NHS

York and Scarborough Teaching Hospitals

NHS Foundation Trust

Quality Report

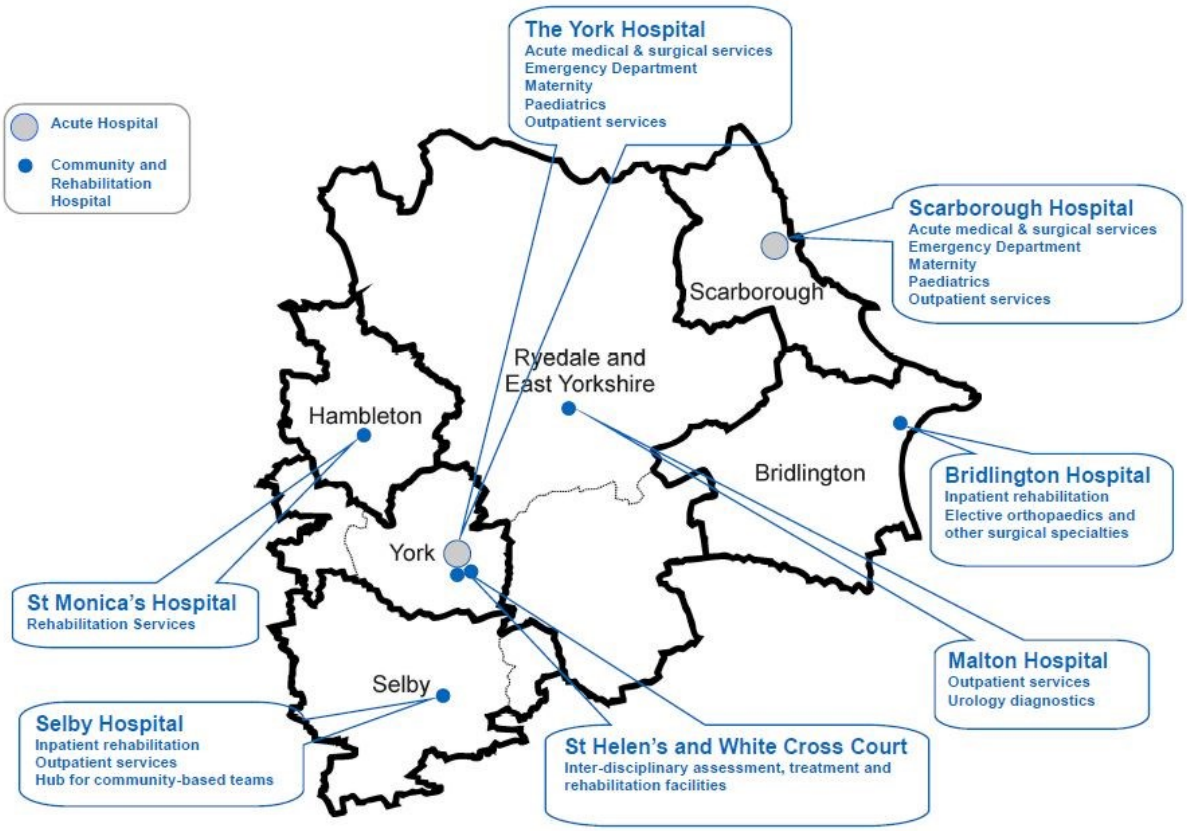
2021 / 2022

About the Trust

York and Scarborough Teaching Hospitals NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale – an area covering 3,400 square miles. Our annual turnover is over £0.6bn and we manage eight hospital sites through a workforce of over 10,000 staff working across our hospitals and in the community. Our values are kindness, openness and excellence.

We are a NHS Foundation Trust. Foundation Trusts operate independently of the Department of Health, but remain part of the National Health Service. This gives us greater freedom and more formal links with patients and staff.

We are accountable to them through an elected and appointed Council of Governors.



Our Values

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

We are KIND meaning we:

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

We are OPEN meaning we:

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

We pursue EXCELLENCE meaning we:

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

Contents

Part One

Part Two

Priorities for Improvement and Statements of Assurance from the Board:

Part Three

Review of Quality Performance:

Appendices

Part One – Statement on Quality from the Chief Executive

Welcome to the annual Quality Account, where we share with you our achievements, challenges and successes for the 2021-22 year.

As with last year, the global Covid-19 pandemic has continued to dominate and whilst there have been some periods of time where case rates have fallen and restrictions in wider society have been eased, in healthcare we have continued to work under stringent guidelines to keep our staff and patients safe.

Our staff have now worked through the pandemic for two years, and I continue to be immensely proud of everyone's resilience and flexibility during these unprecedented times. We continue to focus on the welfare and wellbeing of our staff, both as the pandemic continues and as we start to look at the future and our recovery.

Following national direction, we cancelled planned surgery, routine outpatient appointments at the start of the pandemic. We are working hard to reinstate our normal services and recover the backlog, however the Covid-19 safety measures we have to follow, for example social distancing in clinics and wards, and enhanced cleaning and hygiene procedures, mean we can see fewer patients and carry out fewer operations in a single day than we could before coronavirus. This means that some patients are experiencing long waits for their planned treatment.

Despite the challenges presented by the ongoing pandemic, we have continued to move forward in our improvement journey. At the time of the CQC's last inspection of the Trust in the summer of 2019, we were rated overall as Requires Improvement, and a number of conditions were placed on our registration. Since that time we have worked hard to respond to the CQC's recommendations and have made progress against the action plans. I can also report that all but two of the conditions have been lifted. These are important steps forward for us, particularly in the current climate. In late March 2022 the CQC visited York Hospital and inspected a number of medical and elderly medicine wards. The subsequent report was published on the CQC website in June 2022, and we have responded with a robust plan of action. We have until the end of August 2022 to demonstrate that we have made the required improvements.

This year will see significant change in health and social care as Integrated Care Systems become legal entities. We will also move into a new financial framework following the emergency finance regime that has been in place for the past two years.

We will need to adapt to meet these challenges, however I am confident that we can deliver the quality of care that we all expect for our patients as we move forward with our recovery.

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

Simon Morritt
Chief Executive
June 2022

Tony's Story

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Tony was diagnosed with primary progressive multiple sclerosis (PPMS) in 2012. The level of care and support he receives at York Hospital is brilliant now but this has not always been the case.

Tony received his diagnosis in Norwich and the level of support he received there was excellent. Tony attended a course for newly diagnosed MS patients and was under the care of a hospital consultant and an MS specialist nurse who he could contact as and when required. Tony was also an active member of the MS Society in Norwich.

Tony moved to York in 2013 and his care was transferred to York Hospital. Following his appointment with the Neurologist , he was discharged but luckily for Tony he wasn't newly diagnosed and had come to terms with his MS. However, he felt angry and determined to somehow change what happened to him and other patients and ensure that people with MS received ongoing care and support from the hospital team . The local MS Society suggested he could get involved so he did, and the group now work closely with the trust. From his previous group in Norwich Tony brought the idea of the newly diagnosed course and this is now a regular event and fully funded by the York group.

Tony and the group campaigned for a full time MS Specialist Nurse which was successful, along with a new Consultant Neurologist. Tony describes the service and support for MS patients at York trust as brilliant now and patients with MS are no longer discharged . The service now provides assessment, advice and information for patients from diagnosis onwards.

Tony's Story

Tony's determination and contributions to the current service for MS patients at York has made a huge difference for both himself and other people living with the condition.

As a patient and active member of the local MS Society, Tony continues to work closely with the hospital and Sixth Form College and engages with other MS patients through many social events such as quiz nights, fitness classes and meditation sessions.

Tony's story demonstrates the importance of ensuring that the needs of patients are central to the development of new services and roles and that patients' voices are heard and acted upon

Looking Back on 2021/22

In this last year our work has once again been dominated by Covid-19, which continued to present the NHS with the greatest challenge it has faced since its creation. However, our health service - through our skilled and dedicated staff - is renowned for the professional, flexible and resilient way that it responds to adversity and as an entire Trust pulled together, as one, in a coordinated effort.

As a Trust we are incredibly proud and thankful for everything our staff have done, and continue to do, in the face of pressure and challenges of the global pandemic. We continue to be humbled by their strength, resilience and tenacity.

April 2021

New name for the Trust

Following an extensive engagement exercise with our key stakeholders, the public and extensive staff engagement, from 1 April 2021 we formally changed the Trust name to 'York and Scarborough Teaching Hospitals NHS Foundation Trust'.

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

May 2021

A Great Big Thank You!

In May we launched our 'Great Big Thank You' campaign for staff.

After the most difficult year most people have ever faced on a personal and professional level, the Trust launched 'The Great Big Thank You' campaign, which gave teams a £1,000 reward and every member of staff an extra day's leave for their birthday.

Chief Executive Simon Morritt, said: “Strength, dedication and commitment have been the backbone of everything staff have achieved over the last year. It is difficult to articulate my gratitude; however - as the saying goes - actions speak louder than words.”

There were many more rewards and gestures of thanks throughout the summer, calumniating on the NHS 72 birthday with a Covid thank you keepsake badge for all staff and volunteers.

New values

This month we also launched our new Trust-wide values, which were developed through extensive staff engagement. Our new values are kindness, openness and excellence. Every individual across the Trust is involved in making hundreds of decisions every day and these values help inform our thoughts, words, and actions.

June 2021

Inspiring tomorrow’s leaders

In June, York Hospital collaborated with academics from the University of York and industry partners to offer local sixth form students the opportunity to discover more about the fascinating world of computing and its applications in real world settings.

Dr Paul Laboi, renal physician at York Hospital, teamed up with Dr Ibrahim Habli of the Department of Computer Science at the University of York to organise a virtual programme for Year 12 students at York state schools. The programme mixed theoretical and practical applications of computer science in medicine in particular, offering students a chance to learn about the fundamentals of IT in healthcare, team working, how to put humans at the centre of the development process, as well as considering the ethical and social implications of the use of AI in healthcare.

Dr Laboi said: “Modern technology is hugely inter-linked with medicine. To inspire the interest of tomorrow’s leaders in IT we need to be able to show them what opportunities exist.”

July 2021

Covid-19 mouthwash study

In July, our Research team launched a new innovative clinical trial to see whether using mouthwash can inactivate the Covid-19 virus.

A previous study between the Trust and Public Health England (PHE) has proven that multiple commercially available mouthwashes reduce the level of SARS-CoV-2, the virus that causes Covid-19, in a laboratory setting. This trial investigates how well mouthwashes perform in the real world, and how long the effects last for.

Mr David Seymour, Consultant in Oral Rehabilitation, explained: “Mouthwashes that we found can kill coronavirus in a laboratory is an exciting development, which we are now studying in patients. This simple procedure could be a useful mitigation against coronavirus for the dental sector and potentially other close contact sectors.”

August 2021

Quality Councils

In August, we launched new quality councils in order to improve patient care. The quality councils are made up of staff that are passionate about making the small quality improvements that can make a big difference within child health, women’s health and sexual health. The groups chose small projects to work on that have been identified from staff feedback.

September 2021

A new way for patients to manage their health

In September, the Trust introduced a new patient-powered digital service accredited by the NHS - Patients Know Best (PKB). Designed to improve patient experience, it offers online access to personal health records to revolutionise the way patients access and use NHS services.

The service integrates patient data from existing IT systems - from local hospitals, GP surgeries, social care, and mental health services, to create one complete, ‘live’ health record.

James Taylor, Medical Director at the Trust said: “Patients of the Trust can now access all their outpatient appointments from any device. In the near future they will also be able to view their medical letters, test results, care plans and hospital discharge information, offering patients an active role in tracking and monitoring their health.”

October 2021

Award winning Trust

This month, the Diabetes Education team made their mark at the celebrated Quality in Care Awards sweeping up the best Diabetes Education Programme trophy for their 'Good2Go' education course for people newly diagnosed with Type 2 diabetes. The team adapted their face to face diabetes education programmes into a virtual webinar, delivered daytime or evening, or a workbook with one to-one Q&A for those without internet access.

The judges commented: "The York and Scarborough team's entry was a comprehensive and thoughtful review of how to deliver education and meet varying patient needs."

The Trust's Rapid Diagnosis Centre (RDC) were also finalists in the prestigious BMJ awards. The team were selected from more than 1,000 applicants for the cancer care category.

The RDC has gone from strength to strength since it was launched in January 2020. It offers patients with symptoms that are cause for concern but do not meet the criteria for urgent cancer referral a rapid diagnostic at a one stop clinic. This involves radiology and endoscopy with either onward internal referral to the appropriate speciality, or back to their GP.

The feedback from the judges was extremely positive, highlighting great team work and excellent clinical engagement and praised the service as patient centred and innovative with a holistic approach.

November 2021

Major development to York A&E

In November, work started on a multi-million pound improvement to the Emergency Department (A&E) at York Hospital.

The project will expand and redesign the department's urgent and emergency care facilities. This requires significant work on site to create a two-storey extension which will provide a vital new eight bedded resuscitation area, along with improvements to both the waiting room and the consultation and treatment areas to increase capacity and provide better care for patients. It also includes twelve new assessment and treatment cubicles, where patients will be seen and assessed by a senior member of the team.

Once complete it will bring significant improvement for both staff and patients.

December 2021

Autumn Project

One of the Trust priorities is for patients to live well and die well. This month, a new pilot, the Autumn Project, was launched to support patients at the end of life and their families.

The Autumn Project improves the quality of care for patients and their loved ones as they spend their last days together, as well as providing consistency of care across the wards.

As part of the wider Autumn Project the Trust has invested in Autumn Rooms and specially designed screens to ensure privacy and dignity is maintained.

January 2022

Trust appoints new Chair

In January we confirmed Alan Downey as the new Chair of York and Scarborough Teaching Hospitals NHS Foundation Trust. Alan succeeds Sue Symington, who was appointed as Designate Integrated Care System Chair for the Humber, and North Yorkshire Health and Care Partnership.

Alan's appointment was made and confirmed by the Council of Governors at their meeting on 13 January 2022.

Simon Morritt, Chief Executive said: "I am confident that Alan will provide excellent leadership as the Trust continues to strive to provide excellent care in the very challenging and demanding healthcare environment we are operating in.

“With his wealth of experience Alan is ideally placed to lead our Trust in the next phase of our journey, as we navigate our way through the pandemic and develop our role within the Humber, Coast and Vale Integrated Care System.”

New research hub to improve care for long term conditions

Also in January, the Scarborough Multimorbidity Research Hub was officially launched, in partnership with Hull York Medical School (HYMS). The Hub brings together clinical researchers in both primary and secondary care to deliver research studies to benefit patients on the East Coast.

The Hub will enable patients with two or more long term conditions to take part in research studies into diseases such as chronic obstructive pulmonary disease (COPD), diabetes, asthma, heart failure and stroke.

This means that patients whose care is normally delivered in a community setting, such as GP surgery clinics, will be able to take part in studies that will help researchers improve treatment in the future.

February 2022

Specialist scanner for East Coast cancer patients

In February, a new Specialist scanner was launched at Scarborough Hospital, which saves cancer patients on the East Coast a 90 mile round trip for a crucial scan.

The PET-CT scanner produces detailed three-dimensional images of the inside of the body to determine how far the cancer has spread and how well it's responding to treatment. Previously all cancer patients from York, Scarborough, Malton, Bridlington and Selby needed to travel to other hospital sites to get access to this essential diagnostic test. The closest PET-CT scanners were located at Castle Hill Hospital in Hull, St James in Leeds and Newcastle.

The specialist scan means that clinicians can more quickly identify the presence, location and severity of cancers and the information is used to help ensure patients receive the right treatment.

March 2022

New ICU Pod opens

In March work completed on a new £2.5 million pound purpose built intensive care unit at York Hospital which will provide six new isolation beds for critical care.

The unit, which is linked directly to the Emergency Department, provides vital extra beds for patients who need critical care as well as extra capacity that will mean more day case operations can be carried out. During the pandemic demand on critical care meant that we had to spill out of its usual footprint and use the theatres environment to deliver care to patients, the main reason for this was because we did not have enough isolation facilities on the critical care unit. This resulted in reduced operating for elective surgery which means patients have had to wait longer for their surgery. The Pod will negate the need to use other areas of the hospital in future and the right patients will be in the right place to receive care.

Part Two – Priorities for Improvement

2.1 Looking Back: Progress with Our Quality Priorities for 2021/22

In this section we present our progress in relation to the delivery of our quality priorities developed with members and governors in a virtual event held on 2nd February 2021 and agreed by the Board.

2.1.1 Our Clinical Effectiveness and Improvement Priorities

Why this was important

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

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

What we said we would do in 2021/22

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

What we did

Below is a summary of what we have achieved in relation to this priority

- A Trust 'QI strategy time out' was held where a selection of Qi experts/ patient representatives met to develop the key drivers for the strategy.

- Staff stakeholder events were held in 2021 to gather the feedback from staff and we also have a lay member as a key stakeholder in the QI strategy development group.
- The 'Quality improvement Strategy' is complete and will become part of the wider quality strategy which will be launched in Summer 2022.
- Quality improvement projects have been identified and initiated through thematic analysis of learning from incidents / audits.

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

What we said we would do in 2021/22

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

What we did

Below is a summary of what we have achieved in relation to this priority

- The improvement team now offer expert support across the whole organisation and to all staff groups.
- The team has developed the 'Roadmap to improvement' toolkit a simple 6 stages to Quality improvement – this is an educational resource for staff
- The team have offered additional bespoke training on Qi throughout this year including the 'Quality Councils' – staff groups who are running their own QI programme in specialty areas.
- The improvement team use the 'Experience based design' model for capturing patient feedback in improvement projects.
- The team have supported the development of patient led videos on education.
- Although we share learning as a team, we are looking to source the technology that can support the wider sharing of improvement projects.

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

What we said we would do in 2021/22

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

What we did

Below is a summary of what we have achieved in relation to this priority

- Although we share learning as a team, we are looking to source the technology that can support the wider sharing of improvement projects.
- What do we mean by a QI charters? It's not something we use? We have used the highlight report template for the SI assurance work?
- Clinical Effectiveness have had featured articles in the Safety Spotlight and are a key stakeholder in the Safety Spotlight working group.

2.1.2 Our Patient Safety Priorities

Why this is important

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

Adverse incidents will and do occur but with a strong safety and learning culture the impact in terms of harm and recurrence will reduce. All staff must feel safe to report patient safety issues without fear of retribution, and be empowered to act swiftly to address risk. During the engagement exercise with our members they told us that we need to do more to support and care for our staff to enable them to feel safe to report incidents and learn.

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

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

What we said we would do in 2021/22

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

What we did

Below is a summary of what we have achieved in relation to this priority:

An important shift in culture has commenced in relation to how families are involved in serious incident investigations. It is important that patients, carers and families have the opportunity to ensure that questions they may have about the care form part of the terms of reference and are answered as part of the investigation. In order to achieve this we have revised the investigation report template to include answers to these questions and updated the Serious Incidents Policy to reflect that patients and families should be routinely involved in Serious Incident investigations.

In order to support this important cultural shift and also to strengthen the quality of investigations we commissioned serious incident investigation training which was delivered by Hempsons and over the next year we will build on this with the new Patient Safety Syllabus available from Health Education England.

Following the conclusions of investigations, investigators are expected to share the findings with the patient, carer or family and this is monitored through our serious incident panel. Over the coming year we will work with patients, carers and families to further improve how we involve and communicate with them regarding investigations. To inform this we are part of a research study aiming to improve Patient and Family Involvement with Serious Incident Investigations (PFISII) which is now known as ‘Learning Together’. The Trust has committed five Lead Investigators into the study, who have received bespoke training on the methodology. It is anticipated that the learning from this study will further shape our approach to involvement.

Priority Two: To develop a culture of safety at all levels of the organisation

What we said we would do in 2021/22

We said we would…

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

What we did

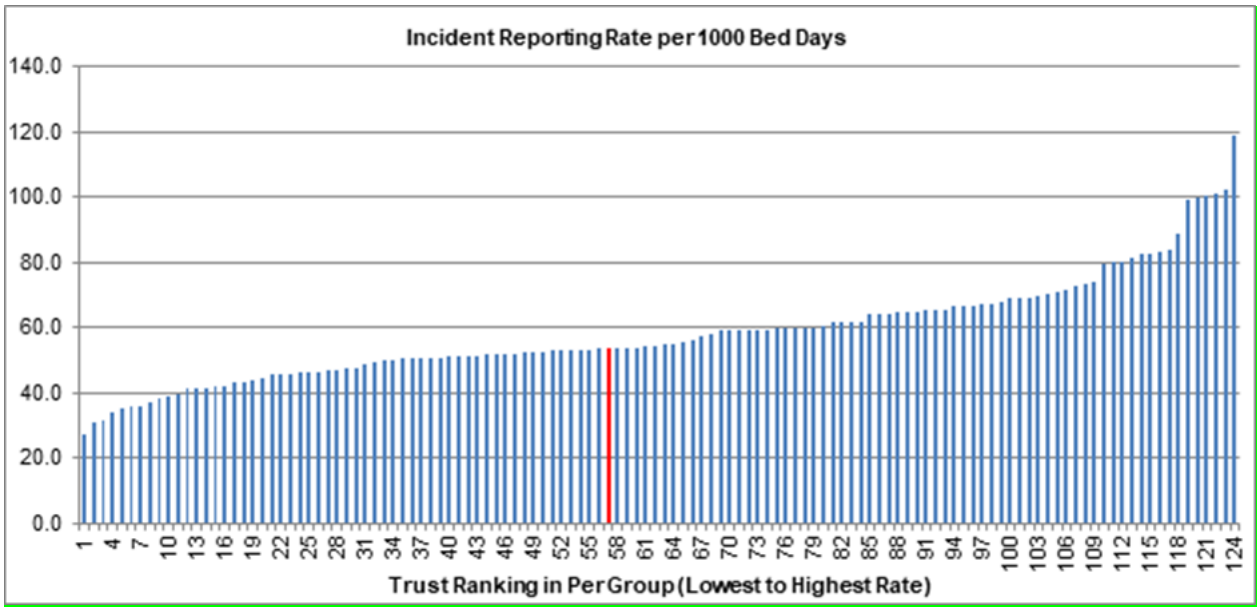
Below is a summary of what we have achieved in relation to this priority:

Patient Safety Walk Abouts were reintroduced in Summer 2021, with a brief trial held virtually due to the ongoing pandemic restrictions. The Walk Abouts are led by executives and non-executives and involve frequent visits to acute hospital and community inpatient wards. The purpose of the Walk Abouts is to enable discussions with frontline staff regarding any safety concerns they may have and champion work they are proud of. Following a further brief pause from January 2022 due to surge of the COVID-19 Omicron variant, these restarted in March 2022.

The Trust has appointed to the nationally required Patient Safety Specialist role. This role is pivotal in ensuring that the Trust is able to transition to the new patient safety Incident response Framework and ensure a robust approach to ensuring and improving patient safety.

The Trust have continued over the last year to strengthen incident reporting systems and embed a culture of reporting. The aim is for the Trust to be in the top quartile nationally for the reporting of no harm incidents. Being in the upper quartile will demonstrate that there is a strong safety culture in the organisation. Reporting is improving, despite the barriers that exist such as staffing pressures. The figure below shows the Trust position (red line) in comparison with other NHS providers across the country. The table below shows that the Trust is currently in the 3rd quartile nationally for reporting which represents an improvement from the 4th quartile the previous year. This demonstrates a positive impact of the work being undertaken.

Figure: Trust incident reporting position in comparison with other Trusts Nationally



The table below shows the quartile ranges and the Trust's performance.

Quartile Ranges

1st Quartile	27.2 - 49.0
2nd Quartile	49.4 - 54.2
3rd Quartile	54.7- 65.4
4th Quartile	66.4 - 118.7

Trust Performance	53.4

Over the last year considerable work has taken place to improve the quality and accessibility of Patient Safety data. The Information Team now produce a monthly report which is reviewed by the Quality and Patient Safety Group. However, data quality remains a key focus for the organisation, particularly in relation to data for quality improvement.

A large piece of work focussing on Serious Incident actions, led to the creation of new and recently reprioritised improvement groups. Ten improvement work streams have been established:

1. Treatment Escalation Plan, DNACPR & End of Life Group
2. Deteriorating Patient & Sepsis
3. Emergency Care – Quality & Safety
4. GI Bleed
5. Vascular Lines
6. Local Safety Standard for Invasive Procedures (LocSSIP)
7. Maternity Services
8. MDT
9. Fractured Neck of Femur
10. SAFER

The workstreams all report to the Oversight and Assurance Group for improvement. This group has a unique element in that workstreams leads can also access quality improvement coaching in addition to being held to account for delivery.

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

What we said we would do in 2021/22

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

What we did

Below is a summary of what we have achieved in relation to this priority

The Trust has rolled out the After Action Review (AAR) process from the 1 October 2021, as recommended by the National Audit of Inpatient Falls (NAIF), to replace the existing review process. This is a multidisciplinary process facilitated by the Matron that reviews what happened at the time of, and following, the fall. Patients and families are offered an opportunity to pose questions as part of this process although more work is needed to embed this.

A revised multifactorial risk assessment has been implemented across adult inpatient wards and a shortened version piloted then rolled out within our emergency departments, to ensure risk of falling is identified at the earliest opportunity and preventative measures put into place.

The Trust Falls Prevention Policy and the Safe and Effective use of Bed Rails Policy have been approved and replace the previous ones in practice. A new patient leaflet has been developed and implemented to support the use of bed rails.

Care following a patient fall has also been a focus of attention. The Trust has rolled out a new post falls sticker and poster that acts as an aide memoire to staff not to move the patient prior to checking for signs of injury and to record this in the notes. Several new pieces of flat-lifting equipment (called Hoverjacks) have been purchased and are now in place to assist safe transfer of patients who have fallen back to the bed.

Bespoke training was provided to wards with a high incidence of falls and improvement methodology used by ward staff to monitor progress and celebrate improvement.

Learning from patient falls is discussed and shared through the Falls Improvement Group and the Falls Learning & Improvement panel, as well as via safety newsletters and local safety huddles.

A steady reduction in the number of falls were reported from January to July 2021 however it has been challenging to attain the agreed trajectory consistently, particularly over the winter period as we have seen the acuity and dependency levels of our patients increase. An improvement programme of work has been agreed to continue to focus required efforts to prevent patient falls in inpatient wards, emergency departments, outpatient/day case areas and within our community services.

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

What we said we would do in 2021/22

We will:

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

What we did

Below is a summary of what we have achieved in relation to this priority

Skin injuries such as pressure ulcers and moisture associated skin damage is a common morbidity encountered by patients who experience prolonged periods of reduced mobility due to acute and chronic illness. This, with the increased use of medical devices, vastly compromises skin integrity further. At a local level, the incidence of pressure ulcer development has continued to be a challenge, increases appearing to coincide with the surges in Covid activity experienced over the last year. The Tissue Viability Nursing Team have been instrumental in supporting wards/areas with the highest incidence of pressure damage, including critical care units who have experienced higher incidence of device-related pressure ulcers, associated with the high acuity of patients. The incidence of pressure damage is monitored closely by the Pressure Ulcer Improvement Group and the Trust Board.

Regrettably the Trust has not met its target of eliminating all category 4 pressure ulcers where lapses in care have been identified and a zero tolerance approach will continue to be adopted.

The Trust has also seen a significant increase in patients admitted with pressure damage over the last year, indicating the deteriorating condition of many patients in our communities, which may be related to the pandemic, and patients choosing to stay at home and/or not access health services earlier.

Patient risk assessments are undertaken using a validated tool called Purpose-T from the moment a patient enters our services, either in the emergency department, inpatient ward when admitted to a District Nursing caseload. Robust care pathways are in place, which are triggered by the output of the risk assessment. Completion of these are monitored through weekly, monthly and quarterly inspections of our clinical areas and reported to the Pressure Ulcer Improvement Group to identify wards/clinical areas requiring additional support.

The Tissue Viability Nursing Team have been instrumental in supporting wards/areas with the highest incidence of pressure damage, including critical care units who have experienced higher incidence of device-related pressure ulcers, associated with the high acuity of patients.

The reporting process and governance arrangements for monitoring improvements and the incidence of pressure damage have been strengthened over the last year. Further work is required to involve patients and their loved ones and the investigation process will be amended in line with the national patient safety strategy and patient serious incident reporting framework from April 2022.

Although the further wave of Covid 19 has caused disruption across all services, and caused immense pressure in clinical areas, good practice relating to pressure area care is still being seen within our organisation. Community services clearly evidence this with the amount of pressure ulcers developed, compared with lapses in care noted.

2.1.3 Our Patient Experience Priorities

Why this is important

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

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

Priority One: Hear the voice of those patients who are seldom heard

What we said we would do in 2021/22

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

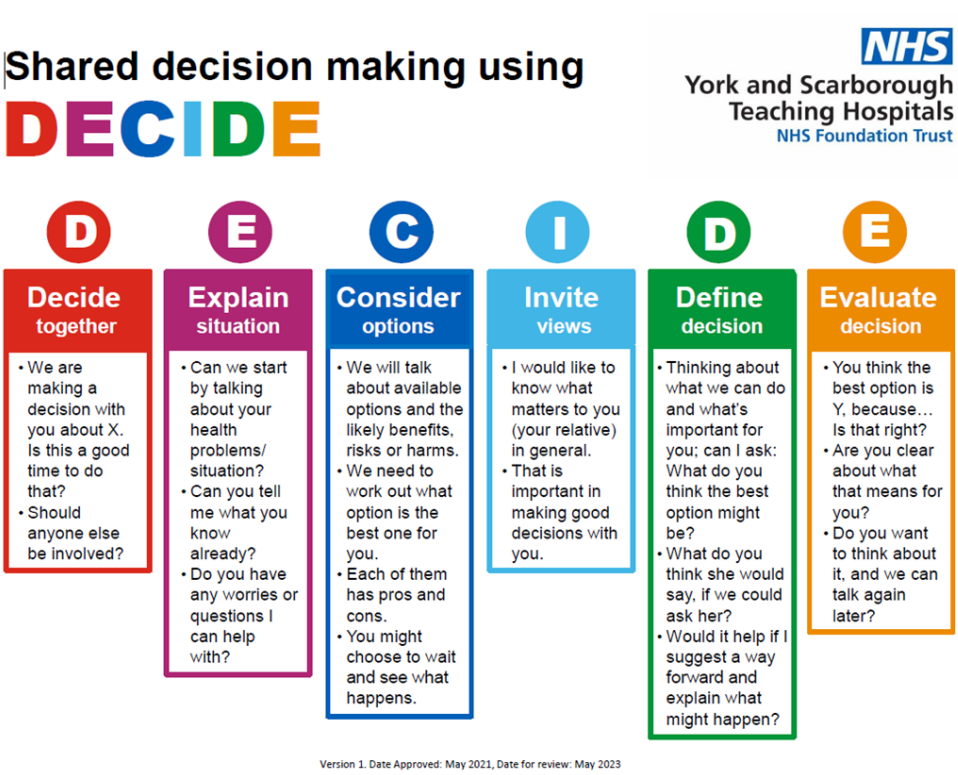
What we did

Below is a summary of what we have achieved in relation to this priority:

The Trust has established strong networking relationships with community groups including MySight, HealthWatch, etc., representatives of which are engaged on the Trust Patient Experience Steering group and Fairness Forum. Reports have been received from groups that are 'seldom heard' and action plans agreed in response.

A new document 'What Matters to Me' has been produced to improve the experience of any patient who finds it difficult to make their needs known when they are in hospital. It is designed to provide professionals with information about the person as an individual. It is not a medical document and can be filled in by staff or the patient's family or carers. It can be used whenever the patient accesses a service that may cause distress. 'What Matters to Me' records useful information such as the best way to communicate with the person, things that they enjoy or may be worried about, and daily routines. It can also help to overcome problems with communication, and prevent more serious conditions such as malnutrition and dehydration. 'What Matters to Me' replaces the previous document 'This is Me' and can be used for anyone who finds it difficult to make their needs known, with exception of patients with learning difficulties.

The Trust has introduced the DECIDE tool to support shared decision making.



Care group colleagues have led targeted improvement work to improve communication with relatives, particularly when visiting has been restricted throughout the pandemic.

In response to the pandemic, many outpatient appointments have taken place over video or telephone. To understand how patients feel about this, outpatients who have had a telephone consultation are asked an additional question via Friends & Family Test. Over the months of September, October and November, 88% of patients who had their outpatient appointment virtually and 94% of patients who had face to face appointments, rated their appointments as "very good" or "good". Positive feedback given by patients about virtual appointments included: no need to take time from work, reduced risks around covid-19 and no travelling or parking fees to pay.

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

What we said we would do in 2021/22

We said we would…
➢ We will work to improve fundamental standards of care, including nutrition and hydration, assistance with hygiene, timely discharge – this will include the use of Always Events improvement methodology to co-design solutions to improve the patient experience; ➢ We will involve patients, families and carers in quality improvement work; ➢ We will ensure we meaningfully capture and share patient feedback.

What we did

Below is a summary of what we have achieved in relation to this priority

Ensuring patients receive fundamental standards of care, is a key priority. The induction and initial training of Health Care Assistants (HCAs) has been redesigned to focus more time on practical aspects of care, including hygiene care, shaving, mouth care, nutrition and hydration. Care Group 3 have recruited a health care assistant to specifically work with HCAs in clinical practice, offering additional support and introducing them to 'the high standards' we expect to see from our workforce, which includes documentation around nutrition, food charts, fluid balance charts, etc.

The Head of Nursing & Patient Experience has worked to develop guidance on person-centred care planning, which was circulated to all Matrons and lead nurses. He has also been revising the questions asked during ward inspections, recorded on the 'Tendable' application for inspections of clinical areas (formerly Perfect Ward). The Patient Experience Team and Steering Group have been involved in reviewing the questions, to ensure they reflect what matters most to patients. This patient feedback will continue to be triangulated with other feedback from mechanisms, including national surveys, complaints and concerns, local surveys and the Friends and Family Test, with improvement actions developed in response.

The Deputy Chief Nurse is coordinating a number of improvement work streams in relation to improving nutrition and hydration for patients. Baseline audits have been undertaken on the quality of fluid balance charts as well as a snapshot survey of patient meal times to ascertain how well patients are supported at meal times. A number of task and finish groups and improvement schemes are working to improve the experience of fasting patients prior to surgery, undertaking effective swallow assessments and ensuring the correct modified texture diet is provided where needed.

The CQC visited on 30 March 2022 and were not assured that the fundamentals of care were being consistently delivered to our patients. Of particular concern was assurance relating to nutrition and hydration, which is impacted by staffing shortages across our wards. As a result we took immediate actions to close beds which had been open in response to the surge in COVID-19 patients at the time of the inspection. A comprehensive action plan has been developed which includes strengthened actions in relation to nutrition and hydration.

The Heads of Nursing are collaborating with the Lead Tissue Viability Nurse to review existing hygiene care plans to ensure they promote individualised patient care.

Significant strides have been made within the development of digital nursing documentation. The 1st phase of the digital development has gone live with the use of mobile devices to record patient observations on ward 11 at the end of January 2022. This has been well received by ward staff who can see many benefits, the use of digital technology releasing time to care for nursing staff.

Patient and carer representatives have supported a number of improvement initiatives, including supporting the development of the Quality Improvement Strategy, and the 'Autumn Project', aiming to improve care and communication for patients and families in the last days of life.

2.2 Looking Forward: Our Quality Priorities for 2022-23

In order to develop our priorities a virtual event was held in January 2022 with Members and Governors. This event chaired by the then interim Trust Chair Jenny McAleese and was the second event that the Trust has held with members to co-produce the quality priorities with lay members, the first being in 2021.

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

2.2.1 Our Improvement Priorities

Priority One: To develop a quality improvement training and education structure from beginner to expert

Why this is important

In order to implement our quality improvement strategy and ambition to develop a culture of continuous improvement, it is essential that we equip our staff with the necessary skills. The provision of quality improvement training will enable our staff to confidently undertake QI projects.

What we will do in 2022/23

We will:

- Develop a QI education structure from beginner to QI mentor
- Develop the 'How to do a QI project' intermediate quality improvement training to support staff in having the skills and confidence to be able to successfully lead and engage in a quality improvement project
- To commence the planning of the advanced QI mentor training programme

Priority Two: To ensure that Qi is accessible to all, part of everyday language and supported by effective leadership.

Why this is important

In order to develop a culture of continuous improvement it is important that quality improvement is embedded and supported by leaders. In doing so leaders need to develop a supportive culture that enables teams to come together to innovate and improve. Staff need access to QI training and coaching to enable them to use QI methodology to improve quality and safety issues they identify.

What we will do in 2022/23

We will:

- Design a quality improvement section in the new intranet with key QI resources for staff;
- Hold a monthly QI day where the improvement team are accessible to staff for education, questions, resources and queries around anything quality improvement
- Market and encourage the use of the 'Quality council' model for supporting quality improvement;
- Review and update the 'QI toolkit' resource to enable staff to undertake QI projects
- Continue to ensure that Quality Improvement is part of all leadership programmes.

Priority Three: Develop mechanisms for sharing and celebrating success

Why this is important

It is important that we share good practice developments across teams in order to improve the quality and safety for our patients. Celebrating success is helping to restore 'joy at work' and encouraging ongoing participation in quality improvement.

What we will do in 2022/23

We will:
➢ Encourage cross site projects where appropriate to encourage the sharing of good practice; ➢ For each project the improvement team supports, we will gather learning from external and internal sources for sharing good practice; ➢ The improvement team to highlight and nominate key projects for nominations in order to celebrate success.

2.2.2 Our Clinical Effectiveness Priorities

Priority One: Implement the use of QR codes for accessing key clinical documents and policies as determined by staff members working in the relevant area.

Why this is important

Accessing key clinical documents is imperative for safe and effective care delivery. It means that staff can check for any updates to practice at the time they need to know. QR codes will make this information much more accessible.

What we will do in 2022/23

We will:
➢ Create a project plan which identifies the key areas to focus on first, with a trajectory for all other areas also noted. ➢ Link Q-Pulse & Dr Toolbox to ensure documents are matched and streamlined prior to generating QR codes. ➢ Procure software to ensure QR codes can be generated in the most stable way for the organisation with minimal impact to practice. ➢ Have specialty specific posters with the most frequently used documents and information QR codes available in one singular space. (Minimum 5 specialties in this year).

Priority Two: Create a summary of learning from audit and effectiveness which can be shared in the 'Safety Spotlight'.

Why this is important

Sharing learning from audits and effectiveness will assist with delivering the most evidence-based care in a safe and effective way. It will enable the Trust to take action in response to findings from audits and shape care delivery for future patients.

What we will do in 2022/23

We will:

- Provide a minimum of 10 monthly summaries across the year for inclusion in Safety Spotlight, to include national audit & baseline assessments.
- Hold a minimum of 9 monthly clinical effectiveness meetings across the financial year, as a forum to share learning and identify improvements for service delivery.
- Receive a quarterly report from each Care Group to identify learning from local audits, and to measure activity against annual audit plans

Priority Three: **Process map National Mandated Audits from the start of the process to the finish to ensure the output can be used to drive improvements in care delivery.**

Why this is important

Accurate data is key to driving improvements in healthcare. Audits require accurate data from a single point of truth. This will ensure any results that are returned to the Trust are reflective of service delivery and will allow for improvements to driven in the right areas.

What we will do in 2022/23

We will:

- Ensure 20% of mandated clinical audits have a process mapped out from the start of the process to the finish to ensure the outputs are appropriately managed.
- Ensure 15% of mandated clinical audits have an agreed data collection process which aligns with the single point of truth from a data accuracy perspective.
- Ensure a trajectory plan is in place for the remaining 80% of mandated clinical audits, aligning this with the Trusts quality strategy.

2.2.3 Our Patient Safety Priorities

Why this is important

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care. The national patient safety strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.

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

Adverse incidents will and do occur but with a strong safety and learning culture the impact in terms of harm and recurrence will reduce. All staff must feel safe to report patient safety issues without fear of retribution, and be empowered to act swiftly to address risk. During the engagement exercise with our members they told us that we need to do more to support staff following the challenges posed by the pandemic, focussing on retention of staff. They also asked us to be better at celebrating the good practice.

Priority One: **Reducing harm to our patients.**

In 2022/23

We will….
➢ Continue to achieve and sustain a 10% reduction in the average number of falls per 1000 bed days (based on the last 12 months data) ➢ Improve compliance with the National Audit of Inpatient Falls (NAIF) audit to be in line with national average ➢ Eliminate all category 4 pressure ulcers where lapses in care have been identified for patients in our care ➢ Achieve 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks ➢ Achieve at least a 20% reduction in C-DIFF bacteraemia in 2022/23

Priority Two: **Deliver sustained safe staffing levels to meet the required care hours per patient day**

In 2022/23

We will…
➢ By April 2023, have no more than a 1% vacancy rate for Healthcare Assistants. ➢ By April 2023, have no more than a 7.5% vacancy rate for Registered Nurses. ➢ Triangulate date to understand impact of reduced staffing on patient care.

Priority Three: **Harness a culture of safety through identifying and sharing learning**

In 2022/23

We will…

- Continue to improve the patient safety incident reporting rate, aspiring to be in the upper quartile nationally.
- Improve staff response rates in both the annual staff survey and in the quarterly pulse surveys.
- Improve staff confidence in how the Trust deals with concerns raised.
- Launch a local just culture toolkit ensuring learning from incidents.
- Transition into the new Patient Safety Incident Response Framework.
- Create and deliver an internal Patient Safety conference in 2022; sharing local learning and improvements.

2.2.3 Our Patient Experience Priorities

In 2021 we commissioned an external review of our Patient Experience Team (PET) in order to identify opportunities for improvement to ensure we provide the best experience of care for our patients, and the staff who deliver our services. A series of recommendations were produced and we have enacted plans to deliver on these recommendations.

Following a recent engagement event linked to the development of the quality strategy, we have developed three strategic objectives to ensure we strive to provide the best patient experience. The following three objectives have been discussed and agreed through various working groups in the organisation, including the Patient Experience Steering Group. We have committed to:

- Provide the best possible experience for everyone accessing our services ensuring the fundamentals of care for all patients are met and they are cared for recognising their individual needs.
- Look after our staff and promote wellbeing, so they in turn can look after our patients and promote wellbeing; Happy Staff = Happy Patients.
- Achieve the authentic engagement of patients and public by ensuring our systems and processes support the embedding of change and influence transformation.

In order to achieve these objectives, for the next academic year we have set and agreed the following priorities.

Priority One: Restructure of patient experience team and development of a roadmap to clearly articulate the vision and journey for the next year

What we will do in 2022/23

We will:

- Articulate a clear vision for our patient experience team to ensure we have the correct structures and processes in place to support a culture of continuous improvement.
- Work with staff members across the organisation to provide a service which helps teams assess the patient experience of those in their care and identify opportunities for improvement.
- Work as a responsive team to ensure appropriate learning has been embedded following feedback from patients through complaints and concerns.

Priority Two: Review Patient Experience Reporting systems to ensure robust use of data and engagement from and with Care Group Leads

What we will do in 2022/23

We will:

- Ensure our reporting of patient experience is accurate, reliable, succinct and enables our healthcare professionals to identify what their local priorities should be;
- Be open and transparent about where we have identified the need for improvement and use data to inform our next steps, reporting on what we have observed and what we plan to do;
- Provide care groups with the support required to proactively take steps to improve patient experience through engagement and play an active role in co-producing service change.

Priority Three: Maximise both the use and support of our volunteer teams in response to significant operational pressures

What we will do in 2022/23

We will:

- Develop a vision and improvement plan for our volunteer services.
- Identify learning from our pilot of a new volunteer induction process to ensure our volunteers have a rewarding and fulfilling experience when they start in the organisation.
- Focus our efforts on recruiting younger adults to support our volunteer services.

2.3 Mandatory Reporting Requirements

2.3.1 Learning from Deaths

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

Learning from a review of the care provided to patients who die should be integral to a provider's clinical governance and quality improvement work. To fulfil the standards and reporting set out in the national guidance the Trust should ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care.

Trusts should also ensure that they share and act upon any learning derived from these processes. The standards expected of Trust boards include having an existing executive director take responsibility for the learning from deaths agenda and an existing non-executive director take responsibility for oversight of progress.

In 2021, a review of the Learning from Deaths process and policy was undertaken and has since been approved in February 2022. This new policy gives clear expectations of the process and responsibilities of individuals and Care Groups.

Learning from deaths mandatory reporting requirements:

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added new mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. These regulations are detailed below, and relate to Regulation 27:

27.1 The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure

- 437 in the first quarter (April 2021 – June 2021);
- 572 in the second quarter (July 2021 – September 2021);
- 673 in the third quarter (October 2021 – December 2021);
- 650 in the fourth quarter (January 2022 – March 2022)

27.2 The number of deaths included in question 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure

By 31 March 2021, 1510 case record reviews, 134 SJCR investigations and 42 Serious Incident investigations have been carried out in relation to the 2332 of the deaths included in item 27.1.

In 1,686 cases a death was subjected to both a case record review and / or an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 371 in the first quarter (April 2021 – June 2021);
- 456 in the second quarter (July 2021 – September 2021);
- 530 in the third quarter (October 2021 – December 2021);
- 329 in the fourth quarter (January 2022 – March 2022);

27.3 An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

11 representing 0.7% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient, however on review of these cases this did not impact on the outcome for the patient.

In relation to each quarter, this consisted of:

2 representing 0.5% for the first quarter (April 2021 – June 2021);
5 representing 1.1% for the second quarter (July 2021 – September 2021);
4 representing 0.8% for the third quarter (October 2021 – December 2021);
0 representing 0.0% for the fourth quarter (January 2022 – March 2022)

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

27.4 A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3. To include; A description of the actions which the provider has taken (27.5) and an assessment of the impact of the actions (27.6).

A summary of investigations conducted in relation to the deaths identified is below:

Thematic learning	Summary of completed action(s)	Impact
Poor awareness and compliance with Hyponatraemia	▪ Article about Hyponatraemia shared via Safety Spotlight Newsletter ▪ Review of Hyponatraemia protocol	▪ Increased awareness of hyponatraemia protocol ▪ Audit of compliance with protocol

Thematic learning	Summary of completed action(s)	Impact
Adherence to NEWS2 monitoring and associated escalation protocols	▪ A dashboard is available for monitoring NEWS2 adherence to enable continuous improvement ▪ A revised improvement group has been set up to improve compliance and effective escalation. ▪ Rebrand of the crash team to the Medical Emergency Team	▪ Continued collaborative working with the Trust Deteriorating Patient Improvement Group
Poor or Inappropriate Fluid Resuscitation	▪ New IV fluid chart launched ▪ Review of junior doctor training to ensure IV fluid is covered. ▪ Article about fluid management shared via Safety Spotlight Newsletter	▪ Increased awareness of fluid resuscitation ▪ More effective prescription chart to allow for reinforcement of key messages.
Failure to recognise, plan for or manage end of life including inappropriate cardiac arrest calls and low use of last days of life documentation / palliative care.	▪ Treatment Escalation Plan (TEP) replaces Ceiling of Care ▪ Electronic Palliative Care Coordination System (EPACC's) has gone live ▪ TEP data is now available on Signal on the Quality & Safety Dashboard.	▪ Allowing patients to choose care choices regarding their EoL care. ▪ Allow for easy access of monitoring compliance at the TEP/DNACPR Improvement Group

27.7 The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period

32 investigations (14 SJCRs and 18 SIs) were completed after 1st April 2020 which related to deaths which took place before the start of the reporting period

27.8 An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

11 representing 0.49% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using several methods; structured judgement case note review (SJCR) and serious investigations (SIs).

27.9 A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.

27, representing 1.2% % of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient

2.3.2. Seven Day Services

A series of clinical standards for seven-day hospital services were founded on published evidence and on the Academy of Medical Royal Colleges (AoMRC) position in relation to consultant-delivered acute care. Ten standards were agreed for adoption in acute in-patient hospitals.

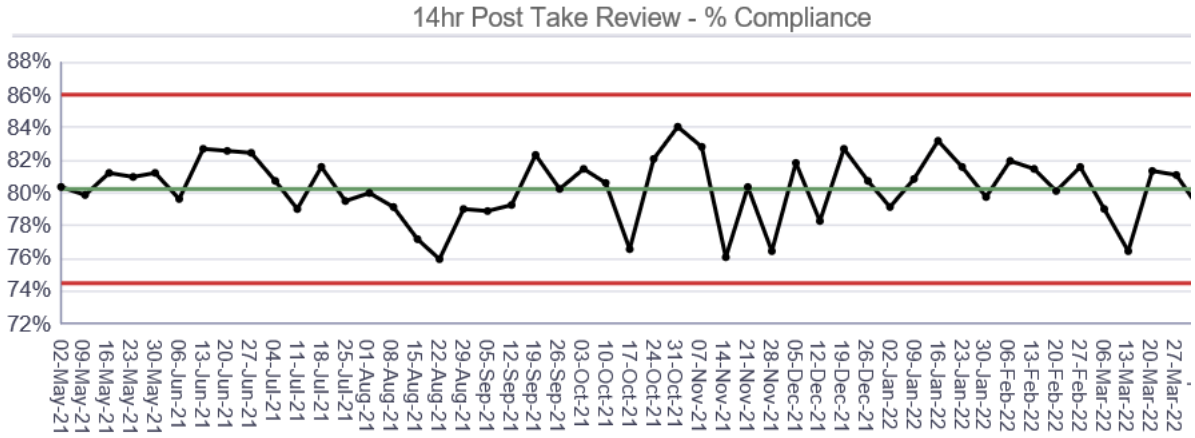
Four of the 10 standards were identified as priority clinical standards on the basis of their potential to positively impact patient outcomes. These shown below:

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

All Acute Trusts in England are required to undertake self-assessment surveys to measure compliance with the four priority standards for seven-day services. Due to the COVID-19 pandemic the external reporting was suspended however, performance in relation to 14-hour post take review and daily senior review is monitored monthly by the Board via the Trust Integrated Board report.

Clinical Standard 2 - Time to first consultant review and (more recently extended to include) the overall proportion of patients made aware of diagnosis, management plan and prognosis within 48 hours of admission.

National compliance for this standard is 90% for weekdays and weekends. Below shows our compliance is variable but was below the 80% mark for 23 weeks of the year and only above 80% for 23 weeks of the year, reaching the highest of 85%. The remaining weeks' compliance was at 80%.



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

Clinical Standard 5: Access to diagnostic tests

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

Within 1 hour for critical patients
Within 12 hours for urgent patients
Within 24 hours for non-urgent patients

Radiology- Currently, neither York nor Scarborough sites seven day access for MRI. However there is network agreement with Hull for out of hours.

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

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

Endoscopy and ERCP services. Saturday/Sunday - Critical acute bleed patients at Scarborough are transferred to York (formal networked arrangement) after discussion between the referring doctor and the on call York Gastroenterologist. This means there is

provision for critical patients over the weekend however there is currently no provision of inpatient endoscopy for Urgent/Routine patients.

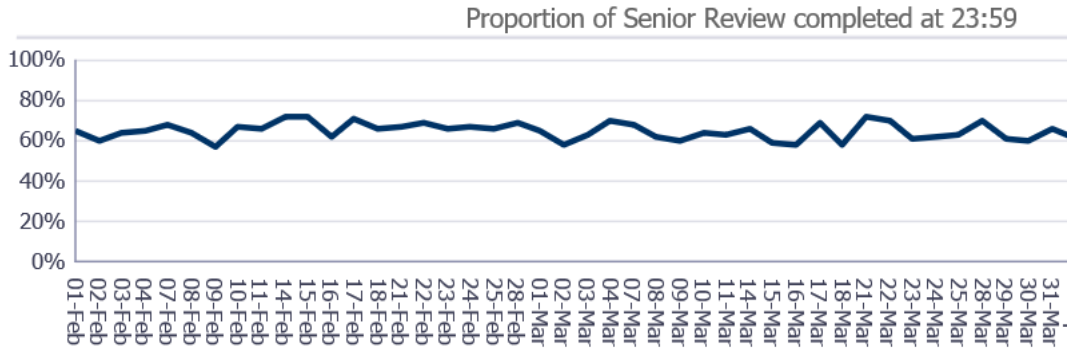
Clinical Standard 6: Access to consultant-directed interventions

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

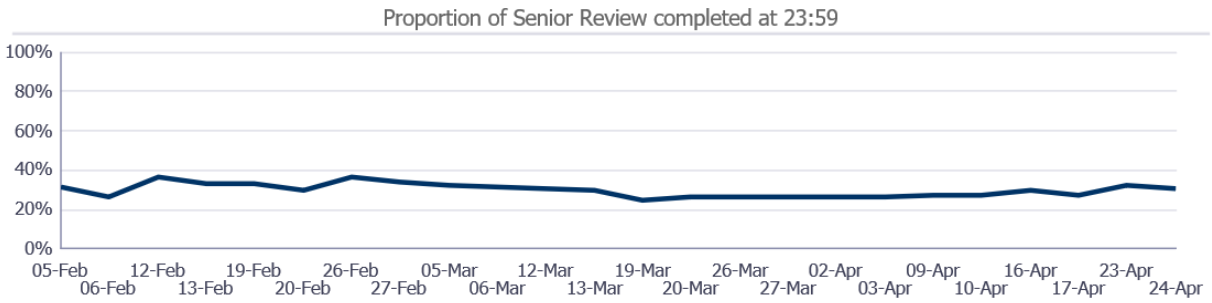
The Trust has determined that it is compliant with this standard.

Clinical Standard 8: Daily review by consultant; twice daily if high dependency

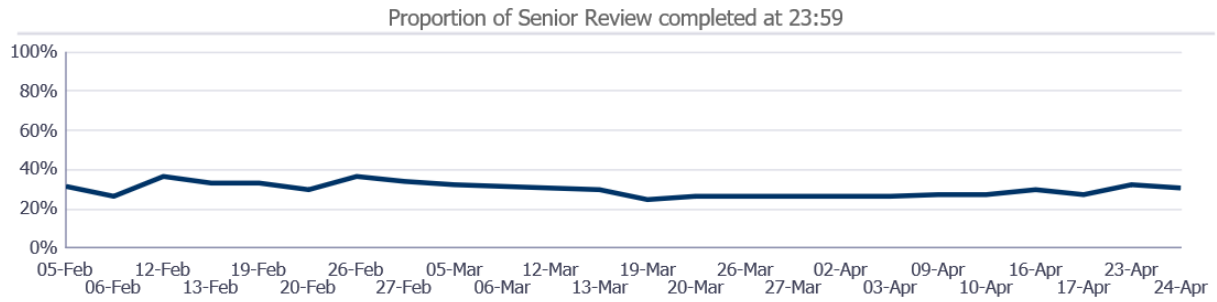
The proportion of senior review is illustrated below. This shows compliance for weekdays only. Hovering at 70% mark with dips shows at Christmas and New Year. This is a reduction from last year when we were reporting 80% compliance during the week Monday- Friday.



Below is compliance at the weekends, which is significantly lower. Below 40% mark, which is a similar position to last year. This is being addressed through ongoing work across the Care Groups and job plans continue to be reviewed to ensure consultants are able to fulfil their review requirements.



Below shows the patterns associated with the weekends.



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

To agree improvement trajectories with directorate teams

- Establish mechanisms at directorate level to monitor compliance with standard 2 and establish escalation processes if the standard is not being met
- Establish robust assurance processes to ensure compliance and improvement as part of Care Group governance
- Ensure workforce requirements meet the expectations of delivery of 7 day services

2.3.3. Freedom to Speak Up

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

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

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

We are committed to listening to our staff, learning lessons and improving patient care. Concerns received by the Freedom to Speak Up Guardian are recorded on a highly confidential database and staff receive an acknowledgement within four working days. The Guardian records the date the concern was received, whether confidentiality has been requested, a summary of the concerns and dates when staff have been given updates or feedback. The Freedom to Speak Up Guardian will also carry out a 3-month

well-being check as appropriate to ensure the member of staff has suffered no detriment as a result of raising a concern.

Ways in which staff can speak up

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

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

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

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

2.3.4 Information about the Guardian of Safe Working Hours

The 2016 national contract for junior doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came the introduction of a 'Guardian of Safe Working Hours' in organisations that employ, or host, NHS doctors and dentists in training to oversee the process of ensuring they do not work excessive hours with inadequate breaks.

The contract has stipulations on the length and frequency of shifts as well as rest breaks. Rosters are designed to these specifications but, the online reporting tool allows junior doctors to highlight variations from their work schedule. Variations include working extra hours (if essential for patient safety), missed teaching or training sessions, missed breaks and unsafe rest periods between shifts. Exception reports are primarily managed by the junior doctor's supervisor with oversight by the Guardian. Outcomes for each report can be closure with no further action (in terms of compensation), the allocation of payment for extra hours worked or time owing in lieu.

Exception reports can also lead to the host department being fined by the Guardian as well as initiating a review of staffing and rostering to tackle any systemic factors that may be contributing to the breach in contractual terms. Reports highlighting problems with teaching or training are shared with the Director of Medical Education.

The role of Guardian sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by the Trust. The work of the Guardian is subject to external scrutiny of doctors'

working hours by the Care Quality Commission (CQC) and by Health Education England (HEE) who oversee the quality of training.

In the 2020/21 Quality Report we described a period of reduced exception reporting relating to the pandemic. A steep rise was seen in the second quarter of this financial year. Reporting is now on par with pre-pandemic levels and we anticipate a further rise due to a change in local practice regarding self-development time (SDT).

SDT is applicable to doctors in Foundation Year Training and states that they should receive on average 2hrs/week to complete non-clinical activities relevant to their professional development, for example, completing audits and quality improvement projects. It became mandatory in August 2021. Official guidance from NHS Employers and HEE is that missed SDT does not fall into the remit of exception reporting. After internal discussions the Trust has opted to use the reporting tool as a method of monitoring and quality assurance.

In August 2021 the Trust moved to a new software provider for the online reporting tool. For the purpose of this report the impact is minimal and primarily relates to the inability for doctors to select more than one reason for each submission. This is the likely explanation for a drop in the number of reports received for "missed breaks" which often occurs in the context of working additional hours. However, if it is clear in the body of text contained within the report that additional options apply this is captured for monitoring and is reflected in the data.
Key metrics for this reporting period are highlighted below. Q1-4 values for 2020/21 contained within [ ] brackets:

Exception reports received by site (for financial year 2021/22 Q1-4)

Site	Number of exception reports
Scarborough Hospital	39 [43]
York Hospital	137 [50]
Total exception reports received	**176**

Types of reports received (for financial year 2021/22 Q1-4)

Nature	Type	Number of exception reports	Percentage of total reports*
Hours and rest	Additional hours worked	145 [83]	82.38%
	Missed breaks	42 [34]	23.86%
Education and training	Missed education and training	14 [12]	7.95%

** Percentage does not add up to 100% as individual reports may encompass more than one type of variance*

Hours and rest outcomes

Outcome type	Number of exception reports	Hours claimed	Value of hours claimed
Payment for additional hours worked	76	128.5	£1,937.25

Outcome type	Number of exception reports	Hours claimed	Value of hours claimed
Time off in Lieu	55	94.25	NA
Other action	45	NA	NA

Guardian fines for levied for contractual breaches of safe working hours: £0.00.

Rostering Gaps

Health Education England manages the national training numbers and regional distribution of doctors accepted into the different programs (grades and specialties).
Due to challenges with national recruitment not all of these posts are filled and the organisation aims to employ Trust Grade/Locally Employed doctors to cover these vacancies. In addition, the number of trainee posts allocated to the organisation as a whole isn't sufficient to deliver the level of care and service required. The Trust has recruited to a number of non-training posts that have been created over the years to combat this shortfall.

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

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

Vacancies in non-training posts vary between 12%-15% in York over Q1-Q4. In Scarborough there is a relatively stable figure of around 11%.
Trainee vacancies in York have increased steadily over the financial year to 12% In Scarborough this has been static at 11% over the same period.

The figures on vacancies are accurate for 11 months to February 2022.

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

- The successful bid for more Health Education England funded trainee placements in York and Scarborough. This will see a further 27 posts created over a period of 3 years.
- Development of innovative posts that combine clinical and non-clinical activities such as research or teaching.
- International recruitment drives with plans to enhance the pastoral support provided to International Medical Graduates (IMG's) when they join the Trust. The aim is to assist their successful integration into not just the organisation but the county of

Yorkshire. This will have implications on retention and further international recruitment through positive feedback to friend, relatives and former colleagues looking to make a similar transition.

- Increasing numbers of Advanced Clinical Practitioners.
- Improving the experience that medical students and junior doctors have in the organisation thereby making us a regional employer of choice. This is being achieved in a number of ways, for example, providing extra annual leave on top of the statutory minimum, improving rest facilities, hosting annual Junior Doctor Awards and providing a voice via the Junior Doctors' Forum.

2.4 Statement of Assurance from the Board of Directors

2.4.1 The Regulations

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

2.4.2 Assurance from the Board

During 2021/22 York and Scarborough Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 30 relevant health services.

York and Scarborough Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 30 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/22 represents 100 per cent of the total income generated from the provision of relevant health services by York and Scarborough Teaching Hospitals NHS Foundation Trust for 2021/22. The income generated has been received from services commissioned by Clinical Commissioning Groups, NHS England, and the Local Authorities.

2.4.3 Participation in National Clinical Audits and National Confidential Enquiries

During 2021/22, 54 national clinical audits and 6 national confidential enquiry reports / review outcome programmes (NCEPOD) covered relevant health services that the York and Scarborough Teaching Hospitals NHS Foundation Trust provides.

During that period the Trust participated in 51 (94%) of the national clinical audits and 6 (100%) of the NCEPODs. Participation did not occur for 3 (6%) national clinical audits due to ongoing improvement work. This renders the Trust 95% compliant with participation for all eligible listings within the Quality Accounts.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2021/22 are as follows:

National Clinical Audits			National Confidential Enquiries
ICNARC CMP Case Mix Programme	NACAP National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care	GICAP National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	*NCEPOD Child Health Clinical Outcome Review Programme – Transition from Child to Adult Health Services*
Chronic Kidney Disease Registry (was previously UK Renal Registry)	NACAP National Asthma and COPD Audit Programme - Adult Asthma Secondary Care	NJR National Joint Registry	*NCEPOD Medical and Surgical Clinical Outcome Review Programme - Community Acquired Pneumonia*
Elective Surgery - National PROMs Programme - Hips	NACAP National Asthma and COPD Audit Programme - COPD Secondary Care	NLCA National Lung Cancer Audit	*NCEPOD Medical and Surgical Clinical Outcome Review Programme – Crohn's Disease*
Elective Surgery - National PROMs Programme - Knees	NACAP National Asthma and COPD Audit Programme - Pulmonary Rehabilitation	NMPA National Maternity and Perinatal Audit	*NCEPOD Medical and Surgical Clinical Outcome Review Programme - Epilepsy*
RCEM Emergency Medicine QIPs - Pain in Children 2021-22	NABCOP National Audit of Breast Cancer in Older People	NNAP National Neonatal Audit Programme	*NCEPOD Medical and Surgical Clinical Outcome Review Programme - Dysphagia in People with Parkinson's Disease*
RCEM Emergency Medicine QIPs - Infection Prevention & Control 2021-22	NACR National Audit of Cardiac Rehabilitation	NPDA National Paediatric Diabetes Audit	*NCEPOD Medical and Surgical Clinical Outcome Review Programme - Physical Health in Mental Health Hospitals*
RCEM Emergency Medicine QIPs - Consultant Sign Off 2021-22	NACEL National Audit of Care at the End of Life	MBRRACE National Perinatal Mortality Review Tool	
FFFAP Falls and Fragility Fractures Audit Programme - National Audit of Inpatient Falls	NAD National Audit of Dementia - Care in General Hospitals	NPCA National Prostate Cancer Audit	
FFFAP Falls and Fragility Fractures Audit Programme - National Hip Fracture Database	Epilepsy12 National Audit of Seizures and Epilepsies in Children and Young People	NVR National Vascular Registry	

National Clinical Audits			National Confidential Enquiries
IBD Inflammatory Bowel Disease - Service Standards	NCAA National Cardiac Arrest Audit	BTS Respiratory Audits – National Outpatient Management of Pulmonary Embolism	
IBD Inflammatory Bowel Disease - Biological Therapies Audit	NCAP National Cardiac Audit Programme - National Cardiac Rhythm Management	BTS Respiratory Audits – National Smoking Cessation 2021 Audit	
LeDeR Learning Disability Mortality Review Programme	NCAP National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	SSNAP Sentinel Stroke National Audit Programme	
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Confidential Enquiries	NCAP National Cardiac Audit Programme - Percutaneous Coronary Interventions	SHOT Serious Hazards of Transfusion: UK National Haemovigilance Scheme	
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	NCAP National Cardiac Audit Programme - Heart Failure Audit	SAMBA Society for Acute Medicine's Benchmarking Audit	
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality Surveillance and Mortality Confidential Enquiries	National Child Mortality Database	RESECT Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	
NDA National Diabetes Audit - Adults - National Core Diabetes Audit	NCA National Comparative Audit of Blood Transfusion Programme – 2021 Audit of Patient Blood Management & NICE Guidelines	TARN Major Trauma Audit	
NDA National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	NEIAA National Early Inflammatory Arthritis Audit	CFR UK Cystic Fibrosis Registry (Adult & Paediatric)	
NDA National Diabetes Audit - Adults - National Diabetes Foot Care	NELA National Emergency Laparotomy Audit	BAUS Urology Audits – Cytoreductive Radical	

National Clinical Audits			National Confidential Enquiries
Audit		Nephrectomy Audit	
NDA National Diabetes Audit - Adults - National Diabetes Inpatient Audit	GICAP National Gastro-intestinal Cancer Programme - Oesophago-Gastric Cancer	BAUS Urology Audits – Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	

The national clinical audits and national confidential enquiries that the Trust participated in during 2021/22 are listed below.

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
CMP Case Mix Programme	This audit looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	Yes	Continuous data collection	Publishes hospital level data only, not benchmarked nationally
NCEPOD Child Health Clinical Outcome Review Programme – Transition from Child to Adult Health services	To explore the barriers and facilitators in the process of the transition of young people with complex chronic conditions from child to adult health services.	Yes	Data collection July 2021 – March 2022	Organisational questionnaire returned December 2021
Chronic Kidney Disease Registry (was previously UK Renal Registry)	Data collected by the Renal Association are used to conduct a wide range of audit and research work to improve the lives of people with kidney disease.	Yes	Continuous data collection	National report expected June 2022
Elective Surgery - National PROMs Programme	This audit looks at patient reported outcome measures in NHS funded patients eligible for hip or knee replacement.	Yes	Continuous data collection	Publishes hospital level data on a monthly basis (>24 months previous)
RCEM Emergency Medicine QIPs - Pain in Children (Care in Emergency Departments)	This QIP will identify current performance in EDs against nationally agreed clinical standards to improve the care provided to paediatric patients in the ED who present in moderate or severe pain with a limb fracture.	Yes	Data collection from 04-October-21 to 04-April-22	No publication date yet identified
FFFAP Falls and Fragility Fractures Audit Programme - National Audit of Inpatient Falls	The audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.	Yes	Continuous data collection	National report published November 2021, not yet benchmarked nationally

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
FFFAP Falls and Fragility Fractures Audit Programme - National Hip Fracture Database	The audit measures quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform.	Yes	Continuous data collection	National report published November 2021
IBD Inflammatory Bowel Disease - Biological Therapies Audit	The IBD Registry biological therapies audit collected data on all patients of all ages diagnosed with the ICD-10 codes and receiving biological therapy at any time during the year. The data was requested at three time points: initiation, post-induction review and 12-month review.	TBA	Continuous data collection	The Trust is yet to start data submission
LeDeR Learning Disability Mortality Review Programme	The learning from deaths of people with a learning disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities.	Yes	Continuous data collection	National report published May 2021, not benchmarked nationally
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Confidential Enquiries	This enquiry concerns intrapartum stillbirths and intrapartum related neonatal deaths in multiple births.	Yes	Continuous data collection	No publication date yet identified
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	The study addresses late foetal losses – baby delivered between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred. Terminations of pregnancy - resulting in a pregnancy outcome from 22+0 weeks gestation onwards. Stillbirths – baby delivered from 24+0 weeks gestation showing no signs of life. Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth. Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of	Yes	Continuous data collection	National report published October 2021

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
	gestation is not available) occurring between 7 and 28 completed days after birth.			
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality Surveillance and Mortality Confidential Enquiries	All deaths of women who die during pregnancy or up to one year after the end of the pregnancy regardless of how the pregnancy ended or the cause of death.	Yes	Continuous data collection	National report published November 2021
NCEPOD Medical and Surgical Clinical Outcome Review Programme – Community Acquired Pneumonia	This study will look at variation in the processes of care of patients presenting to hospital with community acquired Pneumonia.	Yes	Data collection Spring 22	Data collection to commence April 22
NCEPOD Medical and Surgical Clinical Outcome Review Programme – Crohns Disease	A Review of remediable factors in the quality of care provided to patients with Crohn's disease.	Yes	Data collection October 2021 – March 2022	Data collection spreadsheet submitted. Clinician questionnaires to be circulated April 2022
NCEPOD Medical and Surgical Clinical Outcome Review Programme – Epilepsy	To investigate variation and remediable factors in the processes of care of patients presenting to hospital following an epileptic seizure.	Yes	Data collection April 2021 – December 2021	All data submitted. Awaiting publication of National Audit Report
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Dysphagia in People with Parkinson's Disease	This study aims to examine the pathway of care of patients with Parkinson's disease (PD) who are admitted to hospital when acutely unwell. In particular, to identify and explore multidisciplinary care and review organisational factors in the process of identifying, screening, assessing, treating and monitoring the ability to swallow.	Yes	Data collection completed in 2020	National report published August 2021
NCEPOD Medical and Surgical Clinical	This study aims to identify and explore remediable factors in the physical healthcare of adult patients admitted to an inpatient mental	Yes	Data collection April 2021 – March	Data collection closed. Awaiting publication of National Audit

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
Outcome Review Programme - Physical Health in Mental Health Hospitals	health facility.		2022	Report
NDA National Diabetes Audit - Adults - National Core Diabetes Audit	National Diabetes Audit collects information on people with diabetes and whether they have received their annual care checks and achieved their treatment targets as set out by NICE guidelines.	Yes	Continuous data collection	No publication date yet identified
NDA National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	The audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	Yes	Continuous data collection	National report published October 2021
NDA National Diabetes Audit - Adults - National Diabetes Foot Care Audit	Patients referred to specialist diabetes footcare services for an expert assessment on a new diabetic foot ulcer.	Yes	Continuous data collection	No publication date yet identified
NDA National Diabetes Audit - Adults - National Diabetes Inpatient Audit	The National Diabetes Inpatient Audit (NaDIA) is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical wards. NaDIA allows hospitals to benchmark hospital diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and outcomes.	Yes	Continuous data collection	No publication date yet identified
NACAP National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care	The audit looks at the care children and young people with asthma get when they are admitted to hospital because of an asthma attack.	Yes	Continuous data collection	National report published May 2021. Scarborough Hospital did not complete data submission for Organisational Audit 2021 for which additional support has been established to ensure all submissions are locked before the deadline
NACAP National Asthma and COPD Audit Programme - Adult Asthma	The audit looks at the care of people admitted to hospital adult services with asthma attacks.	Yes	Continuous data collection	No publication date yet identified. Review undertaken at care group level and action plan drawn-up regarding

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
Secondary Care				achievement of Best Practice Tariff standard.
NACAP National Asthma and COPD Audit Programme - COPD Secondary Care	The aim of the audit is to drive improvements in the quality of care and services provided for COPD patients.	Yes	Continuous data collection	National report published June 2021
NABCOP National Audit of Breast Cancer in Older People	This audit evaluates the quality of care provided to women aged 70 years and older by breast cancer services in England and Wales.	Yes	Continuous data collection	National report published August 2021
NACR National Audit of Cardiac Rehabilitation	The audit aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.	Yes	Continuous data collection	National report published November 2021
NACEL National Audit of Care at the End of Life	The aim of the audit is to improve the quality of care of people at the end of their life for people receiving NHS funded care in England, Wales and Northern Ireland.	Yes	Yearly June - October	No publication date yet identified
NAD National Audit of Dementia - Care in General Hospitals	The audit measures the performance of general hospitals against criteria relating to care delivery which are known to impact upon people with dementia while in hospital.	No	Casenote Audit June – September 2021	Trust not participating due to ongoing Trustwide improvement work streams – approval from Dementia Group & QPaS noted
Epilepsy12 National Audit of Seizures and Epilepsies in Children and Young People	The audit aims to address the care of children and young people with suspected epilepsy who receive a first paediatric assessment from April 2018 within acute, community and tertiary paediatric services.	Yes	Continuous data collection	National report published July 2021
NCAA National Cardiac Arrest Audit	The project audits cardiac arrests attended to by in-hospital resuscitation teams.	Yes	Continuous data collection	Publishes hospital level data only, not benchmarked nationally
NCAP National Cardiac Audit Programme - National Cardiac Rhythm Management (CRM)	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	Yes	Continuous data collection	National report published October 2021
NCAP National Cardiac Audit Programme - Myocardial	The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 in response to the National Service Framework	Yes	Continuous data collection	National report published October 2021

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
Ischaemia National Audit Project (MINAP)	(NSF) for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.			
NCAP National Cardiac Audit Programme - Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	This project looks at percutaneous coronary intervention (PCI) procedures performed in the UK. The audit collects and analyses data on the nature and outcome of PCI procedures, who performs them and the general health of patients. The audit utilises the Central Cardiac Audit Database (CCAD) which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.	Yes	Continuous data collection	National report published October 2021
NCAP National Cardiac Audit Programme - Heart Failure Audit (HFA)	The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.	Yes	Continuous data collection	National report published October 2021
National Child Mortality Database	The National Child Mortality Database (NCMD) collects data on the deaths of all live-born children in England who die before their 18th birthday. The purpose of collating information nationally is to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.	Yes	Continuous data collection	National report published June 2021
NCA National Comparative Audit of Blood Transfusion Programme – 2021 Audit of Patient Blood Management & NICE Guidelines	The National Comparative Audit of Blood Transfusion (NCABT) is a programme of clinical audits which looks at the use and administration of blood and blood components in NHS and independent hospitals in England and North Wales.	Yes	October – December 2021	National report published March 2022
NEIAA National Early Inflammatory Arthritis Audit	The audit aims to improve the quality of care for people living with inflammatory arthritis.	Yes	Continuous data collection	National report expected January 2022
NELA National Emergency Laparotomy Audit	NELA aims to look at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	Yes	Continuous data collection	National report published November 2021
GICAP National	The oesophago-gastric (stomach) cancer audit aims to examine the	Yes	Continuous data	National report published

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
Gastro-intestinal Cancer Programme - Oesophago-Gastric Cancer	quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all O-G cancer patients, both curative and palliative.		collection	December 2021
GICAP National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	Colorectal (large bowel) cancer is the most common cancer in non-smokers and second most common cause of death from cancer in England and Wales. Each year over 30,000 new cases are diagnosed, and bowel cancer is registered as the underlying cause of death in half of this number.	Yes	Continuous data collection	National report published January 2022
NJR National Joint Registry	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.	Yes	Continuous data collection	National report published November 2021
NLCA National Lung Cancer Audit	Lung cancer has the highest mortality rate of all forms of cancer in the western world and there is evidence that the UK's survival rates compare poorly with those in the rest of Europe. There is also evidence that, in the UK, standards of care differ widely. The audit was set up to monitor the introduction and effectiveness of cancer services.	Yes	Continuous data collection	National report published January 2022
NMPA National Maternity and Perinatal Audit	A new large scale audit of NHS maternity services across England, Scotland and Wales, collecting data on all registrable births delivered under NHS care.	Yes	Data collection is via the NHS Digital Maternity Services Dataset	National report published October 2021
NNAP National Neonatal Audit Programme	To assess whether babies requiring specialist neonatal care receive consistent high quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	Yes	Continuous data collection	National report published March 2022
NPDA National Paediatric Diabetes Audit	The audit covers registrations, complications, care process and treatment targets.	Yes	Continuous data collection	National report published June 2021
MBRRACE National Perinatal Mortality Review Tool	A collaboration led by MBRRACE-UK was appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'.	Yes	Continuous data collection	National report published October 2021

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
	The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.			
NPCA National Prostate Cancer Audit	The National Prostate Cancer Audit is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	Yes	Continuous data collection	National report published January 2022
NVR National Vascular Registry	The National Vascular Registry collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.	Yes	Continuous data collection	National report published November 2021
BTS Respiratory Audits – National Outpatient Management of Pulmonary Embolism	The BTS Audit of Outpatient Pulmonary Embolism Management in the UK seeks to identify where improvements can be made in this area to align practice to BTS Quality Standards and other guidance.	Yes	April – May 2021	Data entry started 01- September-2021. Data submission completed January 2022
BTS Respiratory Audits – National Smoking Cessation 2021 Audit	The treatment of tobacco addiction is one of the cornerstones of the BTS strategic plan. It is hoped that the audit will help hospitals to recognise service deficiencies and provide both impetus and justification for healthcare providers to create an environment that is more conducive to helping patients that smoke to quit.	No	July – October 2021	Trust not participating due to ongoing Trustwide improvement work streams – approval from Care Group & QPAS noted.
SSNAP Sentinel Stroke National Audit Programme	The audit collects data on all patients with a primary diagnosis of stroke, including any patients not on a stroke ward. Each incidence of new stroke is collected.	Yes	Continuous data collection	Post-acute Organisational Audit Report published December 2021. Acute Organisational Report trust level data/ results available April 2022. National report to be published June 2022
SHOT Serious Hazards of Transfusion: UK National Haemovigilance Scheme	The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.	Yes	Continuous data collection	National report publication delayed
SAMBA Society for Acute Medicine's Benchmarking Audit	The SAMBA is a national benchmark audit of acute medical care. The aim is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and	Yes	September 2021 – March 2022	National report published October 2021

National Audit Topic	What is the Audit about	Trust Participation in 2021-22	Data Collection 2021-22	Outcome
	progress at seven days after admission and to provide a comparison for each participating unit with the national average.			
RESECT Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	RESECT aims to answer some key UNKNOWNS: 1. Does reporting and comparing our TURBT quality make us do it better? 2. What things should we measure to determine TURBT quality? 3. What rate of achievement should we aim for in our practice? 4. What factors are associated with better achievement of TURBT quality?	Yes	2021	National report expected late 2022
TARN Major Trauma Audit	TARN is working towards improving emergency health care systems by collating and analysing trauma care.	Yes	Continuous data collection	No publication date yet identified
CFR UK Cystic Fibrosis Registry (Adult & Paediatric)	This audit looks at the care of people with a diagnosis of cystic fibrosis under the care of the NHS in the UK.	Yes	Continuous data collection	National report published December 2021, not benchmarked nationally
BAUS Urology Audits – Cytoreductive Radical Nephrectomy Audit	Results are published by consultant on the website, report is not produced. Outcomes data are only published for those centres or Consultants who have submitted follow-up data on more than 50% of their patients.	Yes	April 2020 – December 2020. Work stream closed, no reporting expected	Consultant Outcome Publication only
BAUS Urology Audits – Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Results are published by consultant on the website, report is not produced. Outcomes data are only published for those centres or Consultants who have submitted follow-up data on more than 50% of their patients.	Yes	April 2021 – December 2021	Consultant Outcome Publication only

The reports of 53 national clinical audits were reviewed by the provider in 2021/22 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- A Clinical Effectiveness Officer will be allocated to each Quality Account as a link person for the audit lead; they will meet on a minimum quarterly basis to determine progress with data submission, ascertain any red-flags from data submission so far, and develop a good working relationship to enhance effective communication.
- Upon receipt of a national audit report, a Clinical Effectiveness Officer will arrange an MDT meeting with the audit lead and any relevant stakeholders to discuss the findings, share learning, determine how the results will be shared, develop an action plan where required, and benchmark against the report recommendations.

- The Clinical Effectiveness Team will contact and request support from the Quality Improvement Team for audits which have metrics demonstrating reduced compliance when compared nationally.
- Upon receipt of national audit reports, they will be added to the weekly Quality & Safety meeting agenda for sharing across the organisation to ensure early stakeholder oversight. Any immediate risks will be determined and shared through the weekly Q&S meeting.

The reports of 105 local clinical audits were reviewed by the provider in 2021/22 and the Trust intends to take the following actions to improve the quality of healthcare provided:

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

2.4.4 Research and Development

The aim of clinical trials is to increase knowledge about treatments to ensure treatments are based on the best possible evidence. Clinical trials are a type of research that studies new tests and treatments and evaluates their effects on human health outcomes. Research offers participants the opportunity to be involved in research which may or may not be of benefit to them.

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

This annual target is divided between the 22 partner organisations, of which we are one. To reach the 65,000 the Y&H CRN requires our hospital to set a stretching target of 4020 patients accrued into clinical trials in our Trust from 1 April 2021 to 31 March 2022. It's important that we meet this target as this will determine our money flow into the Trust next financial year, which pays for all the research staff we have.

Currently we have approximately 136 research studies open to recruitment. The number of patients receiving relevant health services provided or sub-contracted by York & Scarborough Teaching Hospitals in the period 1 April 2021 to 31 March 2022 that were recruited during that period to participate in research approved by a research ethics committee is 4583.

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

- The Trust recruited 1183 participants to complete a short online questionnaire about the impact Coronavirus has had on day-to-day life and mental health. This study helped researchers find out what is helpful for people during this time and what may be causing some people to be affected more than others in terms of their wellbeing.

- Sunflower study has recruited 60 participants at York and Scarborough Teaching Hospitals NHS Foundation Trust. We have been the national top recruiter recently out of 55 sites. The team have been asked to present at the Investigator meeting as recruitment has been so successful due to the hard work of both the research teams in York and Scarborough.

- The Bridlington Eye Assessment Project (BEAP) Age-related Macular Degeneration (AMD) Study: Characterising Phenotypes and Genotypes in a UK Population Cohort hit target with 696 participants recruited into the study. This has been a huge collaborative effort between the research team and clinical staff from the Ophthalmology Unit at York Community Stadium.

- The team alongside colleagues at the University of York recruited 54 participants to a COVID-19 Vaccine Trial in Adults 18 Years of Age or Older. The study has been a huge success resulting in The Medicago plant based Vaccine being approved and licenced for use in Canada, we will therefore, hopefully see this novel vaccine licenced in the UK soon.

- The Research and Development Team have recruited 75 participants to take part in a Trust led clinical trial to see whether using mouthwash can inactivate the COVID-19 virus. This Public Health England (PHE) funded study hope to prove multiple commercially available mouthwashes reduce the level of SARS-CoV-2, the virus that causes COVID-19, in the mouth.

- We have worked hard in the last year to encourage early career researchers, as such we now have 13 members of staff in both Allied Health Professionals and Nursing undertaking research qualifications at both Undergraduate and Doctorate level. This demonstrates our continued collaborations and drive to provide research education at all levels making it accessible to all.

- York and Scarborough Teaching Hospital NHS Foundation Trust have launched the Multi-Morbidity Research Hub at Scarborough Hospital this year. The aim of the research Hub (funded by the Trust and the Clinical Research Network) is to grow and develop clinical research at Scarborough and to improve the access to research for the large, under-researched population of Scarborough. The Hub will provide a route into research for patients with long term conditions that are being managed in primary care but who currently do not have access to research studies.

- This year we have appointed a Commercial Research Manager whose role is to attract commercial research to our Trust. The reason why we wish to attract such funds are two fold, one, having a large commercial portfolio demonstrates that we are a strong high quality research active Trust with a good track record in research delivery. Secondly, commercial income will supply additional income that will allow us to grow our research and deliver on our R&D Strategy.

Finally, our new appointments, research hub and relationships with universities continue to grow with an increasing number of innovative collaborations and joint grants submissions being developed this year.

Yet again 2021-2022 has been a great year for us, we are very proud of our staff and the amazing achievements from this year.

2.4.5 Commissioning for Quality and Innovation Payment Framework

Due to the COVID-19 pandemic CQUINs were suspended for quarter four of 2019-20 and for the entirety of 2020/21 and 2021/22. We have agreed the following CQUINs for 2022-23:

Scheme	Description
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery.	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24.
CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service.	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.
CCG8: Supporting patients to drink, eat and mobilise after surgery.	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.
CCG15: Assessment and documentation of pressure ulcer risk.	Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.

Scheme	Description
PSS1: Achievement of revascularisation standards for lower limb Ischaemia.	Following guidance published by the Vascular Society to reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia and in turn reduce length of stay, in-hospital mortality rates, readmissions and amputation rates. Estimated annual savings are £12 million.
PSS2: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery.	Achieving high quality shared decision making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits and consequences of the options available to them with regard to both their clinical condition and the consequences of the current pandemic.
PSS5: Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines.	The aim of this indicator is to reduce the risks of harm to patients from a combination of: not being categorised and then, should they have been categorised as priority 2 or 3, waiting longer than the clinically advised thresholds of four weeks and twelve weeks respectively.

2.4.6 Care Quality Commission

York and Scarborough Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Registered with Conditions'. The CQC took enforcement action against York Teaching Hospital NHS Foundation Trust in 2019/2020 and during 2021/22 the following conditions on registration remained in place:

York Hospital

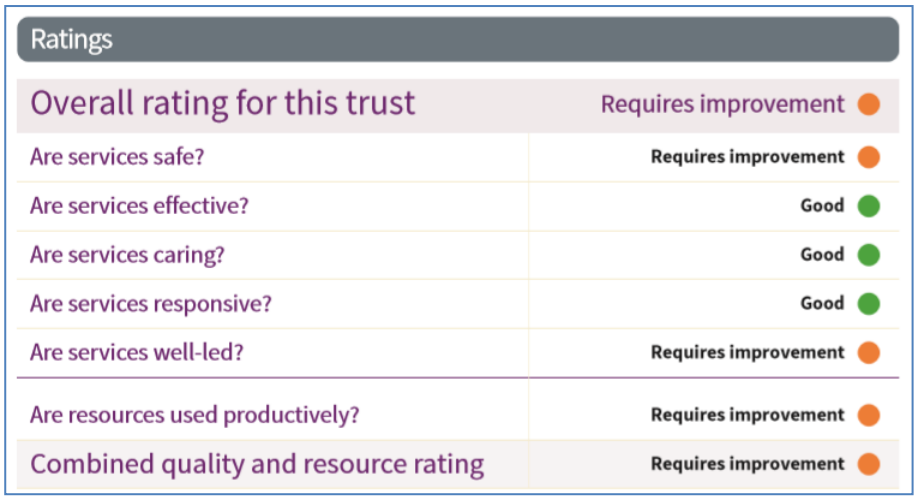
1. The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.

Scarborough Hospital

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

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

York Teaching Hospitals NHS Foundation Trust last received a full inspection in July 2019 with an overall Trust rating of 'Requires Improvement'. Following the last CQC inspections, York and Scarborough Teaching Hospitals NHS Foundation Trust developed a comprehensive action plan. Since the inception of the action plan, significant actions have been taken to improve safety with 97% of all actions having been completed. As a result 5 conditions associated with registration were removed from the Trusts registration status. This demonstrates significant improvements in safe care delivery. The remaining 2 conditions associated with registration are reliant upon the embedding of mental health risk assessments within emergency care practice. Mental Health training has been delivered to staff in conjunction with external mental health care providers. Monthly audits are undertaken to assess progress with compliance.



On the 30th March 2022 the CQC undertook an unannounced focussed inspection of acute medical wards at York Hospital. The report was received in June 2022 and the Trust were issued with a section 29A because the CQC were not assured that effective systems were in place to ensure patient risk assessments were completed contemporaneously and the care provided to mitigate risk was in line with the assessment in relation to nutrition and hydration, pressure area care and falls prevention. The service was not rated at this inspection; therefore the rating was suspended pending further inspection.

The Trust was told that it must take the following action to comply with its legal obligations:

- The service must ensure that where a service user is 16 or over and is unable to give consent because they lack capacity to do so, care is given in accordance with the Mental Capacity Act 2005. (Regulation 11(3)).
- The service must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b).

- The service must ensure that the nutritional and hydration needs of service users are met. Regulation 14 (1).
- The service must maintain 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. Regulation (17) (2) (c)
- The service must ensure there are appropriate numbers of suitably qualified, competent and experienced medical and nursing staff to enable them to meet the needs of patients in their care. Regulation 18 (1).

The Trust was told that it should take the following action:

The Trust should ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

A comprehensive action plan has been developed to address the issues outlined by the CQC and progress against the action plan will be monitored by the Trust Board.

2.4.7 Data Quality

York Teaching Hospital NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

which included the patient's valid NHS number was:
99.9% for admitted patient care;
99.98% for outpatient care;
99.56% for accident and emergency care.

which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care;
100% for accident and emergency care.

2.4.8 Information Governance

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

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

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

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

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

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

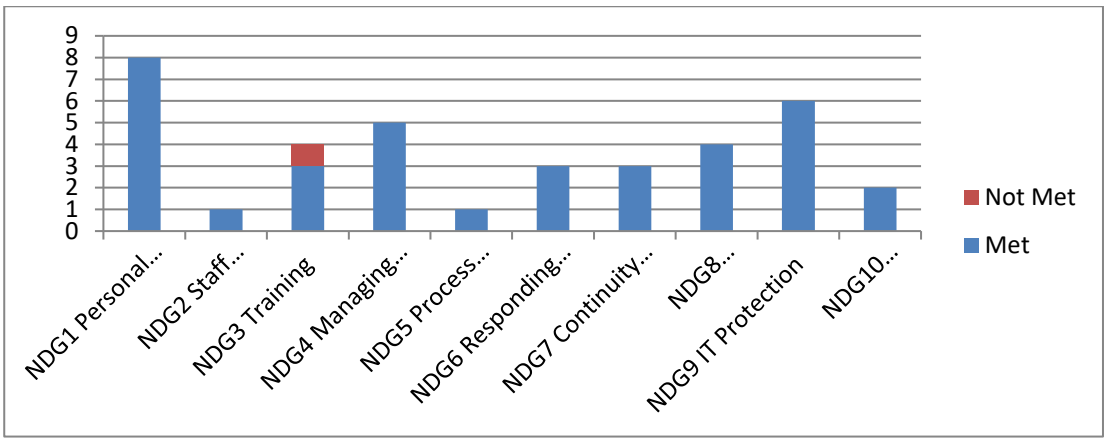
	2021	2022
Fully meeting our expectation	30%	37%
Partially meeting our expectation	39%	38%
Not meeting our expectation	20%	15%
Not applicable or unknown	11%	10%

Data Security and Protection Toolkit

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

The current toolkit has 38 assertions that the Trust is required to assess itself against and provide 111 pieces of mandatory evidence items.

The Trust's current submission status is that all but 1 mandatory assertion are "met". The mandatory assertion where the standard is "not met" is where the requirement is for 95% of staff to have completed their annual Information Governance statutory and mandatory training. The current compliance rate is 89%. Work will continue by the Information Governance Team to improve compliance rates but it is not anticipated that by the 30 June 2022 submission date that this standard will be "met".



Information Asset Owners

The Trust has established a network of Information Asset Owners who are responsible for the information managed in their service areas. As part of this role they are aiding the IG team with updating the Information Asset Register and attending training about their ongoing role in the Trust.

Data Protection Impact Assessments

Work has continued on an ongoing basis to develop Data Protection Impact Assessments between, these assessments enable the Trust to review any data protection risks from using personal data. The Trust has 70+ assessments in place or open for review.

Some of the Information Data Protection Impact Assessments that have been developed are:

- Patient Knows Best, this is a portal for patients to access their information
- Attend Anywhere, this is for patients to access consultation via video link
- Scarborough Hull York Pathology Service, this DPIA has documented the new relationship between the Trusts.

Freedom of Information

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

In 2020/2021 the Trust responded to 282 requests for information under the Freedom of Information Act. 65% of these requests were responded to within the 20 day statutory timeframe.

In 2021/2022 The Trust received a total of 444 requests for information and responded to 75% of these within the required 20 day timeframe.

2.4.9 Payment by Results

York and Scarborough Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

2.5 Reporting against Core Indicators

2.5 Reporting against Core Indicators

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

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

Summary Hospital-level Mortality Indicator (Score and Banding)	Trust Dec 19 – Nov 20	Trust Dec 20 – Nov 21	NHS (England) Dec 20 – Nov 21
Trust score (lower value is better)*	0.95*	0.97*	1.00
Banding	2 - As Expected	2 - As expected	2 - As Expected

* All values rounded to 2 decimal places. The England average SHMI is 1.0 by definition, and this corresponds to a SHMI banding of 'as expected'. Where a trust has an 'as expected' SHMI, it is inappropriate to conclude that their SHMI is lower or higher than the national baseline, even if the number of observed deaths is smaller or larger than the number of expected deaths. This is because the trust has been placed in the 'as expected' range because any variation from the number of expected deaths is not statistically significant.

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers patients admitted to non-specialist acute trusts in England who died either while in hospital or within 30 days of discharge.

SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'. For any given number of expected deaths, a range of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust in question is considered to have a higher or lower SHMI than expected.

As of July 2020, COVID-19 activity has been excluded from the SHMI. The SHMI is not designed for this type of pandemic activity, and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.

York and Scarborough Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

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

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

- Ensuring that all in-patient deaths are reviewed by a consultant within four weeks of the death occurring
- Promoting discussion of learning from mortality review at department governance meetings
- Providing a quarterly report on learning from mortality reviews
- The Learning from Deaths and End of Life Group to provide an emphasis on identification, review and learning from avoidable mortality.
- Thematic analysis of learning from serious incidents is undertaken on a quarterly basis with Quality Improvement projects aligned to address the themes.

We will:

- Continue with our mortality review programme, thematic analysis and Quality improvement programmes.

Palliative Care Coding	Trust – Dec 19 – Nov 20	Trust Dec 20 – Nov 21	*NHS Average (England) Dec 20 – Nov 21	Highest Trust Dec 20 – Nov 21	Lowest Trust Dec 20 – Nov 21
% Deceased patients with palliative care coded	24	27	39	64	11

York and Scarborough Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

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

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

- Continuing with our mortality review programme and ensure we continue to validate the clinical coding of deceased patients as part of the mortality reviews undertaken by consultants.

Patient Reported Outcome Measures (PROMS) - EQ-5D Index - Percentage of Patients Improving scores	Trust Apr 19 – Mar 20	*Trust Apr 20 – Mar 21	*England Apr 20 – Mar 21**	*Highest Trust Apr 20 – Mar 21**	*Lowest Trust Apr 20 – Mar 21**
Hip replacement (Primary)	88.8*	86.1	90.7	100.0	50.0
Knee replacement (Primary)	82.2*	79.2	82.3	100.0	57.1

Please note that the Trust data for April 20 to March 21 has been updated as previously published provisional data has now been finalised. The hip replacement score has changed from 88.4 to 88.8, with the knee replacement data changing from 85.0 to 82.2.** Provisional data

Patients undergoing elective inpatient surgery for the above procedures funded by the English NHS are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves. The above scores indicate the percentage of patients who reported an improvement in their health. As participation is voluntary, patients can choose not to participate in PROMs.

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

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

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

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

We will:

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

Emergency Readmissions within 30 Days of Discharge	*Trust Apr 19 – Mar 20	Trust Apr 20 – Mar 21	NHS Average Apr 20 –Mar 21	Highest Trust Apr 20 –Mar 21	Lowest Trust Apr 20 –Mar 21
Percentage of Readmissions aged 0 to 15	13.8	14.2	11.3	19.2	5.6**
Percentage of readmissions aged 16 and Over	13.5	14.3	14.8	21.7	10.5

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

*In January 2022, NHS Digital changed the methodology used to identify individual patients in their source data, so previous data has been recalculated. As a result, the percentage of emergency readmissions in the 0-15 age group has changed from 13.7, as previously published, to 13.8. The percentage of emergency readmissions in the 16 and over age group for 2019-20 has remained the same.

** The lowest Trust has a caution note attached to the NHS Digital data indicating the numbers of patients discharged were too small for meaningful comparison. The next lowest Trust has an indicator value of 6.2.

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

- Monitoring on readmissions within 30 days of discharge is included in the monthly Integrated Business Report to the Board of Directors.
- The data is consistent with that reported locally on the Trust's electronic performance monitoring system.

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

- Performance Data is monitored through our governance structures.
- The agenda of these meetings includes emergency readmissions and other quality and safety issues.

We will:
- Continue to monitor readmissions through our governance structures.
- Continue to monitor readmission rates as part of our contract monitoring process with our commissioners and take remedial action if the rate is exceeded.

Responsiveness to personal needs of patients	*Trust 2019 - 20	**Trust 2020 - 21	**NHS (England) 2020	**Highest Trust 2020	**Lowest Trust 2020
Responsiveness to inpatients personal needs	65.8	Data to be published 17/03/22	Data to be published 17/03/22	Data to be published 17/03/22	Data to be published 17/03/22

*Data was collected is for hospital stays from 1 July 2019 to 31 July 2019, with the survey data being collected between 1 August 2020 to 31 January 2020.

**The previous Quality Account report noted that data collection for patients who were inpatients at the Trust in November 2020 was currently live, and the results of the survey were due to be published in Autumn 2021. NHS Digital, who publishes the benchmarking data for this indicator, note that this data was not updated as expected, and the publication has been delayed until 17/03/22.

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

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

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

- Further embed the Patient Services Operative role, across all wards following successful evaluation on the elderly wards.
- Continue the implementation o new electronic nursing documentation
  Continue to embed the use of Tendable an electronic audit app as a thorough and trackable way of auditing on our wards.
- Developed a new easy-read menu after a number of patients reported difficulties reading the menu choices
- Developed and implemented new monthly patient experience reports, which provide qualitative

and quantitative data for each ward about the experiences their patients, have reported. This in turn makes it easier to identify themes and trends and action areas to focus on.
- Employed a new Public and Patient Involvement lead to ensure effective involvement and co-production.
- Involved experts by experience in the development of the Mental Health and Quality Improvement strategies.

We will

- Further embed a culture of co-production, to ensure that service improvements are led jointly with our patients.
- Continue to triangulate all types of patient experience feedback to provide meaningful information to Care Groups in order for them to plan action for improvement

Staff recommending the Trust to family and friends	Trust 2020	Trust 2021	NHS Staff Survey Average Score 2021	NHS Staff Survey Highest 2021	NHS Staff Survey Lowest 2021
Percentage of staff who would be happy with the standard of care provided by the organisation	66.8%	57.3%	66.9%	89.5%	43.6%

These results are presented in the context of the best, average and worst results for similar organisations taken from the 2021 NHS Staff Survey. The question asked is: *If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.* The Trust value for 2020 has been updated from 66.9% to 66.8% to reflect the data published in the most recent staff survey.

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

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

The results of the 2021 survey will be used to help form the basis of an action plan to improve employee engagement and ultimately patient care within the organisation.

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

We will:

- Run the new quarterly NHS Pulse Survey, this will give valuable feedback which we will use

to improve staff engagement and outcomes for our patients
- Continue to roll out the just culture framework so individuals feel able to safely raise concerns for everyone to be able to learn from to improve the care delivered to patients.

Patients admitted and risk assessed for venous thromboembolism *(Acute Trusts)*	Trust Jan - Mar 2021	Trust Jan - Mar 2022*	NHS (England) Jan - Mar 2022**	Highest Trust Jan – Mar 2022**	Lowest Trust Jan – Mar 2022**
Percentage of patients risk assessed	94.4	86.2	Data not available	Data not available	Data not available

*The Trust has changed the methodology for calculating VTE risk assessment compliance, so the data for January to March 2021 cannot be directly compared with the data for January to March 2022.
**The Quality Account for 2020-21 noted that the national VTE data collection and publication was paused to release NHS capacity to support the response to Coronavirus. National data collection remains paused, so the above data only reflects local Trust performance data.

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

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

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

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

We will:

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

Clostridium difficile infection (for patients aged 2 and over)	Trust 2019-20	Trust 2020-21	National (England) Rate 2020-21	Highest Trust 2019-20	Lowest Trust 2019-20
Trust apportioned cases - rate per 100,000 bed days (HO Hospital Onset)	22.5	16.6	15.4	80.6	0.0

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

- Clostridium difficile Infection incidence is reviewed and discussed at the Trust Infection Prevention Steering Group TIPSG), Quality and Safety briefing and at Post Infection Reviews (PIR).
- The Trust invited a team from NHSE/I to attend for an external review of the Trust's Clostridium difficile position, including site visits and a review of processes, policies and the IPC governance structures. The review took place on the Scarborough site on the 7 and 8 October 2021 with a subsequent site visit to York on the 2 November 2021.
- The Trust Post Infection Review (PIR) process has been reviewed and strengthened to ensure timely learning and improvement actions
- Incidence of all Healthcare Associated Infection (HCAI) is reported to the Quality Committee and the Trust Board
- HCAI are discussed and actions agreed at the Care Group Quality meetings. Overall figures, themes and trends for the trust are reviewed at TIPSG, chaired by the Director of IPC (DIPC).
- Trajectories for HCAI's for individual care groups have been set and monitored.
-

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

- The bed modelling process has been undertaken to identify a ward that can be used as a decant space for ward refurbishments, which will assist with addressing the causal factors of HCAIs. A modular build is being explored for this purpose at Scarborough as ward space cannot be easily released.
- Continuing to monitor progress against trajectory through multi-disciplinary Post Infection Review (PIR) of all cases.
- Implement the new C-Difficile Improvement group which will which will review each site's position of C. difficile and actions to be completed within the improvement plan. The meeting will feed into the *C. difficile* Assurance Group which will be held quarterly with external partners; to look at the trust position of *C. difficile* and provide an update of the *C.difficile* improvement plan.
- Joint environmental walk-rounds with the IPC team, Facilities, Estates and senior clinical staff to agree on the improvement plan and actions required to sustain an environment that is suitable for patient care. These walk-rounds will take place fortnightly and will include 5 random areas and any areas of concern each month on each site; and including Bridlington and community sites. More work to improve cleanliness is on-going.
- Revised IPC questions on the Tendable audit app were launched in February 2022 and now include specific items to look for in the audit for cleanliness.
- A review of the IPC team structure, training requirements, and resilience took place and as a result a band 5 developmental post and a band 4 Nursing Associate Post were recruited to. Recruitment to a Band 8C lead post is underway.

We will:

- Continue to implement the recommendations from the NHSEI review of IPC across both York and Scarborough sites.
- Work to address the environmental issues through the backlog maintenance scheme and exploration of the development of decant ward space to allow refurbishments.
- Continue with PIR and dissemination to staff of lessons learnt to inspire and generate improvement. Audit of compliance with best practice and antimicrobial stewardship will continue together with seeking new initiatives to reduce incidence.
- Continue to report progress to the Quality Committee and the Board of Directors in the Director of Infection Prevention and Control quarterly report which as previously described, provides assurance to the Board of Directors that initiatives continue to be developed aimed at achieving

sustainable reduction in HCAI.
- Continue to discuss incidence and risk at weekly quality and safety briefings to identify and agree action required.

Patient safety incidents and the number of incidents resulting in severe harm or death	Trust Oct 19 – Mar 20	Trust Apr 20 – Mar 21	Average Apr 20 – Mar 21	Highest Trust Apr 20 – Mar 21	Lowest Trust Apr 20 – Mar 21
Rate of patient safety incidents	41.9	53.4	58.4	118.7	27.2
*Number of incidents resulting in severe harm or death	23	49	55	261	4
% of incidents resulting in severe harm or death	0.3	0.4	0.5	2.8	0.0

Note – data represents acute (non specialist) trusts only, which is the Peer Group the Trust is benchmarked against for this indicator. Patient safety incident data is now published annually, whereas previously it was published every 6 months, so care should be taken when comparing the Trust's performance between the above time periods, as seasonal variation may affect the data.

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

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

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

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

- Continued to strengthen incident management processes, through revision of the serious incident policy and the terms of reference for the weekly Quality and Safety Group and SI panel.
- Introduced quarterly thematic analysis of clinical incidents and serious incidents with associated quality improvement workstreams to address themes.
- Information on numbers of patient safety incidents and those resulting in severe harm or death are reported monthly to the Quality Committee and the Board of Directors as part of the Integrated Board Report.

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

Friends and Family test score (patient element)*	Trust Feb 2021	Trust Feb 2022	England - Feb 2022	Highest Trust – Feb 2022	Lowest Trust – Feb 2022
Inpatient % positive	95	97	94	100	77
A&E % positive	93	83	77	100	29
Maternity % positive**	100	99	92	Data not available	Data not available
Outpatients % positive	95	93	93	100	81

* The data shows the response to the question "Overall, how was your experience of our service?" in the Friends and Family Test (FFT). This has replaced the previously reported indicator, which reported how many patients would recommend the Trust.

** Nationally published Maternity data is not available at individual Trust level, so the Trust's performance is taken from local data and rounded up so that it is consistent with the format of nationally published data.

Note – data for NHS Trusts only. Data submission and publication for FFT was paused during the response to the pandemic, and restarted for acute and community providers from December 2020. NHS England, who collate the FFT data, note that data from December 2020 onwards reflects feedback collected during the COVID-19 pandemic, while, also, implementing the new guidance after a long period of suspension of FFT data submission. The number of responses collected is, therefore, likely to have been affected. Some services may have collected fewer FFT responses, or been unable to collect responses at all, because of arrangements in place to care for COVID-19 patients.

NHS England, who publish the FFT data, note that results are not statistically comparable against other organisations because of the various data collection methods, however, FFT does provides a broad measure of patient experience that can be used alongside other data to inform service improvement and patient choice.

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

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

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

- Results and themes of comments are reported each month to senior Care Group representatives for their response and action.
- A major capital scheme has commenced to improve the ED space at York.
- The key issue with performance across both EDs is related to capacity and flow issues across the broader Trust. The Trust has worked with ECIST to review flow and discharge and as a result has invested in a 6-month project led by 3 senior clinical staff with QI support.

We will:

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

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Trust 2020	Trust 2021	NHS Staff Survey Average 2021	NHS Staff Survey Highest (Worst) Trust 2021	NHS Staff Survey Lowest (Best) Trust 2021
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months from Managers*	13.2%	12.3%	11.9%	17.9%	5.8%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months from other colleagues*	20.1%	20.9%	19.5%	27.2%	12.3%

* These results are presented in the context of the best, average and worst results for similar organisations taken from the 2021 NHS Staff Survey. Relates to percentage of staff saying they experienced at least one incident of bullying, harassment or abuse. The Trust value for 2020 has been updated from 13.1% to 13.2% (managers) to reflect the data published in the most recent staff survey. The 2020 value for other colleagues was unaffected.

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

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

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

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

We will:

Continue to embed the new values within the workplace and launch our new behavioural framework to provide guidance for staff around expected behaviours and areas for personal development. We will continue to work towards embedding a culture where staff feel able to safely challenge if a colleague is not demonstrating behaviours in line with our values.

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

Percentage of staff believing that the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	Trust 2020	Trust 2021	NHS Staff Survey average 2021	NHS Staff Survey Highest Trust 2021	NHS Staff Survey Lowest Trust 2021
Percentage of staff believing that the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?*	85.7%	85.6%	82.5%	92.0%	67.0%

* These results are presented in the context of the best, average and worst results for similar organisations taken from the 2021 NHS Staff Survey.

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

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

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

The results of the 2021 survey will be used to help form the basis of an action plan to improve employee engagement and ultimately patient care within the organisation.

We will:

Continue to work with and support our newly formed staff networks, these are the Race Equality Network, Carers Network and Enable Network.

Continue to work towards achieving our Equality Action plan and we are actively recruiting for a senior Equality, Diversity and Inclusion Lead for the organisation who will have strategic leadership and responsibility for the development and implementation of the ED&I strategy for the Trust.

Part Three – Review of Quality Performance

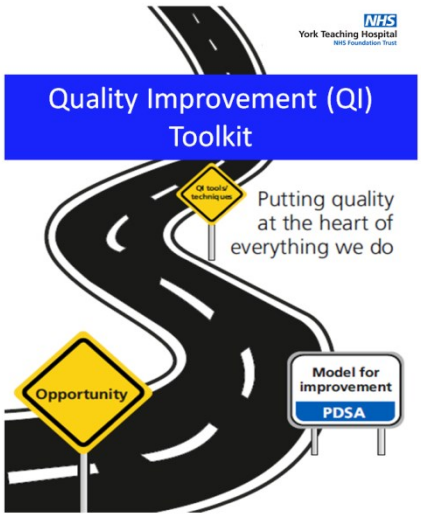
3.1 Trust Performance Against National Quality Indicators

Indicator	2020-21	Target 2021-22	Q1 2021-22	Q2 2021-22	Q3 2021-22	Q4 2021-22	Total 2021-22
Total time in ED under 4 hours – national*	84.74%	95%	80.81%	72.53%	70.01%	71.56%	73.73%
*The Trust is monitored on the total for the Trust (type 1) and (type 3) the minor injuries units For Type 1 attendances at the main Emergency Departments only, compliance for 2021-22 was 56.08%							
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	58.4%	92%	68.2%	67.9%	64.5%	60.9%	65.2%
Cancer 2 week wait (all)	92.8%	93%	91.9%	93.4%	85.6%		
Cancer 2 week wait Breast Symptomatic	92.7%	93%	92.7%	94.2%	57.8%		
Cancer 31 days from diagnosis to first treatment	97.5%	96%	97.4%	97.6%	97.2%		
Cancer 31 days for second or subsequent treatment – surgery	87.0%	94%	94.9%	88.5%	91.4%		
Cancer 31 days for second or subsequent treatment – drug treatment	99.9%	98%	99.6%	100%	99.6%		
Cancer 62 day wait for first treatment (urgent GP)	76.1%	85%	73.5%	66.6%	71.1%		
Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service)	88.6%	90%	91.9%	85.4%	82.1%		
Cancer 28 day Faster Diagnosis Standard	62.8%	75%	64.0%	65.0%	71.7%		
Diagnostics – 6 week wait referral to test	51.9%	99%	64.0%	57.9%	55.5%	54.2%	57.4%

* Cancer figures for Q4 2021-22 are currently unavailable.

3.2 Our Quality Improvement Journey

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



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

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

Development of the Quality Improvement Strategy

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

QI educational resources

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

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

Development of a QI Coaching Programme

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

Quality Councils

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

Appendices

Statements from Key Stakeholders

Statements from the Trust's Council of Governors

Name and Designation	Alastair Falconer. Public Governor for Ryedale and East Yorkshire
Feedback Statement	Reading the patient experience section I was impressed by "What Matters to Me" and "Decide too". The aims behind both are well motivated. These have both been distributed to care areas. Is there data on how they are being used and their impact? As a member of the PESG I have a particular interest in this.
Date of Response	11.4.22

Statement from City of York Council Scrutiny Services

None received

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

Statement from Vale of York Clinical Commissioning Group

Name of Organisation	NHS Vale of York Clinical Commissioning Group
Name and Designation	Michelle Carrington, Executive Director Quality and Nursing
Feedback Statement	On behalf of NHS North Yorkshire CCG, NHS East Riding of Yorkshire CCG, NHS Vale of York CCG is pleased to provide comments on York and Scarborough Teaching Hospital NHS Foundation Trust's Quality Report for 2021/22. The past two years has seen unprecedented challenge across the whole of the health and care system. As such we recognise the impact this has had upon the sustained delivery of quality priorities and core quality / performance standards. Equally we value the collaborative working undertaken by the Trust in many areas to tackle these challenges together with system partners. It is pleasing to see a relentless focus upon improving culture, which has been evidenced through the new Trust Values being developed through extensive staff engagement, the change in the Trust name

	feels more inclusive to the East coast based staff and population and that future quality priorities for 2022/23 have been developed through co-production with lay members. Commissioners would like to acknowledge the work undertaken by the Trust in the past 12 months particularly noting the “Great Big Thank You” campaign and as such we request you pass on our thanks to every single member of staff who has played a key role in helping to keep our patients safe and well cared for whilst striving for continued improvement amid the ongoing challenges we experience. We are pleased to maintain our close partnership with the Trust to improve the quality and safety of patient services. We are especially pleased to note the following achievements as set out in these accounts. The Trust set out to achieve 3 priorities for clinical effectiveness, 4 priorities for patient safety and 3 priorities for patient experience. We note that in many of the areas very good progress has been made. **Clinical effectiveness and Improvement.** The three clinical effectiveness priorities identified for 2021-2022 focussed upon embedding a quality improvement culture within the organisation with collaborative working with staff, patients, and families. We see this has been successfully achieved with the completion of a Quality Improvement Strategy due to be launched in the summer, the development of training for all staff and involvement of staff and patients in quality improvement programmes across the Trust. Commissioners recognise the hard work that has been undertaken this year to develop the quality improvement culture, including establishment of 'Quality Councils' and look forward to reading about how this progresses further next year. We are assured by the work in relation to clinical effectiveness along with the management of local clinical audit and the Trust's proactive approach in participation in research studies. **Patient Safety** We recognise the significant work that has been undertaken to improve patient safety. Key to this has been the need to develop a culture of safety at all levels of the organisation. The reintroduction of Patient Safety walkabouts is welcomed. We can see the work undertaken to increase the number of incidents reported where 'no harm' occurs to the patient and as such the trust has successfully moved from the fourth quartile to the third quartile nationally of trusts reporting. We welcome the setting up of the ten improvement workstreams which will focus on the Serious Incident actions identified as the result of work undertaken at the Trust, of particular strength is the improvement work to ensure effective communication and engagement with patients and families at all stages. With the appointment to the Patient Safety Specialist role and the roll out of the Patient Safety Incident Response Framework (PSIRF) later

	this year, commissioners look forward to continuing to work alongside the Trust to support the implementation of the PSIRF in 2022-2023. We recognise the significant work that has been undertaken to reduce the number of patient falls and recognise the challenges the Trust has faced to achieve and sustain the agreed trajectory. Key initiatives such as implementation of the After Action Review and revised processes in relation to falls prevention development work being introduced and embedded in to the Emergency Departments (ED) are noted alongside the approach to ensuring initiatives are undertaken across all hospital sites. The work to reduce pressure ulcers due to medical devices and the zero-tolerance approach for category 4 pressure ulcers where lapses of care are identified is noted. We look forward to seeing the outcomes of the further planned work. The continued inclusivity of CCG Quality Leads at the Trust's Learning panels is welcomed. There is clear recognition of work the Trust has undertaken to ensure patients are listened to, as demonstrated through the sharing of 'Tony's story'. The Trust has focussed upon improvement work to address the actions required by CQC. Central to patient safety remains the need for continued focus upon reducing harm associated with avoidable Clostridium Difficille infection. We recognise improvements have been made, however it is essential that a relentless system wide focus is maintained in this area as the rates of infection remain a significant concern. **Patient Experience** We welcomed the introduction of the ”What matters to me” document introduced by Trust to support patients who find it difficult to make their needs known and also the introduction of the DECIDE shared decision tool. It is important to note that 88% of patients who responded to the Family and Friends Test who had virtual appointments in outpatients rated their experience as good with many giving positive feedback about these types of appointments. Going forward this demonstrates options for adapting previous styles to patient need are possible and may be more effective and efficient This lends itself to increasing engagement and co-production with patients around new ways of delivering care. Commissioners welcome the work underway at the Trust to ensure that patients receive essential standards of fundamental care as a priority; the recruitment of the post to support Health Care Assistant’s in clinical practice we hope will help drive forward this area of improvement alongside the other work that is being undertaken across the organisation. Improvement initiatives such as the 'Autumn' project for end of life care, and progress at delivery PET scanning at Scarborough site are clear initiatives to improve patient experience and outcomes. We would also like to congratulate the Trust on the awards that they

	have been shortlisted for and won this year, the award for the Diabetes education programme and the recognition of the rapid diagnostic centre in the BMJ awards. Commissioners note the quality priorities for 2022-2023 that have been identified by the Trust in co-production with lay members of the board and fully support the decisions that have been made. In addition commissioners have recently welcomed the collaborative approach in agreeing the CQUIN schemes for 2022/23 since their reintroduction for this year. We recognise the sustained impact that the pandemic has continued to place upon all healthcare services and are pleased that the Trust has continued to work towards its improvement journey despite this. We understand that you are committed to your priorities for 2022/23 and commend your continued focus on patient quality and safety. Never before has it been more important to work collaboratively with system partners to achieve improvements in patient pathways and outcomes for our population health as we address the consequences of the pandemic and continued recovery. As we transition into the Integrated Care System, we as commissioners remain committed to working collaboratively with the Trust and its regulators to improve the quality and safety of services available for our population. We can confirm that with NHS North Yorkshire CCG and NHS East Riding of Yorkshire CCG, NHS Vale of York CCG that to the best of our knowledge, that the data and information contained in the report is accurate and that the report is a true and accurate reflection of the quality of care delivered by York and Scarborough Teaching Hospitals NHS Foundation Trust. We are therefore satisfied with the accuracy of this Quality Report.
Date of Response	30/04/2022

Statements from Healthwatch

Name of Organisation	Healthwatch East Riding of Yorkshire
Name and Designation	Julie Dearing - Manager
Feedback Statement	The Healthwatch Read Right teams reviewed the Quality Accounts and made the following observations: • A delight to read with no mumbo jumbo, written in plain English. Gives confidence of a trust in control and working hard to provide good service to the community by working to achieve their aims and objectives. • It is logical and systematic in its layout. It uses a sans-serif font of a good size and has both pictures, tables and diagrams which are appropriate and to the point.

	• Overall a well laid out and well-presented document which meets its title needs. It has sign in by managers and staff including at Board level. • It sets out what has been achieved and plans for the next year and focusses on staff and patient needs. • Patient and public consultation: the Trust uses reviews of what has happened, questionnaires or feedback given after the event. Rather than involving the public and patients in consultation about future changes or plans of the Trust. Focus needs to be made on how to involve all in considering the changes to systems or practices in the Trust Healthwatch believe that the Quality Accounts are representative and give a comprehensive coverage of the services that the Trust provides. In conclusion Healthwatch welcomes the opportunity to continue providing comments on the Trusts Quality Accounts and would like to thank all members, including staff, patients, and carers for all their hard work during what has been another difficult and challenging year. We also welcome the opportunity to work more closely with the Trust to facilitate independent engagement with patients, carers and the public.
Date of Response	22/04/2022

Name of Organisation	Healthwatch York
Name and Designation	Siân Balsom, Manager
Feedback Statement	Healthwatch York welcome the opportunity to review and comment on the York Teaching Hospital Quality Accounts 2021-22. We agree that the priorities for improvement reflect a number of the priorities for people living in York. It is good to see the continued focus on patient experience, and the commitment to being open and transparent about areas identified for improvement. We welcome the inclusion of patient stories and feedback about when things went well and when they didn't go so well. We also recognise the continuing challenges of the pandemic. We share the hospital's concerns about treatment waiting times, and welcome the commitment to work through the backlog. We know that despite these ongoing challenges we receive reports of excellent and timely care. On behalf of all those who have shared these positive experiences with us we say "thank you."
Date of Response	12.05.22

Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2019-20 and supporting guidance Detailed requirements for quality reports 2019-20.

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

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

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

17 June 2022 .....Chair

17 June 2022 .....Chief Executive

Glossary

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

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

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

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

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

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

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

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

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

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

they show signs of becoming worse can help avoid serious problems.

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

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

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

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

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

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

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

National Institute for Clinical Excellence (NICE) quality standards
National Institute for Clinical Excellence (NICE) quality standards are a set of specific, concise statements that act as markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.

Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with the NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

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

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

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

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

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

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

Pressure ulcers are graded from 1 to 4 as follows:

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

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

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

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

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

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

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

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

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

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