local authority and other agencies by the trust, who during their review of their own procedures had raised this as a consideration.

Our judgement
Patients were able to make choices and decisions about their care and treatment, and staff supported them in this process. Overall we found that the service was meeting this essential standard.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
Some people were not able to share their views with us about their experiences of care on the ward. However, during our observations we judged that peoples' needs were being well met. Those who did comment said, "Don't worry, we are well looked after in here." Another patient said, "They are very very good" when referring to the staff on the ward.

Other evidence
In July 2011 we carried out a review and found that improvements were needed on one ward, where patients being care for were vulnerable and not able to assist themselves. These patients were not receiving adequate fluids. We made a return visit to the ward highlighted in July 2011 and found that the trust and their staff had worked hard to make sure improvements had been made. New practices had been introduced and staff had received appropriate training.

On arrival to the ward we saw that jugs of cold water and beakers on two dining tables and available to patients. Staff told us these were replenished during the day to make sure water was cold and fresh. We arrived on the ward at 10.30am just as the drinks trolley was being prepared. The trolley was well stocked with a good range of hot and cold drinks, a variety of beakers and cups and individually wrapped biscuits and other snacks. Staff knew which cups to use, according to patients individual needs and specialised beakers were provided as appropriate. Patients in their rooms were also offered drinks and assisted where required. We saw staff actively encouraging people to drink and made sure they were comfortable and able to reach their cups with ease, patients were given time to finish their drinks and staff engaged with them in a positive

and encouraging way.

The ward now has at least seven scheduled drinks rounds where patients are offered drinks, and this included three meal times. There were two designated members of staff, on each shift, who were responsible for overseeing the hydration patients received and that paperwork was completed to accurately reflect this.

Staff refer to a 'white board' which was updated daily, and displayed symbols highlighting specific care needs. For example, where a patient had diabetes; required assistance with eating or needs to be encouraged to drink. Staff told us the system was 'working well' and that they knew at a glance what each patient needed. One member of staff told us there was an effort being made to make sure permanent 'core' staff were working alongside agency or bank staff to make sure the improved practices were being maintained and the routines, which have now been established, were followed. Staff on duty told us they had had up to three individual sessions with the dietician where they had gone through the importance of hydration, practical tips for encouraging patients to drink and monitoring fluid intake. Staff said this had been worthwhile and had had a positive impact on how they looked after patients on the ward. They said their raised awareness had made a significant difference to how they viewed patient care. A leaflet highlighting the importance of hydration had been developed and this was on display on the ward and staff talked us through the principles. Staff we spoke with could explain what their objectives were and how they could demonstrate the improvements that had been made. Staff were able to describe symptoms of dehydration and gave recent examples where they would intervene when patients were becoming unwell due to lack of fluids.

We saw new forms being used, which recorded food and fluid intake for patients. A 'standard' combined form was being used for those patients at risk of malnourishment or dehydration. 'Acute' forms were also in use for patients who were unwell or at significant risk. We saw that forms were being monitored and audited and where necessary additional support was being put in place if patients were reluctant to drink. Hydration was also being discussed at the handover on each shift change, to highlight for example, any changes in the way individual patients were to be offered their drinks or to be aware of anyone who was not taking fluids well.

Our judgement
Patients using the service were supported to have adequate fluids, this was monitored and steps were being taken where patients were at risk. Overall we found that the service was meeting this essential standard.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
Patients we spoke with told us they got their medication when they needed it and on a regular basis. One person told us they did not like taking medication but the doctor had prescribed it for pain relief and therefore it was of benefit to her.

Other evidence
In July 2011 we carried out a review and found that improvements were needed to ensure controlled medication was being managed properly. Over the course of this most recent visit we found that the trust and their staff had worked hard to make sure improvements had been made. New practices had been introduced and staff had received appropriate training.

On one ward we visited, a new controlled drugs cupboard had been supplied and staff had received refresher training to make sure they were up to date with procedures. Audits of stored medication were being done weekly and monthly checks were made by the ward matron. Staff told us they felt more informed and support from the pharmacy team had improved. We did a random check of medication held and this corresponded with the records kept.

Our judgement
Patients had their medicines when they need them and they were given in a safe way. Overall we found that the service was meeting this essential standard.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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Health Overview and Scrutiny Committee 20th February 2013

Report of the Assistant Director Adult Commissioning, Modernisation and Provision

Annual Update on the Carer's Strategy and Update on the Implementation of Outstanding Recommendations Arising from the Carer's Review

Summary

1. The Health Overview and Scrutiny Committee (HOSC) completed a Carer's Review in 2010/11. The Committee recommended that the Cabinet Member for Health, Housing and Adult Social Services should receive an annual report on the Carer's Strategy and that the same report should be submitted to the Health Overview and Scrutiny Committee. This is the second annual review to be submitted.

2. The purpose of this report is to update HOSC on the Carer's Strategy and also on the implementation of the outstanding recommendations arising from the Carer's Scrutiny Review.

3. Members are asked to note the annual update on the Carer's Strategy and decide which, if any, of the outstanding recommendations arising from the Carer's Review they wish to sign off as complete and fully implemented

Background

4. Between November 2010 and April 2011 a three Member Task Group of the HOSC undertook a scrutiny review around carers. They worked to the following remit:

   Aim

   To promote the valuable work done by carers and to improve the way City of York Council and its key partners identify carers and ensure they have access to information and the support available.

Key objectives

i. to raise awareness of carers

ii. to improve access to information for carers

5. This led to a number of recommendations being put forward to Cabinet and accepted.

Consultation

6. Consultation took part as part of the Carer's Review with officers being consulted as well as various carers' organisations.

Carers Strategy Update

7. The Carers Strategy Group is a partnership of statutory and voluntary agencies and carer representatives which oversees the implementation of York Strategy for Carers. The Strategy was refreshed in 2011 (Annex 1) and the Group continues work to monitor implementation of the Strategy.

8. An update of achievements discussed by the Carers Strategy Group in October 2012, is summarised below:

Achievements

- The Carers Information Pack continues to be regularly updated and is available from CYC's and York Carers Centre's websites.
- A new factsheet has been developed for carers entitled 'Looking After Yourself' (Annex 2). York's two e-learning carer awareness training courses continue to be promoted.
- Action has been taken to reduce the Carer's Assessment of Need waiting list.
- The Flexible Carer Support scheme has been revised to target carers in greatest need.
- A Young Carers Task Group has been set up and the Common Assessment Framework (CAF) has been established as the assessment route for young carers.
- A Young Carer's Card has been developed and implementation is underway in York's secondary schools.

- A new factsheet has been developed to encourage employers to support carers in their workforce. (Annex 3)
- Vale of York Clinical Commissioning Group (VOYCCG) commissioned York Carers Centre who delivered carer awareness training to GP practice receptionists in spring 2012.
- York Carers Centre are coordinating project work and involving York Carers Forum, to deliver a short-term Back Care project during 2012, developing positive relationships with personnel at York Teaching Hospital NHS Foundation Trust.

What still needs to be done

- Continue to promote work with health commissioners and providers to ensure greater consistency around identifying and addressing the needs of carers.
- Establish a detailed action plan for the Carers Health Steering Group under its new leadership from the VOYCCG.
- Encourage active involvement from the carer's lead at York Teaching Hospital NHS Foundation Trust.
- Promote information for carers and professionals developed by the Back Care project.
- Review Carers Strategy partnership arrangements in the light of the new Health and Wellbeing Board structure.
- Review carer involvement arrangements once CYC's Customer Engagement Strategy is established.
- Pursue work to identify carers from BME communities in York.

Update on the Implementation of the Outstanding Recommendations Arising from the Carer's Review

9. Feedback on the specific recommendations is recorded in Annexes 4 and 5 to this report. The leadership of the Carers Health Steering Group has been handed over to Vale of York Clinical Commissioning Group (VOYCCG) and they have provided information within Annex 4 and 5 as to where we are at in relation to specifically implementing recommendations Ai, Aii and Aiii arising from the review. A representative from VOYCCG will be in attendance at the meeting to answer any questions that the Committee may have.

Options

10. Members are asked to comment on the annual update on the Carer's strategy and in addition to this they have the following options:

Option A	Sign off all the outstanding recommendations arising from this review as complete
Option B	Sign off some of the outstanding recommendations arising from this review as complete
Option C	Do not sign off the outstanding recommendations arising from this review as complete

11. In addition to this Members have the option to request further updates to clarify any recommendations still outstanding.

Analysis

12. In the first instance Members are asked to consider and comment on the annual update given in relation to the Carer's Strategy. They are also asked to clarify whether they still wish to receive this on an annual basis and if so, add this to their workplan.

13. Secondly Members are asked to consider the update at Annex 4 and decide which, if any, of the outstanding recommendations (A; Ai; Aii; Aiii; E and F) to sign off as complete.

Council Plan 2011-15

14. Carers are York residents, or are supporting York residents and as such are affected by all the five key priorities in The Council Plan 2011–15. However, the actions and projects under 'protect vulnerable people' are of particular significance in providing services and support to sustain carers in their caring role.

Implications

15. **Financial** - All of the actions will be accommodated within existing budgets.

16. **Equalities** - An Equalities Impact Assessment has been completed for York Strategy for Carers 2011-15; the actions arising are:
    - Continue to improve accessibility of information for carers and key workers and improve identification of 'hidden' carers.

- Ensure information about carers' ethnicity is appropriately recorded by City of York Council, York Carers Centre and all Carers Strategy partner organisations to inform future service planning.
- Use existing contact mechanisms with BME, multi-faith and multi-cultural groups to identify the numbers of carers from BME communities and take appropriate action.
- Monitor the progress City of York Council makes in implementing the 'Carer Friendly Employer Chartermark' Action Plan.

17. **Other** - There are no implications relating to Human Resources, Legal, Crime and Disorder, Information Technology or Property arising from this report.

Risk Management

18. No risks arise directly from this report. In a broader sense, however, failure to recognise the importance of carers could lead to the Council failing to comply with its statutory duties under the Equalities legislation, and to additional costs falling on social care budgets.

Recommendations

19. Members are asked to:

(i). Comment on the annual update on the Carer's Strategy
(ii). Consider which, if any, of the outstanding recommendations arising from the Carer's Review they wish to sign off as complete
(iii). Give consideration as to whether they wish to receive a further annual update on the Carer's Strategy

Reason: To comply with the recommendations arising from the Health Overview and Scrutiny Committee's Carer's Review.

Contact Details

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Graham Terry, Assistant Director Adult Commissioning, Modernisation and Provision

Report Approved	✓	**Date**	21st January 2013

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes:

Annex 1 York Strategy for Carers 2011-15

Annex 2 Looking After Yourself factsheet

Annex 3 Supporting carers in their workplace factsheet

Annex 4 Carers Review update January 2013

Annex 5 HOSC Overview February 2013

NHS
North Yorkshire and York

CITY OF YORK COUNCIL

York Strategy for Carers

2011 – 2015

York Carers Centre

YORK CARERS FORUM
yorkcarersforum@tiscali.co.uk

CANDI

Young Carers Revolution

YORK STRATEGY FOR CARERS 2011 - 2015

Contents

Appendices

1. Why carers matter

Many of us will be carers at some point in our lives. It is a role that can creep up gradually and for some it can be a life long role. For others it can come unexpectedly and suddenly following a crisis. Supporting carers is in all our interests.

Who are carers?
'A carer is someone who, unpaid, looks after or supports a relative, friend or neighbour who is ill, disabled, frail or in need of emotional support'.

Facts

- There are 6 million carers in the UK.
- Over 1 million carers provide more than 50 hours care per week.
- An estimated 37% of these carers are new to caring every year.
- 58% of carers are women and 42% men.
- Women have a 50% chance of becoming a carer before they are 59.

'Facts about carers' Carers UK, June 2009.

The impact of caring

Carers make a significant contribution in providing health and community care to relatives, friends and neighbours. The impact of caring varies depending on individual circumstances, however it is known that those caring for long hours each week are more likely **not** to be in good health. Caring can also have a financial impact and one in eight workers in the UK combine work with caring responsibilities. [1]

Carers are from all walks of life and all backgrounds. Some carers can face particular disadvantage and we may know little about them. These carers are often called 'hidden carers'. They can be 'hidden' due to the circumstances of the person they care for, or their cultural background. For example, carers of people with mental ill health or substance misuse can find it hard to access support.

Equality and social inclusion

Some carers may be less likely to access appropriate information and support. The City of York Council's 'Equality Action Group' provided feedback about the Carers Strategy in 2010 [2] identifying carers who need specific support:

- People with sensory impairments
- Carers with learning disabilities
- Carers from black and minority ethnic communities
- Lesbian, gay, bisexual and transgender (LGBT) carers
- Travellers
- Carers with mental health problems
- Older carers

[1] Carers UK (June 2009) *Fact about carers*

[2] City of York Council, Equality Action Group (February 2010) *Help us get it right day: feedback report.*

In order to achieve greater equality i ll carers, specific approaches should be adopted to reach carers who are currently unknown.

2. National Picture

All public bodies are engaged in a time of major and unprecedented change in responding to the challenges following the Comprehensive Spending Review of 2010, and the new legislative requirements affecting health, social care and many other aspects of local government.

Carers Strategy

'*Recognised, valued and supported: next steps for the Carers Strategy'* was published by the Coalition Government in November 2010 to outline current priorities for the ten year vision set out in the Carers Strategy of 2008. [3]

Social care

The Coalition Programme committed the Government to reforming the system of social care in England. *A Vision for Adult Social Care: Capable Communities and Active Citizens*[4] was published in 2010 and is one a number of key documents[5] which sets out principles and required actions. The Government plans to publish the Social Care Reform Bill in spring 2012. This follows the Law Commission's review of adult social care legislation and the Dilnot Commission's work on the funding of care and support.

Health

The Health and Social Care Bill was published in January 2011. The Bill provides for significant changes to the health service. This includes the abolition of Strategic Health Authorities and Primary Care Trusts, the transfer of commissioning responsibilities to GPs and the transfer of responsibilities for public health to local authorities.

Performance framework

The national requirements for health and social care are in a process of change. The government describes a vision moving away from top-down performance management, to sector-led improvement and local accountability. New outcomes frameworks for both health and social care have been published in 2010/11, however these have not yet been implemented.

Equality Act 2010

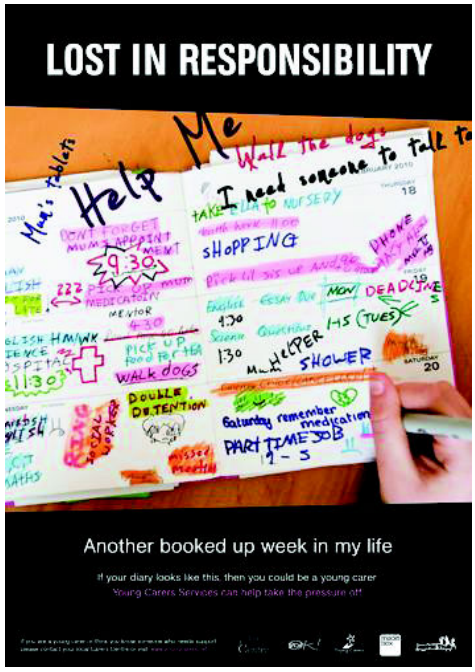
This Act introduces nine 'protected characteristics' replacing what were known as the six equality strands:

- Age
- Disability
- Gender reassignments

[3] HM Government (2010) *Recognised, valued and supported: next steps for the Carers Strategy;* HM Government (2008) *Carers at the heart of 21st-century families and communities: A caring system on your side, a life of your own.*
[4] Department of Health (2010) *A Vision for Adult Social Care*
[5] Department of Health (2010)*Think Local, Act Personal ;* Department of Health (2010) *Transparency in Outcomes :a framework for quality in adult social cares*

- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage and civil partnership
- Pregnancy and maternity

The Act also strengthens the protection of carers against harassment and discrimination at work and in the provision of goods and services. This is because a carer is now counted as being 'associated' with someone who is already protected by the law because of their age or disability.[6]



(Campaign Images produced by Young Carers Revolution 2010)

[6] Government Equalities Office leaflet (2010) *Equality Act 2010: What do I need to know as a carer?*

3. Local picture

Carers in York

Carers in York (2001)	Numbers	%
Total population	181,094	100%
Total population of unpaid carers	17,009	9%

[7]

Carers make up over 9% of the population in York. The 2001 census records 342 young carers aged 8 –17 years in York, which is likely to be an underestimate, as other research suggests there are as many as 1,600.

An estimate based on the increase in population suggests there were 18,676 adult carers in York in 2010.

Hours of care provided by carers (2001)	Numbers	%
Total population of unpaid carers	17,009	100%
Care provided 1 - 19 hours per week	12,478	73%
care provided 20 - 49 hours per week	1,520	9%
Care provided over 50 hours per week	3,011	18%

[8]

Analysis of the 2001 census indicates that 21% of carers caring for 50 hours a week are likely to be in poor health. This is double the percentage of people who are not caring. [9]

Population and demographic change

York's population is rising. A total population of 181,094 was recorded in the 2001 census. The population is predicted to be 202,400 in 2011. A total of 89% of York's population is 'White British', with the BME population rising from 4.9% in 2001 to 11% in 2009. [10]

[7] 2001 Census
[8] 2001 Census
[9] Carers UK, (2004) *In Poor Health: the impact of caring on health.*
[10] City of York Council, Business Intelligence Hub Highlight Report July 2011

Older people

There is a significant growth in the population of older people. The Council reported in 2006 an expected 31% growth in the population of older people over 65 in the following 15 years and an estimated 700 additional older people with dementia.[11] This highlights the associated increase in mental health and physical and sensory needs as the population ages. It is expected that there will be an increase in both the number of older people being supported by carers, as well as the number of older carers. It is likely that more people will become 'mutual carers' where two or more people, each experiencing ill health or disability, will care for each other.

Strategic planning

Without Walls is the name of a group of people who have worked together since 2003 to jointly develop a shared vision for the city. The Partnership is made up of representatives of public, voluntary and business organisations in York. They have developed a '*Strategy for York'*, which sets out the long-term vision for the local area based on what matters most to people. In addition, they have also developed a '*City Plan*' that focuses on a small number of priorities that are critical to address in the next four years to secure York's future.

Partners of the Without Walls Partnership all agreed to include the ambitions of the 'Strategy for York' and 'City Plan' into their own plans and strategies. City of York Council have produced a plan for 2011 – 2015 describing priorities and actions that will be taken to deliver our contribution towards the 'Strategy for York' and 'City Plan'.

Joint Strategic Needs Assessment

This aims to provide a comprehensive analysis of current and future needs in relation to the health and wellbeing of children and adults in the City and to inform future planning and commissioning decisions. The 2010 Assessment included a section about carers which referenced the Carers Strategy Action Plan. The production of a revised Assessment is underway, overseen by the Shadow Health and Wellbeing Board.

Carers Strategy Group

The Carers Strategy Group is a partnership of people from statutory and voluntary organisations as well as carer representatives from the carer led forums. The group meets every three months to monitor progress with the Carers Strategy Action Plan. The group is coordinated by City of York Council's Adults, Children and Education directorate and is working towards increasing carer awareness at all levels of strategic planning.

[11] City of York Council (2007) *City of York Commissioning Strategy for Older People 2006 - 2021*

Funding

York Carers Strategy Group supports partnership working between health and social care agencies in the commissioning and provision of services.

City of York Council dedicates funding from the Area Based Grant and NHS North Yorkshire and York uses funding from its core budget to support carers in the following ways:

- Strategic support and direct payments for carers.
- Services commissioned specifically for carers.
- Respite and sitting services.
- Through support provided to the cared for person which allows carers to take a break.
- Specialist services for example Community Mental Health Services that provide advice and support to carers.

As part of the National Strategy refresh the government announced that it is including £400m over four years in PCT allocations and potentially GP consortia subsequently, to spend on supporting carers. This funding is an indicative amount and is included in the PCTs baseline budget and in many cases is already committed against the current service provision. Therefore there is no new separate allocation specifically for Carers on top of the 'core' funding for PCTs.

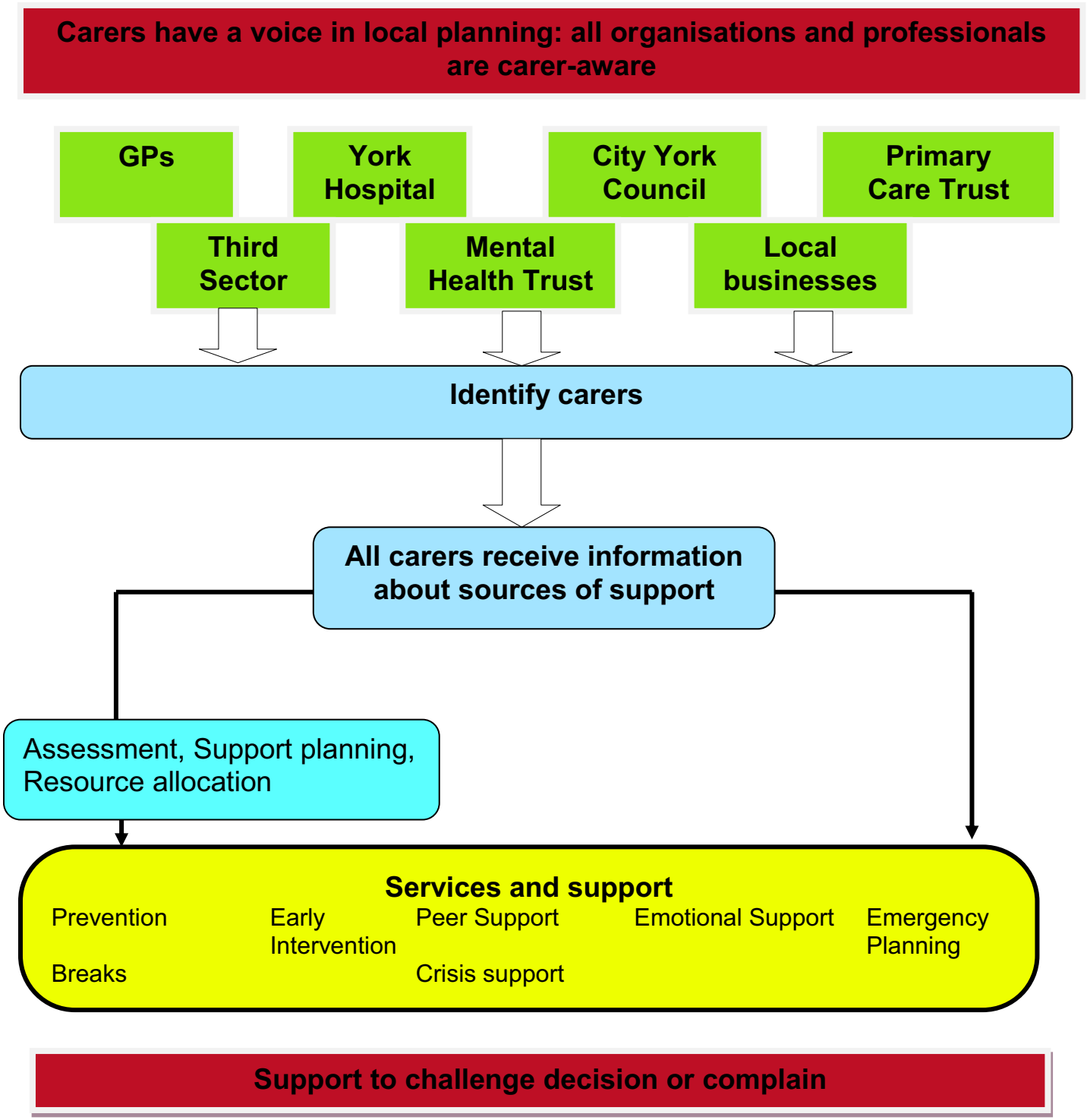
4. Vision and Outcomes Framewor

Our vision in York is to work towards developing a local community where carers' needs are identified and supported by all public services and other organisations in the City. In short: 'Carers are everybody's business'.

Carers should be respected and acknowledged. Each carer has a unique perspective, alongside skills and knowledge gained through the experience of caring.

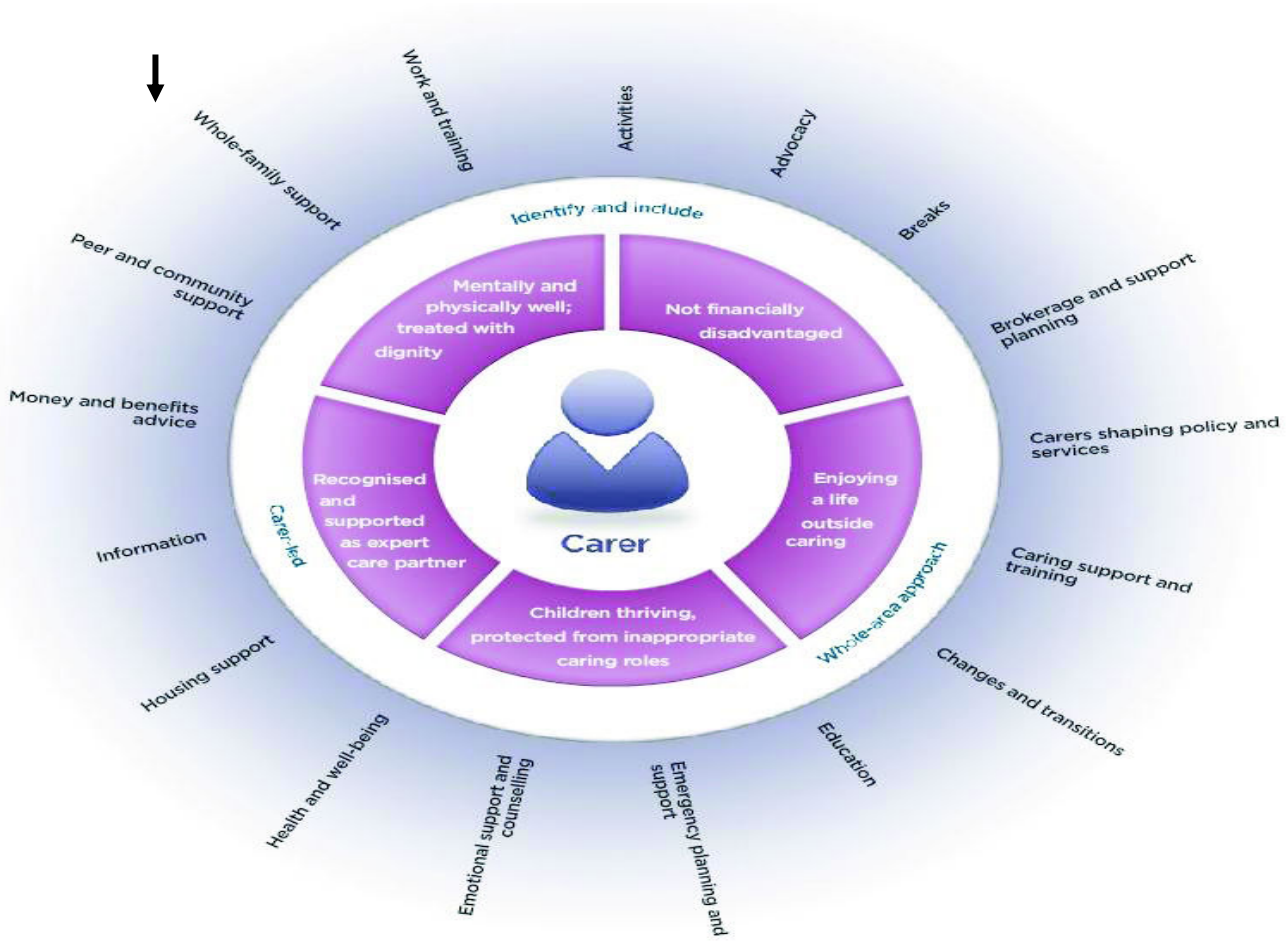
Care pathway for carers support

This has been drafted as a guide for all agencies. The chart below shows how we can work towards making sure carers are always recognised and directed to sources of support .



Outcomes framework

The 'Carers Hub' [12] is a resource developed by the Princess Royal Trust for Carers. It is a model of comprehensive carer support based on the outcomes of the refreshed National Strategy.



The carer is at the centre of the hub. The five outcomes are in the inner section and are universal ambitions for carers. These ambitions underpin the work of York Strategy for Carers.

The middle band states the overarching values:

- 'Identify and include' – we must make sure we reach all carers including those most at risk of being overlooked.

- 'Carer-led' – services and support should be individually tailored, and carers should be part of planning and strategic forums.

- 'Whole-area approach' – effective whole area planning is needed to make sure carers' specific needs are met.

We will use the Carers Hub to help us plan work required to implement the carers strategy in the future.

[12] http://www.carershub.org

5. Achievements and what we still

Recognised and supported as expert care partners

What we have achieved

Information
York Carers Centre is now an established local independent charity and a focal point for information and advice.

Carers shaping policy
There are three active carer led forums in York helping to make sure carers voices are heard: CANDI, York Carers Forum and Young Carers Revolution.

Carer Awareness Training
Regionally funded training held for library staff, workers in primary care health settings and those undertaking Carers Assessments of Need.

Carers Assessments
City of York Council's social work teams have skilled Carers Support Workers carrying out carer assessments.

Carer awareness raising
York Carers Centre led the development of the Young Carer and Adult Carer e-learning tools.

Personalisation
Regional conference on personalisation hosted by York Carers Centre, February 2011.

Young adults carers
York Carers Centre successfully provides specialist support to young adult carers aged 18 and over.

Personalisation
York Carers Forum has worked with City of York Council to inform carers about personalisation.

City of York Council Health Overview Scrutiny Committee
Review successfully undertaken 2010/11 focussing on carer identification and information.

Integrated services and better coordination
A 'Care Pathway for carers support' has been drafted. Initial discussions have taken place about some of the implications for City of York Council's adult social care services.

York LINk review
Review completed and recommendations made spring 2011.

Development work at York Carers Centre
Lead agency in work to develop services for Young Carers, whole family support and expanded to incorporate a specialist service for carers affected by substance misuse.

What we still need to do

- Ensure all Carers Strategy partners adopt the 'Care Pathway for carers support'.
- Set up a robust system for update and distribution of accessible information for carers.
- Identify and display information for carers in key places in York.
- Provide public information in these 'key places' which is accessible to people who may not recognise themselves as 'carers'.
- Establish the potential 'trigger points' for carer recognition, so carers can be identified earlier.
- Involve GPs in the provision of information to carers.
- Ensure Adult Social Services provide a coordinated approach to assessment for the 'whole family'.
- Reduce length of waiting list for Carers Assessment of Need.
- Include carer awareness raising in all workforce development strategies.
- Map carer involvement in local health and social care planning networks with attention to the development of Healthwatch.
- Review carer involvement.
- Ensure information about carers ethnicity is appropriately recorded by City of York Council and York Carers Centre to inform future service planning.
- Scope the work needed to identify the numbers of carers from BME communities and assess their needs.
- Ensure City of York Council reviews its equalities framework enabling carers to become part of all equality and inclusion work.

Enjoying a life outside caring

What we have achieved

Carers Discount Card
York Carers Centre launched a free discount card for carers supported by 50 local businesses.

Carers Emergency Card Scheme
Over 400 carers of all ages registered. Launched for Young Carers.

Carers Breaks- York Carers Forum
In response to feedback from carers, new monthly Art and Craft sessions established in addition to monthly social meetings with massages provided; coach trips trialled- enabling carers to take a break with the person they care for; events during carers week.

Flexible Carer Support Scheme
Direct payments received by 600 carers in 2009/10 and 680 carers in 2010/11 to support and sustain caring role.

Young adult carers
York Carers Centre supported 44 young adult carers in 2010/11 with 14 new carers joining. Monthly pub quiz and cinema groups.

Carer Breaks and Promoting Social Networking - York Carers Centre
Art classes, card making, special events and massage sessions support over 200 carers annually aiming to promote well-being and reduce social isolation.

Telecare *
Small pilot scheme offered 3 months free trial of equipment to carers 2010/11.

* see footnote[13]

[13] **"Telecare is the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living." It can provide people with electronic equipment such as community alarm systems or falls sensors which makes it possible to live independently and also call for help when needed.**

What we still need to do

- Set up a clear framework for provision of breaks for carers which links to self directed support and personalisation.
- Audit existing services and support.
- Agree the concept of what a carers break is.
- Ensure learning from the report of the National Demonstrator Sites is incorporated into future local plans.
- Pursue roll out of Carers Emergency Card to parent carers.
- Ensure telecare services are accessible to carers.

The Carers' Quilt in St Nicholas's Chapel, York Minster

Not financially disadvantaged

What we have achieved

Employment
York Carers Centre Employment Education and Training service supported carers with writing CVs, training, volunteering, becoming 'work ready'. Work with employers to support carers to stay in work.

Benefits uptake
York Carers Centre achieved an increase of £77,000 in welfare benefits uptake during a ten month period in 2011/11.

York Carers Centre – laptops
Funding obtained providing 30 carers with laptops enabling access to digital services to reduce social isolation, access job searches and online shopping, and increase networks.

York Explore training courses
York Carers Centre has established links with York Library Service to help carers access free courses on computer skills and managing finances.

Young adult carers
York Carers Centre supported 2 young carers to volunteer abroad and provided support to others to enable access to higher education.

What we still need to do

- Audit benefits advice services available to carers.
- Improve the availability of financial information and advice to young people aged 16+.
- Ensure carers can access financial advice when the cared for enters residential care and at end of life.
- Ensure City of York Council implements the action plan linked to the 'Carers Friendly Employer' chartermark.
- Develop links and engage with local businesses.
- Ensure information about carers' employment rights is available to employees and employers in York.

What we have achieved

GP surgeries
York Carers Centre has contacted all GP surgeries in York and distributed information, organised 13 awareness raising sessions for surgery staff and held 13 advice sessions at one GP surgery.

Back care support and training for carers
Proposal developed for 2 year training package utilising new non recurrent DH funding.

Self health checklist
This has been piloted and the feedback is positive. It supports carers to identify their own health needs and acts as a prompt for discussion with their GP practice.

Admissions and Discharge Policy
NHS North Yorkshire and York included carers issues in the principles for the Admissions and Discharge Policies for all Acute Trusts to follow.

Drug and Alcohol Misuse
NHS North Yorkshire and York arranged for the Carers Centre staff to access training on support for carers of those with Substance misuse and alcohol misuse.

Dementia Care Pathway
Carers issues have been included in to the Dementia Map of Medicine to prompt primary care to consider the needs of carers and supportive mechanisms such as the Emergency Carers Card.

End of life
York Carers Forum has worked with York Hospital to ensure carers are recognised, supported and included in the End of Life Pathway.

What we still need to do

- Health commissioners and providers ensure greater consistency around identifying and addressing the needs of carers.

- Health commissioners monitor work towards ensuring that all care pathways provide guidance on the information and advice carers will need.

- To engage with the new NHS Commissioning bodies (Clinical Commissioning Groups) as they develop, to promote carer issues and build on existing work in Primary, Community and Acute Care.

Children thriving, protected from inappropriate caring roles and supported in their caring roles

What we have achieved

Supporting schools
York Carers Centre's Young Carers Service started dedicated work with schools in 2009.

Whole family working
York Carers Centre secured funding for a specialist one year post 2010/11 offering direct support to families and work to support strategic change.

Strategy
City of York Council has identified a lead officer for young carers. A task group has been established to plan and implement actions.

Carers Assessments for Young Carers
A Task Group has begun work to implement young carer assessments in York using the Common Assessment Framework.

Young Carers Forum
Ongoing meetings of Young Carers Revolution have started, leadership of the group has been established and new members attended a meeting in April 2011. DVD promoted locally and nationally. York MP Julian Sturdy praised work of Forum in speech in House of Commons.

Young Carers Service
Support for 95 young carers in 2010/11 and 38 new carers joined due mainly to increased awareness in schools.

Young Carers Awareness Raising
Young Carers Revolution (YCR) DVD promoted locally and nationally. York MPs attended YCR meetings. YCR received standing ovation at No Wrong Doors Conference 2010. Links made with Youth Parliament. Best Community Project in York and Volunteer award in London received.

Breaks for young carers
Monthly sessions held for 3 different age groups, 286 sessions of one to one support, 50 separate activities and 36 groups sessions provided by Young Carers Service 2010/11.

Good practice in schools
Staff at Millthorpe School have been supported to run support groups for young carers. Lessons held at All Saints School for year 11 students to raise awareness re young carers. Feedback from Huntington school deputy head confirms that student and teacher awareness about young carers has increased as a result of work by Young Carers Service.

What we still need to do

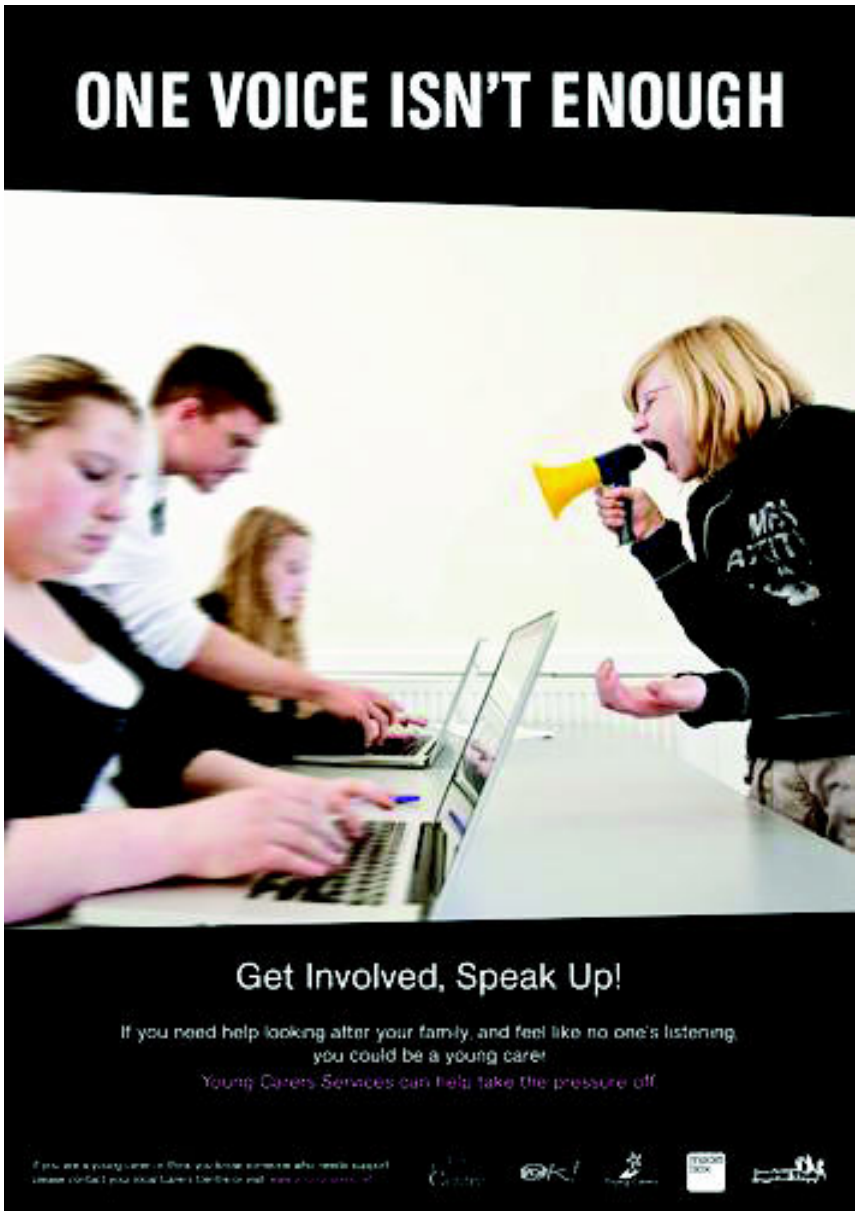
- Support the development of the Young Carers task group and action plan.

- Implement the Common Assessment Framework (CAF) as the assessment tool for Young Carers Assessment.

- Ensure all adult services assessment processes and paperwork includes identification of young carers.

- Develop work in schools which identifies the support needs of young carers and ensures this support is made available.

- Young Carers Task Group to consider York LINk report (March 2011) recommendation: 'Young carers should be given help to get home access to computers'.



6. Priorities

The Carers Strategy Group agreed the following priorities for the renewed Strategy Action Plan at its meeting in July 2011:

- **Develop work with partner agencies which reaches unknown carers and provides appropriate responses.**
- **Increase access to information for carers and key workers in 'key places'.**
- **Raise carer awareness amongst GPs and all workers in health settings.**
- **Engage with the Clinical Commissioning Group for Vale of York to raise awareness of the support needs of carers.**
- **Ensure the need to provide support for carers is included in all work at a strategic level.**
- **Implement the young carers assessment of need.**

York Carers Forum outing to Yorkshire Lavender (Terrington) – 7th July 2011

APPENDIX 1

Progress summary July 2011
York Carers Strategy Action Plan - Key priorities and targets 2009 - 2011

National Strategic Outcome One ***Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.***			
	Outcome	**Local priority**	**Achievements: July 2011**
1A	**Information**: Carers will have easy access to accurate information and advice	• Provision of easily accessible information and signposting	• Carers Information Pack produced and annually updated • York Carers Centre developing as focal point for information • York Carers Centre, CANDI, York Carers Forum, Young Carers Revolution and City of York Council websites provide information for carers
1B	**Carer identification:** Carers will be recognised and valued for their unique role in supporting the cared for person	• Increase identification of carers in Primary Care (see 4C)	• York Carers Centre contacted all GP surgeries and distributed information in 2010/11 • City of York Council Health Overview Scrutiny Committee completed a carer review in spring 2011 focussing on carer identification
1C	**Young Adult Carers:** Carers will have easy access to accurate information and advice	• Establishment of support for young adult carers aged 18 years + by York Carers Centre	• York Carers Centre provides regular ongoing support to 44 young adults (July 2011)

1D	**Integrated services:** Services and information will be provided in a coordinated way across and within agencies	• Closer joint working and partnerships between health, social care and the third sector • Awareness raising for professionals	• Draft 'Care Pathway for Carers Support' presented to Carers Strategy Group April 2011 • E learning carer awareness raising tools re 'Young Carers' and 'Adult Carers' launched May/June 2011
1E	**Personalised services:** Carers will have access to a range of flexible services that meet their individual needs	• Carer Assessment of Need • Common Assessment Framework *(NB not implemented for adults in York)* • Personal budgets	• Continued increase in numbers of separate carer assessment and review completed (673 in 09/10 and 857 in 10/11) • Carer's role acknowledged in assessment questionnaire for cared for person's personal budget
1F	**Carer involvement:** Carers will be involved in planning and monitoring the services they receive	• Training for carers – Living for Learning • Carer involvement	• One Living for Learning course held in 2009 • Three active carer led forums established and offered ongoing support

National Strategic Outcome Two ***Carers will be able to have a life of their own alongside their caring role***			
	Outcome	**Local priority**	**Achievements**
2A	**Break provision:** Carers should have access to a range of flexible breaks	• Joint plans with NYYPCT re new money for breaks • Review current breaks provision • Personal budgets to enable carers to take breaks	• Breaks review presented to Carers Strategy Group April 2010 • Continued increase in numbers of carers benefiting from Flexible Carer Support Scheme (600 in 09/10 and 680 in 10/11)
2B	**Emergency Card Scheme:** Carers should be better equipped to deal with a crisis and have peace of mind	• Emergency Card Scheme	• Card scheme well established for adults, now includes young carers
2C	**Technology:** Carers should have access to a range of services and support	• Telecare	• Small scheme to promote benefits of telecare for carers completed in 10/11
2D	**Housing, Leisure and Transport:** Carers should have access to a range of services and support	• Discount card scheme	• Carers with Carers Emergency Card and those in receipt of Carers Allowance can access discounts at City of York Council leisure classes and swimming pools • York Carers Centre launched a discount card for carers in December 2010 involving 50 local businesses

National Strategic Outcome Three ***Carers will be financially supported so that they are not forced into financial hardship by their caring role***			
	Outcome	**Local priority**	**Acheivements**
3A	**Income:** Carers should have access to benefits advice	• Welfare benefits advice	• York Carers Centre continues to increase uptake of benefits for carers.
3B	**Employment:** Carers should have access to employment support and vocational training	• Ensure carers in employment are supported • Encourage carer aware employment practice • Make local links with new 'care partnership managers' at Jobcentre Plus	• York Carers Centre Employment Education and Training service established. • York Carers Centre works with employers • City of York Council awarded a Carer Friendly Employer charter mark • Care Partnership Manager a member of Carers Strategy Group

National Strategic Outcome Four ***Carers will be supported to stay mentally and physically well and treated with dignity***			
	Outcome	**Local priority**	**Achievements**
4A	**Prevention:** Carers should have access to appropriate medical advice, and support about their own health needs	• Self-health checklist distribution and evaluation	• Check list piloted and distributed • Business case for back care support for carers compiled and short term development work planned • Need to give advice to carers on moving and handling included in principles for Admissions and Discharge policies circulated to Acute Trusts
4B	**NHS:** Carers needs should be addressed in hospital admission and discharge procedures		• NHS North Yorkshire and York included carers issues in the principles for the Admissions and Discharge Policies for all Acute Trusts • Health passport piloted for Neurology patients includes pages about carers. • York Carers Forum worked with York Hospital to ensure carer recognition at End of Life Pathway
4C	**Primary Care and GPs:** Primary care professionals should identify carers ensuring appropriate support, signposting and referrals	• Update GP resource pack (*Decision made not continue with pack)* • Develop work to improve carer identification and signposting in primary care settings	• York Carers Centre contacted all GP surgeries in York and distributed promotional information • Carer issues included in Dementia Map of Medicine to prompt support of carers

4D	**Emotional Support:** Carers should have support to maintain their well being and reduce stress		

National Strategic Outcome Five ***Children and young people will be protected from inappropriate caring and have the support they need to learn, develop, and thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes*.** *(Every Child Matters outcomes: be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well-being)*			
	Outcome	**Local priority**	
5A	**Universal services:** Children will have the support they need to learn develop and thrive	• Support schools in York to support young carers	• York Carers Centre began dedicated work with York Schools in 2009 • Young Carers Revolution produced and publicised a range of carer awareness raising tools
5B	**Targeted support for young carers:** Young carers will be able to make a positive contribution and have their views respected	• Set up a Young Carers Forum	• Young Carers Revolution established as York's carer led forum for young carers
5C	**Whole family support:** Children and young people will be protected from inappropriate caring		• York Carers Centre secured funding f a specialist one year post 2010/11 offering direct support to families and work to support strategic change which enabled the development of the e learning carer awareness raising tools.

York Carers Strategy Action Plan 2011 - 2015

Appendix 2

National Strategic Outcome One ***Recognised and supported as expert care partners***		
	Outcome	**What we need to do**
	Information: Carers will have wider access to accurate information and advice available through a range of communication methods	• Set up a robust system for update and distribution of accessible information for carers, including electronic distribution methods • Decide which are the 'key places' in York where carers information should be available • Develop and distribute public information which is accessible to people who may not recognise themselves as 'carers' • Involve GPs in the provision of information to carers
	Carer identification: Carers will be recognised and valued for their unique role in supporting the cared for person	• Enable professionals to effectively identify carers. • Include carer awareness raising in all workforce development strategies
	Integrated services: Services and information will be provided in a coordinated way across and within agencies	• Ensure all Carers Strategy partners adopt the 'Care Pathway for carers support'

	Personalised services: Carers will have access to a range of flexible services that meet their individual needs	• Adult and Children's Social Services to provide a coordinated approach to assessment for the 'whole family' • City of York Council will reduce length of waiting list for Carers Assessment of Need
	Carer involvement: Carers will be involved in planning and monitoring the services they receive	• Review and increase carer involvement and take appropriate action • Map carer involvement in local health and social care planning networks with attention to the development of Healthwatch
	Equality and social inclusion: All carers will be able to access services and support.	• Ensure information about carers ethnicity is appropriately recorded by City of York Council, York Carers Centre and all Carers Strategy partner organisations to inform future service planning • Use existing contact mechanisms with BME, multi-faith and multi-cultural groups to identify the numbers of carers from BME communities and take appropriate action • City of York Council to review its equalities framework to ensure carers become part of all equality and inclusion work

National Strategic Outcome Two ***Enjoying a life outside caring***		
	Outcome	**What we need to do**
	Break provision: Ensure carers have access to a range of flexible breaks	• Set up a clear framework for provision of breaks for carers which links to self directed support and personalisation • Audit existing services and support • Agree and promote the concept of what a carers break is • Research and adopt good practice • Roll out the Carers Emergency Card to parent carers
	Technology: Ensure carers have access to a range of services and support	• Provide accessible telecare services to adults

National Strategic Outcome Three ***Not financially disadvantaged***		
	Outcome	**What we need to do**
	Income: Ensure carers have access to benefits and financial advice	• Audit current benefits advice services available to carers • Ensure carers can access financial advice when the cared for enters residential care and at end of life
	Employment: Carers should have access to employment support and vocational training	• Monitor City of York Council's implementation of the action plan linked to the 'Carers Friendly Employer' charter mark • Develop links with local businesses • Roll out information about carers employment rights to employees and employers in York

National Strategic Outcome Four ***Mentally and physically well; treated with dignity***		
	Outcome	**What we need to do**
	Prevention: Carers should have access to appropriate medical advice, and support about their own health needs **NHS:** Carers needs should be addressed in hospital admission and discharge procedures **Primary Care and GPs:** Primary care professionals should identify carers ensuring appropriate support, signposting and referrals **Emotional Support:** Carers should have support to maintain their well being an reduce stress	• Health commissioners and providers ensure greater consistency around identifying and addressing the needs of carers • Health commissioners will work towards ensuring that all care pathways provide guidance on the information and advice carers will need • To engage with the new NHS Commissioning bodies (Clinical Commissioning Groups) as they develop to promote carers issues and build on existing work in Primary, Community and Acute Care

National Strategic Outcome Five ***Children thriving, protected from inappropriate caring roles***		
	Outcome	**What we need to do**
	Universal services: Children have access to the support they need to learn, develop and thrive	• Set up the Young Carers task group and action plan • Ongoing development of the work now established in schools which supports young carers • Task group to consider York LINk report (March 2011) recommendation: 'Young carers should be given help to get home access to computers'
	Whole family support: Children and young people are protected from inappropriate caring. Young adults have access to appropriate advice in relation to their transition into adulthood.	• Implement the Common Assessment Framework (CAF) as the assessment tool for Young Carers Assessment. • Ensure adult services identify young carers in their assessment processes and paperwork • Ensure effective sources of advice are available to young carers aged 16-18+

Appendix 3

What carers in York have told us?

National Strategy refresh session – York 2010
25 people attended a consultation meeting on 16th August 2010.
16 were carers, of whom 4 were young carers. Three other carers returned written responses. Nine workers/professionals attended of whom all had specialist roles to support unpaid carers. Carers discussed what the priorities for services and support to carers should be.

KEY MESSAGES (from final discussion at meeting)

"Don't let money rule it, sometimes have to spend a bit to create a lot."

Do not cut services to carers. Carers save money, and are value for money. Protect the carers, and the cared for is protected.

"These services are our rights."

Personalisation and respite is a complex issue.

Third sector equals value for money.

Short breaks are a priority.

Emergency support at short notice.

Development of personal budgets and support to maintain them.

Identification of carers in schools, GPs, hospital and hospital discharge.

Training by carers in carer awareness for professionals/workers.

Carers Allowance: increase and change the rules.

Young Carers need specialist support and support in schools and Further Education.

Carers own health.

Quotes from carers

Peer Support

"The only things that have worked well for me is when I have spoken to other carers….they were the ones who put me on to things that helped me. I would love to say "serviceland" helped me but I can't."

"Enabling parent/carers to speak to other parent/carers. People listen and learn best from people that know what they mean without having to explain."

Health and Well-being

"One of the most important outcomes of the strategy. If the carer doesn't have support and attention to their physical needs then there would be two people in need of care."

"For me, the most important priority for the carer strategy is to ensure both the mental and physical well-being of the carer…..in the long term, funds targeted at ensuring carers are mentally and physically able to continue in their supporting roles will pay huge dividends by avoiding significant costs when things go wrong."

"Emotional support for carers would be very welcome as it is badly needed. The only emotional support I have ever received in my caring role, has come from other carers. Funding carer led support groups should be a priority."

Annex 1

Health Overview Scrutiny Report 2011
In November 2010 the City of York Council's Health Overview Scrutiny Committee set up a Task Group to carry out a Carer's Scrutiny Review.

Aim: to promote the valuable work done by carers and to improve the way City of York Council and its key partners identify carers and ensure they have access to information and the support available.

Key objectives:
1) To raise awareness of carers
2) To improve access to information for carers

20 carers and 10 care workers contributed information in person or via a questionnaire.

Analysis of information from the Public Event and questionnaires

The importance of early identification of carers
Key professionals, especially GPs need to be aware of carers from an early stage and identify them as soon as possible.

Recognising you are a carer
People do not always immediately recognise themselves as a carer. Steps need to be taken to encourage early carer self-identification so that the right information can be provided at the right time. Carer needs to have access to information immediately that they recognise themselves as a carer.

"Many comments were received (at the public event and in returned questionnaires) that recognising that you are a carer was a gradual process, however it often became very clear at a point of crisis (such as hospital admission or diagnosis or a particular condition.)"

Provision of Information
Information would need to be proportionate to the needs of each individual carer.

Carers own needs
Comments at the public event were backed up by questionnaires that identified that frequently more support is given to patients/customers than to carers. This meant that the carer's health often suffered as a consequence and carer didn't always get enough time to spend on their own needs especially if they were caring for more than one person.

York LINk Report 2011

The LINk Steering Group held a Public Information and Awareness Event on Carers Rights on September 8th 2010. Evidence about services for carers in York was provided by a total of 48 individuals and York Carers Centre staff.

Recommendations from "Report on Carers Rights – March 2011" were made on the following themes:

Young Carers

- City of York Council to help fund York Carers Centre to promote young carers awareness in schools
- Implementation of a Young Carers Card Scheme and funding for York Carers Centre for a young carers event
- GPs should keep a record of young carers
- City of York Council provide support to help young carers to find ways of funding home computers

Employment

- City of York Council organise support and advice to help carers combat discrimination in the workplace
- Local organisations to offer work experiencing placements to carers

Parent carers

- City of York Council should improve access for disabled children to social services
- Jointly commissioned (by NHS North Yorkshire and York and City of York Council) posts to help parent carers liaise with community, social services and health services

City of York Council

- Congratulations to City of York Council for the amount of support provided for carers and carer organisations and request that high standards are maintained.

Carers Assessments

- Increased resources from City of York Council to reduce waiting times for Carers Assessments

GPs

- GP surgeries in York should adopt the model used in Somerset called the Carers Champions Scheme, with training delivered by York Carers Centre and York Carers Forum.

York Carers Centre Survey 2011

In January 2011 York Carers Centre sent out a survey to 650 adult carers registered on its database. In total 183 surveys were returned: a response rate of 28%. The following is a summary of feedback from carers.

To view the full survey results go to:
http://www.yorkcarerscentre.co.uk/content/carers-survey-2011

Current services

- 47% of carers heard about York Carers Centre from a social worker or carer support worker.
- 13% of carers heard about York Carers Centre from their GP surgery.
- 57% of carers responded that one of the reasons they initially contacted the Centre was to find information about services, and 42% to register for the Carers Emergency Card.
- 58% of carers usually contact the Centre by phone.
- 94% of carers felt able to speak to someone at the Centre at a convenient time.
- 95% of carers fed back very positively about all aspects of home visits from Centre workers.
- 88% of carers agreed that information in York Carers Centre newsletter was useful and relevant.
- 95% of carers felt that leaflets in the Carers Information Pack were useful and relevant.
- 79% of carers agreed that York Carers Centre helps them with the stresses of being a carer.

What carers would like to see in the future

- 80% of carers would like to have regular advice surgeries in their local area.
- 74% of carers felt if would be useful to have a telephone helpline for emotional support.

Appendix 4

Carers Scrutiny Review March 2011 – summary of recommendations

City of York Council Health Overview Scrutiny Committee Carers Review Task Group met between December 2010 and March 2011.
For further details and the full final report see:
http://democracy.york.gov.uk/ieListDocuments.aspx?CId=718&MId=6313&Ver=4

Carers Scrutiny Review March 2011 – summary of recommendations

To raise awareness of carers:

- Health commissioners and providers ensure that there is greater consistency around how carers are identified and once identified their needs addressed.
- That the Multi-Agency Carer's Strategy Group identifies where it would be helpful to provide public information about what it means to be a carer and how to access support to enable carers to identify themselves earlier.
- That City of York Council reviews its Equalities Framework to ensure that carers become an integral part of all equality and inclusion work.

To improve access to information for carers

- That health commissioners ensure that all care pathways provide guidance on the information and advice carers will need.
- That Adult Social Services develop a clear pathway, which provides an integrated approach to assessment for the whole family.
- To continue to promote carer awareness an annual update on the Carers Strategy for York be presented to the Heath Overview and Scrutiny Committee and thereafter to the Executive Member for Health and Adult Social Services.

York Strategy for Carers

Compiled and agreed by York Carers Strategy Group August 2011.

For more information contact:

Frances Perry
Carers Strategy Manager
City of York Council

Phone **01904 554188**
Email **frances.perry@york.gov.uk**

Acknowledgements

Thanks to Young Carers Revolution for the campaign images page 5 and 19, to see their campaign please visit www.youngcarersrevolution.wordpress.com

Thanks to York Carers Forum for photos page 14 and 20.

Other photos from local and national library sources.

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Looking after yourself

Last updated November 2011

It is really important that you, as a carer, take time to look after yourself. We've put together some information and advice to help you.

Take a break

Make time to relax, keep your hobbies going and see friends and family. This will help you to carry on caring and give your best to the person you care for. It can be easy to sacrifice your own interests and needs when you are busy caring but this may make you more prone to illness and feeling low.

- Put aside some time each day for yourself – read the newspaper, listen to some music, or go for a short walk.
- Get out every week or so to meet a friend, have your hair done or pursue an interest. It is important that you do something enjoyable that keeps you in contact with the outside world.

Stay independent

Try and do things **with** and not **for** the person you care for when they are ill. Encourage the person you care for to do all they can for themselves so they stay able and confident.

Accept support from family and friends

It's natural for you to want to provide the highest standard of care to your loved one and it's easy to turn down offers of help. Try and accept help that might be offered by family and friends. This can be a valuable source of support for yourself and the person you care for.

- Try to involve other family members right from the start so that responsibility doesn't all rest with you,
- Always try to accept help from friends and neighbours if they offer it. If you say that you can manage they may not offer again.
- Suggest ways that people can help.

Looking after yourself

York Carers Centre

01904 715490

enquiries@yorkcarerscentre.co.uk

www.yorkcarerscentre.co.uk

City of York Council

01904 555111

adult.socialsupport@york.gov.uk

www.york.gov.uk/health/carers

Emotional support

Everyone needs a chance to discuss their feelings. You can get different types of support from:

- Friends and family.
- Understanding professionals.
- Local support groups.
- Online discussion forums.

Keep well

Remember to look after yourself as it is in the interests of both you and the person you care for.

- Don't put off your own appointments at your GP surgery. See your GP regularly. Make sure they know that you are a carer.
- Have a look at the **Carers Self-Health Checklist** to help you think about your own health needs.
- Try to eat a well balanced diet, with at least 5 portions of fruit and vegetables a day.
- Try to take regular exercise. This could be a walk in the fresh air each day or some exercise at home.
- Make sure you get enough sleep. If your sleep is disturbed by the person you care for ask your GP about it.
- If you have to help the person you care for move around make sure you don't damage your back. Ask your GP for advice.

Know your limits

Look after yourself and be realistic about what you can and can't do. This will help you and the person you care for in the long term.

If you want a copy of the **Carers Self Health Checklist** and information about sources of support contact York Carers Centre on **01904 715490**, email **enquiries@yorkcarerscentre.co.uk** or visit **www.yorkcarerscentre.co.uk.**

York Carers Centre

01904 715490

enquiries@yorkcarerscentre.co.uk

www.yorkcarerscentre.co.uk

City of York Council

01904 555111

adult.socialsupport@york.gov.uk

www.york.gov.uk/health/carers

Supporting carers in their workplace

Last updated October 2012

What is a carer?

Carers provide regular, unpaid help to someone close to them due to frailty, physical or mental illness, addiction or disability.

Many people do not recognise themselves as carers. In the UK, 12% of the adult population are carers. Becoming a carer can happen to anyone.

Carers in the workplace

- 1 in 8 workers in the UK combine paid work with unpaid care.
- Every year around 30% of carers are new to caring and many will be juggling paid work and care.
- 1 in 5 people give up work to care.

Why support carers?

- It makes good business sense to retain staff.
- It can lead to reduced rates of employee sick leave and stress levels.
- Adopting a carer friendly approach can improve staff morale for the whole workforce

The business case for supporting carers in the workforce:

- The peak age for caring is 45-64 when many employees are a valuable asset and may be in senior positions
- Unsupported carers are more likely to give up work.

Supporting carers in their workplace

York Carers Centre

01904 715490

enquiries@yorkcarerscentre.co.uk

www.yorkcarerscentre.co.uk

City of York Council

01904 555111

adult.socialcare@york.gov.uk

www.york.gov.uk/health/carers

- Turnover costs are estimated to be an average of £6,000 per employee.

Employers who support their employees to combine work and care have reported business benefits all round: **retention, resilience and results**!

What can you do to support carers in your workforce?

- Know who the carers in your workforce are.
- Ensure you have the right information to signpost carers to sources of support.
- Offer flexible working arrangements where possible.
- Communicate your support for carers throughout the organisation.
- Create an atmosphere that values everyone and respects employees' lives outside work

To find out more about supporting carers in the workforce, visit:

www.employersforcarers.org (organisation employers can join for support)

www.carersuk.org (see 'Who Cares Wins' paper – research by Carers UK and Sheffield Hallam University)

www.workingfamilies.org.uk (organisation helping families to achieve work-life balance)

www.skillsforcare.org.uk (organisation helping social care employers to support their workforce)

For further information, including staff training, please contact York Carers Centre or City of York Council on the details below:

York Carers Centre

01904 715490

enquiries@yorkcarerscentre.co.uk

www.yorkcarerscentre.co.uk

City of York Council

01904 555111

adult.socialcare@york.gov.uk

www.york.gov.uk/health/carers

Board & Topic		Recommendation of the Scrutiny Committee	Executive/Comments & Recommendations of 26th April 2011	Update on Recommendations as of November 2011	Update on recommendations as of January 2013
Health Overview & Scrutiny Committee - Carer's Review	**A**	That Health Commissioners and providers ensure that there is greater consistency around how carers are identified and once identified their needs addressed. This would need to include:	Agree subject to assessment of training budgets and accepting that the Council can advise the Hospital Trust but that they are the body charged with responsibilities for activities in the hospital.		
	i	Training in carer awareness for all health professionals and allied staff		NHS North Yorkshire and York promotes good practice in primary care and acute trusts. The responsibility to deliver traning rests with provider organisations.	The first Carers Awareness Training session for practice Carers Champions was held in York on the 24th April 2012 with a further training session held in Selby on 18th July 2012. This scheme aims to increase carers awareness for staff working in GP practices. Further training sessions will be held in the Vale of York locality and these will be arranged in the new year to cover Pocklington, Easingwold and Ryedale practices, along with another session for York practices. A positive meeting was held with the regional RCGP Carers Champion in December 2012 who supported the approach VoY CCG were adopting in Carers Awareness training.
	ii	That the hospital looks at extending the innovative approaches they have been piloting and embedding these into standard practices for all admissions and discharges		NHS North Yorkshire and York included carer issues in admissions and discharge principles. The responsibility for implementation rests with the Acute Trust.	Work is ongoing between Vale of York CCG and the Acute Trust with regard to their admissions and discharge policy.

Board & Topic		Recommendation of the Scrutiny Committee	Executive/Comments & Recommendations of 26th April 2011	Update on Recommendations as of November 2011	Update on recommendations as of January 2013
	iii	That a written report be provided to the Health Overview & Scrutiny Committee on a six monthly basis in relation to quality indicators that are being monitored in respect of carers		NHS North Yorkshire and York would like clarification about the 'quality indicators' being referred to.	Vale of York CCG continue to work with partners on the Carers agenda especially with regard to identifying carers needs.
	E	That Adult Social Services develop a clear pathway, which provides an integrated approach to assessment for the whole family whilst recognising the individual needs within the family and the impact of caring on the carer	Agree		CAF now established as the assessment tool for young carers and young carer identification incorporated into adult services initial assessment paperwork. Needs of carer included in FACE assessment system being implemented by adults services.
	F	To continue to promote carer awareness, an annual update on the Carer's Strategy for York be presented to the Health Overview & Scrutiny Committee and thereafter to the Cabinet member for Health & Adult Social Services	Agree that the Cabinet Member for Health & Social Services should receive an annual report updating the Carer's Strategy and that the same report should be submitted to the Health Overview & Scrutiny Committee		Annual update 2012 prepared.

Annex 5

York Carers Strategy

Health Task Group Overview 2011/12

Achievements

Back Care Project coordinated by York Carers Centre

This project aims to improve the way in which carers can access appropriate support about back care and moving and handling. The questionnaires for clinicians were returned by 61 workers in health and social care and have some really useful information and potential contacts for the future. Carole Zagrovic at York Carers Centre is analysing this. The plan for the DVD has moved on and it be that there will be video clips produced, rather than a DVD, that can be posted and accessed more widely.

Carers Awareness Training

The first Carers Awareness Training session for practice Carers Champions was held in York on the 24th April 2012 with a further training session held in Selby on 18th July 2012. This scheme aims to increase carers awareness for staff working in GP practices.

Further training sessions will be held in the Vale of York locality and these will be arranged in the New Year to cover Pocklington, Easingwold and Ryedale practices, along with another session for York practices.

A positive meeting was held with the regional RCGP Carers Champion in December 2012 who supported the approach VoY CCG were adopting in Carers Awareness training.

Emotional Support Audit

An audit of emotional support for carers in York was undertaken during 2012. The two main issues arising from the audit were:

- The definition of emotional support is unclear and open to interpretation
- The most effective way of providing emotional support relates to individual preferences and circumstances

Work was undertaken to clarify that carers can access the 24 hour Mental Health Support line service and referral processes were confirmed and circulated by the task group.

The Carers Health Task Group will review the specific findings and discuss any actions.

Information for carers

Development and distribution of information for carers that relates to supporting health and well-being continues. The 'Looking After Yourself' factsheet and the revised 'Health Checklist for Carers' are available from York Carers Centre website :
http://www.yorkcarerscentre.co.uk/content/health-checklist and
http://www.yorkcarerscentre.co.uk/content/factsheets-carers

Areas we need to work on/improve

Clarify integrated working arrangements and future structure/role and remit of Carers groups. This work links to the CYC Customer Engagement Strategy currently being finalised and the H&WB Board sub groups.

Identify key priorities to focus attention on and link into emerging H&WB Board sub groups e.g.:

- Carers Training (Older Person & Long Term Conditions)
- Access to MH (MH & Learning Disabilities)
- End of Life (Older Person & Long Term Conditions)

Sarah Kocinski
Vale of York CCG
17.01.13

North Yorkshire and York

BRIEFING FOR INFORMATION:

TITLE: NHS 111

TO: York Health Overview & Scrutiny Committee

MEETING DATE: 20th February 2013

Background

NHS 111 is a new telephone based service for patients that will be available throughout the country no later than 1st April 2013.

The service is being introduced to support access to urgent and emergency healthcare and ensure patients are seen by a service most appropriate for their needs.

It will replace the existing NHS Direct telephone number.

The service will be accessed by calling a three digit number, 111, which will be staffed by a team of fully trained call handlers who will be supported by experienced clinicians.

Call handlers will carry out an initial assessment which will be directed by the use of a specific assessment tool. Depending on the answers given by the patient, appropriate services will be identified on the system, thus enabling the call handler to direct the patient accordingly.

Services may include, for example, Out of Hours GP Service, Walk in Centre, Urgent Care Centre, In Hours GP, Community Nursing Team, Emergency Dental service or Late Opening Pharmacy.

In the vast majority of cases, calls to 111 will be dealt with without the need for call backs.

If the call is an emergency and the patient requires an ambulance, the call handler has the facility to dispatch an ambulance without delay.

NHS 111 will be available 365 days a year, 7 days a week and calls will be free to the caller.

When should you call NHS 111?

Patients should dial 111 if they urgently need medical help or advice but it's not a life-threatening situation.

Patients should call 111 if it's not a 999 emergency, but they:

- think they may need to go to A&E or another NHS urgent care service
- don't think it can wait for an appointment with their GP
- don't know who to call for medical help.

For less urgent health needs patients should still contact their GP in the usual way.

For immediate, life-threatening emergencies, they should continue to call 999.

Establishing the Service

A regional procurement took place throughout 2012 which resulted in the Yorkshire Ambulance Service being identified as the preferred provider of the NHS 111 service across Yorkshire & the Humber.

Mobilisation plans are currently being implemented which include the following:

- Recruitment and training of NHS 111 Call Handlers
- Testing of the NHS 111 service
- Establishment of Clinical Governance & Quality Assurance structures within CCGs
- Completion of the Directory of Service which underpins the NHS 111 Service
- Completion of the Department of Health readiness testing process

Launch Date

Plans are in place to ensure that NHS 111 will be launched across Yorkshire & The Humber as follows:

5th March 2013 – soft launch
19th March 2013 – full launch

Raising awareness of NHS 111

Attendance at a number of stakeholder meetings have taken place throughout the last few months Regional communication campaign is being planned and will be implemented to support awareness raising of the new service.

For more information visit www.nhs.uk/111

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Leeds and York Partnership NHS
NHS Foundation Trust

York Health Overview and Scrutiny Committee Briefing Paper

Access to talking therapies

1. Introduction

In June 2012 Leeds and York Partnership NHS Foundation Trust (LYPFT) presented a paper to York Health Overview and Scrutiny Committee which set out the issues we faced regarding waiting times for talking therapies. We described our plans to improve access to talking therapies, including the implementation of a programme of service transformation to deliver better, simpler and more efficient services. This paper updates the Committee on progress to date.

2. Current talking therapy services

Leeds and York Partnership NHS Foundation Trust provides a range of talking therapies in both primary and secondary care services, based around a 'stepped care' model. This approach is designed to provide different levels of service according to different levels of need; ensuring delivery of appropriate evidence-based care and treatment, based on an assessment of a service user's holistic needs and with a focus on recovery outcomes.

Within secondary care services in York, psychological therapists are fully integrated into our multi-disciplinary teams (community mental health teams and inpatient wards) to build and improve psychological capacity whilst targeting specialist resource to those with the most complex needs. In addition, some secondary care resource is within the St Andrew's counselling and psychotherapy service.

Prior to the integration of psychology into teams, there was a significant waiting list of over a year to access specialist secondary care psychological therapy. Distributing psychology resource into multidisciplinary teams has allowed implementation of new ways of working for psychology such as development of a consultation model; supervision to other clinicians; and training and reflective practice to enhance capacity of other clinicians within the multidisciplinary team to provide psychological interventions; which has ensured that service users psychological therapy needs are met and that waiting times are minimised and managed effectively within secondary care.

Within primary care, the current configuration of services is still complex, consisting of the following service elements:

- primary care mental health link workers
- primary care counsellors
- Improving Access to Psychological Therapy (IAPT) services
- Cognitive Behavioural Therapy (CBT) service
- St Andrew's counselling and psychotherapy service.

This complexity of provision makes referral pathways unclear and referrers may well send the same referral to more than one primary care service at the same time, meaning that we may have duplication in our waiting lists.

Historically, there has been a consistently high demand for non-urgent referrals to these services, resulting in significant waiting lists for therapy. Current waiting times are outlined in table 1 below.

Table 1: waiting times

	Current waiting list	**Current waiting time for access to therapy**
Primary Care Link Worker	55	3-6 weeks
Primary Care Counselling	131	11 weeks
IAPT (York)*	404	Step 2 – 14 weeks Step 3 – 14 months
CBT Service	71	15 months
St Andrew's Counselling ar Psychotherapy Service	Individual Therapy: 11 Outpatient Groups: 5 Intensive Group work:	6-12 weeks 10 weeks 3-4 weeks

*note that IAPT services are provided by LYPFT across the whole of North Yorkshire and York.

LYPFT provides all of these services across York, Selby, Tadcaster and Easingwold; with the exception of IAPT services, which are provided across the entire North Yorkshire and York region. The IAPT service is separately specified and separately managed; our service improvement plans will therefore be described in two parts:

- Improving access to talking therapies in mental health pathways; and
- Improving access to IAPT services.

3. Improving access to talking therapies in mental health pathways

Current Position

We are currently redesigning the way that we provide community services in York and North Yorkshire, in line with the wider Trust wide transformation project. Our aim is to deliver better, simpler and more efficient services, with a recovery and outcome focus. During 2012 we have undertaken detailed process mapping of all services across primary and secondary care, to ensure that we fully understand where 'non-value adding' activity exists (leading to delays, duplication, variation, or other inefficiencies). This has clearly highlighted significant issues with current pathways. The most significant issues relating to talking therapies are:

- There are multiple access points into services for access to talking therapy which are confusing to referrers and can lead to delays if referrals are made to an inappropriate part of the service.
- The CBT service is small and not integrated into pathways.
- Internal referrals, waiting lists and re-assessments also contribute to an inefficient use of clinical resource.
- The St Andrew's service provides a mixture of primary and secondary care services which adds to complexity. It provides a significant element of the current Personality Disorder pathway but access to evidence based talking therapies for service users with personality disorder and complex needs are currently fragmented.

Improvement Plans

In light of these findings we are re-designing our community services to streamline processes. We will create larger, integrated teams with a single point of access to all services; and ensure that pathways are easy to navigate for referrers and service users. Our services will be needs-led to ensure that there is equity of access to a full range of services for older people. We will remove unnecessary internal re-assessments to significantly reduce delays and waiting times. Services will be based on integrated care pathways to provide consistent care packages based on best available evidence. Clear pathways will ensure that service users are always seen by a clinician who has the right skills, experience and expertise to meet their needs.

We have reviewed the pathway for personality disorder. The re-design of this pathway will incorporate access to dialectical behaviour therapy and vocational support, as well as the existing therapeutic community programme based at St Andrew's.

The proposed model will deliver better services to service users and their carers through evidence based, safe, quality services which are delivered based on need. Simplified service user pathways will eliminate duplication and delay; and demonstrate improved efficiency through embedding integrated care.

4. Improving access to IAPT services

Background

The IAPT service in North Yorkshire and York commenced in April 2010. It consisted of teams based in five localities: Harrogate; York and Selby; Hambleton and Richmondshire; Whitby, Scarborough and Ryedale; and Craven. In addition, a specialist IAPT service called Vulnerable Veterans and Adult Dependants (VVADS) was established at Catterick Garrison, in direct response to Veterans being made a Special Interest Group within the National IAPT Programme.

Current position: funding

The North Yorkshire and York IAPT Service is funded to provide 16.6 High Intensity Workers and 16.5 Psychological Wellbeing Practitioners. There are also three Senior CBT Therapist posts which provide management, supervision and a hold a reduced caseload. The York and Selby locality has one senior CBT Therapist, three High Intensity Workers, four Psychological Wellbeing Practitioners and a part time Administrator.

In February 2012 we undertook a review of the service in response to the rising demand and increase in waiting times, using the IAPT Workforce and Gap Analysis Tool. This uses a number of assumptions based on prevalence rates from the Psychiatric Morbidity Survey, and the projected number of contacts and caseloads required at step 2 and 3. The report highlighted that current funding levels give a shortfall of 20 trained PWPs and over 70 High Intensity Workers against requirements. For the York and Selby locality this equates to a shortfall of 6.5 PWPs and over 21 HIWs. The report also highlighted the fact that there were currently no employees within the service able to case manage those requiring assistance with returning to employment, training or meaningful activity.

We have had difficulties accessing reliable activity data for IAPT. Prior to August 2012 the service was reliant on a paper based data collection system. This presented a number of challenges around data returns and the accuracy of the information collected. Since August 2012 all staff within the

service have been using IAPTus, a bespoke IAPT software programme. This has dramatically improved our data collection and our ability to analyse service activity, enabling the service to provide accurate data on performance and activity.

In summary the information below shows that our current performance is strong against commissioned targets and outcomes for people who access IAPT are good; however overall the service is not funded to meet demand.

Current position: referrals and activity

The North Yorkshire IAPT service has continued to experience a rise in the rate of referrals, as the service has established itself in the local communities it serves (see table 1 below). Overall, the service is on target to receive 5,000 referrals for 2012/13. This will represent a year on year increase of 15%. However referrals rate for York and Selby are projected to exceed 1340. This represents an almost six fold increase in the rate of referrals compared to 2011/12.

Table 2: Total IAPT referrals received

	2011/2012	**2012/13 Q1**	**2012/13 Q2**	**2012/13 Q3**	**2012/13 Total To Date**
York	**239**	187	273	270	**730**
Selby	**37**	68	97	111	**276**
York & Selby	**276**	255	370	381	**1006**
N Yorkshire IAPT	**4257**	1198	1320	1222	**3740**

Table 2 shows that of the total number of referrals made to the IAPT service only a small number are not accepted. The service average for the first three quarters of this year is 5.8% with York and Selby slightly higher, with an average of 8.7%.

Table 3: IAPT referrals not accepted April 2012 to January 2013

	N Yorkshire IAPT	**York & Selby**
GP	169	73
PCMHS	26	5
Other Primary Care	2	3

Practitioner		
CMHT	7	3
Other Secondary Service	1	
Other MH Organisation	9	1
Probation	1	1
Community Nurse/Health Visitor	2	
Other	2	2
	219 (5.8%)	**88 (8.7%)**

For 2012/13 the North Yorkshire and York IAPT service was commissioned to provide 8,272 contacts. It is currently projecting to exceed this by over 7,000 contacts, (see table 4). We can also demonstrate a significant increase in the attended activity for the York and Selby team. If current trends continue into Q4 the team is on target to exceed 2011/12 contacts by nearly 1,000.

Table 4 IAPT Attended Activity

	Contract activity target 2012/13	2012 Q1	2012 Q2	2012 Q3	2012/13 Total YTD	Projected FYE
York		714	650	674	**2,038**	**2,717**
Selby		301	356	378	**1,035**	**1,379**
N Yorkshire IAPT total	**8,272**	4,218	3,470	3,923	**11,611**	**15,481**

Table 5 shows a service wide 'did not attend' (DNA) rate of 12.8% for Q1-3. This rate is slightly lower in the York & Selby team at 11.5%. Early investigations show a correlation between waiting list length and first appointment DNA's. This is one of the issues that will be addressed through our service improvement plan.

Table 5 Did Not Attend (DNAs)

	2011/12	**DNA % Rate**	**2012 Q1-Q3**	**DNA % Q1-3**
York	**317**	11.7 %	258	11.2 %
Selby	**86**	10 %	140	11.9 %

York & Selby	**403**	10.8 %	398	11.5 %
N Yorkshire IAPT	**1627**	11.6 %	1713	12.8 %

IAPTus data shows an increase in the number of referrals, year on year, as well as a significant increase in the amount of attended activity undertaken within the service. IAPT The number of people completing treatment within the service has increased from 974 in 2011/12 and is due to exceed over 2000 by the end of 2012/13 (see table 6).

Table 6 Number of People Completing Treatment

N Yorkshire IAPT 2011/12	**N Yorkshire IAPT Q1-Q3 2012/13**	**York & Selby IAPT Q1-Q3 2012/13**
974	1704	205

The National IAPT Programme has set recovery rate targets for those completing treatment. The formulation identifies those who move from 'caseness' to 'non caseness' using the mandatory psychological measures. For 2012/13 the national stretch target for recovery is 48.7%. The North Yorkshire and York IAPT Service, in Q1-3, has exceeded this by 10.3%, (see table 6).

Table 7 IAPT Recovery Rates

N Yorkshire IAPT 2011/12	**N Yorkshire IAPT Q1-Q3 2012/13**	**York & Selby IAPT Q1-Q3 2012/13**	**National IAPT Target 2012/13**
46.8 %	59 %	56.6 %	48.7%

Current position: recruitment and retention

In the early months following their recruitment, the Psychological Wellbeing Practitioners (PWP) and High Intensity Workers (HIW) attended their respective university-based training courses and clinical contact commenced in July 2010.
Following the successful completion of training, the IAPT service experienced a significant turnover of staff as employees relocated to other parts of the country or left to pursue alternative careers. This phenomenon was experienced by other IAPT services.

Until recently the team has been able to recruit to vacancies; however, recruitment has become increasingly difficult for the service. As an example

of this, the team is currently attempting to recruit a HIW on a fixed term contract to cover maternity leave; two attempts to recruit to this post have already been made without success.

Service Improvement Plans

The service cannot meet demand within current funding levels; however we are keen to maximise output from the resources we have available to us and use these as efficiently as possible.

To implement our service improvement plans we are developing five working groups to review the following areas:

- Service Activity
- Service Structure
- Staff Recruitment and Retention
- Training and the use of Information Technology.
- Waiting List Management

Outcomes which we expect to achieve from this work include:

- increase in the use of telephone interventions
- increase in the use of computerised CBT
- increase in group work
- the implementation of a waiting list triage/assessment system

We will also continue to prioritise staff recruitment to reduce the number of vacancies within the service.

We expect these measures to have a significant impact on the activity provided by the service. Recognising that current funding levels are inadequate to meet need we will continue to work with commissioners to accurately specify the service to be provided and agree contract activity levels. We will also work with key stakeholders, including GPs, to ensure that we are targeting our limited resources in the most effective way.

Health Overview & Scrutiny Committee Work Plan 2013

Meeting Date	Work Programme
20th February 2013	1. Update on the North Yorkshire and York Clinical Services Review 2. Final Report of End of Life Care Review 3. Update Report on the Carer's Strategy and Update on the implementation of outstanding recommendations arising from the Carer's Scrutiny Review 4. Update on Implementation of the NHS 111 Service 5. Update from Leeds & York Partnership NHS Foundation Trust (Access to Talking Therapies/Improving Access to Psychological Therapy(IAPT)) 6. Workplan for 2012-13
13th March 2013	1. Third Quarter CYC Finance & Performance Monitoring Report 2. Annual Report of the Director of Public Health – The First 100 Days 3. Monitoring Report from DPH – Identification of issues around provision of medical services for travellers and the homeless 4. Introduction from the Managing Director of the new Commissioning Support Unit (CSU) 5. Workplan for 2012-13
24th April 2013	1. Update Report – Merger of Priory Medical Group Surgery and Abbey Medical Group Surgery 2. Workplan for 2012-13

Reports for the 2013/14 Municipal Year

- June 2013 – Monitor of partnership working and implementation of learning about partnerships (report from LYPFT on the way that older people's mental health services are provided)
- June/July 2013 – DULT Safeguarding Report (Annual Assurance of Governance Arrangements)
- July 2013 – Six Monthly Quality Monitoring Report – Residential, Nursing and Homecare Services
- December 2013 – LYPFT Annual Report to Committee from the Chief Executive

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