Board of Directors (Public) – Blue Box

30 March 2022

Agenda Item	ITEM	PAGE
10.	**Ockenden Report Update** To receive the report to include Perinatal Clinical Quality Surveillance Report and Continuity of Carer Report.	
10.1	Ockenden Action Plan	03
11.	**CQC Update** To receive the report:	
11.1	• January Appendix A	13
11.2	• March Appendix A	23
15.	Full Integrated Business Report	101
19.1	Executive Committee minutes for 2 March	165
19.2	Star Award Nominations – April	183

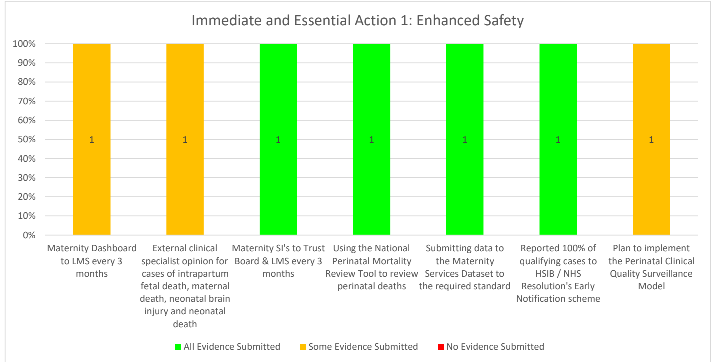
Appendix 1

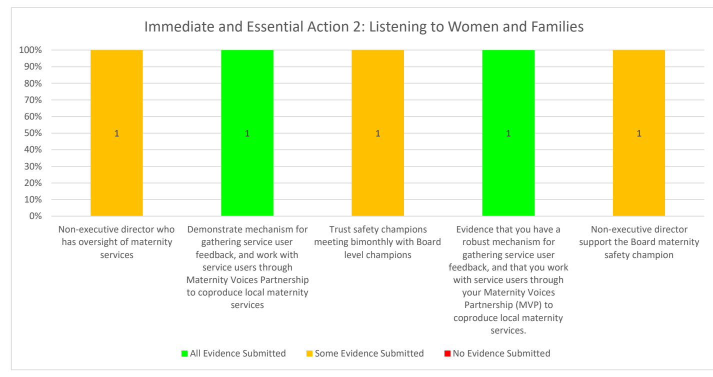
Question Number	Category	Question Number	All Evidence Submitted	Some Evidence Submitted	No Evidence Submitted	December 2021 action plans	leads & timeframe	January 2022 progress	February 2022 progress	March 1 2022 progress
IEA1	Q1	Maternity Dashboard to LMS every 3 months		1		confirm dashboards are submitted to LMS - ?paper required	Q&G team - ongoing oversight	MEETING NOT MDT QUORATE AND DID NOT GO AHEAD	Evidenced via PQSAG report and discussed bi-monthly with LMS	no update today
IEA1	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death		1		Audit to demonstrate this takes place - to audit the year (2021). Policy or SOP which is in place for involving external clinical specialists in reviews.	JF - March 2022		Reported via PQSAG, cases discussed as an LMS, minuted by LMS. Audit underway	no update today
IEA1	Q3	Maternity SI's to Trust Board & LMS every 3 months	1							
IEA1	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	1							
IEA1	Q5	Submitting data to the Maternity Services Dataset to the required standard	1							
IEA1	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	1							
IEA1	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model		1		Full evidence of full implementation of the perinatal surveillance framework by June 2022.LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	SCH - June 2022		ML liaising with LMS PMO - awaiting update from ICS for March meeting	No iupdate today,
IEA2	Q11	Non-executive director who has oversight of maternity services		1		NED JD required to be maternity specific	TR to obtain JD and liaise with SG, action to be picked up by LB - March 2022		JD obtained, maternity specific role updating in progress	Awaiting update from TR
IEA2	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	1							
IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions		1		SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	ML - to add into doc re.SOP. March 2022 (?TOR for SafCh)		ML has completed role descriptor information. TOR for Safety Champions meetings underway,	TOR done, for agreement at SCH 8 Mar 22
IEA2	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	1			One matron linked to each MVP (once new one into post), to collate evidence	SCH - March 2022		DS and AM aware they need to obtain evidence of co-production. There is challenge around this as 2 of the 3 MVPs are not fully functioning. AM and DS to liase with regional lead for supporting evidence LMS wide and update at next meeting	DS to contact RP at LMS to understand how they can regionally support. Evidence of co production and how we can obtain detail around women feeling involved in their care choices
IEA2	Q16	Non-executive director support the Board maternity safety champion		1		Role descriptors - NED JD	(as above) TR to obtain JD and liaise with SG, action to be picked up by LB - March 2022		as above, Q11	
IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	SCH to forward figures to JF who will escalate and support medical staff with training- January 2022		TNA in place. Trajectories in progress for the next 6 months. Challenges continue around training all staff who have fallen out of date quickly while maintaining requirements of MDT across the training period	All staff expevced to be up to date by June 2022. Monthly oversight meetings in place with training teams

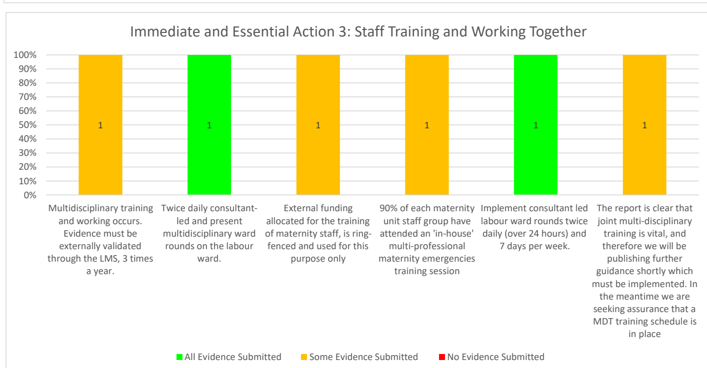
IEA3	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	1			Observe audits cross-site and speak with LM managers	ML - audits to chase and paper requested		Audits completed on new assurance proforma for January. ML has contacted the areas to request increased assurance. To update at next meeting and escalate via PCQS	Assurance required - CD working with MDT leads to ensure attendance.
IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only		1		Confirmation from Directors of Finance. Evidence from Budget statements.Evidence that additional external funding has been spent on funding including staff can attend training in work time.MTP spend reports to LMS	SCH March 2022		Reported spends to LMS upon request, LMS developing annual timetable for financial reporting and will share once completed. Ringfenced budget evidence received	No further update
IEA3	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA. Attendance records - summarised	Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance		TNA in place for 3 years. Training data is collected monthly and escaalted via the PCQS. Trajectories in progress, for update at next meeting	All staff expevced to be up to date by June 2022. Monthly oversight meetings in place with training teams
IEA3	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	1							
IEA3	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	(as above) Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance		TNA in place for 3 years. Training data is collected monthly and escaalted via the PCQS. Trajectories in progress, for update at next meeting	Awwaiting trajectories.
IEA4	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre			1	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians. SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	LF - March 2022		LF, MMN named consultant, updated the group that a pathway has been developed and will be published once finally agreed. Working group progressing at pace. SOP to be developed	gathering information from triage attendance cross-site to try and determine how many women attend that will benefit from the new pathway. No update from region
IEA4	Q25	Women with complex pregnancies must have a named consultant lead		1		SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	DS to undertake audit for compliance - March 2022		DS to undertake audit and update March 2022	100% of notes identified as intermediate or high risk is reviewed. Audit to be presented next meeting
IEA4	Q26	Complex pregnancies have early specialist involvement and management plans agreed			1	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	LF- March 2022		100% of notes identified as intermediate or high risk is reviewed. Audit to be presented next month (JH)	100% of notes identified as intermediate or high risk are reviewed. Audit of women attending ANC (diabetic etc) to be presented next meeting . DS updating AN appts guideline with SOP. JH to undertake reptrospective audit, update at next meeting
IEA4	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	1			evidence of Co monitoring at 36/40. audits and action planning	DS and JH - Feb 2022			
IEA4	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.		1		SOP that states women with complex pregnancies must have a named consultant lead.	DS to undertake audit for compliance - March 2022		Audit to be presented next month	DS updating AN guideline, to add in.

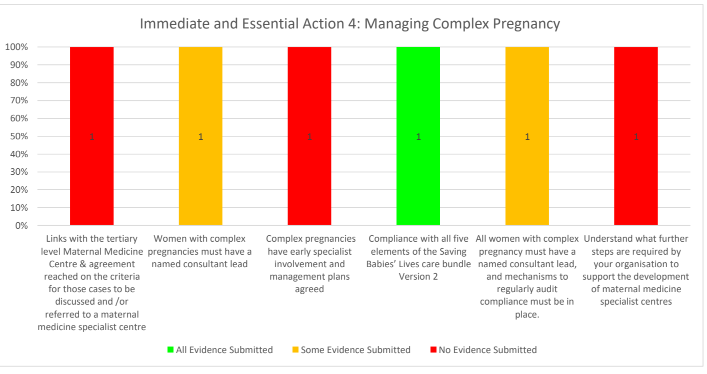
IEA4	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres			1	Agreed pathways. Criteria for referrals to MMC. The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	LF - April 2022		LF, MMN named consultant, updated the group that a pathway has been developed and will be published once finally agreed. Working group progressing at pace. SOP to be developed	no update today
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional		1		Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. SOP that includes definition of antenatal risk assessment as per NICE guidance.	HN and DS -March 2022		>90% notes are reviewed every month to ensure compliance with care planning. Monthly audit is escalated via PCQS from January 2022. SOP to be developed by JH and DS	SOP developed.
IEA5	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.		1		Evidence of referral to birth options clinics. Out with guidance pathway.Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	HN and DS -March 2022		>90% notes are reviewed every month to ensure compliance with care planning. Monthly audit is escalated via PCQS from January 2022. SOP to be developed by JH and DS	SOP developed. Audits ongoing, for escalation via PCQS
IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.		1		Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	HN and DS -March 2022		>90% notes are reviewed every month to ensure compliance with care planning. Monthly audit is escalated via PCQS from January 2022. SOP to be developed by JH and DS	SOP developed. Audits ongoing, for escalation via PCQS
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring		1		Copies of rotas / off duties to demonstrate they are given dedicated time. Incident investigations and reviews	JF to send to ML JD and job plan for medical leads - February 2022		Awaiting job plans to evidence this action. JF to update next meeting	no update today
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health		1		Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision. Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	BA and JF - March 2022		Evidence required around clinical supervision and Medical staffing JD. To progress and update next month	Obstetric leads need to be involved in training. BA to identify lead at SGH and to support York to include in training - to liaise with RMc
IEA6	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	1			evidence of Co monitoring at 36/40. audits and action planning	(as above)ML - audits to chase and paper requested			
IEA6	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA.Attendance records - summarised	Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance		TNA in place for 3 years. Training data is collected monthly and escaalted via the PCQS. Trajectories in progress, for update at next meeting	as above
IEA7	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	1			Website requires updating	ML to support JH to work with MVP once fully in post - March 2022			

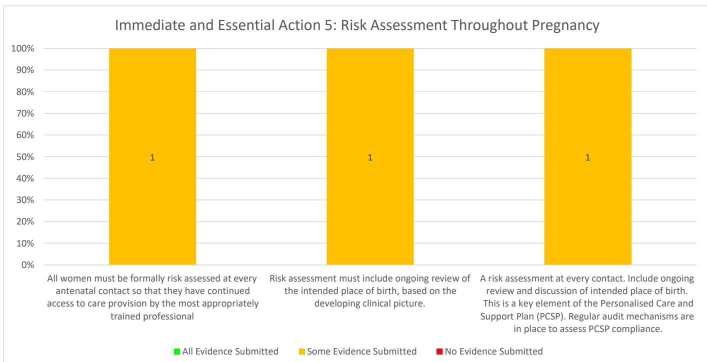
IEA7	Q41	Women must be enabled to participate equally in all decision-making processes			1	An audit of 1% of notes demonstrating compliance.CQC survey and associated action plans. SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	SCH to support action planning between matron (DS) and obstetrician (JF) - March 2022 (see below)		Discussed at length as challenges around identifying complex women via the system. JH will undertake a baseline audit and present next month	Audit underway - JH working with MB to support information gathering
IEA7	Q42	Women's choices following a shared and informed decision-making process must be respected			1	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	SCH to look at CQC survey with matrons and support action planning between matron (DS) and obstetrician (JF). Audit and SOP to include 41 and 42 - April 2022		Discussed at length as challenges around identifying complex women via the system. JH will work with MB to try and obtain these specific notes and undertake a baseline audit and present next month. Action planning to include liaising with LW leads around highlighting women to review	Audit underway - JH working with MB to support information gathering and will develop a SOP
IEA7	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	1							
IEA7	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.		1		Co-produced action plan to address gaps identified. Gap analysis of website against Chelsea & Westminster conducted by the MVP	ML to support JH to work with MVP once in post - March 2022		Website requires significant update, JH liaising with comms. Agreement required aournd the publication of all guidance	JH has met with comms team to update website, new member of staff to support from April. Benchamrking ongoing against C&W hospital. Review of guidelines to be linked on. Different formats, links.
WF	Q45	Demonstrate an effective system of clinical workforce planning to the required standard		1		Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	BA - March 2022		Paper under development, BA to update at next meeting	BA to meet with ML to progress this for next month
WF	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	1			Workforce paper underway. CoC paper to Board in January	SCH - January 2022		workforce paper to Exec committee, Board and LMS January 2022	
WF	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	1							
WF	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:			1	Action plan where manifesto is not met. Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	SCH - March 2022		GAP analysis completed and presented to exec committee and Board January 2022. Action planning involves the production of a business case	No further update
WF	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.			1	Audit to demonstrate all guidelines are in date.Evidence of risk assessment where guidance is not implemented. SOP in place for all guidelines with a demonstrable process for ongoing review.	Q&G team - March 2022		NICE baseline assessments and guidance monitored by Q& G team and escalated via clinical governance. For update at next meeting	No further update

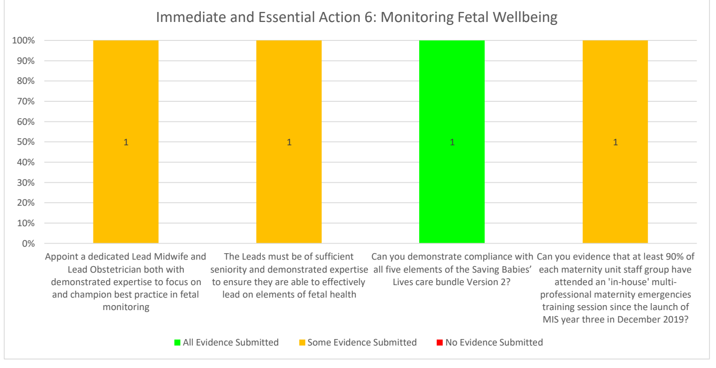

Immediate and Essential Action 1: Enhanced Safety
Maternity Dashboard to LMS every 3 months
External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death
Maternity SI's to Trust Board & LMS every 3 months
Using the National Perinatal Mortality Review Tool to review perinatal deaths
Submitting data to the Maternity Services Dataset to the required standard
Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme
Plan to implement the Perinatal Clinical Quality Surveillance Model
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted

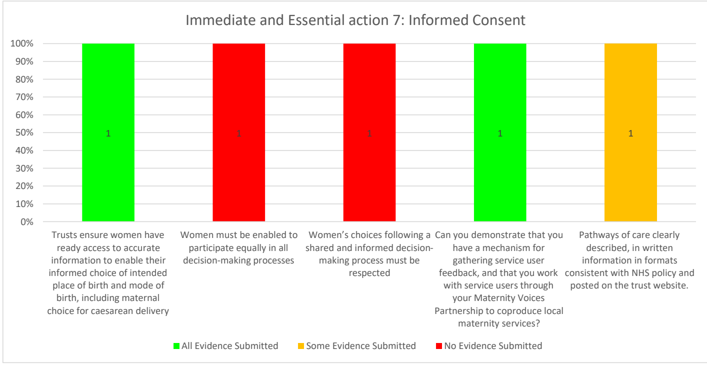

Immediate and Essential Action 2: Listening to Women and Families
Non-executive director who has oversight of maternity services
Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services
Trust safety champions meeting bimonthly with Board level champions
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
Non-executive director support the Board maternity safety champion
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted

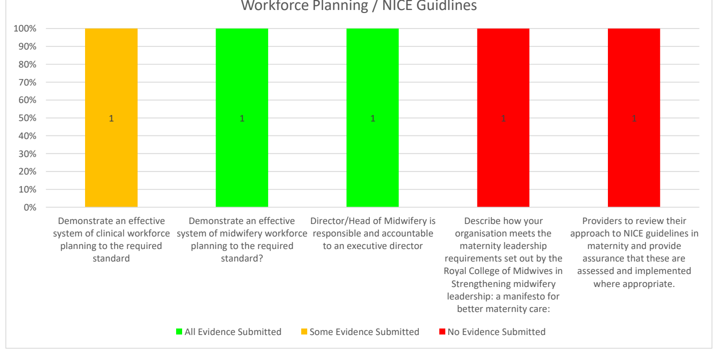

Immediate and Essential Action 3: Staff Training and Working Together
Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.
Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.
External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 4: Managing Complex Pregnancy
Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre
Women with complex pregnancies must have a named consultant lead
Complex pregnancies have early specialist involvement and management plans agreed
Compliance with all five elements of the Saving Babies' Lives care bundle Version 2
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy
All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.
A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 6: Monitoring Fetal Wellbeing
Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health
Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential action 7: Informed Consent
Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery
Women must be enabled to participate equally in all decision-making processes
Women's choices following a shared and informed decision-making process must be respected
Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Workforce Planning / NICE Guidlines
Demonstrate an effective system of clinical workforce planning to the required standard
Demonstrate an effective system of midwifery workforce planning to the required standard?
Director/Head of Midwifery is responsible and accountable to an executive director
Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:
Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted

Reuslts of Phase 2 Audit **York and Scarborough Teaching Hospitals NHS Foundation Trust**

IEA	Question	Action	Evidence Required	York and Scarborough Teaching Hospitals NHS Foundation Trust
IEA1	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	100%
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%
			Submission of minutes and organogram, that shows how this takes place.	0%
		Maternity Dashboard to LMS every 3 months Total		75%
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	0%
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		50%
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%
			Submit SOP	100%
		Maternity SI's to Trust Board & LMS every 3 months Total		100%
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		100%
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%
		Submitting data to the Maternity Services Dataset to the required standard Total		100%
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		100%
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	0%
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	0%
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		33%
IEA1 Total				75%
IEA2	Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	0%
			Evidence of link in to MVP; any other mechanisms	100%
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%
			Name of NED and date of appointment	100%
			NED JD	0%
		Non-executive director who has oversight of maternity services Total		67%
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		100%
	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	100%
			Log of attendees and core membership.	100%
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	0%
		Trust safety champions meeting bimonthly with Board level champions Total		75%
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		100%
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	100%
			Name of ED and date of appointment	100%
			Role descriptors	0%
		Non-executive director support the Board maternity safety champion Total		67%
IEA2 Total				76%

IEA3				
	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	0%
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		60%
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%
			SOP created for consultant led ward rounds.	100%
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		100%
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	0%
			Evidence from Budget statements.	0%
			Evidence of funding received and spent.	100%
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	0%
			MTP spend reports to LMS	0%
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		20%
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%
			Attendance records - summarised	0%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		33%
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		100%
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		50%
IEA3 Total				50%
IEA4				
	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	0%
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	0%
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		0%
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	0%
		Women with complex pregnancies must have a named consultant lead Total		50%
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	0%
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	0%
		Complex pregnancies have early specialist involvement and management plans agreed Total		0%
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%
			Guidelines with evidence for each pathway	100%
			SOP's	100%
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		100%
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	0%
			Submission of an audit plan to regularly audit compliance	100%

		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		50%
	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	0%
			Criteria for referrals to MMC	0%
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	0%
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		0%
IEA4 Total				36%
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	0%
			Review and discussed and documented intended place of birth at every visit.	100%
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	0%
			What is being risk assessed.	100%
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		60%
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	0%
			Out with guidance pathway.	0%
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	0%
			SOP that includes review of intended place of birth.	100%
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		25%
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%
			How this is achieved in the organisation	100%
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	0%
			Review and discussed and documented intended place of birth at every visit.	100%
			SOP to describe risk assessment being undertaken at every contact.	100%
			What is being risk assessed.	100%
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		83%
IEA5 Total				60%
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	0%
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%
			Incident investigations and reviews	0%
			Name of dedicated Lead Midwife and Lead Obstetrician	100%
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		50%
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	0%
			Improving the practice & raising the profile of fetal wellbeing monitoring	100%
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	0%
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%
			Keeping abreast of developments in the field	100%
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	0%
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	100%
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		63%
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%
			Guidelines with evidence for each pathway	100%
			SOP's	100%
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		100%
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%
			Attendance records - summarised	0%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%

Section	Q	Question	Evidence	Score
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		33%
IEA6 Total				61%
IEA7				
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		100%
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	0%
			CQC survey and associated action plans	0%
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	0%
		Women must be enabled to participate equally in all decision-making processes Total		0%
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	0%
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	0%
		Women's choices following a shared and informed decision-making process must be respected Total		0%
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		100%
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	0%
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	0%
			Information on maternal choice including choice for caesarean delivery.	100%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		50%
IEA7 Total				50%
WF	**Q45**	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	0%
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%
			Most recent BR+ report and board minutes agreeing to fund.	100%
		Demonstrate an effective system of clinical workforce planning to the required standard Total		67%
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		100%
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%
		Director/Head of Midwifery is responsible and accountable to an executive director Total		100%
	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	0%
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	0%
		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		0%
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	0%
			Evidence of risk assessment where guidance is not implemented.	0%
			SOP in place for all guidelines with a demonstrable process for ongoing review.	0%
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		0%
WF Total				40%

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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

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-1.4	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	Medical Director	Nov-20	October 2021: Medical Director engaging in conversations to promote the identifcation of an appropriate solution		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

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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
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	October 2021: Document to QPAS for approval in November.	Nov-21	Delivered
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 substantive 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

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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	September 2021: Head of Compliance has met with the Associate Chief Nurse (Corporate) to discuss next steps. An improvement plan will be developed with stakeholder involvement and sign off. Plan to be ready for implementation from November 2021 with clear governance pathways mapped throughout. Upon approval of the improvement plan, it is proposed that this action is closed and monitored through the identified governance route		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
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	Utilise 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

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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
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 ward	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

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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	August 2021: National project - Trust up to date with requirements. Starting testing phase this month, due for completion in October 2021. Timescales out of control of Organsiation - National NHSBA project. Project Board presentation details stored in evidence folder. Jun-21: Following QRG completion date extended in line with national work-stream.	Nov-21	Delivered
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
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

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccommendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
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
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	Privacy screens ordered. Confirmation from Deputy Care Group Manager on 19/08/2021	Aug-21	Delivered
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	Auto-lock functionality currently at 15 minutes across the Trust.	Jul-21	Delivered
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

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21 January 2022

CQC Insight for Acute NHS Trusts

York and Scarborough Teaching Hospitals NHS Foundation Trust

For any content or access queries please email: acute.insight@cqc.org.uk

What was new in the January 2022 release of CQC Insight for Acute NHS Trusts … (Insight is updated daily for internal CQC users)

Facts and figures

Refreshed data streams:

HES activity figures
Workforce statistics
SOF has not been updated, but trusts receiving mandated intensive support as part of the Recovery Support Programme are indicated on page 4

Featured data sources

Pages refreshed since the November 2021 release to trusts:

Featured data sources refreshed: A&E Waiting times, Incidents and Mortality

Outliers featured data source page has been removed: Due to Covid-19 pressures and recovery from them, the identification and publication of new outliers for maternity and mortality was suspended in March 2020. Following review of the ways in which Covid-19 has impacted on hospital mortality data and the usefulness of mortality outlier alerts, alongside other factors, there are no plans for this programme to resume for the foreseeable future. Imperial College also no longer generates mortality alerts. Any outstanding mortality outliers that were flagged by this programme are now two years old or more and have therefore been removed from the CQC Insight report. Maternity outliers will continue to be reported in the Maternity indicators page, but there are no plans to generate new outliers as the programme remains suspended.

Trust and core service analysis

Refreshed data streams:

Trust	STEIS Never Events, CAS, Whistleblowing, NRLS, Complaints, GMC Enhanced Monitoring, HSMR, SHMI, ESR
A&E	STEIS Never Events, A&E Quality, A&E Sitreps, Ambulance turnaround times
Medicine	STEIS Never Events, RTT, in-hospital mortality and readmissions for CCS groups
Surgery	STEIS Never Events, RTT
Critical Care	STEIS Never Events
Maternity	STEIS Never Events, Ratio of senior midwives to midwives
CYP	STEIS Never Events
End of Life	No refreshed data streams
Outpatients	STEIS Never Events, RTT, HES DNAs, Diagnostic waiting times

Notes

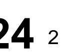
Next date for sharing: before the end of March 2022

As previously communicated to providers, we will continue to share Acute Insight reports with NHS providers every two months during the COVID-19 crisis and recovery period.

Similarly, analysts and inspection teams will continue to take the effects of Covid-19 into account when considering trust data. Publication of some data collections continues to be suspended, but we will recommence refreshes as soon as we can

Unfortunately (as in November), we have not been able to include the indicator DQMI_A02 in this refresh. It will be restored for all users as soon as possible.

Version 1.28 of the methodology and indicator guidance contains the specifications of indicators used in this release of CQC Insight for acute NHS trusts.



York and Scarborough Teaching Hospitals NHS Foundation Trust
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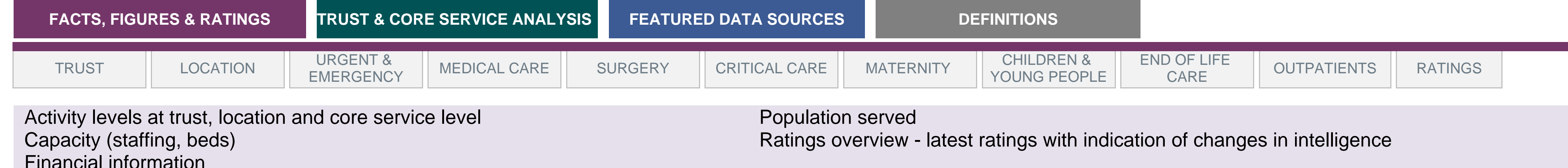
Facts, figures and ratings



Activity levels at trust, location and core service level
Capacity (staffing, beds)
Financial information
Population served
Ratings overview - latest ratings with indication of changes in intelligence

Trust and core service analysis

FACTS, FIGURES & RATINGS | TRUST & CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

OVERVIEW | TRUST WIDE | URGENT & EMERGENCY | MEDICAL CARE | SURGERY | CRITICAL CARE | MATERNITY | CHILDREN & YOUNG PEOPLE | END OF LIFE CARE | OUTPATIENTS

Intelligence overview of key messages
Indicator detail pages - trust wide and for each core service

Featured data sources

FACTS, FIGURES & RATINGS | TRUST & CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

INCIDENTS | MORTALITY | NATIONAL CLINICAL AUDITS | A&E WAITING TIMES | PATIENT SURVEYS | STAFF SURVEYS | WRES

Incident reporting (NRLS)
Mortality (SHMI and HSMR)
National Clinical Audits (HQIP)
A&E waits
WRES
Surveys - NHS Staff Survey, Staff friends and family and Inpatient Survey

Definitions

FACTS, FIGURES & RATINGS | TRUST & CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS

KEY | DATA

Key of symbols and colours
Data definitions and download

Trust level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Date of last inspection: 25/07/2019	RI 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019

Trust organisation history

Under development

Registered locations

- St Helen's Rehabilitation Hospital
- Selby War Memorial Hospital
- The York Hospital
- Scarborough Hospital
- Bridlington Hospital
- White Cross Court Rehabilitation Hospital
- Harrogate Satellite Renal Unit
- Easingwold Satellite Renal Unit
- St Monicas Hospital

Population estimate: 474,651

These experimental population estimates have been calculated by PHE derived from HES admissions and small area population estimates for 2013. Estimates are only presented for non-specialist trusts.

Activity	Previous	Latest	Change	National comparison
Inpatient admissions	126,444 Sep 19 - Aug 20	133,698 Sep 20 - Aug 21	(+6%)	
Outpatient appointments	1,129,836 Aug 19 - Jul 20	1,149,461 Aug 20 - Jul 21	(+2%)	
A&E attendances	118,383 Sep 19 - Aug 20	127,508 Sep 20 - Aug 21	(+8%)	
Number of deliveries	4,041 Jul 19 - Jun 20	3,892 Jul 20 - Jun 21	(-4%)	
Number of deaths	2,059 Sep 19 - Aug 20	2,057 Sep 20 - Aug 21	(0%)	

Capacity (National Guardian Freedom to Speak Up)	Previous	Latest	Change	National comparison
Number of general and acute beds	962 Jul 20 - Sep 20	986 Jul 21 - Sep 21	(+3%)	
Number of maternity beds	50 Jul 20 - Sep 20	65 Jul 21 - Sep 21	(+31%)	
Number of critical care beds	21 Feb 19	21 Feb 20	(0%)	
Number of bed days	332,101 Sep 19 - Aug 20	324,989 Sep 20 - Aug 21	(-2%)	
Number of staff (WTE):	7,402	7,659	(+3%)	
Medical	836 Sep 20	839 Sep 21	(0%)	
Nursing	1,732 Sep 20	1,796 Sep 21	(+4%)	
Other(s)	4,834 Sep 20	5,024 Sep 21	(+4%)	
Care hours	Data not yet available	Data not yet available		

Finance and governance	Previous	Latest	Change	National comparison
Projected surplus [£000s] (deficit)		Data not available		
Turnover [£000s]	556,539	616,373	(+11%)	
NHSI Single Oversight Framework segmentation	NA	Providers offered targeted support.	NA	
Recovery Support Programme		No		

Source(s): Hospital Episode Statistics; NHS England - Bed occupancy; NHS Digital - Workforce statistics; NHS Improvement

Trust level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Date of last inspection: 25/07/2019	RI 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019

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Population estimate: 474,651

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	Inpatient admissions	Previous	Latest	Change	National comparison
	Inpatient admissions (total)	126,444	133,698	(+6%)	
Service	Children	5,699	6,449	(+13%)	
	Medicine	69,460	72,765	(+5%)	
	Surgery	45,601	51,085	(+12%)	
Condition (Top 3)	Miscellaneous	17,685	21,980	(+24%)	
	Gastroenterology and hepatology	18,519	20,779	(+12%)	
	Oncology	19,844	18,678	(-6%)	
Age group (%)	Under 1	1.9%	1.6%	(0%)	
	1 to 3	2.1%	1.7%	(0%)	
	4 to 15	3.2%	2.8%	(0%)	
	16 to 17	0.7%	0.7%	(0%)	
	18 to 74	61.6%	62.3%	(+1%)	
	75 and over	30.5%	31.0%	(0%)	
Ethnicity (%)	White	79.5%	78.9%	(-1%)	
	Not known	14.9%	15.2%	(0%)	
	Not stated	4.5%	4.9%	(0%)	
	Asian	0.3%	0.3%	(0%)	
	Mixed	0.2%	0.3%	(0%)	
	Other	0.3%	0.2%	(0%)	
	Black	0.1%	0.1%	(0%)	
		Sep 19 - Aug 20	Sep 20 - Aug 21		

Source(s): Hospital Episode Statistics

Location level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Overall	RI 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019
Bridlington Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	G 16/10/2019
Scarborough Hospital	I 16/10/2019	RI 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019
The York Hospital	RI 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018

Activity	Bridlington Hospital	Scarborough Hospital	The York Hospital		
Inpatient admissions Sep 20 - Aug 21	6,200	36,996			
Outpatient appointments Aug 20 - Jul 21	62,748	199,893			
Number of deaths (under development)					

Location level facilities	Bridlington Hospital	Scarborough Hospital	The York Hospital		
Neonatal unit type	-	SCU	-		

Source(s): Hospital Episode Statistics; National Neonatal Audit Programme

Location ratings for urgent and emergency care:	Safe	Effective	Caring	Responsive	Well led	Overall
Bridlington Hospital	NA	NA	NA	NA	NA	NA
Scarborough Hospital	I 24/3/2020	RI 16/10/2019	G 16/10/2019	I 24/3/2020	I 24/3/2020	I 24/3/2020
The York Hospital	I 24/3/2020	G 28/2/2018	G 28/2/2018	I 24/3/2020	I 24/3/2020	I 24/3/2020

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where urgent and emergency care service has been rated

- Scarborough Hospital
- The York Hospital

Activity	Previous	Latest	Change	National comparison
A&E attendances (total)	118,383 Sep 19 - Aug 20	127,508 Sep 20 - Aug 21	(+8%)	
Children attending A&E (total)	16,892 Sep 19 - Aug 20	18,863 Sep 20 - Aug 21	(+12%)	
Attendees arriving by ambulance (total)	48,264	51,162	(+6%)	
% of total attendances	40.8% Sep 19 - Aug 20	40.1% Sep 20 - Aug 21	(-1%)	
Number of A&E attendances admitted	45,650	47,949	(+5%)	
% of total attendances	38.6% Sep 19 - Aug 20	37.6% Sep 20 - Aug 21	(-1%)	
Patients left without being seen (%)	4.0% Oct 20	8.0% Oct 21	(+4%)	
Reattendances within 7 days (%)	7.8% Oct 20	7.2% Oct 21	(-1%)	

Source(s): Hospital Episode Statistics; NHS Digital - A&E Quality

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Under development				

Source(s):

Location ratings for medicine:	Safe	Effective	Caring	Responsive	Well led	Overall
Bridlington Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	G 16/10/2019
Scarborough Hospital	I 24/3/2020	RI 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019
The York Hospital	G 28/2/2018	RI 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where medicine service has been rated

- Bridlington Hospital
- Scarborough Hospital
- The York Hospital

Activity	Previous	Latest	Change	National comparison
Admissions (total)	69,460	72,765	(+5%)	
Elective admissions	919	713	(-22%)	
Emergency admissions	40,164	39,767	(-1%)	
Day case	28,377	32,285	(+14%)	
By specialty (top 3):				
General medicine	7,238	14,225	(+97%)	
Gastroenterology	7,644	10,425	(+36%)	
Geriatric medicine	9,392	10,400	(+11%)	
	Sep 19 - Aug 20	Sep 20 - Aug 21		
Average length of stay (days)	4.8 Sep 19 - Aug 20	4.7 Sep 20 - Aug 21	(-1%)	

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Medical wards (number)	Data not yet available	Data not yet available		
Medical beds (number)	Data not yet available	Data not yet available		
Medical consultants (WTE)	92.3 Sep 20	88 Sep 21	(-5%)	

Source(s): NHS Digital - Workforce statistics

Location ratings for surgery:	Safe	Effective	Caring	Responsive	Well led	Overall
Bridlington Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019
Scarborough Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019
The York Hospital	G 28/2/2018	G 28/2/2018	G 28/2/2018	RI 28/2/2018	G 28/2/2018	G 28/2/2018

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where surgery service has been rated

- Bridlington Hospital
- Scarborough Hospital
- The York Hospital

Activity	Previous	Latest	Change	National comparison
Elective admissions (number)	3,513 Sep 19 - Aug 20	3,779 Sep 20 - Aug 21	(+8%)	
Emergency admissions (number)	12,252 Sep 19 - Aug 20	14,162 Sep 20 - Aug 21	(+16%)	
Day admissions (number)	29,836 Sep 19 - Aug 20	33,144 Sep 20 - Aug 21	(+11%)	
Operations (number)	Data not yet available	Data not yet available		

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Operating theatres (number)	Data not yet available	Data not yet available		
Number of wards (number)	Data not yet available	Data not yet available		
Inpatient beds (number)	Data not yet available	Data not yet available		
Day case beds (number)	Data not yet available	Data not yet available		
Consultant surgeons (WTE)	162.8 Sep 20	163.9 Sep 21	(+1%)	

Source(s): NHS Digital - Workforce statistics

Location ratings for critical care:	Safe	Effective	Caring	Responsive	Well led	Overall
Bridlington Hospital	NA	NA	NA	NA	NA	NA
Scarborough Hospital	G 28/2/2018	RI 28/2/2018	G 28/2/2018	RI 28/2/2018	RI 28/2/2018	RI 28/2/2018
The York Hospital	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018

Is there a critical care outreach team?

Data not available

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where critical care service has been rated

- Scarborough Hospital
- The York Hospital

Activity	Previous	Latest	Change	National comparison
Discharges (number)	1,589 Sep 19 - Aug 20	1,559 Sep 20 - Aug 21	(-2%)	
Deaths (number)	0 Sep 19 - Aug 20	0 Sep 20 - Aug 21	NA	

Source(s): Hospital Episode Statistics

Capacity	Previous	Latest	Change	National comparison
Beds (total)	Data not yet available	Data not yet available		
Level 1	Data not yet available	Data not yet available		
Level 2	Data not yet available	Data not yet available		
Level 3	Data not yet available	Data not yet available		
Consultants (WTE)	Data not yet available	Data not yet available		
Registered nurses (WTE)	Data not yet available	Data not yet available		

Source(s): NHS Digital - Workforce statistics

Location ratings for maternity:	Safe	Effective	Caring	Responsive	Well led	Overall
Bridlington Hospital	NA	NA	NA	NA	NA	NA
Scarborough Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019
The York Hospital	G 8/10/2015	RI 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where maternity service has been rated

- Scarborough Hospital
- The York Hospital

Activity	Previous	Latest	Change	National comparison
Deliveries (number)	4,041 Jul 19 - Jun 20	3,892 Jul 20 - Jun 21	(-4%)	
Caesarean sections rate (%)	26.1% Jul 19 - Jun 20	30.0% Jul 20 - Jun 21	(+4%)	
Instrumental delivery rate (%)	11.6% Jul 19 - Jun 20	12.5% Jul 20 - Jun 21	(+1%)	
Non-interventional delivery rate (%)	61.9% Jul 19 - Jun 20	56.8% Jul 20 - Jun 21	(-5%)	

Source(s): Hospital Episode Statistics

Capacity (National Guardian Freedom to Speak Up)	Previous	Latest	Change	National comparison
Antenatal beds (number)	Data not yet available	Data not yet available		
Beds on labour suites (number)	Data not yet available	Data not yet available		
Postnatal beds (number)	Data not yet available	Data not yet available		
Midwives (WTE)	161.1 Sep 20	157.3 Sep 21	(-2%)	
Consultant obstetricians/gynaecologists (WTE)	21.3 Sep 20	21.3 Sep 21	(0%)	

Source(s): NHS Digital - Workforce statistics

Location ratings for children and young people:	Safe	Effective	Caring	Responsive	Well led	Overall
Bridlington Hospital	NA	NA	NA	NA	NA	NA
Scarborough Hospital	RI 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015
The York Hospital	RI 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where children and young people service has been rated

- Scarborough Hospital
- The York Hospital

Activity	Previous	Latest	Change	National comparison
Admissions (total)	9,960	8,912	(-11%)	
Under 1	2,463	2,091	(-15%)	
1 to 3	2,650	2,216	(-16%)	
4 to 15	4,016	3,709	(-8%)	
16 to 17	831	896	(+8%)	
	Sep 19 - Aug 20	Sep 20 - Aug 21		

Source(s): Hospital Episode Statistics

Capacity (National Guardian Freedom to Speak Up)	Previous	Latest	Change	National comparison
Wards (number)	Data not yet available	Data not yet available		
Beds (number)	Data not yet available	Data not yet available		
Paediatric consultants (WTE)			NA	
Paediatric nurses (WTE)			NA	
Neonatal cots (total)	Data not yet available	Data not yet available		
Level 1	Data not yet available	Data not yet available		
Level 2	Data not yet available	Data not yet available		
Level 3	Data not yet available	Data not yet available		

Source(s): NHS Digital - Workforce statistics

Location ratings for end of life care:	Safe	Effective	Caring	Responsive	Well led	Overall
Bridlington Hospital	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015
Scarborough Hospital	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015
The York Hospital	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015

Service availability

Data not yet available

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where end of life care service has been rated

- Bridlington Hospital
- Scarborough Hospital
- The York Hospital

Activity	Previous	Latest	Change	National comparison
In-hospital deaths (number)	2,059 Sep 19 - Aug 20	2,057 Sep 20 - Aug 21	(0%)	
Referrals to specialist palliative care team (number)	Data not yet available	Data not yet available		
Cancer referrals (number)	Data not yet available	Data not yet available		
Non-cancer referrals (number)	Data not yet available	Data not yet available		

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Specialist palliative care consultants (WTE)	1 Sep 20	0.8 Sep 21	(-20%)	
Specialist palliative care nurses (WTE)	Data not yet available	Data not yet available		

Source(s): NHS Digital - Workforce statistics

Location ratings for outpatients:	Safe	Effective	Caring	Responsive	Well led	Overall
Bridlington Hospital	RI 16/10/2019	NA	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019
Scarborough Hospital	RI 16/10/2019	NA	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019
The York Hospital	G 8/10/2015	NA	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015

Current enforcement and regulatory action

Under development

Outstanding practice

Under development

Registered locations where outpatient service has been rated

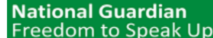
- Bridlington Hospital
- Scarborough Hospital
- The York Hospital

Activity	Previous	Latest	Change	National comparison
Number of appointments (total)	1,129,836	1,149,461	(+2%)	
Ophthalmology	125,050	121,860	(-3%)	
Dermatology	42,088	43,442	(+3%)	
Medical specialties	435,519	431,948	(-1%)	
Surgical specialties	214,057	228,629	(+7%)	
Oncology	61,489	47,129	(-23%)	
Other(s)	251,633 Aug 19 - Jul 20	276,453 Aug 20 - Jul 21	(+10%)	
Number of outpatient clinics held per week	Data not yet available	Data not yet available		

Source(s): Hospital Episode Statistics

Capacity National Guardian Freedom to Speak Up	Previous	Latest	Change	National comparison
Under development				

Source(s):



This page displays the latest ratings and the direction of travel for core service and trust level key question intelligence indicators. Click on the arrows to see the indicator detail.

Key messages

Intelligence indicates that

- Overall performance for this trust is about the same
- Safe performance is declining
- Caring, Effective, Responsive, Well led performance is stable
- Urgent and emergency care performance is declining
- Critical care, Children and young people, Maternity and gynaecology, Medical care, Outpatients, Surgery performance is stable

Core service	Location	Safe	Effective	Caring	Responsive	Well led	Overall	Direction
		↓	→	→	→	→	→	
	Overall	RI 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	
Urgent and emergency care	Bridlington Hospital	NA	NA	NA	NA	NA	NA	↓
	Scarborough Hospital	I 24/3/2020	RI 16/10/2019	G 16/10/2019	I 24/3/2020	I 24/3/2020	I 24/3/2020	
	The York Hospital	I 24/3/2020	G 28/2/2018	G 28/2/2018	I 24/3/2020	I 24/3/2020	I 24/3/2020	
Medical care	Bridlington Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	G 16/10/2019	→
	Scarborough Hospital	I 24/3/2020	RI 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019	
	The York Hospital	G 28/2/2018	RI 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	
Surgery	Bridlington Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	→
	Scarborough Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019	
	The York Hospital	G 28/2/2018	G 28/2/2018	G 28/2/2018	RI 28/2/2018	G 28/2/2018	G 28/2/2018	
Critical care	Bridlington Hospital	NA	NA	NA	NA	NA	NA	→
	Scarborough Hospital	G 28/2/2018	RI 28/2/2018	G 28/2/2018	RI 28/2/2018	RI 28/2/2018	RI 28/2/2018	
	The York Hospital	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	G 28/2/2018	
Maternity	Bridlington Hospital	NA	NA	NA	NA	NA	NA	→
	Scarborough Hospital	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	
	The York Hospital	G 8/10/2015	RI 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	
Children and young people	Bridlington Hospital	NA	NA	NA	NA	NA	NA	→
	Scarborough Hospital	RI 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	
	The York Hospital	RI 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	
End of life care	Bridlington Hospital	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	NA
	Scarborough Hospital	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	
	The York Hospital	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	
Outpatients	Bridlington Hospital	RI 16/10/2019	NA	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019	→
	Scarborough Hospital	RI 16/10/2019	NA	G 16/10/2019	RI 16/10/2019	RI 16/10/2019	RI 16/10/2019	
	The York Hospital	G 8/10/2015	NA	G 8/10/2015	G 8/10/2015	G 8/10/2015	G 8/10/2015	

Source(s): CQC ratings data

Trust level rating:

Date of last inspection: 25/07/2019

Safe	Effective	Caring	Responsive	Well led	Overall
RI 16/10/2019	G 16/10/2019	G 16/10/2019	G 16/10/2019	RI 16/10/2019	RI 16/10/2019

Trust wide and core service indicators

Of the 70 trust wide indicators, 1 (1%) are categorised as much better, 0 (0%) as better, 6 (9%) as worse and 2 (3%) as much worse. 47 indicators have been compared to data from 12 months previous, of which 0 (0%) have shown an improvement and 6 (13%) have shown a decline

Much better compared nationally

- Sick days for medical and dental staff-[set target 3.5%] (%)

Much worse compared nationally

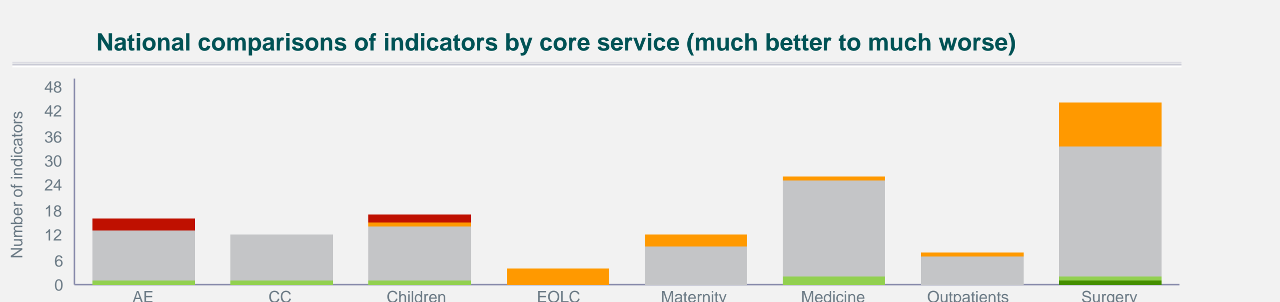
- Active professional registration (nursing and midwifery) (%)
- Whistleblowing alerts

Improved

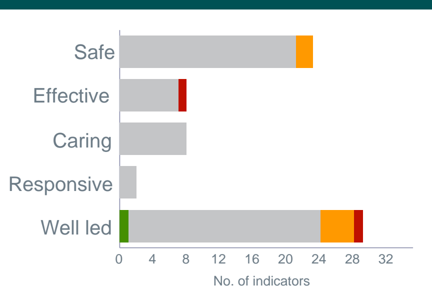
Declined

- Team Working
- Never events (total events with rule-based risk assessment)
- CAS alerts closed late in preceding 12 months
- Active professional registration (nursing and midwifery) (%)
- Equality, diversity & inclusion
- Never events (total events with statistical comparison to bed days)

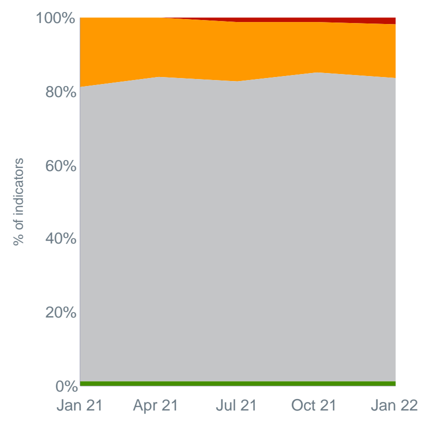
For each core service, there are different numbers of indicators. When compared nationally, each has been categorised as much better, better, about the same, worse or much worse. The graph shows the number of Indicators for each core service and the number within each category:



What's the current performance of trust wide indicators?



How has the trust-wide indicator performance changed over time?



Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Change	National comparison
Safe	S1	**Clostridium difficile infection alert in three months?** Public Health England - PHE - CDIFF (20 Nov 2021)		NA	No Jul 21 - Sep 21	NA	S
	S1	**Clostridium difficile infections (hospital-onset, healthcare associated)** Public Health England - PHE - CDIFF (20 Nov 2021)	-	NA	64 Oct 20 - Sep 21	NA	S
	S1	**MRSA bacteraemia (hospital-onset, healthcare associated)** Public Health England - PHE - MRSA (20 Nov 2021)	-	NA	1 Oct 20 - Sep 21	NA	S
	S1	**MRSA bacteraemia alert in three months?** Public Health England - PHE - MRSA (20 Nov 2021)		NA	No Jul 21 - Sep 21	NA	S
	S1	**Patient-led assessment of cleanliness of environment (%)** NHS Digital - PLACE (30 Jan 2020)	98.6%	94.8% Mar 18 - Jun 18	97.4% Sep 19 - Nov 19	NA	S
	S1	**Patient-led assessment of environment for dementia care (%)** NHS Digital - PLACE (30 Jan 2020)	80.1%	59.1% Mar 18 - Jun 18	71.4% Sep 19 - Nov 19	NA	S
	S1	**Patient-led assessment of facilities (%)** NHS Digital - PLACE (30 Jan 2020)	96.6%	86.6% Mar 18 - Jun 18	95.8% Sep 19 - Nov 19	NA	S
	S2	**Ratio of consultant to non-consultant doctors** Electronic Staff Record - ESR: Contracted FTEs - Medical and Dental (09 Nov 2021)	0.70	0.75 Sep 20	0.76 Sep 21	➡	S
	S2	**Ratio of occupied beds to medical and dental staff** Electronic Staff Record - ESR: Contracted FTEs - All Staff (18 Nov 2021)	3.22	3.95 Oct 19 - Sep 20	4.03 Oct 20 - Sep 21	➡	S
	S2	**Ratio of occupied beds to nursing staff** Electronic Staff Record - ESR: Contracted FTEs - All Staff (18 Nov 2021)	1.70	2.06 Oct 19 - Sep 20	2.05 Oct 20 - Sep 21	➡	S
	S2	**Ratio of occupied beds to other clinical staff** Electronic Staff Record - ESR: Contracted FTEs - All Staff (18 Nov 2021)	1.41	1.43 Oct 19 - Sep 20	1.46 Oct 20 - Sep 21	➡	S
	S2	**Ratio of senior staff nurses to staff nurses** Electronic Staff Record - ESR: Contracted FTEs - Nursing and Midwifery (15 Nov 2021)	0.55	0.55 Sep 20	0.55 Sep 21	➡	S
	S2	**Ratio of ward manager nurses to senior and staff nurses** Electronic Staff Record - ESR: Contracted FTEs - Nursing and Midwifery (15 Nov 2021)	0.21	0.19 Sep 20	0.18 Sep 21	➡	S
	S2	**Ward staff who are registered nurses (%)** Electronic Staff Record - ESR: Contracted FTEs - All Staff (09 Nov 2021)	69.5%	64.6% Sep 20	63.3% Sep 21	➡	S
	S5	**Never event alert in the last three months?** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)		NA	No Oct 21 - Dec 21	NA	S

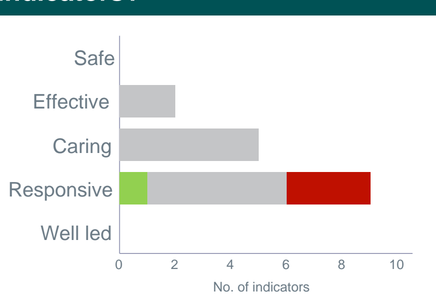
Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Performance: Change	National comparison
	S5	**Never events (total events with rule-based risk assessment)** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)	-	2 Jan 20 - Dec 20	3 Jan 21 - Dec 21	↓	W
	S5	**Never events (total events with statistical comparison to bed days)** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)	-	2 Jan 20 - Dec 20	3 Jan 21 - Dec 21	↓	S
	S5	**Proportion of reported patient safety incidents reported as resulting in harm (%)** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)	26.7%	29.5% Dec 19 - Nov 20	30.5% Dec 20 - Nov 21	→	S
	S6	**CAS alerts closed late in preceding 12 months** MHRA - CAS Alerts (22 Dec 2021)		< 25% of alerts closed late Nov 19 - Oct 20	>=25% & <50% alerts closed late Dec 20 - Nov 21	↓	W
	S6	**CAS alerts not closed by the trust in the preceding 12 months** MHRA - CAS Alerts (22 Dec 2021)		NA	0 alerts still open Dec 20 - Nov 21	NA	S
	S6	**CAS alerts not closed by the trust more than 12 months before** MHRA - CAS Open Alerts (22 Dec 2021)		NA	0 alerts still open Aug 14 - Nov 20	NA	S
	S6	**Risk of under-reporting patient safety incidents resulting in death or severe harm to the National Reporting and Learning System (NRLS)** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)	1.00	0.79 Dec 19 - Nov 20	0.91 Dec 20 - Nov 21	→	S
	S6	**Risk of under-reporting patient safety incidents to the National Reporting and Learning System (NRLS)** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)	1.00	0.90 Dec 19 - Nov 20	0.85 Dec 20 - Nov 21	→	S
Effective	E1	**Help with eating** Care Quality Commission - CQC Inpatient Survey (19 Oct 2021)	-	-	8.0 Nov 20	NA	S
Effective	E1	**Patient-led assessment of food (%)** NHS Digital - PLACE (30 Jan 2020)	91.9%	79.2% Mar 18 - Jun 18	85.0% Sep 19 - Nov 19	NA	S
Effective	E2	**Hospital Standardised Mortality Ratio (HSMR)** Dr Foster - Dr Foster - HSMR (30 Dec 2021)	100.0	100.5 Jul 19 - Jun 20	96.6 Jul 20 - Jun 21	→	S
Effective	E2	**Hospital Standardised Mortality Ratio (Weekday)** Dr Foster - Dr Foster - HSMR (30 Dec 2021)	100.0	97.0 Jul 19 - Jun 20	96.5 Jul 20 - Jun 21	→	S
Effective	E2	**Hospital Standardised Mortality Ratio (Weekend)** Dr Foster - Dr Foster - HSMR (30 Dec 2021)	100.0	110.8 Jul 19 - Jun 20	97.7 Jul 20 - Jun 21	→	S

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**Summary Hospital-level Mortality Indicator (SHMI)** NHS Digital - SHMI (30 Dec 2021)	1.00	0.99 Jul 19 - Jun 20	0.94 Jul 20 - Jun 21	➡	S
	E3	**Active professional registration (medical and dental) (%)** Electronic Staff Record - ESR: Valid Registrations - Medical and Dental (09 Nov 2021)	98.3%	95.3% Sep 20	99.6% Sep 21	➡	S
	E3	**Active professional registration (nursing and midwifery) (%)** Electronic Staff Record - ESR: Valid Registrations - Nursing and Midwifery (09 Nov 2021)	97.9%	91.3% Sep 20	87.2% Sep 21	⬇	MW
Caring	C1	**Confidence and trust in the doctors** Care Quality Commission - CQC Inpatient Survey (19 Oct 2021)	-	-	9.2 Nov 20	NA	S
Caring	C1	**Confidence and trust in the nurses** Care Quality Commission - CQC Inpatient Survey (19 Oct 2021)	-	-	9.1 Nov 20	NA	S
Caring	C1	**Overall experience as an inpatient** Care Quality Commission - CQC Inpatient Survey (19 Oct 2021)	-	-	8.2 Nov 20	NA	S
Caring	C1	**Speaking to staff about worries and fears** Care Quality Commission - CQC Inpatient Survey (19 Oct 2021)	-	-	8.07 Nov 20	NA	S
Caring	C2	**Involvement in decisions** Care Quality Commission - CQC Inpatient Survey (19 Oct 2021)	-	-	7.1 Nov 20	NA	S
Caring	C3	**Pain control by staff** Care Quality Commission - CQC Inpatient Survey (19 Oct 2021)	-	-	8.7 Nov 20	NA	S
Caring	C3	**Patient-led assessment of privacy, dignity, and well being (%)** NHS Digital - PLACE (30 Jan 2020)	85.1%	74.6% Mar 18 - Jun 18	81.1% Sep 19 - Nov 19	NA	S
Caring	C3	**Treatment with respect and dignity** Care Quality Commission - CQC Inpatient Survey (19 Oct 2021)	-	-	9.2 Nov 20	NA	S
Responsive	R3	**Ratio of delayed transfers and number of occupied beds** NHS England - Delayed Transfers of Care (09 Dec 2020)	0.02	0.04 Oct 18 - Dec 18	0.03 Oct 19 - Dec 19	➡	S
Responsive	R4	**Complaints about the provider received by CQC** Care Quality Commission - OBIEE Notifications/Whistle Blowing/Complaints (19 Jan 2022)	-	47 Oct 19 - Sep 20	50 Oct 20 - Sep 21	➡	S
Well led	W3	**Equality, diversity & inclusion** PICKER - NHS staff survey themes and questions (11 Mar 2021)	9.0	9.3 Sep 19 - Dec 19	9.2 Sep 20 - Dec 20	⬇	S

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	W3	**Flu vaccination uptake (%)** NHS England - Flu Vac (28 Jun 2021)	76.9%	71.2% Sep 19 - Feb 20	71.8% Sep 20 - Feb 21	➡	S
	W3	**GMC - Enhanced monitoring** General Medical Council - GMC Enhanced Monitoring (06 Jan 2022)		NA	No concerns Jan 22	NA	S
	W3	**Health & wellbeing** PICKER - NHS staff survey themes and questions (11 Mar 2021)	6.1	6.2 Sep 19 - Dec 19	6.1 Sep 20 - Dec 20	➡	S
	W3	**Immediate managers** PICKER - NHS staff survey themes and questions (11 Mar 2021)	6.8	6.8 Sep 19 - Dec 19	6.7 Sep 20 - Dec 20	➡	S
	W3	**Morale** PICKER - NHS staff survey themes and questions (11 Mar 2021)	6.2	6.2 Sep 19 - Dec 19	6.2 Sep 20 - Dec 20	➡	S
	W3	**Overall trainee satisfaction (trust score compared to doctors' scores)** General Medical Council - GMC National Training Survey (28 Jul 2021)		In middle 50% of scores Mar 19 - May 19	In middle 50% of scores Apr 21 - May 21	➡	S
	W3	**Quality of care** PICKER - NHS staff survey themes and questions (11 Mar 2021)	7.5	7.2 Sep 19 - Dec 19	7.2 Sep 20 - Dec 20	➡	W
	W3	**Safe Environment - Bullying & Harassment** PICKER - NHS staff survey themes and questions (11 Mar 2021)	8.0	8.1 Sep 19 - Dec 19	8.1 Sep 20 - Dec 20	➡	S
	W3	**Safe Environment - Violence** PICKER - NHS staff survey themes and questions (11 Mar 2021)	9.5	9.4 Sep 19 - Dec 19	9.4 Sep 20 - Dec 20	➡	S
	W3	**Safety Culture** PICKER - NHS staff survey themes and questions (11 Mar 2021)	6.8	6.4 Sep 19 - Dec 19	6.5 Sep 20 - Dec 20	➡	W
	W3	**Sick days due to back problems (%)** Electronic Staff Record - ESR: Sicknesss Absence by Staff Group (09 Nov 2021)	0.24%	0.21% Oct 19 - Sep 20	0.28% Oct 20 - Sep 21	➡	S
	W3	**Sick days due to stress (%)** Electronic Staff Record - ESR: Sicknesss Absence by Staff Group (09 Nov 2021)	1.22%	1.33% Oct 19 - Sep 20	1.50% Oct 20 - Sep 21	➡	S
	W3	**Sick days for medical and dental staff-[set target 3.5%] (%)** Electronic Staff Record - ESR: Sicknesss Absence by Staff Group (13 Dec 2021)	1.47%	1.59% Nov 19 - Oct 20	1.75% Nov 20 - Oct 21	➡	MB
	W3	**Sick days for non-clinical staff (%)** Electronic Staff Record - ESR: Sicknesss Absence by Staff Group (13 Dec 2021)	4.63%	5.33% Nov 19 - Oct 20	5.68% Nov 20 - Oct 21	➡	S
	W3	**Sick days for nursing and midwifery staff (%)** Electronic Staff Record - ESR: Sicknesss Absence by Staff Group (13 Dec 2021)	5.30%	5.22% Nov 19 - Oct 20	5.71% Nov 20 - Oct 21	➡	S

Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Performance: Change	National comparison
	W3	**Sick days for other clinical staff (%)** Electronic Staff Record - ESR: Sicknesss Absence by Staff Group (13 Dec 2021)	5.58%	5.69% Nov 19 - Oct 20	5.88% Nov 20 - Oct 21	→	S
	W3	**Stability of Medical and Dental staff** Electronic Staff Record - ESR: Stability - Period End (09 Nov 2021)	0.90	0.88 Oct 19 - Sep 20	0.90 Oct 20 - Sep 21	→	S
	W3	**Stability of non clinical staff** Electronic Staff Record - ESR: Stability - Period End (09 Nov 2021)	0.86	0.88 Oct 19 - Sep 20	0.90 Oct 20 - Sep 21	→	S
	W3	**Stability of Nursing and Midwifery staff** Electronic Staff Record - ESR: Stability - Period End (09 Nov 2021)	0.87	0.86 Oct 19 - Sep 20	0.89 Oct 20 - Sep 21	→	S
	W3	**Stability of other clinical staff** Electronic Staff Record - ESR: Stability - Period End (09 Nov 2021)	0.85	0.91 Oct 19 - Sep 20	0.86 Oct 20 - Sep 21	→	S
	W3	**Staff Engagement** PICKER - NHS staff survey themes and questions (11 Mar 2021)	7.0	6.9 Sep 19 - Dec 19	6.9 Sep 20 - Dec 20	→	W
	W3	**Team Working** PICKER - NHS staff survey themes and questions (11 Mar 2021)	6.5	6.5 Sep 19 - Dec 19	6.3 Sep 20 - Dec 20	↓	W
	W3	**Turnover rate for medical and dental staff (%)** Electronic Staff Record - ESR: Stability - Turnover Leavers All (11 Nov 2021)	6.7%	12.6% Oct 19 - Sep 20	8.4% Oct 20 - Sep 21	→	S
	W3	**Turnover rate for nursing and midwifery staff (%)** Electronic Staff Record - ESR: Stability - Turnover Leavers All (11 Nov 2021)	10.8%	7.8% Oct 19 - Sep 20	8.4% Oct 20 - Sep 21	→	S
	W3	**Turnover rate for other clinical staff (%)** Electronic Staff Record - ESR: Stability - Turnover Leavers All (11 Nov 2021)	13.4%	12.2% Oct 19 - Sep 20	11.4% Oct 20 - Sep 21	→	S
	W3	**Turnover rate for other non-clinical staff (%)** Electronic Staff Record - ESR: Stability - Turnover Leavers All (11 Nov 2021)	12.1%	10.1% Oct 19 - Sep 20	11.1% Oct 20 - Sep 21	→	S
	W3	**Whistleblowing alerts** Care Quality Commission - OBIEE Notifications/Whistle Blowing/Complaints (19 Jan 2022)		NA	1 or more Jan 22	NA	MW
	W4	**Identified level of potential support needs by the provider shadow segmentation** NHS Improvement - SOF (15 Jun 2021)	-	NA	Providers offered targeted support. Jun 21	NA	S

What's the current performance of urgent and emergency care indicators?



Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Performance: Change	National comparison
Safe	S2	**Time from arrival by ambulance to initial assessment** NHS Digital - A&E Quality (14 Dec 2021)	-	12 Oct 20	25 Oct 21	NA	
	S5	**Never events in urgent and emergency care** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)		0 Jan 20 - Dec 20	0 Jan 21 - Dec 21	→	
Effective	E1	**Knowing who to contact after leaving hospital** Care Quality Commission - A&E Survey - Benchmarking (14 Sep 2021)	-	7.7 Sep 18	8.0 Sep 20	→	S
	E2	**Unplanned reattendance to A&E within 7 days (%)** NHS Digital - A&E Quality (14 Dec 2021)	8.2%	7.8% Oct 20	7.2% Oct 21	→	S
Caring	C1	**Confidence and trust in the doctors and nurses** Care Quality Commission - A&E Survey - Benchmarking (14 Sep 2021)	-	8.9 Sep 18	8.7 Sep 20	→	S
	C3	**Getting help when needed** Care Quality Commission - A&E Survey - Benchmarking (14 Sep 2021)	-	8.0 Sep 18	8.0 Sep 20	→	S
	C3	**Pain control by staff** Care Quality Commission - A&E Survey - Benchmarking (14 Sep 2021)	-	7.7 Sep 18	7.6 Sep 20	NA	S
	C3	**Privacy during examination or treatment** Care Quality Commission - A&E Survey - Benchmarking (14 Sep 2021)	-	9.3 Sep 18	9.2 Sep 20	→	S
	C3	**Treatment with respect and dignity** Care Quality Commission - A&E Survey - Benchmarking (14 Sep 2021)	-	9.1 Sep 18	9.0 Sep 20	→	S
Responsive	R2	**Total median time in A&E (all patients)** NHS Digital - A&E Quality (14 Dec 2021)	1.1	1.2 Oct 20	1.2 Oct 21	→	S
	R3	**A&E Attendees spending more than 12 hours from decision to admit to admission** NHS England - A&E SitReps (14 Dec 2021)	-	7 Nov 20	159 Nov 21	↓	MW
	R3	**Admissions waiting 4-12 hours from the decision to admit (%)** NHS England - A&E SitReps (14 Dec 2021)	29%	11% Nov 20	31% Nov 21	↓	S
	R3	**Ambulances remaining at hospital for more than 60 minutes (%)** National Ambulance Information Group - Ambulance Turnaround (22 Dec 2021)	19.7%	4.9% Nov 20	29.9% Nov 21	↓	S
	R3	**Patients spending less than 4 hours in (any type of) A&E (%)** NHS England - A&E SitReps (14 Dec 2021)	71.1%	83.5% Nov 20	70.2% Nov 21	↓	MW

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	R3	**Patients spending less than 4 hours in major A&E (%)** NHS England - A&E SitReps (14 Dec 2021)	61.9%	76.7% Nov 20	49.4% Nov 21	↓	MW
	R3	**Patients spending less than 4 hours in single-specialty A&E (%)** NHS England - A&E SitReps (14 Dec 2021)	97.3%	100.0% Nov 20	100.0% Nov 21	→	B
	R3	**Patients spending less than 4 hours in type 3 A&E, including MIUs (%)** NHS England - A&E SitReps (14 Dec 2021)	94.7%	99.9% Nov 20	95.0% Nov 21	→	S
	R3	**Time to treatment (minutes)** NHS Digital - A&E Quality (14 Dec 2021)	-	62.0 Oct 20	116.0 Oct 21	NA	
	R3	**Waiting time from arrival to examination by doctor or nurse** Care Quality Commission - A&E Survey - Benchmarking (14 Sep 2021)	-	6.4 Sep 18	6.3 Sep 20	→	S

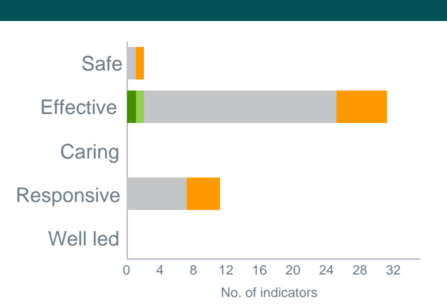
What's the current performance of medicine indicators?

Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Performance: Change	National comparison
Safe	S5	**Never events in medical care** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)		1 Jan 20 - Dec 20	0 Jan 21 - Dec 21	↑	
Effective	E1	**Case mix adjusted percentage of fit patients with advanced Non Small Cell Lung Cancer (NSCLC) receiving Systemic Anti-Cancer Treatment (%)** Royal College of Physicians - National Lung Cancer Audit (NLCA) (03 Jul 2019)	65.0%	NA	62.0% Jan 17 - Dec 17	NA	S
Effective	E1	**Case mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery (%)** Royal College of Physicians - National Lung Cancer Audit (NLCA) (03 Jul 2019)	18.4%	NA	13.1% Jan 17 - Dec 17	NA	W
Effective	E1	**Case mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (%)** Royal College of Physicians - National Lung Cancer Audit (NLCA) (03 Jul 2019)	71.0%	NA	68.3% Jan 17 - Dec 17	NA	S
Effective	E1	**SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator** Royal College of Physicians - Sentinel Stroke National Audit Programme (SSNAP) - Clinical Quarterly audit - Scarborough Hospital (25 Oct 2021)		Level C Oct 19 - Dec 19	Apr 21 - Jun 21	NA	
Effective	E1	**SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator** Royal College of Physicians - Sentinel Stroke National Audit Programme (SSNAP) - Clinical Quarterly audit - The York Hospital (25 Oct 2021)		Level D Oct 19 - Dec 19	Level B Apr 21 - Jun 21	NA	B
Effective	E2	**Case mix adjusted one year relative survival rate (%)** Royal College of Physicians - National Lung Cancer Audit (NLCA) (03 Jul 2019)	37.0%	NA	37.3% Jan 17 - Dec 17	NA	S
Effective	E2	**Emergency readmissions: Acute and unspecified renal failure** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	78.8 Jul 19 - Jun 20	103.5 Jul 20 - Jun 21	→	S
Effective	E2	**Emergency readmissions: Acute bronchitis** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	96.3 Jul 19 - Jun 20	74.5 Jul 20 - Jun 21	→	S
Effective	E2	**Emergency readmissions: Acute cerebrovascular disease** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	81.5 Jul 19 - Jun 20	108.5 Jul 20 - Jun 21	→	S

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**Emergency readmissions: Acute myocardial infarction** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	95.1 Jul 19 - Jun 20	119.2 Jul 20 - Jun 21	➡	S
	E2	**Emergency readmissions: Chronic obstructive pulmonary disease and bronchiectasis** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	98.9 Jul 19 - Jun 20	95.3 Jul 20 - Jun 21	➡	S
	E2	**Emergency readmissions: Fluid and electrolyte disorders** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	72.8 Jul 19 - Jun 20	95.2 Jul 20 - Jun 21	⬇	S
	E2	**Emergency readmissions: Fracture of neck of femur (hip)** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	101.2 Jul 19 - Jun 20	96.3 Jul 20 - Jun 21	➡	S
	E2	**Emergency readmissions: Pneumonia** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	90.8 Jul 19 - Jun 20	83.8 Jul 20 - Jun 21	➡	S
	E2	**Emergency readmissions: Septicaemia (except in labour)** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	87.3 Jul 19 - Jun 20	73.8 Jul 20 - Jun 21	⬆	B
	E2	**Emergency readmissions: Urinary tract infections** Hospital Episode Statistics - HES - Readmissions by CCS group (15 Jan 2022)	100	98.9 Jul 19 - Jun 20	97.6 Jul 20 - Jun 21	➡	S
	E2	**In-hospital mortality: Acute and unspecified renal failure** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	74.9 Jul 19 - Jun 20	61.6 Jul 20 - Jun 21	➡	S
	E2	**In-hospital mortality: Acute bronchitis** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	136.3 Jul 19 - Jun 20	151.7 Jul 20 - Jun 21	➡	S
	E2	**In-hospital mortality: Acute cerebrovascular disease** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	100.1 Jul 19 - Jun 20	93.1 Jul 20 - Jun 21	➡	S
	E2	**In-hospital mortality: Acute myocardial infarction** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	92.9 Jul 19 - Jun 20	98.0 Jul 20 - Jun 21	➡	S

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**In-hospital mortality: Chronic obstructive pulmonary disease and bronchiectasis** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	110.3 Jul 19 - Jun 20	86.6 Jul 20 - Jun 21		S
	E2	**In-hospital mortality: Fluid and electrolyte disorders** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	79.9 Jul 19 - Jun 20	132.1 Jul 20 - Jun 21		S
	E2	**In-hospital mortality: Fracture of neck of femur (hip)** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	70.4 Jul 19 - Jun 20	110.8 Jul 20 - Jun 21		S
	E2	**In-hospital mortality: Pneumonia** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	92.5 Jul 19 - Jun 20	82.5 Jul 20 - Jun 21		S
	E2	**In-hospital mortality: Septicaemia (except in labour)** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	106.0 Jul 19 - Jun 20	103.2 Jul 20 - Jun 21		S
	E2	**In-hospital mortality: Urinary tract infections** Hospital Episode Statistics - CQC - HES Mortality (15 Jan 2022)	100	91.8 Jul 19 - Jun 20	94.7 Jul 20 - Jun 21		S
Responsive	R3	**Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks (%)** NHS England - RTT Admitted (15 Jan 2022)	78.8%	73.8% Nov 20	65.0% Nov 21		S

What's the current performance of surgery indicators?



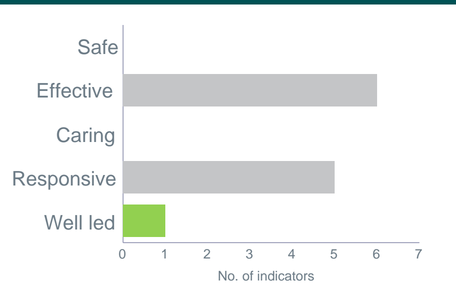
Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Performance: Change	National comparison
Safe	S5	**Crude percentage of patients documented as not developing a pressure ulcer (%)** Royal College of Physicians - National Hip Fracture Database (NHFD) - Scarborough Hospital (02 Aug 2021)	87.0%	100.0% Jan 18 - Dec 18	95.7% Jan 19 - Dec 19	↓	S
	S5	**Crude percentage of patients documented as not developing a pressure ulcer (%)** Royal College of Physicians - National Hip Fracture Database (NHFD) - York District Hospital (02 Aug 2021)	87.0%	91.7% Jan 18 - Dec 18	89.4% Jan 19 - Dec 19	→	W
	S5	**Never events in surgery** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022) National Guardian Freedom to Speak Up		0 Jan 20 - Dec 20	2 Jan 21 - Dec 21	↓	
Effective	E1	**Crude proportion of cases with pre-operative documentation of risk of death** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - York District Hospital (03 Aug 2020)	77.3%	81.5% Dec 16 - Nov 17	82.6% Dec 17 - Nov 18	→	W
	E1	**Crude proportion of cases with pre-operative documentation of risk of death** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - Scarborough Hospital (03 Aug 2020)	77.3%	-	60.6% Dec 17 - Nov 18	NA	W
	E1	**Crude proportion of high-risk cases (>=5% predicted mortality) with consultant surgeon and anaesthetist present in theatre** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - York District Hospital (03 Aug 2020)	83.1%	96.0% Dec 16 - Nov 17	95.4% Dec 17 - Nov 18	→	S
	E1	**Crude proportion of high-risk cases (>=5% predicted mortality) with consultant surgeon and anaesthetist present in theatre** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - Scarborough Hospital (03 Aug 2020)	83.1%	-	97.5% Dec 17 - Nov 18	NA	S
	E1	**Crude proportion of patients having perioperative medical assessment (%)** Royal College of Physicians - National Hip Fracture Database (NHFD) - York District Hospital (02 Aug 2021)	92.8%	98.1% Jan 18 - Dec 18	92.9% Jan 19 - Dec 19	→	S
	E1	**Crude proportion of patients having perioperative medical assessment (%)** Royal College of Physicians - National Hip Fracture Database (NHFD) - Scarborough Hospital (02 Aug 2021)	92.8%	78.3% Jan 18 - Dec 18	79.3% Jan 19 - Dec 19	→	W
	E2	**Abdominal aortic aneurysm risk-adjusted post-operative in-hospital mortality rate (%)** Royal College of Surgeons - National Vascular Registry (NVR) (15 Jul 2021)	1.4%	NA	1.8% Jan 17 - Dec 19	NA	S

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**Carotid Endarterectomy risk-adjusted 30-day mortality and stroke rate (%)** Royal College of Surgeons - National Vascular Registry (NVR) (15 Jul 2021)	1.9%	NA	2.5% Jan 17 - Dec 19	NA	S
	E2	**PROMs: Primary Hip Replacement EQ-5D score** NHS Digital - PROMS (19 Aug 2021)		Nil Significance Apr 19 - Mar 20	Nil Significance Apr 20 - Mar 21	➡	S
	E2	**PROMs: Primary Hip Replacement Oxford score** NHS Digital - PROMS (19 Aug 2021)		Nil Significance Apr 19 - Mar 20	Nil Significance Apr 20 - Mar 21	➡	S
	E2	**Risk adjusted 30-day mortality rate (%)** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - Scarborough Hospital (03 Aug 2020)	9.6%	-	9.6% Dec 17 - Nov 18	NA	S
	E2	**Risk adjusted 30-day mortality rate (%)** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - York District Hospital (03 Aug 2020)	9.6%	9.0% Dec 16 - Nov 17	15.9% Dec 17 - Nov 18	⬇	W
	E2	**Risk adjusted 5 year revision ratio for hips (excluding tumours and neck of femur fracture)** National Joint Registry - NJR Hip - Scarborough Hospital (21 Apr 2021)	1.0	1.3 Aug 14 - Aug 19	1.1 Aug 15 - Aug 20	NA	S
	E2	**Risk adjusted 5 year revision ratio for hips (excluding tumours and neck of femur fracture)** National Joint Registry - NJR Hip - York District Hospital (21 Apr 2021)	1.0	1.6 Aug 14 - Aug 19	1.7 Aug 15 - Aug 20	NA	W
	E2	**Risk adjusted 5 year revision ratio for hips (excluding tumours and neck of femur fracture)** National Joint Registry - NJR Hip - Bridlington Hospital (21 Apr 2021)	1.0	1.2 Aug 14 - Aug 19	1.5 Aug 15 - Aug 20	NA	W
	E2	**Risk adjusted 5 year revision ratio for knees (excluding tumours)** National Joint Registry - NJR Knees - York District Hospital (21 Apr 2021)	1.0	1.6 Aug 14 - Aug 19	1.2 Aug 15 - Aug 20	NA	S
	E2	**Risk adjusted 5 year revision ratio for knees (excluding tumours)** National Joint Registry - NJR Knees - Scarborough Hospital (21 Apr 2021)	1.0	1.0 Aug 14 - Aug 19	1.0 Aug 15 - Aug 20	NA	S
	E2	**Risk adjusted 5 year revision ratio for knees (excluding tumours)** National Joint Registry - NJR Knees - Bridlington Hospital (21 Apr 2021)	1.0	1.5 Aug 14 - Aug 19	1.3 Aug 15 - Aug 20	NA	S

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**Risk adjusted 90 day mortality ratio for hips (excluding tumours and neck of femur fracture)** National Joint Registry - NJR Hip - York District Hospital (21 Apr 2021)	1.0	1.4 Aug 14 - Aug 19	1.4 Aug 15 - Aug 20	NA	S
	E2	**Risk adjusted 90 day mortality ratio for hips (excluding tumours and neck of femur fracture)** National Joint Registry - NJR Hip - Scarborough Hospital (21 Apr 2021)	1.0	0.8 Aug 14 - Aug 19	1.7 Aug 15 - Aug 20	NA	S
	E2	**Risk adjusted 90 day mortality ratio for hips (excluding tumours and neck of femur fracture)** National Joint Registry - NJR Hip - Bridlington Hospital (21 Apr 2021)	1.0	0.8 Aug 14 - Aug 19	0.9 Aug 15 - Aug 20	NA	S
	E2	**Risk adjusted 90 day mortality ratio for knees (excluding tumours)** National Joint Registry - NJR Knees - Bridlington Hospital (21 Apr 2021)	1.0	0.8 Aug 14 - Aug 19	0.9 Aug 15 - Aug 20	NA	S
	E2	**Risk adjusted 90 day mortality ratio for knees (excluding tumours)** National Joint Registry - NJR Knees - Scarborough Hospital (21 Apr 2021)	1.0	1.0 Aug 14 - Aug 19	1.0 Aug 15 - Aug 20	NA	S
	E2	**Risk adjusted 90 day mortality ratio for knees (excluding tumours)** National Joint Registry - NJR Knees - York District Hospital (21 Apr 2021)	1.0	1.6 Aug 14 - Aug 19	1.6 Aug 15 - Aug 20	NA	S
	E2	**Risk-adjusted 30-day mortality rate (%)** Royal College of Physicians - National Hip Fracture Database (NHFD) - York District Hospital (02 Aug 2021)	6.1%	6.8% Jan 18 - Dec 18	8.5% Jan 19 - Dec 19	➡	S
	E2	**Risk-adjusted 30-day mortality rate (%)** Royal College of Physicians - National Hip Fracture Database (NHFD) - Scarborough Hospital (02 Aug 2021)	6.1%	5.8% Jan 18 - Dec 18	3.5% Jan 19 - Dec 19	⬆	B
	E2	**Risk-adjusted 30-day unplanned readmission rate (%)** NHS Digital - National Bowel Cancer Audit (NBOCAP) - The York Hospital (21 Jul 2020)	10.8%	NA	7.6% Apr 17 - Mar 18	NA	S
	E2	**Risk-adjusted 30-day unplanned readmission rate (%)** NHS Digital - National Bowel Cancer Audit (NBOCAP) - Scarborough Hospital (21 Jul 2020)	10.8%	NA	6.8% Apr 17 - Mar 18	NA	S
	E2	**Risk-adjusted 90-day post-operative mortality rate (%)** NHS Digital - National Bowel Cancer Audit (NBOCAP) - The York Hospital (21 Jul 2020)	3.0%	-	2.5% Apr 17 - Mar 18	NA	S

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	E2	**Risk-adjusted 90-day post-operative mortality rate (%)** NHS Digital - National Bowel Cancer Audit (NBOCAP) - Scarborough Hospital (21 Jul 2020)	3.0%	0.0% Apr 16 - Mar 17	2.4% Apr 17 - Mar 18	➡	S
	E2	**Risk-adjusted posterior capsule rupture rate** Royal College of Ophthalmologists - National Ophthalmology Database Audit (26 Jan 2021)	1.1%	0.6% Sep 17 - Aug 18	0.6% Sep 18 - Aug 19	➡	MB
Responsive	R3	**Cancelled operations as a percentage of elective activity (%)** NHS England - Cancelled Operations (18 Feb 2020)	1.1%	1.0% Oct 18 - Dec 18	1.1% Oct 19 - Dec 19	➡	S
	R3	**Cancelled operations not treated within 28 days of non-clinical cancellation (%)** NHS England - Cancelled Operations (18 Feb 2020)	9.1%	7.7% Oct 18 - Dec 18	8.7% Oct 19 - Dec 19	➡	S
	R3	**Crude overall hospital length of stay** Royal College of Physicians - National Hip Fracture Database (NHFD) - Scarborough Hospital (02 Aug 2021)	18.8	14.3 Jan 18 - Dec 18	16.2 Jan 19 - Dec 19	⬇	S
	R3	**Crude overall hospital length of stay** Royal College of Physicians - National Hip Fracture Database (NHFD) - York District Hospital (02 Aug 2021)	18.8	24.0 Jan 18 - Dec 18	23.8 Jan 19 - Dec 19	➡	W
	R3	**Crude proportion of cases with access to theatres within clinically appropriate time frames** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - Scarborough Hospital (03 Aug 2020)	82.4%	-	93.0% Dec 17 - Nov 18	NA	S
	R3	**Crude proportion of cases with access to theatres within clinically appropriate time frames** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - York District Hospital (03 Aug 2020)	82.4%	92.7% Dec 16 - Nov 17	83.8% Dec 17 - Nov 18	⬇	W
	R3	**Crude proportion of highest-risk cases (>=5% predicted mortality) admitted to critical care post-operatively** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - Scarborough Hospital (03 Aug 2020)	77.5%	-	85.3% Dec 17 - Nov 18	NA	S
	R3	**Crude proportion of highest-risk cases (>=5% predicted mortality) admitted to critical care post-operatively** Royal College of Anaesthetists - National Emergency Laparotomy Audit (NELA) - York District Hospital (03 Aug 2020)	77.5%	-	66.4% Dec 17 - Nov 18	NA	W

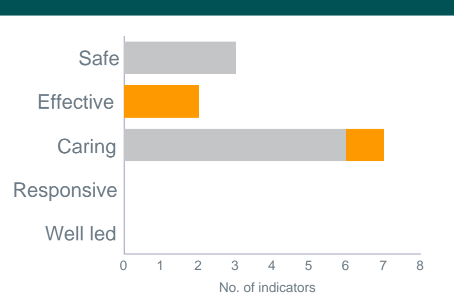
Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	R3	**Crude proportion of patients having surgery on the day or day after admission (%)** Royal College of Physicians - National Hip Fracture Database (NHFD) - York District Hospital (02 Aug 2021)	69.5%	65.6% Jan 18 - Dec 18	52.7% Jan 19 - Dec 19	↓	W
	R3	**Crude proportion of patients having surgery on the day or day after admission (%)** Royal College of Physicians - National Hip Fracture Database (NHFD) - Scarborough Hospital (02 Aug 2021)	69.5%	77.2% Jan 18 - Dec 18	75.9% Jan 19 - Dec 19	→	S
	R3	**Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%)** NHS England - RTT Admitted (15 Jan 2022)	57.6%	41.5% Nov 20	53.3% Nov 21	↑	S



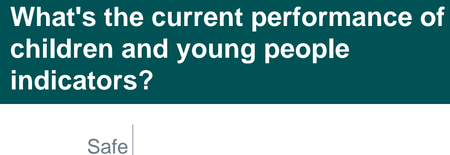
Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Performance: Change	National comparison
Safe	S5	**Never events in critical care** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022) **National Guardian** Freedom to Speak Up		0 Jan 20 - Dec 20	0 Jan 21 - Dec 21		
Effective	E2	**Risk-adjusted hospital mortality ratio** ICNARC - ICNARC - Scarborough Hospital, Intensive Care Unit (23 Jan 2021)	1.00	0.98 Apr 17 - Mar 18	1.15 Apr 18 - Mar 19		
	E2	**Risk-adjusted hospital mortality ratio** ICNARC - ICNARC - York Hospital, Intensive Care/High Dependency Unit (23 Jan 2021)	1.00	1.00 Apr 17 - Mar 18	1.10 Apr 18 - Mar 19		
	E2	**Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)** ICNARC - ICNARC - York Hospital, Intensive Care/High Dependency Unit (23 Jan 2021)	1.00	1.04 Apr 17 - Mar 18	1.30 Apr 18 - Mar 19		
	E2	**Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)** ICNARC - ICNARC - Scarborough Hospital, Intensive Care Unit (23 Jan 2021)	1.00	0.39 Apr 17 - Mar 18	1.26 Apr 18 - Mar 19		
	E4	**Crude, non-delayed, out-of-hours discharge to ward proportion (%)** ICNARC - ICNARC - York Hospital, Intensive Care/High Dependency Unit (23 Jan 2021)	1.9%	2.4% Apr 17 - Mar 18	1.3% Apr 18 - Mar 19		
	E4	**Crude, non-delayed, out-of-hours discharge to ward proportion (%)** ICNARC - ICNARC - Scarborough Hospital, Intensive Care Unit (23 Jan 2021)	1.9%	7.9% Apr 17 - Mar 18	1.2% Apr 18 - Mar 19		
Responsive	R1	**Crude non-clinical transfers (%)** ICNARC - ICNARC - Scarborough Hospital, Intensive Care Unit (23 Jan 2021)	0.34%	1.17% Apr 17 - Mar 18	0.91% Apr 18 - Mar 19		
	R1	**Crude non-clinical transfers (%)** ICNARC - ICNARC - York Hospital, Intensive Care/High Dependency Unit (23 Jan 2021)	0.34%	0.10% Apr 17 - Mar 18	0.00% Apr 18 - Mar 19		
	R3	**Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours) (%)** ICNARC - ICNARC - York Hospital, Intensive Care/High Dependency Unit (23 Jan 2021)	4.4%	3.4% Apr 17 - Mar 18	4.3% Apr 18 - Mar 19		
	R3	**Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours) (%)** ICNARC - ICNARC - Scarborough Hospital, Intensive Care Unit (23 Jan 2021)	4.4%	1.5% Apr 17 - Mar 18	3.0% Apr 18 - Mar 19		

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
	R3	**Full bed occupancy levels for adult critical care beds** NHS England - Critical Care Bed Occupancy (14 Apr 2020)		0-1 month of full occupancy Dec 18 - Feb 19	0-1 month of full occupancy Dec 19 - Feb 20	➡	S
Well led	W6	**Participation in the ICCQIP - Adult critical care services** NHS England - Critical Care Bed Occupancy (12 Jan 2021)		-	All units have authorised local administrator Dec 19	NA	B

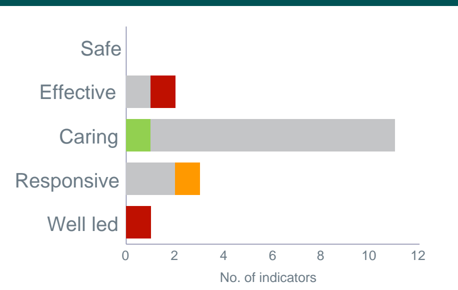
What's the current performance of maternity indicators?



Key question	KLOE	Indicator	National average	Performance Previous	Performance Latest	Performance Change	National comparison
Safe	S1	**Cleanliness of rooms and wards** Care Quality Commission - Maternity Survey - Benchmarking (28 Jan 2020)	-	8.9 Feb 18	9.1 Feb 19	➡	S
	S2	**Ratio of births to midwifery staff** Electronic Staff Record - ESR: Contracted FTEs - Midwifery (15 Nov 2021)	22.21	22.72 Jul 19 - Jun 20	22.27 Jul 20 - Jun 21	➡	S
	S2	**Ratio of senior midwives to midwives** Electronic Staff Record - ESR: Contracted FTEs - Midwifery (13 Dec 2021)	0.26	0.18 Oct 20	0.20 Oct 21	➡	S
	S5	**Never events in maternity and gynaecology** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022) National Guardian Freedom to Speak Up		0 Jan 20 - Dec 20	0 Jan 21 - Dec 21	➡	
Effective	E2	**Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)** MBRRACE-UK - MBRRACE - Perinatal Mortality Surveillance (24 Oct 2020)	4.8	4.9 Jan 16 - Dec 16	4.8 Jan 17 - Dec 17	NA	W
	E2	**Stabilised and risk-adjusted extended perinatal mortality rate excluding congenital anomalies (per 1,000 births)** MBRRACE-UK - MBRRACE - Perinatal Mortality Surveillance (24 Oct 2020)	4.2	-	4.1 Jan 17 - Dec 17	NA	W
Caring	C1	**Being left alone** Care Quality Commission - Maternity Survey - Benchmarking (28 Jan 2020)	-	8.6 Feb 18	8.6 Feb 19	➡	S
	C1	**Raising concerns** Care Quality Commission - Maternity Survey - Benchmarking (28 Jan 2020)	-	8.7 Feb 18	8.6 Feb 19	➡	S
	C1	**Staff introduction** Care Quality Commission - Maternity Survey - Benchmarking (28 Jan 2020)	-	9.4 Feb 18	9.2 Feb 19	➡	S
	C2	**Advice at the start of labour** Care Quality Commission - Maternity Survey - Benchmarking (28 Jan 2020)	-	8.7 Feb 18	8.5 Feb 19	➡	S
	C2	**Comfortable atmosphere during labour** Care Quality Commission - Maternity Survey - Benchmarking (28 Jan 2020)	-	-	8.1 Feb 19	NA	S
	C2	**Information or explanations given after birth** Care Quality Commission - Maternity Survey - Benchmarking (28 Jan 2020)	-	7.6 Feb 18	7.3 Feb 19	➡	W
	C3	**Treatment with respect and dignity** Care Quality Commission - Maternity Survey - Benchmarking (28 Jan 2020)	-	9.6 Feb 18	9.4 Feb 19	➡	S



What's the current performance of children and young people indicators?



Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Change	National comparison
Safe	S5	**Never events in children and young people** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022)		0 Jan 20 - Dec 20	0 Jan 21 - Dec 21	→	
Effective	E1	**Case mix adjusted mean HbA1c; blood glucose control** Royal College of Paediatrics and Child Health - National Paediatric Diabetes Audit (NPDA) - Scarborough Hospital (06 Jul 2021)	65.0	64.8 Apr 18 - Mar 19	62.9 Apr 19 - Mar 20	→	S
	E1	**Case mix adjusted mean HbA1c; blood glucose control** Royal College of Paediatrics and Child Health - National Paediatric Diabetes Audit (NPDA) - York District Hospital (06 Jul 2021)	65.0	70.2 Apr 18 - Mar 19	72.2 Apr 19 - Mar 20	→	MW
Caring	C1	**Being well looked after** PICKER - CQC CYP Survey (07 Jan 2020)	-	9.0 Nov 16 - Dec 16	9.2 Nov 18 - Dec 18	→	S
	C1	**Confidence and trust** PICKER - CQC CYP Survey (07 Jan 2020)	-	8.8 Nov 16 - Dec 16	8.9 Nov 18 - Dec 18	→	S
	C1	**Parents view of child being well looked after** PICKER - CQC CYP Survey (07 Jan 2020)	-	9.1 Nov 16 - Dec 16	9.0 Nov 18 - Dec 18	→	S
	C2	**Explanations parents and carers could understand** PICKER - CQC CYP Survey (07 Jan 2020)	-	9.1 Nov 16 - Dec 16	9.1 Nov 18 - Dec 18	→	S
	C2	**Information about next steps** PICKER - CQC CYP Survey (07 Jan 2020)	-	7.9 Nov 16 - Dec 16	7.8 Nov 18 - Dec 18	→	S
	C2	**Involvement** PICKER - CQC CYP Survey (07 Jan 2020)	-	6.0 Nov 16 - Dec 16	6.5 Nov 18 - Dec 18	→	S
	C2	**Parent and carer involvement** PICKER - CQC CYP Survey (07 Jan 2020)	-	8.5 Nov 16 - Dec 16	8.5 Nov 18 - Dec 18	→	S
	C2	**Parents and carers being given information about next steps** PICKER - CQC CYP Survey (07 Jan 2020)	-	8.1 Nov 16 - Dec 16	8.6 Nov 18 - Dec 18	→	B
	C2	**Understanding what staff say** PICKER - CQC CYP Survey (07 Jan 2020)	-	8.4 Nov 16 - Dec 16	8.6 Nov 18 - Dec 18	→	S
	C3	**Pain management** PICKER - CQC CYP Survey (07 Jan 2020)	-	8.6 Nov 16 - Dec 16	9.0 Nov 18 - Dec 18	→	S
	C3	**Parent and carer views on pain management** PICKER - CQC CYP Survey (07 Jan 2020)	-	8.4 Nov 16 - Dec 16	8.5 Nov 18 - Dec 18	→	S
Responsive	R1	**Appropriate equipment or adaptations** PICKER - CQC CYP Survey (07 Jan 2020)	-	8.8 Nov 16 - Dec 16	9.0 Nov 18 - Dec 18	→	S
	R1	**Type of ward stayed on** PICKER - CQC CYP Survey (07 Jan 2020)	-	9.7 Nov 16 - Dec 16	9.7 Nov 18 - Dec 18	→	S
	R3	**Full bed occupancy levels for neonatal intensive care beds** NHS England - Critical Care Bed Occupancy (14 Apr 2020)		3 months of full occupancy Dec 18 - Feb 19	2 months of full occupancy Dec 19 - Feb 20	↑	W

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Well led	W6	**Participation in the ICCQIP - Neonatal critical care services** NHS England - Critical Care Bed Occupancy (12 Jan 2021)		-	No units registered Dec 19	NA	MW

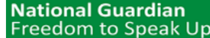
What's the current performance of end of life care indicators?

Key question	No. of indicators
Safe	
Effective	4
Caring	
Responsive	
Well led	

Key question	KLOE	Indicator	National average	Performance: Previous	Performance: Latest	Performance: Change	National comparison
Effective	E4	**Is face-to-face palliative care available 8hrs/7days?** National Audit of Care at the End of Life (NACEL) - The York Hospital (29 Jun 2021)		-	No - not 8 hours a day, 7 days a week Apr 18 - Mar 19	NA	W
	E4	**Is face-to-face palliative care available 8hrs/7days?** National Audit of Care at the End of Life (NACEL) - Scarborough Hospital (29 Jun 2021)		-	No - not 8 hours a day, 7 days a week Apr 18 - Mar 19	NA	W
	E4	**Is face-to-face palliative care available 8hrs/7days?** National Audit of Care at the End of Life (NACEL) - Selby War Memorial Hospital (29 Jun 2021)		-	No - not 8 hours a day, 7 days a week Apr 18 - Mar 19	NA	W
	E4	**Is face-to-face palliative care available 8hrs/7days?** National Audit of Care at the End of Life (NACEL) - St Monicas Hospital (29 Jun 2021)		-	No - not 8 hours a day, 7 days a week Apr 18 - Mar 19	NA	W

What's the current performance of outpatients indicators?

Key question	KLOE	Indicator	National average	Performance			National comparison
				Previous	Latest	Change	
Safe	S5	**Never events in outpatients and diagnostic imaging** NHS Improvement - OBIEE NRLS STEIS (15 Jan 2022) National Guardian Freedom to Speak Up		0 Jan 20 - Dec 20	1 Jan 21 - Dec 21	↓	
Responsive	R3	**Cancer - First treatment in 31 days of decision to treat (%)** NHS England - Cancer Waits 31 Days All Cancers (11 Nov 2021)	93.6%	97.0% Jul 20 - Sep 20	97.6% Jul 21 - Sep 21	→	S
Responsive	R3	**Cancer - First treatment in 62 days of urgent GP/dentist referral (%)** NHS England - Cancer Waits 62 Days All Cancers (11 Nov 2021)	69.8%	78.7% Jul 20 - Sep 20	65.9% Jul 21 - Sep 21	↓	W
Responsive	R3	**Cancer - First treatment in 62 days of urgent national screening referral (%)** NHS England - Cancer Waits 62 Days Screening (11 Nov 2021)	73.4%	42.9% Jul 20 - Sep 20	85.4% Jul 21 - Sep 21	↑	S
Responsive	R3	**Cancer - Seen by specialist in 14 days of urgent GP/dentist referral (%)** NHS England - Cancer Waits 14 Days All Cancers (11 Nov 2021)	84.7%	92.5% Jul 20 - Sep 20	93.4% Jul 21 - Sep 21	→	S
Responsive	R3	**Outpatient DNAs (%)** Hospital Episode Statistics - HES Outpatients (15 Jan 2022)	7.8%	3.4% Jul 20	5.8% Jul 21	→	S
Responsive	R3	**Patients waiting over 6 weeks for diagnostic test (%)** NHS England - Diagnostics Waiting Times (15 Dec 2021)	25.6%	39.0% Oct 20	43.3% Oct 21	→	S
Responsive	R3	**Referral to treatment, on incomplete pathways, within 18 weeks (%)** NHS England - RTT Incomplete (15 Jan 2022)	64.6%	67.5% Nov 20	64.8% Nov 21	→	S
Responsive	R3	**Referral to treatment, on non-admitted pathways, within 18 weeks (%)** NHS England - RTT NonAdmitted (15 Jan 2022)	75.1%	85.4% Nov 20	80.8% Nov 21	→	S



Key messages

Not currently available

This trust
Highest 25% of reporters
Middle 50% of reporters
Lowest 25% of reporters
Median

All reported incidents

Number of incidents (0–1,400)

Reported incidents that resulted in moderate, severe harm or death

Number of incidents (0–30)

Year-month	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10
1. Death	3	1	1	1	1	1	3	1	0	2	1	2	0
2. Severe	4	3	4	6	2	6	4	2	6	4	5	3	3
3. Moderate	11	16	16	19	12	19	23	12	10	24	14	21	8
4. Low	325	382	308	352	346	315	297	334	365	371	341	365	87
5. No Harm	919	810	832	927	801	870	646	851	876	819	829	858	185
6. Total	1,262	1,212	1,161	1,305	1,162	1,211	973	1,200	1,257	1,220	1,190	1,249	283

Comparative reporting rate for incidents in all acute trusts

Reported incidents per 1,000 bed days (0–160)

Indicator	Trend	Performance
Proportion of reported patient safety incidents reported as resulting in harm (%)		S
Risk of under-reporting patient safety incidents resulting in death or severe harm to the National Reporting and Learning System (NRLS)		S
Risk of under-reporting patient safety incidents to the National Reporting and Learning System (NRLS)		S

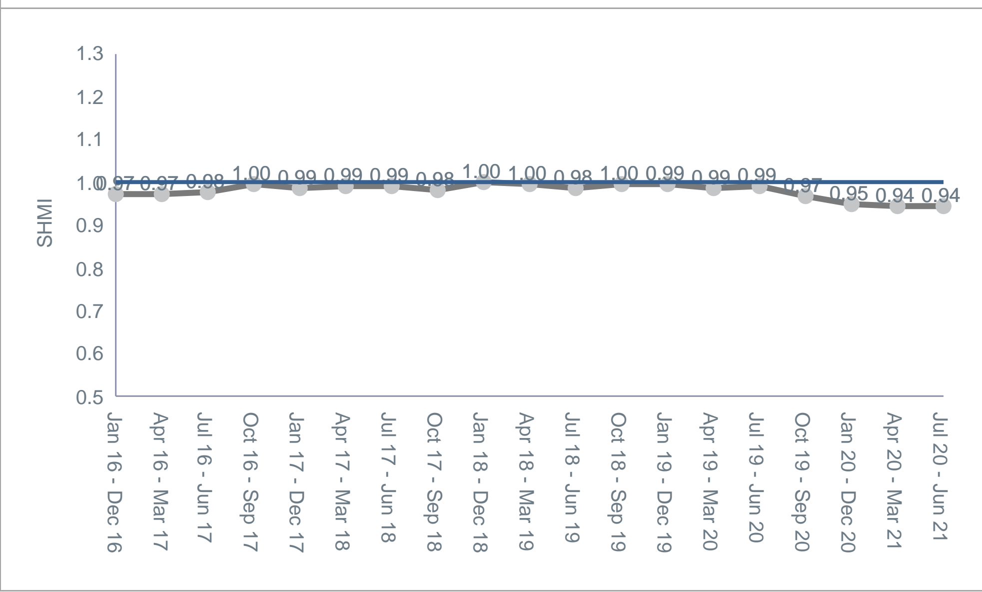
Source: NRLS (Oct 19 - Mar 20)

Key messages

- For the 12-month period from Jul 20 - Jun 21, SHMI was within expected range.
- For the 12-month period from Jul 20 - Jun 21, HSMR was as expected.

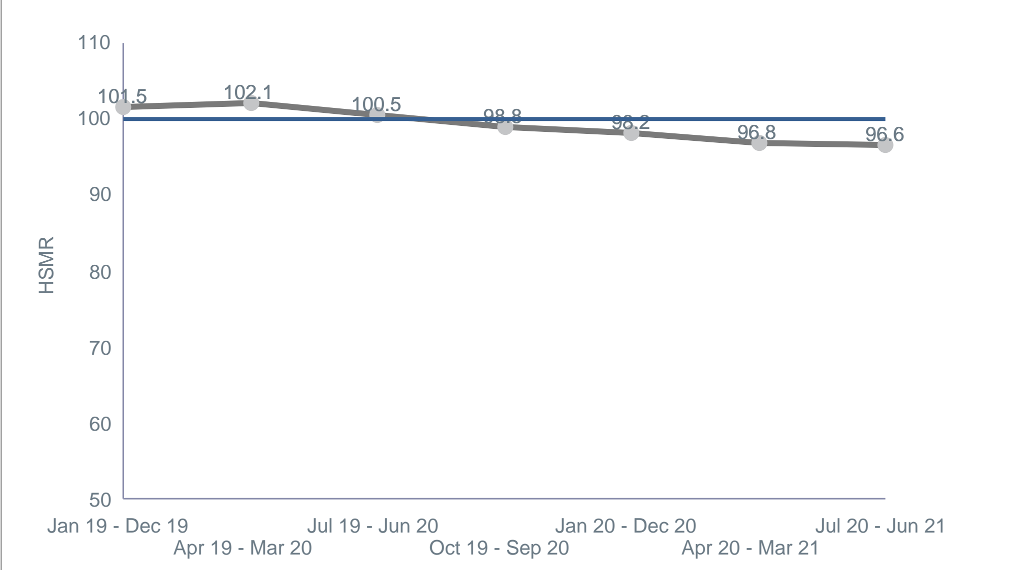
Summary Hospital-level Mortality indicator (SHMI)

For the 12-month period from Jul 20 - Jun 21, SHMI was within expected range with a value of 0.94 (compared to 1.0 for England) and 2,550 deaths compared to an expected 2,705 deaths.



Hospital Standardised Mortality Ratio (HSMR)

For the 12-month period from Jul 20 - Jun 21, HSMR was as expected with a value of 96.63 (compared to 100 for England) and 1,500 deaths compared to an expected 1,552 deaths. Weekend HSMR is within expected range for this time period.



England standardised mortality ratio

This trust

Higher than expected

Within expected range

Lower than expected

Source: NHS Digital and Dr Foster Intelligence

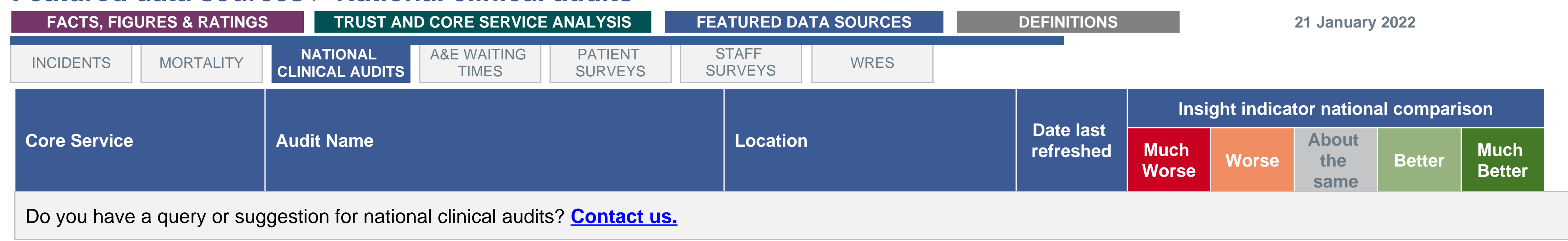
National clinical audits are priority information to inform discussions about quality improvement. The table below provides a high-level summary 'at a glance' of the key clinically relevant indicators which best reflect trust performance. Click on the links to see extra site and ward-level audit results to inform monitoring conversations.

- Audit results should be followed-up during engagement meetings:
  - Better or worse than expected performance should be used to drive quality improvement
  - Where performance is much worse than expected we would expect this to prompt an investigation by the trust
- National clinical audits are reported here only if the trust participated
- More audits will be added each quarter and inspectors will soon receive information on audit outliers and audit data quality concerns
- More audit results may be available for eligible trusts via the automated audit results tool for audits that are in the pipeline for development in Insight

Core Service	Audit Name	Location	Date last refreshed	Insight indicator national comparison				
				Much Worse	Worse	About the same	Better	Much Better
Children and young people	Neonatal Audit	Scarborough Hospital	09/18	see link	see link	see link	see link	see link
Children and young people	Neonatal Audit	York District Hospital	09/18	see link	see link	see link	see link	see link
Children and young people	National Paediatric Diabetes Audit	Scarborough Hospital	07/21	0	0	1	0	0
Children and young people	National Paediatric Diabetes Audit	York District Hospital	07/21	1	0	0	0	0
Medical care	National Lung Cancer Audit	York and Scarborough Teaching Hospitals NHS Foundation Trust	07/19	0	1	3	0	0
Medical care	Stroke Audit	Scarborough Hospital	10/21	0	0	0	0	0
Medical care	Stroke Audit	The York Hospital	10/21	0	0	0	1	0
Surgery	National Bowel Cancer Audit	Scarborough Hospital	07/20	0	0	2	0	0
Surgery	National Bowel Cancer Audit	The York Hospital	07/20	0	0	2	0	0
Surgery	National Emergency Laparotomy Audit	Scarborough Hospital	08/20	0	1	3	0	0
Surgery	National Emergency Laparotomy Audit	York District Hospital	08/20	0	3	1	0	0
Surgery	National Hip Fracture Database	Scarborough Hospital	08/21	0	1	3	1	0
Surgery	National Hip Fracture Database	York District Hospital	08/21	0	3	2	0	0
Surgery	National Oesophago-gastric Cancer Audit	York and Scarborough Teaching Hospitals NHS Foundation Trust	12/20	see link	see link	see link	see link	see link
Surgery	National Vascular Registry	York and Scarborough Teaching Hospitals NHS Foundation Trust	07/21	0	0	2	0	0
Critical care	ICNARC	Scarborough Hospital*	01/21	0	0	5	0	0
Critical care	ICNARC	York District Hospital*	01/21	0	0	5	0	0
Maternity	MBRRACE-UK	York and Scarborough Teaching Hospitals NHS Foundation Trust	10/20	0	1	0	0	0
Maternity	National Maternity and Perinatal Audit	Scarborough Hospital	09/19	see link	see link	see link	see link	see link
Maternity	National Maternity and Perinatal Audit	York District Hospital	09/19	see link	see link	see link	see link	see link

*May be an aggregate of more than one ward's results

Featured data sources > National clinical audits



Core Service	Audit Name	Location	Date last refreshed	Insight indicator national comparison				
				Much Worse	Worse	About the same	Better	Much Better
Do you have a query or suggestion for national clinical audits? **Contact us.**								

York Hospitals NHS FT

	Metric	CQC Key Question	2017 Report[1]	2018 Report[2]	National Aggregate (England and Wales)	National Audit Standard	Comparison to other hospitals
All patients 350 cases	Crude proportion of patients seen by a Cancer Nurse Specialist	Responsive	56.8%	**21.1%**	**n/a**	90%*	Does not meet the audit aspirational standard of 90%
	Case mix adjusted one year relative survival rate	Effective	Within the expected range	**37.3%**	**37.0%**	none	Within expected range
NSCLC 350 cases	Case mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery	Effective	Within the expected range	**13.1%**	**18.4%**	17%*	Worse than expected
NSCLC 51 cases	Case mix adjusted percentage of fit patients with advanced Non Small Cell Lung Cancer (NSCLC) receiving Systemic Anti-Cancer Treatment	Effective	Within the expected range	**62.0%**	**65.0%**	65%*	Within expected range
SCLC 28 cases	Case mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy	Effective	Within the expected range	**68.3%**	**71.0%**	70%*	Within expected range

All trusts in England participate in the audit, and data is submitted for approximately 100% of patients. Case ascertainment is therefore not presented separately.

[1] Jan 16 - Dec 16
[2] Jan 17 - Dec 17

*Audit standard based on NICE guideline

Scarborough Hospital

	Metric	CQC Key Question	2019[1] Report	2020[2] Report	National Aggregate (England and Wales)	National Standard	Comparison to other hospitals
300 cases	Case ascertainment	Well Led	88%	**110%**	**101.0%**	100%*	24.0 / 95.4 / 107.3 / 176.1
300 cases	Crude proportion of patients having surgery on the day or day after admission	Responsive	77%	**76%**	**69.5%**	85%*	24.3 / 61.7 / 79.9 / 96.1
300 cases	Crude perioperative medical assessment within 72 hours rate %	Effective	78%	**79%**	**92.8%**	100%*	4.3 / 90.5 / 97.6 / 100.0
300 cases	Crude proportion of patients documented as not developing a pressure ulcer	Safe	100%	**96%**	**87.0%**	100%*	77.6 / 95.3 / 99.2 / 100.0
300 cases	Crude overall hospital length of stay	Responsive	14 days	**16 days**	**18.8 days**	none	34.4 / 21.2 / 15.8 / 11.4
300 cases	Risk-adjusted 30-day mortality rate	Effective	5.8%	**3.5%**	**6.1%**	none	Better than expected

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

Key:

Much better than expected (below 99.8% control limit)

Hospital

Much worse than expected (above 99.8% CL)

Within expected range

Better than expected (below 95% CL)

Worse than expected (above 95% CL)

Hospital

Bottom 25% | Top 25%

Min | Max

[1] Jan 18 - Dec 18
[2] Jan 19 - Dec 19

Data presented here is a snapshot used for the published annual reports and may not exactly match the live data available on the NHFD website.

*Audit recommendation based on NICE guideline
**England only

York District Hospital

	Metric	CQC Key Question	2019[1] Report	2020[2] Report	National Aggregate (England and Wales)	National Standard	Comparison to other hospitals
407 cases	Case ascertainment	Well Led	105%	**96%**	**101.0%**	100%*	24.0 95.4 107.3 176.1
407 cases	Crude proportion of patients having surgery on the day or day after admission	Responsive	66%	**53%**	**69.5%**	85%*	24.3 61.7 79.9 96.1
407 cases	Crude perioperative medical assessment within 72 hours rate %	Effective	98%	**93%**	**92.8%**	100%*	4.3 90.5 97.6 100.0
407 cases	Crude proportion of patients documented as not developing a pressure ulcer	Safe	92%	**89%**	**87.0%**	100%*	77.6 95.3 99.2 100.0
407 cases	Crude overall hospital length of stay	Responsive	24 days	**24 days**	**18.8 days**	none	34.4 21.2 15.8 11.4
407 cases	Risk-adjusted 30-day mortality rate	Effective	6.8%	**8.5%**	**6.1%****	none	Within expected range

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

Key:

Much better than expected (below 99.8% control limit)
Better than expected (below 95% CL)
Within expected range
Hospital
Worse than expected (above 95% CL)
Much worse than expected (above 99.8% CL)

Bottom 25% | Hospital | Top 25%
Min | Max

[1] Jan 18 - Dec 18
[2] Jan 19 - Dec 19

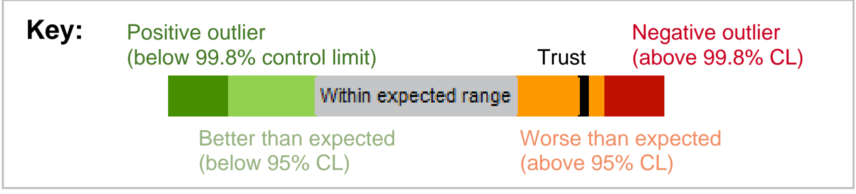
Data presented here is a snapshot used for the published annual reports and may not exactly match the live data available on the NHFD website.

*Audit recommendation based on NICE guideline
**England only

Audit results guide for Inspectors (Internal CQC users only)

York Teaching Hospital NHS Foundation Trust - The York Hospital

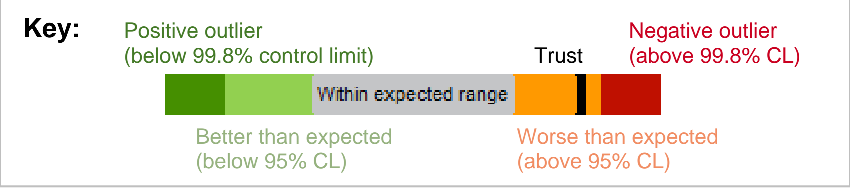
	Metric	CQC Key Question	2018 Report	2019 Report	National Aggregate (England and Wales)	National Standard	Comparison to other hospitals
214 operations	Case ascertainment	Well Led	Not Reported[1]	96.8%[4]	95.0%	none	Good (over 80%)
109 operations	Risk-adjusted post-operative length of stay >5 days after major resection*	Responsive	Not Reported[1]	56.9%[4]	62.0%	none	Better than national aggregate
136 operations	Risk-adjusted 90-day post-operative mortality rate	Effective	Not Reported[1]	2.5%[4]	3.0%	none	0 Within expected range 20
135 operations	Risk-adjusted 2-year post-operative mortality rate	Effective	Not Reported[2]	32.3%[5]	18.9%	none	0 Negative outlier 50
127 operations	Risk-adjusted 30-day unplanned readmission rate	Effective	Not Reported[1]	7.6%[4]	10.8% *	none	0 Within expected range 30
124 operations	Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection	Effective	Not Reported[3]	57.0%[6]	53.0% *	none	0 Within expected range 90



[1] Apr 16 - Mar 17 [2] Apr 14 - Mar 15 [3] Apr 13 - Mar 16 *England only
[4] Apr 17 - Mar 18 [5] Apr 15 - Mar 16 [6] Apr 14 - Mar 17

York Teaching Hospital NHS Foundation Trust – Scarborough Hospital

	Metric	CQC Key Question	2018 Report	2019 Report	National Aggregate (England and Wales)	National Standard	Comparison to other hospitals
132 operations	Case ascertainment	Well Led	108.9%[1]	**109.1%[4]**	**95.0%**	none	Good (over 80%)
48 operations	Risk-adjusted post-operative length of stay >5 days after major resection*	Responsive	65.1%[1]	**66.8%[4]**	**62.0%**	none	Worse than national aggregate
61 operations	Risk-adjusted 90-day post-operative mortality rate	Effective	0.0%[1]	**2.4%[4]**	**3.0%**	none	0 Within expected range 20
68 operations	Risk-adjusted 2-year post-operative mortality rate	Effective	21.3%[2]	**29.0%[5]**	**18.9%**	none	0 Within expected range 50
58 operations	Risk-adjusted 30-day unplanned readmission rate	Effective	10.1%[1]	**6.8%[4]**	**10.8% ***	none	0 Within expected range 30
45 operations	Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection	Effective	68.3%[3]	**70.9%[6]**	**53.0% ***	none	0 Worse than expected 90

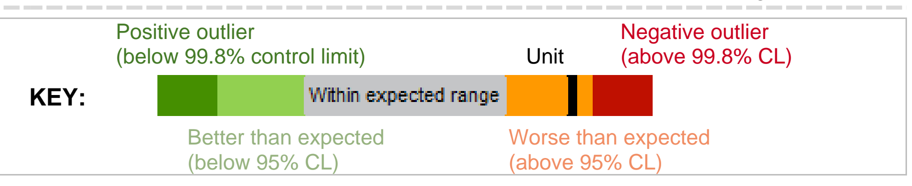


[1] Apr 16 - Mar 17 [2] Apr 14 - Mar 15 [3] Apr 13 - Mar 16 *England only
[4] Apr 17 - Mar 18 [5] Apr 15 - Mar 16 [6] Apr 14 - Mar 17

York Hospital, Intensive Care/High Dependency Unit

	Metric	CQC Key Question	2017/18[1] Report	2018/19[2] Report	National Aggregate (England, Wales & N. Ireland)	National Standard	Comparison to other Units
	Case Ascertainment	Well Led	Not reported for this audit			none	n/a
1097 admissions	Crude non-clinical transfers	Responsive	0.1%	**0.0%**	**0.3%**	0%*	0.0 Within expected range 6.0
769 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	2.4%	**1.3%**	**1.9%**	0%*	0.0 Within expected range 25.0
6205 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	3.4%	**4.3%**	**4.4%**	0%*	Not in the worst 5% of units
1027 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	1.0[3]	**1.1[4]**	**1.0**	none	0.2 Within expected range 2.8
678 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	1.0[3]	**1.3[4]**	**1.0**	none	0.2 Within expected range 2.8

icnarc intensive care national audit & research centre



[1] Apr 17 - Mar 18
[2] Apr 18 - Mar 19
[3] $ICNARC_{H\text{-}2015}$ risk adjustment model
[4] $ICNARC_{H\text{-}2018}$ risk adjustment model

* FICM/ICS guideline

21 January 2022

Scarborough Hospital, Intensive Care Unit

	Metric	CQC Key Question	2017/18[1] Report	2018/19[2] Report	National Aggregate (England, Wales & N. Ireland)	National Standard	Comparison to other Units
	Case Ascertainment	Well Led	Not reported for this audit			none	n/a
441 admissions	Crude non-clinical transfers	Responsive	1.2%	**0.9%**	**0.3%**	0%*	0.0 Within expected range 6.0
164 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	7.9%	**1.2%**	**1.9%**	0%*	0.0 Within expected range 25.0
2920 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	1.5%	**3.0%**	**4.4%**	0%*	Not in the worst 5% of units
419 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	1.0[3]	**1.2[4]**	**1.0**	none	0.2 Within expected range 2.8
284 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	0.4[3]	**1.3[4]**	**1.0**	none	0.2 Within expected range 2.8

icnarc intensive care national audit & research centre

KEY: Positive outlier (below 99.8% control limit); Better than expected (below 95% CL); Within expected range; Unit; Worse than expected (above 95% CL); Negative outlier (above 99.8% CL)

[1] Apr 17 - Mar 18
[2] Apr 18 - Mar 19
[3] $ICNARC_{H\text{-}2015}$ risk adjustment model
[4] $ICNARC_{H\text{-}2018}$ risk adjustment model

* FICM/ICS guideline

21 January 2022

	Metric	CQC Key Question	2019[1] Report	2020[2] Report	National Aggregate (England & Wales)	National Standard	Comparative performance
225 cases	Case ascertainment	Well Led	75-84%	**85-100%**	**90%***	none	85-100% ▲
133 cases	Crude proportion of patients with stage 0-3 cancer with curative treatment plan	Effective	58.5%	**57.9%**	**60.0%**	none	Within expected range
163 cases	Age and sex adjusted proportion of patients diagnosed after an emergency admission	Effective	19.2%	**Poor quality data**	**13.3%**	none	N/A – poor quality data
Not eligible	Risk-adjusted 90-day post-operative mortality rate	Effective	Not eligible	**Not eligible**	**3.3%**	none	Not eligible

National Oesophago-Gastric Cancer Audit

Key: Funnel plot
Positive outlier | Within expected range | Trust | Negative outlier

[1] Apr 16 - Mar 18
[2] Apr 17 - Mar 19

*England only

Audit results guide for Inspectors (Internal CQC users only)

York Teaching Hospital NHS Foundation Trust

		Metric	CQC Key Question	2019 Report	2020 Report	National Aggregate (UK)	National Standard	Comparative performance
Abdominal Aortic Aneurysm	56 cases	Case ascertainment (%)	Well Led	125%[1]	**108%[3]**	**94.0%**	90%	
		Risk-adjusted post-operative in-hospital mortality rate	Effective	1.8%[2]	**1.8%[4]**	**1.4%**	none	0 Within expected range 20
Carotid Endarterectomy	109 cases	Case Ascertainment (%)	Well Led	102%[1]	**102%[3]**	**97.0%**	90%	
		Crude median time from symptom to surgery	Responsive	4 days[1]	**5 days[3]**	**12 days**	14 days*	Better than audit standard
		Risk-adjusted 30-day mortality and stroke rate	Effective	3.1%[2]	**2.5%[4]**	**1.9%**	none	0 Within expected range 15

VSQIP VASCULAR SERVICES QUALITY IMPROVEMENT PROGRAMME

KEY: Positive outlier (below 99.8% control limit) | Within expected range | Trust | Negative outlier (above 99.8% CL)

[1] Jan 18 - Dec 18
[2] Jan 16 - Dec 18

* NICE guideline

[3] Jan 19 - Dec 19
[4] Jan 17 - Dec 19

21 January 2022

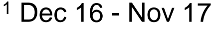
Scarborough Hospital

	Cases	Metric	CQC Key Question	Year 4[1]	Year 5[2]	National Aggregate (England & Wales)	National Standard	Hospital performance
	109 cases	Case Ascertainment	Well Led	7.1%	**96.5%**	84.0%	85%	85% and over (green triangle)
Proportion of patients for which each process of care was met	109 cases	Crude proportion of cases with pre-operative documentation of risk of death	Effective	100.0%	**60.6%**	77.3%	85%	From 55% to less than 85% (amber square)
Proportion of patients for which each process of care was met	100 cases	Crude proportion of cases with access to theatres within clinically appropriate time frames	Responsive	100.0%	**93.0%**	82.4%	85%	85% and over (green triangle)
Proportion of patients for which each process of care was met	79 cases	Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre	Effective	100.0%	**97.5%**	83.1%	85%	85% and over (green triangle)
Proportion of patients for which each process of care was met	75 cases	Crude proportion of highest-risk cases (greater than or equal to 5% predicted mortality) admitted to critical care post-operatively	Responsive	n/a	**85.3%**	77.5%	85%	85% and over (green triangle)
	109 cases	Risk adjusted 30-day mortality	Effective	n/a	**9.6%**	9.6%	None	Within expected range

NELA National Emergency Laparotomy Audit

Key:

- ≥85% (green triangle)
- ≥ 55% and <85% (amber square)
- <55% (red circle)



[1] Dec 16 - Nov 17
[2] Dec 17 - Nov 18

For a given metric, if cases are less than 10, the hospital is ineligible for that metric. A case count and metric value is still reported (unless the case count is zero) but the hospital performance is not assessed.

York Hospital

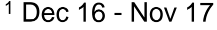
	Cases	Metric	CQC Key Question	Year 4[1]	Year 5[2]	National Aggregate (England & Wales)	National Standard	Hospital performance	
	195 cases	Case Ascertainment	Well Led	90.8%	**99.0%**	84.0%	85%	85% and over	▲ (green)
Proportion of patients for which each process of care was met	195 cases	Crude proportion of cases with pre-operative documentation of risk of death	Effective	81.5%	**82.6%**	77.3%	85%	From 55% to less than 85%	■ (amber)
	154 cases	Crude proportion of cases with access to theatres within clinically appropriate time frames	Responsive	92.7%	**83.8%**	82.4%	85%	From 55% to less than 85%	■ (amber)
	109 cases	Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre	Effective	96.0%	**95.4%**	83.1%	85%	85% and over	▲ (green)
	122 cases	Crude proportion of highest-risk cases (greater than or equal to 5% predicted mortality) admitted to critical care post-operatively	Responsive	n/a	**66.4%**	77.5%	85%	From 55% to less than 85%	■ (amber)
	195 cases	Risk adjusted 30-day mortality	Effective	9.0%	**15.9%**	9.6%	None	Worse than expected	

NELA
National Emergency Laparotomy Audit

Key:

- ▲ ≥85%
- ■ ≥ 55% and <85%
- ● <55%

Positive outlier (below 99.8% CL)
Trust
Negative outlier (above 99.8% CL)
Within expected range
Better than expected (below 95% CL)
Worse than expected (above 95% CL)

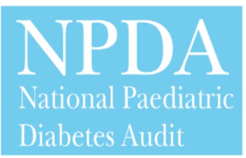


[1] Dec 16 - Nov 17
[2] Dec 17 - Nov 18

For a given metric, if cases are less than 10, the hospital is ineligible for that metric. A case count and metric value is still reported (unless the case count is zero) but the hospital performance is not assessed.

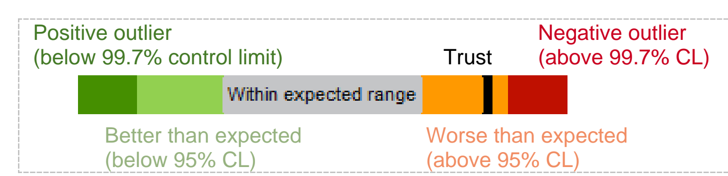
Scarborough General Hospital

		Metric	CQC Key Question	2018/19[1] Report	2019/20[2] Report	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other units
Process measures	36 cases	Completion rate for key health checks for patients aged 12+	Effective	95.4%	**95.6%**	88.6%	n/a	64% Within expected range 98%
Blood glucose diabetes control (HbA1c)	81 cases	**Organisation compared with nationally:** Case-mix adjusted mean HbA1c (mmol/mol)	Effective	Within expected range	**62.9**	65.0	n/a	55 Within expected range 72
	81 cases	**Organisational performance compared between years:** Median HbA1c (mmol/mol)	Effective	62.8	**61.0**	62.0	n/a	Clinically important improvement



HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. Higher values indicate poorer control.

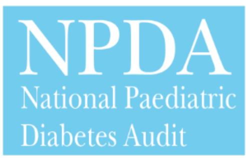
Key:



[1] Apr 18 - Mar 19
[2] Apr 19 - Mar 20

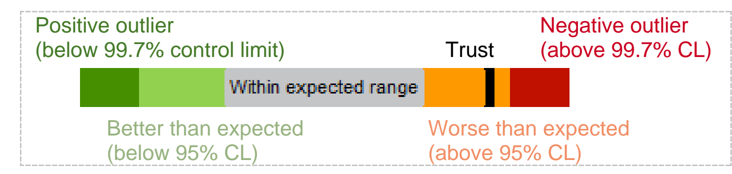
The York Hospital

		Metric	CQC Key Question	2018/19[1] Report	2019/20[2] Report	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other units
Process measures	74 cases	Completion rate for key health checks for patients aged 12+	Effective	75.0%	**91.1%**	88.6%	n/a	64% Within expected range 98%
Blood glucose diabetes control (HbA1c)	142 cases	**Organisation compared with nationally:** Case-mix adjusted mean HbA1c (mmol/mol)	Effective	Negative outlier	**72.2**	65.0	n/a	55 Negative outlier 72
	142 cases	**Organisational performance compared between years:** Median HbA1c (mmol/mol)	Effective	66.5	**66.8**	62.0	n/a	No clinically important change



HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. Higher values indicate poorer control.

Key:



[1] Apr 18 - Mar 19
[2] Apr 19 - Mar 20

York Teaching Hospital NHS Foundation Trust

Key messages

- The table below summarises York Teaching Hospital NHS Foundation Trust performance in the 2019 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2017. Mortality rates are presented both with and without deaths due to congenital anomalies.
- When compared against trusts with a similar service provision, York Teaching Hospital NHS Foundation Trust was up to 5% higher or up to 5% lower than the average for the comparator group in both measures.

	Metric	CQC Key Question	2018[1] Report	2019[2] Report	Comparator group[4] average (UK)	National Standard	Comparison to other trusts with similar service provision
4,674 births	Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)	Effective	4.89 (4.29 to 6.09)[3]	4.78 (4.17 to 5.96)[3]	4.79	n/a	Up to 5% higher or up to 5% lower than the average for the comparator group[4]
4,670 births	Stabilised and risk-adjusted extended perinatal mortality rate, **excluding congenital anomalies** (per 1,000 births)	Effective	Not reported	4.10 (3.63 to 5.16)[3]	4.16	n/a	Up to 5% higher or up to 5% lower than the average for the comparator group[4]

1 Jan 16 - Dec 16
2 Jan 17 - Dec 17
3 Upper and lower 95% confidence intervals
4 (4,000 or more births per annum at 24 weeks or later)

SCARBOROUGH GENERAL HOSPITAL

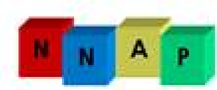
Key messages

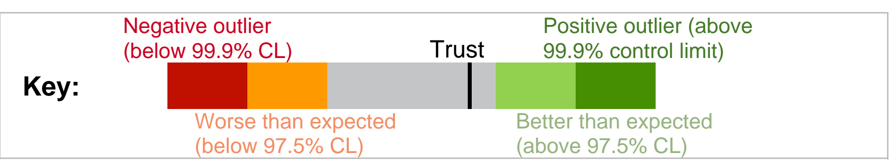
- Comparing this unit to other units in the 2018 National Neonatal Audit, performance was better in 0, worse in 0 metrics and similar in 6 metrics. In this context, 'similar' means that the hospital's performance fell within the expected range, or fell within the middle 50% of units.
- The audit standard was met in 1 of 6 of the relevant metrics.

	Cases	Metric	Core Service	CQC Key Question	2017[1] Report	2018[2] Report	National Aggregate (England & Wales)	Audit Standard	Comparison
Unit level	28	Mothers who deliver babies between 24 and 34 weeks gestation and were given any dose of antenatal steroids	Maternity	Safe	85.4%	**86.5%**	89.1%	85%*	Within expected range
	Suppressed due to low numbers	Mothers who deliver babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery	Maternity	Safe	25.0%	**Suppressed due to low numbers**	65.1%	none	Not applicable
	7	Babies <32 weeks gestation who had temperature taken within an hour of admission that was 36.5ºc-37.5ºc	Children and young people	Safe	62.4%	**60.2%**	64.5%	90%*	Within expected range
	107	Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission	Children and young people	Caring	87.8%	**89.9%**	94.7%	100%*	Within expected range
	6	Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity	Children and young people	Effective	96.3%	**96.6%**	94.4%	100%**	Within expected range
	7	Babies with gestation at birth <30 weeks who had received documented follow-up at 2 years gestationally corrected age	Children and young people	Effective	0.0%	**61.0%**	62.3%	100%*	Within expected range

Please scroll down for more metrics

	Cases	Metric	Core Service	CQC Key Question	2017[1] Report	2018[2] Report	National Aggregate (England & Wales)	Audit Standard	Comparison
Network level	138	Babies born at less than 27 weeks who were born in a hospital with a Neonatal Intensive Care Unit onsite	Children and young people	Effective	Not Reported	68.8%	73.2%	85%*	Within expected range





[1] Jan 16 - Dec 16
[2] Jan 17 - Dec 17

*Audit recommendation
**Audit recommendation based on specialist guideline

YORK DISTRICT HOSPITAL

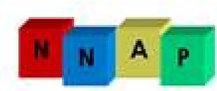
Key messages

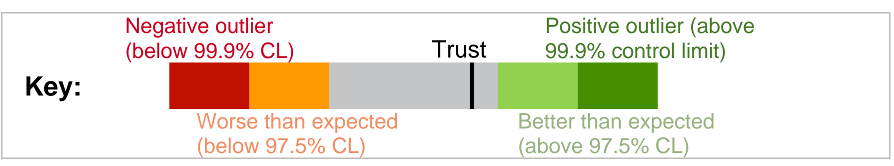
- Comparing this unit to other units in the 2018 National Neonatal Audit, performance was better in 0, worse in 0 metrics and similar in 7 metrics. In this context, 'similar' means that the hospital's performance fell within the expected range, or fell within the middle 50% of units.
- The audit standard was met in 1 of 6 of the relevant metrics.

	Cases	Metric	Core Service	CQC Key Question	2017[1] Report	2018[2] Report	National Aggregate (England & Wales)	Audit Standard	Comparison
Unit level	74	Mothers who deliver babies between 24 and 34 weeks gestation and were given any dose of antenatal steroids	Maternity	Safe	86.1%	**88.0%**	89.1%	85%*	Within expected range
	6	Mothers who deliver babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery	Maternity	Safe	50.0%	**63.4%**	65.1%	none	Within expected range
	33	Babies <32 weeks gestation who had temperature taken within an hour of admission that was 36.5ºc-37.5ºc	Children and young people	Safe	55.7%	**64.3%**	64.5%	90%*	Within expected range
	230	Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission	Children and young people	Caring	85.9%	**86.2%**	94.7%	100%*	Within expected range
	42	Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity	Children and young people	Effective	96.1%	**97.7%**	94.4%	100%**	Within expected range
	15	Babies with gestation at birth <30 weeks who had received documented follow-up at 2 years gestationally corrected age	Children and young people	Effective	82.1%	**64.0%**	62.3%	100%*	Within expected range

Please scroll down for more metrics

	Cases	Metric	Core Service	CQC Key Question	2017[1] Report	2018[2] Report	National Aggregate (England & Wales)	Audit Standard	Comparison
Network level	138	Babies born at less than 27 weeks who were born in a hospital with a Neonatal Intensive Care Unit onsite	Children and young people	Effective	Not Reported	68.8%	73.2%	85%*	Within expected range





[1] Jan 16 - Dec 16
[2] Jan 17 - Dec 17

*Audit recommendation
**Audit recommendation based on specialist guideline

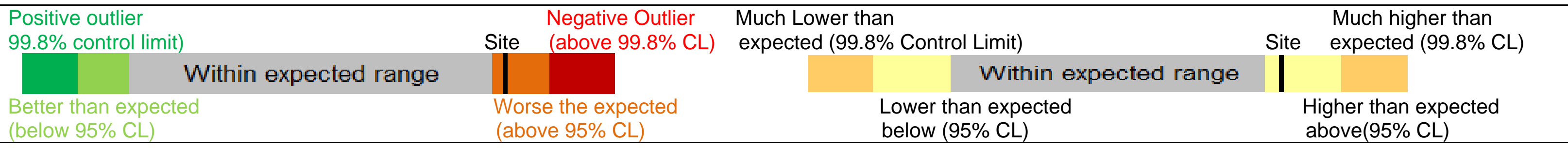
Scarborough Hospital

Key messages

Comparing this site to other sites on the 2019 National Maternity and Perinatal Audit:

- Case ascertainment did not meet the national standard of 95%.
- The 'case-mix adjusted overall caesarean section rate for single, term babies' was within expected limits.The audit advises that a RAG rating is not appropriate for this measure as performance that's either lower or higher than expected should start a conversation.
- The site was in the bottom 25% for the 'Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit
- For the other metrics, rates were a negative outlier in 0, higher in 0, similar in 3, lower in 1 and a positive outlier in 0 metric(s) where benchmarking has been applied. In this context, 'similar' means within expected range. For these metrics, higher rates can be interpreted as worse performance, and lower rates can be interpreted as better performance.
- For all metrics, particularly low rates may reflect poor detection/measurement.

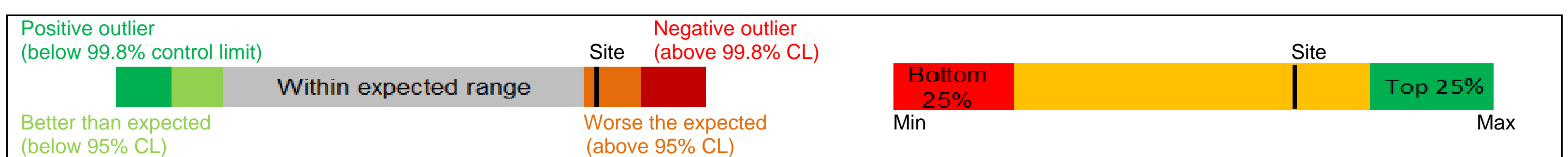
		Metric	CQC Key Question	2018[1] Report	2019[2] Report	National Aggregate	National Standard	Comparison to other sites
		Case ascertainment (Trust level)*	Well-Led	98.8%	Not reported	97.3%		N/A
Ante-natal	103 cases	Case-mix adjusted proportion of all babies at term who are <10th centile, who are born at or after 40+0 weeks	Effective	n/a	54.0%	52.3%	N/A	37.2 Within expected range 74.9
Intra-partum	1,423 cases	Case-mix adjusted overall caesarean section rate for single, term babies	Effective	25.6%	25.9%	25.5%	N/A	15.4 Within expected range 32.4



*May be greater than 100% due to do inconsistencies in hospital coding

1 Apr 15 - Mar 16
2 Apr 16 - Mar 17

		Metric	CQC Key Question	2018[1] Report	2019[2] Report	National Aggregate	National Standard	Comparison to other sites
Intra-Partum	1,361 cases	Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7	Effective	n/a	**0.8%**	1.1%	N/A	0.4 Within expected range 3.8
	1,120 cases	Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear	Safe	2.5%	**2.3%**	3.4%	N/A	1.4 Better than expected 6.6
	1,384 cases	Case-mix adjusted proportion of women with severe post partum haemorrhage of greater than or equal to 1500 ml	Safe	1.6%	**2.4%**	2.8%	N/A	0.8 Within expected range 5.8
Post-Partum	1,530 cases	Proportion of live born babies who received breast milk for the first feed	Effective	n/a	**60.4%**	73.6%	N/A	41.9 Bottom 25% 96.0



1 Apr 15 - Mar 16
2 Apr 16 - Mar 17

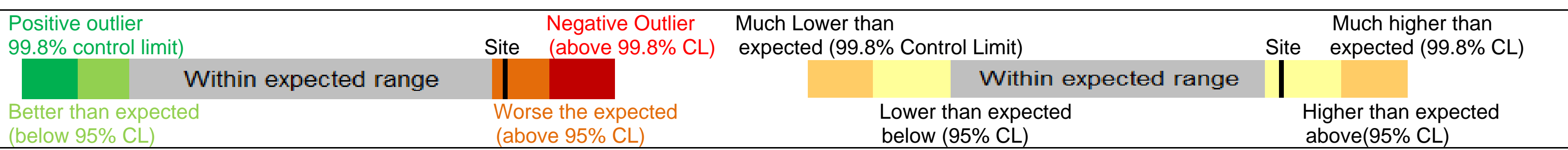
York Hospital

Key messages

Comparing this site to other sites on the 2019 National Maternity and Perinatal Audit:

- Case ascertainment did not meet the national standard of 95%.
- The 'case-mix adjusted overall caesarean section rate for single, term babies' was much lower than expectedThe audit advises that a RAG rating is not appropriate for this measure as performance that's either lower or higher than expected should start a conversation.
- The site was in the middle 50% for the 'Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit
- For the other metrics, rates were a negative outlier in 0, higher in 0, similar in 3, lower in 1 and a positive outlier in 0 metric(s) where benchmarking has been applied. In this context, 'similar' means within expected range. For these metrics, higher rates can be interpreted as worse performance, and lower rates can be interpreted as better performance.
- For all metrics, particularly low rates may reflect poor detection/measurement.

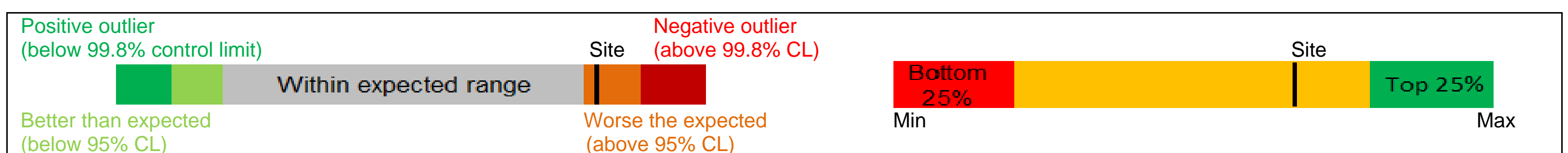
		Metric	CQC Key Question	2018[1] Report	2019[2] Report	National Aggregate	National Standard	Comparison to other sites
		Case ascertainment (Trust level)*	Well-Led	98.8%	Not reported	97.3%		N/A
Ante-natal	180 cases	Case-mix adjusted proportion of all babies at term who are <10th centile, who are born at or after 40+0 weeks	Effective	56.3%	51.9%	52.3%	N/A	37.2 Within expected range 74.9
Intra-partum	3,005 cases	Case-mix adjusted overall caesarean section rate for single, term babies	Effective	25.2%	23.6%	25.5%	N/A	15.4 Much Lower than expected 32.4



*May be greater than 100% due to do inconsistencies in hospital coding

1 Apr 15 - Mar 16
2 Apr 16 - Mar 17

		Metric	CQC Key Question	2018[1] Report	2019[2] Report	National Aggregate	National Standard	Comparison to other sites
Intra-Partum	2,949 cases	Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7	Effective	0.9%	**1.3%**	1.1%	N/A	0.4 Within expected range 3.8
	2,330 cases	Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear	Safe	2.8%	**2.4%**	3.4%	N/A	1.4 Better than expected 6.6
	2,903 cases	Case-mix adjusted proportion of women with severe post partum haemorrhage of greater than or equal to 1500 ml	Safe	3.0%	**2.4%**	2.8%	N/A	0.8 Within expected range 5.8
Post-Partum	3,193 cases	Proportion of live born babies who received breast milk for the first feed	Effective	77.1%	**76.3%**	73.6%	N/A	41.9 Middle 50% 96.0



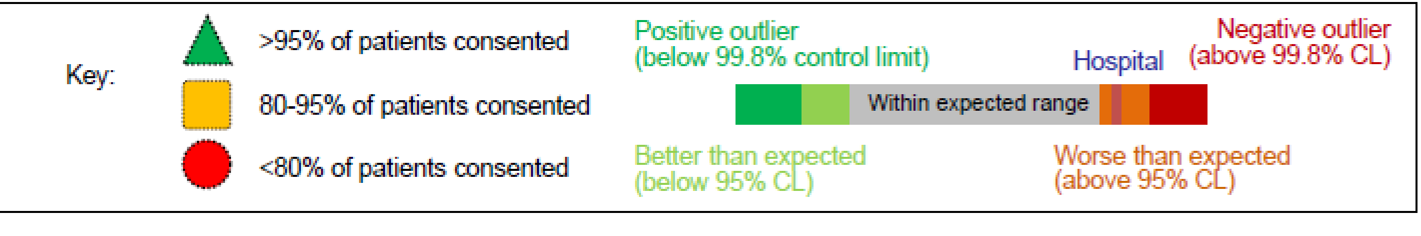
1 Apr 15 - Mar 16
2 Apr 16 - Mar 17

Bridlington and District Hospital

Key Messages

• Comparing this hospital to other hospitals on the 2020 National Joint Registry, performance was better in 0 metric(s), worse in 1 metric(s) and similar in 5 metric(s). In this context, 'similar' means that the hospital's performance fell within the expected range, or had an 'amber' rag rating.

Level	Cases	Metric	CQC Key Question	2019 Report[1]	2020 Report[2]	National Aggregate	National Audit Standard	Comparison to other Independent and NHS hospitals
Trust-level	1296 cases	Case ascertainment (hips, knees, ankles and elbows)	Well Led	100%[5]	**99%[3]**	Not reported	>95%	As expected
Hospital-level	670 cases	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)	Well Led	88.5%[5]	**94.0%[3]**	Not reported	95%	Amber (80-95% of patients consented)
Hospital-level	1516 cases	Risk adjusted 5 year revision ratio (for hips excluding tumours and NOF#)	Effective	1.2[6]	**1.5[4]**	1.0	1.0	0 Worse than expected 3
Hospital-level	1476 cases	Risk adjusted 90 day mortality ratio (for hips excluding tumours and NOF#)	Effective	0.8[6]	**0.9[4]**	1.0	1.0	0 Within expected range 3
Hospital-level	1523 cases	Risk adjusted 5 year revision ratio (for knees excluding tumours)	Effective	1.5[6]	**1.3[4]**	1.0	1.0	0 Within expected range 4
Hospital-level	1488 cases	Risk adjusted 90 day mortality ratio (for knees excluding tumours)	Effective	0.8[6]	**0.9[4]**	1.0	1.0	0 Within expected range 5



NOF#: Neck of femur fracture

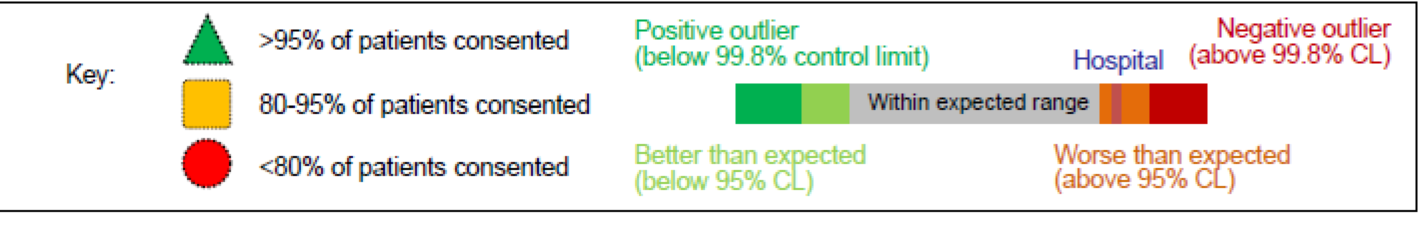
1 Apr 18 - Mar 19
2 Apr 19 - Mar 20
3 Apr 19 - Mar 20
4 Aug 15 - Aug 20
5 Apr 18 - Mar 19
6 Aug 14 - Aug 19

Scarborough General Hospital

Key Messages

• Comparing this hospital to other hospitals on the 2020 National Joint Registry, performance was better in 1 metric(s), worse in 0 metric(s) and similar in 5 metric(s). In this context, 'similar' means that the hospital's performance fell within the expected range, or had an 'amber' rag rating.

Level	Cases	Metric	CQC Key Question	2019 Report[1]	2020 Report[2]	National Aggregate	National Audit Standard	Comparison to other Independent and NHS hospitals
Trust-level	1296 cases	Case ascertainment (hips, knees, ankles and elbows)	Well Led	100%[5]	**99%[3]**	Not reported	>95%	As expected
Hospital-level	67 cases	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)	Well Led	100.0%[5]	**100.0%[3]**	Not reported	95%	▲
Hospital-level	208 cases	Risk adjusted 5 year revision ratio (for hips excluding tumours and NOF#)	Effective	1.3[6]	**1.1[4]**	1.0	1.0	0 Within expected range 3
Hospital-level	24 cases	Risk adjusted 90 day mortality ratio (for hips excluding tumours and NOF#)	Effective	0.8[6]	**1.7[4]**	1.0	1.0	0 Within expected range 3
Hospital-level	3 cases	Risk adjusted 5 year revision ratio (for knees excluding tumours)	Effective	1.0[6]	**1.0[4]**	1.0	1.0	0 Within expected range 4
Hospital-level	3 cases	Risk adjusted 90 day mortality ratio (for knees excluding tumours)	Effective	1.0[6]	**1.0[4]**	1.0	1.0	0 Within expected range 5



NOF#: Neck of femur fracture

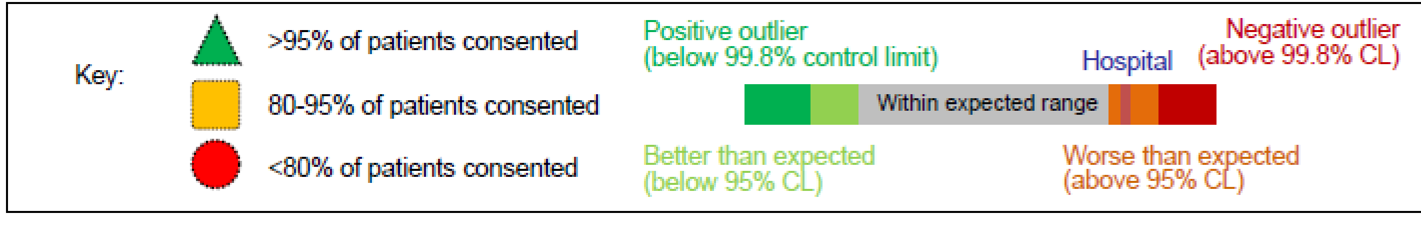
1 Apr 18 - Mar 19
2 Apr 19 - Mar 20
3 Apr 19 - Mar 20
4 Aug 15 - Aug 20
5 Apr 18 - Mar 19
6 Aug 14 - Aug 19

York Hospital

Key Messages

- Comparing this hospital to other hospitals on the 2020 National Joint Registry, performance was better in 0 metric(s), worse in 1 metric(s) and similar in 5 metric(s). In this context, 'similar' means that the hospital's performance fell within the expected range, or had an 'amber' rag rating.

Level	Cases	Metric	CQC Key Question	2019 Report[1]	2020 Report[2]	National Aggregate	National Audit Standard	Comparison to other Independent and NHS hospitals
Trust-level	1296 cases	Case ascertainment (hips, knees, ankles and elbows)	Well Led	100%[5]	**99%[3]**	Not reported	>95%	As expected
Hospital-level	552 cases	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows)	Well Led	84.4%[5]	**89.5%[3]**	Not reported	95%	Amber (80-95% of patients consented)
Hospital-level	1125 cases	Risk adjusted 5 year revision ratio (for hips excluding tumours and NOF#)	Effective	1.6[6]	**1.7[4]**	1.0	1.0	0 Worse than expected 3
Hospital-level	866 cases	Risk adjusted 90 day mortality ratio (for hips excluding tumours and NOF#)	Effective	1.4[6]	**1.4[4]**	1.0	1.0	0 Within expected range 3
Hospital-level	874 cases	Risk adjusted 5 year revision ratio (for knees excluding tumours)	Effective	1.6[6]	**1.2[4]**	1.0	1.0	0 Within expected range 4
Hospital-level	858 cases	Risk adjusted 90 day mortality ratio (for knees excluding tumours)	Effective	1.6[6]	**1.6[4]**	1.0	1.0	0 Within expected range 5



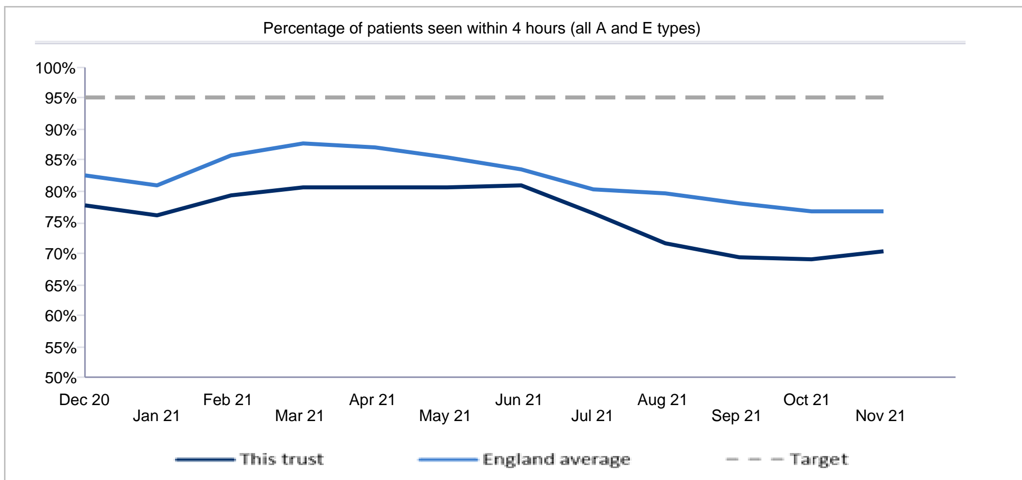
NOF#: Neck of femur fracture

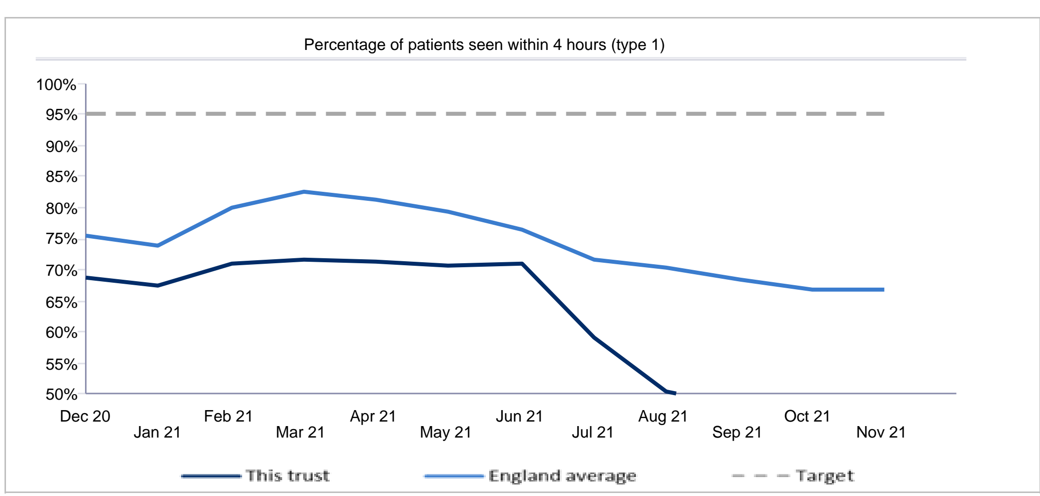
1 Apr 18 - Mar 19
2 Apr 19 - Mar 20
3 Apr 19 - Mar 20
4 Aug 15 - Aug 20
5 Apr 18 - Mar 19
6 Aug 14 - Aug 19

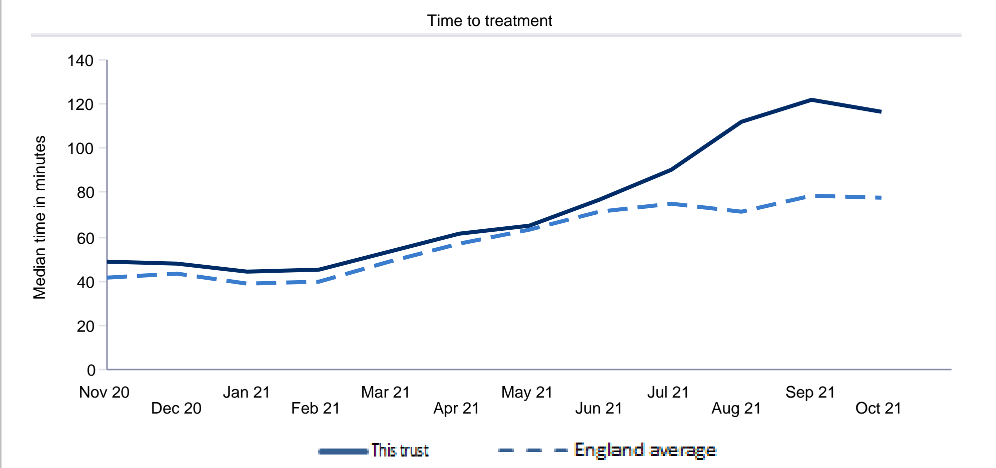
Key messages

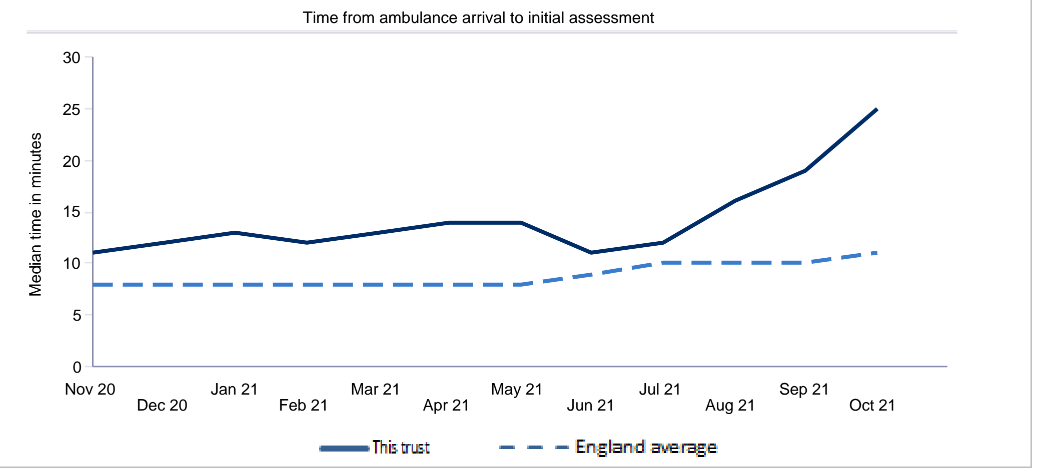
- 76% Patients spending less than 4 hours in A&E (all types) in 12 months.
- 62% Patients spending less than 4 hours in A&E (type 1) in 12 months.

Please click here to access the daily SITREP reports (Internal CQC users only)

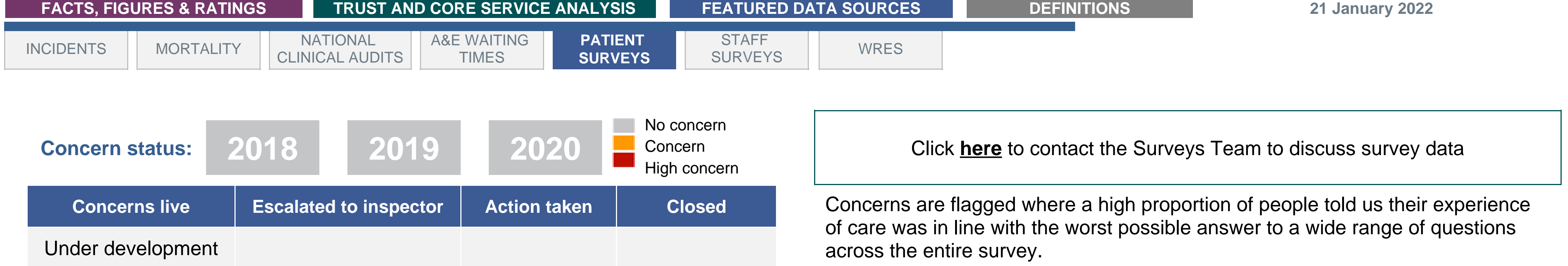








Source: NHS England



Concerns live	Escalated to inspector	Action taken	Closed
Under development			

Click **here** to contact the Surveys Team to discuss survey data

Concerns are flagged where a high proportion of people told us their experience of care was in line with the worst possible answer to a wide range of questions across the entire survey.

The CQC Adult inpatient survey collects feedback from adult inpatients (aged 16 or over) who spent at least one night in hospital during 2020

The results from the inpatient survey 2020 are not comparable to the results in any previous year. Notable changes since the 2019 survey are:

- The survey is now mixed mode
- The sampling period of the survey changed from July to November
- Results of the survey were presented in three bands previously (worse, about the same and better). From 2020 they will be shown in seven bands which are much worse, worse, somewhat worse, about the same, somewhat better, better and much better than/as expected

Trust results can be seen in the benchmarking reports at https://nhssurveys.org/all-files/02-adults-inpatients/05-benchmarks-reports/2020/

Source: Inpatient survey

Key messages

- The 2020 NHS staff survey has used the same methodology and timings as in previous years but a key focus of the survey this year has been on understanding the experience of staff during the Covid-19 pandemic period. Results of the 2020 NHS staff survey should be seen within this context.
- The provider's staff survey results are being compared to a group of 128 Acute non-specialist trusts across ten themes all scored 0-10 with 0 the worst possible score and 10 the best.
- The provider scored significantly above average for no themes and significantly below average for Team Working; Staff Engagement; Quality of care; Safety Culture.

See the full benchmark report on the NHS staff survey website

Sampling approach
Census
Response rate
36%
Average response rate for similar trusts
45%
Completed Questionnaires
2831

Trust (2019) | Trust (2020) | Benchmark group average (2020)

Score out of 10 (higher is better)

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement	Team Working
Score	9.2	6.1	6.7	6.2	7.2	8.1	9.4	6.5	6.9	6.3
Trend	Statistically significant deterioration	No statistically significant change	No statistically significant change	No statistically significant change	No statistically significant change	No statistically significant change	No statistically significant change	No statistically significant change	No statistically significant change	Statistically significant deterioration
Rank* (out of 128, 1 is best)	39	54	86	61	120	55	81	116	104	108
National comparison	S	S	S	S	W	S	S	W	W	W

Key to tables

- Statistically significant improvement
- No statistically significant change
- Statistically significant deterioration
- MB Much better
- B Better
- S About the same
- W Worse
- MW Much worse

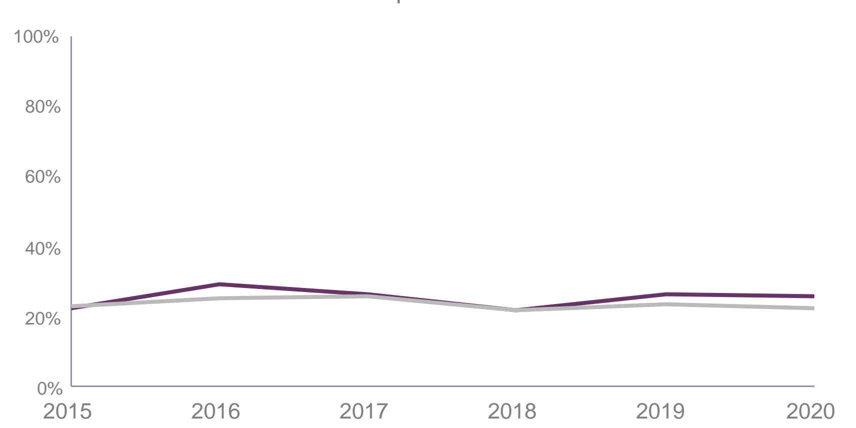
*Rank and national comparison are based on the peer group of 128 Acute non-specialist

SOURCES: NHS Staff Survey

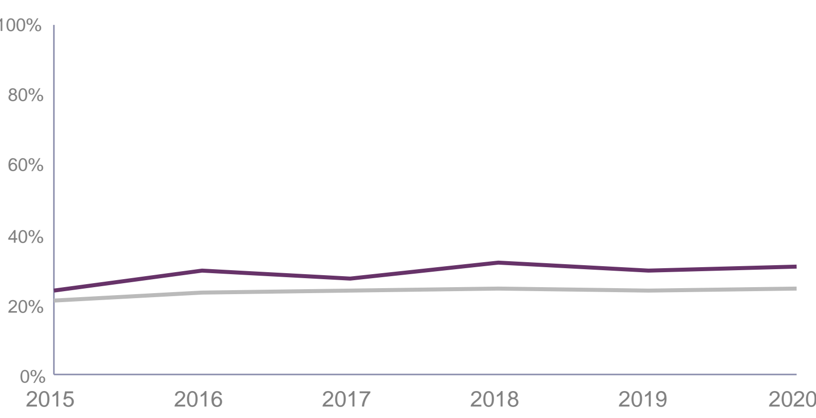
Key messages

These graphs show how BME and White staff at this trust have answered the four WRES staff survey questions over time. See the WRES section of Insight for additional analysis

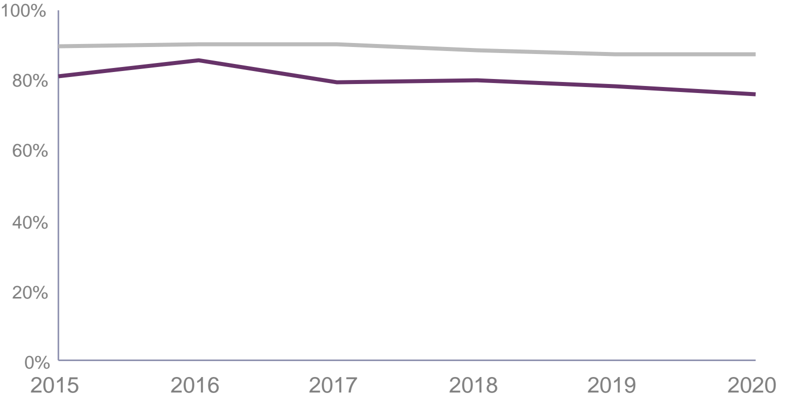
Staff who experienced harassment, bullying or abuse from patients, relatives or the public



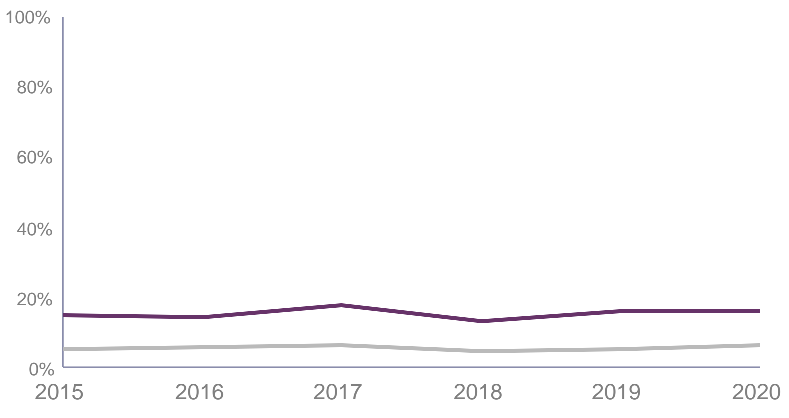
Staff who experienced harassment, bullying or abuse from staff



Staff believing the trust offers equal opportunities for career progression and promotion



Staff experiencing discrimination from their manager and/or colleagues



BME Staff   White Staff

SOURCES: NHS Staff Survey

Introduction

The Workforce Race Equality Standard (WRES) now includes HR indicators derived from Electronic Staff Records (ESR) in addition to findings from the NHS Staff Survey, see box 1 for more details.

This page includes key messages from the WRES indicators which are detailed on the following page. The last WRES page includes some background staffing data and information about the NHS Staff Survey for the trust.

Key Messages

- The difference between the experiences of BME and White staff was significant for 3 indicators at this trust (out of 9)
- When compared with other trusts in its peer group, Acute and Acute & Community Trusts, for the four staff survey indicators, this trust had 1 positive finding and 0 negative findings.
- The experiences of BME staff at this trust have significantly improved for 1 indicator and significantly deteriorated for 0 indicators
- The table (next page) shows whether the experiences of BME and White staff were significantly different for each indicator. The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

Indicator 4, access to non-mandatory training and CPD, is not included in the above summary due to data quality concerns.

Box 1: The 9 WRES Indicators

1a	Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+
1b	Proportion of non-clinical staff in senior roles, band 8+
2	Proportions of shortlisted staff being appointed to positions
3	Proportion of staff entering formal disciplinary processes
4	Proportion of staff accessing non-mandatory training and CPD
5	Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
6	Staff experiencing harassment, bullying or abuse from staff in the last 12 months
7	Staff believing that the trust provides equal opportunities for career progression or promotion
8	Staff experiencing discrimination at work from a manager / team leader or other colleague
9	Board compared to overall staff demographic

Sources: 1 to 4 and 9: ESR, 5 - 8 : NHS Staff Survey

SOURCES: NHS Staff Survey

WRES Indicators from ESR (HR data) (*)	BME Staff	White Staff	Are there statistically significant difference between… BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	2.0%	4.0%	Not statistically significant	0.6% No statistically significant change
1b. Proportion of non-clinical staff in senior roles, band 8+	1.4%	5.0%	Not statistically significant	-0.1% No statistically significant change
2. Proportions of shortlisted candidates being appointed to positions	13.4%	21.2%	Statistically significant difference	10.4% Statistically significant improvement
3. Proportion of staff entering formal disciplinary processes	1.2%	0.7%	Not statistically significant	0.7% No statistically significant change
4. Proportion of staff accessing non-mandatory training and CPD	90.5%	74.8%	Not assessed	

WRES Indicators from the NHS staff survey (**)		Proportion of respondents answering "Yes": BME staff	White staff	All staff	Are there significant differences between… BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	25.5%	22.5%	23.5%	Not statistically significant	Positive finding	-1.0% No statistically significant change
	Peer group	*28.9%*	*25.4%*	*26.3%*			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	31.0%	24.8%	26.5%	Not statistically significant	Not statistically significant	1.0% No statistically significant change
	Peer group	*29.6%*	*24.3%*	*25.6%*			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	75.8%	87.1%	85.7%	Statistically significant difference	Not statistically significant	-2.6% No statistically significant change
	Peer group	*69.2%*	*87.4%*	*83.7%*			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	16.0%	6.3%	7.7%	Statistically significant difference	Not statistically significant	0.0% No statistically significant change
	Peer group	*17.1%*	*6.2%*	*8.7%*			

Trust staffing numbers (*)	2019		2018	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[0]	Not statistically significant	[0]	Not statistically significant

Key

- Statistically significant difference
- Not statistically significant
- Negative finding
- Positive finding
- Statistical analysis not undertaken as less than 30 BME staff responded
- Statistically significant improvement
- No statistically significant change
- Statistically significant deterioration

(*) SOURCES: NHS England (31/03/2019) (**) SOURCES: NHS Staff Survey (2020)

Trust staffing numbers (*)	2019	2018
BME staff	**692**	**637**
White staff	**7,736**	**7,853**
BME Voting Board Members	**0**	**0**
White Voting Board Members	**13**	**13**

NHS Staff Survey Details (**)		2020	2019
Sampling method	**Trust**	**Census**	**Census**
Total number of recipients (ineligible staff removed)	**Trust**	**7,923**	**7,429**
Response rate from total recipients (rec. min. 50%)	**Trust**	**35.7%**	**43.1%**
	Peer group	**44.9%**	**46.5%**

Trusts are encouraged to perform a census rather than a basic or extended sample in order to best understand experiences of different staff groups and to get more of their staff to participate in the survey so the trust can better understand issues affecting their staff. CQC inspection staff should follow up on what the trust is doing to understand the potential underlying causes and improve the experience of staff.

(*) SOURCES: NHS England (31/03/2019) (**) SOURCES: NHS Staff Survey (2020)

Performance level

Much better

Better

Somewhat better (inpatient survey only)

About the same

Somewhat worse (inpatient survey only)

Worse

Much worse

No data

Performance change

Improving

About the same

Declining

Ratings

Outstanding

Good

Requires improvement

Inadequate

Inspected but not formally rated

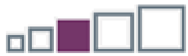
Not rated

Others

National Guardian Freedom to Speak Up — Data that is relevant for 'speaking up'

Understanding data

What do these boxes show?



The boxes represent all Acute NHS trusts from smallest to largest in five groups, or quintiles. The purple highlighted box shows you where this trust lies relative to the other trusts. If the smallest box is highlighted this trust is in the group of the smallest trust or lowest activity level, and if the second largest box is highlighted the trust is in the second largest group, or quintile, for higher activity levels.

What do N/A, *, and - mean when they are used for data values?

n/a	Value is not applicable
-	Data is not available for trust or time period.
*****	Suppressed values between 1 and 5. We apply a strict statistical disclosure control in accordance with the HES protocol to all published data. This requires that small numbers are supressed to prevent individuals being identified and to ensure that patient confidentiality is maintained.

Definitions and guidance documents: (available to internal CQC users only)

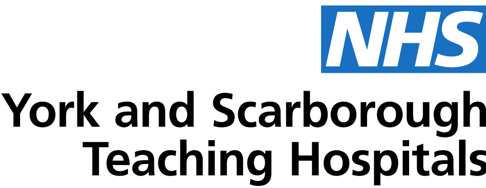
- Statistical methods of analysis guidance
- Trust-wide and core service indicator definitions
- Facts and figures item list (under development)

More information about Insight can be found on the CQC Insight intranet home page

CQC REF (Template version): Acute Insight v1.75 BURST

Download the current data:

Data file link here (Internal CQC users only)



Board of Directors
March 2022 (February 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: March 2022

EXECUTIVE SUMMARIES

Quality & Safety

• The reduced incidence of falls with moderate or severe harm and similarly the reduced number of pressure ulcers is pleasing to see however it should be noted that these numbers have only returned to the levels reported immediately prior to the winter period, and February is also a shorter month.
• A deep dive into the high incidence of falls in January has been completed with the results presented to the Falls Improvement Group and a number of recommendations suggested for improvement. There was a high proportion of patients with dementia or delirium who fell whilst in our care. Many of the falls were unwitnessed and occurred in daylight hours rather than overnight. Patient acuity and dependency continues to be high and patient care is impacted by ongoing workforce challenges.
• Device-related pressure damage appears to be an ongoing challenge, particularly on Covid red wards. Improvement work is ongoing facilitated by the Tissue Viability Team. Performance with the Trust waiting time for the Rapid Chest Pain clinic data has decreased to 89%.
• There were 139 medication incidents this month with one incident causing severe harm, this was reviewed at Quality and Safety in February. The Trust Sedation Group have been commissioned to develop some guidelines for management of patients requiring sedation for scan following the incident.
• Main themes in February 2022 complaints are; Care needs not adequately met, Communication with patient, Delay or failure to diagnose and staff attitude. Themes are discussed at the PESG and care groups continue to provide evidence of learning and service improvements as a result of feedback; overall performance remains at 52%.
• Observation (NEWS2) compliance across the York site remains an issue. There has been escalation to QPAS requesting action plans from care groups in relation to improving this compliance. A trial with electronic handheld devices is currently underway.
• Outreach workload continue to increase which again is secondary to the increase in MET calls. Moving forward there is hope that this data will be collected electronically; cardiac arrest calls remain low at both site.
• The Clostridium difficile-associated diarrhoea objective for 2021/22 has been set at 133 combined Hospital Onset Hospital acquired (HOHA) and Community Onset Hospital Acquired (COHA) cases among patients aged over 2 years. The trust has had a total of 196 cases of C.difficile from April 2021; of which 61 were community-onset healthcare-associated (COHA) and 65 healthcare-onset healthcare-associated (HOHA) cases. Total 126 hospital attributable cases. There were 5 HOHA and 3 COHA cases in February 2022.
• The number of occasions that the homebirth service is being suspended is reducing across both sites and the community midwives are being called into the unit less often
• Post-Partum Haemorrhages (1.5L +) are above the regional average across both sites. Governance team aware. 4.2% York and 5.2% Scarborough. Regional average 3.6% in last quarter. PPH action planning being discussed at March clinical governance, proposal to move in line with weighing all EBL at every birth.

Author	Liam Wilson, Lead Nurse Patient Safety
Director Sponsors	James Taylor, Medical Director Heather McNair, Chief Nurse

Workforce

The most recent validated sickness data shows an increase in staff absences in January to 6.49%, which is the highest rate recorded throughout the pandemic. Daily SitRep records (which include York Teaching Hospital Facilities Management data) demonstrate a reduction in absence in February, though the figures consistently showed that 20-25% absences were for a reason related to Covid-19.

The welfare of the workforce remains our priority. The Trust is seeking to invest in wellbeing facilities and is preparing a bid for charitable funds to support the refurbishment of facilities in York, Scarborough and Bridlington Hospitals to support staff to take a break away from their immediate place of work. The development of staff facilities is a core part of the Trust's strategy to support staff wellbeing and ultimately staff retention. The data in this report shows that staff retention has steadily reduced since the summer of 2021, in line with the national picture in the NHS and more widely.

The Trust is preparing for the publication of its 2021 Staff Survey results at the end of March. The Trust will review the results against the seven commitments which make up the NHS People Promise to understand how they impact on existing plans to improve its offer to staff. These plans include a review of its Equality, Diversity and Inclusion Strategy, which will be supported by the appointment of a new Head of ED&I.

Author	Will Thornton, Head of Resourcing
Director Sponsor	Polly McMeekin, Director of Workforce & Organisation Development

Finance

This paper and individual summary reports on Trust's financial position for period to February 2022 (Month 11).

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 was initially rolled forward and applied to the first half year (April 2021 - September 2021) only.

In late September 2021, NHSE&I announced the financial framework that will be in place for the second half year, 2021/22, which primarily signalled a continuation of the approach adopted in the first half year with some further adjustments for inflation including the meeting the cost of the 3% pay deal; together with an increased efficiency requirement over that required in the first half of the year.

The final financial plan for the second 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 4 November 2021 meeting. The agreed plan was consistent with the System and individual Provider plans submitted to NHSE&I later in November. The agreed plan results in a balanced I&E position for both the second half of the year, and the full year in total.

Month 11 Position

For February, the Trust is reporting an adjusted I&E position of £85k surplus against a £189k adjusted deficit plan, placing it £274k ahead of the adjusted plan agreed by the Board. This is primarily driven by the net impact of ERF income in the first half of the year being behind plan with the associated cost of delivery also being behind plan; offset by other net underlying Trust performance being broadly equally ahead of plan. The Trust is forecasting that it will end the year in I&E balance.

The Trusts overall CIP target for 2021/22 totals £8.1m, of which the Trust has delivered £6.3m.

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

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

Research & Development

Our key outcomes in the last month are as follows:

- As we have already reached our accrual target for the year, and we get nothing for over recruiting so, we have asked teams to relax on recruitment a little on a few studies that bring us big numbers (large data collection etc), to ease the pressure and allow them to focus on the more complex trials
- No grants have been submitted in the last month but we are working on a collaboration with HYMS to submit an NIHR Research for Patient Benefit Grant that will be submitted next month (managing chronic breathlessness), and with University of York on an EPSRC bid to will co-develop and evaluate a simple-to-use diagnostic technology to rapidly support stratification of COVID-19 and related pulmonary infections.
- We are still supporting the Trust by redeploying our pharmacy staff each week.
- We are in the process of arranging a critical friend review, a review by external R&D staff to review our services, governance and our processes, to see if there are any observations and opportunities for shared learning.
- We have drafted a new Commercial Research Income distribution model and we are currently negotiating IP arrangements with two consultants around their inventions.
- Dr James Turvill has had an exciting approach from a commercial company to evaluate a new bowel cancer diagnostic, here at the Trust, that we are currently negotiating

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 to a level 4 national response on the 12th of January 2022. A level 4 national response is defined as “An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level”.

In response to the Omicron variant the Trust has continued to operate within its Pandemic Command and Control structure and as at the 14th of March there were 241 COVID-19 positive inpatients in our acute and community hospitals. The number of COVID-19 positive inpatients previously peaked on the 26th of January 2021 at 215 (reported via Trust’s external SitRep submission).

The Trust has had 4,932 COVID-19 positive inpatients since 17th March 2020, with 3,850 patients discharged, sadly 845 patients have died. Since the beginning of July 2021 there have been 2,069 new COVID-19 positive inpatients and 231 deaths.

As at the 14th of March, York Hospital has three COVID-19 positive wards with three COVID-19 positive wards/areas at Scarborough Hospital. The majority of COVID-19 positive patients are not being treated for COVID-19 as their primary complaint however the Trust is required to cohort these patients under Infection Prevention Control (IPC) measures. This is impacting on the Trust’s ability to admit elective patients as patients cannot be admitted onto wards where there are COVID-19 positive patients.

The Trust’s COVID-19 surge plan is in place to respond to further requirements for additional beds.

Trust Planning

The workforce risk that the Trust has highlighted as part of the first half (H1) of 2021-22 activity plan materialised to a greater extent than was anticipated and has continued throughout H2. This has affected not just the Trust but all partners. NYCC, TEWV, YAS, Primary Care and Vocare who have all been operating at their highest level of escalation due to workforce pressures over the last six months, limiting the availability of support from the system to reduce delays to patients or support urgent care demand. Overall the Trust sickness absence rate is 7% with 680 absent as at the 14th of March, 26% of the absences relate to COVID-19.

The pressure on medical staffing contributed to the cancellation of 258 outpatient clinics within fourteen days of the planned date and there were 252 elective patients cancelled by the Trust within forty eight hours of their intended surgery date due to non-clinical reasons. As in the previous COVID-19 ‘waves’ cancer, urgent priority (P2) and long wait elective procedures are being prioritised.

Compared to the activity outturn in February 2020 the Trust delivered the following provisional levels of elective care activity:

Point of Delivery	January 2020 Outturn	January 2022 Actual	Variance	Proportion of January 2020 delivered in January 2022
First Outpatient Appts	15,653	12,353	-3,300	79%
Follow up Outpatient Appts	35,504	32,584	-2,920	92%
Ordinary Electives*	618	418	-200	68%
Day Cases	6,760	6,056	-704	90%

*Ordinary Elective figures are based on discharge date.

An additional £1bn Elective Recovery Fund (ERF) has been made available to the NHS in the second half of 2021-22 to support activity above the level funded within system financial envelopes.

Systems that achieve completed referral to treatment (RTT) pathway activity above a 2019-20 weighted threshold of 89% will be able to draw down from the ERF. In February 2022 the Trust completed 84% of the weighted RTT pathways that were completed in February 2020.

February 2022 Performance Headlines:

• 71.9% of ED patients were admitted, transferred or discharged within four hours during February 2022.
• The Trust reported 583 twelve hour Trolley Breaches.
• January 2022 saw challenging cancer performance with the Trust achieving one out of the eight core national standards.
• 1,721 fifty-two week wait pathways have been declared for the end of February 2022.
• 103 104+ week wait pathways have been declared for the end of February 2022. This number, as per national guidance, excludes those patients who have requested to defer their treatment. There were three such patients at the end of February 2022.
• The Trust saw a decline against the overall Referral to Treatment backlog, with the percentage of patients waiting under eighteen weeks at month end decreasing from 62.4% in January 2022 to 61% at the end of February 2022.

Author(s)	Andrew Hurren, Operational Planning and Performance Manager 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

PRIORITY ONE SYSTEM OUTAGES

Unusually there were two priority one outages this month. (There are usually about four of these in a whole year and once all of our Essential Services Programme work is done by 2024/25 this should be down to one a year).

The first was an issue with the CPD infrastructure which affected the Data Warehouse that contains the millions of historic and up to date data items the Trust use for reporting and business intelligence. This resulted in all reporting being off for a number of days. The Intelligence and Insight team worked tirelessly to recover the situation which necessitated re-building the entirety of the Data Warehouse from scratch.

The second was an outage on CPD itself – our Electronic Patient Record system – which meant users could not log on for 4-5 hours. Business continuity arrangements were brought to bear and the Trust responded admirably to be able to run without the system. It turned out that the system was able to be fully recovered and stable and most of the continuity arrangements did not have to come into play.

These unfortunate incidents highlighted again some of our key weaknesses. Notably single points of knowledge around particular technologies – we only have one Data Warehouse Architect who understands how that works and we only have one Linux Server and Operating expert who understands how the CPD infrastructure works. These are known issues and subject to budget and resource bids in the coming year.

Also it highlighted the need for us to ensure the Essential Services Programme continues to be supported as that will deliver key infrastructure components that would avoid these failures in the first instance.

Despite these major issues it is great to see that the number of service desk calls being answered and dealt with at first point of contact continue to be going in the right direction which demonstrates that the new best practice arrangements in terms of service management are working.

PRIORITISATION OF KEY PIECES OF WORK

The technical IT skills recruitment and retention issue specifically around the developers of CPD and more recently an inability of third parties, regardless of cost, to augment the team to do the work required has meant the Trust need to prioritise which IT enabled projects are done and not done for 2022/23.

The Executive Committee of the Trust is determining this based on consideration of risks and relative priority and a paper will come to Board to explain the outcome soon as well as the risks and mitigations of that which is not being done.

CDIO DEPARTURE PLAN

The implementation of the new DIS structure and operating model, the establishment and clear costed plans laid out for the Essential Services Programme for 2022/23, 2023/24 and the effective handover of the Electronic Patient Record Strategic Outline Case and plan will have been completed as part of Dylan's exit.

A new CTO has been appointed, new CNIO and Head of Delivery interviews are on 18th and 24th March and should result in appointments.

The interim CDIO, Andy Williams, has started and will be in attendance at key meetings, including Board of Directors. He has clear objectives in terms of some of the deliverable above including the effective handover to a newly appointed CDIO, the recruitment for which has started.

Author(s)	Dylan Roberts, Chief Digital Information Officer
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.

February-2022

Produced March-2022

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:

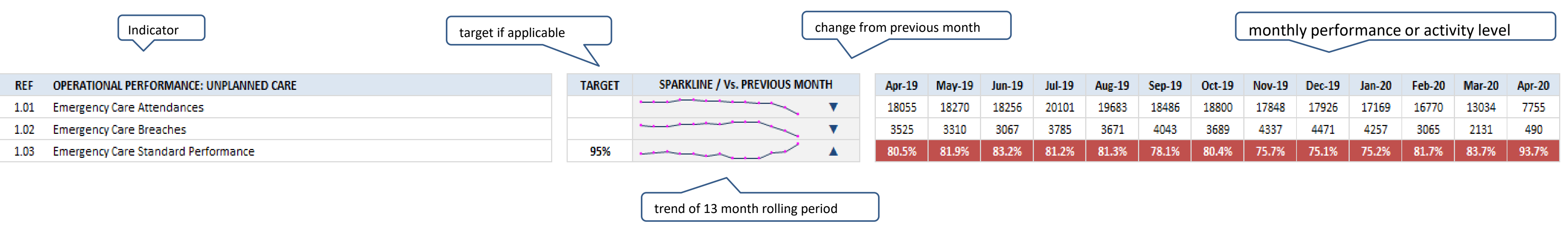
Information Team

Integrated Performance Report : February-2022

Understanding the Report

1. Operational Performance Summary

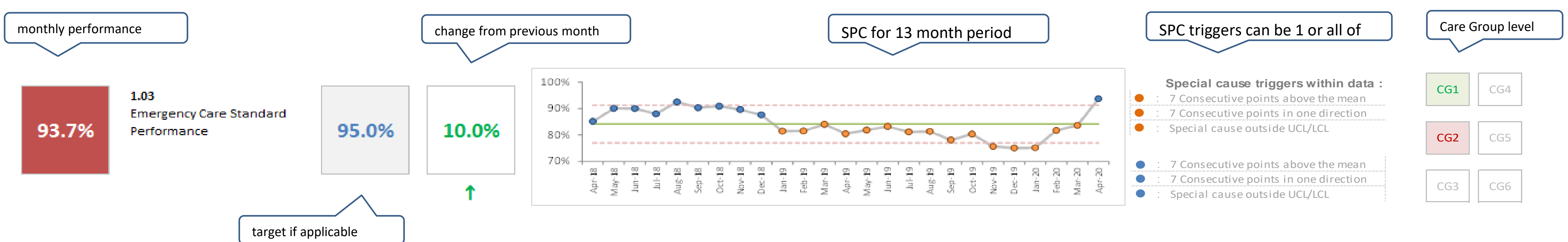
This section provides a summary of key performance targets for NHSI, Quality, Workforce and Finance, plus activity data. The target is either the monthly standard and performance is coloured according to achievement. This should be read in conjunction with overall trends and not taken in isolation. The 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.



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%

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.



QUALITY AND SAFETY REPORT

February-2022

Produced March-2022

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: February-2022

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:

• The reduced incidence of falls with moderate or severe harm and similarly the reduced number of pressure ulcers is pleasing to see however it should be noted that these numbers have only returned to the levels reported immediately prior to the winter period, and February is also a shorter month.
• A deep dive into the high incidence of falls in January has been completed with the results presented to the Falls Improvement Group and a number of recommendations suggested for improvement. There was a high proportion of patients with dementia or delirium who fell whilst in our care. Many of the falls were unwitnessed and occurred in daylight hours rather than overnight. Patient acuity and dependency continues to be high and patient care is impacted by ongoing workforce challenges.
• Device-related pressure damage appears to be an ongoing challenge, particularly on Covid red wards. Improvement work is ongoing facilitated by the Tissue Viability Team. Performance with the Trust waiting time for the Rapid Chest Pain clinic data has decreased to 89%.
• There were 139 medication incidents this month with one incident causing severe harm, this was reviewed at Quality and Safety in February. The Trust Sedation Group have been commissioned to develop some guidelines for management of patients requiring sedation for scan following the incident.
• Main themes in February 2022 complaints are; Care needs not adequately met, Communication with patient, Delay or failure to diagnose and staff attitude. Themes are discussed at the PESG and care groups continue to provide evidence of learning and service improvements as a result of feedback; overall performance remains at 52%.
• Observation (NEWS2) compliance across the York site remains an issue. There has been escalation to QPAS requesting action plans from care groups in relation to improving this compliance. A trial with electronic handheld devices is currently underway.
• Outreach workload continue to increase which again is secondary to the increase in MET calls. Moving forward there is hope that this data will be collected electronically; cardiac arrest calls remain low at both site.
• The Clostridium difficile-associated diarrhoea objective for 2021/22 has been set at 133 combined Hospital Onset Hospital acquired (HOHA) and Community Onset Hospital Acquired (COHA) cases among patients aged over 2 years. The trust has had a total of 196 cases of C.difficile from April 2021; of which 61 were community-onset healthcare-associated (COHA) and 65 healthcare-onset healthcare-associated (HOHA) cases. Total 126 hospital attributable cases. There were 5 HOHA and 3 COHA cases in February 2022.
• The number of occasions that the homebirth service is being suspended is reducing across both sites and the community midwives are being called into the unit less often
• Post-Partum Haemorrhages (1.5L +) are above the regional average across both sites. Governance team aware. 4.2% York and 5.2% Scarborough. Regional average 3.6% in last quarter. PPH action planning being discussed at March clinical governance, proposal to move in line with weighing all EBL at every birth.

Recommendation:

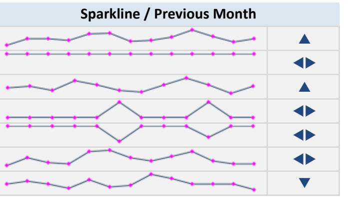
The Board is asked to receive the report and note any actions being taken.

Author(s): Liam Wilson, Lead Nurse Patient Safety

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

TRUST BOARD REPORT : February-2022

QUALITY AND SAFETY SUMMARY: (i)



REF	SERIOUS INCIDENTS (data is based on SI declaration date except given final report)	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.01	Number of SI's reported	▲	6	14	14	12	20	21	11	12	16	25	17	10	14
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)	▲	6	13	14	11	18	15	11	10	15	20	15	9	14
1.04	Number of SIs Where Stage 2 (Written) Duty Of Candour is Outstanding (Moderate or Above Harm)	◀▶	0	0	0	0	0	0	1	0	0	0	1	0	0
1.05	% Compliance with Stage 2 (Written) Duty of Candour for Serious Incidents (Moderate or Above Harm)	◀▶	100%	100%	100%	100%	100%	100%	91%	100%	100%	100%	93%	100%	100%
1.06	-Invitation to be involved in Investigation (Clinical SIs Only)	◀▶	1	6	3	2	10	11	6	4	7	10	4	2	2
1.07	-Given Final Report (If Requested - Clinical SIs Only - based on Investigation End Date)*	▼	4	6	4	1	7	2	3	11	8	4	4	4	0

*Data for 1.07 has been refreshed prior to Feb-21 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 (For Incidents Reported Between 01/03/21 and 14/02/22)
1.10	Incident Graded Moderate or Above			359
1.11	Stage 1 - Verbal Apology Given			320
1.12	Stage 2 - Written Apology Given			313
1.14	% Compliance with Stage 2 (Written) Duty of Candour			87%
1.15	Stage 3 - Final Written Summary Due (for incidents between Mar and Aug 21)			153
1.16	Stage 3 - Final Written Summary Completed (for incidents reported Between Mar and Aug 21)			141

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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.20	Number of Negligence Claims	▲	17	13	11	11	8	13	12	16	10	17	13	15	17
1.21	Number of Claims settled per Month	▲	2	1	4	1	1	1	13	8	2	3	3	1	5
1.22	Amount paid out per month	▲	39,841	32,500	739,500	287,582	20,000	9,500	1,406,144	103,700	1,040,000	73,946	115,000	52,500	288,000
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.

Significant work has recently been undertaken by care groups to identify learning points from all claims settled in the last year. In order to capture this information in the weekly report to the Quality & Safety meeting the actual date of settlement has been omitted from the datix claim record until such point the learning information has been available for circulation. This has resulted in a slight backlog of claims settlement dates being recorded on Datix, hence the apparent rise in the number of claims settled in August and September. Going forward the learning information will be available at a much earlier stage, before settlement is agreed, and so the settlement dates will be more accurately reflected.

REF	MEASURES OF HARM	Target	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.30	Incidents Reported		▼	1,325	1,421	1,364	1,463	1,467	1,510	1,436	1,589	1,583	1,581	1,560	1,616	1,386
1.31	Incidents Resulting in No or Minor Low Harm Not Completed Within 1 Month of Reporting		▲	-	-	-	-	-	655	886	887	853	635	777	918	1,033
1.32	Patient Falls		▼	221	215	208	213	192	198	243	224	241	264	255	313	275
1.33	Pressure Ulcers - Newly Developed Ulcer		▼	117	94	89	94	82	92	97	89	123	126	137	128	104
1.34	Pressure Ulcers - Deterioration of Pressure Ulcer		▼	15	20	25	22	23	12	13	17	27	19	17	22	12
1.35	Pressure Ulcers - Present on Admission		▼	164	201	166	167	150	185	196	185	170	160	213	183	178
1.36	Degree of harm: serious or death		▼	6	7	8	3	8	6	3	4	8	8	6	14	8
1.37	Medication Related Errors		▲	116	125	128	164	157	151	124	156	131	161	130	114	130
1.38	VTE risk assessments *	95%	▼	94.4%	94.2%	93.3%	94.1%	92.5%	92.9%	93.3%	87.9%	87.3%	85.2%	85.1%	86.6%	0.0%
1.39	Never Events	0	◀▶	0	1	0	0	0	0	0	0	0	2	1	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.

Incident reporting monitoring now shows the number of investigations resulting in no or minor/low harm where the investigation has not been completed within 1 month of the incident being reported (excluding incidents which are subject to more in-depth investigation via the SI or 72 Hour reporting process. This data also excludes incidents referred to external organisations for investigation). The data shows the position for the last 11 months in the reporting period (as incidents in the most recently reported month may not yet be completed).

* VTE risk assessment percentage from Sep-21 is now calculated using the VTE Assessments dashboard. New rules have been agreed with the Pharmacy team.

TRUST BOARD REPORT : February-2022

QUALITY AND SAFETY SUMMARY: (ii)

REF	PRESSURE ULCERS***	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.40	Number of Category 2	▼	73	70	58	61	64	64	73	57	79	82	82	83	62
1.41	Number of Category 3	▲	3	3	9	3	2	6	5	5	3	5	5	2	3
1.42	Number of Category 4	▼	2	2	4	0	1	1	0	2	2	1	0	2	1
1.43	Total no. developed/deteriorated while in our care (care of the org) - acute	▼	94	74	67	86	74	81	74	76	100	103	106	113	78
1.44	Total no. developed/deteriorated while in our care (care of the org) - community	▲	38	40	47	30	31	23	36	30	50	42	48	37	38

REF	FALLS****	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.50	Number of falls with moderate harm	▼	4	2	3	4	2	2	3	6	4	7	2	8	4
1.51	Number of falls with severe harm	▼	1	3	5	0	2	2	2	1	2	5	2	6	4
1.52	Number of falls resulting in death	◀▶	1	0	0	0	0	1	0	0	0	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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
10.20	Medication Incidents Resulting in Moderate Harm, Serious/Severe Harm or Death		◀▶	0	0	0	0	1	0	0	1	2	3	0	1	1
10.21	Insulin Incidents		▼	9	20	8	14	13	16	14	12	10	12	14	14	12
10.22	Antimicrobial Incidents		◀▶	14	13	18	17	19	11	13	17	17	26	15	15	15
10.23	Opiate Incidents		▲	27	23	27	43	40	26	31	26	25	33	22	16	28
10.24	Anticoagulant Incidents		▲	15	8	10	14	13	19	7	18	11	19	14	10	17
10.25	Missed Dose Incidents		▼	26	23	15	41	32	41	33	32	23	41	30	32	24
10.26	Discharges Incidents		▼	14	17	32	22	19	11	18	20	20	10	16	7	6
10.27	Prescribing Errors		▼	25	33	22	36	41	36	42	37	37	45	34	30	29
10.28	Preparation and Dispensing Incidents		▲	6	11	10	14	13	13	6	10	4	9	3	6	9
10.29	Administrating and Supply Incidents		▲	55	58	68	74	70	71	48	80	61	66	65	62	63

REF	SAFEGUARDING	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.70	% of staff compliant with training (children)	◀▶	86%	86%	87%	87%	87%	88%	88%	88%	88%	88%	88%	88%	88%
1.71	% of staff compliant with training (adult)	▲	87%	86%	87%	87%	88%	88%	89%	88%	88%	88%	88%	88%	89%
1.72	% of staff working with children who have review DBS checks														

REF	PATIENT EXPERIENCE: COMPLAINTS, PALS AND FFT	Target	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
2.01	New complaints this month †		▲	48	56	41	34	57	56	46	54	61	61	41	39	62
2.02	% Complaint responses closed within target timescale	30 days	◀▶	81%	64%	74%	50%	71%	61%	47%	60%	51%	54%	53%	52%	52%
	CG1	30 days	▼	69%	44%	61%	31%	67%	50%	55%	55%	53%	42%	52%	50%	28%
	CG2	30 days	▲	70%	70%	78%	67%	100%	67%	50%	82%	65%	100%	100%	75%	100%
	CG3	30 days	▼	100%	71%	92%	57%	56%	75%	36%	63%	54%	38%	67%	50%	38%
	CG4	30 days	▲	100%	100%	75%	100%	75%	67%	33%	-	67%	50%	-	50%	-
	CG5	30 days	▼	100%	100%	100%	60%	83%	63%	43%	29%	8%	67%	13%	60%	56%
	CG6	30 days	▲	67%	50%	43%	50%	71%	50%	57%	67%	57%	43%	18%	25%	60%
2.03	New PALS concerns this month		▲	132	132	144	142	159	166	160	150	88	48	24	25	33
2.04	% PALS responses closed within target timescale	10 days	▲	86%	71%	74%	74%	77%	77%	78%	71%	53%	62%	57%	48%	67%
	CG1	10 days	▲	92%	74%	73%	67%	67%	66%	65%	66%	60%	69%	64%	25%	56%
	CG2	10 days	◀▶	72%	63%	96%	90%	95%	80%	88%	100%	83%	90%	100%	100%	100%
	CG3	10 days	▲	88%	68%	68%	63%	69%	84%	77%	71%	46%	60%	57%	50%	57%
	CG4	10 days	▲	88%	100%	82%	100%	92%	90%	83%	73%	80%	100%	33%	50%	75%
	CG5	10 days	▼	100%	77%	67%	55%	69%	76%	82%	44%	20%	29%	25%	75%	33%
	CG6	10 days	▲	86%	67%	50%	72%	87%	76%	79%	65%	44%	50%	100%	0%	100%
2.05	FFT - York ED Recommend %	90%	▼	94.3%	91.5%	86.4%	96.0%	85.0%	78.2%	82.3%	80.2%	81.3%	72.9%	89.5%	89.5%	-
2.06	FFT - Scarborough ED Recommend %	90%	▲	88.4%	85.7%	84.3%	93.5%	87.1%	83.3%	75.6%	80.5%	75.0%	72.1%	75.8%	79.4%	-
2.07	FFT - Trust ED Recommend %	90%	▲	93.5%	90.7%	86.0%	95.5%	85.4%	78.8%	81.2%	80.3%	80.2%	72.8%	86.3%	87.4%	-
2.08	FFT - Trust Inpatient Recommend %	90%	▲	95.3%	98.2%	98.0%	98.3%	97.4%	97.1%	97.2%	95.8%	98.3%	96.9%	97.0%	97.7%	-
2.09	FFT - Trust Maternity Recommend %	90%	▲	100.0%	99.7%	100.0%	100.0%	99.1%	98.4%	98.6%	100.0%	99.0%	97.5%	97.5%	97.6%	-

† 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 : February-2022

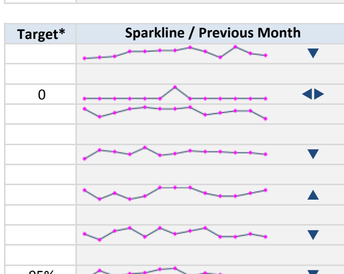
QUALITY AND SAFETY SUMMARY: (iii)

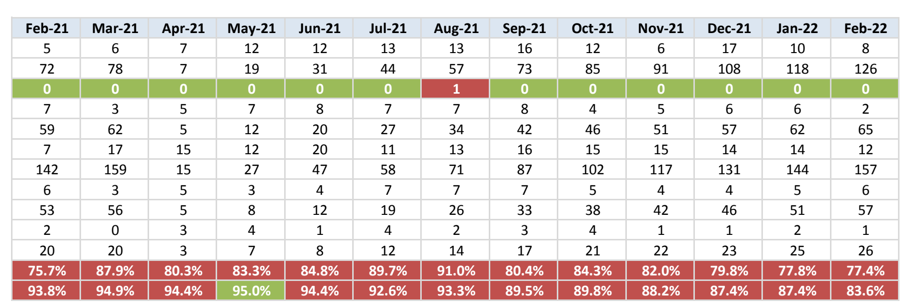
REF	CARE OF THE DETERIORATING PATIENT	Target	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
3.01	14 hour Post Take - York *	90%	▲	82%	79%	79%	79%	81%	79%	78%	80%	80%	79%	79%	79%	79%
3.02	14 hour Post Take - Scarborough *	90%	▼	81%	82%	81%	82%	83%	81%	79%	81%	80%	79%	83%	85%	84%
3.03	NEWS within 1 hour of prescribed time †	90%	▲	89.6%	91.0%	91.8%	91.1%	90.8%	90.3%	90.5%	89.0%	89.1%	88.5%	87.6%	86.7%	87.8%
3.04	Elective admissions: EDD within 24 hours of admission	93%	▼	94.8%	94.1%	93.8%	94.1%	92.8%	90.2%	91.6%	91.8%	94.5%	92.3%	94.2%	94.2%	91.7%

* 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.

† NEWS performance includes MEWS from Dec 2021

REF	MORTALITY INFORMATION	Target	Sparkline / Previous Month	Jul 17 - Jun 18	Oct 17 - Sep 18	Jan 18 - Dec 18	Apr 18- Mar 19	Jul 18 - Jun 19	Oct 18 - Sep 19	Jan 19 - Dec 19	Apr 19- Mar 20	Oct 19 - Sep 20	Jan 20 - Dec 20	Apr 20 - Mar 21	Jul 20 - Jun 21	Oct 20 - Sep 21
10.33	Summary Hospital Level Mortality Indicator (SHMI)	100	▲	99	98	100	100	98	100	99	99	97	95	94	94	96



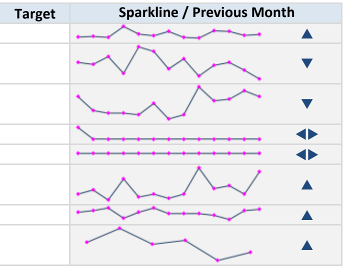


REF	INFECTION PREVENTION	Target*	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
6.01	Clostridium Difficile - meeting the C.Diff objective		▼	5	6	7	12	12	13	13	16	12	6	17	10	8
6.02	Clostridium Difficile - meeting the C.Diff objective - cumulative			72	78	7	19	31	44	57	73	85	91	108	118	126
6.03	MRSA - meeting the MRSA objective	0	◀▶	0	0	0	0	0	0	1	0	0	0	0	0	0
6.04	MSSA			7	3	5	7	8	7	7	8	4	5	6	6	2
6.05	MSSA - cumulative			59	62	5	12	20	27	34	42	46	51	57	62	65
6.06	ECOLI		▼	7	17	15	12	20	11	13	16	15	15	14	14	12
6.07	ECOLI - cumulative			142	159	15	27	47	58	71	87	102	117	131	144	157
6.08	Klebsiella		▲	6	3	5	3	4	7	7	7	5	4	4	5	6
6.09	Klebsiella - cumulative			53	56	5	8	12	19	26	33	38	42	46	51	57
6.10	Pseudomonas		▼	2	0	3	4	1	4	2	3	4	1	1	2	1
6.11	Pseudomonas - cumulative			20	20	3	7	8	12	14	17	21	22	23	25	26
6.12	MRSA Screening - Elective †	95%	▼	75.7%	87.9%	80.3%	83.3%	84.8%	89.7%	91.0%	80.4%	84.3%	82.0%	79.8%	77.8%	77.4%
6.13	MRSA Screening - Non Elective †	95%	▼	93.8%	94.9%	94.4%	95.0%	94.4%	92.6%	93.3%	89.5%	89.8%	88.2%	87.4%	87.4%	83.6%

* 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

† The MRSA Screening data has been refreshed from Sep-20 to align with the Oversight & Assurance Report for Quality and Safety, using the same data model



REF	DOLS	Target	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
8.01	Standard Authorisation Status Unknown: Local Authority not informed the Trust of outcome		▲	5	6	4	32	12	8	19	4	2	21	19	9	11
8.02	Standard Authorisation Not Required: Patient no longer in Trust's care and within 7 day self-authorisation		▼	34	31	44	15	61	53	23	40	11	29	34	21	6
8.03	Under Enquiry: Safeguarding Adults team reviewing progress of application with Local Authority or progress with ward		▼	21	11	9	9	8	16	5	8	28	18	19	25	21
8.04	Standard Authorisation Granted: Local Authority granted application		◀▶	1	0	0	0	0	0	0	0	0	0	0	0	0
8.05	Application Not Granted: Local Authority not granted application		◀▶	0	0	0	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		▲	10	13	6	21	8	10	7	10	29	14	16	10	26
8.07	Safeguarding Adults concerns reported to the Local Authority against the Trust		▲	8	9	11	4	8	11	7	7	7	6	3	9	10
8.08	Application Withdrawn: Patient no longer in Trust's care within the Local Authority 8 week period for assessment		▲	7	4	5	4	6	6	5	15	22	14	16	6	10

TRUST BOARD REPORT : February-2022

QUALITY AND SAFETY SUMMARY: (iv) QUANTITATIVE TABLE

REF	Indicator	Consequence of Breach	Threshold	Sparkline / Previous Month		Q4 20/21	Q1 21/22 †	Q2 21/22 †	Q3 21/22	Nov-21	Dec-21	Jan-22	Feb-22
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		◀▶	-	-	-	39	12	7	-	-
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		▲	22	51	51	34	4	22	17	25
9.04	% Compliance with WHO safer surgery checklist (not currently recorded)	No financial penalty	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%	99.93%	99.86%	99.92%	99.93%	99.93%	To follow	-
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%		▼	99.78%	99.66%	99.41%	99.57%	99.66%	99.71%	99.62%	-
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		▼	5.81%	4.52%	6.55%	10.54%	10.07%	12.22%	5.66%	-
	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%		▲	88.16%	75.63%	83.12%	82.28%	83.18%	95.65%	89.86%	98.90%
	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%		▲	94.32%	94.48%	90.77%	92.53%	91.22%	89.14%	86.80%	To follow
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 (not currently recorded)	General Condition 9	95.00%			-	-	-	-	-	-	-	-
	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									

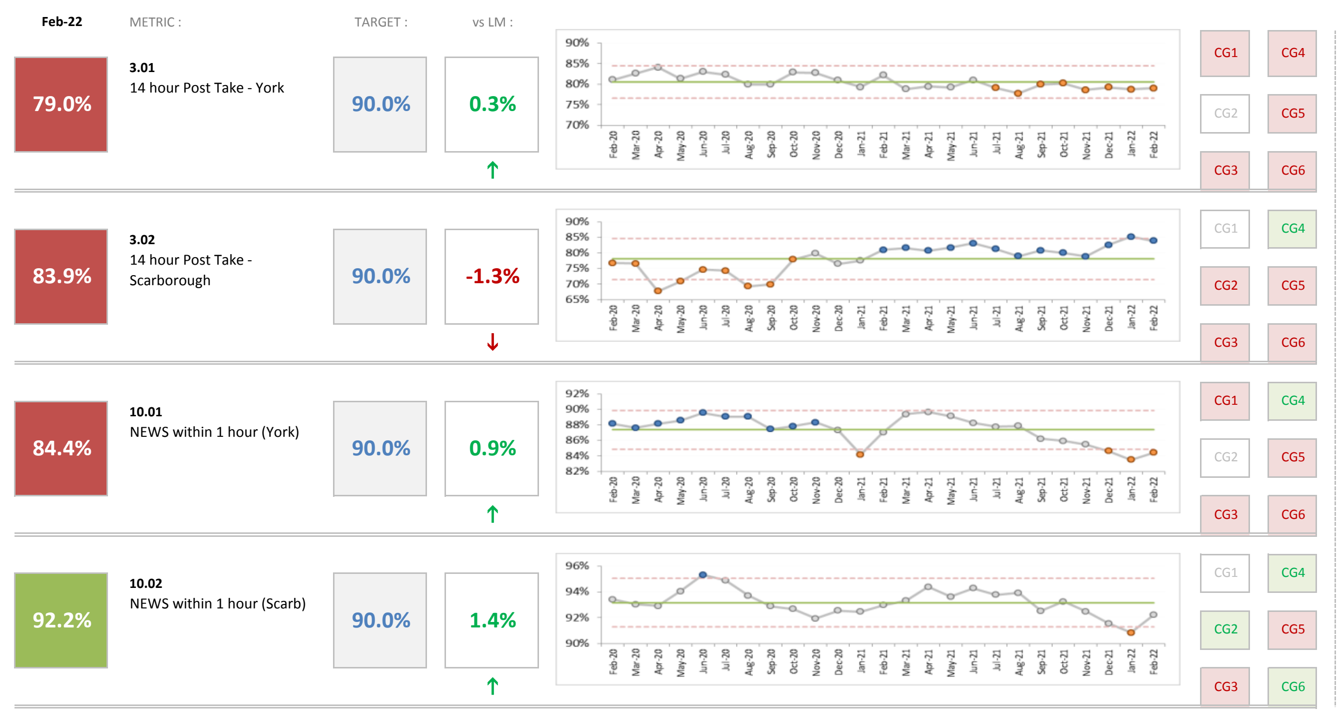
* QMCO and Monthly Sitrep Return suspended due to Covid-19, QMCO re-commenced for Q3 2021-22 submission

† The quarterly figures for Q1 & Q2 21/22 have been refreshed due to error

‡ The Sleeping Accommodation Breaches for Dec-21 are currently unvalidated. For Nov-21, 5 breaches were declared to NHSE but only 4 have been validated as breaches. This figure will be updated when the national window for corrections opens

TRUST BOARD REPORT : February-2022

QUALITY AND SAFETY: CARE OF DETERIORATING PATIENT

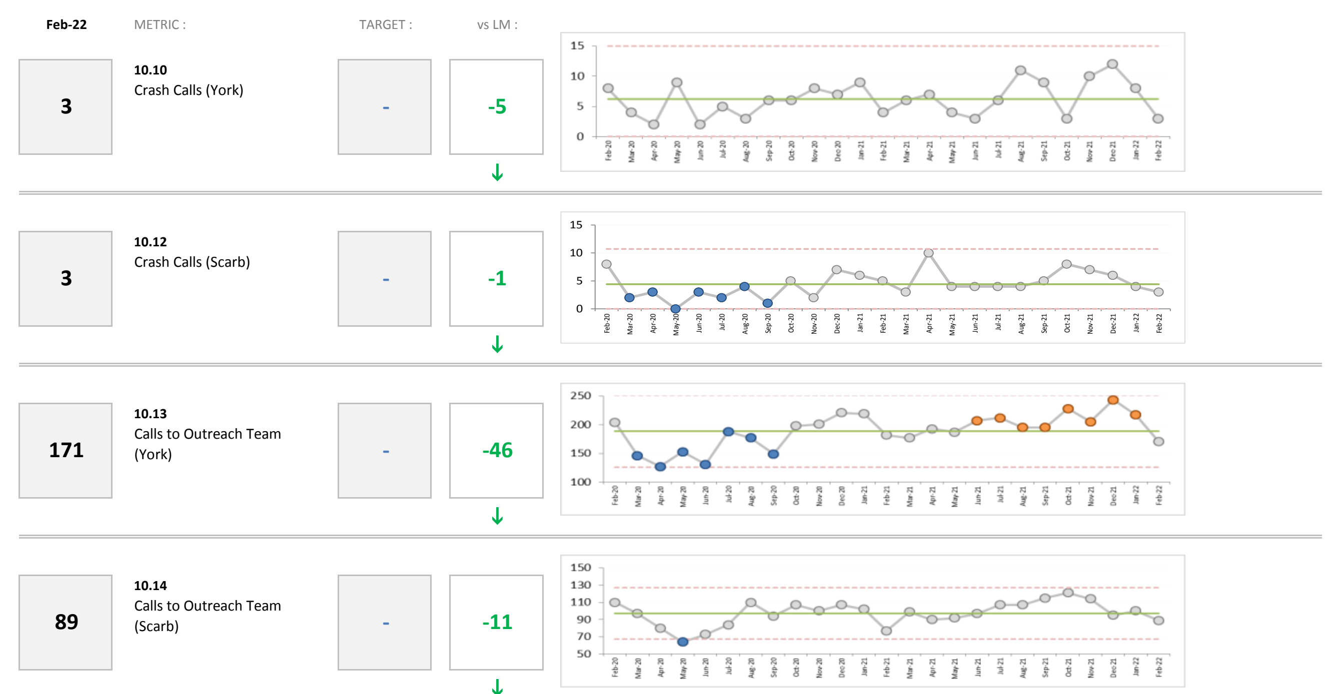


HIGHLIGHTS FOR BOARD TO NOTE :

Observation compliance across the York site remains an issue. There has been escalation to QPAS requesting action plans from care groups in relation to improving this compliance. A trial with electronic handheld devices is currently underway.

TRUST BOARD REPORT : February-2022

QUALITY AND SAFETY: CARE OF DETERIORATING PATIENT



HIGHLIGHTS FOR BOARD TO NOTE :

Cardiac arrest numbers on both sites are lower than the means, only 3 on both sites for the month. No issues identified here.

Outreach workload continue to increase which again is secondary to the increase in MET calls. Moving forward there is hope that this data will be collected electronically.

TRUST BOARD REPORT : February-2022

QUALITY AND SAFETY: MEDICATION INCIDENTS

Feb-22	METRIC :	TARGET :	vs LM :
1	10.20 Medication Incidents Resulting in Moderate Harm, Serious/Severe Harm or Death	-	0
12	10.21 Insulin Incidents	-	-2 ↓
15	10.22 Antimicrobial Incidents	-	0
28	10.23 Opiate Incidents	-	12 ↑
17	10.24 Anticoagulant Incidents	-	7 ↑
24	10.25 Missed Dose Incidents	-	-8 ↓
6	10.26 Discharges Incidents	-	-1 ↓
29	10.27 Prescribing Errors	-	-1 ↓
9	10.28 Preparation and Dispensing Incidents	-	3 ↑
63	10.29 Administrating and Supply Incidents	-	1 ↑

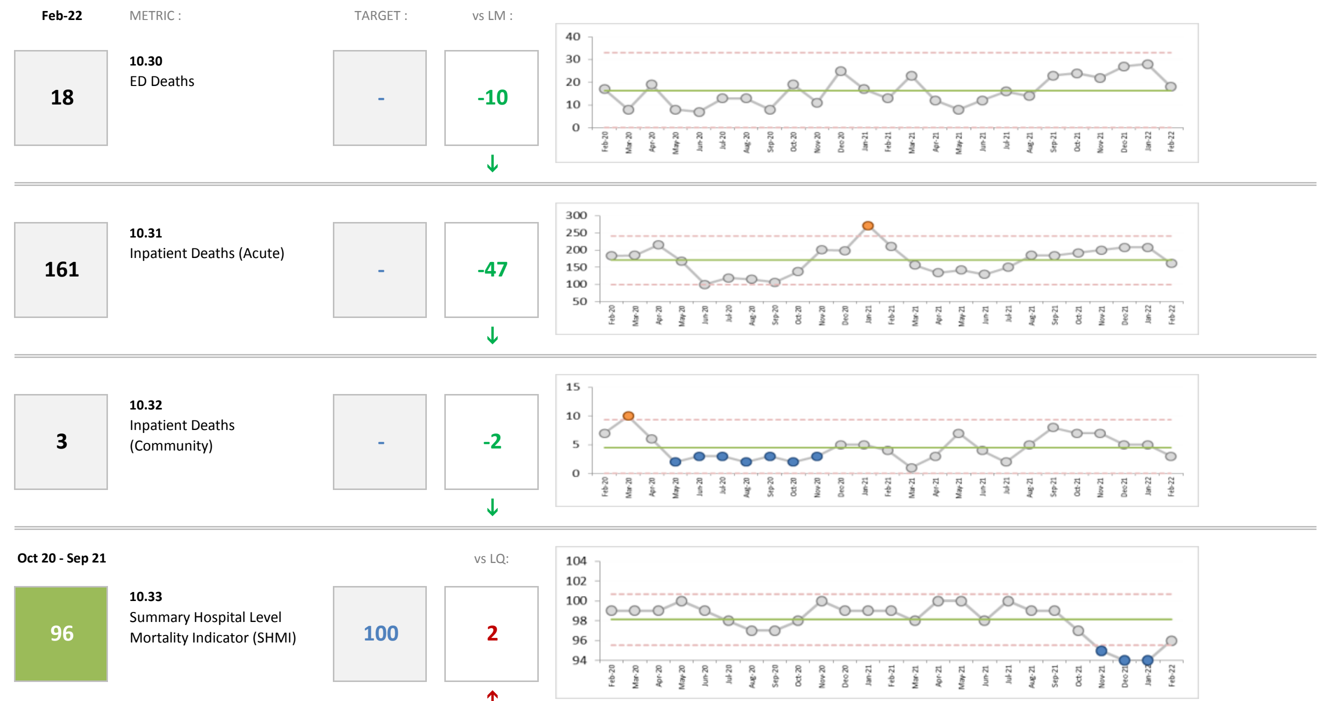
HIGHLIGHTS FOR BOARD TO NOTE :

There were 139 medication incidents this month with one incident causing severe harm. A patient received an inappropriately high dose of Lorazepam for sedation for a CT scan. The patient was peri arrest, aspirated and failed to respond to treatment and sadly passed away. The Trust Sedation Group have been commissioned to develop some guidelines for management of patients requiring sedation for scans.

All incident types and incidents relating to high risk medicines are within normal variation. However, the harm due to missed doses of medication is above normal variation. A deep dive into these incidents to identify themes and areas for improvement is underway.

TRUST BOARD REPORT : February-2022

QUALITY AND SAFETY : MORTALITY



HIGHLIGHTS FOR BOARD TO NOTE :

Please note the February mortality update is unavailable this month due to unforeseen circumstances

In January 2022 the top 3 causes of death were Pneumonia, Sepsis and Covid 19. There were 13 deaths that mentioned Covid 19 as 1a Cause of Death. In December , overall deaths increased in the Emergency Department and the Acute Sites, but declined in the Community.
The number of deaths per 1000 bed days was calculated and is shown below:
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
July 2021 - 6.76 per 1000 bed days
August 2021 - 8.55 per 1000 bed days
September 2021-8.42 per 1000 bed days
October 2021 - 8.78 per 1000 bed days
November 2021 - 9.05 per 1000 bed days
December 2021- 12.63per 1000 bed days
January 2022- 7.03 per 1000 bed days
When compared to January 2021, the number of deaths per 1000 bed days has Decreased inJanuary 2022.
In January 2022 there were 12 Structured Judgement Casenote Reviews (SJCR's) commissioned. The SJCR's requested were as a result of the following; 15 x medical examiner review.

TRUST BOARD REPORT : February-2022

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	18	0	0	**18**	9	0	0	**9**
CG2	0	6	0	**6**	0	5	0	**5**
CG3	11	4	0	**15**	7	0	0	**7**
CG4	4	3	0	**7**	3	2	0	**5**
CG5	4	4	0	**8**	3	1	0	**4**
CG6	6	2	0	**8**	3	0	0	**3**
Corporate	0	0	0	**0**	0	0	0	**0**
Total	**43**	**19**	**0**	**62**	**25**	**8**	**0**	**33**

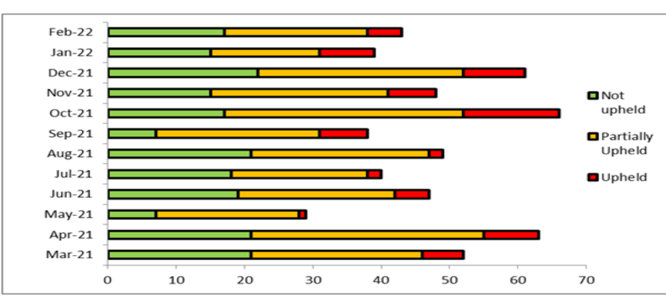
Main themes

- Care needs not adequately met
- Communication with patient
- Delay or failure to diagnose
- Attitude of medical staff
- Attitude of nursing staff/midwives
- Discharge arrangements

Themes are discussed at the PESG and care groups continue to provide evidence of learning and service improvements as a result of feedback.

PATIENT EXPERIENCE: CLOSED CASES

Proportion of closed complaints by outcome



Closed Complaints

Care Group	<30 Closed	<30 Average of No of Days	30-50 Closed	30-50 Average of No of Days	51-100 Closed	51-100 Average of No of Days	>100 Closed	>100 Average of No of Days	Total Closed	Total Average of No of Days	% Within Target
CG1	5	16	6	40	7	58	0	0	**18**	**40**	**28%**
CG2	9	14	0	0	0	0	0	0	**9**	**14**	**100%**
CG3	3	12	3	37	2	62	0	0	**8**	**34**	**38%**
CG4	0	0	0	0	0	0	0	0	**0**	**0**	**None**
CG5	5	16	2	38	2	83	0	0	**9**	**36**	**56%**
CG6	3	15	1	46	1	58	0	0	**5**	**30**	**60%**
Corp	1	24	0	0	0	0	0	0	**1**	**24**	**100%**
Trust Total	**26**	**15**	**12**	**39**	**12**	**63**	**0**	**0**	**50**	**32**	**52%**

Closed PALS

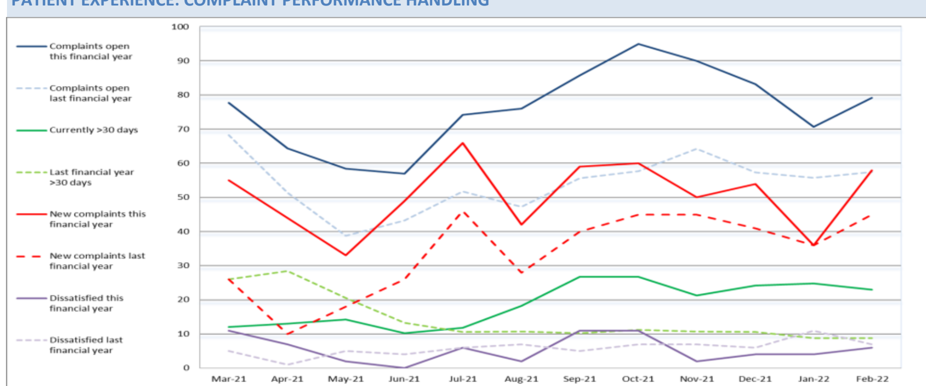
Care Group	<10 Closed	<10 Average of No of Days	10-20 Closed	10-20 Average of No of Days	21-50 Closed	21-50 Average of No of Days	51-100 Closed	51-100 Average of No of Days	>100 Closed	>100 Average of No of Days	Total Closed	Total Average of No of Days	% Within Target
CG1	5	5	0	0	4	38	0	0	0	0	**9**	**20**	**56%**
CG2	3	5	0	0	0	0	0	0	0	0	**3**	**5**	**100%**
CG3	4	4	2	13	1	21	0	0	0	0	**7**	**9**	**57%**
CG4	3	5	1	19	0	0	0	0	0	0	**4**	**8**	**75%**
CG5	1	5	2	16	0	0	0	0	0	0	**3**	**12**	**33%**
CG6	4	4	0	0	0	0	0	0	0	0	**4**	**4**	**100%**
Corp	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**None**
Trust Total	**20**	**4**	**5**	**15**	**5**	**35**	**0**	**0**	**0**	**0**	**30**	**11**	**67%**

In 2020-21- 443 complaints were received. The Trust has received 552 to date this year and we have seen an increase in complaints for Obs and Gynae and ED services.

52% closed complaints were in target (= 52% in January). 24% were addressed within 30-50 working days and 24% within 51-100 working days. 67% of cases over target were extended in agreement with the complainant.

67% closed PALS cases were in target (↑ from 48% in January). 17% were addressed within 10-20 working days. The remaining 17% were addressed in 21-50 working days.

PATIENT EXPERIENCE: COMPLAINT PERFORMANCE HANDLING



Note: All PET data is based on the primary data logged on Datix

TRUST BOARD REPORT : February-2022

QUALITY AND SAFETY: MATERNITY (YORK)

YORK - MATERNITY DASHBOARD			Measure	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Regional Average for last Quarter	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
RESPONSIVE																			
Activity	Births	Bookings	1st m/w visit	≤295	296-321	≥322	N/A	280	203										
		Bookings <10 weeks	No. of mothers	≥90%	76%-89%	≤75%		68.90%	62.10%										
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	< 10%	10.1%-19.9%	>20%		2.9%	5.9%										
		Births	No. of babies	≤245	246-266	≥267		227	236										
		No. of women delivered	No. of mothers	≤242	243-263	≥264		225	233										
		Planned homebirths	No. of mothers	≥2.1%	≤2-1.6%	≤1.5%	1.10%	0.0%	0.4%										
	Closures	Homebirth service suspended	No. of suspensions	0-3		4 or more		16	12										
		Women affected by suspension	No. of women	0		1 or more		1	3										
		Community midwife called in to unit	No. of times	0-3	4-5	6 or more		2	4										
		Maternity Unit Closure	No. of closures	0		1 or more		5	5										
		SCBU at capacity	No of times					0	0										
		SCBU at capacity of intensive cots	No. of times					21	27										
		SCBU no of babies affected	No. of babies affected	0	1	2 or more		1	0										
WELL LED																			
Workforce	Staffing	MW to birth ratio	Ratio	≤29.5	29.6 - 31	>31	DH	31	28										
		1 to 1 care in Labour	CPD	100%		≤99.9%	n/a	93.3%	96.0%										
		L/W Co-ordinator supernumary %	Shift Handover Sheets	100%		≤99.9%		96.7%											
		Anaesthetic cover on L/W	av.sessions/week	10	4-9	≤3		10	10										
SAFE																			
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	≥57%	≤56.9-54%	<54%	57%	61.0%	60.5%										
		Assisted Vaginal Births	No. of instr. Births - %	≤12.4%	≥12.5-14%	≥14.1%	11%	11.1%	9.9%										
		C/S Births	Em & elect - %	≤30.1%	≥30.2-32%	>32.1%	32%	27.6%	29.6%										
		Elective caesarean	%	≤13.2%	≥13.3-16%	≥16.1%	13%	12.9%	14.6%										
		Emergency caesarean	%	≤16.9%	≥17-20%	≥20.1%	19%	14.7%	15.0%										
		Induction of labour	%					37.8%	41.2%										
		HDU on L/W	No. of women	5 or less	6-9	10 or more		14	16										
		BBA	No. of women	2 or less	3-4	5 or more		2	2										
		HSIB cases	No. of babies	0		1 or more		1	0										
	Morbidity	Neonatal Death	No of babies	0		1 or more		0	0										
		Antepartum Stillbirth	No. of babies	0	1	2 or more	n/a	1	0										
		Intrapartum Stillbirths	No. of babies	0		1 or more	n/a	0	0										
	Neonatal Indicators	Cold babies	No of babies admitted to SCBU col	1 or less	2-3	4 or more		3	3										
		Preterm birth rate <37 weeks	% of babies born <37 weeks	≤6%	6-9%	≥10.1%		9.70%	6.40%										
		Preterm birth rate <34 weeks	% of babies born <34 weeks	≤2%	2.1-3%	≥3.1%		3.10%	1.30%										
		Preterm birth rate <28 weeks	% of babies born <28 weeks	≤0.5%	0.6-0.9%	≥1%		0.00%	0.00%										
		Low birthweight rate at term (2.2kg)	% of babies <2.2kg at term	0%	0.1-0.4%	≥0.5%		1.30%	0.00%										
		Right place of birth	% of preterm babies born in approp	100%		<99.9%		100.00%	100.00%										
	Public Health	Breastfeeding Initiation rate	% of babies feeding at birth	≥75%	≤74.9-71%	≤70.9%	67%	66.4%	67.4%										
		Breastfeeding rate at discharge	% of babies breastfeeding at disch	>65%	60.1-64.9%	<60%		47.7%	49.3%										
		Smoking at booking	% of women smoking at booking	≤6%	≥6.1-10%	≥10.1%		7.5%	8.4%										
		Smoking at 36 weeks	% of women smoking at 36 weeks	≤6%	≥6.1-10%	≥10.1%		10.1%	5.5%										
		Smoking at time of delivery	% of women smoking at del.	≤6%	≥6.1-10%	≥10.1%	12%	11.6%	7.7%										
		Carbon monoxide monitoring at booking	% CO completed	≥95%	80-95%	≤79.9%		88.2%	96.6%										
		Carbon monoxide monitoring at 36 weeks	% CO completed	≥95%	80-95%	≤79.9%		87.7%	93.7%										
	Risk Management	SI's	No. of Si's declared	0		1 or more		0	0										
		PPH > 1.5L as % of all women	% of births				3.6	3.9%	4.2%										
		Shoulder Dystocia	No. of women	2 or less	3-4	5 or more		4	2										
		3rd/4th Degree Tear - normal birth	No of women	≤2.8%	2.9- 4.5%	≥4.6%	2.10%	1.0%	0.9%										
		3rd/4th Degree Tear - Assisted birth	No of women	≤6.05%	≥6.1-8%	≥8.1%	5%	8.0%	4.3%										
	New Complaints	Informal	No. of Informal complaints	0	1-4	5 or more		0	0										
		Formal	No. of Formal complaints	0	1-4	5 or more		2	5										

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 : February-2022

QUALITY AND SAFETY: MATERNITY (SCARBOROUGH)

SCARBOROUGH - MATERNITY DASHBOARD			Measure	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Regional Average for last Quarter	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
RESPONSIVE																			
Activity	Births	Bookings	1st m/w visit	≤169	170-184	≥185	N/A	148	113										
		Bookings <10 weeks	No. of mothers	≥90%	76%-89%	≤75%		70.9%	69.9%										
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	< 10%	10%-20%	>20%		6.1%	7.1%										
		Births	No. of babies	≤113	114-134	≥135		115	115										
		No. of women delivered	No. of mothers	≤112	113-133	≥134		114	114										
		Planned homebirths	No of mothers	≥2.1%	≤2-1.5%	≤1.5%	1.10%	1.8%	0.0%										
	Closures	Homebirth service suspended	No. of suspensions	0-3		4 or more		23	22										
		Women affected by suspension	No. of women	0		1 or more		1	1										
		Community midwife called in to unit	No. of times	3	4-5	6 or more		8	3										
		Maternity Unit Closure	No. of closures	0		1 or more		1	0										
		SCBU at capacity	No of times					0	4										
		SCBU at capacity of intensive care cots	No. of times					0	0										
		SCBU no of babies affected	No. of babies affected	0	1	2 or more		0	0										
WELL LED																			
Workforce	Staffing	M/W to birth ratio	Ratio	≤29.5	29.6-30.9	>31	DH	23.0	24.0										
		1 to 1 care in Labour	CPD	≥100%		≤99.9%		94.8%	97.9%										
		L/W Co-ordinator supernumary %	Shift Handover Sheets	≥100%		≤99.9%		100.0%	96.7%										
		Anaesthetic cover on L/W	av.sessions/week	≥10	4-9	≤3		5	5										
SAFE																			
Clinical Indicators	Neonatal/ Maternal	Normal Births	No. of svd - %	≥57%	56.9-54%	<53.9%	57%	56.4%	61.2%										
		Assisted Vaginal Births	No. of instr. Births - %	≤12.4%	≥12.5-14%%	≥14.1%	11%	6.1%	8.8%										
		C/S Births	Em & elect - %	≤30.1%	≥30.2-32%	≥32.1%	32%	36.0%	28.9%										
		Elective caesarean	%	≤13.2%	≥13.3-16%	≥16.1%	13%	14.9%	11.4%										
		Emergency caesarean	%	≤16.9%	≥17-20%	≥20.1%	19%	21.1%	17.5%										
		Induction of labour	%					36.0%	50.9%										
		HDU on L/W	No. of women	5 or less	6-9	10 or more		5	4										
		BBA	No. of women	2 or less	3-4	5 or more		3	4										
		HSIB cases	No. of babies	0	1	2 or more		0	0										
	Morbidity	Neonatal Death	No of babies	0		1 or more		0	0										
		Antepartum Stillbirth	No. of babies	0	1	2 or more	N/A	0	0										
		Intrapartum Stillbirths	No. of babies	0		1 or more	N/A	0	0										
	Neonatal Indicators	Cold babies	No of babies admitted to SCBU co	1 or less	2-3	4 or more		0	2										
		Preterm birth rate <37 weeks	% of babies born <37 weeks	≤6%	6-9%	≥10.%		8.7%	7.8%										
		Preterm birth rate <34 weeks	% of babies born <34 weeks	≤1%	1.1-2%	≥2.1%		2.6%	2.6%										
		Preterm birth rate <28 weeks	% of babies born <28 weeks	≤0.5%	0.6-0.9%	≥1%		0	1										
		Low birthweight rate at term (2.2kg)	% of babies <2.2kg at term	0%	0.1-0.4%	≥0.5%		0.0%	0.0%										
		Right place of birth	% of preterm babies born in approp	100%		≥99.9%		97.40%	97.40%										
	Public Health	Breastfeeding Initiation rate	% of babies feeding at birth	≥75%	71-74%	≤70%	67%	72.2%	45.2%										
		Breastfeeding rate at discharge	% of babies breastfeeding at disch	≥65%	61-64%	≤60%		52.40%	25.00%										
		Smoking at booking	% of women smoking at booking	≤6%	≥6.1-10%	≥10.1%		21.6%	18.6%										
		Smoking at 36 weeks	% of women smoking at 36 weeks	≤6%	≥6.1-10%	≥10.1%		13.7%	12.9%										
		Smoking at time of delivery	% of women smoking at del.	≤6%	≥6.1-10%	≥10.1%	12%	11.4%	19.3%										
		Carbon monoxide monitoring at booking	% CO completed	≥95%	80-95%	≤79.9%		81.6%	68.1%										
		Carbon monoxide monitoring at 36 weeks	% CO completed	≥95%	80-95%	≤79.9%		76.90%	39.70%										
	Risk Management	SI's	No. of Si's declared	0		1 or more		0	0										
		PPH > 1.5L as % of all women	% of births				3.6	5.1	5.2										
		Shoulder Dystocia	No. of women	2 or less	3-4	5 or more		0	0										
		3rd/4th Degree Tear - normal births	No of women	≤2.8%	2.9- 4.5%	≥4.6%	2.10%	1.9%	1.0%										
		3rd/4th Degree Tear - assisted birth	No of women	≤6.05%	≥6.1-8%	≥8.1%	5%	14.3%	0.0%										
	New Complaints	Informal	No. of Informal complaints	0	1-4	5 or more		0	1										
		Formal	No. of Formal complaints	0	1-4	5 or more		2	1										

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.

WORKFORCE PERFORMANCE REPORT

February-2022

Produced March 2022

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 : February 2022

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:

The most recent validated sickness data shows an increase in staff absences in January to 6.49%, which is the highest rate recorded throughout the pandemic. Daily SitRep records (which include York Teaching Hospital Facilities Management data) demonstrate a reduction in absence in February, though the figures consistently showed that 20-25% absences were for a reason related to Covid-19.

The welfare of the workforce remains our priority. The Trust is seeking to invest in wellbeing facilities and is preparing a bid for charitable funds to support the refurbishment of facilities in York, Scarborough and Bridlington Hospitals to support staff to take a break away from their immediate place of work. The development of staff facilities is a core part of the Trust's strategy to support staff wellbeing and ultimately staff retention. The data in this report shows that staff retention has steadily reduced since the summer of 2021, in line with the national picture in the NHS and more widely.

The Trust is preparing for the publication of its 2021 Staff Survey results at the end of March. The Trust will review the results against the seven commitments which make up the NHS People Promise to understand how they impact on existing plans to improve its offer to staff. These plans include a review of its Equality, Diversity and Inclusion Strategy, which will be supported by the appointment of a new Head of ED&I.

Recommendation:

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

Author(s): Will Thornton, Head of Resourcing

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

TRUST BOARD REPORT : February-2022

WORKFORCE

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

REF	Vacancies	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.01	Trust vacancy factor	▼	5.0%	5.0%	6.0%	7.0%	7.3%	6.8%	5.0%	5.0%	8.0%	7.7%	8.0%	9.0%	8.0%
1.02	Nursing and Midwifery vacancy rate - Trust	▲	7.1%	7.8%	8.6%	8.8%	8.8%	5.1%	5.6%	5.7%	8.0%	8.3%	9.7%	9.0%	9.7%
1.03	Nursing and Midwifery vacancy rate - York	▲	4.4%	4.8%	6.6%	6.3%	6.3%	3.0%	3.9%	3.7%	6.1%	7.4%	8.1%	7.8%	9.1%
1.04	Nursing and Midwifery staff group vacancy rate - Scarborough	▼	13.6%	14.8%	13.5%	14.6%	14.6%	10.2%	9.6%	10.5%	12.5%	10.5%	13.6%	12.0%	11.3%
1.05	Medical and Dental vacancy rate - Trust	▼	8.5%	8.9%	8.9%	9.7%	9.7%	9.7%	10.5%	10.5%	11.4%	11.4%	10.9%	10.9%	9.3%
1.06	Medical and Dental vacancy rate - York	▼	7.9%	8.2%	8.2%	10.3%	10.3%	10.3%	9.7%	9.7%	10.6%	10.6%	10.3%	10.3%	8.8%
1.07	Medical and Dental vacancy rate - Scarborough	▼	10.1%	10.6%	10.6%	11.7%	11.7%	11.7%	12.6%	12.6%	13.2%	13.2%	12.4%	12.4%	10.7%
1.08	AHP vacancy rate - Trust	▼	1.8%	2.0%	6.6%	6.2%	6.1%	5.9%	6.4%	5.0%	6.2%	5.9%	6.4%	9.5%	8.5%
1.09	Other Registered Healthcare Scientists vacancy rate - Trust	▲	8.3%	9.1%	6.9%	5.4%	4.7%	-1.8%	-0.3%	-0.5%	-2.3%	-1.6%	-1.2%	-1.2%	0.4%

REF	Retention	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
2.01	Trust stability (Headcount)	▼	90.3%	90.8%	90.9%	90.5%	90.6%	89.1%	89.9%	89.7%	89.3%	89.2%	88.7%	88.0%	87.80%

REF	Temporary Workforce	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
3.01	Total FTE Medical and Dental roles covered by bank and agency	▼	98.7	122.7	110.3	123.8	126.1	169.3	168.4	137.8	158.3	159.9	155.4	157.0	143.0
3.02	Temporary medical and dental shifts covered by bank (% as proportion of all coverage by bank and agency)	◀▶	65.0%	65.0%	63.0%	69.0%	67.0%	76.0%	74.0%	61.0%	63.0%	63.0%	57.0%	63.0%	63.0%
3.03	Temporary medical and dental shifts covered by agency (% as proportion of all coverage by bank and agency)	◀▶	35.0%	35.0%	37.0%	31.0%	33.0%	24.0%	26.0%	39.0%	37.0%	37.0%	43.0%	37.0%	37.0%
3.04	Total FTE nurse staffing roles covered by bank and agency (RN's and HCA's)	▼	450.0	488.0	403.0	417.0	387.0	392.0	449.0	397.0	390.0	388.0	375.0	470.0	417.0
3.05	Temporary nurse staffing bank filled (FTE)	▼	365.0	390.0	311.0	320.0	295.0	300.0	359.0	309.0	297.0	306.0	296.0	387.0	332.0
3.06	Temporary nurse staffing agency filled (FTE)	▲	85.0	98.0	92.0	97.0	92.0	92.0	90.0	88.0	93.0	82.0	79.0	83.0	85.0
3.07	Temporary nurse staffing unfilled (FTE)	▲	199.0	212.0	145.0	156.0	148.0	222.0	210.0	232.0	271.0	232.0	277.0	263.0	272.0
3.08	Temporary nurse shifts covered by bank (% as proportion of all coverage by bank and agency)		81.1%	79.9%	77.2%	76.7%	76.2%	76.5%	80.0%	77.8%	76.2%	78.9%	78.9%	82.3%	79.6%
3.09	Temporary nurse shifts covered by agency (% as proportion of all coverage by bank and agency)		18.9%	20.1%	22.8%	23.3%	23.8%	23.5%	20.0%	22.2%	23.8%	21.1%	21.1%	17.7%	20.4%
3.10	Unfilled temporary nurse staffing requests (%)		31.0%	30.0%	26.0%	27.0%	28.0%	36.0%	32.0%	37.0%	41.0%	37.0%	42.0%	36.0%	40.0%
3.11	Pay Expenditure - Total (£000)	▲	£33,374	£32,624	£33,047	£33,237	£33,059	£33,584	£34,047	£39,327	£34,479	£36,529	£35,498	£36,474	£37,090
3.12	Pay Expenditure - Contracted (£000)	▲	£26,772	£25,919	£27,126	£26,942	£27,169	£27,053	£27,657	£31,896	£28,072	£29,545	£28,765	£29,207	£29,659
3.13	Pay Expenditure - Locums (£000)	▲	£198	£230	£229	£233	£211	£243	£107	£71	£207	£254	£114	£196	£203
3.14	Pay Expenditure - Bank (£000)	▼	£2,512	£2,527	£1,953	£1,993	£1,881	£2,194	£2,413	£2,491	£1,946	£2,294	£2,279	£2,745	£2,740
3.15	Pay Expenditure - Agency (£000)	▲	£1,084	£1,418	£1,384	£1,453	£1,335	£1,401	£1,375	£1,352	£1,638	£1,731	£1,617	£1,443	£1,516
3.16	Pay Expenditure - Additional Hours (£000)	▲	£2,575	£2,283	£2,105	£2,445	£2,292	£2,515	£2,308	£2,823	£2,439	£2,522	£2,547	£2,726	£2,783
3.17	Pay Expenditure - Overtime (£000)	▲	£233	£247	£250	£171	£171	£177	£188	£694	£178	£182	£176	£157	£189

REF	Absence Management	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
4.01	Absence Rate Trust (excluding YTHFM)	▲	4.9%	3.9%	4.4%	4.6%	4.6%	5.0%	4.8%	5.3%	5.6%	5.6%	5.8%	6.5%	-

REF	COVID-19 Absence Management	SPARKLINE / PREVIOUS WEEK	14-Jan	21-Jan	28-Jan	04-Feb	11-Feb	18-Feb	25-Feb
5.01	All absence	▼	863.43	829.14	817.43	792.43	781.57	749.29	749
5.02	COVID-19 related absence	▼	451	439.57	402.57	378.43	363.57	314.71	290.43

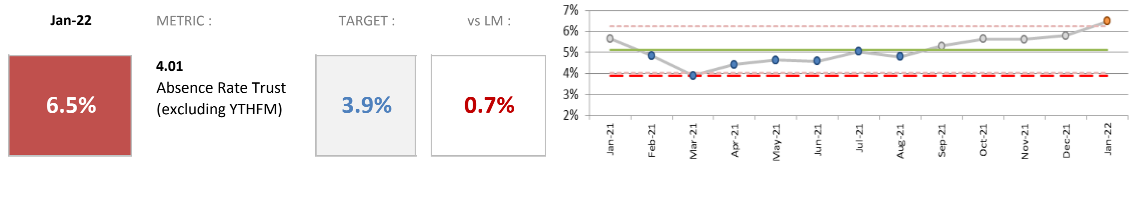
REF	Disciplinary and Grievance	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
6.01	Live disciplinary or bullying and harassment cases (Including investigations)	▼	6	9	8	5	7	7	6	8	8	7	7	8	7
6.02	Live grievance cases	▼	8	10	11	2	5	4	3	4	4	5	2	3	1

REF	Learning and Organisational Development	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
7.01	Trust Stat & Mand Training compliance	◀▶	85.0%	85.0%	86.0%	87.0%	87.0%	87.0%	88.0%	87.0%	87.0%	87.0%	87.0%	87.0%	87.0%
7.02	Trust Corporate Induction Compliance	◀▶	95.0%	95.0%	95.0%	94.0%	95.0%	95.0%	94.0%	94.0%	94.0%	92.0%	94.0%	94.0%	94.0%
7.03	Non-medical staff core training compliance	▲	87.0%	87.0%	88.0%	88.0%	88.0%	89.0%	90.0%	90.0%	90.0%	89.0%	89.0%	89.0%	90.0%
7.05	Non-medical staff corporate induction compliance	▲	97.0%	95.0%	95.0%	95.0%	95.0%	96.0%	96.0%	95.0%	95.0%	93.0%	95.0%	95.0%	96.0%
7.06	Medical staff core training compliance	◀▶	74.0%	75.0%	76.0%	76.0%	75.0%	77.0%	72.0%	71.0%	71.0%	72.0%	73.0%	73.0%	73.0%
7.08	Medical staff corporate induction compliance	▼	90.0%	91.0%	91.0%	91.0%	91.0%	90.0%	82.0%	86.0%	88.0%	87.0%	87.0%	87.0%	86.0%

REF	Appraisal Compliance	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
8.01	Trust (excluding medical and dental)	◀▶	93.4%	93.4%	93.4%	0.7%	6.5%	17.4%	32.7%	45.8%	57.2%	86.2%	89.6%	89.7%	89.7%

TRUST BOARD REPORT : February-2022

WORKFORCE : SICKNESS ABSENCE RATE



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HIGHLIGHTS FOR BOARD TO NOTE :

The latest complete data reported through the Trust's Payroll system shows the absence rate reached 6.49% in January. This is the highest rate reported throughout the period of the pandemic. The figure is for sickness absence only and does not include those instances where a staff member was medically suspended from work on account of Covid isolation rules.

Across staff groups, the highest rate of absence was in the Additional Clinical Services group (predominantly Health Care Support Workers) at 9.55%, followed by Nursing and Midwifery Registered at 7.55% and Additional Professional Scientific & Technical (a high proportion of which is made up of Pharmacy and Theatre workers) at 6.09%.

The top three reasons for absence in January were: mental health which includes anxiety/stress/depression (27.8% of absences), musculoskeletal problems - including back problems (14.4%) and infectious diseases, predominantly Covid (12.8%).

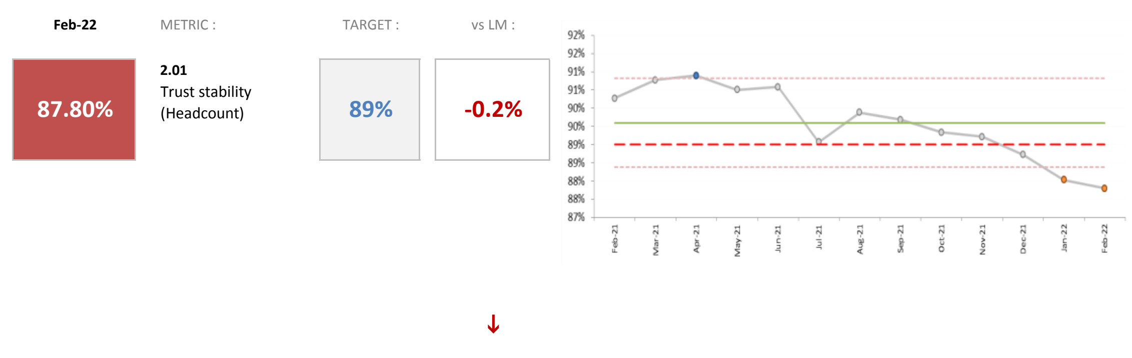
In more recent weeks, daily absence reporting via Care Groups shows a downward trend in terms of staff unavailability for work due to either sickness or isolation. However, Covid has consistently been reported as a contributory reason for absence in 20-25% of all cases that form this data and so continues to have a high impact on staff availability at a point in the year where annual leave rates also tend to be high.

Work continues to plan for dedicated health and wellbeing spaces in our hospitals in York, Scarborough and Bridlington, with further discussion needed to identify a suitable space in York as a precursor to a bid for charitable funds from the NHS Captain Tom Charity. In the meantime work continues to maintain the Trust's wellbeing offer to the workforce. This includes but is not limited to:

* Specific support for distressing incidents
* Health and fitness – mental health first aid, digital health checks, men's health, menopause, gym memberships, sleep, suicide prevention, and distance learning programmes
* Sessions on psychology, dedicated team time, and time to think / reflect
* Chapels for places of prayer, reflection, remembering and quiet time
* Improvements to health and well-being culture

TRUST BOARD REPORT : February-2022

WORKFORCE : RETENTION RATE



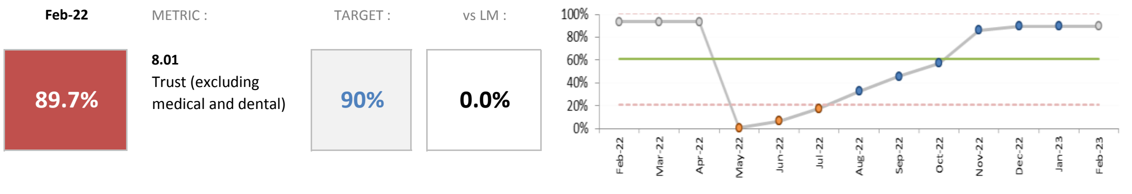
HIGHLIGHTS FOR BOARD TO NOTE :

The trust stability rate has continued to fall since August 2021 in line with the picture of increased movement in the labour market nationally. The Model Hospital System benchmarks the Trust's turnover rates against other NHS providers and indicates that, at December 2021, the Trust's turnover rates were better than the national median across all staff groups with the exception of Allied Health Professions (turnover rate of 15.1% in the Trust vs 15% nationally) and AHP Support roles (30% vs 20.7% nationally). Analysis referenced in the February Board report shows that retirements, work-life balance and relocation have had an impact on leaver rates in these particular groups, which are small in size compared with some other staff groups in the Trust.

As part of the Trust's participation in the Health Care Support Worker Zero Vacancy programme, there has been some recent detailed analysis of HCSW turnover in the Trust. This has noted a significant increase in people leaving the role during the last 12-months (March 2021 - February 2022) compared with the two-years previously (March 2019 - February 2020 and March 2020 - February 2021), particularly amongst staff with less than 1-year's service: in the most recent year's data, those who had been with the Trust for under a year accounted for 42% of HCSW leavers (37.54 FTE) compared with 32% in the year to February 2020 (16.24 FTE). The Trust is stepping up its efforts to understand the experience of recently recruited HCSWs through participation in the national Healthcare Support Worker Survey, which closes on 13 March. The aim is to use its findings to build on recent work to strengthen induction into the organisation. This work has seen the development of a dedicate Support Worker Pastoral Role in the Trust.

TRUST BOARD REPORT : February-2022

WORKFORCE : APPRAISAL COMPLIANCE

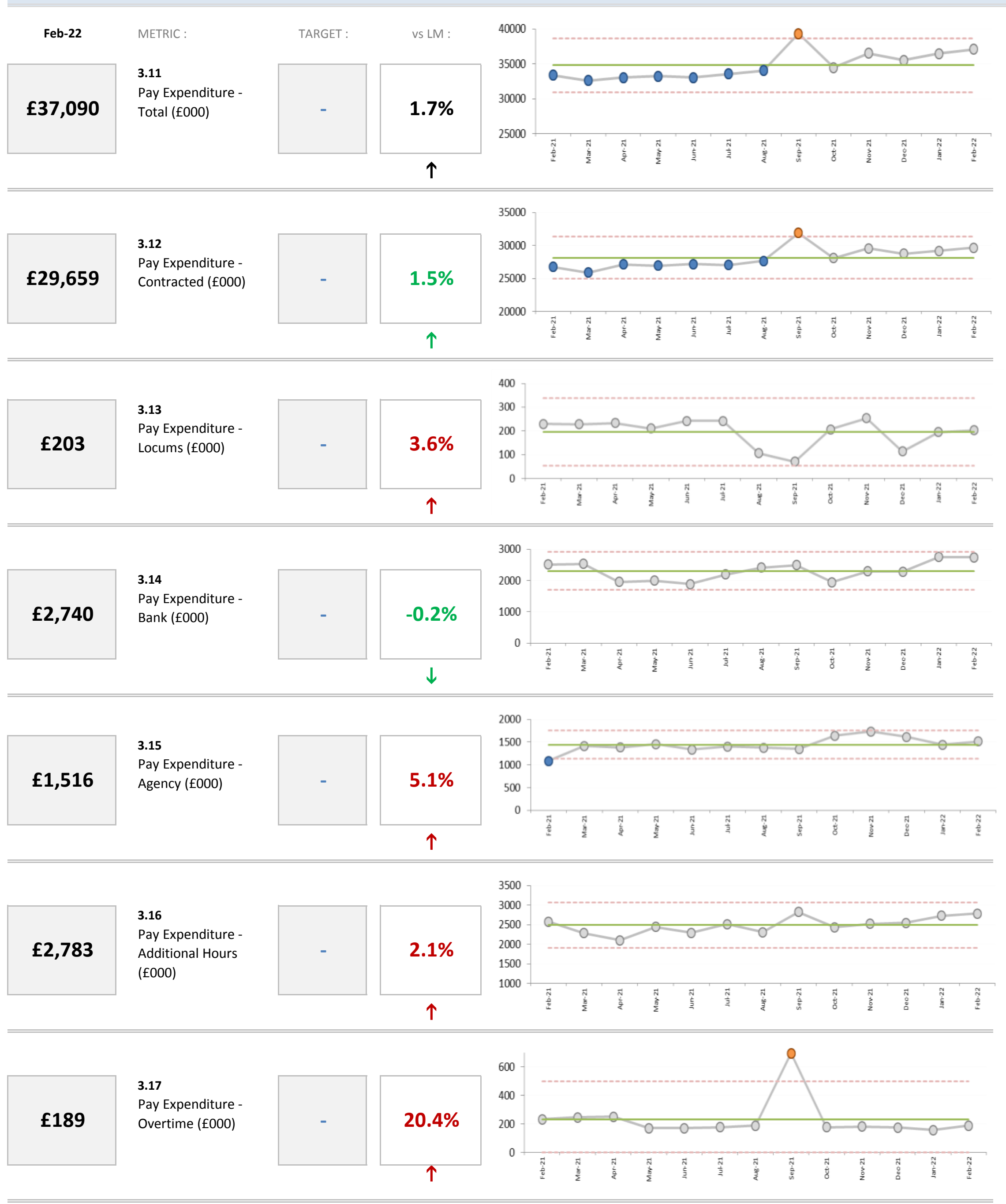


HIGHLIGHTS FOR BOARD TO NOTE :

The appraisal window for non-medical staff was open between 1st June and 30th November. The final appraisal compliance rate at the end of this period was 89.7%. This figure will now not change until the window for next year's appraisal round opens in April 2022.

TRUST BOARD REPORT : February-2022

WORKFORCE : PAY EXPENDITURE (£000)



HIGHLIGHTS FOR BOARD TO NOTE :

The latest nursing vacancy figures reveal a Trust rate of 9.71%. Split by site, this was 9.05% at York and 11.31% at Scarborough.

Over the next 3 months, the trust is expecting to welcome 15 FTE additional nurses as part of its programme of international recruitment. Over the course of 12-months, the Trust has forecasted to Humber Coast and Vale Integrated Care System that the number of registered nurses and midwives that it employs will increase from 2083.13 FTE to 2188.91 FTE.

New starters are due to join Healthcare Support Worker roles with the trust expecting an addition of 29.67 FTE. 17.54 FTE are due to join teams in York, and 12.13 FTE will join teams in Scarborough.

Demand for temporary nurse staffing reduced in February with requests for registered nurses and HCAs totalling 689 FTE, compared to 732 FTE the previous month. 48% of these requests were filled by the trust's internal bank. And 12% of the requests were filled by agency staff. 40% of shifts remained unfilled, which was the equivalent to 272 FTE. In line with the reduction in the demand, February also saw the Trust's Staff Bank pay incentive stepped down from 60% to 30%.

The latest rates for Medical and Dental staff across York and Scarborough sites reveal the overall Trust M&D vacancies of 9.3% following February changeover. Split by site, this was 8.8% at York and 10.7% at Scarborough. New appointments commencing employment with the Trust in February include two Consultant Radiologists and a Consultant Obstetrician and Gynaecologist (all three individuals will be based in York).

Medical and Dental agency and bank figures for December revealed a total of 143.01 FTE shifts that were covered by bank employees and agency workers. 63% of shift pick-up came from our bank employees, while 37% came from agency workers.

TRUST BOARD REPORT : February-2022

WORKFORCE : STATUTORY AND MANDATORY TRAINING AND EDUCATION

HIGHLIGHTS FOR BOARD TO NOTE :

The Trust continues to operate at or above target in relation to three out of six of its key metrics for Statutory and Mandatory Training. The Trust is following its process to improve rates of Corporate Induction compliance. Meanwhile, in relation to Core Training for Medical Staff, compliance with some courses has dropped following the February rotation of doctors in training. Certification for completion of Life Support Programmes is an important focus, with a drive for improved compliance forming part of Care Groups' Executive Performance Assurance Meetings.

In relation to organisational development, the Trust's reverse mentoring programme continues with a view to formally closing at the end of March. Themes for action so far have highlighted international nurse and junior doctor experience, promotion opportunities as well as suggested amendments to programme process. Further feedback, key learning and action points will be collected and summarised during a participant workshop in April.

The Trust continues to provide developmental coaching and supportive conversations through the internal coaching faculty with 10 requests received and actioned in 2022 so far. Themes collated from these, in answer to the question at request "What do you hope to get from coaching?" include career progression, assertiveness, communication, relationships, improving confidence, identifying skills and strengths.

The Trust continues to engage and collaborate with key stakeholders across the organisation to promote and support the embedding of the Trust Values and Behaviour framework. To date, circa 100 values ambassadors have attended development sessions with further support ongoing to help shape action in relation to cultural change and celebrate success in 'Living the Values'; best practice is celebrated and shared through the Trust's internal communication channels.

TRUST BOARD REPORT : February-2022

WORKFORCE : OTHER AND WIDER UPDATES

WORKFORCE: OTHER

Disciplinary & Grievance Cases Trust Wide

No. of open disciplinary cases
7
No. of open investigations exceeded policy timescales
3
No. of open B&H/Grievance cases
1
No. of open cases exceeded policy timescales
0
No. of open MHPS cases
3
No. of open investigations exceeded timescales
2
No. of exclusions
1
No. of suspensions

Vaccination as a condition of deployment
On 1 March, the Government published responses received as part of the consultation to revoke the Regulations that required NHS workers to have two doses of the Covid-19 vaccine by 1 April. Following the completion of the consultation exercise, it has now been confirmed that it will no longer be a requirement for individuals working in th e NHS to be vaccinated against Covid-19. The Trust continues to strongly encourage staff to obtain the vaccine as part of its commitment to staff wellbeing and infection preven tion.

Staff Survey 2021
On 30 March, the results of the 2021 Staff Survey will be published. The Survey ran from 20 September to 26 November and gav e staff employed by the organisation the chance to answer 98 questions about working for the Trust and NHS. The results of the Survey will be grouped around seven themes which make up the NHS Peo ple Promise: We are compassionate and inclusive; We are recognised and rewarded; We have a voice that counts; We are safe and healthy; We are always learning; We work flexibly; and We are a te am. In addition, the Survey provides findings around Staff Engagement and Morale. Following publication, the results will be subject to discussion with the Trust Board and across all Care Groups and corporate directorates.

Equality, Diversity and Inclusion
In line with the People Promise and the Trust's ambitions to become a more inclusive employer, the organisation is investing in a new Head of Equality, Diversity and Inclusion to oversee its strategy. The role will work in partnership with organisations across Humber Coast and Vale and provide senior expertise and advice on equa lity and diversity matters throughout the Trust, ensuring EDI considerations are integral to the delivery of our Clinical Services Strategy and People Strategy.

TRUST BOARD REPORT : February-2022

WORKFORCE : CARE GROUP CORE COMPLIANCE BY STAFF GROUP

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

Feb-22

Monthly Care Group Core Compliance by Staff Group	Adult Advanced Life Support 4 years	Adult Life Support (CSTF) 1 year	Conflict Resolution (CSTF) 3 years	Deprivation of Liberty Safeguards/DoLS Level 1 3 years	Deprivation of Liberty Safeguards/DoLS Level 2 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 3 years	Mental Capacity Act Level 2 3 years	Paediatric Advanced Life Support 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%	67%		100%	100%		100%		100%	100%		67%	100%		100%				100%		100%		100%	100%	100%
Additional Clinical Services		77%	88%	57%	82%	82%	95%	86%	100%	89%	85%	100%	84%	89%	57%	80%		67%	89%	69%	91%	87%	86%	85%	100%	
Administrative and Clerical		67%	97%	94%			97%	96%	95%		95%	95%		97%	92%				96%		95%		95%	100%		
Allied Health Professionals		89%	97%		91%	100%	98%	97%		94%	95%	95%	90%	95%		91%				91%		97%	100%	94%		100%
Healthcare Scientists		93%	93%				100%	100%	93%		93%	93%		93%				80%	93%		100%			93%		
Medical and Dental	61%	69%	85%		66%	85%	55%	82%		75%	80%		73%	79%		70%	67%	30%		78%		75%		77%	67%	
Nursing and Midwifery Registered	75%	87%	94%		86%	93%	94%	95%		93%	91%	100%	87%	94%		85%		75%		89%	100%	92%	100%	91%	84%	100%
Students		50%	100%		100%		100%	100%		100%	100%		100%	75%		100%				100%		100%		100%		
CG2 Acute Emergency and Elderly Medicine-Scarborough																										
Additional Clinical Services		87%	89%		79%	84%	84%	87%	100%	93%	86%	100%	94%	87%		77%		68%	88%	55%		85%	83%	84%	54%	
Administrative and Clerical		80%	92%	72%			91%	95%	93%	100%	91%	90%	100%	89%	75%				93%		89%		94%	90%		
Allied Health Professionals		91%	94%		93%		94%	93%		96%	91%	100%	100%	98%		87%				91%		94%		94%		
Estates and Ancillary		100%	92%	77%			85%	85%	92%		85%	85%		85%	77%				85%		85%		100%	92%		
Healthcare Scientists		100%	100%				75%	100%	100%		100%	75%		100%				38%	100%		100%			100%		
Medical and Dental	96%	80%	89%		71%	92%	61%	87%		85%	80%		79%	81%		76%	85%	67%		87%		83%		75%	84%	
Nursing and Midwifery Registered	73%	88%	96%		84%	94%	93%	97%		92%	93%		93%	95%		84%		90%		88%		93%	100%	91%	89%	
CG3 Surgery																										
Add Prof Scientific and Technic		84%	91%		80%	97%	100%	95%	100%	93%	87%	93%	79%	89%		85%		85%	75%	81%	67%	88%	100%	91%	100%	
Additional Clinical Services		82%	88%	100%	79%	83%	92%	87%	96%	86%	87%	81%	82%	88%	100%	76%		71%	90%	65%	87%	86%	94%	83%		
Administrative and Clerical		83%	95%	86%	100%		97%	96%	95%	0%	94%	92%	0%	94%	86%	100%			95%		94%	100%	94%	96%		
Allied Health Professionals		83%	89%		78%	60%	100%	94%		83%	83%		100%	100%		78%			50%	100%		89%		94%		
Estates and Ancillary		100%	88%	63%			94%	88%	94%		82%	59%		88%	63%				88%		88%		87%	100%		
Healthcare Scientists		78%	97%		84%		97%	97%	97%		91%	97%		97%		84%			100%		100%	100%		100%		
Medical and Dental	100%	70%	88%		76%	85%	71%	87%		83%	84%		77%	86%		76%				83%		82%		79%	100%	
Nursing and Midwifery Registered	85%	91%	93%		84%	92%	96%	93%		91%	88%		87%	92%		82%		67%		88%		92%		91%		
CG4 Cancer and Support Services																										
Add Prof Scientific and Technic		100%	98%		88%	100%	96%	98%	97%	100%	98%	100%	88%	98%		88%			97%	100%	98%	100%	95%	100%		
Additional Clinical Services		89%	89%		88%	88%	93%	91%	94%	94%	89%	90%	90%	92%		87%			89%	100%	94%	91%	94%	93%		
Administrative and Clerical		33%	89%	100%			91%	93%	93%		92%	93%		92%	100%				88%		92%		93%	86%		
Allied Health Professionals		94%	96%		84%	98%	94%	93%	100%	90%	92%	100%	77%	94%		81%			88%	84%	100%	88%	100%	92%		
Estates and Ancillary			100%				100%	100%	100%		100%	100%		100%					100%		100%		100%			
Healthcare Scientists			87%				97%	97%	97%		95%	93%	100%	97%					85%		96%		95%			
Medical and Dental	0%	83%	90%		79%	88%	95%	87%	95%	85%	85%	84%	85%	89%		79%			84%	92%	90%	85%	95%	87%		
Nursing and Midwifery Registered	50%	97%	98%		93%	100%	90%	99%		97%	95%		93%	98%		90%			100%	96%		97%	100%	96%		
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		80%	92%	100%	79%	88%	94%	89%	100%	89%	86%	100%	86%	91%		81%		81%	89%	85%		86%		93%	87%	100%
Administrative and Clerical		86%	98%	85%			97%	96%	96%		97%	96%		98%	93%	60%			95%	86%	96%	100%	96%	67%	86%	
Allied Health Professionals		93%	98%		95%	95%	100%	98%		98%	97%	94%	96%	100%		95%		89%		97%		100%		100%	100%	93%
Estates and Ancillary			100%	100%			100%	100%	100%		100%	100%		100%	100%				100%		100%			100%		
Medical and Dental	50%	75%	95%		82%	90%	94%	92%	100%	92%	90%	100%	90%	87%		79%	56%	71%		89%		88%		93%	86%	79%
Nursing and Midwifery Registered		88%	91%	97%	79%	92%	92%	90%		89%	87%		83%	92%		81%		84%		86%		86%		96%	90%	86%
CG6 Specialised Medicine & Outpatients Services																										
Add Prof Scientific and Technic		77%	97%		90%	100%	98%	99%	97%	75%	96%	95%	75%	97%		90%			96%	100%	100%	96%	100%	94%	100%	100%
Additional Clinical Services		87%	95%	100%	87%	80%	97%	94%	93%	91%	91%		87%	94%	100%	87%			94%	100%	100%	91%	100%	92%		
Administrative and Clerical		67%	96%	92%			96%	96%	96%		94%	96%		96%	100%				94%		96%		96%	88%	100%	
Allied Health Professionals		93%	97%		87%		95%	96%		93%	95%		89%	97%		88%				85%		93%		90%		
Estates and Ancillary			100%	100%			100%	100%	100%		100%	100%		100%	100%				100%		100%			100%		
Healthcare Scientists		100%	100%				86%	100%	100%		100%	86%		100%					100%		100%			100%		
Medical and Dental	100%	71%	87%		81%	87%	92%	90%		84%	86%		83%	90%		79%		100%		80%		85%		86%		
Nursing and Midwifery Registered		90%	93%		88%	94%	94%	91%		90%	92%		82%	93%		85%				88%		93%		91%	100%	
Students		100%	100%				100%	100%	100%		100%		100%	100%					100%		100%			100%		

TRUST BOARD REPORT : February-2022

WORKFORCE : CARE GROUP CORE COMPLIANCE BY STAFF GROUP

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

Feb-22

Monthly Care Group Core Compliance by Staff Group	Adult Advanced Life Support 4 years	Adult Life Support (CSTF) 1 year	Conflict Resolution (CSTF) 3 years	Deprivation of Liberty Safeguards/DoLS Level 1 3 years	Deprivation of Liberty Safeguards/DoLS Level 2 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 3 years	Mental Capacity Act Level 2 3 years	Paediatric Advanced Life Support 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		50%	92%		100%		77%	85%	92%	100%	85%	73%		85%		67%			87%	100%	83%	100%	79%	92%		
Additional Clinical Services		70%	92%		87%	90%	85%	89%	89%	87%	87%	76%	87%	90%		87%			90%	100%	91%	90%	83%	90%		
Administrative and Clerical		58%	94%	79%	67%		94%	94%	95%	25%	93%	93%	25%	93%	83%	67%		0%	94%	67%	93%	67%	93%	39%		100%
Allied Health Professionals		80%	80%		87%	88%	100%	83%		83%	87%	100%	78%	83%		87%				80%		87%		76%		100%
Estates and Ancillary			100%				90%	90%	100%		90%	90%		100%					100%		100%		100%			
Healthcare Scientists			89%				89%	89%	89%		89%	89%		89%					100%	60%	89%		71%	100%		
Medical and Dental	46%	56%	59%		44%	61%	66%	60%		52%	60%	100%	44%	58%		43%	14%	0%		58%		57%		58%	53%	45%
Nursing and Midwifery Registered		87%	95%		88%	94%	93%	96%	75%	94%	93%	93%	87%	93%		89%				91%	86%	94%	95%	94%	100%	85%
CG Trust Estates and Facilities Management																										
Administrative and Clerical			100%				100%	100%	100%		100%	100%		100%					100%		100%		100%			
Estates and Ancillary			100%				100%	100%	100%		100%	100%		100%					100%		100%		100%			
LLP CG Estates & Facilities																										
Additional Clinical Services			100%				100%	100%	100%		100%	100%		100%					100%		100%		100%			
Administrative and Clerical			96%				96%	99%	93%		94%	89%		93%					96%		96%		97%			
Estates and Ancillary			85%	62%			86%	87%	84%		81%	72%	67%	84%	60%				83%		84%		84%			
Healthcare Scientists			96%				96%	100%	100%		96%	92%		100%					100%		100%		100%			

TRUST BOARD REPORT : February-2022

WORKFORCE: MEDICAL AND DENTAL VACANCIES

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

Feb-22

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	**36**	**8**	**0**	**3**	**13.9%**	**19**	**2**	**1**	**0**	**15.8%**	**67**	**14**	**0**	**5**	**13.4%**	**25**	**1**	**0**	**1**	**0.0%**	**147**	**25**	**1**	**9**	**11.6%**
Elderly Medicine	7	1	0	0	14.3%	2	0	0	0	0.0%	13	4	0	0	30.8%	3	0	0	0	0.0%	25	5	0	0	20.0%
Emergency & Acute Medicine	12	3	0	1	16.7%	14	2	0	0	14.3%	24	6	0	4	8.3%	4	0	0	0	0.0%	54	11	0	5	11.1%
General Medicine	17	4	0	2	11.8%	3	0	1	0	33.3%	30	4	0	1	10.0%	18	1	0	1	0.0%	68	9	1	4	8.8%
Care Group 3	**19**	**4**	**0**	**1**	**15.8%**	**16**	**2**	**0**	**1**	**6.3%**	**15**	**1**	**0**	**1**	**0.0%**	**10**	**0**	**0**	**0**	**0.0%**	**60**	**7**	**0**	**3**	**6.7%**
General Surgery & Urology	1	0	0	0	0.0%	6	2	0	1	16.7%	7	0	0	0	0.0%	9	0	0	0	0.0%	23	2	0	1	4.3%
Head & Neck						2	0	0	0	0.0%						1	0	0	0	0.0%	3	0	0	0	0.0%
Theatres, Anaesthetics & CC	18	4	0	1	16.7%	8	0	0	0	0.0%	8	1	0	1	0.0%						34	5	0	2	8.8%
Care Group 4	**2**	**0**	**0**	**0**	**0.0%**																**2**	**0**	**0**	**0**	**0.0%**
Radiology	2	0	0	0	0.0%																2	0	0	0	0.0%
Care Group 5	**21**	**5**	**1**	**1**	**23.8%**	**3**	**0**	**0**	**0**	**0.0%**	**18**	**3**	**0**	**0**	**16.7%**	**6**	**0**	**0**	**0**	**0.0%**	**48**	**8**	**1**	**1**	**16.7%**
Child Health	11	4	0	0	36.4%	1	0	0	0	0.0%	9	2	0	0	22.2%	4	0	0	0	0.0%	25	6	0	0	24.0%
Obstetrics & Gynaecology	10	1	1	1	10.0%	2	0	0	0	0.0%	9	1	0	0	11.1%	2	0	0	0	0.0%	23	2	1	1	8.7%
Care Group 6	**18**	**3**	**0**	**2**	**5.6%**	**7**	**1**	**1**	**1**	**14.3%**	**6**	**1**	**0**	**1**	**0.0%**	**2**	**0**	**0**	**0**	**0.0%**	**33**	**5**	**1**	**4**	**6.1%**
Ophthalmology	4	0	0	0	0.0%	2	0	1	0	50.0%	1	0	0	0	0.0%						7	0	1	0	14.3%
Specialist Medicine	6	1	0	0	16.7%	1	0	0	0	0.0%											7	1	0	0	14.3%
Trauma & Orthopaedics	8	2	0	2	0.0%	4	1	0	1	0.0%	5	1	0	1	0.0%	2	0	0	0	0.0%	19	4	0	4	0.0%
Total	**96**	**20**	**1**	**7**	**14.6%**	**45**	**5**	**2**	**2**	**11.1%**	**106**	**19**	**0**	**7**	**11.3%**	**43**	**1**	**0**	**1**	**0.0%**	**290**	**45**	**3**	**17**	**10.7%**

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	**80**	**18**	**0**	**7**	**13.8%**	**16**	**3**	**0**	**1**	**12.5%**	**86**	**14**	**0**	**2**	**14.0%**	**41**	**0**	**0**	**0**	**0.0%**	**223**	**35**	**0**	**10**	**11.2%**
Community						1	0	0	0	0.0%											1	0	0	0	0.0%
Elderly Medicine	15	2	0	0	13.3%	2	1	0	0	50.0%	16	2	0	0	12.5%	6	0	0	0	0.0%	39	5	0	0	12.8%
Emergency & Acute Medicine	27	11	0	4	25.9%	8	2	0	1	12.5%	33	2	0	1	3.0%	6	0	0	0	0.0%	74	15	0	6	12.2%
General Medicine	38	5	0	3	5.3%	5	0	0	0	0.0%	37	10	0	1	24.3%	29	0	0	0	0.0%	109	15	0	4	10.1%
Care Group 3	**116**	**8**	**3**	**2**	**7.8%**	**34**	**0**	**0**	**0**	**0.0%**	**69**	**10**	**1**	**1**	**14.5%**	**19**	**1**	**0**	**0**	**5.3%**	**238**	**19**	**4**	**3**	**8.4%**
General Surgery & Urology	44	3	0	1	4.5%	12	0	0	0	0.0%	21	3	0	1	9.5%	12	1	0	0	8.3%	89	7	0	2	5.6%
Head & Neck	21	2	1	1	9.5%	11	0	0	0	0.0%	18	2	0	0	11.1%	4	0	0	0	0.0%	54	4	1	1	7.4%
Theatres, Anaesthetics & CC	51	3	2	0	9.8%	8	0	0	0	0.0%	30	4	1	0	16.7%	3	0	0	0	0.0%	92	7	3	0	10.9%
Care Group 4	**65**	**7**	**1**	**6**	**3.1%**	**3**	**0**	**0**	**0**	**0.0%**	**19**	**1**	**0**	**0**	**5.3%**	**3**	**0**	**0**	**0**	**0.0%**	**90**	**8**	**1**	**6**	**3.3%**
Haematology & Oncology	14	1	1	1	7.1%	2	0	0	0	0.0%	5	0	0	0	0.0%						21	1	1	1	4.8%
Laboratory Medicine	15	0	0	0	0.0%	1	0	0	0	0.0%	8	1	0	0	12.5%	3	0	0	0	0.0%	27	1	0	0	3.7%
Radiology	36	6	0	5	2.8%						6	0	0	0	0.0%						42	6	0	5	2.4%
Care Group 5	**40**	**5**	**1**	**3**	**7.5%**	**10**	**4**	**0**	**0**	**40.0%**	**34**	**2**	**0**	**0**	**5.9%**	**6**	**0**	**0**	**0**	**0.0%**	**90**	**11**	**1**	**3**	**10.0%**
Child Health	18	0	0	0	0.0%	2	0	0	0	0.0%	16	2	0	0	12.5%	5	0	0	0	0.0%	41	2	0	0	4.9%
Obstetrics & Gynaecology	19	4	1	3	10.5%	1	0	0	0	0.0%	17	0	0	0	0.0%	1	0	0	0	0.0%	38	4	1	3	5.3%
Sexual Health	3	1	0	0	33.3%	7	4	0	0	57.1%	1	0	0	0	0.0%						11	5	0	0	45.5%
Care Group 6	**68**	**5**	**1**	**1**	**7.4%**	**21**	**4**	**2**	**2**	**19.0%**	**22**	**1**	**0**	**0**	**4.5%**	**4**	**1**	**0**	**0**	**25.0%**	**115**	**11**	**3**	**3**	**9.6%**
Ophthalmology	23	2	1	0	13.0%	7	2	1	1	28.6%	7	0	0	0	0.0%						37	4	2	1	13.5%
Specialist Medicine	31	2	0	0	6.5%	5	1	1	0	40.0%	12	0	0	0	0.0%	0	0	0	0	0.0%	48	3	1	0	8.3%
Trauma & Orthopaedics	14	1	0	1	0.0%	9	1	0	1	0.0%	10	1	0	0	10.0%	4	1	0	0	25.0%	37	4	0	2	5.4%
Total	**369**	**43**	**6**	**19**	**8.1%**	**81**	**11**	**2**	**3**	**12.3%**	**237**	**27**	**1**	**3**	**10.5%**	**73**	**2**	**0**	**0**	**2.7%**	**760**	**83**	**9**	**25**	**8.8%**

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

TRUST BOARD REPORT : February-2022

WORKFORCE: NURSING, MIDWIFERY AND CARE STAFF VACANCIES

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

Feb-22

	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	**2312.08**	**128.82**	**1141.93**	**2084.05**	**145.24**	**1000.95**	**6.43**	**1.00**	**3.19**	**10.01**	**0.00**	**12.34**	**224.45**	**-15.42**	**131.83**	**9.71%**	**-11.97%**	**11.54%**
YORK	**1640.44**	**91.32**	**744.12**	**1490.35**	**88.24**	**638.49**	**5.43**	**1.00**	**1.59**	**7.01**	**0.00**	**4.60**	**148.51**	**4.08**	**102.62**	**9.05%**	**4.47%**	**13.79%**
SCARBOROUGH & BRIDLINGTON	**671.64**	**37.50**	**397.81**	**593.70**	**57.00**	**362.46**	**1.00**	**0.00**	**1.60**	**3.00**	**0.00**	**7.74**	**75.94**	**-19.50**	**29.21**	**11.31%**	**-52.00%**	**7.34%**

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	444.64	38.00	280.80	396.68	53.00	247.91	0.00	0.00	0.00	3.80	0.00	4.00	44.16	-15.00	28.89	9.93%	-39.47%	10.29%
Community	165.26	19.60	136.20	167.51	4.76	107.25	0.00	0.00	0.00	0.00	0.00	0.00	-2.25	14.84	28.95	-1.36%	75.71%	21.26%
Total	**609.90**	**57.60**	**417.00**	**564.19**	**57.76**	**355.16**	**0.00**	**0.00**	**0.00**	**3.80**	**0.00**	**4.00**	**41.91**	**-0.16**	**57.84**	**6.87%**	**-0.28%**	**13.87%**

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																		
	331.46	26.70	254.26	278.28	42.80	235.87	0.00	0.00	0.00	0.00	0.00	4.44	53.18	-16.10	13.95	16.04%	-60.30%	5.49%
Total	**331.46**	**26.70**	**254.26**	**278.28**	**42.80**	**235.87**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**4.44**	**53.18**	**-16.10**	**13.95**	**16.04%**	**-60.30%**	**5.49%**

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	299.96	8.80	107.34	254.11	14.40	95.04	0.00	0.00	0.00	0.61	0.00		45.24	-5.60	12.30	15.08%	-63.64%	11.46%
Theatres	121.31	0.00	42.94	110.96	0.00	37.98	0.00	0.00	0.00	0.00	0.00	0.00	10.35	0.00	4.96	8.53%	0.00%	11.55%
sub-total York	**421.27**	**8.80**	**150.28**	**365.07**	**14.40**	**133.02**	**0.00**	**0.00**	**0.00**	**0.61**	**0.00**	**0.00**	**55.59**	**-5.60**	**17.26**	**13.20%**	**-63.64%**	**11.49%**
SCARBOROUGH																		
Wards/Units	122.34	4.80	48.09	111.38	8.60	40.95	0.00	0.00	0.00	0.00	0.00	3.30	10.96	-3.80	3.84	8.96%	-79.17%	7.99%
Theatres	56.50	1.00	21.13	50.66	1.00	18.10	0.00	0.00	0.00	0.00	0.00	0.00	5.84	0.00	3.03	10.34%	0.00%	14.34%
sub-total Scarborough	**178.84**	**5.80**	**69.22**	**162.04**	**9.60**	**59.05**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**3.30**	**16.80**	**-3.80**	**6.87**	**9.39%**	**-65.52%**	**9.92%**
CG Total	**600.11**	**14.60**	**219.50**	**527.11**	**24.00**	**192.07**	**0.00**	**0.00**	**0.00**	**0.61**	**0.00**	**3.30**	**72.39**	**-9.40**	**24.13**	**12.06%**	**-64.38%**	**10.99%**

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																		
	141.13	8.07	26.19	110.43	2.65	19.44	0.00	0.00	0.00	1.00	0.00	0.00	29.70	5.42	6.75	21.04%	67.16%	25.77%
SCARBOROUGH																		
	23.68	3.00	4.00	20.69	4.00	1.51	0.00	0.00	0.00	1.00	0.00	0.00	1.99	-1.00	2.49	8.40%	-33.33%	62.25%
Total	**164.81**	**11.07**	**30.19**	**131.12**	**6.65**	**20.95**	**0.00**	**0.00**	**0.00**	**2.00**	**0.00**	**0.00**	**31.69**	**4.42**	**9.24**	**19.23%**	**39.93%**	**30.61%**

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	115.92	0.00	0.00	108.08	0.00	0.00	0.00	0.00	0.00	0.80	0.00	0.60	7.04	0.00	-0.60	6.07%	0.00%	0.00%
Registered Nurses	148.74	0.00	0.00	135.97	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.77	0.00	0.00	8.59%	0.00%	0.00%
Other	0.30	11.05	62.35	0.80	9.72	52.65	0.00	0.00	0.00	0.00	0.00	0.00	-0.50	1.33	9.70	-166.67%	12.04%	15.56%
sub-total York	**264.96**	**11.05**	**62.35**	**244.85**	**9.72**	**52.65**	**0.00**	**0.00**	**0.00**	**0.80**	**0.00**	**0.60**	**19.31**	**1.33**	**9.10**	**7.29%**	**12.04%**	**14.60%**
SCARBOROUGH																		
Registered Midwives	62.66	0.00	0.00	64.40	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00	-3.74	0.00	0.00	-5.97%	0.00%	0.00%
Registered Nurses	42.30	0.00	0.00	37.41	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.89	0.00	0.00	11.56%	0.00%	0.00%
Other	0.00	1.00	32.39	0.00	0.60	31.49	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.40	0.90	0.00%	40.00%	2.78%
sub-total Scarborough	**104.96**	**1.00**	**32.39**	**101.81**	**0.60**	**31.49**	**0.00**	**0.00**	**0.00**	**2.00**	**0.00**	**0.00**	**1.15**	**0.40**	**0.90**	**1.10%**	**40.00%**	**2.78%**
CG Total	**369.92**	**12.05**	**94.74**	**346.66**	**10.32**	**84.14**	**0.00**	**0.00**	**0.00**	**2.80**	**0.00**	**0.60**	**20.46**	**1.73**	**10.00**	**5.53%**	**14.36%**	**10.56%**

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																		
	118.34	3.80	76.90	114.72	2.80	69.42	0.00	0.00	0.00	0.80	0.00	0.00	2.82	1.00	7.48	2.38%	26.32%	9.73%
SCARBOROUGH																		
	32.03	1.00	37.94	29.73	0.00	34.54	0.00	0.00	0.00	0.00	0.00	0.00	2.30	1.00	3.40	7.18%	100.00%	8.96%
CG Total	**150.37**	**4.80**	**114.84**	**144.45**	**2.80**	**103.96**	**0.00**	**0.00**	**0.00**	**0.80**	**0.00**	**0.00**	**5.12**	**2.00**	**10.88**	**3.40%**	**41.67%**	**9.47%**

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

FINANCE PERFORMANCE REPORT

February-2022

Produced March-2022

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 : February-2022

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:

This paper and individual summary reports on Trust's financial position for period to February 2022 (Month 11).

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 was initially rolled forward and applied to the first half year (April 2021 - September 2021) only.

In late September 2021, NHSE&I announced the financial framework that will be in place for the second half year, 2021/22, which primarily signalled a continuation of the approach adopted in the first half year with some further adjustments for inflation including the meeting the cost of the 3% pay deal; together with an increased efficiency requirement over that required in the first half of the year.
The final financial plan for the second 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 4 November 2021 meeting. The agreed plan was consistent with the System and individual Provider plans submitted to NHSE&I later in November. The agreed plan results in a balanced I&E position for both the second half of the year, and the full year in total.

Month 11 Position

For February, the Trust is reporting an adjusted I&E position of £85k surplus against a £189k adjusted deficit plan, placing it £274k ahead of the adjusted plan agreed by the Board. This is primarily driven by the net impact of ERF income in the first half of the year being behind plan with the associated cost of delivery also being behind plan; offset by other net underlying Trust performance being broadly equally ahead of plan. The Trust is forecasting that it will end the year in I&E balance.

The Trusts overall CIP target for 2021/22 totals £8.1m, of which the Trust has delivered £6.3m.

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

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: March 2022

TRUST BOARD REPORT : February-2022

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Income and Expenditure Account

	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	FOT £000's
NHS England	66,732	61,187	70,062	8,875	76,825
Clinical commissioning groups	501,011	460,254	444,772	-15,482	486,218
Local authorities	4,718	4,318	4,217	-101	4,615
Non-NHS: private patients	264	242	297	55	329
Non-NHS: other	1,576	1,442	1,629	187	1,751
Operating Income from Patient Care Activities	**574,301**	**527,443**	**520,977**	**-6,466**	**569,738**
Research and development	2,140	1,959	2,369	410	2,623
Education and training	18,807	17,146	21,263	4,117	23,088
Other income	51,886	47,000	43,448	-3,552	52,640
Other Operating Income	**72,833**	**66,105**	**67,080**	**975**	**78,351**
Employee Expenses	-428,655	-390,291	-384,246	6,045	-424,582
Drugs Costs	-52,804	-48,412	-60,204	-11,792	-66,076
Supplies and Services - Clinical	-58,297	-52,824	-54,131	-1,307	-61,434
Depreciation	-11,034	-10,113	-10,115	-2	-11,034
Amortisation	-1,336	-1,225	-1,225	0	-1,336
CIP	1,357	893	0	-893	0
Other Costs	-88,412	-84,511	-70,462	14,049	-75,332
Total Operating Expenditure	**-639,181**	**-586,483**	**-580,383**	**6,100**	**-639,794**
OPERATING SURPLUS/(DEFICIT)	**7,953**	**7,065**	**7,674**	**609**	**8,295**
Finance income	25	23	35	12	27
Finance expense	-464	-430	-431	-1	-460
PDC dividends payable/refundable	-7,542	-6,866	-6,866	0	-7,542
NET FINANCE COSTS	**-28**	**-208**	**412**	**620**	**320**
Other gains/(losses) including disposal of assets	0	0	-9	-9	-5
Share of profit/ (loss) of associates/ joint ventures	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0
Movements in fair value of investments and liabilities	0	0	0	0	0
Corporation tax expense	0	0	0	0	0
Surplus/(Deficit) for the Period	**-28**	**-208**	**403**	**611**	**315**
Remove Donated Asset Income	-452	-421	-758	-337	-795
Remove Donated Asset Depreciation	433	397	397	0	433
Remove Donated Asset Amortisation	47	43	43	0	47
NHSI Adjusted Financial Performance Surplus/(Deficit)	**0**	**-189**	**85**	**274**	**0**

Month 11 Summary Position

The table opposite and the graphs on the following pages show the plan for the whole of 2021/22, following approval of the H2, 2021/22 plan by the Board in November, and are against which actual performance will be measured. For February, the Trust is reporting an adjusted I&E position of £85k surplus against a £189k adjusted planned deficit, placing it £274k ahead of the adjusted system plan submitted to NHSE/I.

Income is £5.5m behind plan, resulting primarily from ERF and other income being behind plan, partially offset by excluded drugs & devices outside of the envelope, and Education & Training income being ahead of plan.

Operational expenditure is £6.1m behind plan, primarily linked to planned spend on ERF and Covid schemes being behind plan, partially offset by expenditure on excluded high cost drugs being ahead of plan, and the CIPs being behind plan.

The Trust is forecasting that it will finish the year in I&E balance.

Matters of Concern and Risks to Escalate	Major Actions Undertaken and Work in Progress
1. CIP planning is currently £0.1m behind the required annual delivery value of £8.1m. 2. The Capital programme has significantly slipped £9m against planned spend for the period of £25.0m, and significant spend is required in the remainder of the financial year to maximise CDEL cover.	1. H2 agreed plan for the Trust and System is in situ. 2. Major CIP delivery work now underway. 3. Micromanagement of the capital programme now underway through CPEG. 4. The financial planing guidance for 2022/23 is now available and system-level allocation details have been issued. Work underway with system partners to prepare income and expenditure plans for 2022/23. Draft plans will be ready for the Board's March meeting with final plans to be submitted to NHSE/I later in April. 5. Work is underway to prepare and propose a 2022/23 capital programme for the Trust.
Positive Updates and Assurance	**Decisions Made and Decisions Required of the Board**
1. North Yorkshire System Plan delivers the required balanced income and expenditure position for H2. 2. The Trust's forecast outturn position supports delivery of the H2 financial plan.	1. H2 plan approved by the Exec Committee and the Board.

TRUST BOARD REPORT : February-2022

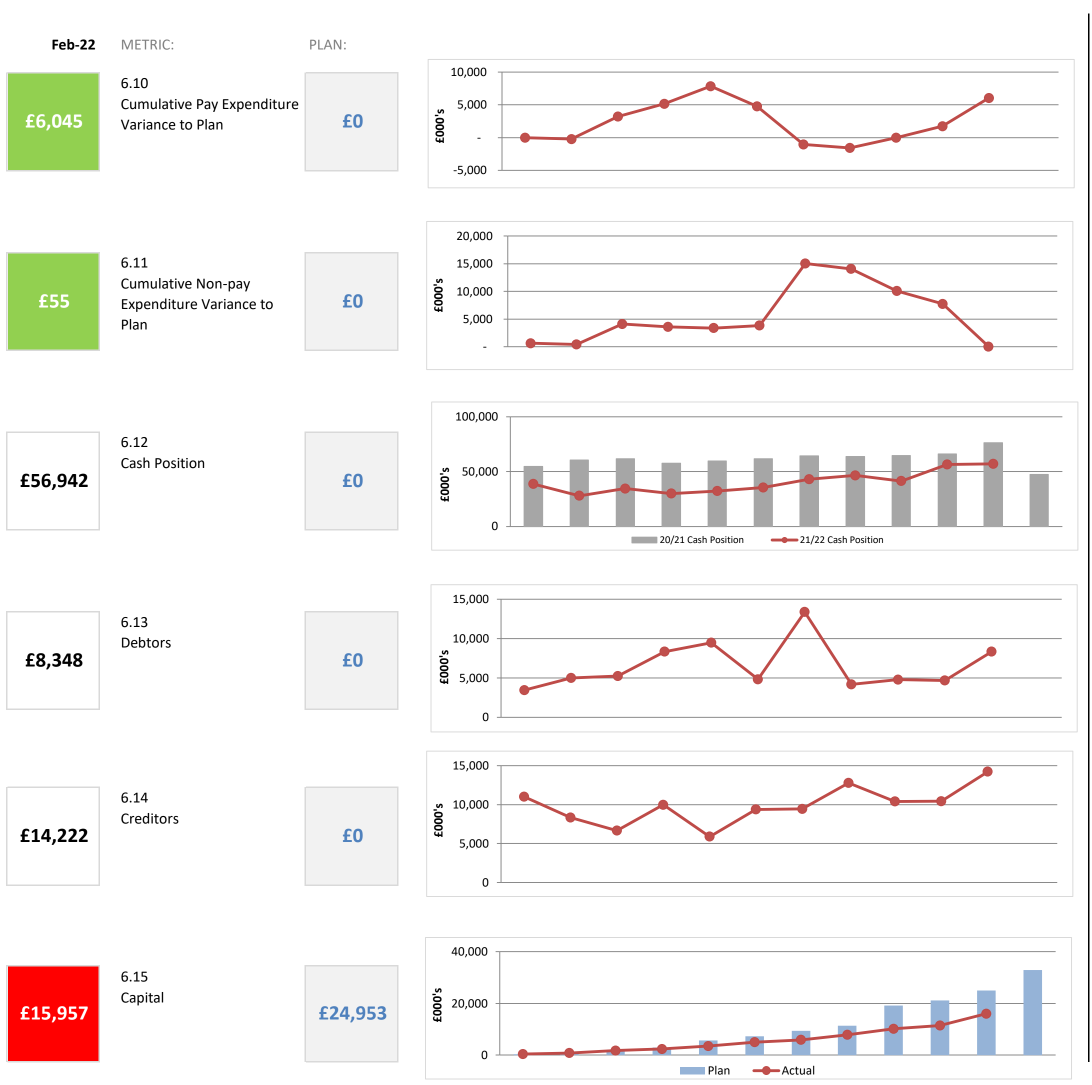
SUMMARY INCOME AND EXPENDITURE POSITION

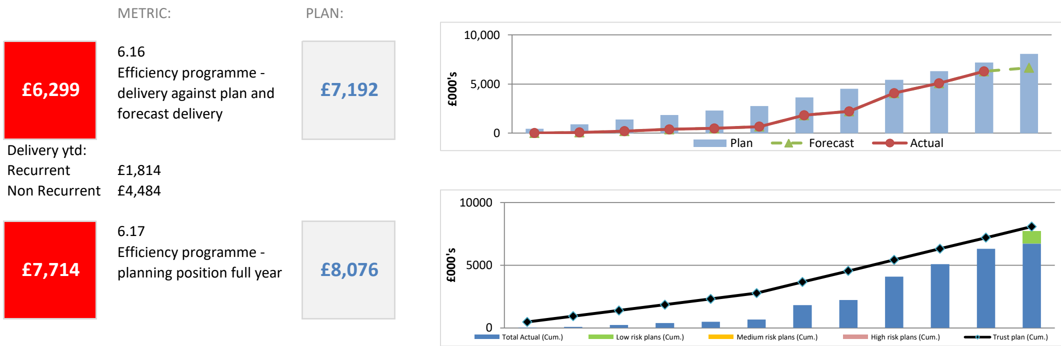
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

TRUST BOARD REPORT : February-2022

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY





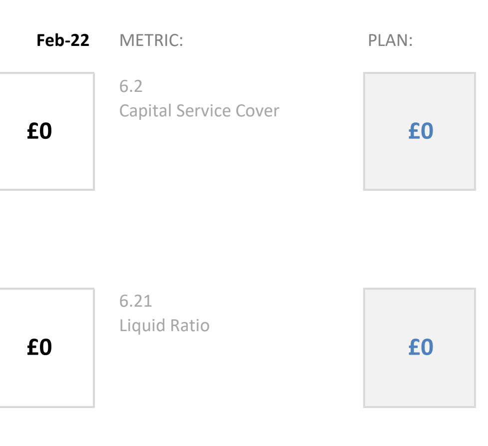
Planning (Gap)/Surplus

	Jan £'000	EOY £'000	Comments
Target	**6,308**	**8,076**	
PLANS			
Low Risk	6,730	8,004	Low Risk plans on track to deliver for March 22. A combination of recurrent and non-recurrent delivery, currently 30:70 split.
Medium Risk	0	0	Medium Risk plans of £0.01m excluded from planning.
High Risk	0	0	No High Risk plans in 2021/22
Total Plans	6,730	8,004	
Planning (Gap)/Surplus	422	-72	
Actions			**New Plans** - continue to work with CG's to identify u/spends; opportunities presented in Model Health System (more likely medium/longer term)

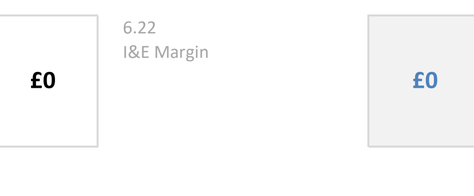
TRUST BOARD REPORT : February-2022

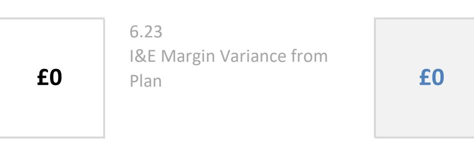
SUMMARY INCOME AND EXPENDITURE POSITION

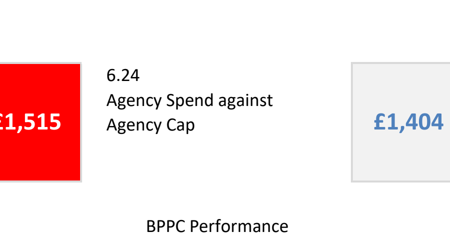
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY



Feb-22	METRIC:	PLAN:
£0	6.2 Capital Service Cover	£0
£0	6.21 Liquid Ratio	£0
£0	6.22 I&E Margin	£0
£0	6.23 I&E Margin Variance from Plan	£0
£1,515	6.24 Agency Spend against Agency Cap	£1,404

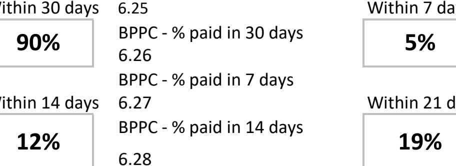


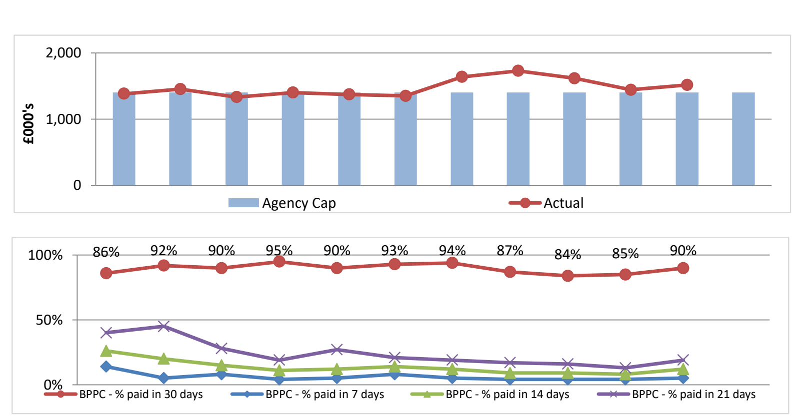




BPPC Performance

Within 30 days		Within 7 days
90%	6.25 BPPC - % paid in 30 days 6.26 BPPC - % paid in 7 days	5%
Within 14 days		**Within 21 days**
12%	6.27 BPPC - % paid in 14 days 6.28 BPPC - % paid in 21 days	19%





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:

The Trusts overall CIP target for the first half of 2021/22 was £2.8m (£5.6m for the full year). This is comprised of a national efficiency requirement of 0.28%; an equal share of the local systems effciency requirement(£0.4m); and a further requirement to meet agreed essential investments (£3.2m). Of this target only £0.6m was delivered in full year terms, leaving the full year balance of £5.0m to be delivered in H2. For the second half of the year, there is a further new national efficiency improvement requirement implicit in the announced allocations of 0.82%, which equates to a further target for the Trust of £2.5m. The full year target is therefore £8.1m of which £7.5m remains to be achieved during the second half of the year. CIPs totalling £5.1m have been delivered in the year to the end of January.

Metrics 6.2 through 6.24 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. 6.24 showing our agency spend against plan remains a live assessment metric and, at present, we are using more agency staff than planned.

The Trust's compliance with the Better Payments Practice Code (BPPC) is currently averaging around 85% of suppliers being paid within 30 days.

RESEARCH AND DEVELOPMENT REPORT

February-2022

Produced March-2022

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 : February-2022

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:

Our key outcomes in the last month are as follows:

• As we have already reached our accrual target for the year, and we get nothing for over recruiting so, we have asked teams to relax on recruitment a little on a few studies that bring us big numbers (large data collection etc), to ease the pressure and allow them to focus on the more complex trials
• No grants have been submitted in the last month but we are working on a collaboration with HYMS to submit an NIHR Research for Patient Benefit Grant that will be submitted next month (managing chronic breathlessness), and with University of York on an EPSRC bid to will co-develop and evaluate a simple-to-use
diagnostic technology to rapidly support stratification of COVID-19 and related pulmonary infections.
• We are still supporting the Trust by redeploying our pharmacy staff each week.
• We are in the process of arranging a critical friend review, a review by external R&D staff to review our services, governance and our processes, to see if there are any observations and opportunities for shared learning.
• We have drafted a new Commercial Research Income distribution model and we are currently negotiating IP arrangements with two consultants around their inventions.
• Dr James Turvill has had an exciting approach from a commercial company to evaluate a new bowel cancer diagnostic, here at the Trust, that we are currently negotiating

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

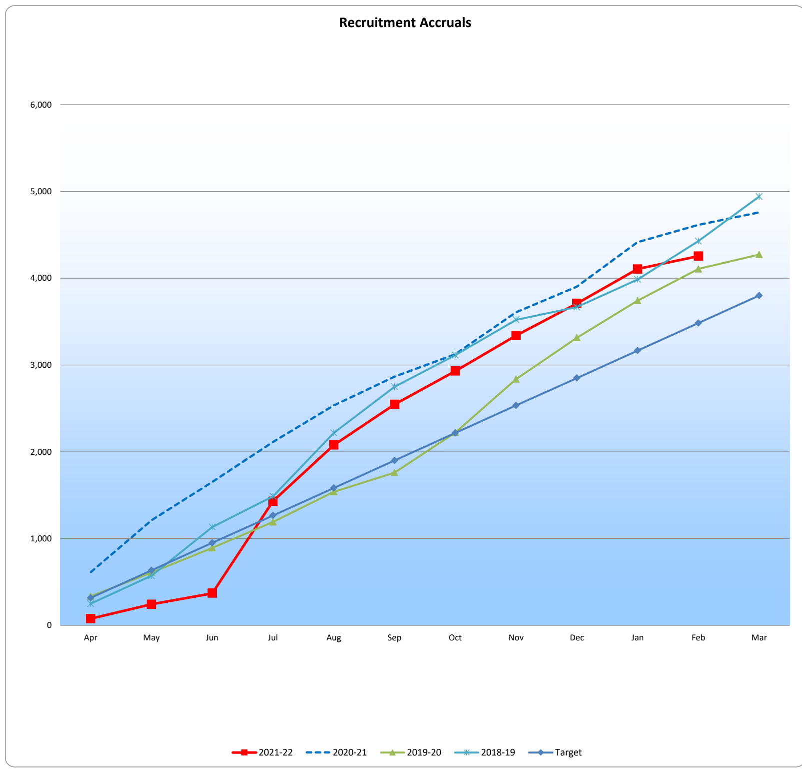
Director Sponsor: Polly McMeekin Director of WOD
Date: March 2022

TRUST BOARD REPORT : February 2022

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021-22	77	166	127	1060	648	469	383	408	372	396	150		4256
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



As we have already reached our accrual target for the year, and we get nothing for over recruiting, we have asked teams to relax on recruitment a little on a few studies that bring us big numbers (large data collection etc), to ease the pressure and allow them to focus on the more complex trials. This has therefore given us an anticipated lower number of accruals this month, with no one study being a big recruiter. Thank you to everyone for all their hard work and support

Breakdown as of end February 22

CG & Directorate	Accruals Running Total 21/22
CG1 Total	**553**
ED	42
Elderly Medicine	0
Stroke	1
Cardiology	13
Cardio Respiratory	0
CF & Respiratory	100
Hepatology	6
Sleep Services	0
Renal	85
Gastroenterology	306
Palliative Care	0
Community	0
Dietetics	0
Tissue Viability	0
CG2 - S'boro Total	**788**
ED	0
Elderly	5
Stroke	0
Cardiology	2
Respiratory	10
Renal	2
Gastroenterology	78
Hepatology	0
Palliative Care	0
Critical Care/ICU	63
Microbiology & Infection	607
Surgery - Non Cancer	13
Diabetes & Endocrinology	1
Rheumatology	7
CG3 Total	**550**
Anaesthetics/Peri-Operative	181
Critical Care/ICU	139
Surgery - Non Cancer	128
Restorative Dentistry	74
ENT	28
Pain	0
Infection	0

CG & Directorate	Accruals Running Total
CG4 Total	**941**
Oncology (inc surgery)	188
Haematology	2
Endoscopy	0
Microbiology & Infection	751
CG5 Total	**5**
Obs & Gynae	5
Paediatrics	0
Sexual Health	0
CG6 Total	**236**
Rheumatology	66
Dermatology	4
Neurology	0
Endocrinology	0
MSK	15
Orthopaedics	0
Ophthalmology	147
Psychological Medicine	0
Patient Safety	4
Services & AHP's	0
CG Total Accruals	**3073**
Psychological Impact - Cross Trust Study	**1183**
TOTAL Accruals	**4256**

Covid Accruals Included in Monthly	1029
Included in Monthly CRN Return Total	617
Covid Accruals Not Included in Monthly	16
Included in Monthly CRN Return Total	31

Breakdown of Open and Closed Trials	
Recruitment Target for Year	4022
Open Trials	93
Total Due to Close 21/22	14

Breakdown of Trial Category	
Commercial	5%
Non-Commercial	95%
Interventional	40%
Observational	59%
I & O	1%

Breakdown of Accrual Category	
Interventional	47%
Observational	53%
Large Interventional	4%

OPERATIONAL PERFORMANCE REPORT

February-2022

Produced March-2022

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

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 to a level 4 national response on the 12th of January 2022. A level 4 national response is defined as "An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level".

In response to the Omicron variant the Trust has continued to operate within its Pandemic Command and Control structure and as at the 14th of March there were 241 COVID-19 positive inpatients in our acute and community hospitals. The number of COVID-19 positive inpatients previously peaked on the 26th of January 2021 at 215 (reported via Trust's external SitRep submission).

The Trust has had 4,932 COVID-19 positive inpatients since 17th March 2020, with 3,850 patients discharged, sadly 845 patients have died. Since the beginning of July 2021 there have been 2,069 new COVID-19 positive inpatients and 231 deaths.

As at the 14th of March, York Hospital has three COVID-19 positive wards with three COVID-19 positive wards/areas at Scarborough Hospital. The majority of COVID-19 positive patients are not being treated for COVID-19 as their primary complaint however the Trust is required to cohort these patients under Infection Prevention Control (IPC) measures. This is impacting on the Trust's ability to admit elective patients as patients cannot be admitted onto wards where there are COVID-19 positive patients.

The Trust's COVID-19 surge plan is in place to respond to further requirements for additional beds.

Trust Planning

The workforce risk that the Trust has highlighted as part of the first half (H1) of 2021-22 activity plan materialised to a greater extent than was anticipated and has continued throughout H2. This has affected not just the Trust but all partners. NYCC, TEWV, YAS, Primary Care and Vocare who have all been operating at their highest level of escalation due to workforce pressures over the last six months, limiting the availability of support from the system to reduce delays to patients or support urgent care demand. Overall the Trust sickness absence rate is 7% with 680 absent as at the 14th of March, 26% of the absences relate to COVID-19.

Executive Summary (cont.):

Key discussion points for the Board are:

The pressure on medical staffing contributed to the cancellation of 258 outpatient clinics within fourteen days of the planned date and there were 252 elective patients cancelled by the Trust within forty eight hours of their intended surgery date due to non-clinical reasons. As in the previous COVID-19 'waves' cancer, urgent priority (P2) and long wait elective procedures are being prioritised.

Compared to the activity outturn in February 2020 the Trust delivered the following provisional levels of elective care activity:

Point of Delivery	February 2020 Outturn	February 2022 Actual	Variance	Proportion of February 2020 delivered in February 2022
First Outpatient Appts	13,982	12,777	-1,205	91%
Follow up Outpatient Appts	30,882	30,938	56	100%
Ordinary Electives*	592	460	-132	78%
Day Cases	6,242	6,059	-183	97%

*Ordinary Elective figures are based on discharge date.

An additional £1bn Elective Recovery Fund (ERF) has been made available to the NHS in the second half of 2021-22 to support activity above the level funded within system financial envelopes.

Systems that achieve completed referral to treatment (RTT) pathway activity above a 2019-20 weighted threshold of 89% will be able to draw down from the ERF. In February 2022 the Trust completed 84% of the weighted RTT pathways that were completed in February 2020.

February 2022 Performance Headlines:

- 71.9% of ED patients were admitted, transferred or discharged within four hours during February 2022.
- The Trust reported 583 twelve hour Trolley Breaches.
- January 2022 saw challenging cancer performance with the Trust achieving one out of the eight core national standards.
- 1,721 fifty-two week wait pathways have been declared for the end of February 2022.
- 103 104+ week wait pathways have been declared for the end of February 2022. This number, as per national guidance, excludes those patients who have requested to defer their treatment. There were three such patients at the end of February 2022.
- The Trust saw a decline against the overall Referral to Treatment backlog, with the percentage of patients waiting under eighteen weeks at month end decreasing from 62.4% in January 2022 to 61% at the end of February 2022.

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, Operational Planning and Performance Manager
Lynette Smith, Deputy Director of Planning and Performance
Steve Reed, Head of Community Services

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: Feb 2022

TRUST BOARD REPORT: February-2022

OPERATIONAL PERFORMANCE SUMMARY

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.01	Emergency Care Attendances		▲	10842	14452	16159	17920	19218	19876	19642	18813	19251	17596	16420	15735	16086
1.02	Emergency Care Breaches		▲	2241	2801	3111	3474	3642	4678	5557	5790	5941	5238	4797	4426	4515
1.03	Emergency Care Standard Performance	95%	▲	79.3%	80.6%	80.7%	80.6%	81.0%	76.5%	71.7%	69.2%	69.1%	70.2%	70.8%	71.9%	71.9%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▼	43%	43%	39%	38%	37%	41%	41%	40%	39%	40%	43%	42%	42%
1.05	ED Total number of patients waiting over 8 hours in the departments		▲	445	402	429	594	658	1072	1517	1725	1858	1596	1661	1512	1521
1.06	ED 12 hour trolley waits	0	▲	43	0	4	1	13	43	43	98	81	159	298	463	583
1.07	ED: % of attendees assessed within 15 minutes of arrival		▼	69%	66%	64%	64%	62%	49%	44%	39%	36%	39%	42%	50%	47%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▼	62%	55%	49%	47%	39%	34%	28%	25%	26%	26%	32%	35%	30%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▲	1.5%	1.8%	1.7%	1.6%	2.3%	3.3%	4.3%	4.4%	4.1%	4.1%	2.8%	2.4%	3.2%
1.10	ED - Median time between arrival and treatment (minutes)			193	194	192	191	192	212	231	236	237	235	233	225	229
1.11	Ambulance handovers waiting 15-29 minutes		▼	598	681	653	757	769	846	836	772	814	745	704	759	654
1.12	Ambulance handovers waiting 15-29 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.13	Ambulance handovers waiting 30-59 minutes		▼	101	155	180	218	243	356	421	445	483	466	479	490	410
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.15	Ambulance handovers waiting >60 minutes		▲	19	48	71	74	62	151	302	445	623	541	675	525	549
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.17	Ambulance handovers: Percentage of Ambulance Handovers within 15 minutes (shadow monitoring)		▲	74.5%	74.9%	74.2%	73.9%	72.1%	65.1%	57.6%	52.9%	43.3%	43.2%	38.4%	40.3%	41.3%
1.18	ED - Mean time in department (mins) for non-admissions (shadow monitoring)		▲	183	183	189	191	195	218	254	257	260	254	249	247	255
1.19	ED - Mean time in department (mins) for admissions (shadow monitoring)		▲	314	275	276	286	297	348	400	443	473	473	521	553	563
1.21	ED - Mean time between RFT and admission (mins) for admissions (shadow monitoring)		▲	146	101	100	106	114	142	164	192	220	231	283	327	342
1.22	ED - Number of non-admissions waiting 12+ hours (shadow monitoring)		▲	39	18	23	38	46	92	141	197	202	163	202	192	226
1.23	ED - Number of admissions waiting 12+ hours (shadow monitoring)		▼	232	132	148	171	265	395	621	757	950	892	1088	1153	1084
1.24	ED - Critical time standards (shadow monitoring - awaiting guidance on metrics)			-	-	-	-	-	-	-	-	-	-	-	-	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity) - based on date of admission		▼	3881	4884	4794	4941	4960	4888	4659	4550	4570	4463	4441	4221	4113
2.02	Non Elective Admissions (Paediatrics) - based on date of admission		▲	381	478	512	631	724	785	803	759	837	889	719	586	708
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▲	1549	1917	1990	2103	2194	2146	2035	1976	1992	1969	1790	1770	1957
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	883	1014	981	959	948	1082	1045	1079	1093	1074	1141	1108	996
2.07	Ward Transfers - Non clinical transfers after 10pm	100	▼	53	56	44	65	53	54	78	95	110	96	113	126	116
2.08	Emergency readmissions within 30 days		▲	679	881	897	911	903	877	772	745	751	718	-	-	-
2.09	Stranded Patients at End of Month - York, Scarborough and Bridlington		▼	291	275	260	270	252	271	322	313	372	376	392	466	449
2.10	Average Bed Days Occupied by Stranded Patients - York, Scarborough and Bridlington		▲	287	253	237	251	247	260	292	335	359	360	375	431	440
2.12	Super Stranded Patients at End of Month - York, Scarborough and Bridlington		▲	86	68	70	74	60	62	84	99	126	118	139	167	189
2.13	Average Bed Days Occupied by Super Stranded Patients - York, Scarborough and Bridlington		▲	85	68	54	55	64	58	71	92	108	124	126	161	179

REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
3.01	Outpatients: All Referral Types		▼	17059	22597	21685	20322	22778	22381	19446	21266	21279	22434	18421	18339	17552
3.02	Outpatients: GP Referrals		▲	7174	10197	9251	8365	9435	9487	8332	9385	9572	10365	8605	8636	8811
3.03	Outpatients: Consultant to Consultant Referrals		▲	1585	1851	1884	1760	1974	2085	1658	1871	1803	2026	1847	1609	1611
3.04	Outpatients: Other Referrals		▼	8300	10549	10550	10197	11369	10809	9456	10010	9904	10043	7969	8094	7130
3.05	Outpatients: 1st Attendances		▲	11169	14394	12408	12782	14263	13020	11819	12995	12627	14025	11592	12319	12742
3.06	Outpatients: Follow Up Attendances		▼	30114	36585	32657	32516	35683	33544	31445	35326	33137	36804	30704	32569	30985
3.07	Outpatients: 1st to FU Ratio		▼	2.70	2.54	2.63	2.54	2.50	2.58	2.66	2.72	2.62	2.62	2.65	2.64	2.43
3.08	Outpatients: DNA rates		▼	6.4%	5.8%	5.7%	5.1%	5.6%	5.9%	6.3%	6.2%	6.0%	7.0%	6.9%	6.8%	6.1%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	180	▼	248	215	242	165	152	251	269	247	287	298	250	367	258
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▼	1002	1133	1170	974	1005	1383	957	1265	2869	2765	2526	2407	2293
3.11	Outpatients: Follow-up Partial Booking (FUPB) Overdue			24835	24778	24421	24624	24504	24826	25984	25610	26252	26784	27294	27318	27712
4.01	Elective Admissions - based on date of admission		▲	505	537	468	486	559	555	469	561	467	614	533	457	489
4.02	Day Case Admissions		▼	4478	5551	5801	5703	6710	6416	5697	6163	5678	6335	6164	6086	6073
4.03	Cancelled Operations within 48 hours - Bed shortages		▼	10	4	1	0	2	6	15	28	1	8	17	97	54
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▼	87	73	114	38	75	102	84	109	57	70	129	358	252
4.05	Theatres: Utilisation of planned sessions		▲	62%	69%	75%	76%	76%	73%	74%	72%	75%	78%	72%	69%	73%
4.06	Theatres: number of sessions held		▼	639	636	629	641	755	663	572	653	678	661	575	609	568

Outpatient appointments data from June 2021 now excludes CAS (Clinical Assessment Service) clinics, in line with SUS reporting. Outpatient appointments data for 1st Attendances and Follow Up attendances has been updated from April 2021 to match NHSI/E counting methodology.

All Referrals figures in the table above (3.01-3.04 for 13 months) have been refreshed in August-21 report due to a data filtering error

Hospital Cancelled Outpatient Appointments for non-clinical reasons have been refreshed from Oct-21 as dataset is now built in OBIEE

TRUST BOARD REPORT: February-2022

OPERATIONAL PERFORMANCE SUMMARY

REF	DIAGNOSTICS	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
3.12	Diagnostics: Patients waiting <6 weeks from referral to test	99%	▲	66.6%	68.5%	66.2%	62.9%	62.8%	61.4%	55.9%	56.4%	56.7%	56.4%	53.8%	51.7%	56.0%
3.13	Diagnostics: Total Fast Track Waiters		▼	671	735	608	786	796	883	916	1115	962	960	1138	1009	995
3.19	Diagnostics: Urgent Radiology Waiters		▼	733	814	819	862	781	774	780	847	701	980	1085	1026	1025
3.38	Total Overdue Planned Radiology Waiters		◀▶	605	451	485	393	259	401	290	374	-	-	-	-	-
3.22	Total Radiology Reporting Backlog		▲	2176	2140	2124	1889	2418	3202	2780	3079	3373	2121	1932	1749	2482
3.31	Total Endoscopy Surveillance Backlog (Red)		▼	1485	1331	1402	1334	1235	1150	1146	1124	1125	902	817	849	821

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
5.01	RTT Percentage of incomplete pathways within 18wks	92%	▼	62.8%	64.7%	65.8%	68.3%	70.5%	69.5%	68.1%	66.2%	65.3%	64.8%	63.5%	62.4%	61.0%
5.02	RTT Waits over 52 weeks for incomplete pathways	0	▲	2581	2446	2023	1713	1488	1361	1348	1549	1688	1584	1586	1615	1721
5.10	RTT Waits over 78 weeks for incomplete pathways	0	▼	410	523	577	632	638	644	692	692	577	426	367	325	312
5.11	RTT Waits over 104 weeks for incomplete pathways (excludes patients who have deferred treatment P5 and P6 as per national guidance)*	0	▼	0	1	8	32	40	56	93	130	137	120	117	121	103
5.05	RTT Total Waiting List †	34261	▲	27193	28691	30069	30321	30707	31959	33187	34261	35031	35869	36897	37008	37478
5.06	Number of RTT patients on Admitted Backlog (18+ weeks)		▲	4328	4355	4306	4073	3862	3822	3897	4116	4243	4258	4410	4551	4655
5.07	Number of RTT patients on Non Admitted Backlog (18+ weeks)		▲	5792	5766	5968	5531	5192	5916	6682	7461	7921	8353	9040	9360	9955
5.08	RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring)	8.5	▲	18.1	17.0	16.4	16.3	15.9	15.5	16.1	16.4	16.5	16.3	17.1	17.6	17.8
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	508	569	644	548	592	600	577	566
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%	76%	70%	74%	70%	75%	66%	69%	70%

*Priority 2: includes all P2 pathways where there is a surgical decision to treat, not just open RTT pathways; P5: Patient Wishes To Defer Surgery Due To Covid-19 Concerns; P6: Patient Wishes To Defer Surgery Due To Non Covid-19 Concerns

† RTT TWL is being measured against the Sep-21 performance target from Oct-21

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
6.01	Cancer 2 week (all cancers)	93%	▼	92.5%	91.1%	88.1%	93.7%	94.0%	95.2%	92.0%	93.0%	88.8%	86.4%	81.6%	70.2%	-
6.02	Cancer 2 week (breast symptoms)	93%	▼	92.6%	92.6%	92.8%	91.5%	93.6%	93.5%	96.0%	92.9%	81.2%	57.8%	33.1%	16.0%	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	▼	99.1%	97.0%	96.3%	98.5%	97.4%	98.5%	97.6%	96.9%	98.6%	95.0%	98.4%	92.5%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	▼	93.9%	93.3%	96.2%	95.5%	93.1%	88.9%	87.5%	87.9%	96.9%	84.8%	94.7%	75.6%	-
6.05	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	▼	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	98.6%	-
6.06	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▼	72.1%	75.0%	70.9%	79.9%	67.1%	67.2%	62.4%	67.9%	70.8%	70.0%	71.6%	65.2%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)**	90%	▼	97.6%	87.2%	96.5%	83.7%	93.2%	84.0%	90.9%	82.5%	81.7%	71.4%	90.2%	79.4%	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▼	60.5%	70.2%	63.1%	63.6%	65.0%	65.3%	64.7%	64.1%	72.7%	68.8%	74.0%	61.7%	-

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

REF	COMMUNITY	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
7.01	Referrals to District Nursing Team		▲	1761	2057	1929	1916	2084	2078	1753	1745	1719	1765	1719	1745	1899
7.02	% CRT Patients Seen within 2 days of Referral		▼	71.4%	79.3%	82.8%	83.5%	78.3%	59.7%	48.3%	59.3%	74.2%	60.0%	60.1%	51.4%	45.2%
7.03	Number of District Nursing Contacts		▼	18139	21505	20984	20859	21103	21433	21270	19720	20606	20431	19817	19026	18314
7.04	Referrals to York Community Response Team		▼	190	182	179	200	206	203	175	170	177	207	201	209	197
7.05	Referrals to Selby Community Response Team		▼	57	64	56	51	40	65	52	52	64	54	66	62	59
7.07	Number of York CRT Contacts		▼	3839	3691	4367	4949	4890	5526	5735	4897	4635	4684	4598	5716	4712
7.08	Number of Selby CRT Contacts		▼	1284	1486	1431	1513	1463	1810	1707	1784	2091	2028	1790	1924	1820
7.10	Community Inpatient Units Average Length of Stay (Days)		▲	12.5	13.5	11.0	13.3	16.1	13.1	16.6	18.4	17.2	17.8	17.5	18.0	21.6
7.11	% Community Therapy Team Patients Seen within 6 weeks of Referral		▲	90.9%	92.4%	84.8%	88.5%	87.4%	82.3%	85.9%	70.5%	72.1%	78.9%	79.5%	75.0%	78.7%
7.12	% CRT Step Up Referrals Seen Within 2 Hrs		▲	15.6%	21.5%	15.4%	9.4%	16.5%	11.5%	26.0%	6.8%	13.4%	15.1%	11.7%	8.2%	15.5%
7.13	% of End of Life Patients Dying in Preferred Place of Death		▼	80.5%	85.7%	71.4%	80.0%	80.0%	90.2%	85.2%	90.6%	75.6%	81.8%	95.0%	88.5%	83.3%

REF	CHILDREN AND YOUNG PERSONS (0-17 YEARS)	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
8.01	Emergency Care Standard Performance (Type 1 only)	95%	▼	97.1%	96.5%	96.2%	95.5%	94.5%	91.6%	87.7%	84.9%	83.9%	84.6%	86.9%	89.6%	88.4%
8.02	ED patients waiting over 8 hours in department		▼	2	1	5	11	7	14	22	26	17	14	11	8	6
8.03	Cancer 2 week (all cancers)	93%	▲	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	75.0%	-
8.05	Diagnostics: Patients waiting <6 weeks from referral to test	99%	▼	50.9%	62.2%	62.4%	72.7%	58.9%	64.1%	57.4%	61.6%	53.6%	52.5%	52.7%	58.4%	47.6%
8.06	RTT Percentage of incomplete pathways within 18wks	92%	▼	66.3%	70.3%	71.8%	73.0%	75.8%	75.3%	73.2%	72.6%	71.4%	70.5%	70.8%	69.6%	68.9%
8.07	RTT Total Waiting List		▲	2102	2285	2395	2433	2511	2702	2741	2803	2924	3055	3131	3166	3304
8.08	RTT Waits over 52 weeks for incomplete pathways		▲	218	191	156	123	102	99	103	119	136	123	112	110	130

REF	STROKE	Target	Sparkline / Previous Month	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
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%	100.00%	-

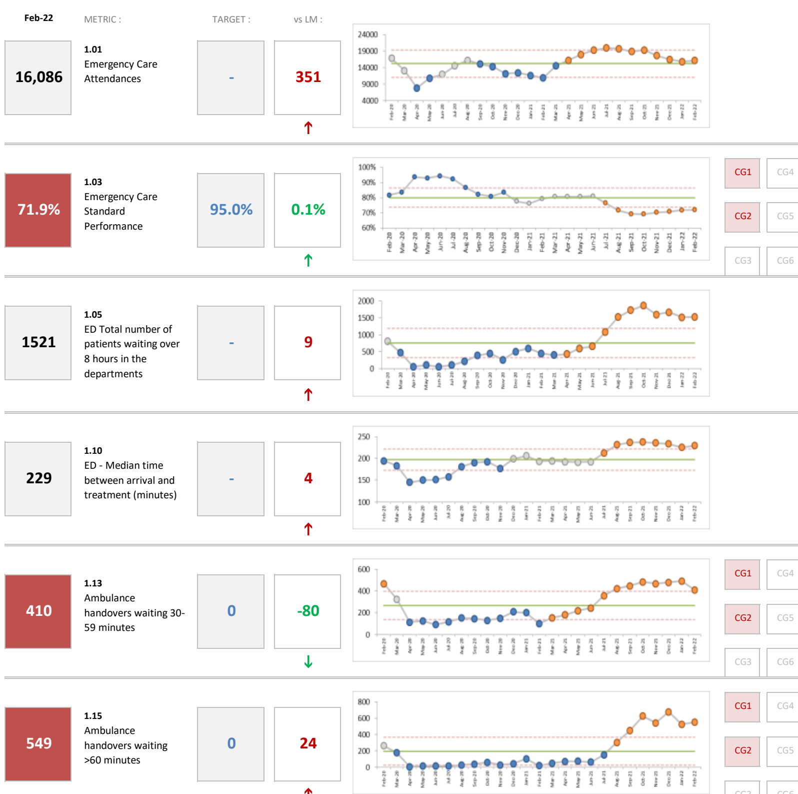
REF	SSNAP Scores:	Target	Sparkline / Previous Month	Jan-Mar 21	Apr-Jun-21	Jul-Sep-21	Oct-Dec-21	Jan-22	Feb-22
9.03	Proportion of patients spending >90% of their time on stroke unit	85%	▼	86.1% B	89.2% B	82.6% C	82.5% C	77.5% D	75.9% D
9.04	Scanned within 1 hour of arrival	43%	▲	52.4% A	57.7% A	56.9% A	51.8% A	46.5% B	48.8% A
9.05	Scanned within 12 hours of arrival	90%	▼	94.3% B	96.0% A	94.4% B	82.5% C	100.0% A	97.7% A

*COVID data set for the period April to June 2020. The full SSNAP data set is now being used. Please note the SSNAP quarters Jul-Sep and Oct-Dec 2020 have been refreshed due to error; many of the patients admitted during that period were transferred to and from Covid wards.

The latest month's SSNAP data is subject to change due to casenote delays and patients not yet being discharged. The Jan-22 figures have been affected by staff sickness and closure of the Stroke ward to admissions due to a Covid outbreak at the beginning of January, so should improve next month

TRUST BOARD REPORT: February-2022

OPERATIONAL PERFORMANCE: ED



HIGHLIGHTS FOR BOARD TO NOTE:

71.9% of ED patients were admitted, transferred or discharged within four hours during February 2022. Across the Scarborough and York localities attendances at the Emergency Departments and Urgent Care and Treatment Centres were below the 2019-20 levels by -4% (February 2022; 16,086 compared to 16,770 in February 2020). The staffing issues in February 2022 have exasperated the pressures that the Trust is experiencing. The ED Capital Build at York which commenced at the beginning of November 2021 has meant that York Emergency Department is operating out of a smaller footprint.

In the latest nationally available data (February 2022), the NHS England position was 73.3%. Nationally the Trust placed 48th out of 126 Trusts. No Trust achieved 95% plus against the Emergency Care Standard (ECS). The 95% standard was last met nationally in July 2015.

York Locality ECS Performance was 73.2%. The hospital inpatient estate has been reconfigured throughout the latest wave to support the COVID-19 Surge Plan, with three COVID-19 positive wards in operation as at the 14th of March.

Scarborough Locality ECS Performance was 70%. Demand at the three independent Sector run services; Bridlington Urgent Treatment Centre, Malton Urgent Care Centre and the Urgent Treatment Centre (UTC) co-located at Scarborough Hospital, are yet to return to pre-pandemic levels. This has impacted the Scarborough locality's overall performance as the number of Type 3 attendances, while increasing through 2021-22 remains significantly reduced from pre-pandemic levels; -27% YTD compared to April 2019 to February 2022. Like many system colleagues, Vocare who operate the UTC at Scarborough Hospital have had significant challenges staffing their service during February 2022, particularly at the weekends. The Trust continues to collaborate with Vocare and has, when possible, backfilled several of their staffing gaps. Weekend planning meetings are now in place between Vocare and the Trust to maximise resilience.

The Scarborough Hospital inpatient estate has been reconfigured throughout the latest wave to support the COVID-19 Surge Plan, with three COVID-19 positive wards/areas in operation as at the 14th of March on the Scarborough site.

There were 583 twelve-hour trolley waits in February 2022; 364 on the Scarborough site and 219 at York.

The Urgent and Emergency Care Project Board (UECB), as part of the 'Building Better Care' Programme, is in place, meeting fortnightly supported by a project manager to drive delivery. The aims and objectives of the UECB are:

Same Day Emergency Care (SDEC); the project aims to deliver Same Day Emergency Care on both acute sites to meet the requirements of the NHS Long Term Plan and Urgent and Emergency Care Network.

This includes meeting the national standards to:

- Provide SDEC services at least 12 hours a day, 7 days a week, providing an alternative to ward admission.
- Provide an acute frailty service at least 70 hours a week, with the aim to complete a clinical frailty assessment within 30 minutes of arrival in the ED/SDEC unit;
- Record all patient activity in EDs, urgent treatment centres and SDECs using same day emergency care data sets.

Urgent Care Pathways; aims to work with partners to deliver effective urgent care pathways across both acute sites to reduce ED attendances or direct admissions that do not require acute hospital care and/or can be managed with alternative care.

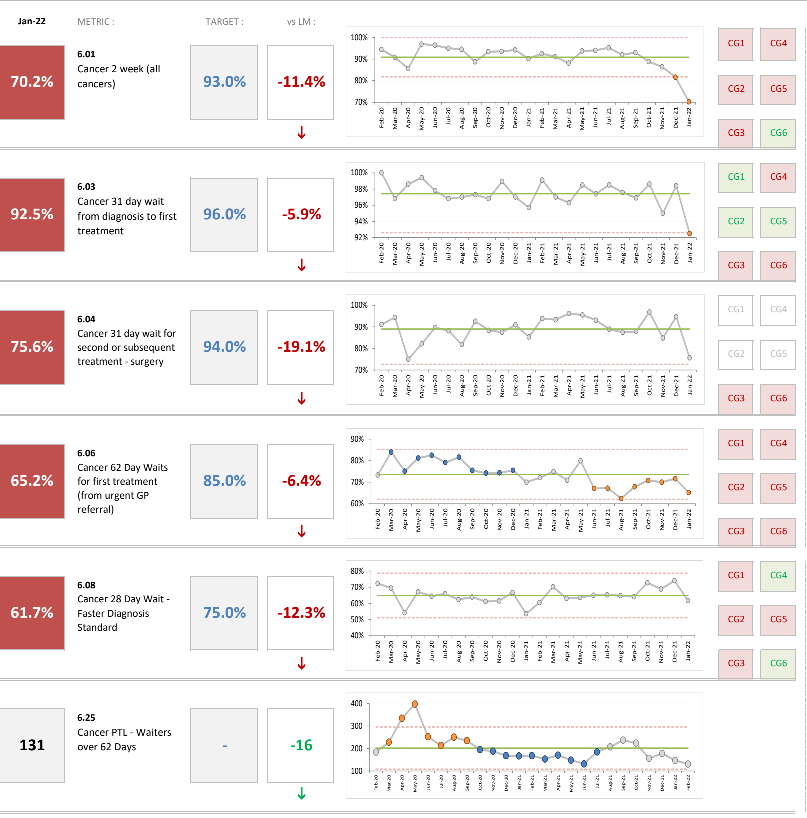
Flow and Site Management; to ensure timely admission for urgent and surgical patients to the appropriate clinical location the project aims to provide clear and effective 24/7 operational arrangements for site management issues and for the flow of patients across both acute hospital sites.

Adult Non-Elective admissions increased in February 2022 when compared to the same period last year: up 6% (232) admissions. Paediatric Non-Electives are detailed within the Children and Young Persons section.

Super-Stranded (Length of Stay of 21+ Days) patients at the end of February 2022 increased compared to the end of January 2022 (167 to 189 patients). Unfortunately this position is a direct consequence of capacity and workforce issues that our Local Authorities are experiencing and is likely to continue for some time.

TRUST BOARD REPORT: February-2022

OPERATIONAL PERFORMANCE: CANCER



HIGHLIGHTS FOR BOARD TO NOTE:

Trust cancer performance in January 2022 continued to be challenged, with one out of the eight cancer standards met;

• Cancer 31 day wait for second or subsequent treatment - Drug treatments.

The Trust's Cancer Team have recently reviewed and made changes to Cancer Governance and Oversight. The key areas for note are:

1. Care Groups are to reinforce their weekly Care Group/tumour level PTL meeting to expedite any outstanding actions required to progress patients along their pathway to treatment as well as a focus on the 28 Day Faster Diagnosis target.

2. Care Group Directors, the Chief Operating Officer and the Planning and Performance Team will receive a weekly cancer performance update that follows Cancer Wall with key information and the list of outstanding actions. This has a focus on size of PTL, 28 Day Faster Diagnosis and 62 Day standard.

3. The cancer action plan will be presented at Cancer Delivery Group on a monthly basis via the Project Management Office documentation. The Trust's Cancer Improvement and Performance Manager will then outline where actions are off plan, as well as the barriers and mitigations to bring back on plan. In addition progress against the improvement actions will be a focus of Care Group Oversight and Assurance Meetings with the Executive Team.

The Trust did not achieve the Cancer two week waiting times for urgent referrals target with performance of 70.2% in January (December: 81.6%). The decline in Trust performance has primarily been caused by a fall in the number of Breast referrals being seen within fourteen days. There was a 32% rise in referrals to Breast services seen across the period September to November 2021 compared to the average monthly referrals seen in the first five months of 2021-22. This rise appears to be linked to recent celebrity deaths and awareness campaigns. The Breast service have tried to put on additional clinics to meet the demand but due to the pressure across diagnostic services, our radiology service has been unable to be able to support additional one stops clinics. This has resulted in a large number of patients having diagnostic scans at days nineteen to twenty one. The services have been working hard to address this and additional clinics, with radiological support, are now being organised.

The latest available data shows the national position for two week waiting times for urgent referrals to be 75% in January 2022.

The Trust did not achieve the 28-day Faster Diagnosis (All Routes) target with performance of 61.7% in January (December: 74%). The latest available data shows the national position to be 63.8% in January 2022.

The Trust was not anticipating improvements in our diagnostic position throughout 2021-22. However the Trust was affected by significant staff absence, including in diagnostics services, that were over and above what had planned been for; a mix of COVID-19 related absence and other sickness. The Trust continues to prioritise urgent and cancer work and have escalated the situation to Quality and Executive Committees.

Actions being taken include the implementation of recommendations from the Cancer Deep Dive completed in June, full review of NHS IST Pathway Analysers by tumour site was undertaken to refresh all recovery plans through quarters two and three of 2021-22, A Cancer Performance Improvement Action Plan, covering the recommendations from the Deep Dive, has been developed and an report is taken to Cancer Delivery Group (CDG) each month. Associate Chief Operating Officers are responsible for updating actions and raising mitigations for RED escalations through CDG. There is work ongoing on the NHS IST Pathway Analysers through the development of a more routine process for completion with more regular updates and review of findings for the Care Groups. The Prostate analyser has been used for to pilot this process and is in its final stages of reporting through to the Care Group for their improvement action development. The Lung pathway will be the next to be taken through this process. A number of Pathway Navigators are now in post who are starting to support improvement against the FDS target with patients being supported from referral to FDS, these posts have been made possible through RDC funding.

Performance against the 62 day wait for first treatment target was particularly challenging at 65.2%. All patients are tracked through the operational teams, with weekly escalations to senior managers.

At the end of February 2022 there were 131 patients on the Trust's Patient Tracking List (PTL) that had waited over 62 days. This puts the Trust fifty four patients below the improvement trajectory for the end of January submitted as part of the 2021-22 H2 plans (185).

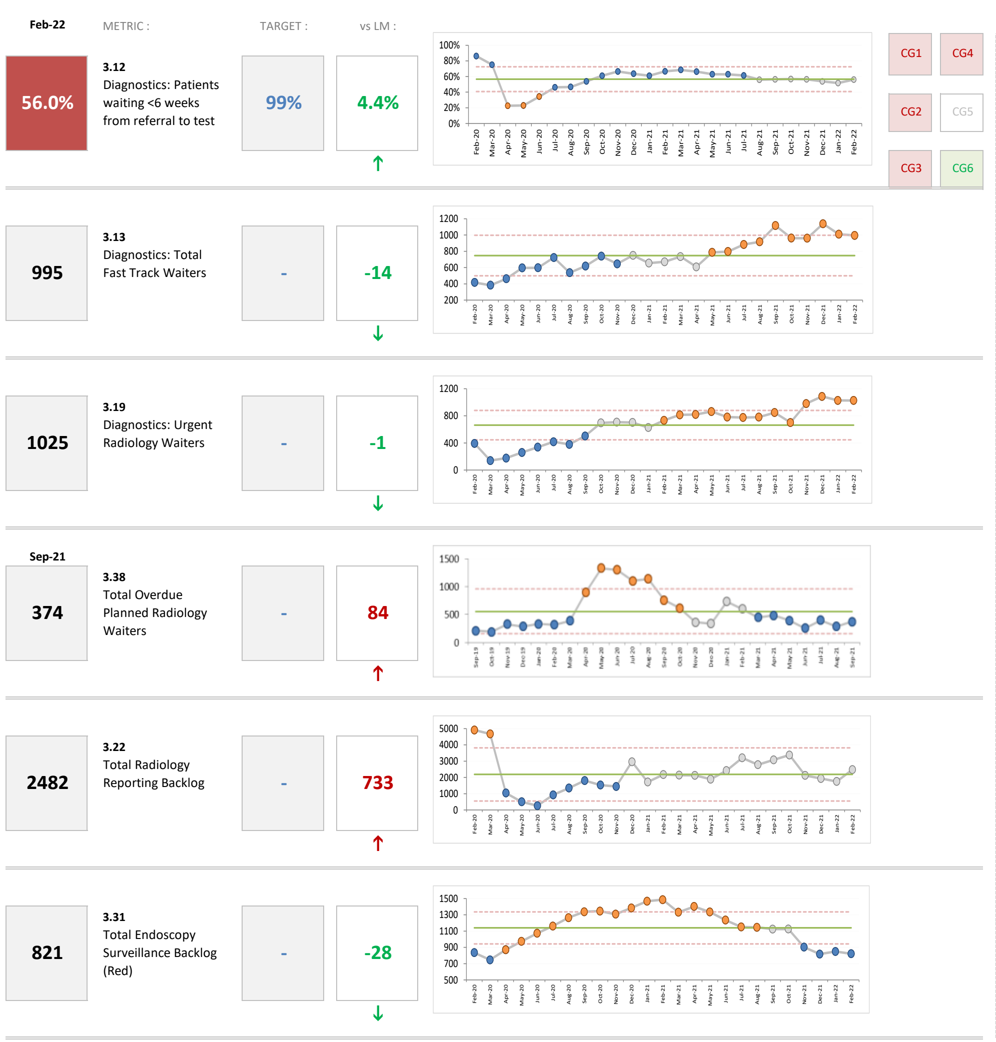
Of those waiting over 62 days, eighty seven are awaiting diagnosis; continuing to tackle this backlog is a top priority for the Trust and the Humber, Coast and Vale system and is a key element of the H2 recovery work.

There were fifteen patients treated in January 2022 who had waited more than 104 days with the majority due to complex diagnostic pathways or health care provider delays. There is a continued focus on the long wait patients at the Trust's weekly PTL Cancer Wall meetings. On the 27th July 2020 there were 108 over 104 days; at the end of February 2022 there were twenty seven. 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.

The latest available data shows the national position to be 61.8% against the 62 day wait for first treatment target in January 2022.

TRUST BOARD REPORT: February-2022

OPERATIONAL PERFORMANCE: DIAGNOSTICS



HIGHLIGHTS FOR BOARD TO NOTE:

The diagnostics target performance for February 2022 was 56% of patients waiting less than 6 weeks for their diagnostic test at the end of the month (January 2022; 51.7%). The latest available data shows the national position at the end of January 2022 was 70%.

The Endoscopy performance was 62.3% (January 2022; 55.8%). Outsourcing opportunities with the Independent Sector and Humber, Coast and Vale provider partners have been secured which will aid the recovery of this position. The Trust was allocated £0.5m for insourcing to tackle the endoscopy surveillance backlog, this commenced in quarter three of 2021-22. It is planned that the backlog will be cleared during quarter four 2021-22.

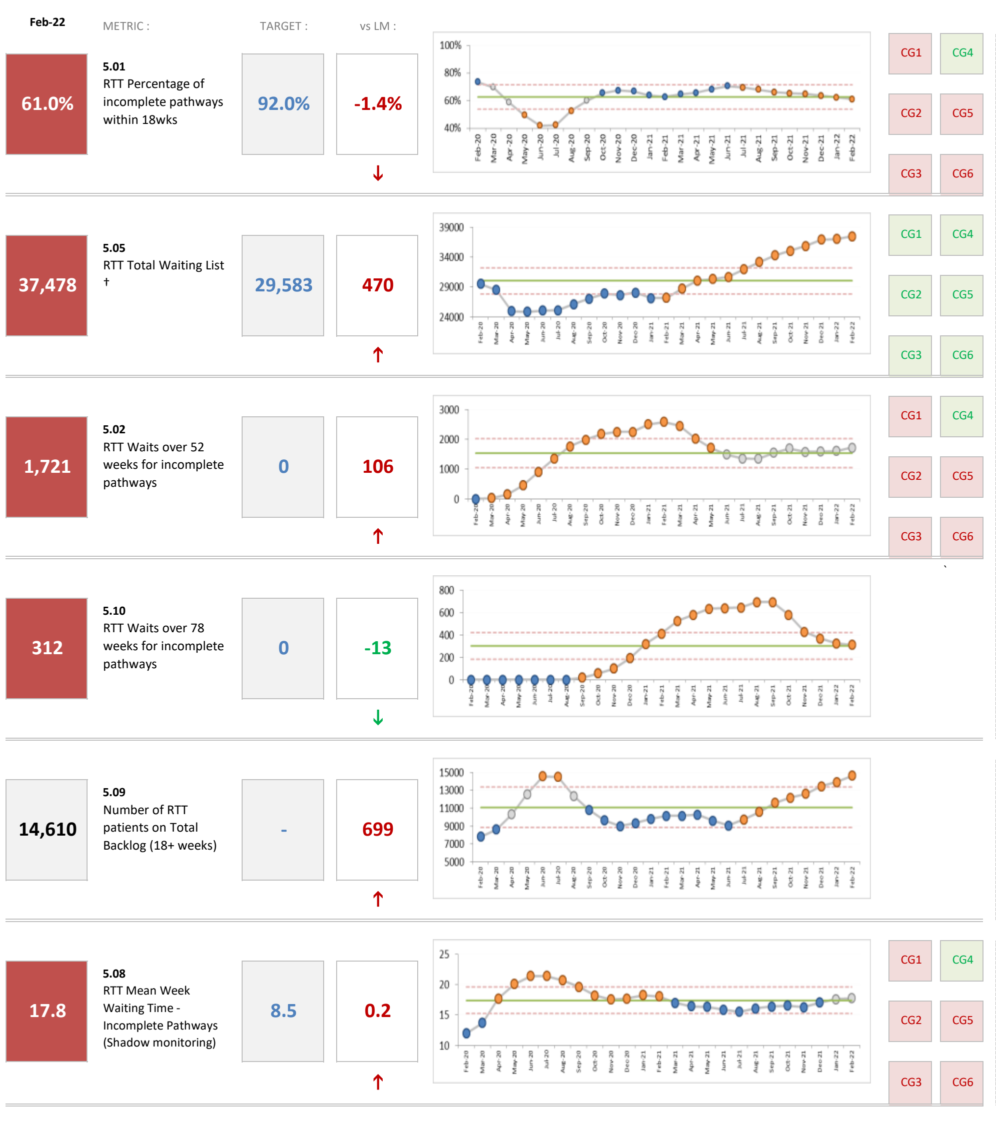
Radiology performance at the end of was February 55.5% (January 2022; 51.3%).

The decline in performance against the Diagnostic standard compared to pre-COVID-19 appears to be driven by the increase in cancer referrals that has required services to prioritise fast track and urgent patients. This has resulted in reduced capacity for routine patients and the 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 continues to push forward with recruitment and training to address this workforce issue. The Trust is continuing to utilise mobile scanner capacity to deliver activity, the mobile scanner is currently procured via the national independent sector contract.

TRUST BOARD REPORT: February-2022

OPERATIONAL PERFORMANCE: REFERRAL TO TREATMENT (RTT)



HIGHLIGHTS FOR BOARD TO NOTE :

The proportion of patients waiting more than eighteen weeks declined in February 2022, with the overall RTT position decreasing from 62.4% (January 2022) of patients waiting less than eighteen weeks from referral to treatment to 61%. The latest available data shows the national position at the end of January 2022 was 62.8%.

The Trust's RTT Total Waiting List (TWL) increased by 470 from the end of January 2022 and stood at 37,478. The increase in the Trust's overall RTT position was primarily driven by the cancellation of outpatient clinics and elective procedures as well a reduced level of planned elective activity caused by increased COVID-19 positive inpatients and the staffing issues the Trust has experienced as a result of the Omicron Variant.

The Trust had 1,721 patients waiting 52 weeks or longer at the end of February 2022, up 106 from the end of January 2022. This position remains a significant reduction from the 'peak' at the end of February 2021 when the Trust declared 2,581 fifty-two week RTT waiters.

NHSI/E has mandated that Trusts have zero 104 week RTT waiters by the end of June 2022. A specialty specific trajectory to achieve this will be submitted to NHSI/E as part of the 2022-23 planning submission.

The Trust has signalled to NHSI/E that there will be circa ninety five patients waiting 104 weeks at the end of March 2022 across Urology, Upper GI and Colorectal. These three specialities have pressured cancer pathways which are reducing available capacity for routine work.

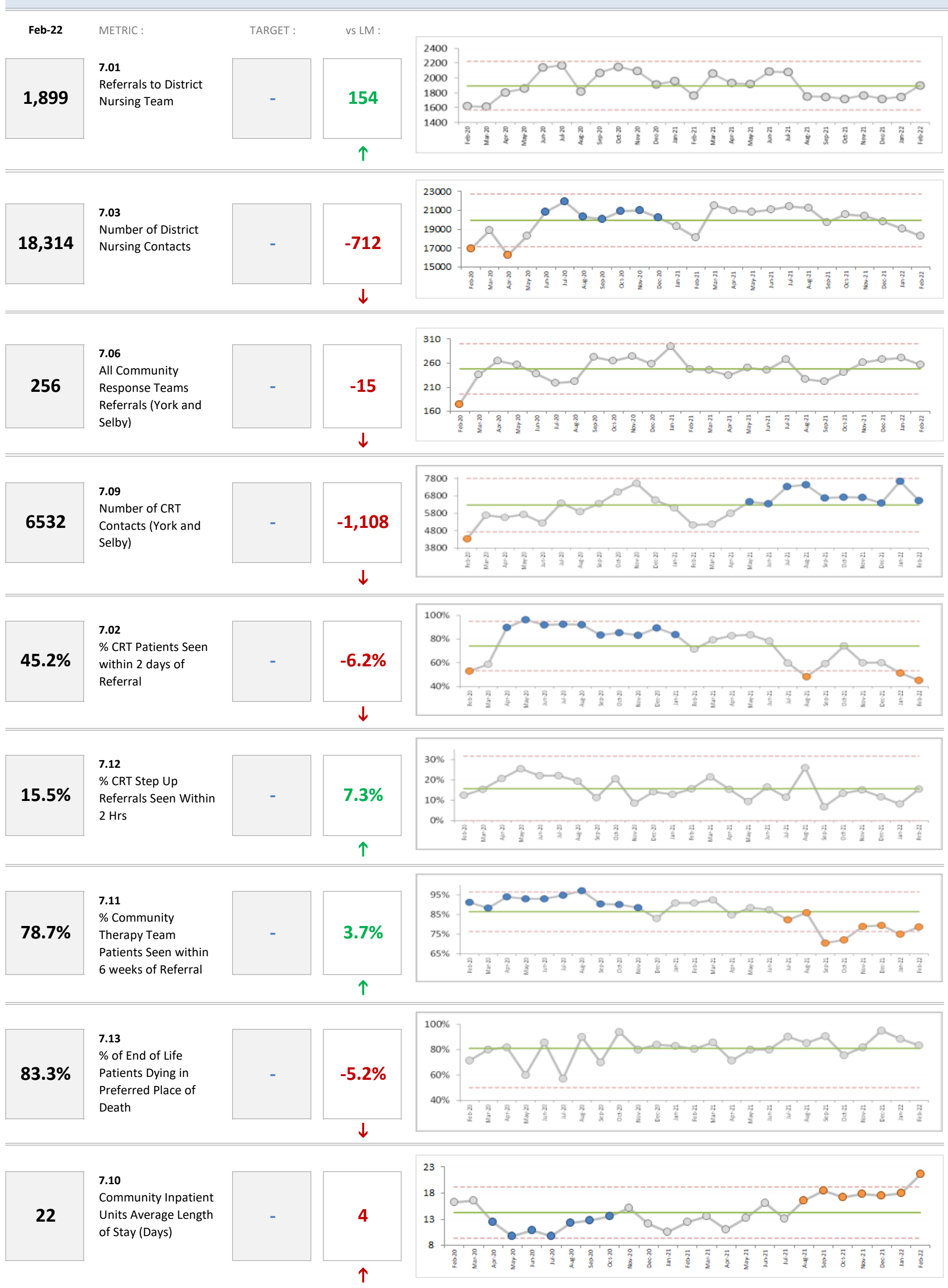
The Trust has, excluding those patients who have requested to defer their treatment, reported 103 RTT 104 plus week waiters at the end of February 2022.

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 four 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; this position was 70% at the end of February 2022. Care Groups are continuing to focus on this cohort of patients with weekly corporate oversight at weekly performance meetings.

The Trust has mobilised its approach to sustainable recovery through the transformational 'Building Better Care' Programme, which is targeted at high impact actions across urgent care, outpatients, surgical pathways, cancer and diagnostics over the two next years.

TRUST BOARD REPORT: February-2022

OPERATIONAL PERFORMANCE: COMMUNITY ACTIVITY



Feb-22	METRIC :	TARGET :	vs LM :
1,899	7.01 Referrals to District Nursing Team	-	154 ↑
18,314	7.03 Number of District Nursing Contacts	-	-712 ↓
256	7.06 All Community Response Teams Referrals (York and Selby)	-	-15 ↓
6532	7.09 Number of CRT Contacts (York and Selby)	-	-1,108 ↓
45.2%	7.02 % CRT Patients Seen within 2 days of Referral	-	-6.2% ↓
15.5%	7.12 % CRT Step Up Referrals Seen Within 2 Hrs	-	7.3% ↑
78.7%	7.11 % Community Therapy Team Patients Seen within 6 weeks of Referral	-	3.7% ↑
83.3%	7.13 % of End of Life Patients Dying in Preferred Place of Death	-	-5.2% ↓
22	7.10 Community Inpatient Units Average Length of Stay (Days)	-	4 ↑

HIGHLIGHTS FOR BOARD TO NOTE :

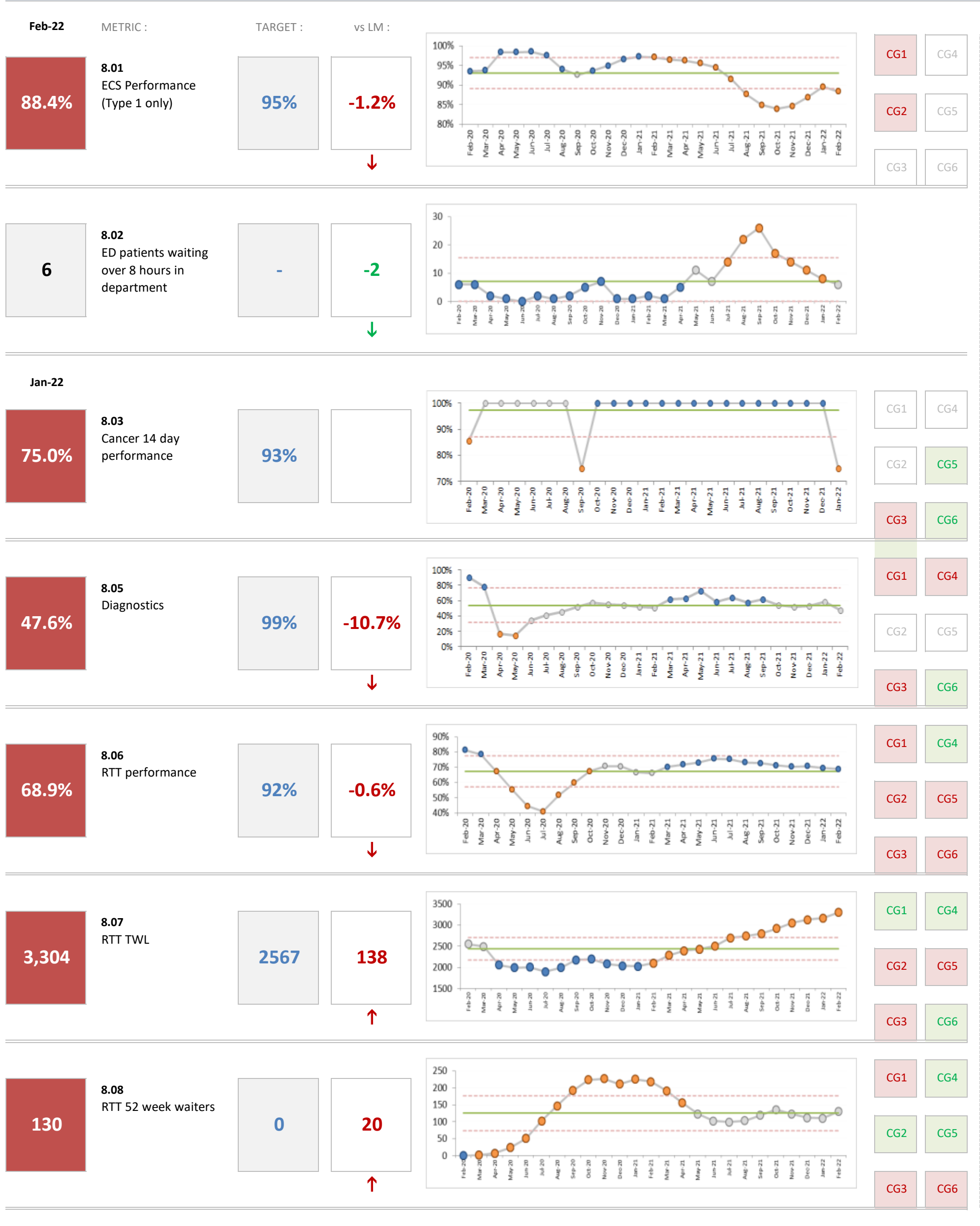
Following several months below average levels, referrals to District Nursing teams rose during February whilst contacts continue to fall (due to a combination of workforce absence and the lower number of days in the month). As a result the number of patients waiting for a District Nursing intervention rose to the highest level to date (over 500 patients) with half of these waiting for a continence assessment. Local plans are being developed to tackle the backlog but uncertainty remains regarding funding available to provide additional capacity to meet expected increases in demand in 2022-23. Until this is known it will be difficult to provide assurance regarding the national planning requirement to reduce community waiting lists.

Continued above average activity for the Community Response Team, again combined with workforce challenges, resulted in greater numbers of patients waiting over two days for the service to commence. This was despite the redeployment of Community Therapy staff to provide additional capacity and the use of the national Hospital Discharge Programme fund to provide additional bank shifts. The end of the Discharge fund will place additional capacity constraints from the 31 March and discussions are ongoing to mitigate this.

Capacity constraints in CRT are exacerbated by the ongoing delays for patients waiting for services within the social care sector to provide longer term care. This is also the case for the Community Inpatient Units who recorded the longest lengths of stay since the transformation work to reduce length of stay commenced in summer 2019. Additions to the national community discharge SitRep will commence in March which will record delays reasons specifically designed for community rehabilitation settings - providing additional granularity in understanding what is preventing patients from moving to their discharge destination.

TRUST BOARD REPORT: February-2022

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



HIGHLIGHTS FOR BOARD TO NOTE:

Performance against the ECS for patients aged 0-17 years was below target at 88.4% in February 2022.

ECS performance is impacted by multiple factors; staffing pressures caused by COVID-19, the requirement to transfer COVID-19 positive patients to Scarborough from York when demand has dictated and during the COVID-19 waves roughly a third of admissions to the Children's Assessment Unit (CAU) and paediatric wards have been due to respiratory conditions.

The pressure from the respiratory surge and COVID-19 waves have inevitably had an impact on ED performance however the resilience plans have been enacted to support additional child health team nursing and medical staffing capacity across ED and CAU has enabled the teams to extend CAU opening hours and manage this additional activity and higher levels of need/acuity.

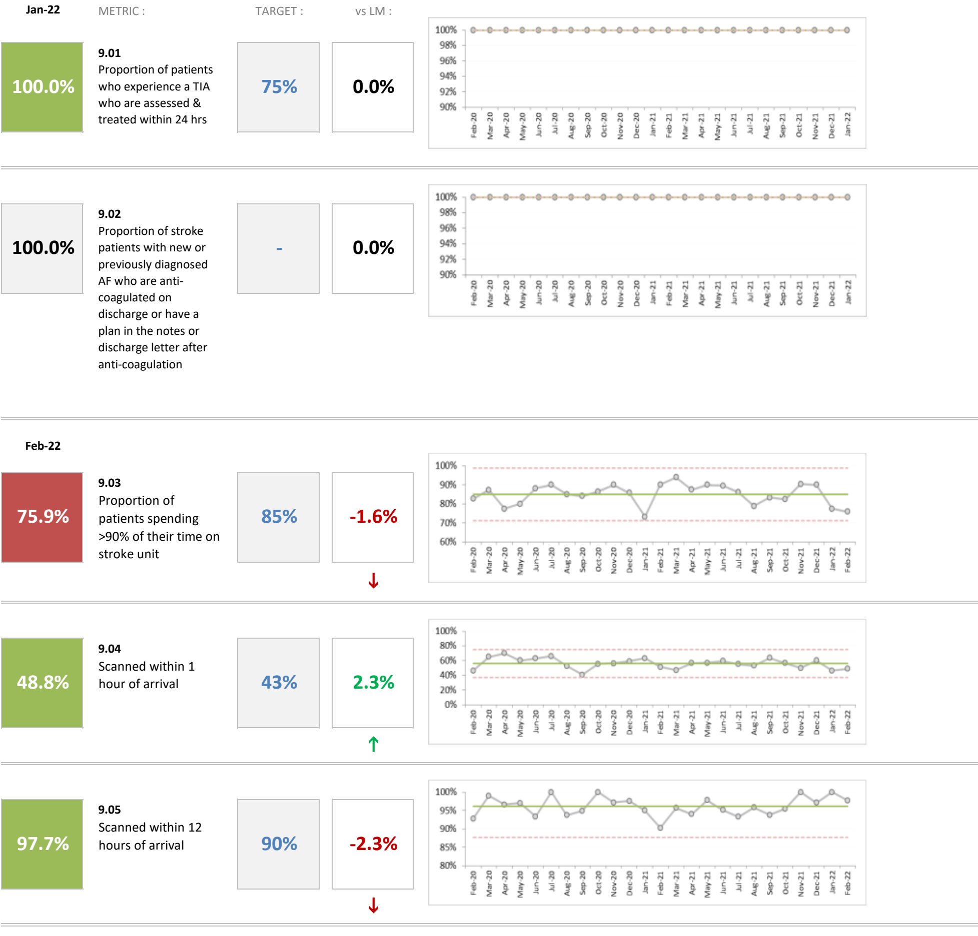
A York pilot Paediatric Ambulatory Treatment Hub scheme continues to help prevent babies and young children coming into hospital with breathing difficulties, the pilot will run to the end of March 2023.

February 2022 has seen an increase in non-elective admissions for children, up 21% from January 2022 (+122 admissions).

RTT performance against the 92% target is higher than the Trust overall performance (68.9% compared to 61%). The Trust is declaring 130 RTT fifty-two week waiters relating to children and young people at the end of February 2022. Children comprise approximately 8% of the total number of the fifty-two week waiters that the Trust is declaring for the end of February 2022 (1,721).

TRUST BOARD REPORT: February-2022

OPERATIONAL PERFORMANCE: STROKE



HIGHLIGHTS FOR BOARD TO NOTE:

The latest Sentinel Stroke National Audit Programme (SSNAP) report for the period July to September 2021 was published in January 2022. For this period the Trust achieved a score of 62.7 which equates to a C rating. This represents a decline on our April to June 2021 performance (B rating).

Compared to the same period last year the Trust saw a 13% increase in admissions to the Acute Stroke Unit. Despite this rise the service is ensuring patients scanned in a timely manner, are admitted to the Stroke Unit with a median time of less than 4 hours and more patients are receiving their thrombolysis in less than 60 minutes than before the introduction of the direct admission model. The domains linked to physiotherapy and speech and language therapy have however been challenging. The service is working to address the issues highlighted by the SSNAP report to improve the Trust's rating back to where it should be.

TRUST BOARD REPORT : February-2022

OPERATIONAL PERFORMANCE SUMMARY - SCARBOROUGH

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.01	Locality Emergency Care Attendances		▲	4436	5824	6718	7508	8303	8707	8785	8043	7906	7045	6840	6361	6387
1.02	Locality Emergency Care Breaches		▲	1098	1217	1466	1732	2057	2220	2517	2682	2399	2290	2249	1845	1919
1.03	Locality Emergency Care Standard Performance	95%	▼	75.2%	79.1%	78.2%	76.9%	75.2%	74.5%	71.4%	66.7%	69.7%	67.5%	67.1%	71.0%	70.0%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▲	51%	55%	52%	50%	49%	45%	44%	41%	45%	44%	43%	45%	47%
1.05	ED Total number of patients waiting over 8 hours in the departments		▲	276	230	290	422	516	635	791	948	896	840	837	705	764
1.06	ED 12 hour trolley waits	0	▲	43	0	4	1	13	42	40	75	68	124	237	282	364
1.07	ED: % of attendees assessed within 15 minutes of arrival		▼	44%	47%	46%	44%	40%	33%	26%	27%	28%	27%	29%	48%	41%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▼	63%	60%	57%	50%	36%	35%	27%	22%	28%	24%	31%	37%	28%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▲	1.8%	2.6%	2.2%	2.0%	4.0%	3.9%	5.2%	5.3%	4.0%	4.4%	3.4%	2.5%	4.2%
1.10	ED - Median time between arrival and treatment (minutes)			237	231	235	238	268	263	318	343	334	341	330	295	315
1.11	Ambulance handovers waiting 15-29 minutes		▼	314	353	374	419	463	517	472	412	453	415	363	395	326
1.13	Ambulance handovers waiting 30-59 minutes		▼	54	98	122	165	160	216	228	246	265	261	272	225	203
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.15	Ambulance handovers waiting >60 minutes		▲	7	34	44	65	31	67	143	241	255	283	293	183	257
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.17	Ambulance handovers: Percentage waiting within 15 mins (shadow monitoring)		▼	69.3%	68.1%	62.3%	63.7%	61.8%	54.6%	48.0%	40.4%	36.7%	34.8%	32.5%	42.6%	40.0%
1.18	ED - Mean time in department (mins) for non-admissions (shadow monitoring)		▲	236	227	238	248	271	272	334	342	329	325	327	304	351
1.19	ED - Mean time in department (mins) for admissions (shadow monitoring)		▲	398	307	331	347	377	415	465	528	529	575	617	626	692
1.21	ED - Mean time between RFT and admission (mins) for admissions (shadow monitoring)		▲	205	105	128	135	158	181	184	221	228	281	338	377	435
1.22	ED - Number of non-admissions waiting 12+ hours (shadow monitoring)		▲	25	14	16	26	43	70	111	143	121	105	136	100	152
1.23	ED - Number of admissions waiting 12+ hours (shadow monitoring)		▲	186	90	128	151	239	301	346	418	470	498	527	568	579
1.24	ED - Critical time standards (shadow monitoring - awaiting guidance on metrics)			-	-	-	-	-	-	-	-	-	-	-	-	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity)		▼	1226	1575	1593	1649	1641	1634	1484	1397	1490	1462	1392	1414	1413
2.02	Non Elective Admissions - Paediatrics		▲	135	178	204	291	316	315	317	271	251	260	242	197	238
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▲	454	567	683	763	794	786	664	591	594	585	552	633	692
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	327	358	390	358	339	387	367	382	405	406	376	373	355
2.07	Ward Transfers - Non clinical transfers after 10pm	33	▲	17	16	19	31	14	19	22	25	25	21	33	38	43
2.08	Emergency readmissions within 30 days		▲	211	283	283	303	274	302	239	234	236	241	-	-	-
2.09	Stranded Patients at End of Month (Scarborough & Bridlington)		▼	124	102	102	121	102	108	118	121	130	149	149	164	158
2.10	Average Bed Days Occupied by Stranded Patients (Scarborough & Bridlington)		▼	117	96	102	100	102	100	113	132	129	135	145	158	153
2.12	Super Stranded Patients at End of Month (Scarborough & Bridlington)		▼	41	26	29	36	25	30	38	42	42	53	55	63	61
2.13	Average Bed Days Occupied by Super Stranded Patients (Scarborough & Bridlington)		▼	34	29	27	26	32	24	36	39	41	44	57	63	62

REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
3.01	Outpatients: All Referral Types		▼	5939	7955	7600	7147	8312	8228	6820	7550	7061	7415	6294	6372	6206
3.02	Outpatients: GP Referrals		▲	2423	3423	3062	2881	3301	3450	2909	3258	3264	3643	3077	3235	3312
3.03	Outpatients: Consultant to Consultant Referrals		▼	465	569	619	546	592	653	506	545	531	588	607	521	507
3.04	Outpatients: Other Referrals		▼	3051	3963	3919	3720	4419	4125	3405	3747	3266	3184	2610	2616	2387
3.05	Outpatients: 1st Attendances		▲	3677	4336	3905	3848	4580	4457	3898	4055	4269	4772	3794	3982	4135
3.06	Outpatients: Follow Up Attendances		▼	8169	9431	8247	8208	9268	8704	8162	9588	8608	9999	8207	8819	8302
3.07	Outpatients: 1st to FU Ratio		▼	2.22	2.18	2.11	2.13	2.02	1.95	2.09	2.36	2.02	2.10	2.16	2.21	2.01
3.08	Outpatients: DNA rates		▼	7.1%	6.5%	6.0%	5.6%	6.1%	6.6%	6.7%	6.7%	6.9%	7.8%	7.2%	7.7%	6.5%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	60	▼	86	97	109	74	59	88	130	97	111	123	104	112	93
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▼	309	309	363	351	375	528	337	461	1025	944	888	665	660
4.01	Elective Admissions		▲	209	180	141	163	195	209	111	191	162	182	174	86	155
4.02	Day Case Admissions		▼	1610	1945	1828	1734	2056	2026	1812	1996	1849	1968	1906	1911	1816
4.03	Cancelled Operations within 48 hours - Bed shortages		▼	0	0	0	0	0	2	2	0	0	5	10	8	1
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▼	31	9	46	9	10	20	16	15	15	14	43	63	27
4.05	Theatres: Utilisation of planned sessions		▲	64%	62%	70%	70%	73%	70%	68%	70%	74%	73%	62%	66%	74%
4.06	Theatres: number of sessions held		▲	198	206	176	187	222	179	148	190	244	192	168	175	181

Outpatient appointments data from June 2021 now excludes CAS (Clinical Assessment Service) clinics, in line with SUS reporting. Outpatient appointments data for 1st Attendances and Follow Up attendances has been updated from April 2021 to match NHSI/E counting methodology.

All Referrals figures in the table above (3.01-3.04 for 13 months) have been refreshed in Aug-21 report due to a data filtering error

Hospital Cancelled Outpatient Appointments for non-clinical reasons have been refreshed from Oct-21 as dataset is now built in OBIEE

TRUST BOARD REPORT : February-2022

OPERATIONAL PERFORMANCE SUMMARY - SCARBOROUGH

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
5.01	RTT Percentage of incomplete pathways within 18wks		▼	66.1%	69.5%	70.7%	72.8%	74.6%	74.1%	72.4%	71.2%	71.1%	71.0%	70.6%	69.6%	67.7%
5.02	RTT Waits over 52 weeks for incomplete pathways		▼	713	665	514	407	348	312	317	332	356	343	330	323	317
5.10	RTT Waits over 78 weeks for incomplete pathways		▼	106	124	128	136	149	139	152	145	126	96	78	69	61
5.11	RTT Waits over 104 weeks for incomplete pathways (excludes patients with Prority 5 / Priority 6 code as per national guidance)*		▼	0	0	0	3	3	12	20	23	33	25	25	26	23
5.05	RTT Total Waiting List		▲	8640	9205	9766	9917	10044	10495	10890	11124	11208	11492	11746	11896	11978
5.06	Number of RTT patients on Admitted Backlog (18+ weeks)		▲	1229	1245	1242	1185	1106	1150	1221	1287	1338	1391	1463	1485	1512
5.07	Number of RTT patients on Non Admitted Backlog (18+ weeks)		▲	1698	1564	1624	1508	1450	1573	1790	1920	1903	1937	1996	2130	2354
5.08	RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)		▲	16.6	15.3	14.6	14.4	14.1	13.4	14.1	14.2	14.4	14.0	14.4	14.6	14.7
5.12	Number of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways at end of month*		▼	-	-	-	133	109	99	94	90	96	110	105	96	95
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%	81%	69%	71%	73%	78%	70%	73%	77%

*Priority 2: includes all P2 pathways where there is a surgical decision to treat, not just open RTT pathways; Priority 5: Patient Wishes To Defer Surgery Due To Covid-19 Concerns; Priority 6: Patient Wishes To Defer Surgery Due To Non Covid-19 Concerns

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
6.01	Cancer 2 week (all cancers)	93%	▼	93.8%	90.4%	91.3%	90.8%	90.6%	94.2%	90.4%	91.4%	90.0%	93.6%	92.6%	81.3%	-
6.02	Cancer 2 week (breast symptoms)	93%	◀▶	-	-	-	-	-	-	-	-	-	-	-	-	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	▼	98.0%	95.6%	98.4%	96.5%	93.4%	100.0%	94.9%	96.2%	96.9%	95.2%	96.8%	87.1%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	▼	66.7%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	88.9%	100.0%	90.9%	85.7%	58.3%	-
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%	▼	69.6%	77.8%	71.7%	75.9%	57.0%	61.4%	62.3%	47.5%	58.3%	69.6%	70.7%	50.9%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	◀▶	-	0.0%	-	-	-	-	0.0%	48.8%	0.0%	-	-	-	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▼	50.3%	64.6%	51.2%	57.0%	49.4%	52.6%	48.0%	54.0%	60.6%	59.8%	64.5%	52.9%	-

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

TRUST BOARD REPORT : February-2022

OPERATIONAL PERFORMANCE SUMMARY - YORK

REF	OPERATIONAL PERFORMANCE: UNPLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
1.01	Locality Emergency Care Attendances		▲	6406	8628	9441	10412	10915	11169	10857	10770	11345	10551	9580	9374	9699
1.02	Locality Emergency Care Breaches		▲	1143	1584	1645	1742	1585	2458	3040	3108	3542	2948	2548	2581	2596
1.03	Locality Emergency Care Standard Performance	95%	▲	82.2%	81.6%	82.6%	83.3%	85.5%	78.0%	72.0%	71.1%	68.8%	72.1%	73.4%	72.5%	73.2%
1.04	ED Conversion Rate: Proportion of ED attendances subsequently admitted		▼	39%	37%	33%	32%	31%	39%	39%	39%	36%	39%	42%	41%	39%
1.05	ED Total number of patients waiting over 8 hours in the departments		▼	169	172	139	172	142	437	726	777	962	756	824	807	757
1.06	ED 12 hour trolley waits	0	▲	0	0	0	0	0	1	3	23	13	35	61	181	219
1.07	ED: % of attendees assessed within 15 minutes of arrival		▼	79%	74%	72%	72%	71%	59%	54%	47%	41%	46%	50%	52%	50%
1.08	ED: % of attendees seen by doctor within 60 minutes of arrival		▼	62%	52%	45%	45%	41%	33%	29%	26%	25%	27%	33%	33%	31%
1.09	ED – Percentage of patients who Left Without Being Seen (LWBS)	5%	▲	1.3%	1.4%	1.5%	1.4%	1.5%	3.0%	3.8%	3.9%	4.2%	4.0%	2.4%	2.4%	2.6%
1.10	ED - Median time between arrival and treatment (minutes)			170	175	174	169	171	192	210	213	219	215	203	204	207
1.11	Ambulance handovers waiting 15-29 minutes		▼	284	328	279	338	306	329	364	360	361	330	341	364	328
1.13	Ambulance handovers waiting 30-59 minutes		▼	47	57	58	53	83	140	193	199	218	205	207	265	207
1.14	Ambulance handovers waiting 30-59 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.15	Ambulance handovers waiting >60 minutes		▼	12	14	27	9	31	84	159	204	368	258	382	342	292
1.16	Ambulance handovers waiting >60 minutes - improvement trajectory			-	-	-	-	-	-	-	-	-	-	-	-	-
1.17	Ambulance handovers: Percentage waiting within 15 mins (shadow monitoring)		▲	78.4%	80.1%	82.8%	82.1%	80.4%	73.9%	64.9%	62.8%	48.8%	50.8%	43.3%	38.2%	42.4%
1.18	ED - Mean time in department (mins) for non-admissions (shadow monitoring)		▼	162	168	173	171	168	197	220	220	235	225	212	224	220
1.19	ED - Mean time in department (mins) for admissions (shadow monitoring)		▼	259	252	236	239	236	299	355	388	433	404	458	502	472
1.21	ED - Mean time between RFT and admission (mins) for admissions (shadow monitoring)		▼	108	98	80	83	80	113	151	173	214	196	247	292	276
1.22	ED - Number of non-admissions waiting 12+ hours (shadow monitoring)		▼	14	4	7	12	3	22	30	54	81	58	66	92	74
1.23	ED - Number of admissions waiting 12+ hours (shadow monitoring)		▼	46	42	20	20	26	94	275	339	480	394	561	585	505
1.24	ED - Critical time standards (shadow monitoring - awaiting guidance on metrics)			-	-	-	-	-	-	-	-	-	-	-	-	-
2.01	Non Elective Admissions (excl Paediatrics & Maternity)		▼	2655	3309	3201	3292	3319	3254	3175	3153	3080	3001	3049	2807	2700
2.02	Non Elective Admissions - Paediatrics		▲	246	300	308	340	408	470	486	488	586	629	477	389	470
2.05	Patients with LOS 0 Days (Elective & Non-Elective)		▲	1095	1350	1307	1340	1400	1360	1371	1385	1398	1384	1238	1137	1265
2.06	Total number of patients during the month with a LoS >= 7 Midnights (Elective & Non-Elective)		▼	556	656	591	601	609	695	678	697	688	668	765	735	641
2.07	Ward Transfers - Non clinical transfers after 10pm	67	▼	36	40	25	34	39	35	56	70	85	75	80	88	73
2.08	Emergency readmissions within 30 days		▲	468	598	614	608	629	575	533	511	515	477	-	-	-
2.09	Stranded Patients at End of Month		▼	167	173	158	149	150	163	204	192	242	227	243	302	291
2.10	Average Bed Days Occupied by Stranded Patients		▲	170	157	135	151	145	160	179	203	230	225	230	274	287
2.12	Super Stranded Patients at End of Month		▲	45	42	41	38	35	32	46	57	84	65	84	104	128
2.13	Average Bed Days Occupied by Super Stranded Patients		▲	51	39	27	29	32	34	35	52	68	80	69	99	117

REF	OPERATIONAL PERFORMANCE: PLANNED CARE	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
3.01	Outpatients: All Referral Types		▼	11120	14642	14085	13175	14466	14153	12626	13716	14218	15019	12127	11967	11346
3.02	Outpatients: GP Referrals		▲	4751	6774	6189	5484	6134	6037	5423	6127	6308	6722	5528	5401	5499
3.03	Outpatients: Consultant to Consultant Referrals		▲	1120	1282	1265	1214	1382	1432	1152	1326	1272	1438	1240	1088	1104
3.04	Outpatients: Other Referrals		▼	5249	6586	6631	6477	6950	6684	6051	6263	6638	6859	5359	5478	4743
3.05	Outpatients: 1st Attendances		▲	7492	10058	8503	8934	9683	8563	7921	8940	8358	9253	7798	8337	8607
3.06	Outpatients: Follow Up Attendances		▼	21945	27154	24410	24308	26415	24840	23283	25738	24529	26805	22497	23750	22683
3.07	Outpatients: 1st to FU Ratio		▼	2.93	2.70	2.87	2.72	2.73	2.90	2.94	2.88	2.93	2.90	2.88	2.85	2.64
3.08	Outpatients: DNA rates		▼	6.1%	5.5%	5.5%	4.9%	5.3%	5.6%	6.1%	6.0%	5.7%	6.6%	6.7%	6.4%	5.9%
3.09	Outpatients: Cancelled Clinics with less than 14 days notice	120	▼	162	118	133	91	93	163	139	150	176	175	146	255	165
3.10	Outpatients: Hospital Cancelled Outpatient Appointments for non-clinical reasons		▼	693	824	807	623	630	855	620	804	1844	1821	1638	1742	1633
4.01	Elective Admissions		▼	296	357	327	323	364	346	358	370	305	432	359	371	334
4.02	Day Case Admissions		▲	2868	3606	3973	3969	4654	4390	3885	4167	3829	4367	4258	4175	4257
4.03	Cancelled Operations within 48 hours - Bed shortages		▼	10	4	1	0	2	4	13	28	1	3	7	89	53
4.04	Cancelled Operations within 48 hours - Non clinical reasons		▼	56	64	68	29	65	82	68	94	42	56	86	295	225
4.05	Theatres: Utilisation of planned sessions		▲	61%	73%	77%	78%	77%	75%	75%	73%	76%	80%	76%	71%	73%
4.06	Theatres: number of sessions held		▼	441	430	453	454	533	484	424	463	434	469	407	434	387

Outpatient appointments data from June 2021 now excludes CAS (Clinical Assessment Service) clinics, in line with SUS reporting. Outpatient appointments data for 1st Attendances and Follow Up attendances has been updated from April 2021 to match NHSI/E counting methodology.
All Referrals figures in the table above (3.01-3.04 for 13 months) have been refreshed in Aug-21 report due to a data filtering error
Hospital Cancelled Outpatient Appointments for non-clinical reasons have been refreshed from Oct-21 as dataset is now built in OBIEE

TRUST BOARD REPORT : February-2022

OPERATIONAL PERFORMANCE SUMMARY - YORK

REF	18 WEEKS REFERRAL TO TREATMENT	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
5.01	RTT Percentage of incomplete pathways within 18wks		▼	61.2%	62.5%	63.5%	66.1%	68.6%	67.3%	66.1%	63.8%	62.5%	61.9%	60.3%	59.0%	57.9%
5.02	RTT Waits over 52 weeks for incomplete pathways		▲	1868	1781	1509	1306	1140	1049	1031	1217	1332	1241	1256	1292	1404
5.10	RTT Waits over 78 weeks for incomplete pathways		▼	304	399	449	496	489	505	540	547	451	330	289	256	251
5.11	RTT Waits over 104 weeks for incomplete pathways (excludes patients with Prority 5 / Priority 6 code as per national guidance)*		▼	0	1	8	29	37	44	73	107	104	95	92	95	80
5.05	RTT Total Waiting List		▲	18553	19486	20303	20404	20663	21464	22297	23137	23823	24377	25151	25112	25500
5.06	Number of RTT patients on Admitted Backlog (18+ weeks)		▲	3099	3110	3064	2888	2756	2672	2676	2829	2905	2867	2947	3066	3143
5.07	Number of RTT patients on Non Admitted Backlog (18+ weeks)		▲	4094	4202	4344	4023	3742	4343	4892	5541	6018	6416	7044	7230	7601
5.08	RTT Mean Week Waiting Time - Incomplete Pathways (Shadow monitoring from Oct-2019)		▲	18.8	17.8	17.3	17.2	16.8	16.5	17.0	17.4	17.5	17.3	18.3	19.0	19.2
5.12	Number of all "Priority 2 - Surgery that can be deferred for up to 4 weeks" pathways at end of month*		▼	-	-	-	505	465	409	475	554	452	482	495	481	471
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%	75%	70%	75%	69%	75%	65%	68%	68%

*Priority 2: includes all P2 pathways where there is a surgical decision to treat, not just open RTT pathways; Priority 5: Patient Wishes To Defer Surgery Due To Covid-19 Concerns; Priority 6: Patient Wishes To Defer Surgery Due To Non Covid-19 Concerns

REF	CANCER (ONE MONTH BEHIND DUE TO NATIONAL REPORTING TIMETABLE)	TARGET	SPARKLINE / PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
6.01	Cancer 2 week (all cancers)	93%	▼	92.1%	91.4%	87.3%	94.9%	95.3%	95.8%	92.7%	93.9%	88.1%	83.5%	76.5%	64.8%	-
6.02	Cancer 2 week (breast symptoms)	93%	▼	92.6%	92.6%	92.8%	91.5%	93.6%	93.5%	96.0%	92.9%	81.2%	57.8%	33.1%	16.0%	-
6.03	Cancer 31 day wait from diagnosis to first treatment	96%	▼	99.4%	97.5%	95.5%	99.0%	98.6%	98.3%	98.3%	97.7%	99.1%	95.4%	98.9%	93.8%	-
6.04	Cancer 31 day wait for second or subsequent treatment - surgery	94%	▼	96.4%	91.7%	95.8%	94.7%	91.3%	87.1%	87.0%	86.4%	96.2%	82.1%	96.4%	83.3%	-
6.05	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	▼	100.0%	100.0%	98.7%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	97.1%	-
6.06	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	▼	72.6%	72.8%	70.4%	80.5%	71.0%	68.7%	62.4%	74.9%	73.9%	70.4%	72.1%	68.9%	-
6.07	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)*	90%	▼	97.6%	97.1%	96.5%	83.7%	93.2%	84.0%	93.5%	74.9%	83.3%	71.4%	93.9%	79.4%	-
6.08	Cancer 28 Day Wait - Faster Diagnosis Standard	75%	▼	62.8%	71.1%	65.0%	65.2%	69.7%	68.0%	70.6%	66.6%	77.4%	72.5%	78.2%	66.0%	-

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

DIGITAL AND INFORMATION SERVICE

February-2022

Produced March-2022

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: February-2022

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:

PRIORITY ONE SYSTEM OUTAGES

Unusually there were two priority one outages this month. (There are usually about four of these in a whole year and once all of our Essential Services Programme work is done by 2024/25 this should be down to one a year).

The first was an issue with the CPD infrastructure which affected the Data Warehouse that contains the millions of historic and up to date data items the Trust use for reporting and business intelligence. This resulted in all reporting being off for a number of days. The Intelligence and Insight team worked tirelessly to recover the situation which necessitated re-building the entirety of the Data Warehouse from scratch.

The second was an outage on CPD itself – our Electronic Patient Record system – which meant users could not log on for 4-5 hours. Business continuity arrangements were brought to bear and the Trust responded admirably to be able to run without the system. It turned out that the system was able to be fully recovered and stable and most of the continuity arrangements did not have to come into play.

These unfortunate incidents highlighted again some of our key weaknesses. Notably single points of knowledge around particular technologies – we only have one Data Warehouse Architect who understands how that works and we only have one Linux Server and Operating expert who understands how the CPD infrastructure works. These are known issues and subject to budget and resource bids in the coming year.

Also it highlighted the need for us to ensure the Essential Services Programme continues to be supported as that will deliver key infrastructure components that would avoid these failures in the first instance.

Despite these major issues it is great to see that the number of service desk calls being answered and dealt with at first point of contact continue to be going in the right direction which demonstrates that the new best practice arrangements in terms of service management are working.

PRIORITISATION OF KEY PIECES OF WORK

The technical IT skills recruitment and retention issue specifically around the developers of CPD and more recently an inability of third parties, regardless of cost, to augment the team to do the work required has meant the Trust need to prioritise which IT enabled projects are done and not done for 2022/23.

The Executive Committee of the Trust is determining this based on consideration of risks and relative priority and a paper will come to Board to explain the outcome soon as well as the risks and mitigations of that which is not being done.

CDIO DEPARTURE PLAN

The implementation of the new DIS structure and operating model, the establishment and clear costed plans laid out for the Essential Services Programme for 2022/23, 2023/24 and the effective handover of the Electronic Patient Record Strategic Outline Case and plan will have been completed as part of Dylan's exit.

A new CTO has been appointed, new CNIO and Head of Delivery interviews are on 18th and 24th March and should result in appointments.

The interim CDIO, Andy Williams, has started and will be in attendance at key meetings, including Board of Directors. He has clear objectives in terms of some of the deliverable above including the effective handover to a newly appointed CDIO, the recruitment for which has started.

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
Nicky Slater, Head of Intelligence and Insight

Director Sponsor: Dylan Roberts, Chief Digital Information Officer

Date: March-2022

TRUST BOARD REPORT: February-2022

DIGITAL AND INFORMATION SERVICE

REF	INFRASTRUCTURE & SERVICE MANAGEMENT TRANSFORMATION	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
9.03	Number of end user devices over 4 years old *		▼	-	4533	4483	4300	4220	4150	4130	4100	4050	3990	3960	5381	5370
9.04	Total number of calls to Service Desk		▼	5190	5006	4178	3780	4227	4355	3951	4088	4324	3719	3533	3896	3276
9.05	Total number of calls abandoned		▼	2584	1665	1224	722	982	994	802	1068	1052	1033	1070	979	539
9.06	Percentage of Service Desk Calls Resolved at First Point of Contact		▲	8.5%	12.0%	11.3%	12.3%	12.2%	12.0%	11.7%	11.0%	12.3%	12.3%	15.0%	13.9%	14.8%
9.07	Number of Open calls (last day of month)		▼	3146	1965	2212	1811	1608	1705	1768	1834	1769	1895	1733	1895	1882
9.08	Number of PCs that have been through W10 H2 update		▲	-	-	-	-	-	-	-	3200	4000	4500	5700	6500	7700
9.09	Number of users that have had NHS mail account set up for N365			-	-	-	-	-	-	-	-	-	3410	3410	3450	3450

* The number of end user assets (laptops,desktops) over 4 years old rose in Jan-22 by circa 1500. This is due to a batch of devices triggering their anniversary and moving from 3 year plus to 4

REF	INFORMATION GOVERNANCE	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
9.10	Number of incidents reported and investigated		▼	27	44	26	37	38	33	28	27	34	30	24	38	33
9.11	Number of Patient SARs		▲	157	170	247	252	224	214	210	192	217	298	236	310	329
9.12	Number of Patient SARS processed within one calendar month*		▲	157	170	288	252	197	213	145	180	217	194	235	309	329
9.13	Number of FOIs received (quarterly)			-	192	-	-	151	-	-	123	-	-	86	-	-
9.14	Percentage of FOIs responded to within 20 working days (quarterly)			-	51%	-	-	77%	-	-	76%	-	-	87%	-	-
9.15	Number of IG complaints made about Trust data handling to ICO			0	0	0	0	1	0	0	0	0	0	0	0	0

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

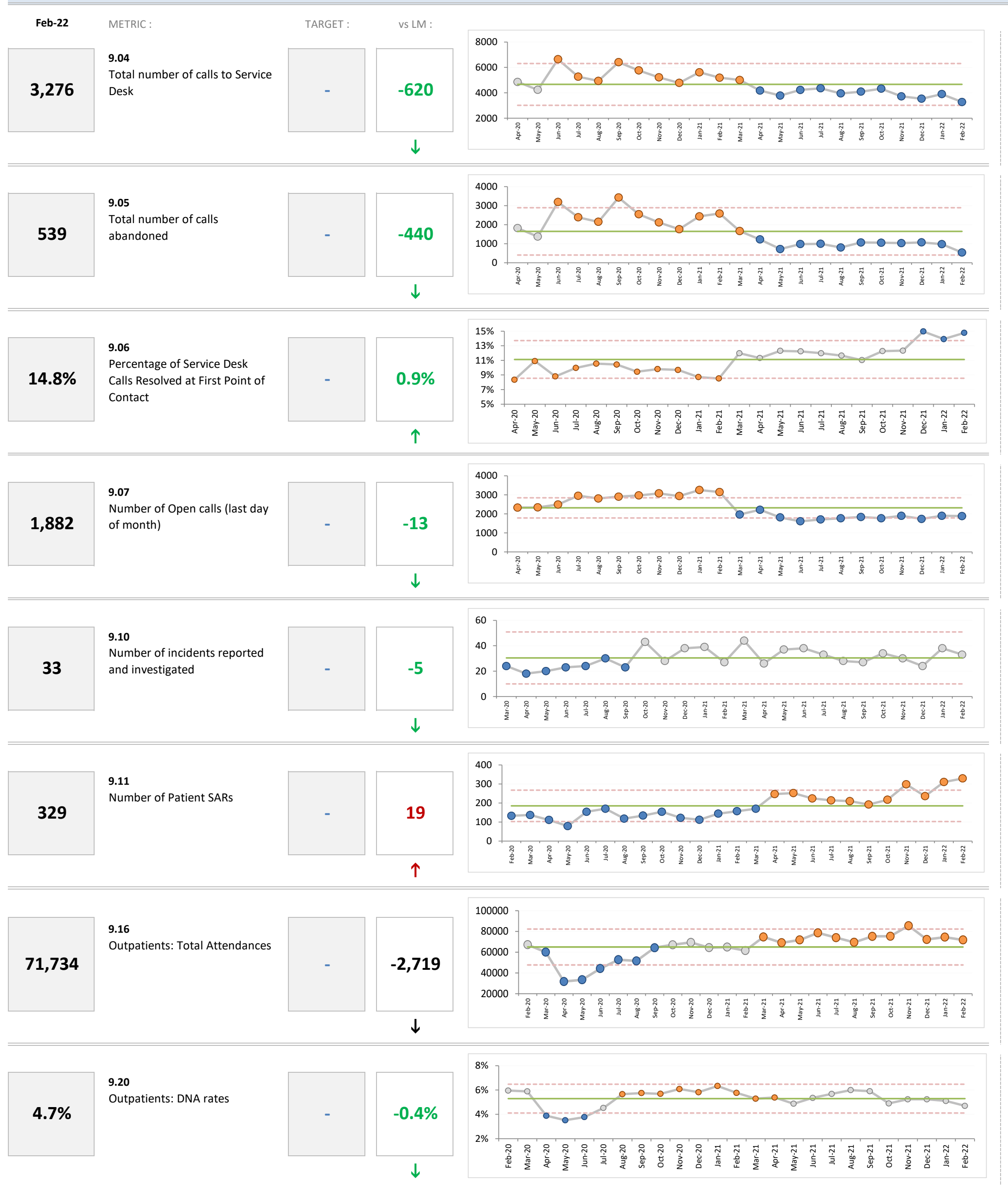
REF	OUTPATIENT TRANSFORMATION	TARGET	SPARKLINE / Vs. PREVIOUS MONTH	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
9.16	Outpatients: Total Attendances		▼	61506	74655	69093	71742	78557	74008	69448	75227	75355	85451	72234	74453	71734
9.20	Outpatients: DNA rates		▼	5.8%	5.3%	5.4%	4.9%	5.4%	5.7%	6.0%	5.9%	4.9%	5.2%	5.2%	5.1%	4.7%

KEY:

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

TRUST BOARD REPORT: February-2022

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



HIGHLIGHTS FOR BOARD TO NOTE:

CTO Update on KPI's - March 2022

End User Compute:

- As informed in February's report the assets over 4 years old increased due to an anniversary. The end user team will refresh where possible for the rest of this financial year. In 2022/2023 financial year we ahve a number of streams that will look to reduce the number of aged assets and associated risks including the introduction of Virtual Desktop, the introduction of devices to enable digital working in wards and wider Trust and the need to refresh a significant part of the estate (DIS have submitted a £1 million bid as part of wider capital submission for 2022/23).

End User Regulatory Compliance:

The end user team have been successful in the following:
- migration of the Trust estate from windows 7 (non compliant) to windows 10 - as stated last month
- migration of 93% of the end user estate to the upgraded windows 10 solution (H2) - delivering compliance, new functionality and enhahnced security. The team are looking to complete in April 22.

IT Service Management:

- The number of calls in to the service desk reduced in month and was lower than the last 4 month average (3600). We will review the detailed information to understand if the drop was in specific areas, or broadly across all services.
- The abandoned call number (539) was significantly lower than previous month and previous 3 month average (1000). We will review the work we have acrried out to improve the call answering service to underrstand impact. We will review next months data and ensure we are on the right path for reduction/improvement in service.
- The first time fix rate (incidents and requests completed at the desk with end user) was inkeeping with the last 3 month average.
- The outstanding icnident and request number reamins high, however this will be a target area for the new Service Operations lead within DIS Service Management

Improvements:
- In March DIS took on a FTE Service Operations lead who will own the drive around service and operations improvement
- In March IT Service are initiating process improvement around incident and request management

Outpatient Transformation

The number of outpatients seen via either telephone or video in February equated to 22.9% of attendances (excluding radiology).

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Action Notes

Executive Committee
02 March 2022

/ Attendance: Simon Morritt (SM) (Chair), Andrew Bertram (AB), Wendy Scott (WS), Heather McNair (HM), Polly McMeekin (PM), James Taylor (JT), Dylan Roberts (DR), Amanda Vipond (AV), Jo Mannion (JM), Mark Quinn (MQ), Srinivas Chintapatla (SC), Mike Harkness (MH), Gerry Robins (GR), Donald Richardson (DRi), Ed Smith (ES), Stuart Parkes (SP), Michael Taylor (MT), Lisa Gray (LG) (action note taker), Kim Hinton (KH) (Diagnostics item only), Jenny Hey (JH) (Bed Occupancy item only), Lynette Smith (LS) (Operational activity item only)

/ Apologies for Absence: Lucy Brown (LB)

Agenda Item:	Declaration of Interests
/ Notes	No declarations of interest were declared.
/ Actions agreed	• Nil.

Agenda Item:	Minutes of the meeting held on 16 February 2022
/ Notes	The minutes were approved as an accurate record.
/ Actions agreed	• Nil.

Agenda Item:	Matters Arising from the minutes and any outstanding actions
/ Notes	Updates for outstanding actions to be sent outside of the meeting due to time constraints at today's meeting.
/ Actions agreed	• LG to update action log.

Agenda Item:	Staff well-being space and calm room at York Hospital
/ Notes	PM highlighted this proposal follows on from previous discussions the committee have had around securing a staff breakout area on the York Hospital site, which is a mandate of the NHS People Plan. The proposal to the committee is to approve the use of the soon to be vacated patient access area, with a view to bidding for £198k of charitable funding to refurbish the space, which PM highlighted needed to be submitted by 17 March 2022. Other areas such as meeting rooms and reducing the space in the

chapel to accommodate this space have all previously been discounted.

The committee had a lengthy debate and supported the need to have a staff breakout area, potentially also with shower and changing facilities however the committee was not supportive of the staff breakout area going into the soon to be vacated patient access area given this is in a prime location for alternative patients services.

The committee suggested PM submit a paper to the next meeting with several different options for where the staff breakout area could be located on site, which included previously discounted areas such as part of the chapel, meeting rooms, covering courtyard areas and adding heaters. The committee agreed to make a decision following this to allow the bid to be submitted as it would be a shame to lose the charitable money.

AB agreed to support PM and LB to complete the business case pro-forma required for the bid given PM highlighted it required a high level of detail.

/ Actions agreed

- PM to submit an updated paper with several options to allow the committee to approve where the staff breakout area is best located.
- AB to support PM and LB to complete the business case pro-forma required for the charitable bid given it needs to be submitted on 17 March 2022.

Agenda Item:	**Diagnostics Performance**

/ Notes

AB welcomed KH to the meeting. SM joined the meeting part way through the item.

KH highlighted the presentation within the meeting pack is focussed on imaging and endoscopy however KH acknowledged there are other diagnostic services, some of which are not within CG4, who are likely to have similar significant challenges.

KH added it was important to understand that diagnostics is core to a significant amount of patient pathways with it affecting the performance and outcome for acute, cancer, urgent and routine elective care pathways. In addition to the ability to deliver against RTT standards, therefore it is a key service for both patients and clinicians.

KH presented the ask of diagnostics highlighting some are being achieved but highlighted a few which are challenging including:

- The increase in activity to a minimum of 120% pre-

pandemic levels across 2022/23 compared to 2019/20. Equating to an additional 5000 CT scans, 5000 MRI's and 9000 ultrasound scans. Throughout 2021/22 the Trust only delivered 65% of 2019/20's activity.
- The York site not having JAG accreditation however the CG is looking to be in a position to apply for this next year.
- The impact of time diagnostic pathways and the ability to deliver them, including the ability to return to a 6 week diagnostic standard, which was not being delivered pre-covid-19.

KH noted there was a lot happening regionally and nationally some of which presents opportunities and risks. The development of the Community Diagnostic Centres (CDC) is a great opportunity to increase diagnostic capacity across the region and Lucy Turner is leading on this work with ICS and PLACE colleagues to deliver a plan. The CDC's do however create a risk in relation to workforce as there is a potential staff will apply for jobs within the CDC's, as some have done for the mobile CT scanner the ICS procured as they are not required to work weekends or 24 hours a day.

The Scarborough Hull York Pathology Network has realised some good opportunities and there may be an opportunity to create an imaging network and endoscopy network in the coming years.

KH confirmed the 3 things which are impacting diagnostics locally is the workforce, increasing demand and capital/equipment.

Workforce: The RCR consensus forecasts a 44% shortfall of consultant radiologists. It is estimated there is a need to increase national radiographers by 17% to meet demand and there remains nursing workforce challenges.

Demand: There has been acute demand growth, an increase for cancer diagnosis, staging and surveillance, an increase in patient expectations which convert to complaints if expectations are not met, and an increase in screening programmes and age extensions.

Capital/Equipment: Imaging and endoscopy are capital heavy and IRF16 may present challenges going forwards. The age of the existing equipment will be difficult to manage as national guidance is not to have equipment over 10 years old. If this is followed there would be £4-5m worth of equipment that will hit 10+ years within the next year. There are also infrastructure issues related to the age and maintenance of the Trust sites.

KH noted the impact of covid-19 over the last 2 years has seen the majority of the waiting lists double across the board.

CT has seen a real growth in acute activity, as 64% of work that goes through the statics is acute which is impacting on the times to undertake elective work. There is currently insufficient capacity across the Trust to meet the demand. In addition to this there are other services who want to put CT into their pathways which has an impact and remains challenging.

MRI acute activity has grown and is seeing more complex elective cases which take longer, again KH highlighted there was insufficient capacity to meet demand however this was due to workforce capacity rather than machine capacity as the team struggle to recruit and retain staff.

Endoscopy has sufficient financial resources to increase to 7 days but the biggest issue in not being able to do this is recruitment and retention of staff. Nursing staff in this area are regularly redeployed into the acute setting which is leading to them leaving as they do not spend enough time within endoscopy. Due to the nursing workforce challenge endoscopy is unable to open rooms 6&7.

KH noted in terms of workforce revenue/planning there is an ongoing requirement to use the independent sector which the Trust has put in £5.1m of activity related cost pressures. There is a need to look at doing something different in relation to recruitment and retention of nursing and AHP workforce, with the CG looking at recruitment and retention premia for MRI. In addition to developing an international model for AHP's and expanding the use of apprenticeships and supporting the students.

KH confirmed the medical workforce has been the biggest success having managed to recruit 10 consultants over the last 2 years and queried whether the team should capitalise on others wanting to work within the department and over recruit outside of the establishment, and consider what is outsourced and look to convert it into substantive consultant posts.

There is a need to have substantive development and investment in RDC, further development of the navigator and non-clinical support roles as well as support and pilot new services.

In terms of the capital ask KH noted there was a need to focus on replacing CT3 on the York site before looking at a 4th CT and to get a 2nd CT on the Scarborough site as well as the need to procure new equipment and technology. Plus any additional support needed for the CDC's. A business case in relation to EUS and the 2nd CT in Scarborough are due to be discussed later in the meeting.

WS thanked KH for the presentation and highlighted she had asked KH to present this as it is one of the biggest areas of

concern in the organisation. It will require focussed effort around workforce, investment in capital and it is critical to the delivery of everything else across the Trust therefore the committee needs to be fully sighted, support and monitor it.

The committee acknowledged the significant challenges within diagnostics and the impact challenged diagnostics has on the rest of the organisation and the need to put a key focus on ensuring the infrastructure is fit for purpose as well as developing the workforce to deliver the increase in demand. Adding diagnostics is pivotal as there needs to be accessible diagnostics for all aspects of acute care, as it is the key to unblocking the system.

The challenges were discussed in detail and it was agreed there was a need to work offline to look at a risk based approach for the imaging backlogs and to get a working group together with a number of energised consultants to look at what more could be done in relation to medical recruitment and retention, to look at whether this is scalable across the Trust, how to implement it and to look at how corporate teams support this. SM added it would influence what the Trust does, and it could help across other workforce groups too.

/ Actions agreed

- The committee acknowledged the significant challenges and gave its support to the key work needing to be undertaken.

Agenda Item:	**Chief Executive's Update**

/ Notes

SM noted there was nothing additional to highlight.

/ Actions agreed

- Nil.

Agenda Item:	**Bed occupancy & ward configuration**

/ Notes

SM welcomed JH to the meeting.

JH highlighted the model captures who the consultant is on a specific bed through CPD every 15 minutes and then captures the maximum occupancy by that sub-specialty through consultants all the way up through to specialty that has been maintained for a minimum of 4 hours within a 24 hour period. This has been done across elderly, medicine, surgery and orthopaedics and where productivity gains are currently, these have been applied.

The key principles for this are adequate admitting capacity, flow, discipline around day cases, supporting recovery, and creating decant space where possible.

JH confirmed the key findings for the York medical bed base show:

- Limited gains for model hospital peer review although need to consider the recording of assessment areas
- Covid-19 shows a significant shift of elderly medicine to covid-19 wards
- Medical bed base insufficient pre and post covid-19. The site has not been able to deliver ward 29 as elective ward
- Oncology a major outlier – 10 beds and needs to support acute pathway out of ED
- Despite stroke transfer the site is challenged
- Cardiology is a full ward plus CCU

JH confirmed the key findings for the York surgery bed base show:

- Surgery can manage if ESA is fully staffed as an inpatient ward 7 days
- 5 day case beds to be gained on BADS
- 6 Urology beds transferred from Scarborough
- This does not include capacity for orthopaedics – looking at potential of flexi beds in a set area
- Cancellations on the day usually inpatients
- Pressure on surgical beds will lead to theatre under booking and a culture of under booking to avoid cancellation
- Day case default Day case booking for all BADS procedures with CG sign off procedure for all conversions to overnight stay

JH highlighted this showed overall it is running on average 20 beds short on the York site.

JH confirmed the key findings for the Scarborough site show:

- It has seen significant benefits since the opening of Graham Ward
- It needs an enhanced model for frailty patients
- Trauma outliers must lead to new pathways and care off site
- Bridlington may be able to support minor injury or trauma post op recovery
- Beech ward is needed at 30 beds
- Haldane a key and necessary development for surgery
- Transfer of Urology elective to York has helped
- No current space to deliver decant ward

JH highlighted this shows overall it is running on average 15 beds short on the Scarborough site.

JH confirmed the key messages from this work are:

- The Trust cannot support ward 29 returning to elective orthopaedics
- The need to invest in SDEC and the success could mean the difference between a winter ward or not
- It can provide a decant ward on the York site if G1 is kept empty
- There's a need for another 7 day surgical ward
- The need to invest in oncology activity
- This does not account for delays in the bed base
- Scarborough is at the maximum even with Beech ward open
- The need for a frailty model which will support flow

JH confirmed the next steps for this works was to work up a combined business case which JH has discussed with Corporate Directors and will include:

- Oncology ward increasing to 24 beds – Must sit with ICB strategy
- ESA to be a 7 day surgical ward
- Need to support small orthopaedic bed base -flexi beds
- SDEC is 24/7
- Resource to backfill ward 31 for specialty medicine
- Dales Unit to be used as a frailty unit
- Consider Covid-19 in the longer term
- G1 remains empty for a decant ward – invest in side room capacity
- Need to consider decant facility at Scarborough until new build completed
- Does the Trust want to deliver domiciliary care
- Need to quantify how much of the above is within run rate and what is new spend.

SM queried whether the additional work has been done on the outstanding work in relation to quantifying the right to reside beds, as from a cost perspective there is a need to see where is the right place to invest in and this may not be within York and Scarborough Hospitals, instead it may be looking at getting into business not traditionally been involved in. JH confirmed this detail had been asked for and JH was awaiting the information.

The committee discussed JH's presentation and feedback their thoughts. It was agreed an updated paper following the next step actions being completed was submitted to the committee within the next two months.

SM suggested a similar presentation was used to talk through with the Trust's partners, NYCC, CYC and the ICS to use as a key argument that if there is no resource within the NHS to expand the bed base where does the pressure go. If partners made an investment then there may be an opportunity to function more effectively as an organisation.

/ Actions agreed	• JH to submit an update by the end of May 2022.
Agenda Item:	**Operational Activity Plan**
/ Notes	SM welcomed LL to the meeting. LS noted the committee has received a paper previously outlining the risks and discussed at the last meeting some of the actions that have come out of activity plan. The draft plan needs to be submitted to the ICS on 7 March. The ICS will collate this and submit the overall ICS plan on 17 March. The national 'Delivery plan for tackling the COVID-19 backlog of elective care' was published in February and set out slightly revised timescales for elective performance recovery compared to the January Planning Guidance. These updated timescales have been reflected in the proposed performance trajectories for 2022/23. Factored into this are the large funds of money for the Targeted Investment Fund, Digital Technology Fund and the CDC funding. Following the committees previous conversations confirm and challenge meetings took place with the CG's with workforce leads present. There has not been workforce assumptions set for the CG's to model on but this is something to add in future as some had based their workforce capacity around current staffing levels this year whereas others had based it on their establishment. One of the key risks is in relation to theatre nurse staffing and not being able to deliver the full SLA for theatres. LS noted the CG's were asked to consider what the non-elective position looks like in terms of demand. As this is ramped up across the CG's this results in a 10% increase in the Trust's non-elective position but this has not been seen as the Trust has been at 80-85% of the non-elective position since 2019/20. This therefore feels like a huge jump and will be challenging given the Trust's capacity and LS felt it would play out in delays rather than actual non-elective admissions. This will be reviewed for the final plan. The proposed draft activity plan for the Trust will deliver 94% of 2019-20 baseline activity levels, which is below the national expectations. For note - the baseline is not directly comparable to the 2022/23 activity plan, as the current activity plan does not include outpatient activity within the CPD 'contacts' module as they were removed in April 21 from the Trust submission for data quality purposes. If we compare the proposed planned activity to 19/20 activity baseline with those contacts removed, the plan will deliver 106% of 19/20 activity.

There is significant risk within the plan, notably around workforce capacity and the impact of non-elective pressures (including COVID-19) on elective capacity.

LS confirmed CQUINS have been agreed with commissioners and are included in the plan, and some of the performance trajectories have been set for the committee to consider.

LS talked the committee through the below the recommendations which the committee are being asked to approve:

- To consider and note the risks associated with the draft activity plan and performance trajectories (for submission to the Integrated Care System).
- To approve the submission of the draft activity and performance plan to the Integrated Care System on the 7th March, subject to any revisions agreed at Committee.
- To approve the proposed CQUIN indicators that will see financial penalties if not achieved.
- The Trust re-instates contacts in the activity submissions in 2022/23 following the CPD changes to improve data quality from 1st April 2022.
- A reduction to Follow Up activity is applied across the Trust in order to move capacity to increase First outpatient capacity, with a detailed review by specialty to be undertaken to inform the final plan.
- A review of radiological appointment reporting is undertaken before the final submission to understand the changes to 1st and Follow Up appointment reporting following the implementation of Radiology Information System.

LS highlighted what has been shared with the committee is the narrative the Trust is submitting into the system however this is not what the narrative plan will look like when it returns as there will be an editing of this across all providers.

The committee discussed the plan and approved the recommendations to allow for the draft plan and narrative to be submitted to the ICS, with LS agreeing to feedback any responses received.

LS agreed to share the CQUIN parameters with the committee for information.

/ Actions agreed

- The committee agreed for the draft plan and narrative to be submitted.
- LS to share the CQUIN parameters with the committee for information.

Agenda Item:	Sexual Health NYCC – S75 agreement update
/ Notes	JM highlighted the committee have been briefed on the fact the Trust is entering into a section 75 agreement to provide integrated sexual health services with North Yorkshire County Council. JM noted today's paper outlines the details of the final consultation with the majority of respondents being happy, although there were a few negative comments. Despite this the shadow board were happy to progress based on the consultation. Work is continuing to develop plans to support the new service delivery models to deliver the refreshed service. In the new models of care there is a focus on self-care, prevention and collaboration with primary care, e-consultations and accessibility of easy testing. The finances for the initial four years are thought to be reasonably robust provided the Trust can continue the collaborative and non-adversarial working between health and care as it works really well. The final S75 agreement will be submitted to the next meeting for the committee to review and approve.
/ Actions agreed	• The final Sexual Health NYCC - S75 agreement is to be submitted to the next meeting for the committee to review and approve.

Agenda Item:	Care Group Verbal Reports
/ Notes	**Care Group 1 including an update on the York ED Build** MH highlighted a paper had been shared with the committee in relation to the York ED build and confirmed the construction work is progressing. The work is a week behind due to an unexpected find but the CG has been given assurance this time can be caught up between now and the completion date of March 2023. Planning is ongoing in terms of improvements to signage, which has come back from feedback received. Covid-19 difficulties have remained in relation to moving areas/wards around but it is hoped this has now been achieved however there has been outbreaks on multiple wards and due to this it is making things difficult. MH noted the CG's biggest piece of work currently is the emergency assessment. The CG is looking to see how this can be actively set up to improve the experience. Adding there is a

bigger piece of work that needs to run alongside this which includes 7 day standards and services.

Care Group 2
GR highlighted pressures are ongoing in ED.

Bridlington community unit is proving a success. Three patients have returned from this but this has not been due to medical deterioration and the average length of stay on the unit is 7 days.

SM queried if Buckrose was still being looked at as a second area to open. WS confirmed this would need a considerable amount of work to bring it to standard so the team are looking at Waters ward as it is believed the service in there will cease at the end of March and it is fit for purpose. There would just be a need to look at how it is commissioned and funded in a different way and this is ongoing.

GR added the CG have started to look at improving patient flow through the downstream wards by giving the ward teams senior management intensive support which includes soft challenge, re-education and making them aware of the options available on board rounds.

Care Group 3
AV confirmed Alison Pollard, the CG's new associate chief nurse commenced in post this week.

On 7 March 2022 the plan is for pre-theatres to move back into Ward 27 which will allow for more day case capacity and make more efficient use of theatres.

The ICU pod is being officially opened with a ribbon cutting ceremony which will be done by a patient on 8 March 2022.

AV highlighted she required guidance on who to speak to in relation to ICU admissions when there is no admitting capacity. A paper including an updated standard operating procedure (SOP) was shared in relation to this outside of today's meeting pack as there is a real need to address this. Feedback being is that it is not being managed currently at the right level. AV noted when there is no admitting capacity there are queues of patients within ED and patients are suffering harm across the hospital and this is being managed by the bed managers with only the occasional escalation. Therefore there is a need to have a more robust process in place to ensure patients are prioritised appropriately.

The committee discussed AV's points and the updated SOP and agreed as a committee they were happy for the SOP to be rolled out with a view to it being reviewed in two months to see what impact it has made, noting the need to always have admitting

capacity within ICU.

Care Group 6
MQ confirmed the CG appointed a consultant neurologist last week who will secure the team on the York site and allow more input into the Scarborough site.

There are challenges coming in relation to Dermatology and Rheumatology on the East Coast and an update on options for this will be brought to a future meeting for discussion.

Care Group 5
JM highlighted York and Scarborough had a good outcome in the children's national inpatient survey which is conducted every two years. The Trust was in the top 20% of Trusts for 50% of the questions asked. The survey is completed by children, young people and parents.

A challenge in paediatrics currently, in particular in the community, is there are long follow up times and an increasing number of referrals for the autism pathway. In addition there is some long term sickness for the adoption and fostering community paediatrician but there is plan to talk through some possible solutions with the ICS.

Care Group 4
SC confirmed the CG has appointed a radiologist who has a specialist interest in paediatrics. In addition to an interventional radiologist who will start in October following the completion of their registrar training.

Insourcing in endoscopy is working well with the contract coming to an end at the end of March so SC noted he is not sure what happens then noting there will be a need to keep an eye on it as insourcing is being used for both diagnostic and surveillance work.

SC highlighted workforce continues to be an issue.

/ Actions agreed

- To receive a review on the updated ICU discharges SOP in two months.

Agenda Item:	Business Cases

/ Notes

2021/22-108 Interim Scarborough CT Provision
SC highlighted the committee have discussed this several times in relation to other diagnostics capacity.

A second CT scanner on the Scarborough Hospital site is a requirement from recent guidelines for acute hospitals, and there are plans to have one installed within the new ED build however this is some way off. The existing CT scanner on site is

9 years old and has broken down numerous times leaving the hospital site exposed.

SC confirmed several options have been considered and the favoured option is for a CT scanner to be placed adjacent to the current radiology unit with a walkway built next to it. The cost of this would be £80k plus additional revenue costs of £300k to staff the radiographer and support teams.

ES added that the site cannot wait another 2 years for the ED build to be completed with AV noting the site is an unsafe hospital without the second CT scanner.

SM highlighted it was worth noting the Trust had no money for this and the committee have already committed to £1.5m that it doesn't have on a mobile scanner too however he does not doubt the clinical case therefore there is a need to find a way to support the case.

The committee had a lengthy discussion and agreed the need to reduce the £1.5m already approved for the mobile scanner to allow this case to be approved.

SM noted in terms of purchasing the second CT scanner there was a need to see whether the Scarborough ED build business case is approved by the Joint Investment Committee as then the Trust would have a legitimate source of funding for the scanner from a capital point of view, leaving a need to find a creative way of funding the place it will be located.

AB and KH are to review whether the mobile time can be reduced given a second CT scanner would give the site extra capacity in addition to the looking at the impact of using the ICS scanner which has been put in place at Hull which the Trust can use two days per week. If the mobile time can be reduced this would reduce the £1.5m making this investment achievable.

Post discussion note: AB highlighted at the end of the meeting that correspondence had come through via email to confirm that some national capital was being released to support the delivery of extra diagnostics and the region is suggesting priority access is given to sites with an ED and a single CT scanner, with Scarborough Hospital being on the list. The Trust has been instructed to confirm by tomorrow if it is interested in having the funding for the second CT scanner, so AB confirmed the Trust's response would be yes. AB hopes this will enable both the scanner and the build to be able to be funded through this route.

The committee noted this was a great news.

2021/22-72 Interventional Radiology Workforce
SC highlighted the case was asking to continue paying the rate of £99 per hour for two retire and return consultants until

January 2023 to ensure the on call interventional radiology rota continues. At this point two other consultants will become active and the two retire and return consultants will stop working.
It is within the run rate given the two consultants have been paid the rate this year. If it is not approved this would reduce the on call rota to 1 in 3 which is not sustainable.

The committee discussed and approved the case.

2021/22-89 Ensuring Sustainable Pancreatic, Biliary and Liver services (Medical and Surgical) Trust wide
MH noted this is a multi CG discussion and initiative. The initial case was brought to the committee in May 2022 by SC and KH when the two aspects of it were discussed.

One aspect was the training for the new modality, endoscopic ultrasound which at the time it was felt was a niche thing but it is actually a must do to future proof the hospital from an education and training, recruitment and retention perspective. In addition to providing patients with a high quality clinical service.

It was agreed at the last time of discussing this that Tom Berriman (TB) could go to Leeds for the training which would last 12-18 months. TB is due to start training in the next couple of months however Leeds will not train him unless the Trust invests in the service moving forwards.

The second aspect was in relation to the significant costs around the service however these have been reduced but are still substantial.

MH, GR and SC all agreed not delivering this service will reduce the ability to attract future candidates, and lead to those in post resigning which would leave the Trust without an ERCP service in the next two to three years. GR added that it will get to a point in the near future where it will be inexcusable to have a significant complication when having done a therapeutic ERCP, a EUS wasn't done first. NICE guidelines around EUS have been in place since 2014 and the need for the service will only increase.

The committee had a lengthy debate and noted their support for the service development however before it could fully approve the case there was a need to have conversations with Hull, Leeds and the ICS to gain agreement from a revenue perspective, given the patients are currently seen in Hull or Leeds. The committee agreed it will look to do everything it can to gain the agreements to allow it to take forward the service development in the 2023/24 financial year, as this is when TB will be fully trained.

The committee agreed to prioritise the capital resource in 2023/24 to take the service development forward.

The committee asked for the case to be re-submitted once the conversations with Hull, Leeds and the ICS have taken place within the next month to allow for final sign off before TB starts his training.

/ Actions agreed

- **2021/22-108 Interim Scarborough CT Provision**
  - The committee approved for the scanner to be purchased with the resource from the Scarborough ED build should this be approved by the Joint Investment Committee and if the £1.5m already committed for the mobile CT scanner could be reduced.
  - AB and KH to review capacity from the second CT scanner and the ICS scanner to see how much the mobile capacity can be reduced to be able to fund this case.
- **2021/22-72 Interventional Radiology Workforce**
  - The committee discussed and approved the case.
- **2021/22-89 Ensuring Sustainable Pancreatic, Biliary and Liver services (Medical and Surgical) Trust wide**
  - The committee were supportive of the case however there was a need to undertake conversations with Hull, Leeds and the ICS to gain agreement from a revenue perspective.
  - The committee agreed to prioritise the capital resource in 2023/24 to take the service development forward.
  - The case is to be re-submitted once the conversations with Hull, Leeds and the ICS have taken place within the next month to allow for final sign off before TB starts his training.

Agenda Item:	Items to note

/ Notes

Business cases - approved outside of meeting:

2021/22-103 Data manipulation services for legacy laboratory data
The committee noted the business case had been approved outside of the meeting using external funding and as a case of urgency.

2021/22-91 Replacement of Patient Controlled Anagesia (PCA) pumps
The committee noted the business case had been approved outside of the committee due to the urgency to get these in before the end of the financial year and the fact that these are essentially replacements.

No PIR is required.

2021/22-106 Replacement of existing Stone Holmium Laser

The committee noted the business case had been approved outside of the committee due to the urgency to get the purchase in before the end of the financial year. In addition to the committee and Board having already agreed to this as part of the 6 month review of the capital programme.

No PIR is required.

2021/22-107 Replacement of 4 x Uretero-Renoscopes
The committee noted the business case had been approved outside of the committee due to the urgency to get the purchase in before the end of the financial year. In addition to the committee and Board having already agreed to this as part of the 6 month review of the capital programme.

No PIR is required.

/ Actions agreed

- Nil.

Agenda Item:	**Any other business**

/ Notes

No other business was discussed.

/ Actions agreed

- Nil.

Date of next meeting:
The next meeting will be held on Wednesday 16 March 2022 via Webex.

ACTION LOG – Outstanding

Meeting Date	Action	Due	Owner
07.07.2021	Agree a solution offline for the Lead Clinician for Paediatric Emergency Medicine and seek approval from SM and AB, unless the solution is catastrophic as which point it would need to return to the committee for approval.	~~ASAP~~	CGD 1, 2 & 5
21.07.2021	JT confirmed he had a conversation with Gary Kitching and an ED consultant is interested in a 4PA role. DT noted he was calling the consultant this week to explore this further.	~~ASAP~~	
01.12.2021	An update is to be received in January 2022.	January 2022	
02.02.2022	JT highlighted the PEM consultant action was not resolved and he is in discussions with MH and is meeting with MH later in the day to look to try move this forwards.		
16.02.2022	HM noted in the CQC update there was no further progress with this.		

06.10.2021 15.01.2022	To receive a presentation on the AHP external review and its recommendations in January 2022. WS informed LG prior to the meeting the AHP external review report which was due has been drafted but it is not yet at a point for it to be submitted to the committee, an update will return once it is ready for sharing for discussion and approval.	~~January 2022 – 2nd meeting~~ TBC	Melanie Liley
05.01.2022	**DIS Funding Bids** A regular update to keep sight of the risk around the Essential Services Programme and procurement following the holistic partner challenge.	Ongoing	Dylan Roberts
05.01.2022	Business case 2021/22-93 Brid Care Facility 3 month review.	April 2022	Gerry Robins
02.02.2022	JT, WS and HM to get together and create a steering group to progress the pathway zero improvement work.	March 2022	James Taylor, Wendy Scott & Heather McNair
02.02.2022	VIU options - feasibility works to be undertaken to look at potentially including some additional theatres, and procedural rooms to allow the Trust to bid for some additional elective recovery funds to make the overall scheme affordable.	March 2022	Andrew Bennett
02.02.2022	6 and 12 month review of the change to the management of the Trust's Cancer Nurse Specialist Teams	August 2022 & February 2023	Srinivas Chintapatla
16.02.2022	**Triage** • WS to submit the 15 minute triage paper to the committee before it is shared with March's Quality Assurance Committee. • WS to pick up a conversation with Vocare's Regional Medical Director and Managing Director in relation to streaming and governance.	March 2022	Wendy Scott
16.02.2022	An update on the harmonisation of local pay is to be submitted to the committee in April 2022.	April 2022	Polly McMeekin
16.02.2022	**2021/22-59 Community Stadium and Community Estate Utilisation Plan – Update** • Quarterly updates to be submitted from the Community Estate Working Group. • Expansion into any vacated space will require a business case as no funding is available to service or recommission these areas. • SM and AB to meet with Ian Floyd and Keith Aspden to escalate issues	Various June 2022 Ongoing March 2022	Various Neil Wilson CGD & ACOO's Simon Morritt / Andrew Bertram

	with car parking at the stadium. MS to provide an options briefing.		
02.03.2022	Staff well-being space and calm room at York Hospital • PM to submit an updated paper with several options to allow the committee to approve where the staff breakout area is best located. • AB to support PM and LB to complete the business case pro-forma required for the charitable bid given it needs to be submitted on 17 March 2022.	March 2022 – 2nd meeting	Polly McMeekin
02.03.2022	JH to submit an update on the bed occupancy and ward reconfiguration work by the end of May 2022.	May 2022	Wendy Scott
02.03.2022	The final Sexual Health NYCC - S75 agreement is to be submitted to the next meeting for the committee to review and approve.	March 2022 – 2nd meeting	Jo Mannion
02.03.2022	To receive a review on the updated ICU discharges SOP in two months.	May 2022	Amanda Vipond
02.03.2022	**2021/22-89 Ensuring Sustainable Pancreatic, Biliary and Liver services (Medical and Surgical) Trust wide** • To be re-submitted once the conversations with Hull, Leeds and the ICS have taken place within the next month to allow for final sign off before TB starts his training.	April 2022	Mike Harkness

April 2022

Fran Woodcock, Resuscitation Lead	**York**	**Nominated by Sue Dawson and Liz Burton, colleagues**
Following a recent change of management structure, Fran has had to step up as leader and manager for the cross-site Resus and Clinical Skills Team. With little experience of management, Fran has brought a group of individuals together and made us feel like a real team that can make a difference to the Trust. Although anxious underneath, Fran has shown great courage in learning new skills and communicating ideas, while making us feel safe, valued and listened to. By believing in us, Fran has given us the confidence to believe in ourselves. In such difficult times, when morale is low, Liz and I would like to nominate our manager Fran, and thank her for her support and leadership of our team. Thank you.		
Gillian Richardson, Senior Operating Department Assistant	**York**	**Nominated by Neil Norman, colleague**
Gillian has worked for the York Hospital trust for over 40 years. She has retired and returned to work and was among the first wave of peer vaccinators at the York Hospital site. When the vaccination hub closed she continued to help deliver the Covid-19 vaccine in schools and the community working in tents and pop up clinics on her days off, which has earned praise from the public for her exemplary conduct, friendly manner, dedication and professional behaviour.		
Helpdesk	**York**	**Nominated by a colleague**
They are constantly dealing with issues and problems from all levels and locations of the Trust. Every time I walk into that office they still check in, make sure I'm okay and see if they can help even on a busy day. They are a welcoming, kind group of people who provide support to multiple areas throughout the Trust and I feel deserve some recognition for all their great work - from helping with accommodation through to supporting with uniforms - it is all greatly appreciated.		

Keira Norwood, Sister	York	Nominated by Jason Angus, colleague
Keira is a RN and new addition to the Paediatric team and has fitted in straight away. On her first night shift and only third week in the new role, the Paediatric sister she was supposed to be working with had to isolate due to testing positive for Covid. Keira then had to step up and be the senior nurse for that shift, along side an RN borrowed from the children's ward, (and later one from adult A&E) but this wasn't like any normal shift. Due to an exceptional demand for their services, UCC had to close their doors to new patients as soon as her shift started, which meant these all had to be triaged and looked after in Paediatric A&E, which soon became over run with patients. Throughout all this, Keira kept her cool and coordinated the ward through the night, and made sure patient care was the priority. It was a baptism of fire, and Keira coped amazingly.		

Anna Simons, Staff Nurse	York	Nominated by Kirsty Grainger, patient
Anna is a great nurse who looked after me on ward 11. I first came across Anna when she was working nights. She ensured I was comfortable; my pain relief was kept on top of and was happy to answer any concerns I had. If she didn't know the answer she was more than happy to find out. Anna is a very caring and supportive nurse and willing to learn new things. She accompanied me to Pinderfields hospital on transport for my outpatient appointment. She was very reassuring during the journey and had everything prepared in advance in case we needed anything like catheter supplies and medications etc. She kept on top of my pain whilst in transit and ensured all my usual medications and anything extra I could need she had prepared in advance. While at Pinderfields Anna was really interested in learning how my catheter was changed to which my specialist nurse in Pinderfields talked her through everything and showed her how it was done. Also any day or night shift she has worked while I've been on ward 11, she always came in to check on me and see if there was anything she could do or If I needed anything. I'm very grateful for everything Anna has done for me and continues to do for me whilst I am still on ward 11. She is a fantastic nurse and will go far as a nurse.		

Endoscopy Decontamination Team	York	Nominated by Val Dixon and Debbie Lloyd, colleagues
The Decontamination Unit had a fault with the RO plant (this provides water for processing of the endoscopes) from 26 to 31 January. This meant that they were unable to process any of the endoscopes at York Hospital. Lucasz and his team went above and beyond their duty by transporting of the endoscopes to and from Scarborough Hospital. This could be up to 60 endoscopes a day. Lucasz even came in at 4:30am to ensure that they were transported to Scarborough, processed and then returned them back to York in time for the start of the procedure lists. Due to their hard work and commitment no in-patients or out-patients were cancelled at all during this time.		
Irene Bunag, Pre-Registration Staff Nurse	**York**	**Nominated by Sam Freer, patient**
I was very scared and felt very alone but Irene always made time, even when she was not on our bay that day. She supported a lady in the bed next to me through some extremely difficult mental health issues and remained calm, professional and also went above and beyond to make sure they felt well. She just knew the right things to say. I find hospitals extremely difficult to be in due to my own PTSD and Irene absolutely made sure that I never felt alone and that we felt super supported in our bay. We were a rowdy bunch in our area and she looked after us like no other nurse I've ever known (and I've spent a lot of time in hospital!). I honestly have a big place in my heart for her, thank you Irene.		
Navia Crossley, Bank Nurse	**Scarborugh**	**Nominated by a colleague**
All staff has been working hard during this pandemic but it is amazing to see a Bank Staff Nurse who works effortlessly. She has been helpful to most of the new nurses by providing them with guidance when on shift. Whenever on duty, she makes sure not just her patients all patients on the ward have their Covid swabs labels printed and Covid swabs are done and taken to the lab.		

<table>
<tr><td>Jennifer Pyatt, Radiology Interventional Booking Coordinator</td><td>York</td><td>Nominated by Pauline Ducat, colleague</td></tr>
<tr><td colspan="3">Jenny has taken on a new role as Radiology Interventional Coordinator for main X-Ray. She goes 'above and beyond' every day to ensure patients receive their procedures. She is an asset to the department and greatly valued by the nursing team in main X-Ray.</td></tr>
<tr><td>Emergency Department domestics - nights</td><td>Scarborough</td><td>Nominated by Lorraine Noble, colleague</td></tr>
<tr><td colspan="3">During this pandemic, the night domestics work load has hugely increased due to the extra bays and SR that require a deep clean. On many occasions cleaning that would ideally be done during the day when there are more hands on deck, has been moved to out of hours, this is for many varying reasons.

The night domestics however have risen to the challenge and always with a smile on their faces, assist all the wards with deep cleaning at all times of the night, to keep flow of patients through the hospital going. Without their prompt service, patients would have a much longer wait in ED and ward staff would have even more work to achieve. It would be lovely for them to know how much this is appreciated not only by the bed office team, but also by the ward staff and I am sure the patients too.</td></tr>
</table>

Leonie Shaw, Healthcare Assistant	**York**	**Nominated by Nicky Kerslake, colleague**
I was scrubbed in for a procedure and Leoni was in the room assisting the patient. The patient had complex needs and found the procedure frightening, painful and distressing. Throughout the whole of the procedure Leoni displayed outstanding levels of communication with the patient. Her manner, tone of voice and de-escalation skills made such a difference to the emotions that the patient was feeling and helped them to go through with the procedure. Unfortunately, the procedure became more complex and the patient required further surgery as a matter of urgency. This caused a new height of distress for the patient to which Leoni responded to their every need. She remained calm, collected and supportive and explained everything that was happening so that the patient understood and could process the situation. This level of patient care, advocacy and communication is something that is a consistent feature of Leoni's practice, but often goes unnoticed. She always goes the extra mile for her patients and really cares about them as individuals. She is never afraid to stand up for what is right and to advocate for her patients and for her colleagues.		
Kerry Gover, Staff Nurse	**York**	**Nominated by Katherine Dealtry, patient**
Today I attended YDH for Dental Surgery due to my anxiety, and when I arrived Kerry was so welcoming and put me at ease immediately. She ensured I knew exactly what was happening, and spent her time offering care and reassurance, even when it was visibly apparent how busy the unit was!! I am really grateful for her reassurance during what was to me a really big deal! Kerry's personality really shone through, and is exactly what is needed in the nursing profession! So lovely to see an up-beat, positive and caring person! I really think Kerry has a promising career' Thank you		

Dr Srinivas Chintapatla, Consultant Surgeon and Kate Midgely, Associate Practitoner	**York**	**Nominated by Sharon Simpson, patient**
The team made me so at ease throughout my procedure. They explained everything in detail and were incredibly helpful in easing my anxieties about having this procedure done and I knew what was happening at every stage. They were amazing.		
Accident and Emergency Department	**York**	**Nominated by Joanne Williams, patient**
I was asked to attend A and E at York by my GP on Friday 11th February 2022, and arrived in the department at around 8pm. I was immediately shocked at how busy it was, and the Triage Nurses were rushed off their feet. Some patients were being rude and challenging in their behaviour, and some were ignoring requests for relatives/friends to leave the department, meaning the nurses were constantly having to deal with this as well as their important job of Triage. Whilst all this was going on, I sat in the waiting area and watched as the nurses remained compassionate, professional and resilient with every patient, one after the other, again and again. I was then transferred to the 'Majors' part of the department, and again was met with a full waiting area. The 2 nurses looking after the desk were again rushed off their feet - it was relentless. They were dealing with a patient who was very unwell being constantly sick and elderly patients who were obviously struggling with mobility. They took the time to help them walk to the treatment rooms, and much more. Whilst this was going on, people kept going into the toilets and appeared to be pulling the emergency cord just to get attention, meaning the nurses had to keep responding to false alarms. I really felt for them, they were under so much pressure, and they again remained professional and kind, and kept me updated with the progress of my treatment. An appointment was made for me to come back the next day for an emergency MRI, and again this was handled very well. The Dr who dealt with me was great, and took time out to give me a full update on my results, in-between being called to Resus, and much more. York Hospital should be very proud of the amazing staff that they have working for them in the A and E Department, they truly are amazing. Please pass on my thanks to the team, I am in total admiration of the work they do.		

Joanna Meier, Administrative Assistant	**York**	**Nominated by Kevin Richardson, colleague**
As the individuals manager I would like Joanna recognised for the outstanding hard work she has put in over the last month, after x3 short notice staff leavers, including her direct line manager, Joanna has taken on the work of x4 individuals to keep the ID badge & Car Parking permit function operational, not missing a days work and often coming in early and finishing late without complaint whilst delivering an exceptional service for its users. Not only has she gone the extra mile in her own full time role, she has worked tirelessly for the LLP domestic team picking up extra shifts at short notice to ensure the quick turn around of wards and general areas are kept clean with the staffing issues currently facing the department with COVID absences. Joanna is a key member of the team and is a real credit to the hospital, always displaying the Trust Values, Kindness, Openness & Excellence.		
Clare Inkster, Ward Clerk	**York**	**Nominated by Bernadette Foster, colleague**
Following a review of patient who was identified as being in the last hours of her life, scared of dying alone her only wish was to hold somebody’s hand. Unfortunately due work demands there was nobody available from the nursing team to do this, family had been called in but had been delayed on route, Clare without any hesitation chose to sit with the patient held her hand until the family arrived. Both the patient and their family felt comforted by Clare's kind actions.		
Sherrie France, Healthcare Assistant	**Scarborough**	**Nominated by Gemma Coultas, colleague**
Sherrie showed huge compassion for a gentleman that wasn't himself after looking after him for the last two days. Sherrie knew instantly that the patient had become very unwell on the third day of looking after him. Sherrie knew that there was something dreadfully wrong and sought an opinion of a senior charge nurse who then ordered complete observations for the patient and a doctor was bleeped. The patient was diagnosed with a suspected bowel blockage.		

John Mensah, Consultant and Jo Blades, Acute Learning Disablilities Liaison Nurse	**Scarborough**	**Nominated by Delia Hopkins, colleague**
Jo Blades Learning Disability Liaison Nurse coordinated the care of a patient who required adjustments to due to Learning Disability and Behaviours of Concern. These adjustments were necessary to facilitate head and leg CT scans, a dental review and blood tests. Jo worked closely with the parent and consultant anaesthetist to ensure necessary capacity assessments and relevant documentation were completed, adjustments were made on the day to ensure the care could be delivered safely and the necessary interventions could take place. Consultant Anaesthetist John Mensah and all those involved went above and beyond which resulted in the patient receiving the necessary interventions with minimal impact to him and his mum. A big thank you to all those involved.		
Sophie Cundall, Sister	**Scarborough**	**Nominated by Kate Simpson, colleague**
I feel Sophie's support of her staff and leadership during an incredibly difficult and challenging time needs to be recognised. Since the passing of our colleague, not only did she ring to inform numerous staff individually about what had occurred, but she has organised shifts to be changed to accommodate staff wishing to attend the funeral, flowers for staff to take to the funeral and a book of condolence for staff to sign. She has demonstrated her genuine care and concern for staff, not only under her management but those who have left the ward and now work in other areas, and I believe this needs to be recognised. A demonstration of true care of her staff and a compassionate leader.		
Daniella Lamb, Healthcare Assistant	**Scarborough**	**Nominated by Karen Johnson, visitor**
My husband came into A&E last week and the Healthcare Assistants were amazing and so caring in the job they do, especially Daniella Lamb. The whole team of staff were so good on the day my husband was admitted staff nurses and doctors. As a department you are stretched to the max but you all work so hard and care so much thank you for your care. You all deserve a star award and the government needs to look at giving hospitals more staff. Thank you all again		

Krystal Talmadge, Healthcare Assistant	**York**	**Nominated by Jasmine Spendlove, patient**
Krystal is an attentive, hard-working individual who has supported me during numerous visits to hospital. I am an anxious patient and when in a&e she made me feel at ease, offered me a hot drink and made sure I was comfortable and kept me up to date with my care. On a separate occasion I was waiting to be admitted to a ward and she took time out of her break to come and check on me to see how I was coping. She also came to visit me up in the ward to check in with me again and make sure I was comfortable and all my needs were being met correctly. Despite being rushed off her feet she takes the time to connect with people and provide excellent care, her attitude and work ethic is outstanding and she deserves to be recognized for the hard work she provides.		
Dr Philippa Satchwell, Specialist Registrar	**York**	**Nominated by a colleague**
Philippa is an invaluable member of the paediatric team at York Hospital. She consistently goes above and beyond to ensure that patients receive the best care. She is supportive to other members of the team and is heavily involved in the junior doctor's induction program. She is always willing to help others and provide support and advice when needed. It has been an absolute pleasure working with her!		
Matron Tea,	**Scarborough and Bridlington**	**Nominated by Freya Oliver, colleague**
Since Early summer last year the Matron team across Scarborough and Bridlington sites have had shortfalls in the team which have at times been really significant for very prolonged periods and is still an ongoing issue. Despite this they have worked tirelessly, gone over and above to ensure support is in place for all patients and staff. Also continuing to work to develop services. This has been despite incredibly sustained operational pressure. Their cheerful 'can do' attitude and desire to work as a team to really deliver results and improve the care and service we deliver makes it a pleasure to work with them. I really feel they need recognition for what they continue to do so well in such challenging times. Also working with the Matron team and deserving of this recognition are Diane Watkin who was part of the team and is now lead theatre nurse, and Vicci Anderson who is seconded into a development role with the team and providing invaluable support.		

Clinical Biochemistry Team	**York and Scarborough**	**Nominated by a colleague**
SHYPS has had its first successful UKAS assessment On the 11/01/2022 the York and Scarborough Clinical Biochemistry team, were assessed by UKAS for the addition of Faecal Calprotectin, Faecal Elastase, Serum IgG4 subclasses. Following a successful assessment it was recommended that these can be included on the York and Scarborough scope of practice, bringing these tests in house rather than having to send these away. The team have worked extremely hard. Prior to the assessment they provided excellent supporting evidence that was informative and clear, and on the assessment day where they provided extra information in a succinct timely manner, helping the assessment run smoothly. There were no mandatory findings , and only one recommendation. It cannot be stressed enough how well the team have performed, often there are mandatory findings that must be cleared before UKAS accredit it and recommend that a test can be added to the scope of practice. In further testament to the teams hard work the assessor was very complimentary of the Clinical Biochemistry team, and the Quality Manager giving high praise: ''The laboratory's approach to the ETS application followed a well-designed plan with defined milestones and responsibilities identified.'' ''Technical SOPs and associated documentation were well-written and included clear technical instruction and scientific information.'' ''The approach to scientific evaluation and review of verification data was particularly well documented and gives confidence the addition of the test methods to the schedule has been fully considered.'' The Clinical Biochemistry team can be rightly proud of their achievements.		
Elaine Dixon, Acting Domestic Services Manager	**York**	**Nominated by Debra Hudson, colleague**
Elaine works hard, always supporting others. She cares about her team, goes above and beyond and her day never stops even when she is at home. Even on her days off she is always working. I think she truly deserves to be recognised for all the hard work she has given the trust for many years and definitely shows the trust values everyday at work and out of work caring, listening, helpful and very supportive.		

William Smith, Junior Doctor	**York**	**Nominated by Sandra Horwell, patient**
Will is an incredible doctor who clearly showed his attentiveness, professionalism, and duty to care for me as a patient from the second he called me from the emergency room, to when he directed me to the main lobby on my way out almost 2 hours later. The NHS is understaffed, bedblocked, and every worker is just trying their best, but Will really went above and beyond. Every problem, none of which caused by him, he overcame without it affecting the patient, and still managed to listen to me, reassure me, make me laugh even, and make sure I was comfortable during his examinations. Junior doctors are given so many responsibilities, and they do it all because they care, not for the pat on the back. That's why he deserves this award.		
Chloe Mason, Sister	**Scarborough**	**Nominated by Callum McKell, colleague**
Chloe has worked tirelessly and with unrelenting dedication during the pandemic. Through her hard work, she has been a key player in establishing EAU, and ensuring it is as slick and as effective as possible. She is not only an excellent nurse, one whom always sets examples for others to follow; but also an effective leader of the unit. In addition to her clinical work, she has been a driving force of helping to expand the remit of EAU. She has worked closely with multiple other units within SGH, such as the ambulance service, oncology, Brontë and ED to streamline patient care. In particular, she has worked hard recently to set up direct referrals from the ambulance service to EAU, which has been a great success in reducing waiting times for many patients, considering how desperately busy and overcrowded ED has been of late. Being an incredibly busy unit with such a high daily patient turnover, Chloe has also set an excellent example for all of her nursing staff to follow. She always ensures that upon arrival to the unit, new patients have all relevant investigations ordered, and knows the exact plan for every patient. Her excellent example sets a great precedent, and is I believe a large part of why the other nurses on the unit are also so hard-working and so good at their jobs. By creating this ethos of hard and efficient work, with patient care at its very centre, Chloe has been invaluable in establishing EAU and making it the success that it currently is. With the hospital being under more pressure than ever, EAU has been of immense value to the trust. And it would not have happened without Chloe. It is for these reasons that she deserves great thanks.		

Emma Deans, International Nurse Project Manager	**York**	**Nominated by a colleague**

Emma Deans is our International Nurse Project Manager for new registered nurses coming from overseas. As new nurses in this country, living so far away from our families is already difficult but Emma makes sure that she is there for us and that we can always lean on her when things get rough; any issues, may it be personal or work-related, Emma is always there to listen to us with no judgement at all. I can say I feel confident living and working here in York because I know there is somebody who is there to guide me in every step of the way, even after I feel settled. Emma deserves this recognition as she has been a 'family' to every overseas nurse who has just started life here in the UK. Thank you Emma!

Ian, Security Officer	**York**	**Nominated by Katie Gledhill, colleague**

Ian goes above and beyond when carrying out his duties as a security guard who is mainly stationed at the south entrance. I often observe Ian when he is working and he is always polite, calm and helpful. He is often met with verbal abuse, intoxicated people or genuinely frightened people who need help. Ian has the ability to adapt and tailor his approach to people to suit their current emotional state. Ian appears to do this with ease and without a second thought. Today I witnessed Ian help a very distressed couple who were outside A&E. He came with a wheelchair to help and when was told that they needed a different wheelchair he immediately went to source a different wheelchair. When Ian came back to the distressed couple he even brought a paramedic with him. He got them inside and got them sorted. Ian is an asset to this hospital and A&E would be lost without him!

Kate Miller, Staff Nurse	**York**	**Nominated by Olivia Pearcey, patient**

Kate was such an amazing nurse. She was so professional and attentive throughout and not once complained when the bay was short staffed. Kate was so caring to all the ladies on the bay and went above and beyond; nothing was too much trouble for her. Kate made my experience in hospital a lot more comfortable and put a smile on my face. Thank you Kate - keep being you ☺

Sarah Atalay, Matron	**York**	**Nominated by a colleague**
I would like to nominate Matron for a star award, as I feel she should not be totally defined by her title, now or at any time during the pandemic. Nurse, Healthcare, Matron, Counsellor. She has cleaned beds on our ward, handed patients over, no doubt given out cups of tea and generally tried to care about the Staff wellbeing and breakdowns. Whilst there is only so much Sarah can do, as she clearly has to attend to much in the Unit, as Matron, it has been very pleasant to see her hands on, being a truly caring nurse, whilst also making time to speak to staff who are struggling. A real role model to current and new members of staff and I am truly grateful Sarah is around.		
Laura McIntyre, Orthopaedic Plaster Technician	**York**	**Nominated by Jenny Ward, relative**
My baby girl was diagnosed with bilateral talipes during my pregnancy. Violet is currently undergoing treatment using the ponseti method. During the first phase of this treatment, she required weekly plaster casts on her feet. Laura did Violets initial casting, and was so enthusiastic about ensuring she got the casts just right for Violet. Every appointment she has been to, Laura has taken the time to come and see her, bringing with her her positive outgoing personality, making the whole process an enjoyable experience. Laura is a perfectionist in her work, and on the one occasion when she wasn't completely satisfied with the cast application, she started the process again to ensure that Violets casts where set as they should be. Laura has shown a dedication to her work, and genuinely feels as amazed and happy with Violets results as we as a family have been. I would like to thank Laura for making our visits for weekly casting a pleasure, and I'm sure Violet will miss seeing her bubbly enthusiastic face now she is moving on to the next stage of her treatment.		

<table>
<tr><td>Debbie Scott, Matron</td><td>Community</td><td>Nominated by a colleague</td></tr>
<tr><td colspan="3">During the pandemic Debbie Scott has shown what it is to be a compassionate leader. She is a visible member of the management team, Not afraid to pitch in and lend a hand during an unprecedented staffing crisis. She is supportive to all that need her support, encourages staff to work hard and also supportive to those that need an additional hand. She is, despite her position, very much on the 'shop floor' and has a true understanding of what the work is, what is required, what is needed and above all else steps in when others don't. She is fantastic with women and their families whilst also being a compassionate listener to her staff.</td></tr>
<tr><td>Tracey Butterfield, Midwifery Support Worker</td><td>York</td><td>Nominated by Beth Laverick, patient</td></tr>
<tr><td colspan="3">Tracey made me feel listened to and supported. She was so caring and genuine that it has eased my anxiety following the trauma of my past maternity experience. In fact the whole team have been brilliant this time and I appreciate all that they have done for me. Dr Johnson was very informative and I felt involved in decisions. They both helped me deal with a difficult decision and made me feel safe. I feel lucky to have met Tracey she is an asset to the department.</td></tr>
<tr><td>Sandie McEwan, Midwifery Support Worker</td><td>York</td><td>Nominated by Michelle Wilson, colleague</td></tr>
<tr><td colspan="3">Sandie goes over and above her role, she is so efficient and so helpful always supportive in all she does. When she is not at work we really miss her. If we need anything she will make sure we have it, she helps with visits, supports women with infant feeding problems. She's a star!</td></tr>
</table>

Patricia McCready, Service Manager	**York**	**Nominated by Katherine Drury, relative**
My son has been a regular visitor to the eye clinic since developing a squint at the age of two. Every member of the team has been kind, welcoming and understanding that children can be nervous in a hospital environment, especially when eye drops are needed. We received excellent care through his corrective surgery, performed by Mr Taylor, and all appointments before and after. My son is very fond of the singing lobster. However, special recognition and the reason for this nomination is Patricia McCready. The continuity of care, patience, attention to detail and willingness to explain every step of our journey has provided us with everything we needed to make informed decisions. My son has changed and grown up in so many ways during this time and Patricia McCready has adapted to his needs at every appointment. Her professionalism and approach has built trust with both my son and us and it's wonderful to see him bouncing in and out of his appointments. Samson, age 7, says... "I like Kevin the minion. Patricia is kind and fun. Thank you for looking after my eyes. " We are grateful for all Patricia has done for us over the last five years. We feel lucky to have had her as our orthoptist. Thank you.		
Scott Harrison, Healthcare Assistant	**Scarborough**	**Nominated by Rajeswari Madaswami, colleague**
Scott is a very good team player and hard-working member of staff. Being always available to help the team members. He is professional and caring.		
Rita Thomas, Domestic	**York**	**Nominated by Janet King, colleague**
Rita has been such a tremendous support to the team and patients on the renal unit for many years. Her caring, compassionate and supportive nature has been appreciated by us all but especially when the unit has been so busy during Covid. Staff have not been able to leave to get a break and Rita has provided us with sustenance, humour and care and kept us going. She never changes, even in times of stress and always goes above and beyond to care for us all. We really want to say thank you and show the trust what a valuable member of our team that she is.		

<table>
<tr><td>Laura Rycroft, Sister</td><td>York</td><td>Nominated by a colleague</td></tr>
<tr><td colspan="3">The MES department are a vital service to many specialities within the trust. In the General Surgery department, we have a vast number of patients requiring infusions either prior to surgery, or for long-term patient care that would otherwise require an inpatient admission. MES are always so accommodating and helpful, even when they have very little notice for an urgent treatment. This is crucial in avoiding inpatient admissions for patients which is in neither the patient's nor the trusts best interests. They have been solely responsible in avoiding admissions in a number of surgical patients, as well as Oncology patients and other specialities. The patients always speak very highly of the team there and from personal experience they are very hard working and have dealt with so much during the COVID pandemic when their staffing levels have been reduced. Despite this I have not noticed any deterioration in their ability to care for patients and this is why they deserve recognition for this effort.</td></tr>
<tr><td>Danielle Hudson, Staff Nurse</td><td>York</td><td>Nominated by Emma Garner, colleague</td></tr>
<tr><td colspan="3">Danni went above and beyond when caring for a palliative patient and his partner. On what may have been their last day together, Danni went to other departments and collected some hand print keepsakes and did family imprints of the patient, his partner and their dog for them to keep and treasure forever, this clearly meant a lot to them and is testament to Danni's caring and compassionate approach towards patients and their families.</td></tr>
<tr><td>Lucy Hayman, Secretary</td><td>York</td><td>Nominated by Imogen Fairburn, colleague</td></tr>
<tr><td colspan="3">On Monday the 28th Feb as she was leaving work for the day, Lucy came across a panic stricken mother trying to carry her unconscious daughter in very heavy rain. She had not realised that the A&E entrance had moved and was clearly struggling. Lucy stepped in to help and told her to wait there and she would go get help, after running to the current A&E entrance she shouted that she needed help in the car park and then ran back to the Mother who by this point was exhausted and soaked from the rain. Lucy offered to carry her daughter to A&E and the grateful mother handed over her daughter and Lucy carried her to A&E getting soaked herself and abandoning her personal belongings to do so.</td></tr>
</table>

Catherine Williamson, Advanced Specialist Practitioner	**York**	**Nominated by a colleague**
Cath joined the Trust at an incredibly tricky time, and embraced a service (ophthalmology at the Community Stadium) in its relative infancy. From day one, Cath has taken on this challenge with a great positive attitude, and has achieved great results. Staff have embraced Cath as 'part of the furniture' and she should be proud of the impression she has made in a short period of time. We are all very grateful for the work Cath continues to do in building a fantastic ophthalmology service at the Stadium.		
Emma Darrell, Medical Secretary and Gemma Williams, Consultant	**Scarborough**	**Nominated by Sharon Miles, colleague**
I have recently been sent an email from a patient's parent, praising Emma Darrell and Dr Williams for their assistance. On a particularly bad day where I needed help I tried to maintain composure, Emma understood and she actually showed such compassion for me in my situation at a time where no one else had and that is something very special a soft skill that is not learned behaviour it is genuine and authentic. Where other NHS departments are blaming lack of information, lack of paper trail, lack of appointments, lack of everything on Covid you never hear this excuse once from this particular department. Emma will ring you back, she will nudge other departments and she will do as they say on the tin. In many ways it’s quite sad that this is stood out so apparently amongst the rest of your NHS community. The NHS are blessed to have these ‘earth angels’ as I called them work for them. Also your doctor Dr Williams who talks to people on a human level and considers the well-being of everyone - and not consider them as a number on a conveyor belt and this method of treatment shines. Between them in that department I am sure you have had no escalated problems or complaints and thank the Lord they are there but just for sick children; but for the support network behind them - this effect ripples. I know this because I care for families too and is the ethos benchmark I work to also. This is not down to luck; but to Excellent people doing excellent work - and most importantly owning it from start to end. Thank you again Emma and Dr Williams.		

<table>
<tr><td>Kerry Gover, Staff Nurse</td><td>York</td><td>Nominated by Charlotte Scotter, patient</td></tr>
<tr><td colspan="3">Kerry Gover was the staff nurse I was allocated when admitted for surgery. I was very nervous however she was warm and welcoming from the very beginning all the way to the end. Kerry made sure I was ok numerous times throughout the day. To begin with she helped me get ready for surgery with her positive, upbeat attitude. It was clear Kerry was very professional and efficient getting all the patients ready for surgery in her room that day. When I found out my surgery time had been put back she assured me it wouldn’t be long and made sure I was ok during this time. Once I returned she went out of her way to make sure I was comfy and gave me everything I needed. I felt so much better for coming back to a familiar face. Nothing was a problem for her. Kerry is the most friendly and caring nurse I have had the pleasure of meeting and she made a worrying experience much better. Thank you!</td></tr>
<tr><td>Lucy Bruce and Collette Kelly, Domestics</td><td>York</td><td>Nominated by John Dickinson, colleague</td></tr>
<tr><td colspan="3">Raising the standards of hygiene within the Estates and Capital buildings due to a colleague having a medical condition, which requires them to self-medicate in clean and safe environment. This has allowed them to return to work before they can undergo a future operation reducing the workload pressures on the wider team.</td></tr>
<tr><td>Maria Burns, Ophthalmic Imaging Technician</td><td>York</td><td>Nominated by Dawn Lowe, colleague</td></tr>
<tr><td colspan="3">This is one great lady who always makes everyone laugh, she puts her patients first always and goes that extra mile for them. We recently had a problem and when no- one would help Maria found a way of sorting this out. She will do this all the time helping whenever she can even when busy herself.</td></tr>
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Ward 17	**York**	**Nominated by Helen Gornall, relative**
We visited ward 17 on 3/3/22 with our child George. We were greeted with big smiles on arrival. Our experience from start to finish was amazing, from the doctors, staff nurses, student nurses, play nurses, domestics. Absolutely fantastic. They made sure my 4 year old son was comfortable and happy throughout the whole day. They communicated well with us as parents, just wonderful. I myself am a nurse, and really appreciate how hard they work. We didn't feel like we were going for surgery, it felt like an enjoyable experience. I hope these staff are recognised not only for today but every day. Thank you x		
Joanne Smith, Deputy MLA Manager	**York**	**Nominated by Carroll Adgo, colleague**
I'd like to nominate our supervisor for a star award, Jo is a massive team player and is there to help and advise us, also to confide in should we need to. On Thursday we were very short staffed due to covid and holidays etc, and finishing the shift felt like a monumental task, Jo came back from going home after an already intense 8 hour shift to help us out! She came in with a smile on her face, gee'd us all up and was so much help. She goes above and beyond constantly in what has become a very challenging work situation! thanks for being there for us Jo		
Paula Curtis, Switchboard Operator	**York**	**Nominated by Carol Fawcett, relative**
In the early hours of Saturday 5th March my mother Sheila Dando was admitted to A&E. I live near Peterborough and my brother in Halesowen. We made several attempts to find out how my mother was, diagnosis and prognosis and to track which ward she had been moved to and in fact if she was being admitted to the main hospital. We had problems with doing this and made numerous phone calls in our quest. Initially we were told she was being admitted to ward 14, then ward 28 and then heard she was being returned to A&E. I eventually tracked her down by coming to the hospital after travelling up, which I needed to do to get some personal belongings to her. Every time we phoned Paula, in our opinion went above and beyond what she needed to do and in doing so made a difficult process less daunting. I did thank her but would like to nominate her for a Star Award. Regards Carol Fawcett and also on behalf of my brother Paul Dando		

Christos Miamiliotis, Speciality Trainee Doctor	**York**	**Nominated by Katherine Beattie, colleague**
My Dad was admitted to ED Resus on 15th February 2022 following a brain haemorrhage. The team in ED were fantastic from the minute he arrived until his transfer to ICU, where he unfortunately passed away. The care and support they gave to him and to our family was amazing, it was one of the most devastating days of our lives and their care meant everything to us. As a cardiac outreach nurse in this trust, I work with the ED team regularly, and I have seen them give the same care to many other patients and families but had never realised just what a difference it makes. Thank you.		
Adele Richardson, Student Nurse	**Scarborough**	**Nominated by Phillippa Corner, patient**
I was taken to the emergency department with chest pains on Friday evening, 4th March 2022. Adele looked after me for several hours along with other patients being cared for on trolleys in the ED corridor. She combined clinical tasks such as taking bloods and checking my blood pressure with ensuring I was comfortable and confident in the situation by keeping me informed of what was happening. She also fetched us sandwiches and drinks when needed. She has a lovely friendly manner and remained good humoured, calm and kind to all patients in her care while some of the patients' visitors created an unpleasant and intimidating atmosphere. The team was excellent all evening. Adele displayed extraordinary compassion and warmth and contributed to the sense of calm over several hours on a busy Friday shift.		

Christopher Templeman, Doctor	**York**	**Nominated by Imogen Clarke, patient**
On 5th December I went to A&E with palpitations and on getting triaged was found to be in SVT with heart rate of around 240. Dr Christopher Templeman came to see me in triage and then transferred me to resus where he quickly treated me. Throughout the whole process he was extremely kind and reassuring, offering a quick diagnosis and information so that I knew what was going on at all times. He also arranged for my ECGs to be sent up to cardiology, with the result that I was referred onto LGI and seen by specialists there within 2 weeks. I think Dr Templeman deserves a Star Award for his kind and caring actions. He was so reassuring in what was quite a scary situation, and the fact he took the time to give me the information about what was happening was very helpful for me. He was not actually on duty when he treated me - his shift had not yet started, but the triage nurse had caught him in the corridor and asked him to see me. He told the nurse in resus that he hadn't yet had his breakfast and would have it after treating me. I know how long doctors shifts in the hospital are, and I feel this makes his actions all the more special. He made a big difference to my experience.		
Sarah McDarby, Deputy Sister	**York**	**Nominated by Thalia Wareing, colleague**
Sarah has been a rock in the chaos of being a newly qualified nurse in that she always checks in with me both through my progress in a shift and emotionally in general. She is always there to listen, is easy to talk to and makes you feel listened to. This extends to all patients and every colleague, Sarah is an incredibly compassionate and supportive nurse and I thank her for giving me strength and solace in my nursing journey.		

Libby Ridsdale, Healthcare Assistant	**York**	**Nominated by Julie Goddard, patient**
Whilst I've been a patient my Mum passed away and Libby has been a rock. Constantly going above and beyond, helping me to cope, come to terms with it all and even came to the chapel of rest with me when it was Mum's funeral. She read out something I had written as I was too choked up, sat with me for pretty much an hour as we lit candles and talked about my Mum. We laughed, we cried and the Reverand said a beautiful prayer. Libby constantly checks in on me, makes sure I have everything I need and am as comfortable as possible. Libby is not just like this with me. Watching her work and interact with other patients is incredibly refreshing. She treats everyone with such dignity and respect, it's truly a beautiful thing and she is a very precious member of the team. A real asset! If only everyone has such dedication, commitment and compassion.		
Vicky Davey, Deputy Sister	**York**	**Nominated by Julie Goddard, patient**
I would like to nominate Vicky for her outstanding care and continuous support. She has been incredibly supportive, caring and offered continuous help with my mental health which has been very trying throughout this difficult time having lost my Mum whilst in hospital as a patient. This level of continuity of care has been essential for my wellbeing and saved me from falling into a very dark place. Vicky cheers me up, makes me smile and has never dismissed the importance of what I am going through. To be treated like I'm a person that matters really helps me to cope. Without all this care I don't know where I'd be!		
HYMS SLO Team	**Scarborough**	**Nominated by Alison Culpepper, colleague**
The team have worked relentlessly at half the team capacity (due to staff sickness and vacancy) - to support and facilitate medical students at Scarborough. They have adapted timetables and teaching at very short notice, are always polite, approachable and willing to go the extra mile to ensure students get the most out of the time in SGH. Despite the pressures the team are a joy to work with.		

<table>
<tr><td>Rachael Bealey, Diabetes Specialist Nurse</td><td>York</td><td>Nominated by Richard Connell-Smith, patient</td></tr>
<tr><td colspan="3">My care as a Type 1 Diabetic has always been excellent at York Hospital. I would like to nominate Rachael Bealey for a Star Award. Over the last few months she has helped me enormously with my diabetic control. I can contact her at any time if I have problems or need advice about glucose readings and my pump settings. Nothing is too much trouble for her. She takes a genuine interest in me as a person and although professional in every way, she shares my delight in having recently become the grandfather of two granddaughters. Rachael is indeed a star and it gives me great pleasure to nominate her for an award.</td></tr>
<tr><td>Karen Cooper, Domestic</td><td>Scarborough</td><td>Nominated by Jennifer Robinson, colleague</td></tr>
<tr><td colspan="3">Karen goes above and beyond to keep our high risk SCBU unit clean and tidy. She is always very caring towards parents and families members. Nothing is ever too much for Karen, she is always happy and its easy to see how conscientious and enthusiastic about her job on the unit. Karen although never expects it she deserves recognition for her amazing work, dedication and high standards.</td></tr>
<tr><td>Karen Hart, Midwife</td><td>Scarborough</td><td>Nominated by a colleague</td></tr>
<tr><td colspan="3">Karen is always extremely supportive of all the labour ward staff regardless of their experience. Nothing is ever too much to ask, she is always keen to help in anyway and makes staff feel happy to ask questions and escalate concerns. Furthermore, she always prioritises the women, their wishes and protects their dignity while advocating for them. She is in absolute credit to the maternity team; and Scarborough are blessed and very lucky to have her, as are the women who birth at Scarborough.</td></tr>
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<tr><td>Lois Cook, Senior Sister</td><td>York</td><td>Nominated by a colleague</td></tr>
<tr><td colspan="3">Lo has been a superb force for positive growth in ophthalmology since she joined us. Her leadership and ability to solve problems with insight, professionalism and kindness has helped steer the team's ship through a tremendously tricky period.</td></tr>
<tr><td>Cheryl Evans, Catering Services Operative</td><td>York</td><td>Nominated by a colleague</td></tr>
<tr><td colspan="3">Cheryl is the absolute embodiment of 'service with a smile' - she is so kind, so friendly and an absolute joy to interact with. Plus she makes very nice coffee!</td></tr>
<tr><td>Christine Minay, Healthcare Assistant</td><td>York</td><td>Nominated by Rebecca Howells, colleague</td></tr>
<tr><td colspan="3">Over the past two months we have had the privilege to care for a patient with severe depression on Ward 34. When this patient first arrived she was very withdrawn and not engaging with health care professionals. She was frightened and wary of her surroundings. Kris has gone above and beyond to make her feel safe, cared for and important. She has taken the time to understand her likes and dislikes in an attempt to provide food and drink that she might want to try, often buying items in her own time and with her own money. Kris has developed games and activities in an attempt to interact and develop trust which has seen our patient begin to receive the treatment she needs. Recently Kris has knitted a security blanket for our patient to use on her twice weekly transfers to another hospital for treatment, on her return she makes sure that she is there to greet her and provide her with the reassurance that she is safe and valued as a person. Whilst it has been a team effort to start our patient on the road to recovery, I believe that it is the dedication and personal touch provided by Kris that has been instrumental in putting a smile back on her face. Kris embodies our Trust values and her kindness deserves to be recognised.</td></tr>
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Louise Martin, Research and Development Assistant	**York**	**Nominated by Ellis Bramall, colleague**
Louise joined the R&D team late last year and the work she has done so far has been nothing short of miraculous. The role is a new temporary role with a work-in-progress job description, but this didn't stop Louise from making it her own by helping every single member of the department both with their workload and with personal issues. To me she is a human embodiment of the NHS values, not only does she strive to improve her own work, her positive attitude makes others strive to do better too, just to keep up! She finds the good in everyone and brings it to the surface. She is a conflict resolver and preventer. Aside for her work bring the team together she has also taken on many of the, shall we say, arduous jobs like the filing system and is on her way to perfecting the process. Never mind not liking Mondays, we have grown to dislike Fridays as that's Louise's day off!		
Christopher Swain, Healthcare Assistant	**Scarborough**	**Nominated by Melvyn Johns, patient**
I feel that I have had better treatment with Christopher than I have had with any other staff on all the wards I have been on in Scarborough hospital during my time in hospital while having treatment. He makes me feel at ease and ensures every need of mine is met. I feel that he has treated me as a person rather than a number.		
Jeanette Prime, Healthcare Assistant	**York**	**Nominated by Ann Newman, patient**
I am in an elderly care ward in York (15) following a pelvic fracture. Jeanette has been on duty many times when I have had episodes of extreme pain, and her kindness and thoughtfulness have been beyond compare. Florence Nightingale would have been proud of Jeanette.		

Massimo Fiori, Data Warehouse Architect and Ruth Kendall, Information Manager	**York**	**Nominated by Nicky Slater, colleague**
Following the significant IT challenges with data and reporting, both Massimo and Ruth have gone absolutely above and beyond what was asked of them, working incredibly long hours and cancelling leave. Without their dedication and support the situation within the Trust could have continued for much longer, NHSE have expressed their thanks for all the hard work. This is a back office function but with far reaching consequences when it doesn't work. I really appreciate their dedication and that of the wider Business Intelligence and Insight Team - a great team to be part of!		