NHS

York and Scarborough Teaching Hospitals

NHS Foundation Trust

Quality Report

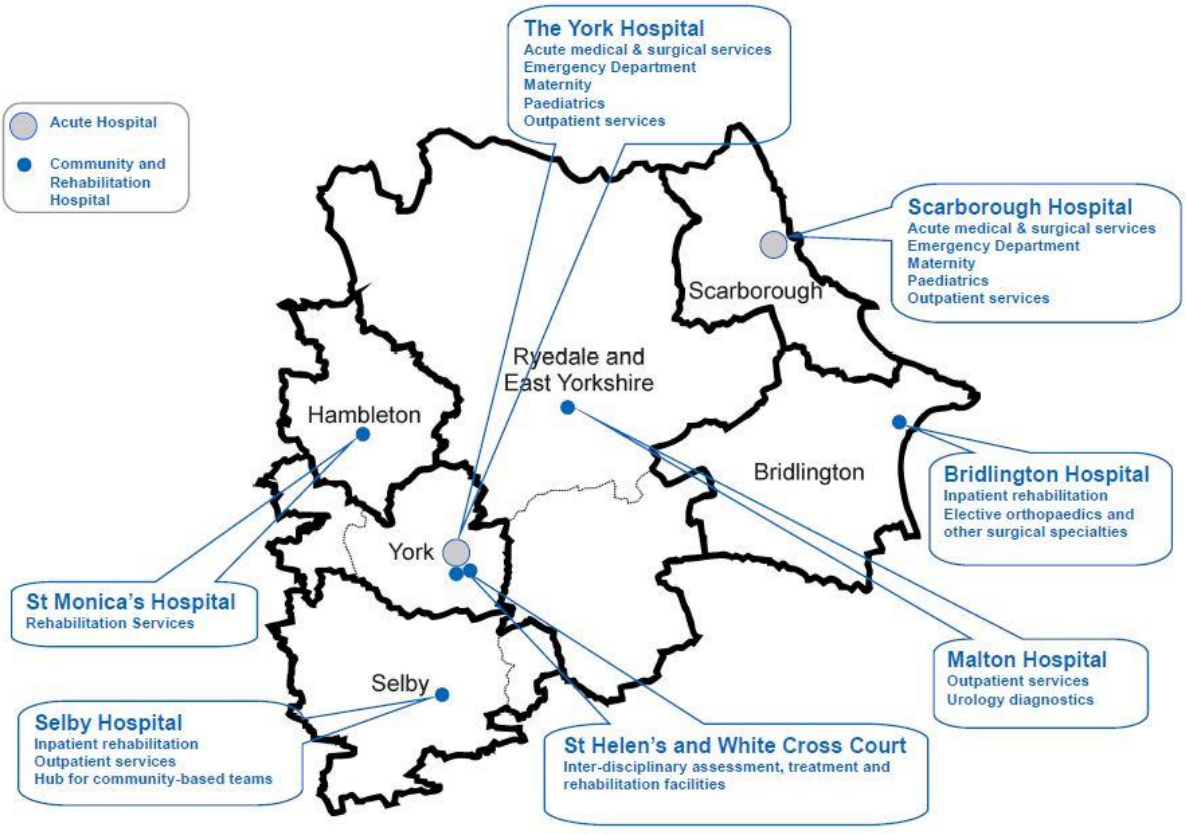
2022 - 2023

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 £0.5bn 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 – 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 2022-23 year.

Over the past year it has been well documented that we are under severe strain across every sector of the NHS and in social care, and our Trust is no different.

There has been no let-up in pressure, and we continue to experience issues with flow, leading to delays in our emergency departments and in the ambulance queue, as well as a large cohort of patients who are waiting to be discharged. Our Covid-19 inpatient numbers have remained consistently high throughout the year, coupled at times with high number of flu cases. In addition, we are under significant pressure with our elective backlog and cancer delivery, with diagnostic capacity playing a major part in this.

To help our recovery, we were moved to Tier 1 in relation to our current elective performance and the high risk to delivery of our 78-week trajectory. Through the Tier 1 regime we are receiving support including management and analytical capacity, and a dedicated member of staff to progress mutual aid and agreed support for analytics on diagnostic demand and capacity. Positive progress has been made for 78 week waits and the 62-day cancer target, particularly in the final quarter of the year, and as a result we ended the year ahead of our original trajectories.

We are also receiving onsite support from the Intensive Support Team for six months from the end of January 2022. The focus is on strengthening governance and recovery planning for core specialities, refreshing the patient tracking processes, demand and capacity analysis, and data reporting.

Concurrently, we have been under CQC inspection for much of the year. Following publication of their earlier report in March 2022, the CQC visited both the York and Scarborough sites in October. This was in part to re-inspect the areas they visited at York Hospital in March, but also to carry out a fuller inspection which included the emergency departments, medicine, and maternity at both York and Scarborough hospitals.

The CQC also carried out a well-led inspection of the Trust as part of its wider inspection of the organisation. This involved interviews and focus groups with the board and other senior leaders and subject-matter experts. They also re-visited several clinical areas on both sites, including the emergency departments and maternity units, to follow up on the actions we committed to undertake following their October inspection.

The CQC found improvements in the emergency department at York in relation to management of demand, risk and escalation, as these were flagged as areas of concern during the October visit. They observed improved systems for managing demand particularly in the majors waiting room, improved record keeping, and more timely risk assessment and response to escalation of risk to patient safety.

However, they did flag concerns in the maternity department at York, specifically in relation to governance processes, and assessing and responding to risks for patients.

In response to the concerns raised by the CQC we submitted detailed action plans, and regularly report progress against these plans to the CQC. We are yet to receive the formal report, however we expect it to be published in the first quarter of 2023-24.

Improving the quality and safety of our services and responding to the CQC's recommendations will be a key priority in the year ahead and we have already made real progress in several areas.

In August, we launched a new quality improvement programme, Journey to Excellence - or J2E for short - designed to drive quality improvement across the Trust as part of our everyday business. It focusses on improving the safety and quality of care, utilising the care quality commission (CQC) standards - safe, effective, caring, responsive and well led.

This is complemented with our refreshed approach to quality improvement, which encourages our people to feel engaged, enabled and empowered to start and deliver quality improvement projects in their own areas. This is done by working to a principle where staff ask how they can make the experience of care better and improve their own working experience. This approach is already helping our people get creative and make improvements in their work area from the ground up.

At the same time, we focussed on improving awareness and understanding of the fundamentals of care, and how we need to improve in response to the CQC's findings in relation to this. The fundamentals of care are the basic elements needed to deliver a safe and person-centred experience for patients which link to the CQC's key lines of enquiry. By clearly defining our fundamentals of care and creating a common language that we can all understand, it is helping to guide us towards the high standards of patient care that we are all striving to achieve.

The implementation of our new approach to digital documentation has made a significant difference to quality for both our patients and staff.

The 'Nucleus' system was developed in house in response to feedback from staff regarding the challenges with our current paper system. The system facilitates a much quicker admission process and is recorded in real time meaning we can immediately know what care has been delivered and what still needs to be done. This has already proven to be successful in reducing the time taken to document findings, while also freeing up time to care for patients.

At the same time, we updated our In-Hospital Adult Sepsis Screening Tool to reflect learning from serious incidents. It now considers pre-hospital NEWS2 scores, neutropenia, and chemotherapy administration in the last six weeks as indicators for step 1 screening.

Finally, the implementation of BadgerNet, an electronic maternity healthcare record system for all documentation in pregnancy, birth, and the postnatal period, has also started, which will deliver significant benefits for midwives as they do not have to double enter data onto paper handheld notes and the electronic paper record.

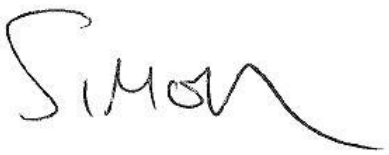
In terms of workforce, we have expedited recruitment to employ more patient services operatives (PSOs) across our medicine and elderly medicine wards, and healthcare support workers. PSOs have a direct role in working closely with healthcare staff to support several ward processes and tasks such as preparing bed spaces for admissions, assisting patients with menu completion, and serving patients' drinks. Both roles are key roles for supporting delivery of the CQC action plan, and in helping ensure that fundamentals of care are consistently delivered.

Looking ahead, our new emergency departments are on the horizon and are on track to deliver better facilities and much-needed space. Our York Emergency Department will be the first to be completed and operational by the summer. The multi-million pound two-storey extension includes twelve new assessment and treatment cubicles, a new children's waiting and treatment area separate from the adult area, and a new resuscitation zone which will increase capacity significantly. The £47 million investment to build a new Urgent and Emergency Care Centre at Scarborough is also on track to open in 2024. Both developments will undoubtedly help make a difference to the flow of patients in our hospitals.

Finally, during year we welcomed a new Medical Director, Karen Stone, who has brought a wealth of experience in medical leadership, quality improvement, patient safety, and clinical reconfiguration. Karen is a welcome addition to the Trust and is already helping us in our improvement journey.

Despite the pressures, 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
Chief Executive

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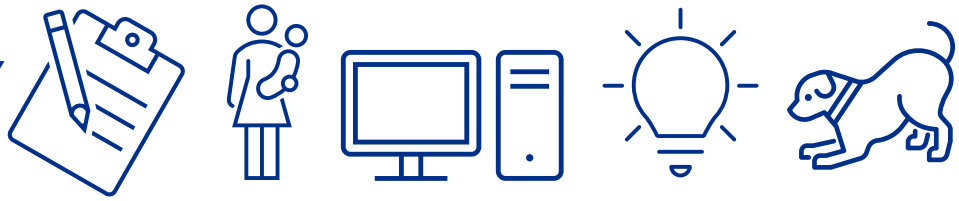
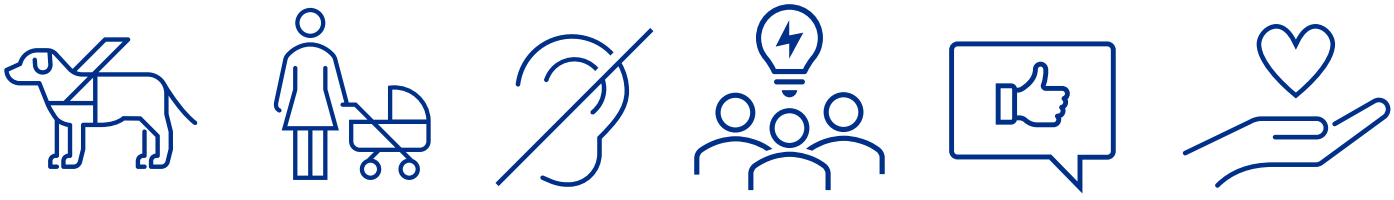
Deaf Awareness –

Patient Lived Experience

These include:



- Adopting the message, “Assistance Dogs welcome!” across the Trust.
- Enabling Kirsten to share her experiences with the Trust Directors and for them to hear first-hand how the health services we provide impact on people who are deaf.
- Involving Kirsten and other patients who use assistance dogs in the development of the Trust’s Assistance Dogs policy.
- Engaging with deaf and hearing-impaired people (including representative from York Deaf Club) as part of the work to use the Equality Delivery System to review the translation and interpreting services.
- Developing a Disability Awareness Training module for staff (Learning Hub) which is to support the key messages in the mandatory Equality module.
- Inviting Kirsten and other patients to participate in the simulation exercise for the ED new build in York.
- Successfully secured hospital charity funding to provide several new portable hearing loops in key reception areas, to accelerate work in line with our Access Strategy.
- Kirsten’s experience and our engagement conversations also inspired the Trust to participate in Disability History Month (Nov–Dec 2022). Driven by the Patient Equality, Diversity and Inclusion Lead and Access Advisor, we put up Guide Dogs UK ‘*Open Doors for Guide Dogs*’ campaign stickers at main and ED receptions; raised awareness with reception staff about the variety of assistance dogs people use, with information from the charity, Assistance Dogs UK; we reminded staff about the importance of lowering masks to support lip reading; gave demonstrations to staff on how to use new portable hearing loops or existing equipment in their area; carried out more staff briefings on how to access the services available for sign language and spoken language interpreters we use to support patients in their appointments, treatment and care; and started to talk to Estates & Facilities staff about ‘spending areas’ for assistance dogs at our main hospital sites.



Looking Back on 2022/23

April 2022

New Urgent and Emergency Care Centre offers Acute Medical Model

In April, work began on the new £47m Urgent and Emergency Care Centre at Scarborough Hospital, which will offer a new approach to care - the Acute Medical Model (AMM). It will care for all patients from minor to complex needs served by one team of healthcare professionals working collaboratively, operating an assess to admit model of care.

Many patients will be managed without the need for a prolonged hospital admission to reduce the risk to those individuals of hospital acquired infection and other nosocomial risks as well as deconditioning in our elderly population.

The facility is being built to allow for patients to be cared for across a full spectrum of acuity - from the very basic minor injury or illness to full stabilisation and resuscitation. Throughout, the emphasis will be on rapid assessment, senior decision making for definitive care, 'Home First' and admission avoidance.

The new centre is planned to open in the Spring of 2024.

Autumn Room opens at Scarborough Hospital

A project to support patients at the end of life took a step forward with the opening of the first Autumn Room on Juniper Ward at Scarborough Hospital.

The dedicated Autumn room signalled the roll out of the project across the Trust where, with the patient's or loved one's consent, end of life patients are visible by an autumn leaf symbol placed on their curtain or side room door. This ensures that anyone involved in their care can easily see that they are receiving end of life care. Staff are empowered and equipped with the confidence to play their part in making it a more positive experience for someone who is at the end of their life which fulfils an important responsibility which will remain in the memory of those that live on.

New Changing Places facility for Scarborough

A Changing Places toilet was installed at the Scarborough Hospital as one of almost 1700 registered changing places toilets in the UK. The provision of Changing Places toilets can vastly improve people`s quality of life allowing disabled people and their assistants to visit the site with the confidence of knowing that the facility is available should they need it.

Changing Places toilets are larger accessible toilet facilities equipped to accommodate disabled people with profound, complex, and multiple needs. The toilet cubicles include enough room for a disabled person and a family member or carer to support with any needs,

a hoist to allow transfer between a wheelchair, the WC and an adult sized changing bench. Surfaces are designed to assist people with visual impairments using the space.

Professional Nurse Advocates trained to support

A new professional nurse advocate (PNA) programme was pioneered by the Trust to support the wellbeing of nurses by offering restorative supervision. It is the first of its kind for nursing not just in England, but across the world and the professional nurse advocate is a new national role.

Training provides nurse volunteers with skills to facilitate restorative supervision to their colleagues. Restorative supervision supports reflective practice, builds practitioner resilience, sustains wellbeing and increases motivation through facilitated reflection, exploratory questioning and supportive challenge.

Emma George, Assistant Chief Nurse and Lead for the PNA programme, said: “The national aim is to have one PNA for every twenty nurses in patient facing roles and for restorative supervision to be available to all nursing staff. This role is so important right now, more than it has ever been, and we are keen to recruit more PNAs to reach our goal of supporting every one of our nursing staff.”

May 2022

Digital nurses appointed

In 2022 Ruth May, England’s chief nurse, highlighted the crucial role of digital and data in nursing. The nursing team has created two nursing roles to work closely with Digital and Information Services.

The Chief Nursing information Officer and Digital Midwife are new roles for the Trust and bring an essential voice to shared ideas and projects that will maximise the digital opportunities emerging for nursing teams.

Nik Coventry, Chief Nursing Information Office (CNIO), explained: “We are strengthening the relationship between digital and information services and our nurses by connecting teams in the design phases all the way through to testing any new solutions of a new digital system before it’s deployed across the Trust.

“As well as supporting our Trust, the role will also work directly with other trusts and partners to share best practice and stay informed about the latest thinking in frontline digitisation for our nursing teams.”

June 2022

First Allied Health Professional strategy launches

A new focus on developing and supporting Allied Health Professionals (AHPs) in the Trust has reached a milestone with the launch of the first ever Trust AHP Strategy.

The vision is to ‘Start Well, Live Well, Age Well, End Life Well’, highlighting the hugely important role AHPs play in prevention, self-care, and diagnostics.

Vicky Mulvhana-Tuohy, Deputy Chief AHP, said: “The strategy provides a real foundation for the future. It is the start of a new era which demonstrates commitment to our workforce as our key priority. The strategy reflects our aspirations to develop and support AHPs to work at the top of their licence and to support staff to be the best they can be. We are also promoting routes onto professional apprenticeships to grow our own next generation of Allied Health Professionals.

“Our role is all about reducing health inequalities and the strategy focuses on person centred approaches, empowering our clients, co-production, involving families and carers in their localities and to deliver acute care closer to home.”

July 2022

Urology ‘one-stop’ celebrates five years

The revolutionary ‘one-stop’ urology diagnostics unit at Malton Hospital is celebrating five years of providing specialist consultation for patients presenting with urological symptoms across North Yorkshire and the East Coast. The unit has seen around 18,000 patients since it first opened in 2017 and for many of them it has ended weeks of worry in just one day.

As one of the first specialist centres to have launched in the UK, the service has been hailed as a genuinely patient-centred experience - patients get their initial specialist consultation, almost all diagnostic investigations and a treatment plan during a single visit to the unit. The unit’s site at Malton Hospital means it is right at the centre of the area covered by the Trust so, while patients may initially have to travel, it has reduced time down from several hospital visits over many weeks to a matter of hours.

Ben Blake-James, Consultant Urologist, said: “As well as the obvious benefits to patients, the service is a very efficient way of using our resources and provides excellent teaching and training opportunities for clinicians of all levels.”

August 2022

Journey to Excellence improvement programme launched

A new quality improvement programme, Journey to Excellence - or J2E for short – was launched to drive quality improvement across the Trust. It focusses on improving the safety and quality of care, utilising the care quality commission (CQC) standards - safe, effective, caring, responsive and well led.

Simon Morritt, Chief Executive, said: “It’s important that everyone engages in the programme as we work to make CQC requirements part of our everyday business. We have to improve, and to do this the programme has a weekly focus on an area of quality that includes useful frequently asked questions and answers. These kinds of questions could

be asked by CQC inspectors, demonstrating how, when used effectively, the CQC framework supports the journey to excellence."

September 2022

New Head of Equality, Diversity and Inclusion appointed

Virginia Golding was appointed in the new post as lead for Equality, Diversity and Inclusion (EDI) for the Trust.

Virginia has worked for the NHS for 30 years and joined the Trust from Rotherham, Doncaster and South Humber NHS Foundation Trust. She has a wide-ranging understanding of the many aspects of equality and diversity in organisations and is highly experienced in diversity training. Virginia is also a Workforce Race Equality Standard Expert (WRES) and brings to the Trust a wealth of experience, connections, passion and enthusiasm.

Virginia said: "I'm excited to work with the Trust on its inclusion journey and will be looking at the Trusts mandatory and statutory EDI compliance, training, the staff networks, governance and inclusive interventions."

New research study to tackle respiratory infections in infants

The Trust is playing a vital role in a new research study, the ground-breaking HARMONIE study into Respiratory Syncytial Virus (RSV), the leading cause of infant hospitalisation.

The York Hospital Harmonie Team, led by the Principal Investigator Dr Dominic Smith, became the first research site in the Yorkshire and Humber region to recruit participants.

Respiratory Syncytial Virus (RSV) is one of the leading causes of hospitalisation in all infants worldwide and affects 90 percent of children before the age of two. Recently there has been a resurgence of RSV following the easing of Covid public health measures.

The first HARMONIE Clinic took place at the York Hospital's Children's Development Centre in September. Dr Dominic Smith, Consultant Paediatrician and Principal Investigator for the HARMONIE study, said: "It has been well received by new parents with many families registering to take part from the study start up in September. Our first research clinic appointments were fully booked. A reduction in the rates of infection would make a great difference to babies in their first two years and help reduce admissions to children's wards during the busiest months of the year."

October 2022

Veteran Aware award

Richard Chadwick, Emergency Planning Manager and Armed Forces Veteran, picked up the Veteran Aware Award on behalf of the Trust.

The award was presented by Professor Tim Briggs, Chair of the Veteran Covenant Healthcare Alliance (VCHA) and national lead in recognition of NHS organisations who provide the best standards of care for the Armed Forces Community.

The VCHA is a formal partnership between the NHS and the Armed Forces that champions the moral obligation the country must support those who serve in the armed forces, including serving personnel, veterans, reservists and their families.

Richard said: “The Trust’s accreditation is something to be very proud of and a partnership that will grow and go from strength to strength. It recognises compliance with eight different standards.”

Trust team scoops British Academy of Audiology Award

The Trust’s audiology team were given top honours at the recent British Academy of Audiology Awards at the organisation’s national conference.

The prize is awarded to a team who has worked together to improve the quality of service in their area. The team’s welcoming student-friendly approach inspired one their audiology students to nominate them for the prestigious award.

The nomination refers to the cohesion, relentless spirit and selflessness shown by the team throughout the pandemic.

Kate Iley, Head of Audiology, said: “We are absolutely thrilled to be awarded team of the year by our peers. It’s even more rewarding to know we have made such a positive impression on one of our students who feels we have ignited their passion for learning and for a career in audiology.”

New women’s network launched

A new women’s network has been launched at the Trust to look at practical ways to support women, raising understanding and awareness of the barriers they face in the workplace.

The women’s network aspires to improve employee experience and confidence in the workplace. It gives a voice to women and provides an open forum for colleagues to share their experience of the workplace in a supportive and safe environment. Some of the things the network will be looking at is pay parity, childcare, flexible working, health and wellbeing and above all helping women to reach their potential.

Kim Hinton, Associate Chief Operating Officer, said: “Women’s networks can provide a space for female colleagues to come together and support one another. They work with members and supporters to identify issues and barriers in relation policies, procedures and practices and advise on required actions and identify and share good practice. It will celebrate women in the workplace and ensure there are visible role models across the organisation and our wider community.”

November 2022

New quality improvement support

A new approach to quality improvement is helping people get creative and make improvements in their work area from the ground up.

Phil Dickinson, Associate Medical Director, has been appointed to lead on clinical quality improvement (QI) for the Trust, working alongside the improvement team.

Phil explained: “Ground up quality improvement recognises that improvement is often best delivered by those closest to the issue.

“Our ambition as a Trust is to encourage all staff to feel engaged, enabled and empowered to start and deliver quality improvement projects in their own areas. This is done by working to a principle where staff ask how they can make the experience of care better and improve their own working experience.”

BSL Video interpreting on-demand

Interpretation for British Sign Language is the most requested service at the Trust and is in huge demand. There is now the option to use a tablet to dial up a video British Sign Language interpreter on demand. Other languages also available using the tablets.

New Nursing Council set to improve the voice of nursing

The latest staff network to be led by frontline staff is the new Nursing Council, created to ensure there is no decision about nursing without nursing being involved.

This will mean a member of the nursing council will be involved in decision making that affects the profession, ensuring the nursing voice is heard.

Jason Angus, Healthcare Assistant, said: “There are many occasions where decisions are made in the organisation without any nursing input and this can ultimately impact on nursing colleagues and cause issues farther down the line.

“It could be anything from IT and new systems to catering or wellbeing initiatives, where nurses could provide valuable insights before final decisions are made and implemented.”

Carbon reduction work begins

Work to improve energy use and sustainability at York and Bridlington hospitals has begun following grants awarded to the Trust in 2022 from the Department for Business, Energy and Industrial Strategy (BEIS).

Work to clad the outside of the main ward block and replace windows at York Hospital is well underway and at Bridlington Hospital work has taken place to replace a twenty-year-old boiler with low carbon air source heat pumps.

Jane Money, Head of Sustainability, explained: “The work will result in a total carbon saving of around eight percent for York Hospital and Bridlington Hospital is set to make the site a shining example of sustainability, achieving more than 80 percent carbon emissions.”

December 2022

York ablution room complete

A dedicated space for ablutions at York Hospital has been created by refurbishing an old doctor’s on-call room near to the prayer room in the chapel.

The space has been reconfigured to fit a large ablution room and a small bookstore and includes new sanitary appliances, fixtures, and fittings along with new finishes to walls, floors and ceilings plus full wheelchair accessibility to all appliances.

The room was designed in consultation with the Race Equality Network. Hassena Karbani from the network said: “Having a dedicated ablution area will make an important difference to our colleagues and service users in enabling them to fulfil their daily prayers seamlessly when on site. On behalf of them, I would like to express my gratitude to everyone one who has been involved in the process over the years and to the Hospital Charity for their funding.

“This is a great step in recognising the diversity of our workforce and promoting inclusion within the workplace.”

Clinics at Bridlington Hospital mean less travel for patients

A new service has launched at Bridlington Hospital to make it easier for local people when they need an operation at York or Scarborough hospitals.

Prior to having an operation patients need a pre-assessment to make sure they are fit for an anaesthetic and surgery. Until recently these assessment clinics have been held where people are having their surgery at either York or Scarborough hospitals. The new service now means Bridlington patients can have their pre-op bloods, ECGs or Covid PCR testing locally.

January 2023

New apprenticeship offers nurse training

A new initiative launched by the chief nurse’s team will see local universities deliver nursing associate and registered nurse degree apprenticeships for staff at the Trust, where staff will be able to further their career in nursing for free.

The apprenticeships will be delivered by university partners Coventry University Scarborough and University of York.

Emma George, Associate Chief Nurse, said: “This is fantastic news for staff in our nursing teams who will be able to apply for these amazing opportunities through the recruitment campaigns we will be running throughout the year.

“In the current financial climate, it’s a real bonus to be able to learn on the job and avoid student loans. We know we have incredible staff working on our wards and in community and there’s nothing we would like more than to have our own home-grown nurses and nursing associates.”

February 2023

Cultural Festival comes to York

Following a successful cultural festival at Scarborough Hospital in September 2022, plans are underway for an event in York this April.

The idea was sparked by Liz Alinaitwe, ward sister on Scarborough’s Acute Medical Unit. Originally from Uganda, Liz joined the Trust in 2019 and with such a variety of cultural backgrounds in the Trust’s hospitals and community it struck her how much everyone could learn from each other.

Liz said: “The festival is a wonderful opportunity to deepen our understanding about cultural diversity and have appreciation for each other’s cultures. Last year we found listening to presentations from different cultural groups, as well as having a family day out together was stimulating and thought provoking for us all.

“We will use this cultural week to reflect and learn new perspectives of why other cultures do things differently. It helps us to be more tolerant with each other, as well as being more respectful and united.”

March 2023

New app for maternity patients

A new electronic system has been launched to pregnant women across the region, giving them more access to and control of their pregnancy records and care notes.

The online portal and app, known as Badger Notes, will see women access maternity records over the internet through a PC, tablet device or mobile phone. The information is generated in real-time from the hospital’s maternity system record, using details entered by a midwife or other health professionals involved in a patient’s care.

Jo Holleran, Digital Midwife, said: “With the new app, records can be easily updated at each maternity visit or appointment. It’s fantastic for our patients as they can see a week-by-week timeline of their pregnancy and learn about their baby's development. Women can also access information recommended by their midwife, view booked appointments, write a personal diary, and even add a photo.”

Part Two – Priorities for Improvement

2. Looking Back: Progress with Our Quality Priorities for 2022/23

In this section we present our progress in relation to the delivery of our quality priorities for 2022-23.

2.1 Our Improvement Priorities

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

Why this was important

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 said we would 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

What We Did

We have developed and delivered a three-level approach to QI training based on the Institute for Healthcare Improvement (IHI) Model for Improvement and the trusts previously described 6 stage approach:

1. Basic QI Online Training – provided by the Leadership Academy Duration 1-2 hours, available to all staff - Quality Improvement Training - Bronze - Improvement Academy.
2. Intermediate QI training – 1 day Face to Face, delivered alternately at York and Scarborough sites, commenced March 22.
3. QSIR (Quality, Service Improvement and Redesign) 5 day advanced/Mentor level qualification supported by NHS England. Cohort 1 completed November 2022 (25 Candidates including representation from all 6 care groups and larger corporate departments (Workforce; Estates/Facilities, Finance). Cohort 2 planned for March 2023 (30 candidates).

We are in the process of building a QI education guide so staff can navigate themselves to the right level of QI training for their role.

In addition, supported bespoke training for some staff groups:

- New Consultants – 1 day QI training provided
- Senior Doctors - Quality training including quality improvement
- Preceptorship training commenced for all new starters in March 2023.
- Junior Doctors – Attended Junior Doctor Induction event in February 2023, this will continue twice yearly.

This programme of QI skillset development will continue into the 2023-24 financial year and beyond. This programme of work is fundamental to the Trust building a culture of continuous improvement.

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

Why this is important

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 said we would 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.

What we did

The improvement team have created a list of quality improvement resources, educational links, ready for the arrival of the new intranet.

Following the completion of the QI section of the quality strategy, a QI delivery group was established which is the key mechanism for ensuring that QI becomes a fundamental part of what we do as a Trust. We also appointed an 'Associate Medical Director' post to clinically

lead QI. The Board of Directors have requested a 3 monthly update on the progress with Quality improvement in the organisation.

A QI self-assessment tool has been developed and we are meeting with each care group / corporate service to establish where they are in their QI journeys. This will be repeated each year as we hope to see an improving position over time. This included discussions around building resource with clinical leadership for quality improvement and leadership fellow roles.

The improvement team continue to market the idea of the 'Quality Council' model for teams they are working within the organisation. Quality Councils are local quality groups where frontline staff come together to develop quality improvement initiatives for their wards/teams.

The QI toolkit has been reviewed and is a regularly distributed and utilised resource in the organisation.

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.

What we did

Multiple projects have been undertaken across the sites in the organisation to ensure standardisation of processes and shared learning. Key examples of cross site working are where we have stakeholder groups in areas such as diabetes care, infection prevention, fractured neck of femur, falls, nutrition and hydration. This encourages the sharing of ideas and collaborative working to create more standardised practices.

The improvement team seeks ‘good practice’ for each new project so any new creative ideas can be shared. The improvement team also create the links to other work of similar content in the organisation, to share good practice/learning. For example, we invited Bradford Teaching Hospital NHS Foundation Trust to come and share with the development team, the work that they had completed on fractured neck of femur as a site with high outcomes in this area. We were able to take the learning and replicate some of their ideas within our Trust. For the nutrition and hydration improvement work, we brought in new ideas for trialling in our organisation, some of which were adapted for local use.

The celebration of achievement annual awards ceremony had an extra category for ‘Quality Improvement’ added last year (2022). This is the space to nominate projects with particularly excellent use of QI methodology and evidence of significant improvements for patients. The award was won by the Tissue Viability Team as they recognised patients in the community with lower leg wounds often didn't receive the compression therapy they required for these to heal. They researched to understand more and discovered it was often because the patient had not undergone a 'Doppler' test. This is used to ensure sufficient blood flow to safely use compression bandaging. The team found teams understood the tests were important but they needed to be done by a trained nurse while the patient was laid flat, which took an hour. As they were not critical to be completed on the same day, they were often deferred for more urgent care to be delivered. After further research and testing, the team identified an automated machine that no longer required a patient to lie flat, could be undertaken by any member of staff with suitable training and took just ten minutes rather than an hour. The result was a reduction over three months from over 150 patients awaiting a Doppler test to fewer than 30, meaning at least 120 patients could commence the appropriate treatment to support their wound healing.

The improvement team also identify individuals and teams who they feel they can nominate for the monthly star award

2.1.2 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 said we would do in 2022/23

We said we would…

- 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).

What we did

- Procured and introduced a Trust QR code account and process that utilises dynamic codes thus allowing documents to be updated as necessary and the QR code to remain the same. This affords QR code displays to always lead to current documents.
- Redesigned the Trust Patient Information Leaflet (PIL) templates to include the addition of QR codes.
- Worked with the Trust emergency departments to add QR codes to the department discharge PILs and with the development of posters displayed in the departments for the public to access in a timely and efficient manner.

Further analysis identified that use of QR codes to access Trust policies and clinical documents requires alignment with other workstreams, including upgrade of the Trust intranet and a review of our document storage facility.

Work is ongoing in this area and in line with the launch of the new intranet, specialty specific QR code posters with frequently used documents and information will be available in one singular accessible space.

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

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 said we would do in 2022/23

We said we would…

- 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

What we did

- Provided monthly summaries across the year to Quality and Patient Safety Group and to Care Group governance teams encompassing progress with, and any escalations regarding, national audit and baseline assessments.
- Held regular meetings with Care Group governance teams to review performance and implementation of improvements in service delivery.
- Developed and implemented the use of a cloud-based platform for registering local audits. The platform allows oversight of progress across the organisation and the ability develop specific action plans to implement improvements identified.
- The improved reporting and shared communication have contributed to the Trust achieving 94% of the recommendations from NICE baseline assessments in 2022-2023 as opposed to 77% in 2021-2022.

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 said we would do in 2022/23

We said we would…

- 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.

We said we would…
➢ Ensure a trajectory plan is in place for the remaining 80% of mandated clinical audits, aligning this with the Trusts quality strategy.

What we did

- Worked with the information team in the production of a report requesting support for a dedicated audit team in order to fulfil the requirements of this priority. The request will feature on the 2023-2024 business case list for consideration.
- Undertook a process mapping exercise with the subsequent development of a national mandated audit process flowchart in support of those involved understanding expectations and responsibilities. In turn this allows for improvement plans to be to be focused on priority areas.
- All national mandated audits are now recorded on our electronic platform called InPhase which affords visibility across the organisation. Action plans are created within InPhase, linked to the relevant national mandated audit and are used to drive improvements in care delivery.
- In practice this has resulted in a more streamlined process and in care groups using their action plan dashboards at governance meetings to better focus efforts and track progress.

2.1.3 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: Reducing harm to our patients.

What we said we would do in 2022/23

We said we would….

- 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

What we did

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

- **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)**

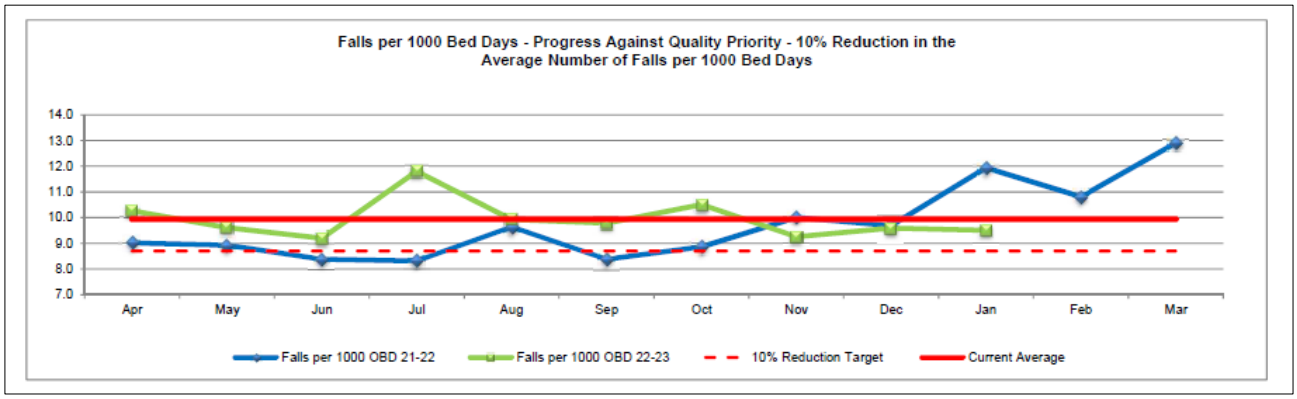
Data below inclusive of January 2023, shows the target reduction to achieve and sustain a 10% reduction in the average number of falls per 1000 bed days has not been achieved to date this financial year. The Falls Improvement Group continues to work towards this target.

Quality Priority - 10% Reduction in Average Number of Falls per 1000 Bed Days - 2022-23 (Reduction based on 2021-2022 Data)

2021-2022 Data	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	TOTAL
Number of Acute and Inpatient Falls	187	195	178	187	218	201	222	240	237	292	252	291	2700
Occupied Bed Days	20734	21850	21244	22484	22621	23971	25052	23980	24457	24464	23310	22567	276734
Rate per 1000 Bed Days	9.0	8.9	8.4	8.3	9.6	8.4	8.9	10.0	9.7	11.9	10.8	12.9	9.8

2022-2023 Data	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	TOTAL
Number of Acute and Inpatient Falls	266	262	234	303	258	236	258	231	234	245	0	0	2527
Occupied Bed Days	25917	27270	25442	25667	25986	24126	24569	24968	24403	25787	0	0	254135
Rate per 1000 Bed Days	10.3	9.6	9.2	11.8	9.9	9.8	10.5	9.3	9.6	9.5	-	-	9.9

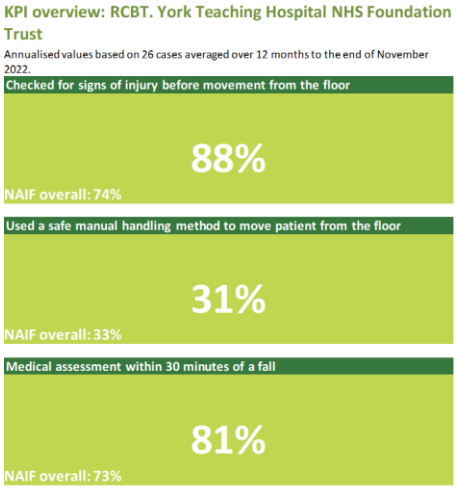
A 10% reduction based on the average rate of falls per 1000 bed days equates to a target of 8.7 falls per 1000 bed days for 2022-23.



KINDNESS
OPENNESS
EXCELLENCE

- **Improve compliance with the National Audit of Inpatient Falls (NAIF) audit to be in line with national average**

The NAIF information and data covers from January 1st 2022- November 30th 2022, there are 4 more audits from falls/#NOFs in December that have yet to be submitted and the end of year report from NAIF will not be available until April time. As presented below, the Trust is showing positive improvements and are now above national average with both checking for injury before movement from the floor and medical assessment within 30 minutes of a fall. Use of a safe manual handling method to move patient from the floor continues to require improvement and we remain slightly below national average in this area.



- **Eliminate all category 4 pressure ulcers where lapses in care have been identified for patients in our care**

This quality aim was set for the second year, as the Pressure Ulcer Improvement Group (PUIG) recognise all category 4 pressure ulcers, with lapses in care should follow a zero-tolerance approach due to the significant complications they cause patients. This includes delays in discharge as well as vastly increasing the risk of infection, requiring equipment and additional care on discharged or for ongoing care requirements in community.

The expectation going into 2022, were many of the category 4 pressure ulcers 2021/22 were the consequence of the Covid Pandemic and this will have reduced/ resolved during the following year. However, unfortunately this did not consider the ongoing pandemic pressures, staffing issues, high volume of frailty in our patients and delayed discharges due to social care issues.

For the 7 patients that have been declared as Serious Incidents during this time, the lapses in care determined during the investigations appear to determine recognised themes and include:

Failure to complete documentation relating to risk assessments, re-assessments, and skin checks.

All of these themes are captured on the Pressure Ulcer Trust Improvement Strategy.

- **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**

			Q1			Q2			Q3			Q4			Total 22/23		
	Minimum Target	Maximum Target	Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator	%
CCG15: Assessment and documentation of pressure ulcer risk (INCLUDED IN CONTRACT)	40%	60%	15	33	45%	103	122	84%	99	104	95%	114	114	100%	331	373	89%

Initially capturing the CQUIN Pressure Ulcer data was a difficult task and overlapped with the introduction of Nucleus electronic records. The first wave implementation of Nucleus included the PURPOSE T (Pressure Ulcer Risk Primary & Secondary Evaluation Tool). This mitigation was submitted to the ICB during Q1. Following this, amendments to the Nucleus templated were added to ensure data collection could be completely acquired from the electronic system. This has been very successful, and compliance has risen from 45% to 84% during Q2, 95% in Q3 and 100% in Q4.

- **Achieve at least a 20% reduction in C-Difficile bacteraemia in 2022/23**

The incidence of *C.difficile* infection has not reduced for 2022/23. Reduction strategies are in place to improve this picture accros the organisation.

The *C.difficile* Improvement Group (CDIG) has been developed as part of the IPC governance; with membership from clinical teams. This groups meets monthly to review the *C.difficile* incidence and share any learning from themes from Post Infection Reviews (PIRs). The group also reviews the *C.difficile* Improvement Plan to ensure actions are tracked and implemented appropriately.

A proactive Hydrogen Peroxide Vapour (HPV) program has been completed in Scarborough for all in-patient areas including the Emergency Department since April 2023; to reduce environmental burden of *C.difficile.* This program has been a challenging piece-meal approach as there is no dedicated space to be used for decanting wards. In York the HPV program is on-going utilising the window replacement program when wards are decanted.

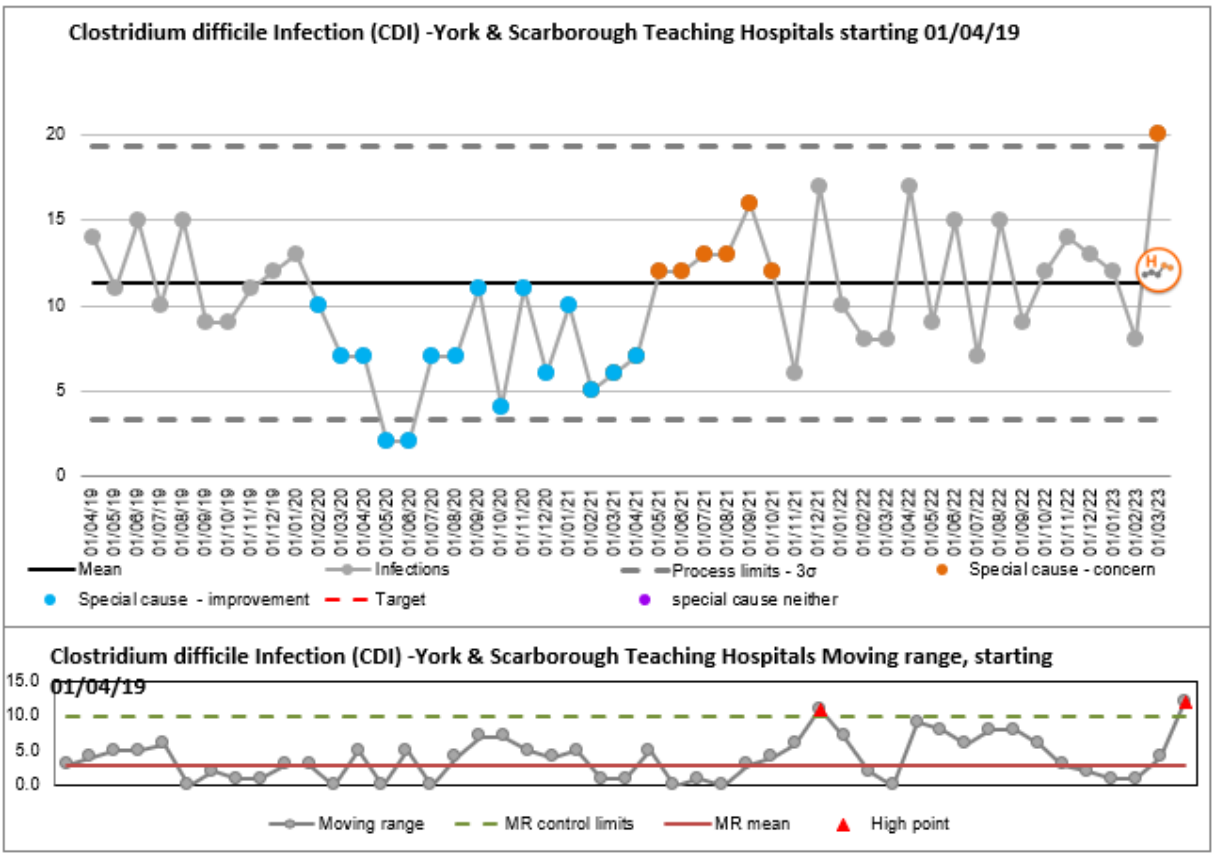
The PIR process has been embedded into CGs to ensure local learning from themes. 60% of PIRs have been completed across all CGs since April 2023 to date. This is an improvement from previous years.

There is a focus in raising awareness for all staff groups in relation to *C.difficile* through training programs and engagement with IPC link Champions. The IPC team held a conference in October 2022 with *C.difficile* included to the main topics. Further funding has been sourced from NHSE/I to hold another conference for 2023/24 focusing on main IPC challenges including *C.difficile.* The team in currently planning some study drop in sessions in April 2023 for clinical staff to highlight basic IPC practices which impact on the *C.difficile* incidence.

The electronic Nucleus app is in the process of incorporating the *C.difficile* care plan to guide clinical staff in effective management of patients with *C.difficile*

The IPC team in collaboration with an external company INIVOS is developing a cleaning poster guide which is colour coded and stipulates cleaning requirements for common organisms. This will be useful in guiding appropriate cleaning including for *C.difficile.*

Executive Board is sighted on IPC issues, and challenges faced in regards to *C.difficile* across the organisation.



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

Why this is important

Evidence shows that safe levels of Nursing staff, within the NHS, is associated with improved outcomes for both patients and staff. For example, lower mortality rates, higher patient satisfaction, shorter hospital stays and increased staff morale.

What we said we would do in 2022/23

We said we would..
➢ 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 data to understand impact of reduced staffing on patient care.

What we did

➢ **By April 2023, have no more than a 1% vacancy rate for Healthcare Assistants.**

Whilst we have reduced our overall HCSW vacancy position to 7.0% we have not achieved the 1% vacancy target for the trust, York has a vacancy rate of (9.24%) and Scarborough (16.77%). Regionally, when the trust is reviewed against peer organisations there is a sustained improvement to vacancy rates, which is reflected in monthly data received from NHS England. This has been achieved by the development of a robust HCSW recruitment and retention group. Which highlighted areas for improvement, leading to mapping sessions for the HCSW journey, from advertisement to completion of induction attended by all stakeholders who all contributed to highlight how the trust could improve the recruitment and retention of the HCSW further.

Improvements to date include

Redesign of the generic events to include a “Values based assessment method” – candidates are assessed in a group using a patient scenario – this approach has been shared regionally as a good practice model by presenting at a regional roadshow for NHS England.

The introduction of a “Welcome Checklist” to support the onboarding of new starters to wards/departments.

Healthcare support forum – established across sites to provide HCSW’s with a platform to discuss concerns and receive support.

Associate Educators have been piloted across care group 1, 2 and 3 to provide pastoral support to HCSW’s on the ward/department areas – this support has been instrumental in

the retention of HCSW's – unfortunately there is a lack of funding to support the continuation oof this role in all care groups which will be a challenge in particular for CG1 moving forward.

Pastoral Award pilot is currently under review for the HCSW – in May we will receive the quality mark for NHS England to denote our achievement of providing pastoral support to date.

- **By April 2023, have no more than a 7.5% vacancy rate for Registered Nurses.**

The vacancy rate for Registered Nurses for adult inpatient wards stands at 8.14%, there has been a marked improvement in retention within this staff group in 2022/23. This has been achieved by the development of a robust retention plan for nursing, including implementing career clinics for nurses who have itchy feet to support their development. Embedding the preceptorship programme and aiming to achieve the NHSE quality mark, we have received positive feedback from the preceptees this year. The nursing council has been formed and is led by nurses to ensure they have a voice within the organisation and can influence decision making to ensure they feel valued.

Recruitment of international nurses has continued with 134 overseas nurses joining the trust during 2022/23 and further recruitment of 90 international nurses is planned for 2023/24.

Challenges continue within the nursing workforce but with plans to ensure we offer support and the retention plans for 2023/24 on going it is expected that the retention figures will continue to improve for our Registered Nursing workforce.

The overall nurse staffing vacancy for all staff groups is 7.41% in February 2023

- **Triangulate data to understand impact of reduced staffing on patient care.**

We have developed a ward-based dashboard with key indicators showing ward-level monthly data in relation to workforce, quality, Healthcare Associated Infections, and incidents alongside ward assurance data from the nurse electronic documentation system Nucleus and the audit tool Tenable. This dashboard will be implemented during Q1 2023-24 and will be provided monthly and show on a month-on-month basis changes to performance and provide a single source for the clinical leads within the care groups. This will provide assurance to the quality committee where there are wards that require further support and assurance and an ongoing trend to inform any improvement and or deterioration.

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

Why this is important

When incidents occur, it is essential that we seek to understand the contributory and causal factors. In doing so we can take action to prevent reoccurrence. However, all too often in

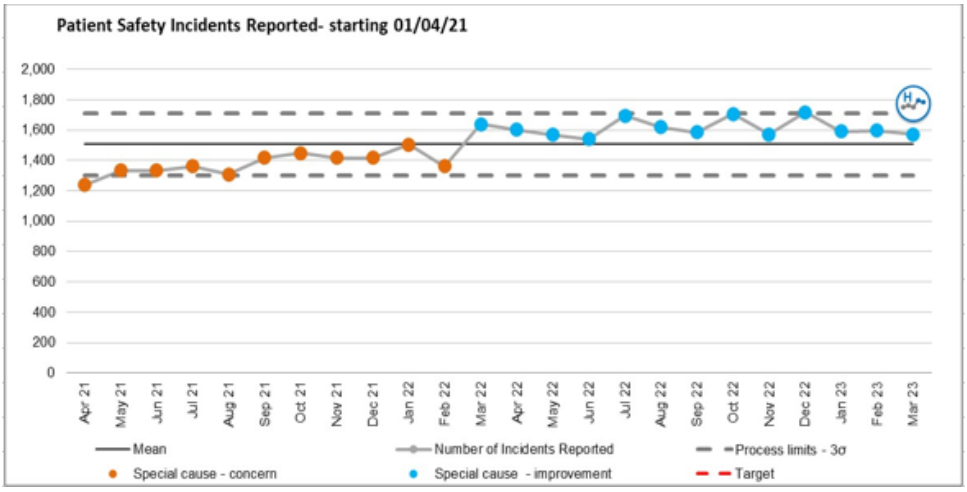
healthcare incidents can occur in one part of an organisation or system but the learning not shared. This means that the incident is likely to reoccur as the actions to address the issues are not understood and embedded. Sharing learning and embedding improvements is essential to improving the safety, quality and experience of health care.

What we said we would do in 2022/23

What we said we would..
➢ 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.

➢ **Continue to improve the patient safety incident reporting rate, aspiring to be in the upper quartile nationally.**

The number of incidents reported in the organisation has had a significant increase in February 2022 and has remained above the mean.

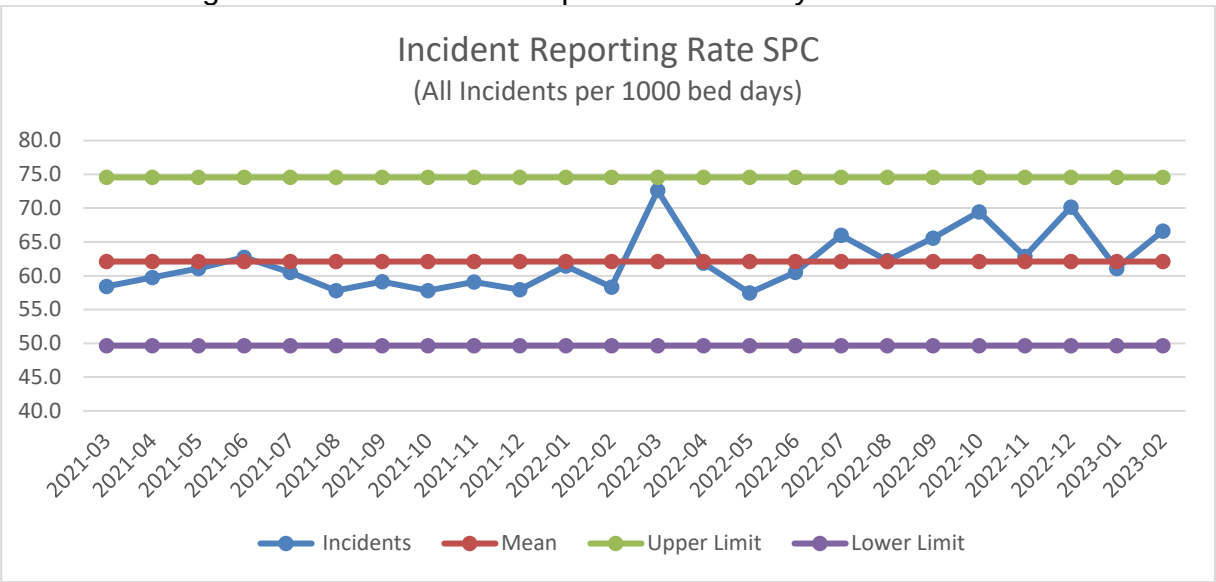


Trusts have recorded data on the National Reporting and Learning System (NRLS) for many years. This data is collated with information from other English Trusts and reports published to enable organisations to monitor reporting rates over time and to benchmark against other

Trusts in England. The reporting rate uses the number of incidents per "1000 bed days[1]" as the denominator rather than the number of incident reports. This takes into account different activity levels, e.g., size of the Trust, which enables reporting rates to be compared with other organisations.

Prior to March 2020 the reports were published every 6 months; and thereafter annually. There is a significant data processing lag which means validated finalised reports are now published 6 months after the end of the financial year. The most recent report therefore covers April 2021-March 2022.

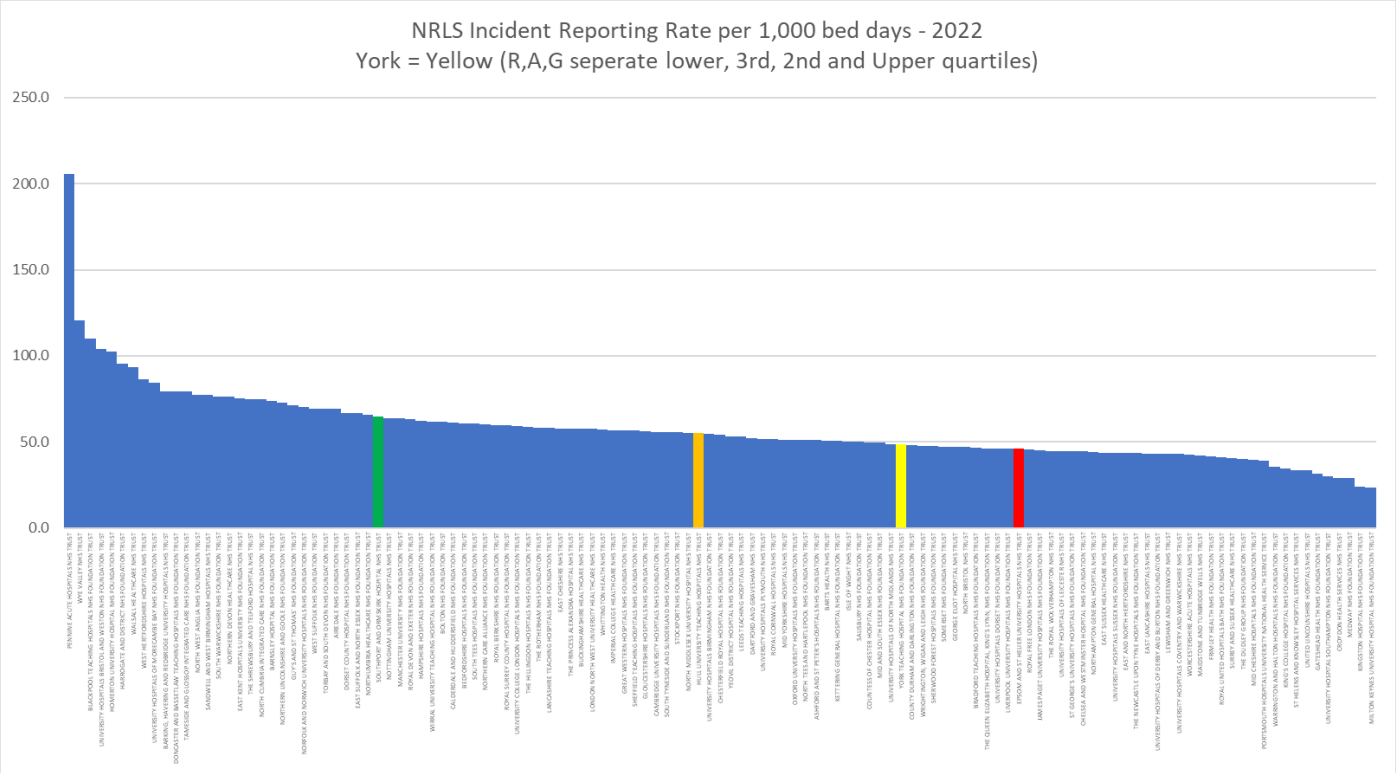
The Trust incident reporting rate since March 2021 is shown in the table below. The rate generally shows consistent reporting patterns over the last two years with the most recent data confirming a rate of 66.6 incidents per 1000 bed days for all incidents.



It is considered that higher reporting rates demonstrate a better safety culture i.e.. staff are willing to report and learn from errors. The Trust will endeavour to improve reporting rates through the safety priorities established for 2023/24 and beyond.

The table below shows the relative position of the Trust compared to other participating Trusts in England with most recent data ranking the Trust in 79th position of 123 Trusts. Note NRLS data only counts patient safety incidents therefore a lower rate than reported above which includes all incidents.

[1] Bed days are calculated by counting the number of beds available in a Trust each day and multiplying that by the time period in question. The use of 1000 bed days makes the numbers more manageable. (Eg. a Trust with 1000 beds will have approx. 181,000 bed days in half a year. Measuring "per 1000 bed days" is therefore 181.)



Clearly the ambition to reach the top quartile has not been reached and we sit in the 3rd quartile for reporting rates. Benchmarking is of limited value because it does not recognise individual improvements amongst a group of other improvers. Improvement methodology focuses on continuous improvement rather than benchmarking so future reports will continue to publish reporting rates, but not benchmarked data. As a Trust we continue to raise awareness of the importance of reporting incidents, even those which result in no harm as learning from these can prevent harms from occurring in the future.

NHS England, using NRLS data, currently publishes rolling monthly data covering the last 12 months. It is refreshed every month and provides more readily available recent data for review of reporting patterns. The data however cannot be used for benchmarking.

The NRLS system is being phased out and replaced by the Learning from Patient Safety Events (LFPSE) service. The Trust will transition to the LFPSE during 2023/24 but the reporting criteria are different so it may not be possible to compare NRLS and LFPSE data in the future.

- **Improve staff confidence in how the Trust deals with concerns raised.**

We have made changes to our incident reporting system to ensure feedback is sent to the reporter at the time of finalising the investigation. This has provided more assurance to the reporter that a thorough investigation has taken place and the necessary action has been identified.
Our monthly safety spotlight newsletter aims to share learning from investigations of concern. We are continuing to build on including more information within this newsletter for example the themes identified from the reported concerns and the actions taken to mitigate these.

- **Improve staff response rates in both the annual staff survey and in the quarterly pulse surveys.**

Increased communication and engagement with colleagues during 2022 including 'You Said We Did' items about actions taken in response to staff feedback, have resulted in increased response rates for both the annual national staff survey and the national quarterly People Pulse survey.

Staff Survey response rates:

	2021	2022
Trust	40%	43%
National Average for Acute / Acute & Community Trusts	46%	44%

National Quarterly pulse Survey responses:

Quarter	Q4 (Jan 2022)	Q1 (April 2022)	Q2 (July 2022)	Q4 (Jan 2023)
Number of responses	154	232	169	481

[note – the NQPS in Q3 (October) is included in the annual Staff Survey]

It is normal for a quarterly pulse survey to have a lower response rate compared to the annual staff survey. The national recommended target for the NQPS is a 10% response rate (which would be approximately 1,000 responses for this Trust).

- **Launch a local just culture toolkit ensuring learning from incidents.**

Work is being undertaken jointly between the Workforce and Patient Safety teams to embed a local Just & Learning Culture to ensure learning from incidents – both patient and staff related.

- **Transition into the new Patient Safety Incident Response Framework**.

We have a Project Team focused on the development and planning of the Patient Safety Incident Response Framework. There is an ongoing project plan with specific timeframes for each stage throughout its development and implementation. As this is still in progress it has been made one of our top priorities for 2023/2024.

- **Create and deliver an internal Patient Safety conference in 2022, sharing local learning and improvements.**

Unfortunately, due to the continual impact of Covid-19 this was unable to go ahead. We aim to create and deliver other opportunities for shared learning and improvement as we transition into the new Patient Safety Incident Response Framework.

2.1.5 Our Patient Experience Priorities

As a Trust we are committed to ensuring that our patients and their carers have the best possible experience of our care. There are times however, when this experience will not be of the standard that we or the patient and their family would expect to have. The Trust has faced considerable challenges over the last year as we try to return to activity levels seen pre-pandemic and recognise the ongoing impact that the pandemic had on both patients and our staff.

It has been a year of significant change for the Patient Experience Team, which has seen new roles developed and recruited to. We have continued to invest in the recruitment and onboarding of volunteers across the Trust, many of whom are supporting patients by being involved in nutrition and hydration services, and we have strengthened partnerships with Friends of York Hospital and more groups across our communities.

The Trust values and appreciates all those patients, carers and members of the public who have contributed by sharing their lived experiences, discussing service improvements, and being involved in a range of engagement events over the last year.

Good progress has been made towards the priorities agreed with patients and public members a year ago.

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 said we would do in 2022/23

We said we would…
➢ 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.

What we did

- Implemented a comprehensive restructure following a formal consultation with the patient experience team
- Established a complaints and concerns officer team to respond and support the care groups with responses to PALS concerns and formal complaints
- Established a renewed focus on Patient and Public Involvement (PPI) with the appointment of a PPI Lead (secondee) and a Patient Experience Facilitator

- Established and recruited to a Head of Patient Experience & Involvement
- Worked with the corporate improvement team to embed PPI into the Trust Quality Improvement (QI) roadmap and training for front-line staff
- Worked with the Patient Safety Team to recruit and induct two Patient Safety Partners in line with the renewed national focus on patient safety across the NHS.
- Worked in collaboration with care groups, to engage with patients and service user groups, e.g., involved service users, including a wheelchair user and a member of the public who has an assistance dog, in a simulation exercise to map the patient journey through the new-build emergency department at York. This was successful and will be replicated on the Scarborough site next year in relation to the new build emergency department.
- Delivered PPI presentations to groups of medical staff and Allied Health Professionals

In addition, we have also ensured that patient representatives have been included on the interview assessment centre panels for recruiting new members of the Patient Experience Team.

Priority Two: **Review patient experience reporting systems to ensure robust use of data and engagement from and with Care Group Leads**

What we said we would do in 2022/23

We said we would…
➢ 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.

What we did

- Shared regular information through Care Group complaint dashboards and monthly reports to support Care Groups to identify themes and improvement goals
- Provided access to information from the completion of Family and Friends Test (FFT) to triangulate with other sources of patient feedback

- Introduced QR codes for FFT within the Emergency Departments and produced bespoke feedback for display in the departments
- Developed a Trust-wide improvement plan to oversee initiatives arising from patient feedback themes
- Increased visibility of patient stories within organisation meetings – Board/ patient experience/care group meetings to connect experience and impact to the workforce and to share learning.

Examples of improvement work in response to patient feedback include:

- Medical wards are implementing agreed discharge standards, aiming to improve the discharge experience for patients
- The trial of a new family liaison officer role on Oak ward has been completed and the role expanded to other wards at the Scarborough site – this role is established to help improve communication between families and the ward staff
- The Family Health Care Group commenced a culture work stream with the emphasis on good leadership and treating staff with care and respect, recognising that the interactions between members of staff have a huge impact on their attitude to work
- The Trust has undertaken work to improve fundamentals of care including introducing measures to improve nutrition and hydration, making sure that those who are not able to feed themselves or drink fluid unaided are supported. Initiatives have included the introduction of a traffic-light coloured lid scheme for water jugs and promotion of uninterrupted mealtimes. Children's services are working with families and children to improve menus, ensuring healthy options are available.
- Our Patient Equality Diversity & Inclusion lead has worked with service users to raise awareness that assistance dogs are welcome, and our duty is to make reasonable adjustments to support disabled people to access the hospitals except in exceptional circumstances, i.e., allowed anywhere in the hospital except an operating theatre, area where radiation is used, or in a commercial kitchen.

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

What we said we would do in 2022/23

We said we would…
➢ 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

What we did

- Moved to regular structured recruitment ‘phases’ every three months, to concentrate the team’s effort and capacity into two distinct areas of recruitment and then retention of the volunteers
- Focused efforts within recruitment on those aged 16 – 18yrs to grow this cohort
- Reviewed all volunteer records to ascertain how many volunteers had returned and were active post-pandemic
- Introduced a better and comprehensive induction process including shadow shifts for new volunteers before they commence regular volunteering, which in turn has created a ‘lead volunteer’ role for longer standing volunteers to be able to share their experience with newer recruits
- Successfully helped volunteers to move into paid employment with the Trust – 23 individuals moved from ‘volunteer to career’
- Explored the appetite among the volunteers for more variety in the roles and opportunities offered, including inviting them to be part of the simulation exercise for ED in York, PPI activities and discussions, and recruitment and induction sessions for new volunteers
- Strengthened the partnership with Friends of York Hospital by bringing their Volunteers in line with Trust Volunteers for recruitment, retention, and day to day support

2.2 Looking Forward: Our Quality Priorities for 2023-24

The following priorities have been identified and agreed by our Board for 2023-24. These priorities continue to build upon the progress made in the 3 domains of quality (safety, experience, and effectiveness) over the previous year.

2.2.1 Our Improvement Priorities

Why this is important

For the Trust to be most effective, quality must become the driving force of the organisation culture from service level to Board. Fundamental to creating this culture is our commitment to listening and involving our patients, and the families and carers, people important to them to understand what is important to them and where we can improve. Quality improvement provides a systematic approach to enabling staff to identify quality issues and work through a process to deliver better quality care and improved patient experience. Quality improvement requires clinical staff/non-clinical staff at all levels across the organisation to work alongside patients to ensure that problem solving and decision making happens as close to the issues being experienced as possible. We must ensure we are open and transparent in our approach to quality improvement.

Our ambition for the future

Whilst the demand for our services increases year-on-year, we need to find new and innovative ways to deliver high quality services which are accessible to all. The Core20PLUS5 NHS England initiative seeks to inform action to address healthcare inequalities and quality improvement initiatives co-produced with the populations we serve will be key to achieving sustainable action. Core20 relates to the 20% most deprived, plus are those groups identified at local level and 5 relates to 5 key groups:

1. **Maternity**

Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

2. **Severe mental illness (SMI)**

   Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. **Chronic respiratory disease**

A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. **4. Early cancer diagnosis**

75% of cases diagnosed at stage 1 or 2 by 2028.

5. **Hypertension case-finding and optimal management and lipid optimal management**

To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

As a Trust we strive for excellence and those Trusts rated outstanding by the Care Quality Commission (CQC) all have an embedded culture of continuous quality improvement. Therefore, key to achieving our ambition for excellence is to successfully embed improvement through a consistent methodology.

We aim to develop a QI culture which includes:

- bringing a systematic approach to tackling complex problems
- focusing on outcomes
- flattening hierarchies
- giving everyone a voice, and bringing staff and service users together to improve and redesign the way that care is provided

We will support staff at all levels to lead and deliver measurable change with the use of our chosen model of delivery the IHI ‘model for improvement’ at its core. To achieve this, we

have created a simple, easy to use, 6 step approach to Quality Improvement which we have called our 'Roadmap to improvement'. The 'Model for Improvement' has been used successfully by a range of healthcare organisations across the world, to improve care by working in teams. The model supports staff identifying the improvements required and using plan, do study, act (PDSA) methodology to test their change ideas. We will continue to develop educational QI resources in a simple format, to ensure that they are accessible to all members of staff in the organisation.

We have developed a QI education and training structure which supports staff to develop their knowledge of QI from basic level to QI Faculty. A QI delivery group was established in September 2022 and is the key mechanism for ensuring that QI becomes a fundamental part of what we do as a Trust.

To continue our journey to achieving our quality improvement vision and ensuring we strive to deliver accessible services for the population we serve we have identified the following priorities. These continue to build upon the progress we have made in 2022-23.

Priority one: We will focus improvements in a patient centred way and ensure QI is delivered in a way that we target interventions and improvements to tackle healthcare inequalities as part of the Core 20 plus 5 initiative

What we will do in 2023/24

We will..
• We will focus improvements in a patient centred way, with patient carer and service user engagement in projects • Increase the understanding of the impact of deprivation on access to healthcare • Ensure QI is delivered in a way that we target interventions and improvements to tackle healthcare inequalities as part of the Core 20 plus 5 initiative.

Priority two: Provide a Quality Improvement training and education structure, from beginner to expert.

What we will do in 2023/24

We will..
• Continue to deliver our programme of QI skills development from beginner to expert. • Continue the roll out of the QSIR Practitioner programme with a further 2 cohorts on 2023-24 • Act to ensure that QI assumes a key role in the organisation. • Develop the required support mechanisms to ensure the growth of QI capability in care groups and corporate departments and estates/facilities • Ensure leading for QI is part of all leadership programmes in the trust • Update the Board on a quarterly basis in relation to QI infrastructure development

Priority three: **Develop mechanisms for sharing and celebrating success following involvement in Quality Improvement**

What we will do in 2023/24

We will
• Develop mechanisms for sharing and celebrating success • Introduce an annual QI celebration event

Priority four: **Enable easy access to the data required for measurement of improvement.**

What we will do in 2023/24

We will
• Ensure staff have access to Digital and data enablers to ensure they can implement and measure the impact of improvement. • Ensure that through the Qi training staff are enabled with the skills to use data for improvement

2.2.2 Our Clinical Effectiveness Priorities for 2023-2024

Priority One: **Develop an accessible, user-friendly patient information webpage on the Trust website**

Why this is important

People who access services in the organisation should have information available to them in an accessible, consistent, and uniform way to help guide them in their health journey. This provides support and reassurance that they can rely on the quality of healthcare being provided.

What we will do in 2023/24

We will:
➢ Utilise insight gained from a series of focus groups held with patients, carers, and members of the public to better understand people's experience of finding and using patient information leaflets on the Trust websiteWork with the members of the focus groups, the patient experience, communication and web design teams to redesign the page ➢ Test the redesigned page with patients, carers, organisation and members of the public ➢ Hold further focus groups to receive feedback and adjust the page as required in line with this feedback ➢ Launch the page both internally and publicly on the website ➢ Audit improvements through measurement of webpage activity and patient/public surveys

Priority Two: Improve timely and effective review/update of Trust clinical policies

Why this is important

The management and control of procedural documents is essential, not only to comply with corporate and clinical governance requirements, but as a key means of ensuring standardisation in the provision of safe care and a safe working environment across the organisation.

Being able to access key clinical documents efficiently means that staff can easily check for any updates to practice. A new Trust intranet and use of QR codes will support in making this information more accessible at the point of need.

What we will do in 2023/24

We will:
➢ Work alongside Care Groups to promote continuous improvement in the timely review of clinical documents by provision of monthly position data and regular review meetings ➢ Facilitate the transition of policy 'housing' to the new intranet in an efficient and organised manner, including improving the keyword/search function enabling easier access ➢ Embed the use of QR code posters in departments to guide to relevant documents ➢ Implement a process that ensures compliance with national guidance and guarantees Trust policies reflect guidance from professional bodies

We will:
➢ Promote the new policy page on the intranet to ensure staff are aware and able to navigate it effectively ➢ Demonstrate a continual improvement trajectory.

Priority Three: Increase oversight, review, and implementation of clinical effectiveness recommendations

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 act in response to findings from audits and shape care delivery for future patients.

What we will do in 2023/24

We will:
➢ Develop Terms of Reference, membership and reporting structure for a Clinical Effectiveness Group and initiate the group accordingly ➢ Ensure the Clinical Effectiveness Group provides oversight of timely review and implementation of National Mandated Audits, NICE baseline assessments and Care Group local audits to support with completion of audit cycles and drive improvement from them ➢ Embed use of InPhase for audit and quality purposes to help drive improvement projects and improve patient care ➢ Oversee the implementation of individual Care Group and the Trust Annual Audit Plans through the group with quarterly progress report from Care Groups feeding into it ➢ Provide robust governance and oversight of applications for new interventions and procedures ➢ Provide monthly escalation reports to the Quality and Patient Safety Group

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.

Celebrating and learning from good practice is essential within a positive safety culture. Bringing into focus aspects of everyday practice is known as safety II. The Safety II perspective was developed with the recognition that complexity and variability is inherent in healthcare, failure in systems do not necessarily arise from individual components but rather from the structure of the systems within which we operate. Therefore, in order to improve safety, we need to understand how people manage and overcome complexity and uncertainty. An example is how we learn how to adapt systems at times of peak demand to respond safely and effectively. What may work at lower demand periods may actually make the situation worse when demand increases.

From Autumn 2023 the Patient Safety Incident Response Framework (PSIRF) will replace the current Serious Incident Framework and sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The key purpose of the framework is to learn and improve safety through placing an increased focus on understanding how incidents happen – including the factors that contribute to them.

Priority One: **Complete the transition to the Patient Safety Incident Response Framework (PSIRF).**

Why this is Important

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

Over the last year we have been preparing for the transition, and this priority sets out our continued approach to successful implementation.

What we will do in 2023/24

We will….
➢ Triangulate data to identify and agree our key focuses within PSIRF. ➢ Recruit and work effectively with Patient Safety Partners[2]. ➢ Engage with teams during the planning, development, and implementation of PSIRF. ➢ We will identify a level of understanding required by staff to meet the needs of the PSIRF Framework and the resources to achieve this

Priority Two: Enhance Patient Safety Systems and Culture

Why this is important

This priority will encourage shared learning across Care Groups and the Multi-disciplinary teams. Staff will feel more empowered to report incidents, raise concerns and make positive changes to health care systems to improve patient safety across the organisation.

In 2023/24

We will…
➢ Embed effective Multi-disciplinary Improvement Groups based on our PSIRF key focuses. ➢ The Improvement Groups will demonstrate cross care group working to enhance patient safety and shared challenges. ➢ Evidence an improvement in safety culture through the national staff survey. ➢ Enhance the understanding of human factors science within the organisation. ➢ Safety II (current and positive practice) will be promoted and evidenced in the work undertaken by the improvement groups.

[2] Patient Safety Partners are a requirement of the National Patient Safety Strategy and are lay members of the public who play an important role in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

Priority Three: Improve our delivery and monitoring of Sepsis

Why this is important

Sepsis is a serious condition life threatening condition in which the immune system overreacts to an infection or injury. According to the UK Sepsis Trust 5 people die every hour in the UK from Sepsis, which underlines the importance of addressing this life-threatening condition.

What we will do in 2023/24

We will…
➢ Work towards implementing the new NICE recommendations in relation to Sepsis care due to be released in June 2023. ➢ Ensure a robust Action plan is linked to the auditing of Sepsis to ensure care is improving across the trust. ➢ Reduce time from recognition of sepsis to administration of antibiotics to within 1 hour (high risk) or 3 hours (moderate to high risk) ➢ Implement targeted quality improvement initiatives within key areas of the Trust to improve recognition and reduce time to treatment.

Priority Four: Increase staff training and education in Pressure Ulcer Prevention and Management to 90% via the Pressure Ulcer e-Learning package

Why this is important

To enable staff to support patients with pressure ulcer prevention and management, by ensuring an understanding of pressure ulcer risk factors and how they can be addressed and managed whilst in our care. The pressure ulcer e-Learning package offers the required information for staff on individualised assessment of risk, opportunities and options for management and support of risk, and guidance on the post pressure ulcer development procedures. It is important for all patient facing staff in the organisation to have a knowledge of the Trust pressure ulcer policy and the expectations and ways to facilitate patient safety. We have a duty to provide evidence-based pressure ulcer assessment and person-centred care to our patients and providing the training via the e-Learning package, to ensure training is standardised, consistent and accessible.

What we will do in 2023/24

We will:

- Ensure the pressure ulcer e-Learning package is accessible on the Learning Hub
- Record and monitor compliance within care groups and specific ward/department areas monthly ensuring oversight quarterly at Pressure Ulcer Improvement Group (PUIG).
- Conduct a full training needs analysis to ensure requirements of the National Wound Care Strategy Programme (NWCSP) are included, e.g., preventative care, wound care, and locally identified topics, i.e., care of patient heels, continence care, categorisation of pressure ulcers (PU) and moisture-associated skin damage (MASD), etc.
- Encourage the completion of the e-Learning package via staff competencies, face to face training sessions and linked to action plans developed as part of the pressure ulcer investigation process.
- Training needs analysis completion, including Allied Health Professional lead to ensure all appropriate staff are identified.
- In Ward/ Community base face to face pressure ulcer training package to be delivered by Tissue Viability Nursing (TVN) service and recorded on Learning Hub.
- Target training requirements in line with Investigation and Serious Incident (SI) reports based upon specialist need of area.
- Provide education to skin champions on holistic individualised approach to pressure ulcer prevention - support cascade training to colleagues regarding the importance of documenting individualised care and discussions

Priority Five: Achieve CQUIN12: Assessment and documentation of pressure ulcer risk for inpatients in acute and community hospital settings (trajectory 70-85%)

NICE clinical guideline CG179 sets out clear best practice for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently republished NPIAP (National pressure injury advisory panel) international clinical practice guidelines. This indicator has been expanded for 2022/23 to include inpatients in acute settings as well as community hospitals. This is expected to contribute to reducing the number of pressure ulcers nationally, improving standards of care for patients in both settings.

Why this is important

The early identification and management of patients at risk of pressure damage within healthcare services, will prevent long term complications by preventing and managing patients appropriately, who are deemed ‘at risk’ or have existing pressure damage.

The Trust adopted the nationally recognised PURPOSE T risk assessment within both Inpatient and Community Healthcare settings. This tool is embedded within all initial

assessment documents. However, challenges occur by ensuring the risk assessment are correctly calculated and care pathways are implemented as recommended, to prevent lapses in care.

What we will do in 2023/24

We will:
➢ Learn from Integrated Care collection of audit data to fulfil CQUIN requirements. ➢ Promote the purpose of accurate PURPOSE T assessments with educational material and training needs. ➢ Identify and confirm responsibility of undertaking both Step 1 (Screening) and Step 2 (Full Assessment & Care Pathway) (Qualified staff and/or assistant staff) & identify/support with any training needs ➢ Monitor compliance with accurate PURPOSE T assessments by means of the Nucleus and Tendable audit platforms reporting areas of concern into PUIG.

Priority Six: Reducing pressure ulcer incidence by 25% of all categories of pressure ulcer over a 12-month period.

Why this is important

The reporting of patients with pressure damage has seen an increase over the past 24 months. At times, the monthly time series data has been reported outside the upper control limits on our statistical process control (SPC) charts.

Following a deep dive of various pressure ulcer data sets, it is estimated that Datix incident reports submitted are not accurate at times, are misleading regarding the type of wound diagnosed and the category of ulcer. This can have significant impact on a patient's treatment and potentially delay discharge. Also, several Datix's have been noted as duplications of previous reports and therefore double counting of incidents can occur.

What we will do in 2023/24

We will:
➢ Policy - update the Trust policy to reflect the changes made in line with the National Wound Care Strategy ➢ Collaborate with clinical governance teams and Matron reps to enact the re-coding of Category 2 incidents where narrative supports moisture-associated damage and to reject duplicate incident reports ➢ Task and finish group to be set up to look at reducing duplication of Datix reports in admission areas and including stakeholders from Clinical Governance.

We will:
➢ Develop additional training materials in response to the TNA and review above, e.g., aide memoires, core e-learning package ➢ Map services to understand how pressure ulcer 'red flag' risk factors are considered at every contact with a health professional ➢ Develop educational materials for staff regarding immediate care for pressure ulcer prevention in response to risk factors and escalation to the GP as required

Priority Seven: Increase staff training and education in falls prevention and management to 90% via the Falls e-Learning package

Why this is important

To enable staff to support patients in falls prevention and management an understanding of falls risk factors and how they can be addressed or managed whilst in our care is vital. The falls e-Learning package offers the required information for staff on individualised assessment of risk, opportunities and options for management and support of risk, and guidance on the post fall procedures. It is important for all patient facing staff in the organisation to have a knowledge of the Trust falls policy and the expectations and ways to facilitate patient safety. We have a duty to provide evidence-based falls assessment and person-centred care to our patients and providing the training via the e-Learning package enables this to be standardised, consistent and accessible.

What we will do in 2023/24

We will:
➢ Ensure the Falls e-Learning package is accessible on the Learning Hub ➢ Record and monitor compliance within care groups and specific ward/department areas ➢ Monitor national and local developments in falls prevention and management and update the e-Learning package accordingly ➢ Review monthly as an agenda item at the trust Falls Improvement Group (FIG) monitoring uptake and feedback from staff. ➢ Encourage the completion of the e-Learning package via staff competencies, face to face training sessions and linked to action plans developed as part of the After Action Review (AAR) process.

Priority Eight: Improve lying and standing blood pressure assessments for all patients aged over 65 years (or under 65 years with increased risk of falls)

3 year plan:

Year 1 2023/2024 - 50%

Year 2 2024/2025 - 75%

Year 3 2025/2026 – 90%

Why this is important

The early identification and management of Postural (Orthostatic) Hypotension (OH) is important in falls prevention and management and the safety of our patients. A drop in blood pressure (BP) on standing (OH) is a common occurrence in acutely unwell hospitalised patients and is a risk factor for falls. NICE Guidelines (CG161,2013) and the current NAIF (National Audit of Inpatient Fractures) recommendations specify the evidence-based implementation of the lying and standing blood pressure assessments for all patients admitted of 65 years and above, or under 65 with increased risk factors/complex needs. Within the Trust, lying and standing blood pressure assessments form part of the initial assessment process for falls however they are currently not fully embedded, standardised, or consistent.

What we will do in 2023/24

We will:
➢ Promote the purpose of accurate lying and standing blood pressure assessments and their value in falls prevention & management and ultimately patient safety ➢ Identify and confirm responsibility of lying and standing blood pressure assessments (Qualified staff and/or assistant staff) & identify/support with any training needs ➢ Monitor compliance with accurate (lying after 5 minutes, standing at 1 minute and standing at 3 minutes) lying and standing blood pressure assessments by means of the Nucleus and Tendable audit platforms ➢ Embed the use of electronic (including QR codes), and paper guidance of the recommended procedure for lying and standing blood pressure assessments on wards and departments, to assist clinical teams in standardising their assessment approach ➢ Promote the RCP guidance in all fall's prevention and management training and education sessions including induction packages, e-Learning and falls champions training sessions ➢ Focus on Lying and Standing blood pressure assessments including the purpose, process, escalation, treatment & management opportunities, and patient education/information via monthly infographics and updates ➢ Finalise and publish the Trusts patient information leaflet 'Postural (Orthostatic) Hypotension', launch and communicate Trust-wide ➢ Ensure wards and departments have adequate equipment to perform effective assessments ➢ Develop MDT skills and responsibilities in performing lying and standing blood pressure assessments ➢ Address variability in recording lying and standing blood pressure ➢ Ensure easy and quick access to the Trusts Lying and Standing Blood Pressure Assessment video via quick links on the Trust Intranet and via Health Toolbox

We will:
➢ Develop a plan to move towards all lying and standing blood pressure assessments to be completed using the manual technique by year 2 (2024/2025)

Priority Nine: Increase access to, and provision of, walking aids for all patients who need walking aids from the time of admission, 24/7

Why this is important

Early provision of walking aids to patients who require one has been identified to be a key action in effective falls prevention. Patients admitted to hospital often do not have a new mobility deficit or medical reason to limit or restrict their mobility. In many cases the patient's usual mobility aid is not brought with them into hospital and there is a period of time where the patient may be awaiting therapy teams to assess and provide walking aids. During this time the patient is at increased risk of falls if mobilising without their correct walking aid and/or deconditioning if the patient limits their mobility because they do not have their aid, ultimately increasing their falls risk. In circumstances where the patient has a new mobility deficit, a deterioration in their mobility and/or a medical reason/condition for limiting/restricting their mobility, a therapy assessment would be indicated. By developing a policy within the Trust to provide walking aids early in a patients admission, we aim to decrease the risk of falls and deconditioning in patients who do not have a change in their mobility requiring a therapy assessment and intervention.

What we will do in 2023/24

We will:
➢ Develop a workable policy to ensure that all patients who need walking aids have access to the most appropriate type from the time of admission, 24/7 ➢ Engage with Therapy colleagues to identify appropriate education and skills for staff ➢ Initial focus on admission areas across the Trust ➢ Ensure wards and departments have access to walking aid stock and stock is supplied and monitored effectively ➢ Develop posters/information providing the key guidance for assessment, measurement, and provision of walking aids ➢ Monitor and review numbers of falls in admission areas ➢ Identify a Train the Trainer programme for peer support (falls champions) ➢ Link with therapies to review the feedback & outcomes ➢ Introduce a question in the assessment process to identify if a patient requires a walking aid

- Develop a process for patient feedback and suggestions to further improve the opportunities

Priority Ten: Reduce the number of post-partum haemorrhage

Why this is important

Post-partum haemorrhage is a traumatic experience for the woman, partner and staff involved. Risk assessment and early recognition can reduce progression to a major obstetric haemorrhage. Multi-disciplinary teams who work together and train together are crucial to respond and effectively manage post-partum haemorrhage to enhance patient experience and reduce trauma.

What we will do in 2023/24

We will:

- Establish a multi-disciplinary post-partum haemorrhage review group
- Embed the post-partum haemorrhage risk assessment for all women
- Ensure standard operating procedures and guidelines are cross site and in line with national recommendations
- Postpartum haemorrhage multidisciplinary training is delivered to all relevant staff groups
- Ensuring weighing scales are available for the ongoing accurate measurement of blood loss
- Post partum haemorrhage emergency trolleys are available in all areas
- Ensure effective debrief services are available to women and their families in the post-partum period

Priority Eleven: Reduce the number of term admissions to the neonatal unit

Why this is important

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child.

This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

What we will do in 2023/24

We will:
➢ Reduce harm leading to avoidable admissions to the neonatal units for babies born at or after 37 weeks to avoid unnecessary separation of mother and baby ➢ Ensure consistent guidelines and practices across sites ➢ Ensure monthly ATAIN multi-disciplinary reviews are scheduled for all term admissions to the neonatal unit to ensure ongoing learning and changes to practice are sustainable ➢ Review the provision of transitional care services across both sites to ensure equity for service users ➢ Ensure adequate training for all staff around the immediate care of the new-born

2.2.4 Our Patient Experience Priorities

Priority One: Develop a Patient Experience 5-year plan

Why this is important

Patients and their families are at the heart of everything we do as a Trust. The co-creation of the development of a new Patient Experience and Involvement Plan (2024-2029) will establish how we intend to build on the work we are already undertaking to deliver high quality and compassionate care and will ensure that our activities are aligned to Trust priorities in a planful way recognising that we do not have unlimited resources. Listening to the lived experience of our patients will provide insights in how we can further improve existing services and find new ways to meet the needs of the people we serve.

What we will do in 2023/24

We will:
➢ Establish a working group to scope out the relevant stakeholders we need to engage in developing the plan ➢ Communicate an “Expression of Interest” process to recruit a diverse and inclusive group of patients, carers, service users, community groups and members of staff who will co-create the new Patient Experience and Involvement Plan ➢ Use data readily available supplemented by surveys, focus groups and interviews to help shape the content of the new plan ➢ Establish tangible and measurable actions and priorities for our Patient Involvement and Engagement plan ➢ Create a draft of the new plan and consult with key stakeholders ➢ Develop a communication plan to ensure that the Patient Experience and Involvement plan is understood by our patients and community to be used at the time of launching the plan in mid-2024.

Priority Two: Develop a suite of resources, e.g., Patient Experience Toolkit, training resources, to equip members of staff to feel more confident in facilitating patient involvement/engagement

Why this is important

Authentic inclusive engagement of patients and public is essential to support the embedding of change and influence transformation. Engagement is also essential to support the Trust to review and improve the experience for people with characteristics protected by the Equality Act 2010. Whilst the patient experience team are available to support this, to increase and embed patient involvement and engagement across the Trust requires increased awareness, skills, and tools to be developed.

What we will do in 2023/24

We will:

- Develop a Patient Experience Toolkit, available on the Trust Intranet, to support Trust staff in learning how to engage and involve patients, including through co-production, when implementing and enhancing services. This should involve the development of guidelines regarding reimbursement for expenses for those involved
- Establish a community of Patient Experience Champions based in each care group and key service
- Update the governance and Terms of Reference for the Patient Experience Steering Group
- Develop training resources, available on the Learning Hub training site, for a range of staff groups
- Develop payment policy and guidelines for patient involvement
- Develop and nurture networks, building on the learning from existing relationships with other providers and community groups, to ensure that the voice of patients and carers are listened to and influence service development and delivery
- Review and refine the processes, governance, and training of Volunteers
- Establish metrics to review the impact that volunteers have on patient experience

Priority Three: Develop accessible digital and off-line communications/materials, including a user-friendly patient experience webpage on the Trust website

Why this is important

People who access services in the organisation or wish to be involved with improving the patient experience, should be able to access information in a format that is most preferable for them. The current patient experience pages on the Trust website are an important touchpoint for patients and their loved ones and require review and updating. It is also essential that the process and data capture of FFT (Friends & Family Test) are clear, and that patients and loved ones understand how to register a compliment, concern, or complaint and how they might expect to receive feedback.

What we will do in 2023/24

We will:
➢ Use insight gained from a series of focus groups held with patients, carers, and members of the public to better understand people's experience of finding information on the Trust Patient Experience web pages ➢ Work with members of the focus groups, communication, and web design teams to redesign the page, ensuring it is accessible and available in key languages ➢ Test the redesigned page with patients, carers, organisation, and members of the public ➢ Hold further focus groups to receive feedback and adjust the page as required in line with this feedback ➢ Launch the page both internally and publicly on the website ➢ Audit improvements through measurement of webpage activity and patient/public surveys. ➢ Review the process and communication materials for data capture through Friends & Family Test (FFT) and update to include the use of QR codes and visible promotion of this feedback mechanism ➢ Review patient leaflets and communication materials regarding how to register a compliment, concern or complaint and expected feedback methods

Priority Four: **Evidence learning from patient feedback, and 'closing the loop' including communication of outcomes to patients and carers**

Why this is important

The Trust is committed to learning from and improving the patient experience. Such feedback is crucial if we are to learn and continuously improve. The Trust has worked hard to provide opportunities to receive patient feedback, including from those who are easily ignored. It is imperative that we can evidence actions taken in response to feedback, including sharing the learnings to further enhance services alongside recognising and celebrating success where patients have had a positive experience of our services. It is equally important that we ensure outcomes are feedback to those involved.

What we will do in 2023/24

We will:
➢ Oversee the implementation of individual Care Group and the Trust Improvement Plans through the Patient Experience Steering Group with quarterly progress report from Care Groups ➢ Collaborate with individual Care Groups, providing support to reduce the number of overdue concerns and complaints showing on the Patient Experience Team/Care Group dashboards

We will:
➢ Provide evidence of learning from patient feedback, and 'closing the loop', within the quarterly patient experience reports to the Quality and Patient Safety Group

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 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 2022 additional staff were appointed to the Medical Examiner's office. This has enabled an increase in the number of deaths receiving Medical Examiner scrutiny to over 90%. A change in process now enables the Care Groups to determine how best to address any concerns raised by the Medical Examiner. Any concerns meeting the criteria for Structured Judgement Casenote Reviews (SJCR) will have a SJCR; otherwise, is addressed as an incident, PALS concern or as an opportunity for sharing important findings. Where more significant concerns are raised the need for in-depth investigation as a serious incident is considered.

Learning from deaths mandatory reporting requirements:

The NHS (Quality Accounts) Amendment Regulations 2017 published by the Department of Health and Social Care require mandatory disclosure of information relating to 'Learning from Deaths'. These regulations are detailed below, and relate to Regulation 27:

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

- 629 in the first quarter (April 2022 – June 2022);
- 631 in the second quarter (July 2022 – September 2022);
- 724 in the third quarter (October 2022 – December 2022);
- 632 in the fourth quarter (January 2023 – March 2023)

By 31 March 2023, 2107, case record reviews, 83 SJCR investigations and 59 Serious Incident investigations have been carried out in relation to the 2616 of the deaths included in item.

In 2249 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:

- 402 in the first quarter (April 2022 – June 2022);
- 572 in the second quarter (July 2022 – September 2022);
- 679 in the third quarter (October 2022 – December 2022);
- 596 in the fourth quarter (January 2023 – March 2023);

5 representing 0.19% 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:

0 representing 0.0% for the first quarter (April 2022 – June 2022);
1 representing 0.2% for the second quarter (July 2022 – September 2022);
2 representing 0.3% for the third quarter (October 2022 – December 2022);
2 representing 0.3% for the fourth quarter (January 2023 – March 2023)

These numbers have been estimated using 2 methods; structured judgement case note review (SJCR) and serious investigations (SI's).

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

Thematic learning	Summary of completed action(s)	Impact
Some patients nearing end of life were moved multiple times to different wards which negatively affected their experience and that of their families	▪ An audit of bed moves of patients who subsequently died helped to understand the extent of the concern ▪ IT systems have been changed so the number of bed moves made for	▪ Increased visibility of bed moves supports decision making thus minimising multiple moves

Thematic learning	Summary of completed action(s)	Impact
	each patient can be seen on the ward screen	
Nutrition & hydration (specifically concerns about poor fluid balance chart documentation, NG feeding charts, mouth care and weight measurements)	▪ Appointment of two Nutrition Nurse Specialists who have set up a nutrition support service ▪ Nutrition and hydration eLearning has become required learning for all clinical staff ▪ Intravenous fluid prescribing audit confirmed maintenance fluids were prescribed appropriately in 90% of cases. ▪ Fluid balance guidelines have been updated ▪ Awareness raising of swallowing difficulties via newsletters	▪ Nutrition support service helps staff with practical and ethical matters around feeding and nutrition ▪ Training improves knowledge and expectations about nutrition and malnutrition; standardises practices
Management of Nasogastric tubes	▪ The nasogastric feeding protocol has been updated to improve safety checks ▪ A 'hot' reporting process in radiology allows near time confirmation of correct positioning of naso-gastric tubes ▪ Twice-yearly Trust-wide enteral feeding audits were introduced.	▪ Improved safety checks ▪ Reduced delays in commencing tube feeding ▪ Audits have helped to identify concerns and have informed future projects
Deteriorating patient	▪ A sepsis trial in the Emergency Department tested the effectiveness of having a sepsis team to deliver timely antibiotics. ▪ Launch of updated Sepsis screening and action tool ▪ The introduction of sepsis audits in the	▪ The results of the sepsis trial helped to shape later sepsis-related work ▪ Improved guidance about sepsis management and forms are easier to use ▪ Regular sepsis audits enable monitoring of

Thematic learning	Summary of completed action(s)	Impact
	Emergency Department ▪ Launch of revised Deteriorating Patient Policy, supported by a range of pathways to help decision making ▪ Clarification of when to escalate concerns regarding neurological deterioration when early warning scores may not change ▪ The use of a 'Tasking app' allows for tasks to be quickly referred to the correct person for timely action	effectiveness of the new guidance ▪ The tasking app is easy to use and shows which tasks remain outstanding, thereby reducing accidental omissions
End of life care and experience	▪ Appointment of two palliative care consultants ▪ Opening of the 'Autumn Room' at Scarborough Hospital. The 'autumn leaf' identifies people at end of life – aiming to provide a better environment and experience	▪ Timely and effective management of end-of-life care – supporting staff in making decisions and ensuring appropriate medicines are prescribed.
Communication and documentation at end of life	▪ Regular board rounds in selected wards and ED by Palliative care consultant and CNS to help in early identification and improve education ▪ eLearning package available in learning Hub on End-of-life care and individualised care plan.	▪ Earlier identification of end of life to better plan the care needs

The Trust has seen an increase in operational pressures which have affected end of life care. These include delays in being assessed because of the volume of patients in the Emergency Department; long stays in the Emergency Department which reduce patient and

family experiences; management of patients on 'general' covid wards which reduces the provision of care specific to the patient needs.

Importantly, learning from death is also about identifying good practices. Our reviews have found many examples of excellent end of life care where communication has been kind; families have been well informed and where staff have been there when families couldn't. There have also been accounts of excellent multi-disciplinary team working. The results of the National Audit of Care at the End of Life (2021), which became available in 2022 showed that the experience reported by families of those at the end of life was better than the national average.

66 investigations (42 SJCRs and 24 SIs) were completed after 1st April 2022 which related to deaths which took place before the start of the reporting period.

6 representing 0.26% 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).

13, representing 0.56% 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. 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).

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 (either in writing or verbal)

- Through their line manager/supervisor/ tutor/senior clinician
- Through HR or HR process such as a grievance
- Through Fairness Champions
- Through the FTSU Guardian
- Through listening exercises
- Through Datix

Since the pandemic, the Guardian has been working to be more visible and accessible by holding “Speak Up” drop-in surgeries and running roadshows to promote “speaking up” and the role of the Guardian and the Fairness Champions.

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.

NHSE/I have published the new national Speaking Up Policy (previously referred to as Whistleblowing policy) therefore the Trust’s Raising Concern/ Whistleblowing policy will be reviewed in line with this national policy and be implemented by January 2024.

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. The Guardian’s role is to oversee the process of ensuring junior doctors 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 and work schedules are designed to these specifications but, the online reporting

tool allows junior doctors to highlight variations. 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. Fines are split between the affected doctor and Guardian funds using nationally established criteria. Junior doctors determine how Guardian funds are utilised via the Junior Doctor Forum.

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 safe 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.

Key metrics for this reporting period are highlighted below. Q1-4 values for 2021/22 contained within [ ] brackets:

Exception reports received by site (for financial year 2022/23 Q1-4)

Site	Number of exception reports
Scarborough Hospital	40 [39]
York Hospital	214[137]
Total exception reports received	**254[176]**

Types of reports received (for financial year 2022/23 Q1-4)

Nature	Type	Number of exception reports	Percentage of total reports*
Hours and rest	Additional hours worked	225[145]	88.58%
	Missed breaks	41 [42]	16.14%
Education and training	Missed education and training	8[14]	3.15%
	Inadequate clinical exposure	1 [0]	0.39%
	Inadequate supervision	42[0]	0.79%

** Total does not add up to 254 and 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	114 [76]	157 [128.5]	£2419.09 [£1,937.25]
Time off in Lieu	92 [55]	119.25 [94.25]	NA
Other action & pending review	48 [45]	NA	NA

- Guardian fines for levied for contractual breaches of safe working hours: £735.32.
- Guardian fine proportion paid to Doctor: £275.65.
- Guardian fine proportion retained for use by Junior Doctor Forum: £459.67.
- Amount spent/allocated by Junior Doctor Forum: £199.43 (all on catering for Junior Doctor Forum meetings).

Rostering gaps

Health Education England manages recruitment into national training and regional distribution of doctors accepted into the different programs (grades and specialties).
Due to challenges with national recruitment not all these posts are filled, and the organisation aims to employ Trust Grade/Locally Employed Doctors on a fixed-term or permanent contract to cover these vacancies. In addition, the number of trainee posts allocated to the organisation is not sufficient to deliver the level of care and service required. The Trust has recruited to several 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.
- National challenges with recruitment and retention of healthcare professionals in general, not just training posts.

The organisation is constantly exploring methods of becoming an employer of choice in the region to minimise vacancies. Notable actions from this year are:

- Restructure of human resources Medical Workforce Team and Medical Deployment Team to separate out the contractual, rostering and day-to-day management aspects from actual medical recruitment / talent solutions. It is hoped that this will improve communication and overall experience doctors have interacting with the department.

- Continuing to move departments over to eRostering systems and Apps from old fashioned Excel spreadsheets to allow better transparency, oversight of staffing levels and management of leave. Consultant rotas will soon move to eRostering as well.

- Appointment of Tutors for Specialty and Specialist (SAS) and Locally Employed Doctors. They have dedicated time each week and work alongside the Medical Education Centre to offer help and advice, organise educational events and advocate for this group of doctors.

- Reviewing and improving the experience International Medical Graduates have of recruitment, induction and support provided to settle into the country, hospital and specific department.

- Reinstating face-to-face induction for junior doctors; using it as an opportunity to redesign the events. Induction is more interactive, welcoming and informative. It demonstrates on day one the Trusts commitment to supporting doctors during their time in the organisation. They get to meet with the Guardian, learn about exception reporting and the Junior Doctor Forum.

- Re-invigorating the Junior Doctor Forum by establishing representatives across departments and grades. The Forum meets monthly and provides a direct line of communication between doctors and Medical Workforce, Medical Deployment, union representatives, and operational managers amongst others.

- Incorporating a session on exception reporting into local training for new supervisors. Their opinion of the tool influences the confidence and safety juniors feel in highlighting unsafe working hours. Enhancing their understanding feeds into the Trust's commitment to a culture of openness.

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 2022/23, York and Scarborough Teaching Hospitals NHS Foundation Trust provided clinical services under a range of healthcare contracts with NHS bodies and Local Authority commissioners.

Most clinical services were provided under the NHS Standard Contract but also included agreements with Local Authorities, including one Section 75 partnership agreement and several NHS Provider to Provider agreements. The Trust also sub-contracted a small number of services including elective care, endoscopy, and diagnostics with 6 Independent Sector providers.

York and Scarborough Teaching Hospitals NHS Foundation Trust through its contract management framework, regularly reviews sub-contracted activity data and provider key performance indicators, including quality of care and assurance within these services.

The clinical income generated by the health services provided under contract represents 100 per cent of the total clinical income generated from the provision of relevant health services by York and Scarborough Teaching Hospitals NHS Foundation Trust for 2022/23.

The income generated has been received from services commissioned by NHS Integrated Care Boards, NHS England, and Local Authorities.

2.4.3 Participation in National Clinical Audits and National Confidential Enquiries

During 2022/23, 59 national clinical audits and 7 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 98% of the national clinical audits and 100% of the NCEPODs of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2022/23 are as follows:

National Clinical Audits			National Confidential Enquiries
CMP Case Mix Programme	NDA National Diabetes Audit - Adults - National Diabetes Inpatient Audit	NMPA National Maternity and Perinatal Audit	*NCEPOD Child Health Clinical Outcome Review Programme – Transition from Child to Adult Health Services*
Elective Surgery - National PROMs Programme - Knees	NACAP National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care	NNAP National Neonatal Audit Programme	*NCEPOD Child Health Clinical Outcome Review Programme – Testicular Torsion*
Elective Surgery - National PROMs Programme - Hips	NACAP National Asthma and COPD Audit Programme - Adult Asthma Secondary Care	NOA National Obesity Audit	*NCEPOD Medical and Surgical Clinical Outcome Review Programme -*

National Clinical Audits			National Confidential Enquiries
			Community Acquired Pneumonia
RCEM Emergency Medicine QIPs – Infection Prevention and Control	NACAP National Asthma and COPD Audit Programme - COPD Secondary Care	NOD National Ophthalmology Database Audit – Adult Cataract Surgery Audit	*NCEPOD Medical and Surgical Clinical Outcome Review Programme – Crohn's Disease*
RCEM Emergency Medicine QIPs – Care of Older People	NACAP National Asthma and COPD Audit Programme - Pulmonary Rehabilitation	NPDA National Paediatric Diabetes Audit	*NCEPOD Medical and Surgical Clinical Outcome Review Programme – End of Life Care*
RCEM Emergency Medicine QIPs – Mental Health Self Harm	NABCOP National Audit of Breast Cancer in Older People	MBRRACE National Perinatal Mortality Review Tool	*NCEPOD Medical and Surgical Clinical Outcome Review Programme – Endometriosis*
Epilepsy12 National Audit of Seizures and Epilepsies in Children and Young People	NACR National Audit of Cardiac Rehabilitation	NPCA National Prostate Cancer Audit	*NCEPOD Medical and Surgical Clinical Outcome Review Programme - Epilepsy*
FFFAP Falls and Fragility Fractures Audit Programme - National Audit of Inpatient Falls	NACEL National Audit of Care at the End of Life	NVR National Vascular Registry	
FFFAP Falls and Fragility Fractures Audit Programme - National Hip Fracture Database	NAD National Audit of Dementia - Care in General Hospitals	PQIP Perioperative Quality Improvement Programme	
GICAP National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	NBSR National Bariatric Surgery Registry	Renal Audits – Adult Acute Kidney Injury Audit	
GICAP National Gastro-intestinal Cancer Programme - Oesophago-Gastric Cancer	NCAA National Cardiac Arrest Audit	Renal Audits – UK Renal Registry Chronic Kidney Disease Audit	
IBD Inflammatory Bowel Disease - Biological Therapies Audit	NCAP National Cardiac Audit Programme - National Cardiac Rhythm Management	BTS Respiratory Audits – Adult Respiratory Support Audit	
LeDeR Learning Disability Mortality Review Programme	NCAP National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	BTS Smoking Cessation Audit – Maternity and Mental Health Services	
MBRRACE Maternal, Newborn and Infant Clinical Outcome	NCAP National Cardiac Audit Programme -	SSNAP Sentinel Stroke National Audit Programme	

National Clinical Audits			National Confidential Enquiries
Review Programme - Perinatal Mortality Confidential Enquiries	Percutaneous Coronary Interventions		
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	NCAP National Cardiac Audit Programme - Heart Failure Audit	SHOT Serious Hazards of Transfusion: UK National Haemovigilance Scheme	
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality Surveillance and Mortality Confidential Enquiries	National Child Mortality Database	SAMBA Society for Acute Medicine's Benchmarking Audit	
MITRE Muscle Invasive-Bladder Cancer at Transurethral Resection of Bladder Cancer	NEIAA National Early Inflammatory Arthritis Audit	TARN Major Trauma Audit	
NDA National Diabetes Audit - Adults - National Core Diabetes Audit	NELA National Emergency Laparotomy Audit	CFR UK Cystic Fibrosis Registry (Adult & Paediatric)	
NDA National Diabetes Audit - Adults - National Pregnancy in Diabetes Audit	NJR National Joint Registry	UK Parkinson's Audit	
NDA National Diabetes Audit - Adults - National Diabetes Foot Care Audit	NLCA National Lung Cancer Audit		

The national clinical audits and national confidential enquiries that the Trust participated in during 2022/23 are listed below.

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	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 to March 2022	No publication date yet identified

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
NCEPOD Child Health Clinical Outcome Review Programme – Testicular Torsion	To review the complete pathway and quality of care provided to children and young people 2 – 24 years of age who present to hospital with testicular torsion.	Yes	Data collection August 2022	This study is currently under development
Elective Surgery – National PROMs Programme Knees	This audit looks at patient reported outcome measures in NHS funded patients eligible for knee replacement.	Yes	Continuous data collection	Publishes hospital level data monthly (>24 months previous)
Elective Surgery – National PROMs Programme Hips	This audit looks at patient reported outcome measures in NHS funded patients eligible for hip replacement.	Yes	Continuous data collection	Publishes hospital level data monthly (>24 months previous)
RCEM Emergency Medicine QIPs – Infection Prevention and Control	The purpose of this QIP is to improve patient safety and quality of care as well as workspace safety, by collecting sufficient data to track change; but with a rigorous focus on actions to improve.	Yes	Data collection from 03 October 2022 to 03 October 2023	No publication date yet identified
RCEM Emergency Medicine QIPs – Care of Older People	TBC	Yes	Data collection from 04 April 2023 to 04 October 2023	No publication date yet identified
RCEM Emergency Medicine QIPs – Mental Health Self Harm	This QIP will track the current performance in EDs against clinical standards in individual departments and nationally on a real time basis over a 2-year period. The aim is for departments to be able to identify where standards are not being reached so they can do improvement work and monitor real time change.	Yes	Data collection from 03 October 2022 to 03 October 2023	No publication date yet identified
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 2022
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 2022
FFFAP Falls and Fragility	The audit measures quality of care for hip fracture patients and has	Yes	Continuous data collection	National report published

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
Fractures Audit Programme – National Hip Fracture Database	developed into a clinical governance and quality improvement platform.			September 2022
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 December 2022
GICAP National Gastro-intestinal Cancer Programme – Oesophago-Gastric Cancer	The oesophago-gastric (stomach) cancer audit aims to examine the quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all O-G cancer patients, both curative and palliative.	Yes	Continuous data collection	National report published December 2022
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 expected 2023
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	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 -	Yes	Continuous data collection	National report published October 2022

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
Programme – Perinatal Mortality Surveillance	resulting in a pregnancy outcome from 22+0 weeks gestation onwards. Stillbirths – baby delivered from 24+0 weeks gestation showing no signs of life. Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth. Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.			
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 2022
NCEPOD Medical and Surgical Clinical Outcome Review Programme – Community Acquired Pneumonia	To identify and explore avoidable and modifiable factors in the care of adults presenting to hospital with a presumed diagnosis of community acquired pneumonia.	Yes	Data collection January 2022 to March 2022	National report expected Summer 2023
NCEPOD Medical and Surgical Clinical Outcome Review Programme – Crohn's Disease	To review of remediable factors in the quality of care provided to patients aged 16 and over with a diagnosis of Crohn's disease who underwent a surgical procedure.	Yes	Data collection October 2021 to March 2022	National report expected Spring 2023
NCEPOD Medical and Surgical Clinical Outcome Review Programme – End of Life Care	This study is currently in the design phase, with the study advisory group being set up. More information will become available after the advisory group meetings.	Yes	Data collection Spring/Summer 2023	No publication date yet identified

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
NCEPOD Medical and Surgical Clinical Outcome Review Programme – Endometriosis	To review remediable factors in the quality of care provided to patients aged 18 and over with a diagnosis of endometriosis.	Yes	Data collection started October 2022	No publication date yet identified
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 to December 2021	Report Published December 2022
MITRE Muscle Invasive-Bladder Cancer at Transurethral Resection of Bladder Audit	TBC	Yes	Data collection from 1st April 2022 to 15th April 2022	National report expected late 2022
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	National Report expected January 2023
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	No publication date yet identified
NDA National Diabetes Audit - Adults – National Diabetes Foot Care Audit	Patients referred to specialist diabetes footcare services for an expert assessment on a new diabetic foot ulcer.	Yes	Continuous data collection	National report published May 2022
NDA National Diabetes Audit - Adults – National Diabetes Inpatient Safety 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	National report published July 2022
NACAP National Asthma and COPD Audit	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	Organisational audit report published June 2022.

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
Programme – Paediatric Asthma Secondary Care				Scarborough Hospital did not complete data submission for which additional support has been established to ensure all submissions are locked before the deadline. First combined national report published January 2023
NACAP National Asthma and COPD Audit Programme – Adult Asthma Secondary Care	The audit looks at the care of people admitted to hospital adult services with asthma attacks.	Yes	Continuous data collection	Combined adult asthma and COPD organisational audit report published June 2022. Scarborough Hospital did not submit data due to internal communication issues within the Respiratory Team regarding the return of information. These issues are being addressed internally. First combined national report published January 2023
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	Combined adult asthma and COPD organisational audit report published June 2022. First combined national report published January 2023
NACAP National Asthma and	This audit looks at the care people with COPD get in pulmonary rehabilitation services.	Yes	Continuous data collection	Organisational audit report published June

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
COPD Audit Programme – Pulmonary Rehabilitation				2022. First combined national report published January 2023
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 May 22
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 December 2022
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	National report published July 2022
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.	Yes	Data collection from 19 September 2022 to 14 July 2023	No publication date yet identified
NBSR National Bariatric Surgery Registry	The key objective of the registry is to accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include reportage on weight loss, co-morbidity and improvement of quality of life.	Yes	Continuous data collection	Publishes Surgeon-level data only, not benchmarked nationally
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 June 2022
NCAP National Cardiac Audit Programme – Myocardial Ischaemia National Audit Project (MINAP)	The Myocardial Ischaemia National Audit Project (MINAP) was established in 1999 in response to the National Service Framework (NSF) for Coronary Heart Disease, to examine the quality of management of heart attacks	Yes	Continuous data collection	National report published June 2022

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
	(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 June 2022
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 June 2022
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 thematic report published July 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 published October 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 expected February 2023
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 September 2022
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 expected April 2023

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
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 NHS Digital Maternity Services Dataset	National report published June 2022
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 November 2022
NOA National Obesity Audit	Brings together data to drive improvement in quality of care available to those living with overweight and obesity in England.	Yes	Continuous data collection	No publication date yet identified
NOD National Ophthalmology Database Audit – Adult Cataract Surgery Audit	The Royal College of Ophthalmologists (RCOphth) runs the National Ophthalmology Database (NOD) Cataract audit which measures the outcomes of Cataract surgery.	Yes	Continuous data collection	National report published May 2022
NPDA National Paediatric Diabetes Audit	The audit covers registrations, complications, care process and treatment targets.	Yes	Continuous data collection	National report expected March 2023
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'. 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'.	Yes	Continuous data collection	National report published October 2022
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 2023
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 2022
PQIP Perioperative Quality Improvement Programme	Measures complications, mortality and patient reported outcome from major non-cardiac surgery. The ambition is to deliver real benefits to patients by supporting clinicians in using data to improve patient outcomes across the UK, reducing	Yes	Continuous data collection	No publication date yet identified

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
	variation in processes of care and supporting implementation of best practice.			
Renal Audits – Adult Acute Injury Audit	Laboratories were mandated to submit their AKI alerts, with accompanying demographic information about each person (age, sex, postcode, etc.), to the UK Renal Registry (UKRR) to enable nationwide analyses of the data.	Yes	Continuous data collection	No publication date yet identified
Renal Audits – UK Renal Registry Chronic Kidney Disease Audit	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	No publication date yet identified
BTS Adult Respiratory Support Audit	This audit aims to capture data on patients outside critical care that have required respiratory monitoring or intervention (i.e. either admitted to an acute respiratory support unit or treated in another ward setting with NIV/CPAP/HFNO), with a view to better understanding variations in clinical practice and outcome.	Yes	Data collection from 01 February 2023 to 31 March 2023	No publication date yet identified
BTS Smoking Cessation Audit – Maternity and Mental Health Services	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.	Yes	TBC	No publication date yet identified
SSNAP Sentinel Stroke National Audit Programme	The audit collects data on all patients with a primary diagnosis of stroke, including any patients not on a stroke ward. Each incidence of new stroke is collected.	Yes	Continuous data collection	Acute organisational audit report published June 2022. National report published November 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	No publication date yet identified
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	Yes	Data collection 23 June 2022	No publication date yet identified

National Audit Topic	What is the Audit about	Trust Participation in 2022/23	Data Collection 2022/23	Outcome
	assessment, their pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national average.			
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 August 2022, not benchmarked nationally
UK Parkinson's Audit	The UK Parkinson's Audit is the recognised quality improvement tool for Parkinson's services. It allows measurement of practice against evidence-based standards and patient feedback in a continuous cycle of improvement.	Yes	Data collection from 01 May 2022 to 30 September 2022	National report published March 2023

The reports of 52 national clinical audits were reviewed by the provider in 2022/23 and the Trust undertook the following actions to improve the quality of healthcare provided:

- Upon receipt of a national audit report, a Clinical Effectiveness Officer arranged an MDT meeting with the audit lead and relevant stakeholders to discuss the findings, share learning, determine how the results were to be shared, developed an action plan where required, and benchmarked against the report recommendations.
- The Clinical Effectiveness Team contacted and requested support from the Quality Improvement Team for audits which had metrics demonstrating reduced compliance when compared nationally. This resulted in key workstreams being initiated, triangulated with incident data.
- National audit reports were added to the weekly Quality & Safety (Q&S) meeting agenda for sharing across the organisation to ensure early stakeholder oversight. Any immediate risks were determined and shared through the weekly Q&S meeting.
- The Clinical Effectiveness Team provided progress reports to Care Groups monthly, highlighting any escalations as appropriate.

The reports of 84 local clinical audits were reviewed by the provider in 2022/23 and the Trust undertook the following actions to improve the quality of healthcare provided:

- Local clinical audit was managed within individual Care Groups with coordination from Clinical Governance Co-ordinators & Clinical Governance Facilitators.
- Approval and ownership is the responsibility of Care Group governance teams allowing for approval in line with Care Group / department priorities.
- Audit activity is now captured on InPhase and enabling Care Groups and Corporate teams to have oversight of the activity, with learning captured in one place.

For 2023-2024, quarterly local audit update reports will be provided to the Quality& Patient Safety Group through a new Clinical Effectiveness Group for oversight and shared learning.

2.4.4 Research and Development

- The aim of clinical research is to increase knowledge about treatments to ensure we are treating based on the best possible evidence. Research offers participants the opportunity to be involved in clinical studies which may or may not be of benefit to them.

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

- This annual target is divided between the 22 partner organizations, of which we are one. To reach the 65,000 the Y&H CRN requires our hospital to set a stretching target of recruiting 3500 patients into clinical trials in our Trust from 1 April 2022 to 31 March 2023.

- Currently we have approximately 100 research studies open to recruitment. The number of patients receiving relevant health services provided or sub-contracted by York Teaching Hospitals in the period 1 April 2022 to 31 March 2023 that were recruited during that period to participate in research approved by a research ethics committee is 3882.

- These patients were recruited across a wide range of specialties as most of our hospital now offers clinical trial opportunities for patients. Some areas where we have performed well over the past year are as follows:

- Our Trust has recruited over 50,000 patients to clinical trials in the past 12 years, we reached this milestone in the year and celebrated this at our first Celebration of Research event held on 21st November. This was a great success and 200 people attended to hear about some of the many studies we have been involved in. The highlight of the day was Professor Sir Martin Landray, who gave a talk about the main global Covid 19 study we participated in called Recovery. He gave a very moving speech and thanked our Trust for participating in such an important trial.
- Our Trust been involved in the world's largest study of the genetics of critical Covid-19, involving more than 57,000 people. The study has revealed fresh details about some of the biological mechanisms behind the severe form of the disease. Some 16 new genetic variants associated with severe Covid-19, including some related to blood clotting, immune response and intensity of inflammation, have been identified. These findings will act as a roadmap for future efforts, opening new fields of research focused on potential new therapies and diagnostics.

- We have recruited well to the Harmonie vaccine study under Dr Dominic Smith. The study is looking at RSV (Respiratory Syncytial Virus) that is one of the leading causes of hospitalisation in all infants worldwide and affects 90% of children before the age of two. We are currently top in the region in terms of our accruals and in the top 5 sites nationally.
- We assisted in making our region first in England for number of patients enrolled into clinical trials for Gastroenterology (2386 patients) and second in the country for Ophthalmology
- Mr Alaghband and the team were the highest recruiting centre for the TRITON study in the UK. The study is looking at improving the treatment for glaucoma patients by assessing the effectiveness and safety of a medication-based eye implant. The implant is designed to slowly and gradually release the drug to the patients' eye over a 1–2-year period and should reduce the need for further treatments and injections.
- During 22/23 we recruited a further 925 patients into the BEAP study which took place within the Bridlington community. The BEAP study is looking at deepening our understanding of the relation genetics can play in determining and predicting the occurrence and types of Age-related Macular Degeneration (AMD) that can occur within a general population. AMD is currently the most common cause of eyesight loss.
- Our Trust in collaboration with Humber and North Yorkshire Cancer Alliance and PinPoint Data Science, have commenced a research study this year to evaluate the diagnostic accuracy and clinical utility of the PinPoint Test. This simple blood test, developed with machine learning, aims to optimise NHS urgent cancer referral pathways by helping GPs to refer patients quickly to the correct place for early investigation.
- In acknowledgement of their continued participation in the academic activities of HYMS, Professor Richard Gale (Consultant Ophthalmologist) and Dr Simon Davies (Consultant Anaesthesiologist) have both been awarded clinical academic status, this allows them to dedicate 50% of their time to research
- In acknowledgement of his continued participation in the academic activities of HYMS, and impressive gastroenterology research portfolio Professor James Turvill has been appointed to a personal chair at Hull York Medical School, the Trust Clinical Director of Research and Innovation and the regional Clinical Research Network for SPED (Screening, Prevention and Early Diagnosis)
- We were recently awarded funds from NHS England to undertake a full assessment of the patient view and experiences of having a colon capsule endoscopy. We are working with researchers from the University of York who will hold interviews and focus groups with patients to get their views and opinions. This puts our Trust at the forefront of this study as we will yet again be managing an England wide research study with just under 1000 patients taking part.
- In collaboration with South Tees Hospital NHS Foundation Trust we have this year launched the North Yorkshire Academic Alliance of Perioperative Medicine
- Finally, our relationships with our two local universities continue to grow from strength to strength with an increasing number of collaborations and joint grants submissions being developed this year.
- Yet again 2022-2023 has been a great year for us, we are very proud of our staff and the amazing achievements from this year.

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2.4.5 Commissioning for Quality and Innovation Payment Framework

The Trust agreed the following CQUINs for 2022-23 and full delivery for quarters one to three has been achieved:

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.
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.

Scheme	Description
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.

Work is ongoing during quarter four of 2022-23 to agree the CQUIN schemes with Commissioners for 2023-24.

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 Trust in 2019/2020 and 2021/22. Inspection activity in October and November 2022 resulted in conditions on registration being put in place for the maternity and midwifery service. At the time of writing, the CQC Inspection Report for the maternity and midwifery service has not been received. The following conditions on registration are 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.

Maternity and Midwifery Service.

1. The registered provider must implement an effective system for managing and responding to patient risk to ensure all mothers and babies who attend the York Hospital are cared for in a safe and effective manner and in line with national guidance.

2. The registered provider must operate an effective clinical escalation system to ensure every woman attending the hospital is triaged, assessed and streamlined by appropriately skilled and qualified staff.

3. The registered provider must implement an effective risk and governance system which ensures that:
    I. There is oversight at service, division and board level in the management of the maternity services.
    II. There are effective quality assurance systems in place to support the delivery of safe and quality care;
    III. Risk and occurrence of incidents are properly identified and managed, to include an effective system of recording actions taken and ensuring learning from any incidents.
    IV. Serious incidents are reflected and reported correctly in line with national guidance and adequately investigated.
    V. Ensuring learning is shared from the investigation.
    VI. Incident grading is reviewed to ensure it is accurate and in line with national guidance.

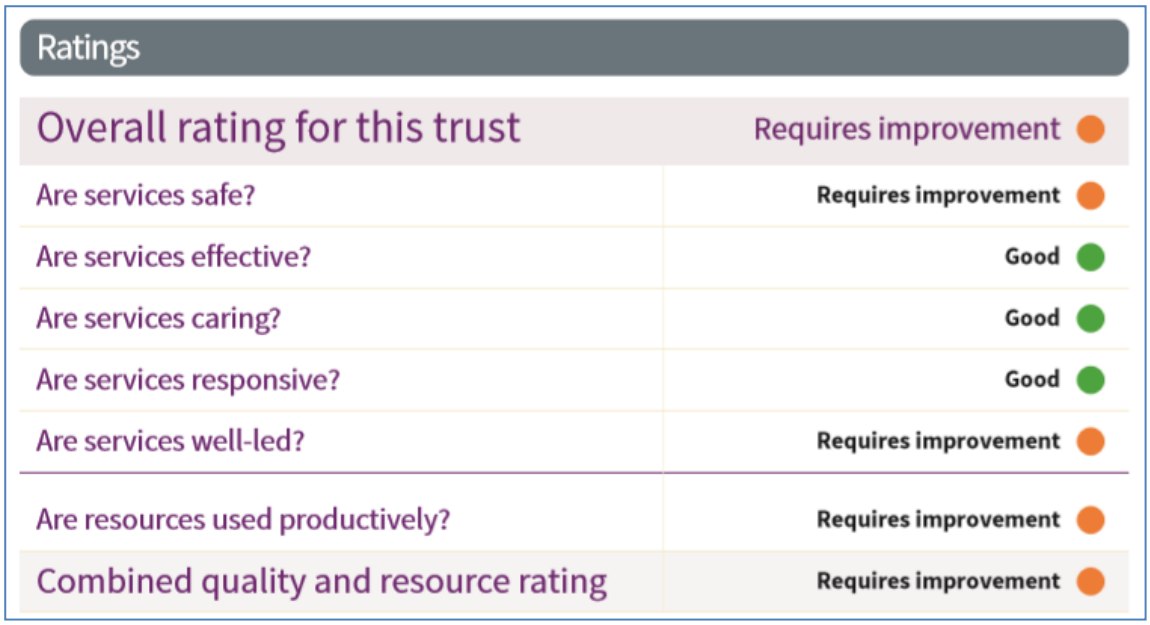
The Care Quality Commission has taken enforcement action against York Teaching Hospitals NHS Foundation Trust during the reporting period. York Teaching Hospitals NHS FT has not participated in any special review or investigations by the CQC during the reporting period.

In response to the immediate feedback at the conclusion of the inspection in October the following immediate actions were taken to safeguard the safety of our women and babies:

- A safety briefing was implemented and was discussed at all huddles and handovers to ensure that staff were aware of the following:
    - Arterial lines are not managed on the maternity unit instead are managed in ICU.
    - All Post-Partum Haemorrhage of 500mls and above is reported via the incident reporting system.
    - In line with the findings of the Ockenden report all CTG monitored women have fresh eyes review every 60 minutes with any concerns being escalated to the senior midwife/obstetrician.
    - Staff were reminded of the importance of all babies being security tagged as soon as possible after delivery. This applies to all babies on the maternity unit. Parents should be informed of the importance of the tag.
- The fire doors were addressed to ensure all doors had the appropriate fire safety mechanisms and security were placed in maternity department while further work was undertaken to address the issues identified.

A comprehensive action plan was subsequently submitted to the CQC in response to the section 31 warning notice, and updates in relation to the delivery of the actions is provided on the 23rd of each month are provided to the CQC.

The Trust established a Maternity Transformation Committee supported by a Maternity Improvement Project Team to lead and oversee the improvement activity. We also commissioned an independent review in to post-partum haemorrhage from an external Professor of Obstetrics which further informed the improvement action plan.



Ratings	
Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement
Are resources used productively?	Requires improvement
Combined quality and resource rating	Requires improvement

2.4.7 Data Quality

York Teaching Hospital NHS Foundation Trust submitted records during 2021/22 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:
99.91% for admitted patient care;
99.98% for outpatient care;
99.57% 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

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 always handled legally and appropriately.

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	2023
Fully meeting our expectation	30%	37%	47%
Partially meeting our expectation	39%	38%	38%
Not meeting our expectation	20%	15%	6%
Not applicable or unknown	11%	10%	9%

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 36 assertions that the Trust is required to assess itself against and provide 113 pieces of mandatory evidence items.

The Trust submitted the Toolkit in June 2022 and achieved "Approaching Standards". There are several areas where standards are being improved but not met, including accountable suppliers and process reviews. There is an improvement plan in place and a new security lead has been appointed.

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 84%. Work will continue by the Information Governance Team to improve compliance rates, but it is not anticipated that by the 30 June 2023 submission date that this standard will be "met".

Information Asset Register

The Trust has established a basic Information Asset Register with entries from all Care Groups and Directorates. This allows us to understand how personal data is being processed across the Trust and highlight any risks to the accountable managers.

Data Protection Impact Assessments

Work has continued in relation to Data Protection Impact Assessments; these assessments enable the Trust to review any data protection and privacy risks. The Trust has 100+ assessments in place or open for review.

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

- Various Artificial Intelligence products used in radiology
- Bi-directional text messaging provider
- Surgical Robot (intuitive)

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 the first three quarters of financial year 2022/2023 the Trust processed a total of 405 requests for information and responded to 59% of these within the required 20-day timeframe.

In financial year 2021/2022 the Trust responded to 444 requests for information under the Freedom of Information Act. 75% of these requests were responded to within the 20-day statutory 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 2022/23 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 20 – Nov 21	Trust Dec 21 – Nov 22	NHS (England) Dec 21 – Nov 22
Trust score (lower value is better)*	0.97*	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 Quality and Safety Assurance Committee and Board of Directors

when published within the Learning from Deaths report. 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.
- All deaths are subject to review by our Medical Examiners, who escalate any concerns via Datix. All Datix concerns are reviewed, and the appropriate level/type of investigation response is taken, in accordance with the governance framework.

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 20 – Nov 21	Trust Dec 21 – Nov 22	*NHS Average (England) Dec 21 – Nov 22	Highest Trust Dec 21 – Nov 22	Lowest Trust Dec 21 – Nov 22
% Deceased patients with palliative care coded	27	29	40	66	13

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 Palliative 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:

- Identification for need for early palliative care involvement during learning from deaths meetings and improve education through palliative care team presence in board rounds.

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	88.4	90.7	100.0	50.0
Knee replacement (Primary)	82.2	81.5	82.3	100.0	0.0

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 86.1 to 88.4, with the knee replacement data changing from 79.2 to 81.5.

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 20 – Mar 22	Trust Apr 21 – Mar 22	NHS Average Apr 21 –Mar 22	Highest Trust Apr 21 –Mar 22	Lowest Trust Apr 21 –Mar 22
Percentage of Readmissions aged 0 to 15	14.2	15.8	11.8	18.4	6.2
Percentage of readmissions aged 16 and Over	14.3	12.5	13.8	18.8	10.2

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

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

- 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	75.5	74.5	85.4	67.3

*Data was collected 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, noted that this data was not updated as expected, and the publication was then delayed until 17/03/22.

**As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the corresponding scoring regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years. The 2020-21 survey is showing as having a break in the time series (2020-21[b]).

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 of 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

Patients admitted and risk assessed for venous thromboembolism *(Acute Trusts)*	**Trust Jan - Mar 2022***	**Trust Jan - Mar 2023**	**NHS (England) Jan - Mar 2023***	**Highest Trust Jan – Mar 2023***	**Lowest Trust Jan – Mar 2023***
Percentage of patients risk assessed	86.2	82.5	Data not available	Data not available	Data not available

*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. Compliance is reported on the Signal, the Trust's electronic activity and performance monitoring dashboard and reported to the Quality and patient safety Group. 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.

Staff recommending the Trust to family and friends	Trust 2021	Trust 2022	NHS Staff Survey Average Score 2022	NHS Staff Survey Highest 2022	NHS Staff Survey Lowest 2022
Percentage of staff who would be happy with the standard of care provided by the organisation	57.3%	44.9%	61.9%	86.4%	39.2%

These results are presented in the context of the best, average and worst results for similar organisations taken from the 2022 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 York & Scarborough Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is published by the national staff survey co-ordination centre. The results go through a series of rigorous quality checks and are deemed official statistics. The results of the annual staff survey are reported to the Board of Directors

The results of the 2022 survey will be used to update the action plan to improve staff experience and therefore engagement and retention, 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:

- Use the improved quarterly NHS Pulse Survey that will enable feedback to be reported at Care Group level for the first time (from April 2023), this will give valuable feedback which we will use to improve staff engagement and outcomes for our patients at both Trust and Care Group levels.
- Continue to roll out the Just & Learning 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.

Clostridium difficile infection (for patients aged 2 and over)	Trust 2021-22	Trust 2022-23	National (England) Rate 2022-23	Highest Trust 2022-23	Lowest Trust 2022-23
Trust apportioned cases - rate per 100,000 bed days (HO Hospital Onset)	22.88	30.50	24.75	57.33	0.0

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

- All *Clostridioides difficile* infection (CDI) cases are reviewed by the IPC team and reported to the UKHSA on the monthly basis, through the Data Capture Server, in line with national reporting requirements.
- Clostridium difficile Infection incidence is reviewed and discussed at the Infection Prevention Strategic Assurance Group (IPSAG), 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. An improvement plan was developed in response to this visit and continues to be delivered.
- 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 and Safety Assurance 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:

- Introduce a monthly *C. difficile* Improvement Group (CDIG) meeting. This multidisciplinary forum is chaired by the DIPC and includes representation from Microbiology, IPC, Estates and Facilities, Antimicrobial Pharmacy and each of the Care Group management teams. Its main responsibilities are reviewing CDI performance (at Trust and Care Group level) and overseeing implementation of the *C. difficile* Improvement Plan. CDIG reports to the Infection Prevention Strategic & Assurance Group.
- Increase engagement in the Post Infection Review (PIR) process, by embedding it in Care Groups, to ensure timely learning and improvement actions.
- Linking IPC nurses to provide advice and support to Care Groups.
- Developing and implementing a *C. difficile* Improvement Plan, the main aims of which are outlined in the "We will" section.
- Expanding the IPC nurse team (completed) and recruiting another consultant microbiologist (to start in October 2023).
- Hosting IPC education days and rolling out "toolbox training" on CDI prevention for staff.
- Addressing problems with hand hygiene dispensers: working with Facilities to ensure broken dispensers are repaired/replaced in the short term.
- Introducing new cleaning competencies for bed and commode cleaning.

- Setting up a Cleaning Standards Group to oversee implementation of the new National Cleaning Standards.
- Introducing ultraviolet light decontamination technology at both main hospital sites, for area where hydrogen peroxide vapour (HPV) cannot be deployed.
- Undertaking proactive deep-cleaning and HPV decontamination of all wards on an annual basis
- Promoting better antimicrobial stewardship through use of guidelines, audit and education. This work is overseen by the Antimicrobial Stewardship Group.
- Working with Estates to deliver a backlog maintenance programme.
- Undertaking, monitoring and acting on deficiencies in regular audits of hand hygiene, cleaning and the care of patients with CDI.
- Undertaking fortnightly environmental walk rounds (involving IPC, senior nursing, Estates and Facilities).

We will:

- Work to complete the actions in the C. difficile Improvement Plan.
- Ensure all staff have had up to date training on CDI prevention, completed hand hygiene competency assessment and (where appropriate) been assessed for bed and commode cleaning.
- Introduce a standard chlorine-based disinfectant (Tristel) for environmental cleaning across the trust.
- Expand the HPV programme to provide a reactive service overnight.
- Complete implementation of the new National Cleaning Standards.
- Ring fence ward 25 as a decant space for York, to facilitate a proactive programme of deep cleaning and backlog maintenance.
- Complete a de-clutter programme in clinical areas.
- Introduce a new SOP for terminal cleaning and guidance on the nature of terminal cleans, depending on the organism involved.
- Roll-out the use of sporicidal wipes in clinical areas.
- Implement single patient use equipment for CDI cases.
- Improve the checking and cleaning of mattresses; implement and complete a replacement programme.
- Enhance antimicrobial stewardship by re-introducing and expanding use of the Antibiotic Review Kit (ARK) tool. Also complete the IV to oral switch CQUIN for antibiotics.
- Work with Go-Jo to introduce new hand hygiene dispensers across the organisation.
- Expand the IPC link champions programme.
- Continue to report progress to the Quality Committee and the Board of Directors in the Director of Infection Prevention and Control quarterly report which as previously described, provides assurance to the Board of Directors that initiatives continue to be developed aimed at achieving sustainable reduction in HCAI.
- Continue to discuss incidence and risk at weekly quality and safety briefings to identify and agree action required.

Patient safety incidents and the number of incidents resulting in severe harm or death	*Trust Apr 20 – Mar 21	Trust Apr 21 – Mar 22	Average Apr 21 – Mar 22	Highest Trust Apr 21 – Mar 22	Lowest Trust Apr 21 – Mar 22
Rate of patient safety incidents	53.4	48.4	57.5	205.5	23.7
*Number of incidents resulting in severe harm or death	49	49	58	216	3
% of incidents resulting in severe harm or death	0.4	0.4	0.4	1.7	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.

*Issues were identified with submissions to the National Reporting and Learning System (NRLS) for a small number of providers and data have been corrected and updated in October 2022. The updated data does not affect the figures reported previously in this report.

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 Patient Safety Team 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, and shared learning through Quality and Safety Group and Serious Incident panel.
- Continued thematic analysis of clinical incidents and serious incidents with associated quality improvement workstreams to address themes. This has also informed our Local priorities for the move to the Patient Safety Incident Response Framework, planned for Autumn 2023.
- 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 2022	Trust Feb 2023	England - Feb 2023	Highest Trust – Feb 2023	Lowest Trust – Feb 2023
Inpatient % positive	97	99	94	100	66
A&E % positive	83	77	80	95	38
Maternity % positive**	99	92	92	Data not available	Data not available
Outpatients % positive	93	95	93	100	82

* 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. Please note that response rates for Maternity in Dec 2022 were low.

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.

York and Scarborough Teaching Hospitals 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 in both York and Scarborough ED's
- The main cause of ED dissatisfaction is linked to waiting times and poor communication.

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

- Results and themes of comments are reported each month to senior Care Group representatives for their response and action
- The key issue with performance across both EDs is related to capacity and flow issues across the broader Trust. We anticipate that these issues will improve following a major capital scheme, which is underway to improve the ED spaces at York and Scarborough. We have begun to involve patient and the public in simulations to support our plan to ensure the new environments are accessible

We will:

- Further enhance our efforts to seek meaningful feedback from patients which we can celebrate and act on through making the Friends and Family Test able to be administered digitally

through using QR code rolls and exploring the use of SMS messaging in addition to our traditional cards
- Explore how to best support Care Groups in understanding and acting on their patient experience performance, to ensure that we identify and share best practice to support quality improvement in the Trust
- 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 2021**	**Trust 2022**	**NHS Staff Survey Average 2022**	**NHS Staff Survey Highest (Worst) Trust 2022**	**NHS Staff Survey Lowest (Best) Trust 2022**
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months from Managers*	12.3%	11.1%	11.6%	6.4%	17.9%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months from other colleagues*	21.0%	19.0%	20.0%	12.3%	25.9%

* These results are presented in the context of the best, average and worst results for similar organisations taken from the 2022 NHS Staff Survey. Relates to percentage of staff saying they experienced at least one incident of bullying, harassment or abuse.

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

The results of the annual staff survey are deemed official national statistics and reported to the Board of Directors. The data is consistent with that reported to the Board of Directors.

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

Continuing to embed the new values within the workplace and launching the complementary behavioural framework to provide guidance for staff around expected behaviours and areas for personal development. We have also appointed a Head of Equality, Diversity & Inclusion who has strategic responsibility for EDI with an operational focus on workforce issues. A Trust-wide workforce action plan has been created which will support the Trust in becoming more a more inclusive employer. The Trust has also developed a Leadership Framework that is centred around

the values and behaviours that we expect of our leaders, and their responsibility for creating cultures within their teams of civility and respect.

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. The Trust's challenging bullying and harassment, and grievance policies are being revised and will become a combined Civility, Respect & Resolution policy (following national good practice set by Mersey Care), as part of the continuing work to create a civil and respectful culture.

Work will continue to publicise the Freedom to Speak Up Guardian and the Fairness Champions within the organisation. We will continue to hold regular drop-in 'surgeries' for staff with the Chief Executive, Director of Workforce & OD, and Chief Nurse's team to give increased opportunities to understand the lived experiences of our colleagues.

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 2021**	**Trust 2022**	**NHS Staff Survey average 2022**	**NHS Staff Survey Highest Trust 2022**	**NHS Staff Survey Lowest Trust 2022**
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?*	55.4%	54.3%	55.6%	69.4%	43.7%

* These results are presented in the context of the best, average and worst results for similar organisations taken from the 2022 NHS Staff Survey.

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

The results of the annual staff survey are deemed national official statistics and reported to the Board of Directors. The data is consistent with that reported to the Board of Directors.

The York & Scarborough Teaching Hospitals 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 2022 survey will be used to update the action plan to improve staff experience, engagement and retention, and ultimately patient care within the organisation.

We will:

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

Continue to work towards achieving our Equality Action plan by implementing the new Head of Equality, Diversity & Inclusion's workforce action plan which will support the Trust in becoming more a more inclusive employer.

Part Three – Review of Quality Performance

3.1 Trust Performance Against National Quality Indicators

icator	2021-22	Target 2022-23	Q1 2022-23	Q2 2022-23	Q3 2022-23	Q4 2022-23	otal 2022-3
Total time in ED under 4 hours – national*	73.73%	95%	71.78%	71.31%	69.65%	70.59%	70.84%
*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 2022-23 was 47.17%							
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	65.2%	92%	58.8%	55.8%	53.3%	50.1%	54.3%
Cancer 2 week wait (all)	85.2%	93%	88.3%	85.8%	70.8%	79.3%	81.2%
Cancer 2 week wait Breast Symptomatic	65.0%	93%	83.8%	94.7%	96.0%	89.3%	90.8%
Cancer 31 days from diagnosis to first treatment	96.9%	96%	95.9%	96.9%	97.1%	96.2%	96.5%
Cancer 31 days for second or subsequent treatment – surgery	93.2%	94%	81.3%	90.2%	89.7%	87.1%	87.0%
Cancer 31 days for second or subsequent treatment – drug treatment	98.3%	98%	98.8%	99.1%	98.6%	97.3%	98.3%
Cancer 62 day wait for first treatment (urgent GP)	69.1%	85%	63.9%	61.9%	51.9%	59.7%	59.4%
Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service)	85.3%	90%	78.9%	84.1%	80.5%	87.4%	82.6%
Cancer 28-day Faster Diagnosis Standard	67.8%	75%	70.6%	64.1%	57.4%	64.5%	64.1%
Diagnostics – 6- week wait referral to test	57.4%	99%	51.4%	48.4%	47.1%	53.5%	50.0%

Statements from Key Stakeholders

Statements from the Trust's Council of Governors

Name and Designation	Michael Reakes, Public Governor, York
Feedback Statement	Well done, considering all the challenges.
Date of Response	30 May 2023

Name and Designation	Maya Liversidge, Staff Governor
Feedback Statement	Positives: • Patients lived experience • Looking back section • What we said and did Improvements: • Would be good to know why the decision was taken to prevent Kirsten bringing in the dog to ensure that behaviour is understood. • In what we said section, give example of the actions taken to reduce falls rather than just showing the statistics t o give greater understanding.
Date of Response	01/06/23

Statement from Humber and North Yorkshire Integrated Care Board

Name of Organisation	Humber and North Yorkshire ICB
Name and Designation	Michelle Carrington, Director of Nursing, North Yorkshire and York Healthcare Partnership Nikki Henderson, Senior Nursing, Quality and Clinical Governance Manager, North Yorkshire Healthcare Partnership
Feedback Statement	The Humber & North Yorkshire Integrated Care Board (ICB) welcome the opportunity to review and comment on York and Scarborough Teaching NHS Foundation Trust's (YSTHFT) Quality Report for 2022/23. We note the Quality Account provides an informative overview of the Trust's ongoing work

	across the last year we would like to take this opportunity to thank all the staff at YSTHFT for their continued hard work and dedication during what has been a challenging year. We note the Trust's ongoing work and approach to Quality Improvement noting the Journey to Excellence methodology utilising CQC standards and appreciate the wealth of work that has been undertaken across the past year in the response to CQC's recommendations which has been a key priority. The Quality Accounts reflect the progress the Trust has been made towards the quality priorities identified for 2022/2023 and we particularly note the Trust's Quality Improvement Strategy and the way in which the Trust have embraced a culture of continuous improvement which has been adopted across leaders and all staff disciplines. It is assuring that 3 monthly progress updates are shared with the Trust Board and we look forward with interest to hear how the quality priorities are further developed in 2023/2024 and become embedded in to practice across the Trust. The Trust wide work and motivation to drive various projects forward with the Improvement Team being at the centre of the coordination has been noted however the investment into the Trust's approach to adopting change across all Care Group's is to be commended. The areas of improvement that are to be further addressed across 2023/2024 are highlighted in this Quality Account and we particularly note the following: • Whilst YSTHFT highlight they did not achieve a 10% reduction in the average number of falls progress has been made against the National Audit of Inpatient Falls (NAIF) in 2 areas which take the Trust above the national average. The ICB acknowledge the continued work of the Falls Improvement Group to achieve towards the 10% reduction target and it is both welcoming and assuring to see a number of Patient Safety Priorities for 2023/2024 that continue to focus on falls improvement which include lying and standing blood pressure, early provision of walking aids and staff training and education. • Eliminate all category 4 pressure ulcers: in light of the ongoing pressures of Covid against progress to achieve this priority area we do congratulate the Trust on noting their compliance has improved from 45% to 100% in Quarter 4, 2022/2023 in capturing pressure ulcer risk and associated documentation. • The ambition set to achieve at least a 20% reduction in CDIFF bacteraemia in 2022/2023 was not achieved however the ICB recognises the challenges associated with Infection Prevention and Control, in particular the ward decant provision at the Scarborough

	site. We do however note the improvement in Post Infection Review (PIR) completion and look forward with interest to observing continued improvements in CDIFF rates as we progress across 2023/2024, in particular to the development of the CDIFF care plan on the recently implemented Nucleus technology, the continued estates work and commitment of the Executive Board support. • In addition to the information in the Account relating to Infection Prevention and Control (IPC) the ICB would like to see the Trust articulate a quality priority around IPC given the ongoing challenges the Trust faces particularly relating to IPC governance processes and standards in maternity. We note there will be continued support provided to the Trust by NHSE and the ICB. We continue to commend the Trust's openness in the reporting of patent safety incidents and acknowledge the promotion of a better safety culture across all Care Group's. We particularly welcome the work to date as the Trust transitions into the new approach brought about by the Patient Safety Incident Response Framework (PSIRF). We are pleased at the inclusivity of the York and North Yorkshire Place partners as the Trust develop their implementation plans and move further towards PSIRF roll-out across 2023/2024. The ICB notes the amount of positive work undertaken in the establishment of a refreshed plan of how the Trust manages patient experience and patient and public involvement. We note there has been a restructure of the Patient Experience Team including a review of leadership for patient and public involvement. The description of the simulation exercise to map the patient journey through the new-build Emergency Department at York is reflective of a successful way to engage with people using the service and we note and welcome the plans to replicate this approach at the Scarborough site. We also note and look forward to the improvement work as the medical wards implement agreed discharge standards using the experience of patients to inform the work. The co-creation and development of a new Patient Experience and Involvement Plan for 2024-2029, a patient experience 5 year plan, sounds like an exciting initiative and we note the first steps towards achieving the Plan across 2023/2024. We also note that the Trust encourage the staff voice and following CQC inspection have strived to learn from other Trust's with the aim to develop a strong Quality Improvement Culture. In setting out the Quality Priorities for 2023/2024 we also note the recognition of, and appetite to harness the Core 20Plus5 NHSE Initiative in order to address healthcare inequalities and quality improvement initiatives across the areas of maternity,

	severe mental illness, chronic respiratory disease, earlier cancer diagnosis and hypertension case-finding/lipid optimal management. As set out in Priority 3: Patient Safety Priorities we note the work in relation to the improved recognition and treatment of sepsis which is to be delivered in line with the new NICE recommendations due for publication in June 2023. The ICB acknowledge the information set out in the Account relating to the Learning from Deaths reviews and subsequent actions that have been identified following thematic analysis. We particularly note: • The negative experience of multiple bed moves for people nearing end of life • Nutrition and hydration care that includes specifically poor fluid balance monitoring and documentation, mouthcare and weight measurement • Management of nasogastric tubes • Recognition of the deteriorating patient highlighting the detail as previously mentioned as set out in Priority 3 • End of Life Care and experience. We acknowledge the continued pressures across the Trust's workforce however note from the Quality Account some of the measures taken to support staff with an outline of the Freedom to Speak Up approach in place and also the Guardian of Safe Working Hours to support junior medical staff. The Trust's participation in the 2022/2023 National Clinical Audits is acknowledged and we will look with interest as the results are published in particular the NCEPOD Child Health Clinical Outcome Review programme, the RCEM emergency medicine and Diabetes QIP's, LeDeR and the MBRACE programmes. The Trust's approach to maintain oversight of outcomes and to share the learning provides assurance to Commissioners. We note the Trust's success in achieving full delivery of the CQUIN schemes following their re-introduction in 2022/2023 and we continue to welcome the collaborative approach taken in agreeing the areas for improvement against the CQUIN schemes for 2023/2024. Following the CQC enforcement action and subsequent conditions placed on the Trust relating to maternity and emergency department care of people with mental health needs, the ICB particularly note the progress to date with the implementation of effective risk and governance systems in the speciality of maternity to promote the safety of mother and baby.

	The Trust's ongoing work and compliance updates in relation to their CQC action plan is welcomed. We note the extreme pressures across the Trust's emergency department with extreme "front door" pressures and the subsequent impact on waiting times as well as the impact of the pressures across the whole patient journey through to discharge. We particularly note the continued challenges the Trust has faced with Covid 19 inpatient numbers as well as a high number of Influenza cases. We note that despite the continued pressures, CQC found improvements in the management of demand, risk and escalation during their October 2022 visit. We are pleased to see the progress made to improve the Urgent and Emergency Care offer at both the York and Scarborough sites and note the efforts made to keep on track with final completion at the Scarborough site for Spring 2024. We also note the challenges that impacted on the Trust's performance against the National Quality Indicators, both of emergency department performance and cancer waiting times however do note the achievement against the 2022/2023 targets in 2 areas against cancer treatment times. The ICB agrees that the Quality Account is presented as a transparent and balanced picture of YSTHFT's performance across 2022/2023 and we can finally confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by York and Scarborough Teaching NHS Foundation Trust and that the data and information contained in the report is accurate. The Humber & North Yorkshire Integrated Care Board remain committed to working with our Trust partners and its regulators to improve the quality and safety of services available in order to improve and strive to excellent quality and safe care in to 2023/2024.
Date of Response	12 June 2023

Statements from Healthwatch

Name of Organisation	Healthwatch York
Name and Designation	Emily Douse Deputy Manager

	Healthwatch York
Feedback Statement	Healthwatch York welcome the opportunity to review and comment as a critical friend of York and Scarborough Teaching Hospital. Part of our work is to collate feedback from patients and to pass this on in the form of our monthly issues logs. We often receive written responses from the hospital. We also work with the hospital to unpick and address patient cases when necessary. Our working relationship with PALS helps us to resolve queries for patients, and at times offer public reassurance around a particular issue – most recently LGBTQ+ friendly inpatient spaces. Our staff publicise and attend various patient experience meetings and groups, representing community voice and providing the public with information from the hospital. We welcome the hospital's ongoing commitment to listening to patients. We're particularly pleased to see investment going into the local maternity voices partnership. Our readability service is well used by the hospital, with regular requests for our panel of volunteers to look at patient publications. Our volunteers also undertake PLACE assessments with the hospital and host a regular engagement stall on the grounds.
Date of Response	7.6.23

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 2022 to 26 May 2023;

- papers relating to quality reported to the board over the period April 2022 to 26 May 2023;
- feedback from the ICB dated 12 June 2023;
- feedback from Governors dated 30 May, 1 June 2023;
- feedback from Healthwatch York dated 7 June 2023;
- feedback from Overview and Scrutiny Committee not received
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
- the latest national patient survey
- 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

???? 2023 .....Chair

???? 2023 .....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.

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.

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.