York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Blue Box

28 July 2021

NHS
York and Scarborough Teaching Hospitals
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NHS Foundation Trust

Board of Directors Meeting
28 July 2021
Staff Asymptomatic Testing Policy and the LAMP Programme

/ Trust Strategic Goals

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

/ Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☒
For assurance	☒		

/ Purpose of the Report

This paper is intended to highlight the importance of staff asymptomatic testing, summarising the requirements of a recently issued letter from NHS England/Improvement before going onto describe, analyse and discuss the Trust's response and approach to date.

It will then make a series of recommendations about the Trust's future policy and steps for implementation.The Executive Committee have considered and endorsed the recommendations at its meeting on 21st July.

/ Executive Summary – Key Points

Given the importance of staff asymptomatic testing and the expectation from NHSE/I that NHS organisations ensure staff comply with a locally agreed testing regime, the following recommendations were endorsed and approved by Executive Committee at its meeting on 21st September:-

a) Endorsement and support for the LAMP asymptomatic testing programme as the best regime for staff to use given its accuracy and reliability.

b) Support for the expectation from the Chief Executive set out in his weekly bulletin of 12th July that as part of professional responsibility, all staff, (particularly those working on site and in clinical areas) register and commit to self-testing as the right thing to do for patients, their families and each other.

c) Senior leaders in the organisation actively endorse and promote the LAMP programme through the line management structure and communicate the expectation of a commitment to self-testing to their teams.

d) The senior leader group identify staff within their teams at all levels to act as champions for the programme, taking responsibility for encouraging staff to register and as points of contact for advice and guidance.

e) As part of the Board Assurance Framework, the Board of Directors are sighted on monthly compliance metrics and data with an agreed reporting schedule detailing uptake which is produced and shared through the care group and corporate departmental performance management structure.

f) The Task and Finish Group identify best practice from other Networks and share this and appropriate communications material with care groups and corporate departments on a regular basis to support the development of the LAMP asymptomatic testing programme.

Recommendation

The Board of Directors is asked to note the content and recommendations of the Report approved by the Executive Committee at its meeting on 21st July.

Authors: Neil Wilson, Head of Partnerships and Alliances and Lucy Turner, Deputy Chief Operating Officer

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: 21st July 2021

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Staff Asymptomatic Testing Policy and the LAMP Programme

1. Introduction

This paper is intended to highlight the importance of staff asymptomatic testing, summarising the requirements of a recently issued letter from NHSE/I before going onto describe, analyse and discuss the Trust's response and approach to date.

It will then make a series of recommendations about the Trust's future policy and steps for implementation.

2. The importance of staff asymptomatic testing

Despite the national vaccination campaign, given the recent trend of rising numbers of COVID cases in the community, it is very important that staff participate in a testing programme that identifies asymptomatic cases to limit the spread of the disease and protect themselves and patients.

Nationally, the latest data from swab tests in the community suggests one in every 160 people now has the virus. That is up from one in every 250 in the previous week. For England, it is the highest level since mid-February and numbers of COVID inpatients are also increasing across trusts in all geographical areas including our own.

While the vast majority of Trust staff (85%) are now fully vaccinated, it is still entirely possible to catch and spread COVID-19 while not displaying symptoms of the disease. There are examples of this having occurred nationally, locally and to Trust staff who have been doubly vaccinated

3. Letter from NHSE/I on NHS asymptomatic staff testing

A letter dated 29 June 2021 to senior leaders in all NHS organisations (copy attached) set out the approach for lateral flow testing kit distribution for staff and the expectation for assuring compliance to agreed testing regimes.

The letter highlights asymptomatic staff testing as an important component of Infection Prevention and Control, which all organisations and staff have a duty to adhere to.

The authors express gratitude for organisational efforts to keep staff and patients safe from potential transmission of COVID-19 in healthcare settings.

From early July, there will be no central supply of lateral flow testing kits to trusts from NHSE/I although staff will be free to request supplies through the national government website.

With effect from early May 2021, the Trust has been promoting the LAMP asymptomatic saliva testing platform as the favoured method of testing for staff (see below).

In the letter, NHS organisations are asked to:

- ensure local systems in place for patient-facing staff to demonstrate that they are compliant with their asymptomatic staff testing regimes when attending their workplace.
- support compliance of individual members of staff with the local organisation's testing regime through line management structures, or conversations with local leaders and champions, where required.
- ensure that the Trust Board is sighted monthly on organisational compliance as part of their Board Assurance Framework and IPC practice.
- make use of the NHS Digital gov.uk reporting tool for staff to report their test results, where local Trust reporting tools are not able to provide the levels of management information required to support chief executives in their assurance processes.
- access support from regional testing leads to share good practice in increasing uptake of testing and reporting
- work with national and regional teams, and NHS Digital as required, to improve the quality of reporting data to support the production of appropriate management information in relation to staff reporting rates.

The letter acknowledges that although most NHS staff will have been participating in the lateral flow testing programme, other testing regimes have been set up in some Trusts or geographic areas, such as LAMP testing or PCR testing.

The recommended actions are seen to be applicable to all NHS asymptomatic staff testing programmes.

4. The asymptomatic testing approach/regime within the Trust

a) Lateral Flow staff testing programme

From its introduction within the Trust in November 2020 to the end of the second wave of the pandemic in spring 2021, participation in the Lateral Flow programme amounted to approximately 30% of the overall staff group. There is evidence that some staff were/are still using the kits and not reporting tests.

With the promotion of the LAMP asymptomatic saliva testing programme (see below) and the success of the vaccination initiative, the reported take up figure has dropped to approximately 11% as at July 2021.

b) LAMP staff testing programme

The Trust has been an active participant in planning and promoting this saliva testing programme for all staff since early 2021. The programme has been operational from early May 2021 after a month's pilot period.

The key benefits and advantages of the programme are that for asymptomatic staff the results are more accurate sensitive and reliable than the lateral flow test (as evidenced by a number of DHSC funded studies) the actual LAMP test is less intrusive than the lateral flow equivalent participation is more convenient with only one test a week required as opposed to the twice weekly stipulation for lateral flow

Unlike the lateral flow test, a follow up PCR test is not required to confirm accuracy for positive cases but is being recommended for sequencing purposes.

In the light of the above, previous briefing to the Trust Executive Committee and Board of Directors has recommended the intention to phase out the lateral flow system and replace it with the LAMP programme.

In line with guidance from DHSC, pathology networks across England have been encouraged to lead on the deployment of the programme within their areas through NHS and university partnerships to maximise capacity.

The Scarborough/Hull/York Pathology (SHYP) Network was successful in being accepted onto Phase Two of the programme along with networks from the Norfolk and Norwich Eastern Pathology Alliance and the East and South East London Pathology Partnership.

A purpose built laboratory at the University of York is being used for the SHYP Network Programme. CAPITA, a partner consulting, transformation and digital services business used by the University, are providing overall operational and supplies management.

Medical laboratory assistant staff are being employed by the University to process the tests, overseen by NHS biomedical scientist staff.

The above partnership arrangement is funded totally by DHSC as part of a contract with the SHYP Network with the Trust acting as the lead contractor. The contract is in place until the end of December 2021, with discussions currently ongoing with DHSC to extend it to the end of March 2022.

Currently, the University Laboratory is processing test samples from staff from the Trust and Hull University Teaching Hospitals NHS Trust, who have had access from early June.

Plans are in place to extend the programme to staff working in Yorkshire Ambulance Service, Humber Teaching NHS Foundation Trust and Leeds and York Partnership NHS Foundation Trust over the next month, or so.

There is sufficient physical and staffing capacity planned for the laboratory to be able to process the volume of tests for all partner organisations which is unlikely to rise to above 40% of combined staff groups (see below). This would account for a weekly capacity of 7,600 tests per week.

A Trust Task and Finish group consisting of operational management, senior clinicians and the senior communications manager has been meeting since early 2021 overseeing the planning and deployment of logistical and publicity arrangements connected with the programme.

An information portal solution, 'Lantern', developed by DHSC in partnership with the Royal Free London NHS Foundation Trust for use on mobile phones, laptops and pc's has been shared for staff registration and submission of samples.

The receptacles, tubes and funnels and packaging to be used for the samples have been specified and sufficient quantities have been obtained and have been made up with instructions as part of kits for staff to use.

They are distributed to wards, departments work areas, canteens, staff shops within the organisation on a monthly basis.

Secure lockable 'post box' receptacles have been obtained and placed in prominent areas at main entrance and reception areas in all of the hospitals and many of the other premises within the Trust for drop off of samples.

These are then uplifted at set pick up times throughout the working day and week and transported to the University Laboratory.

Sample results are communicated to registered users by text or email within 24 hours of the Laboratory receiving the sample.

Ahead of the full rollout of the programme, a number of areas operated the system on a pilot/trial basis for most of April. They included the York and Scarborough Renal Service, the York Medical Elective suite the Hospital and Community Palliative Care Team across York and Scarborough and the York and Scarborough Laboratory and Pharmacy Departments (around 500 staff).

There has been an extensive and thorough communications plan enacted which has included regular Chief Executive briefings to all email users within the organisation.

The briefings have highlighted the importance of LAMP testing, signposting staff to Trust intranet links on how to register, an instructional video on how to provide record and submit samples and a list of all sample drop off points within the Trust and collection times. This messaging has also featured prominently within the Trust's weekly COVID bulletins which go out to all Trust email users.

More recently, there have been information and kit hand out sessions held within York and Scarborough hospitals publicising the programme and a short promotional video has been produced by the Head of Nursing Corporate Services which has featured within the Chief Executive Brief and Matron WhatsApp and twitter groups.

There will also be a programme team presence at the Staff Benefit Fairs planned for 21st and 28th July at Scarborough and York hospitals respectively.

5. LAMP Programme take-up rate

Despite the successful organisation and deployment of the logistical arrangements to support the programme and an extensive communications plan, the general take up rate within the organisation has remained relatively low.

As at mid-July, this stands at approximately 11% of the total staff group within the Trust. The figure within Hull University Teaching Hospitals NHS Trust is slightly below this.

Experience from other networks who have gone live ahead of the SHYP Network have indicated that following an initial 'slow burn' trend over two months the participation rate has gone up generally to a rate of around 20-35% with the highest recorded at 40%. The average figure has now fallen back though to around 20-25%.

The trusts in the East and South East London network who have gone live at the same time or after the SHYP network have however been experiencing similar take up rates as ourselves, although not all departmental areas have been targeted.

Following internal discussion, the Trust Task and Finish Group have identified the following factors behind the low take up rate:-

a) Perception of immunity following double vaccination

This has prevented/inhibited staff from registering and participating despite the fact that it is still possible to catch and transmit the disease and be asymptomatic.

This factor can also explain higher participation/take up rates of Networks who have gone live ahead of us (particularly those who started at the height of the second wave earlier this year before all staff were doubly vaccinated).

b) Staff being used to/continuing with the Lateral Flow System

As indicated previously the take up rate for the lateral flow system is running at almost the same rate as the LAMP Programme. This could be connected to a familiarity with the lateral flow process and system.

The lateral flow process could also be seen as more suitable by the proportion of Trust staff who have been working from home as it does not require them to come into their place of work initially.

Obviously, there is an opportunity to engage with this particular staff group as they start to return to their workplace as COVID restrictions are lifted.

Also as part of the recently introduced National Track and Trace team pilot programme for asymptomatic NHS staff that have been doubly vaccinated and are self-isolating, either a LAMP or a lateral flow negative test is required to be obtained to enable return to work. This may also have limited the uptake of the LAMP tests.

There is a particular issue affecting Trust staff working in the community setting who have to go into Care Homes given the nature of their duties. Nursing Home owners locally have insisted that Community staff have to provide evidence of 72 hour negative COVID status before entering the homes and that the lateral flow system is the only one that can satisfy this requirement.

To date, for this reason Trust community staff in this position have not been actively encouraged to take up the LAMP test.

However, information has emerged from the Cheshire and Merseyside Pathology Network that working with CCG/Local Authority colleagues, they have been able to persuade Care Home owners to recognise the accuracy and reliability of the LAMP test and that it need only be done on a once a week basis.

The Task and Finish Group have asked for a copy of the guidance issued to Care Homes from Cheshire and Merseyside colleagues and will enter into discussions with local CCG/LA officers to progress this further.

c) Issues around information portal 'Lantern', registration and feedback on sample rejection

There has been feedback from users who have had difficulty registering on the information portal system because of technical issues connected with the system or the inability of android phones to scan barcodes.

There have also been issues of users not receiving sufficient detailed feedback on the reason for samples being rejected (i.e. due to there being an insufficient quantity of saliva or too old or because of contamination). This has led to the impression that some users may have found the process too difficult to follow and have not registered or continued or may have stopped submitting samples because of insufficient feedback on the reasons for them being invalid.

It is understood that 23% of Trust registered users have not submitted a sample while 27% have only submitted one sample.

Taking the above feedback on board, the Task and Finish group have shared this with the national Lantern team who have worked to improve and streamline the registration process and find a way for android phones to scan barcodes. They have also managed build in particular user messages on reasons for invalid samples into the system which is taking effect this month.

6. Next steps and recommendations

Given the importance of staff asymptomatic testing and the expectation from NHSE/I that NHS organisations ensure staff comply with a locally agreed testing regime, the following recommendations are made for Executive Committee approval:-

a) Endorsement and support for the LAMP asymptomatic testing programme as the best regime for staff to use given its accuracy and reliability.

b) Support for the expectation from the Chief Executive set out in his weekly bulletin of 12th July that as part of professional responsibility, all staff, (particularly those working on site and in clinical areas) register and commit to self-testing as the right thing to do for patients, their families and each other.

c) Senior leaders in the organisation actively endorse and promote the LAMP programme through the line management structure and communicate the expectation of a commitment to self-testing to their teams.

d) The senior leader group identify staff within their teams at all levels to act as champions for the programme, taking responsibility for encouraging staff to register and as points of contact for advice and guidance.

e) As part of the Board Assurance Framework, the Board of Directors are sighted on monthly compliance metrics and data with an agreed reporting schedule detailing uptake which is produced and shared through the care group and corporate departmental performance management structure.

f) The Task and Finish Group identify best practice from other Networks and share this and appropriate communications material with care groups and corporate departments on a regular basis to support the development of the LAMP asymptomatic testing programme.

To: Trusts:
- Chief operating officers
- Chief executive officers
- Medical directors
- Directors of nursing
- HR directors

Regions:
- Regional directors
- Medical directors
- Directors of nursing

CCG
- Chief operating officers
- Clinical leads

PCN clinical directors
General Practice
Community Pharmacy

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

29 June 2021

Dear Colleagues

NHS asymptomatic staff testing: Lateral flow device distribution and assuring compliance to testing regimes

We are writing to inform you of important changes to the NHS staff asymptomatic COVID-19 testing programme. As you know, **asymptomatic staff testing is an important component of Infection Prevention and Control, which all organisations and staff have a duty to adhere to**. We are grateful for your continued efforts to keep staff and patients safe from potential transmission of COVID-19 in healthcare settings.

At the time when Test and Trace started allocating lateral flow device (LFD) tests to the NHS in November, they were not at that point able to deliver a self-reporting system for staff. We are grateful for the huge amount of work that trusts have undertaken to enable staff to report tests in the interim, as the national system has been developed by Test and Trace. The combination of the move to the 'pull' model and the rollout of the national ordering and reporting systems to NHS staff should overcome some of the limitations and administrative burden of the current system, and allow tests and data to flow more seamlessly.

LFD distribution

From 5 July 2021, the NHS will move to an individual 'pull' model of LFD supply. This means that, from this date, staff will replenish their tests by ordering a box online from

https://www.gov.uk/order-coronavirus-rapid-lateral-flow-tests to be sent to them at home. This will mean:

- For primary care, organisations will no longer order tests for their staff via the Primary Care Support England (PCSE) portal. Staff will be able to order their own tests online and input the postcode of their workplace to ensure the tests are registered as belonging to an NHS member of staff. A box of seven tests will be posted to staff at their home address. Staff will continue to report the results of their tests on the gov.uk website as per current practice. Organisations and regions will receive management information from NHS Test and Trace to help them understand what proportion of their staff have ordered and reported tests including contractor group and region.

- For trusts: LFDs for staff will no longer be distributed to trusts. Staff will be able to order their own tests and input the trust name of their workplace to ensure the tests are registered as belonging to an NHS member of staff. A box of seven tests will be posted to staff at their home address. Organisations can choose whether to continue with their internal method of reporting results as per current practice, or whether to direct staff to reporting on the gov.uk website going forwards. Organisations and regions will receive management information from NHS Test and Trace to help them to understand what proportion of their staff has ordered and reported tests.

  However, trusts will still receive a supply of LFDs for patient use as per existing use cases (emergency departments, maternity and neonatal, end of life care visitors).

This move will not only make best use of the supplies of LFDs currently available to NHS Test and Trace, but will also provide a greater level of assurance by organisation that devices are routinely being ordered and used.

We are currently updating relevant LFD standard operating procedures (SOPs) and frequently asked questions (FAQs). These, and any other related guidance documents, will be available shortly.

Assuring compliance with staff asymptomatic testing regimes

Since the LFD staff testing programme was launched in November, we know that extensive efforts have been made to communicate with staff across the NHS about their local testing regime in order to keep themselves and their patients safe.

In parallel with communicating the new ‘pull’ model to staff, we now need to ensure that all staff are continuing to comply with IPC guidance. To this end, NHS organisations should now ensure the following is undertaken:

- Ensure that you have local systems in place for patient-facing staff to demonstrate that they are compliant with your organisation's asymptomatic staff testing regime when attending their workplace.
- Support the compliance of individual members of staff with your organisation's testing regime through line management structures, or conversations with local leaders and champions, where required.
- Ensure that the trust board is sighted monthly on organisational compliance as part of their Board Assurance Framework and IPC practice.
- Make use of the NHS Digital gov.uk reporting tool for staff to report their test results, where local trust reporting tools are not able to provide the levels of management information required to support chief executives in their assurance processes. This tool, currently used as standard by primary care staff, has been extended to be open to all NHS organisations.
- Access support from regional testing leads to share good practice in increasing uptake of testing and reporting.
- Work with national and regional teams, and NHS Digital as required, to improve the quality of reporting data. This will support the production of appropriate management information in relation to staff reporting rates.

Although most NHS staff will be participating in the lateral flow testing programme (twice per week), other testing regimes have been set up in some trusts or geographic areas, such as LAMP testing or PCR testing. The above actions should cover all NHS asymptomatic staff testing programmes.

Thank you for your continued efforts as we continue together to mitigate the risks of transmission of COVID-19.

Yours sincerely,

Prerana Issar
NHS Chief People Officer

Ruth May
Chief Nursing Officer, England

Pauline Philip DBE
National Director of Emergency and Elective Care

Professor Stephen Powis
National Medical Director

B7 Appendix 1

Quotes from Friends and Family Feedback June 2021

Please tell us what was particularly good about your care and anything that could be improved.

Since Friday (day 5) in the hospital I was overwhelmed with how nice everyone has been with myself and my daughter. I can't thank you all enough for everything you have done for us. Everything was explained to me especially when my daughter was unwell. Thank you so much ☺

Amazing team and great service. Can't fault you all are angels. Thank you xxx

Feels like I'm in a hotel! Any problems or questions big or small answered clearly and always offered help. Everyone so lovely and helpful.

Can't say thank you enough. Everyone has been outstanding. So lovely and caring to not just the baby but me also. The visits from everyone went far more than just a job you can see clear passion from everyone. Honestly couldn't have asked for a better team looking after myself or my daughter.

Every member of staff involved in my care was professional, courteous and friendly. All went above and beyond to help me in any way they could. Thank you for your care and compassion. Exceptional all round.

All staff have been absolutely incredible. We are so grateful for the care we have received and all of the advice and the chats and the cups of tea. We have learnt so much and will never forget the amazing treatment given.

Local Maternity System - Ockenden Evidence Portal Information
IEA7 Informed Consent – Question 44

Existing website information

York and Scarborough Teaching Hospitals has a maternity section on their website: York and Scarborough Teaching Hospitals NHS Foundation Trust - Maternity Services (yorkhospitals.nhs.uk)
The trust website is complimented by the Humber, Coast and Vale Local Maternity System website: Local Maternity System - Home (humbercoastandvalematernity.org.uk)

In June 2021 the York and Coast & Country MVP chairs have undertaken narrative reviews of the LMS and Trust websites, to assess the current offer:

I think the LMS website is extensive and very informative. I like the links to the MVP and all the information especially the fruits and veg rotating at the bottom. The support groups are clearly a fantastic addition, as Mums need to be signposted where to help. My only reservation, is how are we pushing this fantastic website out to Mums and Mums to be? Is this being done? It is great when you know where to find it but tricky to find from scratch.

The trust website is fairly basic with not a huge amount of information. Under Antenatal classes - it should read 28 "weeks" pregnant. The Scarborough information is out of date and still has Freya as head of midwifery. I can't even find the meet the team for York. The Malton information needs context. To me the there is no structure to this website and it leaves me concerned that a lot of the information is out of date (it may not be) but the mistakes give that impression. There is no reference made to the MVP. Does this website need to be so dissimilar from the LMS website?

As a pregnant lady, I wouldn't know to look on either of these websites without advice from a midwife.

https://humbercoastandvale.org.uk/maternity/

I think the order of content on this website should be re-ordered as follows.

1. Humber, Coast and Vale LMS website
2. Our Work
3. Better Births

At the moment the video under “our work” is quite detailed about the systems and structure of the LMS which is really useful for context but I think if parents are looking for relevant information to them…they may not scroll down and see the link to the Humber coast and vale maternity website which has a lot more information on.

Also the tone of this website is a little bit robotic – the video talks about women and families are at the heart and focus of all the changes/improvements but the tone doesn’t carry through in the page copy.

http://www.humbercoastandvalematernity.org.uk/ - these bits might be too specific but I thought I'd share anyway

- Landing page - Bump the habit banner > when you click on the banner at the top of the page (which you are naturally drawn to), this it takes you away from the HCV website and takes you to the bump the habbit website. Can this be set up to open a new window so we are encouraging people to still read more content on the HCV website?
- On the landing page – on the second paragraph where it says that women are likely to give birth at York, Hull etc > I would add a hyperlink to where people can find the contact details of those hospitals rather than having to click through so many other pages to get there. Or underneath the VT and the map – could you have a bit about hospitals and links to trusts websites there as I think this would make the user journey easier?
- On the Hull trust site there is a really nice bit of copy that sits on the landing page around how pregnancy is a natural life event, mum is at the focus etc – It would be nice to have something like this on the York and Scarborough Trust website that reaffirms the caring nature of the teams that will look after these families and it isn't just information overload, there's heart at the center of it all http://www.humbercoastandvalematernity.org.uk/labour-and-birth/coping-strategies-for-labour-and-birth/
- Landing page – paragraph 3 it says "If you have any questions you can contact us" > need to say how….by emailing XXX or by clicking on the "Contact" tab on the menu above.

http://www.humbercoastandvalematernity.org.uk/labour-and-birth/york-and-scarborough-teaching-hospitals-nhs-foundation-trust/

- It would be good to include somewhere what is included in birthing rooms at York and Scarborough – do families need to bring their own bounce balls. Can we show pictures so women do not have this fear of the unknown. Also would be great to tell women on the page what happens when people have had their baby – break it down for them so they know what to expect and where they will go.
- It may be useful to have a page for each hospital so that the copy can be broken up with photos?
- On the menu bar at the top of the page – could you have the sub-menu appear if you hover over the title? I think there's a lot of information across the site but some people may not find it unless they go and read a specific page which then opens up other useful topics?
- The MVP information is listed under support but it would also be really helpful to have the MVP's reference in the "Pregnancy Journey" tab as we want people to be aware of the MVP across their entire maternity journey, not just if they are looking for support.
- For each hospital, the way the information is set out is quite copy heavy… could it be broken up so that key information is highlighted such as contact details etc, like this for York;

York Teaching Hospital
York Hospital
Wigginton Road
York
YO31 8HE
Contact switchboard: 01904 631313
Maternity Triage: XXX
Google map: https://goo.gl/maps/EkjFC9XtHABbXXNN7

York Hospital is approximately 15 minutes walk from the centre of the city.

Travel & Parking

- You are also able to hop on board a new service from Rawcliffe Bar Park and Ride and be dropped off right outside York Hospital's front door. Services run every 20 minutes between 6am and 8:30pm, with tickets costing £3.20 return (£1.50 return if you have a valid hospital staff pass). All you have to do is park on site at Rawcliffe Bar and catch the bus at the dedicated Hospital Park and Ride bus stand opposite the terminal building, tickets can be purchased through the bus driver.
- Our MultiStorey Car Park (MSCP) is open for patient and visitor parking. This operates a 'pay on exit' system. Visitors and staff are required to pay for parking at the York Hospital site between 7.30am and 8.00pm.
- A reduced parking rate is available for partners of women in labour. The rate is £2 a day and partners are required to park in the designated area which is signed close to the main entry to the Maternity Unit. After labour, partners and visitors are required to park in the MSCP - standard charges apply.

At the hospital

The Maternity Unit is based on the Ground Floor, York Hospital. There are a number of different areas you can access and all are well signposted from the main entrance on arrival:

- Main entrance: Junction 4
- Antenatal Day Services: Junction 5
- Early Pregnancy Assessment Unit: Junction 8
- Labour Ward Delivery Suite Maternity Triage: G2 & G3

Labour ward has ten labour/birthing rooms, two birthing pool rooms, and two obstetric theatres.

Ward G3 is an antenatal ward of 12 beds which includes four induction or early labour rooms.

Ward G2 is a postnatal ward consisting of 20 beds and 20 cots.

Should you have any questions about the facilities at York Hospital, please contact XXXXX

http://www.humbercoastandvalematernity.org.uk/labour-and-birth/coping-strategies-for-labour-and-birth/

- Are all of these pain relief methods available across all of the trust hospitals and should we note what is available?

The maternity section of the York Hospital site seems very basic compared to the LMS information shared. There doesn't seem to be anywhere on the site that includes comprehensive overview of a maternity journey from finding out you are pregnant to birth and post-labour with information relevant to each part of that journey with links to all of the relevant information shared on the LMS website. There is reference to better births but nothing that sets up the maternity experience with the appropriate tonality about parent to be and the baby at the core focus of everything. It would be nice for more information about the hospital facilities, the teams working in maternity, whats involved in a maternity ward (pre-labour and post) and some information around the logistics to be incorporated. If people live in the York and Scarborough area I would think they would look to this website for the information that is currently sitting on the LMS website.

Actions for improvement

York and Coast & Country MVPs plan to work collaboratively on a gap analysis of the trust website and co-produce an action plan to address gaps identified.

Humber, Coast and Vale

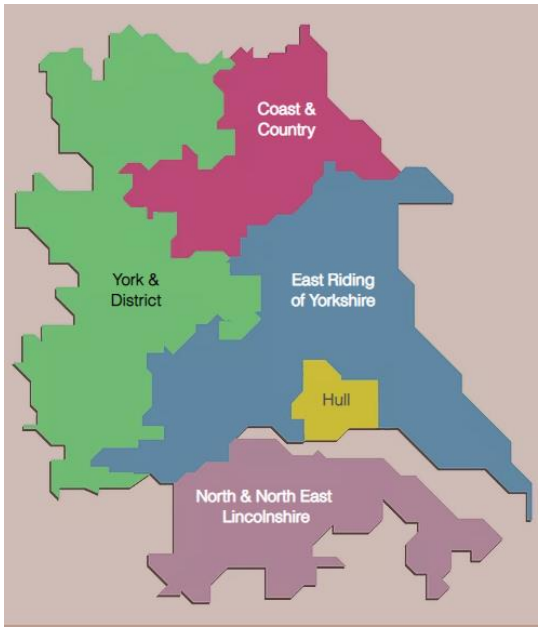
Humber, Coast and Vale Health and Care Partnership - Local Maternity System

Maternity Voices Group
Summary of ongoing interactions/work with HCV LMS, Provider Trusts and stakeholders

February 2021

Humber, Coast and Vale Maternity Voices is a group of five local Maternity Voices Partnerships (MVPs) working within the Humber Coast and Vale Local Maternity System (LMS).

The local Maternity Voices Partnerships, supported by their CCG(s), are as follows:



- Coast and Country; supports the Scarborough and Ryedale areas, maternity services mostly from York Teaching Hospitals NHS Foundation Trust
- East Riding of Yorkshire; supports this geographical area, maternity services split across all three LMS Trusts, the majority to York and Hull
- Hull; supports the City of Hull area, maternity services mostly from Hull University Teaching Hospitals NHS Trust
- North and North East Lincolnshire; supports this geographical area, maternity services mostly from Northern Lincolnshire and Goole NHS Foundation Trust
- York and District; supports the City of York and Selby areas, maternity services mostly from York Teaching Hospitals NHS Foundation Trust

"We ask people using maternity services to share their experiences and feedback - what was good, what was not good and ideas for change. By sharing this you help shape maternity care in your area."

Membership of the local MVPs includes a lay (remunerated service user) chair, representation from: maternity service providers, service users, doula/breastfeeding support organisations, local health visitors, commissioners, the LMS and a number of other interested parties. All MVPs currently meet virtually, with an aim to meet quarterly, and coordinate local information via email.

Each local MVP has a Facebook page, and in some cases other social media sources, where they can share messages from local Trusts, the LMS and other sources of reputable and accurate information. Social media is the key point of engagement during the pandemic: service users have opportunities to provide feedback and comment via posts, survey links and messaging services. Service users can also make contact by email or by text/WhatsApp via a dedicated mobile phone and access contact information, surveys and MVP news via the shared website: Maternity | Maternity Voices HCV

Information about the Maternity Voices can also be found on the LMS and National Maternity Voices websites:
Local Maternity System - Maternity Voices Partnership (humbercoastandvalematernity.org.uk)
National Maternity Voices – Networking Maternity Voices Partnerships in England

The lay chairs, provider/commissioner representatives from each MVP and representatives from the LMS, perinatal mental health services and the ICS meet as the Maternity Voices group bi-monthly to facilitate joint working in LMS-wide communications, engagement and coproduction, including targeted work with minority ethnic and disadvantaged communities; sharing of and learning from local feedback; and service user representation at all workstream and board meetings. The LMS supports the Maternity Voices group lay chair role, which provides liaison with the LMS core team, the regional and national groups, supports coordination of co-produced communications, engagement and reporting across the area for LMS-wide work.

Working as a group enables feedback to be gathered across the LMS footprint and findings reported for this and local level learning. Key areas covered as part of this work include:

- Presentation of service user experiences at LMS Delivery Board, Oversight & Assurance Board, Commissioners, regional Clinical Network & Maternity Transformation meetings (ongoing)
- Lay attendance at weekly LMS Co-ordinated Activity Calls – commenced during pandemic and ongoing
- Ongoing development of LMS website, for example 'What to pack in your bag for hospital birth' – written by parents and staff
- Ongoing involvement in Humber Acute Services Review engagement program, including co-production of animation and initial questionnaire
- Maternity care during the pandemic antenatal and postnatal surveys to enable services to prioritise and develop according to needs and feedback (surveys launched July 2020, ongoing):
    - Co-produced development of 'Ask a Midwife' services (Autumn 2020)
    - Care pathway information for each Trust added to the LMS website, regularly reviewed (August 2020)
    - Co-produced communications for service changes due to pandemic (from April 2020, ongoing)
- Choice and personalisation workstream:
    - Continuity of carer survey (started February 2020, ongoing)
    - Co-produced birth pool hire pilot (from January 2020, ongoing)
    - Maternal postnatal check by GPs survey (survey run December 2020)
- Perinatal mental health: ongoing support of co-production of information leaflets; developing support for dads and partners; feedback from surveys
- Prevention workstream: ongoing involvement in smoking cessation, breastfeeding support, healthy lifestyle services development, including feedback from surveys
- Safety workstream:
    - Pertussis vaccine survey, to understand barriers to uptake and support co-production of service development in 2021 (survey planned for February 2021)
    - Improvement care pathway following loss, with support of local bereavement charities (ongoing, from December 2020)
    - Service user feedback to understand barriers to flu vaccination uptake (November 2020)
- IT system development: service user representation and facilitation of engagement/co-production are integral to this work, started in 2021.

Ruth Prentice
Lay Chair - North and North East Lincolnshire Maternity Voices Partnership
Lay Chair - Humber, Coast and Vale Maternity Voices group
8th February 2021

B7 Appendix 4

	Mat Neo Staff Safety Forum Action Log					
Date	Issue/Risk Identified	Action Required	Lead	Target Completion Date	Date Action Completed	Required Evidence/Assurance
7.5.19	HCA discussed concern around trip hazards for both staff and mothers in postnatal areas as women bringing large amounts of luggage in.	To email all community team to remind women only top bring one bag and emind hospital staff to ask women not to leave bags and belongings laid around on the floor.	Freya Oliver	May-19	07/05/2019	email
6.3.19	When babies are transferred from SCBU to postnatal ward the SBAR does not give enough detail of feeding history. There have been several minor incidents and concerns at ward level on the York site, no datix or SI's	Design a feeding specific SBAR to use alongside SBAR for neonatal transfer. Take to Clinical Governance - SCH to do this.	Suzie Kinsella	Apr-19	Jun-19	New neonatal SBAR for approval at CG - NOV 12 2019.Feeding SBAR in place and working well.
3.7.19	Concerns voiced that two Sundays running a midwife has been taken from Hawthorn to support a busy labour ward leaving Hawthorn ward inadequately staffed. Midwives feeling unsafe. One midwife was taken for seven hours. Escalation plan not used.	Discuss with LW manager.Education needed re. escalation policy.	Susan Jackson (Gill Locking)	Aug-19	Jul-19	Discussed with coordinator on that shift. Email sent to all coordinators. On the agenda for next coordinators meeting. IOL times changing to alleviate pressure on Hawthorn at peak times. Agreement from HOM for extra support during section lists when staffing allows.
6.3.19	Concerns that the number of babies requiring at least a day case admission or overnight stay to CAU is high on the York site.	Deep dive into data. Look at reasons for admissions. Initial impression is that the issues are mainly breastfeeding related. Look at Scarborough data ? Same issues. If not, why not?	Suzie Kinsella	May-19	Aug-19	Evidence provided by IFC of recent audits. Email saved in Mat Neo Staff Safety Forum. 
06.11.19	Scarborough SCBU staff raised the issue of the resuscitaire placement in labour ward theatre. This has been moved to the anaesthetic room. Staff feels this affects patient experience and the safety related concern to this is that it takes longer to get the emergency trolley in the room and the new process is 'less smooth'.	Discussed at Safety Champions. HOM confirmed that this has been escalated to CG Director who supports the LW Manager decision to have the resuscitaire in anaesthetic room (IPC reasons)	Susan Jackson/Freya Oliver	Nov-19	Nov-19	HOM confirmed that this has been escalated to CG Director who supports the LW Manager decision to have the resuscitaire in anaesthetic room (IPC reasons)
06.11.19	Staff member concerned that a locum Consultant on Labour Ward had been blocked from working and then turned up and did a shift.	Discussed at Safety Champions. Broad discussion re. what are we saying about a practitioner if we block them from working.	Sara Collier-Hield	Nov-19	Nov-19	On this occasion an Obs Consultant made the decision that the staff member should work with LW co-ordinators to escalate if any concerns.

3.4.19	Staff on G2 concerned about their levels of activity and acuity. Remarks about time spent answering the buzzer. Number of visitors too high / difficult to police, especially other people's children. Discharge computer work taking more than should be as often antenatal details not entered. Three staff suggested more support workers could be part of the solution	On-going monitoring. Staff SCORE culture results due June 24th. Consider role of volunteer. Look for local solution to buzzer issue.	Debbie Sharp	on-going	Dec-19	New Sister in post. Meeting planned with core staff Sept 17th 2019 to get ideas. Volunteers in place 3-4 lunchtimes a week. Working well and viewed positively by staff.
5.2.20	Staff nurse at York SCBU concerned about being moved to ward 17 to cover short term sickness etc and not orientated to the area.		Vikki Smith	Mar-20	Feb-20	Vikki has worked with the clinical educator on ward 17 to develop a solution. All new employees to SCBU spend time on the ward as part of their paediatric preceptorship.
3.4.19	CPD, the maternity computer records (that only midwives have access too) and the inpatient care record in maternity is disjointed. This leads to: 1) Failure to act on high MEWS scores to recognise the unwell pt. 2) Minimal communication with GPs regarding pregnant patients admitted and discharged with medical problems – no adequate eDNs, no record of medication discharge with pt, no record of investigations carried out. This adds to the problem of GPs not willing to continue the care / prescribe medications. 3) Discrepancy between national guidance / our own guidance and CPD assessments e.g VTE		Sara Collier-Hield/Freya Oliver	On-going		Nov 19. Meeting with Kev Beatson, Donald Richardson and Magda Borucszowska re. new Maternity records standard. Linking up to LMS and digital plans for the future.
7.5.19	No staff attended- walk around of unit staff raised concern around SCBU staffing, what is happenning in relation to current cot reduction and recruitment. Explained rationale for cot reduction and gestation raise is around safety, awaiting RCPCH report with staffing model suggestions for whole service.	N/A- await RCPCH report	Directorate team	Jun-19	Mar-20	cot capacity restored, staff recruited. Medical cover beeing reviewed as part of ASR
7.8.19	Junior Doctor planning at August (and other) handover periods. Inadequate cover.	Rota planning in advance.	Jamie Todd (or team)	TBC	Jun-20	rota being reviewed in ongoing fashion and locum cover sought as needed
2.10.19	Staffing concerns raised re levels and also staff being moved to new areas without orientation	Discussed all vacancies recruited to , awaiting pin dependent starters. D/W senior team possibility of 1-2 orientation shifts if moving to a new area where not worked for significant period.	Freya Oliver	Oct-19	Mar-20	orientation plan , clinical skills midwives aware
2.10.19	ADU staff raised concern regarding ability to get bed out of door for emergency transfer to Labour ward	Being looked at by Matron following issue, difficult to widen door access but may consider replacing beds with trolleys	Debbie Scott	Dec-19	May-20	trolley in place
2.10.19	SCBU staff raised concern baby tagging system cannot be used as tags and bands not suitable for preterm babies	To contact company again as they were developing a prototype for preterm babies	Vikki Smith	Sep-20	Dec-20	SCBU working with x tag medical and looking to try a new product in March 2020. Paused due to Covid email regarding this, prototype avaioable w/c23/11. supplier has delivered prototype and [illegible]

8.1.2020	Midwife concerned re. low staffing levels in Malton team and now embarking on providing continuity of carer.	review of rotas and recruitemnt	Michala Little	Mar-20	Jun-20	email
	Concern raised escalation policy not clear or easy to follow	to be reviewed and coordinator involved in development	Susan Jackson	May-21		20/7/20- in draft to circulate for comments. Additional work undertaken to draft to add medical staff escalations- current guideline
13.3.20	concern raised about staff absence due to covid and staff not being tested	to be reviewed at trust level	Heather McNair	Mar-20	20.3.20	staff testing in place initially for family member but affected staff added 14/4/20
	partogram not working well	New partogram needed	Susan Jackson	Oct-20		5/1/21continuing to use national PI partogram- to reconsider if further developemnt needed
26.5.20	Anonymous whistleblowing letter received by CEO- citing issues around culture, recruitment, visibility of managers,	actions in cells below	as below	as below	Nov-20	
3.6.20	action around issues raised from culture survey	restart paused work around culture survey. Introduce kindness champions	Michala Little	Nov-20		culture work commencing jan 21
	SCBU environment concerns	minor works forms being actioned	Vikki Smith	Sep-20		update awaitied jan 21
	Mimimum 30 hours for band 7	already resolved for labour ward- can be 22.5	susan Jackson	complete		
	rotation of band 7 posts from ward	discuss with senior team, survey staff in post to understand impact to them	Freya Oliver	Dec-20	Dec-20	complete
	Visibility of managers	Staff drop in sessions, appointments for new starters with HOM, daily walkaround	Freya Oliver	Jul-20	Jul-20	diary for staff surgeries and walk arounds
	Recruitment process	senior team review	Freya Oliver	Jul-20	Jul-20	agreed all band 7 or above substantive posts to be advertised externally
	Culture and raising issues	Senior care group management to discuss	Freya Oliver	Jul-20	Oct-20	managerial cross site precence and utilising
4.7.20	no attendees					
5.8.20	concern around lack of support from TVN's regarding complex would care	to raise with TVN service	Heather McNair	Aug-20	6.8.20	H McNair discussed with Sam haigh
09/09/2020	no attendees					
28/10/2020	shower facilities on ward too small for pregnant women	escalate to estates as very dated and need replacement	Freya Oliver	Apr-21		
28/10/2020	staffing concerns on SCBU due to recruitment delays, sickness and shielding staff	plan in development and utilising long term agency	Sal Katib	Dec-20	Dec-20	
02/12/2020	walkaround no issues raised					
21/01/2021	walkaround all areas SGH- no issues raised					
19/03/2021	walkaround all areas - no concerns raised					
07/05/2021	walkaround all areas - no concerns raised					
10/06/2021	ANC seminar room booked - staff expressed concerns over staffing and unfilled shifts.	Review of rotas and recruitemnt	Senior Team	Jun-21		

B7 Appendix 5 – CNST Action Plan

Action Plan

Maternity Incentive Scheme Year 3 (CNST) Safety Action 6 and 8: Plan to achieve a minimum of 90% compliance with mandatory maternity training as required by CNST in the multidisciplinary workforce				
Action Required	Lead	Target Completion Date	Date Action Completed	Required Evidence/Assurance
Identify reasons for not achieving the 90% target	Michala Little	July 2021	July 2021	Review of training compliance demonstrates that multiple reasons for not being compliant with target, exacerbated by the pandemic.
Review training provision and ensure there is enough to capture all staff	Michala Little	September 2021		TNA meeting, evidence of new timetabling including any additional national training requirements and include updates from datix/incidents/complaints
Identify clear leads for monitoring allocation and attendance at training	Michala Little	August 2021		Confirmation of anaesthetic, neonatal and obstetric leads with a commitment to managing allocation and attendance
Have a clear SOP for how non-attendance will be managed	Michala Little	August 2021		SOP
Monitor training compliance monthly at Care Group Quality Committee and Board. Capture on the PCQS and escalate concerns to the Maternity Safety Champions and to Board	Michala Little	August 2021		Training dashboard and minutes of meetings

B3 Appendix 1. Clostridium difficile action plan

ACTION PLAN FOR:	Reduction in Clostridium Difficile Cases at SGH/BDH	DATE:	07/05/2021
OVERALL STATUS:	10 of the last 17 hospital attributable C.diff cases at SGH/Bridlington have been Ribotype 001 (59%)	OVERALL RAG:	

RED	Unlikely to be completed without additional time or resource	Amber	Likely to be completed but may require addition resource or time	Green	Due to be completed with no additional resource or time required

	Issue	Date added	Action	RAG	Owner	Review Date	Measure of Success	Escalation Required	UPDATE
1	**Estates:** Wash hand basin not at every ward entry point	n/a	Request quote from LLP for the installation of a wash hand basin at the entry point to every ward on the Scarborough/Bridlington sites.		A Whitfield	31/07/2020	A Wash hand sink is installed at every ward entry location on the SGH site.	YES - Escalated to PR/H McN	**07/05/21 - awaiting official confirmation of monies from HMc/PR/TF . Initial meeting held with estates regarding design of sink** 09/03/2020 - £ 26K allocated for sinks at entrances to wards at sgh. Remains issue of where to site the sinks - need to revisit with a walk around with estates - ACW 28/09/20 - issue of where to site sinks. Space is limited and there is a concern that the basins will get smashed or knocked of the wall when moving beds. The door edges around the wards have clear damage where they have been struck by beds and the basins will be more even prone to damage. 24/08/2020 - Third party contractors have assessed the work and we await the quotation. In terms of an indicative cost whilst we await the quote, £3000 per sink is an acceptable figure. J Wilshire will speak to the contractor to see if the quote can be expedited.
10	Improve Antibiotic prescribing	n/a	ARK Project – Relaunch/ reinvigorating the projec		D Mawer/ Anita Chalmers	31st May 2021	An increase of the proportion of antibiotics stopped within 72 hours.		**6/5/21 - project to be Launched 1st June 2021 on site. E-learning in place** 13/04/21 - update to follow from DM 9/3/21 - D Mawer to revisit as Covid work subsides
11	Reduce Intra-ward transfers throughout the Trust	n/a	Intra ward transfer reduction project and associated documentation launched		S Kelly	31st May 2021		YES - Escalated to PR	**04/05/21 - Project to be re-launched. Original Paperwork obtained PR to speak with Freya O/Michael Mawhinney** 13/04/21 - SK/ACW to meet w/c 19/04/21 9/3/21 - PR/ACW to revisit as COVID allows 5/10/20 - Challenging at present due to COVID operational pressures
22	Delays in stool Sampling (2)	**NEW** 04/05/21	Simplify Stool Sampling Flow Chart		ACW	31st May 2021	New Sampling Poster in use across Trust	NO	**04/05/21 - Draft poster developed. Awaiting agreement on changes required**
23	Hand Hygiene - numerous dispensers not working - soap and alcohol gel	**NEW** 04/05/21	Move to hand operated Hand dispensers (Currently battery) (Soap required for C.Diff but all types of dispensers need replacing)		ACW	31st May 2021	All battery operated dispensers removed and replaced on	NO	**04/05/2021 - Newly added. Numerous dispensers not is use. Battery replacement appears to be main issue. There was a move to go to Hand operated ones pre COVID. To re-explore possibility**
24	Hand Hygiene - Discrepancy between ward audits and IPC	**NEW** 04/05/21	IPC Peer review Hand Hygiene Audits		Astrida Ndhlovu	31st May 2021	5 x Peer Review HH audits carried out a month	NO	**04/05/21 - Newly added**
25	Hand Hygiene - Particular issue surrounding 5 moments identified	**NEW** 04/05/21	Improve training		Anne Tateson/Jane Tulley	31st May 2021	Improvement in IPC Hand Hygiene Results	NO	**07/05/21 - HH training voa GOJO to be repeated Attendance was 40 + on first session** 04/05/21 - JT has been providing additional training on Chestnut and Cherry wards. AT has arranged GOJO to provide free training on HH for staff on HH day (5th May)
26	Hand Hygiene - improve education	**NEW** 07/05/21	Development of Hand Hygiene Tool Box Teaching		TBC	TBC	TBC	NO	**07/05/210 - to be agreed/identify lead**
27	Patient Beds not Cleaned to a high enough standard after a patient is discharged	**NEW** 04/05/21	Bed Cleaning Compentencies to be developed		TBC	TBC	TBC	NO	**07/05/2021 - Lead to be identified to develop compentancies**
28	Improve Commode Audit results further	**NEW** 07/05/21	Recent improvements across site - IPC to develop commode cleaning competencies		TBC	TBC	TBC	NO	**07/05/21 - Lead to be identified**
29	Inconsistancies in the use of sporical wipes to clean commodes when C.Diff has not been identified	**NEW** 07/05/21	To explore the standardisation of the use of sporicidal wipes for all commodes - all the time		TBC	TBC	TBC	NO	**07/05/21 - To be agreed at IP**T
30	Improve Education of C.Diff amongst staff	**NEW** 07/05/21	Development of C.Diff Tool Box Teachong		TBC	TBC	TBC	NO	**07/05/2021 - To be agreed/identify lead**
31	Ensure C.Diff care standardised	**NEW** 07/05/21	Development of new C.Diff care plan		TBC	TBC	TBC	NO	**07/05/2021 - To be agreed/identify lead**
32	Numerous ward Refurbishments required	**NEW** 07/05/21	Numerous ward Refurbishments required		TBC	TBC	TBC	NO	**07/05/2021**
33	Poor condition of ward environment	**NEW** 07/05/21	Re-launch environmental audits and walk arounds involving Ward leaders		TBC	TBC	TBC	NO	**07/05/2021 - TO be discussed at IPT**
34	Cleanliness of Environment	**NEW** 07/05/21	Introduction of Cleanliness standards meeting		Paul Rafferty	31st May 2021	Meeting Established	NO	**07/05/21 - first meeting due 13th May 21**
34	Increase prevalence of 001 strain - ?community	**NEW** 04/05/21	TBC - possible period of sampling all loose stools and ribotype on admission. There are some circumstances on our current stool sampling flow chart where this would not occur		TBC	TBC	TBC	NO	**07/05/2021 - To be agreed at IPT**

18 items closed/completed (see completed tab)

ACTION PLAN FOR:	Reduction in Clostridium Difficile Cases at SGH/BDH	DATE:	07/05/2021
OVERALL STATUS:	10 of the last 17 hospital attributable C.diff cases at SGH/Bridlington have been Ribotype 001 (59%)	OVERALL RAG:	

RED	Unlikely to be completed without additional time or resource	Amber	Likely to be completed but may require addition resource or time	Green	Due to be completed with no additional resource or time required

	Issue	Date added	Action	RAG	Owner	Review Date	Measure of Success	Escalation Required	UPDATE
2	**Estates:** Unclear which areas of SGH site can't be HPV'd	n/a	Undertake/update review of locations suitable for HPVing		J Pownell	31/07/2020	Up to date list of suitable areas for HPVing.		Survey completed on Monday 10th August at SGH and on Tuesday 11th at York
3	Currently have a reactive model with regards to HPV Program	n/a	Identify a decant facility for SGH and BDH		D Thomas	24/07/2020	Identify an area to use as a decant facility.		Ann Wright Identified as a decant area whilst awaiting potential work to be done to convert into 11 siderooms.
4		n/a	Develop Proactive HPV plan for SGH and BDH		A Whitfield/ S Kelly	31/07/2020	Have an agreed plan for the proactive HPVing of all areas at Scarborough hospital.		Plan published - 1st ward area Beech being completed w/c 31/8/20
5	**Estates:** Lack of isolation facilities	n/a	Work up plans to increase sideroom capacity		D Thomas	August	Increase of Sideroom capacity onsite from siderooms		Bid Successful - awaiting tender
6	Estates: Decontamination of beds	n/a	Complete Decontamination of Beds program at SGH and Enterprise Bed Upgrades		A Whitfield	24/07/2020	All beds have gone through Decontamination and upgrade program of work.		19/10/20 16 out of original 423 left to do (96% complete). 13 in York, 2 in Bridlington, 1 in Scarborough 5/10/20 64 out of original 423 left to do (85% up from 79%). Further finances will have to be secured to get this project completed. 2/9/20 Relying on Medical Engineering staff to do the overtime to get them done and as most are in Brid it will be difficult. It takes 2 - 3 hours to do each bed. Have had volunteers for one weekend and a couple of nights so far. We have 10 in Scarborough, 2 not been used that we are going to do soon and try and find the other 8. In Brid we have 27 to do across all wards. 31/7/20 we have 11 beds in Scarborough and 27 in Bridlington out of a total of 182 left to complete (79% completed). Pause during Covid due to lack of spares and resources. We now have the spares but we are waiting for confirmation from LLP finance manager that we have the money from the trust to claim overtime to complete the process.
7	**Facilities:** Use of Kentucky Mop heads across SGH site	n/a	Move to the use of reusable Microfibre Mop heads across site		J Louth	End April '21	Reusable Microfibre mop heads in use across SGH and BDH.		**09/03/21 - Microfibre mops have been delivered - Staff training commences 20th April followed by roll out**
8	Cleanliness: Commode's regularly identified as being soiled via Audit	n/a	Regular Commode 19 audits (Weekly) performed		A Smith	31/07/2020	Weekly IPC audits completed and Improvement in results over a period of time (End August 2020).		Results from 16/10/20 showed improvement in most areas. Areas of concern: DOK - 67% Chestnut - 75% Lilac - 67% S.Freer requested we include ED in future audits
9	Patients currently transferred from ward to ward on own hospital bed	n/a	Setting up of a group to look at this particular issue and implement process		S Kelly/ S Freer	10/08/2020	Trolley's used to transfer patients, unless absolutely necessary to occur on a bed.		**SGH Transfer team in place**
12	Learning from Post Infection Reviews (PIR's) to sit within the appropriate care group	n/a	Move to a model where the PIR's are run by the individual care groups - In this first instance by CG2 as a pilot for rest of Trust		P Rafferty/ A Whitfield	Nov	Care Group 2 C- Diff PIR's run by CG and monitored by Care Group Quality Group and then plans to replicate across all other care groups.		**5/10/20 - Launch of new process November 2020. Reports being made to auto report from Datix system**
13	Lack of awareness on site of current Clostridium Difficile issue on SGH/BDH sites	n/a	Develop a strategy with the communications team to raise awareness		A Whitfield	10/08/2020	Have a communication strategy document.		Materials produced by comms team. Screen Savers gone out twice W/C 24th and 31st August Item in Friday's Staff bulletin Went out 4/9/20
14		n/a	Identify a lead clinician on site to drive message forward		Tim Houghton	03/08/2020	To have an identified consultant to lead/assist in program of work to reduce C.diff across the site.		Tim Houghton/Ed Jones attending C.diff outbreak meetings
15	Improve awareness on site of current Clostridium Difficile issue on SGH/BDH sites	n/a	Introduce weekly IPC matron's huddles		IPC Team	31/08/2020	To have weekly IPC matron huddles.		**13/04/21 - AW to join 1 day a week from w/c 12/04/21** 9/3/21 - AW to join SGH Matron Huddle 1 day a week
16	Different products in use by staff to decontaminate equipment. Including separate Sporicidal wipes that require water to be activated	n/a	Explore potential of moving to a single wipe which contained detergent, disinfectant and sporicidal agents to reduce confusion among staff and to ensure that the sporicidal was being used all the time everywhere.		IPC Team/ Annette Williams	Q4 2020	Identify potential alternative product to be put forward to procurement		**April 2021 - Currently on Trial of Tristel** 5/10/20 - Annette Williams will look at after COVID work decreases
17	When a patient with C.diff is moved out of a bay it is currently adhoc as to if the bay would be decanted to allow for terminal a clean and HPV.	n/a	Look at establishing a process that when a patient with C.diff is moved out of a bay, the bay has to be decanted to allow for terminal clean and HPV.		Alison Wright	End Sept	It becomes the exception not to decant a bay to allow for a terminal clean and a HPV .		**April 2021 has become standard practice - to datix when not able to complete** 1 instance of this in August 2020 and we did empty the bay and HPV. About to do the same on Chest nut ward (as of 8/9/20)
18	Lack of storage in general and equipment stored in inappropriate places	n/a	Introduction of declutter programs		IPC Team/Anne Tateson	Q4 2020	Have a declutter program established.		**May 2021 - Declutter Month to be added to IPC rolling Program of EVENTS** 05/10/2020 - A Tateson will progress this as COVID work allows
19	Improve assurance around cleanliness and quality of Mattresses	n/a	Introduction of mattress audits which results in replacing damaged/soiled mattresses.		IPC Team	Q4 2020	Regular Mattress audits introduced and established.		26/10/20 - Meeting Sam Haigh this week to discuss 05/10/2020 - ACW to meet with Sam Haigh (TVN) to progress work. We are looking at a Trust wide mattress audit program collaboration between IPC and TV
20	Reduce the number of minor works that are outstanding in clinical areas	02/09/2020	A joint IPC, Estates, matron walk round would held to identify minor works needing completing		IPC Team SGH	completed or in diaries by Sept 30th	Assurance that list of works outstanding is correct.		**May 2021 - CLOSED. NEW ITEM REPLACED REGARDING ENVORONMENT MEETING AND ENVIRONMENT AUDITS** Ross Chamberlin and Shaun Fletcher as leads on this from the Estates Department.
21	Delays in stool sampling	02/09/2020	In intentional rounding document stool chart is not for 1 day and contains incorrect information (it only identifies type 6 and 7 as Diarrhoea)		IPC Team/ACW	30th Sept 2020	Stool chart removed from intentional rounding document (as not a wholly owned nursing document) and corrected.		**04/05/21 - Moved to Green as awaiting digital solution. Paper stool charts now back in use** 13/04/21 - Paper stool charts in use on majority of SGH site - Nic Coventry aware. working on a digital solution - ACW 9/3/21 - Group didn't meet during latest COVID wave - ACW to re-pick up with Documentation lead nurse (N Coventry) 26/10/20 - discussing at steering group on 28/10/20 30/9/20 - Took issue to Documentation steering group. Group accept corrections needed. The nurse's from York site feel that the ward staff like and use the Bristol stool chart in the intentional rounding document. ACW to meet with new documentation lead nurse mid October. Audit required on the York site about it's use

B3 Appendix 2 - Wall Mounted Visual “Sani-Station”

B3 Appendix 3 - York Labour ward IPC recommendations

Findings and recommendations for improvement following Period of Increased Incidence (PII)

Background; Following a period of increased incidence of Caesarean section wound infection cases on…York Hospital labour ward a walk round of the Labour Ward theatres undertaken on the 07/04/2021 following discussion with Gill Locking (Matron) our findings were that the patient environment unit does not meet CQC standards in relation to the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infection and related guidance (updated 2009) criterion 2 with particular reference to;
'all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition'

Findings - estates	• Theatre 1 flooring tiles damaged therefore unable to clean theatre floor. • Environment looking tired with some wall damage and visible plaster. • Theatre windows have foam strips along the edges. • Theatre & anaesthetic room 1 - Medical gases boxing on wall damaged with high levels of dust inside and on top. • Large theatre electrical panel with clock visibly dirty and dusty with surgical tape over switches. • Scrub sink inside theatre 1 – damaged tap (lime scale), underneath scrub sink tiles appear to have water damage. • Nail brush holder plastic coating damaged exposing rust.	**Recommendations -**	Flooring to be replaced as not appropriate for a functioning theatre. . Wall damage to be repaired as not appropriate for a functioning theatre. Review windows and remove foam to edges. Replace medical gas boxing. Clean and repair theatre panel. Relocate scrub sink into anaesthetic room Clean scrub sink tap Remove and replace any damaged/ broken equipment Cleaning schedules/ SOP's to be developed for each area and equipment

	• Anaesthetic room 1 WHB seal perished near wall. • Ventilation grill near floor underneath scrub sink broken		Repair seal Estates to review and repair grill
Findings - storage	Excess of equipment/ consumables in both theatres, clutter on worktops.	**Recommendations -**	Rationalisation of space , declutter and keep only required kit in the theatre. Additional Danicentres for PPE storage
Findings – MDT practice	Drip stands and pumps dusty Soap in sanitizer dispenser High and low level dust in theatre 1	**Recommendations -**	Cleaning schedules/ SOP's to be developed for each area and equipment
Findings – staffing	Staff awareness of environmental issues	**Recommendations -**	Include weekly environmental checks as part of the 'My perfect ward' audits
Findings - general	• The general environment is cramped • High & low level dust within the theatre environment. Anaesthetic equipment dusty, visible blood on theatre 2 main lights. • Leg support attachment for theatre trolley damaged split seams • Rusty bowl trolley wheels • Damaged rusty theatre storage trolley with adhesive tape on top.	**Recommendations -**	Declutter and rationalise available space. Deep clean of theatre 1 Damaged / rusty equipment to be disposed of.

B3 Appendix 4 - IPC Board Assurance Framework

June 2021
Infection Prevention and Control Board Assurance Framework

Trust Strategic Goals

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☐	A regulatory requirement	☒
For assurance	☒		

Purpose of the Report

This report is to provide assurance to the Board that the Trust is compliant with the Health and Social Care Act (2008) in relation to infection control practices. The report highlights the evidence and gaps associated with the infection prevention and control board assurance framework (IPCBAF). The IPCBAF uses the Health and Social Care Act (2008) as its guide for assessing practice in relation to the COVID-19 pandemic.

Executive Summary – Key Points

The Trust has adopted NHSE/I Board Assurance Framework and assessed compliance against the key lines of enquiry. A RAG rated approach has been used to assess the ten key lines of enquiry:

- Six out of ten key lines are RAG rated as green – compliant
- Four out of ten key lines are RAG rated as amber – compliant with appropriate mitigations
- There are no key lines of enquiry RAG rated as red – non compliant

The IPCBAF is re-assessed on a quarterly basis by the IPC Quadrumvirate team and any changes are documented. The ability to maintain social distancing remains a significant risk to compliance for the Foundation Trust. Ventilation remains a specific issue for the Foundation Trust and this is being assessed by the Trust's Ventilation Committee.

Recommendation

The Quality Committee is asked to accept this report as assurance that appropriate IPC practice is being maintained and that the IPCBAF is used to monitor this on behalf of the Trust Board.

Author:
Paul Rafferty - Deputy Chief Nurse
Director Sponsor: Heather McNair - Chief Nurse

Date: 26 May 2021

1. Introduction and background

NHS England published an Infection Prevention and Control board assurance framework (Appendix 1) for Trust boards to provide assurance that their approach to the management of COVID-19 is in line with PHE infection prevention and control (IPC) guidance, and that risks have been identified and mitigated.

The framework is structured around the Health and Social Care Act (2008) Code of Practice for the prevention and control of infection. The framework focuses on the ten key elements of the act and is broken down into several key lines of enquiry (KLOE).

2. Approach

The IPCBAF is not a compulsory framework however the Trust agreed via the Director of Infection Prevention and Control (DIPC) meeting that it would be used to assess compliance and provide assurance with the recommended practice in relation to COVID-19.

The IPCBAF has been reviewed by the Deputy DIPC, Deputy Chief Nurse for Infection Prevention and Control (IPC) and the Lead Nurses for IPC. A RAG rated scoring matrix has been developed to demonstrate areas of compliance and gaps. The IPCBAF is reviewed quarterly and updated accordingly. Assurance has been provided via the Trust's command and control structure and the Trust Infection Prevention Steering Group that it has been adopted and implemented into IPC practice.

3. Compliance Matrix

Section	1	2	3	4	5	6	7	8	9	10
RAG										

Key	
	No identified gaps.
	Identified gaps with appropriate mitigations in place or being implemented.
	Identified gaps with no appropriate mitigations.

4. Current position – gaps narrative

Section one received an amber rating due to the following:

- No audit process currently in place to monitor compliance with assessment at the front door. This is now in development to incorporate into C. To mitigate this staff are asked to report any breaches via the Datix incident reporting system to ensure that this is recorded and immediate learning takes place.
- Daily quota of supply kits for Abbott machine does not currently meet demand, to counter this a lab PCR test would be undertaken when demand outstrips supply.

Section three received an amber rating due to the following:

- Increased use of antimicrobials in Scarborough, the Trust is implementing the ARK antimicrobial project on the Scarborough site in June 2021. This will raise awareness and has associated audits to assess the impact of this project.

Section five received an amber rating due to the following:

- The Trust's inability to consistently maintain social distancing across all sites and clinical areas. The Trust has implemented a quality impact assessment which is led by Care Groups with a range of mitigations to counter this issue. The issue is assessed on a daily basis in operational command meetings and escalated as required. Where appropriate and safe to do so wards flex their beds to manage surges in demand, this includes de-escalating flex beds as soon as possible.

5. Appendix One

Publications approval reference: 001559

Infection prevention and control board assurance framework

V1.6 – reviewed May 2021 (Next review September 2021)

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	Booking questions in ED are embedded in practice to identify any patients who may pose a risk of infection New Covid screening poster.pdf ED booking in screening quesions - 1 Rapid testing using the Abbott ID machine is being set up in ED and/or admissions units at both acute hospital sites. Patients are moved from the red admission wards when the results are known and it is challenging operationally to keep patients in one place until they get 2 negative swabs There has not been a requirement to cohort COVID and non-COVID patients	There are no processes in place to monitor compliance with assessment at the front door Daily quota of supply kits for Abbott machine does not currently meet demand	Datix reporting for any breaches. ED working on a solution with IT to record that screening questions have been asked. Those unable to run through Abbott machine undergo a lab PCR test

• that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance. • monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice ○ staff adherence to hand hygiene?	Weekly COVID-19 precautions audits are embedded within the 'Perfect Ward' electronic application system to monitor adherence to IPC precautions for COVID-19 Synbiotix cleanliness audits assist in identifying areas of low compliance with cleaning. Escalation is through TIPSG to Executive Board		
○ staff social distancing across the workplace ○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical ▪ b) non-clinical setting • monitoring of staff compliance with wearing appropriate PPE, within the clinical setting consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Daily IPC clinical visits encompass spot checks of compliance to all COVID-19 precautions with feedback provided to staff in real time Care Group performance dashboard is shared at the CG Quality Committee meetings as escalation  ED booking in screening quesions - :  goggle and mask poster.pdf Posters to remind staff about		

	wearing PPE is displayed in clinical areas		
• implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace • additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team. • training in IPC standard infection control and transmission-based precautions are provided to all staff	All patient facing staff have been offered the opportunity to have LFT kits - these were replaced by LAMP (Loop-mediated Isothermal Amplification) technology in May 2021. The See and Swab service is established to swab asymptomatic staff during outbreaks, staff with positive LFTs and symptomatic staff who are referred by their managers https://www.yorkhospitals.nhs.uk/seecmsfile/?id=5179 The power point presentation of the clinical training is available on request (File size > 30,000KB) The Clinical IPC training presentation has been updated with emphasis on COVID precautions and standard and transmission based precautions		

• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training • all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • national IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to national guidance are brought to the attention of boards and	Information for staff regarding donning and doffing is available on the trust intranet. https://www.yorkhospitals.nhs.uk/covid-19/ppe-guidance/  Donning and Doffing Course Completions 2 Training continues to be provided to staff by the Clinical Skills team and Clinical Educators  Sanistation poster v1.pdf  goggle and mask poster.pdf  protect eyes wear mask space p...  20210125_Patients social distancing post The COVID-19 SILVER Staff Officer is responsible for checking the emergency planning inbox 'in hours' and the 1st on call manager checks the inbox for anything urgent 'out of hours'		

any risks and mitigating actions are highlighted • risks are reflected in risk registers and the board assurance framework where appropriate	Changes to national guidance is through the trust Command route –Silver to bronze and escalation to Gold The Board Assurance Framework is reviewed monthly alongside the Risk Register to identify any gaps in assurance; to then escalate to the risk register and updates and assurances shared with the Director of IPC at the monthly DIPC meetings. Further escalations of the BAF are made through the Command route (Silver and Gold).		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Respiratory staff with appropriate training in NIV are allocated to care for patients who require NIV on the red wards. Staff caring for suspected and confirmed COVID-19 patients are appropriately fit tested for use of FFP3 masks and trained in Donning and doffing. Compliance of training is kept by the Health and Safety Team		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Staff training in donning and doffing and use of PPE includes domestic staff		

• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	The IPC COVID guidelines are updated in line with national guidance and accessible on the trust intranet https://www.yorkhospitals.nhs.uk/seecmsfile/?id=5421		
• Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	Domestic cleaning records are checked and signed off by domestic supervisors		
• increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	The trust Standard Precaution guidelines have been updated to reflect requirements for decontamination of the environment during COVID  CAS briefing note for QS - IPI...		
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is	A trial of Tristel disinfectant has been carried out in COVID red areas. Consultation with the Microbiologists was carried out prior to the trial		

effective against enveloped viruses • manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance • 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily • rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance	 COVID-19_Infection_prevention_and_cor The CAS alert in response to the new variants received in December 2020 was disseminated via the command and control structure in the Trust and a request for completion was logged at silver command. A clinical response to this was implemented at Care Group level led by the ward teams.  SOP.DOC An SOP for cleaning electronic equipment is accessible on the trust. This is used in conjunction with the COVID IPC guidance		

and the appropriate precautions are taken • single use items are used where possible and according to single use policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment • ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air • monitor adherence environmental decontamination with actions in place to mitigate any identified risk • monitor adherence to the decontamination of shared equipment with actions in place to mitigate any Identified risk	Management of linen is captured in the COVID IPC guidance and in the trust IPC guidelines for management of infections Guidance on equipment used on patients is accessible on the trust intranet within the COVID IPC guidance and in the trust IPC guidelines Synbiotix cleaning scores provide assurance of cleaning using the RAG rating monthly and fed back to areas Monthly Audits on cleanliness of reusable equipment (e.g. commodes) conducted by IPC with results uploaded to Care Group dashboards and feedback via the Quality Committee meetings		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship is maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Production of guidance to treat pneumonia associated with Covid, including Remdesivir (and then Remdesivir retraction in line with NICE) and Tocilizumab. (Available on request) Audit of Gentamicin, Aztreonam and vancomycin prescribing. Vancomycin monograph SBAR for linezolid safety IV oral switch campaign Action plan for Scarborough COTE for antimicrobial reviews Audit of severe and catheter related urinary tract infections Audit of orthopaedic prophylaxis Expanded use of OPAT Quarterly board report Monthly Care group report including suggestion for improving stewardship.	Still increased use of antimicrobials on theScarborough compared to York	ARK implementation at Scarborough – Commences 1st June 2021. Reports will be produced on a weekly basis to monitor impact on the baseline stop rate for antimicrobials New post of Deputy medical director for the east coast appointed. The role will provide additional senior medical leadership on site to improve quality issues (such as antimicrobial stewardship) In Jan 21 Antimicrobial consumption for CG2 had fallen by 38%. Awaiting a new data refresh in June ’21.

			All Care groups have personalised AMS objectives assigned to them The care groups are challenged on the objectives in the CG quality and safety meetings. They are also discussed in the monthly care group medicines optimisation report. Quarterly board report produced by pharmacy.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	National guidance implemented with screening questions applied for all visitors, appropriate PPE is provide for visitors and IPC checks put in place to allow a safe working space for staff		
• areas in which suspected or confirmed COVID-19 patients are being treated are clearly displayed with appropriate signage and have restricted access	Posters displaying Covid status of ward (Red, Amber or Green) available for each ward to utilise		
• information and guidance on COVID- 19 is available on all trust websites with easy read versions	Information available on Trust's website		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Infection Alerts added on CPD to aid communication. Also see:  IPC Discharge - Stepdown and discha (Updated 21/02/21)		

• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Posters in all clinical areas to highlight information to visitors and staff to comply with hands, face and space advice. IPC have developed "What posters do you need" for all clinical areas.		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 cases to minimise the risk of cross-infection as per national guidance • staff are aware of agreed template for triage questions to ask • triage undertaken by clinical staff who are trained and competent in the	Daily screening all inpatients in place. If a patient developed a pyrexia above 37.8C a trigger was added to our e-observations solution to instigate a patient assessment to review the patient and check if they have symptoms of COVID-19. This is outlined in the below document:  IPC SOP_ Identification of Covi (Updated 15.02.21) Departmental SOP's in place for Triaging of patients and their placement available on Intranet. Also information available in "York Teaching Hospital – COVID-19: Infection Prevention and Control Guidance Version 1.5" available below:		

clinical case definition and patient is allocated appropriate pathway as soon as possible • face coverings are used by all outpatients and visitors • face masks are available for all patients and they are always advised to wear them • provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care • monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	COVID-19_Infection _prevention_and_cor (Updated 21.01.21) Hygiene stations available at main entrances at both main hospital sites that include a supply of face coverings. These stations also reinforce the national “Hands, Face, Space” messaging. See image below:  Masks are available at all reception desks and in wards and departments. Patient’s face mask compliance on in-patient areas are monitored via Covid-19 ward audit Posters on display in bay areas regarding mask usage by patients where appropriate. Compliance with the social distancing of patients is	The social distancing of in-patient beds, remains a challenge and is relaxed at times due to operational pressures. This is in order to manage and minimise the risk across the whole organisation with patients	Mitigations (E.g. face coverings for patients, curtains drawn) in place for when social distancing I not achievable.

• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. • to ensure 2 metre social & physical distancing in all patient care areas	monitored by care groups and also included on IPC Covid audit In areas where the social distancing of patients has not been able to be achieved a quality improvement document has been produced with appropriate mitigations in place (Quality Improvement Documents available upon request) Footfall is minimised in areas where the social distancing of patients is not achievable The Trust's IPC principles for recovery planning document addresses the IP requirements prior to an elective or non-elective service restarting.  IPC principles for recovery planning v2. Where a patient or a member of Staff member is swabbed and has been processed by the Trust Laboratory (Not pillar 2); the result will be shared with Occupational Health and the IPC team. The (internal) track and trace team; which will form	awaiting admission to the Trust. Trust Board aware of this issue. Remote community sites where YHFT owned the building but multiple Trusts operated different services continues to be a Challenge.	De-escalation of social distancing beds used is enacted as soon as possible and discussed at daily operational meetings. IPC nurses have visited 30 + of our community sites and offered support

• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	part of the Occupational Health function will be notified and will commence the tracking and tracing of potential contacts within the Trust environment with the assistance of the IPC team. Issues arise when a member of staff is tested at a pillar 2 site Also see:  IPC SOP_ Identification of Covi (Last updated 15.02.21) Compliance with day 3 and 5-7 testing this is available on Signal (Trust's live dashboard). Data are updated every 3 minutes. Rates of screening compliance are reviewed at Bronze level. Compliance spreadsheets available upon request.	Compliance with routine testing runs at 70-80%. Work is ongoing to improve this at Bronze command level.	Staff, whenever possible, are strongly encouraged to get Tested via the Trust when appropriate (Pillar 1 testing).

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	3 clear pathways (Red, Amber and Green) exist throughout the Trust for elective, non-elective and outpatient patients. These utilise all sites. Operational SOPS available via: York Teaching Hospital NHS Foundation Trust - Covid-19 (yorkhospitals.nhs.uk) (Last updated March 22nd 2021) Checklist for the restating of services (Completed by IPC) utilised to incorporate appropriate measures to minimise contact between pathways (See embedded document below)  IPC Checklist for Restarting Services in	Elective requiring ongoing postoperative inpatient care have to be admitted to an amber ward to ensure they receive appropriate specialist care.	

• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it. • a record of staff training is maintained • adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk • hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:	Staff caring for suspected and confirmed COVID-19 patients are appropriately fit tested for use of FFP3 masks and trained in Donning and doffing. Compliance of training is kept by the Health and Safety Team. **As of 25/03/21 12,371 members of staff have been fit tested across the Trust.** PPE Donning & Doffing posters updated and available via Intranet Weekly COVID-19 precautions audits are embedded with the 'My perfect ward' electronic application system to monitor adherence to all IPC precautions for COVID-19 (this includes PPE) PPE adherence also audited by IPC IP audit tool – COVID-19 Covid audit (April 2020).xlsx Hand Hygiene posters audited on the weekly 'My perfect ward' electronic application "Cough it, Bin it, Kill it" posters in clinical areas		

○ hand hygiene facilities including instructional posters ○ good respiratory hygiene measures ○ staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care ○ staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace ○ frequent decontamination of equipment and environment in both clinical and non-clinical areas ○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand hygiene and observe standard infection control precautions	Staff social distancing audited on the weekly 'Perfect ward' electronic application. Regular communications sent out to all staff via staff bulletin. Example from Nov 2020: http://staffroom.ydh.yha.com/communications/uploaded-files/StaffBrief_November2020_Briefingpack.pdf High touch points cleaned QDS Communal toilets cleaned QDS Monitored via internal audits, external company (Synbiotics) and within care groups – inc. walk arounds. Care groups have confirmed their compliance with the "SARS-CoV-2 virus new variants of concerns CAS alert" – which includes increased frequency of decontaminating equipment and the environment. Response to alert can be found here:  CAS briefing note for QS - FINAL.docx (Updated 01/04/21) **See Section 5** Hand Hygiene audited monthly at ward level. Also audited via Covid-19 IPC audit and the "Perfect ward' application		

• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	All hand dryers have been removed from non-clinical areas that had them (Or have been turned off awaiting removal) . There are no hand dryers in clinical areas		
• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	**See Section 5**		
• staff understand the requirements for uniform laundering where this is not provided for on site	Appearance and Uniform policy in place and monitored by matrons and ward managers re: laundering uniforms at home  Appearance and Uniform Policy v5 May		
• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	Staff briefed regularly regarding COVID symptoms. Also messaging via staff bulletins		
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases	Rates monitored through surveillance program (IPT) and also via Bronze, Silver,		

(staff and patients/individuals) • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported. • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	Gold command structure. The IP team monitor for outbreaks of COVID-19. Covid-19 outbreaks managed as per appendix 9 of outbreak SOP:  ICP Guidelines - Management of outbr (Updated for Covid-19 July 2020) To date, 27 COVID-19 outbreaks have been reported via the national portal All outbreak meetings are minuted.		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms	3 clear pathways (Red, Amber and Green) exist throughout the Trust for elective, non-elective and outpatient patients. These utilise all sites. Operational SOPS available via: York Teaching Hospital NHS Foundation Trust - Covid-19 (yorkhospitals.nhs.uk) (Last updated March 22nd 2021) Compliance with appropriate signage monitored weekly via the 'My perfect ward' electronic application system and also IPC Covid-19 ward audits. Identified negative pressure machines are prioritised for patients receiving AGPs in dedicated areas of the Trust with adequate ventilation. All new admissions are treated as high risk for COVID and isolated until a swab result is obtained on both main hospital sites	Some bays in wards around the Trust have less than the recommended 6 air changes per hour. These areas are not used for "Red" pathway patients.	An additional 6 side rooms have been constructed, and are in use, at York utilising former office space A new modular ICU build at York is currently under construction to provide an addition 6 critical care beds with centrally adjustable ventilation 11 side rooms have been created on Ann Wright ward at Scarborough hospital and are in use. This was from converting the former ward space. An additional 12 side rooms have been created on Haldane ward at Scarborough hospital (Former closed ward space) but are currently not open due to staffing.

are managed according to local IPC guidance, including ensuring appropriate patient placement	Placement of patients with Non-Covid alert organisms are managed via IPT and the bed management teams utilising the IPT Hospital' s Transmission Based Precautions guidelines available via: Transmission Based Precautions v2 (9).pdf (yha.com) When suitable isolation of other alert organisms is not achievable these are reported via the Trust's Incident reporting system (Datix) and investigated appropriately.		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Competencies in place for staff who perform testing Testing SOP's available via Inranet and via this link: https://www.yorkhospitals.nhs.uk/seecmsfile/?id=4682 From May 2021 onwards, all asymptomatic staff will be offered LAMP(Loop-mediated Isothermal Amplification) testing. Once in place this will replace the Trust's lateral flow test swabbing for staff. Details on staffroom. COVID-19 Staff & Family Members Swabbing Service SOP (last update Feb'21) available via: Microsoft Word - SOPCOVID-19%20Staff%20%20Family%20Members%20Swabbing%20Service%20-%20Version%2016%20NR%20Feb%2021.docx (yorkhospitals.nhs.uk)		

• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Covid-19 Testing subgroup meets and monitors key performance indicators – such as turnaround times. Issues escalated via Control and Command Structure	
• screening for other potential infections takes place	Labs continue to screen for other infections. Excel spreadsheets available if required to demonstrate screening is taking place.	
• that all emergency patients are tested for COVID-19 on admission. • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	Identification of COVID-19 cases in hospital inpatients SOP - Last update 15/02/21 (includes details of Inpatient testing on non-elective admissions, day 3, day 5-7 and discharge testing) https://www.yorkhospitals.nhs.uk/seecmsfile/?id=5071 Compliance with testing reported weekly via informatics directly to care groups and monitored via command and control structure.	

	Daily prompts on CPD are in place to aid staff with the daily screening of Inpatients for Covid-19 symptoms	
• that sites with high nosocomial rates should consider testing COVID negative patients daily.	The outbreak control group for individual wards/departments with Covid-19 outbreaks would review need for testing of asymptomatic patients on a daily basis in collaboration with the testing subgroup.	
• that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	Guidance for stepdown of IPC precautions and discharge of COVID-19 patients (Last updated 22/02/21) in place to aid management (Including testing) of patients who are being discharged to a care home. Available via: Microsoft Word - Stepdown%20and%20discharge%20guidance%20V6.1.docx (yorkhospitals.nhs.uk)	
• that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation	Patients within their 14 day isolation period are only discharged to a designated care setting (unless a home setting)	

• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	Please see the below SOP:  SOP managing positive swabs elecive (Last updated 2/12/20)	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Changes to IPC Covid policies are communicated to staff via Gold, Silver & Bronze command structure Latest Version of Covid-19 SOP (dated 25th January 2021), including PPE guidance, available on Intranet under Covid "Hot button" via the following link: York Teaching Hospital NHS Foundation Trust - Standard operating procedures and clinical guidelines (yorkhospitals.nhs.uk) All other non-Covid IPC policies available via: Infection Prevention and Control (IPC) — York NHS Staff Room (yha.com) All non-Covid-19 IPC policies have undergone review to update. As of 23/03/21, 4 policies are post, or close to, review date but there is a road map to get these updated.		

	Changes to the PHE national guidance on PPE are monitored via the wider IPT team via automated email alerts from PHE when a policy is updated. These are then briefed through the command and control structure with additional communications via staff bulletins plus IPT visits to individual ward areas affected. The Clinical Skills Team Trust-wide are utilized for significant changes to PPE guidance. PPE/Donning & Doffing posters updated and available via Intranet Weekly COVID-19 precautions audits are embedded with the 'My perfect ward' electronic application system to monitor adherence to all IPC precautions for COVID-19 (this covers PPE and waste management) Waste management forms a part of the IPC Covid SOP and is available via the Covid "Hot" button on intranet. This has been developed with guidance from the Waste management team.	
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance		

• PPE stock is appropriately stored and accessible to staff who require it	PPE stores available on both main sites with satellite units for community sites. Newly refurbished PPE store opened in October 2020 on York site. Procurement have an e-mailing ordering process with escalation plans for acute issues. Stock checks completed daily at height of the pandemic.	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	Risk assessment is in place for at risk groups. Occupational health maintain a database of risk assessments  Covid-19 Health Risk Assessment Nov 202((Last updated November 2020)		
• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	The Trust has a comprehensive well-being programme available which is available through the Trust Intranet site (Staff-Room)		

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally • staff who carry out fit test training are trained and competent to do so • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Staff are trained in accordance with National guidance and a training log is maintained as with FFP3 mask fit Testing The Trust now has a fit test instructor who trains the staff responsible for fit testing. All staff are fit tested to the type of mask they are wearing. As new models of FFP3 mask have become available, staff have been invited in again to undergo further fit tests. Staff are now going through the process of being invited in again to undergo a further fit test to ensure all staff have a choice of at least 2 different types of FFP3 masks.		

• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	A fit test certificate is given to every staff member for every fit test undertaken. They also have the result uploaded electronically to their learning hub account which they can access at any time. This is their copy and a record is held centrally within the organization so reports can be run.		
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	The report that is run centrally has all fit tests which includes multiple fit tests for employees over the last year. All staff will take a way a certificate either pass or fail on a FFP3 mask.		
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	Please see the Trust's redeployment policy:  Redeployment policy v5 May 15 - Jan 21 -r		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	Documented discussions surrounding Covid-19 risk assessments are shared with the employee and are kept in personal files		
• following consideration of reasonable			

adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Current numbers on fit tests are at: • Passed fit tests 12394 • Failed fit tests 2298 • Total fit tests 14692  Number of tests.xlsx  Passed tests.xlsx  Qualitative Fit Test Report V2.docx		

• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Movement between wards is reduced through careful planning by the matron team. Staff are moved in 2 week blocks to support areas rather than on a daily basis to prevent frequent changes. Staffing ratios have been reviewed in light of reduced bed capacity, which enables staffing to be consistent. Almost all staff have now returned to their usual places of work now that the surge has eased.	There will be occasions where staff sickness/unplanned absence results in moves of staff between wards. This is managed by the matrons and clinical directors on a daily basis.	
• all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	Comprehensive guidance has been developed in line with National Guidance and is available on the Trust Intranet. Which also contains a full range of posters that are on display around the hospital Desks have been rearranged to ensure 2m rule is adhered to. The loss of desk space is mitigated by home working arrangements. Break out areas have all been		Posters are on display across the hospital, security remind staff and patients in public areas regarding the use of masks. Peers take responsibility for reminding each other and managers are equally ensuring constant reminders. Reminders are also in on the computer

	assessed in relation to how many people can safely social distance in them at any one time. This informs the staggering of breaks. In addition given reduced bed capacity due to social distancing the staff: patient ratios have been reviewed which further enables reduced numbers to be in break out spaces.		screensavers Staff are using additional space and outdoor spaces during the summer months. The challenge is greater during inclement weather when outdoor space is not feasible. The canteen areas are staff only which has enabled social distancing to be enacted while providing a comfortable relaxing environment
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	A daily report of staff absence is circulated to all managers and executives and monitored through the Integrated Board Report		
• staff who test positive have adequate information and support to aid their recovery and return to work	A comprehensive staff wellbeing offer is on the Trust Intranet with a strong emphasis on psychological support, given the significant impact that COVID has had from a trauma perspective Occupational Health Manage all test results. Each individual case is risk assessed and given		

	appropriate advice in line with their needs. Return to work is carefully managed in line with residual symptoms and ongoing health needs		

CQC Benchmarking Assessment (IPC - Well Led)

Key Line of Enquiry (KLOE)		Assurance Requirement	Supporting Evidence	RAG Rating	Subsequent Actions Required
Leadership	W1: Is there the leadership capacity and capability to deliver high quality, sustainable care?	W1.1:Does the trust have sufficient leadership capacity for IPC? (i.e. management time and competency?) at executive team level and at IPC team level?	The DIPC is the Chief Nurse The Deputy DIPC is also the IC Doctor/microbiologist The Deputy Chief Nurse is alighned to the IPC management 2 IPC Lead Nurses for the trust		
Leadership	W1: Is there the leadership capacity and capability to deliver high quality, sustainable care?	W1.2: Are leaders addressing the most significant IPC challenges? Do they have an impact at service level?	Current IPC challenges are COVID-19-addressed via the trust command chain where IPC is represented C.difficile-Weekly C.difficile meetings chared by the Deputy DIPC or the Deputy Chief Nurse		
Leadership	W1: Is there the leadership capacity and capability to deliver high quality, sustainable care?	W1.3: Have leaders self-assessed the trust's governance of IPC against the criterion in the IPC code of practice?	the DIPC reports IPC matters including cleanliness to Board. The Deputy Chief Nurse for IPC oversees the strategic IPC work and escalates to the DIPC the IPC Lead nurses manage the operational side of IPC and escalates strategic matters to the DCN of IPC		
Vision & Strategy	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?	W2.1: Does the trust have a clear vision and strategy for continuously improving its IPC practices? Do these take into account future service developments?	Development of a bussiness case for ICNET to improve service delivery in IPC has been included to the 2021/22 annual plan		Awaiting for the lab IT system to be developed to be able to interface with ICNET Business cae to be developed
Vision & Strategy	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?	W2.2: How has the trust implemented the HSIB report on COVID Transmission in Hospitals recommendations?	Clear designated areas for red patients Staff testing was initiated through lateral Flow testing to identify early any asymptomatic staff Staff fit testing was carried out by a dedicated team from Health and Safety and training in PPE undertaken by the Clinical Skills team IT technology has been adopted to reduce face to face meetings IT services have enabled staff to work from home to avoid overcrowding and sharing work spaces Social distancing of beds in clinical araes remains a challenge due to increasing demand on services. Quality Impact Assessments have been developed with mitigations where social distancing cannot be achieved		Ventilation remains a challenge in the older buildings although mobile units of Air Handling Units were used for hugh risk red areas and for Aerosol Generating Procedures (AGPs)
Vision & Strategy	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?	W2.3: How does the trust ensure that the IPC priorities are understood by staff and integrated into its wider strategy and service plans?	IPC representation within the trust command chain (daily Bronze meetings and monthly Quality Committee meeting for Care Groups) Trust communications through the staff bulletin for any matters of priority that need dissemination		
Vision & Strategy	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?	W2.4: Is there a strategy in place for antimicrobial stewardship within the Trust?	Antimicrobial Stewardship team reporting to the Trust Infection Prevention and Control Steering Group (TIPSG)		ARK initiatives partly rolled out across the organisation. This is planned for 2021/22
Vision & Strategy	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?	W2.5: Do other trust plans take account of IPC priorities, for example do the trust's asset and facilities management plans support IPC improvements?	IPC representation at PLACE, Water Safety, Ventilation steering group and Decontamination Group and escalation from the groups to TIPSG IPC risk assessments required for any capital/Estates work		Operational demand and capacity impedes on initiatives such as decant programs to facilitate terminal cleanes and HPV. Identification of priority areas for terminal cleans and HPV with refurbishment work carried out for 2021/22
Vision & Strategy	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?	W2.6: How does the IPC strategy/action plan align with joint working with partners in the wider health and social care economy to manage COVID 19 and other risks?	IPC Lead Nurses are members of the NEY IPC Lead forum Regional meetings and outcomes are shared through the trust command structure		
Vision & Strategy	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?	W2.7: Is progress against the IPC action plan monitored and reviewed? Is this reported?	The Board Assurance Framework is reviewed and shared with the DIPC and escalations made to Excutive Board		

Culture	W3: Is there a culture of high-quality, sustainable care?	W3.1: Are staff supported in raising concerns about IPC?	Datix system for reporting IPC enquiries email address monitored daily IPC mandatory training encourages staff to challenge and report poor practice		
Culture	W3: Is there a culture of high-quality, sustainable care?	W3.2: How robust and open is the trust's safety culture to support good IPC practices?	Quality and Safety (Q&S) meetings held weekly to discuss incidents Monthly IPC reports presented at Q&S with any adverse incidents reported at the meeting weekly Datix reporting is encouraged and promoted		
Culture	W3: Is there a culture of high-quality, sustainable care?	W3.3: Is the culture centred on the IPC needs of patients and visitors?	The trust vision emphasises that the patient is at the centre of evrything we do Post Infection Reviews have been intergrated into the Datix system to provide standrad method of investigating and leaning from incidents		
Culture	W3: Is there a culture of high-quality, sustainable care?	W3.4: Are there special arrangements to promote staff physical and mental wellbeing during the pandemic?	Staff Matters, COVID Bulletin produced by the Communications team highlight staff wellbeing services Staff risk assessments produced by the Health and Safety team to identify and take approriate meausres for vulnerable staff		
Culture	W3: Is there a culture of high-quality, sustainable care?	W3.5: Has the trust adequately risk assessed and taken measures to protect clinically vulnerable groups of staff and those at higher risk because of their protected characteristics (different ethnic groups, physical and learning disabilities, autism, mental illness)?	Staff risk asessments have been developed by the Health and Safety team Appropriate PPE such as FFP3 respirators have been provided to enable clinically vulnerable staff to work in clinical areas Staff that can work from home have been facilitated to do so		
Culture	W3: Is there a culture of high-quality, sustainable care?	W3.6: Do staff work cooperatively and constructive across teams on IPC issues?	Care Group Quality Committee monthly meetings have IPC as a standing agenda and any IPC issues are highlighted		IPC environmeantal audits are being planned to resume in June 2021. Escalation of actions and recommendation will be through the Datix reporting system to ensure a trial and tracking of actions
Governance	W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?	W4.1: Are there effective structures, processes and accountability to support standards of IPC including managing cleanliness and a suitable environment?	Synbiotix cleaning scroes are shared through the monthly IPC report to Board Weekly 'My Perfect ward' audits are conducted by the ward namagers with results visible to IPC via the app. Issues of concern are escalated to TIPSG There is a gap in assurance for self-asessed audits		The first 'My perfect ward' peer audits were conducted in April 2021 IPC environmental audits will provide further assurance and engaement with clinical areas
Governance	W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?	W4.2: Do all levels of IPC governance and management interact with each other appropriately and effectively?	The Water Safety, Ventilation and Decontamination groups report into TIPSG		A Cleaning Standards group is in the process of being formed to highlight any issues of cleaning and other environmental issues and escalation wil be through TIPSG
Governance	W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?	W4.3: Do staff understand their roles regarding IPC? Has the organisation developed an effective and inclusive approach to ensuring guidance and policies are up to date, understood and practical for staff?	Notifications of policies and guidelines that require revising are made by the Trust Healthcare governance team		The IPC 2021/22 annual plan includes intiatives to form a guideline and policies group within the IPC team to ensure deligence and timely review of all documents
Management of Risks, Issues and Performance	W5: Are there clear and effective processes for managing risks, issues and performance?	W5.1: Is there a comprehensive and robust assurance system for IPC which enables performance issues and risks to be addressed? How regularly is this reviewed?	The IPC risk register is embedded within the Trust Datix system		Review of the register is scheduled to take place quartely by the IPC Lead Nurses, the IC doctor and the Deputy Chief Nurse for IPC

Management of Risks, Issues and Performance	W5: Are there clear and effective processes for managing risks, issues and performance?	W5.2: Does the trust audit IPC processes and ensure that the learning improves IPC quality?	Weekly catch up meetings are held with the IPC Lead nurses, the Deputy Chief Nurse for IPC and the IC doctor to discuss any issues of immediate attention Monthly IPC team meetings to discuss progress and review practices within the team Monthly IPC meetings with Consultant microbiologists to discuss complex IPC issues and ratify IPC guidelines IPC policies are ratified at TIPSG		
Management of Risks, Issues and Performance	W5: Are there clear and effective processes for managing risks, issues and performance?	W5.3: What processes does the trust have to identify and treat people who have or are at risk of developing an infection so that they don't infect other people?	Alert system for patients who have conditions that can be transmitted to others are placed on the Core Patient Database to ensure identification and appropriate mangement of these patients		
Management of Risks, Issues and Performance	W5: Are there clear and effective processes for managing risks, issues and performance?	W5.4: Does the trust have an effective system to manage and eliminate nosocomial transmission?	Guidelines and policies are accessible via the trust intranet. The standard precaution gudeline promotes prompt isolation of infected patients and cohort where single rooms are unavailable.The hand hygiene policy promotes the 5 Moments for hand hygiene with asurance obtained through hand hygiene audits		
Management of Risks, Issues and Performance	W5: Are there clear and effective processes for managing risks, issues and performance?	W5.5: Is there oversight of risk in all of the buildings including corporate and public areas? For example, the education centre?	Health and Safety work place risk assessments. During the COVID pandemic non-clinical areas have received a risk assessment for safe working and to reduce transmission of COVID		
Management of Risks, Issues and Performance	W5: Are there clear and effective processes for managing risks, issues and performance?	W5.6: How does the trust identify patients at increased risk of COVID (for example communities of different ethnic groups, people who might need reasonable adjustments and people with pre-existing conditions) and mitigate risk, tailoring treatment to the individual? (this is a legal requirement)	Risk assessment is in place for staff in at risk groups. Occupational health maintain a database of risk assessments. Departmental SOPS in place to mitigate risks for patients. Specific cases advised on as and when e.g. recent example of working with safeguarding team for a plan for when a patient with LD was coming to the Trust for an elective procedure		
Management of Risks, Issues and Performance	W5: Are there clear and effective processes for managing risks, issues and performance?	W5.7: How does the trust use equipment to control the risk of nosocomial infection? For example, ventilation, technology, PPE, uniforms.	Use of Loop-mediated Isothermal Amplification (LAMP) testing to identify early any asymptomatic staff. Replaced lateral Flow testing. Ventilation steering group triage requests for improved ventillation and provide solutions to improve air flow/air changes per hour Detailed guides on PPE usage and correct donning and doffing methods. Assisted by clinical skills team to deliver training to staff Standard operating procedure for the control of Covid-19 includes section on single use and shared equipment.		
Management of Risks, Issues and Performance	W5: Are there clear and effective processes for managing risks, issues and performance?	W5.8: Has finance ever been a constraint when planning effective IPC or obtaining IPC consumables? What happened?	No particular issues raised during pandemic. Examples of prompt finance being obtained include the conversion of 2 wards at SGH into 100% siderooms and a further major capital project to create 6 additional siderooms on the York site		
Information Management	W6: Is appropriate and accurate information being effectively processed, challenged and acted on?	W6.1: Does the trust use valid, timely, reliable and relevant measures for IPC? Does it take timely action on nosocomial and other infections? Are there clear and robust IPC measures?	Active surviellance in place - monitoring for a variety of health care associated infections including laboratory and microbiology support 24/7 microbilogy support and IPC advice service 7 days (9-5) a week Numerous IPC policies in place and currwently under review. As of 11/05/21 only 3 remain out of date with a road map to update in place.		
Information Management	W6: Is appropriate and accurate information being effectively processed, challenged and acted on?	W6.2: How does the trust ensure that IPC data quality is reliable?	2 Infection Prevention Team Audit & Surveillance Coordinators in place Data reviewed during process of Monthly reports to Quality committee Scrutiny at Quality committee, Trust Infection Prevention Steering Group		

Information Management	W6: Is appropriate and accurate information being effectively processed, challenged and acted on?	W6.3: How are information technology systems used to share, monitor and report on IPC information to improve the quality of care?	Trust has an Electronic system for observations, infection alerts, document storage, nursing handovers etc. Prompts on this system exist for screening e.g. if a pyrexia is recorded it prompts staff to screen for Covid-19		Business case to be developed for ICNET once new regional lab IT system in place
Information Management	W6: Is appropriate and accurate information being effectively processed, challenged and acted on?	W6.4: How is information shared about IPC history when referring, admitting, transferring, discharging and moving service users within and between health and adult social care facilities?	Information shared by referring area Discharge letters automatically generated with infection alerts		Trust is part of a region wide project for a combined laboratory system meaning appropiate information can be shared in a timely fashion between healthcare organisations
Information Management	W6: Is appropriate and accurate information being effectively processed, challenged and acted on?	W6.5: Are IPC Plans in place for patients who need them? Are records clear, accurate and up to date?	IPC team review appropiate patients (e.g. those with C.Diff) on a regular basis with a plan of care. More work to be done around care plans		Review current care plans and update - Project commenced May 2021 to update care plans
Engagement	W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?	W7.1: Does the trust use staff and public views to improve IPC practices?	Friend and family feedback includes any IPC issues Regular attendance by IPC at various staff forums		IPC Champions project being launched to improve staff engagement
Engagement	W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?	W7.2: What does it do to encourage feedback from underrepresented communities or groups, for example for example different ethnic groups?	Trust's Fairness Forum meets Quarterly Trust performs Equality Analysis in Line with Department of Health guidance Equality and Freedom to speak up champions in place Trust Race Equality Network in place Annual equality and inclusion report produced		
Engagement	W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?	W7.3: Does the trust communicate it's IPC performance, for example information about outbreaks, to staff and the public? How?	Daily updates of outbreaks and closed areas are sent out by the IPC team At York site a TV screen at the front entrance highlights areas with outbbreaks The Trust intranet is populated with information regarding any outbreaks and restricted areas due to infection		
Engagement	W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?	W7.4: How does the trust communicate IPC changes to staff and the public? Does it do this in a variety of formats?	Daily operational meeting by care groups Covid-19 e bulletin's Allocation of IPN to individual care groups Close working with PHE and CCG		
Learning, Continuous Improvement and Innovation	W8: Are there robust systems and processes for learning, continuous improvement and innovation?	W8.1: How does the trust promote a continuous improvement culture around IPC?	Post infection reviews held - ownership of learning has moved to the individual care groups with IPC identifying themes to drive continuous improvement "Tool Box" teaching developed to provide up to date, bite sized training to staff IPC team represented on the FutureNHS Collaboration Platform IPC lead nurse attends Regional IPC Lead Nurses Forum		
Learning, Continuous Improvement and Innovation	W8: Are there robust systems and processes for learning, continuous improvement and innovation?	W8.2: Does the trust innovate regarding IPC practices?	IPC represention on FutureNHS Collaboration Platform IP Lead nurses belong to a national network of lead IP nurse's set up as part of NHSE/I Future IP Leaders group Trust is part of a region wide project for a combined laboratory system meaning appropiate information can be shared in a timely fashion between healthcare organisations		
Learning, Continuous Improvement and Innovation	W8: Are there robust systems and processes for learning, continuous improvement and innovation?	W8.3: Is there an active search for best practice on IPC? What has the trust learnt from top performing trusts?	Weekly search of latest research papers performed by Librarian and shared with IPT IPC team represented on the FutureNHS Collaboration Platform IPC lead nurse attends Regional IPC Lead Nurses Forum		

Learning, Continuous Improvement and Innovation	W8: Are there robust systems and processes for learning, continuous improvement and innovation?	W8.4: How does the trust learn from internal/external review to improve IPC?	Annual plan is in place with goals set quarterly Monthly internal scrutiny from Quality and safety report and group Post infection reviews held with IPC identifying themes to improve practise External partners advice on spefic IP issues e.g. CCG/PHE involvement with C.Diff steering group		

CQC Regulatory Action - Trust-Wide Action Plan

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jan20/R29A-1.1	Section 29A	Medical Director	Care Group 1	Emergency Department	York	Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Jan-21	Delivered
Jan20/R29A-1.2	Section 29A	Medical Director	Care Group 1	Emergency Department	York	Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	Senior Operational Manager (A.W)	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered
Jan20/R29A-2.1	Section 29A	Chief Operating Officer	Care Group 1	Patient Flow Team	York	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of patient flow systems and processes, implementing new processes as identified in the review.	Care Group Manager (G.E)	Mar-20	A review has been undertaken and new systems and processes including roles and responsibilities are being implemented. Social distancing is likely to provide a challenge on available beds and flow. Daily attendances continue to increase.	May-20	Delivered
Jan20/R29A-2.3	Section 29A	Chief Operating Officer	Care Group 1	Emergency Department	York	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of the environment for ambulance handovers and those awaiting triage.	Senior Operational Manager (A.W)	Mar-20	A review has been undertaken and the coridoor previously used for ambulances awaiting triage is no longer in use.	Mar-20	Delivered
Jan20/R29A-2.5	Section 29A	Chief Operating Officer	Care Group 1	Patient Flow Team	York	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of the systems and processes for discharge, updating and implementing new processes as required.	CG1 Quadrumvirate	Mar-20	New SAFER bundles have been implemented in the Discharge Lounge, flow matron team and bed management team. Home first has recently been implemented in the trust and is becoming embedded.	May-20	Delivered
Jan20/R29A-2.7	Section 29A	Chief Operating Officer	Care Group 1	Emergency Department	York	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake improvement work with ECIST	CG1 Quadrumvirate	Mar-20	Work commenced, however put on hold due to COVID19. This work stream was reinstated for Streaming in Nov-20	Nov-20	Delivered
Jan20/R29A-6.4	Section 29A	Medical Director	Care Group 1	Emergency Department	York	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Advertise Consultant vacancies for York Hospital Emergency Deparmtnet	Senior Operational Manager (A.W)	Mar-20	Full establishment of ED consultants.	Nov-20	Delivered
Jan20/R29A-6.5	Section 29A	Chief Nurse	Care Group 1	Emergency Department	York	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Undertake Emergency Department establishment reviews to ensure staffing establishment refelects the requirements.	Emergency Department Matron (N.G)	Dec-20		Dec-20	Delivered
Jan20/R29A-1.3	Section 29A	Medical Director	Care Group 2	Emergency Department	Scarborough	Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Nov-20	Delivered

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Jan20/R29A-1.4	Section 29A	Medical Director	Care Group 2	Emergency Department	Scarborough	Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	CG2 Quadrumvirate	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered
Jan20/R29A-2.2	Section 29A	Chief Operating Officer	Care Group 2	Patient Flow Team	Scarborough	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of patient flow systems and processes, implementing new processes as identified in the review.	Care Group Manager (D.T)	Apr-20	A review has been undertaken and new systems and processes including roles and responsibilities are being implemented. Social distancing is likely to provide a challenge on available beds and flow. Daily attendances continue to increase.	May-20	Delivered
Jan20/R29A-2.4	Section 29A	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Implement a Triage Nurse dedicated to caring for patients who are waiting for initial assessment or awaiting admission		Mar-20	Front door Nurse in situ.	Mar-20	Delivered
Jan20/R29A-2.6	Section 29A	Chief Operating Officer	Care Group 2	Patient Flow Team	Scarborough	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of the systems and processes for discharge, updating and implementing new processes as required.	CG2 Quadrumvirate	Mar-20	New SAFER bundles have been implemented in the Discharge Lounge, flow matron team and bed management team. Home first has recently been implemented in the trust and is becoming embedded.	May-20	Delivered
Jan20/R29A-2.8	Section 29A	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake improvement work with ECIST	CG2 Quadrumvirate	Mar-20	Action closed following discussions at March QRG - superseded by Quality & Performance Summit and the subsequent improvement plan created. Evidence to be held in CQC folder.	Mar-21	Delivered
Jan20/R29A-6.1	Section 29A	Chief Nurse	Care Group 2	Care Group 2	Scarborough	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Introdcue a daily staffing huddle for CG2, utilising a daily staffing template which feeds into a monitoring database.	CG2 Quadrumvirate	Mar-20	Staffing database monitored monthly.	Mar-20	Delivered
Jan20/R29A-6.6	Section 29A	Chief Nurse	Care Group 2	Emergency Department	Scarborough	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Undertake Emergency Department establishment reviews to ensure staffing establishment refelects the requirements.	Emergency Department Matron (S.F)	Mar-21	Establishment reviews completed and will feature at Care Group Board and Executive Committee for an overall decision to be made.	Mar-21	Delivered
Jan20/R29A-6.7	Section 29A	Chief Nurse	Care Group 2	Emergency Department	Scaborough	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Responsive Well-Led	Create a rolling programme of PILS training to enable a consistent departmental compliance rate of above 85%	Emergency Department Matron (S.F)	Feb-21	Clinical Educator holds evidence	Feb-21	Delivered

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Jan20/R29A-3.1	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Re-establish a Joint Operational Delivery Group between the Emergency Department and Paediatric Department in both of the Trusts Emergency Departments.	CG5 Quadrumvirate	Feb-20		Feb-20	Delivered
Jan20/R29A-3.2	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Establish a Paediatric Strategic Oversight Group.	CG5 Quadrumvirate	Feb-20		Feb-20	Delivered
Jan20/R29A-3.3	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Audit against 'Royal College of Paediatrics and Child Health: Facing the Future Standards' and develop an action plan subsequently.	CG5 Quadrumvirate	Jun-20	As a result fast track pathways were reviewed and refreshed.	Jun-20	Delivered
Jan20/R29A-3.4	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Add the lack of Paediatric Emergency Medicine (PEM) Consultant at Scarborough Hospital Emergency Department to the risk register and identify mitigations.	CG5 Quadrumvirate	Aug-20	The initial risk rating was 'High' with a score of 16. Mitigations were implemented.	Aug-20	Delivered
Jan20/R29A-3.5	Section 29A	Medical Director	Care Group 2	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Recruit a Paediatric Emergency Medicine (PEM) Consultant for Scarborough Hospital Emergency Department	Paediatric Strategic Oversight Group	Nov-20			Behind Delivery - Ongoing
Jan20/R29A-4.1	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Implement standardised paper documentation across the Trust including care plans and risk assessments.	Deputy Chief Nurse (H.H)	Mar-20		Mar-20	Delivered
Jan20/R29A-4.2	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Recruit a Documentation Lead Nurse to lead the docmentation standards within the Trust.	Deputy Chief Nurse (H.H)	Nov-20	Lead Nurse for documentation is in place and leading a steering group.	Dec-20	Delivered
Jan20/R29A-4.3	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Produce a long term plan for introudcing standarised electronic documentation across the Trust.	Deputy Chief Nurse (H.H)	Dec-20	Paper to Exec Committee with approval for a 2 year digital docuemntation project.	Dec-20	Delivered
Jan20/R29A-4.4	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Purchase and implement the "perfect ward" app for use across the Trust	Deputy Chief Nurse (H.H)	Sep-20	Perfect-Ward now in use and providing assurance reports including documentation standards.	Oct-20	Delivered
Jan20/R29A-5.1	Section 29A	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	Staff did not always report incidents and where they did there were often significant delays in reporting	Safe Well-Led	To ensure that staff are appropriately reporting incidents as per trust policy	Deputy Director of Governance (F.J)	Jan-20	CQC response received in January 2020 advising no further information reqired.	Jan-20	Delivered

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Jan20/R29A-6.2	Section 29A	Chief Nurse	Trust-Wide	Trust-Wide	Trust-Wide	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Undertake ward establishment reviews to ensure staffing establishment refelects the requirements.	Deputy Chief Nurse (H.H)	Nov-20	Proposal has been submitted to Exec Committee and further work is required before a decision can be reached.	Dec-20	Delivered
Jan20/S31-2.3	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of Scarborough Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Effective	Carry out a PLAN / RCEM compliance benchmarking assessment within the Emergency Department	Emergency Department Matron (S.F)	Jun-21	This tool is being used as a "live" working document, updated on a minimum monthly basis. Document owned by ED Tri Team.		Delivered
Jan20/S31-1.1	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	Senior Operational Manager (A.W)	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered
Jan20/S31-1.2	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Operational Steering Group' between TEWV & York Emergency Department	Senior Operational Manager (A.W)	Mar-20	Established in April-2020. Action log maintained on a monthly basis.	Apr-20	Delivered
Jan20/S31-1.3	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a Mental Health Referral Pathway which is used for all Mental Health presentations within York Emergency Department.	Mental Health Strategic Oversight Group	Jun-21		Apr-21	Delivered
Jan20/S31-1.4	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a risk assessment tool to assess the level of risk a patient presents to themselves and others.	York Mental Health Operational Steering Group	Mar-20	Risk Assessment implemented from beginning of May 2020 in line with RCEM standards. Several adaptions since initial version. Latest version signed off at QPAS in December-2020 and is now a trust-wide document with version control.	May-20	Delivered
Jan20/S31-1.5	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Responsive	Implement a rolling programme of education for Emergency Department staff	Senior Operational Manager (A.W)	Mar-20	2 day course delivered by MIND to Senior Medics and Senior Nurses. 1 day course delivered by MIND to Junior Medics and Junior Nurses. X Drive CG1 - Emergency and Acute - Emergency Dept Steering Group - Mental Health in ED Operational Steering Group - MH First Aid Training Trust attendance.	Aug-20	Delivered
Jan20/S31-2.1	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Effective	Carry out a PLAN / RCEM compliance benchmarking assessment within the Emergency Department	Senior Operational Manager (A.W)	Mar-20	Monitored twice monthly through Governance Meetings.	Mar-20	Delivered
Jan20/S31-2.2	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Jan-21	Delivered
Jan20/S31-1.10	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a risk assessment tool to assess the level of risk a patient presents to themselves and others.	York Mental Health Operational Steering Group	Mar-20	Risk Assessment implemented from beginning of May 2020 in line with RCEM standards. Several adaptions since initial version. Latest version signed off at QPAS in December-2020 and is now a trust-wide document with version control.	May-20	Delivered
Jan20/S31-1.11	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Responsive	Implement a rolling programme of education for Emergency Department staff	Emergency Department Matron (S.F)	Mar-20	2 day course delivered by MIND to Senior Medics and Senior Nurses. 1 day course delivered by MIND to Junior Medics and Junior Nurses. X Drive CG1 - Emergency and Acute - Emergency Dept Steering Group - Mental Health in ED Operational Steering Group - MH First Aid Training Trust attendance.	Aug-20	Delivered

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Jan20/S31-1.7	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	CG2 Quadrumvirate	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered
Jan20/S31-1.8	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Operational Steering Group' between TEWV & Scarborough Emergency Department	Emergency Department Matron (S.F)	Apr-21	Informal meetings are held with TEWV on a regular basis. Formalised meeting to be established. New Action	Jan-21	Delivered
Jan20/S31-1.9	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a Mental Health Referral Pathway which is used for all Mental Health presentations within Scarborough Emergency Department.	Mental Health Strategic Oversight Group	Jun-21		Apr-21	Delivered
Jan20/S31-2.5	Section 31	Medical Director	Care Group 1	Emergency Department	Trust-Wide	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Well-Led	Develop a SOP for the use of the PLAN compliant Mental Health Assessment Suite	Mental Health Strategic Oversight Group	Jun-21	New action. This will be incorporated into "Mental Health Care within the ED" SOP. Draft SOP has been shared. For final comments followed by approval at Mental Health Steering Group and QPAS in August 2021.		Behind Delivery - Ongoing
Jan20/S31-2.4	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Nov-20	Delivered
Jan20/S31-4.1	Section 31	Chief Nurse	Care Group 2	Medical Wards	Scarborough	The registered provider must ensure that there are sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff at all times to meet the needs of patients within all medical wards at Scarborough hospital.	Safe Responsive Well-Led	Introdcue a daily staffing huddle for CG2, utilising a daily staffing template which feeds into a monitoring database.	CG2 Quadrumvirate	Mar-20	Staffing database monitored monthly.	Mar-20	Delivered
Jan20/S31-3.1	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Utilisie Nurse Agencies to ensure adequate Registered Childrens Nurses on each clinical shift across both Emergency Departments	Head of Childrens Nursing (S.K)	Jan-20		Jan-20	Delivered
Jan20/S31-3.2	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Establish a Paediatric 'In-Reach' Service to enable consistent support for times where RCN cover is less than optimal.	Head of Childrens Nursing (S.K)	Jan-20	Audit undertaken in July 2020 to demonstrate effectiveness of the service being used.	Jan-20	Delivered
Jan20/S31-3.3	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Recruit substantive RCN's for York and Scarborough Emergency Department	Head of Childrens Nursing (S.K)	Jun-20	Due to the very low numbers of paediatric attendance in the Scarborough ED and the support which can be offered from the acute Paediatric ward a proposal was made for Scarborough to have one RCN on shift at all times, rather than the guidance of 2.	Oct-20	Delivered
Jan20/S31-3.4	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Add the lack of substative Registered Childrens Nurses within the Emergency Deparments to the Risk Register.	Head of Childrens Nursing (S.K)	Jan-20	Risk added to Care Group 5 Risk register with a risk rating of 12. Reviewed in November 2020 and risk rating now 1.	Feb-20	Delivered
Jan20/S31-1.6	Section 31	Medical Director	Trust-Wide	Emergency Department	Trust-Wide	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Strategic Oversight Group' which governs the Operational Steering Groups for the Emergency Departments.	Deputy Director of Patient Safety & Governance (C.J)	Jan-21	First meeting took place in January 2021, second meeting scheduled for February 2021. TOR and agenda required.	Jan-21	Delivered
Jan20/R29A-6.3	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Responsive Well-Led	Re-launch and utilise Safe-Care as a tool for measuring CHPPD across the organisation	Deputy Chief Nurse (H.H)	Jun-21	Trust-wide improvement plan to be created with realistic timescales. Updates to be ascertained from Matron who attended safe-care workshop in beginning July-21.		Behind Delivery - Ongoing
Jan20/MD1	Must Do	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	The service must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered

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Jan20/MD2	Must Do	Chief Nurse, Medical Director	Care Group 2	Emergency Department	Scarborough	The service must ensure there are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department, especially in relation to paediatric care.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD3	Must Do	Chief Nurse	Care Group 5	Emergency Department	Scarborough	The service must ensure that care is provided in line with national standards and risks to patients and children attending the emergency department identified, mitigated and effectively managed	Safe Responsive	Create and implement a Paediatric risk assessment tool to assess the level of risk a patient presents to themselves and others.	CAMHS Nurse	Mar-20	Implemted across the Trust	Apr-20	Delivered
Jan20/MD4	Must Do	Chief Nurse	Care Group 2	Emergency Department	Scarborough	The service must ensure that there is an effective system to identify, mitigate and manage risks to patients who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD5	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD6	Must Do	Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure staff are maintaining securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of thecare and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	Safe Well-Led	Covered in Section 29A & 31 Actions	Deputy Chief Nurse (H.H)	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD7	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure systems for recording clinical information, risk assessments and care plans are used in a consistent way across the medical wards. This should include ensuring staff are aware of how to effectively use systems to identify, assess and monitor patients at risk of deterioration.	Safe Well-Led	Covered in Section 29A & 31 Actions	Deputy Chief Nurse (H.H)	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD8.1	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Uttilise the Staff magazine to educate staff of the value of incident reporting.	Associate Director of Patient Safety & Governance	Nov-20	November 2020 Edition of 'Safety Spotlight'	Nov-20	Delivered
Jan20/MD8.2	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Update dashboards on Datix to enable senior leaders to monitor and understand their incident reporting data.	Associate Director of Patient Safety & Governance	Oct-20		Oct-20	Delivered
Jan20/MD8.3	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Develop a monthly Patient Safety assurance report regarding incidents and present this at QPAS.	Patient Safety & Governance Team	Jan-21		Jan-21	Delivered
Jul19/MD1.1	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Undertake promotion exercise to ensure ALL staff understand the current processes for identifying learning from deaths and Sis	Deputy Director of Healthcare Governance (F.J)	Feb-20	In Jan 2020 Staff Matters Policy to Feb Quality Committee Presentation of Policy to EB March 2020	Mar-20	Delivered
Jul19/MD1.2	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Develop a policy for the identification of learning from deaths and serious incidents	Deputy Director of Healthcare Governance (F.J)	Feb-20	In Jan 2020 Staff Matters Policy to Feb Quality Committee Presentation of Policy to EB March 2020	Mar-20	Delivered
Jul19/MD1.3	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Undertake a multi-professional engagement exercise and in response review and revise the processes for the dissemination of learning from deaths and serious incidents	Deputy Director of Healthcare Governance (F.J)	Feb-20	Review document Revised processes and publications	Mar-20	Delivered
Jul19/MD10	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure the processes for the management of risks, issues and performance, and the governance and oversight of these processes are fully embedded within its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Review, revise and deliver a Governance Management structure that meets the needs of the new Care Group	Care Group Quadrumvirate	Apr-21	Draft structure created. Next steps to feature at Quality Committee for approval and sharing with wider team.	May-21	Delivered

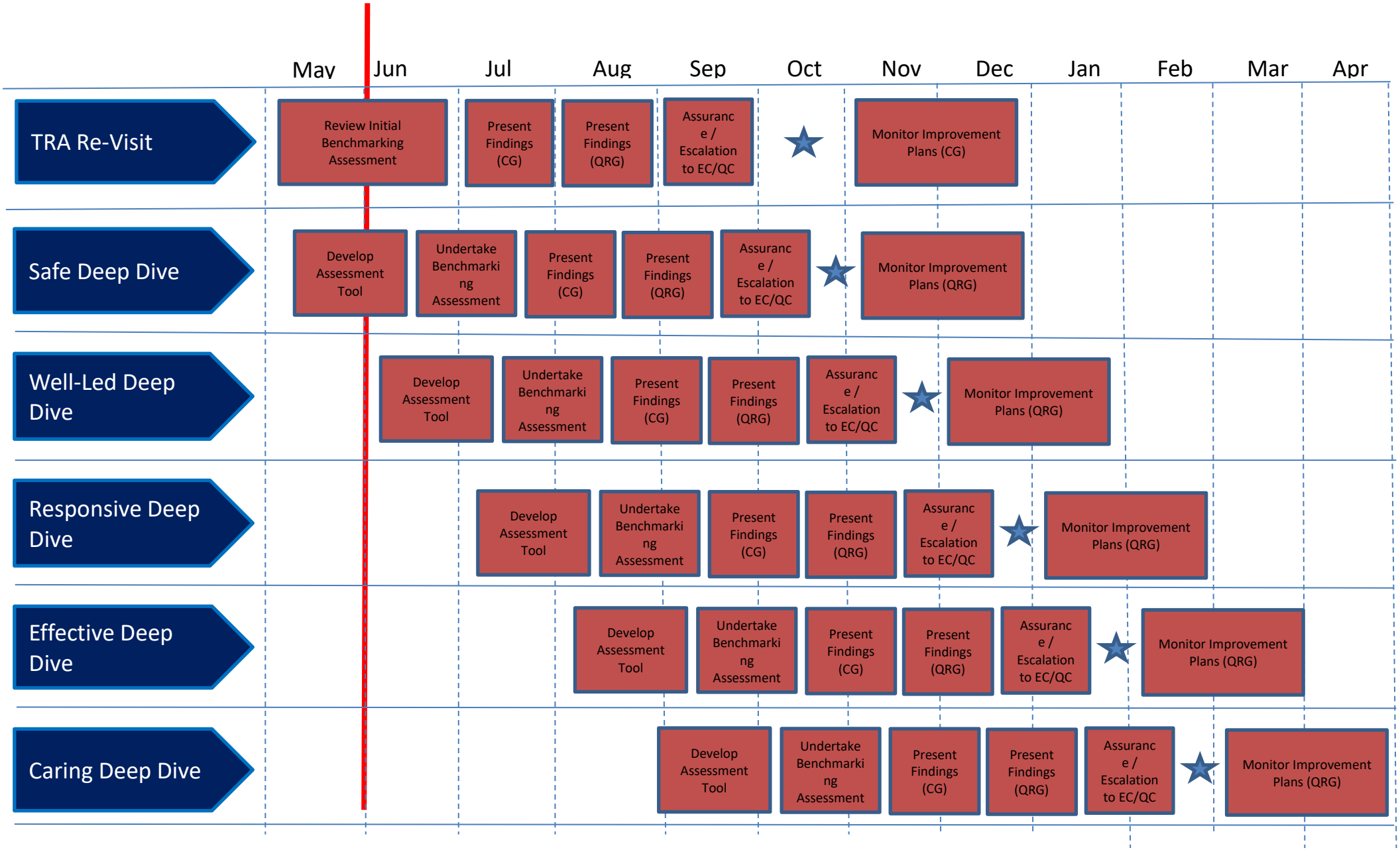
Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jul19/MD11	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.	Safe Well-Led	Medical staff in surgery will be issued with their individual compliance data and set a target date for full compliance, specifically safeguarding training modules	Care Group Director (A.V)	Mar-20	Letters have been issued. Learning Hub compliance discussed and monitored through CG3 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly	Nov-20	Delivered
Jul19/MD12.1	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy.	Safe	Chief Executive to examine recruiting to a director position with a specific focus on digital part of whose remit will be to review how IT can support record keeping.	Chief Executive	Apr-20	Digital Director is in post	Sep-20	Delivered
Jul19/MD12.2	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy.	Safe	The Medical Director will write to ALL medical colleagues detailing their responsibility to comply with the Record Keeping Standards Medical Staff – Records Management Policy. In addition, the screensaver will be refreshed during September 2019 and a feature in Staff Matters article October 2019.	Medical Director	Oct-19		Oct-19	Delivered
Jul19/MD13	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy.	Safe Well-Led	Review current appraisal rate for medical & nursing staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	Care Group Quadrumvirate	Sep-20		Nov-20	Delivered
Jul19/MD14	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all records are secure when unattended.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered
Jul19/MD22	Must Do	Medical Director	Care Group 3	Surgery	Bridlington	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.	Safe Well-Led	Medical staff in surgery will be issued with their individual compliance data and set a target date for full compliance, specifically safeguarding training modules	Care Group Director (A.V)	Mar-20	Letters have been issued. Learning Hub compliance discussed and monitored through CG3 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly	Nov-20	Delivered
Jul19/MD15	Must Do	Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.	Safe Responsive Well-Led	Where the Trust has unfilled shifts bank, agency and locums will be utilised.	Care Group Director	Mar-20	Daily monitoring is in place to ensure the safety of the wa	Mar-20	Delivered
Jul19/MD16	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.	Safe Responsive Well-Led	Replaced with Section 29A & Section 31 Actions.	N/A	N/A	Replaced with Section 29A & Section 31 Actions.	Dec-20	Delivered
Jul19/MD17	Must Do	Medical Director / Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	Safe Effective Well-Led	Replaced with Section 29A Actions	N/A	N/A	Replaced with Section 29A Actions	Dec-20	Delivered
Jul19/MD18.1	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	A review of all substances hazardous to health to be undertaken to ensure only appropriate substances are stored correctly and that COSHH risk assessments are in place	Head of Health, Safety & Security	Mar-20	All Wards have files in place, but need to provide assurance. Evidence of compliance has been provided	Apr-20	Delivered
Jul19/MD15.1	Must Do	Director of Workforce & Organisational Development	Care Group 5	Maternity	Scarborough	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy	Safe Well-Led	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Aug-21	Following QRG completion date extended in line with national work-stream. Aiming for implementation from end of Aug-21.		On Target
Jul19/MD18.2	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	Up to date list of COSHH Appropriate training or training updates to be delivered to COSHH Leads for all areas to be provided and reported through CG2 Quality Assurance Meeting	Head of Health, Safety & Security	Mar-20	List held by CLAD Evidence requested 50-60 staff have been trained. Staff were trained in 2018 and will require refresher training. Business case has been approved to appoint a Health and Safety Traner which is currently (June 2020) going out to advertisement	Apr-20	Delivered

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jul19/MD18.3	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	COSHH Leads to provide local training and ensure staff in each department understand their roles and responsibilities associated with the management of hazardous substances	Head of Health, Safety & Security	Mar-20	Evidence has been provided, there is a need to provide refresher training that will be a priority for the H&S Trainer when appointed. Interviews July 2020	Apr-20	Delivered
Jul19/MD23	Must Do	Director of Workforce & Organisational Development	Care Group 3	Surgery	Bridlington	The service must ensure that all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy.	Safe Well-Led	Review current appraisal rate for medical & nursing staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	Care Group Quadrumvirate	Sep-20		Nov-20	Delivered
Jul19/MD19	Must Do	Director of Workforce & Organisational Development	Care Group 5	Maternity	Scarborough	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy	Safe Well-Led	Ensure that there is adequate and accessible mandatory training sessions for staff to access. Medical staff in urgent and emergency care will be issued with their individual compliance data and set a target date for full compliance	Care Group Quadrumvirate	Feb-20	Mandatory Training monitored through Care Group Structure and IBR.	Mar-20	Delivered
Jul19/MD2.1	Must Do	Director of Workforce & Organisational Development	Trust-Wide	Trust-Wide	Trust-Wide	The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.	Safe Well-Led	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Apr-21	Duplicate action - See Action Jul19/MD15.1	N/A	Delivered
Jul19/MD2.2	Must Do	Director of Workforce & Organisational Development	Care Group 2	Emergency Department	Scarborough	The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.	Safe Well-Led	Ensure that there is adequate and accessible mandatory training sessions for staff to access. Medical staff in urgent and emergency care will be issued with their individual compliance data and set a target date for full compliance	Care Group Quadrumvirate	Feb-20	Mandatory Training monitored through Care Group Structure and IBR.	Mar-20	Delivered
Jul19/MD20	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Scarborough	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved	Safe Effective Responsive Well-Led	Deliver the Outpatient Transformation Programme	Care Group Manager	Jun-20	Superseded by COVID-19. Phase 3 plan submitted and in delivery. The focus for the national ask is on restoring activity levels which will not address backlogs in 2020/21. The Outpatients Dashboard provides increased oversight of the outpatients and Follow Up position. The Trust has implemented Clinical Risk Stratification for overdue FU as part of the risk management processes following the pandemic.	Jun-20	Delivered
Jul19/MD21	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Scarborough	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment	Responsive Well-Led	Update the RTT Recovery Plan to clearly state the projections for service delivery and backlog reduction	Care Group Manager	Mar-20	Enhanced management of Follow up partial booking currently being rolled out in Diabetes and will follow in cancer and gastroenterology. Two way text reminder service for all OP appointment and follow up. The specific action could be closed as completed. Recommend a new action to meet the national standards for Clinical Validation of the Waiting List and ongoing Risk Stratification.	Dec-20	Delivered
Jul19/MD25	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Bridlington	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved	Safe Effective Responsive Well-Led	Deliver the Outpatient Transformation Programme	Care Group Manager	Jun-20	Superseded by COVID-19. Phase 3 plan submitted and in delivery. The focus for the national ask is on restoring activity levels which will not address backlogs in 2020/21. The Outpatients Dashboard provides increased oversight of the outpatients and Follow Up position. The Trust has implemented Clinical Risk Stratification for overdue FU as part of the risk management processes following the pandemic.	Jun-20	Delivered
Jul19/MD26	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Bridlington	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment	Responsive Well-Led	Monitor progress against the Performance Delivery Plan at Trust Board	Chief Operating Officer	Mar-20	Action is complete. The Trust Board receives the performance each month and position against the plan.	Dec-20	Delivered
Jul19/MD3.1	Must Do	Director of Workforce & Organisational Development	Care Group 2	Emergency Department	Scarborough	The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department.	Safe	Ensure that there is adequate and accessible paediatric life support training sessions for staff to access and that this is monitored by the care group	D.T (Care Group Manager)	Feb-20	Rolling programme in place, monitored by the Clinical Educator.	Nov-20	Delivered
Jul19/MD4.1	Must Do	Executive Committee	Care Group 2	Emergency Department	Scarborough	The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting.	Safe Responsive Well-Led	Replaced with Section 29A & Section 31 Actions.	N/A	N/A	Replaced with Section 29A & Section 31 Actions.	Mar-20	Delivered

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jul19/MD5.1	Must Do	Chief Nurse	Care Group 1	Emergency Department	Scarborough	The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital.	Safe	Update the Trusts Medicines Management policy with 7 key messagesand display in the clean utility / drug storage areas.	Lead Nurse Medicines Management	Oct-19	Policy updated and key message circulated.	Jun-20	Delivered
Jul19/MD5.2	Must Do	Chief Nurse	Trust-Wide	Pharmacy	Trust-Wide	The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital.	Safe	Chief Pharmacist has commissioned Internal Audit to undertake: Safe and Secure Handling of Medicines Audit	Chief pharmacist	Mar-20	Internal Audit Completed in June 2020 - This showed an increasing risk with a Red/Amber rating. An action plan has been developed and this is monitored through Medicines Management Group on a monthly basis.	Jun-20	Delivered
Jul19/MD6.1	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered
Jul19/MD6.2	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Consider privacy screens for monitors in Acute Admission areas such as Emergency Department, SDEC, SAU, AMU to reduce the risk of unintentional viewing of patient identifiable information during situations whereby locking the computer has not been possible.	Care Group Quadrumvirate	Jun-21			Behind Delivery - Ongoing
Jul19/MD6.3	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Agree with IT a suitable time for implementing an automatic locking function for computers which are inactive for a period of time.	Service Desk	Jun-21	New Action. Awaiting outcome from Service Desk.		Behind Delivery - Ongoing
Jul19/MD7	Must Do	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure it takes action to improve its performance in the RCEM standards in its urgent and emergency care service at Scarborough hospital.	Safe Effective Well-Led	Undertake a gap analysis against previous RCEM audit standards and as necessary develop and action plan that delivers improved performance against the standards	Care Group Director	Jun-20	Clinical Director has provided a response to the RCEM audit findings on the latest audits • QA2018-002 Feverish Children (Care in Emergency Departments) 2018/19 • QA2018-003 Vital Signs in Adults (Care in Emergency Departments) 2018/19	Mar-20	Delivered
Jul19/MD8	Must Do	Chief Nurse	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure all nursing staff have an up to date appraisal each year in its urgent and emergency care service at Scarborough hospital.	Well-Led	Review current compliance rates within the Care Group and dedicate time to achieve required compliance	Head of Nursing (J.B)	Mar-20	Compliance rates monitored within the Care Group and at Trust Board.	Dec-20	Delivered
Jul19/MD9.1	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital. • the median time from arrival to treatment. • the percentage of patients admitted, transferred or discharged within four hours. • the monthly percentage of patients that left before being seen.	Safe Effective Responsive Well-Led	Develop a recovery plan relating to performance	Deputy Chief Operating Officer (M.L) / Care Group Manager (D.T)	Jan-20	Acute Pathway Programme Board overseeing a programme of work with ECIST, to strengthen site management at York, and improve flow and performance in Emergency Departments in York and Scarborough. Opened Home First Unit SGH. Restoration of Services Plan post COVID submitted to board.	Mar-20	Delivered
Jul19/MD9.2	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital. • the median time from arrival to treatment. • the percentage of patients admitted, transferred or discharged within four hours. • the monthly percentage of patients that left before being seen.	Safe Effective Responsive Well-Led	Engage with the offer of support from ECIST to further develop approaches to improve the Trusts' performance as identified during the CQC visit.	Deputy Chief Operating Officer (M.L) / Care Group Manager (D.T)	Jan-20	Action closed following discussions at March QRG - superseded by Quality & Performance Summit and the subsequent improvement plan created. Evidence to be held in CQC folder.	Mar-21	Delivered
Jul19/MD24	Must Do	Medical Director	Care Group 3	Surgery	Bridlington	The service must ensure that all records are secure when unattended.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered

CQC Regulatory Action - Trust-Wide Action Plan

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jan20/R29A-3.5	Section 29A	Medical Director	Care Group 2	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Recruit a Paediatric Emergency Medicine (PEM) Consultant for Scarborough Hospital Emergency Department	Paediatric Strategic Oversight Group	Nov-20			Behind Delivery - Ongoing	
Jan20/S31-2.5	Section 31	Medical Director	Care Group 1	Emergency Department	Trust-Wide	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Well-Led	Develop a SOP for the use of the PLAN compliant Mental Health Assessment Suite	Mental Health Strategic Oversight Group	Jun-21	New action. This will be incorporated into "Mental Health Care within the ED" SOP. Draft SOP has been shared. For final comments followed by approval at Mental Health Steering Group and QPAS in August 2021.		Behind Delivery - Ongoing	
Jan20/R29A-6.3	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Responsive Well-Led	Re-launch and utilise Safe-Care as a tool for measuring CHPPD across the organisation	Deputy Chief Nurse (H.H)	Jun-21	Trust-wide improvement plan to be created with realistic timescales. Updates to be ascertained from Matron who attended safe-care workshop in beginning July-21.		Behind Delivery - Ongoing	
Jul19/MD15.1	Must Do	Director of Workforce & Organisational Development	Care Group 5	Maternity	Scarborough	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy	Safe Well-Led	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Aug-21	Following QRG completion date extended in line with national work-stream. Aiming for implementation from end of Aug-21.		On Target	
Jul19/MD6.2	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Consider privacy screens for monitors in Acute Admission areas such as Emergency Department, SDEC, SAU, AMU to reduce the risk of unintentional viewing of patient identifiable information during situations whereby locking the computer has not been possible.	Care Group Quadrumvirate	Jun-21			Behind Delivery - Ongoing	
Jul19/MD6.3	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Agree with IT a suitable time for implementing an automatic locking function for computers which are inactive for a period of time.	Service Desk	Jun-21	New Action. Awaiting outcome from Service Desk.		Behind Delivery - Ongoing	


May
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TRA Re-Visit
Review Initial Benchmarking Assessment
Present Findings (CG)
Present Findings (QRG)
Assurance / Escalation to EC/QC
Monitor Improvement Plans (CG)
Safe Deep Dive
Develop Assessment Tool
Undertaking Benchmarking Assessment
Present Findings (CG)
Present Findings (QRG)
Assurance / Escalation to EC/QC
Monitor Improvement Plans (QRG)
Well-Led Deep Dive
Develop Assessment Tool
Undertaking Benchmarking Assessment
Present Findings (CG)
Present Findings (QRG)
Assurance / Escalation to EC/QC
Monitor Improvement Plans (QRG)
Responsive Deep Dive
Develop Assessment Tool
Undertaking Benchmarking Assessment
Present Findings (CG)
Present Findings (QRG)
Assurance / Escalation to EC/QC
Monitor Improvement Plans (QRG)
Effective Deep Dive
Develop Assessment Tool
Undertaking Benchmarking Assessment
Present Findings (CG)
Present Findings (QRG)
Assurance / Escalation to EC/QC
Monitor Improvement Plans (QRG)
Caring Deep Dive
Develop Assessment Tool
Undertaking Benchmarking Assessment
Present Findings (CG)
Present Findings (QRG)
Assurance / Escalation to EC/QC
Monitor Improvement Plans (QRG)

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report

Board of Directors
July 2021 (June data)
Integrated Business Report Executive Summaries

/ Trust Strategic Goals

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

/ Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

/ Purpose of the Report

Executive Summaries from Integrated Performance Report

/ Executive Summary – Key Points

As contained in individual summaries

/ Recommendation

The Board is asked to receive the summaries and note the impact on KPIs and actions been taken to address performance challenges

Author: Shown on individual Executive Summaries

Director Sponsor: Shown on individual Executive Summaries

Date: July 2021

EXECUTIVE SUMMARIES

Quality & Safety

Clostridium difficile continues to be a challenge across the organisation. We have developed a Trust-wide action with a strategic meeting taking place monthly, the IP Lead Nurse's for each site attend and disseminate the actions across their teams. There is a robust action plan and we have involved our commissioning and PHE colleagues including the regional IPC team from NHS England.

MSSA cases continue to be of significance, there is on-going work reviewing line care and management including the development and implementation of a video for best practice in line care. A business case is being developed to enhance the line care service. MSSA improvements form part of the IPC annual work plan.

Improvements in 14-hour post take review performance across the Scarborough have continued in June, and are supported by the quality improvements being undertaken and monitored by the SAFER group.

Learning from the success of the insulin improvement work undertaken on the York site a similar group has been established to address an emerging theme in incidents related to insulin.

Author	Caroline Johnson, Deputy Head of Patient Safety & Governance
Director Sponsors	James Taylor, Medical Director Heather McNair, Chief Nurse

Workforce

Sickness absence rates increased for the second month in a row. Detailed analysis shows that this is across all Care Groups and staff groups. The report details the range of actions being taken to improve attendance and support staff health and wellbeing.

Work continues to embed the new co-created values and behaviours. A platform has been set up for the sharing of ideas for ensuring that all employee and patient touchpoints are aligned to the new values.

An Agile and Flexible working group has been set up to scope the modernisation of the Trust's working practices. Five sub groups have been established covering a range of issues relating to Agile & Flexible working.

Author	Sian Longhorne, Deputy Head of Resourcing
Director Sponsor	Polly McMeekin, Director of Workforce & Organisation Development

Finance

The report for June 2021 marks the end of quarter 1 of the financial year 2021/22.

Emergency Financial Regime

For 2021/22, NHSE&I have decided to continue to employ a similar emergency financial regime used during 2020/21, in supporting the NHS address the Covid-19 pandemic.

With regard to the first half year of 2021/22 only (April 2021 to September 2021), the Trust will be subject to the same allocation based approach used in the second half year of 2020/21. NHSE&I have as yet made no formal announcement regarding the financial framework that will be in place for the second half year of 2021/22.

Under the announced framework, the Trust has received a base allocation to cover normal activities linked to its actual performance in Q3, 2020/21 doubled to give a half year allocation, and then adjusted for inflation and other issues. A secondary allocation to cover additional costs resulting from the Covid-19 pandemic has also been received at a similar level to that seen in the second half year, 2020/21. In addition, the Trust has also planned to receive other 'non-patient' activity income at similar levels seen in Q3, 2020/21.

A notable change to the 2020/21 regime is the reintroduction for 2021/22 of national and local efficiency targets, which had been suspended throughout the previous financial year.

The final financial plan for the first half year of 2021/22 (with an indicative full year plan for information only), was submitted to and agreed by the Board at its 28 April 2021 meeting. The agreed plan produced a balanced I&E position.

Since the April Board meeting, and at the request of NHSE&I, the Trust has submitted an updated plan to reflect both the income and costs of delivery associated with the Elective Recovery Fund. Initial projections for the Trust identify that our forecast activity levels for H1 could deliver an additional £21.5m of income under this scheme. The cost of delivering this activity has been estimated at £13m, although for planning purposes a risk provision has been created in the sum of £8.5m, thereby having a net neutral impact on the bottom line I&E plan.

Elective Recovery Fund (ERF)

The ERF is a system implemented at national level that incentivises provider organisations to accelerate the delivery of elective care to address the backlog that has developed during the covid-19 pandemic. Additional funding is being made available to providers to support this process.

The estimated income and expenditure linked to ERF is now included in the position to date and in the forecast, although this is not guaranteed and is subject to change. The amount of funding that the Trust will receive is dependent upon a number of factors including the performance of the other provider organisations within our Integrated Care System (ICS), and the actual receipt of ERF will be on a basis agreed by the ICS. The income figures included in the I&E position and forecast position at June are calculated based on the information available at present, and reflect an agreed position with our ICS partners. The figures will be refined as appropriate in the coming months as actual income allocations are notified to the ICS by NHSE&I. Due to the nature of counting the activity linked to the ERF scheme there is a three month delay in learning the actual income, so we would expect to learn about actual April ERF income in July.

Month 3 Position

For June, the Trust is reporting an I&E position of £10.6m surplus against a £0.1m deficit plan, placing it £10.7m ahead of the system plan submitted to NHSE&I. This is primarily

driven by ERF income being ahead of plan with the associated cost of delivery being behind plan (£7.8m); with the balance linked to other net underlying Trust performance being £2.9m ahead of plan.

The Trusts overall CIP target for the first half of 2021/22 is £2.8m. In June the Trust has delivered £0.2m of the £1.4m year to date target.

The Trust's compliance with the Better Payments Practice Code (BPPC) is currently averaging around 90% of suppliers being paid within 30 days.

Forecast H1 Position

The forecast outturn position for H1 2021/22 (1st April 2021 to 30th September 2021) is a break even I&E position.

Author	Graham Lamb, Deputy Finance Director
Director Sponsor	Andrew Bertram, Finance Director

Research & Development

The next R&D strategy is complete and is just being formatted before wider circulation and it covers our objectives and aspirations for the coming three years. In addition to this in the last month our key outcomes are as follows:

- HYMS have offered 5 Clinical Academic posts of mutual benefit to both organisations research and HR agenda, and the post are being moved forward (Cardiology, Oncology, Dermatology, Ophthalmology and Peri Operative Medicine)
- The following grants for external funding were submitted in the last month
    - York Cancer Research £1.5M
    - NHSE is £120K
    - Macular Society £183K
- We are working on several grants for external funding that will be submitted in the coming weeks
    - NIHR Research for Patient Benefit 250K
- Commercial Research Manager has been approved and is currently out for advert
- We have secured 30K from the CRN to support the opening of a multimorbidity research Hub at Scarborough and are in negotiations with Tryst Exec board for further funding to develop this important asset.

This is alongside delivering a large portfolio of clinical trials spread throughout all our six Care Groups. The challenges now are how to support this portfolio, alongside our Covid 19 trials (that still require a lot of support) and open up new opportunities, with the staff we have.

We are a very busy team!

Author(s)	Lydia Harris Head of R&D
Director Sponsor	Polly McMeekin Director of WOD

Operational Performance

Nationally, the COVID-19 Pandemic NHS Emergency Preparedness, Resilience and Response incident level moved back to a level 3 national response on the 25th of March. A level 3 national response is defined as “an incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level”.

The Trust has continued to operate within its COVID-19 Command and Control structure throughout June and as at the 8th of July there were twenty COVID-19 positive inpatients in our acute and community hospitals. The number of COVID-19 positive inpatients peaked on the 26th of January at 216.

The Trust has had 2,837 COVID-19 positive inpatients since 17th March 2020, with 2,198 patients discharged, sadly 614 patients have died. Since the end of May 2021 there have been fifty new COVID-19 positive inpatients and zero deaths.

As at the 9th of July, York Hospital has one COVID-19 positive ward. The Trust’s COVID-19 surge plan has been refreshed to respond to further requirements for additional wards.

There were twelve elective patients cancelled by the Trust for COVID-19 reasons during June 2021; all due to theatre staff being required to isolate.

National planning guidance was released on the 25th of March covering the period April to September 2021.

An additional £1bn Elective Recovery Fund (ERF) has been made available to the NHS in 2021-22 to support the start of the recovery of elective activity, and the recovery of cancer services. Systems were asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2021 to September 2021.

The Trust has engaged with partners in the HCV ICS and the finalised operational plan for the first half of 2021-22 was submitted on the 3rd of June.

Our ambition for 2021-22 is to over-achieve the national ‘ask’ on our hospital sites, focussing on delivering clinically urgent work within reasonable timescales (cancer and Priority 2 surgical patients) and to stabilise the long wait position. Over-achieving on the national activity ‘ask’ will enable the Trust to access the ERF and support further improvement in patient care and timely treatments.

The Trust over-achieved against the national activity ‘ask’ for outpatient and day case elective points of delivery in June 2021.

Point of Delivery	June 2019 Outturn	June 2021 Actual	Variance	Proportion of June 2019 delivered in June 2021
First Outpatient Appts	14,114	15,787	1,673	112%
Follow up Outpatient Appts	30,878	35,945	5,067	116%
Ordinary Electives	730	520	-210	71%
Day Cases	5,982	6,714	732	112%

Please note: colour key denotes performance against national activity 'ask'. For June 2021 any elective Point of Delivery above 80% achieved the national activity 'ask'.

June 2021 Performance Headlines:

• 81.0% of ED patients were admitted, transferred or discharged within four hours during June 2021.
• May 2021 saw challenging cancer performance with the Trust achieving four out of the seven core national standards.
• 1,488 fifty-two week wait pathways have been declared for the end of June 2021.
• The Trust saw improvement against the overall Referral to Treatment backlog, with the percentage of patients waiting under 18 weeks at month end, increasing from 68.3% in May to 70.5% at the end of June 2021.

Author(s)	Andrew Hurren, Deputy Head of Operational Planning and Performance Lynette Smith, Deputy Director of Operational Planning and Performance Steve Reed, Head of Community Services
Director Sponsor	Wendy Scott, Chief Operating Officer

Digital and Information Service

The Revised Digital and Information Strategy is being presented to board this month which articulates how Digital and Information will be core to the delivery of our future Trust and ICS strategies.

It is accompanied by the detailed delivery plans and funding requirements to be submitted for consideration by the ICS and NHS X for the following areas of work :

• The Essential Services Programme that will address some of the fundamental IT infrastructure issues and mitigate the Trust's risks of major IT failure and cyber-attack as well as providing the smart foundations to improve the delivery of care.
• The presentation of the draft Strategic Outline Case for the future Electronic Healthcare Record strategy for the Trust and Integrated Care System.
• Proposals on the future operating model for the new Digital and Information Services to bring in the skills and capabilities to ensure the effective delivery of Information, Intelligence and Technology Services.
• Proposals on how we will develop of Intelligence and Insight service as part of the ICS.

In addition to this the first Senior Information Risk Owner (SIRO) report, of the new Chief Digital and Information Officer, to board will provide assurance on the controls in place relating to Information Governance and the law which will be supported by a new Information Governance Strategy to be led by our newly appointed Head of Information Governance and Data Protection Officer.

These combined clearly set the ambition and what is necessary for which we hope to secure external funds to support.

Author(s)	Dylan Roberts, Chief Digital Information Officer Simon Hayes, IT Service and Infrastructure Transformation Lead
Director Sponsor	Dylan Roberts, Chief Digital Information Officer

Integrated Business Report

Quality and Safety, Workforce, Finance, Research and Development, Operational Performance, Digital and Information Service.

June-2021

Produced July-2021

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

To ensure financial stability

Report produced by:

Information Team

Integrated Performance Report : June-2021

Understanding the Report

1. Operational Performance Summary

This section provides a summary of key performance targets for NHSI, Quality, Workforce and Finance, plus activity data. The target is either the monthly standard and performance is coloured according to achievement. This should be read in conjunction with overall trends and not taken in isolation. The table will show performance for a 13 month rolling period, which is also displayed in the snapshot overview. Change from previous month is displayed using arrow, but again this must be read in conjunction with trend analysis.

Indicator

target if applicable

change from previous month

monthly performance or activity level

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1.01	Emergency Care Attendances		▼	18055	18270	18256	20101	19683	18486	18800	17848	17926	17169	16770	13034	7755
1.02	Emergency Care Breaches		▼	3525	3310	3067	3785	3671	4043	3689	4337	4471	4257	3065	2131	490
1.03	Emergency Care Standard Performance	95%	▲	80.5%	81.9%	83.2%	81.2%	81.3%	78.1%	80.4%	75.7%	75.1%	75.2%	81.7%	83.7%	93.7%

trend of 13 month rolling period

2. Focus Sections

This section provides a summary of key performance targets for NHSI, Quality, Workforce and Finance, plus activity data. The target is either the monthly standard and performance is coloured according to achievement. This should be read in conjunction with overall trends and not taken in isolation. The table will show performance for a 13 month rolling period, which is also displayed in the snapshot overview. Change from previous month is displayed using an arrow, but again this must be read in conjunction with trend analysis. There is also a Red/Green indicator to ascertain where the Care Group is passing/failing target at a service level, where applicable.

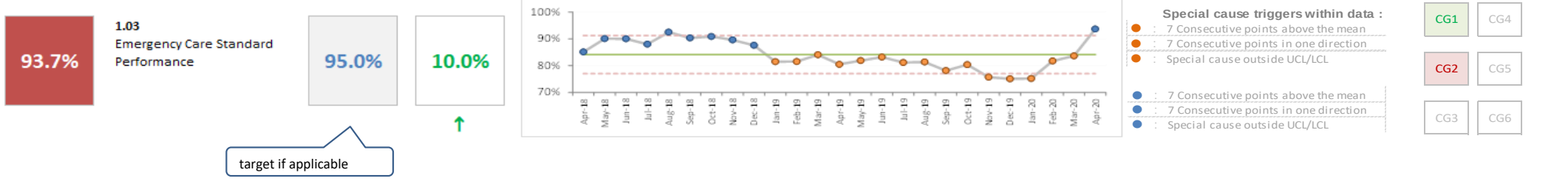
monthly performance

change from previous month

SPC for 13 month period

SPC triggers can be 1 or all of

Care Group level



target if applicable

QUALITY AND SAFETY REPORT

June-2021

Produced July-2021

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

To ensure financial stability

Report produced by:

Information Team

Quality and Safety Report: June-2021

Executive Summary

Trust Strategic Goals:

[X] to deliver safe and high quality patient care as part of an integrated system
[X] to support an engaged, healthy and resilient workforce
[X] to ensure financial sustainability

Purpose of the Report:

To provide the Board with an integrated overview of Quality and Safety indicators within the Trust

Executive Summary:

Key discussion points for the Board are:

Clostridium difficile continues to be a challenge across the organisation. We have developed a Trust-wide action with a strategic meeting taking place monthly, the IP Lead Nurse's for each site attend and disseminate the actions across their teams. There is a robust action plan and we have involved our commissioning and PHE colleagues including the regional IPC team from NHS England.

MSSA cases continue to be of significance, there is on-going work reviewing line care and management including the development and implementation of a video for best practice in line care. A business case is being developed to enhance the line care service. MSSA improvements form part of the IPC annual work plan.

Improvements in 14-hour post take review performance across the Scarborough have continued in June, and are supported by the quality improvements being undertaken and monitored by the SAFER group.

Learning from the success of the insulin improvement work undertaken on the York site a similar group has been established to address an emerging theme in incidents related to insulin.

Recommendation:

The Board is asked to receive the report and note any actions being taken.

Author(s): Caroline Johnson, Deputy Head of Patient Safety & Governance
Liam Wilson, Lead Nurse Patient Safety

Director Sponsor: James Taylor, Medical Director
Heather McNair, Chief Nurse

TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY SUMMARY: (i)

REF	SERIOUS INCIDENTS (data is based on SI declaration date except given final report)	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.01	Number of SI's reported	▲	2	6	6	10	9	12	18	10	6	14	14	12	20
1.02	% SI's notified within 2 working days of SI being identified	◀▶	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
1.03	Number of SIs where Duty of Candour is Applicable (Moderate or Above Harm)	▲	2	5	5	7	9	10	15	5	6	13	14	12	18
1.04	Number of SIs Where Stage 2 (Written) Duty Of Candour is Outstanding (Moderate or Above Harm)	▲	0	0	0	0	0	1	0	0	0	0	0	0	7
1.05	% Compliance with Stage 2 (Written) Duty of Candour for Serious Incidents (Moderate or Above Harm)	▼	100%	100%	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%	61%
1.06	-Invitation to be involved in Investigation (Clinical SIs Only)	▼	0	4	1	3	4	2	10	3	1	6	2	2	1
1.07	-Given Final Report (If Requested - Clinical SIs Only - based on Investigation End Date)*	◀▶	3	1	4	0	4	1	2	4	2	5	3	1	1

*Data for 1.07 has been refreshed for the last 13 months due to error

The harm for incidents reported within the last week of the reporting period have not been validated as investigations are ongoing. The degree of harm may change from the reporter's initial depending on the outcome of the investigation.

REF	DUTY OF CANDOUR (All Incidents - data is based on the date reported)	Target	Sparkline / Previous Month	TOTAL
1.10	Incident Graded Moderate or Above			258
1.11	Stage 1 - Verbal Apology Given			246
1.12	Stage 2 - Written Apology Given			237
1.14	% Compliance with Stage 2 (Written) Duty of Candour			92%
1.15	Stage 3 - Final Written Summary Due (for incidents reported in January 2021)			14
1.16	Stage 3 - Final Written Summary Completed			11

*** For Incidents Reported Between 01/07/20 and 16/06/21**

Note: Duty of Candour data is based on the dates incidents were reported, not the incident date, so the number of incidents graded as moderate or above harm in the DoC data may be different to those in the incident data. All harms of moderate or above are subject to ongoing validation, so degree of harm data is subject to change. In exceptional cases, it may not be possible to provide letters to patients / relatives / carers, so percentage compliance is calculated on the number of incidents where the DoC process has been signed off signed as complete.

The Trust introduced a three stage Duty of Candour process on 18 January 21, which requires a final written summary of the investigation findings and actions taken being sent within 6 months of the incident being reported. Data on the third stage of Duty of Candour is now included above. However, compliance with Duty of Candour continues to be measured as compliance with Stage 2 where an initial written apology is provided, due to the long time period for completion of the third stage.

REF	CLAIMS	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.20	Number of Negligence Claims	▼	8	7	11	19	20	12	11	9	17	13	11	11	8
1.21	Number of Claims settled per Month	▼	5	4	4	3	2	1	1	2	2	1	4	1	0
1.22	Amount paid out per month	▼	239,000	290,000	111,000	415,686	12,510,000	10,654,648	7,500	29,000	36,500	32,500	683,500	250,000	0
1.23	Reasons for the payment		Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability	Accepted Liability

Please note that damages data may be adjusted some time after a claim has been settled if there is a delay in agreeing a final settlement, hence data is subject to change.

REF	MEASURES OF HARM	Target	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.30	Incidents Reported		▼	1,023	1,115	1,263	1,262	1,391	1,360	1,309	1,492	1,320	1,413	1,360	1,434	1,384
1.31	Incidents Awaiting Sign Off		▼	502	484	570	697	700	725	920	1,014	1,010	942	823	720	414
1.32	Patient Falls		▼	152	139	178	198	221	221	187	261	221	214	208	212	194
1.33	Pressure Ulcers - Newly Developed Ulcer		▼	65	67	87	90	74	102	94	138	117	94	89	94	84
1.34	Pressure Ulcers - Deterioration of Pressure Ulcer		▲	16	13	16	12	14	7	22	22	15	20	25	23	24
1.35	Pressure Ulcers - Present on Admission		▼	130	127	148	111	142	145	159	174	164	201	167	167	147
1.36	Degree of harm: serious or death		▲	4	2	4	5	9	5	6	8	5	8	8	4	5
1.37	Medication Related Errors		▼	104	114	108	125	100	140	105	157	115	124	128	163	152
1.38	VTE risk assessments	95%	▼	90.7%	95.5%	94.2%	95.3%	95.2%	95.0%	94.3%	94.7%	94.4%	94.2%	93.3%	94.1%	92.5%
1.39	Never Events	0	◀▶	0	0	0	0	0	0	0	0	0	1	0	0	0

As at the beginning of November, the degree of harm is being determined by the incident reporter at the time of reporting rather than being determined during the investigation The degree of harm for incidents reported within the last week of the reporting period have not been validated as investigations are ongoing. The degree of harm may change from the reporter's initial depending on the outcome of the investigation.

VTE risk assessment performance for Jan-21 has been updated due to error

TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY SUMMARY: (ii)

REF	PRESSURE ULCERS***	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.40	Number of Category 2	▲	40	46	57	54	56	58	74	89	73	70	57	61	71
1.41	Number of Category 3	▼	3	3	3	2	2	3	2	3	3	3	9	3	2
1.42	Number of Category 4	▲	1	2	2	1	0	1	2	2	2	2	4	0	1
1.43	Total no. developed/deteriorated while in our care (care of the org) - acute	▼	53	52	67	74	62	74	87	127	94	74	67	87	77
1.44	Total no. developed/deteriorated while in our care (care of the org) - community	▲	28	28	36	28	26	35	29	33	38	40	47	30	31

REF	FALLS****	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.50	Number of falls with moderate harm	◀▶	1	1	2	9	5	7	5	2	4	3	5	2	2
1.51	Number of falls with severe harm	▲	2	1	0	1	0	0	1	4	1	4	5	1	2
1.52	Number of falls resulting in death	◀▶	0	0	0	0	0	0	0	0	1	0	0	0	0

Note *** and **** - falls and pressure ulcers are subject to ongoing validation. The degree of harm for incidents reported within the last week of the reporting period have not been validated as investigations are ongoing. The degree of harm may change from the reporter's initial depending on the outcome of the investigation. Inpatients developing pressure ulcers in Community Hospitals are now counted in the Acute care data above (as the care they receive is the same as patients on acute wards) so this data has been recalculated. Community pressure ulcers includes the RATS and DN Teams.

REF	DRUG ADMINISTRATION	Target	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
10.20	Medication Incidents Resulting in Moderate Harm, Serious/Severe Harm or Death		▼	0	2	0	2	1	1	0	2	0	0	0	1	0
10.21	Insulin Incidents		▼	15	10	15	16	7	15	7	13	9	19	8	14	13
10.22	Antimicrobial Incidents		▲	12	16	13	15	10	14	12	16	14	13	18	17	19
10.23	Opiate Incidents		▼	25	17	23	20	28	25	30	30	27	23	27	43	38
10.24	Anticoagulant Incidents		▼	9	8	9	6	16	14	6	13	15	8	10	14	12
10.25	Missed Dose Incidents		▼	15	26	18	28	21	24	14	38	26	23	15	41	28
10.26	Discharges Incidents		▼	21	13	11	9	14	11	11	12	14	17	32	23	18
10.27	Prescribing Errors		▲	27	27	22	42	31	33	18	33	25	32	22	35	38
10.28	Preparation and Dispensing Incidents		▼	5	11	6	13	7	14	4	8	6	11	10	14	12
10.29	Administrating and Supply Incidents		▼	51	47	58	49	45	58	52	73	54	58	68	75	70

REF	SAFEGUARDING	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.70	% of staff compliant with training (children)	◀▶	86%	87%	86%	86%	86%	87%	87%	86%	86%	86%	87%	87%	87%
1.71	% of staff compliant with training (adult)	▲	87%	88%	87%	87%	87%	87%	87%	87%	87%	86%	87%	87%	88%
1.72	% of staff working with children who have review DBS checks														

REF	PATIENT EXPERIENCE: COMPLAINTS, PALS AND FFT	Target	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
2.01	New complaints this month †		▲	28	41	29	39	46	46	37	36	48	56	41	34	57
2.02	% Complaint responses closed within target timescale	30 days	▲	56%	60%	57%	50%	58%	71%	65%	61%	81%	64%	74%	50%	71%
	CG1	30 days	▲	50%	55%	63%	63%	37%	71%	43%	25%	69%	44%	61%	31%	67%
	CG2	30 days	▲	25%	60%	60%	43%	75%	33%	61%	33%	70%	70%	78%	67%	100%
	CG3	30 days	▼	57%	67%	54%	40%	60%	75%	71%	82%	100%	71%	92%	57%	56%
	CG4	30 days	▼	0%	50%	50%	0%	100%	100%	100%	-	100%	100%	75%	100%	75%
	CG5	30 days	▲	75%	100%	75%	100%	80%	100%	100%	83%	100%	100%	100%	60%	83%
	CG6	30 days	▲	100%	0%	40%	33%	63%	50%	67%	50%	67%	50%	43%	50%	71%
2.03	New PALS concerns this month		▲	114	133	149	174	134	104	92	86	132	132	144	142	159
2.04	% PALS responses closed within target timescale	10 days	▲	81%	77%	74%	76%	71%	69%	73%	77%	86%	71%	74%	74%	77%
	CG1	10 days	◀▶	83%	74%	64%	71%	73%	67%	69%	69%	92%	74%	73%	67%	67%
	CG2	10 days	▲	73%	69%	63%	72%	58%	59%	56%	78%	72%	63%	96%	90%	95%
	CG3	10 days	▲	72%	77%	71%	70%	63%	69%	85%	67%	88%	68%	68%	63%	69%
	CG4	10 days	▼	100%	83%	100%	88%	91%	83%	71%	75%	88%	100%	82%	100%	92%
	CG5	10 days	▲	79%	83%	86%	86%	86%	75%	71%	100%	100%	77%	67%	55%	69%
	CG6	10 days	▲	79%	87%	77%	82%	74%	68%	88%	79%	86%	67%	50%	72%	87%
2.05	FFT - York ED Recommend %	90%	▲	92.2%	87.8%	85.6%	90.7%	91.7%	91.7%	90.4%	93.0%	94.3%	91.5%	86.4%	96.0%	-
2.06	FFT - Scarborough ED Recommend %	90%	▲	95.7%	85.1%	82.9%	87.9%	93.9%	92.6%	87.1%	83.9%	88.4%	85.7%	84.3%	93.5%	-
2.07	FFT - Trust ED Recommend %	90%	▲	93.0%	87.1%	84.8%	89.7%	92.2%	91.9%	90.0%	91.6%	93.5%	90.7%	86.0%	95.5%	-
2.08	FFT - Trust Inpatient Recommend %	90%	▲	99.1%	95.4%	95.3%	96.1%	94.9%	98.7%	97.7%	98.8%	95.3%	98.2%	98.0%	98.3%	-
2.09	FFT - Trust Maternity Recommend %	90%	◀▶	-	-	-	-	98.7%	99.5%	99.5%	98.4%	100.0%	99.7%	100.0%	100.0%	-

† Please note that the Feb-21 figure for New Complaints has been corrected to 48. On previous reports it was stated as 42.

TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY SUMMARY: (iii)

REF	CARE OF THE DETERIORATING PATIENT	Target	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
3.01	14 hour Post Take - York *	90%		83%	82%	80%	80%	83%	83%	81%	79%	82%	79%	79%	79%	81%
3.02	14 hour Post Take - Scarborough *	90%		75%	74%	69%	70%	78%	80%	77%	78%	81%	82%	81%	82%	83%
3.03	NEWS within 1 hour of prescribed time	90%		91.9%	91.6%	91.2%	89.9%	89.9%	89.8%	89.6%	87.7%	89.6%	91.0%	91.8%	91.1%	90.8%
3.04	Elective admissions: EDD within 24 hours of admission	93%		93.9%	96.2%	94.1%	90.1%	92.2%	93.3%	93.2%	93.9%	94.8%	94.1%	93.8%	94.1%	92.8%

* Data includes non-elective inpatients only, excludes Maternity, and excludes patients only admitted to the Patient Lounge. The numerator (those included as having had a Senior Review within 14hrs) includes any patient who has been marked on CPD as having had a Senior Review (post take still required) or Post Take Completed within 14 hours of admission time. It also includes any patients who have had a Length of Stay less than 14hrs.

REF	MORTALITY INFORMATION	Target	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
10.33	Summary Hospital Level Mortality Indicator (SHMI)	1.00		0.99	0.99	0.99	0.99	1.00	0.99	0.99	0.99	0.97	0.96	0.95	0.95	-

REF	4AT ASSESSMENT		Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
5.01	4AT Screening	90%		85.9%	67.4%	63.6%	58.7%	60.0%	59.4%	58.8%	54.8%	53.4%	62.2%	63.1%	64.3%	67.8%

REF	INFECTION PREVENTION	Target*	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
6.01	Clostridium Difficile - meeting the C.Diff objective			2	7	7	11	4	11	6	10	5	6	7	12	12
6.02	Clostridium Difficile - meeting the C.Diff objective - cumulative			11	18	25	36	40	51	57	67	72	78	7	19	31
6.03	MRSA - meeting the MRSA objective	0		0	0	0	0	0	0	0	0	0	0	0	0	0
6.04	MSSA			2	1	3	4	6	7	11	7	7	3	5	7	8
6.05	MSSA - cumulative			13	14	17	21	27	34	45	52	59	62	5	12	20
6.06	ECOLI			10	18	13	9	23	14	6	20	7	17	15	12	20
6.07	ECOLI - cumulative			32	50	63	72	95	109	115	135	142	159	15	27	47
6.08	Klebsiella			4	7	4	8	7	4	4	6	6	3	5	3	4
6.09	Klebsiella - cumulative			7	14	18	26	33	37	41	47	53	56	5	8	12
6.10	Pseudomonas			1	2	1	2	2	3	0	3	2	0	3	4	1
6.11	Pseudomonas - cumulative			5	7	8	10	12	15	15	18	20	20	3	7	8
6.12	MRSA Screening - Elective	95%		80.00%	73.47%	82.47%	86.44%	83.08%	79.49%	78.15%	82.46%	81.34%	83.64%	78.83%	85.44%	84.24%
6.13	MRSA Screening - Non Elective	95%		93.29%	90.23%	92.42%	91.12%	92.12%	89.59%	89.78%	87.57%	90.04%	91.93%	90.71%	91.15%	90.58%

* Thresholds to be confirmed for 2021-22 for MSSA, ECOLI and C-DIFF.
From April 2020 - PHE change of definitions for Trust attributed cases - reported cases include any patient positive within 28 days of last discharge

REF	DOLS	Target	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
8.01	Standard Authorisation Status Unknown: Local Authority not informed the Trust of outcome			10	28	1	1	4	8	6	9	5	6	4	32	12
8.02	Standard Authorisation Not Required: Patient no longer in Trust's care and within 7 day self-authorisation			23	0	6	31	19	54	25	34	34	31	44	15	61
8.03	Under Enquiry: Safeguarding Adults team reviewing progress of application with Local Authority or progress with ward			14	9	24	9	20	17	14	8	21	11	9	9	8
8.04	Standard Authorisation Granted: Local Authority granted application			0	0	0	0	0	0	0	0	1	0	0	0	0
8.05	Application Not Granted: Local Authority not granted application			0	0	1	0	0	0	0	0	0	0	0	0	0
8.06	Application Unallocated as Given Local Authority Prioritisation: Local Authority confirmed receipt but not yet actioned application			25	36	20	10	9	10	6	14	10	13	6	21	8
8.07	Safeguarding Adults concerns reported to the Local Authority against the Trust			6	4	3	6	6	11	4	8	8	9	11	4	8
8.08	Application Withdrawn: Patient no longer in Trust's care within the Local Authority 8 week period for assessment			0	1	15	9	10	11	13	9	7	4	5	4	6

TRUST BOARD REPORT : June-2021

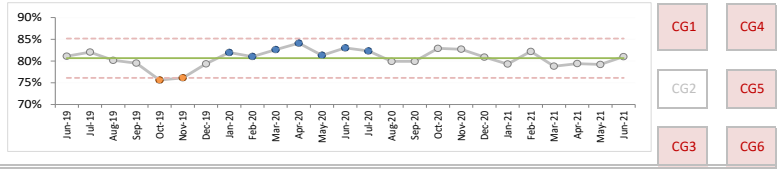
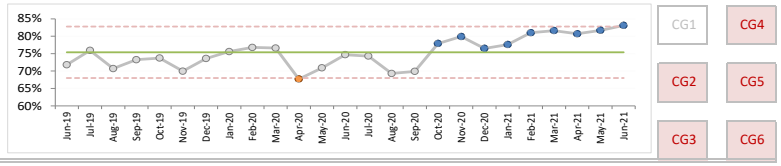
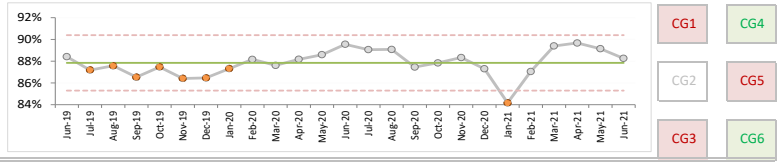
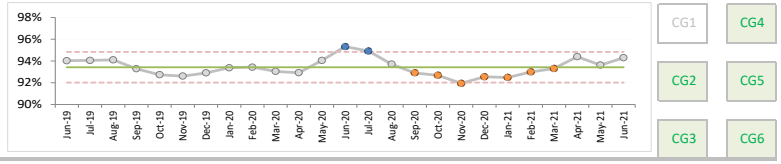
QUALITY AND SAFETY SUMMARY: (iv) QUANTITATIVE TABLE

REF	Indicator	Consequence of Breach	Threshold	Sparkline / Previous Month		Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Mar-21	Apr-21	May-21	Jun-21
9.01	All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days*	Non-payment of costs associated with cancellation and re-scheduled episode of care	0		◀▶	-	-	-	-	-	-	-	-
9.02	No urgent operation should be cancelled for a second time*	£5,000 per incidence in the relevant month	0		◀▶	-	-	-	-	-	-	-	-
9.03	Sleeping Accommodation Breach	£250 per day per Service User affected	0		▼	0	0	8	22	10	20	16	15
9.04	% Compliance with WHO safer surgery checklist	No financial penalty	100.00%		◀▶	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
9.05	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	99.00%		▲	99.95%	99.91%	99.93%	99.95%	99.95%	99.92%	99.95%	-
9.06	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	95.00%		▼	99.58%	99.51%	99.52%	99.78%	99.77%	99.71%	99.67%	-
9.07	Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	>4% slot unavailability if		▲	12.10%	8.04%	7.61%	5.81%	8.06%	4.43%	5.22%	-
	Delayed Transfer of Care – All patients medically fit for discharge and issued a 'notification notice' as per joint protocol for the transfer of care	As set out in Service Condition 3 and General Condition 9	Set baseline in Q1 and agree trajectory	Monthly Provider Report									
9.08	Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	99.00%		▲	75.17%	85.06%	88.78%	88.16%	92.93%	75.00%	69.39%	84.72%
	Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	As set out in Service Condition 3 and General Condition 9	Best Practice Standards	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced and tabled at sub CMB quarterly.									
9.09	Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	90.00%		▼	93.29%	93.03%	91.36%	94.32%	94.44%	95.19%	95.97%	91.41%
9.10	Number/Percentage of maternity patients recorded as smoking by 12 weeks and 6 days that are referred to a smoking cessation service subject to patient consent	General Condition 9	95.00%		◀▶	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	All Red Drugs to be prescribed by provider effective from 01/04/15, subject to agreement on list	Recovery of costs for any breach to be agreed via medicines management committee	0	CCG to audit for breaches									
	All Amber Drugs to be prescribed as per shared care guidelines from 01/04/15	Recovery of costs for any breach to be agreed via medicines management committee	0	CCG to audit for breaches									

*QMCO and Monthly Sitrep Return suspended due to Covid-19

TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY: CARE OF DETERIORATING PATIENT

Jun-21	METRIC :	TARGET :	vs LM :	
81.0%	**3.01** 14 hour Post Take - York	90.0%	1.8% ↑	
83.1%	**3.02** 14 hour Post Take - Scarborough	90.0%	1.4% ↑	
88.3%	**10.01** NEWS within 1 hour (York)	90.0%	-0.9% ↓	
94.3%	**10.02** NEWS within 1 hour (Scarb)	90.0%	0.7% ↑	

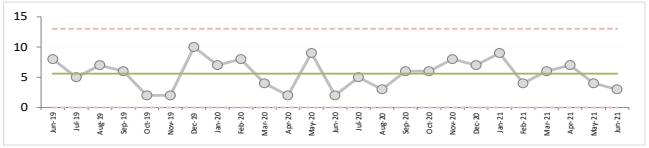
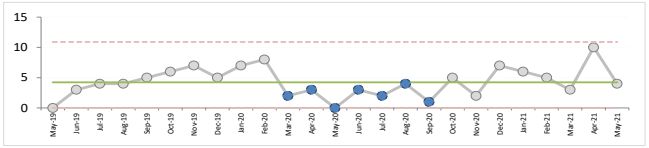
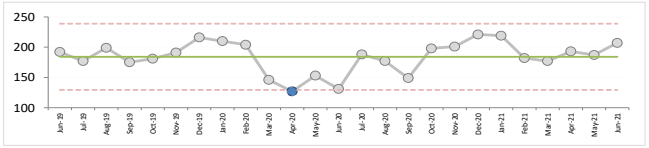
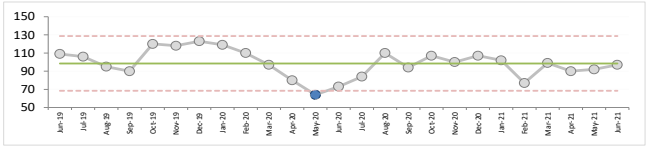
CG1 CG4 CG2 CG5 CG3 CG6

HIGHLIGHTS FOR BOARD TO NOTE :

The SAFER group continues to address factors impacting on all aspects of the the SAFER Care bundle, of which 14-hour post-take reviews are an element. The Scarborough site continues to show special cause variation of an improving nature, indicating a positive impact of initiatives. Learning is shared across sites and teams through the group. Work is underway to review CPD and ensure ease of reporting as this has been identfied as a barrier to accurate reporting of reviews in surgery.

TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY: CARE OF DETERIORATING PATIENT

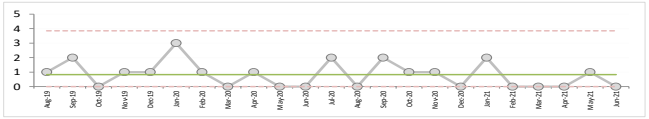
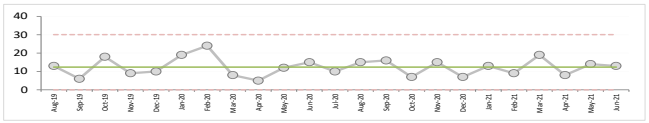
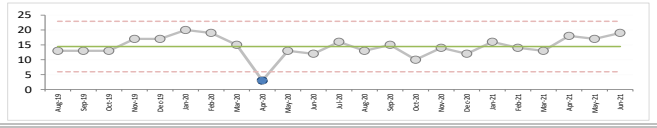
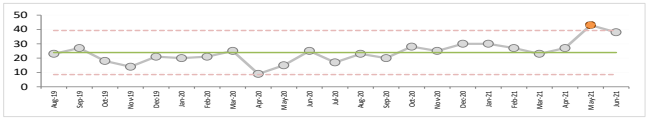
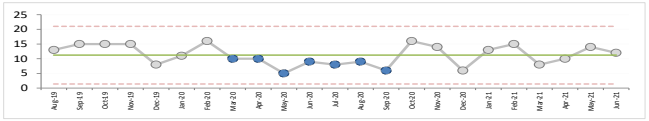
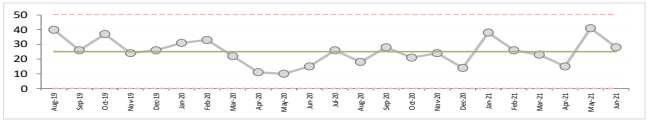
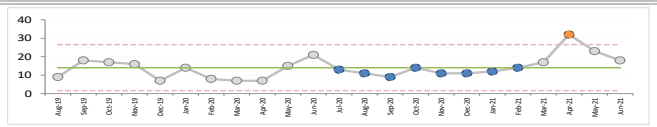
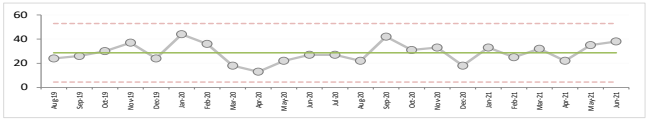
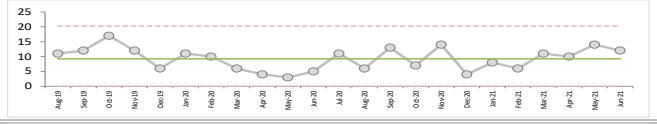
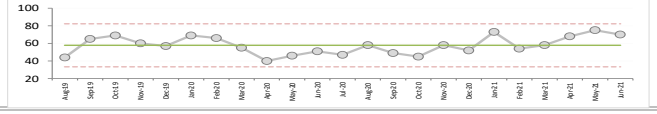
Jun-21	METRIC :	TARGET :	vs LM :	
3	**10.10** Crash Calls (York)	-	-1 ↓	
May-21				
4	**10.12** Crash Calls (Scarb)	-	-6 ↓	
Jun-21				
207	**10.13** Calls to Outreach Team (York)	-	20 ↑	
Jun-21				
97	**10.14** Calls to Outreach Team (Scarb)	-	5 ↑	

HIGHLIGHTS FOR BOARD TO NOTE :

Cardiac arrests across both sites remain low. In York lower than the mean during June, with a reduction from April to May in Scarborough. Not reflected in this data but it has come to our attention that there remains certain confusion about when to call the crash team and confusion about DNACPR. Ongoing challenges persist with DNACPR education.
Of note the outreach workload has increased in York but remained static in Static.

TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY: MEDICATION INCIDENTS

Jun-21	METRIC :	TARGET :	vs LM :	
0	**10.20** Medication Incidents Resulting in Moderate Harm, Serious/Severe Harm or Death	-	-1 ↓	
13	**10.21** Insulin Incidents	-	-1 ↓	
19	**10.22** Antimicrobial Incidents	-	2 ↑	
38	**10.23** Opiate Incidents	-	-5 ↓	
12	**10.24** Anticoagulant Incidents	-	-2 ↓	
28	**10.25** Missed Dose Incidents	-	-13 ↓	
18	**10.26** Discharges Incidents	-	-5 ↓	
38	**10.27** Prescribing Errors	-	3 ↑	
12	**10.28** Preparation and Dispensing Incidents	-	-2 ↓	
70	**10.29** Administrating and Supply Incidents	-	-5 ↓	

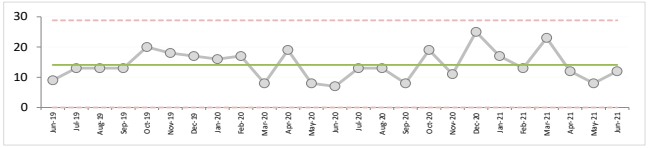
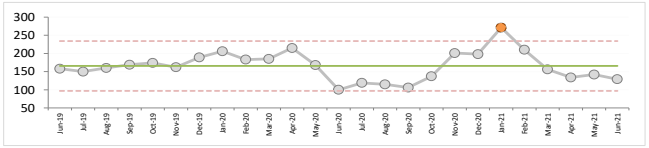
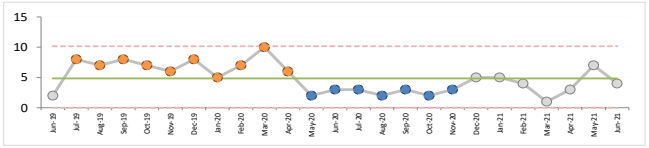
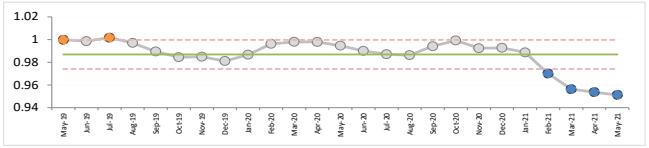
HIGHLIGHTS FOR BOARD TO NOTE :

Total number of medication incidents, types of medication incidents and incidents relating to critical medications remain within normal distribution, with the exception of opiate drugs. This is due to errors in Controlled Drug record keeping at ward level and is been addressed through regular CD inspections by the Pharmacy Governance Team.

A number of initiatives have commenced to attempt to reduce the number of incidents relating to insulin. An insulin safety group has been established for Care Group 2, to mirror the successful Group in Care Group 1. Work has commenced to scope a register of insulin patients on CPD which will highlight the requirement to prescribe insulin on admission and a guideline is in development to support prescribers to prescribe an initial insulin dose when the patient does not know their usual dose.

TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY : MORTALITY

Jun-21	METRIC :	TARGET :	vs LM :	
12	**10.30** ED Deaths	-	4 ↑	
129	**10.31** Inpatient Deaths (Acute)	-	-13 ↓	
4	**10.32** Inpatient Deaths (Community)	-	-3 ↓	
May-21				
0.95	**10.33** Summary Hospital Level Mortality Indicator (SHMI)	1.00	0.00	

HIGHLIGHTS FOR BOARD TO NOTE :

In June 2021 the top 3 causes of death were Pneumonia, Cardiac Failure and Sepsis. There was 1 death recorded as 1a Covid Pneumonia.

In June overall deaths increased in the Emergency Department, but decreased in the Acute Sites and in the Community. The number of deaths per 1000 bed days was calculated and is shown below:
August 2020 - 3.97 deaths per 1000 bed days
September 2020 - 5.75 deaths per 1000 bed days
October 2020 - 7.53 deaths per 1000 bed days
November 2020 - 10.65 deaths per 1000 bed days
December 2020 - 11.41 deaths per 1000 bed days
January 2021 - 13.45 deaths per 1000 bed days
February 2021 - 11.75 deaths per 1000 bed days
March 2021 - 8.56 per 1000 bed days
April 2021 - 7.15 per 1000 bed days
May 2021 - 7.10 per 1000 bed days
June 2021 - 6.90 per 1000 bed days
When compared to the total number of deaths per 1000 bed days during June 2020 (6.54 deaths per 1000 bed days), June 2021 has seen a minor increase.

In June 2021 there were 11 Structured Judgement Casenote Reviews (SJCR's) commissioned . The SJCR's requested were as a result of the following; 1 x elective admission, 4 x medical examiner review, 2 x Q&S request. 2 x - learning impairment, 1 x elective surgery, 1 x complaint and 1 x Initial Mortality Score.

TRUST BOARD REPORT : June-2021

PATIENT EXPERIENCE: NEW COMPLAINTS AND PALS CASES

New complaints and PALS cases by care group and site

Care Group	COMPLAINTS				PALS			
	York	Scarb	Brid	Total	York	Scarb	Brid	Total
CG1	15	0	0	**15**	44	0	0	**44**
CG2	0	8	0	**8**	0	16	0	**16**
CG3	11	3	1	**15**	32	2	0	**34**
CG4	2	1	0	**3**	10	2	0	**12**
CG5	7	3	0	**10**	10	5	0	**15**
CG6	2	2	1	**5**	30	4	1	**35**
Corporate Service	0	1	0	**1**	3	0	0	**3**
Total	**37**	**18**	**2**	**57**	**129**	**29**	**1**	**159**

There has been a slight increase in the number of complaints received this month for CG3 but these are across specialism and no pattern identifed.

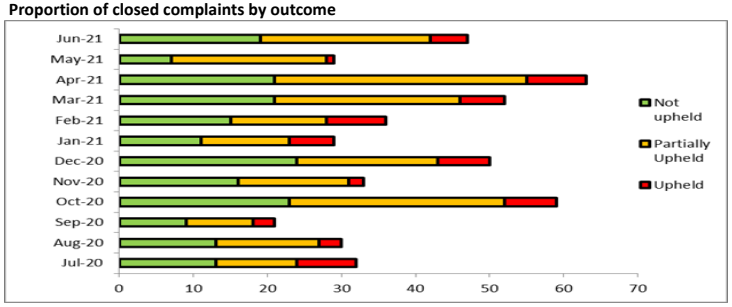
Top 5 sub-subjects

COMPLAINTS	York	Scarb	Brid	Total	PALS	York	Scarb	Brid	Total
Delay or failure in treatment or procedure	7	4	0	**11**	Appointment availability	15	5	1	**21**
Attitude of nursing staff/midwives	5	6	0	**11**	Attitude of nursing staff/midwives	13	2	0	**15**
Delay or failure in arranging/undertaking tests etc.	5	4	0	**9**	Communication with relatives/carers	10	4	0	**14**
Care needs not adequately met	8	1	0	**9**	Communication with Patient	11	1	0	**12**
Delay or failure to diagnose	7	2	0	**9**	Discharge Arrangements	8	3	0	**11**
Total	**32**	**17**	**0**	**49**	**Total**	**57**	**15**	**1**	**73**

Care group leads are working on action places to address the themes for their areas and actions/improvements are discussed and shared at the PESG.

PATIENT EXPERIENCE: CLOSED CASES

Proportion of closed complaints by outcome



Awaiting two outstanding outcomes from CG5

Closed Complaints

Care Group	<30		30-50		51-100		>100		Total Closed	Total Average No of Days	% Within Target
	Closed	Average No of Days	Closed	Average No of Days	Closed	Average No of Days	Closed	Average No of Days			
CG1	10	15	2	36	3	55	0	0	**15**	**26**	67%
CG2	6	18	0	0	0	0	0	0	**6**	**18**	100%
CG3	5	20	4	35	0	0	0	0	**9**	**26**	56%
CG4	3	27	0	0	1	63	0	0	**4**	**36**	75%
CG5	5	19	1	45	0	0	0	0	**6**	**23**	83%
CG6	5	20	0	0	1	73	1	151	**7**	**46**	71%
Corporate Se	1	15	1	31	0	0	0	0	**2**	**23**	50%
Total	**35**	**18**	**8**	**36**	**5**	**60**	**1**	**151**	**49**	**28**	71%

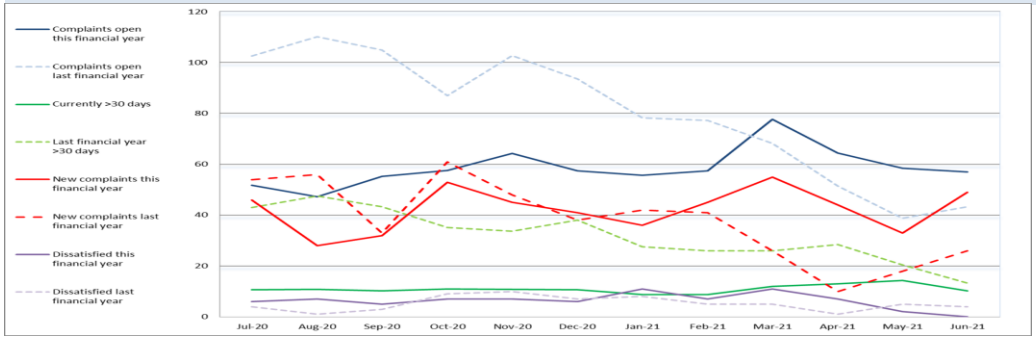
71% closed complaints were in target. 16% were addressed within 30-50 days, 10% within 51-100 working day and 2% were addressed in >100 days. 50% of the cases over target were extended in agreement with the complainant.

Closed PALS

Care Group	<10		10-20		21-50		51-100		>100		Total Closed	Total Average of No of Days	% Within Target
	Closed	Average of No of Days	Closed	Average of No of Days	Closed	Average of No of Days	Closed	Average of No of Days	Closed	Average of No of Days			
CG1	28	3	11	13	2	25	1	58	0	0	**42**	**8**	67%
CG2	18	3	1	11	0	0	0	0	0	0	**19**	**4**	95%
CG3	27	4	10	14	2	23	0	0	0	0	**39**	**8**	69%
CG4	11	4	1	15	0	0	0	0	0	0	**12**	**5**	92%
CG5	11	6	3	13	2	24	0	0	0	0	**16**	**9**	69%
CG6	27	4	3	11	1	22	0	0	0	0	**31**	**5**	87%
Corporate Se	3	2	1	20	0	0	0	0	0	0	**4**	**6**	75%
Total	**125**	**4**	**30**	**14**	**7**	**24**	**1**	**58**	**0**	**0**	**163**	**7**	**77%**

77% closed PALS cases were in target and 18% were addressed within 10-20 working days. 4% cases were addressed in 21-50 working days and 1% within 51-100 working days.

PATIENT EXPERIENCE: COMPLAINT PERFORMANCE HANDLING



TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY: MATERNITY (YORK)

YORK - MATERNITY DASHBOARD			Measure	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Regional Average for last Quarter	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
RESPONSIVE																			
Activity	Births	Bookings	1st m/w visit	≤312	313-340	≥341	N/A	270	236	326	319	237	263						
		Bookings <10 weeks	No. of mothers	≥90%	76%-89%	≤75%		92.6%	93.2%	87.7%	81.8%	81.4%	81.0%						
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	< 10%	10.1%-19.9%	>20%		4.1%	2.5%	2.8%	2.5%	2.5%	3.8%						
		Births	No. of babies	≤245	246-266	≥267		230	241	258	238	230	261						
		No. of women delivered	No. of mothers	≤242	243-263	≥264		226	239	254	234	226	257						
		Planned homebirths	No. of mothers	≥2.1%	≤2-1.6%	≤1.5%	1.50%	2.2%	1.3%	0.8%	1.3%	0.9%	0.0%						
	Closures	Homebirth service suspended	No. of suspensions	0-3		4 or more		9	13	11	5	10	-						
		Women affected by suspension	No. of women	0		1 or more		3	2	5	0	2	-						
		Community midwife called in to unit	No. of times	3	4-5	6 or more		1	5	4	5	4	-						
		Maternity Unit Closure	No. of closures	0		1 or more		0	3	1	0	2	0						
		SCBU at capacity	No of times					3	3	0	0	0	0						
		SCBU at capacity of intensive cots	No. of times					25	3	16	14	8	4						
		SCBU no of babies affected	No. of babies affected	0	1	2 or more		1	0	0	0	0	0						
WELL LED																			
Workforce	Staffing	MW to birth ratio	Ratio	≤29.5	29.6 - 30.9	>31	DH	29	29	29	31	31	30						
		1 to 1 care in Labour	CPD	100%		≤99.9%	n/a	96.6%	97.6%	96.7%	97.2%	100.0%	99.6%						
		L/W Co-ordinator supernumary %	Shift Handover Sheets	100%		≤99.9%		97.0%	91.0%	92.0%	88.3%	93.5%	80.0%						
		Anaesthetic cover on L/W	av.sessions/week	10	4-9	≤3		10	10	10	10	10	10						
SAFE																			
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	≥57%	≤56.9-54%	<53.9%	59%	56.4%	54.9%	56.4%	59.0%	56.1%	50.4%						
		Assisted Vaginal Births	No. of instr. Births - %	≤12.4%	≥12.5-14%	≥14.1%	11%	15.0%	15.5%	13.4%	9.8%	19.0%	20.2%						
		C/S Births	Em & elect - %	≤30.1%	≥30.2-32%	>32.1%	31%	27.0%	29.3%	29.9%	30.3%	24.8%	28.8%						
		Elective caeserean	%	≤13.2%	≥13.3-16%	≥16.1%	13%	8.8%	12.6%	15.4%	11.1%	11.9%	13.2%						
		Emergency caeserean	%	≤16.9%	≥17-20%	≥20.1%	18%	18.1%	16.7%	14.6%	19.2%	12.8%	15.6%						
		HDU on L/W	No. of women	5 or less	6-9	10 or more		12	13	16	13	14	21						
		BBA	No. of women	2 or less	3-4	5 or more		5	6	3	2	3	2						
		HSIB cases	No. of babies	0		1 or more		0	0	0	0	0	0						
	Morbidity	Neonatal Death	No of babies	0		1 or more		0	0	0	1	0	0						
		Antepartum Stillbirth	No. of babies	0	1	2 or more	n/a	2	2	1	0	1	0						
		Intrapartum Stillbirths	No. of babies	0		1 or more	n/a	0	0	0	0	0	0						
	Risk Management	Cold babies	No of babies admitted to SCBU co	1 or less	2-3	2 or more		3	5	1	3	5	4						
		Breastfeeding Initiation rate	% of babies feeding at birth	≥75%	≤74.9-71%	≤70.9%	68%	75.0%	72.8%	68.9%	71.4%	69.4%	73.2%						
		Smoking at time of delivery	% of women smoking at del.	≤6%	≥6.1-10%	≥10.1%	13%	8.0%	6.7%	10.6%	8.1%	10.2%	7.4%						
		SI's	No. of Si's declared	0		1 or more		1	1	1	0	0	0						
		PPH > 1.5L	No. of women	3 or less	4-5	6 or more		7	9	7	7	6	11						
		PPH > 1.5L as % of all women	% of births				3.9	3.0	3.7	2.7	2.9	2.6	4.1						
		Shoulder Dystocia	No. of women	2 or less	3-4	5 or more		4	1	1	5	3	1						
		3rd/4th Degree Tear - normal birth	No of women	≤2.8%	2.9- 4.5%	≥4.6%	1.90%	1.5%	1.5%	0.9%	2.3%	1.1%	1.4%						
		3rd/4th Degree Tear - Assisted birth	No of women	≤6.05%	≥6.1-8%	≥8.1%	6%	8.8%	2.7%	2.9%	4.3%	2.3%	3.8%						
	New Complaints	Informal	No. of Informal complaints	0	1-4	5 or more		3	4	2	4	2	2						
		Formal	No. of Formal complaints	0	1-4	5 or more		1	2	1	1	1	2						

Please note: Due to data cleansing that takes place, the data for the current quarter may be subject to change.

Formatting and benchmarking amended April 2021 to reflect the most current National averages. Insert of Regional figures from the Regional dashboard where available. These will be changed when new quarterly figures are published.

TRUST BOARD REPORT : June-2021

QUALITY AND SAFETY: MATERNITY (SCARBOROUGH)

SCARBOROUGH - MATERNITY DASHBOARD			Measure	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Regional Average for last Quarter	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
RESPONSIVE																			
Activity	Births	Bookings	1st m/w visit	≤171	172-185	≥186	N/A	188	156	178	158	107	142						
		Bookings <10 weeks	No. of mothers	≥90%	76%-89%	≤75%		94.7%	95.5%	84.3%	79.2%	84.5%	78.5%						
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	< 10%	10%-20%	>20%		2.1%	1.9%	4.5%	5.0%	1.8%	4.2%						
		Births	No. of babies	≤113	114-134	≥135		96	94	105	105	93	121						
		No. of women delivered	No. of mothers	≤112	113-133	≥134		96	93	104	103	92	119						
		Planned homebirths	No of mothers	≥2.1%	≤2-1.5%	≤1.5%	1.50%	3.1%	2.2%	3.8%	1.0%	3.3%	2.5%						
	Closures	Homebirth service suspended	No. of suspensions	0-3		4 or more		21	18	17	18	18	16						
		Women affected by suspension	No. of women	0		1 or more		0	0	0	0	0	0						
		Community midwife called in to unit	No. of times	3	4-5	6 or more		1	1	0	3	1	2						
		Maternity Unit Closure	No. of closures	0		1 or more		1	0	0	0	0	0						
		SCBU at capacity	No of times					0	0	0	0	0	0						
		SCBU at capacity of intensive care cots	No. of times					0	0	0	0	0	0						
		SCBU no of babies affected	No. of babies affected	0	1	2 or more		0	0	0	0	0	0						
WELL LED																			
Workforce	Staffing	M/W to birth ratio	Ratio	≤29.5	29.6-30.9	>31	DH	23.0	20.0	20.0	22	22	22						
		1 to 1 care in Labour	CPD	≥100%		≤99.9%		96.5%	97.5%	98.9%	97.9%	97.8%	94.8%						
		L/W Co-ordinator supernumary %	Shift Handover Sheets	≥100%		≤99.9%		100.0%	100.0%	100.0%	95.0%	100.0%	98.3%						
		Anaesthetic cover on L/W	av.sessions/week	≥10	4-9	≤3		5	5	5	5	5	5						
SAFE																			
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	≥57%	56.9-54%	<53.9%	59%	62.9%	68.8%	53.6%	65.4%	53.1%	57.4%						
		Assisted Vaginal Births	No. of instr. Births - %	≤12.4%	≥12.5-14%%	≥14.1%	11%	5.2%	5.4%	10.6%	5.8%	5.4%	4.2%						
		C/S Births	Em & elect - %	≤30.1%	≥30.2-32%	≥32.1%	31%	30.2%	24.7%	33.7%	27.2%	39.1%	37.8%						
		Elective caeserean	%	≤13.2%	≥13.3-16%	≥16.1%	13%	10.4%	15.1%	13.5%	8.7%	13.0%	16.0%						
		Emergency caeserean	%	≤16.9%	≥17.20%	≥20.1%	18%	19.8%	9.7%	20.2%	18.4%	26.1%	21.8%						
		HDU on L/W	No. of women	5 or less	6-9	10 or more		3	4	3	6	7	6						
		BBA	No. of women	2 or less	3-4	5 or more		1	1	0	2	0	4						
		HSIB cases	No. of babies	0	1	2 or more		0	0	0	1	0	0						
	Morbidity	Neonatal Death	No of babies	0		1 or more		0	0	0	0	0	0						
		Antepartum Stillbirth	No. of babies	0	1	2 or more	N/A	1	1	0	0	0	1						
		Intrapartum Stillbirths	No. of babies	0		1 or more	N/A	0	0	0	1	0	0						
	Risk Management	Cold babies	No of babies admitted to SCBU co	1 or less	2-3	4 or more		3	2	3	0	2	4						
		Breastfeeding Initiation rate	% of babies feeding at birth	>75%	74.9-71%	≤70.9%	68%	61.1%	73.1%	63.8%	59.6%	67.7%	57.5%						
		Smoking at time of delivery	% of women smoking at del.	≤6%	≥6.1-10%	≥10.1%	13%	24.2%	23.7%	16.3%	9.7%	9.8%	17.6%						
		SI's	No. of Si's declared	0		1 or more		0	0	0	0	0	1						
		PPH > 1.5L	No. of women	3 or less	4-5	6 or more		1	3	3	5	5	3						
		PPH > 1.5L as % of all women	% of births				3.9	1.0	3.1	2.7	4.7	5.2	2.5						
		Shoulder Dystocia	No. of women	2 or less	3-4	5 or more		0	1	1	2	0	2						
		3rd/4th Degree Tear - normal births	No of women	≤2.8%	2.9- 4.5%	≥4.6%	1.90%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%						
		3rd/4th Degree Tear - assisted birth	No of women	≤6.05%	≥6.1-8%	≥8.1%	6%	0.0%	20.0%	18.2%	0.0%	0.0%	0.0%						
	New Complaints	Informal	No. of Informal complaints	0	1-4	5 or more		1	1	1	0	1	0						
		Formal	No. of Formal complaints	0	1-4	5 or more		1	0	0	0	0	0						

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WORKFORCE PERFORMANCE REPORT

June-2021

Produced July 2021

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

To ensure financial stability

Report produced by:

Information Team

Workforce Performance Report : June-2020

Executive Summary

Trust Strategic Goals:

[X] to deliver safe and high quality patient care as part of an integrated system
[X] to support an engaged, healthy and resilient workforce
[X] to ensure financial sustainability

Purpose of the Report:

To provide the Board with an integrated overview of Workforce Performance within the Trust

Executive Summary:

Key discussion points for the Board are:

Sickness absence rates increased for the second month in a row. Detailed analysis shows that this is across all Care Groups and staff groups. The report details the range of actions being taken to improve attendance and support staff health and wellbeing.

Work continues to embed the new co-created values and behaviours. A platform has been set up for the sharing of ideas for ensuring that all employee and patient touchpoints are aligned to the new values.

An Agile and Flexible working group has been set up to scope the modernisation of the Trust's working practices. Five sub groups have been established covering a range of issues relating to Agile & Flexible working.

Recommendation:

The Board is asked to receive the report and note any actions being taken.

Author(s): Sian Longhorne, Deputy Head of Resourcing

Director Sponsor: Polly McMeekin, Director of Workforce & Organisation Development

TRUST BOARD REPORT : June-2021

WORKFORCE

STRATEGIC OBJECTIVE : To support an engaged, healthy and resilient workforce

REF	Vacancies	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.01	Trust vacancy factor	▲	6.0%	6.0%	4.1%	7.0%	7.0%	6.0%	7.0%	6.0%	5.0%	5.0%	6.0%	7.0%	7.3%
1.02	Nursing and Midwifery vacancy rate - Trust	▲	8.0%	4.6%	4.9%	6.5%	6.5%	7.0%	7.7%	7.4%	7.1%	7.8%	8.6%	8.8%	-
1.03	Nursing and Midwifery vacancy rate - York	▲	5.0%	0.8%	1.4%	3.2%	4.1%	4.0%	5.3%	5.0%	4.4%	4.8%	6.6%	6.3%	-
1.04	Nursing and Midwifery staff group vacancy rate - Scarborough	▲	14.9%	13.3%	13.2%	14.3%	12.2%	14.2%	13.2%	13.1%	13.6%	14.8%	13.5%	14.6%	-
1.05	Medical and Dental vacancy rate - Trust	▲	10.0%	6.9%	6.9%	9.7%	9.5%	9.6%	9.7%	8.5%	8.5%	8.9%	8.9%	9.7%	-
1.06	Medical and Dental vacancy rate - York	▲	9.7%	5.5%	5.5%	9.9%	9.2%	8.7%	9.3%	7.8%	7.9%	8.2%	8.2%	10.3%	-
1.07	Medical and Dental vacancy rate - Scarborough	▲	10,6%	10.6%	10.6%	9.0%	10.0%	11.9%	10.9%	10.4%	10.1%	10.6%	10.6%	11.7%	-
1.08	AHP vacancy rate - Trust	▲	4.8%	6.2%	2.7%	2.5%	1.5%	1.0%	2.1%	1.8%	1.8%	2.0%	6.6%	6.2%	-
1.09	Other Registered Healthcare Scientists vacancy rate - Trust	▲	-1.4%	3.1%	3.5%	3.9%	4.9%	5.1%	6.9%	8.6%	8.3%	9.1%	6.9%	5.4%	-

REF	Retention	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
2.01	Trust stability (Headcount)	▲	88.8%	88.8%	89.5%	89.8%	89.8%	89.7%	89.6%	90.3%	90.3%	90.8%	90.9%	90.5%	90.58%

REF	Temporary Workforce	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
3.01	Total FTE Medical and Dental roles covered by bank and agency	▲	118.9	128.4	124.3	115.5	111.9	118.6	107.4	115.0	98.7	122.7	110.3	123.8	126.1
3.02	Temporary medical and dental shifts covered by bank (% as proportion of all coverage by bank and agency)	▼	55.0%	56.0%	55.0%	52.0%	51.0%	61.0%	59.0%	66.0%	65.0%	65.0%	63.0%	69.0%	67.0%
3.03	Temporary medical and dental shifts covered by agency (% as proportion of all coverage by bank and agency)	▲	45.0%	44.0%	45.0%	48.0%	49.0%	39.0%	41.0%	34.0%	35.0%	35.0%	37.0%	31.0%	33.0%
3.04	Total FTE nurse staffing roles covered by bank and agency (RN's and HCA's)	▼	352.5	383.0	427.0	424.0	455.0	477.0	432.0	493.0	450.0	488.0	403.0	417.0	387.0
3.05	Temporary nurse staffing bank filled (FTE)	▼	305.1	313.0	339.0	334.0	353.0	378.0	334.0	403.0	365.0	390.0	311.0	320.0	295.0
3.06	Temporary nurse staffing agency filled (FTE)	▼	47.5	70.0	88.0	90.0	102.0	99.0	98.0	90.0	85.0	98.0	92.0	97.0	92.0
3.07	Temporary nurse staffing unfilled (FTE)	▼	86.7	91.0	121.0	161.0	201.0	215.0	232.0	229.0	199.0	212.0	145.0	156.0	148.0
3.08	Temporary nurse shifts covered by bank (% as proportion of all coverage by bank and agency)		86.5%	81.7%	79.4%	78.8%	77.6%	79.2%	77.3%	81.7%	81.1%	79.9%	77.2%	76.7%	76.2%
3.09	Temporary nurse shifts covered by agency (% as proportion of all coverage by bank and agency)		13.5%	18.3%	20.6%	21.2%	22.4%	20.8%	22.7%	18.3%	18.9%	20.1%	22.8%	23.3%	23.8%
3.10	Unfilled temporary nurse staffing requests (%)		19.7%	19.0%	22.0%	28.0%	31.0%	31.0%	35.0%	32.0%	31.0%	30.0%	26.0%	27.0%	28.0%
3.11	Pay Expenditure - Total (£000)	▼	£32,383	£31,639	£32,544	£33,131	£32,110	£32,623	£34,367	£34,006	£33,374	£32,624	£33,047	£33,237	£33,059
3.12	Pay Expenditure - Contracted (£000)	▲	£26,148	£26,087	£26,293	£27,130	£26,384	£26,616	£27,808	£27,580	£26,772	£25,919	£27,126	£26,942	£27,169
3.13	Pay Expenditure - Locums (£000)	▼	£231	£268	£189	£206	£122	£75	£351	£185	£198	£230	£229	£233	£211
3.14	Pay Expenditure - Bank (£000)	▼	£1,990	£1,688	£2,347	£1,758	£1,963	£2,522	£2,143	£2,473	£2,512	£2,527	£1,953	£1,993	£1,881
3.15	Pay Expenditure - Agency (£000)	▼	£1,222	£1,139	£1,442	£1,463	£1,576	£1,231	£1,406	£1,118	£1,084	£1,418	£1,384	£1,453	£1,335
3.16	Pay Expenditure - Additional Hours (£000)	▼	£2,609	£2,327	£2,165	£2,448	£1,942	£2,002	£2,472	£2,509	£2,575	£2,283	£2,105	£2,445	£2,292
3.17	Pay Expenditure - Overtime (£000)	◀▶	£184	£130	£108	£127	£122	£176	£187	£141	£233	£247	£250	£171	£171

REF	Absence Management	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
4.01	Absence Rate Trust (excluding YTHFM)	▲	4.5%	4.2%	4.4%	4.5%	4.9%	5.7%	5.2%	5.7%	4.8%	3.9%	4.4%	4.6%	-

REF	COVID-19 Absence Management	SPARKLINE / PREVIOUS WEEK	14-May	21-May	28-May	04-Jun	11-Jun	18-Jun	25-Jun
5.01	All absence	▲	532.86	508.43	478.57	470.29	483.29	405.14	412.14
5.02	COVID-19 related absence	▲	154	112.29	65.29	59.71	55.14	59.29	71

REF	Disciplinary and Grievance	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
6.01	Live disciplinary or bullying and harassment cases (Including investigations)	▲	2	3	6	3	3	4	4	4	6	9	8	5	7
6.02	Live grievance cases	▲	2	1	3	8	9	6	5	7	8	10	11	2	5

REF	Learning and Organisational Development	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
7.01	Trust Stat & Mand Training compliance	▲	87.0%	88.0%	88.0%	86.0%	87.0%	87.0%	87.0%	85.0%	85.0%	85.0%	86.0%	87.0%	87.0%
7.02	Trust Corporate Induction Compliance	▼	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	94.0%	95.0%
7.03	Non-medical staff core training compliance	◀▶	87.0%	88.0%	89.0%	88.0%	87.0%	87.0%	87.0%	87.0%	87.0%	87.0%	88.0%	88.0%	88.0%
7.05	Non-medical staff corporate induction compliance	◀▶	94.0%	95.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	97.0%	95.0%	95.0%	95.0%	95.0%
7.06	Medical staff core training compliance	◀▶	73.0%	74.0%	68.0%	70.0%	70.0%	72.0%	72.0%	73.0%	74.0%	75.0%	76.0%	76.0%	75.0%
7.08	Medical staff corporate induction compliance	◀▶	95.0%	95.0%	88.0%	88.0%	88.0%	89.0%	90.0%	90.0%	90.0%	91.0%	91.0%	91.0%	91.0%

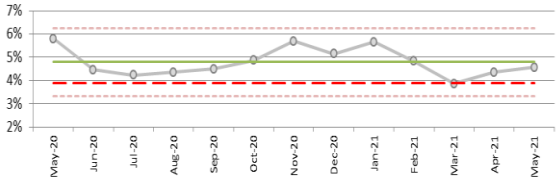
REF	Appraisal Compliance	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
8.01	Trust (excluding medical and dental)	▲	13.1%	22.0%	36.3%	70.5%	83.6%	89.6%	93.4%	93.4%	93.4%	93.4%	93.4%	0.7%	6.5%

TRUST BOARD REPORT : June-2021

WORKFORCE : SICKNESS ABSENCE RATE

May-21	METRIC :	TARGET :	vs LM :
4.6%	**4.01** Absence Rate Trust (excluding YTHFM)	3.9%	0.2%

↑



HIGHLIGHTS FOR BOARD TO NOTE :

The overall trust sickness absence rate has risen by 0.2% since April, returning 4.57% by the end of May. While we are seeing fewer absences in comparison to this time twelve months ago, the current sickness rate remains much higher than this time two years ago, in May 2019 (3.67%).

Increases in absences were trust wide. Anxiety/stress/depression, musculoskeletal injuries, back problems, gastrointestinal problems and 'other unspecified' reasons were the five most reported absence reasons. Absences attributed to anxiety/stress/depression and back problems were higher than at any point in the previous 12-months.

Covid-related absences were at their lowest level for 12-months; though it is notable that there has been an upward trend in daily Covid absence data since May. Aside from the small number of ongoing absences and redeployments due to clinical vulnerability (5 medical suspensions and 19 redeployment cases) recent increases relate to increased community transmission, in particular due to contact cases via track and trace and caring responsibilities linked to the collapse of education bubbles. The Trust is working with NHSE/I to help present a clear picture of the impact of recent Covid-related absences.

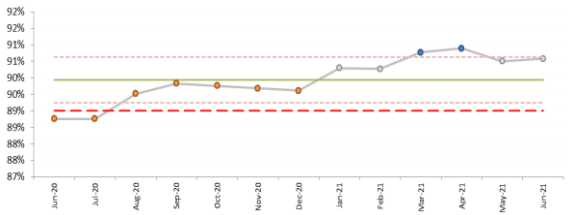
A number of actions are being taken with the aim of improving attendance and supporting staff health and wellbeing;

- Roll out of the revised sickness absence training is underway and all managers will have been trained by September 2021. We are getting good feedback on the new style of training, which also include Staff Side co-delivering part of the session.
- REACT mental health training roll out. 4 staff have been trained as REACT facilitators and will pilot the training over the summer with a plan to fully roll out in the Autumn.
- 52 mental health first aiders have been trained and are operational. There is an aspiration to increase this to 100 trained mental health first aiders, dependent on funding.
- Wellbeing conversations have been launched across the Trust.
- From this month the Trust has joined the People Pulse survey (runs monthly). The survey will allow us to explore various aspects of experience and sentiment of our NHS people. It asks employees how supported, informed, motivated or anxious they may feel, and what support would make the biggest difference to their experience at work. There is a link with H&W and engaging with our workforce.
- We are working on plans to deliver flu vaccinations and COVID booster vaccinations from Autumn 2021.
- The operational HR team are supporting management teams to prioritise sickness absence management, after the pause on this during the early stages of the pandemic.
- Attendance Challenge meetings will be launched in CGs by the end of 2021 to enable senior teams to scrutinise overall sickness absence, and offer support and advice.

TRUST BOARD REPORT : June-2021

WORKFORCE : RETENTION RATE

Jun-21	METRIC :	TARGET :	vs LM :
90.58%	2.01 Trust stability (Headcount)	89%	0.1% ↑



HIGHLIGHTS FOR BOARD TO NOTE :

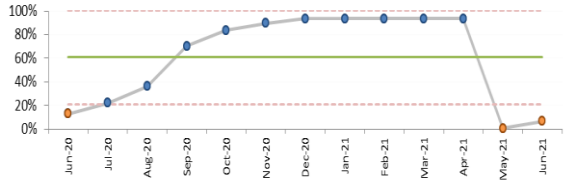
June returned a slight increase in stability at 90.58% by the end of the month. The Trust continues to compare favourably with others Trusts for retention and is ranked 36/122 nationally, 7/21 in North East and Yorkshire, and 1/4 in Humber Coast and Vale.

In the quarter to 30 June, the Trust recorded near-parity between starters and leavers in most registered staff groups. There was a small reduction (-5) in the number of medical staff, while in non-registered groups the Trust recorded a +32 position over the period in relation to Health Care Support Workers and a -17 position for admin, clerical, estates and ancillary staff. The Trust will continue to monitor the latter groups closely to understand the impact of the re-opening of business as Covid-19 restrictions ease.

TRUST BOARD REPORT : June-2021

WORKFORCE : APPRAISAL COMPLIANCE

Jun-21	METRIC :	TARGET :	vs LM :
6.5%	8.01 Trust (excluding medical and dental)	90%	5.8% ↑

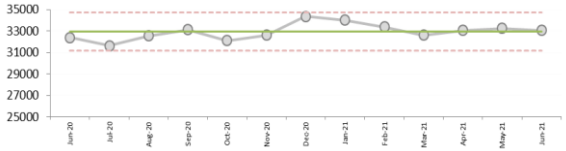
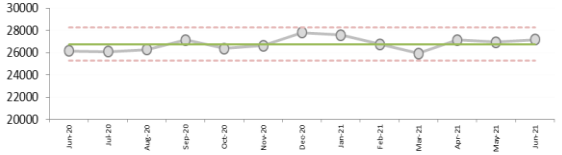
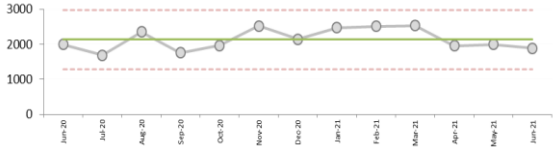
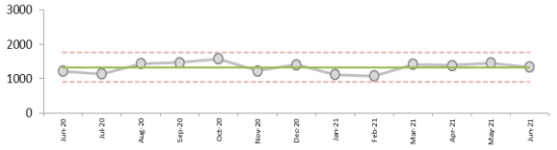
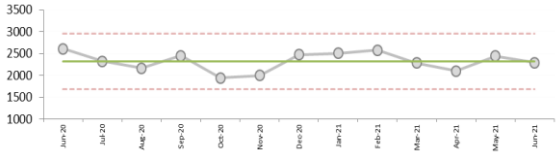
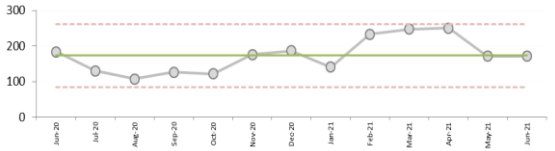


HIGHLIGHTS FOR BOARD TO NOTE :

Since phase two of the appraisal window opened on 1st June, we have seen a steady increase in the number of appraisals taking place for non-medical staff. By the end of June 6.5% of the non-medical workforce returned a completed appraisal. The appraisal window is due to close on 30 September.

TRUST BOARD REPORT : June-2021

WORKFORCE : PAY EXPENDITURE (£000)

Jun-21	METRIC :	TARGET :	vs LM :	
£33,059	**3.11** Pay Expenditure - Total (£000)	-	-0.5% ↓	
£27,169	**3.12** Pay Expenditure - Contracted (£000)	-	0.8% ↑	
£211	**3.13** Pay Expenditure - Locums (£000)	-	-9.4% ↓	
£1,881	**3.14** Pay Expenditure - Bank (£000)	-	-5.6% ↓	
£1,335	**3.15** Pay Expenditure - Agency (£000)	-	-8.1% ↓	
£2,292	**3.16** Pay Expenditure - Additional Hours (£000)	-	-6.3% ↓	
£171	**3.17** Pay Expenditure - Overtime (£000)	-	0.0% ↑	

HIGHLIGHTS FOR BOARD TO NOTE :

The Trust's overall vacancy position remains steady at 7%.

Nurse recruitment continues to be a high priority following the increases to the Trust's registered nursing establishment. A further 12 nurses arrived at the Trust from overseas in June as the international recruitment programme continues. In the same month, 46 nurses who arrived in earlier months underwent their OSCE examination with the NMC: 12/29 passed on their 1st attempt and 15/17 passed on their 2nd attempt. The Trust is continuing to support our overseas nurses who need a re-take to obtain their professional registration as soon as is practically possible.

Temporary Staffing

Finance expenditure reports reveals that temporary staffing expenditure has decreased or remained steady across all areas over the past month.

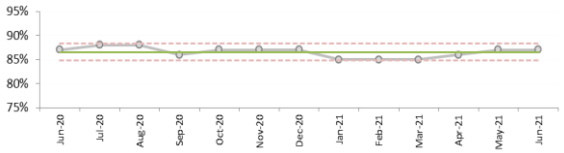
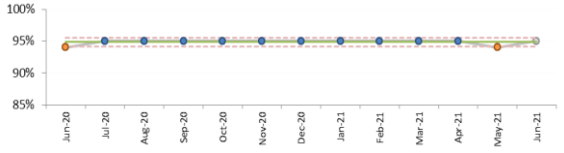
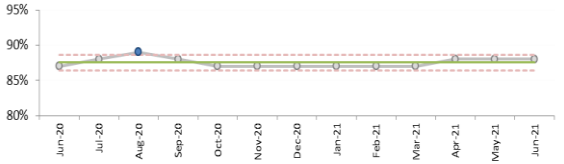
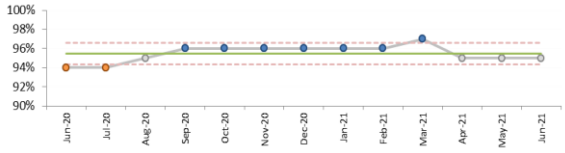
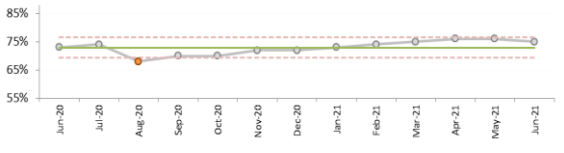
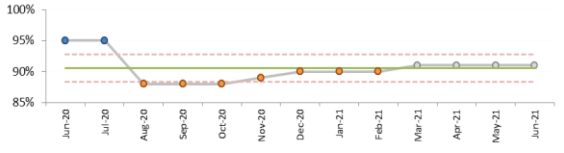
Temporary nurse staffing (RNs and HCAs) requests saw a reduction in FTE shift vacancies in June, with a total of 534 FTE shifts, compared to 573 FTE shifts in May. 76% of shift pick-up came from our bank employees.

M&D agency and bank figures for June revealed a total of 126.11 FTE equivalent shifts that were covered by bank employees and agency workers. 67% of shift pick-up came from our bank employees.

An issue that will have a bearing on availability of bank staff in the near future is the reset of the Trust's training compliance standards. The Quality and Safety Committee has agreed that from September, bank workers must be up to date with their training before they can book shifts. Bank workers are being asked to update any outstanding training over the summer. Those who are non-compliant at 1st October will be restricted from working bank shifts until their training is brought up to date, with a final deadline for completion then being set. New bank starters will have 12 weeks to undertake their training once in role.

TRUST BOARD REPORT : June-2021

WORKFORCE : STATUTORY AND MANDATORY TRAINING AND EDUCATION

Jun-21	METRIC :	TARGET :	vs LM :	
87.0%	**7.01** Trust Stat & Mand Training compliance	85%	0.0% ↑	
95.0%	**7.02** Trust Corporate Induction Compliance	95.0%	1.0% ↑	
88.0%	**7.03** Non-medical staff core training compliance	85.0%	0.0% ↑	
95.0%	**7.05** Non-medical staff corporate induction compliance	95.0%	0.0% ↑	
75.0%	**7.06** Medical staff core training compliance	85.0%	-1.0% ↓	
91.0%	**7.08** Medical staff corporate induction compliance	95.0%	0.0% ↑	

HIGHLIGHTS FOR BOARD TO NOTE :

University of York & OFSTED Updates

The Trust has supported the University of York with a successful OFSTED 'New programme monitoring visit. The University achieved 'reasonable progress' which is a positive outcome. The inspectors were very impressed with the partnership working between the two organisations, and complimentary about the support that the Trust's apprentices receive in practice.

Library Services

The Trust is promoting and delivering Health Education England's one hour health literacy awareness training, which has been reaccredited by the Royal Society for Public Health.

Values Training Updates

The Trust is continuing with the programme of embedding the new co-created values and behaviourss. Following the Board session, Senior Leader Sponsor sessions have taken place with an additional one scheduled for 13th July. As part of these sessions Sponsors are asked to start looking for Values Ambassadors within their teams and planning what they will need to do within their service area to embed the new values, ensuring that all employee and patient touchpoints are reviewed and align with the new values. A platform was set up with Clever Together to help this process for the sharing of ideas and for us to understand the support that may be needed in the organisation, so far there has been 263 visits to the platform and 51 contributions, the common theme is in relation to holding people to account and challenging poor behaviour so the Trust is looking at how these skills are incorporated into the sessions with the Values Ambassadors.

Reverse Mentoring

Following a successful recruitment campaign supported by the Race Equality Committee, the Trust has 17 mentor/mentee partnerships participating in the pilot Reverse Mentoring Programme. Workshops for both mentors and mentees are being delivered in late July/August, prior to the start of one to one developmental conversations held over a 6 month period. Evaluation workshops for participants will be offered mid-way and at the end of the programme to assess programme success. Following the learning from this pilot, it is intended to roll this opportunity out to staff with other protected characteristics.

TRUST BOARD REPORT : June-2021

WORKFORCE : OTHER AND WIDER UPDATES

WORKFORCE: OTHER

Violence and Aggression Towards the Workforce

- Reported violence against staff within the Trust increased by 60.1% from 18/19 to 19/20
- The Trust was averaging 7.9 incidents per week (based on the last 3 years figures).
- This reduced during 2020/21 to 6.4 incidents (334) and more recently reporting of violence has reduced since April 2021 to 6%.
- The issue of violence and aggression is not local to our Trust, with the last published figures nationally (17/18) showing over 70,000 incidents.

The top 5 areas reporting violence and/or aggression within the Trust (last 3 years) are:

1. York ED - 141 incidents
2. Ward 37 - 99 incidents
3. SGH ED - 83 incidents
4. Ann Wright - 50 incidents
5. Ward 22 - 44 incidents

The People Plan committed to NHS England and Improvement launching the NHS violence reduction standard in December 2020. This new standard went live in April 2021 and there is a gap analysis currently being completed to show where we are currently against those standards. Meanwhile work is underway with the Patient Safety Team to attempt to streamline the datix reporting against this standard. All datix reports are flagged to Security which triggers contact to be made with the staff member to check their welfare and also capture any incidents where a reportable criminal offence has occurred.

Disciplinary & Grievance Cases Trust Wide

No. of open disciplinary cases
7
No. of open investigations exceeded policy timescales
1
No. of open B&H/Grievance cases
5
No. of open cases exceeded policy timescales
1
No. of open MHPS cases
4
No. of open investigations exceeded timescales
2

Agile & Flexible Working Group update

The Agile & Flexible Working Group was set up to scope the modernisation of the Trust's working practices, taking into account lessons learned from the pandemic. Five sub-groups have subsequently been established to cover:

- practical issues (IT and physical work spaces);
- training, guidance and support for working differently (both for managers and employees);
- developing a framework to enable managers to review every role for its suitability for hybrid working – and then having conversations with individuals undertaking those roles
- health and safety and risk, information governance and contractual employment issues; and
- engagement and communication.

These sub-groups are in the early stages and continue to refine their remits in alignment with other ongoing work/developments in the Trust (e.g the Digital & Information Strategy and Car Parking Review to ensure join-up between different workstreams.

Another piece of work is looking to address short-term lack of capacity for staff to work from one of the Trust's sites, as well as the impact that working remotely or in a different location is having on service delivery and staff

TRUST BOARD REPORT : June-2021

WORKFORCE : CARE GROUP CORE COMPLIANCE BY STAFF GROUP

STRATEGIC OBJECTIVE : To support an engaged, healthy and resilient workforce

Jun-21

Monthly Care Group Core Compliance by Staff Group	Adult Advanced Life Support (CSTF) 4 years	Adult Life Support (CSTF) 1 year	Conflict Resolution (CSTF) 3 years	Deprivation of Liberty Safeguards/DoLS Level 1 (CSTF) 3 years	Deprivation of Liberty Safeguards/DoLS Level 2 (CSTF) 3 years	Fire Safety Awareness High Risk (CSTF) 2 years	Fire Safety Awareness Low Risk (CSTF) 2 years	Health, Safety and Welfare (CSTF) 3 years	Infection Prevention and Control Level 1 (CSTF) 3 years	Infection Prevention and Control Level 2 (CSTF) 1 year	Information Governance and Data Security (CSTF) 1 year	Manual Handling Practical Level 1 (CSTF) 3 years	Manual Handling Practical Level 2 (CSTF) 2 years	Manual Handling Theory (CSTF) 3 years	Mental Capacity Act Level 1 (CSTF) 3 years	Mental Capacity Act Level 2 (CSTF) 3 years	Paediatric Advanced Life Support (CSTF) 4 years	Paediatric Life Support (CSTF) 1 year	PREVENT Awareness Basic (CSTF) 3 years	PREVENT Awareness Level 3 (CSTF) 3 years	Safeguarding Adults Level 1 (CSTF) 3 years	Safeguarding Adults Level 2 (CSTF) 3 years	Safeguarding Children Level 1 (CSTF) 3 years	Safeguarding Children Level 2 (CSTF) 3 years	Safeguarding Children Level 3 Core (CSTF) 3 years	Safeguarding Children Level 3 Specialist (CSTF) 3 years
CG1 Acute Elderly Emergency General Medicine and Community Services York																											
Add Prof Scientific and Technic		100%	100%		100%	100%		100%		100%	100%	100%	67%	100%		100%					75%		100%		100%	100%	100%
Additional Clinical Services		83%	91%	60%	85%	89%	94%	89%	92%	92%	89%	100%	86%	90%	60%	83%		86%	91%	71%	88%	88%	100%	88%	71%		
Administrative and Clerical		64%	95%	89%			97%	95%	97%		95%	98%		98%	88%				96%			94%		96%	96%		
Allied Health Professionals		90%	97%		91%	93%	98%	97%		99%	97%	95%	89%	96%		91%			0%	100%		97%	100%	96%		100%
Healthcare Scientists		100%	100%				100%	100%	100%		100%	94%		94%				83%	89%		100%			100%			
Medical and Dental	75%	79%	89%		83%	95%	77%	95%		90%	92%		81%	92%		82%	71%	25%		93%		91%	100%	88%	90%	0%
Nursing and Midwifery Registered	61%	90%	97%		90%	95%	97%	97%		95%	95%	100%	88%	94%		88%		85%		97%	100%	95%		94%	87%	100%
Students		100%	100%		100%		100%	100%		100%	100%		100%	100%		100%				100%		100%		100%		
CG2 Acute Emergency and Elderly Medicine-Scarborough																											
Additional Clinical Services		85%	91%		83%	90%	100%	91%	100%	88%	91%	100%	88%	91%		83%		89%	93%	59%		91%	100%	92%	80%		
Administrative and Clerical		78%	91%	70%			91%	93%	93%	100%	91%	90%	100%	92%	75%				92%		91%		92%	89%			
Allied Health Professionals		93%	98%		94%		98%	98%		96%	98%	100%	86%	94%		87%				98%		98%		96%			
Estates and Ancillary		100%	100%	70%			90%	100%	100%		100%	80%		90%	80%				100%		100%			100%			
Healthcare Scientists		100%	86%				71%	71%	100%		71%	71%		100%				57%	71%		71%			86%			
Medical and Dental	76%	86%	93%		78%	98%	81%	97%		92%	92%		84%	93%		82%	87%	0%		88%		91%		84%	76%		
Nursing and Midwifery Registered	67%	92%	95%		89%	94%	100%	95%		94%	97%		89%	95%		88%		96%		97%		95%	100%	94%	90%		
CG3 Surgery																											
Add Prof Scientific and Technic		84%	96%		88%	93%	100%	96%	83%	97%	91%	91%	87%	89%		90%		85%	100%	97%	100%	93%	83%	95%	100%		
Additional Clinical Services		80%	91%		81%	89%	94%	91%	91%	89%	90%	82%	87%	89%		79%		100%	88%	74%	86%	87%	89%	88%			
Administrative and Clerical		100%	93%	82%	100%		95%	95%	95%		96%	94%	100%	92%	82%	100%			95%		95%	100%	96%	92%			
Allied Health Professionals		86%	100%		100%		100%	100%		100%	100%		100%	100%		100%				100%		100%		100%			
Estates and Ancillary		100%	100%	65%			90%	95%	95%		100%	74%		100%	65%				95%		100%		94%	100%			
Healthcare Scientists		94%	94%		87%		97%	94%	94%		94%	94%		94%		83%			97%		100%	97%		94%			
Medical and Dental	67%	76%	87%		82%	92%	86%	90%		88%	90%		74%	89%		82%				90%		87%		86%	100%	0%	
Nursing and Midwifery Registered	78%	92%	95%		88%	94%	95%	95%		94%	92%		87%	92%		87%		100%		96%		94%		94%			
CG4 Cancer and Support Services																											
Add Prof Scientific and Technic		86%	100%		100%	100%	100%	98%	100%	100%	98%	99%	80%	98%		100%			97%	100%	98%	100%	100%	97%			
Additional Clinical Services		87%	94%		92%	94%	93%	95%	95%	93%	93%	94%	91%	95%		90%			94%	86%	94%	93%	93%	92%			
Administrative and Clerical			93%	75%			98%	94%	92%		93%	93%		95%	75%				94%		95%		95%	88%			
Allied Health Professionals		89%	92%		87%	92%	97%	93%	100%	92%	94%	67%	94%	94%		85%			86%	97%	100%	91%	100%	93%			
Estates and Ancillary			100%				100%	100%	100%		100%	100%		100%					100%		100%		100%				
Healthcare Scientists			95%				95%	94%	93%		94%	94%		96%					92%		94%		95%				
Medical and Dental	100%	86%	87%		82%	93%	91%	91%	85%	88%	86%	75%	80%	91%		82%			85%	94%	85%	86%	85%	96%			
Nursing and Midwifery Registered		96%	94%		91%	95%	96%	98%		94%	92%	100%	91%	92%		90%			100%	99%		93%	100%	93%			
CG5 Family Health & Sexual Health																											
Add Prof Scientific and Technic		100%	100%		100%		100%	100%	100%		100%	100%		100%		100%		100%		100%		100%				100%
Additional Clinical Services		88%	92%		83%	91%	94%	93%	88%	90%	91%	50%	90%	96%		84%		90%	90%	90%		85%		94%	89%	100%
Administrative and Clerical		0%	95%	83%	100%		95%	95%	94%		94%	94%		94%	83%	100%			90%	100%	90%	100%	97%	75%	100%		
Allied Health Professionals		88%	96%		91%	90%	100%	95%		96%	93%	100%	94%	91%		91%		94%		100%		88%		100%	100%	92%
Estates and Ancillary			100%	100%			100%	100%	100%		100%	100%		100%	100%				100%		100%			100%			
Medical and Dental	77%	72%	90%		84%	92%	97%	90%		87%	88%		85%	88%		81%	61%	75%		92%		88%		92%	83%	92%
Nursing and Midwifery Registered		93%	95%		88%	94%	91%	95%		93%	91%		88%	92%		88%		90%		98%		92%		96%	93%	89%
CG6 Specialised Medicine & Outpatients Services																											
Add Prof Scientific and Technic		81%	97%		88%	67%	97%	96%	95%	33%	96%	88%	50%	97%		88%			96%	90%	100%	90%	100%	93%	0%	100%
Additional Clinical Services		87%	95%	100%	85%	100%	95%	93%	96%	96%	94%		90%	94%	100%	84%			94%	83%	100%	91%	100%	90%			
Administrative and Clerical		67%	95%	93%			98%	96%	96%		96%	96%		96%	100%				93%		94%		95%	94%	100%		
Allied Health Professionals		88%	96%		93%		95%	95%		96%	96%		83%	95%		93%				95%		94%		91%			
Estates and Ancillary			100%	100%			100%	100%	100%		100%	100%		100%	100%				100%		100%			100%			
Healthcare Scientists		100%	100%				100%	100%	100%		100%	100%		100%					100%		100%			86%			
Medical and Dental	100%	71%	87%		83%	92%	85%	86%		87%	83%		79%	86%		82%		100%		90%		85%		85%			
Nursing and Midwifery Registered	100%	95%	90%		86%	95%	94%	92%		91%	90%	0%	84%	90%		85%				98%		93%		90%	100%		

TRUST BOARD REPORT : June-2021

WORKFORCE : CARE GROUP CORE COMPLIANCE BY STAFF GROUP

STRATEGIC OBJECTIVE : To support an engaged, healthy and resilient workforce

Jun-21

Monthly Care Group Core Compliance by Staff Group	Adult Advanced Life Support (CSTF) 4 years	Adult Life Support (CSTF) 1 year	Conflict Resolution (CSTF) 3 years	Deprivation of Liberty Safeguards/DoLS Level 1 (CSTF) 3 years	Deprivation of Liberty Safeguards/DoLS Level 2 (CSTF) 3 years	Fire Safety Awareness High Risk (CSTF) 2 years	Fire Safety Awareness Low Risk (CSTF) 2 years	Health, Safety and Welfare (CSTF) 3 years	Infection Prevention and Control Level 1 (CSTF) 3 years	Infection Prevention and Control Level 2 (CSTF) 1 year	Information Governance and Data Security (CSTF) 1 year	Manual Handling Practical Level 1 (CSTF) 3 years	Manual Handling Practical Level 2 (CSTF) 2 years	Manual Handling Theory (CSTF) 3 years	Mental Capacity Act Level 1 (CSTF) 3 years	Mental Capacity Act Level 2 (CSTF) 3 years	Paediatric Advanced Life Support (CSTF) 4 years	Paediatric Life Support (CSTF) 1 year	PREVENT Awareness Basic (CSTF) 3 years	PREVENT Awareness Level 3 (CSTF) 3 years	Safeguarding Adults Level 1 (CSTF) 3 years	Safeguarding Adults Level 2 (CSTF) 3 years	Safeguarding Children Level 1 (CSTF) 3 years	Safeguarding Children Level 2 (CSTF) 3 years	Safeguarding Children Level 3 Core (CSTF) 3 years	Safeguarding Children Level 3 Specialist (CSTF) 3 years
CG Corporate Services																										
Add Prof Scientific and Technic		54%	54%		13%		48%	50%	61%	23%	54%	61%	12%	50%	12%	13%		50%	55%	25%	50%	25%	86%	25%		
Additional Clinical Services		58%	69%		60%	65%	81%	68%	90%	66%	64%	64%	64%	74%		58%			69%	75%	89%	67%	84%	67%		
Administrative and Clerical		0%	88%	50%			89%	88%	89%	100%	89%	89%	100%	89%	50%				89%		88%		88%	100%		
Allied Health Professionals		61%	68%		68%	69%	100%	65%		68%	65%		58%	65%		68%				68%		74%		60%		100%
Estates and Ancillary			91%				100%	82%	100%		82%	91%		100%					100%		91%		100%			
Healthcare Scientists			75%				75%	100%	100%		100%	100%		75%					100%	0%	100%		100%	0%		
Medical and Dental	53%	61%	54%		48%	63%	100%	58%		58%	55%		37%	57%		48%	16%	18%		51%		55%		55%	45%	38%
Nursing and Midwifery Registered		80%	80%		72%	75%	94%	78%	83%	78%	79%	86%	72%	79%		72%				87%	100%	79%	90%	79%	100%	66%
CG Trust Estates and Facilities Management																										
Administrative and Clerical			88%				100%	100%	88%		100%	100%		88%					100%		100%		100%			
Estates and Ancillary			100%				100%	100%	100%		100%	100%		100%					100%		100%		100%			
LLP CG Estates & Facilities																										
Administrative and Clerical			96%				94%	96%	96%		92%	89%		95%					94%		95%		92%			
Estates and Ancillary			86%	61%			84%	88%	84%		82%	74%	89%	80%	60%				74%		82%		85%			
Healthcare Scientists			100%				100%	100%	100%		100%	100%		100%					100%		100%		100%			

TRUST BOARD REPORT : June-2021

WORKFORCE: MEDICAL AND DENTAL VACANCIES

STRATEGIC OBJECTIVE : To support an engaged, healthy and resilient workforce

May-21

Scarborough

Directorate	Consultant					SAS Grades					Training Grades (inc Trust Grades)					Foundation Grades					Total				
	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %
Care Group 2	**33**	**10**	**0**	**3**	**21.2%**	**20**	**2**	**1**	**1**	**10.0%**	**55**	**12**	**0**	**1**	**20.0%**	**25**	**1**	**0**	**0**	**4.0%**	**133**	**25**	**1**	**5**	**15.8%**
Elderly Medicine	6	2	0	1	**16.7%**	2	0	0	0	**0.0%**	12	2	0	2	**0.0%**	3	0	0	0	**0.0%**	23	4	0	3	**4.3%**
Emergency & Acute Medicine	13	5	0	1	**30.8%**	14	2	1	1	**14.3%**	17	2	0	0	**11.8%**	4	0	0	0	**0.0%**	48	9	1	2	**16.7%**
General Medicine	14	4	0	1	**21.4%**	4	0	0	0	**0.0%**	26	5	0	2	**11.5%**	18	1	0	0	**5.6%**	62	10	0	3	**11.3%**
Care Group 3	**19**	**3**	**0**	**0**	**15.8%**	**15**	**3**	**0**	**0**	**20.0%**	**16**	**2**	**0**	**0**	**12.5%**	**12**	**0**	**0**	**0**	**0.0%**	**62**	**8**	**0**	**0**	**12.9%**
General Surgery & Urology	1	0	0	0	**0.0%**	5	1	0	0	**20.0%**	7	2	0	0	**28.6%**	11	0	0	0	**0.0%**	24	3	0	0	**12.5%**
Head & Neck	0	0	0	0	**0.0%**	3	1	0	0	**33.3%**	0	0	0	0	**0.0%**	1	0	0	0	**0.0%**	4	1	0	0	**25.0%**
Theatres, Anaesthetics & CC	18	3	0	0	**16.7%**	7	1	0	0	**14.3%**	9	0	0	0	**0.0%**	0	0	0	0	**0.0%**	34	4	0	0	**11.8%**
Care Group 4	**3**	**0**	**0**	**0**	**0.0%**	**0**	**0**	**0**	**0**	**0.0%**	**0**	**0**	**0**	**0**	**0.0%**	**0**	**0**	**0**	**0**	**0.0%**	**3**	**0**	**0**	**0**	**0.0%**
Radiology	3	0	0	0	**0.0%**	0	0	0	0	**0.0%**	0	0	0	0	**0.0%**	0	0	0	0	**0.0%**	3	0	0	0	**0.0%**
Care Group 5	**19**	**1**	**1**	**0**	**10.5%**	**4**	**0**	**1**	**0**	**25.0%**	**20**	**3**	**1**	**3**	**5.0%**	**5**	**0**	**0**	**0**	**0.0%**	**48**	**4**	**3**	**3**	**8.3%**
Child Health	11	1	1	0	**18.2%**	1	0	0	0	**0.0%**	10	1	1	1	**10.0%**	4	0	0	0	**0.0%**	26	2	2	1	**11.5%**
Obstetrics & Gynaecology	8	0	0	0	**0.0%**	3	0	1	0	**33.3%**	10	2	0	2	**0.0%**	1	0	0	0	**0.0%**	22	2	1	2	**4.5%**
Care Group 6	**18**	**1**	**1**	**0**	**11.1%**	**9**	**1**	**0**	**0**	**11.1%**	**6**	**2**	**0**	**0**	**33.3%**	**2**	**0**	**0**	**0**	**0.0%**	**35**	**4**	**1**	**0**	**14.3%**
Ophthalmology	4	0	1	0	**25.0%**	3	1	0	0	**33.3%**	1	0	0	0	**0.0%**	0	0	0	0	**0.0%**	8	1	1	0	**25.0%**
Specialist Medicine	6	1	0	0	**16.7%**	1	0	0	0	**0.0%**	0	0	0	0	**0.0%**	0	0	0	0	**0.0%**	7	1	0	0	**14.3%**
Trauma & Orthopaedics	8	0	0	0	**0.0%**	5	0	0	0	**0.0%**	5	2	0	0	**40.0%**	2	0	0	0	**0.0%**	20	2	0	0	**10.0%**
Total	**92**	**16**	**2**	**3**	**16.3%**	**48**	**6**	**2**	**1**	**14.6%**	**97**	**16**	**1**	**7**	**10.3%**	**44**	**1**	**0**	**0**	**2.3%**	**281**	**39**	**5**	**11**	**11.7%**

York

Directorate	Consultant					SAS Grades					Training Grades (inc Trust Grades)					Foundation Grades					Total				
	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %	Estab	Vacs	Leavers	Starters	Net vac %
Care Group 1	77	17	0	6	**14.3%**	16	2	0	0	**12.5%**	77	8	2	1	**11.7%**	35	0	0	0	**0.0%**	205	27	2	7	**10.7%**
Community	0	0	0	0	**0.0%**	1	0	0	0	**0.0%**	0	0	0	0	**0.0%**	0	0	0	0	**0.0%**	1	0	0	0	**0.0%**
Elderly Medicine	15	3	0	1	**13.3%**	2	1	0	0	**50.0%**	14	1	0	0	**7.1%**	6	0	0	0	**0.0%**	37	5	0	1	**10.8%**
Emergency & Acute Medicine	26	9	0	2	**26.9%**	9	1	0	0	**11.1%**	34	4	1	1	**11.8%**	6	0	0	0	**0.0%**	75	14	1	3	**16.0%**
General Medicine	36	5	0	3	**5.6%**	4	0	0	0	**0.0%**	29	3	1	0	**13.8%**	23	0	0	0	**0.0%**	92	8	1	3	**6.5%**
Care Group 3	117	3	2	0	**4.3%**	32	3	0	1	**6.3%**	68	4	0	0	**5.9%**	24	0	0	0	**0.0%**	241	10	2	1	**4.6%**
General Surgery & Urology	44	0	1	0	**2.3%**	12	0	0	0	**0.0%**	20	1	0	0	**5.0%**	16	0	0	0	**0.0%**	92	1	1	0	**2.2%**
Head & Neck	22	0	0	0	**0.0%**	12	2	0	0	**16.7%**	16	1	0	0	**6.3%**	6	0	0	0	**0.0%**	56	3	0	0	**5.4%**
Theatres, Anaesthetics & CC	51	3	1	0	**7.8%**	8	1	0	1	**0.0%**	32	2	0	0	**6.3%**	2	0	0	0	**0.0%**	93	6	1	1	**6.5%**
Care Group 4	63	10	1	4	**11.1%**	3	1	0	0	**33.3%**	19	1	1	0	**10.5%**	2	0	0	0	**0.0%**	87	12	2	4	**11.5%**
Cancer Support	14	1	0	0	**7.1%**	3	1	0	0	**33.3%**	6	0	1	0	**16.7%**	0	0	0	0	**0.0%**	23	2	1	0	**13.0%**
Laboratory Medicine	16	1	0	0	**6.3%**	0	0	0	0	**0.0%**	6	1	0	0	**16.7%**	2	0	0	0	**0.0%**	24	2	0	0	**8.3%**
Radiology	33	8	1	4	**15.2%**	0	0	0	0	**0.0%**	7	0	0	0	**0.0%**	0	0	0	0	**0.0%**	40	8	1	4	**12.5%**
Care Group 5	38	3	1	2	**5.3%**	10	4	0	0	**40.0%**	30	3	2	0	**16.7%**	7	0	0	0	**0.0%**	85	10	3	2	**12.9%**
Child Health	19	0	0	0	**0.0%**	2	0	0	0	**0.0%**	16	2	1	0	**18.8%**	5	0	0	0	**0.0%**	42	2	1	0	**7.1%**
Obstetrics & Gynaecology	16	2	1	2	**6.3%**	1	0	0	0	**0.0%**	13	0	1	0	**7.7%**	2	0	0	0	**0.0%**	32	2	2	2	**6.3%**
Sexual Health	3	1	0	0	**33.3%**	7	4	0	0	**57.1%**	1	1	0	0	**100.0%**	0	0	0	0	-	11	6	0	0	**54.5%**
Care Group 6	65	4	3	1	**9.2%**	19	2	1	0	**15.8%**	27	2	1	0	**11.1%**	6	0	0	0	**0.0%**	117	8	5	1	**10.3%**
Ophthalmology	20	1	1	0	**10.0%**	6	0	0	0	**0.0%**	6	0	0	0	**0.0%**	0	0	0	0	-	32	1	1	0	**6.3%**
Specialist Medicine	31	3	2	1	**12.9%**	5	1	0	0	**20.0%**	12	2	1	0	**25.0%**	3	0	0	0	**0.0%**	51	6	3	1	**15.7%**
Trauma & Orthopaedics	14	0	0	0	**0.0%**	8	1	1	0	**25.0%**	9	0	0	0	**0.0%**	3	0	0	0	**0.0%**	34	1	1	0	**5.9%**
Total	**360**	**37**	**7**	**13**	**8.6%**	**80**	**12**	**1**	**1**	**15.0%**	**221**	**18**	**6**	**1**	**10.4%**	**74**	**0**	**0**	**0**	**0.0%**	**735**	**67**	**14**	**15**	**9.0%**

Net vacancy % = (Vacancies + Leavers Pending - Starters Pending) / Establishment
Includes all known leavers and new starters

TRUST BOARD REPORT : June-2021

WORKFORCE: NURSING, MIDWIFERY AND CARE STAFF VACANCIES

STRATEGIC OBJECTIVE : To support an engaged, healthy and resilient workforce

May-21

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy (WTE)			Net Vacancy (%)		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
TRUST	**2213.85**	**121.84**	**1084.96**	**1992.00**	**180.17**	**1015.35**	**14.07**	**0.00**	**13.17**	**41.88**	**0.00**	**4.66**	**194.04**	**-58.33**	**78.12**	**8.76%**	**-47.87%**	**7.20%**
YORK	**1558.91**	**92.75**	**696.52**	**1441.73**	**115.80**	**686.88**	**10.47**	**0.00**	**11.01**	**28.98**	**0.00**	**4.00**	**98.67**	**-23.05**	**16.65**	**6.33%**	**-24.85%**	**2.39%**
SCARBOROUGH & BRIDLINGTON	**654.94**	**29.09**	**388.44**	**550.27**	**64.37**	**328.47**	**3.60**	**0.00**	**2.16**	**12.90**	**0.00**	**0.66**	**95.37**	**-35.28**	**61.47**	**14.56%**	**-121.28%**	**15.82%**

CARE GROUP 1	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy (wte)			Net Vacancy (%)		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
YORK																		
Acute	422.77	33.38	270.31	381.65	55.00	285.01	6.40	0.00	5.60	16.80	0.00	2.00	30.72	-21.62	-11.10	7.27%	-64.77%	-4.11%
Community	150.54	19.60	120.45	158.04	12.40	109.99	3.07	0.00	3.21	3.18	0.00	1.60	-7.61	7.20	12.07	-5.06%	36.73%	10.02%
Total	**573.31**	**52.98**	**390.76**	**539.69**	**67.40**	**395.00**	**9.47**	**0.00**	**8.81**	**19.98**	**0.00**	**3.60**	**23.11**	**-14.42**	**0.97**	**4.03%**	**-27.22%**	**0.25%**

CARE GROUP 2	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy (wte)			Net Vacancy (%)		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
SCARBOROUGH																		
	307.45	19.69	241.83	233.99	39.80	200.79	1.60	0.00	1.00	8.00	0.00	0.00	67.06	-20.11	42.04	21.81%	-102.13%	17.38%
Total	**307.45**	**19.69**	**241.83**	**233.99**	**39.80**	**200.79**	**1.60**	**0.00**	**1.00**	**8.00**	**0.00**	**0.00**	**67.06**	**-20.11**	**42.04**	**21.81%**	**-102.13%**	**17.38%**

CARE GROUP 3	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy (wte)			Net Vacancy (%)		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
YORK																		
Wards/Units	278.46	10.20	102.47	258.79	22.20	102.13	1.00	0.00	0.00	5.00	0.00	0.40	15.67	-12.00	-0.06	5.63%	-117.65%	-0.06%
Theatres	120.31	0.00	45.74	100.97	2.00	40.52	0.00	0.00	0.00	0.00	0.00	0.00	19.34	-2.00	5.22	16.08%	0.00%	11.41%
sub-total York	**398.77**	**10.20**	**148.21**	**359.76**	**24.20**	**142.65**	**1.00**	**0.00**	**0.00**	**5.00**	**0.00**	**0.40**	**35.01**	**-14.00**	**5.16**	**8.78%**	**-137.25%**	**3.48%**
SCARBOROUGH																		
Wards/Units	132.21	3.80	48.00	116.58	13.80	42.36	0.00	0.00	0.00	2.00	0.00	0.00	13.63	-10.00	5.64	10.31%	-263.16%	11.75%
Theatres	55.68	0.00	23.21	46.00	1.80	19.53	0.00	0.00	0.00	0.00	0.00	0.00	9.68	-1.80	3.68	17.39%	0.00%	15.86%
sub-total Scarborough	**187.89**	**3.80**	**71.21**	**162.58**	**15.60**	**61.89**	**0.00**	**0.00**	**0.00**	**2.00**	**0.00**	**0.00**	**23.31**	**-11.80**	**9.32**	**12.41%**	**-310.53%**	**13.09%**
CG Total	**586.66**	**14.00**	**219.42**	**522.34**	**39.80**	**204.54**	**1.00**	**0.00**	**0.00**	**7.00**	**0.00**	**0.40**	**58.32**	**-25.80**	**14.48**	**9.94%**	**-184.29%**	**6.60%**

CARE GROUP 4	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy (wte)			Net Vacancy (%)		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
YORK																		
	138.63	10.61	26.19	106.05	5.65	27.96	0.00	0.00	1.00	2.00	0.00	0.00	30.58	4.96	-0.77	22.06%	46.75%	-2.94%
SCARBOROUGH																		
	23.68	3.60	5.00	24.00	6.17	2.61	0.00	0.00	0.00	0.00	0.00	0.00	-0.32	-2.57	2.39	-1.35%	-71.39%	47.80%
Total	**162.31**	**14.21**	**31.19**	**130.05**	**11.82**	**30.57**	**0.00**	**0.00**	**1.00**	**2.00**	**0.00**	**0.00**	**30.26**	**2.39**	**1.62**	**18.64%**	**16.82%**	**5.19%**

CARE GROUP 5	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy (wte)			Net Vacancy (%)		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
YORK																		
Registered Midwives	105.98	0.00	0.00	108.77	0.00	0.00	0.00	0.00	0.00	3.00	0.00	0.00	-5.79	0.00	0.00	-5.46%	0.00%	0.00%
Registered Nurses	147.83	0.00	0.00	134.55	0.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	13.28	0.00	0.00	8.98%	0.00%	0.00%
Other	0.00	11.36	58.55	0.00	12.64	49.48	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-1.28	9.07	0.00%	-11.27%	15.49%
sub-total York	**253.81**	**11.36**	**58.55**	**243.32**	**12.64**	**49.48**	**1.00**	**0.00**	**0.00**	**4.00**	**0.00**	**0.00**	**7.49**	**-1.28**	**9.07**	**2.95%**	**-11.27%**	**15.49%**
SCARBOROUGH																		
Registered Midwives	62.63	0.00	0.00	68.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-5.87	0.00	0.00	-9.37%	0.00%	0.00%
Registered Nurses	41.87	0.00	0.00	34.63	0.00	0.00	0.00	0.00	0.00	0.90	0.00	0.00	6.34	0.00	0.00	15.14%	0.00%	0.00%
Other	0.00	1.00	32.46	0.00	1.80	31.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-0.80	1.27	0.00%	-80.00%	3.91%
sub-total Scarborough	**104.50**	**1.00**	**32.46**	**103.13**	**1.80**	**31.19**	**0.00**	**0.00**	**0.00**	**0.90**	**0.00**	**0.00**	**0.47**	**-0.80**	**1.27**	**0.45%**	**-80.00%**	**3.91%**
CG Total	**358.31**	**12.36**	**91.01**	**346.45**	**14.44**	**80.67**	**1.00**	**0.00**	**0.00**	**4.90**	**0.00**	**0.00**	**7.96**	**-2.08**	**10.34**	**2.22%**	**-16.83%**	**11.36%**

CARE GROUP 6	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy (wte)			Net Vacancy (%)		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
YORK																		
	122.01	5.60	72.41	110.84	4.40	71.79	0.00	0.00	1.20	0.00	0.00	0.00	11.17	1.20	1.82	9.15%	21.43%	2.51%
SCARBOROUGH																		
	30.75	1.00	37.94	25.42	1.00	31.99	1.00	0.00	1.16	0.00	0.00	0.00	6.33	0.00	7.11	20.59%	0.00%	18.74%
CG Total	**152.76**	**6.60**	**110.35**	**136.26**	**5.40**	**103.78**	**1.00**	**0.00**	**2.36**	**0.00**	**0.00**	**0.00**	**17.50**	**1.20**	**8.93**	**11.46%**	**18.18%**	**8.09%**

Notes:
Net vacancy % = (Vacancies + Leavers Pending - Starters Pending) / Establishment
Leavers = currently serving notice
Starters = accepted appointment, now pending start date

FINANCE PERFORMANCE REPORT

June-2021

Produced July-2021

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

To ensure financial stability

Finance Performance Report : June-2021

Executive Summary

Trust Strategic Goals:

[x] to deliver safe and high quality patient care as part of an integrated system
[x] to support an engaged, healthy and resilient workforce
[x] to ensure financial sustainability

Purpose of the Report:

To provide the Board with an integrated overview of Finance Performance within the Trust

Executive Summary:

Key discussion points for the Board are:

The report for June 2021 marks the end of quarter 1 of the financial year 2021/22.

Emergency Financial Regime

For 2021/22, NHSE&I have decided to continue to employ a similar emergency financial regime used during 2020/21, in supporting the NHS address the Covid-19 pandemic.

With regard to the first half year of 2021/22 only (April 2021 to September 2021), the Trust will be subject to the same allocation based approach used in the second half year of 2020/21. NHSE&I have as yet made no formal announcement regarding the financial framework that will be in place for the second half year of 2021/22.

Under the announced framework, the Trust has received a base allocation to cover normal activities linked to its actual performance in Q3, 2020/21 doubled to give a half year allocation, and then adjusted for inflation and other issues. A secondary allocation to cover additional costs resulting from the Covid-19 pandemic has also been received at a similar level to that seen in the second half year, 2020/21. In addition, the Trust has also planned to receive other 'non-patient' activity income at similar levels seen in Q3, 2020/21.

A notable change to the 2020/21 regime is the reintroduction for 2021/22 of national and local efficiency targets, which had been suspended throughout the previous financial year.
The final financial plan for the first half year of 2021/22 (with an indicative full year plan for information only), was submitted to and agreed by the Board at its 28 April 2021 meeting. The agreed plan produced a balanced I&E position.

Since the April Board meeting, and at the request of NHSE&I, the Trust has submitted an updated plan to reflect both the income and costs of delivery associated with the Elective Recovery Fund. Initial projections for the Trust identify that our forecast activity levels for H1 could deliver an additional £21.5m of income under this scheme. The cost of delivering this activity has been estimated at £13m, although for planning purposes a risk provision has been created in the sum of £8.5m, thereby having a net neutral impact on the bottom line I&E plan.

Executive Summary (cont.):
Key discussion points for the Board are:

Elective Recovery Fund (ERF)

The ERF is a system implemented at national level that incentivises provider organisations to accelerate the delivery of elective care to address the backlog that has developed during the covid-19 pandemic. Additional funding is being made available to providers to support this process.

The estimated income and expenditure linked to ERF is now included in the position to date and in the forecast, although this is not guaranteed and is subject to change. The amount of funding that the Trust will receive is dependent upon a number of factors including the performance of the other provider organisations within our Integrated Care System (ICS), and the actual receipt of ERF will be on a basis agreed by the ICS. The income figures included in the I&E position and forecast position at June are calculated based on the information available at present, and reflect an agreed position with our ICS partners. The figures will be refined as appropriate in the coming months as actual income allocations are notified to the ICS by NHSE&I. Due to the nature of counting the activity linked to the ERF scheme there is a three month delay in learning the actual income, so we would expect to learn about actual April ERF income in July.

Month 3 Position

For June, the Trust is reporting an I&E position of £10.6m surplus against a £0.1m deficit plan, placing it £10.7m ahead of the system plan submitted to NHSE&I. This is primarily driven by ERF income being ahead of plan with the associated cost of delivery being behind plan (£7.8m); with the balance linked to other net underlying Trust performance being £2.9m ahead of plan.

The Trusts overall CIP target for the first half of 2021/22 is £2.8m. In June the Trust has delivered £0.2m of the £1.4m year to date target.

The Trust's compliance with the Better Payments Practice Code (BPPC) is currently averaging around 90% of suppliers being paid within 30 days.

Forecast H1 Position

The forecast outturn position for H1 2021/22 (1st April 2021 to 30th September 2021) is a break even I&E position.

Recommendation:

The Board is asked to receive the report and note any actions being taken.

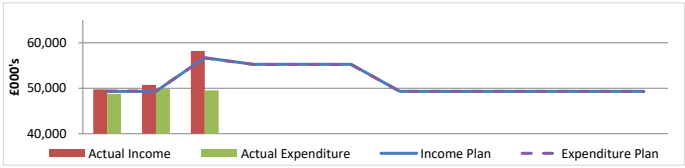
Author(s):	Graham Lamb, Deputy Finance Director
Director Sponsor:	Andrew Bertram, Finance Director
Date:	May 2021

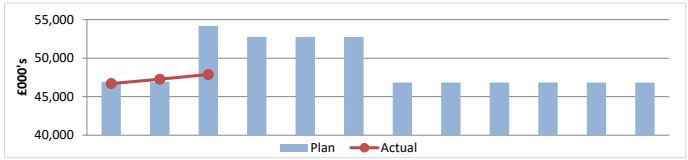
TRUST BOARD REPORT : June-2021

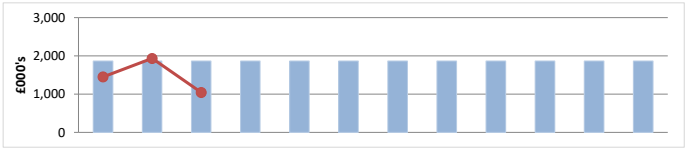
SUMMARY INCOME AND EXPENDITURE POSITION

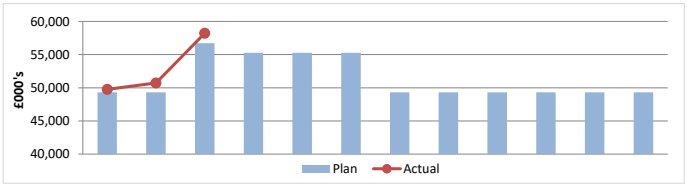
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Jun-21	METRIC:	PLAN:
£10,581	6.01 Income and Expenditure	-£129
£47,878	6.02 Operational Expenditure against Plan (exc. COVID)	£54,199
£1,042	6.03 COVID-19 Expenditure	£1,866
	Monthly % Covid Spend of Operational Spend:	2.2%
£58,217	6.04 Income against plan	£56,720









Highlights for the Board to Note:

Emergency Financial Regime

During 2020/21, to support the NHS in its response to COVID-19 all normal financial arrangements were suspended and a new national, temporary, emergency financial framework was put in operation. This saw an arrangement where for the first half year of 2020/21 the focus was on providing whatever resources organisations needed, within reason, in responding to the pandemic; with the second half of the year seeing a change in focus through the reintroduction of financial control with the Trust being expected to live within a defined allocation agreed with system partners.

For 2021/22, the allocation based approach used in the second half year of 2020/21 has been rolled forward and applied to the first half year (April 2021 - September 2021) only. Currently, NHSE&I have yet to announce the financial framework that will be in place for the second half year, 2021/22. The base allocation to cover normal activities for the first half of the year is closely linked to the actual performance in Q3, 2020/21 doubled to give a half year allocation, and then adjusted for inflation and other issues. A secondary allocation to cover additional costs resulting from the Covid-19 pandemic will also be received at a similar level to that seen in the second half year, 2020/21 . The Trust has also planned to receive other 'non-patient' activity income at similar levels seen in Q3, 2020/21. A notable change to the 2020/21 regime is the reintroduction for 2021/22 of national and local efficiency targets.

The final financial plan for the first half of the year, 2021/22 (with an indicative full year plan for information only), was submitted to and agreed by the Board at its 28 April 2021 meeting. The agreed plan results in a balanced I&E position. At NHSE&Is request the plan was resubmitted in June for the purpose of including the estimated I&E impact of the Elective Recovery Fund scheme. Estimated additional income of £21.5m was matched by an identical estimated increase in costs, thereby having a net neutral impact on the overall plan.

Month 3 Position

The graphs show the plans for the whole of 2021/22, although only months 1 to 6 feature as approved by the Board, and are against which actual performance will be measured. For June, the Trust is reporting an I&E position of £10.6m surplus against a £0.1m planned deficit, placing it £10.7m ahead of the system plan submitted to NHSE&I.

Income is £3.3m ahead of plan, resulting primarily from income for ERF activity, excluded drugs & devices outside of the envelope, and Education & Training income being ahead of plan, partially offset by other income being behind plan.

Operational expenditure is £7.4m behind plan. Pay, Clinical Supplies and Other Expenses are behind plan; partially offset by Drugs linked to increased spending on excluded drugs & devices being ahead of plan, and CIPs being behind plan.

Forecast H1 Position

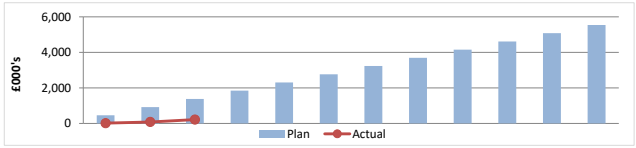
The forecast outturn position for H1 2021/22 (1st April 2021 to 30th September 2021) is a balanced position as per plan.

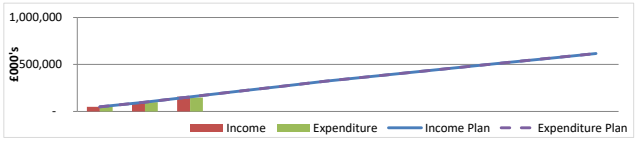
TRUST BOARD REPORT : June-2021

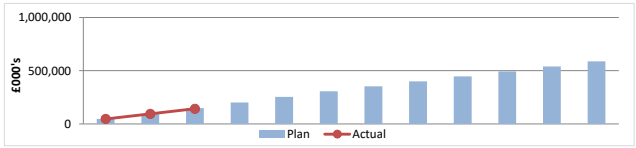
SUMMARY INCOME AND EXPENDITURE POSITION

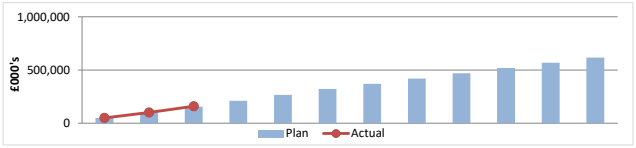
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Jun-21	METRIC:	PLAN:
£220	6.06 Efficiency Programme	£1,386
£10,581	6.07 Cumulative Income and Expenditure Position against Plan	-£129
£141,852	6.08 Cumulative Operational Expenditure against Plan (exc. COVID)	£148,028
£158,712	6.09 Cumulative Income against plan (exc. Truing Up)	£155,365









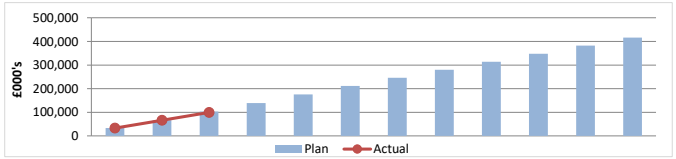
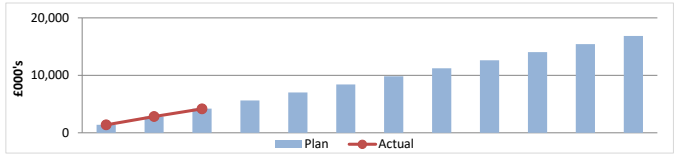
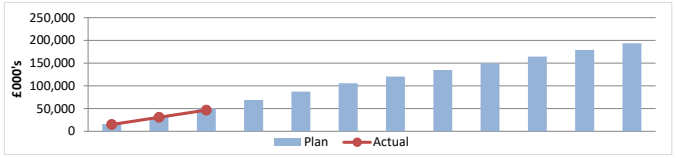
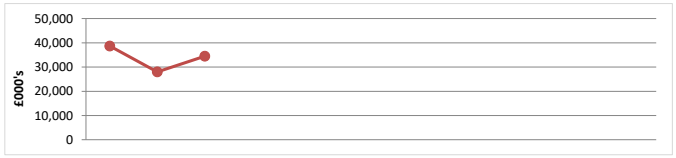
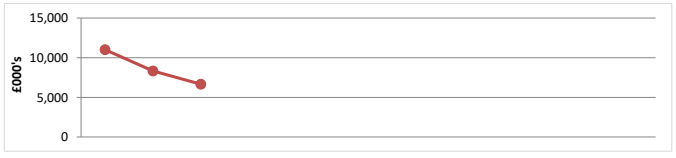
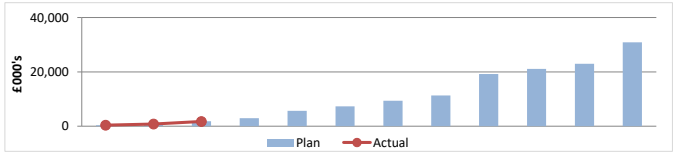
Income and Expenditure Account

	Annual Plan	YTD Plan	YTD Actual	YTD Variance	H1 Plan	H1 Forecast Outturn
	£000's	£000's	£000's	£000's	£000's	£000's
NHS England	65,830	16,458	18,284	1,826	32,915	36,494
Clinical commissioning groups	483,898	120,975	123,770	2,795	231,199	252,699
Local authorities	4,656	1,164	1,166	2	2,328	2,328
Non-NHS: private patients	260	65	70	5	130	130
Non-NHS: other	1,553	387	345	-42	878	878
Operating Income from Patient Care Activities	**556,197**	**139,049**	**143,635**	**4,586**	**267,450**	**292,529**
Research and development (both IFRS 15 and non-IFRS 15 income)	2,100	525	578	53	1,222	1,222
Education and training (excluding notional apprenticeship levy income)	17,684	4,421	5,047	626	9,372	9,372
Other income	41,144	11,370	9,452	-1,918	17,890	17,890
Other Operating Income	**60,928**	**16,316**	**15,077**	**-1,239**	**28,484**	**28,484**
Employee Expenses	-413,238	-103,866	-99,684	4,182	-195,954	-210,973
Drugs Costs	-54,677	-13,670	-15,675	-2,005	-28,280	-33,880
Supplies and Services - Clinical	-57,503	-15,193	-12,471	2,722	-24,832	-26,853
Depreciation	-12,040	-3,010	-2,759	251	-5,514	-5,514
Amortisation	-330	-83	-334	-252	-666	-666
CIP	4,762	1,168	0	-1,168	0	0
Other Costs	-76,653	-18,975	-15,352	3,623	-36,964	-39,403
Total Operating Expenditure	**-609,679**	**-153,628**	**-146,274**	**7,354**	**-292,210**	**-317,289**
OPERATING SURPLUS/(DEFICIT)	**7,446**	**1,737**	**12,438**	**10,701**	**3,724**	**3,724**
Finance income	10	3	7	4	5	5
Finance expense	-516	-129	-122	7	-258	-258
PDC dividends payable/refundable	-6,969	-1,742	-1,742	0	-3,485	-3,485
NET FINANCE COSTS	**-29**	**-131**	**10,581**	**10,712**	**-14**	**-14**
Other gains/(losses) including disposal of assets	0	0	0	0	0	0
Share of profit/ (loss) of associates/ joint ventures	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0	0
Movements in fair value of investments, investment property and financia	0	0	0	0	0	0
Corporation tax expense	0	0	0	0	0	0
SURPLUS/(DEFICIT)	**-29**	**-131**	**10,581**	**10,712**	**-14**	**-14**

TRUST BOARD REPORT : June-2021

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Jun-21	METRIC:	PLAN:	
£33,172	6.1 Pay expenditure against plan	£36,628	
£1,335	6.11 Agency expenditure against plan	£1,404	
£15,747	6.12 Non-pay expenditure against plan	£19,437	
£34,486	6.13 Cash Position	£0	
£5,244	6.14 Debtors	£0	
£6,666	6.15 Creditors	£0	
£1,739	6.16 Capital	£1,829	

Pay Expenditure Analysis

Staff Group	Annual Plan	Year to Date						
		Plan	Contract	WLI/ Overtime	Bank	Agency	Total	Variance
Consultants	63,481	15,910	14,984	165	0	425	15,573	337
Medical and Dental	53,567	13,425	11,792	89	0	1,062	12,943	481
Nursing	116,344	29,289	22,525	187	3,327	2,038	28,077	1,211
Healthcare Scientists	13,016	3,268	3,148	9	2	57	3,215	53
Scientific, Therapeutic and technical	17,543	4,407	4,004	41	4	0	4,049	358
Allied Health Professionals	27,328	6,864	6,268	126	0	277	6,671	193
HCAs and Support Staff	58,744	14,851	13,602	193	28	314	14,138	713
Exec Board and Senior managers	16,380	4,098	3,859	4	0	0	3,864	234
Admin & Clerical	45,540	11,416	10,763	7	0	0	10,771	646
Pay Reserves	103	41	0	0	0	0	0	41
Apprenticeship Levy	1,192	298	383	0	0	0	383	-85
TOTAL	**413,239**	**103,866**	**91,328**	**821**	**3,362**	**4,173**	**99,684**	**4,182**

TRUST BOARD REPORT : June-2021

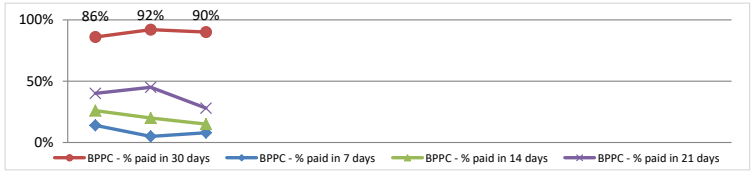
SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Jun-21	METRIC:	PLAN:
£0	6.17 Capital Service Cover	£0
£0	6.18 Liquid Ratio	£0
£0	6.19 I&E Margin	£0
£0	6.2 I&E Margin Variance from Plan	£0
£1,335	6.21 Agency Spend against Agency Cap	£1,404

BPPC Performance

Within 30 days	6.22 BPPC - % paid in 30 days	Within 7 days
90%		8%
Within 14 days	6.23 BPPC - % paid in 7 days 6.24 BPPC - % paid in 14 days	Within 21 days
15%		28%
	6.25 BPPC - % paid in 21 days	



Highlights for the Board to Note:

	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Capital Service Cover (20%)				
Liquidity (20%)				
I&E Margin (20%)				
I&E Margin Variance From Plan (20%)				
Agency variation from Plan (20%)				
Overall Use of Resources Rating				

Other Financial Issues:

For 2021/22 the Board should be aware that the delivery of national and local efficiency targets has been reintroduced; in comparison to 2020/21 where as part of the emergency financial regime the delivery of the Trust's Cost Improvement Programme (CIP) was suspended.

The Trusts overall CIP target for the first half of 2021/22 is £2.8m. This is comprised of a national efficiency requirement of 0.28% (£0.8m); an equal share of the local systems effciency requirement(£0.4m); and a further requirement to meet agreed essential investments (£1.6m). Whilst actual delivery of the CIP was suspended during 2020/21, work continued with Care Groups and Directorates to prepare plans; including the continued review of model hospital opportunities, the development of regular efficiency opportunities and the capture of transformational changes to service delivery accelerated as part of the Trust's (and wider NHS) COVID-19 response effort. CIPs totalling £220k have been delivered in June against a year to date target of £1.386m.

Metrics 6.17 through 6.20 are not being actively reviewed by NHSE/I due to the operation of the current emergency financial regime. When normal operation resumes it is expected these will remain key assessment metrics. 6.21 showing our agency spend against plan remains a live assessment metric and, at present, we are using more agency staff than plan.

The Trust's compliance with the Better Payments Practice Code (BPPC) is currently averaging around 90% of suppliers being paid within 30 days.

RESEARCH AND DEVELOPMENT REPORT

June-2021

Produced July-2021

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

To ensure financial stability

Research & Development Performance Report : Jun-2021

Executive Summary

Trust Strategic Goals:

[x] to deliver safe and high quality patient care as part of an integrated system
[x] to support an engaged, healthy and resilient workforce
[x] to ensure financial sustainability

Purpose of the Report:

To provide the Board with an integrated overview of Research Development Performance within the Trust

Executive Summary:

Key discussion points for the Board are:

The next R&D strategy is complete and is just being formatted before wider circulation and it covers our objectives and aspirations for the coming three years. In addition to this in the last month our key outcomes are as follows:

• HYMS have offered 5 Clinical Academic posts of mutual benefit to both organisations research and HR agenda, and the post are being moved forward (Cardiology, Oncology, Dermatology, Ophthalmology and Peri Operative Medicine)
• The following grants for external funding were submitted in the last month
o York Cancer Research £1.5M
o NHSE is £120K
o Macular Society £183K
• We are working on several grants for external funding that will be submitted in the coming weeks
o NIHR Research for Patient Benefit 250K
• Commercial Research Manager has been approved and is currently out for advert
• We have secured 30K from the CRN to support the opening of a multimorbidity research Hub at Scarborough and are in negotiations with Tryst Exec board for further funding to develop this important asset.

This is alongside delivering a large portfolio of clinical trials spread throughout all our six Care Groups. The challenges now are how to support this portfolio, alongside our Covid 19 trials (that still require a lot of support) and open up new opportunities, with the staff we have.

We are a very busy team!

Recommendation:

The Board is asked to receive the report and note any actions being taken.

Author(s): Lydia Harris Head of R&D

Director Sponsor: Polly McMeekin Director of WOD
Date: May 2021

TRUST BOARD REPORT : June-2021

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021-22	74	159	112										345
2020-21	615	597	440	461	421	331	259	484	293	513	201	145	4760
2019-20	334	275	284	298	348	220	464	615	477	426	365	166	4272
2018-19	249	322	562	354	731	531	365	408	145	319	442	512	4940

We have had a busy start to the year as the team were running the new Covid Vaccine trial, running out of the University of York, which is a very important study for us strategically. Work on this has reduced now though, so we are now working hard to open our non Covid research studies within our care groups.

Breakdown as of end June 21

CG & Directorate	Accruals Running Total 21/22
CG1 Total	**26**
ED	0
Elderly Medicine	0
Stroke	0
Cardiology	0
Cardio Respiratory	0
CF & Respiratory	6
Hepatology	0
Sleep Services	0
Renal	20
Gastroenterology	0
Palliative Care	0
Community	0
Dietetics	0
Tissue Viability	0
CG2 - S'boro Total	**91**
ED	0
Elderly	5
Stroke	0
Cardiology	0
Respiratory	0
Renal	0
Gastroenterology	0
Hepatology	0
Palliative Care	0
Critical Care/ICU	24
Microbiology & Infection	62
CG3 Total	**106**
Anaesthetics/Peri-Operative	50
Critical Care/ICU	31
Surgery - Non Cancer	4
Restorative Dentistry	0
ENT	21
Pain	0

CG & Directorate	Accruals Running Total
CG4 Total	**96**
Oncology (inc surgery)	13
Haematology	1
Endoscopy	0
Microbiology & Infection	82
CG5 Total	**4**
Obs & Gynae	4
Paediatrics	0
Sexual Health	0
CG6 Total	**22**
Rheumatology	0
Dermatology	1
Neurology	0
Diabetes & Endocrinology	0
MSK	19
Orthopaedics	0
Ophthalmology	2
Psychological Medicine	0
All Diagnostic Services & AHP's	0
Total Accruals	**345**

Covid Accruals Included in Monthly CRN Return Total (York)	108	
Covid Accruals Included in Monthly CRN Return Total (S'boro)	73	
Covid Accruals Not Included in Monthly CRN Return Total (York)	16	COVID-19 PD UK
Covid Accruals Not Included in Monthly CRN Return Total (S'boro)	31	COVID-19 PD UK

Breakdown of Open and Closed Trials	
Recruitment Target for Year	4022
Open Trials	75
Total Due to Close 21/22	36

Breakdown of Trial Category	
Commercial	5%
Non-Commercial	95%
Interventional	36%
Observational	64%
I & O	0%

OPERATIONAL PERFORMANCE REPORT

June-2021

Produced July-2021

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

To ensure financial stability

Report produced by:

Information Team

Operational Performance Report: June-2021

Executive Summary

Trust Strategic Goals:

- [x] to deliver safe and high quality patient care as part of an integrated system
- [x] to support an engaged, healthy and resilient workforce
- [x] to ensure financial sustainability

Purpose of the Report:

To provide the Board with an integrated overview of performance within the Trust.

Executive Summary:

Key discussion points for the Board are:

Nationally, the COVID-19 Pandemic NHS Emergency Preparedness, Resilience and Response incident level moved back to a level 3 national response on the 25th of March. A level 3 national response is defined as “an incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level”.

The Trust has continued to operate within its COVID-19 Command and Control structure throughout June and as at the 8th of July there were twenty COVID-19 positive inpatients in our acute and community hospitals. The number of COVID-19 positive inpatients peaked on the 26th of January at 216.

The Trust has had 2,837 COVID-19 positive inpatients since 17th March 2020, with 2,198 patients discharged, sadly 614 patients have died. Since the end of May 2021 there have been fifty new COVID-19 positive inpatients and zero deaths.

As at the 9th of July, York Hospital has one COVID-19 positive ward. The Trust’s COVID-19 surge plan has been refreshed to respond to further requirements for additional wards.

There were twelve elective patients cancelled by the Trust for COVID-19 reasons during June 2021; all due to theatre staff being required to isolate.

Executive Summary (cont.):

Key discussion points for the Board are:

National planning guidance was released on the 25th of March covering the period April to September 2021.

An additional £1bn Elective Recovery Fund (ERF) has been made available to the NHS in 2021-22 to support the start of the recovery of elective activity, and the recovery of cancer services. Systems were asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2021 to September 2021.

The Trust has engaged with partners in the HCV ICS and the finalised operational plan for the first half of 2021-22 was submitted on the 3rd of June.

Our ambition for 2021-22 is to over-achieve the national 'ask' on our hospital sites, focussing on delivering clinically urgent work within reasonable timescales (cancer and Priority 2 surgical patients) and to stabilise the long wait position. Over-achieving on the national activity 'ask' will enable the Trust to access the ERF and support further improvement in patient care and timely treatments.

The Trust over-achieved against the national activity 'ask' for outpatient and day case elective points of delivery in June 2021.

Point of Delivery	June 2019 Outturn	June 2021 Actual	Variance	Proportion of June 2019 delivered in June 2021
First Outpatient Appts	14,114	15,787	1,673	112%
Follow up Outpatient Appts	30,878	35,945	5,067	116%
Ordinary Electives	730	520	-210	71%
Day Cases	5,982	6,714	732	112%

Please note: colour key denotes performance against national activity 'ask'. For June 2021 any elective Point of Delivery above 80% achieved the national activity 'ask'.

- 81.0% of ED patients were admitted, transferred or discharged within four hours during June 2021.
- May 2021 saw challenging cancer performance with the Trust achieving four out of the seven core national standards.
- 1,488 fifty-two week wait pathways have been declared for the end of June 2021.
- The Trust saw improvement against the overall Referral to Treatment backlog, with the percentage of patients waiting under 18 weeks at month end, increasing from 68.3% in May to 70.5% at the end of June 2021.

Recommendation:

The Board is asked to receive the report and note the impact on the Trust KPIs and the actions being taken to address the performance challenges.

Author(s): Andrew Hurren, Deputy Head of Operational Planning and Performance
Lynette Smith, Deputy Director of Planning and Performance
Steve Reed, Head of Community Services

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: Jul 2021

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE SUMMARY

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.01	Emergency Care Attendances		▲	11889	14453	16142	15001	14254	12112	12370	11553	10842	14452	16159	17920	19218
1.02	Emergency Care Breaches		▲	673	1098	2146	2661	2734	2001	2766	2752	2241	2801	3111	3474	3642
1.03	Emergency Care Standard Performance	95%	▲	94.3%	92.4%	86.7%	82.3%	80.8%	83.5%	77.6%	76.2%	79.3%	80.6%	80.7%	80.6%	81.0%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▼	42%	41%	39%	41%	42%	44%	43%	43%	43%	43%	39%	38%	37%
1.05	ED Total number of patients waiting over 8 hours in the departments		▲	53	102	209	384	444	258	503	593	445	402	429	594	658
1.06	ED 12 hour trolley waits	0	▲	0	0	0	0	0	7	14	21	43	0	4	1	13
1.07	ED: % of attendees assessed within 15 minutes of arrival		▼	70%	65%	61%	60%	61%	65%	63%	65%	69%	66%	64%	64%	62%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▼	77%	68%	52%	48%	49%	58%	58%	60%	62%	55%	49%	47%	39%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▲	0.8%	1.4%	1.8%	1.8%	1.6%	1.1%	1.7%	1.4%	1.5%	1.8%	1.7%	1.6%	2.3%
1.10	ED - Median time between arrival and treatment (minutes)			151	158	181	190	192	177	199	206	193	194	192	191	192
1.11	Ambulance handovers waiting 15-29 minutes		▲	502	586	611	542	613	561	696	710	598	681	653	757	769
1.12	Ambulance handovers waiting 15-29 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.13	Ambulance handovers waiting 30-59 minutes		▲	91	118	152	147	129	151	209	200	101	155	180	218	243
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.15	Ambulance handovers waiting >60 minutes		▼	14	13	27	37	60	26	44	102	19	48	71	74	62
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.17	Ambulance handovers: Percentage waiting within 15 mins (shadow monitoring)		▼	78.1%	77.0%	76.9%	77.4%	76.6%	72.0%	71.1%	69.5%	74.5%	74.9%	74.2%	73.9%	72.8%
1.18	ED - Mean time in department (mins) for non-admissions (shadow monitoring)		▲	140	150	177	184	190	170	185	192	183	183	189	191	195
1.19	ED - Mean time in department (mins) for admissions (shadow monitoring)		▲	183	194	234	269	269	247	310	341	314	275	276	286	297
1.21	ED - Mean time between RFT and admission (mins) for admissions (shadow monitoring)		▲	47	48	66	87	92	89	134	170	146	101	100	106	114
1.22	ED - Number of non-admissions waiting 12+ hours (shadow monitoring)		▲	0	7	15	15	36	23	38	40	39	18	23	38	46
1.23	ED - Number of admissions waiting 12+ hours (shadow monitoring)		▲	2	8	45	94	132	81	225	323	232	132	148	171	265
1.24	ED - Critical time standards (shadow monitoring - awaiting guidance on metrics)			-	-	-	-	-	-	-	-	-	-	-	-	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity)		▼	3989	4545	4707	4678	4692	4383	4482	4233	3881	4884	4790	4912	4845
2.02	Non Elective Admissions - Paediatrics		▲	352	369	364	479	454	471	382	351	381	478	512	631	724
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▲	1628	1899	1861	1930	1973	1903	1737	1479	1549	1917	1990	2102	2194
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	705	766	934	962	985	946	982	1062	883	1014	982	959	946
2.07	Ward Transfers - Non clinical transfers after 10pm	100	▼	15	25	25	41	50	39	47	35	53	56	44	65	53
2.08	Emergency readmissions within 30 days		▲	698	760	788	842	997	931	810	761	679	881	897	-	-
2.09	Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	184	149	230	264	273	266	266	325	291	275	260	270	252
2.10	Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington		▼	176	175	203	253	266	278	264	303	287	253	237	251	247
2.12	Super Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	34	30	35	70	87	63	67	81	86	68	70	74	60
2.13	Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington		▲	43	40	40	57	80	78	72	79	85	68	54	55	64

REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
3.01	Outpatients: All Referral Types		▲	15307	17700	16462	20347	20802	19326	19478	16975	16657	21937	21064	19610	20607
3.02	Outpatients: GP Referrals		▲	5663	7056	6551	7667	8127	7671	7458	6315	6966	9821	8904	8025	8285
3.03	Outpatients: Consultant to Consultant Referrals		▲	1219	1430	1351	1714	1694	1655	1661	1579	1583	1842	1858	1732	1801
3.04	Outpatients: Other Referrals		▲	8425	9214	8560	10966	10981	10000	10359	9081	8108	10274	10302	9853	10521
3.05	Outpatients: 1st Attendances		▲	7771	9668	9287	11631	12149	12727	12084	12174	11235	14499	13472	13807	15833
3.06	Outpatients: Follow Up Attendances		▲	21627	25124	24384	30125	31457	32680	30253	31250	30141	36646	33123	33050	36238
3.07	Outpatients: 1st to FU Ratio		▼	2.78	2.60	2.63	2.59	2.59	2.57	2.50	2.57	2.68	2.53	2.46	2.39	2.29
3.08	Outpatients: DNA rates		▲	4.3%	5.1%	6.3%	6.4%	6.4%	6.6%	6.2%	7.1%	6.4%	5.8%	5.7%	5.1%	5.4%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	180	▲	734	707	236	249	188	263	216	333	248	215	242	165	169
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	3571	4441	2192	1867	1461	1276	1271	1036	1002	1133	1170	974	1005
3.11	Outpatients: Follow-up Partial Booking (FUPB) Overdue			21994	24726	26543	28149	28225	28182	27550	25782	24835	24778	24421	24624	24504
4.01	Elective Admissions		▲	254	341	351	416	557	505	513	436	505	537	469	486	556
4.02	Day Case Admissions		▲	3414	4435	4447	5440	5902	5628	5430	4653	4478	5551	5787	5697	6689
4.03	Cancelled Operations within 48 hours - Bed shortages		▲	3	0	2	3	5	8	10	121	10	4	1	0	2
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▲	19	28	37	57	65	89	37	183	87	73	114	38	75
4.05	Theatres: Utilisation of planned sessions		▲	41%	66%	72%	66%	68%	69%	68%	57%	62%	69%	75%	76%	76%
4.06	Theatres: number of sessions held		▲	264	537	586	693	726	712	675	604	639	636	629	641	755

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE SUMMARY

REF	DIAGNOSTICS	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
3.12	Diagnostics: Patients waiting <6 weeks from referral to test	99%	▼	34.3%	46.2%	46.6%	53.7%	61.0%	66.4%	63.5%	61.0%	66.6%	68.5%	66.2%	62.9%	62.8%
3.13	Diagnostics: Total Fast Track Waiters		▲	597	723	537	618	740	645	750	655	671	735	608	786	796
3.19	Diagnostics: Urgent Radiology Waiters		▼	337	417	379	502	695	707	702	627	733	814	819	862	781
3.38	Total Overdue Planned Radiology Waiters		▼	1300	1103	1137	760	617	367	341	735	605	451	485	393	259
3.22	Total Radiology Reporting Backlog		▲	260	926	1346	1804	1530	1441	2962	1718	2176	2140	2124	1889	2418
3.31	Total Endoscopy Surveillance Backlog (Red)		▼	1073	1161	1264	1337	1345	1307	1384	1467	1485	1331	1402	1334	1235

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
5.01	RTT Percentage of incomplete pathways within 18wks	92%	▲	42.0%	42.3%	52.7%	60.0%	65.5%	67.5%	66.7%	63.9%	62.8%	64.7%	65.8%	68.3%	70.5%
5.02	RTT Waits over 52 weeks for incomplete pathways	0	▼	910	1360	1764	1986	2176	2250	2251	2506	2581	2446	2023	1713	1488
5.10	RTT Waits over 78 weeks for incomplete pathways	0	▲	0	0	0	20	58	99	191	319	410	523	577	632	638
5.11	RTT Waits over 104 weeks for incomplete pathways	0	▲	0	0	0	0	0	0	0	0	0	1	8	32	40
5.05	RTT Total Waiting List		▲	25057	25107	26141	27042	27908	27646	28040	27154	27193	28691	30069	30321	30707
5.06	Number of RTT patients on Admitted Backlog (18+ weeks)		▼	7114	7182	6654	6019	5318	4716	4375	4341	4328	4355	4306	4073	3862
5.07	Number of RTT patients on Non Admitted Backlog (18+ weeks)		▼	7429	7296	5711	4787	4323	4275	4963	5453	5792	5766	5968	5531	5192
5.08	RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring)	8.5	▼	21.4	21.4	20.7	19.6	18.2	17.5	17.7	18.2	18.1	17.0	16.4	16.3	15.9
5.12	Number of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways at end of month*			-	-	-	-	-	-	-	-	-	-	604	638	574
5.13	Percentage of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways under 4 weeks at end of month*			-	-	-	-	-	-	-	-	-	-	68%	67%	75%

*Priority 2: includes all P2 pathways where there is a surgical decision to treat, not just open RTT pathways.

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
6.01	Cancer 2 week (all cancers)	93%	▲	96.4%	95.0%	94.5%	88.7%	93.4%	93.5%	94.2%	90.2%	92.5%	91.1%	88.1%	93.7%	-
6.02	Cancer 2 week (breast symptoms)	93%	▼	97.6%	96.4%	95.1%	95.1%	88.0%	93.9%	97.3%	80.0%	92.6%	92.6%	92.8%	91.5%	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	▲	97.8%	96.8%	97.0%	97.3%	96.8%	98.9%	97.0%	95.7%	99.1%	97.0%	96.3%	98.5%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	▼	89.7%	88.2%	81.8%	92.6%	88.4%	87.5%	90.9%	85.3%	93.9%	93.3%	96.2%	95.5%	-
6.05	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	▲	100.0%	100.0%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	-
6.06	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▲	82.5%	79.1%	81.6%	75.5%	74.2%	74.3%	75.5%	70.0%	72.1%	75.0%	70.9%	79.9%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)**	90%	▼	-	-	-	-	91.2%	91.1%	86.7%	80.5%	97.6%	87.2%	96.5%	83.7%	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▲	64.4%	65.9%	62.3%	63.9%	61.1%	61.5%	66.7%	53.6%	60.5%	70.2%	63.1%	63.6%	-

**62 day screening: months with five or fewer records from May-20 are not included

REF	COMMUNITY	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
7.01	Referrals to District Nursing Team		▲	2139	2169	1816	2068	2148	2091	1913	1956	1761	2057	1929	1916	2080
7.02	% CRT Patients Seen within 2 days of Referral		▼	91.9%	92.4%	92.1%	83.3%	85.3%	83.1%	89.3%	83.7%	71.4%	79.3%	82.8%	83.5%	78.4%
7.03	Number of District Nursing Contacts		▼	20800	21927	20296	20081	20941	21013	20271	19317	18139	21505	20984	20711	20608
7.04	Referrals to York Community Response Team		▲	179	171	157	214	196	216	198	227	190	182	179	200	205
7.05	Referrals to Selby Community Response Team		▼	58	48	65	58	69	58	60	68	57	64	56	51	40
7.07	Number of York CRT Contacts		▼	3711	4653	4444	4782	5265	5793	5218	4847	3839	3691	4367	4936	4831
7.08	Number of Selby CRT Contacts		▲	1529	1734	1451	1574	1759	1731	1342	1269	1284	1486	1431	1513	1435
7.10	Community Inpatient Units Average Length of Stay (Days)		▼	10.9	9.8	12.3	12.8	13.5	15.1	12.1	10.5	12.5	13.5	11.0	13.3	16.1
7.11	% Community Therapy Team Patients Seen within 6 weeks of Referral		▲	71.7%	70.8%	64.8%	62.8%	54.9%	53.0%	56.3%	52.9%	54.4%	49.9%	52.3%	52.4%	36.6%
7.12	% CRT Step Up Referrals Seen Within 2 Hrs		▼	22.1%	22.1%	19.4%	11.3%	20.6%	8.6%	14.2%	12.9%	15.6%	21.5%	15.4%	9.4%	17.6%
7.13	% of End of Life Patients Dying in Preferred Place of Death		▲	83.3%	50.0%	90.0%	70.0%	93.9%	80.0%	93.5%	82.9%	80.5%	85.7%	74.1%	78.8%	79.2%

REF	CHILDREN AND YOUNG PERSONS (0-17 YEARS)	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
8.01	Emergency Care Standard Performance (Type 1 only)	95%	▼	98.5%	97.5%	94.1%	92.6%	93.6%	94.9%	96.6%	97.3%	97.1%	96.5%	96.2%	95.5%	94.5%
8.02	ED patients waiting over 8 hours in department		▼	0	2	1	2	5	7	1	1	2	1	5	11	7
8.03	Cancer 2 week (all cancers)	93%	▲	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
8.05	Diagnostics: Patients waiting <6 weeks from referral to test	99%	▼	34.2%	41.4%	44.8%	52.0%	57.8%	55.5%	54.5%	51.8%	50.9%	62.2%	62.4%	72.7%	58.9%
8.06	RTT Percentage of incomplete pathways within 18wks	92%	▲	44.6%	41.1%	51.7%	59.8%	67.4%	70.7%	70.5%	66.8%	66.3%	70.3%	71.8%	73.0%	75.8%
8.07	RTT Total Waiting List		▲	2009	1903	1997	2179	2195	2081	2040	2026	2102	2285	2395	2433	2511
8.08	RTT Waits over 52 weeks for incomplete pathways		▼	51	102	147	192	224	227	211	225	218	191	156	123	102

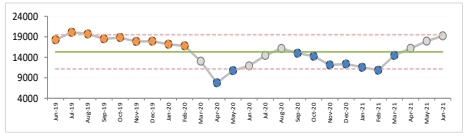
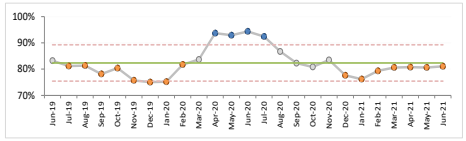
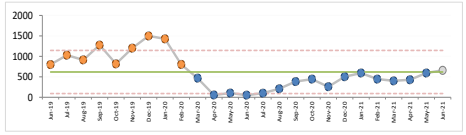
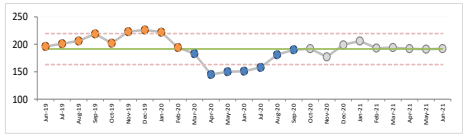
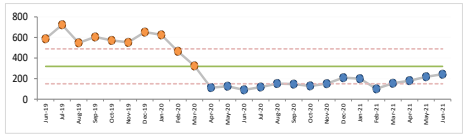
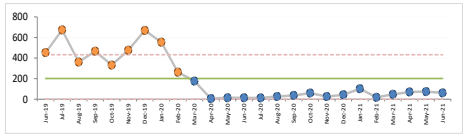
REF	STROKE	Target	Sparkline / Previous Month	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
9.01	Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	◀▶	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
9.02	Proportion of stroke patients with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation		▲	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-
	SSNAP Scores:			**Jun-20***	**Jul-Sep 20**			**Oct-Dec 20**			**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**
9.03	Proportion of patients spending >90% of their time on stroke unit	85%	▼	88.1% (B)	85.6% (B)			89.3% (B)			73.2% (E)	90.1% (A)	93.9% (A)	91.7%(A)	90.6%(A)	89.4%(A)
9.04	Scanned within 1 hour of arrival	43%	▲	63.1% (A)	51.9% (A)			58.9% (A)			63.3% (A)	51.4% (A)	47.1% (B)	68.3%(A)	64.3%(A)	100%(A)
9.05	Scanned within 12 hours of arrival	90%	▲	93.4% (B)	95.3% (A)			96.6% (A)			95% (B)	90.3% (B)	95.7% (A)	97.6%(A)	97.3%(A)	100%(A)

*COVID data set for the period April to June 2020. The full SSNAP data set is now being used.

The latest month's SSNAP data is subject to change due to casenote delays and patients not yet being discharged. The January figures for the 90% time in Stroke services are low because unfortunately the acute stroke unit at York had a COVID outbreak which meant the SSNAP Data Administrators were not allowed up on to the clinical ward to start records. Also the ward was only taking potential Thrombolysis patients, so many stroke patients initially were admitted to other wards and therefore were not admitted to Stroke services in a timely manner.

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE: ED

Jun-21	METRIC :	TARGET :	vs LM :	
19,218	**1.01** Emergency Care Attendances	-	1,298 ↑	
81.0%	**1.03** Emergency Care Standard Performance	95.0%	0.4% ↑	 CG1 CG4 CG2 CG5 CG3 CG6
658	**1.05** ED Total number of patients waiting over 8 hours in the departments	-	64 ↑	
192	**1.10** ED - Median time between arrival and treatment (minutes)	-	1 ↑	
243	**1.13** Ambulance handovers waiting 30-59 minutes	0	25 ↑	 CG1 CG4 CG2 CG5 CG3 CG6
62	**1.15** Ambulance handovers waiting >60 minutes	0	-12 ↓	 CG1 CG4 CG2 CG5 CG3 CG6

HIGHLIGHTS FOR BOARD TO NOTE:

81.0% of ED patients were admitted, transferred or discharged within four hours during June 2021. This compares with 94.3% in June 2020 however it should be noted that there was a full national lockdown in place for the majority of that month. The lockdown in 2020 resulted in a significant reduction in demand; illustrated by the 37% rise in attendances at our two Emergency Departments (+3,998 attendances) in June 2021 compared to last year.

The national position for June 2021 was 81.3%. Nationally the Trust placed 52nd out of 126 Trusts (of note, 14 of the 126 Trusts are not required to submit ECS performance as they were the pilots for the new ED metrics and thus are exempt). Only two Trusts achieved 95%+ (Sheffield Children's NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust) against the ECS. The 95% standard was last met nationally in July 2015.

In terms of the North East & Yorkshire region, the Trust placed 11th out of 22 providers. Our HCV ICS acute provider partners achieved the following performance; HDFT 83.1%, NLAG 74.6% and HUTH 70.9%.

Attendances at both Emergency Departments have returned to pre-pandemic levels; however the bed base remains reduced due to social distancing. This has created pressure within the emergency care flows across the Trust. Analysis is underway to identify key factors for the increased footfall into the ED departments. This will be shared with partners to develop shared actions to contain demand.

York Hospital Locality ECS Performance was 85.5%. The estate has been reconfigured throughout the third wave to support the COVID-19 Surge Plan, with one COVID-19 positive ward in operation as at the 9th of July.

Scarborough Hospital Locality ECS Performance was 74.9%. Demand at the three independent Sector run services; Bridlington Urgent Treatment Centre, Malton Urgent Care Centre and the Urgent Care Centre co-located at Scarborough Hospital, are yet to see demand return to pre-pandemic levels. This has impacted the Scarborough locality's overall performance as the number of Type 3 attendances has significantly reduced; -27% YTD compared to April to June 2019.

The Scarborough Hospital Quality and Performance Summit (Emergency Care) was held on the 22nd of March, as a result of challenged performance in February and to identify improvements against the new emergency care metrics. Six immediate action areas were agreed, including process mapping of the acute model, bed modelling refresh, workforce recommendations and surge planning. A follow up workshop was held on the 9th of June and actions to reduce congestion in the Emergency Department and a range of options to improve flow across the Hospital have been developed. These will be presented to Executive Committee in July 2021.

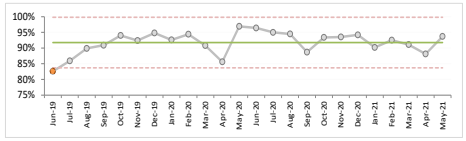
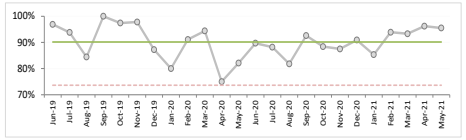
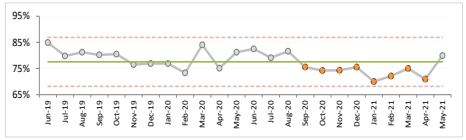
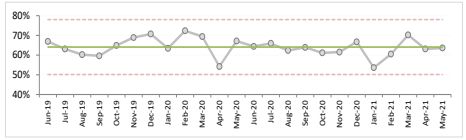
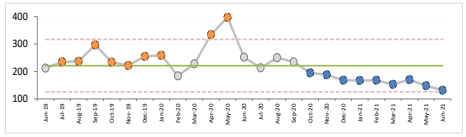
There was thirteen twelve-hour trolley waits on the Scarborough site in June 2021.

Adult Non-Elective admissions rose in June 2021 compared to the same period last year; up 12% (+469 admissions) however it must be noted that the first national lockdown was in place throughout the majority of June 2020 which resulted in a significant fall in non-elective demand. York Hospital saw an increase of 304 admissions (+11%) with Scarborough seeing a rise of 165 admissions (+13%) compared to May 2020. Paediatric Non-Electives are detailed on the Children and Young Persons section.

Super-Stranded (Length of Stay of 21+ Days) patients at the end of June 2021 were reduced compared to the end of May (74 to 60 patients). System level escalation meetings have been reinstated to ensure all efforts are made to ensure patients who do not have the right to reside (medically fit) are in an appropriate place of care or supported at home. The system Discharge Coordinators and Executive Leads (as per the COVID-19 Discharge Guidance) supports escalation and action.

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE: CANCER

May-21	METRIC :	TARGET :	vs LM :	
93.7%	**6.01** Cancer 2 week (all cancers)	93.0%	5.6% ↑	
98.5%	**6.03** Cancer 31 day wait from diagnosis to first treatment	96.0%	2.2% ↑	
95.5%	**6.04** Cancer 31 day wait for second or subsequent treatment - surgery	94.0%	-0.7% ↓	
79.9%	**6.06** Cancer 62 Day Waits for first treatment (from urgent GP referral)	85.0%	9.0% ↑	
63.6%	**6.08** Cancer 28 Day Wait - Faster Diagnosis Standard	75.0%	0.5% ↑	
132	**6.25** Cancer PTL - Waiters over 62 Days	-	-16 ↓	

CG1 CG4 CG2 CG5 CG3 CG6

HIGHLIGHTS FOR BOARD TO NOTE:

Trust cancer performance in May 2021 continues to be challenged, with four out of the seven cancer standards met;

- 14 Day Fast Track
- 31 day wait from diagnosis to first treatment.
- 31 day wait for second or subsequent treatment – Surgery.
- 31 day wait for second or subsequent treatment - Drug treatments.

The Trust saw an improvement against the Cancer two week waiting times for urgent referrals, achieving the target with performance of 93.7% in May (April; 88.1%). The latest available data shows the national position to be 87.5% in May 2021.

For 32% of the patients that were not seen within 14 days, the delay was initiated by the patient. COVID-19 prevalence continued to reduce in May however this may still have been of concern to patients and may have influenced patient decisions to delay their appointments. This was particularly notable in Breast (100% of breaches were due to patient choice) and Colorectal (73%). Issues were identified in the Upper GI straight to test process during April, this has been rectified and 14 day performance improved significantly in May 2021.

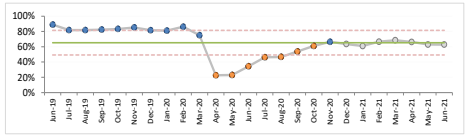
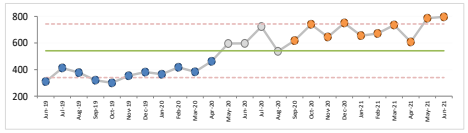
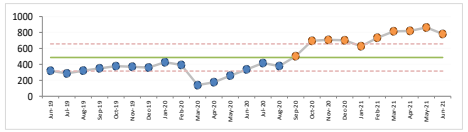
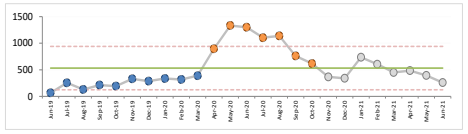
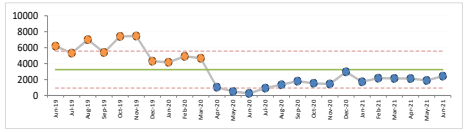
Performance against the 62 day wait for first treatment target was 79.9%, up from 70.9% in April 2021. This equates to 31.5 breaches, with over 50% percent on Colorectal, Urological and Lung pathways. Overall, 68% of the breaches were due to capacity or health care initiated delays. All patients are tracked through the operational teams, with weekly escalations to senior managers. The latest available data shows the national position to be 73.0% against the 62 day wait for first treatment target in March 2021.

At the end of June 2021 there were 132 patients on the Trust's Patient Tracking List (PTL) that had waited over 62 days, a decrease of 16 against the end of May 2021 position. Of those waiting over 62 days, 92 are awaiting diagnosis; tackling this backlog is a top priority for the Trust and the Humber, Coast and Vale system and is a key element of the recovery work.

Of the patients treated in May 2021, there were eight patients who had waited more the 105 days. The majority were due to either a complex diagnostic pathway or had their treatment delayed for medical reasons. There has been a real focus on the long wait patients at the Trust's weekly PTL Cancer Wall meetings. There were 108 on the 27th July 2020, at the end of June 2021 there were 17. To understand the impact of longer waits for patients the Trust undertakes Clinical Harm Reviews (CHR). All long waiting (105+ days) patients receive a CHR that looks at the chronology of a patient's care and ascertains whether the delay to treatment has resulted in any harm. This is a clinician-led process that reports to the Cancer Delivery Board and then into the Trust's Quality Committee.

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE: DIAGNOSTICS

Jun-21	METRIC :	TARGET :	vs LM :	
62.8%	**3.12** Diagnostics: Patients waiting <6 weeks from referral to test	99%	-0.1% ↓	
796	**3.13** Diagnostics: Total Fast Track Waiters	-	10 ↑	
781	**3.19** Diagnostics: Urgent Radiology Waiters	-	-81 ↓	
259	**3.38** Total Overdue Planned Radiology Waiters	-	-134 ↓	
2418	**3.22** Total Radiology Reporting Backlog	-	529 ↑	
1,235	**3.31** Total Endoscopy Surveillance Backlog (Red)	-	-99 ↓	

CG1 CG4 CG2 CG5 CG3 CG6

HIGHLIGHTS FOR BOARD TO NOTE:

The diagnostics target for June 2021 remained static with 62.8% of patients provisionally waiting less than 6 weeks for their diagnostic test at the end of the month (May 2021; 62.9%). The latest available data shows the national position at the end of May was 78%.

The Endoscopy performance was 55.2% (April; 46.1%). Outsourcing opportunities with the Independent Sector and Humber, Coast and Vale provider partners are being explored and additional booking capacity has been put in place which will aid the recovery of this position. The Trust is also exploring insourcing opportunities to increase capacity on site.

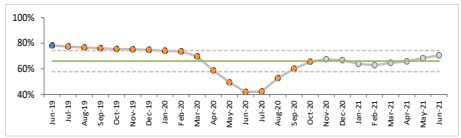
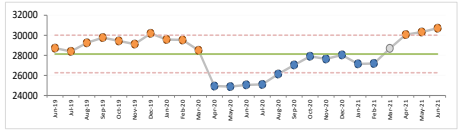
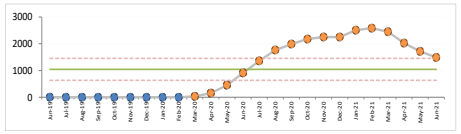
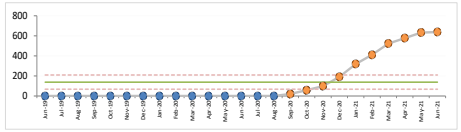
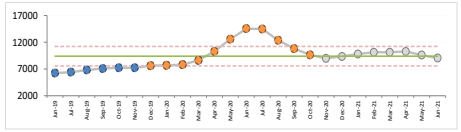
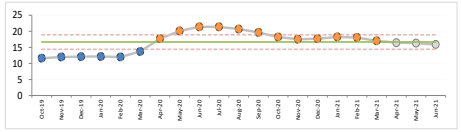
Radiology continues to be affected with a decline seen in the radiology diagnostics performance at the end of June; down to 61.3% (May; 64.3%), with CT performing at 74%.

The performance against the Diagnostic standard continues to be affected by the increase in referrals; in particular cancer referrals that has required services to prioritise fast track and urgent patients. This has resulted in reduced capacity for routine patients and a decrease in performance against the 6 week target.

Currently in Radiology, the MRI radiographer workforce is under 50% capacity which means that the service is unable to run additional lists in order to meet the increased demand. The Cancer & Support Services Care Group is actively pushing forward with recruitment and training to urgently address this workforce issue. The Care Group have successfully procured the rental of a mobile MRI scanner which will be onsite and increase capacity from the 19th of July 2021.

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE: REFERRAL TO TREATMENT (RTT)

Jun-21	METRIC :	TARGET :	vs LM :		
70.5%	**5.01** RTT Percentage of incomplete pathways within 18wks	92.0%	2.2% ↑		CG1 CG4 CG2 CG5 CG3 CG6
30,707	**5.05** RTT Total Waiting List	29,583	386 ↑		CG1 CG4 CG2 CG5 CG3 CG6
1,488	**5.02** RTT Waits over 52 weeks for incomplete pathways	0	-225 ↓		CG1 CG4 CG2 CG5 CG3 CG6
638	**5.10** RTT Waits over 78 weeks for incomplete pathways	0	6 ↑		
9,054	**5.09** Number of RTT patients on Total Backlog (18+ weeks)	-	-550 ↓		
15.9	**5.08** RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring)	8.5	-0.4 ↓		CG1 CG4 CG2 CG5 CG3 CG6

HIGHLIGHTS FOR BOARD TO NOTE :

The proportion of patients waiting more than 18 weeks decreased in June 2021, with the overall RTT position improving from 68.3% of patients waiting less than 18 weeks from referral to treatment to 70.5%. The latest available data shows the national position at the end of May 2021 was 67.4%.

The Trust's RTT Total Waiting List (TWL) increased by 386 from the end of May and stood at 30,707. The continued increase in the Trust's overall RTT position was primarily driven by referrals from GPs returning to pre-COVID-19 pandemic levels.

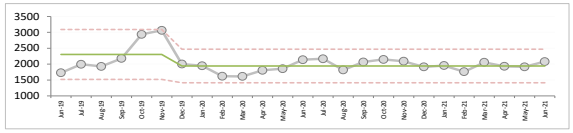
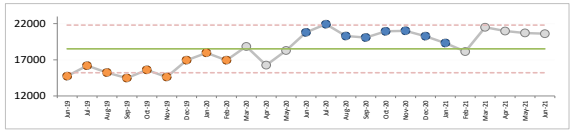
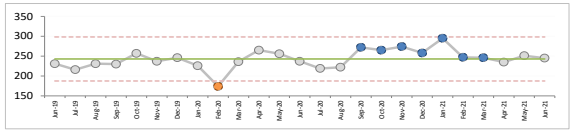
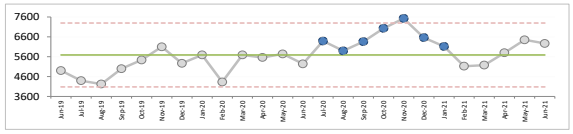
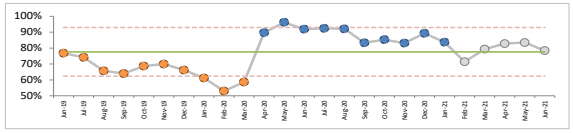
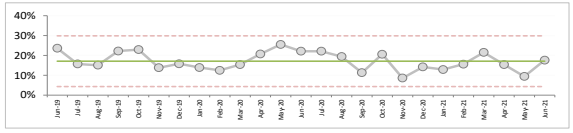
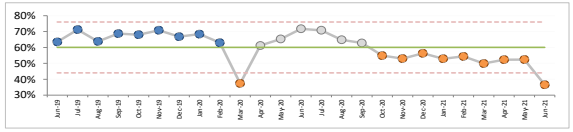
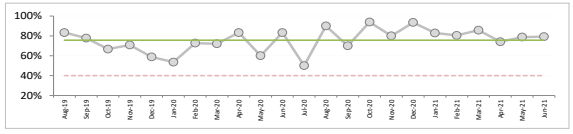
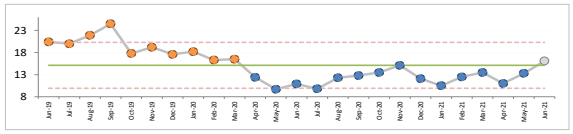
The Trust continues to make significant progress in reducing the number of long waiter patients. The Trust had 1,488 patients waiting 52 weeks or longer at the end of June 2021; a reduction of 225 on the end of May 2021 position. This position is a reduction of 1,093 from the 'peak' at the end of February 2021 when the Trust declared 2,581 fifty-two week RTT waiters.

A key focus of the National Planning Guidance for 2021-22 is the treatment of the most urgent elective patients within agreed timescales. Surgical patients who are clinically prioritised as a priority 2 should be treated within 4 weeks of being added to the waiting list. At the end of March 2021 51% of priority 2 surgical patients had been waiting less than four weeks, therefore the Trust has set a month by month improvement trajectory to increase this to 90% by the end of September 2021. The Trust made significant progress in June 2021; with 75% of priority patients waiting less than four weeks compared to 67% at the end of May 2021, this improvement is in line with the monthly improvement trajectory submitted to the HCV ICS.

The Trust is developing its approach to sustainable recovery as COVID-19 prevalence reduces through a transformational 'Building Better Care' Programme, targeted at high impact actions across urgent care, outpatients, surgical pathways, cancer and diagnostics over the next two years.

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE: COMMUNITY ACTIVITY

Jun-21	METRIC :	TARGET :	vs LM :	
2,080	**7.01** Referrals to District Nursing Team	-	164 ↑	
20,608	**7.03** Number of District Nursing Contacts	-	-103 ↓	
245	**7.06** All Community Response Teams Referrals (York and Selby)	-	-6 ↓	
6266	**7.09** Number of CRT Contacts (York and Selby)	-	-183 ↓	
78.4%	**7.02** % CRT Patients Seen within 2 days of Referral	-	-5.1% ↓	
17.6%	**7.12** % CRT Step Up Referrals Seen Within 2 Hrs	-	8.2% ↑	
36.6%	**7.11** % Community Therapy Team Patients Seen within 6 weeks of Referral	-	-15.8% ↓	
79.2%	**7.13** % of End of Life Patients Dying in Preferred Place of Death	-	0.4% ↑	
16	**7.10** Community Inpatient Units Average Length of Stay (Days)	-	3 ↑	

HIGHLIGHTS FOR BOARD TO NOTE :

Although length of stay in community inpatient units continues below the historical average through a combination of a transformation programme that began in autumn 2019 and the new national discharge guidelines that came into effect in April 2020, June saw the highest length of stay for over a year which is linked to capacity constraints in the long term care market, particularly domiciliary care. This is causing patients to wait longer for their identified care package to commence.

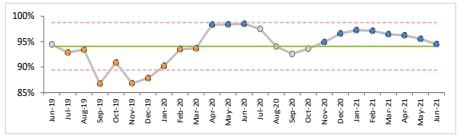
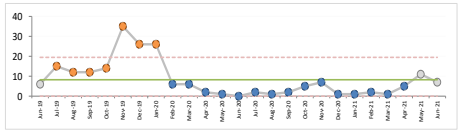
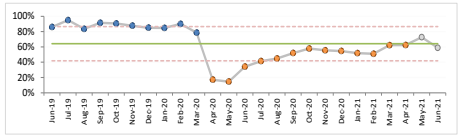
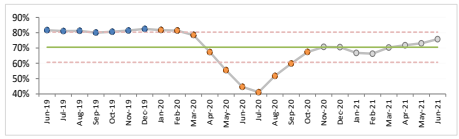
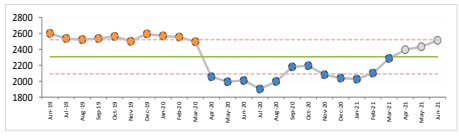
Following the inclusion of the metric demonstrating the percentage of Community Response Team (CRT) patients referred from the community that were seen within 2hrs it should be noted that this is a proxy measure of our baseline performance in the new Urgent Community Response standard. Whilst not all patients currently referred would require a 2hr response, understanding that currently around 20% of patients receive a response in this timeframe has supported the development of plans, now submitted to commissioners and awaiting approval, for additional capacity to increase the proportion of patients that can be assessed within this timeframe. Necessary changes are being made to the electronic patient record to enable the capture of the Urgent Community Response standard in line with the technical guidance.

As detailed over recent months, staff from our Community Therapy Teams were redeployed over winter months to maintain capacity in the Community Response Teams to ensure rapid discharge from hospital and provide alternatives to admission despite increases in demand and COVID-related staff absence. Despite a small fall in February, it can be seen that this has enabled the CRTs to maintain the improved performance on the 2 day standard. However, this has been to the detriment of routine referrals in the Community Therapy Teams where we have seen a further decline in the percentage of patients seen within six weeks. Staff have now returned to their normal roles and work to tackle the backlog has commenced, with ongoing review and clinical prioritisation taking place. Monitoring of increased demand for the service (linked to patients who have deconditioned through lockdowns and expansion of 'discharge to assess' approaches) has commenced to establish if additional capacity is required to prevent further backlog growth.

Demand for District Nursing services remains high, with contacts returning to upper control levels between March and June. A workforce review of community nursing is being undertaken which will reflect the higher demand for services.

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE: CHILDREN AND YOUNG PERSONS (0-17 YEARS)

Jun-21	METRIC :	TARGET :	vs LM :		
94.5%	**8.01** ECS Performance (Type 1 only)	95%	-1.0% ↓		CG1 CG4 CG2 CG5 CG3 CG6
7	**8.02** ED patients waiting over 8 hours in department	-	-4 ↓		
May-21					
100.0%	**8.03** Cancer 14 day performance	93%	0.0%		CG1 CG4 CG2 CG5 CG3 CG6
58.9%	**8.05** Diagnostics	99%	-13.8% ↓		CG1 CG4 CG2 CG5 CG3 CG6
75.8%	**8.06** RTT performance	92%	2.7% ↑		CG1 CG4 CG2 CG5 CG3 CG6
2,511	**8.07** RTT TWL	2567	78 ↑		CG1 CG4 CG2 CG5 CG3 CG6
102	**8.08** RTT 52 week waiters	0	-21 ↓		CG1 CG4 CG2 CG5 CG3 CG6

HIGHLIGHTS FOR BOARD TO NOTE:

Performance against the ECS for patients aged 0-17 was below at target at 94.5% in June 2021, the first time in seven months that the target was not achieved. This was driven by significant surges in demand over two weekends in June at Scarborough ED. In total thirty patients breached the ECS at Scarborough ED with two-thirds due to either ED or Specialty delays; the Family Health Care Group are working on measures to patients waits during periods of high demand.

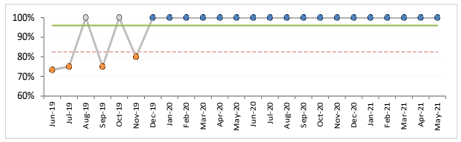
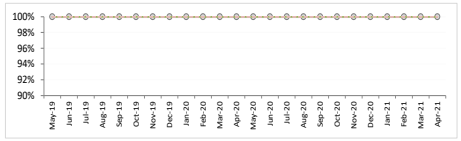
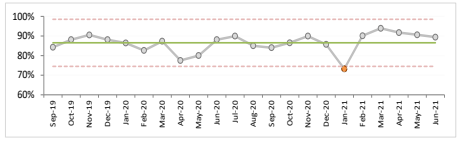
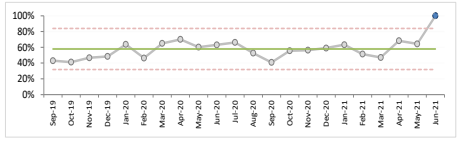
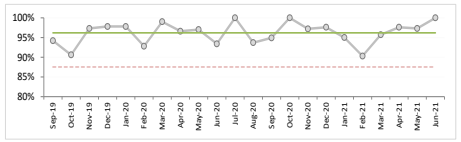
June 2021 has seen an increase in non-elective admissions for children, up 25% from May 2021 (+88), and was 7% higher than June 2019.

Cancer 14 Day performance for those aged 0-17 was 100% in May 2021. On average each month the Trust sees three to four patients in this age category.

RTT performance against the 92% target is higher than the Trust overall performance (75.8% compared to 70.5%). The Trust is declaring 102 RTT fifty-two week waiters relating to children and young people at the end of June 2021; down from 123 at the end of May 2021. Children comprise approximately 8% of the total number of the fifty-two week waiters that the Trust is declaring for the end of June 2021 (1,488).

TRUST BOARD REPORT: June-2021

OPERATIONAL PERFORMANCE: STROKE

	May-21	METRIC :	TARGET :	vs LM :	
9.01	100.0%	Proportion of patients who experience a TIA who are assessed & treated within 24 hrs	75%	0.0%	
9.02	100.0%	Proportion of stroke patients with new or previously diagnosed AF who are anti-coagulated on discharge or have a plan in the notes or discharge letter after anti-coagulation	-	0.0%	
9.03	89.4%	Proportion of patients spending >90% of their time on stroke unit	85%	-1.2% ↓	
9.04	100.0%	Scanned within 1 hour of arrival	43%	35.7% ↑	
9.05	100.0%	Scanned within 12 hours of arrival	90%	2.7% ↑	

HIGHLIGHTS FOR BOARD TO NOTE:

The latest Sentinel Stroke National Audit Programme (SSNAP) report for the period October to December 2020 was published in April 2021. For this period the Trust achieved a score of 76 which equates to a B rating. This represents an improvement on our pre-pandemic performance, and was attained during the months where there was increasing pressure as COVID-19 cases were rising (the Trust score for the period January to March 2020 was 73).

Domains associated with the new 'Direct Admission Model' have performed well, and have improved, which signals that the model employed by this Trust is working.

The rate of thrombolysis within one hour (Door to needle time) has fallen, however the time at which patients present at hospital is out of our control. The service is hoping the new 'Act FAST' campaign will educate individuals and lead to earlier presentation at hospital.

Speech and Language Therapy continues to be an area of concern, with the service well sighted on the reasons and there is ongoing work to improve this.

TRUST BOARD REPORT : June-2021

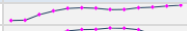
OPERATIONAL PERFORMANCE SUMMARY - SCARBOROUGH

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.01	Locality Emergency Care Attendances		▲	4930	6483	7486	6415	5998	4830	4881	4608	4436	5824	6718	7508	8303
1.02	Locality Emergency Care Breaches		▲	375	650	1089	1088	1357	965	1251	1018	1098	1217	1466	1732	2057
1.03	Locality Emergency Care Standard Performance	95%	▼	92.4%	90.0%	85.5%	83.0%	77.4%	80.0%	74.4%	77.9%	75.2%	79.1%	78.2%	76.9%	75.2%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▼	52%	50%	47%	52%	52%	53%	53%	53%	51%	55%	52%	50%	49%
1.05	ED Total number of patients waiting over 8 hours in the departments		▲	38	75	139	169	303	152	318	359	276	230	290	422	516
1.06	ED 12 hour trolley waits	0	▲	0	0	0	0	0	7	14	17	43	0	4	1	13
1.07	ED: % of attendees assessed within 15 minutes of arrival		▼	34%	25%	27%	32%	33%	34%	33%	40%	44%	47%	46%	44%	40%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▼	85%	71%	51%	50%	44%	54%	61%	67%	63%	60%	57%	50%	36%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▲	1.4%	2.1%	2.3%	1.9%	2.3%	1.8%	1.6%	1.1%	1.8%	2.6%	2.2%	2.0%	4.0%
1.10	ED - Median time between arrival and treatment (minutes)			181	191	213	217	236	221	237	227	237	231	235	238	268
1.11	Ambulance handovers waiting 15-29 minutes		▲	272	304	317	293	289	311	376	368	314	353	374	419	463
1.13	Ambulance handovers waiting 30-59 minutes		▼	56	74	100	93	78	100	135	82	54	98	122	165	160
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.15	Ambulance handovers waiting >60 minutes		▼	13	12	24	21	51	24	27	20	7	34	44	65	31
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.17	Ambulance handovers: Percentage waiting within 15 mins (shadow monitoring)		▼	75.2%	75.9%	73.6%	74.7%	73.6%	66.5%	64.0%	67.2%	69.3%	68.1%	62.3%	63.7%	63.0%
1.18	ED - Mean time in department (mins) for non-admissions (shadow monitoring)		▲	169	184	217	212	251	217	237	219	236	227	238	248	271
1.19	ED - Mean time in department (mins) for admissions (shadow monitoring)		▲	209	221	274	291	326	299	371	351	398	307	331	347	377
1.21	ED - Mean time between RFT and admission (mins) for admissions (shadow monitoring)		▲	45	47	77	86	115	109	179	169	205	105	128	135	158
1.22	ED - Number of non-admissions waiting 12+ hours (shadow monitoring)		▲	0	6	11	11	30	20	29	22	25	14	16	26	43
1.23	ED - Number of admissions waiting 12+ hours (shadow monitoring)		▲	2	8	41	64	118	71	168	152	186	90	128	151	239
1.24	ED - Critical time standards (shadow monitoring - awaiting guidance on metrics)			-	-	-	-	-	-	-	-	-	-	-	-	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity)		▼	1307	1551	1579	1520	1536	1322	1403	1360	1226	1575	1591	1640	1472
2.02	Non Elective Admissions - Paediatrics		▲	132	160	144	170	165	151	153	124	135	178	204	291	316
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▲	481	594	537	587	618	527	475	468	454	567	683	763	794
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	253	291	390	362	371	347	364	386	327	358	391	358	339
2.07	Ward Transfers - Non clinical transfers after 10pm	33	▼	4	10	5	10	16	11	12	5	17	16	19	31	14
2.08	Emergency readmissions within 30 days		◀▶	231	250	233	261	287	278	247	230	211	283	283	-	-
2.09	Stranded Patients at End of Month (Scarborough & Bridlington)		▼	60	52	104	111	117	102	100	131	124	102	102	121	102
2.10	Average Bed Days Occupied by Stranded Patients (Scarborough & Bridlington)		▲	66	67	88	113	111	111	117	115	117	96	102	100	102
2.12	Super Stranded Patients at End of Month (Scarborough & Bridlington)		▼	11	10	16	37	44	29	27	28	41	26	29	36	25
2.13	Average Bed Days Occupied by Super Stranded Patients (Scarborough & Bridlington)		▲	16	16	19	29	40	38	30	31	34	29	27	26	32

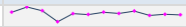
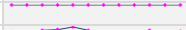
REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
3.01	Outpatients: All Referral Types		▲	5040	6159	5714	7494	7670	6780	7054	5903	5758	7665	7408	6957	7989
3.02	Outpatients: GP Referrals		▲	1894	2336	2119	2661	2620	2470	2486	2241	2335	3222	2925	2761	3142
3.03	Outpatients: Consultant to Consultant Referrals		▲	367	408	465	551	522	454	515	521	464	573	627	551	564
3.04	Outpatients: Other Referrals		▲	2779	3415	3130	4282	4528	3856	4053	3141	2959	3870	3856	3645	4283
3.05	Outpatients: 1st Attendances		▲	1890	2415	2569	3468	3688	3769	3605	3798	3691	4388	4147	4063	4906
3.06	Outpatients: Follow Up Attendances		▲	5086	6232	6094	7422	7855	8367	8223	8444	8166	9432	8470	8416	9534
3.07	Outpatients: 1st to FU Ratio		▼	2.69	2.58	2.37	2.14	2.13	2.22	2.28	2.22	2.21	2.15	2.04	2.07	1.94
3.08	Outpatients: DNA rates		▲	4.4%	5.7%	7.1%	7.2%	7.4%	7.8%	7.4%	8.3%	7.1%	6.5%	6.0%	5.6%	6.1%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	60	▼	290	208	63	89	57	108	93	109	86	97	109	74	72
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	1170	1049	442	285	239	344	451	336	309	309	363	351	375
4.01	Elective Admissions		▲	105	76	74	119	198	180	154	174	209	180	142	163	195
4.02	Day Case Admissions		▲	1145	1386	1459	1695	1846	1750	1728	1656	1610	1945	1827	1734	2061
4.03	Cancelled Operations within 48 hours - Bed shortages		◀▶	0	0	1	0	1	3	0	0	0	0	0	0	0
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▲	2	3	1	17	7	18	3	24	31	9	46	9	10
4.05	Theatres: Utilisation of planned sessions		▲	32%	53%	64%	64%	70%	72%	70%	64%	64%	62%	70%	70%	73%
4.06	Theatres: number of sessions held		▲	97	112	159	182	203	209	205	208	198	206	176	187	222

TRUST BOARD REPORT : June-2021

OPERATIONAL PERFORMANCE SUMMARY - SCARBOROUGH

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
5.01	RTT Percentage of incomplete pathways within 18wks		 ▲	44.9%	45.5%	56.3%	63.4%	68.2%	69.4%	68.6%	66.0%	66.1%	69.5%	70.7%	72.8%	74.6%
5.02	RTT Waits over 52 weeks for incomplete pathways		 ▼	234	335	445	544	627	669	676	722	713	665	514	407	348
5.10	RTT Waits over 78 weeks for incomplete pathways		 ▲	0	0	0	8	21	27	51	79	106	124	128	136	149
5.11	RTT Waits over 104 weeks for incomplete pathways		◀▶	0	0	0	0	0	0	0	0	0	0	0	3	3
5.05	RTT Total Waiting List		 ▲	7860	7896	8374	8939	9068	9057	9200	8856	8640	9205	9766	9917	10044
5.06	Number of RTT patients on Admitted Backlog (18+ weeks)		▼	1845	1836	1625	1710	1510	1378	1266	1239	1229	1245	1242	1185	1106
5.07	Number of RTT patients on Non Admitted Backlog (18+ weeks)		 ▼	2484	2469	2034	1564	1370	1389	1620	1768	1698	1564	1624	1508	1450
5.08	RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)		▼	20.2	20.0	19.2	18.2	17.2	16.8	16.8	17.0	16.6	15.3	14.6	14.4	14.1
5.12	Number of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways at end of month*		▼	-	-	-	-	-	-	-	-	-	-	-	133	109
5.13	Percentage of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways under 4 weeks at end of month*		▲	-	-	-	-	-	-	-	-	-	-	-	57%	78%

*Priority 2: includes all P2 pathways where there is a surgical decision to treat, not just open RTT pathways.

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
6.01	Cancer 2 week (all cancers)	93%	 ▼	92.9%	96.9%	94.0%	85.6%	91.8%	91.1%	92.9%	91.9%	93.8%	90.4%	91.3%	90.8%	-
6.02	Cancer 2 week (breast symptoms)	93%	 ◀▶	-	-	-	-	-	-	-	-	-	-	-	-	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	 ▼	95.3%	98.0%	95.1%	95.8%	96.8%	96.6%	96.7%	97.6%	98.0%	95.6%	98.4%	96.5%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	 ▼	100.0%	100.0%	90.0%	66.7%	85.7%	100.0%	80.0%	50.0%	66.7%	100.0%	100.0%	92.3%	-
6.05	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	 ◀▶	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-
6.06	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	 ▲	75.0%	70.3%	77.8%	79.1%	83.9%	77.8%	67.9%	57.1%	69.6%	77.8%	71.7%	75.9%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	 ◀▶	-	-	-	-	0.0%	0.0%	-	0.0%	-	0.0%	-	-	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▲	48.5%	50.2%	45.4%	46.1%	53.2%	50.0%	53.9%	41.1%	50.3%	64.6%	51.2%	57.0%	-

*62 day screening: months with five or fewer records at Trust level from May-20 are not included

TRUST BOARD REPORT : June-2021

OPERATIONAL PERFORMANCE SUMMARY - YORK

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
1.01	Locality Emergency Care Attendances		▲	6959	7970	8656	8586	8256	7282	7489	6945	6406	8628	9441	10412	10915
1.02	Locality Emergency Care Breaches		▼	298	448	1057	1573	1377	1036	1515	1734	1143	1584	1645	1742	1585
1.03	Locality Emergency Care Standard Performance	95%	▲	95.7%	94.4%	87.8%	81.7%	83.3%	85.8%	79.8%	75.0%	82.2%	81.6%	82.6%	83.3%	85.5%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▼	36%	36%	35%	35%	36%	40%	38%	38%	39%	37%	33%	32%	31%
1.05	ED Total number of patients waiting over 8 hours in the departments		▼	15	27	70	215	141	106	185	359	169	172	139	172	142
1.06	ED 12 hour trolley waits	0	◀▶	0	0	0	0	0	0	0	4	0	0	0	0	0
1.07	ED: % of attendees assessed within 15 minutes of arrival		▼	88%	86%	78%	74%	74%	79%	77%	76%	79%	74%	72%	72%	71%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▼	73%	66%	52%	47%	52%	60%	56%	57%	62%	52%	45%	45%	41%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▲	0.6%	1.1%	1.5%	1.8%	1.3%	0.8%	1.7%	1.6%	1.3%	1.4%	1.5%	1.4%	1.5%
1.10	ED - Median time between arrival and treatment (minutes)			133	139	161	175	170	155	176	191	170	175	174	169	171
1.11	Ambulance handovers waiting 15-29 minutes		▼	230	282	294	249	324	250	320	342	284	328	279	338	306
1.13	Ambulance handovers waiting 30-59 minutes		▲	35	44	52	54	51	51	74	118	47	57	58	53	83
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.15	Ambulance handovers waiting >60 minutes		▲	1	1	3	16	9	2	17	82	12	14	27	9	31
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.17	Ambulance handovers: Percentage waiting within 15 mins (shadow monitoring)		▼	81.0%	78.3%	80.1%	80.2%	79.2%	77.5%	77.1%	71.2%	78.4%	80.1%	82.8%	82.1%	80.7%
1.18	ED - Mean time in department (mins) for non-admissions (shadow monitoring)		▼	129	135	159	174	167	152	165	182	162	168	173	171	168
1.19	ED - Mean time in department (mins) for admissions (shadow monitoring)		▼	165	173	206	254	228	214	269	334	259	252	236	239	236
1.21	ED - Mean time between RFT and admission (mins) for admissions (shadow monitoring)		▼	48	48	57	88	75	75	103	170	108	98	80	83	80
1.22	ED - Number of non-admissions waiting 12+ hours (shadow monitoring)		▼	0	1	4	4	6	3	9	18	14	4	7	12	3
1.23	ED - Number of admissions waiting 12+ hours (shadow monitoring)		▲	0	0	4	30	14	10	57	171	46	42	20	20	26
1.24	ED - Critical time standards (shadow monitoring - awaiting guidance on metrics)			-	-	-	-	-	-	-	-	-	-	-	-	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity)		▼	2682	2994	3128	3158	3156	3061	3079	2873	2655	3309	3199	3272	2986
2.02	Non Elective Admissions - Paediatrics		▲	220	209	220	309	289	320	229	227	246	300	308	340	403
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▲	1147	1305	1324	1343	1355	1376	1262	1011	1095	1350	1307	1339	1400
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▲	452	475	544	600	614	599	618	676	556	656	591	601	607
2.07	Ward Transfers - Non clinical transfers after 10pm	67	▲	11	15	20	31	34	28	35	30	36	40	25	34	39
2.08	Emergency readmissions within 30 days		▲	467	510	555	581	710	653	563	531	468	598	614	-	-
2.09	Stranded Patients at End of Month		▲	124	97	126	153	156	164	166	194	167	173	158	149	150
2.10	Average Bed Days Occupied by Stranded Patients		▼	110	108	115	140	155	167	147	188	170	157	135	151	145
2.12	Super Stranded Patients at End of Month		▼	23	20	19	33	43	34	40	53	45	42	41	38	35
2.13	Average Bed Days Occupied by Super Stranded Patients		▲	27	24	20	28	40	40	42	48	51	39	27	29	32

REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
3.01	Outpatients: All Referral Types		▼	10267	11541	10748	12853	13132	12546	12424	11072	10899	14272	13656	12653	12618
3.02	Outpatients: GP Referrals		▼	3769	4720	4432	5006	5507	5201	4972	4074	4631	6599	5979	5264	5143
3.03	Outpatients: Consultant to Consultant Referrals		▲	852	1022	886	1163	1172	1201	1146	1058	1119	1269	1231	1181	1237
3.04	Outpatients: Other Referrals		▲	5646	5799	5430	6684	6453	6144	6306	5940	5149	6404	6446	6208	6238
3.05	Outpatients: 1st Attendances		▲	5881	7253	6718	8163	8461	8958	8479	8376	7544	10111	9325	9744	10927
3.06	Outpatients: Follow Up Attendances		▲	16541	18892	18290	22703	23602	24313	22030	22806	21975	27214	24653	24634	26704
3.07	Outpatients: 1st to FU Ratio		▼	2.81	2.60	2.72	2.78	2.79	2.71	2.60	2.72	2.91	2.69	2.64	2.53	2.44
3.08	Outpatients: DNA rates		▲	4.2%	4.8%	6.0%	6.1%	6.0%	6.2%	5.8%	6.6%	6.1%	5.5%	5.5%	4.9%	5.1%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	120	▲	444	499	173	160	131	155	123	224	162	118	133	91	97
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▲	2401	3392	1750	1582	1222	932	820	700	693	824	807	623	630
4.01	Elective Admissions		▲	149	265	277	297	359	325	359	262	296	357	327	323	361
4.02	Day Case Admissions		▲	2269	3049	2988	3745	4056	3878	3702	2997	2868	3606	3960	3963	4628
4.03	Cancelled Operations within 48 hours - Bed shortages		▲	3	0	1	3	4	5	10	121	10	4	1	0	2
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▲	17	25	36	40	58	71	34	159	56	64	68	29	65
4.05	Theatres: Utilisation of planned sessions		▼	47%	70%	75%	66%	67%	68%	66%	54%	61%	73%	77%	78%	77%
4.06	Theatres: number of sessions held		▲	167	425	427	511	523	503	470	396	441	430	453	454	533

TRUST BOARD REPORT : June-2021

OPERATIONAL PERFORMANCE SUMMARY - YORK

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
5.01	RTT Percentage of incomplete pathways within 18wks		▲	40.6%	40.9%	51.0%	58.4%	64.1%	66.5%	65.8%	62.9%	61.2%	62.5%	63.5%	66.1%	68.6%
5.02	RTT Waits over 52 weeks for incomplete pathways		▼	676	1025	1319	1442	1549	1581	1575	1784	1868	1781	1509	1306	1140
5.10	RTT Waits over 78 weeks for incomplete pathways		▼	0	0	0	12	37	72	140	240	304	399	449	496	489
5.11	RTT Waits over 104 weeks for incomplete pathways		▲	0	0	0	0	0	0	0	0	0	1	8	29	37
5.05	RTT Total Waiting List		▲	17197	17211	17767	18103	18840	18589	18840	18298	18553	19486	20303	20404	20663
5.06	Number of RTT patients on Admitted Backlog (18+ weeks)		▼	5269	5346	5029	4309	3808	3338	3109	3102	3099	3110	3064	2888	2756
5.07	Number of RTT patients on Non Admitted Backlog (18+ weeks)		▼	4945	4827	3677	3223	2953	2886	3343	3685	4094	4202	4344	4023	3742
5.08	RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)		▼	21.9	22.0	21.4	20.3	18.7	17.9	18.2	18.8	18.8	17.8	17.3	17.2	16.8
5.12	Number of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways at end of month*		▼	-	-	-	-	-	-	-	-	-	-	-	505	465
5.13	Percentage of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways under 4 weeks at end of month*		▲	-	-	-	-	-	-	-	-	-	-	-	70%	74%

*Priority 2: includes all P2 pathways where there is a surgical decision to treat, not just open RTT pathways.

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
6.01	Cancer 2 week (all cancers)	93%	▲	97.2%	94.5%	94.5%	89.8%	93.9%	94.4%	94.7%	89.7%	92.1%	91.4%	87.3%	94.9%	-
6.02	Cancer 2 week (breast symptoms)	93%	▼	97.6%	96.4%	95.1%	95.1%	88.0%	93.9%	97.3%	80.0%	92.6%	92.6%	92.8%	91.5%	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	▲	98.6%	96.6%	97.7%	97.6%	97.2%	99.6%	97.1%	95.0%	99.4%	97.5%	95.5%	99.0%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	▼	85.0%	85.2%	79.2%	100.0%	88.6%	86.4%	92.1%	92.9%	96.4%	91.7%	95.8%	94.7%	-
6.05	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	▲	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	-
6.06	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▲	86.3%	82.3%	83.6%	74.9%	71.2%	73.0%	79.1%	73.4%	72.6%	72.8%	70.4%	80.5%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)*	90%	▼	-	-	-	-	96.8%	97.7%	86.7%	91.7%	97.6%	97.1%	96.5%	83.7%	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▲	67.1%	68.5%	65.1%	66.8%	63.2%	63.7%	69.0%	56.9%	62.8%	71.1%	65.0%	65.2%	-

*62 day screening: months with five or fewer records at Trust level from May-20 are not included

DIGITAL AND INFORMATION SERVICE

June-2021

Produced July-2021

The Board Assurance Framework is structured around the Trust's three Strategic Goals:

To deliver safe and high quality patient care as part of an integrated system

To support an engaged, healthy and resilient workforce

To ensure financial stability

Report produced by:

Information Team

Digital and Information Service: June-2021

Executive Summary

Trust Strategic Goals:

[x] to deliver safe and high quality patient care as part of an integrated system
[x] to support an engaged, healthy and resilient workforce
[x] to ensure financial sustainability

Purpose of the Report:

To provide the Board with an integrated overview of the Digital and Information Service

Executive Summary:

Key discussion points for the Board are:

The Revised Digital and Information Strategy is being presented to board this month which articulates how Digital and Information will be core to the delivery of our future Trust and ICS strategies.

It is accompanied by the detailed delivery plans and funding requirements to be submitted for consideration by the ICS and NHS X for the following areas of work :

• The Essential Services Programme that will address some of the fundamental IT infrastructure issues and mitigate the Trust's risks of major IT failure and cyber-attack as well as providing the smart foundations to improve the delivery of care.
• The presentation of the draft Strategic Outline Case for the future Electronic Healthcare Record strategy for the Trust and Integrated Care System.
• Proposals on the future operating model for the new Digital and Information Services to bring in the skills and capabilities to ensure the effective delivery of Information, Intelligence and Technology Services.
• Proposals on how we will develop of Intelligence and Insight service as part of the ICS.

In addition to this the first Senior Information Risk Owner (SIRO) report, of the new Chief Digital and Information Officer, to board will provide assurance on the controls in place relating to Information Governance and the law which will be supported by a new Information Governance Strategy to be led by our newly appointed Head of Information Governance and Data Protection Officer.

These combined clearly set the ambition and what is necessary for which we hope to secure external funds to support.

Recommendation:

The Board is asked to receive the report and note the impact on the DIS KPIs and the actions being taken to address the performance challenges.

Author(s): Dylan Roberts, Chief Digital Information Officer
Simon Hayes, IT Service and Infrastructure Transformational Lead

Director Sponsor: Dylan Roberts, Chief Digital Information Officer
Date: Jun 2021

TRUST BOARD REPORT: June-2021

DIGITAL AND INFORMATION SERVICE

REF	INFRASTRUCTURE & SERVICE MANAGEMENT TRANSFORMATION	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
9.03	Number of end user devices over 4 years old		▼	-	-	-	-	-	-	-	-	-	4533	4483	4300	4220
9.04	Total number of calls to Service Desk		▲	6639	5266	4936	6406	5763	5214	4780	5613	5190	5006	4178	3780	4227
9.05	Total number of calls abandoned		▲	3189	2384	2151	3425	2546	2114	1761	2437	2584	1665	1224	722	982
9.06	Percentage of Service Desk Calls Resolved at First Point of Contact		▼	8.8%	10.0%	10.6%	10.4%	9.4%	9.8%	9.7%	8.7%	8.5%	12.0%	11.3%	12.3%	12.2%
9.07	Number of Open calls (last day of month)		▼	2491	2950	2808	2903	2965	3075	2932	3250	3146	1965	2212	1811	1608

REF	INFORMATION GOVERNANCE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
9.10	Number of incidents reported and investigated		▲	23	24	30	23	43	28	38	39	27	44	26	37	38
9.11	Number of Patient SARs		▼	154	170	118	134	154	122	112	144	157	170	247	252	224
9.12	Number of Patient SARS processed within one calendar month*		▼	153	169	118	134	153	122	112	144	157	170	288	252	197
9.13	Number of FOIs received (quarterly)			105	-	-	162	-	-	173	-	-	192	-	-	151
9.14	Percentage of FOIs responded to within 20 working days (quarterly)			81%	-	-	69%	-	-	78%	-	-	51%	-	-	77%
9.15	Number of IG complaints made about Trust data handling to ICO			0	0	0	0	0	0	0	0	0	0	0	0	1

* Refers to SARS received in previous calendar month but completed in report month.

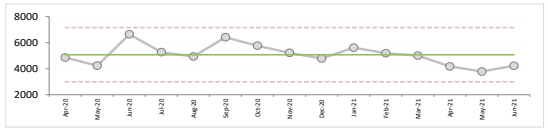
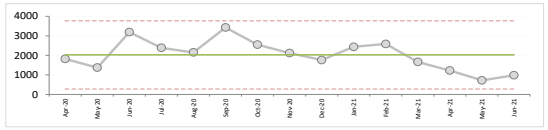
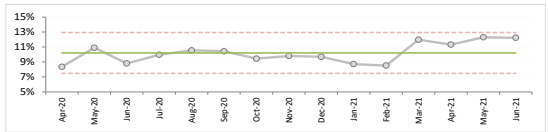
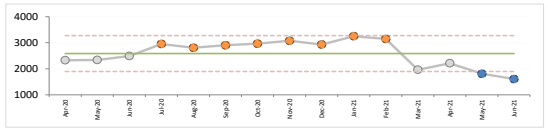
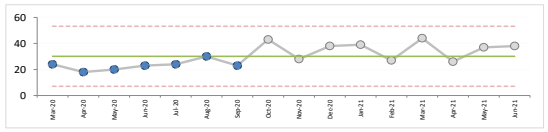
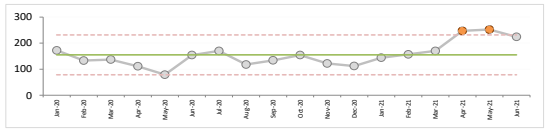
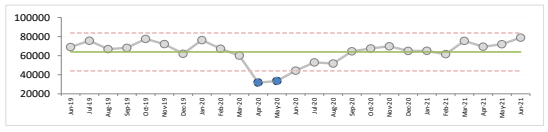
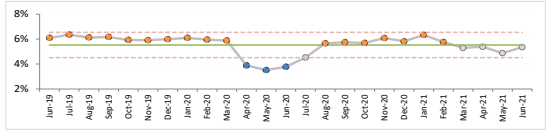
REF	OUTPATIENT TRANSFORMATION	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
9.16	Outpatients: Total Attendances		▲	44264	52912	51707	64566	67502	69798	64922	65000	61502	75456	69333	71950	78857
9.20	Outpatients: DNA rates		▲	3.8%	4.5%	5.7%	5.7%	5.7%	6.1%	5.8%	6.3%	5.8%	5.3%	5.4%	4.9%	5.4%

KEY:

SAR	Subject Access Request
FOI	Freedom of Information
IG	Information Governance
ICO	Information Commissioner's Office
DNA	Did Not Attend

TRUST BOARD REPORT: June-2021

DIGITAL AND INFORMATION SERVICE: Infrastructure and Service Management Transformation; Information Governance; Outpatient Transformation

Jun-21	METRIC :	TARGET :	vs LM :	
4,227	9.04 Total number of calls to Service Desk	-	447 ↑	
982	9.05 Total number of calls abandoned	-	260 ↑	
12.2%	9.06 Percentage of Service Desk Calls Resolved at First Point of Contact	-	-0.1% ↓	
1,608	9.07 Number of Open calls (last day of month)	-	-203 ↓	
38	9.10 Number of incidents reported and investigated	-	1 ↑	
224	9.11 Number of Patient SARs	-	-28 ↓	
78,857	9.16 Outpatients: Total Attendances	-	6,907 ↑	
5.4%	9.20 Outpatients: DNA rates	-	0.5% ↑	

HIGHLIGHTS FOR BOARD TO NOTE:

Infrastructure and Service Management Transformation

This month has seen further improvement against the DIS Service and Operations KPI's, alongside good progress made in the Essential Services Transformation programme (Projects initiated, new organisation and operating model implemented).

Operationally:
Small reduction in the number of devices over 4 years old after further small scale refresh of laptops and desktops by the End User team.
The number of abandoned calls rose in month, however they remain much lower than the numbers recorded pre April 21. The team will work on understanding the increase in month as part of ongoing improvement plan.
The team continue to focus on open incidents and requests which has seen the successful reduction on outstanding tickets again in month. The reduction is circa 50% on the numbers from February 2021

Outpatient Transformation

The number of outpatients seen via either telephone or video in June equated to 22.6% of all attendances.

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Fire Safety Management Policy

Author(s):	Mick Lee & Kevin Hudson Fire Advisors YTHFT
Owner:	Simon Morritt - Trust C.E.O.
Publisher:	Trust Fire Safety Managers
Version:	4.1
Date of version issue:	July 2021
Approved by:	Corporate Directors
Date approved:	July 2021
Review date:	July 2024
Target audience:	All Trust Employees
Regulations/Standards and Guidance	The Regulatory Reform (Fire Safety) Order 2005 NHS Fire code HTM 05 (01-03)
Links to Organisational/Service Objectives, business plans or strategies	CQC Essential Standards of Quality and Safety – Outcomes 10 and 11
Executive Summary This policy sets out the Trust approach to Fire Safety Management	

This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.

Version History Log

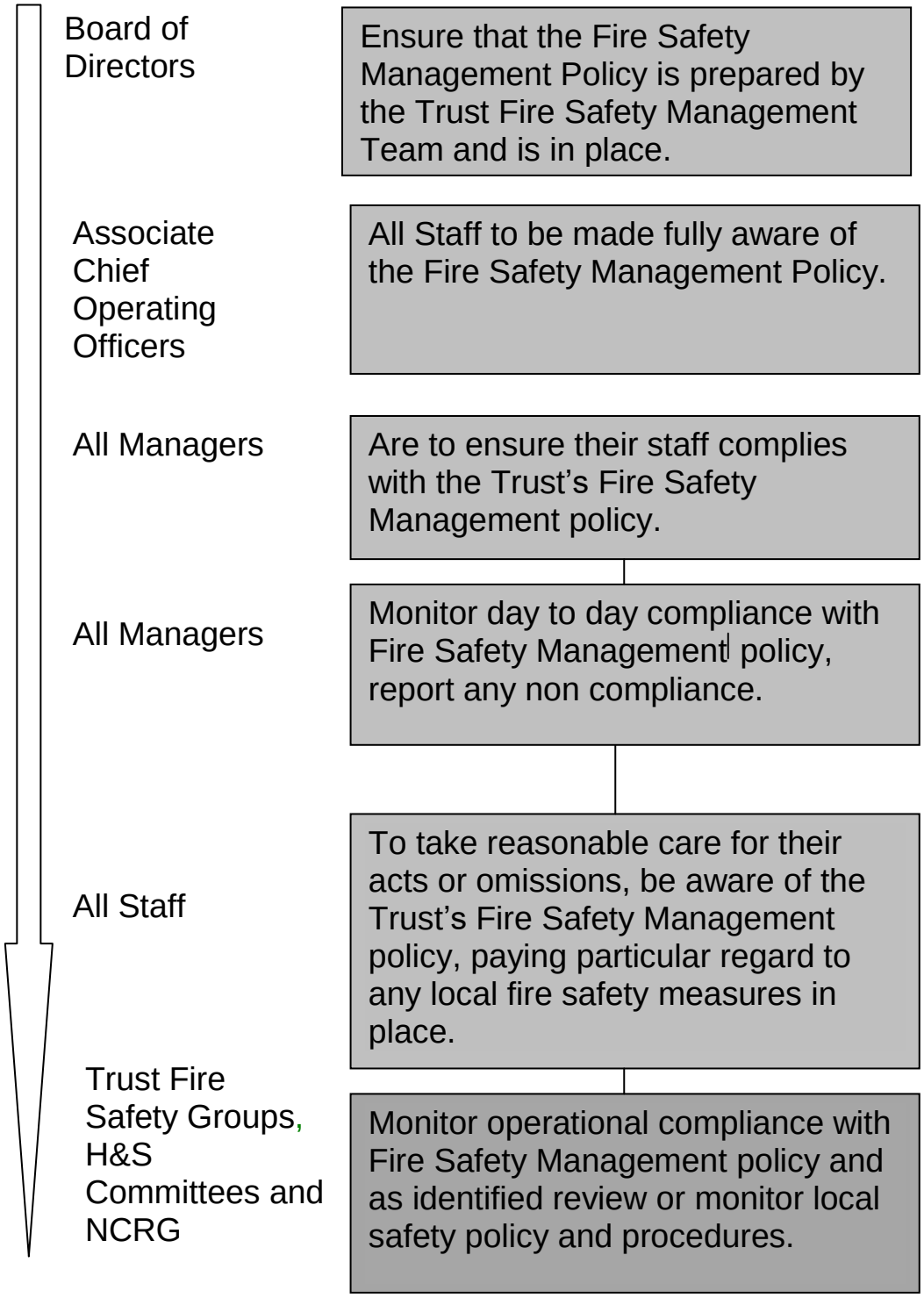
This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
1.0	October 12	M Lee & K Hudson	Policy Archive	Consultation of New Policy for enlarged organisation
1.1	November 2012	M Lee & K Hudson	Policy Archive	Consultation and amend arrangements and content
1.2	December 2012	M Lee & K Hudson	Policy Archive	Consultation and final amend to arrangements and format
1.3/1.4/1.5	February 2013	M Lee & K Hudson	Policy Archive	Addition to 3.3 Non Executive responsibilities for fire management. Amend final draft into trust format for group / committee promulgation and approval
2.0	January 2017	M Lee & K Hudson	Staffroom	Annual review January 2017 Appendix 2 Fire Incident Co-ordinator
3.0	January 2019	M. Lee & K. Hudson		Removal of Whitby site arrangements & small alteration to the Training paragraph
4.0	January 2021	M. Lee & K. Hudson		Changes due to reflect new fire alarm systems becoming operational, corporate name change & introduction of Care Groups to replace directorates
4.1	July 2021	C Weatherill	Staff	Update post Q&A

				Committee comments; change from care group managers to deputy chief operating officers, change to flow chart, referencing and formatting.

Contents

Process flowchart



The audit for OH&S (Inc Fire) is to be provided for annual Board level review.

1 Policy Statement and Commitment – Fire Safety

The York & Scarborough Teaching Hospital NHS Foundation Trust (The Trust) will ensure so far as is reasonably practicable, that the risk from fire will be managed in compliance with the Regulatory Reform (Fire Safety) Order 2005, FIRECODE and other appropriate legislative requirements and guidelines.

The management of any identified fire risks will be undertaken in such a way as to prevent injury or ill-health to Trust employees, patients, visitors, contractors or others who may be affected by its activities.

The Chairman, Chief Executive and Board of Directors are fully committed to providing a safe environment for patients, service users, employees and visitors. This is achieved through a framework of policies and procedures ensuring that all Trust premises meet the statutory and mandatory fire safety standards.

The Trust recognises that their employees are paramount to the effective management of fire safety and will therefore ensure that they are given the appropriate information, instruction, training and supervision to enable them to undertake their roles & responsibilities. It is also recognised that employees and contractors have a responsibility to ensure the safety of themselves and others who may be affected by their acts or omissions.

The Trust will ensure that all of its employees and contractors are made aware of this requirement; in particular to comply with all current fire safety legislation and procedures.

When commissioning or leasing new buildings, the Trust will ensure that they comply fully with current fire safety legislation.

The Trust has in place, systems which ensure that any policy is regularly reviewed; in this case a biennial review as a minimum or when required to do so by any change in legislation, or if there should there be any other reason to do so.

2 Introduction & Scope

The Regulatory Reform (Fire Safety) Order 2005 – (RRO) sets out in detail the roles and responsibilities for those charged with fire safety management in any organisation. The order is enforced by the local fire authority and failure to comply with any aspect of the order can result in significant fines, enforcement action or even custodial sentences.

This policy outlines the framework of measures in place to ensure effective fire safety management; including roles, responsibilities and arrangements. The policy is applicable to all Trust properties. Where there are other premises leased or occupied by the Trust, then Trust employees must be familiar with both the Trust's & Landlords respective policies.

The purpose of this policy is to ensure there are effective systems for the management of fire safety in place across all Trust premises. The policy applies to all persons connected to or employed by the trust, including; agency staff, patients, contractors, regular visitor's, voluntary workers and any other relevant persons using Trust premises to operate a business.

3 Definitions / Terms used in policy

None – Explained within the document

4 Fire Safety Policy Arrangements

4.1 Trust Wide Fire Safety

The Trust recognises that the activities undertaken by its employees are varied and are undertaken throughout many premises and locations across the organisation. As far as is reasonably practicable systems and procedures for fire safety should afford the highest standards of safety to people, Trust property and assets.

The task of preventing fire and for ensuring that no one is put at risk is a shared and a collective responsibility placed on all Trust employees. The Trust recognises that it has a statutory duty in regards to fire safety, in order to best meet that responsibility, it has a series of organisational and Care Group specific procedures in place.

4.2 Fire Safety Arrangements

This policy is supported by local procedural fire safety documentation, as appropriate. Elements which may be included in these arrangements are indicated in the table below. Whilst it will be necessary for all staff members to be aware of key elements within this section, namely actions in the event of fire, means of escape etc, those personnel allocated specific roles and responsibilities within the Trust will need a greater knowledge of specific arrangements such as conducting the risk assessments, reviews & training etc.

Action in the event of fire	Fire safety & electrical equipment
Catering fire safety management	Fire safety furnishings & fabrics
Contingency planning	Fire safety inspections reviews & audits
Emergency lighting	Fire service liaison
Evacuation exercises	Emergency planning
Fixed fire-fighting equipment	Flammable liquids transportation, storage & use
Management of contractors	Fire alarms & detection
Means of escape	Fire investigation & reporting
PEEPs	Fire plans
Extinguishers	Fire risk assessments
Security against arson	Training

4.3 Premises with more than one employer

Where the Trust has shared occupancy of a premise with another employer, each employer is to be made responsible for managing fire safety within their own designated areas. There must be a formal arrangement put in place to share information about any identified risks or emergency procedures. Each employer must cooperate fully with the other to ensure fire safety within the premises is not compromised

5. Impact upon Individuals with Protected Characteristics

The authors recognises that due regard has to be given to the more vulnerable occupancy of the Trust premises, patients and staff members, who may have a disability or a lack of capacity.

This policy has strived to give due regard in order to ensure that legislative compliance and CQC essential standards of quality and safety are met.

Engagement and involvement in the development of the policy has included relevant staff groups from across all sites including executive/non-executive board members. The Trust has both a moral and legal commitment to provide a safe working environment for its employees and all those who have a reason to occupy/visit Trust premises.

5.1 Personal Emergency Evacuation Plans (PEEPs)

It is recognised that to facilitate the safe and efficient evacuation of any area, there may need to be a specific individual evacuation plan in place, for those who may have issues that would prevent them from exiting a building in an emergency situation. These plans, (PEEPs), can be organised and agreed through the individual's line management. Advice can be sought from any member of the Trust's fire safety management team.

6 Accountability

Operational implementation, delivery and monitoring of the policy will reside with:-

6.1 Chief Executive

The Chief Executive is required to clearly define fire safety policies for all premises under their control. They are responsible for ensuring compliance with all current fire safety legislation and have ensured appropriate policies and procedures are in place, to maintain and improve fire precautions throughout all Trust properties. They shall ensure that any policies are reviewed in the light of any changes in working practice and or statutory legislation or for any identified significant risks that have not been addressed and ensure that adequate resources be made available to implement the policy and carry out any remedial action or amendments to this policy.

6.2 Directors of the Board

The Trust Board as a corporate body; share the ultimate responsibility for the general activities of the Trust and should act

as role models for best practice. They are to ensure that all current fire safety legislation is being met and complied with.

6.3 Non Executive Directors

It is the role of all Non Executive Directors (NED's) to hold the executive board to account and where appropriate challenge the Board on matters of fire safety.

6.4 Board level Director (Responsible for Fire)

The Chief Nurse has been identified as the individual with a responsibility for promoting Fire Safety issues at the board level. As far as is reasonably practicable' he/she should ensure that the highest fire safety standards are being maintained across all Trust premises. He/she is to ensure that suitably qualified and experienced fire safety managers and advisors are in place and supported in their respective roles.

He/she will ensure that the appropriate policies, procedures and audit protocols are in place and being reviewed. He/she will be required to present an annual fire safety report to the Board, ensuring where applicable, that any certificates of compliance are completed and signed off.

6.5 Fire Safety Manager

The role of the Fire Safety Manager will be included in the portfolio of the Trust's head of safety and security who will report to the board level director (Responsible for Fire). As the senior member of the Trust's fire safety management team they will act as chair of the Trusts fire safety group (FSG).

The Fire Safety Manager should have a nominated deputy to assume the duties, during any period of absence; this will normally be a member of the fire safety team (as appropriate).

They are to ensure that an appropriate system for carrying out Trust wide fire risk assessments and for the auditing of their effectiveness is in place.

6.6 Fire Safety Advisors

Providing specialist advice on the interpretation of fire safety legislation and guidance to the Trust, including technical support in the interpretation of statutory and mandatory fire safety requirements by:

- Developing and advising on Trust fire safety policy & strategy;
- Ensuring that suitable and sufficient fire risk assessments are in place for all premises/departments.
- Assisting in the development of and as required the delivery of a suitable and sufficient training programme;
- Liaising with local authority fire and rescue enforcement personnel regarding fire safety issues within the Trust;
- Liaison with, and advice to directorate and senior management personnel specifically their individual responsibilities in regards to fire safety issues within their respective areas;
- Act as the nominated deputy to the fire safety manager;
- Where required develop a suitable & sufficient Trust wide action plan which will prioritise any actions in respect of improving the overall standard/compliance of fire safety related issues;
- To ensure accurate records of all fire safety related issues are maintained by the Trust.
- Carry out where appropriate any investigation into the cause of fire within the Trust, and to report findings and recommendations to the relevant authorities;
- Produce an annual report on behalf of the Director responsible for fire safety, for submission to the Board, which details the current levels of compliance/non compliance in respect of fire safety issues throughout the Trust;
- To keep up to date their knowledge and skills in regards to fire safety management.

6.7 Care Group Fire Safety Management

Deputy Chief Operating Officers and senior nursing staff are to ensure that this policy and any associated procedures are implemented and adhered to. They are to ensure:

- That every member of staff under their direct control attends statutory fire training; they should act as a role model for best practice in this regard;
- A suitable & sufficient fire risk assessment (FRA) is in place for their respective areas.

- That any findings/recommendations are being addressed and measures for controlling any risk from fire are being maintained;
- That their areas of responsibility have a suitable and effective evacuation plan in place and that staff are being made fully aware of their actions and responsibilities in relation to them;
- They report any faults damages or defects;
- That fire safety standards or provisions within their areas of responsibility are never compromised;
- Ensure that they and their staff, are adequately trained in fire safety procedures and are familiar with the contents of this policy.

6.8 Fire Wardens

Where applicable are to monitor their areas of responsibility and report to the management, any problems such as wedged open fire doors, missing extinguishers, or other fire related issues.

6.9 Employee Responsibilities

All employees share a collective responsibility and “Duty of care” not just for themselves but for others with respect to fire safety.

All employees are required to comply with the arrangements made to control risks from any identified fire hazards. In addition they are to:

- Attend any mandated statutory fire safety training;
- Be familiar with the relevant contents of this policy and the day to day observation of general fire safety precautions;
- Ensure their actions do not compromise any fire safety provisions provided in their place of work;
- Promote and be pro-active in the implementation of good fire safety practices;
- Be aware of their individual roles and responsibilities in an emergency situation and to follow any instructions given to them by their managers, or any other person in authority;
- Report any deficiencies in fire safety provisions or bad practice to their line manager or directly to the Trust’s fire safety advisor(s) where appropriate;

- Maintain good housekeeping standards in relation to the accumulation of rubbish particularly in and around designated escape/evacuation routes and exits.

6.10 Hospital Response Teams

The teams are under the control of the senior person present at the time of the activation and prior to the arrival of the local authority fire & rescue services (LAFRS).

The response team may consist of one or more of the following Trust personnel:

Site Co-ordinator / Bed Managers
Fire Safety Manager or Advisor
Specialist Managers
YTHFM LLP Portering Staff
YTHFM LLP Engineers (Normally 2)
YTHFM LLP Security
Local Managers
Nominated staff

The team will liaise with the senior person at the incident and offer assistance and specialist advice when requested.

Specific information regarding the support teams can be found in Annexes A – D which is attached to this policy document

6.11 YTHFMLLP / Capital Projects

YTHFMLLP (including capital projects) will where appropriate, consult the Trust Fire Safety Advisor(s) and or Manager on matters concerning the design of new builds and the redevelopment or the redesign of any existing building or area in relation to passive and active fire protection measures. This may include installed fire alarm systems, automatic fire detection, fire-fighting equipment, emergency lighting, or evacuation strategies. This consultation should ensure compliance with all relevant legislation.

6.12 Fire Safety Group (FSG)

The FSG shall be responsible for reviewing all trust & regional fire safety related issues. The group will meet at quarterly intervals as

a minimum throughout the year. Standard agenda items for discussion will include:

Fire Incidents
Unwanted Fire Signals
Enforcement Action (Where applicable)
Staff Training
DATIX (relating to fire safety)

The FSG will provide terms of reference for its members, minutes and where appropriate raise any specific issues with the appropriate Trust H&S and non-clinical risk management groups.

Reports and minutes of these meetings are to be maintained as evidence that the trust is managing fire safety in line with the Trust policy and fully reflects the requirements of the Regulatory Reform (Fire Safety) Order, FIRECODE and other associated guidance.

6.13 Trade Union & Employee Representatives

On occasion make representation to the employer on behalf of members or staff groups in relation to any health, safety or welfare issues and as deemed appropriate represent members in consultation with any enforcing authority such as Local Fire & Rescue Services.

Appendix 1

York Hospital Support Team

The response team will attend all site based fire alarm activations. The team is to be made up of the following personnel:

Duty Bed Manager (Fire Incident Co-ordinator)
YTHFMLLP Personnel to include the following:
Shift Engineers
Portering Staff
Security Personnel
Fire Safety Advisor (if available)

The individual members of the team will react to all hospital based fire alarm activations. All members of the team will be contacted via pager from switchboard who will give details in regards to the location of the incident.

The team is to liaise with the senior person present and thereafter will take control of the incident until the arrival of the Local Authority Fire & Rescue Services (LAFRS).

NB: The team may be augmented by delegated staff members from adjacent areas.

Under no circumstances should members of the support team attempt to enter any area where they suspect a fire, before the arrival of the fire and rescue services.

General Roles & Responsibilities:

Bed Manager/Locality Manager (where applicable/available)

Fire Incident Coordinator

Are to make contact with the senior person present at the incident and assess the situation. They are to don the appropriate tabbard and assume control of the incident until relieved by the *Trust Fire Safety Advisor or a member of the fire & rescue services upon their arrival. In addition they are to:

1. Establish a communications link through a member of the security or portering staff in attendance
2. Offer specialist advice and assistance to the fire & rescue services
3. Coordinate any specific evacuation tasks
4. Authorise the re-occupation of any incident area upon being given clearance to do so by a member of the fire service
5. Assist in any authorised investigation (post incident)
6. Complete a fire incident report (York Site Only) and submit a DATIX(all sites
7. May stand down the LAFRS if it is a 100% known false alarm activation (eg) Toaster or Aerosol etc

*NB: the fire incident coordinator will form part of the Bronze command structure in the event that a fire related incident is designated as a **MAJAX event.***

The Bed Manager will generally not be required to attend incidents at the following locations: Park House, Multi Storey Car Park(MSCP) or the YTHFMLLP Building

*** Where the fire advisor may be on site**

YTHFM - Portering Staff

Following any fire alarm activation and/or pager/radio notification they are to:

1. Despatch one porter to report to the Staff Assembly Point on Main street (Opposite switchboard) to gain access to fire box and collect the red grab bag, don tabbard and proceed directly to the incident and report to the FIC.

2. A porter (if available) is to proceed to the designated entrance point dependant on the incident location to meet and escort the fire service personnel to the incident.

If they are aware of the location being unoccupied or otherwise secured they are to inform security personnel.

Portering and security personnel are to act in tandem as a communication link for the support team throughout the duration of the incident.

NB: Portering staff will not generally be required to attend incidents at the following locations: Park House, YTHFM-LLP Building or the MSCP.

YTHFM – LLP Duty Shift Engineers x 2

Where they can be provided, two duty shift engineers are to respond to **ALL** fire alarm activations, and are to proceed direct to the incident location. They must make themselves known to the Bed Manager (FIC) upon arrival. They are to be responsible for the following:

- Natural Gas Services
- Steam services
- Water Services
- High & Low Voltage Electrical Services
- Designated Alarm circuits
- Silencing and re-setting of the fire alarm system

Whilst they must not isolate any medical gas systems they can offer relevant advice to the bed manager (FIC), or other clinical staff. Clinical staff are responsible for the isolation of medical gases, based on the clinical needs of their patients.

It will be the responsibility of the engineers to silence/re-set the fire alarm when authorisation has been given by the fire advisor, bed manager or the attending fire service officer in charge. They are to submit a DATIX report for all fire alarm activations.

Security Staff

Nominated members of the security team are to attend **ALL** fire alarm activations at the York & Scarborough sites and are to proceed to the incident and report directly to the bed manager (FIC) or fire safety advisor if in attendance. In addition they are to carry out the following actions:

- Switch radios to the appropriate channel and in conjunction with members of the portering team act as a communications link for the duration of the incident.
- Control access in and around the incident area, under no circumstances are they to enter or allow others entry into any area where a fire is suspected, prior to the arrival of the Trust Fire Advisor or a member of the fire service.
- If arson is suspected they are to ensure the preservation of evidence in the event it is deemed a crime scene.
- Liaise with car parking personnel or other security based colleagues to control the movement of vehicle traffic around the hospital entrance points, thereby allowing free access for fire services vehicles.

Appendix 2

New Selby War Memorial Hospital (SWMH)

In the event of **CONTINUOUS** fire alarm activation the following actions are to be carried out:

- A member of staff from each dept within the hospital to proceed to main fire panel and report to the Fire Incident Co-ordinator (FIC)
- With the exception of the ward area an immediate evacuation should commence upon hearing a continuous alarm tone

WARD AREA
The **Duty Nurse** is to ensure:

- All nursing staff report to the nurse station
- Check the alarm panels to confirm incident location
- A sweep of the ward is carried out
- All fire doors remain closed
- A patient headcount is carried out
- FIC is informed of all actions/findings
- Patients are to be readied for possible evacuation
- Visitors & non essential staff are directed to proceed to designated assembly point area
- Mobility impaired patients are prepared using all available evacuation aids/equipment
- Ambulant patients are assembled in a designated area to await further instructions.
- Staff are not to re-enter any part of the building once it has been fully evacuated with the following exceptions:

1. They are a member of the evacuation team
2. They have a specific duty authorised by the FIC
3. Or they have been given clearance by a member of the Fire & Rescue Service unit in attendance.

Roles & Responsibilities:

Fire Incident Coordinator (FIC)

The FIC during the period 0800-1700hrs will be the senior nurse, administrator or manager from the outpatient dept (OPD). They are to attend all on site fire alarm activations. Post 1700hrs the FIC role will be covered by the senior nurse in charge of the in-patient unit. The role of the FIC is to take control of the incident until relieved by a member of the LAFRS. They should be clearly identified by the wearing of a **Green Tabbard.**

The FIC can:

- Offer specialist advice and assistance to the LAFRS
- Coordinate any specific evacuation tasks
- Authorise the re-occupation of any incident area upon being given clearance to do so by a member of the LAFRS
- Assist in any authorised investigation (post incident)
- Complete a fire incident report where applicable and submit DATIX
- Authorise the re-setting of the fire alarm on clearance to do so being given by the attending LAFRS officer in charge (OIC)

Fire Warden or a nominated individual (Where applicable)

Should be suitably trained, who, following any fire alarm activation are to:

(On hearing the intermittent alarm):

Proceed to the main fire alarm panel (Ambulance Lobby) and report to the FIC.

(Continuous Alarm)

Ensure a sweep of their respective areas is carried out (Non Clinical areas).
Ensure that where applicable any staff and or visitor logs are taken to the assembly point.

Ensure (if safe to do so) that everybody has left the building.
Ensure that all doors and windows are closed/secured (If safe to do so).
Only attempt to tackle a fire, if it is safe and will not compromise theirs or anyone else's safety.
Brief the FIC upon his/her arrival.

They will be identified at any incident by the wearing of an **Orange Tabbard**.

Evacuation Lifts X 2

There are 2 designated evacuation lifts available. They are controlled by key points on each respective floor level and only the FIC, duty nurse, or a member of the fire services will have access to the key.

If the fire alarm is activated the lifts are designed to:

- Descend to the ground floor & remain there
- Descend or ascend to the floor above or below the fire incident area

In all of the above the lift doors will open.

Appendix 3

Malton Hospital

The Fire Alarm is configured in such a way that warning is given by the activation of a continuous alarm.

Any continuous alarm must be assumed as an immediate threat in that particular area/zone and personnel should react accordingly.

Action to be taken upon hearing the Continuous Alarm

One member of staff from each area must proceed to the main fire alarm panel located in the **Fitzwilliam Ward/Ambulance** entrance and report to, the Fire Incident Co-ordinator (F.I.C.).

In all areas **with the exception of the In Patient ward(s)** personnel are to evacuate immediately to a designated assembly point, using all available and identified evacuation routes. **Close all doors and windows** as you leave (If safe to do so). When at the assembly point personnel should await further instruction. **Under no account** are personnel to re-enter any evacuated area without the express permission of the FIC or a member of the fire and rescue service in attendance.

WARD AREA (Humberside Trust)

Located on the ground floor level and made up of a number of 1 hour fire compartments with further 30min sub-compartments. An initial sweep of the ward is to be carried out. All fire doors & windows must remain closed. Where patients are dependant on support for their evacuation, staff should prepare them as follows:

1. A patient headcount is carried out
2. Patients are to be readied for any possible evacuation
3. Visitors & non essential staff are directed to proceed to the designated assembly point area
4. Mobility impaired patients are prepared using all available evacuation aids/equipment Such as wheelchairs etc
5. Ambulant patients are assembled in a designated area to await further instructions.
6. Carry out any instructions from the FIC or from any member of the attending fire service crew

Continuous Alarm
The duty nurse is to ensure all staff report to the ward staff base and are to carry out the following actions:

- Check the wards fire panel to confirm the location of the fire alarm activation
- Conduct a full sweep of the area to confirm or otherwise the fire or smoke which may have activated the alarm
- Confirm the fire or false alarm where applicable
- Move patients to a pre-determined area if a fire incident is declared/confirmed
- Ensure all doors and windows are closed where this is deemed safe to do so (Includes bedroom doors)
- Report to and fully brief the FIC upon their arrival.
- If required to do so as a result of a fire or any large volume of smoke move all personnel (patients, staff, visitors) etc into the nearest adjacent compartment.

NB: If the ward is to be fully evacuated the holding point is to be the ground floor outpatient area. Personnel are to remain there until transport is available to move patients off site.

Roles & Responsibilities:

Fire Incident Coordinator (FIC)

During the normal core working hours the FIC will be the on-site YTHFM engineer or a nominated deputy from the Trust. After 1700hrs this role will be fulfilled by the senior nurse from Fitzwilliam ward (Humberside Trust). They will attend all on site fire alarm activations and take control of the incident until relieved by a member of the attending Fire & Rescue Service. They will be identified at the incident by the wearing of a **Red Tabbard**.

The FIC can:

- Offer assistance to the fire & rescue services
- Coordinate any evacuation tasks
- Authorise the re-occupation of any incident area upon being given clearance to do so by a member of the fire service
- If requested assist in any investigation (post incident)
- Complete a DATIX report and forward on to the Trust Fire Safety Advisor
- Authorise the re-setting of the fire alarm on clearance to do so being given by the attending fire service officer in charge

NB Ward Managers, Senior nursing staff should be sufficiently familiar with the hospital evacuation plan & offer advice in relation to layout/evacuation routes etc.

Appendix 4

Scarborough/Bridlington Arrangements

Fire Work Instruction Number: F01 (Revision V 1.0 - 01/13)

Title:	Instruction for duties to be undertaken by on call engineer, porters and security staff on activation of fire alarm Scarborough Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives:	To allow on call engineer, porters and security personnel to assist in the management of a potential or actual fire situation at Scarborough Hospital.
Scope:	**Porters, on call engineer, security personnel also the Hospital fire team of the site coordinator, switchboard, security control & relevant management on site** at the time of an incident.
Specific To:	On Call Engineer, Porters and Security Personnel.
Training Required:	Yes via dissemination and following of this procedure; specific fire training by the fire advisor as applicable.

Procedure:

1. The Switchboard Scarborough will upon activation of the fire alarm, contact the fire brigade, on call engineer, duty porter & security personnel by mobile phone, fast bleep 109 and security control room respectively (7721241)[1] .

2. The bed manager will don a fire team tabard; these tabards will be located in bed mangers office in Scarborough Hospital

3. The duty engineer, porters / security team will carry out the following functions:

[1] The switchboard will detail the fire alarm location and any other relevant information i.e. has the fire brigade been summoned.

a. **One porter** ‘or security personnel in their absence’ is to attend the location of the fire alarm activation (if known). If not known they must attend the nearest fire panel to identify the location of the activation and proceed with care to this location.

b. **The duty engineer** (out hours) will find the location of the fire alarm from the alarm panel and make their way to the incident location.

c. **The duty porter or security personnel in their absence** will greet the fire brigade (if summoned) at the main entrance (South side) of the hospital to direct the brigade to the site of the fire alarm activation (if known) and to assist as required.

d. **The security personnel and any porters on duty** will attend the main entrance to liaise with the site coordinator and the fire team the security supervisor or their nominated deputy will don a fire tabard and as required may deputise for the duty porter, the porters and security team are to assist as part of the assembled fire team in any way as required; ***the porters / security team will be key in internal communication by use of their 2 way radio’s.***

e. **The porter** ‘or security personnel’ attending the fire alarm activation site are to assist in the search of the immediate area for signs of fire and if they are confident and there is no **imminent risk to personal safety**, tackle any fires they discover, they will keep contact with the other fire team members via 2 way radio communication at all times during the incident.

4. **Porters / Security team** members located at the main entrance will follow instruction initially from the site coordinator (site fire warden) who working with the fire brigade, when summoned will coordinate the incident and management of the fire team.

Fire Work Instruction Number: F02 (Revision V 1.0 - 02/13)

Title:	Instruction for duties undertaken by the site coordinators (and deputies), on activation of fire alarm Scarborough Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives:	Instructions to follow for site coordinator (and deputies) in managing any potential or actual fire situation at Scarborough Hospital.
Scope:	**Site Coordinators and Deputies** also the Hospital fire team & relevant management.
Specific To:	Site Coordinators (and deputies).
Training Required:	Yes via dissemination and following of this procedure; specific fire instruction by the fire advisor as applicable.

Procedure:

1. The site coordinator (deputies) upon being made aware of fire alarm activation will make the way to the main entrance locate the fire alarm activation from the fire panel.

2. The site coordinator (deputies) will ensure a fire team member is sent to the area where the fire alarm activation is; to ascertain the fire status (actual fire or false alarm) and inform the site coordinator of this via 2 way radio or telephone in the main entrance.

3. In the event of this being an **obvious false alarm**, the site coordinator will call switchboard and ask for the fire alarm to be silenced **NOT RESET**.

4. The site coordinator will wait for the fire brigade to arrive at site and then attend the fire alarm activation site with the fire brigade representative to ensure the area is safe and confirm the false alarm.

5. The on call engineer or maintenance team will on arrival, reset the fire alarm system (subject to confirmation of false alarm from fire brigade).

6. In the event of an **ACTUAL FIRE** the alarm must not be silenced, so all staff are aware of the ongoing situation.

7. The site coordinator will remain at main entrance, to manage the Trust response to the fire incident and if necessary coordinate any evacuation, by management of the fire team and available staff.

8. The site coordinator will liaise with the fire service on arrival; ensuring they are taken to the scene of any fire; following directions from the fire brigade.

Fire Work Instruction Number: F03 (Revision V 1.0 - 02/13)

Title:	Instruction for duties undertaken by the switchboard on activation of fire alarm Scarborough Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives:	Instructions to follow for switchboard personnel in the event of a potential or actual fire situation at Scarborough Hospital.
Scope:	**Switch Board Personnel** also the Hospital fire team & relevant management.
Specific To:	Switch Board Personnel.
Training Required:	Yes via dissemination and following of this procedure; specific fire instruction by the fire advisor as applicable.

Procedure:

1. Upon activation of the fire alarm system, the fire alarm panel located in the switchboard room will alert switchboard personnel, who will look at the fire panel to identify the location of the fire.

2. They will immediately call the fire brigade to inform them of the activation via 999 and inform the emergency services of any details they are aware of.

3. The switch board personnel will then inform the site coordinator (deputies), on call engineer, duty porter and security team (as per Fire Work Instruction F01) as a minimum. Also the security and porters.

4. In the event of an actual fire incident, the switch board personnel will monitor the situation and as required by the site coordinator, fire team or brigade and pass on relevant information.

5. The switch board personnel are only to silence the fire alarm if instructed by the site coordinator or a member of the senior facilities team (Ref: FO4).

6. In the event of false alarm activation, the switchboard personnel on direct instruction from the site coordinator or senior facilities management team

only, will contact the fire brigade and inform them of the verified false alarm and they are not required.

7. The senior facilities management team is defined as:
    a. Fire Safety Officer
    b. Fire Manager (H&S Manager)
    c. Assistant Head of Facilities (Scarborough)
    d. Facilities Supervisors

Fire Work Instruction Number: F04 (Revision V 1.0 - 02/13)

Title: Instruction for duties undertaken by senior facilities team on activation of fire alarm Scarborough Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives: Instructions to follow for senor facilities team in the event of a potential or actual fire situation at Scarborough Hospital.

Scope: **Senior Facilities Team** also the Hospital fire team & relevant management.

Specific To: Senior Facilities Staff.

Training Required: Yes via dissemination and following of this procedure; specific fire instruction by the fire advisor as applicable.

Procedure:

5. Upon activation of the fire alarm system, the senior facilities team member will as applicable make their way to the nearest fire panel, to ascertain the location of the fire alarm.

6. Once the location is identified, they will make their way to the location of the fire alarm activation.

7. On arrival, they will access the situation and decide on the correct course of action to take, this being:
    a. Known false alarm, with obvious cause (e.g. burnt toast, aerosol), contact switchboard and request fire brigade to be stood down, not to attend site and inform site coordinator and staff assembled at main entrance.

    b. False alarm suspected (e.g. smell of smoke no obvious source), continue to search area for location of potential fire and assist fire brigade on arrival until brigade confirm false alarm;

    c. Confirmed fire contained (e.g. a small fire in paper bin), if no imminent risk to personal safety and confident it is safe to do so, fight the fire as appropriate. Once extinguished assist fire brigade on arrival;

    d. Confirmed fire uncontained (e.g. medium or large fire beyond safe intervention), close all doors and windows if safe to do so, immediately

inform site coordinator and fire team located at the x-ray foyer. Assist in evacuation of immediate area as required and assist fire brigade on arrival.

(At no point is any staff member to take action which will knowingly put them at risk)

The senior facilities management team is defined as:

- Fire Safety Officer
- Fire Manager (H&S Manager)
- Assistant Head of Facilities (Scarborough)
- Facilities Supervisors

Fire Work Instruction Number: F05 (Revision V 1.0 - 02/13)

Title:	Instruction for duties undertaken by all staff (non clinical areas) on activation of fire alarm Scarborough Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives:	Instructions to follow for all staff (non clinical areas) in the event of a potential or actual fire situation at Scarborough Hospital.
Scope:	**All Employees (non clinical areas)**
Specific To:	All Employees and contractors working on site (non clinical)
Training Required:	Yes via dissemination and following of this procedure; specific fire instruction by the fire advisor as applicable.

Procedure:

1. Upon activation of the fire alarm system **continual alarm** sounding, staff must respond in line with specific local departmental protocols for fire alarm activations (staff are to make themselves aware of these on local induction and refresher);

2. As a minimum, staff **will** evacuate and make their way to the nearest fire exit closing doors and windows (if safe to do so) as they leave the building, checking for other people and request them to evacuate as they exit;

3. Assemble at the designated fire assembly point for their department or place of work;

4. The departmental or local manager is to confirm the building is evacuated and wait for further instruction from the fire team or fire brigade.

5. In the event of **intermittent alarm** sounding take no action

(All staff are to make themselves aware of local fire management procedures for their place of work)

Fire Work Instruction Number: F06 (Revision V 1.0 - 02/13)

Title:	Instruction for duties undertaken by all staff (clinical areas) on activation of fire alarm Scarborough Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives:	Instructions to follow for all staff (**clinical areas**) in the event of a potential or actual fire situation at Scarborough Hospital.
Scope:	**All Employees (clinical areas)**
Specific To:	All Employees and contractors working on site (clinical areas)
Training Required:	Yes via dissemination and following of this procedure; specific fire instruction by the fire advisor as applicable.

Procedure:

6. Upon activation of the fire alarm system **continual alarm**, staff must respond in line with specific local departmental protocols for fire alarm activations (staff are to make themselves aware of these on local induction and refresher);

7. The ward manager or senior staff member will initiate an search of the area to ascertain the cause of the alarm activation;

8. For a known false alarm, inform the fire team member on arrival; no further action is required;

9. If an actual fire is identified, access the situation and decide on the correct course of action to take, this being:

    e. False alarm suspected (e.g. smell of smoke no obvious source), continue to search area for location of potential fire and await arrival of fire team and fire brigade;

f. Confirmed fire contained (e.g. a small fire in paper bin), if no imminent risk to personal safety, confident and it is safe to do so, fight the fire as appropriate, await arrival of fire team or fire brigade;

g. Confirmed fire uncontained (e.g. medium or large fire beyond safe intervention), close all doors and windows if safe to do so, immediately inform site coordinator and fire team located at the main entrance; if not already alerted. Prepare to commence evacuation of patients and / or others to adjoining fire compartment / place of safety.

10. Senior ward manager or senior member of staff will make a decision (based on clinical needs) to isolate supplies of medical gases to the wards or department affected.

11. In the event of an intermittent alarm sounding in the area take no action

(All staff are to make themselves aware of local fire management procedures for their place of work)

Fire Work Instruction Number: F07 (Revision V 1.0 - 02/13)

Title:	Instruction for duties undertaken by all staff (non clinical areas) on activation of fire alarm Bridlington Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives:	Instructions to follow for all staff (**non clinical** areas) in the event of a potential or actual fire situation at Bridlington Hospital.
Scope:	**All Employees (non clinical areas)**
Specific To:	All Employees and contractors working on site (non clinical)
Training Required:	Yes via dissemination and following of this procedure; specific fire instruction by the fire advisor as applicable.

Procedure:

1. Upon activation of the fire alarm system **continual alarm** sounding, staff must respond in line with specific local departmental protocols for

fire alarm activations (staff are to make themselves aware of these on local induction and refresher);

2. As a minimum, staff **will** evacuate and make their way to the nearest fire exit closing doors and windows (if safe to do so) as they leave the building, checking for other people and request them to evacuate as they exit;

3. Assemble at the designated fire assembly point for their department or place of work;

4. The departmental or local manager is to confirm the building is evacuated and wait for further instruction from the fire team or fire brigade.

5. In the event of **intermittent alarm** sounding, a representative member of staff will be identified and sent to the supervisors office (main fire panel location), to assist in any evacuation and communicate to each area as required, following instructions from the site coordinator or senior fire team member.

(All staff are to make themselves aware of local fire management procedures for their place of work)

Fire Work Instruction Number: F08 (Revision V 1.0 - 02/13)

Title:	Instruction for duties undertaken by all staff (**clinical areas**) on activation of fire alarm Bridlington Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives:	Instructions to follow for all staff (**clinical areas**) in the event of a potential or actual fire situation at Bridlington Hospital.
Scope:	**All Employees (clinical areas)**
Specific To:	All Employees and contractors working on site (clinical areas)
Training Required:	Yes via dissemination and following of this procedure; specific fire instruction by the fire advisor as applicable.

Procedure:

12. Upon activation of the fire alarm system **continual alarm**, staff must respond in line with specific local departmental protocols for fire alarm

activations (staff are to make themselves aware of these on local induction and refresher);

13. The ward manager or senior staff member will initiate an search of the area to ascertain the cause of the alarm activation;

14. For a known false alarm, inform the fire team member on arrival; no further action is required;

15. If an actual fire is identified, access the situation and decide on the correct course of action to take, this being:

    h. False alarm suspected (e.g. smell of smoke no obvious source), continue to search area for location of potential fire and await arrival of fire team and fire brigade;

    i. Confirmed fire contained (e.g. a small fire in paper bin), if no imminent risk to personal safety, confident and it is safe to do so, fight the fire as appropriate, await arrival of fire team or fire brigade;

    j. Confirmed fire uncontained (e.g. medium or large fire beyond safe intervention), close all doors and windows if safe to do so, immediately inform site coordinator and fire team located at the porter's lodge (main fire panel location); if not already alerted. Prepare to commence evacuation of patients and / or others to adjoining fire compartment / place of safety.

16. Senior ward manager or senior member of staff will make a decision (based on clinical needs) to isolate supplies of medical gases to the wards or department affected.

17. In the event of an intermittent alarm sounding in the area, a representative member of staff will be identified and sent to the nearest fire panel to ascertain the location of the activation then make their way there to assist in any possible evacuation and communicate to each area as required.

(All staff are to make themselves aware of local fire management procedures for their place of work)

Fire Work Instruction Number: F09 (Revision V 1.0 - 02/13)

Title:	Instruction for duties undertaken by the site coordinators (and deputies), on activation of fire alarm Bridlington Hospital.

Note this fire work instruction forms part of a series of specific work instructions for management of fire across the Trust (F0 series).

Objectives:	Instructions to follow for site coordinator and nominated persons in managing any potential or actual fire situation at Bridlington Hospital.
Scope:	**Site Coordinators and Nominated Persons** also the Hospital fire team & relevant management.
Specific To:	Site Coordinators and nominated persons.
Training Required:	Yes via dissemination and following of this procedure; specific fire instruction by the fire advisor as applicable.

Procedure:

1. The site coordinator and nominated person, upon being made aware of fire alarm activation will make their way to the porters lodge (location of main fire panel); locate the fire alarm activation from the fire panel.

2. The site coordinator and nominated person will ensure a fire team member[2] is sent to the area where the fire alarm activation is; to ascertain the fire status (actual fire or false alarm) and inform the fire team at the porter's lodge of this via 2 way radio or mobile telephone.

3. In the event of this being an **obvious false alarm**, the site coordinator can silence the alarm via the closet fire panel, **NOT RESET**.

4. The site coordinator will wait for the fire brigade to arrive at site and then attend the fire alarm activation site with the fire brigade representative to ensure the area is safe and confirm the false alarm.

5. The engineer or maintenance team member either within normal working hours Mon/Friday or outside these hour on arrival, reset the fire alarm system (subject to confirmation of false alarm from fire brigade).

6. In the event of an **ACTUAL FIRE** the alarm must not be silenced, so all staff are aware of the ongoing situation.

7. The site coordinator will remain in the porter's lodge (main panel location) to manage the Trust response to the fire incident and if necessary coordinate any evacuation, by management of the fire team and available staff.

8. The site coordinator will liaise with the fire service on arrival; ensuring they are taken to the scene of any fire.

[2] Site coordinator or nominated person, porter and member of facilities staff.

Appendix 5

Policy Management

1 Consultation, Quality Assurance and Approval Process

Consultation Process

This policy is prepared in consultation with the Fire Safety Advisors, Head of Safety & Security and the Director (Responsible for Fire). The policy will be placed before the relevant group for consultation, comment and endorsement. This policy will be reviewed and endorsed by the Fire Safety Group, Trust Health and Safety Committee and the Health & Safety Non Clinical Risk Group (HSNCRG) prior to the approval of the Trust Board.

Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the appropriate committee as determined by the **Policy Development Guideline**

Following completion of the consultation process, this policy, and any subsequent policy revisions will require the approval of fire safety advisors / manager and the nominated Director to ensure this policy is submitted to the appropriate committee for approval.

Quality Assurance Process

The authors have consulted with the following to ensure that the document is robust and accurate:-

- Trust Head of Safety & Security
- Director responsible for fire safety.
- Trust Fire and Health and Safety groups
- Health & Safety Non Clinical Risk Group (HSNCRG)
- Board of Directors

The policy has also been proof read and the review checklist completed by the Policy Manager prior to being submitted for approval.

Approval Process

The approval process for this policy complies with that detailed in section 3.3 of the Policy Guidance.

2. Review and Revision Arrangements

The Policy Authors will be responsible for reviewing this policy in line with the timeline detailed on the cover sheet.

The policy will be reviewed biannually or earlier should there be any legislative or other reason to do so in conjunction with those name in the Consultation section above; subsequent reviews of this policy will continue to require the approval of the HSNCRG and Board of Directors.

This policy will be reviewed biannually or earlier should there be any legislative or other reason to do so; once reviewed the HSNCRG & as appropriate Trust Board will consult and ratify the policy.

3 Register/Library of Policies/Archiving Arrangements/ Retrieval of Archived Policies

Please refer to the Policy Development Guideline for detail

4 Standards/Key Performance Indicators

These have been developed by the Trust Fire Safety Advisors and will be approved by the Fire Safety Group and Health, Safety and Non-Clinical Risk Groups.

They will include assessments, inspections, audits and statistical information.

The key aims are to reduce the risk of fire so far as is reasonably practicable and to provide a safe working environment for staff, patients, and others by achieving and promoting a positive fire safety culture.

Achieve excellence in the management of fire safety through compliance with statutory duties and continuous improvement

5 Training

All Trust employees will be informed of the Trust fire safety arrangements as part of defined Trust induction and ongoing Trust safety training programmes. Fire safety training is included as part of the corporate induction and features within all individuals stat/mand required learning on the learning HUB.

6 Trust Associated Documentation

Health and Safety Policy
Policy Development Guideline
Adverse Incident Reporting System, (AIR's) Policy and Procedure
Risk Management Policy
Serious Incident Policy
Other Fire Safety related documents - stored on Q-Pulse and available via Staffroom.

7 External References

- Regulatory Reform (Fire Safety) Order 2005;
- Health & Safety at Work Act 1974;
- Management of Health & Safety at Work Regulations 1999;
- Human Rights Act 1998
- Firecode (2006);
- Health & Social Care Act 2008 (Regulated Activities) Regulations 2009;
- The Disability Discrimination Act (2005);
- The Building Regulations 1991;
- HM Government Fire Safety Risk Assessment Guidance: Healthcare Premises
- HM Government Fire Safety Risk Assessment Guidance: Means of Escape for Disabled People (2007);
- British Standards Institute. (2001). British Standard 8300:2001, Design of buildings and their approaches to meet the needs of disabled people – Code of Practice. London: BSI.

8 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and ensure effective review, the policy will be monitored as follows:-

Minimum requirement to be monitored	**Process for monitoring**	**Responsible Individual/ committee/ group**	**Frequency of monitoring**	**Responsible individual/ committee/ group for review of results**	**Responsible individual/ committee/ group for developing an action plan**	**Responsible individual/ committee/ group for monitoring of action plan**
a Risk assessments and action plans produced	A regular review of all existing Fire Risk Assessments and action plans	Appropriate Fire Safety Advisor	As per Risk Management Policy & Procedure	Relevant Trust FSG and Fire Advisors/Managers HSNCRG	Fire Advisor in liaison with CGM	Fire Advisors HSNCRG
b Monitoring of incidents	Incidents DATIX (Fire incidents)	Care Group managers/ Heads of Department, Bed Managers Fire Advisor & Fire Manager	Ongoing	Fire Advisors/Managers HSNCRG	Relevant Reviewers or Investigators	Relevant Reviewers or Investigators in liaison with DM

Minimum requirement to be monitored	**Process for monitoring**	**Responsible Individual/ committee/ group**	**Frequency of monitoring**	**Responsible individual/ committee/ group for review of results**	**Responsible individual/ committee/ group for developing an action plan**	**Responsible individual/ committee/ group for monitoring of action plan**
c) Area inspections and audits undertaken	Area Inspections OH&S Audit (Fire Safety)	Managers/ Heads of Departments/ Fire Wardens (where applicable) Fire Advisors	Monthly (as required) or following any changes to building or occupancy levels.	Fire Advisors & Care Group management HSNCRG	Fire Advisors & Care Group Management	Fire Advisors as part of any review process HSNCRG
d) Fire Safety training attended	Fire Safety Training reports provided by CLaD	CLaD/care Group Management/ Heads of Department & Fire Advisors	Annually	FSG	Fire Advisors through CLaD	Appropriate CLaD Teams
e) Any issues identified are addressed	Reports from regulatory bodies such as fire inspections/findings	Fire Safety Group & HSNCRG	As undertaken	Fire Advisors through FSG & Fire Wardens(Where applicable)	Fire Advisors & Care Group Management	Fire Advisors as part of any review process

Appendix 4 Dissemination and Implementation Plan

Title of document:	Fire Safety Management Policy
Date finalised:	July 2021
Previous document in use?	Yes
Dissemination lead	Mick Lee & Kevin Hudson
Implementation lead	Policy Authors
Which Strategy does it relate to?	Electronic and Paper via Intranet

Dissemination Plan	
Method(s) of dissemination	Referenced during Staff Training sessions Posted on Staffroom Policy emailed to Directors, Deputy Chief Operating Officers, Clinical Directors, Senior Managers and Matrons, Fire Wardens (if applicable) who should ensure that this is discussed with all staff at local induction
Who will do this	Policy Authors
Date of dissemination	On approval
Format (i.e. paper or electronic)	Mainly Electronic
Implementation Plan	
Name of individual(s) with responsibility for operational implementation, monitoring etc	*Colin Weatherill (Head of Safety & Security)*
Brief description of evidence to be collated to demonstrate compliance	*Internal Audit findings and recently introduced Premises Assurance Model (P.A.M).*

York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

A MONTHLY AWARD WHICH RECOGNISES THE ACHIEVEMENTS OF STAFF AND VOLUNTEERS

NOMINATION BOOKLET

August 2021

Nominations for August 2021

Joanne Iveson and Mellony Pinkney Community Nurses	**Community Based**	**Nominated by Allan Machen A relative Rebecca Bradley and Jane Venable Colleagues**

Allan Said:
I cannot thank Jo and Mellony enough for stopping to assist my wife who had collapsed outside. They reacted quickly and through their actions saved my wife's life.

Rebecca and Jane said:
We would like to nominate Community Staff Nurses Joanne Iveson and Mellony Pinkney for a star award following an incident recently in the Community. One weekend, both Jo and Mellony were working. Jo was driving to her next visit when she noticed a collapsed person at the side of the road and she stopped to help. A few moments later Mellony just happened to drive past and noticed Jo with the collapsed person. The patient was in cardiac arrest and both Jo and Mellony performed CPR until an ambulance arrived. They also kept the situation calm and supported the patient's relative. Thanks to their prompt heroic intervention and the care provide by the ambulance service and hospital care, the patient survived and is now recovering well.

Sharon Barnes and Clair Spaven Community Healthcare Assistants	**Community Based**	**Nominated by Marie Lacy A patient**

Sharon and Claire were very prompt in getting my care set up. They were very polite and friendly and very encouraging trying to get me to help myself. They put me at ease and I couldn't have done without them.

Emma Hind
Cardiac Rehabilitation Specialist Nurse

Community Based

Nominated by
Andrea Durston
A colleague

I would like to put Emma forward for a Star award to thank her for all she has done for the Cardiac Rehab Team and service over the last Year. Emma brought her experience from an acute Cardiology unit, VIU, and really embraced the Community in January 2019, a time when everything was changed so suddenly. She has been really supportive to the patients and to all the members of staff within Rehab. Not only did she support the Community and go back into the Trust in the Cardiac Rehab Acute Team, when they had a staff shortage, she is also helping with the integration of two Teams, and went back onto the wards, frontline, to support Covid staffing services when asked. This was at the same time as still keeping the Community going as well, working extra despite her family commitments. The Team is continuing to face immense staffing pressures and Emma's enthusiasm, relentless dedication, commitment and kindness continues with her hard working practice.

The Team on Duke of Kent Ward

Scarborough Hospital

Nominated by
Sophie Garrison
A relative

The entire team but especially Tracy and the lady (whose name I didn't get) were both particularly excellent. They were patient, caring, genuine, understanding and full of humour. These ladies and the team as a whole are exactly what I'd expect from the NHS. Perfection doesn't do them justice, they were so brilliantly attentive and kind I would love for someone to say thanks on our behalf. It's ladies like this who make an anxious and frightening experience for a 2 year old more of an adventure.

Magdalena Wawrzkiewicz
Domestic

Scarborough Hospital

Nominated by
Victoria Messruther and Jamie Lee-Kelly
Colleagues

Magda provided translation when a Polish patient in A&E started to become aggressive towards the nursing staff and we were unable to communicate with him to calm him down. Magda continued to stay with the patient and provide translation not only for the nursing team, but also for security and eventually the police, remaining calm even after the patient became aggressive towards her. She also contacted the patient's family to try to facilitate getting him home to prevent him spending the night in police cells. Magda is always happy to translate and goes out of her way to help even when she is busy with her own work.

Shirley Major
Domestic

Scarborough Hospital

Nominated by
A colleague

Shirley is so brilliant with the patients. Again today cajoled and encouraged a patient when they were distressed. She will hold their hands and talk to them while nurses are administering needles etc. The patients all love and trust her and she has a brilliant calming influence on them.

Laura Wilson, Louise Metcalfe, Khubaib Arif, Emily Buckley, Nicola Farebrother and Khaled Sulaiman
The Paediatric ED and Children's Ward Team

Scarborough Hospital

Nominated by
Georgina Askey
A colleague

During an extremely busy night shift, Laura Wilson, Louise Metcalfe, Khubaib Arif, Emily Buckley, Nicola Farebrother and Khaled Sulaiman, paediatric ED and children's ward team, were under extreme pressures with high numbers of complex patients and referrals. I'd like to say a massive thank you to all staff on this shift for their amazing efforts, supporting each other and working together as one team.

The Team on Ann Wright Ward

Scarborough Hospital

Nominated by
Orlando Villanueva
A colleague

I would like to nominate Ann Wright Ward for helping and supporting Cherry Ward whilst their ward is closed and under renovation. Lead by Yvonne MacLeod, the nurses and healthcare assistants were very caring to patients helping me and the Cherry Ward team to deliver high standards of care at all times. I received great feedback from my team on Cherry Ward that the all of Ann Wright Ward Team were really approachable and friendly. They made a big difference on sharing their experiences and knowledge to us. Thank You!

The Discharge Lounge Team

Scarborough Hospital

Nominated by
Orlando Villanueva
A colleague

I am so thankful for all the Discharge Lounge Team for ensuring our patients in Cherry Ward were discharged safely at home. The team were very helpful and compassionate when taking patients from Cherry Ward down to Discharge Lounge. They were amazing, always smiling and caring when I see them up in our ward in Cherry. Thank You Discharge Team!

The Team on Cherry Ward | **Scarborough Hospital** | **Nominated by**
Orlando Villanueva
A colleague

I would like to nominate my team on Cherry Ward for working tirelessly during the pandemic. They are an amazing and compassionate team, delivering high standards of care to our Elderly population in Scarborough. I witnessed how every single member of our team, from ward clerk, housekeeper, healthcare assistants, nursing associates, TNA, staffs nurses and International nurses, clinicians, OT/PT, discharge coordinators worked together to achieve great outcomes for our patients. Whilst walking and speaking to the relatives and patients, one patient mentioned "The staff on Cherry Ward are very caring and helpful." Relatives also had a feedback that the doctors on Cherry Ward are very helpful in updating them regularly and their loved ones plan of care.

Rachel O'Mara
Deputy Sister | **Scarborough Hospital** | **Nominated by**
A relative

My son was admitted to Hospital on 14/06/2021 struggling to breathe with a high temperature and cough. Nurse Rachel O'Mara calmly and professionally treated my son with great detail and attention for his care and needs pinpointing what was wrong with him along with a Doctor (to me in their professional view) and not dismissing my concerns / representations as a worried parent in anyway but providing a clear and concise answer to any questions I had (no matter how silly they may have sounded or trivial they may have come across). Nurse O'Mara was amazing when I was with my son in resuscitation and he was on oxygen. This was when it hit me (the reality) how poorly my son was and I saw him on oxygen with a mask on his face. Seeing this (I am not ashamed to say it as a grown man) I burst into tears. Nurse O'Mara was there when this happened and kindly and professionally comforted me providing verbal reassurance that my son would be okay and that he was in the best place (I knew he was) even though you will always worry as I was seeing your child in this state. Nurse O'Mara personally took him down to Duke of Kent Ward on a trolley with another member of staff as she could not locate a porter. This kept him and I calm and there was continuity for him seeing her before she left and she said goodbye to him when he was admitted to the ward and comforted him when he was upset when first on the ward. Nurse O'Mara is an exceptional lady and professional person.

Hawthorne Ward Team | **Scarborough Hospital** | **Nominated by**
Terri Rogers
A patient

This amazing team went above and beyond after I had a C-section then due to a tear to my bladder and complications due to infections they all went out their way to look after me and my baby. They acted fast when I first got an infection and nothing was too much to ask they always made time for me and I cannot thank them enough for what they did. It's thanks to them I am still here today recovering. Thank you, you are amazing people.

Trueman Talavera
Staff Nurse

Scarborough Hospital

Nominated by
Karen Brown
A colleague

Truman is one or our previous intake of international nurses. He has an outstanding commitment to the ward, his colleagues and the patients in his care. Nothing is too much trouble he helps out in every way and often puts his breaks aside to help others. He is polite and courteous and an asset to my team. Patients are always commenting on his bedside manner and often comment on how he listens and explains everything he is doing clearly and precisely prior to giving care. I would like him to have recognition from the Oak ward team.

Lynie Balicao
Staff Nurse

Scarborough Hospital

Nominated by
Erin Bergin
A colleague

I am an agency paediatric nurse, from my first shifts in department, Lynie has welcomed me, she is very caring and supportive with patients and staff she is a great team player.

Lorna Arnall
Buyer

Scarborough Hospital

Nominated by
Chris Pidgeon
A colleague

I'd just like to write and say a big thank you to Lorna who kindly purchased a requisition for me at short notice, and went beyond her usual finish time to do so. I'm so sorry that was the case but it was massively appreciated by me, Sue, Dave and Adrian who only asked me to raise the requisition at 15:57 for next day delivery!

Samira Giwa
Sister

Scarborough Hospital

Nominated by
Cassie Halpin
A colleague

Sam was caring for a gentleman who was approaching his last days of life. On the day in question he had deteriorated rapidly and was very unwell. He had informed Sam that he wanted to be able to see his two Cavalier King Charles spaniels Sacha and Toby, in order to say goodbye. She facilitated this by contacting his neighbour and arranging for them to bring them to the hospital. Due to his deteriorating condition, he was unable to be transferred to a wheelchair and wheeled down to say goodbye. So Sam and I wheeled him down to the main entrance on his bed. Sacha and Toby were lifted onto the bed and he was able to spend some time stroking them and getting doggy kisses off them. You could see instantly how this had made him feel being able say goodbye to them. Not only did Sam facilitate this; but she is terrified of dogs and put the patients' needs above her own; to ensure he got his one wish.

Adele Metcalfe **Scarborough Hospital** **Nominated by**
Ultrasound Principal **Helen Gilbert**
A colleague

Adele was super helpful today when organising imaging requests for a number of maternity patients!! She was polite and understanding on the telephone, came up to the ward to scan a Covid positive patient and did extra requests at short notice! She even found it in her heart to squeeze in one extra scan at 5pm on a Friday afternoon!!!! Really appreciate her help!!

Vicky Lamb **Scarborough Hospital** **Nominated by**
Neonatal Support Worker **Rebecca Balf**
A colleague

Vicky is member of the Care Group 5 Quality Council. She goes beyond the extra mile when working on projects and her passion and 'can do' attitude is infectious! Recently, she has been the driving force behind getting a new front desk on SCBU at Scarborough Hospital. She saw this project go from a 'wouldn't it be nice if…' dream, to a safe, operational, reality, and a source of pride for her team. When there are setbacks on projects Vicky does not let it bring her down. She epitomises perseverance and exemplifies the Trust Values at every turn. She is not afraid to think outside of the box and to walk round literally knocking on doors to make things better for her colleagues and patients alike. Vicky is truly a star in my eyes.

Syed Asher Asif and **Scarborough Hospital** **Nominated by**
Anurjan Balendra **A colleague**
Junior Doctors

Ash and Nurj are our junior Drs on Holly and sometimes the doctors office can be a very daunting place to visit when you need help. But they have changed that and are always happy to help, professional and extremely approachable. I have always found them proactive in their help and they always try to find a solution in any problem but they will equally admit and accept feedback from non medical staff if they do not know the answer which shows they value and respect others. I really want to emphasize how much this helps to ensure that a patient receives the correct follow up care. I would like to nominate them for a star award as Junior Drs do not often get the recognition they deserve in their busy environment as they are seen as 'just doing their job' but actually they do more than that.

Ruth Dixon
Consultant Clinical Psychologist

Scarborough Hospital

Nominated by
Loren Harwood
A colleague

I would like to nominate Ruth Dixon who has been invaluable to me over the last 12 months. I was unfortunately one of the early members of staff who contracted COVID-19 back in April 2020 and then went on to develop Long Covid with organ impairment. I suffered both mentally and physically, during a time when Long Covid was not an official diagnosis and many GP's and other medical professionals just did not know how to deal with people like myself presenting with symptoms following the initial period of infection. I found myself in an extremely dark place, not knowing where to turn for help. I saw the staff wellbeing drop in sessions listed on one of the staff communications and booked in straight away- knowing I was feeling very helpless. At my first session, I was welcomed by Ruth, who immediately took charge of the situation and after a few sessions, arranged for occupational health (who I was already under) to refer me to her for more formal treatment. Since then I have had regular sessions with Ruth and she has gone above and beyond, helping me through my issues by giving me lots of constructive advice, coping strategies and generally just being the only person to listen and believe that what I was suffering post COVID-19 was real! She has helped me to accept my new limitations- a difficult task for anyone young who never had any major health issues prior to contracting COVID-19. She has now enabled me to return to work by working with Occupational Health to arrange reasonable adjustments to prevent a further failed phased return. On Monday I completed my phased return, and today I was discharged from Ruth's care. I just wanted to highlight this story to you, as it is very raw and real and shows how amazing our staff are; Ruth being one of them! I honestly don't know how I would have coped without her.

Liz David
Switchboard Manager

Trust Wide

Nominated by
Paula Curtis

I would like to nominate my manager Liz David for a star award. Switchboards across York and Scarborough must be manned 24 hours a day, 7 days a week by fully trained members of staff. I developed long Covid and was signed off work. My manager was very supportive, kind and caring during a very stressful period for the NHS. It was a very daunting experience to feel so poorly, luckily things got better and Liz also made the transition back to work for me effortlessly.

Tanya Harper **York Hospital** **Nominated by**
Medical Secretary **Amanda Sharkey**
A visitor

Tanya has gone above and beyond to work with me as an external Occupational Health Advisor to find a way of providing sufficient medical information to ensure individuals could access their Ill Health Retirement benefits. This information would usually be a specialist report, but at present, due to demands on the NHS, consultants are understandably unable to provide such reports readily. I just wanted to say thank you to Tanya for being so open and collaborative in order to support the best interest of the patients in question.

Bernie Darby **York Hospital** **Nominated by**
Sister **Gill**
A colleague

Bernie has helped the team a lot very kind warm hearted great teacher very understanding member of the team.

Deborah Bloor **York Hospital** **Nominated by**
Radiographer Specialist **Steve Baker**
A colleague

The partner of a patient sent a letter of thanks to the Radiology Department. The patient has advanced Alzheimers and " Debs was a total star from the beginning to end of the appointment." Deborah was with the patient for each stage of the process which included her being given tablets to swallow. The patient finds this very hard to do. An injection which needed plenty of reassurance to keep the patient's hand still and then the scan itself. Throughout the process Deborah was focused on the patient, she was patient, supportive and engaged. She instantly understood the patient's (quite complex) needs with out needing to be given any explanation. This included knowing that the patient needed someone to hold each of her hands to keep her calm through the actual scan. Knowing we have staff as caring as this makes me extremely proud.

The MRI Administration Team **York Hospital** **Nominated by**
Tm Everton
A colleague

The MRI administration team have shown resilience and drive to continue to give the best possible patient service during a difficult time with building work and disruptions within the office. The team have also gone above and beyond on multiple occasions to help patients and ensure that they have their appointment and are supported by the department.

The Team on Ward 16 **York Hospital** **Nominated by**
Lissy Fyall and The Specialist Palliative Care Team
Colleagues

On behalf of myself and the whole specialist palliative care team at York hospital we have seen outstanding palliative care for very complex patients with symptom control needs, family support and psychological support on Ward 16. Our team feel the Ward 16 staff from all the senior nurses, to junior nurses, band 4's, HCA's, ward clerk staff and domestic/support staff have gone above and beyond to provide excellent, compassionate care in a very busy ward environment. They have cared for some very emotional and challenging symptom control needs of some of our patients over the past few months particularly with younger patients. Despite everything with the pandemic they have continued to provide excellent care in very challenging circumstances. They all deserve this recognition.

Peter Wanklyn **York Hospital** **Nominated by**
Consultant **Hannah Bentley**
A relative

Mr Wanklyn received my father as he was suffering a very serious stroke. He had lost use of his right side, his speech and appeared to be at risk of severe disability. The care he received, including thrombolysis, and onward referral to Hull for a thrombectomy have saved my father from a future of severe disability. He recovered almost completely following his emergency treatment. Mr Wanklyn spoke to me with great compassion and clarity and went on to salvage my father's future. I cannot express my gratitude in words. He really is a star.

Jennifer Ramon **York Hospital** **Nominated by**
Associate Practitioner **Bernadette Foster**
A colleague

Jenny always goes above and beyond to give the patients in her care the absolute best. At the centre of her working day is always the patient, she treats every patient as an individual each one has their own problem or concerns that Jenny tries to resolve. A special case in which Jenny demonstrated this was when we had a patient admitted whose first language was not English and she had very limited understanding, Jenny took time out to translate and print out common questions/answers, used google translate and even tried to speak Greek (the patients language) this not only reassured the patient but made her laugh (we weren't sure what Jenny had actually said). Jenny works hard every minute of every shift, willing to undertake any task needed always with a smile on her face.

Marijke brown **York Hospital** **Nominated by**
Sister **Colleagues**

During what has been one of the hardest years in the NHS and for most teams within York Hospital, we could not be more grateful to have Marijke as our Ward Sister. She goes above and beyond on a daily basis for Ward 14 even during some of the most difficult times in her own personal life but has always reassured us and supported the team. Her main aim is to always make sure her staff are supported and will fight our corner every step of the way, which makes us deliver the best patient care and safety we can. A prime example of her selflessness is volunteering herself to work on the Covid ward, to prevent any more stress to her team. She always, without fail, offered to help and went above and beyond to support her colleagues and the patients. As a team, we would like to nominate Marijke and wholeheartedly thank her for being the best Ward Sister a team could wish for. Marijke is appreciated and admired by all her colleagues across the surgical floor, and we should celebrate her achievements and kindness especially as she will be retiring later this year.

The Team on Ward 35 **York Hospital** **Nominated by**
Courtney Swan
A colleague

I wish to nominate my team for their resilience, adaptability and teamwork during the Covid pandemic over winter. As a team we were moved to 3 different wards over 4 months to look after patients under various specialities, the most challenging was the 7 weeks running ward 34 respiratory. As an elderly care team we all needed training imminently on the ward undertaking very specialist care which was well out of our comfort zone and for the first time for many. The leadership and support from Caroline aided and led the staff to work as a strong team and adapt to this new learning opportunity, every individual demonstrated integrity and professionalism during uncertain times and for that I am immensely proud. The team are an asset to this trust and still continue to give their best and go the extra mile every day during what is now a testing time for our care of the elderly ward. This award would give the staff a well needed moral boost and show how much their hard work is appreciated by the trust. Thank you.

Clare Inkster
Ward Clerk

York Hospital

Nominated by
Jasmine Rayner
A colleague

Clare has been a shining light in keeping patients connected with their loved ones. She has been kind, caring, compassionate and has always gone the extra mile to make patients happy. Recently, a patient on ward 14 became distressed and unhappy in himself, Clare took it upon herself to print out and hand deliver the lovely messages his family sent in everyday and also took the time out of her busy job to sit and read them to him to lift his sprits. Alongside this, she made sure the family were kept up to date and in constant contact with him using zoom calls and phone calls. This made ALL the difference in how the family felt with a loved one they couldn't see and also played a huge part in the compassionate care he received. Examples such as this are only a small part in the vital role Clare plays and the trust is beyond lucky to have such a great team member on the ward. The Patient Experience team are so grateful for all you do Clare, thank you one hundred times over.

Marie Lawrence
Healthcare Assistant

York Hospital

Nominated by
Linda Gude
A colleague

I'd like to nominate Marie for this star award, for her support during Covid. I was a newly qualified nurse at just less than 6 months and was redeployed to the HDU Covid Ward with Marie. I was so frightened about going to this ward and was unsure if I'd be able to step up and be the nurse I needed to be. But with Marie's help I survived. Marie started out as a cleaner at York Hospital then went on to be a HCA on the Day Unit/ESA. Ward work was out of Marie's comfort zone too as the area we worked on is totally different to the normal wards. But Marie absolutely smashed it. She was one of the first ones to get her PPE on and look after the first patient we received on to the ward. Although her anxiety and fear was through the roof she approached it face on. Without Marie I wouldn't have got threw it, the endless phone calls she's received from me, she always picked me straight back up. A healthcare assistant is not just somebody who does the "joey" jobs or "just a carer, they are the nurses rocks and our back bones. They are the ones whom make the team without them the wards wouldn't survive. Marie truly did go above and beyond. Not only for the patients but for her colleagues too.

Claire Stephenson
Radiographer Specialist

York Hospital

Nominated by
Harley Cockayne
A colleague

Claire always goes above and beyond for all her patients and colleagues. She has been a huge support throughout my training as a mammographer and I wouldn't be the mammographer I am today without the help and support of Claire. She lights the whole room up with her lovely personality, everyone is always smiling and happy when Claire is around.

Joseph James
Healthcare Assistant

York Hospital

Nominated by
Zoe Dunning and Dawn Lowe
Colleagues
Donna Kemp
A colleague

Zoe and Dawn said:
Joe is an invaluable member of the team. He always goes above and beyond to make sure the patients are well looked after in clinic and he takes patient to and from clinic, many of our patients are frail and visually impaired. He makes sure clinic runs smoothly and will always help anytime. He keeps everyone in our department's spirits high and will always take the time to ask you about your day.

Donna said:
Joe is a credit to the NHS. He is always positive and upbeat and keeps moral high when we are all having difficult days. He is caring and compassionate with the patients and he wins them all over with his sense of humour, making them feel at ease. Nothing is too much trouble for him. During the difficult move to the Stadium he's been outstanding, even going out on his break and buying water for his colleagues out of his own pocket as we were unable to drink the water and the site has no shop/café/vending machines and the weather was really hot. Every department needs a "Joe"

Bridie Riley
Healthcare Assistant

York Hospital

Nominated by
Dawn Lowe
A colleague

Bridie is always polite and helpful she goes above for the patient as a few weeks ago showed when she helped someone who had fallen outside on her lunch break at the new community stadium and missed her lunch.

The Ground Floor Outpatients Team

York Hospital

Nominated by
Hailee Henderson
A colleague

The whole team have been so welcoming, patient and supportive with all the new members of staff that have recently joined the Outpatients Department. Nothing has ever seemed too much trouble for them to help us with, offering guidance and helping us all learn the way the clinics are run and what is expected of us. I for one ask a lot of questions and no-one has ever made me feel like it is a silly question (even though it may well have been!) At the moment I only work 1.5 days a week however I still feel a part of the team and am offered training sessions, mentors and I am frequently asked if everything is ok or if they can do anything to help. I have never worked with such a supportive and friendly team. Feeling very happy to have been placed here so just wanted to say a huge thank you to them all.

Sarah Davidson
Bereavement Support Officer

York Hospital

Nominated by
A colleague

Sarah is new to the role and recently helped facilitate a wedding for a patient at end of life. She not only contacted the registry office but also the local Morrison's Champion for some donations such as a cake to help make the day special. Staying late the day before and going on the day of the wedding in early to ensure that everything was in place even though she had only been in the role a few weeks, Sarah and her colleagues made sure that it was a special day for the couple.

Cristian Triboi
Healthcare Assistant

York Hospital

Nominated by
Maylyn Segovia
A colleague

Cristian is a very hard working member of staff. He is an asset to the ward. The team feel comfortable and can always rely on him. You really do not need to tell him what to do, he is always there to help and support you, even if you have not asked him for help, he has already done it for you, like cannulating a patient, collecting bloods from the fridge, and other jobs that HCAs can do. He will also remind you of other things/jobs to be done which is very helpful as we nurses most of the time have a lot of things on our mind that we need to do but he is there to remind us as a support for us. You can also rely on him with any non-nursing jobs, like computers, electricals. He applies all the trust values and goes beyond his role. He is very assertive, has very good communication skills, patients love him. Also when other wards are short, he is always ready to help. He makes sure that all jobs are done before the end of the shift. He guides and supports other staff with their assigned tasks. Always keen to learn new things and keen to improve and go up the ladder with his career. He deserved to be recognised for his hard work, he deserves a star!

Yvonne Stone
Healthcare Assistant

York Hospital

Nominated by
Denise Tonner
A colleague

Yvonne is a really hard worker, she's helpful to both patients and other members of staff. She goes above and beyond every day.

The Endoscopy Team **York Hospital** **Nominated by**
4 May 2021 **Lynn Watson**
A relative

On Tuesday 4th May my 19 year old daughter had to have a colonoscopy and I would just like to say thank you to the whole team from the lady in waiting list to Mr Alexander. My daughter has autism and anxiety and was so worried about having the procedure. The waiting list lady arranged for me to take Amy round the unit beforehand so she was a little prepared, Katie who took her round was absolutely fantastic, really put Amy at ease and even offered to make sure she would be with Amy when having her procedure, she told Amy to bring something with her to comfort her (she should be an autistic nurse) absolutely got what Amy was going through. On the day I was allowed to sit with her in reception and she was getting upset while waiting, staff came to her to reassure her, I was allowed in the office where she was clerked in, she was even shown a cannula that would be used. Katie appeared and took Amy to get changed and for her procedure. I got a call to say she was in recovery and was allowed to go in to her, she was fine, sleepy but fine, being looked after by a brilliant nurse, Amy told me she didn't feel a thing and Katy had been with her the whole time. Everything was explained to us while we had a coffee and hot chocolate and discharged. Everyone was lovely that came into contact with Amy, she was reassured the whole time and being given a chance to see where she would be going really helped.

Lindsay Robinson **York Hospital** **Nominated by**
Healthcare Assistant **Laura Galbraith**
A colleague

Lindsay goes above and beyond not only for the patients but also supporting other staff. The way she looks after people is a pleasure to see! Lindsay looks after the patients as though they are her own family and manages to get a smile out of everyone! She really brightens up the ward. Personally Lindsay has supported me while at work during what has been a very difficult time and has gone out of her way to cover shifts for me which I am really grateful for. Lindsay's kind words and care for everyone is something that should be rewarded! She's worth her weight in gold!

Lesley Dowson **York Hospital** **Nominated by**
Ophthalmic Technician **Denise Tonner**
A colleague

Lesley is a team player, always friendly and smiling and willing to go the extra mile for both patients and colleagues alike.

Mohamad Kajouj
Speciality Registrar

York Hospital

Nominated by
Liz Depnering
A relative

Mo went above and beyond to help when my 23 month old son had a deep cut to his forehead - I was told it was likely he would need a general anaesthetic as the cut was too deep and difficult to manage on an awake toddler, but Mo listened to my concerns and was happy to try when everyone else was sceptical. He patiently sutured for 20 minutes while my son watched Tractor Ted Episodes. Without his confidence, care and patience, I am certain we would have been subjected to a general anaesthetic. It would have been so easy (and quicker) for him to pass us on to the surgical team but by staying with us, he not only saved the NHS a lot of money in unnecessary surgery but also removed the need for a risky procedure for my little boy. I am so very grateful!

Andrea Readman
Specialist Biomedical Scientist

York Hospital

Nominated by
A colleague

Andrea deserves a star award because of her amazing effort and dedication to the Microbiology department - especially during the SARS CoV-2 pandemic. Over the past year and a half, Andrea really has gone above and beyond by continuously working more than her contracted hours, is the first person to volunteer for shifts nobody else wants, steps in for contingency when other staff are ill or analysers have failed, even if it means giving up her evenings, weekends and even lieu days or leave, and often comes in early and stays behind to ensure patient's get their results. She has played a big part in the Microbiology lab's COVID service and deserves recognition for it.

Muhammad Naveen
Consultant

York Hospital

Nominated by
June Walmsley
A patient

Dr Naveed is a brilliant consultant/specialist. He is caring, kind, hard working and thoughtful, and because of this he makes that extra effort. An example: - many times in his lunch break he came to see me on the cancer ward, just to ask if I was doing ok. He made me feel safe, and I knew I was in good hands. Dr Naveed is a wonderful asset to the Haematology Unit, and I think he's worthy of this award.

Amanda Mullin
Operational Service Manager

York Hospital

Nominated by
Pouya Alaghband
A colleague

Mandy has been instrumental in overhauling the ophthalmology department. Her relentless efforts have made a tremendous impact in the department in terms of staffing, equipment and services. She deserved to be recognised for her stellar endeavours.

Andy Robinson
Nurse Manager

York Hospital

Nominated by
Pouya Alaghband
A colleague

Andy has proven to be an exemplary leader. Within a short period of his tenure, his influence and professionalism has become so obvious. He has got a positive "can-do" attitude. He has made a massive difference in terms of how staffing is run and has managed to improve staff morale as well. He deserves to be recognised as a shining star.

Lois Bennett
Midwife

York Hospital

Nominated by
Pouya Alaghband
A colleague

I don't think there are words that can describe how truly grateful I am to this superwoman! Thank you so much for all you help, support and guidance to deliver my little boy safely. You were so wonderful and I am so grateful for all you did for us. I put my whole trust in you as soon as we meet without any hesitation or worry. You were so calming, caring and I was so impressed that you knew about my previous birth and got me another water birth. You then we're just brilliant post birth as well getting everything sorted and nothing was a problem and I know labour ward was extremely busy that night!! You made the whole thing such a positive experience and I am so grateful to you. Thank you so so so much for being the most amazing midwife and a truly wonderful person.

Richard Gale
Consultant

York Hospital

Nominated by
Rebecca Harrison
A patient

Richard has been instrumental in leading the ophthalmology department to excel in all aspects of patients' care and safety. He has been very supportive in implementing change in the entire department. He is open to ideas. He always looks for ways to improve patients' journey within the department. His leadership in research has been exemplary as well. He deserves to be recognised by the star award.

The Rheumatology Specialist Nursing Team | **York Hospital** | **Nominated by Linda Dunlop A colleague**

The small but mighty Rheumatology Specialist Nurse team at York have moved mountains to re-design how they manage their patient advice line (both phone and email) over the past 2 months. By the end of the last Covid wave their advice line had a backlog of over 100 calls and messages to manage which was not ideal for their patients. As a team they looked for some help to manage this and started an improvement project to change things around. Their aim was to clear the backlog and achieve a response to acute flare ups and medication reactions within 24hrs and all other general enquires within 7 days by September 2021. They have not just achieved this in 2 months but gone above this aim with all enquires answered within 48hrs. The team have been successful by changing the way they work and focusing on the best outcome for their patients. There is still a long way to go but they are all putting in a massive effort which is paying off. Patients and primary care teams are already congratulating them on a fantastic service.

Sarah Newton Physiotherapist | **York Hospital** | **Nominated by Andrew Calvert A colleague**

Sarah was on shift in ED and was asked to review a patient for discharge who had been thrown off a horse and had multiple rib fractures. Sarah quickly identified due to the number of rib fractures sustained that discharge was not advised and her recommendation was for a period of observation and pain management under the major trauma pathway. This was due to the high likely hood of this patient developing complications in the next 24-48 hours. Whilst the ED department was very busy that day Sarah unfortunately was unable to review this patient in person. The next day Sarah discovered the patient had in fact been sent home with simple analgesia. Recognising the seriousness of the situation and that the current management was insufficient, Sarah contacted the Orthopaedic ACS and registrar. They agreed that the patient required admission and greater pain management. She contacted the patient at home who was well but indeed struggling to manage with pain mobility and breathing. Sarah organised the patient to return immediately to ED with her partner for admission to the trust and the necessary treatment required.

Marie Kirby and Chelsea Palmer
Healthcare Science Practitioner
York Hospital
Nominated by
A colleague

Marie and Chelsea are two fantastic individuals. The last few years of their careers have been quite challenging (first their department closing, then the pandemic), however they always go the extra mile in everything they do, nothing is ever too much trouble, and if you need volunteers you know exactly where to go first. The are always organising events to help keep peoples spirits up, a Christmas quiz, poster competitions etc., and when it comes to promoting science they throw themselves into all the task, recently organising York and Scarborough's Biomedical Science day, running competitions, putting up the stands, and engaging all our users. They are exemplary individuals dedicated to science and it is my pleasure to work with them.

Bart Chmielewski
Pharmacy Technician
York Hospital
Nominated by
Beryl Longthorp
A colleague

Shortly before pharmacy was due to close a request was received for an extensive list of medications for a patient due to be discharged. This patient would need a compliance aid and a community drug chart both of which are time consuming to prepare. Bart contacted the ward and asked for the community chart to be sent to dispensary so that it could be reviewed. On reviewing the only new items were 2 antibiotics. Bart then contacted the ward again and obtained the number for the carers who would be administering the medications. On contacting the carers Bart was able to confirm that there was enough medication at home and that the carers were happy for the patient to be supplied with the antibiotics only on an extra community chart. The result was the patients discharge was not delayed the carers were updated and a long list of medications that would have been duplicated were not supplied.

Matt Smith
Theatre Nurse
York Hospital
Nominated by
Kirsty Beckett
A patient

It is highly likely Matt sees a lot of patients in my situation but his kindness, reassurance and understanding made me feel like I was his only ever priority. Matt channelled his own experiences and used them to empathise on a level I had not experienced during my journey and in that moment, it meant the world. He listened with intent, did not rush me, was knowledgeable and calming and with me every step of the way in one of the most vulnerable moments of my life. He made sure I knew that too – before and after my surgery - which gave me the inner strength I thought I had lost. I cannot thank Matt enough for helping me through. I will never forget what he did for me and he deserves to be recognised and thanked with a Star Award because it is the difference Matt made that makes all the difference to patient lives.

Megan Rimmer **York Hospital** **Nominated by**
Staff Nurse **Maisie Hopwood**
A colleague

Megan is a brilliant nurse; she is always so kind, patient and caring towards both patients and staff. I really appreciate her help and work. Thank you Megan!

Jane Wentworth **York Hospital** **Nominated by**
Midwife **Jennie Cox**
A patient

Outstanding care and compassion during our recent hospital stay following the complicated birth of our daughter. Jane went above and beyond to make us comfortable and happy - some of the other midwives, particularly those in senior positions, could learn a lot from her excellent people skills. Compassion and genuine care goes a long way and Jane has this in abundance. She is also experienced and knowledgeable. We will always remember the kindness she showed us and be grateful for it.

Jacqueline Tang **York Hospital** **Nominated by**
Consultant **Jennie Cox**
A patient

Miss Tang has been outstanding in her care for us from diagnosing our daughter with a cleft lip and palate to supporting us through a difficult decision making process and amniocentesis. She showed so much compassion and care as well as being a skilled specialist and explained everything in a manner that helped us through the whole journey. She went above and beyond to offer her time to talk through things and even come and visit us on the postnatal ward after our daughter was born. Some people touch your lives with their kindness and will always stick in your memory because of it - Miss Tang is definitely one of those people for us and she sets a shining example for other medical professionals who could develop their people skills. We will always be grateful for having such a wonderful individual involved in our care.

Vikki Beattie **York Hospital** **Nominated by**
Staff Nurse **Nina Dunn**
A patient

Finding myself experiencing an early miscarriage, I was scared and sad. At the time I didn't know if the pregnancy would be viable or not but Vikki showed so much compassion and kindness to me. She took the time to listen to me and reassure me.

Anna Beeby
Foundation Doctor

York Hospital

Nominated by
Pin-Tsung Huang
A Colleague

Incredibly willing to help obstetric team out of hour's access to critical information regarding a mutual patient. Friendly, helpful, and lovely attitude. Thank you!

Melanie Bootland
Sister

York Hospital

Nominated by
Maria Laura Lopez
A Colleague

Melanie was my Sister when I was working in AMU during the last 2 years. She was incredible amazing as a manager, I learned a lot with her, now I have moved area, and I miss her a lot.

The Star award nomination form can be accessed through the Star Award link on the website and Staff Room.

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STAR AWARD

A MONTHLY AWARD WHICH RECOGNISES THE ACHIEVEMENTS OF STAFF AND VOLUNTEERS

NOMINATION BOOKLET

September 2021

Nominations for September 2021

Janine McFarlane
Staff Nurse

Community Setting

Nominated by
Helena Demir
A colleague

Janine is a kind and considerate individual who provides excellent patient care. Her experience of over 30 years in ICU provides a wealth of knowledge when dealing with a deteriorating patient and Janine will support both the medical and nursing team in a crisis in a calm and professional manner. Janine also uses her wealth of knowledge when working with students and is often heard explaining the rationale for drug use, side effects and whether patients need further monitoring as a result of the medication they've taken. Janine is a respectful and fair colleague but will challenge practice or attitudes she does not feel adheres to Trust values and will always advocate on behalf of the patient with integrity. Janine is a hardworking member of the team and is always willing to help her colleagues.

Emma Nield, Pete Lawrence, Lucy Oates, Arriane Coulson and Anna Love
Community Response

Community Setting

Nominated by
Laura Moss
A colleague

These staff members from York Community Response Team were seen to go above and beyond recently when a gentleman fell and became acutely unwell outside the White Cross Court building. They were all going about their normal working days and all rushed to support this gentleman in such a professional and caring way. They went above and beyond to ensure the safety of this gentleman and also ensure he felt comfortable and dignified while they waited for an ambulance to arrive. I am so proud to say I work alongside these people, not only on this occasion, but every day. I admire how they put this gentleman first, particularly in very complicated times where PPE and safe procedures out of the hospital setting can be difficult to understand and know what to do for the best.

Abi Pilot
Phlebotomist

Community Setting

Nominated by
John Hellier
A patient

I visited the Community Stadium for my blood test and knowing my phobia of having blood taken Abi took blood without me really knowing it! She did this by us talking about beach dreams and memories. The easiest blood taking I've had since 1995 when I started needing annual checks. Please give her a virtual hug from me.

Helen Wood and Annette Mitchell
Community Nurses

Community Setting

Nominated by
Sharon Hurst
A colleague

The triage sister went off sick on Saturday 26 June leaving Helen (student District Nurse) to triage to all urgent calls across 5 community hubs. Community nursing teams have approximately 3000 patients on their virtual ward and urgent calls are prioritised (triaged) and passed to community staff across York City and the Vale. Some urgent calls are from known patients but others are new referrals. The teams work tirelessly to care for patients in their own homes and do their utmost to prevent hospital admission and support early hospital discharges. On average 80 calls are passed to the triage team and addition, the triage team manage any staff absences and are a point of contact if staff have any issues or queries. There was sickness to manage on the day and patient visits had to be re-allocated to existing team members. Helen's husband had been taken into hospital and because Helen has 3 children, she opted to work from home so she could continue to lead the service. Annette a retired District Nurse was working a bank shift. Some of her visits were re-allocated to other team members to enable Annette to support Helen in her role as triage sister. Both Nurses worked closely together to ensure the needs of our patients and staff were met on the day and I would like to recognise them both. They are both conscientious, focused on patient care and putting the needs of patients and staff at the forefront of what they do. They are outstanding. Thank you!

The Phlebotomy Team **Community Stadium** **Nominated by**
Cheryl Alexander
A Relative

I have poor hearing and went to York Stadium for a blood test 20/07. There were large fans operating so I could hear almost nothing. I told the receptionist, who was amazing. She stood back and removed her mask so I could lip read. She told me what numbers were being called. It would have been very difficult without this. The phlebotomist (blond lady) did the same. I was very grateful and what would have been a very difficult experience was absolutely fine.

Kim Robinson **Scarborough Hospital** **Nominated by**
Midwife **Ross Fowler**
A relative

From the moment of the handover to Kim, she was extremely driven and determined to bring our daughter into the world promptly and safely. She was able to get Lauren who was in considerable induced pain into a position that allowed her waters to be broken, she swiftly identified that the baby had passed a stool in the waters indicating distress. It was shortly after this point when the baby's heartbeat began to drop and without Kim's quick actions in raising the alarm we would have lost our baby. Whilst I will forever be in awe and owe an indescribable amount of thanks to the team that came to our aid when the alarm was raised, Kim's care and professionalism throughout the whole experience during and after the delivery went above and beyond. Kim is a shining example of the good in this world.

Courage Young **Scarborough Hospital** **Nominated by**
Staff Nurse **Katie Brice**
A patient

I was recently admitted to Lilac Ward, and during what was a very difficult time, Courage ensured that I felt safe, supported and looked after. Being a staff member as well as a patient can be difficult, however Courage remained extremely professional throughout, and it was great to see such positivity from him. Courage ensured every procedure/step was explained to me, and made sure I felt at ease during my admission. He is a shining example of how we should live through the Trust Values, and an asset to our organisation.

Suzie Marsden Hendrick
Administrator

Scarborough Hospital

Nominated by
Maria Wilkinson
A colleague

I'd like to nominate Suzie for a Star Award because she has gone above and beyond looking after the team during the Pandemic. Suzie is an Admin Assistant within the Education Centre and she has sanitised every door handle, every keypad, every computer mouse and keyboard throughout the Centre each morning. She has done this every day with a lovely smile on her face and without complaint. I really believe Suzie's efforts have kept the whole team safe and I'd like her to know it is appreciated.

The Coronary Care Unit Team

Scarborough Hospital

Nominated by
Alison Heblich
A colleague

I would like to nominate Vicky and the CCU team, in particular to Richard Hutchinson for demonstrating outstanding trust values and for making a difference to patients and their families. On Sunday 4 July, after stunning efforts by Richard to transform CCU's patient garden, a garden party was held in honour of the NHS's 73rd birthday for the entire ward to celebrate. Careful arrangements were made to fulfil the wishes of a poorly patient to attend the party in her bed as she was not able to walk outside. The staff took pictures, which showed the patient sitting in the sunshine under a parasol with the most beautiful and happy smile on her face. The patient died the following day. My reason for this nomination is that many of us were involved in the care of this lady and were saddened by her death; however, both we and her family were able to take comfort from the fact that her last hours were not traumatic. The actions of Vicky and the team had a positive effect in such difficult circumstances. This has really demonstrated the true caring spirit and compassion of the CCU team in the care that they provide by putting patients needs first.

Phil Michulitis
Capital Planning Project Manager

Scarborough Hospital

Nominated by
Darren Ford
A colleague

Faced with a difficult issue to overcome for a visiting student I mentioned the issue to Phil in passing. Despite being clearly busy and the issue not being in Phil's remit to resolve he went out of his way to find the individuals to speak to, visiting and communicating with departments in turn and showed no sign of being deterred despite the resolution not being forthcoming. He went above and beyond and his efforts made a very real difference to the individual involved.

Jen Harford
Healthcare Assistant

Scarborough Hospital

Nominated by
Natalie Davison
A relative

My daughter attended her outpatient appointment on the children's ward unfortunately she was having a relapse in her illness and needed bloods doing. My daughter has become very scared due to previously having them done on the ward. Jen came and spent time getting to know her and reducing her anxieties. Afterwards Megan said she didn't feel a thing and would be happy for Jen to do them again. Thank you so much for helping her with this.

Dr Oweye
Locum Paediatrician

Scarborough Hospital

Nominated by
Natalie Davison
A relative

My daughter was diagnosed with nephrotic syndrome in Oct 2020 she is under the care of Dr Oweye. 3 weeks ago she had a relapse and he was quick acting and supported us and Megan and got her back on the medication. He takes the time to get to know Megan so that she is not scared and is building a therapeutic relationship with her. We appreciate all he does for Megan.

Tim Adams
Consultant

Scarborough Hospital

Nominated by
Rachael Gray
A patient

I had a C-section last Friday, as an 18 year old having my first baby I was so worried as I suffer with anxiety. I honestly feel if Tim was not there I would not have been able to go through with the C-section. Before I went in I was so nervous and he did so much to put me at ease and I ended up laughing through my c section and it is now one of my best experiences. He held my hand through the procedure and showed so much support. He made jokes and really went the extra mile without a thought. After the epidural he went over and cut a bit of string and tied it in a bow around my gown, made sure my glasses were on throughout and even moved my hair from my face whenever it moved down, and in recovery he even poked his head round to say congratulations again and overall made my experience. There were countless gestures and small things he did to put me at ease during my C-section and epidural that he really did not need to do. I will always look back on my Freddie's birth being an amazing experience and that's thanks to this man.

Alex Sharp
Care Group
Operational Manager

Trust Wide

Nominated by
A colleague

Alex has been working tirelessly behind the scenes to make the skin cancer service for our Trust as streamlined and efficient as possible. He has taken on board numerous suggestions from clinicians in the trust, across various specialties and has been able to gradually implement changes to our referral, triage, clinical and surgical practices that are beginning to show great benefits for patients and staff alike. His first question is always "will this help our patients'?" and if it will he does all he can to facilitate this within his budgetary, personnel and infrastructure restraints. People like Alex have more of an impact on patient outcomes than they are given credit for. This star award submission is to say "thank you"!

The Rota Coordinator Team **Trust Wide** **Nominated by**
Beth Carsey
A colleague

I would like to nominate the Rota Coordinator Team at Scarborough and York Hospitals for a star award for their hard work and dedication to their roles over the last 6 months. On a whole they are a relatively new team, carrying significant vacancies, whilst learning their roles and covering a never-seen-before level of work due to the pandemic. They are all excellent ambassadors for the trust and its values and deserve some recognition. Many times they will stay late and go above and beyond their duty to ensure that they have done everything in their power to provide our clinical services the medical staffing they need with many external factors working against them, their work ethic and dedication never wavers.

Andrea Ward **York Hospital** **Nominated by**
Macmillan Breast Care Specialist Nurse
Jackie Pye
A patient

All the breast care nurses are amazing but I would like to give a special thank you to Andrea. She always gives that extra attention and support, going out of her way and giving extra time out of office hours. She regularly supports me and other cancer patients on a local social media cancer support group, answering our queries and giving advice and emotional support during the evening and weekends. She has recently been my advocate when I wanted further surgery and was able to help this happen sooner as I was really struggling with mental ill health. Andrea really is what nursing is all about; she puts patients first, is kind, considerate, empathetic, and professional and is always there when needed.

Christy Davidson
Chief Audiologist

York Hospital

Nominated by
Steve Mitchell
A patient
Sam Gaunt
A patient

Steve said:
Praise where praise is due, As a result of my second appointment within Audiology, I was again seen by Christy, to experience such care, detailed attention and professionalism upon my first visit was great. To be treated with equal care for the second time demonstrates consistency, care and commitment. Christy's devotion in patient care is so obvious and evident in her professionalism and clear knowledge in treatment and services for her patients. This commitment instils great faith for me as a patient and should also be recognised and rewarded. In my opinion Christy is an asset to the NHS as an employee. York Hospital should recognise what a Star she is. I would like to recommend Christy; she is a real star and works above and beyond.

Sam said:
Christy is the first Audiologist I have met who gave me a sense of hope with my situation (tinnitus). She took the time to explain my situation, the possibilities behind it and the current thinking around it as well as ways it might be managed - the different methods and ways certain devices work, as well as looking at the hearing aid I'd been given by a different NHS trust and explaining why that probably wasn't the best fit. She took the time to answer all my questions in a knowledgeable and empathetic way, with a level of detail and expertise I haven't experienced anywhere else. She gave me information that I could take to the next NHS trust I am moving to (since I'm moving from York), suggested other trusts I could look at if the one I am moving to cannot provide the treatment I need and mentioned about the possibility of remote care further in the future. I entered being pessimistic due to previous care I had received and left feeling more hopeful. My only regret is that in moving house I'll be out of Christy's remit, which is such a shame!

Alexandra Clark and Helen Stead
Principal Operating Department Practitioner and Operating Department Practitioner

York Hospital

Nominated by
Duncan Fryer
A colleague

A few weeks ago I was really homesick for my native New Zealand, for me this is pretty rare however on this particular day it hit me very hard especially as it is pretty hard to travel home for visits at the moment. On the 30th June I arrived in the theatre complex to begin my night shift only to find that Both Helen and Alex had decked out my office in New Zealand flags, baked cakes, provided lots of Kiwi sweets and treats and even included a couple of stuffed sheep, pictures of the All Blacks and a lovely card stating how much I mean to the department. To say I was gob-smacked is a complete understatement, it was such a lovely thing to do, a real act of random kindness that I will always cherish and hold dear. I would like to nominate Alex and Helen for this because I feel like this action really did show how much they care, not just for their colleagues but for the happiness and morale of the entire department.

Gemma Robinson
Staff Nurse

York Hospital

Nominated by
Daniel Palmer
A colleague

Gemma works very hard, always gives 100%, willing to help others despite her workload, eagerness and enthusiasm to learn and develop herself, fantastic mentor to students, positive attitude. Gemma has an ability to take her team through a bad shift and come out smiling with everyone feeling supported at the end.

Rodi Demaisip
Associate Practitioner

York Hospital

Nominated by
Daniel Palmer
A colleague

I would like to nominate Rodi for perseverance in her studies and her ever optimism on the ward. She brings morale up and works tirelessly to help her colleagues. An incredibly hard worker who always has a smile even on the hardest days.

The Team on AMU **York Hospital** **Nominated by**
Lizzie Kennedy
A patient

I would like to nominate all the Team who looked after me on Wednesday and Thursday this week. I was admitted on Wednesday night. I didn't know I was so ill. I was cared for by some gorgeous kind nurses and doctors through the night. I'm so sorry that I don't know their names. They were just amazing. I have a feeling that the treatment they gave me was more important than I currently realise. I would also like to praise all who worked and helped me on Thursday. The whole team were wonderful. Finally, Elle, she is a gem. She is so lovely; she kept me calm, helped me so much and should be treasured. She got me through the day. You are all wonderful and I don't know how you stay calm.

Ian Fowler **York Hospital** **Nominated by**
Charge Nurse **Colleagues**

Ian is an amazing boss. He makes sure that all staff are ok after a death- shown most recently when a young lady who we knew very well died. He made time for anyone and everyone but never mentioned how he was. He supports any new staff and all trainee nurses. He makes coming to work on the ward fun, which by the very nature of this ward, is sometimes difficult to do. Ian ensures he knows all the patients and family members and has a laugh and joke with them all, but when dealing with a bereaved family is so sympathetic and a shoulder to cry on - that is admirable in this day and age. He doesn't expect anyone to do anything that he wouldn't do himself, except the Costa run on a Friday! He truly embodies what a Star award should be used for.

Pam Sear **York Hospital** **Kyle Nicholson**
Midwife **A Patient**

Today, Pam went above and beyond her duties of care and ensured me and my partner (who was being induced in labour) had the most special delivery possible. She was there from start to finish, including staying later than her finish time. She treated us with respect, dignity, care, and with truly open hands and kindness. Pam delivered my baby boy, and ensured my partners wishes were met whilst in labour, reassuring her at every single contraction for 8 hours straight, only stopping once to have a cup of coffee. The whole tram deserves a well done ideally, but Pam in general was amazing.

The Teams in Eye Clinic and Eye Theatre | **York Hospital** | **Nominated by Rory King A patient**

I was referred as an emergency to York Eye clinic at 5pm by my optician on Mon 21 June for a possible tear in my retina I was seen again on Tuesday and then operated on, on Wednesday 23 June for what I understand to be a detached retina. This itself was an amazing service however, for the past 11 years I have suffered terribly with panic and anxiety and of course this has been more extreme due to Covid 19. Being a 6ft 2" large frame male, suffering like this can often be misunderstood. Your team in the Eye Clinic were truly, truly exceptional!!! To say I was frightened is an understatement but this wonderful team took me by the hand literally and helped me through the treatment and left me feeling in awe of them all. The consultant was Izabela Mitrut who was amazing, the nurse who originally took my blood pressure, and made me feel so comfortable was a Nurse Called Deborah, but for me the icing on the cake was Nurse Holt, the theatre nurse. Without her I'm not sure I could have endured the process, she went above and beyond any service you would normally expect from a clinic. She literally held my hand through the whole procedure, explaining what the noises were and what was happening without being too specific. I would also like to nominate a male nurse who was around in the eye clinic on the days I was there I didn't get his name but he was bald and was friendly beyond words. I would like to nominate the whole team for a star award. In these times when I'm sure they are all pushed to the limits, and working to catch up with many appointments that were delayed due to Covid they can still show the care, compassion and love that only our NHS could ever show! Thankyou just isn't a big enough word. Take it easy and stay safe you wonderful bunch.

The Security Team **York Hospital** **Nominated by**
25/03/21 – 2/03/21 **Daniel Botwright**
A relative

My brother was in York A&E during a psychotic episode and required security to sit with him (and me) throughout the day, night and morning - whilst the crisis team arrived. From 3pm until 8am the next day we were confined to a room with 2 security guards making sure he was not causing any bother. Throughout the entire stay, the care, patience and understanding of those security guards was absolutely second to none. They could tell my brother was not an ordinarily violent character and was just someone going through a challenging episode and treated him accordingly – being hands-off unless absolutely necessary and really trying to talk to him/us to try and calm him down and reassure him. During my stint we were sat with Ian and Adam and before that I am unsure of the 2 guys' names. The room was hot and stuffy but they sat there for nearly 12 hours straight and showed professionalism yet good humour throughout. I cannot express how amazing they were and really hope they can be recognised for their work that night – they helped make a stressful situation a whole lot better than it could have been, by their manner and kindness. Although my brother probably doesn't remember much from that night, I certainly do and Ian and Adam (plus the others on the earlier shift) really, really helped. I cannot thank them enough.

Martina Flaugnatt **York Hospital** **Nominated by**
Healthcare Assistant **Zoe Dunning**
A colleague

Martina is a pleasure to be around, she is such a hard worker, dedicated and is amazing with patients. No matter how busy she is she always takes the time to ask you how you are and is always smiling. She is a credit to the ophthalmology department and deserves to be recognised for all she does.

Stephen Szabo **York Hospital** **Nominated by**
Inpatient Services **Gail Bentley**
Officer **A colleague**

Stephen is a member of the Waiting List Team and covers evening shifts through to 8pm. He often makes contact with patients who could not be contacted during the day. His night calls can make a big difference to theatre lists being filled at the last moment or for patients getting information that they would not get in time by letter/day contact, Ever helpful in attitude and he has a very high patient care ethos for those coming into direct contact with him at reception.

Megan Harvey **York Hospital** **Nominated by**
Deputy Sister **Ian Fowler**
A colleague

At the height of the pandemic Ward 35 became a Covid ward. Staff were brought from all over the trust to staff it. All these staff had different working hours, flexible working patterns and specific requirements. Staff were attending the ward not knowing what shifts they were working the following week. Meg was responsible for the roster on Ward 31 but had gone on maternity leave. I asked her if she could help organize a roster for the ward and she said yes without hesitation. She managed to sort the roster which enabled optimized care for the Covid patients. She was inundated with telephone calls from staff at home but she always allowed the time and patience to deal with their concerns and requests. Without Meg Ward 35 would have been in real trouble. Thank you Meg.

Olivia Polkinhorne
Deputy Sister

York Hospital

Nominated by
Katherine Johnson
A relative

Olivia was assigned as my sons 1:1 nurse whilst he was in ICU. My son who is 13 years old suffered an eruption of the appendix. He was seriously ill. I felt helpless when my son needed help the most. I was scared, frightened, and unsure if he would survive. The next morning I received a phone call from a friendly lady, Olivia inviting me to ICU so I could be reunited with my child. Her calming, reassuring manner made me trust her instantly. Olivia has shown us so much kindness from a sweet tea to a reassuring chat! Her professional conduct and thorough care I have no doubt has contributed to saving my son's life. Constantly watching him, providing medication, bathing him, brushing his teeth all the small bits of care that don't need to be done, but would make him feel more comfortable, she did without hesitation. All whilst accurately recording notes, liaising with other staff members across departments. Olivia was on a 13 hour shift and was at his side the whole time only leaving us for breaks. We will never forget her kindness to us, her smiling eyes and nods of reassurance when things were not great. A true angel and definitely a life saver. Please consider a Star for her as she truly is one.

The Team in Emergency Department

York Hospital

Nominated by
Kathy Cook
A patient

I was rushed to A&E today (8th July 2021) and don't remember the first part, but when I came round the staff were all brilliant so thank you everyone, and the doctor called Will who held my hand and explained everything, so thank you all.

Katie Coulson
Physician Associate

York Hospital

Nominated by
Matthew Hirst
A colleague

Katie has been incredibly helpful these past few days when ward 26 has gotten extremely busy. Katie could see that we were under pressure and without hesitation got stuck in with feeding patients who couldn't feed themselves as well as reassuring patients who were distressed and helping with cleaning and moving patients. She really helped relieve pressure from the rest of the team which let us get back on track for the rest of the shift. She is always there if we need her and she is a great asset to trauma and orthopaedics.

Jasper Roos and Team 7/7/21
Consultant

York Hospital

Nominated by
Katherine Johnson
A relative

Please recognise this amazing man. He saved my beautiful boys life and saying thank you just isn't enough. Working through the night with his team, through what sounds like a horrendous operation to getting him into ICU he didn't stop working hard to save him. As I write this my boy is still very sick, however Mr Roos has been multiple times to see him. He checks everything thoroughly and counsels me too! When I say thank you to him he replies that it's his job...I know technically he is right, but what he did is more than a job. He has given my son his childhood back and I hopefully can watch him grow into a wonderful young man. If Mr Roos hadn't acted the way he did in a time critical situation then...well to be honest I can't write the reality as it's too scary. Please thank him from Henry and I. We will never ever forget him.

Paul Barton
Staff Nurse

York Hospital

Nominated by
Lauren Foster
A colleague

I would like to nominate Paul, for being such a special credit to Ward 34. It would give me great pleasure in seeing him receive a star award. He's such an amazing colleague, kind natured, constantly offering support and help throughout the wards. Paul always gives a high standard of care to the patients, keeping positive attitude daily. Thank you Paul for everything you do!

Rachael Duffy **York Hospital** **Nominated by**
Clerical Officer **Peter Hallam**
A patient

When I was in the x-ray department on Thursday 9th July, I was very impressed by the calm and professional way that Rachel dealt with a patient who turned up for an X-ray, but who had received a notification from NHS that she should be isolating at home following Covid contact. She calmly advised the patient that she should have stayed at home to isolate, when the patient argued that she felt it was more important to her to have the X-ray, she took her off to a quiet area to allow for a conversation to take place, which would appear to have been done to reduce the risk to and concerns of other patients.

The Team on Ward 28 **York Hospital** **Nominated by**
Kirsty Walsh
A relative & Colleague

I would like to nominate the team on ward 28 for the fabulous care they gave my grandma, Freda Rushton in her last days on your ward. She was palliated and moved from Ward 23 to 28 during the middle of June. The staff on the ward were exceptionally caring and compassionate and cared for her so well in her last days. Thank you from all her family.

Katie Wiggins **York Hospital** **Nominated by**
Clerical Officer **A Colleague**

Katie has throughout the pandemic worked above and beyond making sure that maternity notes are there for Ante Natal clinics/Day unit, Audits and other anomalies needed by midwifes, ward clerks, office staff and other departments throughout the trust. This is at times a very stressful job and can go unnoticed by many but nothing is ever too much trouble for Katie, as long as there's a bag of peanuts to nibble on at her desk she's happy. During Covid there were low staffing levels as colleagues were shielding and unfortunate sickness due to the pandemic, Katie was and still is the backbone of maternity records and I feel her meticulous working practices are what has and still is what keeps the department going. Don't ever leave!!! Katie most definitely deserves a star.

Gemma Spriggs **York Hospital** **Nominated by**
Locum Doctor **Zoe Scott**
A Colleague

Gemma has been a great support to the recovery trial whilst she has been working on 25. She is always really helpful and approachable. She has helped consent and randomise lots of patients in to the trial, which is looking at treatments for patients hospitalised with Covid. We really appreciate the support she gives whilst also being extremely busy on the ward and will miss her when she rotates into her new job. Thank you Gemma.

Deborah Coll **York Hospital** **Nominated by**
Domestic **Kylie Theaker**
A Colleague

Debbie is an extremely hard worker, she always goes the extra mile to make sure our hospital is clean and safe for our community. Debbie gives every job 100% and has worked so hard throughout the pandemic picking up extra hours every shift and walking home alone in the early hours of the morning. Debbie is a pleasure to work with and will help out whenever she can. Thanks for being a great colleague Deb.

Hannah Wheatley **York Hospital** **Nominated by**
Domestic **Kylie Theaker**
A Colleague

Hannah has been working for weeks doing extra hours at the new Stadium keeping the area clean, showing round different staff members and training them on the job up there. Not only this, Hannah has been picking up staff members to take them to the stadium to work and dropping them off using her own vehicle, Hannah has also been picking up stores from the main hospital and bringing them to the stadium so that the domestics are able to carry out their role properly - none of this is in Hannah's job title but she has continued to do it all for weeks without any recognition from her superiors as the department are struggling to staff the stadium- Well done Hannah, you're an example to us all, you deserve a great big Thank you and well done!

Clare Page
Discharge Liaison Sister

York Hospital

Nominated by
Amber Thompson
A Colleague

Clare provided amazing care and support when we were trying to get a lady home from hospital for end of life care. The patient was being cared for on the Critical Care Unit, but wanted to be at home for her final days of life. We had minimal experience of fast track discharges but Clare made sure that everything was in place, chased up delays and kept us all in the loop, before she went off shift Clare made sure we had everything we needed and knew what needed to be done to ensure the patient would receive the out of hospital care she required. Clare stayed late to help reposition the patient before the transport was due to arrive and put last minute calls in to all the relevant agencies to ensure this lady would be able to be supported at home. Clare provided support to the patient, her family and the unit staff to ensure that this lady got her final wish. Thank you Clare!

The Star award nomination form can be accessed through the Star Award link on the website and Staff Room.

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