York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 26th June 2024
Time: 10:00am – 12:50pm
Venue: PGME Discussion Room, Scarborough Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	10:00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 22 May 2024** To be agreed as an accurate record.	Chair	Report	**5**	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	**15**	
6.	**Chair's Report** To receive the report.	Chair	Report	**16**	10:05
7.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	**18**	10:10
8.	**Quality Committee Report** To receive the June meeting summary report.	Chair of the Quality Committee	Report	**68**	10:20

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Resources Committee Report** To receive the June meeting summary report.	Chair of the Resources Committee	Report	70	10:30
10.	**Trust Priorities Report (TPR)** May 2024-25 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	 Chief Operating Officer Interim Chief Nurse Director of Workforce & OD Chief Digital Information Officer Finance Director	Report	 75 110 132 142 148	10:40
Break 11.30					
11.	**CQC Compliance Update Report** To consider the report.	Interim Chief Nurse	Report	158	11:40
12. 12.1 12.2	**Maternity and Neonatal Reports** To consider the reports: • Maternity and Neonatal Quality & Safety Update • CQC Section 31 Update	Interim Chief Nurse	Report	To follow	11.50
13.	**Infection Prevention and Control Annual Report** To consider the report.	Interim Chief Nurse	Report	169	12:00

Item	Subject	Lead	Report/ Verbal	Page No	Time
14.	**Q4 2023/24 Mortality Report – Learning from deaths report** To consider the report.	Medical Director	Report	**191**	12:10
Governance					
15.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	12:40
16.	**Time and Date of next meeting** The next meeting held in public will be on 31 July 2024 at 9.30am at York Hospital.				
17.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
18.	**Close**				12:45

Minutes
Board of Directors Meeting (Public)
22 May 2024

Minutes of the Public Board of Directors meeting held on Wednesday 22 May 2024 in the Boardroom, Trust Headquarters, York Hospital. The meeting commenced at 9.30am and concluded at 12.45pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (& Maternity Safety Champion)
- Mr Jim Dillon
- Mrs Jenny McAleese *(via Teams)*
- Mrs Lynne Mellor
- Dr Stephen Holmberg *(via Teams)*
- Prof. Matt Morgan
- Ms Helen Grantham (Associate)

Executive Directors
- Mr Andrew Bertram, Deputy Chief Executive/Finance Director
- Ms Claire Hansen, Chief Operating Officer
- Dr Karen Stone, Medical Director
- Mrs Dawn Parkes, Interim Chief Nurse & Maternity Safety Champion
- Miss Polly McMeekin, Director of Workforce and Organisational Development
- Mr James Hawkins, Chief Digital Information Officer (late)
- Mr Steven Bannister, Managing Director of York Teaching Hospitals Facilities Management LLP (YTHFM)

Corporate Directors
- Mrs Lucy Brown, Director of Communications

In Attendance:
- Mr Mike Taylor, Associate Director of Corporate Governance
- Mrs Lydia Harris, Head of Research and Development (for Item 14)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Julie Southwell, Staff Governor
- Ms Linda Wild, Public Governor (East Coast)
- Ms Carina Wahlgren, Head of Nursing for the Emergency Department at Skane University Hospital (Malmo and Lund), Sweden (Hospitals of EurOPE programme)
- Dr Ritva Kanervo, Chief Medical Officer, Kainuu Hospital, Finland (Hospitals of EurOPE programme)
- One member of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting, with a particular welcome to Ms Wahlgren and Dr Kanervo from the HOPE programme. Dr Stone provided information about their programme. Ms Grantham was also welcomed to her first meeting as an Associate Non-Executive Director.

2 Apologies for absence

Apologies for absence were received from Mr Simon Morritt, Chief Executive.

3 Declaration of Interests

There were no declarations of interest to note.

4 Minutes of the meeting held on 24 April 2024

The Board approved the minutes of the meeting held on 24 April 2024 as an accurate record of the meeting.

5 Matters arising/Action Log

The Board noted the outstanding actions which were on track or in progress. The following updates were provided:

BoD Pub 30 *Waiting List Harms Task and Finish Group - proposal for a process of identifying and monitoring patients on waiting lists to be presented to the Quality Committee.* Ms Hansen reported that a paper had been presented at the meeting of the Quality Committee on 21 May. The action was therefore closed.

BoD Pub 42 *Provide update to the Board on Datix reporting levels*. As agreed at the last meeting, an update had been provided to the Quality Committee on 21 May. The action was therefore closed.

BoD Pub 44 *Develop action plan from Staff Survey to be brought to the Resources Committee.* An action plan had been presented at the Resources Committee meeting on 21 May. The action was therefore closed.

BoD Pub 45 *Add dates re: initial targets to CQC report*. These had been added – the action was therefore closed.

BoD Pub 01 *Make recommendations to the Board on how plans for diagnostic improvement, Urgent and Emergency Care, and elective care programmes could be brought together and where best to present the reports.* Ms Hansen advised that a paper had been presented to the Executive Committee. The format for reporting metrics was still being discussed. It was agreed that the action could be closed.

BoD Pub 02 *Investigate data for 12 hour trolley waits in the Emergency Department.* Mr Hawkins reported that the target had been removed and the figures should now align. The action was closed.

BoD Pub 03 *Circulate new strategy for Urgent and Emergency Care, as presented to the Resources Committee in April.* This had been completed.

BoD Pub 04 *Remove the data on "Cancer two week waits" from the TPR.* This had been completed.

BoD Pub 05 *Supply more detailed information on patients waiting more than 63 days for referral to treatment, by length of wait and specialty, to the Quality Committee on a quarterly basis.* Ms Hansen reported that she had met with the Head of Cancer and had drafted a report which would be presented quarterly to the Quality Committee, beginning in July. The action was therefore closed.
Mr Barkley asked if there were any outliers amongst the specialties. Ms Hansen responded that there were longer waits in lung, neurology and colorectal. Workstreams were already in place to effect improvement.

BoD Pub 06 *Investigate and address incomplete data on pathways with an ethnicity code.* Mr Hawkins advised that efforts were being made to increase the level of information being provided on ethnicity. The Patient Administration group were reviewing procedures with a view to increasing the level of information provided by patients and families. Data might also be sourced from primary care. The action was ongoing, and it was agreed to amend the target date to July.

BoD Pub 07 *Provide further information about children and young people on community waiting lists.* Ms Hansen advised that work was ongoing with the Digital and Information Service to extract this information which would be presented first to the Children's Board. The target date was amended to July.

BOD Pub 08 *Provide an update on possible alternative platforms for the telephony service.* Mr Hawkins referred to the incident affecting call queues to some the Trust's services which had been the trigger for this action point and advised that a temporary solution had been implemented on the same day. This should have been reported at the last meeting. Mr Hawkins noted that he had not intended to investigate alternative platforms for the telephony, but he would bring options for strengthening the infrastructure to the next meeting.

BoD Pub 09 *Write a detailed response to the question explaining the Board's rationale for unanimously supporting the leadership development programme exclusively for BME staff.* A copy of the response had been circulated to Board members and it was agreed that a copy of the letter (suitably redacted) should be added to the minutes of this meeting. The action was therefore complete.

6 Chair's Report

The Board received the Chair's report.

7 Chief Executive's Report

The Board received the Chief Executive's report. Referring to the section entitled *Adopting the York Poverty Truth Commission Charter*, Mr Barkley queried the implications for the Trust of adopting the Commission's Charter for Organisational Standards. Ms Brown advised that this was a city wide initiative which aligned with the Trust's values. Melanie Liley, Chief of Allied Health Professionals, was involved in the work and it was agreed that she would prepare a brief paper for the next meeting summarising the implications of adopting the Charter.

Action: Ms Liley

Mr Barkley highlighted the examples of individuals demonstrating the Trust's values as illustrated by the Star Awards.

Mrs Mellor also noted the Hull York Medical School Teaching Excellence awards which were a further reflection of the Trust's values.

The Board recorded its congratulations to all those in receipt of an award.

The Board recognised the contribution of those responsible for the successful outcomes of the recent NHS England tiering review: the Trust was no longer in the tiering process for elective care and had moved from tier 1 to tier 2 for cancer.

8 Quality Committee Report

Dr Holmberg briefed the Board on key discussion points from the meeting of the Quality Committee on 21 May:

- concerns had been raised about progress in maternity services being hampered by funding issues; a further £4m in funding was needed to bring staffing to a level to deliver against national standards; this was a significant risk for the department and for the Trust as a whole; Mrs Parkes had commissioned a QIA to identify the implications of a lack of further investment in the service;
- two never events had been reported to the Committee;
- the Cancer, Specialist and Clinical Sciences Care Group had presented to the Committee, and had highlighted a recent review of appointment booking and follow up processes in Ophthalmology which had led to a much more robust system;
- the Care Group had been subject to a number of regulatory inspections recently, all of which had had positive outcomes;
- the implications of the Infected Blood report had been discussed; no specific concerns had been raised in relation to the Trust's historic practice;
- the Medical Elective Suite had moved permanently to Nelson's Court; this had been well-received by patients and staff;
- the Committee received the Infection Prevention and Control (IPC) Annual Report which raised a number of concerns; the Committee had mandated Care Groups to report the outcomes of their IPC audits as part of their presentation to the Committee;
- other reports received and discussed by the Committee included:
    - a paper outlining processes to identify waiting list harms;
    - a positive report from the End of Life Service;
    - the Safeguarding Annual Report;
    - a report identifying causes of long waits for children in the Emergency Department; this was due to older children being inappropriately placed on adult pathways and would now be addressed;
    - a paper summarising recent levels of Datix reporting which reflected those of pre-Covid levels; efforts had been made to simplify the reporting process although most of the fields were mandated by NHS England. Mr Barkley asked if the Committee received information on outstanding Datix reports. Mrs Parkes explained that overdue reports would be reviewed at the Care Group Performance meeting.

There was further discussion on the Trust's performance against national IPC standards. It was noted that the position had been impacted by issues relating to the estate and higher bed occupancy levels. However, Executive Directors were fully sighted on the position and there was a strong focus on a rapid improvement of practice.

9 Resources Committee Report

Mrs Mellor briefed the Board on the key discussion points from the meeting of the Resources Committee on 21 May:

- the Committee had discussed recent 8 hour ambulance handover breaches; it was noted that those affected were mainly Category 4 patients whose treatment pathway was not through the Emergency Department; processes were being reviewed with clinicians, the Yorkshire Ambulance Service (YAS) and the wider system to improve patient prioritisation;
- the Committee had received the Workforce Race Equality Standard (WRES) Annual Report and the Workforce Disability Equality Standard (WDES) Annual Report and expressed disappointment at the lack of progress in improving the metrics recorded in both reports; the correlation with the outcomes of the Staff Survey was noted and was followed by a broader discussion of the raft of pressures on the workforce and the plans in place which aimed to address these issues;
- the Committee received papers which offered assurance on the nursing workforce and noted that the vacancy rate trend was downwards; a new inpatient nursing review paper had been presented, and would be presented bi-annually, to provide robust assurance of safe staffing levels; it was noted that the Board should be kept informed of the outcomes of these reviews as the accountable body;
- in terms of finance, the Committee noted that the efficiency programme had started well, albeit with challenging targets still to meet;
- Mr James, Director of Procurement at the Humber & North Yorkshire Procurement Collaborative, had attended the meeting to report on the benefits realised thus far and the next steps, which would be around the standardisation on contracts and product pricing;
- improvements in the Emergency Care Standard, and the Faster Diagnosis Standard and in cancer waiting times were noted by the Committee;
- the Committee had received the Staff Survey Improvement Plan, to which the Change Makers had contributed; the Committee asked for further assurance with a request for more detail on the current plan including regular checks on the impact of actions;
- in terms of risks identified, a data cleansing exercise on waiting lists might uncover further issues; Ms Hansen had been asked to report back.

Mrs Parkes referred to the Inpatient Nurse Staffing review and explained that this was the first review of a process which was now being implemented. She observed that the review did not suggest that an increase in inpatient nurse staffing was needed but further exploration would be required before any conclusion could be drawn. She highlighted that the review was a statutory procedure as the Board was accountable for safe staffing levels. The report would be presented to the Board at the next meeting.

Dr Boyd asked if ambulance waits were significant at both York and Scarborough. Ms Hansen responded that there were long waits at both sites, but the 8 hour breaches were confined to York. The new model of acute flow would improve the position and an implementation date in July was currently foreseen. Ms Hansen reported that she had also met with representatives from YAS: the proportion of patients not being conveyed to the Emergency Departments had improved and compared well with other areas. However, there was a continuing rise in the volume and acuity of patients being conveyed: the numbers of patients arriving at Emergency Departments had increased by 21% in April, with a 15% rise in ambulance arrivals, compared to the same period in 2023.

10 Group Audit Committee Report

Mrs McAleese highlighted the key points from the meeting of the Group Audit Committee on 13 May, noting that the meeting had focussed on preparations for year-end:

- External Audit was progressing well, not least due to the engagement and timely responses from the Finance Team to requests from the external auditors;
- the Head of Internal Audit was likely to issue a significant assurance opinion, subject to the continued implementation of audit recommendations in a timely manner;
- the accounts would be agreed on a Going Concern basis.

Mrs McAleese flagged that the Committee sought clarification about the audit on space utilisation, specifically the link between the current right-sizing work and a future review of the clinical strategy. Ms Hansen explained that the results of the right-sizing work had been presented to the Executive Committee at its last meeting and the recommendations approved. Services had been identified for relocation, which would provide larger assessment units. Space for 17 additional side rooms had been identified and this would support IPC measures. The right-sizing work addressed current issues with the use of the estate and did not directly influence the clinical strategy long term, which would underpin a programme of service transformation.

11 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

There was a brief discussion on discharge processes. Ms Hansen reported that she was continuing to discuss with Local Authorities the discharge of patients with No Criteria to Reside and she provided further details, noting that all parties were in agreement on the actions needed. She had requested a plan, with a timeline, to be drafted by the summer.

With reference to the Referral to Treatment (RTT) scorecard, it was noted that further information was needed around the metric for the proportion of incomplete pathways waiting less than 18 weeks. Mr Hawkins was asked to remove the metric of waits over 78 weeks as this was no longer relevant.

Action: Mr Hawkins

The Board noted the number of RTT “clocks stopped” in April which, at 9,300, was the highest monthly total in the last two years. Ms Hansen confirmed that the majority of these patients had now been treated and the remainder had not needed treatment.

Referring to the Diagnostics scorecard, Mr Barkley questioned whether the Board could be confident that there was sufficient capacity for echocardiography, given the high proportion of patients waiting over six weeks. Ms Hansen responded that there was a plan in place to address this, but it would be challenging to improve the metrics significantly in the short term. It was noted that the target for all diagnostics on the scorecard was for 95% of patients to be waiting less than six weeks from referral. The graphs represented performance over a two year period, as required by NHS England.

It was noted that the number of outpatients with an overdue follow-up partial booking had reached over 26,000. Ms Hansen explained that this reflected challenges around capacity and prioritisation. She acknowledged that work needed to be done in this area and that she was mindful of potential harms to patients waiting for treatment.

Mr Barkley queried whether the figure for children waiting for Speech and Language therapy could be categorised in a way which would attract specific funding. Mr Bertram agreed to investigate.

Action: Mr Bertram

There was a brief discussion on the reasons for the large waiting list and actions being taken in mitigation.

Quality and Safety

With reference to the IPC information, Mrs Parkes agreed with Mr Barkley that the actions needed to reduce infection rates were not difficult to implement. She confirmed that infection rates could be analysed by ward and that each ward had an improvement plan, which matrons were leading. Mrs Parkes provided further details about the strategies in place. Dr Holmberg commented that he had noticed a significant change in practice as senior nurses were now much more focussed on leading their teams to raise IPC standards. It was noted that Board members could also challenge poor practice when undertaking their ward visits.

Mr Barkley flagged the increasing level of complaints which, when paired with low staff morale, was a concern for the Board in terms of the potential impact on patient safety. Mrs Parkes agreed that senior leaders must focus on investigating safety concerns. She agreed that more responses to the Friends and Family test and other methods of collating patient feedback were needed.

Maternity

It was noted that the data regarding mothers smoking was incomplete. Dr Stone advised, in response to a question, that women at higher risk of blood loss during birth were always cared for in York, hence the difference in the metric for York and Scarborough.

Workforce

In response to a query, Miss McMeekin explained that health surveillance was provided by the Occupational Therapy service which now had an increased presence on the York site. This had increased the number of appointments available.

The Board noted the impressively low staff turnover rate and overall vacancy rate.

Digital and Information Services

The Board noted the significant increase in Freedom of Information requests in the last quarter.

Finance

Mr Bertram reminded the Board of the £53m savings target for 2024/25 which represented 7% of budget and reported that the adjusted position for the year overall showed a £20.8m deficit. The predicted deficit was typical of the position across the NHS and, as the deficit plan was not affordable nationally, he was expecting further pressure to be exerted to reduce the gap.

Mr Bertram referred to the Month 1 position which showed an actual adjusted deficit of £4.67m against a planned deficit of £2.9m, this being £1.2m adrift of plan. The most material source of the variance was a shortfall against the savings programme.

Mr Bertram reported that the Efficiency programme had begun well. On the Core Efficiency Programme, £2.3m of recurrent savings had already been delivered. On the Corporate Efficiency Programme, £6.8m of savings had been delivered in full year terms, most of which was due to a £4m reduction in the utility bill. In summary, £9.1m of the efficiency total of £53m had been delivered in April. The Efficiency Delivery Group had met twice, and the next meeting would focus on a deep dive into nurse staffing. Mr Bertram underlined that the programme was challenging and would need to maintain momentum.

Mr Bertram advised that the Elective Recovery Fund continued to perform well with 112% of activity delivered in April, which represented £0.75m of surplus income. The increased activity would also impact positively on waiting lists. In response to a query, Mr Bertram agreed to add phasing information to the next report and a year-end forecast based on trends to date and other known factors

Action: Mr Bertram

Mr Barkley noted the significant variances in the cost of drugs and clinical supplies and services. Mr Bertram reported that the Trust had agreed a position with the ICB to address pressures from contracts, but the figures were a reflection of growth in demand. He advised that some costs were offset by elective income and there was some compensating income for high cost drugs from NHS England. He acknowledged, however, that the trend was concerning and had continued from last year. It was noted that financial pressures on the system added to concerns around patient safety. Mrs Mellor commented that the position on high cost drugs and devices had been discussed by the Resources Committee and it had been agreed to invite the Chief Pharmacist to a meeting for a discussion on whether costs could be reduced further with work on the supply chain. Mr Bertram highlighted the growth in demand from GPs on pathology services; the Trust was working with the wider system to address this as currently the Trust was not being recompensed for this growth.

Mr Barkley highlighted that the Trust was already adrift of the financial plan and that a key focus for NHS England would be the cost of agency and bank staffing. Board members agreed that the Trust faced a challenging year and that they must be united in taking difficult decisions.

The meeting was adjourned at 11.41am and reconvened at 11.52am.

12 CQC Compliance Update Report

Mrs Parkes presented the report and highlighted the following:

- 33 actions had been completed since the last report;
- four actions were off track but had been put forward for closure;
- actions relating to the Section 31 Mental Health Risk Assessment had now been implemented and the Trust would look to evidence compliance, as a move towards closure of the Section 31;
- five concerns had been raised with the CQC; Mrs Parkes shared further details and noted that the CQC was reviewing its internal processes for reviewing concerns.

Mr Barkley reported that final confirmation that the Trust would remain in Segment 3 of the CQC framework had now been received.

13 Maternity and Neonatal Reports

Maternity and Neonatal Quality and Safety Update

Mrs Parkes presented the report and highlighted the following:

- there had been an increase in the number of cases of babies born without an appropriate health care professional present; Ms Wells-Munro had been asked to investigate the circumstances of each case;
- there had been an increase in Post Partum Haemorrhages over 1500mls; Mrs Parkes observed that there should be evidence of a steady improvement soon, but it was disappointing that the actions implemented were not yet showing a sustained impact;
- feedback from staff who had attended the recent engagement event was evidence of a significant improvement in morale and culture from that received at a similar event in November 2023; Mrs Parkes outlined strategies being implemented with a view to addressing some areas of negative feedback; Ms Brown advised that more frontline staff would be involved in the next engagement event which would support this;
- the culture survey used as part of Workstream 2 *Growing and Retaining our Workforce* had received a response rate of 37%; the responses were currently being analysed.

CQC Section 31 Update

The Board approved the Section 31 Update.

14 Research and Development Annual Report

Lydia Harris, Head of Research and Development, joined the meeting to present the report. She shared a Powerpoint presentation and highlighted the following:

- the Trust had had its strongest year for grant submissions and wins, including a first major NIHR grant for Professor Turvill;
- the Trust's commercial research portfolio continued to grow; Mrs Harris provided details;
- the Scarborough Coastal Health and Care Research organisation (SHARC) had been established;
- challenges included difficulties in filling research opportunities with local universities and a lack of staff willing to act as principal investigators.

Mrs Harris shared plans for the year and advised that she would present the annual Research and Development strategy to the Board in October. She explained that the strategy would be developed to take account of national themes, and to align with other work in the Trust. Mrs Harris advised that consultants received communication by email about the Research and Development programme but there was not a high level of response.

Mr Barkley suggested that, if possible, the East Coast governors should be invited to the opening of SHARC.

Post meeting note: all Governors had been invited to the opening of SHARC.

Dr Stone thanked Ms Harris on behalf of the Board for the work of the Research and Development team.

15 WRES and WDES Annual Reports

Miss McMeekin presented the reports, explaining first that both sets of data now included staff employed by YTHFM and that the reports were due to be submitted at the end of May. She highlighted a deteriorating picture across both standards. A two year action plan was now in place and her team would seek engagement with staff at regular intervals to determine if any changes to the plan were needed. Professor Morgan had agreed to work with Miss McMeekin to clarify some of the metrics used in the report before publication.

Mr Barkley asked if the Trust had adopted the NHS England high impact measures for Equality, Diversity and Inclusion. Miss McMeekin confirmed that these were included in the action plan. She emphasised that a substantial amount of work had already been done in these areas, but it would take time to change ingrained culture. The last staff engagement programme had been interrupted by the pandemic, and this had not set the best platform for a new plan to be implemented. Referring to the downturn in metrics, Miss McMeekin observed that it was also important to increase the numbers of staff completing the survey, as there was a risk that the minority who had completed it this year were more disaffected than the majority. There was further discussion: the Board noted the role of line managers at all levels to engage in change and to share this with their teams, and to demonstrate a zero tolerance approach to poor behaviour.

The Board approved the WRES and WDES Annual Reports, subject to the amendments agreed with Professor Morgan.

16 Cancer and Elective Care Tier Review Update

The Board noted the update and the good news it contained.

17 Questions from the public

There were no questions from the public.

There was a brief debate on whether the letter written to the question raised at the last meeting should be shared on the website.

The Board noted that the response to the Infected Blood Inquiry had been published and expressed its regret for the impact of the scandal on its patients. The Trust would continue to work with affected patients and staff.

18 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 26 June 2024 at 10.00am at Scarborough Hospital.

Action Ref.	Date of Meeting	Minute Number Reference	Title (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / comments	Due Date	Status
BoD Pub 23	29 November 2023	92 23/24	Research and Development Update	Share relevant connections with established clinical activities to support portfolio research delivery	Medical Director	31.01.24 - Miss McMeekin requested the due date be extended from February. As this was in tandem with the strategy programme and the research strategy, it was more realistic for July 24. The Executive Lead was to be amended to the Medical Director following recent changes in portfolios.	Jul 24 (from Feb 24)	Amber
BoD Pub 06	24-Apr-24	10	Trust Priorities Report	Investigate and address incomplete data on pathways with an ethnicity code.	Chief Digital & Information Officer	Update 22.05.2024: Mr Hawkins advised that the Patient Administration group were looking at procedures to increase the level of information provided by patients and their families. The action was ongoing. It was agreed to amend the target date to July.	Jul 24 (from May 24)	Amber
BoD Pub 07	24-Apr-24	10	Trust Priorities Report	Provide further information about children and young people on community waiting lists.	Chief Operating Officer	Update 22.05.24: Ms Hansen advised that she was working with DIS to collate this information which would first be presented to the Children's Board before coming to the Board. The target date was amended to July.	Jul 24 (from May 24)	Amber
BoD Pub 08	24-Apr-24	10	Trust Priorities Report	Investigate options for strengthening the telephony infrastructure.	Chief Digital & Information Officer	Update 22.05.24: Mr Hawkins that he would consider the overall strategy for telephony and bring options for strengthening the infrastructure to the next meeting.	Jun-24	Green
BoD Pub 09	22-May-24	7	Chief Executive's Report	Prepare brief paper summarising the implications of the Trust adopting the York Povery Truth Commission Charter	Chief of Allied Health Professionals		Jul-24	Green
BoD Pub 10	22-May-24	11	Trust Priorities Report	Remove the metric on "waits over 78 weeks"	Chief Digital & Information Officer		Jul-24	Green
BoD Pub 11	22-May-24	11	Trust Priorities Report	Investigate whether children and young people waiting for Speech and Language Therapy can be categorised in a way which attracts specific funding	Finance Director		Jul-24	Green
BoD Pub 12	22-May-24	11	Trust Priorities Report	Add phasing information to the next Finance report, and a year-end forecast based on trends to date and other known factors	Finance Director		Jul-24	Green

Report to:	Board of Directors
Date of Meeting:	26 June 2024
Subject:	Chair's Report
Director Sponsor:	Martin Barkley, Chair
Author:	Martin Barkley, Chair

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ A Regulatory Requirement ☐

Trust Priorities	**Board Assurance Framework**
☒ Our People ☒ Quality and Safety ☒ Elective Recovery ☒ Acute Flow	☒ Quality Standards ☒ Workforce ☒ Safety Standards ☒ Financial ☒ Performance Targets ☒ DIS Service Standards ☒ Integrated Care System

Summary of Report and Key Points to highlight:

To provide an update to the Board of Directors from the Chair on recent visits and meetings.

Recommendation:

For the Board of Directors to note the report.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

Board of Directors only

Meeting	Date	Outcome/Recommendation
Board of Directors	26 June 2024	

Chair's Report to the Board – June 2024

1. I visited Malton Hospital for the first time. I met with colleagues in virtually all of the teams based at the hospital as well as visiting the ward to learn from the ward manager how that ward operates (which is run by Humber Teaching NHS FT).
2. I Chaired my third meeting of the Council of Governors. I am delighted that there was unanimous agreement to extend the terms of office of Lorraine Boyd for 12 months and Lynne Mellor for 6 months. Although NHSE are encouraging NEDs to not be extended after their second term has finished there were significant reasons why extensions were appropriate for Lorraine and Lynne.
3. I chaired the Trust's first Members Constituency meeting held in Selby on Friday 7th June 2024. Just two Members attended- who were terrific. They made a good contribution and thought the format and the amount of information shared was about right. A de-briefing meeting is taking place at the end of the month to identify any changes that should be made for our next constituency meeting in September.
4. I attended the excellent Long Service Awards presentation that was held in York at the beginning of June. A similar Long Service Awards evening takes place in Scarborough the day after our Board meeting.
5. Along with our Lead Governor I have undertaken the end of year appraisals of the Non-executive Directors, the outcome of which will be reported to Remuneration & Nomination Committee of the Council of Governors.
6. I have continued to have several "introductory" 121 I chaired meetings with senior colleagues.
7. I visited St Monica's to meet with the Chair and officers of the Friends of St Monica's. The Friends provide significant support to the hospital and its patients.

Martin Barkley

Trust Chair

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 June 2024
Subject:	Chief Executive's Report
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Simon Morritt, Chief Executive

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ A Regulatory Requirement ☐

Trust Priorities	**Board Assurance Framework**
☒ Our People ☒ Quality and Safety ☒ Elective Recovery ☒ Acute Flow	☒ Quality Standards ☒ Workforce ☒ Safety Standards ☒ Financial ☒ Performance Targets ☒ DIS Service Standards ☒ Integrated Care System

Summary of Report and Key Points to highlight:

To provide an update to the Board of Directors from the Chief Executive in relation to the Trust priorities. Key areas include: Operational performance update, industrial action, Our Voice Our Future update, infected blood inquiry, Dame Cally Palmer visit, celebrating our people, Sally Light OBE, HSJ Digital Awards, National Volunteers' Week, York Poverty Truth Commission Charter, and Star Award nominations.

Recommendation:

For the Board of Directors to note the report, and to formally support the Trust signing up to the York Poverty Truth Commission Charter.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

Board of Directors only

Meeting	**Date**	**Outcome/Recommendation**
Board of Directors	26 June 2024	

Chief Executive's Report

1. Operational performance update

I am pleased to share that steady progress continues on the elective pathways, with sustained improvement in the numbers of patients waiting of 65 and 52 weeks.

In my report last month, I shared an update that our acute and emergency services remain under significant pressure following on from a very busy April. These pressures continue with no signs of letting up. The overall number of attendances to our emergency departments and urgent treatment centres in May saw a rise of 5% on the 19,983 visits recorded during April, and 4% more than the 20,196 patients seen in May 2023.

Like the rest of the country, demand, acuity, and dependency of our patients has been increasing, which has consequently impacted on our emergency departments. Patent flow has been further impacted by an infection outbreak on the Scarborough site, resulting in bed closures.

I recognise it has been a really challenging spring; if anything, much more challenging than the winter period. I offer my heartfelt and genuine thanks to all our staff for their ongoing and sustained efforts under very challenging circumstances.

2. Industrial action

The British Medical Association (BMA) has announced further industrial action for junior doctors from 7am on Thursday 27 June to 7am on Thursday 2 July 2024.

While we are now well-rehearsed in planning for action, it will inevitably have some impact on our elective activity, as well as continuing to place additional pressure on our consultants, SAS doctors, and wider clinical workforce who are relied upon to cover services.

3. Our Voice, Our Future update

Since my last update to the Board, we have continued to make good progress with our Culture and Leadership Programme, Our Voice, Our Future.

On Monday 10 June, I met with the Change Makers in Malton to consolidate all the separate elements of the Discovery Phase, which has now ended, before we enter the 'Design Phase.'

I am grateful to everyone who took the time to provide feedback. Through the Discovery Phase, we received over 800 responses as part of the informal feedback collection from staff, Board members, senior leaders, patients to carers. The Change Makers are now reviewing all the feedback to identify which cultural elements we need to focus on to make this a place people want to work.

In addition to the longer-term cultural changes, they are also working on 'quick wins' based on the feedback they have received. I will continue to share progress on what they have achieved in my future updates to the Board.

4. Infected Blood Inquiry

Since my last update, the final report of the Infected Blood Inquiry, led by Sir Brian Langstaff KC, has been published. This independent public statutory inquiry was established to examine the circumstances in which men, women and children treated by national health services in the United Kingdom were given infected blood and infected blood products, in particular since 1970. You can read the report on the Inquiry website.

My thoughts are foremost with those patients who were given infected blood and blood products, and their families and the wider community who have been impacted.

5. Dame Cally Palmer, National Cancer Director for NHS England

Earlier this month, we welcomed Dame Cally Palmer, National Cancer Director for NHS England, to York Hospital to see the plans for the new £2.1 million Cancer Care Centre, which will officially open in 2025. Dame Cally is responsible for the implementation of the NHS Long Term Plan for Cancer, which aims to improve survival and quality of life for all those affected by cancer. She used the opportunity to meet with our teams to understand and acknowledge the improvements we have made and to understand the challenges we have. She also acknowledged the hard work of all our teams and expressed her thanks.

6. Celebrating our people

Nominations have now closed for this year's Celebration of Achievement Awards, which will take place at York Racecourse on Thursday 19 September 2024. Over 200 nominations were received from colleagues and patients, recognising the fantastic work that has been happening across the organisation over the past year.

The judging panels are deliberating as we speak, and I am looking forward to hearing all of the different stories about how our staff are working hard to make a difference. It is so important that we take the time out to celebrate and recognise all the positive things that are happening in the organisation, more so than ever when we are under pressure and circumstances are particularly challenging. Thank you to everyone who took the time to nominate.

Along the same vein, earlier this month we held the first of two long service awards for staff celebrating 25 and 40 years' service in the NHS. The awards celebrate the service, commitment, and skills of staff who have shown their loyalty to the NHS over many years.

Another long service event will take place later this month in Scarborough, for staff based on the east coast and surrounding areas.

7. Sally Light OBE, Public Governor

I am delighted to share that one of our Public Governors, Sally Light, has been awarded an OBE in the King's Birthday Honours. Sally is currently the Chief Executive of the MND Association, a charity and membership organisation serving people living with Motor Neurone Disease. She has been awarded her OBE for services to people affected by the disease.

In addition to the charity sector, Sally has 25 years of clinical and managerial experience in the NHS, including serving on the Board of Barnsley Hospital Trust. Most of her NHS career was spent working with clinical teams to improve patient experience and the way services were delivered. A truly well-deserved award.

8. HSJ Digital Awards

I am incredibly proud of our digital team, who were finalists at this year's HSJ Digital Awards in the categories of Digital Team of the Year and Enhancing Workforce Engagement, Productivity and Wellbeing through Digital. The team was nominated for the Nucleus project, which is bringing digital workflow to nursing, releasing time to patient care, and helping to get nurses home on time.

9. National Volunteers' Week, 3-6 June 2024

This year's 40th anniversary National Volunteers' Week was a perfect opportunity for us to say a heartfelt thank you to the 200+ volunteers who freely give their time in our hospitals. The contribution they make to our Trust, for our patients, and for our service users is remarkable and really helps us deliver the best care we can.

10. Adopting the York Poverty Truth Commission Charter

In my last report to the Board, I provided an update on the work of the York Poverty Truth Commission. As Chief Executive I was part of a group of people in the city who acted as civic commissioners, with the Poverty Truth Commission acting as a link between those with experience and decision makers in the area, building real relationships and real trust with a view to influencing change.

Phase 3 of the York Poverty Truth Commission process began with a successful *Celebration and Next Steps* event on 24 April 2024, which saw the launch of the Commission's Charter for Organisational Standards.

The four standards outlined in the charter are:

1. We listen.
2. We are understanding.
3. We are respectful and friendly.
4. We are responsive, honest and care about getting you the right support.

In Appendix 1 of my report there is more detail about the standards in the charter and three recommendations for the Board:

1. That the Board formally pledges its support for adopting the Charter and integrating it into our working practices
2. That the Charter, and its standards, are communicated to all staff and that they are encouraged to think about how they will adopt these practices in their particular area of work.
3. That the Trust recognises those living in poverty and their needs as part of the ongoing work related to understanding and reducing health inequalities.

I am sure Board colleagues will agree that these standards and the aims of the commission are aligned not only to our Trust values but also with our growing focus on reducing health inequalities and improving access for everyone we serve.

12. Star Award nominations

Our monthly Star Awards are an opportunity for patients or colleagues to recognise individuals or teams who have made a difference by demonstrating our values of kindness, openness, and excellence through their actions. It is fantastic to see the nominations coming in every month in such high numbers, and I know that staff are always appreciative when someone takes the time to nominate them.

June's nominees are in Appendix 2.

Date: 26 June 2024

Chief Executive's Report: APPENDIX 1:

Summary of Report:
The report provides an overview of the York Poverty Truth Commission work to date, and the launch of the Charter, with the recommendation that the Trust formally adopts the Charter into its working practices.

Recommendations:

1. That the Board formally pledges its support for adopting the Charter and integrating it into our working practices
2. That the Charter, and its standards, are communicated to all staff and that they are encouraged to think about how they will adopt these practices in their particular area of work.
3. That the Trust recognises those living in poverty and their needs as part of the ongoing work related to understanding and reducing health inequalities.

Report Exempt from Public Disclosure
No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

Report History Board of Directors only		
Meeting	**Date**	**Outcome/Recommendation**
Board of Directors	26 June 2024	

Chief Executive's Report: APPENDIX 1

Adopting the York Poverty Truth Commission Charter

The York Poverty Truth Commission was established in March 2023.

A Poverty Truth Commission begins by putting those with direct experience of poverty first, asking them to share their knowledge about what is truly needed to make change.

It acts as a vital link between those with experience and decision makers in the area, building real relationships and real trust with a view to influencing change.

Phase 3 of the York Poverty Truth Commission process is now underway, and began with a successful Celebration and Next Steps event on 24 April 2024, which saw the launch of the Commission's Charter for Organisational Standards.

The four standards outlined in the charter are:

1. **We listen:**

- Ensure that feedback systems are varied and accessible
- Openly and constructively engage with the feedback you receive
- Explore ways to involve people with experience of poverty in your employee and service reviews
- Establish feedback as a top three indicator of success
- Establish ways to proactively involve and listen to people who have experienced poverty as part of your decision making processes, where those decisions are likely to impact people living in poverty
- Understand a person's situation and respond in a supportive and proportionate way if the person appears stressed, frustrated or anxious
- Ensure you have processes in place that allow other people to speak on a person's behalf

2. **We are understanding**:

- Ensure you are not making assumptions about individuals or their situation at the start of your interactions
- Take time to really listen to a person and understand their unique situation
- Frequently check you are correctly understanding what you are being told by asking questions (it may help to explain why you are doing this so it doesn't appear as though you are interrogating the person or trying to trip them up)
- At the end of your interactions, check if people felt understood and whether you have responded to their needs
- Support everyone in your organisation to attend training or experiences that will help to improve their understanding of poverty

3. **We are respectful and friendly:**

- Although approaches should be responsive to the personal and cultural preferences of individuals, it is likely that being respectful and friendly would include:
    - Introducing yourself
    - Making eye contact
    - Smiling
    - Using good manners
    - Adopting an appropriate and friendly tone of voice
    - Being conscious of what we say, how we say it, the words we use and the impact that these may have on people
    - Asking if it's ok to make notes while speaking to a person

4. **We are responsive, honest and care about getting you the right support:**

- Adopt an empowering and engaging approach in your interactions, with an emphasis on helping people to find solutions that are right for them and their circumstances
- Ensure your teams have the skills and capability to make decisions and resolve the issues people need help with
- Empower colleagues to use their discretion to give people the support they need and find solutions
- Recruit, train and support colleagues so that they have both the right skills and the right values

- Acknowledge when you don’t understand or have made a mistake
- Be open about what you can and can’t do. If you can’t so something explain the reasons why, and where possible, help the person identify someone who can help
- Ensure you leave people with appropriate contact details at the end of your interaction

As one of the initial civic commissioners of the York Poverty Trust Commission, I am recommending to the Board that we publicly pledge to adopt and integrate this Charter into our working practises.

These standards and the aims of the commission are aligned not only to our Trust values but also with our growing focus on reducing health inequalities and improving access for everyone we serve.

Recommendations:

1. That the Board formally pledges its support for adopting the Charter and integrating it into our working practices

2. That the Charter, and its standards, are communicated to all staff and that they are encouraged to think about how they will adopt these practices in their particular area of work.

3. That the Trust recognises those living in poverty and their needs as part of the ongoing work related to understanding and reducing health inequalities.

You can read the full document [here].

Date: 26 June 2024

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

June 2024

Gavin Lawrence, HR Business Partner | **York** | **Nominated by colleague**

Gav has been a really valued member of the team, providing expert and consistent advice relating to all HR matters. He always demonstrates the Trust values, being approachable, kind, and willing to provide open and reliable advice. His contribution has been highly regarded, and we wish him well in his future endeavours.

Linda Flint, Staff Nurse **York** **Nominated by patient (1) and colleague (2)**

(1) My partner and I sadly experienced a miscarriage earlier this year. Following our current pregnancy, we had to attend the EPU again last week and are currently waiting on news of a potential second miscarriage. As you can imagine having to visit the EPU again so soon after our first miscarriage was a very traumatic experience, and finding out we would have a further two weeks wait is horrendous.

However, I'd like to commemorate Linda for her care whilst we visited. She was patient and empathetic and showed so much care to myself and my partner, taking time to answer all the questions we had and make us feel as comfortable as we could at such a hard time. From the moment we stepped into a side room with her she was just amazing, and she really did make things that little bit easier for us. I really feel she went above and beyond and was made for the job she does, my partner and I agreed she was outstanding in her role. Thank you.

(2) Linda has been supremely supportive of me since I started working in Women's Unit last year. It is my first job as a newly qualified nurse and she has been patient and generous with her time, explaining things and showing where things are while I got familiar with my work area. She is kind and approachable. Recently we were both having extremely busy shifts in different areas of the same unit; Linda still came and helped me when I was struggling. She has been instrumental in me transitioning to a more confident nurse.

Laura Barley, Directorate Secretary **York** **Nominated by colleague**

I would like to nominate Laura for a Star Award as over the last six months she has been continuing to do her own role in York and has also been doing work for our Scarborough colleagues while the secretary role there has been vacant. She has taken all the extra work on without complaint and has still time to help anyone who asks. We now have a new person in the post at Scarborough and, once again, Laura has taken on additional work by helping to write up 'how to guides' for lots of the processes and is taking the lead with training our new starter up. I know she will be a huge support to our new starter as she finds her way in the new role over the next few months. Laura has only been on the team for a couple of years, but quickly became an invaluable member of the department. We are very lucky to have her! Thank you, Laura, for everything you do.

Thomas Antonyraj, Clinical Support Worker **York** **Nominated by colleague**

Thomas is an excellent team member and has been a huge help on busy shifts. While I have never worked with him on the same team, he goes above and beyond his role and responsibilities. I have requested his help many times when I've been on acute medicine shifts, and he is always eager to insert cannulas and take blood samples. This has given us valuable time to either manage new admissions or facilitate discharges.

I can think of a specific example on a night where we had a septic patient on IV antibiotics in AMU. We were heavily short-staffed doctor-wise and would have had to abandon admission in ED to insert a tissued cannula for the patient to get their time-critical medication. Fortunately, Thomas was around and volunteered to do it, and did it quickly on the top of his work for that night. Overall, Thomas is an excellent worker with a bright attitude and holistic approach to care, always carrying his work to completion. He goes to extents many other people in his place don't go to. That is why I believe he deserves to be recognized for his hard work, which often goes unnoticed in the background. It is something he has absolutely earned.

Haldane Ward	**Scarborough**	**Nominated by patient**

I attended Haldane Ward for surgery. The staff on the ward, in theatres, the anaesthetist, the ODP, the scrub nurse, the PACU nurse, and all the ward staff were amazing. The ward was very welcoming, the care and support was second to none, and I felt comfortable and well looked after. It was lovely having my own room with a TV and I felt completely safe. I just wanted to thank them and I would recommend them to family and friends.

Selby Community Response Team	**Selby**	**Nominated by colleague (on behalf of a relative)**

The team recently received some lovely feedback from a patient and his wife:

"I would like to thank everybody in the Selby Community Response Team who have come to our aid when my husband came out of hospital. You have all been fantastic; from the nurses that have visited and have been so patient and understanding, to Ashley, the physiotherapist, who has come and the occupational therapist who advised on what aids we should have to make my husband's life easier. Frankly, I do not know what I would have done without all your support. Life would have become overwhelming. Thank you all from the bottom of my heart. I did not know such caring help in the community was available. The Selby team are amazing. Thank you again."

Thank you to the whole team; this just shows what wonderful wraparound care the community response teams offer to every patient. Collective and collaborative care at its best.

Helen Pickard, Outpatient Services Administrator **York** **Nominated by relative**

I must put in writing my gratitude, praise, respect, and utter admiration for Helen Pickard for her compassion, professionalism, 1000% (yes, I do mean 1000) customer service. and determination to reach a resolution to my distressing situation. She was fantastic and a great role model for the NHS. I was extremely lucky that she answered my call today, although she might not have felt the same. She had to deal with a blubbering, stressed out, frustrated person who had been struggling to contact anyone who might be able to help me. I explained to her, through my tears, that I had been calling but had not been able to get hold of anyone who could help. I was frustrated and distressed as my husband had been booked in for an incorrect appointment and I could not get through to anyone to have this corrected. That was until I spoke to Helen. She gave me time to compose myself and was very reassuring, she listened and understood the problem and fully appreciated the importance and urgency of having the correct appointment booked. She promised to contact a medical secretary who could help on my behalf and to call me as soon as possible to update me.

Helen held true to her promise and called me back after having contacted the necessary people and she booked the new appointment whilst she was on the phone with me. I could not have asked for more and my husband and I are so incredibly grateful for the help she gave me today. Thank you, from one very relieved person who will hopefully sleep better tonight knowing my husband has the correct appointment.

Operating Department Practitioners and Anaesthetic Nurses

York

Nominated by colleague

At York Hospital, the surgical and anaesthetic support is provided by Operating Department Practitioners (ODP) and anaesthetic nurses who cover routine and emergency treatment for all age groups and all specialities 24/7. They are highly skilled members of the resuscitation, anaesthetic, recovery, and surgical teams, supporting patients in complex life-changing environments. They also provide a vascular access service, perform research, teach, administer vaccines, and supply ambulance transfer of the critically ill. The team work hard and play harder; through annual team building exercises we have raised the profile of organ donation, pancreatic cancer, and Parkinson's disease, and raised thousands for charities for orphans and the disabled, Veterans in Need, Help the Heroes, and our colleagues in the Yorkshire Air Ambulance.

I honestly cannot express within the limits of this description all the attributes that the ODP Team possesses to qualify for this nomination. To describe the team, the words that I would include would be intelligence, vision, tact, responsibility, caring, respect, humility, commitment, dedication, humour, honesty, integrity, empathy, transparency, hard work, resiliency, decisiveness, diplomacy, and great leadership. If you want to see Trust values in action, look no further.

Macmillan Palliative Care	**Scarborough**	**Nominated by relative**

The Macmillan team deserve this award. It takes a very special person and team to do what they do. The care and compassion they showed to my partner and his family, in the very short time he was in their care, was truly touching. Lucy and the team with their kindness and understanding made his fear and anxiety of being in hospital more bearable. Even making his last wish possible when they arranged for his four-legged friend to be allowed to visit to say their goodbyes. We will always be grateful to the Macmillan team and ward staff for making his last few days as good as they could be, for him and for us.

Lisa Wright, Ward Sister	**York**	**Nominated by colleague**

Since Lisa joined the Day Unit as the ward sister, she has gone above and beyond to make sure the patients' care is always excellent. She is so kind, caring, and compassionate with staff and patients. She makes everyone feel welcome and supported. Keep up all the hard work and keep being the star you truly are.

Claudius George, CT1-CT2	**Scarborough**	**Nominated by patient**

After falling downstairs and arriving at ED, Dr Claudius treated me. He was so kind and thorough in the tests he carried out, arranging scans which uncovered fractured vertebrae. Despite being very busy with lots of other patients, Dr Claudius wanted to make sure he had explored every aspect of this injury. He gave me feedback following the scan which I understood and took time to explain what I needed to do. I felt very reassured by Dr Claudius and his professionalism. I felt grateful that he communicated honestly. Thank you, Dr Claudius, we really appreciated all your efforts on that very stressful day.

Bridlington Catering Team | **Bridlington** | **Nominated by colleague**

Patients are often on Johnson ward, receiving rehabilitation, for many weeks after they have had a stroke. In some cases, the stroke causes swallowing difficulties and the patients are unable to eat normal diet options. Speech and Language Therapy (SLT) work with patients to help them to get back to normal diet as soon as possible, but this can still mean having a repetitive menu of modified food choices for prolonged periods, often leading to patients enjoying their meals less and consequently eating less. I am nominating Ken and the catering team for a Star Award because they always pay attention to the SLT recommendations for our patients' meals, try to support increased patient choice, and are super supportive of the SLT team's work.

There are many examples of ways in which the Bridlington catering team are fantastic, some of these include when SLT have been able to upgrade a patient to a less-modified diet option, Ken and his team are agile in their response, providing the patient with the new menu choices quickly, sometimes even by teatime the same day. We recently identified a potential issue with one of the modified pudding options that had been delivered, and Ken was quick to volunteer to make additional flavours of "whip" puddings on-site, so that the patients would not be affected by having further reduced menu options. As patients' swallowing improves, SLT assess safety on normal diet, and recently Ken and the team supported a breakfast assessment by preparing a patient's special request of egg on toast - a meal that the patient had been dreaming of having since his admission weeks before, when he had been nil by mouth with an NG tube to manage all hydration and nutrition. The patient was absolutely thrilled to have this meal, a lovely example of the power of person-centred care. Ken has even been known to personally bring bananas to the ward for SLT to use in assessment when they have been delivered late in the day.

Eating and drinking have such an enormous role in patients' quality of life, as well as supporting healing, maintaining skin integrity, and giving energy to engage in therapies. The support of a catering team like ours at Bridlington is invaluable in improving patients' experiences and outcomes as they and their families navigate a difficult period. I love that I get to work with this team!

Neck of Femur Committee | **York** | **Nominated by colleague**

The Neck of Femur (NOF) team go above and beyond to provide patient-tailored care when delivering their service. The patient-centred focus includes the holistic review of patients, tailoring treatment to patients' dietary requirements, and tailoring nutritional supplements to patients' palate, lifestyle (use of alternative medicines and physical lifestyles) and physical needs. The NOF committee have a strong devotion to improving patient outcomes with evidenced focus on reducing hospital admission duration. This in in part due to the dedication to research and development in developing guidelines such as a pioneering vitamin D policy, bringing the NOF treatment algorithm in line with advanced tertiary centres and using relevant recent research and guidance. The team undertake a thorough bone health history and consider all physical factors to provide the most appropriate bone health treatments to reduce future bone health injuries.

The team's dedication to NOF and patients is clearly illustrated through their passion for education and training, each member of the NOF team can, without hesitation, provide insight, advice, and education on a range of NOF specific and general medical or surgical queries. This teaching has always been delivered to me in a non-judgemental and thorough manner. This learning has been highly beneficial to me, and I'm confident many other members of staff who have rotated through this ward too. Even in the context of a very active ward they have taken the time to furnish me with educational and developmental opportunities. From working with this team and patients, I have witnessed how true multi-disciplinary teamworking and patient-centred care on a busy NHS scale is possible. This team, led by Dr Watt, Jan, and Sophie, reflect the Trust values in their work and behaviours and for this reason are deserving of a Star Award. The NOF team are incredibly friendly, welcoming, and, above, all the epitome of an excellent team.

Joe James, Healthcare Assistant	**York**	**Nominated by colleague**

I would like to nominate Joe for a star award for several reasons. First, Joe has a great way of brightening up everyone's day; whether it be the patients that often remember and ask after him or his colleagues. He is a great colleague to have because he not only makes shifts a lot more fun, but he will always help you with anything, and always with a smile. He also has your back and will support you and help if he notices that you are not having the best day. He is very knowledgeable and is always happy to share his knowledge with his colleagues. Joe also deserves a Star Award for all the extra things that he does behind the scenes that help the stadium clinic to run smoothly. Thank you, Joe.

Michelle Weighell, Cleaning and Catering Operative	**Scarborough**	**Nominated by colleague**

Michelle has been our domestic for quite some time now, and always maintains a high standard. Recently Michelle has achieved 100% on the audits (which is awesome) and all the staff on the Women's Unit feel privileged to work on such a clean unit. This is all down to Michelle, her hard work, and attention to detail. Thank you, Michelle, we all really appreciate your hard work.

Rebekah McKeown, York Student Midwife

Nominated by colleague

Rebekah provided continuity of care to a labouring woman during a night shift, seamlessly transitioning her from the antenatal ward to the labour ward. She delivered individualised care, advocated for her patient, and supported her in receiving an epidural. Rebekah effectively supported both the patient and the birthing partner, while ensuring patient safety throughout the process. She communicated efficiently with all members of the multidisciplinary team, adapting her approach to meet the patient's unique needs and preferences.

During moments when the patient became anxious and frightened, Rebekah employed various calming techniques and offered continuous reassurance, demonstrating her ability to maintain composure and provide emotional support under pressure. Her dedication to patient-centred care was evident in her meticulous attention to detail and her empathetic, compassionate approach. Rebekah's ability to multitask and manage complex situations was exemplary. She maintained a calm and professional demeanour, even during the most challenging moments of labour. Her proactive approach and quick decision-making skills contributed to a positive birthing experience for the patient. In addition to her clinical skills, Rebekah's interpersonal skills fostered a trusting and supportive environment for both the patient and her birthing partner. She demonstrated a deep understanding of the emotional and physical demands of childbirth, providing holistic care that encompassed both medical and emotional support.

Rebekah will undoubtedly make an excellent midwife, and I sincerely hope we can retain her within York. Her dedication, skill, and compassionate care make her a true asset to our team, and I am confident she will continue to positively impact the lives of many families.

Claire Grover, Fracture Clinic Manager	**Scarborough**	**Nominated by colleague**

Claire has single handedly organised the fracture and elective orthopaedic clinics in Scarborough. Her care for our patients is inspiring, her attention to detail is impressive, and her organisational skills are outstanding. She has helped staff to improve their skills and take on more responsibilities. She also keeps us consultants in line. She has also found time to be the principal investigator in a multi-centred clinical trial in fracture management. I look forward to my fracture clinics.

Sara Goldsmith, Ophthalmic Photographer	**York**	**Nominated by colleague**

A young child on my caseload required imaging of the back of his eye due to severe sight loss. He has significant speech and communication delay and has become increasingly anxious about hospital appointments. Sara took the time, over multiple appointments, to get the child used to the camera equipment and make him feel comfortable, allowing for breaks for snacks, play time, etc. The equipment can be challenging for children in general, requiring them to sit still, put their head against a large, noisy machine, and look at a flashing light in a darkened room. Throughout his appointments Sara reassured the child and his mother.

Sara liaised with me so we could ensure we were both in clinic at the same time to allow the child, and his mother, to always be met by familiar faces. Sara successfully obtained excellent images across the multiple appointments which have helped negate the need for the child to undergo an examination under general anaesthetic. The child's mother praised Sara's kind and patient attitude. Sara demonstrated all the Trust values and helped create a positive experience for the child and his family. She is a credit to the photography team.

Michelle Wright, Midwife | **Scarborough** | **Nominated by colleague (1) and colleague (2)**

(1) Michelle had a busy night shift and left a busy ward late off her shift. Michelle was concerned for her colleagues as she knew the day would be busy and short staffed. She went out of her way to go to the supermarket to buy treats for her colleagues and brought them back to Scarborough Hospital despite then having to drive home to the other side of Hull after a busy night.

Michelle always puts her colleagues first, always has a positive attitude despite the current pressures on the unit, and always welcomes everyone with a smile. The world needs more Michelle's and the whole team is so grateful for her. Thanks, Michelle, you are amazing.

(2) The day staff had arrived and it was an extremely busy day as Labour Ward was full. Michelle had finished her busy night shift but she had gone after shift to get everyone working that day chocolates and sweets to bring morale up. Michelle is very lovely and thoughtful of her colleagues.

Emma Redford, Maternity Support Worker | **Selby** | **Nominated by colleague**

Emma is one of the most supportive and influential professionals I have ever had the pleasure of working with. She goes above and beyond to support the Selby midwifery team, managing our office, our stock, our admin, as well as supporting countless families in our large community area. Emma single-handedly provides specialist breastfeeding workshops for women in the Selby area, and then continues to support each of them with their feeding journeys when baby has arrived. Without Emma, we as a team feel we could not manage as well as we do, and the women of Selby would be deprived of one of the most passionate and hardworking support workers who has ever existed. Thank you, Emma, for everything you do, going above and beyond for all of us and our community.

Becky McClelland, Deputy Sister **York** **Nominated by colleague**

Becky works as an experienced deputy sister on the Special Care Baby Unit (SCBU) and volunteers to chair the local SCBU parent support group for local families. This support group has achieved a huge amount to generate funding and by providing practical and emotional support to many of the families of the 10% of all newborn babies that require some additional medical support on SCBU.

Over the last year, Becky has worked on researching information on any additional sources of financial support that can be accessed by families with financial pressures. She has put this information into patient-accessible leaflets and a clear poster to signpost families to extra support they may be entitled to access. Families can learn about all available benefits very quickly without having to do their own searches. She has also gained agreement to some direct funding support to help families with travel and living costs. We have already seen many families benefit from this clear communication and the support group's actions on financial hardship. Becky has driven this change and taken time to create and print engaging resources. She has worked alongside the Trust Finance department who have been helpful with this project. This is work that has gone on in the background and few people will be aware Becky has managed this.

Francisco Raposo, Charge Nurse **York** **Nominated by colleague**

Francisco delivered a patient to PACU. Seeing frazzled nurses managing two patients each, he took charge, initiating recovery himself to lighten their load.

Lynsey Duck, Nursing Band 7, Jemma Cropley, Nursing Band 7, and Katie Neale

York

Nominated by colleague

I would like to nominate these three individuals as a management team. I have many problems this past year and could have easily had a breakdown. However, I have felt fully supported in the workplace in spite going through very difficult times. The team have been there for me at every point and have kept me in the workplace. I cannot thank them enough for their ongoing support. If you ever want a leader, these are the best.

Niamh Danby, Acute Oncology CNS | **Scarborough** | **Nominated by colleague**

Niamh has shown the utmost care, compassion, and support for a patient whose cancer is progressing and is struggling to come to terms with this devastating news and the uncertainty of what the future holds. Niamh acted in the most professional and caring way providing the patient with comfort and support after their recent scan showed their cancer was progressing and they may not be able to have further chemo. The patient built a relationship with Niamh and felt safe, comfortable, and reassured in her care. Niamh always made sure to keep the patient up to date with plans as this was important to the patient. Niamh ensured all the relevant tests and investigations were performed quickly to minimize further stress and anxiety for the patient and tried to improve their condition. She reviewed the patient regularly in clinic and via phone calls daily to monitor their condition and provide support and reassurance to help get them through a very difficult and uncertain time.

From the little hand holds to the big hugs, Niamh was always there for them, either via phone call daily or face-to-face in clinic, Niamh gave her time and attention without the compromise of other patients' needs and care. Niamh really has gone above and beyond what is expected of her to ensure this patient had the care, support, and compassion to help get them through an uncertain and difficult time in their cancer journey; to which the patient expressed her immense gratitude for Niamh's care and support during a very difficult and upsetting time.

Gemma Messruther, Ophthalmic Imaging Technician	**Scarborough**	**Nominated by patient**

I attended the eye clinic at Scarborough Hospital following a referral from my optician. I was unclear on the process, but I was greeted by Gemma at the eye clinic. From the onset Gemma showed the utmost care, compassion, and reassurance to support me. Gemma advised me to go for a hot drink while she explored my referral and found the next steps. Gemma then came to find me in the coffee shop with an update and gave clear information on what I needed to do. This resulted in me been seen in the clinic that day. Gemma's professionalism and communication was outstanding, and at a time of high anxiety she was able to reassure and find solutions. I cannot thank Gemma enough for the way she went above and beyond to help me and ensure such a positive experience. She is a role model to her profession and the hospital should be proud to have staff like her.

Lilac Ward	**Scarborough**	**Nominated by relative**

My son was recently admitted to Lilac Ward and was extremely anxious about the whole experience having never been in hospital before. Jade really helped to put his mind at ease with her caring and professional manner despite what looked like a very busy day on the ward. The Deputy Sister, Charlotte, could also see how anxious my son was and offered for one of us to stay all day and night if needed as she knew that he needed to stay in for IV antibiotics or he would get worse. Charlotte and Jade are only two of names to mention but the whole of Lilac Ward staff have been amazing, and you can see they go above and beyond for their patients.

Donna O'Neill, Senior Operating Department Practitioner	**York**	**Nominated by patient**

I had a PICC line insertion prior to starting a 12-week course of chemotherapy treatments. As I suffer from needle phobia, this appointment was my dominant worry, way surpassing my concerns about the chemotherapy treatment. I told Donna about this while going through the consent procedure. She paused the consent process and really listened to my concerns. She explained that in her 35 years of experience she has had many patients with similar fears. She allayed my anxiety by listening and dealing in order with the issues I was frightened of, namely: needles, bleeding, feeling the line progressing through my body, and being so tense as to increase the pain of the procedure. Her reassuring and friendly manner very much calmed me down and the honesty of saying the only thing she could not stop was the stinging from the local anaesthetic injection really helped.

Once I had stopped shaking, she encouraged me to choose which background music we would listen to during the procedure and only then continued with the consent forms. At no point did I feel as if things were rushed or as if I was wasting her valuable time. The benefit to me and my needle phobia was that I was far less terrified when an hour later I had a three-minute Herceptin injection. The experience with Donna has allayed fears about needles I have suffered with for more than 40 years.

Lottie Gilham, Pre-registered Nurse	**Scarborough**	**Nominated by patient**

I have met Lottie several times over the many years that I have been in and out of hospital. She always has a smile on her face and is very friendly. Over the years she has treated me with the upmost care. Nothing is too much trouble for her and if I had a problem or needed certain treatment she always went above and beyond to try and help me. She is one in a million.

Abigail Wilson, Midwife **York** **Nominated by relative**

Abs is a total star and more than deserving of multiple awards for the exceptional care she provided for myself and family! Abs is the midwife who delivered our second child and from the moment we arrived we were made to feel supported, welcomed, and like there was no better place for us to be. The professionalism combined with world class people skills that Abs demonstrated was amongst the best I have experienced in all settings and topping the list for a medical setting.

The atmosphere created to bring our child into the world was really special, the attention and support was well above anything I expected, and we all feel genuinely lucky to have been Abs' patient. All the staff are awesome and deserve praise, but Abs needs a plaque and a picture on the wall please! Thank you, Abs and York Hospital, for all you have done for my family.

Hester Baverstock, Specialty Registrar **York** **Nominated by colleague**

As president of the doctors' mess, Hester took proactive steps to foster an inclusive and safe environment for all doctors in the hospital. The doctors' community in York is diverse and includes numerous ethnicities and nationalities and through her leadership of the mess, Hester successfully created an environment that lends itself to a sense of community and celebrates our diversity.

Lisa Hamilton, Senior Manager, Joanne Blackman, Retinal Eye Screener, and Samantha Hadaway, Retinal Screening Administrator	**Community**	**Nominated by colleague**

Joanne arrived at a GP surgery to carry out her screening clinic. The surgery had overbooked their rooms and there was no space for Joanne to screen her patients. Rather than cancel her clinic and leave a full clinic of patients unscreened, Joanne rang the office and made them aware. Lisa and Sam then banded together and contacted Selby Hospital as the nearest alternative screening venue and secured a room for that morning. Sam contacted the patients from the clinic list and apologised for the change and directed them to the new venue. A practice nurse allowed Joanne access to her room before her clinic started so she quickly unpacked her equipment and carried out the appointments for the patients who had already arrived. Joanne then repacked her equipment, loaded up the van and drove across to Selby Hospital where she then unpacked again and managed to continue screening the rest of her patients.

The three of them went above and beyond to ensure that patients were not cancelled and still received their important screening appointment. They remained calm and professional in a highly stressful situation and Joanne continued to provide first class care to the patients she screened.

Catherine Williamson, Advanced Specialist Practitioner	**Community Stadium**	**Nominated by colleague**

Cath is always approachable, dedicated, and diligent. As a professional manager, she ensures that her staff are well supported and shows great care and compassion. Alongside her managerial duties, she also works on the floor whenever there are staff shortages. We are all lucky and proud to have her as our manager.

Pauline Clark, Healthcare Assistant	**Nelsons Court**	**Nominated by colleague**

Pauline is a hard worker and demonstrates compassionate care in all the jobs she does. Pauline goes above and beyond in caring for the patients at Nelsons Court, she always has a smile on her face, and she cheers staff and patients up, even if she is having a bad day. Pauline will help any member of staff with anything that need and personally has helped me.

Sara Punshon, Occupational Therapist	**Scarborough**	**Nominated by colleague**

I would like to nominate Sara for a Star Award as she is very helpful and very friendly. She goes above and beyond to help anyone and very supportive to every member of staff she meets. She is very helpful to all relatives and makes sure they are happy and confident to accept their relatives back home after discharge. She has fitted in to the hospital very well after been in post for only nine months. Sara is approachable and friendly to everyone she meets and I want her to know she is appreciated.

Terri Sloan, Midwife | **Scarborough** | **Nominated by patient**

It has taken me almost three months to write this nomination, as the road to recovery has been long, plus settling into life with a newborn, so this nomination may seem out of the blue. I want Terri to know that the intent to write this nomination has been the plan from day one, as I truly believe that she deserves so much credit and recognition for the amazing job she does.

First, I want it to be known that all the midwives, doctors, and nurses that work on the Maternity Unit of Scarborough Hospital are so kind and caring and go above and beyond. Everyone who looked after us did a fantastic job and deserves so much praise for what they do. However, this nomination is for Terri Sloan in particular, as she was the midwife who was mainly responsible for my delivery and postpartum care, and who truly went above and beyond to look after me, my daughter, and my partner.

I will be forever grateful for Terri and I will honestly never forget the care and compassion she showed me. Our birth was far from straight forward, there was many complications with me and the delivery of my daughter, which resulted in me developing pre-eclampsia and having an emergency c-section. Terri was by my side through all of it; she was there to reassure me, give me positive words of encouragement and praise, and give me empathy and compassion when I needed it. She explained everything to me in a way that made me feel so comfortable at such a scary time with my health and my baby's health.

Terri returned the evening after I had delivered my baby, made sure I rested and recovered, looked after my baby all night. She sang to her, comforted her when she needed comforting, fed her, changed her, and looked after me all the while, putting her own needs at the back of the priority order to make sure we had everything we needed to be comfortable. Even though she was looking after my baby until I was well enough to do so myself, she taught me what I needed to do. Even when I felt like a failure, Terri was the one who made me appreciate the journey we had been on and made sure I didn't feel low or like a failure. She lifted me up and made sure I had everything I needed to be able to give my baby the best start in life.

I will never forget Terri. She has made a huge impact on my life. The way she cares and loves her job, even through the tough times, puts everyone else's needs above her own, works long hours, and still manages to have a smile on her face and put a smile on my face is commendable. I just want Terri to know how grateful I am and always will be for her care and support. I truly hope that if I have another baby in the future, Terri is still doing what she does best and I get the privilege to call her my midwife. Thank you so much.

Eye Clinic Team	**Bridlington**	**Nominated by colleague**

I want to nominate the team for their amazing can-do attitude and for always putting patients first. They are great team who receive many compliments from the patients about how they put them at ease and, although many of the patients dread their treatment, the staff are always so caring, making it as bearable as can be.

Last week the staff went above and beyond. There was an IT issue in Bridlington Hospital with many areas of the hospital having no access to phones, computers, or CPD. In the eye clinic, we were lucky to have three computers that still had IT access, but the main scanner and none of the doctors' rooms had access to CPD. By the time the computer issues were realised many of the patients had already arrived. Rather than cancel the clinic, the staff worked together to come up with a solution and reversed the flow of the clinic, moving all the equipment between the clinic rooms so that the scanner could be connected to the network and the doctors could see the scan results and access CPD. To help with clinic flow, they made temporary signs for all the clinic doors to help identification of the new role of the rooms.

Without this versatility and positive attitude, a whole clinic would have had to be cancelled, but, as it was, it all ran smoothly and everyone was seen on time. The patients were all impressed that, apart from going around the clinic the' wrong way', everything carried on. I wanted to nominate the team as it was great display of Trust values and using their initiative to get the job done!

Emma Hunter, Specialist Nurse	**Sexual Health Clinic York**	**Nominated by relative**

Emma recently treated a relative of mine with such care and understanding. She was so compassionate and non-judgemental and provided such a relaxed approach to quite a sensitive situation. My relative was made to feel comfortable and this helped with answering difficult questions. My relative was so appreciative of how she was cared for and I saw at first-hand how this approach impacted them.

Medicines management assistants	**York**	**Nominated by colleague**

I feel as though the medicines management assistants have been working very hard over the last few months with some changes to management and new members of the team coming in. They have always been taking initiative when working on the wards. Well done guys!

Vijay Joshi, Service Manager	**York**	**Nominated by colleagues**

Vijay has worked tirelessly since he came into post two years ago and has always gone above and beyond within the general surgery department. Vijay is Service Manager for the secretaries within breast, vascular, and urology, and cares about our wellbeing and has been very supportive with all staff who have had work and personal issues. He is always there to offer guidance and lend an ear when help is needed within the service. He is a well-respected, kind, and caring manager who is well liked and very approachable. He is moving on to pastures new within the hospital and will be sorely missed.

SHYPS Biochemistry team | **Cross-site** | **Nominated by colleague**

The Biomedical Science Team in York Biochemistry were recently forced to deal with a catastrophic equipment failure which left them without the ability to analyse a large number of tests, including time critical tests like troponin and hCG. The team in York remained calm, notified clinical teams about the issue, and, with the help of the medical laboratory assistants in specimen reception, arranged for samples to be referred over to Scarborough laboratory for testing to ensure the service could be maintained with as minimal impact on turnaround times as possible. Staff at our Scarborough laboratory were amazing in coping with the extra workload of samples, with staff working extra hours to help support the team in York and the patients waiting for the results. Even when the immediate issue was fixed, staff within the lab at York worked extra hard, including staff volunteering for overtime, for the next two days to catch up with the backlog of samples and ensure no patient samples missed testing.

The way in which this issue was dealt with highlights the team approach and mentality adopted across the Trust by the Biochemistry team and how dedicated lab staff are in maintaining a laboratory service for all our patients in the Trust, GP practices, and across the local area. The very limited number of queries the service received during this period is probably the best measure of how well the teams enacted their business continuity plans and communicated the issues to service users.

There was also great dedication and teamwork from our transport colleagues within the Trust and at Bloodfast who provided additional and urgent blue light runs for the critical samples. I would also thank our analyser manufacturer Roche, who had engineers on site and parts replaced as quickly as possible, and already agreed to pick up the bill for the extra transport costs. Given it was "National Biomedical Science Day" this week, and terrible impact the cyber-attack at one of the pathology laboratories in London has had and continues to have, I think it a great to recognise how hard the whole team worked to avoid serious impact to service delivery and patient care.

Wendy Oliver, Deputy Sister | **York** | **Nominated by colleague**

Wendy is such a compassionate and supportive colleague and I always feel reassured when working with her. She always has time to help and answer any questions. She is there as a listening ear and will always try her utmost to help and guide you when needed. Both staff and patients comment on how great she is, and she really goes above and beyond for others. Wendy does not hesitate to give you a hand during busy periods, and I can ask her about anything, no matter how big or small. I know that not only myself, but others as well, really appreciate her wisdom and guidance, and always feel so supported working alongside her.

Julie Tiley, Healthcare Assistant | **Scarborough** | **Nominated by colleague**

During a very busy night shift on the unit of CCU following a cardiac arrest, Jules was more than happy to help with cleaning down the equipment and restocking the crash trolley alongside a staff nurse. When noticing how busy we were, no request was too much. The teamwork she showed during the shift was remarkable and I am forever grateful for the hard work she put in that night shift. Thanks Jules, you really went above and beyond!

Hannah Taylor, Healthcare Assistant | **Scarborough** | **Nominated by colleague (1) and colleague (2)**

(1) Hannah demonstrates an incredibly high level of professionalism and deliverance of patient care with every shift she works. Her passion about delivering high levels of patient care and her organically excellent communication skills perfectly illustrate the underpinning values of York and Scarborough Trust. Hannah has no hesitation when it comes to going the extra mile for patients to ensure their attendance to the Emergency Department is as stress free as possible.

Recently Hannah has demonstrated an increased awareness of unwell and/or deteriorating patients and on several occasions has escalated care appropriately in a timely and professional manner. Finally, Hannah has demonstrated excellent emotional fortitude following the death of a patient that for a time was partly under her care, returning to work and continuing to deliver the exceptionally high standards she is accustomed to.

(2) Hannah was caring for a young woman who was admitted to ED with her newborn baby. The patient was breastfeeding and concerned about losing her milk supply as she felt too unwell to breastfeed. The patient's observations stayed stable throughout the afternoon but Hannah had a gut feeling that the patient was deteriorating, was seriously unwell and escalated until a consultant reviewed the patient. The patient was subsequently moved to resus but later sadly died.

Hannah went beyond to ensure that the patient received the appropriate care and followed her gut instincts rather than relying on the patient's observations to show deterioration.

Sarah Hillery, Advanced Surgical Care Practitioner	**York**	**Nominated by patient**

During my visit to York Day Surgery Unit, Sarah Hillery efficiently resolved a prescription issue in a professional manner, and I was both reassured and grateful for this. The kindness which I was afforded throughout my visit deserves to be recognised. Taking the time to ask after my welfare as she showed me out of the ward was a small gesture which I will not forget. Thank you!

Tilli Geaves, Healthcare Assistant	**Scarborough**	**Nominated by colleague**

Tilli has worked in her first job in the hospital in ED for two months and she is brilliant. Tilli works so hard and is always busy, normally completing tasks before I have even had chance to ask anything. She is always willing to help anyone, all with a smile on her face. I just wanted to say thank you for her hard work and, considering she has only been here for two months, she has taken to it like she's been here for a lot longer.

John Mensah, Consultant	**Scarborough**	**Nominated by colleague**

Dr Mensah is my educational supervisor and has gone above and beyond to make me feel settled within Scarborough, both in the hospital and in general. From helping me at work, to making recommendations and helping me with things outside of work. He has met with me regularly when I have had difficulty and has been very supportive.

Queen Ojo Ojo, Healthcare Assistant **York** **Nominated by colleague**

Queen always works following the Trust values and treats every person she meets with respect, dignity, and compassion. Nothing is too much to ask of her; she always go the extra mile to ensure patients' needs are met and their rights and choices are respected. She is a true example of displaying what the NHS values are and always puts a smile on the face of everyone she meets, from patients to patients' families and colleagues. We are so lucky to have you as part of our team, Queen.

Rachael Bealey, Team Leader - Diabetes Specialist Nurse **York** **Nominated by patient**

I cannot describe how kind and compassionate Rachael has been with me. I have lived with diabetes for over 25 years and had got to a point where I was really struggling with the management of my condition. Rachael has taken the time to listen to me and really understand my struggles. She was the ultimate patient advocate and, although I am not shy in expressing my needs, I have been really struggling with articulating what I want to change. Rachael was pragmatic and understanding and supported me in so many ways. She is an absolute credit to the Trust, and I am not sure how I would carry on without her. Throughout my time at the Trust, Rachael has been responsive, and nothing is ever too much trouble. When COVID hit and Rachael was redeployed I missed her support. I cannot thank her enough for all she has done for me.

Rachel Dodds, Senior Clerical Officer	**Scarborough**	**Nominated by colleague (1) and colleague (2)**

(1) Rachel has demonstrated amazing leadership skills during the implementation of Soliton in the Antenatal Department. Although it has been challenging at times, Rachel's continuous support towards her team, through patience and kindness has made the transition of the process run smoothly. Thank you, Rachel, you are a star!

(2) I have nominated Rachel for a star award, as I feel her dedication, determination, and drive for what she does for the Trust and her team is not recognised. A lot of changes have been made to the antenatal services recently which has massively impacted Rachel's workload. Without complaint she has taken all this on and is doing everything to the best of her ability. I would just like Rachel to know that she is a superstar!

Emergency Department Team, Glyn Dolben, Site Coordinator, and Sal Katib, Clinical Estates Lead	**Scarborough**	**Nominated by colleague**

I would like to nominate the team on shift during the early hours of Monday 10th June within the Emergency Department at Scarborough Hospital as well as Glyn Dolben and Sal Katib. The site was already pressurised with 16 beds remaining closed due to IPC and only 16 discharges having occurred on the Sunday. Whilst they were OPEL 3, they had supported York with several diverts during the day and consequently had 16 patients waiting to be admitted.

At approximately 1am, two RTCs occurred resulting in eight ambulances arriving together with very sick patients, some requiring transfer to Hull as the local Major Trauma Centre. Various calls were made with YAS and the ICB Director on call to seek wider system support, but unfortunately no wider support was available. The team, led by Vicky (NIC) and supported by Glyn and Sal, navigated a tricky and potentially dangerous workload with calmness and professionalism. This was exactly what was required. By 4:14am there were no ambulances on site. As the Director on call, I was massively appreciative of the team's approach which is deserving of a Star Award.

Jenna Raby, Deputy Sister	**Site**	**Nominated by colleague**

I am pleased to nominate Jenna Raby for her exceptional support in developing and facilitating a training program to update the NEWS2 and deteriorating patient awareness within the teams. Jenna played a pivotal role in creating this comprehensive program and has invested significant effort into ensuring its success.

Jenna, alongside her dedicated colleagues, has provided thorough training to our team, and she continues to extend this knowledge to other teams, promoting a wider understanding and application of the training. Her commitment and hard work have not gone unnoticed and are greatly appreciated by all who have benefited from her expertise. This work is expected to make a significant impact on patient safety within these teams, enhancing the overall quality of care provided.

Betsy Baby, Sister	**Scarborough**	**Nominated by colleague**

Betsy is my ward manager, and she is exceptional. She views the affairs of her team members as highly important. She is an outstanding leader who is fair and equitable. She has made my transition process as an international nurse so easy. She is ever ready to listen to her team members and make us feel really valued.

Katie Smallwood, Admin Assistant	**York**	**Nominated by colleague**

Thank you for going the extra mile with all the things recently.

Steven Rice, Storekeeper	**York**	**Nominated by colleague**

Thank you for the other day when I wasn't feeling great!

Sheena Campbell, Senior Healthcare Assistant **Bridlington** **Nominated by colleague**

I am so happy with Sheena Campbell, our Senior Healthcare Assistant in Bridlington. She is amazing! She is not just a lovely person and a great professional, but she also goes above and beyond her duties, making my job extremely easy. I cannot thank her enough for what she does. Please let her know how much I appreciate her.

Colonoscopy Team **York** **Nominated by patient**

I attended York Hospital for a colonoscopy. From the receptionists to the discharge nurse, I was treated with courtesy and care. I was anxious and frightened. I told my initial nurse, Judy, that I really wanted to hold someone's hand whilst I had the procedure. She passed this information on, and I held the hand of a delightful guy who comforted me when I was so scared. The doctor who undertook the procedure explained in simple terms what was happening to me. It was a difficult procedure, but the staff made it as easy as they could for me. The nurse at the end gave me a very welcome tea and biscuit. Well done to each and everyone in this team!

Leeanne Caw, Healthcare Assistant **Scarborough** **Nominated by colleague**

Leeanne is the Infection Prevention Champion for Mulberry Ward. She has recently designed and made an information board, detailing relevant important IPC information for her colleagues on the ward. Healthcare acquired infections cost the NHS millions each year and affect 300,000 hospital patients. The boards that Leeanne has made, not only looks brilliant and informative, but will help the team to follow key infection prevention principles to help keep their patients safe.

Domestic Services Team **Scarborough** **Nominated by colleague**

I am nominating the domestic staff and HPV decontamination team for a Star Award as recognition for their hard work, flexibility, and commitment to patient safety during an exceptionally busy period at Scarborough Hospital. The hospital has been experiencing high numbers of bed closures due to norovirus. Both staff and patients have been significantly affected by the virus and this has included the domestic services team. One of the control mechanisms is enhanced cleaning during the outbreak and post-outbreak cleaning, which in some circumstances required HPV deployments. The whole team have been responsive, accommodating short notice deployments of cleaning teams to keep the Scarborough Hospital site operational and bringing beds back into use as soon as possible.

I have seen many examples of staff working above and beyond their contracted roles. I have offered my personal thanks but feel their work is not always recognised as a vital part of our delivery of safe patient care. Their commitment to the patients, wards and departments should be celebrated and Star Award would show the Trust appreciation for their hard work and commitment.

Emily Maurice, Midwife	**York**	**Nominated by colleague**

Emily has led the team through many QI projects with motivation, enthusiasm, and dedication to improve our service users' experience. The last few months have been really challenging for the maternity team, throughout which Emily has provided support as manager of the day for the unit, provided training schedules for our new midwives in the antenatal team, and participated in four separate projects, all of which have been in a leadership capacity. The QI projects include improving antenatal clinic efficiencies to reduce wait times, renovating and moving ANC rooms to maximise clinic space available, and reviewing scan capacity and demand whilst implementing a digital referral system to provide greater oversight and reduce risk and induction of labour. All whilst undertaking her substantive operational leadership role.

Emily's support has been invaluable to the MDT team, ensuring the QI projects are undertaken with the participation of the team and service users. I am proud to have Emily as part of the team and truly appreciate how much she has gone above and beyond to ensure our service users receive the best care. Her involvement and participation cannot be underestimated and will lead to successful implementation of the QI projects.

Antenatal Clinic Administration Team	**York**	**Nominated by colleague**

Rachel and her team have worked exceptionally hard to ensure the smooth role out of Soliton and digital scan requesting for maternity services. From initial discussions, the team have embraced the changes, understanding the safety this will provide to our service users. Rachel has used innovation and motivation to plan training and put new systems and processes in place, along with organising a soft launch to ensure the system is working before transitioning over. Thank you, Rachel and team, you really have supported us in this roll out and I am confident that, down to your commitment and motivation, we will have a successful transition over. You have been key to making this happen. The difference you make should not be underestimated.

Antenatal Screening Team	**Scarborough**	**Nominated by colleague**

Jolene, Judith, and the screening team have worked exceptionally hard throughout the launch of two new IT systems, resulting in changing processes and failsafe measures to ensure that all our service users receive screening within the nationally recommended time frame. Alongside this, the team have taken ownership of the foetal medicine clinic and created new robust processes to ensure all referrals were captured and actioned within the recommended time frame, whilst ensuring communication between us and tertiary units.

The leadership shown by Jolene and Judith has been exceptional. They have both gone above and beyond to ensure the relevant processes are in place and training has been provided across Maternity, administration teams, and radiology. Their active participation in the QI project and solution-focused attitude is evident and ensures the safety of our service users is at the forefront of all we are trying to achieve.

Same Day Emergency Care	**York**	**Nominated by relative**

We have had occasion to attend the SDEC unit over two days and would like to express our sincere gratitude to all the highly professional and caring members of staff who attended to my husband. A special mention goes to Wendy who kept us refreshed with tea and biscuits, delivered with such a friendly and caring manner. Many thanks to you all.

Muhammad Arif, Speciality Doctor	**Scarborough**	**Nominated by relative**

Dr Arif has been caring for my son with his ongoing medical and inpatient stays for several years. He goes above and beyond for not only my son, but every patient he sees. He has formed such a bond with my son so now he trusts him with his medical procedures. With having a child with complex medical needs, you need a doctor you can trust and that is Dr Arif. I would love for him to win a Star Award as I think he does not get the recognition he truly deserves.

Minor Injuries Team	**Scarborough**	**Nominated by patient**

I attended Scarborough Emergency Department with an injury to my foot and ankle. Upon arriving, all the staff members I dealt with were a credit to the Trust and the two stand out members were Tracy and Jane (I think it was Jane but please forgive me if it is the wrong name). I was made to feel at ease and, as well as sorting my injury out, we had a chat and a laugh. It was all done very promptly and efficiently.

Nicola Morris, Healthcare Assistant	**York**	**Nominated by colleague**

We are nominating Nicola as a ward, and we are extremely proud to have her as part of the team. She is hardworking, diligent, and caring. She recently showed this when a colleague from another department came on the ward to bring a patient. The colleague was having some chest pain and feeling unwell. Nicola saw this and immediately noticed that something wasn't quite right with him, so she got him into a chair and took him to ED. We are so proud of her and her actions, as this positively helped the outcome of our colleague who was found to be unwell. Well done, Nicola!

Patient Transfer Team	**York**	**Nominated by colleague**

The Patient Transfer Team at York Hospital are amazing. They have done an amazing job in transferring patients from ward to ward. They move patients on beds and in wheelchairs. Without these heroes the hospital would struggle and grind to a halt. Nothing is a problem for the transfer team, they help the discharge lounge bring patients down when needed as well as their usual work and work well as a team. They always make sure everyone in the transfer team is looked after even when things do not go to plan. The hospital would struggle without them. The work of the transfer team is outstanding.

Rhys Evans, Doctor | **York** | **Nominated by colleague**

During a difficult shift while Rhys was on call, a patient of his became critically unwell. During this critical situation we were not sure if that patient would survive. As I was administering fluids to the patient, I noted Rhys was holding the patient's hand to comfort him during this difficult time. He showed compassion and care when it was needed most. Not only was he instrumental as the doctor responsible for looking after the patient in saving his life, he took time to also show humility and kindness. I believe this shows Rhys truly embodies all the Trust values and NHS values.

Zoe Grayston, Clinical Nurse Specialist | **York** | **Nominated by colleague**

Zoe went above and beyond after her shift had finished to facilitate a wedding within the hospital for patient who had planned to get married had unfortunately suffered from a stroke. She found out what needed to be done and liaised with the relevant services, chasing doctors to complete the paperwork which needed sending off to make it all happen within a day. She then decorated the room within the hospital to make it as special as possible for the bride and groom and stayed well after her shift to ensure there was a nurse available to stay with the patient throughout the ceremony.

Rachel Dixon, Staff Nurse | **Scarborough** | **Nominated by colleague**

Rachel is an absolute asset to Scarborough Hospital and Aspen Ward. I have never met a kinder and more compassionate nurse. She goes above and beyond for both patients and staff. Rachel has also recently taken on a role as a legacy nursing mentor, supporting our newly qualified nurses. I could not think of a better person to support and guide our new nurses, and they have truly appreciated her help. Keep up the fantastic work!

Monika Krupczak, Imaging Support Worker **York** **Nominated by colleague**

Over the weekend the CT department had a Polish patient who had a learning disability and needed a different procedure to what they had been told. The CT team asked Monika to help as she speaks polish. Monika went above and beyond in helping explain the appointment and assisting with the procedure. Monika stepped up and helped the patient get the treatment they required and without Monika's helped that would not have been possible.

Anna Ward, Ward Clerk **York** **Nominated by relative**

My husband, brother-in-law, and I arrived to visit my father-in-law on ICU and were met by Anna at the door. Anna knew about my father-in-law, knew who we were, and knew the story. She was incredibly kind and caring. My brother-in-law is blind. She instantly realised that he needed to be guided and she took his arm and did this, talking to him all the way to my father-in-law's room. I cannot really express what it was that Anna did that was so amazing. She just knew what to say and how to say it without any drama or fuss. This made a very stressful situation a little less awful. She totally deserves a Star Award.

Megan Ellis, Deputy Sister | **York** | **Nominated by relative**

Megan cared for my father-in-law on his last day in the ICU. The care that she gave was outstanding. She created a space which was calm and as non-clinical as possible. She ensured that this was fully prepared before we arrived in the morning. She was entirely calm and competent. She was completely comfortable with the technical equipment that was required to keep him stable until his whole family were ready for care to be withdrawn. Her patience and empathy were outstanding. She knew when to be quiet, when to offer a word of reassurance, and when to act. She allowed her own emotion to be shown just enough to demonstrate her empathy without this distracting from the family's distress.

Megan demonstrated her care and compassion as much by what she did not do as what she did. She was a quiet, reassuring presence who knew when to keep back and when to offer a hug. She was brilliant. I am a midwife and was a nurse with experience in hospice care. I am now a lecturer in midwifery. My assumption was that a death in ICU would be awful, clinical, and harsh. Megan ensured that this was not the case and proved to me that superb palliative care can take place in the most clinical of environments. I really hope that you give her a Star Award.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Committee Report

Item 8

Report from:	Quality Committee
Date of meeting:	18th June 2024
Chair:	Steve Holmberg

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT
Never Events – 3 occurrences currently under investigation. Committee heard that emerging themes were non-adherence to protocols and other cultural issues such as actual/perceived barriers to challenge by junior staff **Ambulance Waits –** Committee discussed 18 patients who had ambulance waits of greater than 8 hours during May. Intention is to derive learnings to try and minimise case numbers moving forward and to mitigate unintentional harms
ASSURE
Audit Reports – Committee agreed to review relevant audit reports to derive assurance that required improvements are being appropriately actioned

ADVISE
Maternity – PPH rate slightly lower in month but more assurance required over time that any improvement is sustainable. Committee received QIA analysis relating to lack of additional funding to improve staffing levels. Prior to Board presentation, Committee recommended that paper was expanded to detail risk mitigations and benefits associated with incremental investment **CQC –** Committee continues to receive assurance that CQC is responding positively to Trust plans and progress which is nearing completion. A reducing number of overdue actions remain outstanding but Committee was assured that process by which completion dates are extended is robust and supported by CQC **Quality Account –** Draft paper presented but some revisions were required and Committee intends to receive final version next month prior to Board approval **Hospital Mortality Indices –** Trust is performing well as measured by SHMI rates but Committee noted the rise in actual deaths and HSMR. These changes are thought to reflect high numbers of 'Patients with no criteria to reside' and on-going challenges to community provision but further assurance will be sought
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
Maternity – York midwifery currently recruited to budget (Scarborough remains with modest shortfall). This creates a potential risk that student midwives may receive their experience at York but then have no opportunity to take up substantive position. This situation may worsen should

York St John develop a course. This reputational risk has to be seen against agreed position that funded establishment is below safe staffing levels

IPC – Number of C. diff and MSSA infections remained high in-month. Ward 11 identified as a new area of concern for C. diff. Hand hygiene compliance remains a concern and pressure on beds and absence of 'decant' area makes use of HPV difficult to achieve in some situations

Paediatric SaLT/Autism Services – Committee received report that highlights significant increase in demand and the excellent work by the department to target services for those at greatest risk. Committee retain some concerns that some vulnerable patient groups may not be able to access service equitably and requested further information form the Health Inequalities team

Children in ED – Last month, Committee received information relating to earlier concerns about long paediatric ED stays. Cases centred round 'older' children inappropriately on adult pathways. Discussion with CG has identified that further work through the Paediatric Board will be required to resolve this concern

Complaints – Numbers remain high both in Medicine and Surgery. Increasing numbers of complaints needing to be reopened. Long waits and poor communication are dominant themes

Volunteers – Funding for coordinators has not been renewed that may put programme at risk

VTE Prophylaxis – Compliance identified as not being adequate and will become focus of targeted improvement work

Committee Report

Report from:	Resources Committee
Date of meeting:	18 June 2024
Chair:	Lynne Mellor

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT
• **Operations**: The Committee discussed the continuing increased attendances at both Emergency Departments (EDs) and the increase in ambulance arrivals. The Committee sought assurance again concerning 8-hour plus ambulance breaches at York. The Committee noted again that there were still patients being brought by ambulance that did not need the services of the Emergency Department. The Committee also discussed the increase in Category 1 & 2 patients i.e. acute patients. The Committee discussed concerns of increasing risk for patients and staff. The Committee took some assurance that discussions were continuing with YAS, EMAS the ICS and wider system to improve prioritisation of cases and patient flow especially to ensure that category 4 patients, who do not need to attend hospital are diverted for treatment elsewhere. • The Committee noted the Ambulance report. The Committee asked for an update following the introduction of the Optimal Care Service with more detail also on actions following key partner/system meetings to address the above issues. • **Workforce**: The Committee discussed the workforce plan both the operational and strategic matters arising e.g. the impact of the slow-down in workforce growth 2024-5 and the associated strategic risks e.g. the increasing gap between demand and supply. The Committee welcomed the SWOT analysis and asked for an accompanying action plan.
ASSURE
• **Nursing and Midwifery:** The Committee was assured the erostering and efficiencies work continues, noting that of the 57 nursing workforce rosters 33% are at or just below 22% headroom. The cost improvements seen in the reduction of agency staff is evident and it is anticipated spend will be significantly reduced as plans are on track to deliver the vacancy forecast of 2% unregistered nurses and 1% registered by October 2024. The Committee welcomed the Trust's 'team-effort' approach in the training of new midwives. The Committee continues to note the success of the Healthcare Academy, with its positive impact and positive outcomes e.g. survey results of 120 healthcare academy graduates are very encouraging. • **Operations:** The Committee noted the Trust had achieved the 2024/5 improvement trajectory for the Emergency Care Standard with a performance of 68.1%. • The Committee noted the increase in long stay patients and those who have No Criteria to reside i.e. 1,021 lost bed days re NCTR equivalent to 33 bedded-ward occupied every day in May. The Committee gained assurance plans are on track to continue to make improvements: the Trust achieved its current target of 18.8% NCTR patients with a performance of 18.5% (down from 30% pre Christmas). • Cancer was discussed and is continuing to see some areas of improvement across a number of pathways e.g. Breast, Head and Neck, Lung Skin and Upper GI, NSS and Haematology exceeded 75% FDS. Diagnostics was discussed and remains a concern e.g. patients waiting greater than 6 weeks from referral in CT and Urodynamics. The Committee discussed the challenges to fulfil plans e.g. ageing equipment and asked for a further deep dive on Diagnostics by August. • The Committee noted the Trusts RTT position as it continues to be ahead of trajectory submitted to NHSE. The Trust continues to maintain its RTT 78-week position.

- **Workforce:** The Committee welcomed the progress made by the Change Makers with the identification of 'quick wins' from their event 10 June.

ADVISE

- **Nursing and Midwifery:** The Committee noted and discussed the Bi-Annual Midwifery, Maternity and Neonatal Staffing report. Concerns were raised about Red Flag entries; the Committee discussed the plans to address: as well as accurate data entry, there's also a cultural shift needed in adherence to process.
- Allied to the overall workforce plan, the Committee discussed the Maternity and Neo Natal Staffing report and the safe staffing levels – currently the Trust has 44 WTE shortfall. The Committee received some assurance that following a QIA, plans will be brought to board and also discussions taking place at ICB level to consider the shortfall alongside other Trust priorities given current financial pressures.
- **Operations:** The Committee welcomed Elective waiting list paper: the Committee discussed the issues including data quality and process. It discussed the data cleanse of the waiting lists and the need to identify priority patients – some assurance was given with the priority of some paediatric and cancer patients on the waiting list for over 2 years. The Committee asked for a monthly update on progress. The Committee also raised concerns that the outpatient follow-up partial booking over due over 6 weeks continues to rise from 26617 previously, to 27121 - some assurance was given around plans to address.
- The Committee noted data is being reviewed for ED attendance duplication – the Committee asked for an update in July.
- **Finance:** The Committee noted the adjusted financial surplus/deficit plan for the Trust is down from £20.8 to £16.6M deficit following the anticipated release of provisions from the ICB to reduce the overall system to a £50m deficit. Month 2 position for the Trust has an adverse variance to plan of £3.3M. ERF is £3.2M ahead of plan. CIP status shows still a long way to go with circa £11M of recurrent revenues identified. The Committee discussed run rate and asked to see 12 month forecast plan next month including projected benefits.
- **Workforce:** The Committee discussed the need to align reported vacancy numbers between Eroster, the Financial Ledger and ESR with a request to report back to the Committee in September with an update on actions to resolve issues and agree one-truth data source.
- The Committee raised concerns that the pulse survey response rates were at 4% and what more could be done across the Trust in gaining momentum for encouraging staff survey completions – both pulse and annual.
- The Committee noted the Trust is undertaking a review of Healthcare Support Worker (HCSW) Nursing and Midwifery banding (Band 2 and 3) in partnership with the Trade Unions. The review will inform workforce modelling and in discussion with the Trade Unions possible redress for duties already worked for HCSWs who may have been carrying out tasks identified at a higher level.
- **YTHFM:** the Committee discussed the Q4 report. It welcomed the positive news on achieving the CIP target for the third successive year. The Committee welcomed the update on improvement activities including the taxi-review, plans for Preventative Planned Maintenance, and the asset survey. The Committee discussed the KPIs overall and noted positive improvements. The Committee did raise concerns on maintenance particularly P1 scheduled checks and the status of backlog maintenance; the Committee agreed YTHFM would report back on next steps.
- The Committee welcomed the new Head of Sustainability to the Trust and noted the Sustainability report – discussing e.g. positive impact of LED lighting, and its benefits as well as revised travel plan and funding bids. The Committee noted the EPAM report.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The Committee discussed the need for a Board review on risk including risk appetite.
- Risk discussed with each report, with a plan to do a deeper quarterly dive on risk:
  - The Committee noted the new addition of the deterioration of results in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
  - Continued concern discussed about diagnostic waiting times and plans in place to meet targets – to review again in July/August.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 10

TRUST PRIORITIES REPORT

June 2024

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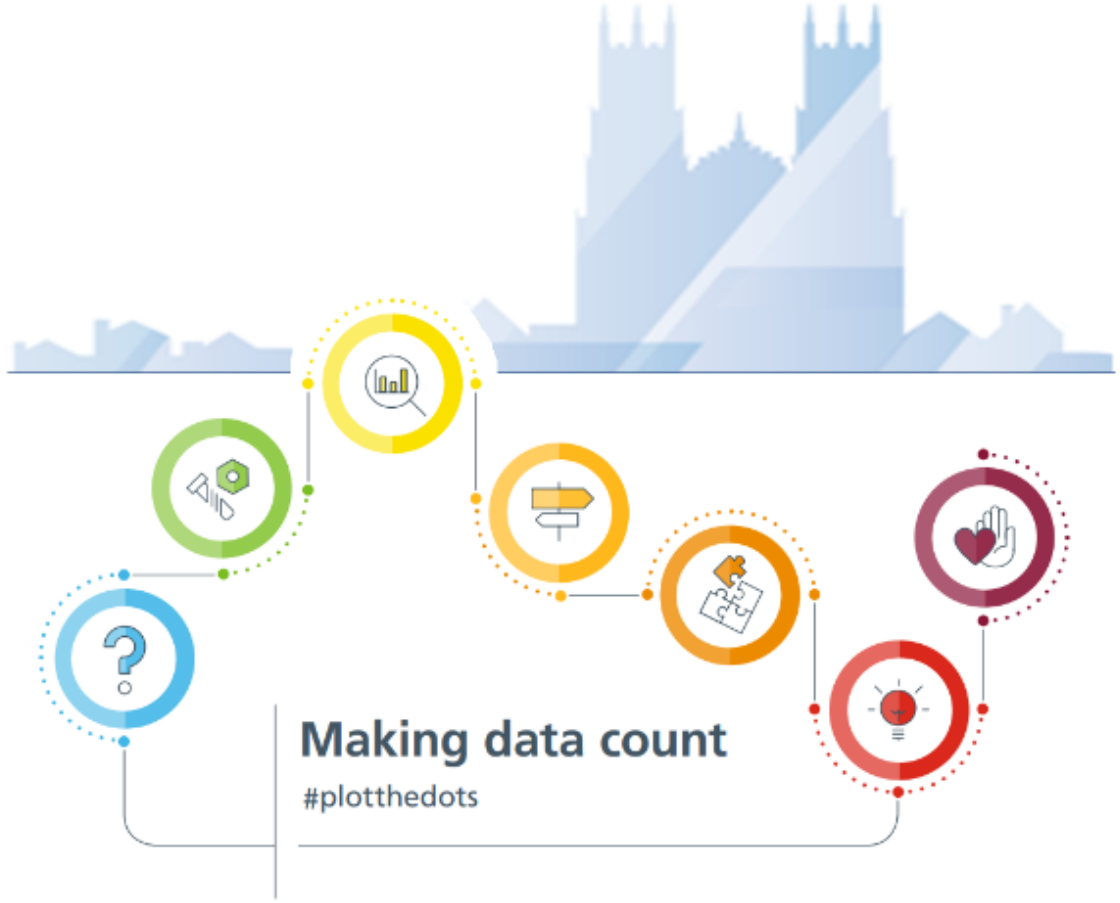
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust



Executive Summary

Priority Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
ED - Proportion of all attendances having an initial assessment within 15 mins	2024-05		F	66%	Target	53.7%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2024-05		F	7.5%	Target	18.6%
ED - Emergency Care Standard (Trust level)	2024-05	L	?	66.9%	Target	68.1%
ED - Median Time to Initial Assessment (Minutes)	2024-05	L	?	18	Target	10
ED - Proportion of Ambulance handovers waiting > 60 mins	2024-05		F	10%	Target	30.7%
Cancer - Faster Diagnosis Standard	2024-04		?	68.1%	Target	68.6%
Cancer - 62 Day First Definitive Treatment Standard	2024-04	H	?	60.1%	Target	66.8%
RTT - Total Waiting List	2024-05	L	F	45992	Target	45643
RTT - Waits over 104 weeks for incomplete pathways	2024-05	L	?	0	Target	0
RTT - Waits over 78 weeks for incomplete pathways	2024-05	L	F	0	Target	0
RTT - Waits over 65 weeks for Incomplete Pathways	2024-05	L	F	159	Target	162

Executive Summary:

The May 2024 Emergency Care Standard (ECS) position was 68.1%, against the trajectory of 66.9%. Median wait time to initial assessment in ED remained unchanged at ten minutes in May 2024.

Please note; in line with national reporting deadlines cancer reporting runs one month behind. The Cancer performance figures for March 2024 saw a small decline in the 28-day Faster Diagnosis standard (FDS) to 68.6% (compared to 70.3% in March 2024). This was ahead of the trajectory submitted to NHSE for the end of April 2024 (68.1%). 62 Day waits for first treatment performance was 66.8%.The Trust has, as part of the 2024 Operational Planning, submitted trajectories to achieve the national ambition of 77% for FDS and 70% for 62 Day waits for first treatment by March 2025.

There were zero RTT 104-week and zero RTT 78-week waiters at the end of May 2024.

At the end of May 2024, the Trust had 162 RTT patients waiting over sixty-five weeks, three above the end of month trajectory of 159. The Trust is working to achieve the national ambition to have zero RTT65 week waits by the end of September 2024. There are currently 2,741 patients who if not treated will breach 65 weeks by the end of September 2024 (a reduction of 1,349 on the end of April 2024 position; 4,090).

OPERATIONAL ACTIVITY AND PERFORMANCE

June 2024

Summary MATRIX
Acute Flow

MATRIX KEY
- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

ASSURANCE

VARIATION

	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT	* % of SDEC admissions transferred to downstream acute wards	* ED - Median Time to Initial Assessment (Minutes) * Number of SDEC attendances * Number of RAFA attendances (York Only) * Number of zero day length of stay non-elective admitted patients	* Inpatients - Proportion of patients discharged before 5pm
COMMON CAUSE / NATURAL VARIATION	* Community bed occupancy/availability	* ED - A&E attendances – Other type attendances * Percentage of SDEC attendances transferred from ED * Percentage of SDEC attendances transferred from GP * % ED attendances streamed to SDEC Within 60 mins * Number of attendances at SAU (York & Scarborough) * ED - Ambulance average handover time (number of seconds) * Patients with Senior Review completed at 23:59 * Inpatients - Percentage of adult G&A beds occupied by patients not meeting the criteria to reside * Inpatients - Super Stranded Patients, 21+ LoS (Adult) * Overnight general and acute beds open * Of those overnight general and acute beds open, percentage occupied	* ED - Proportion of all attendances having an initial assessment within 15 mins * ED - Proportion of all attendances seen by a Doctor within 60 mins * ED - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - 12 hour trolley waits * ED - Proportion of Ambulance handovers waiting > 30 mins * ED - Proportion of Ambulance handovers waiting > 60 mins * Patients receiving clinical Post Take within 14 hours of admission
SPECIAL CAUSE CONCERN	* ED - Number of ambulance arrivals	* ED - Total waiting 12+ hours - Actual number of all Type 1 attendances * ED - Emergency Care Attendances * ED - Emergency Care Standard (Trust level) * ED - A&E attendances – Type 1 * ED - Emergency Care Standard (Type 1 level) * Inpatients - Lost bed days for patients with no criteria to reside * Number of non-elective admissions	* ED - Proportion of Ambulance handovers within 15 mins

Acute Flow (1)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
ED - Proportion of all attendances having an initial assessment within 15 mins	2024-05		F	66%	Target	53.7%
ED - Proportion of all attendances seen by a Doctor within 60 mins	2024-05		F	55%	Target	24.9%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2024-05		F	7.5%	Target	18.6%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2024-05	H	?	1870.8	Baseline	2144
ED - 12 hour trolley waits	2024-05		F	0	Target	762
ED - Emergency Care Attendances	2024-05	H	?	19796.7	Baseline	20973
ED - Emergency Care Standard (Trust level)	2024-05	L	?	66.9%	Target	68.1%
ED - A&E attendances – Type 1	2024-05	H	?	10425	Target	11572
ED - Emergency Care Standard (Type 1 level)	2024-05	L	?	47%	Target	44.8%
ED - A&E attendances – Other type attendances	2024-05		?	7382	Target	7373
ED - Median Time to Initial Assessment (Minutes)	2024-05	L	?	18	Target	10

KPIs – Operational Activity and Performance

Acute Flow (1)

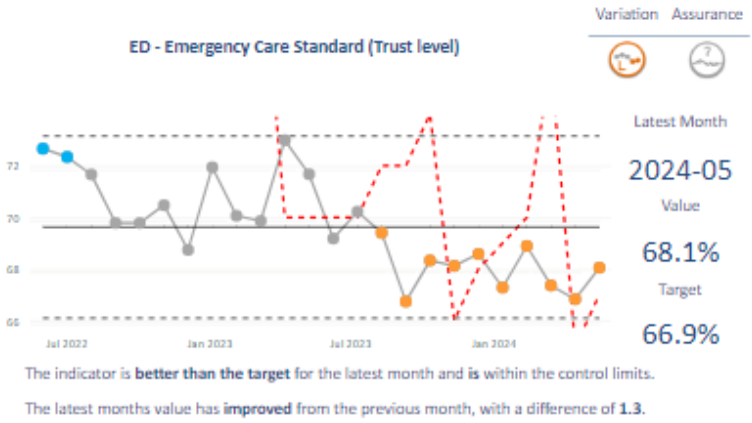
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor waiting times in A&E and Urgent Care Centres.

Target: NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025.



Factors impacting performance:

- The Trust achieved the 2024/25 improvement trajectory of 66.9% for the Emergency Care Standard with performance of 68.1%.
- Increased attendances across both of our Emergency Departments (EDs) compared to May 2023, The Trust saw an average of 53 more attendance per day throughout the month of May 2024, a rise of 13%. Ambulances also continue to rise (May 2024 average of 139 per day against the May 2023 average of 128, a rise of 9%). The acuity of ambulance arrivals has also increased. The two most acute categories (1&2) saw a rise from a daily average of 102 in May 2023 to a daily average of 115 in May 2024 putting significant pressure on our EDs (13% increase).
- Increase in long stay (21+ LoS) leading to bed delays.
- 1,021 lost bed days due to patients with No Criteria To Reside (NCTR). This level equates to a thirty-three bedded ward being occupied for every day of May.

Actions:

The Programme Team and the Care Group team are united in their ambition to deliver the Optimal Care Service on 3rd July, which is outlined as below:

- Changing front-door model at both EDs.
- OCS Senior Decision Maker at the front door, navigating to ED (majors) or OCS (minors) – this is before the current streaming function – only ED (majors) patients will need full triage.
- This decision will inform whether reception book patients in on CPD (Majors and Injuries) or SystmOne (OCS Minor illness).
- OCS will be ringfenced minor illness and minor injury, with MDT skilled practitioners who can take on more minor illness patients than GPs alone, hence need for MDT.
- Workforce will need flexibility; we are not substantively changing people's roles, but the multidisciplinary team may have shifts assigned to minor illness on one day, and majors on another.
- Principle of 'only appropriate and necessary investigation' - should see a reduction in diagnostics.
- Minor illness practitioners are likely to see 4 patients per hour.
- 95% OCS patients should be seen within 2 hours.
- Pressure in Majors should reduce, and the waiting room should be less crowded.

KPIs – Operational Activity and Performance

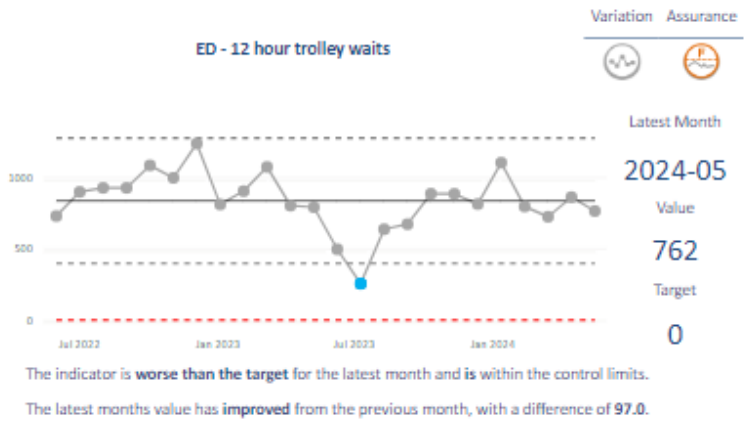
Acute Flow (2)

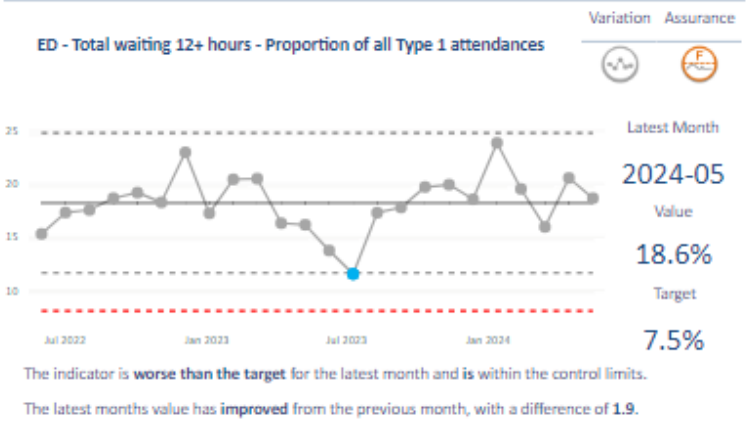
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor long waits in A&E.
Target: SPC1: Zero patients to wait over 12 hours from decision to admit to being admitted. **SPC2:** Less than 7.5% of patients should wait more than 12 hours.





Factors impacting performance:

- Increase in long stay (21+ LoS) leading to bed delays
- 1,021 lost bed days due to patients with No Criteria To Reside (NCTR).

Actions:

- Alongside the actions outlined about changes to our front-door clinical model, work is underway to transform the timeliness and quality of our discharges. This will improve flow.

- The Discharge Improvement Group brings together partners from right across the system to ensure the focus is across Urgent and Emergency Care (UEC) pathways from both acute and community perspectives and to ensure pace around transformation work. The group is chaired by the Deputy Chief Operating Officer and work is split into three cells, each with clinical leadership:
    - Cell 1 relates to hospital processes such as effective board rounds, clinical management plans and the adoption of criteria-led discharges. This should specifically support proportion of discharges before 5pm.
    - Cell 2 focuses on processes which link acute and community provision, including trusted joint assessment.
    - Cell 3 ensures that our local authority and community processes are supported to improve the timeliness of provision of packages of care.

- Leads for all three cells have been appointed.

- We have established a baseline position for the average number of discharges and referrals per day for each local authority, and the backlog relating to the number of patients remaining in acute care more than 3 days after their Trusted Assessment Form (TAF) has been submitted. Work is underway to agree a trajectory for improvement, specifically bringing the >3day delay numbers down. As part of this work, we will establish what would be required to clear the backlog completely by December 2024.

- Resolving these issues and making improvements in this area will lead to better flow and fewer patients waiting over 12hrs for an acute bed after the decision to admit.

Acute Flow (2)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

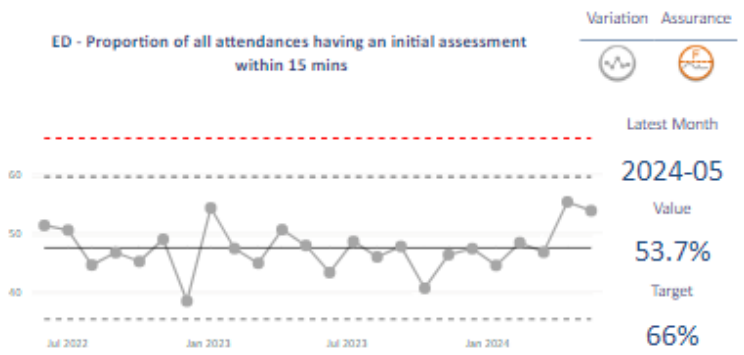
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Number of SDEC attendances	2024-05	H	?	2268	Baseline	2467
Percentage of SDEC attendances transferred from ED	2024-05		?	64.7%	Baseline	63.6%
Percentage of SDEC attendances transferred from GP	2024-05		?	22.7%	Baseline	26%
% ED attendances streamed to SDEC Within 60 mins	2024-05		?	41.2%	Baseline	44%
% of SDEC admissions transferred to downstream acute wards	2024-05	L	P	20%	Target	13.4%
Number of RAFA attendances (York Only)	2024-05	H	?	110.2	Baseline	153
Number of attendances at SAU (York & Scarborough)	2024-05		?	828.7	Baseline	829
ED - Proportion of Ambulance handovers within 15 mins	2024-05	L	F	65%	Target	20.9%
ED - Proportion of Ambulance handovers waiting > 30 mins	2024-05		F	5%	Target	53.3%
ED - Proportion of Ambulance handovers waiting > 60 mins	2024-05		F	10%	Target	30.7%
ED - Number of ambulance arrivals	2024-05	H	P	3840.5	Baseline	4136
ED - Ambulance average handover time (number of seconds)	2024-05		?	1661	Target	3482

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

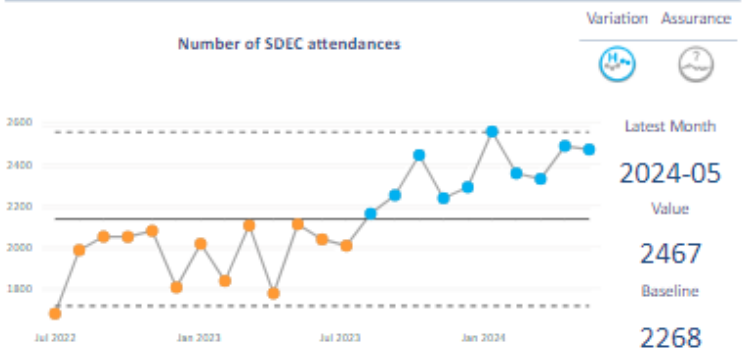
Rationale: SPC1: To monitor waiting times in A&E. Patients should be assessed promptly by within 15 minutes of arrival based on chief complaint or suspected diagnosis and acuity. **SPC2:** SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.

Target: SPC1: 66% assessed within 15 mins. **SPC2:** No target.



The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **1.5**.



The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **17.0**.

Factors impacting performance:

- Increased attendances across both of our Emergency Departments (EDs) compared to May 2023, The Trust saw an average of 53 more attendance per day throughout the month of May 2024, a rise of 13%. Ambulances also continue to rise (May 2024 average of 139 per day against the May 2023 average of 128, a rise of 9%). The acuity of ambulance arrivals has also increased. The two most acute categories (1&2) saw a rise from a daily average of 102 in May 2023 to a daily average of 115 in May 2024 putting significant pressure on our EDs (13% increase).
- Demand increasing for beds, the daily average admissions via ED in May 2024 was 161 patients compared to 131 in May 2023. A rise of 23%.
- Increase in long stay (21+ LoS) leading to bed delays
- 1,082 lost bed days due to patients with No Criteria To Reside (NCTR).
- SDEC attendance numbers remain above the baseline.

Actions:

- We have implemented the 'Ambulance pit-stop +' model at York. This involves dedicated cubicle capacity to support specifically with ambulance handover. This is facilitating improved ambulance handover times when ring-fenced robustly. Work still ongoing to ensure these cubicles are ring-fenced and not reverted for general use when the department is under significant pressure.
- Planning for the integrated assessment units (IAU) is underway, which will result in an improved same day and short stay provision for patients.
- To achieve IAUs we need acute physicians; recruitment is live, and we have received applications. Interviews are taking place late June 2024.

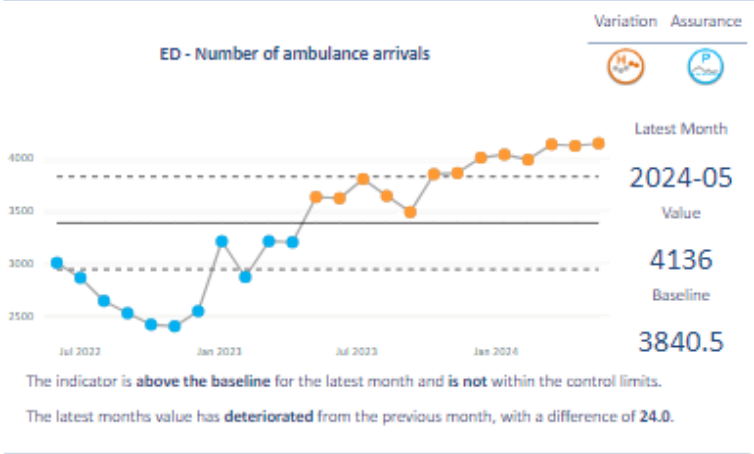
Breakdown of adult admissions to assessment areas in May 24:

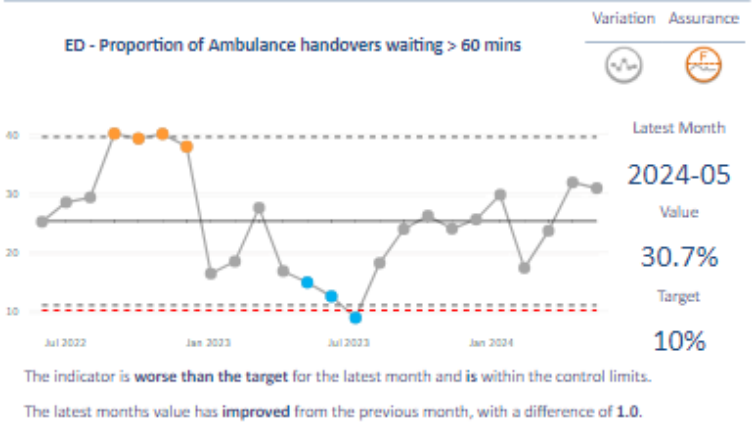
PERIOD	SITE	Medical SDEC	Emergency Assessment Unit	Surgical Assessment Unit	Rapid Access Frailty
May-24	York	786		695	161
May-24	Scarborough		707	127	

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: SPC1: To monitor Ambulance demand in A&E. **SPC2:** Proportion of ambulances which experience a delay in transferring the patient over to the care of ED staff.
Target: SPC1: No target. **SPC2:** Patients arriving via an ambulance should be transferred over to the care of ED staff within 15 minutes of arrival. Less than 10% should wait over 60 minutes to handover.





Factors impacting performance:

- Increased attendances across both of our Emergency Departments (EDs) compared to May 2023, The Trust saw an average of 53 more attendance per day throughout the month of May 2024, a rise of 13%. Ambulances also continue to rise (May 2024 average of 139 per day against the May 2023 average of 128, a rise of 9%). The acuity of ambulance arrivals has also increased. The two most acute categories (1&2) saw a rise from a daily average of 102 in May 2023 to a daily average of 115 in May 2024 putting significant pressure on our EDs (13% increase).

- The Trust did not achieve the May 2024 average ambulance handover time target of 27 minutes and 41 seconds with performance of 57 minutes and 50 seconds. Average ambulance handover time is calculated by taking the total combined handover times divided by the number of ambulances that attended the Trust's EDs.

- May 2024 saw several infection outbreaks (including NOROVIRUS) particularly at Scarborough Hospital which impacted on ability to discharge with knock on effect to ED and Ambulance queues.

Actions:

- Development of Emergency Practitioner In Charge (EPIC) and Nurse In Charge (NIC) to ensure patients advance through their journey in a timely manner meeting relevant standards of care.

- The introduction of the Optimal Care Service (see previous slide) will support ambulance handovers.

- Alongside that work, the Deputy Chief Operating Officer is working closely with colleagues at YAS to consider CAT3 and CAT5 triage, to ensure that people are only conveyed to hospital when required.

- Ambulance steering group set up in April, held fortnightly. Its effectiveness has been reviewed and it will be extended to include more team leaders at YAS. Discussions include learning from issues relating to delayed ambulance handovers; feedback suggests these meetings would be more helpful and have more practical use and impact with more preparation. A new process is being put in place in June to remind people of the expectations and responsibilities in advance of each meeting.

Acute Flow (3)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Patients receiving clinical Post Take within 14 hours of admission	2024-05		F	90%	Target	76.6%
Patients with Senior Review completed at 23:59	2024-05		?	48.8%	Baseline	45.3%
Inpatients - Proportion of patients discharged before 5pm	2024-05	H	F	70%	Target	65.9%
Inpatients - Lost bed days for patients with no criteria to reside	2024-05	H	?	913.4	Baseline	1021
Inpatients - Percentage of adult G&A beds occupied by patients not meeting the criteria to reside	2024-05		?	18.8%	Target	18.5%
Number of non-elective admissions	2024-05	H	?	5916	Target	6242
Number of zero day length of stay non-elective admitted patients	2024-05	H	?	2077	Target	2323
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2024-05		?	127	Target	151
Overnight general and acute beds open	2024-05		?	838	Target	866
Of those overnight general and acute beds open, percentage occupied	2024-05		?	92%	Target	93.4%
Community bed occupancy/availability	2024-05		P	100%	Target	94.6%

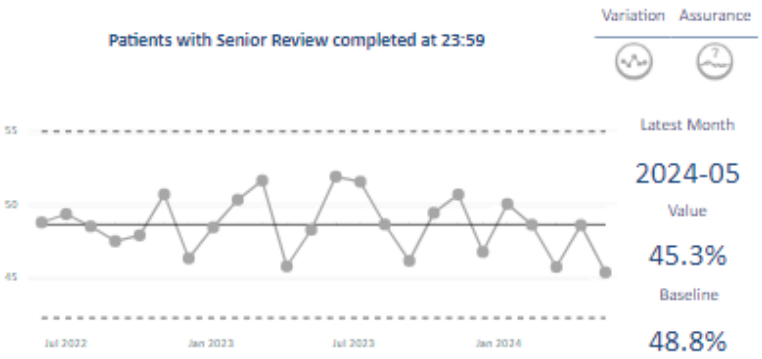
Executive Owner: Karen Stone

Operational Lead: Abolfazl Abdi

Rationale: Patient safety.
Target: **SPC1:** 90% of patients receiving clinical Post Take within 14 hours of admission. **SPC2:** No target.

The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **0.5**.



The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **3.2**.

Factors impacting performance:

- Demand and acuity.
- Workforce challenges.

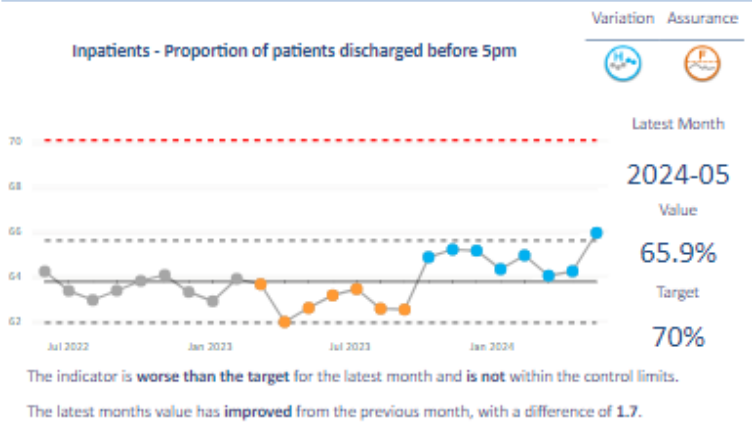
Actions:

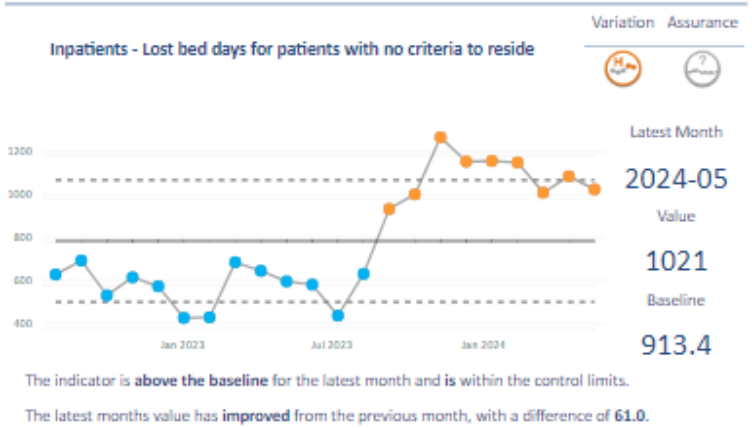
- As part of the Integrated Assessment Unit (IAU) the Trust is strategically moving towards real-time post take. This means patients will receive a senior review by a physician in real-time within the operating hours of the IAU (8am to 8pm).
- Outside IAU operating hours post take happens by conventional on-call Consultant. In combination with the above action the Trust will ensure a high achievement against this standard.
- In the short-term the Trust is developing capacity for and mentoring for senior clinicians to ensure patients receive timely post take.
- The Internal Professional Standards project of 2023-2024 was paused in Q4 due to the requirement to focus on other priorities at that time. The work is now being aligned to UCIP and will be restarted, with support from the Quality Improvement team. Increases in post-take and senior daily review compliance were two of the desired outcomes from this work. We have already established reasons for non-compliance and non-recording of completion and the next steps are to develop plans for improvement.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: Understand flow in the acute bed base.
Target: Internal target of 70%.





Factors impacting performance:

- Demand and acuity.
- Timing of Ward Rounds and Senior Review.
- Community capacity in particular social provision.
- Infection Prevention Control (IPC) outbreaks.
- Workforce challenges.

Actions:

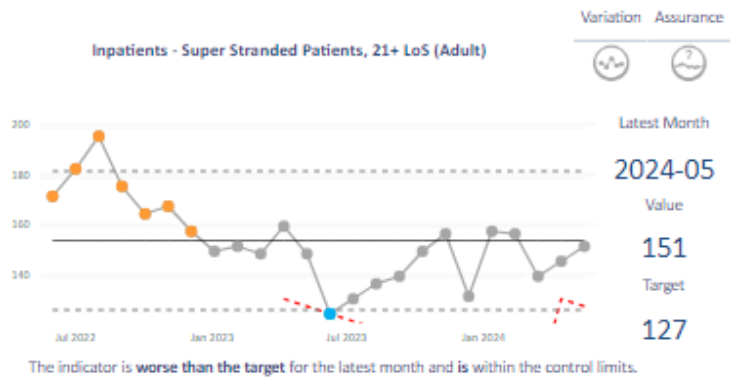
- As per the previous slide, the work of the Discharge Improvement Group will support improvement in this area through three Cells. The group leads the coordination and completion of tasks to achieve alignment with the national discharge policy.

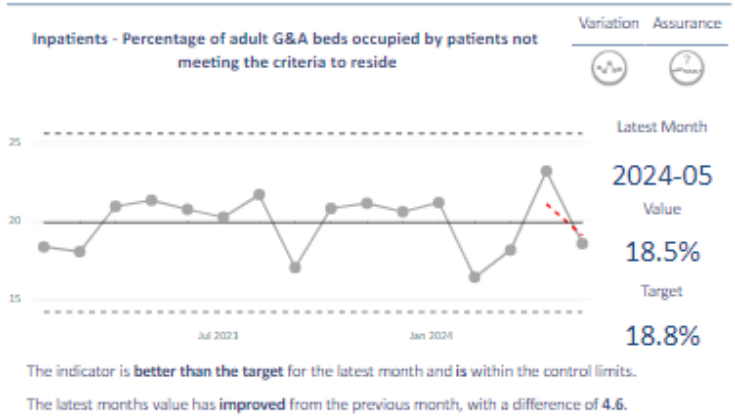
- Adoption of the OPTICA application which is a digital discharge management tool that is integrated with all other partner's systems, so all partners can see the status of a patient and can allocate actions to progress discharge. Implementation is being scoped and likely to be delivered in Q3 of 2024/25.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: Less than 15% as per activity plan (March 2025).





Factors impacting performance:

- Demand increasing for beds, the daily average admissions via ED in May 2024 was 161 patients compared to 131 in May 2023. A rise of 23%.
- Increase in long stay (21+ LoS) leading to bed delays.
- 1,021 lost bed days due to patients with No Criteria To Reside (NCTR). Although the Trust did achieve the target to have less than 18.8% of beds occupied by NCTR patients with performance of 18.5%.
- As part of 2024/25 planning the Trust is aiming to have less than 15% occupied by NCTR patients by March 2025.

Actions:

- As per the previous slides, a discharge programme is underway and will support improvements to NCTR occupancy rates.
- As part of this, we continue to implement super discharge teams where possible to expedite and encourage safe discharges. Super discharge teams should include a senior nurse, medic, AHP and ops lead; together they can add professional challenge into board rounds and keep a focus on ‘why not home, why not today?’.
- Adoption of OPTICA (see previous slide).

Summary MATRIX
CANCER

MATRIX KEY

HIGH IMPROVEMENT
IMPROVEMENT
NEUTRAL
CONCERN
HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Cancer - 62 Day First Definitive Treatment Standard * Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL * % of patients waiting 63 or more days after referral from cancer PTL * Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result	
COMMON CAUSE / NATURAL VARIATION		* Cancer - Faster Diagnosis Standard * Cancer 31 day wait from diagnosis to first treatment * Total Cancer PTL size	
SPECIAL CAUSE CONCERN			

CANCER
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Cancer - Faster Diagnosis Standard	2024-04			68.1%	Target	68.6%
Cancer - 62 Day First Definitive Treatment Standard	2024-04	H		60.1%	Target	66.8%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2024-05	L		143	Target	139
% of patients waiting 63 or more days after referral from cancer PTL	2024-05	L		12%	Target	6.8%
Cancer 31 day wait from diagnosis to first treatment	2024-04			96%	Target	94.9%
Total Cancer PTL size	2024-05			2618.9	Baseline	2194
Percentage of Lower GI Suspected Cancer referrals with an accompanying FIT result	2024-04	H		80%	Target	71.2%

KPIs – Operational Activity and Performance

Cancer (1)

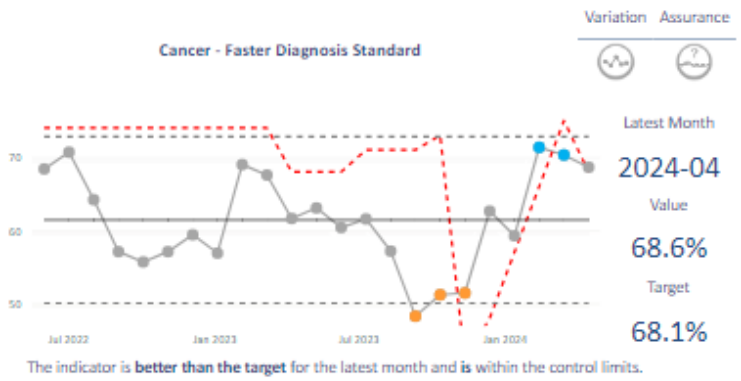
York and Scarborough Teaching Hospitals NHS Foundation Trust

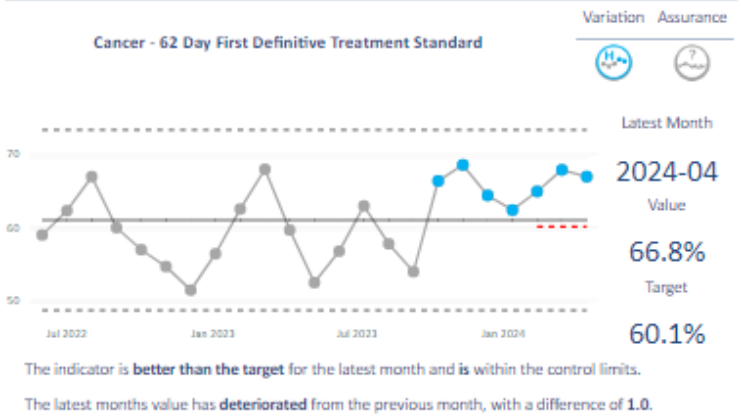
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: SPC1: Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. **SPC2:** National focus for 2024/25 is to improve performance against the headline 62-day standard**.** Rationale to be inserted by Corporate Ops Teams.

Target: SPC1: 77% by March 2024. **SPC2:** 70% by March 2025.





Factors impacting performance (please note; in line with national reporting deadlines cancer reporting runs one month behind):

- April had broadly similar referral volumes across all sites (2,775 total)
- The following cancer sites exceeded 75% FDS in April: Breast, Head and Neck, Lung Skin and Upper GI, NSS and Haematology achieved internal trajectories. Urology, Colorectal and Gynaecology remain below trajectory, with recovery plans around additional WLI's and insourcing to recover the position.
- The following cancer sites exceeded 70% 62-day performance in April: Breast, Haematology and Skin. Colorectal and Upper GI exceeded internal trajectories.
- Diagnostic turnaround times remain challenged in CT reporting and pathology sample reporting. Recovery plans are in place.
- The proportion of patients waiting over 104+ days continues to equate to 1% of the PTL size.

Actions:

- Use of pathway IST analyser to review cancer site pathways against Best Practice Timed Pathways (BPTP) to achieve FDS. Specific improvement workstream set up to support Urology and mapping underway with Skin and Head and Neck to review streamlining opportunities.
- Cancer sites who have experienced increase in demand are reviewing capacity and implementing additional activity.
- Awaiting SLA and receipt of circa £2million 2024-25 system development funding (SDF) via cancer alliance, including schemes that directly impacting performance by providing additional capacity and those directly impacting patient experience and treatment.
- Further funding bid for as part of NHSE national cancer performance recovery fund (£250k allocated to the trust from regional funding). Expectation to receive funding and progress schemes in Q3.
- SACT demand and capacity modelling commencing June 2024 and being lead in partnership with the cancer alliance using nationally approved tool, to inform future treatment planning.
- BI development of IPT dashboard to give improved visibility of patient moves and timescales, due to be available on SIGNAL during Q1 2024/25. This is anticipated to aid planning for actions around site specific improvements for 62-day performance.

Summary MATRIX
Referral to Treatment (RTT)

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* RTT - Waits over 104 weeks for incomplete pathways	* RTT - Total Waiting List * RTT - Waits over 78 weeks for incomplete pathways * RTT - Waits over 65 weeks for Incomplete Pathways * RTT - Waits over 52 weeks for Incomplete Pathways * RTT - Mean Week Waiting Time - Incomplete Pathways
COMMON CAUSE / NATURAL VARIATION		* Proportion of most deprived quintile pathways on RTT PTL (S056a)	* RTT - Proportion of incomplete pathways waiting less than 18 weeks
SPECIAL CAUSE CONCERN	* Proportion of pathways with an ethnicity code on RTT PTL (S058a)	* Proportion of BAME pathways on RTT PTL (S056a)	

Referral to Treatment (RTT)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
RTT - Total Waiting List	2024-05			45992	Target	45643
RTT - Waits over 104 weeks for incomplete pathways	2024-05			0	Target	0
RTT - Waits over 78 weeks for incomplete pathways	2024-05			0	Target	0
RTT - Waits over 65 weeks for Incomplete Pathways	2024-05			159	Target	162
RTT - Waits over 52 weeks for Incomplete Pathways	2024-05			1851	Target	1620
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2024-05			92%	Target	54.4%
RTT - Mean Week Waiting Time - Incomplete Pathways	2024-05			9	Target	19.5
Proportion of BAME pathways on RTT PTL (S056a)	2024-05			1.8%	Baseline	1.6%
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2024-05			12%	Baseline	12.2%
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2024-05			67.4%	Baseline	66.3%

KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

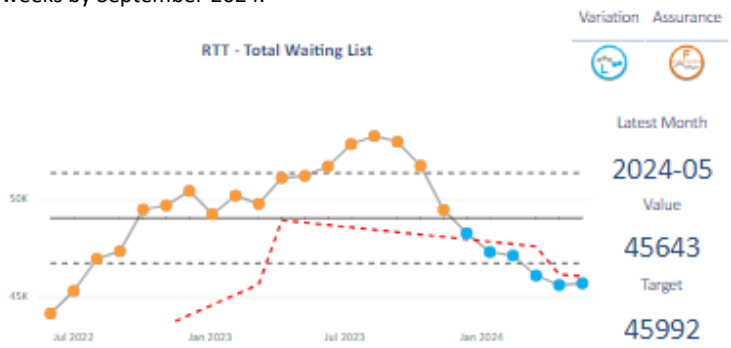
York and Scarborough Teaching Hospitals NHS Foundation Trust

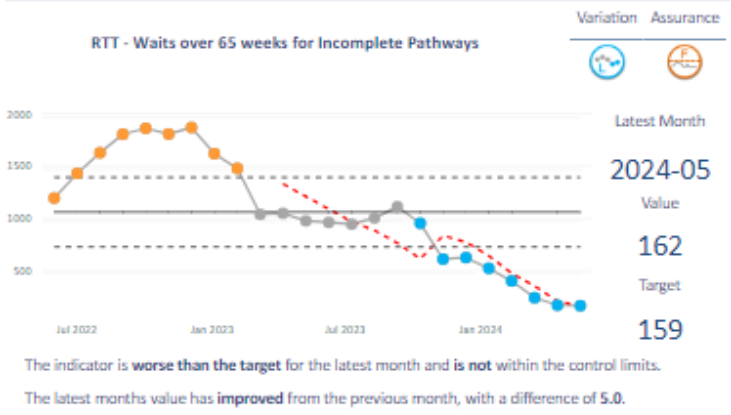
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: SPC1: To measure the size of the Referral to Treatment (RTT) incomplete pathways waiting list. **SPC2:** To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.

Target: SPC1: Aim to have less than 44,663 patients waiting by March 2025 as per activity plan. **SPC2:** Aim to have 0 patients waiting more than 65 weeks by September 2024.





Factors impacting performance:

- The Trust's RTT Waiting list position continues to be ahead of the trajectory submitted to NHSE as part of the 2024/25, 45,643 against the trajectory of 45,992. The RTT waiting list has increased on the end of April position (45,556) largely due to rise in referrals received from GPs; 10,008 against the previous twelve-month average of 9,392 per month.
- The proportion of the waiting list waiting under 18 weeks improved from 53.2% at the end of April 2024 to 54.4% at the end of May 2024.
- The Trust maintained the position of having zero RTT78 week waits at the end of May 2024 but marginally failed to deliver the RTT65 weeks trajectory (162 against 159) submitted as part of the 2024/25 Activity Plan. The RTT65 week trajectory was not delivered primarily due to a significant number of patients choosing to change their treatment outpatient appointments and surgery dates that were booked in May into June.

Actions:

- Implementation of new Power business intelligence (BI) RTT patient tracklog list (PTL) tool for Operational Managers continues with significant progress made throughout May.
- ECHO at York had completed demand and capacity and forecast that with additional 45 extra patients per week delivered through the CDC, the backlog will be cleared in 13 weeks following full go live. Currently live at Askham Bar but delayed at Selby due to internal infrastructure works.
- The Trust's RTT Waiting List has a data quality RTT PTL Confidence Rating of 99.6% as awarded by the LUNA National data quality (DQ) RTT Benchmarking tool. The Trust is in the top 25 Trusts in the country for this metric and signals that our RTT waiting list is 'clean', accurate and the patients are legitimate waiters.
- The Trust is part of cohort 2 of the national Further Faster Programme, several specialties perform well against the key metrics including the did not attend (DNA) rate, pre-referral triage and advice and guidance. Next steps are to focus on further patient initiated follow up (PIFU) roll out, Rapid Expert Input (REI) roll out, clinic slot utilisation and new to follow up ratios.
- 24/25 Elective Recovery plan has been developed with Trust and Place colleagues and includes the following workstreams:
    - Outpatient improvement.
    - Theatre improvement.
    - Diagnostic improvement.
    - Cancer.
    - Children and Young People.
    - Productivity and Efficiency.
    - Health inequalities.

KPIs – Operational Activity and Performance

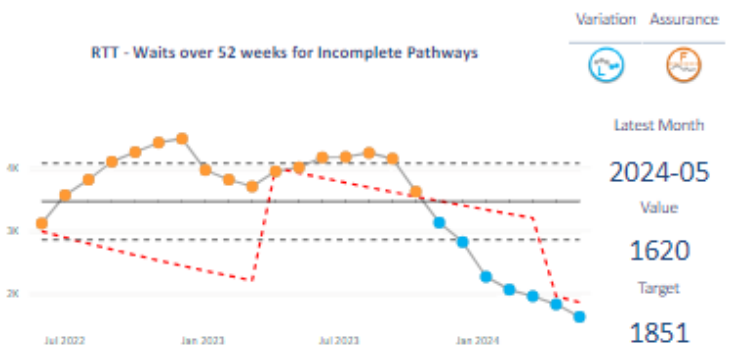
Referral to Treatment RTT (2)

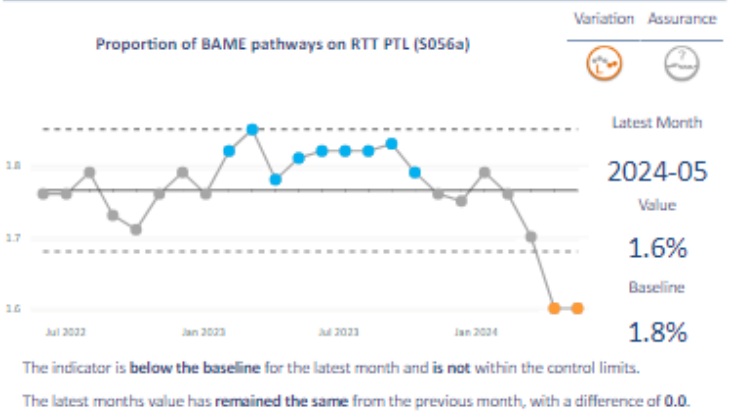
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.
Target: SPC1: Aim to have less than 923 patients waiting more than 52 weeks by March 2025 as per activity plan. **SPC2:** No Target





Factors impacting performance:

- The Trust delivered the trajectory for RTT52 weeks; 1,620 against the trajectory of 1,851.
- RTT52 week waits reduced by 198 compared to the end of April 2024 (1,818).

Actions:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 and RTT65 weeks.
- The Trust's activity plan that is aligned to improvement trajectories; delivering zero RTT65 week waits by the end of September 2024 and an improvement to no more than 923 RTT52 week waits by the end of March 2025, was submitted to the national team on the 2nd of May 2024. To achieve this trajectory our Care Groups will need to make a collective net monthly reduction of between 90 to 110 patients per month throughout 2024-25. This was achieved in May 2024.
- Delivery of the 2024/25 elective recovery plan. Initial analysis shows that at the end of May 2024 the Trust is ahead of the 2024/25 activity plan with a provisional performance of 113% of the Weighted Value Trust Activity Plan submitted to NHSE.
- Elective Health inequalities group established, reporting into elective recovery board and Trust Health Inequalities Steering Group.

KPIs – Operational Activity and Performance

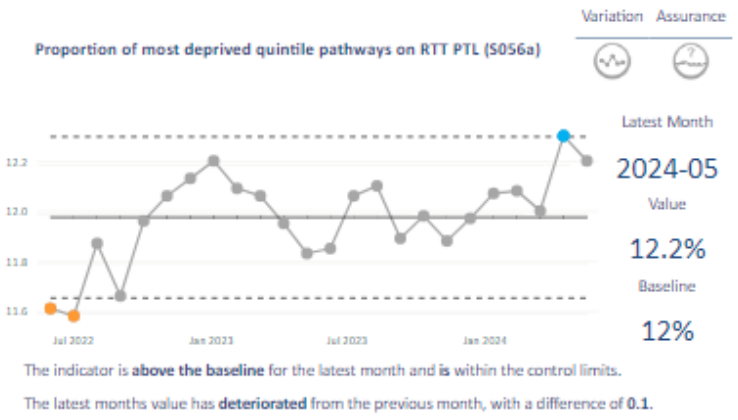
Referral to Treatment RTT (3)

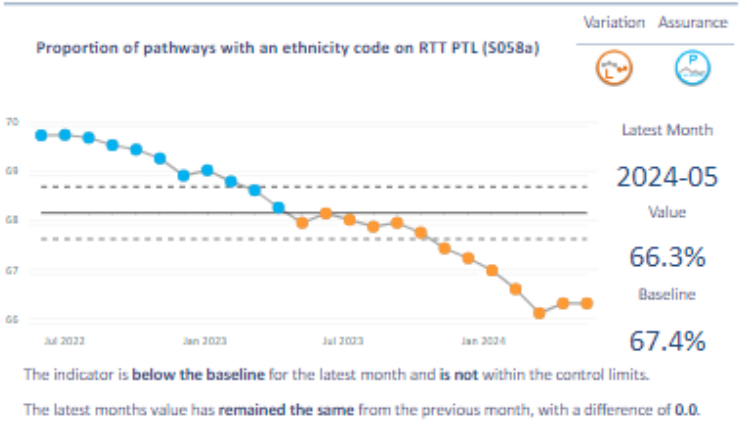
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: To identify any health inequalities.
Target: No target.





Factors impacting performance:

- Removal of the question regarding ethnicity from the inpatient admission form has impacted performance.
- Consistency of outpatient reception staff asking patients at the point of booking in.

Actions:

- Elective Health inequalities group established, reporting into elective recovery board and Trust Health Inequalities Steering Group.
- 8-week surgical pathway for patients with learning disabilities on an elective waiting list task and finish group established and piloting new pathway in May 2024 with SOP and full implementation to be signed off in June 2024. Baseline position for median waiting time is 17.5 weeks.
- Q2 2024/25 focus will be a review of DNAs and correlation with deprivation index.
- Professional Lead for Patient Access has developed a laminated sheet for all outpatient receptions to provide patients with information on why we collect this information.

Health Inequalities

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Melanie Liley

RTT PTL by Indices of Multiple Deprivation (IMD) Quintile

At end of: **May 2024**

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	19	5505	12.32%	8.88%
2	20	6201	13.88%	13.59%
3	20	9479	21.22%	20.94%
4	19	9716	21.75%	20.68%
5	19	13772	30.83%	35.90%
Unknown	20	970		
Total	**20**	**45643**		

Highlights For Board To Note

As per national planning mandate, RTT Waiting List data has, in order to identify any potential health inequalities, been split to view Ethnic Groups and IMD Quintile.

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation. IMD is a combined measure of deprivation based on a total of thirty seven separate indicators that are grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area.

IMD quintiles range from one to five, where one is the most deprived. Please note that IMD quintiles are not available where we have no record of a patient postcode, the postcode is not an English postcode or is an unmatched postcode.

Ethnic codes have been grouped as per the 2021 census. Any patient where Ethnic Group is either 'Unknown' or 'Not Stated' is excluded from the PTL proportions. Areas to take into consideration when interpreting the data include the lack of available site split for Trust Catchment, and the variation that Clinical Prioritisation can bring to weeks waiting.

The Trust has established a Health Inequalities and Population Health Steering Group; the primary aim is to develop a plan that encompasses the overall Trust Inequality Strategy to address and mitigate health disparities within the Trust's catchment area. This will align to the refreshed Trust Strategy 2024. A number of Task and Finish Groups will be established to facilitate focused and efficient implementation of specific aspects of the strategy. The overarching goal is to foster a healthcare environment that prioritises equity, inclusivity, and improved health outcomes for all individuals, considering socio-economic, demographic, or other determinants.

RTT PTL by Ethnic Group

At end of: **May 2024**

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	19	29960	98.40%	94.34%
Black, Black British, Caribbean or African	16	55	0.18%	0.94%
Mixed or multiple ethnic groups	19	111	0.36%	1.26%
Asian or Asian British	19	226	0.74%	2.97%
Other ethnic group	23	94	0.31%	0.49%
Unknown	20	12115		
Not Stated	20	3082		
Total	**19**	**45643**		

Data source for trust catchment area: Public Health England NHS Acute Catchment Areas.
*Proportion on waiting list excluding not stated and unknown.

Summary MATRIX
Outpatients & Elective

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			* Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)
COMMON CAUSE / NATURAL VARIATION	* Outpatients: Follow Up Attendances * Outpatient procedures * Percentage of elective admissions which are day case	* Outpatients - DNA rates * All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days* * Day Cases (based on Activity v Plan) * Electives (based on Activity v Plan)	* Outpatients - Proportion of appointments delivered virtually (S017a) * Outpatients: 1st Attendances
SPECIAL CAUSE CONCERN			* Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks) * Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)

Outpatients & Elective Care
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Outpatients - Proportion of appointments delivered virtually (S017a)	2024-05		F	25%	Target	20.9%
Outpatients - DNA rates	2024-05		?	5%	Target	5.2%
Outpatients: 1st Attendances	2024-05		F	18268	Target	17351
Outpatients: Follow Up Attendances	2024-05		P	45028	Target	44460
Outpatient procedures	2024-05		P	7988	Target	13128
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2024-05	H	F	0	Target	27121
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2024-05	H	F	4.1%	Target	3.5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2024-05	L	F	99%	Target	15.2%
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days*	2024-03		?	0	Target	11
Day Cases (based on Activity v Plan)	2024-05		?	6783	Target	7673
Electives (based on Activity v Plan)	2024-05		?	567	Target	706
Percentage of elective admissions which are day case	2024-05		P	85%	Target	91.6%

KPIs – Operational Activity and Performance

Outpatients (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

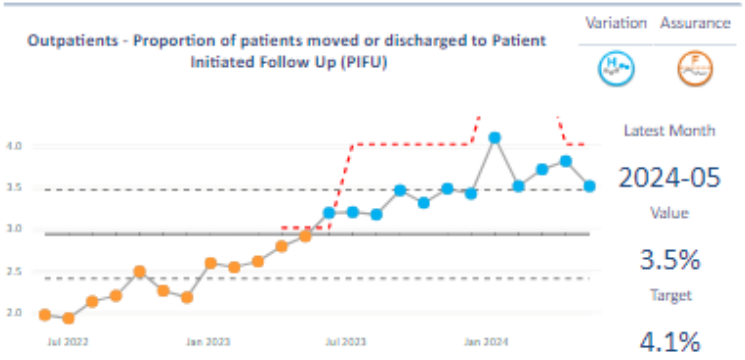
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: SPC1: Need to reduce instances where people miss their outpatient appointments ('did not attends' or 'DNAs') to improve patient experience, free up capacity to treat long-waiting patients and support the delivery of the NHS's plan for tackling the elective care backlog. **SPC2:** Helps empower patients to manage their own condition and plays a key role in enabling shared decision making and supported self-management in line with the personalised care agenda.
Target: SPC1: Internal target of less than 5%. **SPC2:** Above 5% by March 2025.

The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **0.8**.



The indicator is **worse than the target** for the latest month and **is not** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **0.3**.

Factors impacting performance:

- Outpatient bi-directional text messaging positively impacting DNA rates.
- PIFU roll out is paused awaiting an automated solution to add patients to PIFU list and lack of call handling capacity.
- Increasing demand on the Rapid Access Chest Pain service has been seen, service are undertaking capacity and demand work before options appraisal developed.

Actions:

- DIS Development team developing an automated process to ensure PIFU patients are correctly added to PIFU list. Go live is planned for July 2024.
- Review of call handling solutions to ensure we have capability to respond to additional patient contacts.
- Development of PIFU pathways across specialities as part of elective recovery plan and further faster workstream.
- Elective bi-directional text messaging has just been implemented with evaluation of impact to be undertaken.

Summary MATRIX
Diagnostics

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

ASSURANCE

VARIATION

	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT		* Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI * Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy * Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	* Diagnostics - Proportion of patients waiting <6 weeks from referral
COMMON CAUSE / NATURAL VARIATION		* Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema * Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology * Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography * Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral * Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	* Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound * Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan * Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies
SPECIAL CAUSE CONCERN	* Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	* Diagnostics - Proportion of patients waiting <6 weeks from referral - CT * Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	

DIAGNOSTICS – 95%
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Diagnostics - Proportion of patients waiting <6 weeks from referral	2024-05	H	F	66.3%	Target	59.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2024-05	H	?	62.1%	Target	60.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2024-05	L	?	68.7%	Target	54.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2024-05		F	82%	Target	65.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2024-05		?	75.5%	Target	76.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2024-05		F	62%	Target	43.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2024-05		?	83.6%	Target	57.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2024-05		?	29.5%	Target	29.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2024-05		?	95.7%	Target	99.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2024-05		F	95.2%	Target	65.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2024-05	L	?	28.7%	Target	19%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2024-05	H	?	46.6%	Target	74.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2024-05	H	?	37.7%	Target	58.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2024-05		?	75%	Target	65.4%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2024-05	L	P	71.9%	Target	79.1%

KPIs – Operational Activity and Performance

Diagnostics (1)

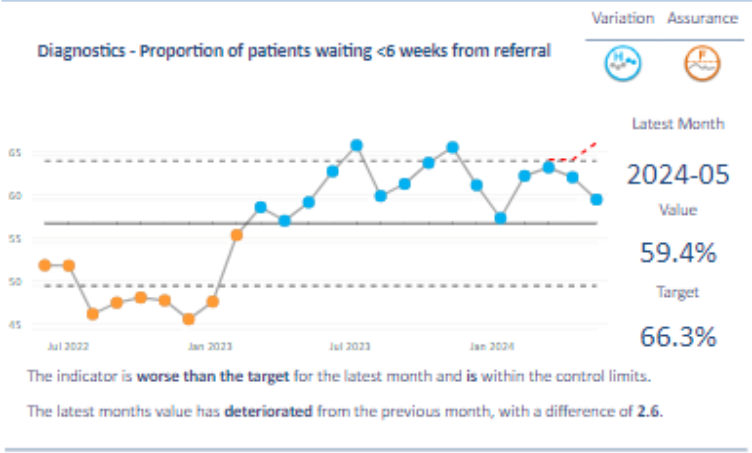
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: Maximise diagnostic activity focused on patients of highest clinical priority.

Target: Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%.



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Factors impacting performance:

- Complexity of CDC programme delivery.
- Workforce challenges across most imaging modalities and consequence of higher banding for CDC mobile so seeing increased attrition of staff.
- Acute and cancer demand for CT and MRI.
- Aging equipment (MRI at York and SGH, CT3 at York) causing increased downtime.
- Complex booking and administrative processes which adds to delays.
- Workforce challenges within Gastroenterology but recent recruitment successful.
- Development of non-consultant workforce.
- Age-extension of bowel cancer screening programme demand.
- Increase in outsourced work leading to longer reporting times due to lack of in-house reporting capacity.
- Delays in purchase of IT equipment to allow off site reporting.

Actions:

- Onboarding of all services by end of May 2024 at Askham Bar CDC (CT, MRI, DEXA scans, Cardiorespiratory and Phlebotomy).
- Go live of new Selby CDC activity with completion of onboarding of all services by August 2024 (NOUS and Cardiorespiratory).
- 3rd MRI scanner at York received external funding approval and business case approved at Executive Committee.
- ECHO at York had completed demand and capacity and forecast that with additional 45 extra patients per week delivered through the CDC, the backlog will be cleared by the end of July 2024. Improvement plans for Scarborough being developed.
- Demand and Capacity work for all DM01 diagnostics tests being completed during Q1&Q2 2024/25 as part of elective recovery plan.
- Urodynamics have developed a recovery plan to deliver by Q2 2024/25 including additional extra contractual activity attracting ERF through the outpatient procedure tariff.
- Endoscopy insourcing continues with additional 10 lists per week to end of Q2 2024/25. They are currently ahead of the improvement trajectory.

Summary MATRIX
Children & Young Persons

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Children & Young Persons: RTT - Total Waiting List	* Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks * Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways
COMMON CAUSE / NATURAL VARIATION		* Children & Young Persons: ED - Patients waiting over 12 hours in department	* Children & Young Persons: ED - Emergency Care Standard (Type 1 only)
SPECIAL CAUSE CONCERN			

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Children & Young Persons: ED - Patients waiting over 12 hours in department	2024-05		?	0	Target	7
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2024-05		F	95%	Target	82.7%
Children & Young Persons: RTT - Total Waiting List	2024-05	L	?	4200.5	Baseline	3630
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2024-05	H	F	92%	Target	69.5%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2024-05	L	F	16	Target	28

KPIs – Operational Activity and Performance

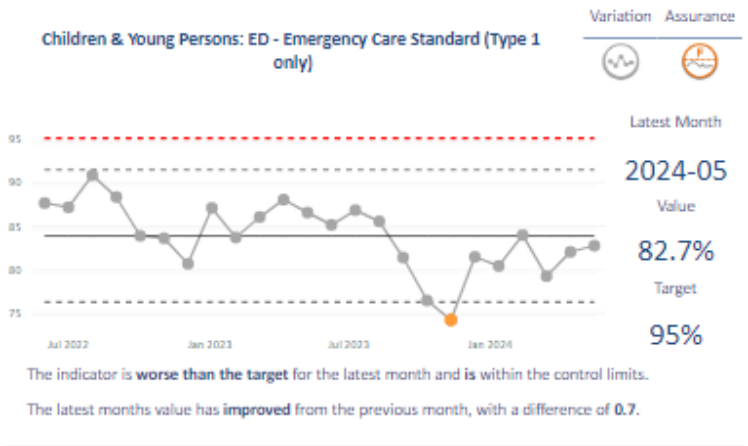
Children & Young Persons (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

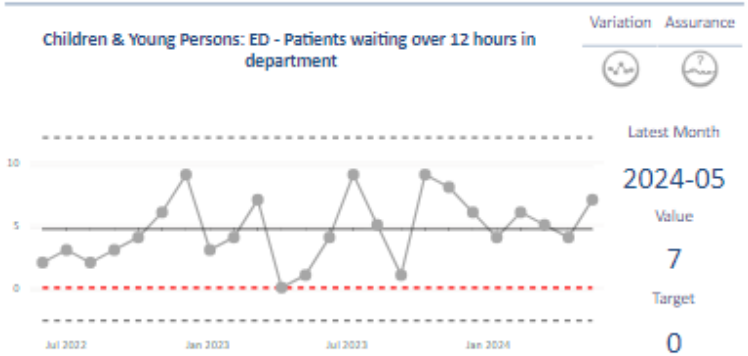
Operational Lead: Abolfazl Abdi

Rationale: SPC1: To monitor waiting times in A&E**. SPC2:** To monitor long waits in A&E.
Target: SPC1: NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2025.
SPC2: No paediatric patients should wait more than 12 hours.



The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **0.7**.



The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **3.0**.

Factors impacting performance:

- Increased attendances across both of our Emergency Departments (EDs) compared to May 2023, The Trust saw an average of 53 more attendance per day throughout the month of May 2024, a rise of 13%. Ambulances also continue to rise (May 2024 average of 139 per day against the May 2023 average of 128, a rise of 9%). The acuity of ambulance arrivals has also increased. The two most acute categories (1&2) saw a rise from a daily average of 102 in May 2023 to a daily average of 115 in May 2024 putting significant pressure on our EDs (13% increase).

- The children and young people waiting longer than 12 hours in the department were all aged 17 years old and are being managed through an adult pathway with the four who were admitted having their wait being impacted by the wait for an adult ward resulting in delays.

Actions:

- Scoping improvement actions for children and young people with family health care group.

KPIs – Operational Activity and Performance

Children & Young Persons (2)

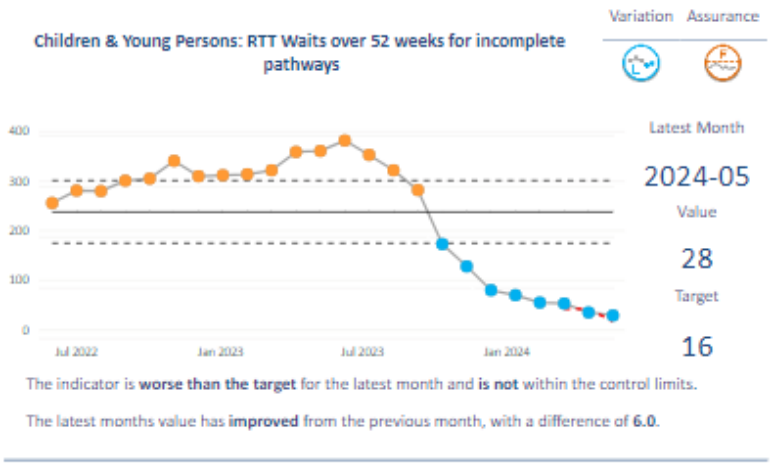
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.

Target: Aim to have 0 patients waiting more than 52 weeks by July 2024 (internal target).



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Factors impacting performance:

- The Trust did not deliver the trajectory for RTT52 weeks wait for patients aged under eighteen submitted as part of the 2024/25 Activity Plan with 28 against a trajectory of 16. This was impacted by patients requesting to delay their treatment into June.

Actions:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 weeks wait for patients aged under eighteen.

- Children and Young People are a workstream within the 2024/25 elective recovery plan with a focus on the following improvements:
  - Increase outpatient capacity at Scarborough through the Scarborough right sizing priorities.
  - Strategy for day case surgery for children.
  - Going further for children waiting times for surgery
  - Stabilise community waiting lists.

Summary MATRIX
Community

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Total Urgent Community Response (UCR) referrals * 2-hour Urgent Community Response (UCR) care Referrals * Number of Adults (18+ years) on community waiting lists per system	* Number of open Virtual Ward beds * Number of CYP (0-17 years) on community waiting lists per system
COMMON CAUSE / NATURAL VARIATION	* 2-hour Urgent Community Response (UCR) Compliancy %	* Percentage of Virtual Ward beds occupied * Number of District Nursing Contacts * Number of York CRT Contacts * Referrals to District Nursing Team	
SPECIAL CAUSE CONCERN		* Community Response Team (CRT) Referrals * Number of Selby CRT Contacts * Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	

COMMUNITY
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

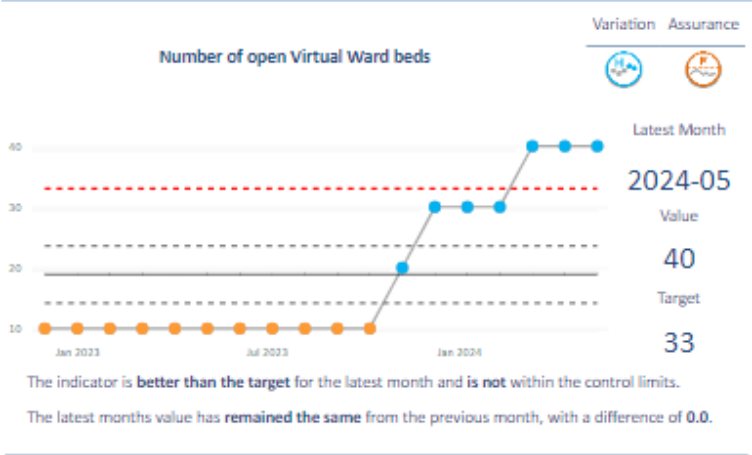
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

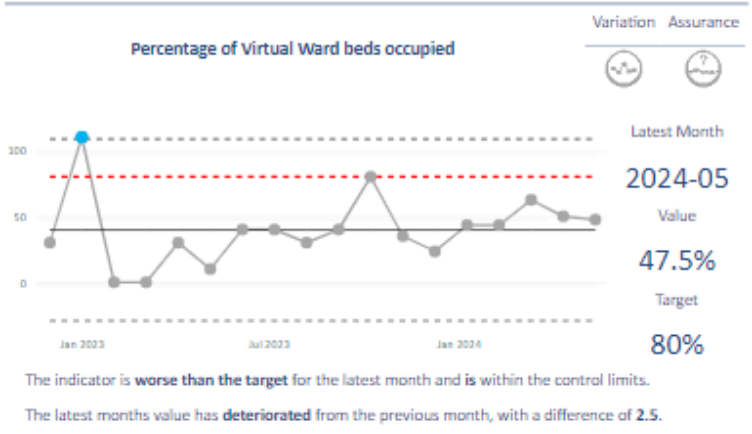
Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Number of open Virtual Ward beds	2024-05	H	F	33	Target	40
Percentage of Virtual Ward beds occupied	2024-05		?	80%	Target	47.5%
Community Response Team (CRT) Referrals	2024-05	H	?	430.1	Baseline	468
Total Urgent Community Response (UCR) referrals	2024-05	H	?	170.7	Baseline	654
2-hour Urgent Community Response (UCR) care Referrals	2024-05	H	?	85.4	Baseline	111
2-hour Urgent Community Response (UCR) Compliancy %	2024-05		P	70%	Target	91%
Number of Adults (18+ years) on community waiting lists per system	2024-05	L	?	797.6	Baseline	781
Number of CYP (0-17 years) on community waiting lists per system	2024-05	L	F	726	Baseline	2034
Number of District Nursing Contacts	2024-05		?	21191.8	Baseline	21802
Number of Selby CRT Contacts	2024-05	H	?	2709.2	Baseline	3283
Number of York CRT Contacts	2024-05		?	4819.8	Baseline	4240
Referrals to District Nursing Team	2024-05		?	2229.8	Baseline	2295
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2024-05	H	?	972	Target	920

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor demand on Community services.
Target: No Target.





Factors impacting performance:
- Workforce challenges.
- Acute pressures.

Actions:
The trajectory for March 2024 was capacity for 33 patients on virtual wards, which we met. That target is not changing in 2024-25, and there is reduced scrutiny from the ICB to the programme team leading the virtual ward work.

Our open beds number of 40 consists of the following:
York Frailty: 10 beds reported as open. Utilisation varies based on the number of patients meeting the criteria.

Heart Failure: 10 bed are open. In March 2024, the team was routinely taking 12-15 patients while they tested the ability to increase capacity safely and consistently. Since then, the heart failure team has been asked to support alternative work in cardiology and therefore have not been able to increase capacity or hold high levels of use.

Vascular Virtual Ward: 10 beds are open on CPD, they are open for suitable patients who are awaiting callback for scans who can wait at home. Utilisation varies based on the number of patients meeting the criteria.

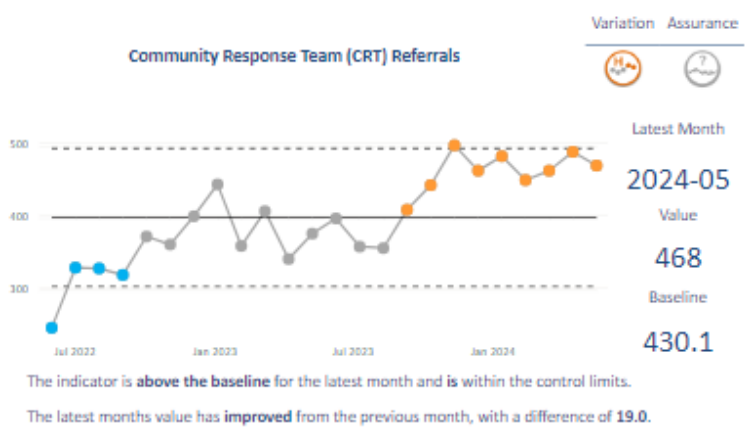
Cystic Fibrosis: 10 beds are open on CPD; in addition to the beds the team have alternative remote monitoring technology in place for patients and are testing whether using the CPD virtual ward space can assist with clinical interventions when avoiding step-up admissions. The team are seeing benefits to using the virtual ward, so we may see an increase in occupancy.

The Trust has now entered a contract with Inhealthcare, a virtual hospital technology provider which can support better remote monitoring of patients on a virtual ward. Frailty and Heart Failure will be the first teams to use this technology, with implementation planned through summer 2024. The renal team are also taking part in demos and designing an Inhealthcare pathway for their kidney failure patients, expected to be running in Autumn 2024.

Executive Owner: Claire Hansen

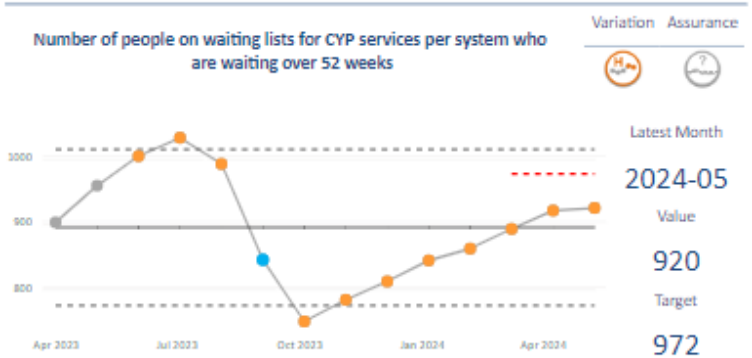
Operational Lead: Abolfazl Abdi

Rationale: To monitor demand on Community services.
Target: SPC1: No target. **SPC2:** no more than 1,056 by end of March 2025 as per activity planning submission.



The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **19.0**.



The indicator is **better than the target** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **4.0**.

Factors impacting performance:

- **SPC1:** Referrals to York Community Response Team and Urgent Community Response was consistent with previous months in May 2024 remaining near the upper control limit. The continued development of the frailty Crisis hub will likely have further impact on referrals with the YAS pathway developments. There is continued demand for hospital discharge support. To manage the competing demands community teams flex capacity to provide a responsive service where they can, however with continued growth and no further investment meeting this demands will become challenging. The additional resource for Discharge to Assess bridging will provide little impact on type and complexity of the rehab and reablement referrals.

- **SPC2:** Continuing increase in demand and static funded current capacity resulting in increasing waiting times.

Actions:

- **SPC1:** There is ongoing conversations with the South Hambleton and Ryedale and Selby Primary Care Networks re the UCR model and creating better integrating with primary care to ensure better equity of service.

- **SPC1:** Continue to monitor the demand and capacity of the team.

- **SPC2:** Community paediatrics waiting lists includes; speech and language, occupational therapy, autism and sleep. Options appraisal being undertaken to identify improvement opportunities to be completed in Q1 24/25.

QUALITY AND SAFETY

June 2024

Summary MATRIX 1 of 2
Quality and Safety

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Inpatient Acquired Pressure Ulcers * Medication incidents per thousand bed days * Patient Safety Incidents per thousand Bed Days * Harmful Incidents per thousand bed days	
COMMON CAUSE / NATURAL VARIATION		* Total Number of Trust Onset MSSA Bacteraemias * Total Number of Trust Onset MRSA Bacteraemias * Total Number of Trust Onset C. difficile Infections * Total Number of Trust Onset E. coli Bacteraemias * Total Number of Trust Onset Klebsiella Bacteraemias * Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias * Pressure Ulcers per thousand Bed Days * All Patient Falls * Patient Falls per thousand Bed Days * Percentage of Patient Safety Incidents with Moderate or Above Harm * Trust Duty of Candour (Stage 1) * Trust Duty of Candour (Stage 2) * Trust Duty of Candour (Stage 3) * Number of Serious Incidents Reported * In-Hospital Deaths * Monthly SHMI * Monthly HSMR	
SPECIAL CAUSE CONCERN		* Total Number of Never Events Reported	

Quality & Safety
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sue Peckitt

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Total Number of Trust Onset MSSA Bacteraemias	2024-05			5	Target	8
Total Number of Trust Onset MRSA Bacteraemias	2024-05			0	Target	1
Total Number of Trust Onset C. difficile Infections	2024-05			10	Target	15
Total Number of Trust Onset E. coli Bacteraemias	2024-05			15	Baseline	18
Total Number of Trust Onset Klebsiella Bacteraemias	2024-05			6	Baseline	4
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2024-05			1	Baseline	2
Inpatient Acquired Pressure Ulcers	2024-05			144	Baseline	117
Pressure Ulcers per thousand Bed Days	2024-05			4	Baseline	3.5
All Patient Falls	2024-05			251	Baseline	263
Patient Falls per thousand Bed Days	2024-05			9	Target	8.6
Medication incidents per thousand bed days	2024-05			6	Baseline	4.8

KPIs – Quality & Safety

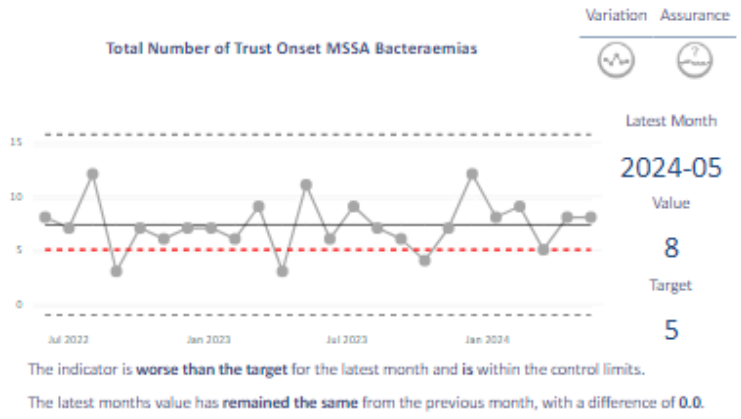
Q&S (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Dawn Parkes

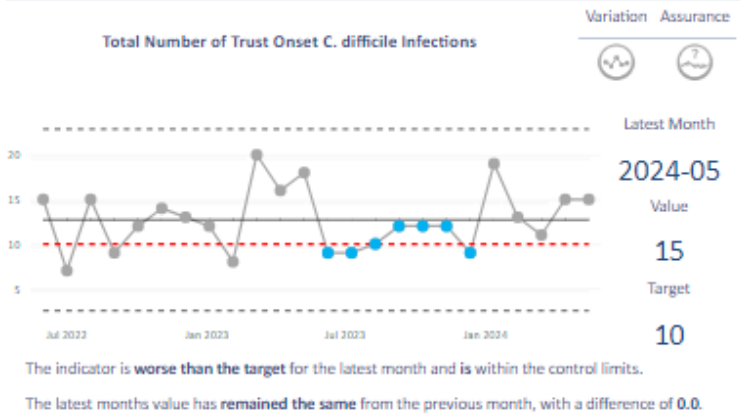
Operational Lead: Sue Peckitt

Rationale: To drive reduction in avoidable health care associated infection, facilitate patient safety and improve patient outcomes
Target: National targets for 2024/25 not yet set, working on 2023/24 threshold – 1 for all mandatory surveillance organisms.



The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **remained the same** from the previous month, with a difference of **0.0**.



The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **remained the same** from the previous month, with a difference of **0.0**.

Factors impacting performance:

- MSSA bacteraemia breached the internally set target of 5 cases with 8 cases recorded, 6 cases attributed to York Hospital, 1 attributed to Scarborough Hospital and 1 attributed to a community unit
- 1 MRSA bacteraemia reported in May against a zero target. This was attributed to Hospital although the patient was septic on admission. This takes the Trust to 2 MRSA cases for 2024/25
- Clostridioides difficile breached the monthly target in April by 5 cases. Of the 15 cases 9 were attributed to York Hospital, 5 attributed to Scarborough Hospital, 1 attributed to a community hospital site . This is equal to last month's performance.
- Whilst not directly related to performance Scarborough Hospital is seeing a significant impact from outbreaks of Norovirus

Actions:

- A post infection review of the MRSA case has been undertaken and identified that the patient had clinical signs of sepsis on admission but the Blood Culture was negative. Further testing became positive, therefore the case was attributed to the Trust. The patient had not had health care intervention since 2020. A review of care post admission identified some learning regarding delayed antimicrobial administration . All MSSA bacteraemia undergo a review using a PSIRF approach, learning identified improvement needed with hand hygiene compliance, IV cannula documentation, ANTT compliance
- Internal audit of Cannula Management Action plan in progress which addresses ANTT and IV cannula documentation, peripheral intravenous cannula devices guideline has been updated and approved via IPSAG, to be uploaded on staff room.
- Clostridioides difficile cases are reviewed using PSIRF approach, learning identified inappropriate antibiotic prescribing, delay in isolation, need for improved communication during handover and with Microbiology regarding treatment advice, improvements required for Hand Hygiene, commode cleanliness and completion of Bristol Stool Chat. Learning being addressed via the Care Group.
- Working with Care Groups to introduce Care Group Infection Prevention and Control Groups.

Quality & Safety
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Adele Coulthard **Operational Lead:** Dan Palmer

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Patient Safety Incidents per thousand Bed Days	2024-05	L	?	51	Baseline	42.4
Harmful Incidents per thousand bed days	2024-05	L	?	18	Baseline	13.6
Percentage of Patient Safety Incidents with Moderate or Above Harm	2024-05		?	3%	Baseline	4.2%
Trust Duty of Candour (Stage 1)	2024-05		?	93%	Baseline	91.2%
Trust Duty of Candour (Stage 2)	2024-05		?	91%	Baseline	89.7%
Trust Duty of Candour (Stage 3)	2024-05		?	91%	Baseline	93.1%
Number of Serious Incidents Reported	2024-05		?	9	Baseline	4
Total Number of Never Events Reported	2024-05	H	?	0	Target	3
In-Hospital Deaths	2024-05		?	199	Baseline	199
Quarterly SHMI	2023-12			100	Target	98.8
Monthly SHMI	2024-01		?	100	Target	90.6
Quarterly HSMR	2023-12			100	Target	108.2
Monthly HSMR	2024-02		?	100	Target	108.7

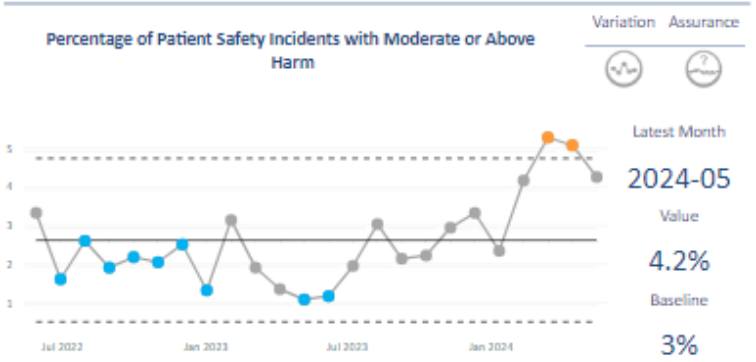
Executive Owner: Adele Coulthard

Operational Lead: Dan Palmer

Rationale: Rationale to be inserted by leads
Target: Target to be inserted by leads

The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **3.7**.



The indicator is **above the baseline** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **0.9**.

Factors impacting performance:

With the move to DCIQ, there have been issues with the new system bedding into business as usual. These issues are known about and are addressed through regular discussions with the system provider and with staff using the system. The previous figures show that even with concerns being raised across the organisation, the completion of incidents has not dropped as a result and has been consistent for 8 months.

- The numbers of reported incidents remain within levels of normal variation.
- Work is now completed on improving the Datix reporting form to make this easier for staff to complete and load.
- Use of the system is constantly monitored and any operational issues are discussed with the system provider.

As stated on the last TPR report the Patient Safety team have now reduced the fields in the form by removing categories. The categories were reviewed as to how much they were used and the usefulness of being able to pull off the data within these categories. Those underutilised categories, or those that can be included in other categories have been removed.

Previously there were 196 subcategories and initial figures identified that 73 of these will be removed tis is a reduction of 37% in the Datix reporting form that will be loaded.

This work was completed by on the 30th of May 2024 and was communication with safety via Q&S and in the weekly safety brief.

The patient safety team are awaiting feedback on the new form. A change request form has been developed to capture future changes for audit purposes that will be shared with the care groups.

The increase in Moderate harms and above will be monitored after the datix has been investigated and validated.

Summary MATRIX 2 of 2

Quality and Safety

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Intrapartum Stillbirths * Obstetrics and Gynaecology: Serious Incidents	
COMMON CAUSE / NATURAL VARIATION	* Friends and Family Test - Trust Inpatient Recommend % * Friends and Family Test - Trust Maternity Recommend %	* Needlestick Injury or Sharps Incident * Staff Slips, Trips and Falls * RIDDOR * Antepartum Stillbirths * Early neonatal deaths (0-7 days) * PPH > 1.5L as % of all women - York * PPH > 1.5L as % of all women - Scarborough * Obstetrics and Gynaecology: Moderate Incidents	* Friends and Family Test - Trust ED Recommend %
SPECIAL CAUSE CONCERN		* Trust Complaints	

Quality & Safety
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Tara Filby/ Sacha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Friends and Family Test - Trust ED Recommend %	2024-04		F	90%	Target	71.3%
Friends and Family Test - Trust Inpatient Recommend %	2024-04		P	90%	Target	95.2%
Friends and Family Test - Trust Maternity Recommend %	2024-04		P	90%	Target	99%
Trust Complaints	2024-05	H		73	Baseline	111
Needlestick Injury or Sharps Incident	2024-05			15	Baseline	19
Staff Slips, Trips and Falls	2024-05			4	Baseline	3
RIDDOR	2024-05			2	Baseline	1
Antepartum Stillbirths	2024-04			0.7	Baseline	2
Intrapartum Stillbirths	2024-04	L		0	Baseline	0
Early neonatal deaths (0-7 days)	2024-04			0.8	Baseline	2
PPH > 1.5L as % of all women - York	2024-04			4.9%	Baseline	5.2%
PPH > 1.5L as % of all women - Scarborough	2024-04			2.5%	Baseline	0%
Obstetrics and Gynaecology: Serious Incidents	2024-05	L		0	Baseline	0
Obstetrics and Gynaecology: Moderate Incidents	2024-05			9.8	Baseline	12

Executive Owner: Dawn Parkes/Karen Stone **Operational Lead:** Tara Filby

Rationale: Rationale to be inserted by XXXXXX.
Target: Target to be inserted by XXXXXX.

Factors impacting performance: The number of new complaints remains high and is almost three times the average pre pandemic. In the month of May, 12% new complaints related to the Emergency Department at York Hospital. Unsurprisingly the majority of complaints relate to delayed treatment across services but complaints about staff attitude and poor communication also remain high.
As at 04/06/24 194 complaints remain open, of which 57 are overdue and 28 due in the next 10 days.

Actions:

MATERNITY

June 2024

Summary MATRIX 1 of 3

Maternity Scarborough

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Bookings - Scarborough * Community midwife called in to unit - Scarborough	
COMMON CAUSE / NATURAL VARIATION		* Bookings ≥13 weeks (exc transfers etc.) - Scarborough * Births - Scarborough * No. of women delivered - Scarborough * Women affected by suspension - Scarborough * Maternity Unit Closure - Scarborough * SCBU at capacity - Scarborough * SCBU at capacity of intensive care cots - Scarborough * SCBU no of babies affected - Scarborough * 1 to 1 care in Labour - Scarborough * L/W Co-ordinator supernumerary % - Scarborough	* Bookings <10 weeks - Scarborough * Planned homebirths - Scarborough * Homebirth service suspended - Scarborough * Anaesthetic cover on L/W - Scarborough
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Bookings - Scarborough	2024-04	L	?	169	Target	104
Bookings <10 weeks - Scarborough	2024-04		F	90%	Target	58.7%
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2024-04		?	10%	Target	7.7%
Births - Scarborough	2024-04		?	113	Target	95
No. of women delivered - Scarborough	2024-04		?	112	Target	94
Planned homebirths - Scarborough	2024-04		F	2.1%	Target	1.1%
Homebirth service suspended - Scarborough	2024-04		F	3	Target	27
Women affected by suspension - Scarborough	2024-04		?	0	Target	1
Community midwife called in to unit - Scarborough	2024-04	L	?	3	Target	0
Maternity Unit Closure - Scarborough	2024-04		?	0	Target	0
SCBU at capacity - Scarborough	2024-04		?	1.2	Baseline	0
SCBU at capacity of intensive care cots - Scarborough	2024-04		?	5.9	Baseline	1
SCBU no of babies affected - Scarborough	2024-04		?	0	Target	0
1 to 1 care in Labour - Scarborough	2024-04		?	100%	Target	99.5%
L/W Co-ordinator supernumerary % - Scarborough	2024-04		?	100%	Target	96.6%
Anaesthetic cover on L/W - Scarborough	2024-04		F	10	Target	5

Summary MATRIX 2 of 3

Maternity Scarborough

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* HSIB cases - Scarborough	
COMMON CAUSE / NATURAL VARIATION	* Intrapartum Stillbirths - Scarborough	* Normal Births - Scarborough * Assisted Vaginal Births - Scarborough * C/S Births - Scarborough * Elective caesarean - Scarborough * Emergency caesarean - Scarborough * Induction of labour - Scarborough * HDU on L/W - Scarborough * BBA - Scarborough * Antepartum Stillbirth - Scarborough * Cold babies - Scarborough * Preterm birth rate <37 weeks - Scarborough * Preterm birth rate <34 weeks - Scarborough * Preterm birth rate <28 weeks - Scarborough	
SPECIAL CAUSE CONCERN		* Neonatal Death - Scarborough	

Maternity Scarborough
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Normal Births - Scarborough	2024-04			57%	Target	50.5%
Assisted Vaginal Births - Scarborough	2024-04			12.4%	Target	9.5%
C/S Births - Scarborough	2024-04			41.1%	Baseline	37.9%
Elective caesarean - Scarborough	2024-04			19.1%	Baseline	21.1%
Emergency caesarean - Scarborough	2024-04			21.8%	Baseline	16.8%
Induction of labour - Scarborough	2024-04			42.5%	Baseline	45.7%
HDU on L/W - Scarborough	2024-04			5	Target	0
BBA - Scarborough	2024-04			2	Target	0
HSIB cases - Scarborough	2024-04	L		0	Target	0
Neonatal Death - Scarborough	2024-04	H		0	Target	2
Antepartum Stillbirth - Scarborough	2024-04			0	Target	0
Intrapartum Stillbirths - Scarborough	2024-04		P	0	Target	0
Cold babies - Scarborough	2024-04			1	Target	0
Preterm birth rate <37 weeks - Scarborough	2024-04			6%	Target	7.4%
Preterm birth rate <34 weeks - Scarborough	2024-04			1%	Target	2.1%
Preterm birth rate <28 weeks - Scarborough	2024-04			0.5%	Target	2.1%

Summary MATRIX 3 of 3

Maternity Scarborough

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Breastfeeding Initiation rate - Scarborough * 3rd/4th Degree Tear - assisted birth - Scarborough	
COMMON CAUSE / NATURAL VARIATION		* Low birthweight rate at term (2.2kg) - Scarborough * Breastfeeding rate at discharge - Scarborough * Smoking at booking - Scarborough * Smoking at 36 weeks - Scarborough * Smoking at time of delivery - Scarborough * Carbon monoxide monitoring at booking - Scarborough * Carbon monoxide monitoring at 36 weeks - Scarborough * SI's - Scarborough * PPH > 1.5L as % of all women - Scarborough * Shoulder Dystocia - Scarborough * 3rd/4th Degree Tear - normal births - Scarborough * Informal Complaints - Scarborough * Formal Complaints - Scarborough	
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Low birthweight rate at term (2.2kg) - Scarborough	2024-04			0%	Target	0%
Breastfeeding Initiation rate - Scarborough	2024-04	H		75%	Target	70.5%
Breastfeeding rate at discharge - Scarborough	2024-04			65%	Target	51.7%
Smoking at booking - Scarborough	2024-04			6%	Target	10.6%
Smoking at 36 weeks - Scarborough	2024-03			6%	Target	14.4%
Smoking at time of delivery - Scarborough	2024-04			6%	Target	13.4%
Carbon monoxide monitoring at booking - Scarborough	2024-04			95%	Target	82.7%
Carbon monoxide monitoring at 36 weeks - Scarborough	2024-04			95%	Target	79.1%
SI's - Scarborough	2023-10			0	Target	1
PPH > 1.5L as % of all women - Scarborough	2024-04			2.5%	Baseline	0%
Shoulder Dystocia - Scarborough	2024-04			2	Target	1
3rd/4th Degree Tear - normal births - Scarborough	2024-04			2.8%	Target	0%
3rd/4th Degree Tear - assisted birth - Scarborough	2024-04	L		6.1%	Target	0%
Informal Complaints - Scarborough	2024-04			0	Target	1
Formal Complaints - Scarborough	2024-04			0	Target	0

Summary MATRIX 1 of 3

Maternity York

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Community midwife called in to unit - York * Maternity Unit Closure - York * L/W Co-ordinator supernumerary % - York	
COMMON CAUSE / NATURAL VARIATION	* Bookings ≥13 weeks (exc transfers etc.) - York * Anaesthetic cover on L/W - York	* Bookings - York * Bookings <10 weeks - York * Births - York * No. of women delivered - York * Women affected by suspension - York * SCBU at capacity - York * SCBU at capacity of intensive care cots - York * SCBU no of babies affected - York * 1 to 1 care in Labour - York	* Planned homebirths - York * Homebirth service suspended - York
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Bookings - York	2024-04			295	Target	315
Bookings <10 weeks - York	2024-04			90%	Target	77.1%
Bookings ≥13 weeks (exc transfers etc.) - York	2024-04		P	10%	Target	3.8%
Births - York	2024-04			245	Target	215
No. of women delivered - York	2024-04			242	Target	212
Planned homebirths - York	2024-04		F	2.1%	Target	0.9%
Homebirth service suspended - York	2024-04		F	3	Target	13
Women affected by suspension - York	2024-04			0	Target	1
Community midwife called in to unit - York	2024-03	L		3	Target	1
Maternity Unit Closure - York	2024-04	L		0	Target	1
SCBU at capacity - York	2024-04			0.8	Baseline	0
SCBU at capacity of intensive care cots - York	2024-04			18.3	Baseline	29
SCBU no of babies affected - York	2024-04			0	Target	0
1 to 1 care in Labour - York	2024-04			100%	Target	99.5%
L/W Co-ordinator supernumerary % - York	2024-04	H		100%	Target	98%
Anaesthetic cover on L/W - York	2024-04		P	10	Target	10

Reporting Month: May 2024

Summary MATRIX 2 of 3

Maternity York

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* HSIB cases - York * Intrapartum Stillbirths - York * Cold babies - York	
COMMON CAUSE / NATURAL VARIATION		* Normal Births - York * Assisted Vaginal Births - York * C/S Births - York * Elective caesarean - York * Emergency caesarean - York * HDU on L/W - York * BBA - York * Neonatal Death - York * Antepartum Stillbirth - York * Preterm birth rate <37 weeks - York * Preterm birth rate <34 weeks - York * Preterm birth rate <28 weeks - York	
SPECIAL CAUSE CONCERN		* Induction of labour - York	

Maternity York
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Normal Births - York	2024-04			57%	Target	54.4%
Assisted Vaginal Births - York	2024-04			12.4%	Target	10.2%
C/S Births - York	2024-04			36%	Baseline	35.3%
Elective caesarean - York	2024-04			14.8%	Baseline	17.2%
Emergency caesarean - York	2024-04			21.2%	Baseline	18.1%
Induction of labour - York	2024-04	H		45.1%	Baseline	46.2%
HDU on L/W - York	2023-10			5	Target	8
BBA - York	2024-04			2	Target	1
HSIB cases - York	2024-04	L		0	Target	0
Neonatal Death - York	2024-04			0	Target	0
Antepartum Stillbirth - York	2024-04			0	Target	2
Intrapartum Stillbirths - York	2024-04	L		0	Target	0
Cold babies - York	2024-04	L		1	Target	1
Preterm birth rate <37 weeks - York	2024-04			6%	Target	8.8%
Preterm birth rate <34 weeks - York	2024-04			2%	Target	2.3%
Preterm birth rate <28 weeks - York	2024-04			0.5%	Target	0%

Summary MATRIX 3 of 3

Maternity York

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Breastfeeding Initiation rate - York * Breastfeeding rate at discharge - York	* Carbon monoxide monitoring at 36 weeks - York
COMMON CAUSE / NATURAL VARIATION	* 3rd/4th Degree Tear - assisted birth - York	* Low birthweight rate at term (2.2kg) - York * Smoking at booking - York * Smoking at 36 weeks - York * Smoking at time of delivery - York * Carbon monoxide monitoring at booking - York * SI's - York * PPH > 1.5L as % of all women - York * Shoulder Dystocia - York * 3rd/4th Degree Tear - normal births - York * Informal Complaints - York * Formal Complaints - York	
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Dawn Parkes **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Low birthweight rate at term (2.2kg) - York	2024-04			0%	Target	0%
Breastfeeding Initiation rate - York	2024-04	H		75%	Target	88.3%
Breastfeeding rate at discharge - York	2024-04	H		65%	Target	75%
Smoking at booking - York	2024-04			6%	Target	6.6%
Smoking at 36 weeks - York	2024-04			6%	Target	5.9%
Smoking at time of delivery - York	2024-04			6%	Target	4.7%
Carbon monoxide monitoring at booking - York	2024-04			95%	Target	82.2%
Carbon monoxide monitoring at 36 weeks - York	2024-04	H	F	95%	Target	68.1%
SI's - York	2023-10			0	Target	2
PPH > 1.5L as % of all women - York	2024-04			4.9%	Baseline	5.2%
Shoulder Dystocia - York	2024-04			2	Target	1
3rd/4th Degree Tear - normal births - York	2024-04			2.8%	Target	1.9%
3rd/4th Degree Tear - assisted birth - York	2024-04		P	6.1%	Target	0.5%
Informal Complaints - York	2024-04			0	Target	0
Formal Complaints - York	2024-04			0	Target	1

WORKFORCE

June 2024

Summary MATRIX
Workforce

MATRIX KEY
- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* 12 month rolling turnover rate Trust (FTE) * Overall vacancy rate * Midwifery vacancy rate * Registered Nursing vacancy rate * AHP vacancy rate * Overall stat/mand training compliance * Overall corporate induction compliance * A4C staff stat/mand training compliance * A4C staff corporate induction compliance	* Annual absence rate * Medical & dental staff stat/mand training compliance * Medical & dental staff corporate induction compliance
COMMON CAUSE / NATURAL VARIATION		* Monthly sickness absence * Medical and dental vacancy rate * Total Agency Whole Time Equivalent Filled * Total Bank Whole Time Equivalent Filled * Appraisal Activity	* HCSW vacancy rate
SPECIAL CAUSE CONCERN			

Workforce
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Monthly sickness absence	2024-04			4.9%	Baseline	4.6%
Annual absence rate	2024-04			4.7%	Target	4.9%
12 month rolling turnover rate Trust (FTE)	2024-05			10%	Target	9%
Overall vacancy rate	2024-05			6%	Target	7%
HCSW vacancy rate	2024-05			5%	Target	10.3%
Midwifery vacancy rate	2024-05			0%	Target	-5.8%
Medical and dental vacancy rate	2024-05			6%	Target	7%
Registered Nursing vacancy rate	2024-05			5%	Target	5.1%
AHP vacancy rate	2024-05			8.5%	Target	6.1%
Total Agency Whole Time Equivalent Filled	2024-03			151	Target	189.2
Total Bank Whole Time Equivalent Filled	2024-03			557	Target	735.9

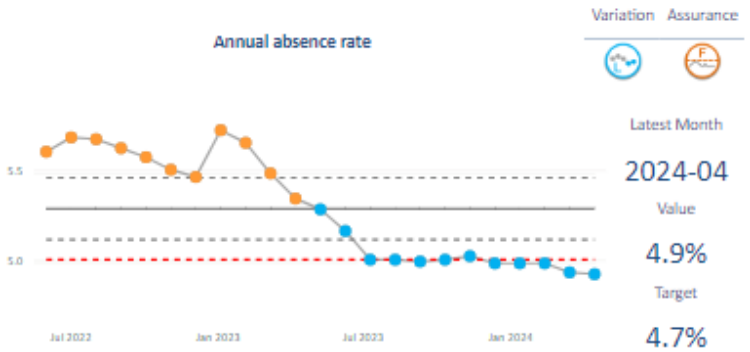
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.7%

The indicator is **below the baseline** for the latest month and **is** within the control limits.

The latest months value has **remained the same** from the previous month, with a difference of **0.0**.



The indicator is **worse than the target** for the latest month and **is not** within the control limits.

The latest months value has **remained the same** from the previous month, with a difference of **0.0**.

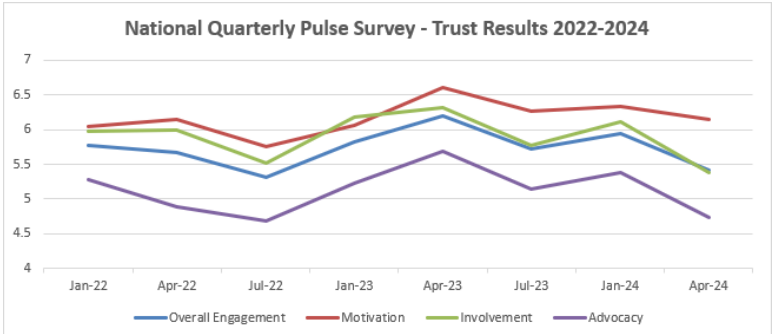
Factors impacting performance and actions:

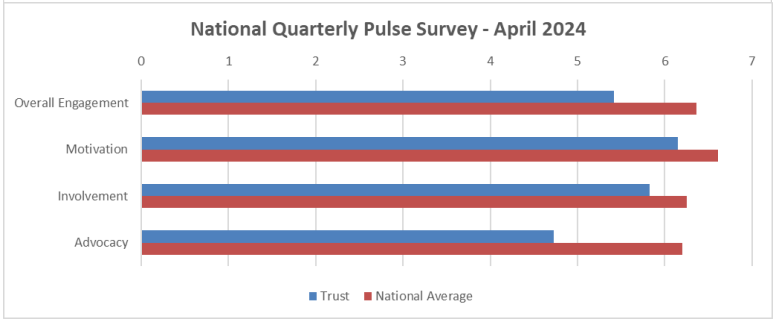
Last month we saw 409.14 WTE lost to sickness out of a total of 8940.60 leading to an absence rate of 4.58%. The top 2 reasons for sickness in the month of April were: Stress/ Anxiety (106.26 WTE) and Cold/Flu (36.67 WTE).

Our Voice Our Future is continuing and the synthesis event, at the end of the discovery phase, took place on 10th June. Change Makers have also discussed 'quick wins' based on feedback from staff and patients with members of the Trust Board so that the impact of the programme can be felt within the two-year period, drawing on responses received as part of the informal feedback collection from staff members. The Trust's People Promise Manager, recruited as part of the NHSE Exemplar Programme has now commenced in post.

The Trust has received the results of the National Quarterly Pulse Survey from April (right). The survey focuses on the engagement-themed questions from the annual NHS Staff Survey so organisations can regularly obtain a sense of how staff feel about their experience of work. Improving staff experience and engagement (and therefore retention) is a key objective of the Our Voice Our Future culture transformation programme.

Response rates for the survey have been consistently below the Trust target of 10% (over 2 years they have ranged from 1.6% to 4.81%). In April 2024, the response rate was 4.0%. The Trust is following a new communications plan to encourage more people to complete the survey.

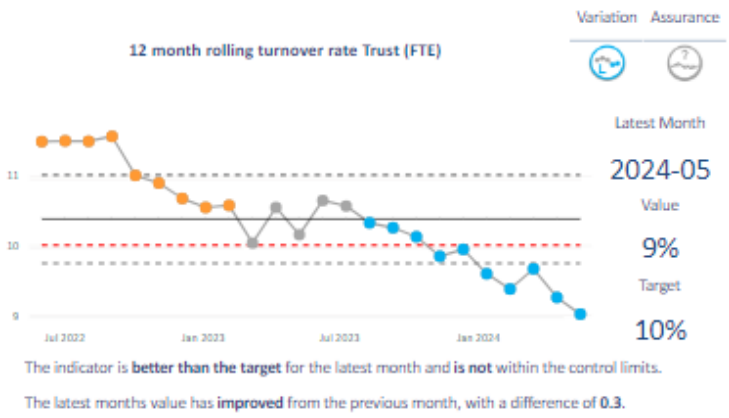


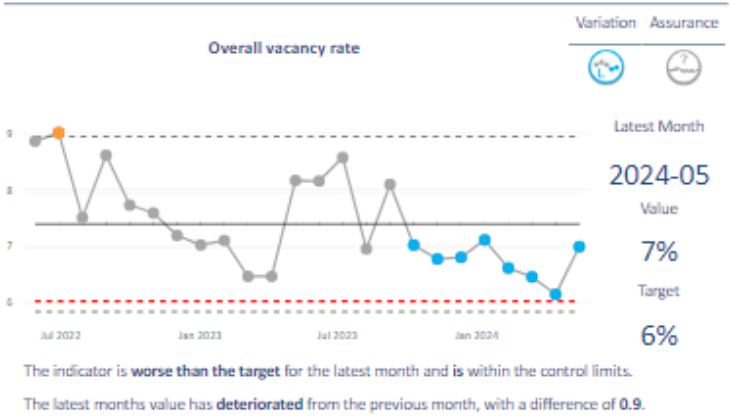


Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 10% Vacancy Rate 6%





Factors impacting performance and actions:

The Trust welcomed our latest cohort of 12 internationally recruited nurses at the end of May, taking the total recruited this year to 24 international nurses. The Trust has committed to recruiting 55 international nurses in 2024/25. This month, the first round of interviews will be held for newly qualified nurses who will join us through a bridging course run directly between the Nursing Colleges in India and the Trust, thereby establishing a new international recruitment pipeline for the organisation. The plan is to build a cohort of 10 nurses that will qualify in 2024 and be ready to join the Trust in March 2025.

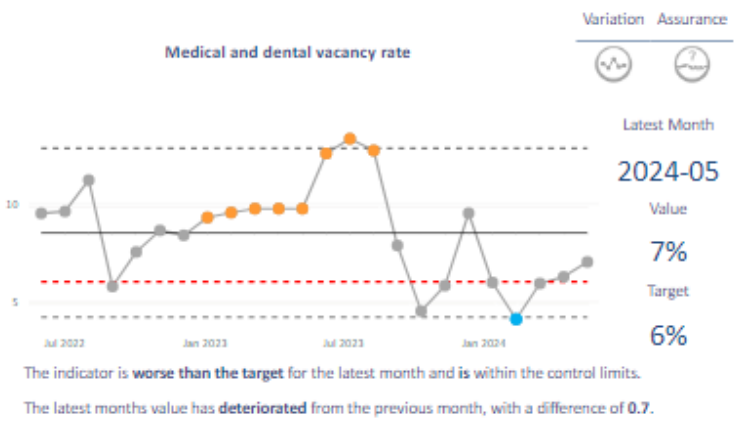
There are currently 20 WTE registered nurses undertaking pre-employment checks with the Trust, with a further eight nurses ready to commence and have start dates booked in.

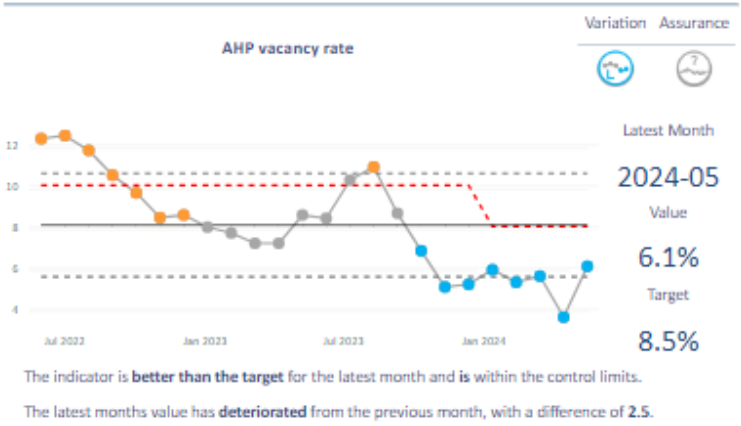
The organisation continues to have a healthy student nurse pipeline, with 90 pre-registered nurses recruited to join the organisation in September. The Trust is holding Welcome Days for our pre-registered nurses in July across both sites, giving our new recruits the opportunity to meet their teams, have a tour of the hospitals and fill in any outstanding onboarding information before they embark on their preceptorship in Autumn. These days are always well-received by our new starters and help to build a positive on-boarding experience and reduce instances of attrition prior to the start of employment.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 8.5%





Factors impacting performance and actions:

The Trust made five offers for medical posts in May, including four Consultant posts within Medicine and Surgery, with candidates expected to commence from August onwards. Two new recruits commenced in post during May, including a Locum Consultant in Trauma and Orthopaedics.

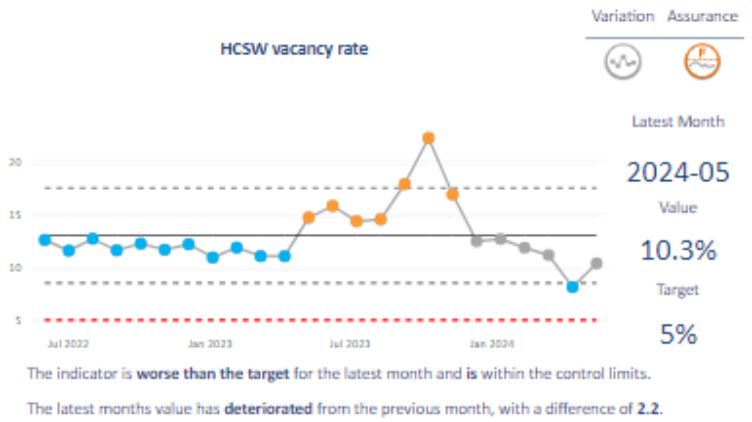
The Trust continues to target hard to fill posts through our existing recruitment pathways while exploring new international pipelines in conjunction with Humber and North Yorkshire Integrated Care Board.

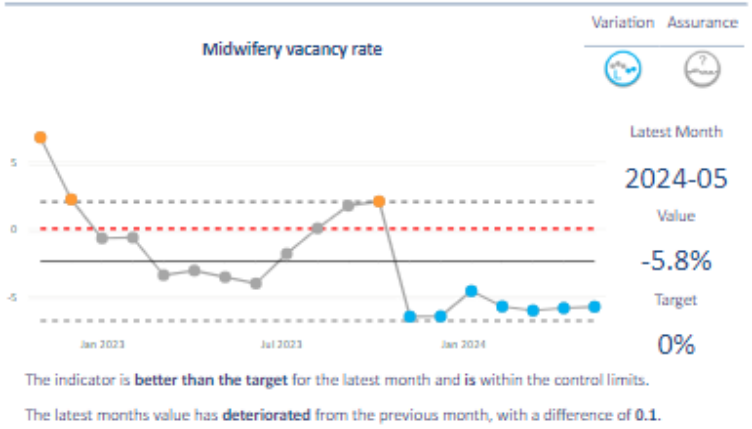
The Trust is working to ensure that our pre-registered Allied Health Professionals will be ready to start with us in late summer. There are currently 10 pre-registered Allied Health Professionals in the pipeline, and they will join with pre-registered nurses and others on the Autumn preceptorship programme.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: HCSW vacancy rate 5%, Midwifery vacancy rate 0%





Factors impacting performance and actions:

There are 38.29 WTE Health Care Support Workers undertaking pre-employment checks with the Trust, with a further 136 candidates due to be interviewed in June and early July. In addition, 74 HCSWs (63.97 WTE) have been allocated places on the next three HCSW Academy dates. Due to the high number of applicants, the Trust has paused its rolling adverts for HCSWs, to enable time to review applications and provide outcomes for candidates, including allocating those whose applications were successful into vacancies.

In parallel with recruitment, the Trust is working in partnership with Trade Unions to review the banding of HCSWs across Nursing and Midwifery areas. The work is linked to the evolution of national job profiles for 'Clinical Support Worker' (Band 2) and 'Clinical Support Worker Higher Level' (Band 3), which were updated in 2021. The majority of HCSWs in the Trust have a Band 2 job description; however, this work will scope how many of these HCSWs are carrying out tasks identified within the Higher-Level profile. The review will be used to inform workforce modelling, as well as discussions with Trade Unions about possible redress for duties already worked at the Higher-Level.

As part of the ongoing monitoring of Nursing Associates it was agreed to include the number of Nursing Associates employed by the Trust in the TPR. There has been a further decrease in terms of WTE in May compared to April. The WTE decreased from 51.36 to 51.01 although the headcount remains the same at 55.

Interviews are being held for the Deputy Director of Midwifery in June which is a key role in supporting plans to improve our Maternity Services. Work is on-going to support recruitment of pre-registered Midwives following the Trust's recent recruitment campaign.

Workforce Table

Workforce (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

	WTE Funded Establishment	WTE Vacancy	WTE Sickness	WTE Temporary Staffing Requested	WTE Variance between Requested and Vacancy & Sickness	WTE Filled by Bank	WTE Filled by Agency	WTE Variance between Total Filled and Vacancy & Sickness
Nursing								
Feb-24	2463.03	93.68	114.23	347.46	139.55	173.37	117.06	82.52
Mar-24	2462.43	79.92	107.45	356.16	168.79	189.31	85.24	87.18
Apr-24	2461.99	64.51	105.94	275.13	104.68	147.02	77.17	53.74
HCA								
Feb-24	1244.59	147.01	53.73	326.65	125.91	245.42	0	44.68
Mar-24	1244.59	138.39	51.53	343.91	153.99	264.5	0	74.58
Apr-24	1219.59	98.89	49.40	296.18	147.89	228.5	0.00	80.21
M&D								
Feb-24	1032.73	42.26	44.91	160.92	73.75	62.95	51.32	27.1
Mar-24	1032.73	61.03	42.71	116.58	12.84	63.79	51.76	11.81
Apr-24	1021.48	63.89	42.56	141.25	34.80	82.59	41.29	17.43

Factors impacting performance and actions:

The Nursing eRostering Efficiency Group continues to monitor KPIs and ensure temporary staffing use is being managed effectively. The group is driving efficiencies within temporary staffing usage, with key areas of focus including; reducing day shift times for bank and agency, removing bank incentives and ensuring nights and weekends are rostered effectively, to reduce requirements for bank and agency at these peak cost times. In March and April, reductions in shift times reduced costs for the organisation by an estimated £159k.

From the start of the month, the bank incentive of paying staff at their substantive band for bank work has been removed, and all future nursing bank shifts will be paid at the required band of the shift. In parallel, the Trust will only use agencies charging within the NHS England agency price caps for general nursing shifts. This is another key milestone for the organisation in our continued efforts to reduce agency expenditure and work in line with best practice. The Trust continues to negotiate with other agency suppliers to reduce rates for supply to 'critical' nursing shifts (as defined by agencies, relating to designated specialities) and has successfully moved three suppliers to within the agency price caps, as well as removing three of the most expensive suppliers from our agency cascade. Over the last six months, the Trust has reduced its agency expenditure for nursing by over 50% from £849k in October to £420K in April. This reduced overall temporary staffing spend from £2.4million in October to £1.3million in April.

Last month, the Trust ended a long-term (7-year) medical locum booking following successful recruitment within Paediatrics. Three medical agency staff in the Emergency Department are also due to move onto Trust bank contracts in June, with work underway to support a fourth long-term agency locum in the same department to make the same move. Work continues to remove or replace existing agency bookings and resulted in the successful replacement of two agency bookings in May. The lower cost associated with these new bookings generated savings of up to £1,244 per week for the Trust.

Workforce
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Overall stat/mand training compliance	2024-05	H	?	87%	Target	88%
Overall corporate induction compliance	2024-05	H	?	95%	Target	96%
A4C staff stat/mand training compliance	2024-05	H	?	87%	Target	89%
A4C staff corporate induction compliance	2024-05	H	?	95%	Target	96%
Medical & dental staff stat/mand training compliance	2024-05	H	F	87%	Target	78%
Medical & dental staff corporate induction compliance	2024-05	H	F	95%	Target	94%
Appraisal Activity	2024-05		?	0%	Target	1%
Staff engagement staff survey score	2024-05			6.9	Target	6.4
Staff morale staff survey score	2024-05			5.9	Target	5.5
Percentage recommending the Trust as a place to work (quarterly)	2024-04			31.7%	Baseline	27.9%
Percentage recommending the Trust as a place to receive treatment (quarterly)	2024-04			34.6%	Baseline	31.4%

Executive Owner: Polly McMeekin

Operational Lead: Will Thornton

Rationale: Trained workforce delivering consistently safe care
Target: Mandatory Training 87% and Corporate Induction 95%

Factors impacting performance and actions:

In May, completion of corporate induction has increased to 96%, and mandatory training compliance maintained at 88%. When compared with the previous month, rates of mandatory training compliance amongst the eight different staff groups were largely static and ranged from 78% for Medical & Dental staff to 94% for Health Care Scientists. Estates and Ancillary (81%) are the only other staff group with a compliance rate below the 87% target. Work continues with both groups to improve access to mandatory training programmes, including to ensure staff are allocated sufficient time for training.

At subject level, 13/25 programmes continue to achieve the 87% mandatory training compliance target. The 12/25 subjects which have not achieved 87% have seen nominal movements (-1% to 1%) in compliance between April and May. Compliance ranges from 55% (Paediatric Advanced Life Support) to 85% (Information Governance, Deprivation of Liberty Safeguards Basic Awareness). Both Adult Life Support (78%) and Mental Capacity Act higher level training (75%) which form part of the Trust's CQC Improvement Action Plan remain below target and compliance rates have not changed from the previous month.

DIGITAL AND INFORMATION SERVICES

June 2024

Summary MATRIX

Digital

MATRIX KEY

- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Percentage of Patient Subject Access Requests (SARs) processed within one calendar month	
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents* * Total number of calls to Service Desk * Total number of calls abandoned * Number of information security incidents reported and investigated * Number of Patient Subject Access Requests (SARs)	
SPECIAL CAUSE CONCERN			

Digital & Information Services (DIS)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: James Hawkins **Operational Lead:** Steve Lawrie/Rebecca Bradley

Metric Name	Month	Variation	Assurance	Target / Baseline Value	Target / Baseline	Value
Number of P1 incidents*	2024-05			0	Target	7
Total number of calls to Service Desk	2024-05			3500	Target	4498
Total number of calls abandoned	2024-05			500	Target	956
Number of information security incidents reported and investigated	2024-05			43	Baseline	32
Number of Patient Subject Access Requests (SARs)	2024-05			407	Baseline	404
Percentage of Patient Subject Access Requests (SARs) processed within one calendar month	2024-05			100%	Target	100%
Number of Freedom Of Information requests (FOIs) received (quarterly)	2024-03			85.4	Baseline	284
Percentage of Freedom Of Information requests (FOIs) responded to within 20 working days (quarterly)	2024-03			100%	Target	90%

Digital & Information Services (DIS)

DIS (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy

Rationale: Reduction in P1 Incidents and Service Desk Calls are a proxy for better digital service

Target: 0 P1 Incidents 3500 Calls to Service Desk

The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **5.0**.

The indicator is **worse than the target** for the latest month and **is** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **665.0**.

Factors impacting performance:

7x P1 incidents occurred
1/5 Terminal Server (TS2008) unavailable due to a load balancer fault. Internal users diverted to alternate Terminal Server (TS2012) but external users were impacted until this was resolved (i.e. remote workers, Harrogate, TEWV, Hull)
7/5 Clifton Chapel physio - network fault - external break in fibre on Gillygate
9/5 Staffroom "502 bad gateway error" - external hosting provider fault
10/5 YHCR/GP Connect issues affecting availability of information in CPD - external provider fault
23/5 PACS unavailable - storage issues due to incorrect configuration/alerting
24/5 PPM & BHLY unavailable – issue resolved by changing our firewall settings
29/5 Springhill House network connection lost - issue with network provider's hardware at site

Actions:

Telephone demand management steps include promoting the use of Self Service using the 4Me platform. This can provide support information for staff 24/7, and provide alternate routes to raise a support request and get support.

- A small change has been made in early June to provide callers with feedback on their queue position, and an "overflow" process to distribute calls to additional support staff when waiting times reach a threshold.
- This is expected to result in changes to abandoned call levels as staff are better informed about their likely wait to speak with support staff, and long waits are responded to in a more automated way.

Problem management reviews of common support incidents focus on fixing underlying causes, to minimise disruption and support demand.

Digital & Information Services (DIS)

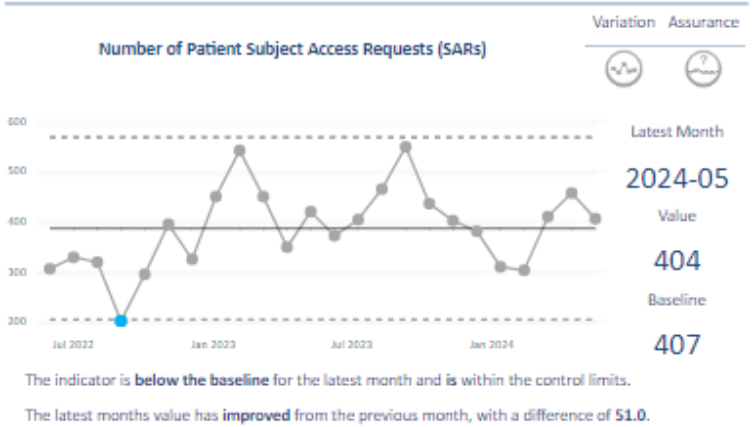
DIS (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate
Target: to identify and minimise incidents



Number of information security incidents reported and investigated

Factors impacting performance:

There was a peak of information security incidents in July 2023, due to an audit undertaken which led to an increase of reporting of misfiled information.

The other recent increase in the Autumn was due to an increase in data disclosed in error which the majority of were related to the introduction of NHSMail and the adoption of the global address list.

Actions: Continue targeted communication to reduce this trend.

Number of information security incidents reported and investigated

Factors impacting performance:

This month saw a reduction in SARs.

Actions:

The team reviewed the increase in SARs in the previous periods against the Trust's complaints data and found no correlation. The Team are seeing an increase in requests where patients need their notes as they have chosen to access private healthcare.

Digital & Information Services (DIS)

DIS (3)

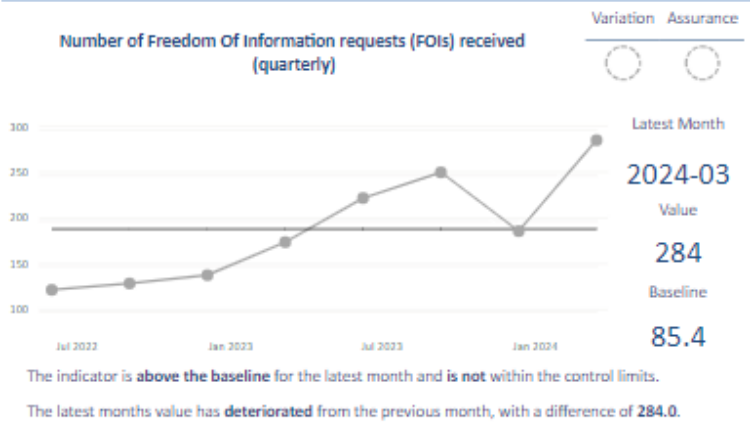
York and Scarborough Teaching Hospitals NHS Foundation Trust

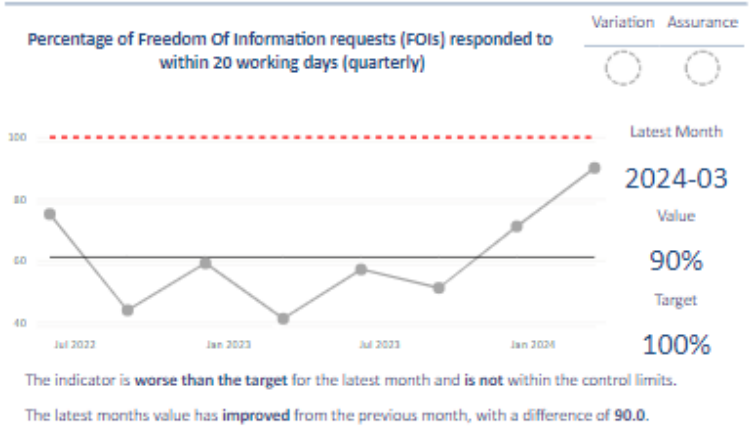
Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Rationale: Ensuring the Trust responds to FOI in line with legislation

Target: FOIs responded to within 20 days





Factors impacting performance:.

Number of FOIs Received

The Information Governance team has experienced a significant increase in the volume of FOIs received. This was partly due to the way that FOIs were logged and reported.

This increase has been challenging given the limited resources available to manage the increase in FoIs alongside other IG priorities.

Actions:

Percentage of FOIs responded to within 20 working days

We can see that comparatively to last year the team is responding to more requests in line with legislation even with the increase in those received, and the team are working to continue this improvement.

FINANCE

June 2024

- The Trust has resubmitted its Operational Financial Plan to NHSE on 12 June 2024, which presented an adjusted I&E deficit of £16.6m as per the table opposite.
- The Trust's I&E deficit forms part of a wider HNY ICB I&E deficit plan of £50.0m.
- The Trust's actual operational I&E deficit is £33.7m, but for the purposes of assessing financial performance NHSE allow certain technical adjustments to arrive at underlying financial performance. The most notable of these is the removal of impairments relating to the revaluation of capital assets.
- It should be noted that the Trust's projected deficit is after the planned delivery of a significant efficiency programme of £53.3m (6.4%), more of which is discussed under cost improvement programme below.
- The plan is designed to assist the Trust meet all the required performance targets in 2024/25.

OPERATIONAL FINANCE PLAN 2024/25
SUMMARY INCOME & EXPENDITURE POSITION

	£000
INCOME	
Operating Income from Patient Care Activities	
NHS England	79,591
Integrated Care Boards	589,043
Other including Local Authorities, PPI, etc.	7,142
	675,776
Other Operating Income	
R&D, Education & Training, SHYPS, etc.	76,547
Total Income	**752,323**
EXPENDITURE	
Gross Operating Expenditure	-827,158
Less: CIP	53,266
Total Expenditure	**-773,891**
OPERATING SURPLUS/ (DEFICIT)	**-21,568**
Finance Costs (Interest Receivable/Payable, PDC Dividend)	-12,152
SURPLUS/ (DEFICIT) FOR THE YEAR	**-33,720**
ADJUSTED FINANCIAL PERFORMANCE	
Add Back	
I&E Impairments	16,734
Remove capital donations/grants net I&E impact	435
ADJUSTED FINANCIAL SURPLUS/(DEFICIT)	**-16,551**

Summary Dashboard and Income & Expenditure

Finance (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£1.7m	-£3.3m	↓	Deteriorating
Forecast Outturn I&E Variance to Plan	£0.0m	£0.0m		Static
Core CIP Delivery Variance to Plan (£20.0m Target)	-£0.5m	-£0.6m	↓	Deteriorating
Corporate CIP Delivery Variance to Plan (£33.3m Target)	-£0.7m	-£1.3m	↓	Deteriorating
Variance to Agency Cap	£0.3m Above	£0.8m Above	↓	Deteriorating
Month End Cash Position	£4.8m behind plan	£3.4m ahead of plan	↑	Improving
Capital Programme Variance to Plan	£0.7m ahead of plan	£1.7m ahead of plan	↓	Deteriorating

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	675,483	112,070	117,520	5,451
Other Income	73,865	12,311	13,612	1,301
Total Income	749,348	124,380	131,133	6,752
Pay Expenditure	-499,486	-86,175	-88,396	-2,221
Drugs	-65,852	-10,975	-13,306	-2,331
Supplies & Services	-83,794	-13,985	-16,021	-2,036
Other Expenditure	-168,229	-18,842	-20,915	-2,073
Outstanding CIP	42,233	1,899	0	-1,899
Total Expenditure	-775,127	-128,078	-138,638	-10,559
Operating Surplus/(Deficit)	-25,780	-3,698	-7,505	-3,807
Other Finance Costs	-12,225	-2,193	-1,731	461
Surplus/(Deficit)	-38,004	-5,890	-9,237	-3,346
NHSE Normalisation Adj	17169	72	50	-22
Adjusted Surplus/(Deficit)	-20,835	-5,818	-9,187	-3,368

The I&E table confirms an actual adjusted deficit of £9.19m against a planned deficit of £5.82m for May (Month 2), leaving the Trust with an adverse variance to plan of £3.37m. For M2 reporting the annual plan has not yet been updated for the revised plan submission referred to on the previous slide.

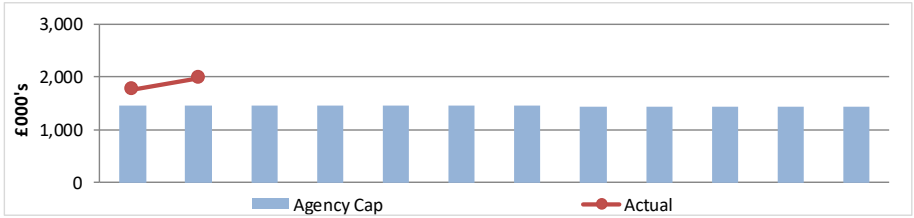
Whereas based on the position at month 2 mitigating actions will need to be applied, we are will continue to review and update our I&E forecast tool to assess our likely year end outcome, but at this early stage of the financial year the working assumption is that actions applied will be successful, so the forecast is that the Trust will deliver its plan. This position will be kept under review as we progress through the financial year.

Key Subjective Variances
Finance (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	574	Primarily linked to the usage of high-cost drugs and devices being slightly ahead of plan, for which income is earned on a pass-through basis and matched by expenditure; partially offset by ERF being slightly behind plan.	No mitigation or action required.
ICB Income	4,906	Primarily linked to ERF being significantly ahead of plan and accrued additional income from HNY ICB regarding the Integrated Urgent Care service, which is matched by expenditure, and subject to an in-year contract variation.	Contract variation for the Integrated Urgent Care service to be completed.
Other income	1,071	Primarily linked to the SHYPS unitary payment from HUTH being ahead of plan partially offsetting increased expenditure due to Pathology activity being ahead of plan.	No mitigation or action required.
Employee Expenses	-2,221	Agency, bank and WLI spending is ahead of plan to cover vacancies, and delivery increased elective activity.	To control agency spending within the cap into 2024/25. Work being led by HR Team to apply NHSE agency best practice controls, Care Group reduction programme for off-framework agency usage, continued recruitment programmes (including overseas recruitment). Vacancy control measures now in place.
Drug expenses	-2,331	Relates primarily to an increase of in-tariff drug and device costs which were previously contracted on a pass-through basis but now included in the block contract, plus out of tariff drugs & devices costs covered by NHSE contracts for which additional income is earned.	To continue discussions with HNY ICB regarding additional income in recognition of the constraints that the block contract is placing on the Trust.
Clinical Supplies & Services	-2,575	Increased spending linked to increased elective activity for which additional ERF income is expected to compensate. Also includes overspending on pathology direct access and devices, which was previously covered by a variable tariff, but is now included in the block contract with the ICB.	To continue discussions with HNY ICB regarding additional income in recognition of the constraints that the block contract is placing on the Trust.
CIP	-1,899	CIP behind plan	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group.
Other Costs	-2,073	Primarily linked to increased spending on insourcing/ outsourcing services particularly within diagnostic services, and within SHYPS and the contract with Ramsey mainly linked to increased elective activity for which additional income through ERF income is expected to compensate. Some other smaller adverse variances to be investigated.	Investigation of other variances not linked to increased elective activity.

Agency, Workforce, Elective Recovery Fund
Finance (4)



Agency Controls

Controls around agency spending, which recommenced in 2023/24 have continued into 2024/25. The Trust's has assumed agency is capped at 3.7% of its overall pay spend in its plan. At the end of May expenditure on agency staffing was £0.8m ahead plan.

	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,470.92	2,369.71	101.21	22,130	22,818	-688
Scientific, Therapeutic and Technical	1,249.03	1,187.30	61.73	11,036	11,097	-61
Support To Clinical Staff	1,911.19	1,681.85	229.34	10,359	10,422	-62
Medical and Dental	1,043.43	970.62	72.81	21,496	25,295	-3,798
Non-Medical - Non-Clinical	3,073.23	2,868.10	205.13	18,499	18,409	90
Reserves				2,324	0	2,324
Other				330	356	-26
TOTAL	9,747.80	9,077.58	670.22	86,175	88,396	-2,221

Workforce

This table presents a breakdown by staff group of the planned and actual workforce establishment in whole time equivalents (WTE) and spend for the year. The reserves relate to agreed but at this point undrawn activity and cost pressures, and nursing investments linked to the YCU, BCU , and IUC services.

The table illustrates that a key driver for the pay position (other than reserves) is spend against Medical and Dental staff, although establishment is under plan. The key driver for the residual adverse variance is agency cover for vacant posts across the Care Groups.

Trust Performance Summary vs ERF Target Performance

Commissioner	24-25 Target % vs 19/20	ERF Indicative Targets Weighted Value at 24/25 prices	ERF Month 2 Phase (Av %)	Activity to Month 2 Actual	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	105.60%	£128,404,371	£20,914,504	£24,098,951	£3,184,447	121.7%
West Yorkshire	103.00%	£1,325,995	£215,978	£223,795	£7,817	106.7%
Cumbria and North East	115.00%	£166,760	£27,162	£36,578	£9,416	154.9%
South Yorkshire	118.00%	£149,186	£24,299	£25,701	£1,402	124.8%
Other ICBs - LVA / NCA	-				*£0*	-
All ICBs	***105.20%***	***£130,046,311***	***£21,181,943***	***£24,385,025***	***£3,203,081***	**121.1%**
NHSE Specialist Commissioning	112.00%	£4,608,170	£750,579	£707,723	-£42,856	105.6%
Other NHSE	104.00%	£278,855	£45,420	£49,467	£4,048	113.3%
All Commissioners Total	**105.42%**	**£134,933,336**	**£21,977,942**	**£25,142,215**	**£3,164,273**	**120.6%**

Elective Recovery Fund

To give an early indication of ERF performance, we have developed an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date before applying average tariff income to the activity. Whilst acknowledging the limitations of using partially coded activity and estimates, the indications are that activity is up against plan and potentially presents a £3.2m surplus for the period.

ICB activity is ahead of the revised 105% target value for 2024/25, whereas NHSE Specialist Commissioned activity is slightly behind plan.

Cost Improvement Programme
Finance (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Trust' efficiency programme comprises the following:	
- Prior Year programme (non-recurrent)	£15.5m
- ICB Prior year Stretch Target (non-recurrent)	£8.5m
- New year base ask (1.1%)	£6.7m
- New year additional convergence ask	£5.0m
- New year covid reduction (testing)	£1.4m
- Further stretch target for 2024/25	£16.2m
- TOTAL REQUIREMENT	£53.3m

2024/25 Cost Improvement Programme - May Position

	Full Year CIP Target	May Position			Full Year Position		Planning Position		Planning Risk		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Corporate Programme	33,326	2,476	1,131	1,346	6,784	26,542	24,945	8,381	8,473	2,565	13,907
	33,326	**2,476**	**1,131**	**1,346**	**6,784**	**26,542**	**24,945**	**8,381**	**8,473**	**2,565**	**13,907**
Core Programme											
Medicine	4,721	351	127	224	223	4,498	1,482	3,239	1,334	59	90
Surgery	4,120	306	127	179	829	3,291	3,513	607	2,324	1,190	0
CSCS	6,290	467	339	128	2,033	4,256	3,610	2,679	3,523	0	87
Family Health	1,227	91	69	22	415	812	1,177	51	599	577	0
CEO	104	8	0	8	0	104	0	104	0	0	0
Chief Nurses Team	207	15	3	12	19	189	117	91	117	0	0
Finance	382	28	176	-148	207	175	207	175	207	0	0
Medical Governance	23	2	0	2	1	22	46	-24	46	0	0
Ops Management	233	17	1	16	7	227	150	84	150	0	0
DIS	427	32	1	31	7	419	244	183	244	0	0
Workforce & OD	361	27	1	26	6	355	55	306	55	0	0
YTHFM LLP	1,840	137	84	53	502	1,338	1,709	131	728	79	902
Central	0	0	0	0	0	0	7,625	-7,625	7,500	120	6
	19,936	**1,482**	**929**	**553**	**4,250**	**15,686**	**19,936**	**0**	**16,828**	**2,025**	**1,084**
Total Programme	**53,262**	**3,958**	**2,059**	**1,899**	**11,034**	**42,228**	**44,881**	**8,381**	**25,300**	**4,590**	**14,991**

2024/25 Efficiency Target

The 2024/25 efficiency target is £53.3m. This allocation of the target to the Care Groups, Directorates, and YTHFM has been based on variable percentage rates for different cost pools but capped at 3% in any one cost pool. This result is £20.0m (Core) of the target being directly allocated to Care Groups, Directorates, and YTHFM; with the remaining £33.3m (Corporate) held centrally with corporate plans being developed to meet this. The governance for the overall delivery of the target is through the Efficiency Delivery Group.

Corporate Efficiency Programme

The Corporate efficiency programme currently consists of 26 schemes which, following an initial risk assessment, give planned savings of £24.9m towards the £33.3m target.

In May £6.8m of the target was delivered in full year terms, all of which are recurrent savings. The YTD position shows delivery of £1.1m against target of £2.5m, £1.3m behind plan.

Core Efficiency Programme

The core efficiency programme currently has plans totalling £20m towards the required £20m target.

In May £4.2m of the target was delivered in full year terms £3.9m of which was recurrent. The YTD position shows delivery of £0.9m against target of £1.5m, £0.6m behind plan.

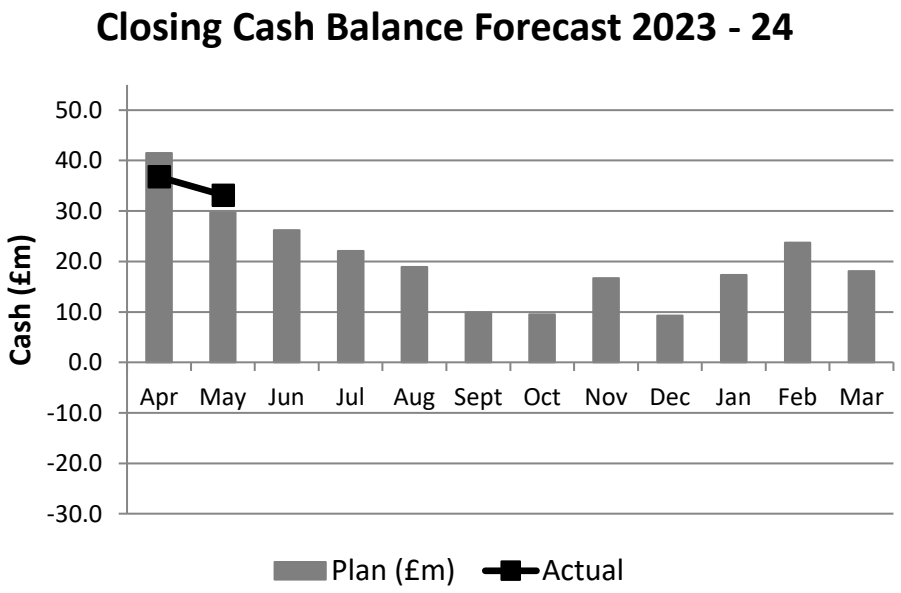
Current Cash Position

Finance (6)

The Group's cash plan for 2024/25 is for the cash balance to reduce from £47.5m at the end of March 2024 to £18.2m at the end of March 2025, with the planned I&E deficit being a key driver in the reduced balance. The cash balance for May was £3.4m adverse to plan.

The table below summarises the planned and actual month end cash balances.

Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	41,551	29,774	26,258	22,134	19,012	10,024	9,551	16,777	9,341	17,295	23,752	18,170
Actual	36,793	33,128										



The cash forecast graph illustrates the cash position based on the actual cash balance at the end of May at £33.1m against a plan balance of £29.8m, the £3.4m variance is due to the reduction of capital creditors earlier than planned.

At this stage, we are not expecting a requirement for cash support in 2024/25, however this will be closely monitored alongside the delivery of the Trust's efficiency programme as any slippage will impact cash reserves and a cash support application may have to be made.

Current Capital Position and Better Payment Practice Code (BPPC)

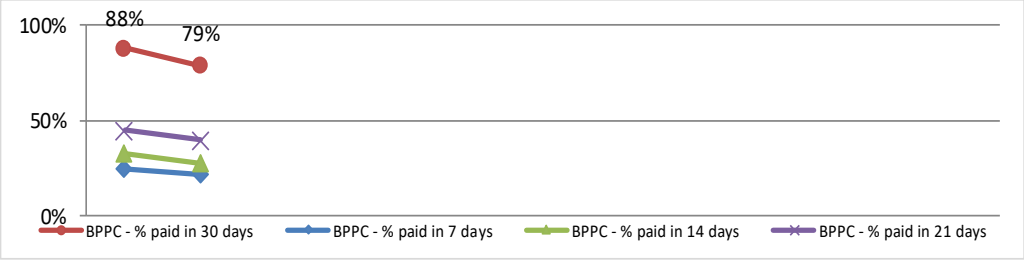
Finance (78)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Capital Plan 2024-25 £000s	Capital FOT 2024-25 £000s	M2 Planned Spend £000s	M2 Actual Spend £000s	Variance to Plan £000s	Variance to FOT £000s
52,870	52,870	1,259	2,923	1,664	0

For 2024/25 the main schemes are the completion of SGH UECC and SGH CDC and the commencement of the construction phase of VIU / PACU plus the start of the implementation of the EPR scheme.

The capital programme at month 2 is £1.7m ahead of plan. This is mainly due to orders which were expected to be delivered in 2023-24, being delivered 2024-25, for the Selby & Askham Bar CDC scheme £300k, and £245k for SGH UECC, alongside backlog maintenance ahead of plan £430k.



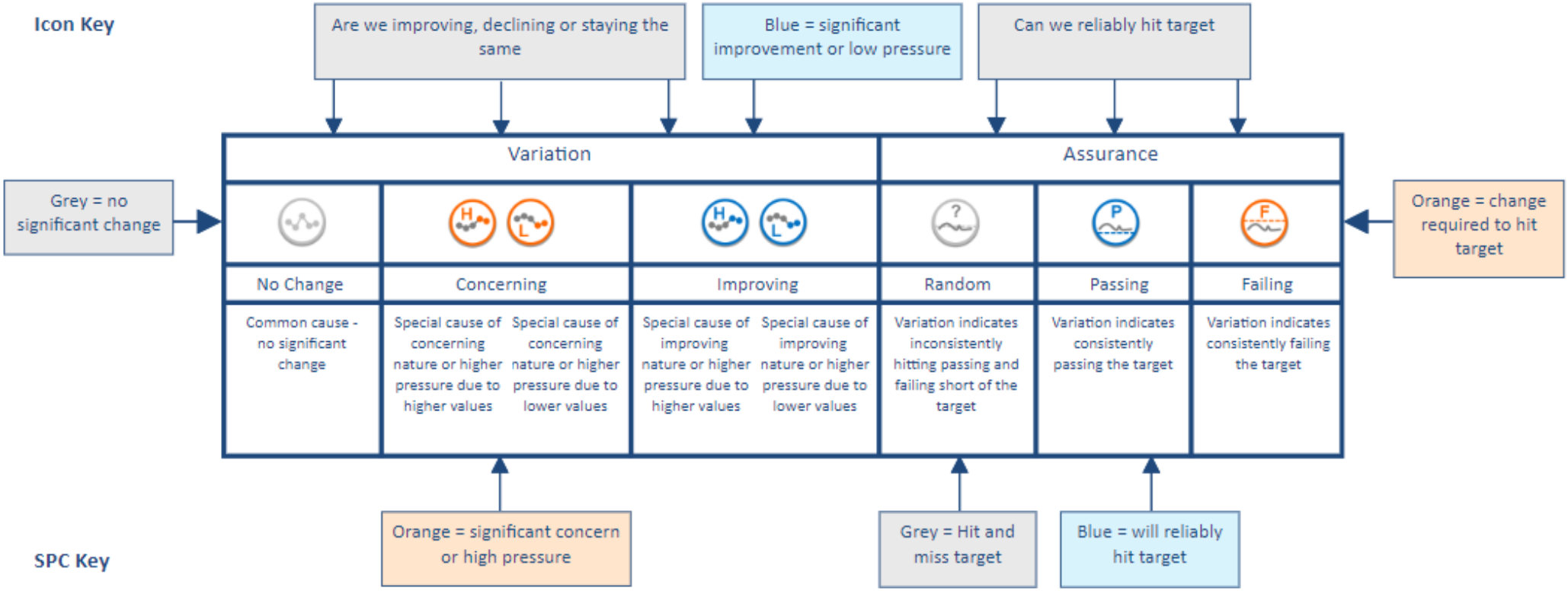
Better Payment Practice Code

The BPPC is a nationally prescribed target focussed on ensuring the timely payment by NHS organisations to the suppliers of services and products to the NHS. The target threshold is that 95% of suppliers should be paid within 30 days of the receipt of an invoice.

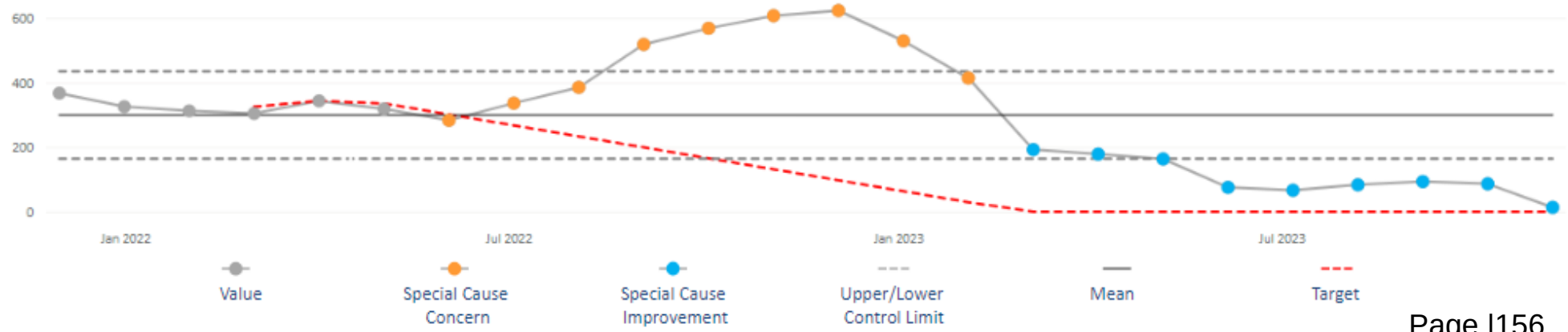
The table illustrates that in May the Trust managed to pay 79% of its suppliers within 30 days.

Keys

Icon Key



SPC Key



The orange and blue points indicate either increasing or decreasing trends. The colour will update if 7 points appear either above or below the mean or if 2 out of 3

Icon Descriptions

			
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently HIT OR MISS the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.
	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.
	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

Report to:	Board of Directors
Date of Meeting:	26 June 2024
Subject:	CQC Update Report
Director Sponsor:	Dawn Parkes, Chief Nurse Adele Coulthard, Director of Quality, Improvement and Patient Safety
Author:	Emma Shippey, Head of Compliance and Assurance

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	**Board Assurance Framework**
☐ Our People ☒ Quality and Safety ☐ Elective Recovery ☐ Acute Flow	☒ Quality Standards ☐ Workforce ☐ Safety Standards ☐ Financial ☐ Performance Targets ☐ DIS Service Standards ☐ Integrated Care System

Summary of Report and Key Points to highlight:

Progress with delivery of actions within the Trust CQC Improvement Plan is being overseen through the fortnightly Journey to Excellence meeting.

The monthly section 31 maternity submission was last made on 21 May 2024.

There are 10 open enquiries with the CQC.

A Journey to Excellence update has not been included in the paper this month. The meeting on the 27 May 2024 was cancelled due to the bank holiday and the next scheduled meeting is the 10 June 2024, the day Quality Committee papers were due. An update will be included in the July paper.

Recommendations:
The Board of Directors is asked to:

- Note the current position regarding the recent CQC inspection activity.
- Note the current position of the open CQC enquires.

Report History

Meeting	**Date**	**Outcome/Recommendation**
Patient Safety and Clinical Effectiveness	12 June 2024	Presented and accepted
Quality Committee	18 June 2024	*Not presented at the time of submitting this paper.*

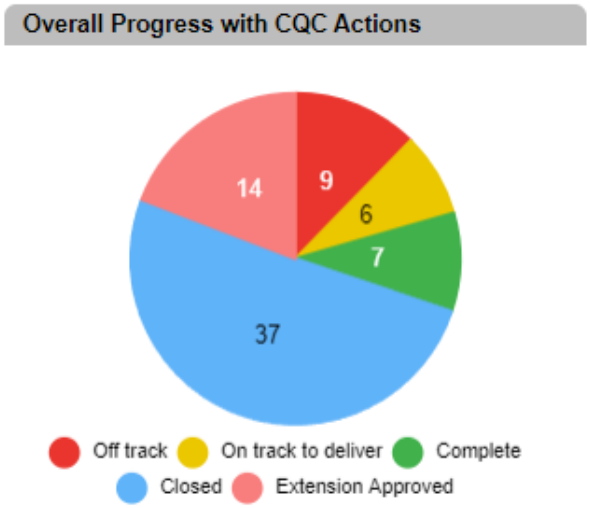
1. CQC Inspection Update

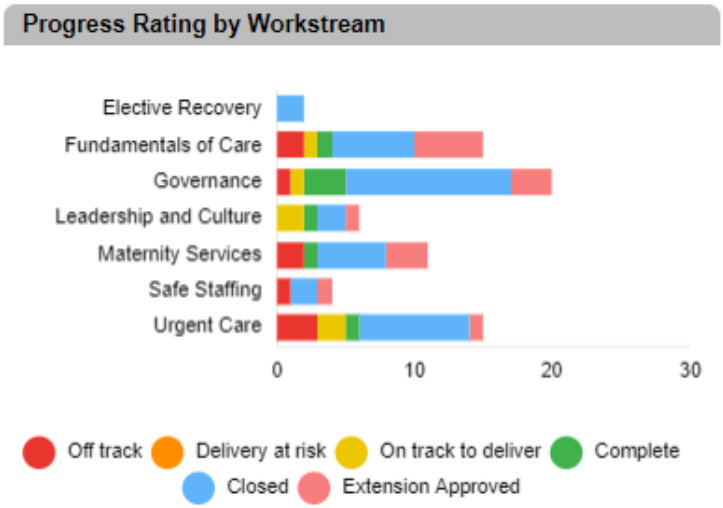
The Board of Directors has agreed seven improvement workstreams providing a framework for the Trust's 12-month quality recovery programme: Journey to Excellence. Each of the workstreams will include actions to deliver each of the CQC Must and Should actions.

The workstreams are as follows:

- Maternity Services
- Governance; Corporate / Quality
- Urgent Care
- Elective Care
- Leadership and Culture
- Safe Staffing
- Fundamentals of Care

Progress with the CQC Improvement Plan, as of 31 May 2024, can be seen in the charts below:





2. Actions Off Track and Extensions

Nine actions are considered off track meaning the original target date for delivery has not been met and an extension request has either yet to be made or approved. These are detailed in **Appendix A**.

In total, there are 14 actions which remain open and have had extensions approved by the Executive Leads and through the Journey to Excellence meetings. These are included in **Appendix B.**

3. Achievements

Since the last report was written, a further four actions have been approved for closure. A total of 37 actions have now been closed.

Ref	Must / Should	Action
11	Must	The trust must ensure that there is adequate oversight of the harms caused by delays to assessment and treatment.
34	Must	The trust must ensure that the new ED environments do not compromise the fundamental standards of care staff can provide to patients, protects their privacy and dignity, and ensures staff can offer them emotional support. There should be sufficient side rooms for medical staff to see and treat patients, barriered isolation rooms for infectious patients, handwash basins and storage areas for equipment
64	Must	The service must implement a robust governance process and risk management strategy. For example, they must ensure they instigate a process to effectively triage women in a safe environment. They must ensure they have effective risk management processes in place to manage and mitigate all risks.
72	Must	The trust must ensure that in Maternity, the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance.

Seven actions are considered complete with the closure form being drafted or awaiting approval at the next Journey to Excellence meeting.

4. Maternity Section 31 Submission

A monthly submission is made to the CQC providing an updated position on progressing in addressing the issues highlighted in the Section 31 notice. The submission is due on the 23rd of each month. The monthly section 31 maternity submission was last made on 21 May 2024.

The Interim Chief Nurse has invited the CQC to re-visit the Maternity Service with a view of assessing the progress made with the conditions of registration. A date for the on-site visit is being arranged.

5. Mental Health Risk Assessment Section 31

In January 2020, the CQC imposed a Section 31 as they were not assured that patients who presented to the York and Scarborough emergency departments with mental health needs were being risk assessed and cared for safely.

The CQC have asked to be updated when the new Mental Health Risk Assessment form has been transferred onto Nucleus, when staff have received training on use of the form and monthly audit results to be provided once launched.

The Urgent and Emergency Care assessment, Mental Health triage, mental health care plan and Emergency Department comfort checks have been live in Scarborough ED since 6 February 2024. The electronic assessment tool went live at York Emergency Department on 30 April 2024.

The Trust is looking to evidence that it now meets the conditions of registration placed on the Trust in January 2020 once the use of the screening assessment is embedded at both the York and Scarborough hospital sites.

6. CQC Cases / Enquiries

The CQC receive information from a variety of sources in relation to the quality of care provided at the Trust. This information can be related to known events, for example serious incidents (SI's), formal complaints and Datix incidents, or unknown events, such as concerns submitted directly to the CQC from either patients, staff, members of the public, or other organisations. Following receipt of such information, the CQC share the concerns with the Trust for review, investigation, and response. The CQC monitor themes and trends of enquiries received, and these can inform inspection and other regulatory activity.

There has been one CQC case received since the last report was written (30 April 2024) regarding concerns raised by the family of the patient relating to a lack of communication. A response is being drafted by the Medicine Care Group.

At the time of writing, the Trust had 10 open cases / enquiries. The enquiry dashboard can be viewed in **Appendix C**.

7. CQC Updates

Integrated Care System (ICS) assessments update

The CQC announced a delay in starting ICS assessments. After the general election, the CQC will be engaging with the new government to obtain the approvals required to begin such assessments.

When the CQC have received government approval of our ICS assessment methodology, they will publish the reports of the pilot assessments, an evaluation of the pilots, and updated guidance on the approach ahead of starting ICS assessments.

Interim Chief Inspector for Healthcare Appointment

Chris Dzikiti has been appointed as Interim Chief Inspector of Healthcare to cover for Sean O'Kelly.

New Assessment Report

On 22 May 2024 the CQC published an inspection report for Royal Court Care Home in Barnsley. The report appears to be one of the first published under the single assessment framework. When the domain headings are selected (on the left hand side – safe, effective, caring, responsive, well-led) the narrative and scores are visible. The Head of Compliance and Assurance has queried whether 'actions' will be included in the revised reporting templates as there are none published in this report.

8. Recommendations

The Board of Directors is asked to:

- Note the current position regarding the recent CQC inspection activity.
- Note the current position of the open CQC enquires.

Appendix A
CQC Actions 'Off Track'

Ref	Action	Target Date to Complete	Current Position	Workstream Lead
10	The trust must ensure there is full clinical engagement to support operational performance and that challenges are resolved with a focus upon patient safety across the organisation.	26/04/24	A closure form has been drafted. The closure form is scheduled to be presented at the J2E meeting on 24 June 2024.	Claire Hansen
14	The trust must ensure that attendance to patient 'fundamental care needs' are met, including getting enough help to wash or keep clean and to eat meals, as well as being able to get help from staff when needed.	29/03/24	Closure form was presented at J2E 29 April and not approved. An extension form is being drafted, all sub actions are complete but with the metrics for assurance on the delivery of the fundamentals of care are under review. The extension form is scheduled for J2E 24 June 2024.	Dawn Parkes
23	The trust must ensure that in Maternity and Medical Care, all staff are aware of and consistently follow the trust policy to safely store medicines including controlled drugs and controlled substances hazardous to health (COSHH). The trust must also ensure adequate action is taken following audits which identify medication storage issues.	29/03/24	Further assurance is needed for the management of medicines within maternity services and medicine. An extension is needed and will be presented to J2E on 24 June 2024.	Dawn Parkes
29	The trust must ensure that there are sufficient allied healthcare professional, nursing, midwives and medical staff in Medical Care and Maternity to keep people safe.	29/03/24	The Head of Compliance and Assurance is the process of collating evidence in support of the progress made with this action.	Dawn Parkes
38	The trust must ensure the Urgent and Emergency service continues to work to improve the following performance standards at Scarborough hospital; - the median time from arrival to treatment. - the percentage of patients admitted, transferred, or discharged within four hours. - the monthly percentage of patients that left before being seen.	30/04/24	Actions form part of the Urgent and Emergency Care Workstream. Meeting scheduled with the Deputy Chief Operating Officer to draft current position.	Claire Hansen

Ref	Action	Target Date to Complete	Current Position	Workstream Lead
55	The trust should ensure that in Medical Care at York, patients have venous thromboembolism (VTE) checks and risk assessments are completed and documented within the current trust protocol within 14 hours.	30/04/24	Original target date 30.11.23 Trust compliance of VTE checks within 14 hours at approx. 50%. The VTE Committee has been asked to feedback to Medicines Optimisation Group for March around plans for mandating VTE within EPMA. Specifically, they have been asked:- • Clear view of whether VTE risk assessments or risk assessments and prescribing (or reason for not prescribing) should be mandated . • To engage with Care Group Clinical teams around whether there are any risks regarding mandating VTE risk assessments. Particularly in admission areas. • Once this has been determined it will need to be scheduled within the DIS prioritisation process for action.	Dawn Parkes
60	The trust should ensure that patients discharge plans in medical care at York are commenced on admission to the service so that support is in place where needed on the patients discharge.	30/04/24	Action discussed at the J2E meeting 10 June 2024. An extension is needed and links with the Discharge Improvement Group. Ownership of action to be reviewed by the Chief Operating Officer.	Claire Hansen
63	The trust must ensure that in Maternity, fire risk assessments are up to date, thoroughly assessed and documented to meet best practice guidance. For example, they must ensure fire exits are clearly marked and have safe exit routes. They must ensure fire drills are completed regularly and audited.	29/03/24	Evidence to support the closure of this action is being collated. Additional assurance is needed.	Karen Stone
65	The trust must ensure that in Maternity, key environmental and clinical audits are completed and monitored with action plans. For example, audits on fresh eyes assessments and WHO safety checklists.	30/04/24	An audit planning session is arranged 6 June 2024 with support from the Consultant Midwife. An extension request form is being drafted for J2E 24 June 2024.	Karen Stone

Appendix B
CQC Actions – Target Date Extended

Ref	Action	Target Date to Complete	Update	Workstream Lead
3	The trust must ensure that the guidance within all policies is up to date, accurate and relevant to the service. This includes, but is not limited to: - The guidance within the workforce and equality diversity, and inclusion (EDI) - Freedom to speak up - Policies for transgender and non-binary people - Unacceptable behaviours from patients - Maternity Services	31/08/24	Original target date 29.12.23, extended 8.1.24 and 29.4.24 A Trans and Non-Binary Policy has been drafted, but there has been a revision to the NHS Constitution and an eight week consultation period (ends 31/07/24).	Dawn Parkes
4	The trust must demonstrate it supports its staff by challenging unacceptable behaviours and language. This includes, but is not limited to, racism and discrimination.	31/05/24	Original target date 29.12.23 The exclusion guidance within the Violence and Aggression Policy (reference as unacceptable behaviours) is under review by the Director of Quality, Improvement and Patient Safety.	Polly McMeekin
12	The trust must ensure ongoing patient safety concerns such as falls, pressure ulcers and healthcare care acquired infections are addressed in a timely way and all possible actions are taken to address concerns.	29/03/24	Original target date 29.3.24 Part A of the form relating to fundamentals of care was approved for closure. Part B linked to IPC performance, for which the Trust is not in a position to close. IPC aspects of the action on the agenda for J2E meeting on 24 June 2024.	Dawn Parkes
13	The trust must ensure that complaints are responded to in a timely way, result in further investigation if indicated and where possible involve family in the investigation.	28/06/24	Original target date 30.4.24 Whilst we have seen improvement especially in the complaints outstanding over 50 days over the last few months, looking at the analysis, we cannot demonstrate that complaints responses have significantly improved over the fiscal year. The Patient Experience Team is meeting with the Interim Chief Nurse and the Associate Chief Nurses later this month to review the complaints position and bi-weekly meetings are commencing for the Interim Chief Nurse and ACMs to provide assurance that complaints responses will be completed in a timely manner.	Dawn Parkes

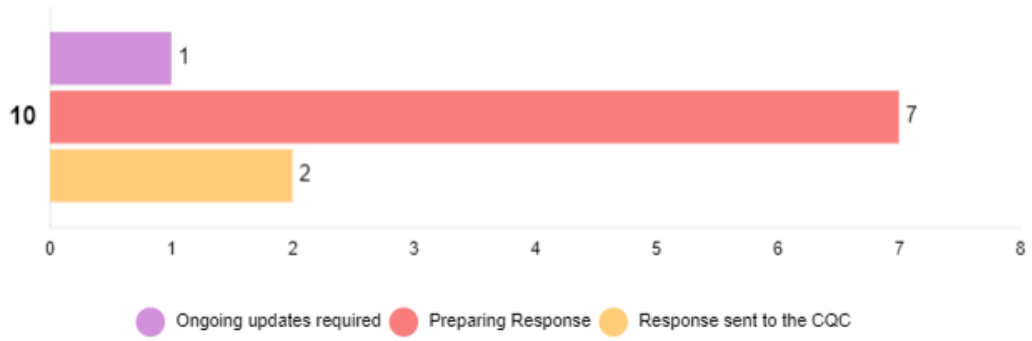
Ref	Action	Target Date to Complete	Update	Workstream Lead
21	The trust should ensure it meets the criteria for accessible information standard (AIS).	28/06/24	Original target date 31.1.24 Extension request approved on 18-03-24 due to CPD development work on new fields for capturing patient information relating to accessible information expected to be completed on 24 June 2024	Dawn Parkes
25	The trust must ensure that all staff groups in Medical Care, Maternity and Urgent and Emergency Services complete designated mandatory training sessions. Including: - Safeguarding, PREVENT, Adult Life Support and Advanced Life Support (MC York and Scarborough) - Theatre recovery training, practical obstetric multi-professional training and saving babies lives version 2 (Mat York and Scarborough) - ED Medical Staff, esp. Safeguarding, learning disabilities and dementia (Scarborough)	28/06/24	Original target date 31.1.24 For the areas and subjects listed, the Trust is on track to achieve the 85% compliance except in the following: • Adult Life Support (MC York and Scarborough) • Learning Disabilities and Dementia (ED Medical Scarborough) • Saving Babies Lives version 2 (Mat York and Scarborough) As a multi-stranded action, the subjects which are outstanding are all at different stages; but the one which will take longest to reach its target and then sustain compliance for three-months is Adult Life Support in Medicine (119 further completions needed + maintain existing level) – the requested deadline has been selected on that basis	Dawn Parkes
27	The trust must continue to ensure patients nutritional and hydration needs are met and this is confirmed through the Malnutrition universal screening tool (MUST) auditing process. The Urgent and Emergency Care services must ensure ED and SDEC staff fully and accurately complete patients' fluid and nutrition charts and offer patients drinks, especially long waiters, and those in recovery.	30/11/24	Original target date 30.4.24 Actions from the original plan are complete however there is still concern around impact measures of the 24-hour ward checklist for the monitoring mechanism for the fluid balance chart, and lack of evidence that MUST is embedded across the Trust.	Dawn Parkes

Ref	Action	Target Date to Complete	Update	Workstream Lead
33	The trust should ensure that resuscitation trollies in Maternity and Urgent and Emergency Care are checked in line with trust policy and records are available to evidence completion.	31/05/24	Original target date 29.2.24 Assurance provided for the resus trolley checks in Medicine, but performance not at 100% in Maternity. Compliance checks are now being led by the Deputy Head of Midwifery	Dawn Parkes
40	The trust should ensure ED staff recognise or make reasonable adjustments to meet patient needs such as those with mental health issues or anxiety. ED staff must complete all sections of risk assessments for patients who show signs of mental ill health. They should consider revising this documentation's length to improve staff compliance	28/06/24	Original target date 29.12.23 The UEC electronic screening tool is in place at Scarborough ED and went live in York 30 April 2024. Dashboard to be produced to show compliance with the assessment and the care plans.	Claire Hansen
56	The trust should ensure that patients on the acute stroke ward 23 received their daily 45 minutes of rehabilitation.	31/08/24	Original target date 31.01.24 The refurb of ward 23 has been delayed - rehab facilities are within the ward plans	Dawn Parkes
61	The trust should consider identifying dedicated rehabilitation and kitchen areas for use when undertaking patient assessments on the acute stroke ward.	31/08/24	Original target date 31.01.24 Plans have been drafted and approved for the rehabilitation space and kitchen facility for the Acute Stroke Ward, however, there has been a delay in the commencement of the refurbishment.	
69	The trust must ensure that in Maternity, persons employed receive such appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform.	30/11/24	Original target date 29.12.23 Mandatory training compliance has significantly improved since the CQC inspection. There have been an additional two clinical practice midwives recruited in 2023 to support training delivery. The training plan for 2024 has time built in for clinical staff to complete online statutory and mandatory training. The appraisal rate for 2023/24 was 70%. The appraisal window has reopened for 2024 and the service aims to achieve 95% by November 2024. Appraisal rates are to be overseen by the Senior Leadership Team on a monthly basis.	Karen Stone

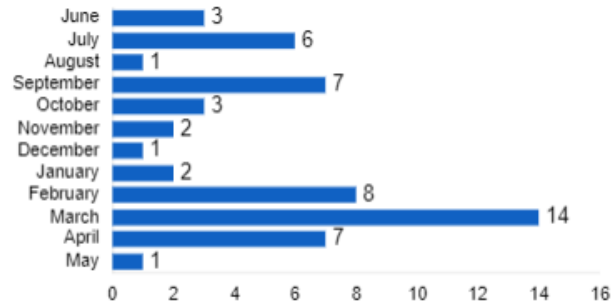
Ref	Action	Target Date to Complete	Update	Workstream Lead
71	The service must implement an effective system to assess and monitor compliance to ensure the baby tagging process is adhered to in line with trust policy.	28/06/24	Original target date 31.1.24 X tag in place at York and Hugs at Scarborough. Incidents have been raised which include babies not having a tag in place. Daily assurance checks are being undertaken within maternity and will be added once compliance can be evidenced.	Karen Stone
73	The trust must ensure both Maternity theatres are serviced, maintained, and fit for purpose in line with best practice guidance.	31/07/24	Original target date 29.2.24 York Maternity Theatre renovation commenced 12.2.24. Both Maternity Theatres will undergo renovation, one at a time. Expected to be completed by the end of June 2024.	Karen Stone

Appendix C
CQC Cases / Enquiries (1 June 2023 to 31 May 2024)

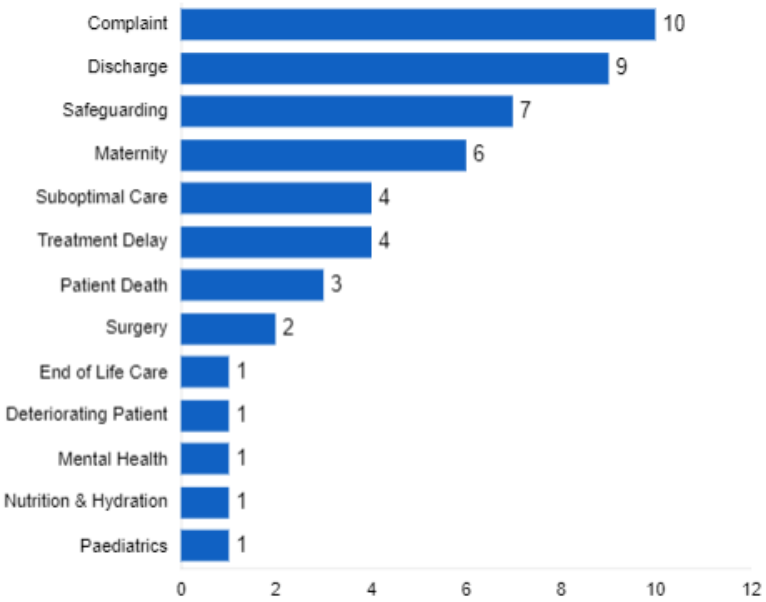
Number of Open CQC Enquiries / Cases



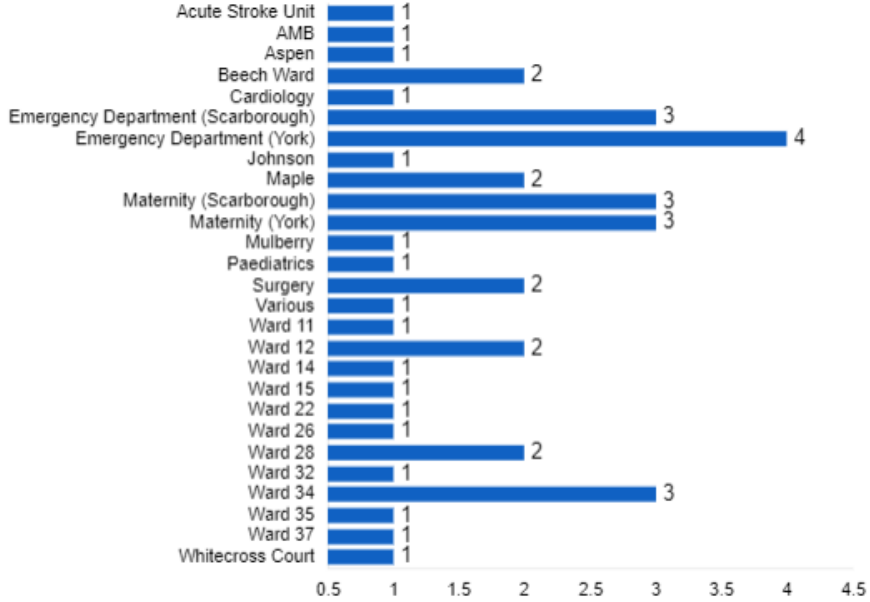
Number of Enquiries Received



Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Report to:	Public Board of Directors
Date of Meeting:	26th June 2024
Subject:	Infection Prevention and Control Annual Report, 1st April 2023 to 31st March 2024
Director Sponsor:	Dawn Parkes-Director of IPC
Author:	Sue Peckitt-Deputy Director of IPC

Status of the Report (please click on the appropriate box)
Approve ☐ Discuss ☐ Assurance ☒ Information ☒ A Regulatory Requirement ☒

Trust Priorities	**Board Assurance Framework**
☐ Our People	☒ Quality Standards
☒ Quality and Safety	☐ Workforce
☐ Elective Recovery	☒ Safety Standards
☐ Acute Flow	☐ Financial
	☒ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

To provide the Quality Committee with key performance data from Infection Prevention and Control (IPC) Team and details of improvement actions through the year and planning for 2024/25.

- The Trust has exceeded all its annual objectives for all mandatory healthcare acquired infection with the exception of Pseudomonas bacteraemia,
- The IPC team has intensified clinical education on back to basics, including planned educational sessions for all staff groups.
- The IPC Team have conducted IPC Hierarchy of Control Audits on all in-patient areas, action plans for the ward areas are now with the ward managers for delivery by the ward teams.
- The IPC Team commenced using Patient Safety Incident Report Framework (PSIRF) for post infection reviews for *Clostridioides difficile* with bacteraemia cases now coming on-line.
- A Clostridioides difficile improvement plan is in place for the Elderly Care wards at Scarborough. This is overseen and delivered by the Care Group and regular updates are provided to NHSE via the regional Infection Prevention and Control lead.
- The Trust was involved with an extensive contact tracing programme following the identification of the first case of a new Avian Flu strain in November 2023.
- The Antimicrobial Stewardship (AMS) team activity is detailed within the report which includes information related to intravenous to oral switch CQUIN compliance, AMS reviews and AMS improvement activities.
- The IPC Team, Microbiologists and Pharmacy team have undertaken the National Point Prevalence Survey on Health Care Acquired Infections, Antimicrobial Usage and Stewardship which commenced 18th September 2023 for 4 weeks. The national report providing feedback has not yet been received.

Recommendation:
The Board of Directors is asked to note the Trust performance with regards to health care associated infections (HCAIs), acknowledge the actions being taken to reduce the incidence of HCAI and note the plans for improvement in 2024/25.

Report History
(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
Quality Committee	21/05/2024	Accepted

Infection Prevention and Control (IPC) 2023/24 Annual Report

1. Introduction and Background

The Health and Social Care Act 2008: code of practice on the prevention and control of infections (Department of Health 2015) stipulates the importance of the Director of Infection Prevention and Control (DIPC) reporting regularly to the Board of Directors. This includes an annual written report summarising key Infection Prevention and Control (IPC) issues and progress against agreed improvements.

This annual report for 2023/24 highlights Healthcare Associated Infections (HCAI) performance for the trust and includes activity to prevent and control the spread of infection within the Trust.

This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving patient safety and the quality of patient experience as well as striving to reduce the risk of infections.

2. The Infection Prevention and Control Team (IPC Team)

There have been a number of changes to the team in 2023/24. A new Director of Infection Prevention and Control (DIPC) was appointed in June 2023, a new Deputy DIPC commenced within the Trust on a temporary basis in July 2023 and became substantive in January 2024. The Senior Infection Prevention and Control Nurse left the organisation in January 2024, that post remains vacant with a plan to recruit in 2024/5. A trainee IPC Nurse commenced on both York and Scarborough sites in quarter 3 2023/24 and an audit and surveillance support practitioner commenced on each site in quarter 3 2023/24. This has resulted in opportunities to review and refresh the way the IPC team are delivering the service but with four junior members of the team a significant investment of time and resource has been required for their orientation and mentorship.

We look forward to a further Consultant Microbiologist joining the Trust in April 2024 who will provide further enhancement to the IPC team.

2.1 Infection Prevention and Control Governance

The Infection Prevention Strategic Assurance Group (IPSAG) terms of reference and membership has been reviewed this year. IPSAG now meets monthly and reports to the Patient Safety and Clinical Effectiveness Sub-Committee (PSCE), the DIPC and Deputy DIPC are members of the PSCE.

The IPC Board Assurance Framework was revised in quarter 4 of 2022/23 and requires further review in the coming year.

3. Current Position/Issues

3.1 *Clostridioides difficile infection (CDI)*

The Trust attributed annual objective for 2023/24 was set by NHS England at 116 cases. This includes community-onset healthcare-associated (COHA) and healthcare-onset healthcare-associated (HOHA) cases in patients aged over 2 years.

The Trust ended the year with 150 Trust attributed cases; COHA=40; HOHA=110. The objective was exceeded by 34 cases which is equal to the number of cases exceeded in 2022/23.

Of the 150 Trust attributed cases this year, 89 (59%) are attributed to Scarborough and Bridlington, 57 (38%) to York and 4 (3%) to Community In-patient Units. High operational pressures have placed an additional strain on both the workforce and isolation capacity across the Trust which has implications on patient placement, timely and effective environmental decontamination and fundamental infection prevention and control (IPC) practice.

Limited side room capacity results in delayed isolation of patients with diarrhoea thereby increasing the risk of environmental contamination. Competing priorities for side rooms during winter is made worse due to respiratory viruses that also require isolation. A Transmission Based Precautions guidance is available to all the staff on the Trust intranet to aid with prioritisation of side rooms. As part of the resizing work additional side room capacity has been identified to move back to patient availability.

Within Appendix1, Figure 1 demonstrates the monthly Trust attributed case against trajectory. Figure 2 shows the rolling mean annual CDI rates per 100,000 bed days for the trust versus comparator organisations in the region. Figure 3 provides a comparison of annual cumulative CDI cases from the three years 2021/22 to 2023/24 which highlights that the CDI case rate has been static over the three years with the year-end total number of cases being the same in the last two years.

Actions taken within 2023/24 to reduce the incidence of CDI have included:

- The CDI Reduction Strategy was developed in October 2023 and is overseen by *Clostridioides difficile* Improvement Group (CDIG) to progress actions for improvement. The plan on a page is shown in Appendix 2
- The CDI review process has progressed to a PSIRF approach from the end of December 2023. All cases from 2023/24 have either been reviewed using a thematic approach or using the Patient Safety Incident Response Framework (PSIRF) approach within quarter 4. The learning has informed the on-going CDI improvement action plan however we are not yet seeing sustained improvements in practice.
- A *Clostridioides difficile* summit was held for Cherry and Chestnut ward in November 2023 due to period of increased incidence of CDI on these wards at Scarborough Hospital. A quality improvement programme is ongoing and overseen by the Medical Care Group. Regular updates are provided to the NHSE Regional Infection Prevention and Control Lead. Since December 2023 there has been a reduction of cases on Chestnut ward, however Cherry ward has not yet seen a reduction of cases. The rates per 100,000 bed days on both wards remains higher than the overall Trust rate, see Appendix 1, Figure 4. An NHSE led assurance meeting was held on the 27th of March 2023 to review the actions taken to date, including antimicrobial stewardship. The Antimicrobial stewardship section of the action plan has been revised following this meeting.

- The IPC team continues to carry out clinical visits and CDI audits to re-enforce guidance relating clinical practice. The Trust annual average for compliance with the CDI care bundle was 88%
- The IPC team have introduced fundamental practice audits which currently include Hand Hygiene compliance, commode and bedpan cleanliness. Where areas do not meet the compliance standards, face to face education is provided and follow up audits conducted. There is a process embedded for escalations should timely improvements not occur. The audit data can be seen in Section 5, table 1, further improvement work will be delivered in 2024/25
- A replacement plan for mattresses continued into 2023/4 following identification of contaminated mattresses, which is a potential source of cross transmission for CDI. A business case for a full mattress replacement was approved and installation of new mattresses was completed within this year.
- A Standard Operating Procedure (SOP) for checking and cleaning mattresses was developed and was rolled out at the same time as the new mattresses were put into use.
- The Trust achieved the proactive Hydrogen Peroxide Vapour (HPV) decontamination programme within this year for all inpatient areas. The requests for reactive deployments of HPV or Ultra-Violet (UV) following cases of infection have been monitored throughout the year and when operational pressures have meant one of these options was not able to be deployed, a risk assessment is undertaken by the IPC team and Site co-ordinators and a suitable alternative manual decontamination undertaken. These are recorded by the Domestic Services Team and HPV or UV deployed as soon as the bedspace becomes available.
- A standardised ward checklist has been introduced to support ward cleanliness and provide assurance.

3.2 Meticillin resistant Staphylococcus aureus (MRSA) Bacteraemia and Meticillin sensitive Staphylococcus aureus (MSSA)

There were 4 cases of Trust attributed MRSA bacteraemia for 2023/24 against a zero-tolerance target, deterioration from the annual position of 2022/23 of 3 cases. All 4 cases were attributed to York Hospital and all cases have undergone a multidisciplinary clinical team post infection review (PIR).The lessons and actions identified in each case are being enacted via the care groups and bacteraemia reduction working groups, detailed below for MRSA and MSSA.

There has been a total of 87 Trust attributed cases of MSSA bacteraemia for 2023/24 against an agreed internal target of 59 cases. The incidence shows slight improvement from the previous year where 90 cases Trust attributed cases were recorded. Figure 5, Appendix 1 demonstrates the monthly Trust attributed cases against trajectory and Figure 6 shows the rolling mean annual MSSA bacteraemia rates per 100,000 bed days for the trust and comparator organisations in the region.

Of 87 Trust attributed cases this year, 59 (68%) are attributed to York, 25 (29%) are attributed to Scarborough and Bridlington, 3 (3%) to a Community Renal Dialysis Unit. The process of post infection review of MSSA bacteraemia was not robust and reliant on one member of the IPC team, however a PSIRF approach for review has been developed which will become embedded in quarter 1 of 2024/25.

The common themes of learning and actions of the MRSA and MSSA bacteraemia reviews include:

- Cannula observation records incomplete on CPD in all cases. This is despite on-going work via the Staphylococcus Aureus Bacteraemia Reduction Group. A directive was issued by the interim Chief Nurse in quarter 4 regarding improving cannula documentation and management.
- Blood Culture and MRSA sampling needs re-iteration through the Care Groups that samples need to be correctly labelled to ensure they are processed and facilitate optimum treatment. Blood Culture Pathway quality improvements are being driven by the Trust Sepsis Group.
- MRSA decolonisation treatment delays in prescribing/administering which is being addressed with development of a patient group directive (PGD)

Actions taken within 2023/24 to reduce the incidence of MRSA and MSSA bacteraemia have included:

- The Staphylococcus Aureus Reduction Group have continued to meet and have refreshed the Peripheral Insertion of Vascular Cannula (PIVC) guideline which has been approved for publication by IPSAG. They have also rolled out cannulation trollies and training across the Trust in December 2023. These have been well received in Scarborough hospital but not as well on the York site. Further consideration to their use is required.
- An internal audit report regarding cannula management was published in March 2024. The report identified 1 major and 6 moderate recommendations which are currently being addressed.
- Cannula inspection and documentation improvement is being driven by the Chief Nurse

Appendix 1, Figures 5 and 6 demonstrate the monthly Trust attributed cases and cases against trajectory. The rolling mean annual MSSA bacteraemia rates per 100,000 bed days for the trust and comparator organisations in the region are shown in Figure 7

3.3 Gram Negative Blood Stream Infections (GNBSI)

The NHS Long Term Plan 2019 detailed an ambition for a 50% reduction of healthcare associated GNBSI by 2024/2025. From the 2019/20 data of E.coli 556 cases, Klebsiella 139 cases, Pseudomonas 57 cases the Trust achieved the required reduction in all GNBSI in the first year, however over the last 3 years the only ongoing reduction has been in Pseudomonas bacteraemia as demonstrated in the comparative charts, Appendix 1, Figure 8, 10 and 12.

- *Escherichia coli (E.coli)* bacteraemia Trust objective was set at 150 cases and the Trust breached the objective by 24 cases completing the year at 174 cases. See Appendix 1 Figure 7 and 8
- *Klebsiella* bacteraemia Trust objective was set at 52 cases and the Trust breached the objective by 17 cases, completing the year at 69 cases. See Appendix 1 Figure 9 and 10

- *Pseudomonas* bacteraemia Trust objective was set at 24 cases and the Trust finished the year 7 cases below the objective with a total of 17 cases. See Appendix 1 Figure 11 and 12

A focus on reducing all blood stream infections is required in 2024/25.

4. IPC Training

The IPC team continue to deliver IPC training with face-to-face training in classroom settings and clinical areas in both a reactive manner to observed practice during ward and department visits and proactively, such as the response to the increasing incidence of Measles within the UK.

The Trust annual IPC Conference ran on the 12th of October and was focussed on "back to basics" 160 staff attended the event. The feedback from delegates was excellent.

The team have provided new Healthcare Assistant training within the newly established academy at Bridlington Hospital. Since it's opening in October 2023, 149 staff have received training. This is an excellent opportunity to deliver scenario based training and practical application of fundamentals of IPC.

The mandatory IPC training compliance has been consistent over the year with IPC Core Level 1 at 93% and core level 2 at 82%. We have taken the opportunity to remind ward managers of this mandatory training requirement and it is an improvement action in the Hierarchy of Control Audits that have been conducted through the last two quarters of the year.

A focus on Aseptic Non-Touch Technique (ANTT) training continues as a key element on reducing bacteraemia rates. Quarter 4 has seen a slight improvement with the ANTT theory compliance reaching 87% whilst the practical compliance is 71%, see Appendix 1, Figure 13. Further work is required in 2024/25 to ensure that the ANTT training is undertaken, and individual's competency declared.

5. IPC Audits

Hierarchy of Control audits were commenced in quarter 3 by the IPC team, 63 audits were completed, including all in-patient areas and some out-patient areas such as endoscopy where the IPC team felt was important to complete All audits have an action plan incorporated within the feedback to the area and we are now working with the clinical teams on the delivery of those action plans. The themes for improvement are listed in Appendix 3.

Audit information on Hand Hygiene, Symbiotix Cleaning Scores, bedpan and commode cleanliness, CDI practice compliance and MRSA screening for mothers of babies admitted to SCBU is available in the care group dashboards located via this link Care Group Dashboards. Key points of note are listed in table 1. Data submission could be improved, and the IPC team are encouraging care groups to do so.

Table 1 IPC Audit points of note					
Audit	Medicine Care Group Average compliance	Surgery Care group Average compliance	Family Health Care Group Average compliance	CSCS Average compliance	Trust Average
CDI, Saving lives bundle	87%	87%	91%	88%	86%
Hand Hygiene **	87%	87%	91%	94%	87%
Commode cleanliness	75%	72%	84%	83%	77%
Bedpan cleanliness	95%	95%	98%	100%	95%

**Hand hygiene audits were removed from Tendable in October 2023 and an alternative manual recording was introduced in December 2023

The IPC Team, Microbiologists and Pharmacy team have undertaken the National Point Prevalence Survey on Health Care Acquired Infections, Antimicrobial Usage and Stewardship which commenced 18th September 2023 for 4 weeks. The national report has not yet been made available, although some preliminary results has been used by the Antimicrobial Stewardship team to deliver focused training.

6. Orthopaedic Surgical Site Infections (SSI)

The trust has been working on reducing the incidence of orthopaedic SSI in the past year. See table 2 below.

Concerns regarding staff practice, and deterioration of the theatre environment have been raised. The Care Group have been holding simulation sessions to discuss and embed good practice and teamwork, including empowering staff to challenge and speak up when things are done inappropriately.

Post infection review meetings have been taking place within the Care Group with support from the IPC team; looking at improving the environment and patient management through the theatre journey. Some improvements have been demonstrated but this focus will continue into 2024/25

Table 2 Orthopaedic SSI rates per site and procedure

Infection rate to date (number of infections/number of operations)

	Bridlington		York			Scarborough	
	THR	TKR	THR	TKR	#NoF	#NoF	THR
Hospital rate 2024/25	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
Hospital rate **2023/24**	0.33%	0.30%	0.62%	1.22%	0.69%	0.00%	0.00%
Hospital rate **2022/23**	2.07%	1.06%	1.42%	0.00%	0.47%	0.00%	3.85%
Hospital rate **2021/22**	0.0%	0.9%	0.0%	0.0%	0.7%	1.03%	x
National rate 2022/23	0.5%	0.4%	0.5%	0.4%	0.7%	0.7%	0.5%

7. Standards for Healthcare Cleanliness (2021)

The Trust is still operating within the 2007 cleaning standards but is moving towards the National Standards for Healthcare Cleanliness, 2021 with agreed derogations. The cleanliness standards and implementation continue to be in review and discussed regularly within the Cleaning Standards Committee, IPSAG and YHTFM meetings. There is a plan to present the revised cleaning policy and compliance ratings to IPSAG in June 2024 for approval prior to publication and sharing across the Trust.

Whilst the reviews and plan for implementation are in development, assurance can be provided that all tasks identified within the updated standards are captured within the current methodologies with monitoring of these by the Trust's Compliance Team in line with Service Level Agreements for YTHFM, and performance criteria for cleaning elements that have clinical responsibility.

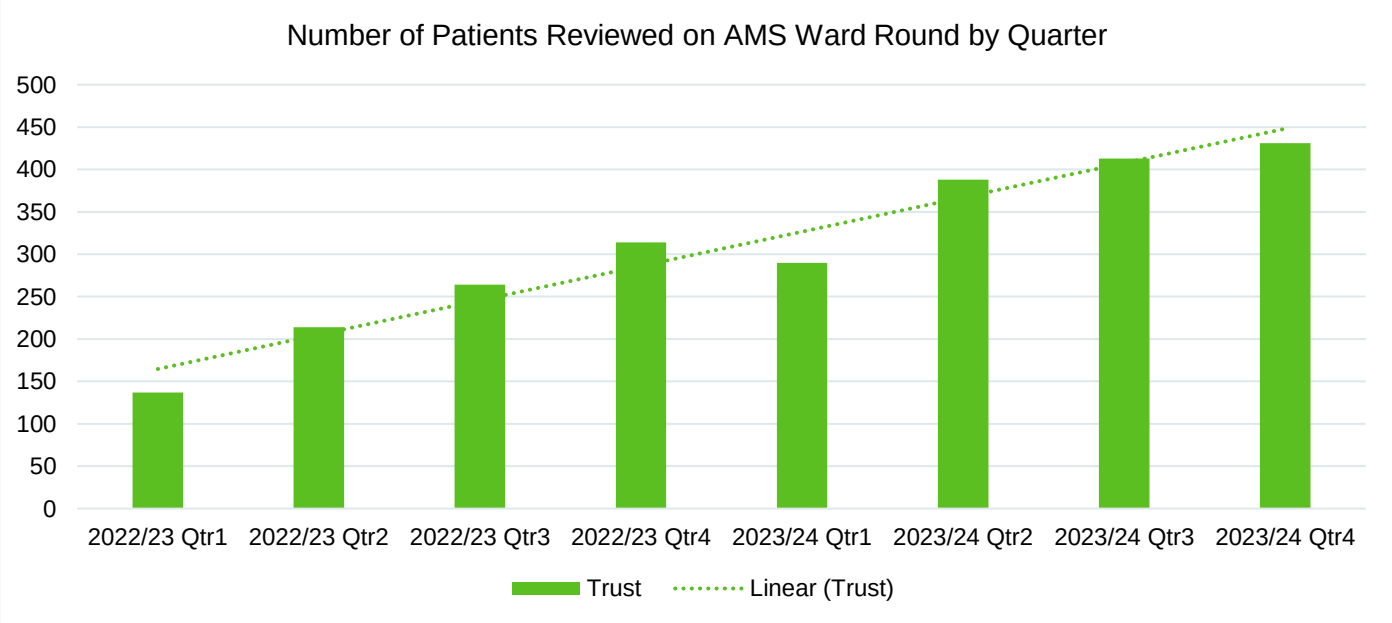
An internal audit for cleaning was published in March 2023 and an improvement plan is currently being addressed.

8. Antimicrobial Stewardship (AMS)

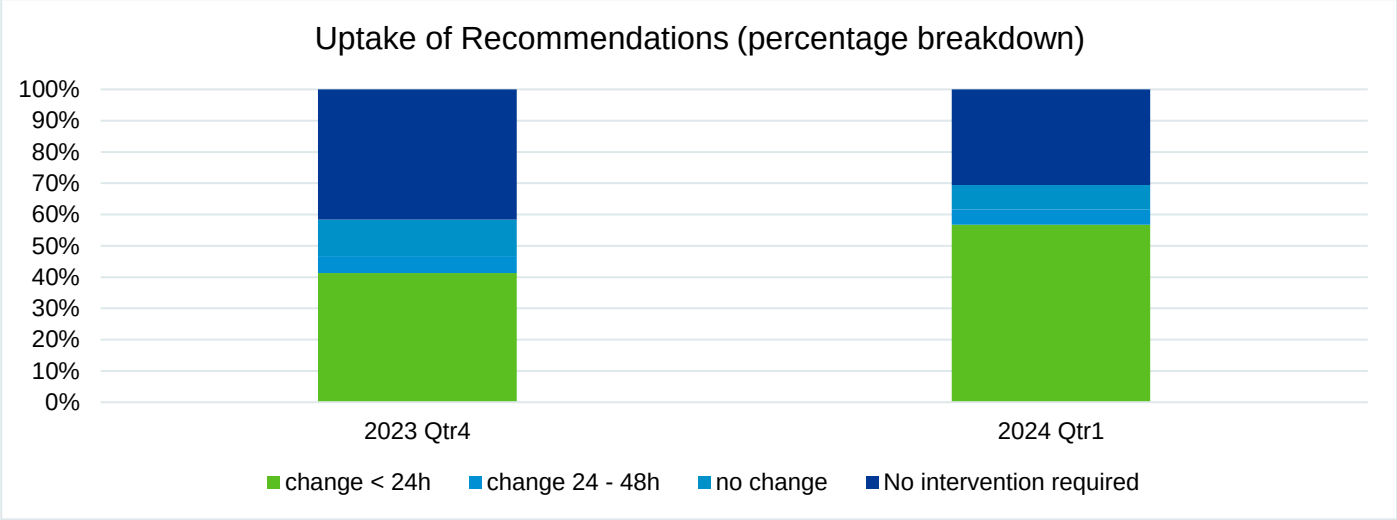
The AMS team continues to work to optimise the use of antimicrobials at the Trust, to improve patient outcomes and safety and reduce risk of resistance. Areas of focus of the 2023/24 AMS strategy are discussed in this report.

7.1a DIRECT PATIENT REVIEWS (AMS WARD ROUNDS)

The AMS team conduct twice weekly ward rounds on both sites, focusing on broad spectrum antimicrobials.



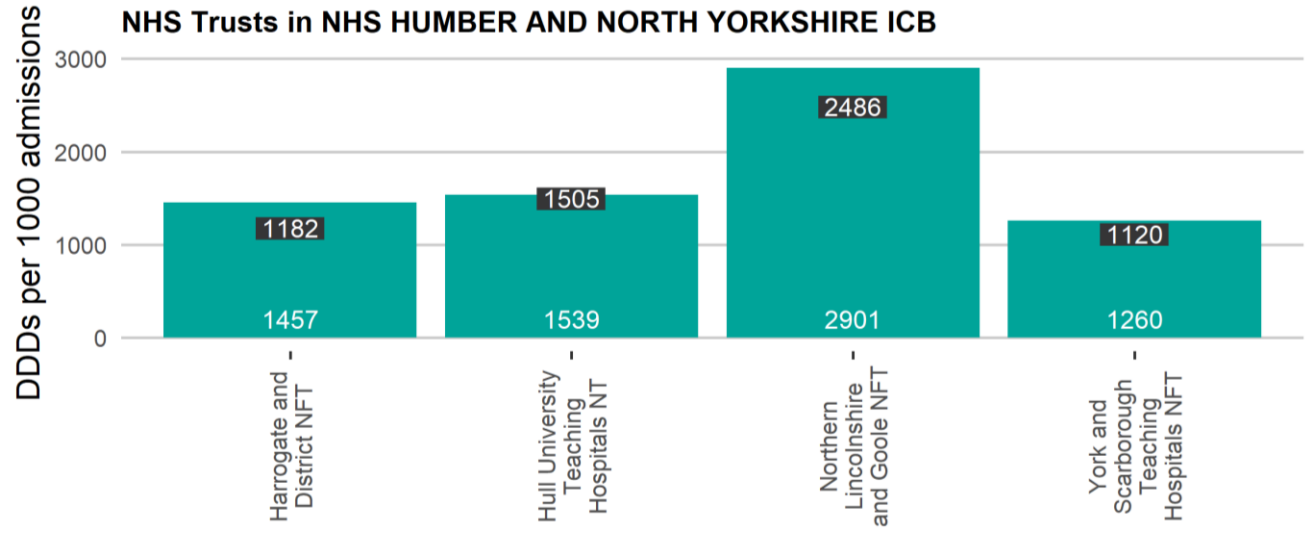
The number of patients seen on AMS ward rounds has increased consistently over the last two financial years, due to consistent ward rounds at SGH and a change in process for patient identification at YDH. The pharmacy antimicrobial team now share recommendations with ward pharmacists to support follow-up, which has been well received by the team and increases ward-level engagement.



In Q4 2023/24 the pharmacy AMS team started recording uptake of recommendations. Since then, with the work to improve IVOS (see section 1.1c), the proportion of treatments requiring intervention have reduced, and the uptake of recommendations has increased, demonstrating the effectiveness of the ward rounds. Wards and teams which were associated with lower uptake have been identified, with plans to work with them for focused improvements.

7.1b. NATIONAL CONTRACT DATA

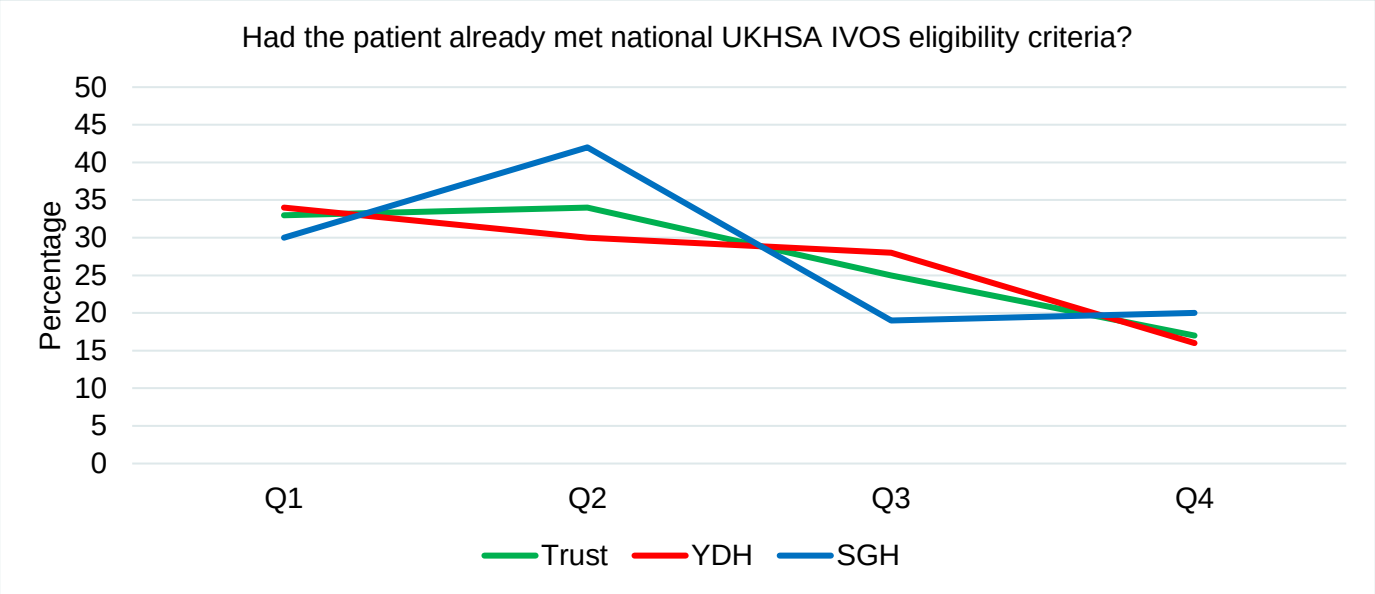
The 23/24 Standard Contact required a 10% reduction in use of Watch and Reserve antibiotics vs 2017 baseline. Watch and Reserve (WaRe) antibiotics are those which should be most restricted as part of the AWaRe classification. This is measured using defined daily doses (DDDs – an estimate of 1 day of antibiotic) per 1000 admissions. The target is shown in the black boxes below.



Although the Trust is not currently meeting the contract target of 10% reduction of watch and reserve antimicrobials from 2017 baseline, it is recognised to have the lowest consumption in the region. At last reporting, The Trust had achieved a 1.3% reduction and further improvement is anticipated through activities described below.

7.1c CQUIN 03: IV TO ORAL SWITCH (IVOS)

The 2023/24 AMS CQUIN related to optimising IV to Oral Switch (IVOS). The target for the CQUIN was < 40% of patients on IV antibiotics met IVOS criteria assessed using the Nationally developed tool. This was achieved in all four quarters, with an overall reduction from 33% to 17% and a 30% reduction in numbers of patients on IV antimicrobials on day 2 or more of admission using point prevalence methodology.



Regional Q4 data was not available at the time of reporting, but Q3 showed this Trust had a lower percentage than NLAG and HUTH, but higher than Harrogate (25%, vs 28%, 40% and 6% respectively).

Improvement activities implemented prior to Q3 and Q4 data collection included:

- Pharmacist review of patients on day 3 after initiation of IV antibiotics as a new part of routine practice.
- Education at ward level and through displays as part of World Antimicrobial Resistance Awareness Week
- IVOS tool at point of care via QR codes on wards and electronically on staffroom and Health Toolbox.
- Reporting results and benefits of IVOS in; Care Group Governance Meetings, Surgical and Medical Clinical Audit Meetings, Surgical Specialities Governance Meetings, Pharmacy Meetings.
- Championing as a priority by Medical Director

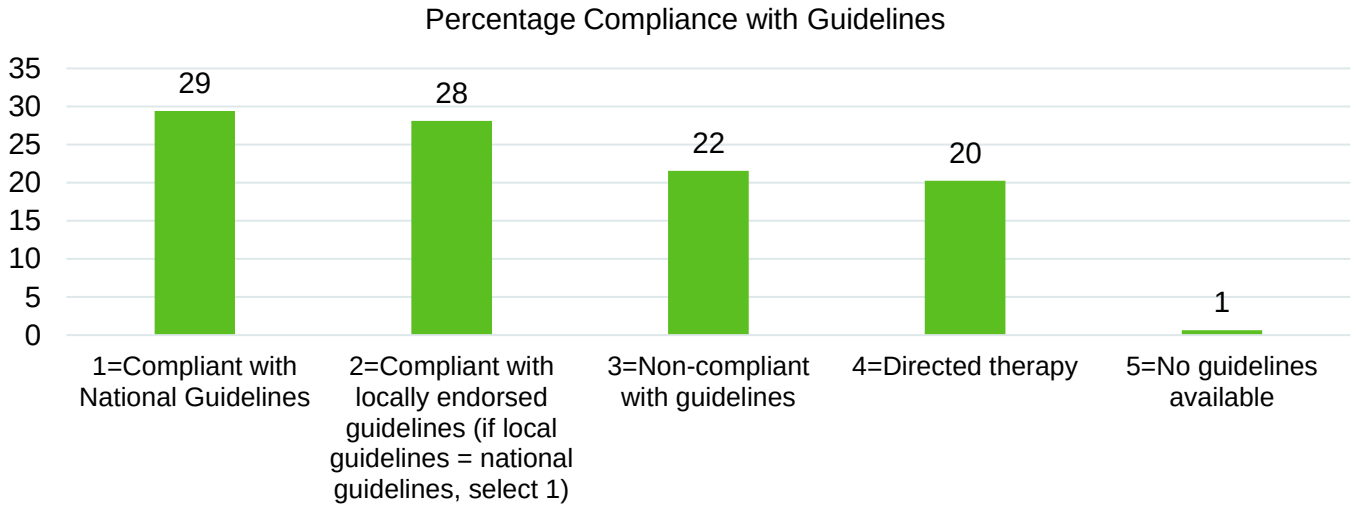
This successful IVOS improvement work is known to reduce cost and free up nursing time (as shown in the following table) along with reduction of carbon footprint, healthcare acquired infections and improve patient flow.

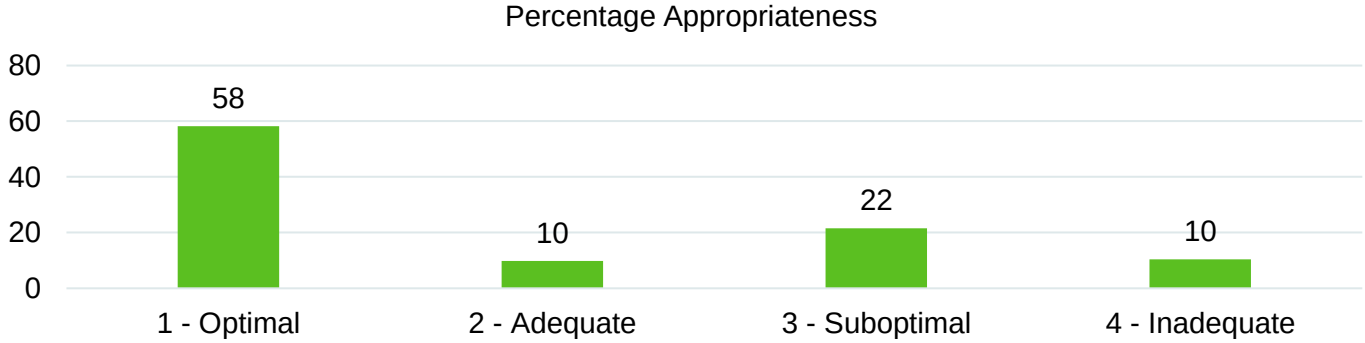
	Annual saving if IV antibiotics reduced by 10% (one dose from a 3.5 day course of 8-hourly dosing)	**Annual saving if IV antibiotic DDDs* reduced by 10% & were replaced by oral antibiotics**	**Total hours saved if IV DDDs reduced by 10%** (40mins per DDD)	**Value of total hours saved * mid-point AfC Band 6** (£18.19 per hour)	**Total projected saving** (New DDD cost + Nursing time)
Typical 1000 bed hospital	£122,682	£111,909	11,035	£200,736	£311,245
Y&S Trust (est. 1128 beds)	£194,185	£180,011	10,013	£182,145	£362,156

Source: IVOS CQUIN drug cost and nurse time savings by Trust v1.0 – Antimicrobial Resistance Programme – FutureNHS Collaboration Platform.

7.1d NATIONAL POINT PREVALENCE SURVEY (PPS) 2023

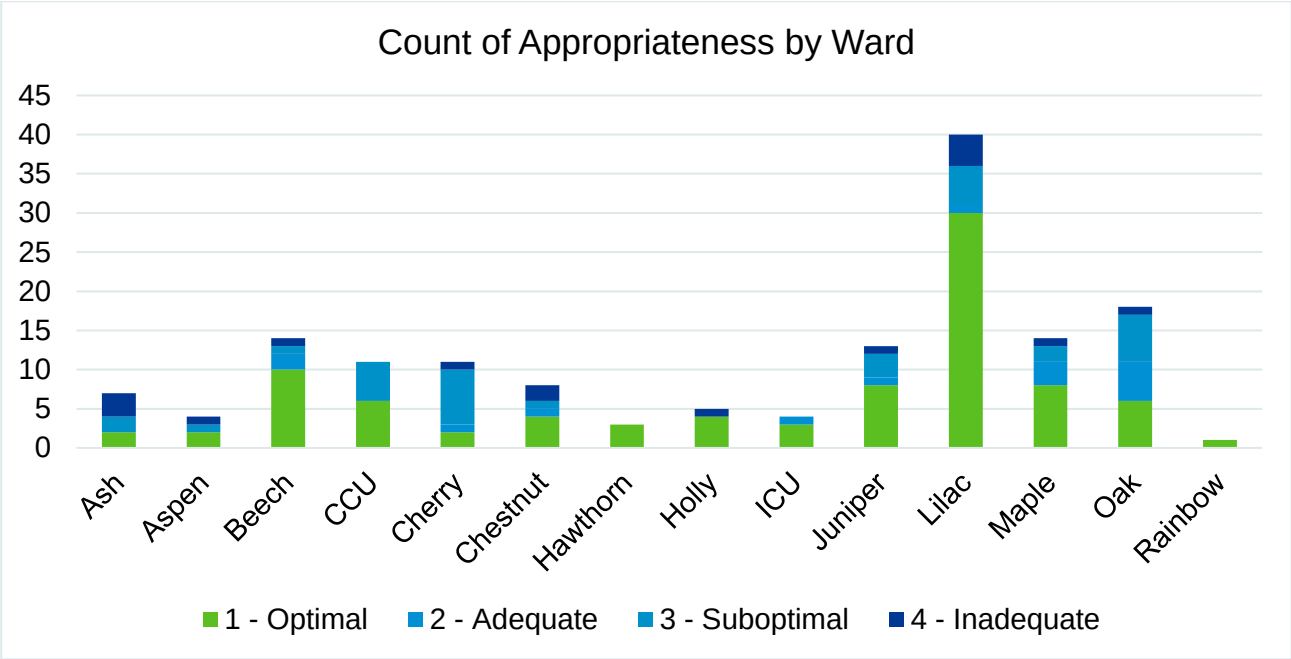
The National PPS was conducted over Sept-Oct 2023 at Scarborough, with IPC, microbiology and pharmacy reviewing risk factors for Healthcare Acquired Infections (HCAIs), prevalence of HCAIs and antimicrobial prescribing. As a change from previous PPS (conducted 2016), this iteration included quality review of antimicrobial prescribing.
The assessments of antimicrobial prescribing are illustrated below. (NB this data is pending national validation, but has been validated locally, with no national benchmarking is available at the time of reporting). This data collection occurred prior to the improvement work on IVOS was commenced, which must be taken into consideration when reviewing the following.





Overall, 77% of prescriptions were compliant with guidelines or directed therapy, and 68% of prescriptions were deemed appropriate (optimal or adequate).

Of the 23% which were deemed inappropriate, the majority related to missed opportunity of effective review. This is expected to have improved since improvement work on IVOS has been implemented.



The highest proportion of prescriptions being deemed inappropriate were on Cherry and Ash wards. Cherry and Chestnut are currently under focus due to high prevalence of CDI The highest number of prescriptions were in Lilac ward, which is where many of the Cherry patients are transferred from.

It remains a plan to perform the antimicrobial review aspect of the PPS at York site.

7.1e CHERRY & CHESTNUT WARD ACTION PLAN

The AMS team have prepared an action plan to support the optimisation of antimicrobial prescribing on Cherry and Chestnut wards, and therefore reduce the number of lapses in care that can lead to C. difficile infections. This action plan has been integrated into the wider Care Group led action plan and is being progressed. It includes elements of the Antibiotic Review Kit (ARK), intravenous to oral switch (IVOS), Proton Pump Inhibitor medication review and actions which will facilitate the AMS team to perform a surrogate for point prevalence surveillance of CDI, addressing antibiotic course lengths, comprehensive review of practice and identify any areas for optimisation. The action plan is monitored via the monthly specific Quality Improvement meeting with multi-disciplinary clinical involvement. There are 14 actions, 3 have been completed, 6 are in progress, 5 are outside the target completion date.

Actions implemented so far include but are not limited to attending Cherry and Chestnut on each AMS ward round, providing a daily list of patients on antimicrobials to the lead nurses, supporting changes in practice around antimicrobial reviews, including improved documentations, with associated data collection to inform further opportunities for improvement.

7.1f ANTIBIOTIC REVIEW KIT (ARK)

The aim for 2023/24 was to relaunch the ARK program across the Trust. ARK is a program which has demonstrated an increase in stop rate of antimicrobials within 72 hours of initiation. It is most effective and sustainable when delivered collaboratively with the specialities, supported by pharmacy and microbiology antimicrobial team members. Prior to putting the program on hold as part of the pandemic measures, junior doctors and pharmacy team members performed the data collection.

Engagement from the Care Groups and provision of prescribers from the specialities remains a gap, and capacity constraints within pharmacy and microbiology teams have prevented the relaunch. However, a tool combining IVOS, ASK and PPS elements has been developed which is to be utilised as part of the Cherry / Chestnut improvement plan. With greater support for the ward based clinical teams, the aim would be for relaunch ARK on a wider scale, with focus guided by performance figures.

7.1g ANTIMICROBIAL STEWARDSHIP TEAM (AST) MEETINGS

The AST meeting structure has been reviewed. With an annual strategy developed, and a comprehensive program of audit and surveillance implemented. Lack of attendance from Care Group representatives has been a persistent problem, affecting quoracy and effectiveness of the program. AMS Pharmacist links for the Care Groups have been identified to support the representative, and a request has been made to the Care Groups via the Medication Safety Officer/Deputy Chief but without consistent improvement.

9. Other IPC Activity

- The Trust Winter Respiratory Virus management plan was approved and in place from 22nd December 2023. The high bed occupancy level has made it difficult to use ward 35 as the designated Flu/COVID cohort ward at York. Flu/COVID cohort bays were established in other areas on an ad hoc basis, at variance with the plan. The review of the plan for 2024/25 will need to take this into account.
- Legionella water monitoring, improvement actions and remedial work on the taps and water system in affected areas is continuing across the organisation in line with the Trust Water Safety Plan .
- The Pseudomonas risk assessment for augmented care areas has been undertaken in quarter 4 this year, a report is due to be presented to IPSAG in June 2024.
- Several capital schemes have been progressing with IPC involvement this year including the Scarborough new build for critical care services and Emergency department, York Maternity Theatre refurbishment, MES service transfer to Nelson's Court, Community Diagnostic Units at Scarborough and York and ASU York. There have been a number of capital schemes that IPC have had late involvement with resulting in some required changes to the schemes to meet required standards, work to develop a Standard Operating Procedure (SOP) is underway with the Capital Planning team to avoid such issues in the future .

- All IPC policies and Patient Information Leaflets are undergoing a review and being updated to reflect the National IPC manual.
- A co-ordinated cross site hand hygiene dispenser replacement programme was commenced at the end of February 2024. However, we are now aware that the product manufacturer has gone into administration so the work will not be completed. The Purchasing team are working with the IPC team on a full soap and alcohol handrub replacement programme.
- In November 2023 a patient who had attended an out-patient appointment was confirmed to be positive for a strain of Avian Flu, the first reported case of this strain in the UK, UK Health Security Agency (UKHSA) and NHS England North East and Yorkshire (NEY) Emergency Preparedness, Resilience and Response (EPRR) team held national incident meetings, with relevant stakeholders. A regional de-brief document has commended the response of the Trust who demonstrated exemplary practices in contact tracing. The response to this sole case was time consuming and had the potential for significant impact to staffing within the Trust.
- The response to high risk of infection cases presenting to the York Emergency Department has been tested on several occasions this year. This has included cases of possible/confirmed Measles and possible/ not confirmed Middle Eastern Respiratory Syndrome (MERS). Lessons learnt have been shared and built into improvements in guidelines and practice.

10. Summary

The overall HCAI performance for the organisation requires improvement. The IPC team are committed to change their working practice and improve the delivery of the IPC service. The governance, ownership and accountability for IPC needs strengthening within the care groups and by introducing care group IPC meetings this will develop. The monitoring metrics are currently being reviewed to increase the assurance that the IPC team can provide to the organisation.

11. Next Steps

- Stabilise the IPC Team
- Complete IPC Board Assurance Framework
- Develop Trust IPC strategy.
- Strengthen IPC Governance by introducing IPC Care Group meetings.
- Consolidate IPC working Groups to reduce the number of meetings but deliver improvement actions – for example, an overarching IPC Operational Group with clear workstreams that address all bacteraemia, environmental issues, and fundamental IPC practice. This will report into IPSAG.
- Agree 5 high impact IPC actions which will be delivered and measured within the care groups.

Appendix 1 – HCAI Data

Figure 1: Cumulative Trust attributed Clostridioides difficile cases against trajectory

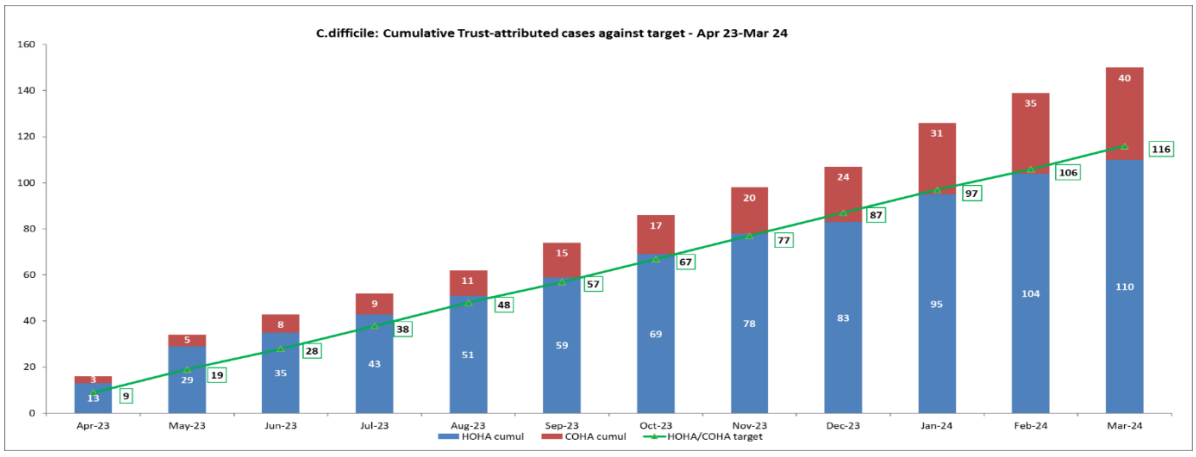


Figure 2: Clostridioides difficile rates per 100,000 bed days & day admissions monthly rate

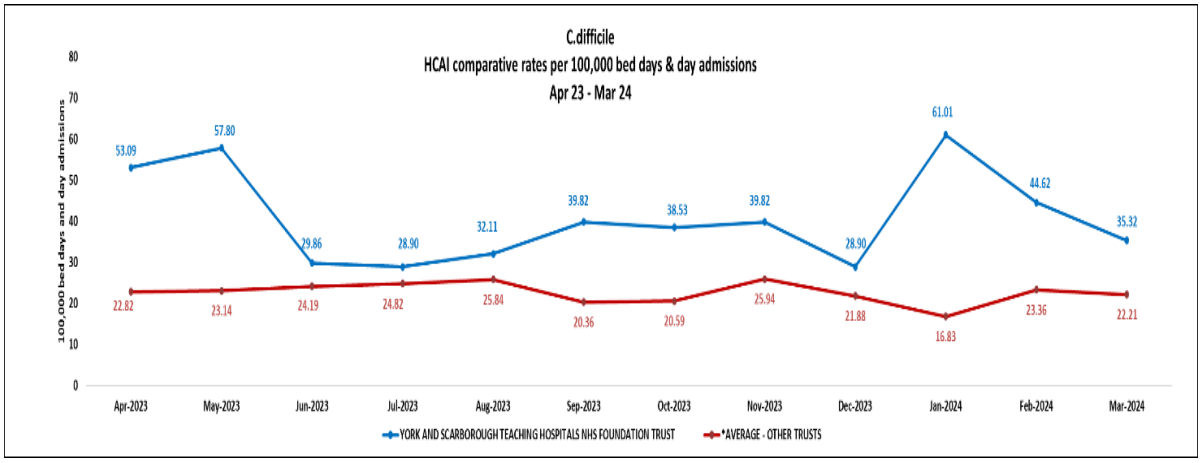


Figure 3: Cumulative Trust attributed Clostridioides difficile 2021-2024 comparison

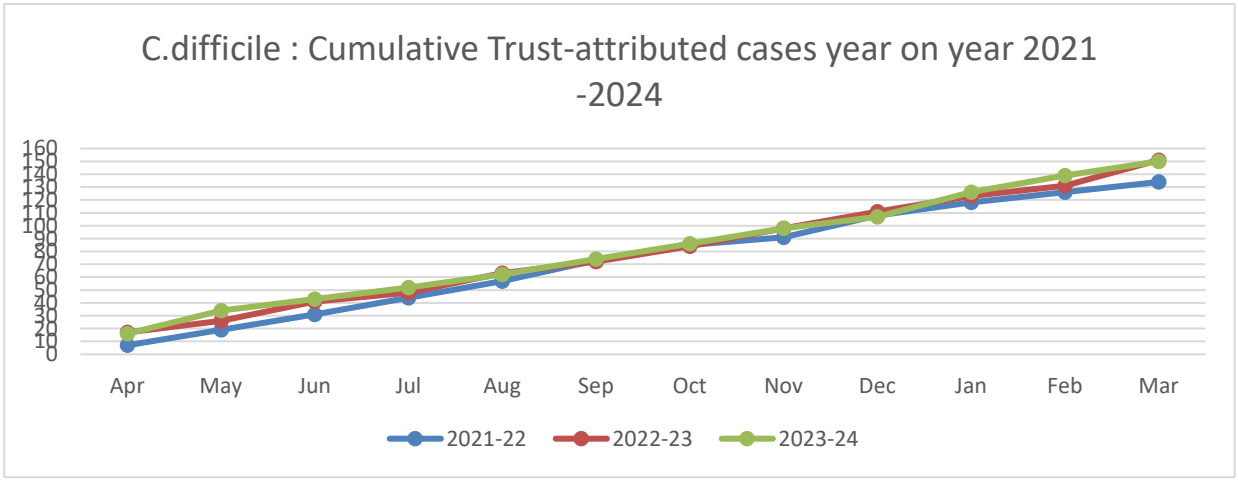


Figure 4: Clostridioides difficile rates on Cherry and Chestnut ward, Scarborough Hospital

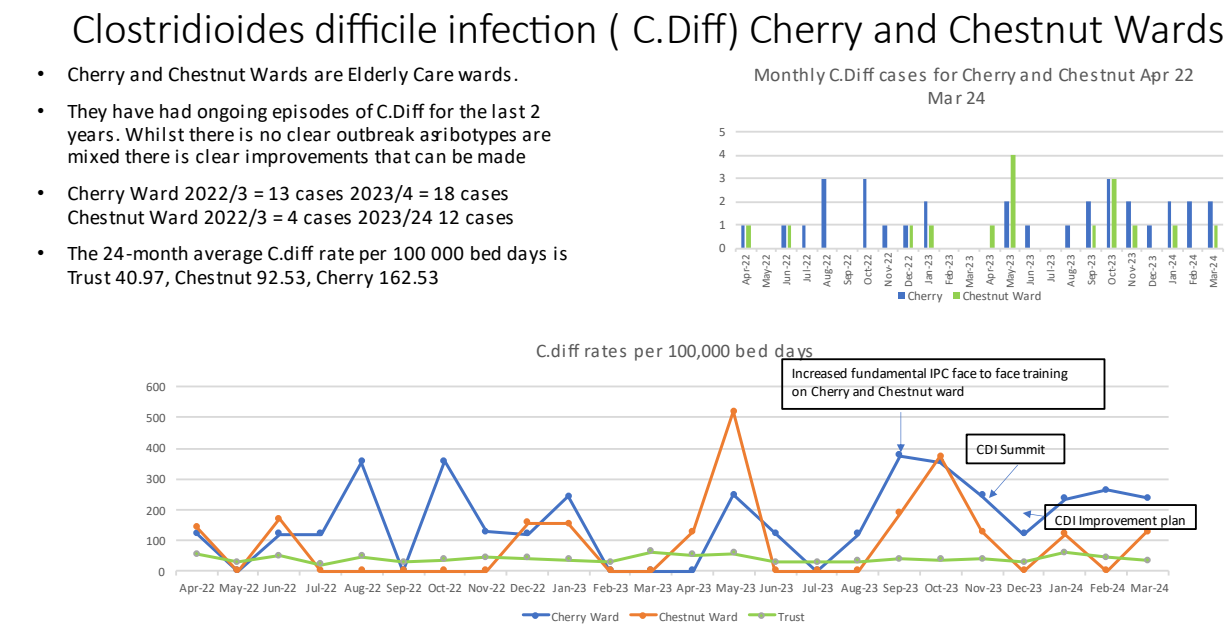


Figure 5: Cumulative Trust attributed MSSA Bacteraemia against trajectory

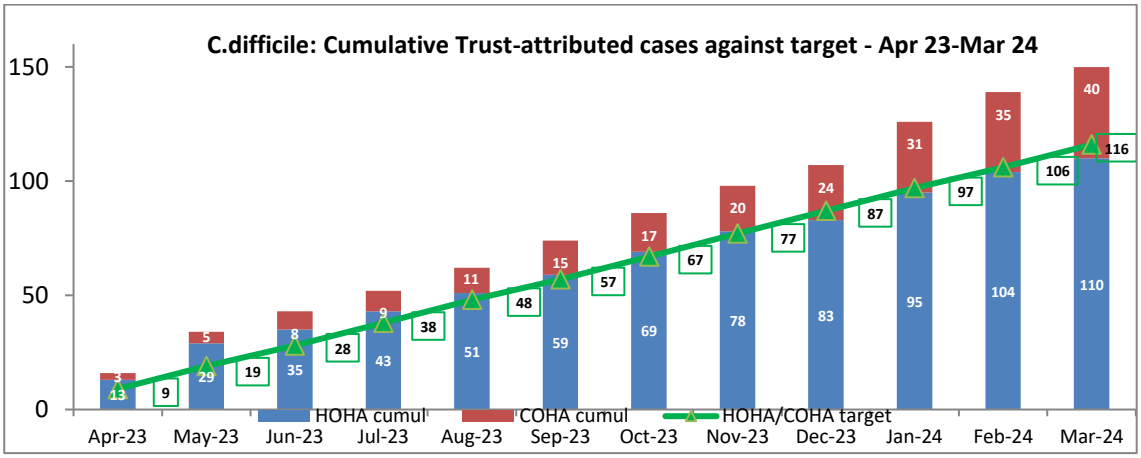


Figure 6: MSSA rates per 100,000 bed days and day admissions annual average

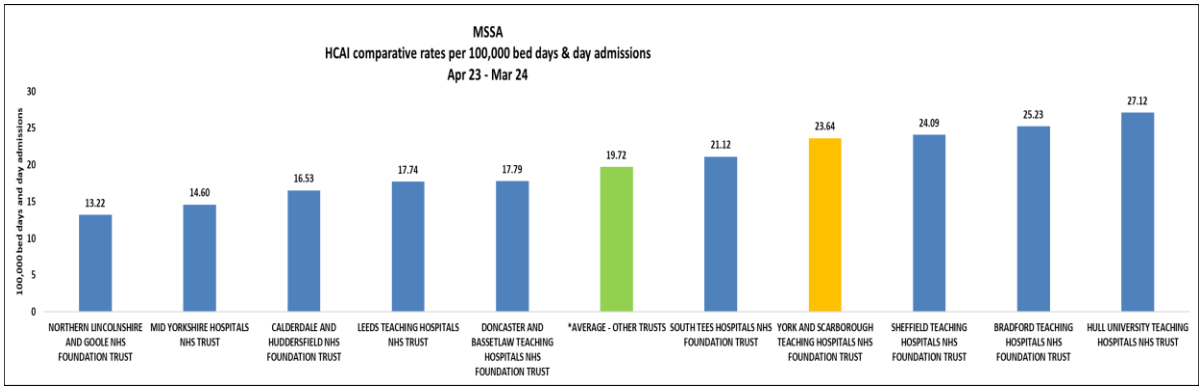


Figure 7: Cumulative Trust attributed E.coli Bacteraemia against trajectory

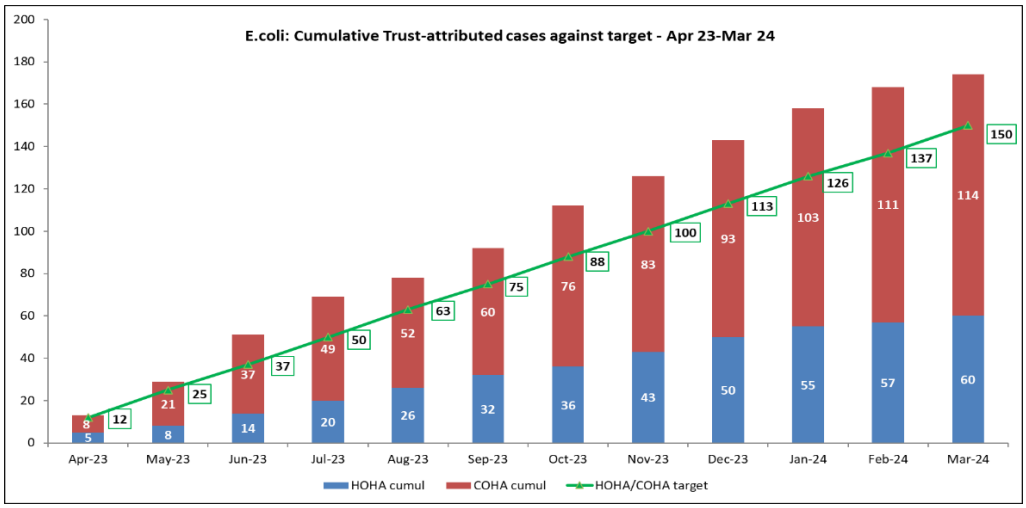


Figure 8: Cumulative Trust attributed E.coli 2021-2024 comparison

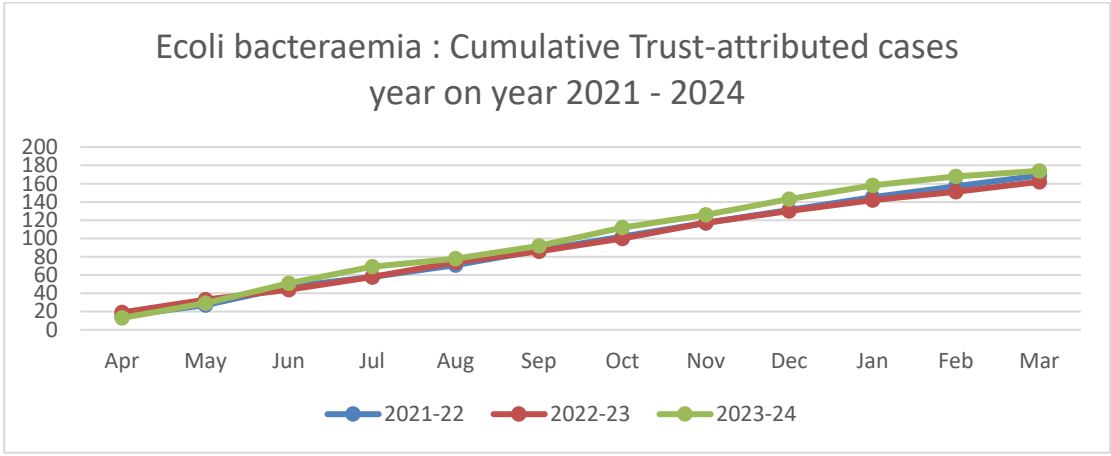


Figure 9: Cumulative Trust attributed Klebsiella Bacteraemia against trajectory

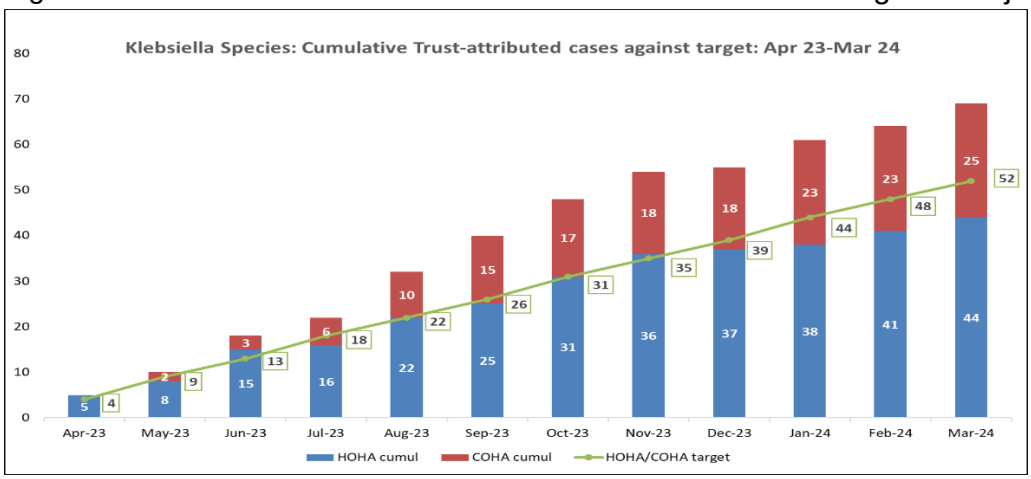


Figure 10: Cumulative Trust attributed Klebsiella bacteremia 2021-2024 comparison

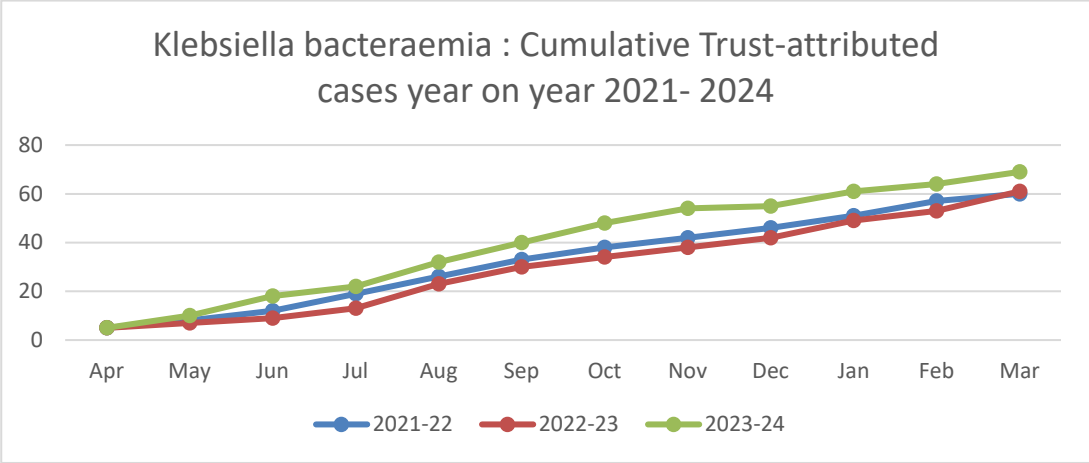


Figure 11: Cumulative Trust attributed Pseudomonas Bacteraemia against trajectory

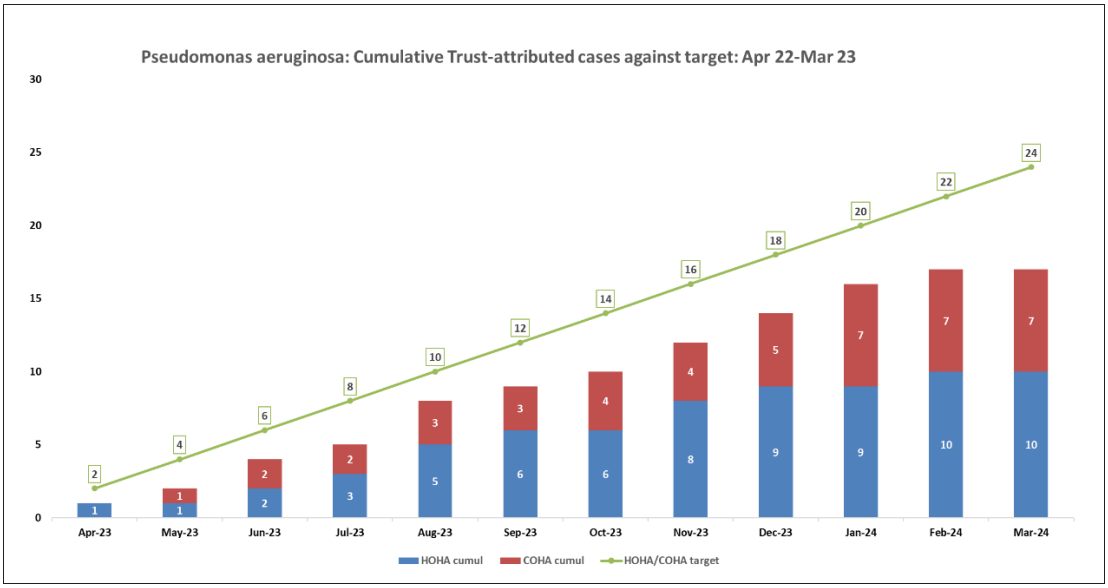


Figure 12: Cumulative Trust attributed Pseudomonas bacteremia 2021-2024 comparison

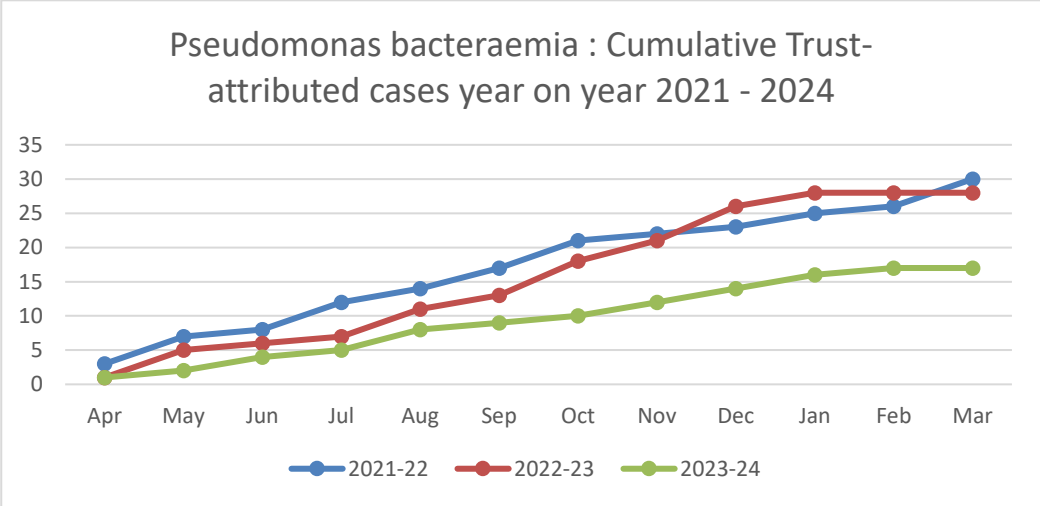
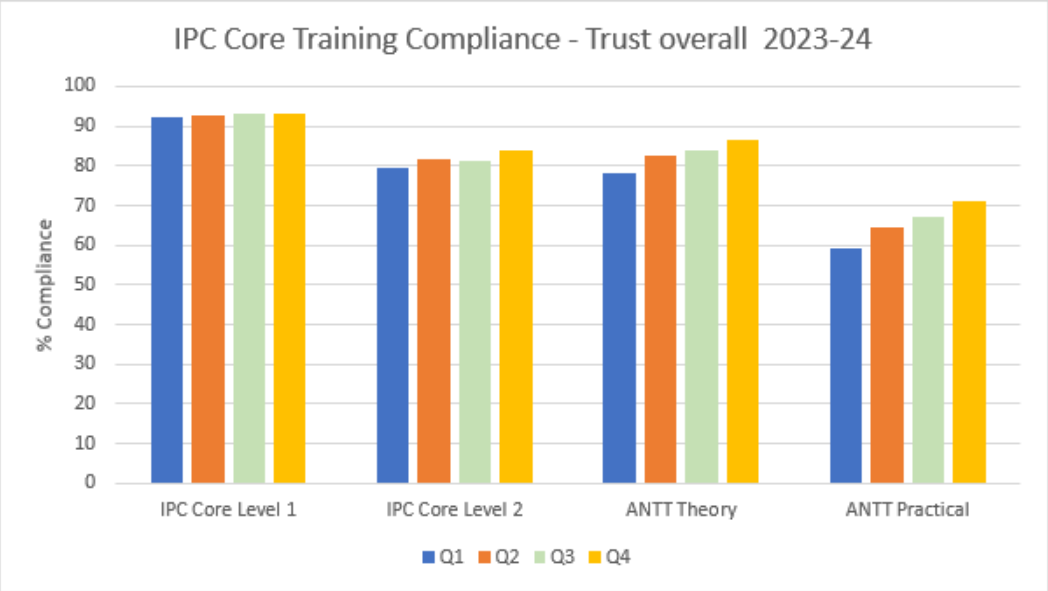
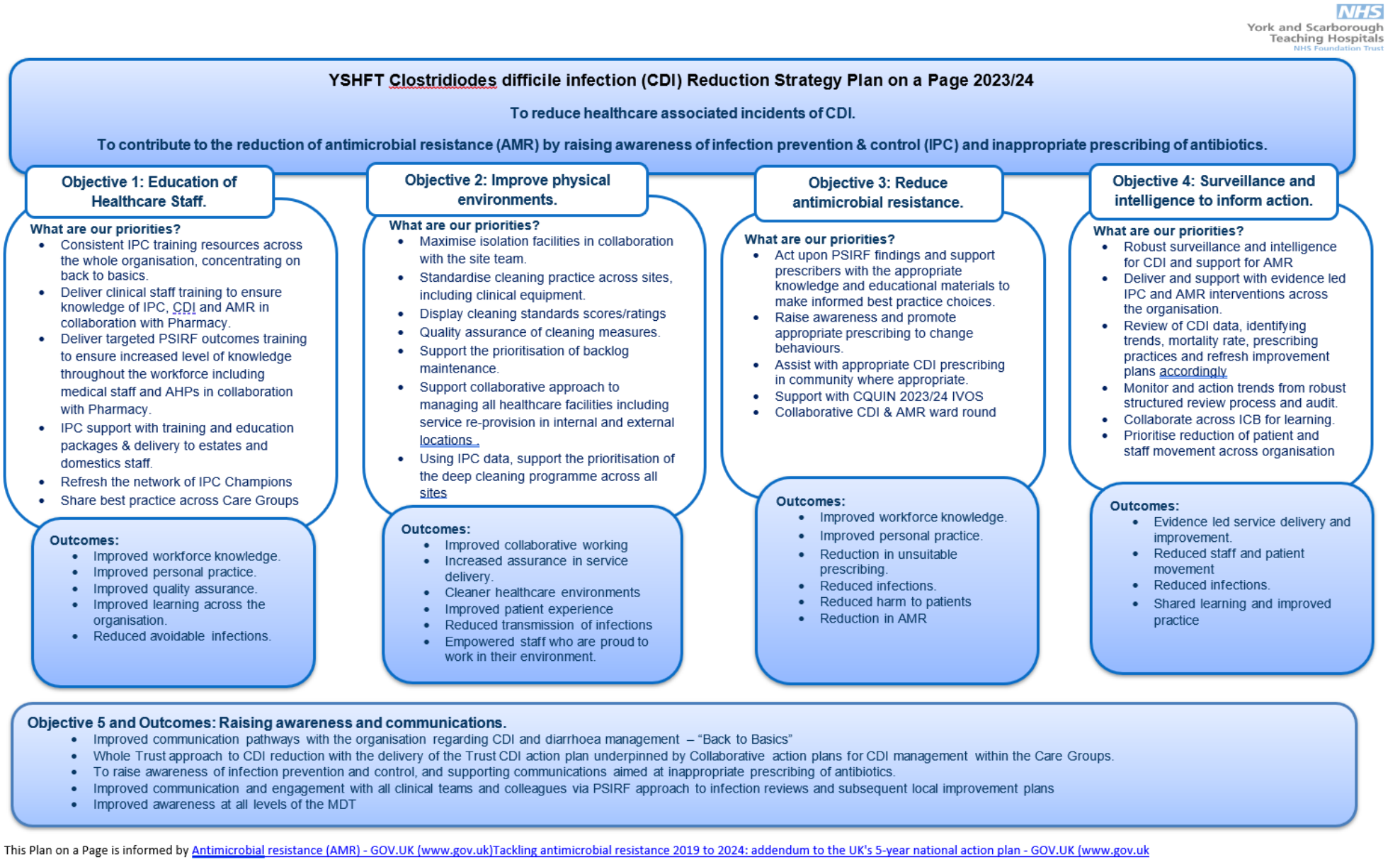


Figure 13 IPC core training compliance



Appendix 2: Clostridioides difficile Infection Reduction Strategy – plan on a page 2023/24



Appendix 3: Hierarchy of Control audits key themes

- Areas need to improve upon the checking of CPD Infection Alerts on admission, to support best placement in clinical areas. This is to be reiterated via ward safety briefings.
- It has been identified that patient handover on transfer to in-patient units is not always comprehensive. An SBAR approach should be used, and staff must check patient risks and alerts in a timely manner This is to be reiterated via ward safety briefings.
- IPC team need to include information on how to screen patients for Carbapenemase-producing Enterobacteriaceae (CPE) within training packages.
- Ward managers need to ensure that staff have undertaken including mandatory IPC training and aseptic non-touch technique theory and practical training.
- Patients are not always supported with hand hygiene. This is a fundamental of care and is being addressed via the Trust quality improvements.
- Multiple ward moves for patients has been identified in many of the audits and is in part a symptom of operational pressures. IPC team are attending daily operational meetings and now supporting side room reviews to facilitate optimum placement for patients with known or suspected infections.
- Awareness of appropriate use of hand hygiene basins to prevent contamination needs further work and this is included within basic IPC training.
- The ward staff are not always aware of care group actions from the Infection Prevention and Control Strategic Assurance Group (IPSAG). Care groups are being asked to improve cascading of IPC information.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 14

Report to:	Board of Directors
Date of Meeting:	26 June 2024
Subject:	Quarter 4 Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Ed Smith – Deputy Medical Director Tim Lord – Patient Safety Lead

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	Board Assurance Framework
☐ Our People	☒ Quality Standards
☒ Quality and Safety	☐ Workforce
☐ Elective Recovery	☒ Safety Standards
☐ Acute Flow	☐ Financial
	☐ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
  - HSMR (Hospital Summary Mortality Indicator)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:
  - Nationally mandated data
  - Locally mandated data
  - Quality account data
- Learning from deaths – themes and actions
  - Themes from SJCRs considered by the LfD Group in Q4
  - MCA completion & operational pressures highlighted
- Service developments
  - Revision of theming of SJCRs and escalations from LfD meetings. Patient Safety Team to do more analysis and investigation to gain assurance of potential themes.

Metric	Result
Crude mortality	Crude mortality is **2.98%** (HSMR) and **3.10%** (SHMI) for this current fiscal year
SHMI – HES HED[1] (Data to Nov 2023)	SHMI year to November 2023 is **94.79**
SHMI - NHS Digital[2] (Data to Dec 2023)	SHMI for year to November 2023 is **95.78**
HSMR[3]	HSMR for year to February 2024 is **112**

[1] SHMI HES HED - Summary Hospital Mortality Indicator using Hospital Episode Statistics and published by Healthcare Evaluation Data for UK Health Data Benchmarking
[2] SHMI NHS Digital - Summary Hospital Mortality Indicator
[3] HSMR – Hospital Standardised Mortality Ratio

Recommendation

Patient Safety and Effectiveness Group to note the report and receive the escalations.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
LfD Group	23/05/2024	
Quality Committee	18/06/2024	

1. Y&SH NHS FT mortality rates

The references in section 6 provide details about the methodologies for measuring mortality and their context.

1.1 Crude Mortality - unadjusted

Crude Mortality rate is the percentage of patients that have died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.

The crude mortality stands at 2.98% of all non-elective admissions. Crude mortality was 3.19% during the previous fiscal year.

Benchmarking of crude mortality against other Trusts is not recommended due to significant operational variations between Trusts. Instead, Trusts should monitor local trends comparing data from the same month or quarter each year. This takes account of seasonal variation seen locally and nationally.

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

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

A standard approach is taken to ‘adjust’ the figures so that the England average is always reported as ‘100’. Values below 100 represent a better outcome, ie lower mortality, and vice versa.

Further information regarding the methodology can be found in the references towards the end of the report.

Two risk-adjusted mortality rates are presented:

- NHS Digital-SHMI: uses HES data and is available 6 months in arrears.
- HED HES-SHMI: This is provided by Healthcare Evaluation Data for UK Health Data Benchmarking (HED). It uses Trust hospital episode statistics (HES) to generate the outcomes. Data is available 3 months in arrears.

The latest **NHS-Digital Summary Hospital Mortality Index (SHMI)** to November 2023 shows the SHMI was **95.78** The SHMI in comparison to other Trusts is displayed below (Figure 2).

The **SHMI HES data** reports the SHMI at **94.79**;
Expected deaths 2830, observed deaths 2683
In-hospital deaths 1832
Out of hospital deaths 851

This is categorised ‘as expected’.

Figure 1 SHMI benchmarked against other Trusts (our Trust highlighted)

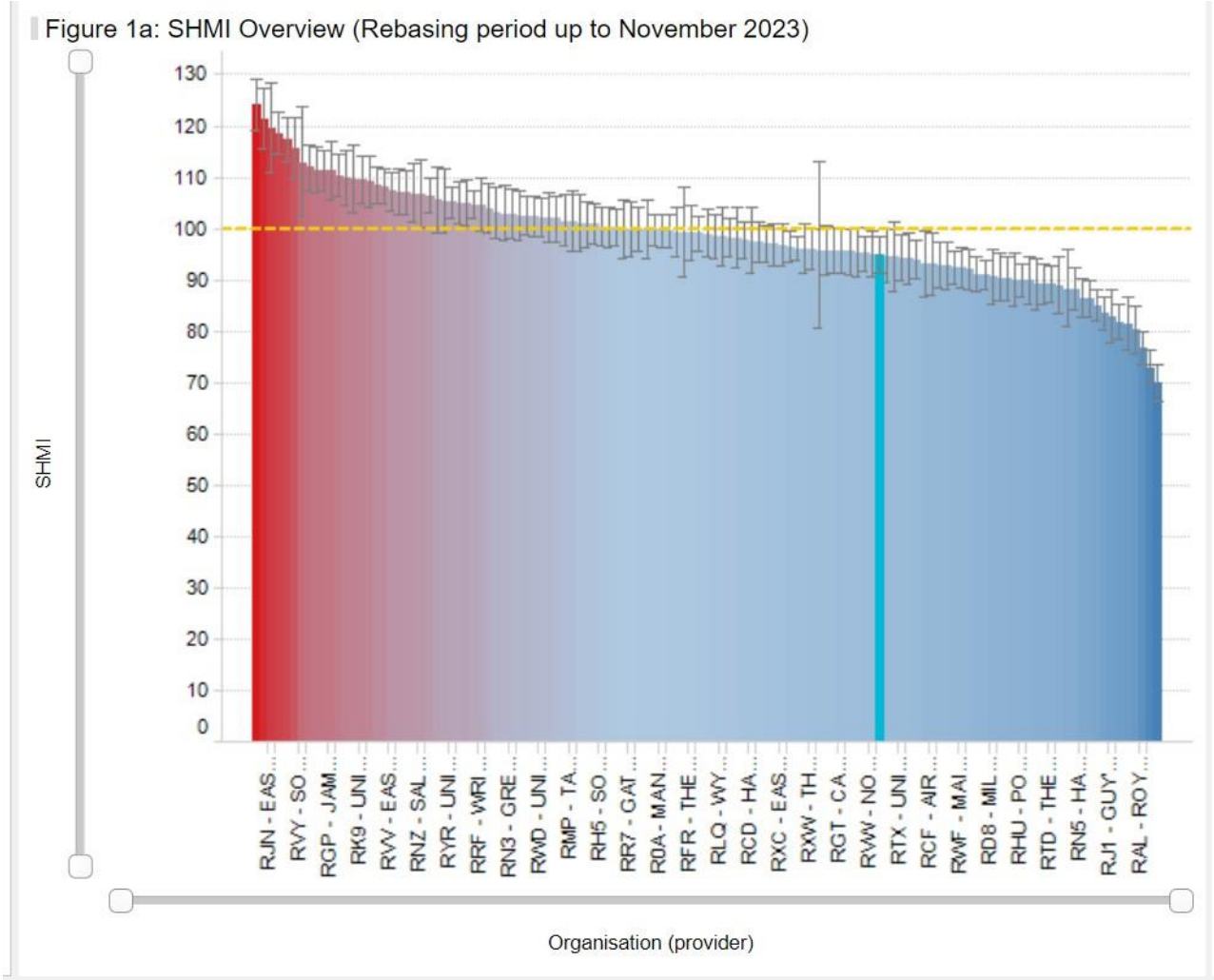
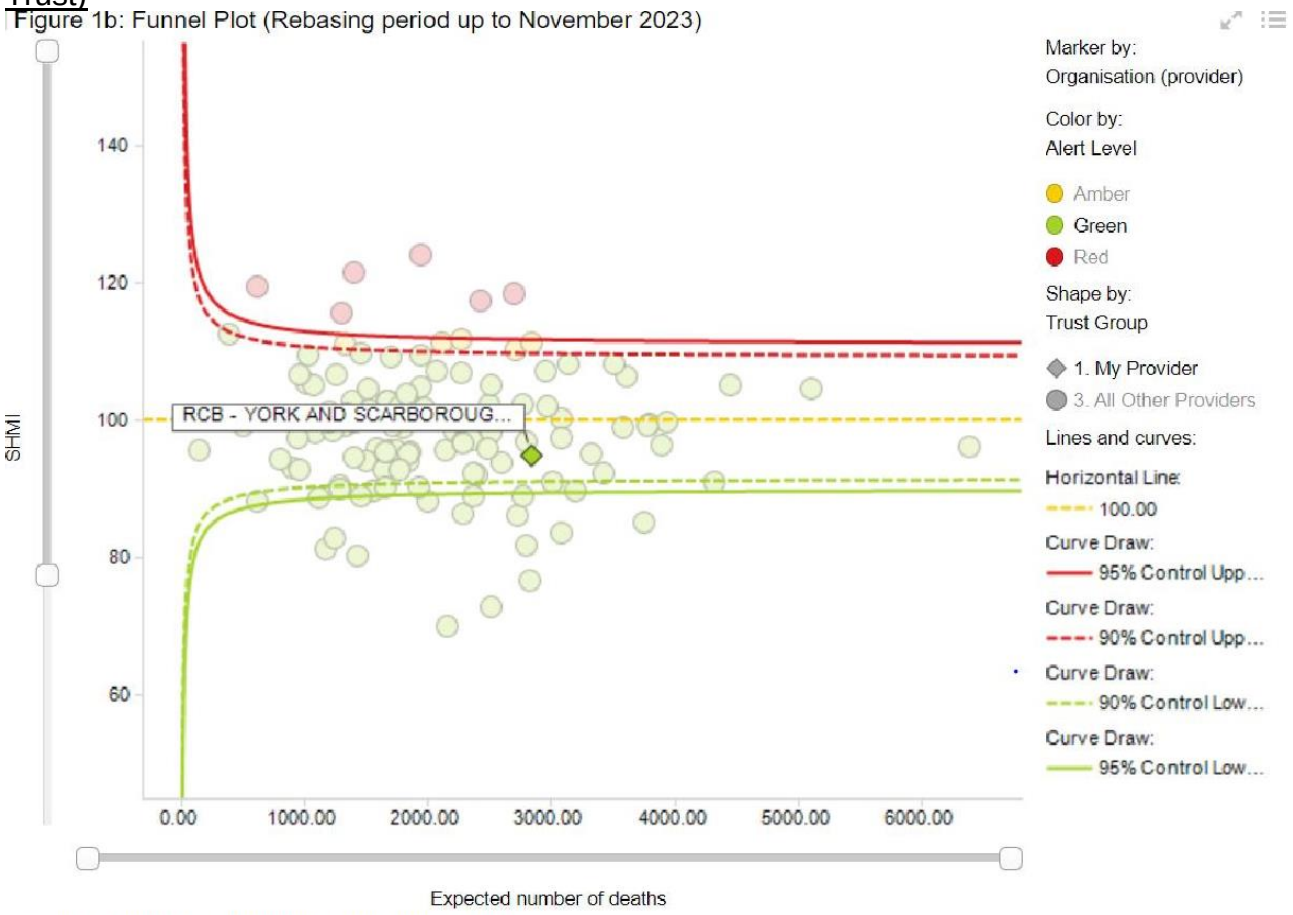


Figure 2 SHMI Funnel plots (in comparison with other Trusts and between acute sites within Trust)



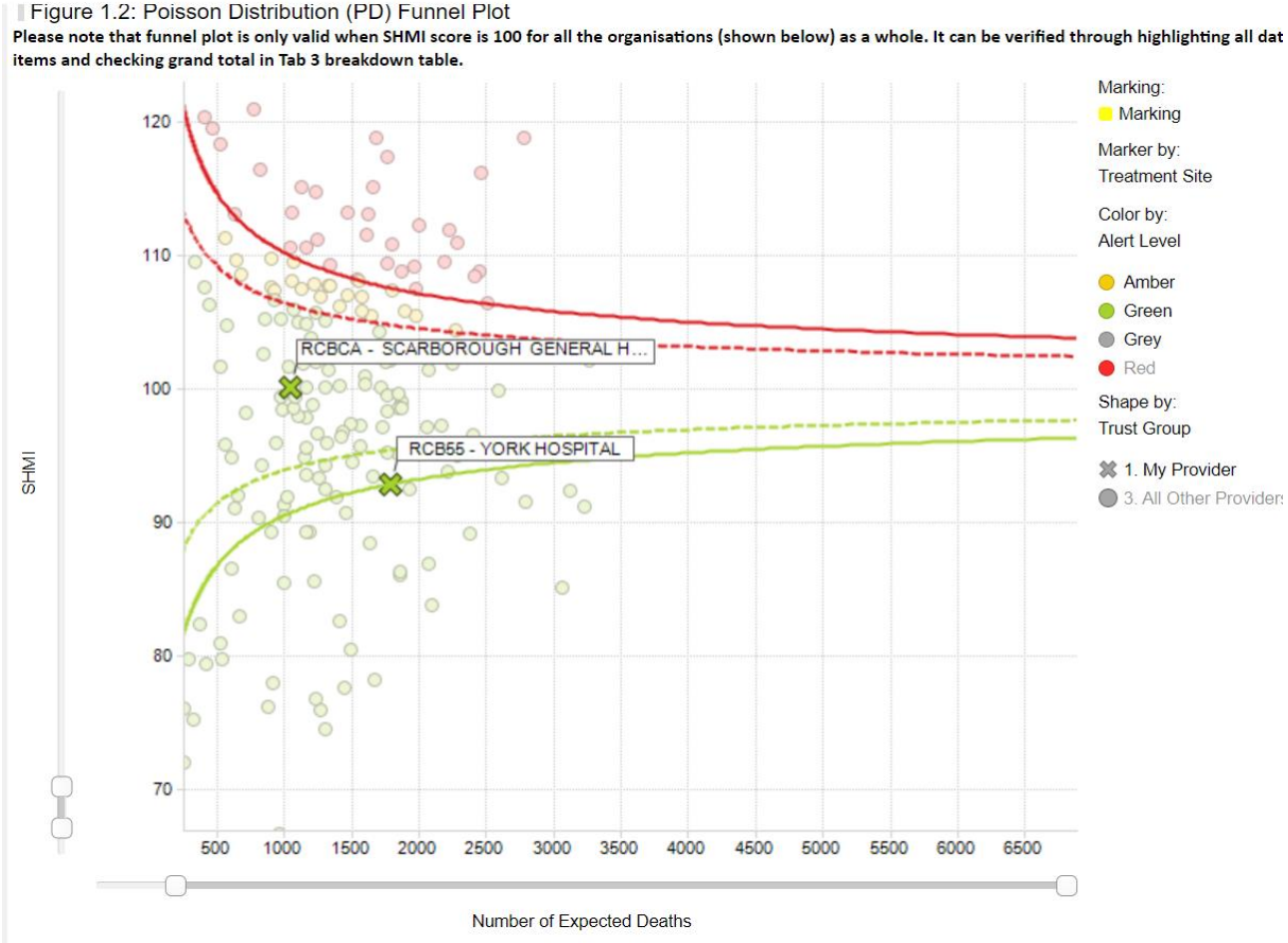
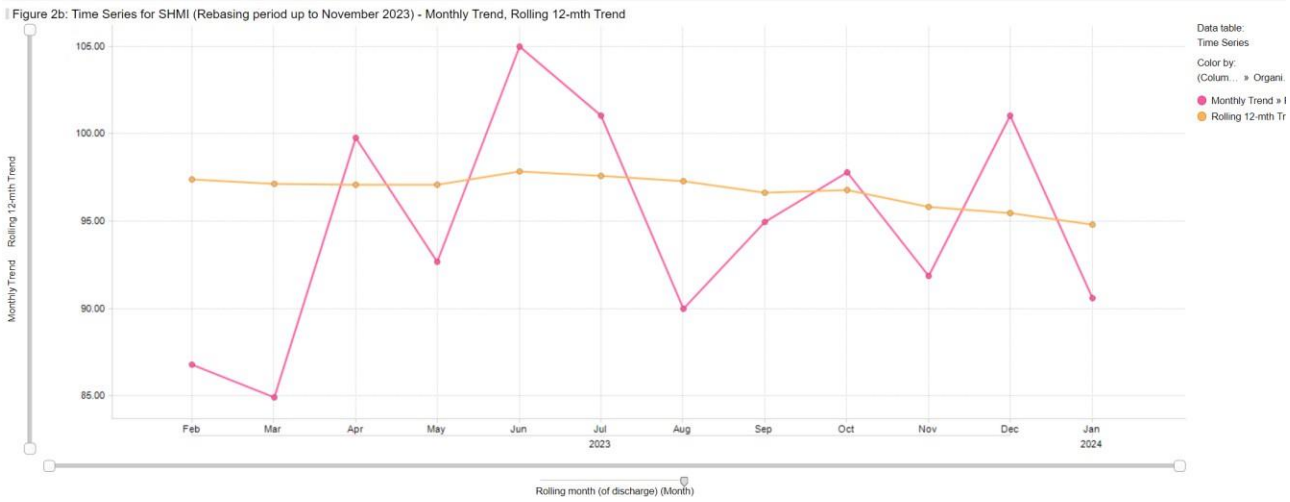


Figure 3: Time series data for SHMI showing downward trend over time



1.3 Hospital Standardised Mortality Ratio (HSMR)

The HSMR measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics e.g., demographics. It does not include as many diagnostic groups as the SHMI (only about 85% of total patient numbers) and this may affect applicability of the measure.

The most recent HSMR covers the period to October 2023 and is reported as follows:

Crude mortality rate 2.98%

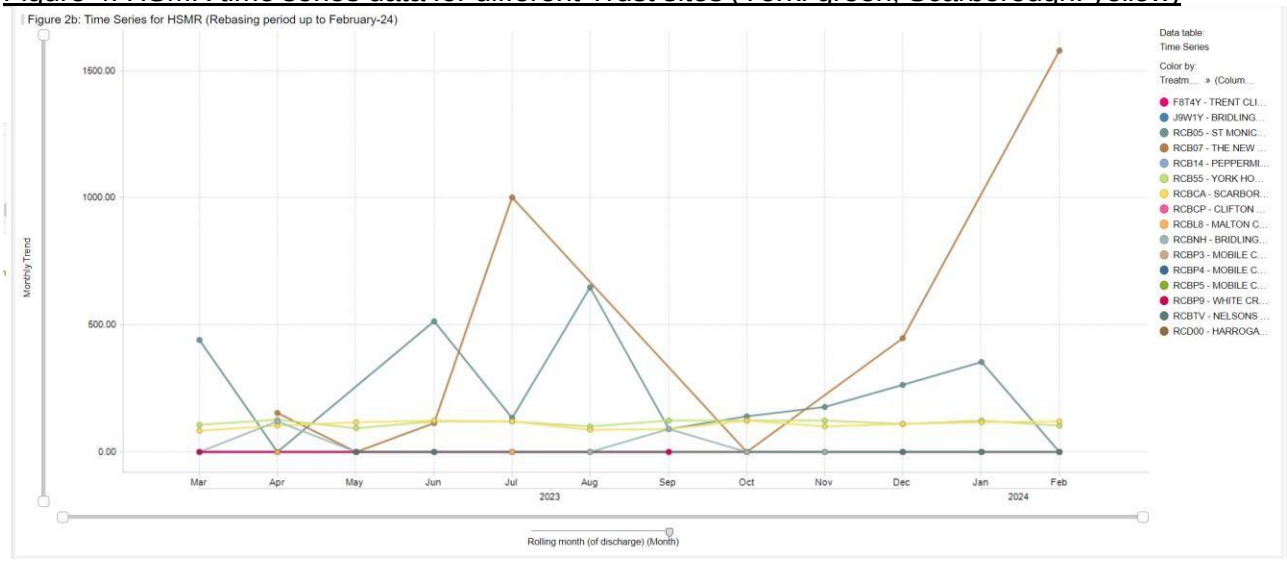
Expected deaths 1629, Observed deaths 1826

HSMR: 112.07

HSMR York Hospital: 114.30
HSMR Scarborough Hospital 107.89

The HSMR remains higher than would be expected and it is unclear at present as to what might be contributing to this. We are currently looking at the hospital mortality coding to understand potential influences on this rate, and to understand the variability of the reported rate over time.

Figure 4: HSMR time series data for different Trust sites (York: green, Scarborough: yellow)



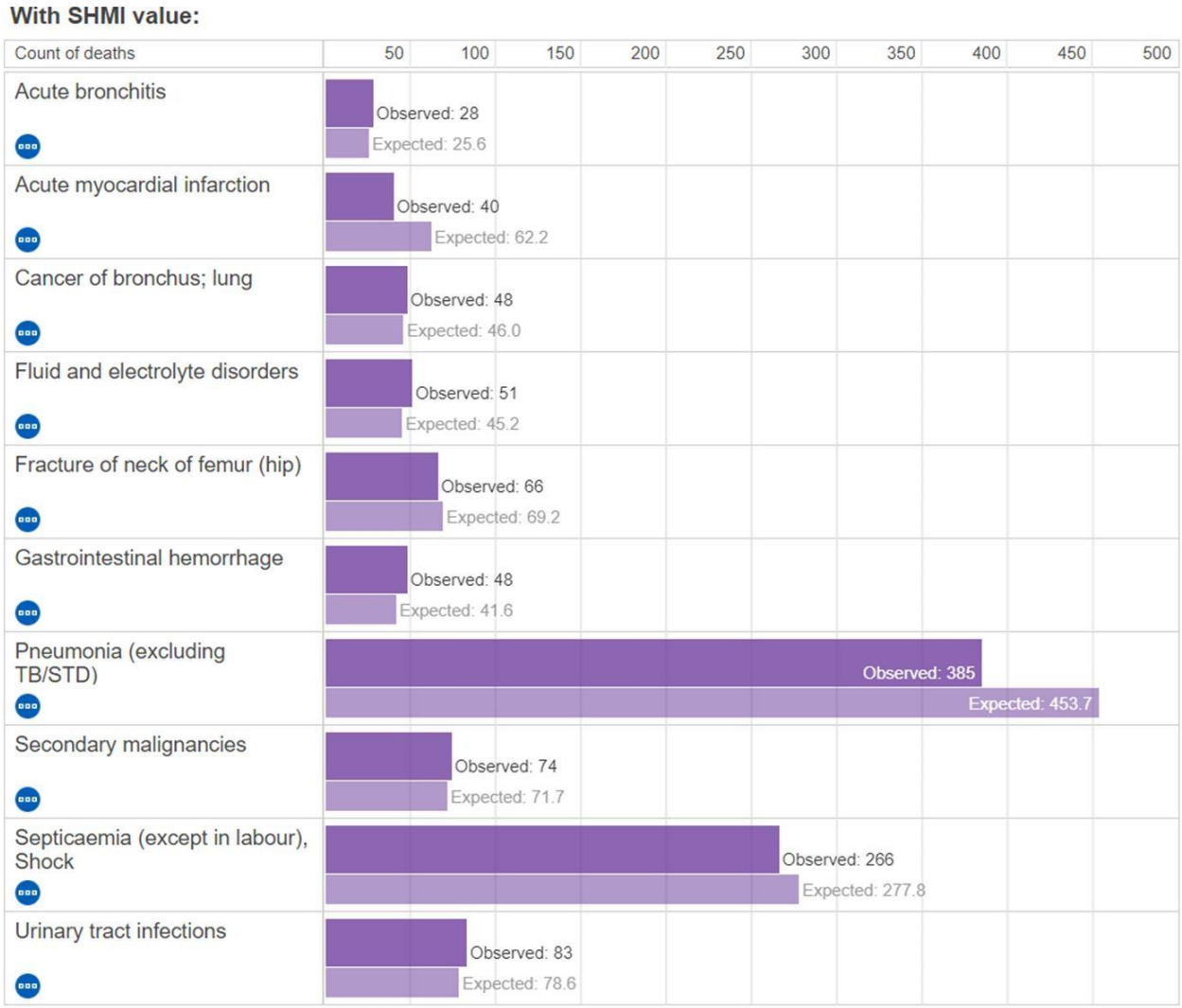
2. Diagnostic groups most contributing to our mortality rates

There are 142 diagnostic codes that contribute to the NHS-Digital SHMI aggregate to give each Trust an overall SHMI value.

The way in which coding is applied to patients that die in the Trust can significantly affect mortality statistics. The “depth of coding” (coding of co-morbidities as well as primary diagnosis) is important as it allows for more accurate calculation of the expected number of deaths that should be seen during a specific time period. Coding of the primary diagnosis will also affect mortality statistics in particular diagnostic groups. We are working with the coding team to understand how better to managing this reporting and we are using the learning provided from Trust mortality reviews via the Learning from Deaths process to triangulate our current mortality outliers and ascertain if any further investigation is required.

The most recent breakdown of differential SHMI for common diagnostic groups is displayed in figure 5 below. At present there are no particular diagnostic groups causing concern, however this data does triangulate with other patient safety work that we are undertaking. For instance, there is a potential for a mortality association of gastrointestinal bleed patients transferred as emergencies for endoscopies from Scarborough to York, and we are working on a transfer protocol to ensure that this transfer does not cause delays in patient care that might lead to harm.

Figure 5: SHMI associated with various diagnostic groups (from HES data)



3. Learning from Deaths

The national Learning from Deaths (LfD) Framework, 2017 sets expectations for Trusts to conduct reviews of the care and treatment of patients who died in their care, acting on the findings and reporting outcomes. The requirement to publish outcomes from LfD within Quality Accounts was mandated at the same time.

This section provides data and outcomes in line with the requirements of the:

- National Guidance on Learning from Deaths (National Quality Board, 2017)
- Trust's Learning from Deaths Policy
- Department of Health and Social Care NHS (Quality Accounts) Amendment Regulations 2017

Whilst the report focuses on quarter 4 data, some information is provided for quarter 3 for comparison.

3.1 Nationally mandated data and information

The data provided in the table below is mandated by the national LfD framework. A narrative on learning and actions is provided in section 4.

When reading the table, SJCRs are Structured Judgement Case-note Reviews; SIs are Serious Incidents and PSII are Patient Safety Incident Investigation. It should be noted that that PSIIs replaced SIs when the new PSIRF

Table 1 – National data summary

	Oct	Nov	Dec	Jan	Feb	Mar
	Quarter 3 (23/24(22/23)			Quarter 4 (23/24)		
Total in-patient deaths (inc ED, exc community)	228	200	238	258	202	202
No. SJCRs commissioned for case record review[1]	6	6	3	5	6	9
No. SIs/PSII commissioned of deceased patients	7	3	1	0	0	0
No. deaths likely due to problems in care	See tables below					

1 The SJCRs are those requested in month (adjusted to account for reassignments; and including deaths from 2021/22, 22/23 and 23/24).

National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Tables 2 and 3 show the outcomes of the SJCRs **completed and reviewed** during Q3 and Q4:

- Table 3 - the 'overall score' provides the rating from the Reviewer based on their assessment of care during the last admission.
- Table 4 - the 'degree of harm' agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q4 12 SJCRs were reviewed (19 in Q3):

- The overall care score was given in 12/12 of cases.
  - The Reviewer found care good in 2/12 of cases and excellent in 3/12 of cases.
  - The Reviewer found care to be adequate in 4/12 of cases.
  - Reviewers found there to be 3/12 cases with poor care and 0 with very poor care.
- The Learning from Death Group agreed harm leading to death in 0 cases, moderate harm in 1 case, minor in 6 of cases and no harm in 4 of cases.

Table 3 – SJCR outcomes assigned by the Reviewer (overall score)

Overall score	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03
Very poor care	0	0	0	0	0	0
Poor care	1	0	0	0	2	2
Adequate care	1	5	1	1	2	2
Good care	1	7	1	0	0	2
Excellent care	1	1	0	1	0	2
TOTAL	**4**	**13**	**2**	**2**	**4**	**6**

Table 4 – SJCR outcomes following review by LfD Group (degree of harm)

Degree of harm	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03
Death	0	0	0	0	0	0
Severe	0	0	0	1	0	0
Moderate	0	1	0	0	1	0
Minor	0	6	0	1	1	3
No harm	0	4	1	2	1	2
TOTAL	**0**	**11**	**1**	**4**	**3**	**5**

3.2 Locally mandated data

Trust policy requires that the national data is supplemented with locally mandated data to provide a richer picture of performance as we move towards the Medical Examiners review of 100% of deaths; and the timely completion of structured judgement case-note reviews.

Table 5– locally mandated data

	Oct	Nov	Dec	Jan	Feb	Mar
	Q3 (23/24)			Q4 (23/24)		
No. SJCRs requested[1]	6	6	3	6	8	7
No. SIs commissioned	7	3	1	0	0	0
No. PSII commissioned	N/A	N/A	1	0	0	0

1 The SJCRs are those requested in month (adjusted to account for reassignments and including deaths from 2021/22, 22/23 and 23/24).

Points to note:

Due to the introduction of PSIRF in December SIs were no longer commissioned after 8/12/23. The one SI commissioned was before this date. The equivalent automatic investigation following death within the PSIRF framework is Patient Safety Incident Investigation (PSII) of which there was one declared.

Table 6 - Incidents Reported by Referral Type

	ME Concerns	Family Concerns	ME & Family Concerns
Quarter 3 (23/24)	61	95	Data not available
Quarter 4 (23/24)	42	84	16

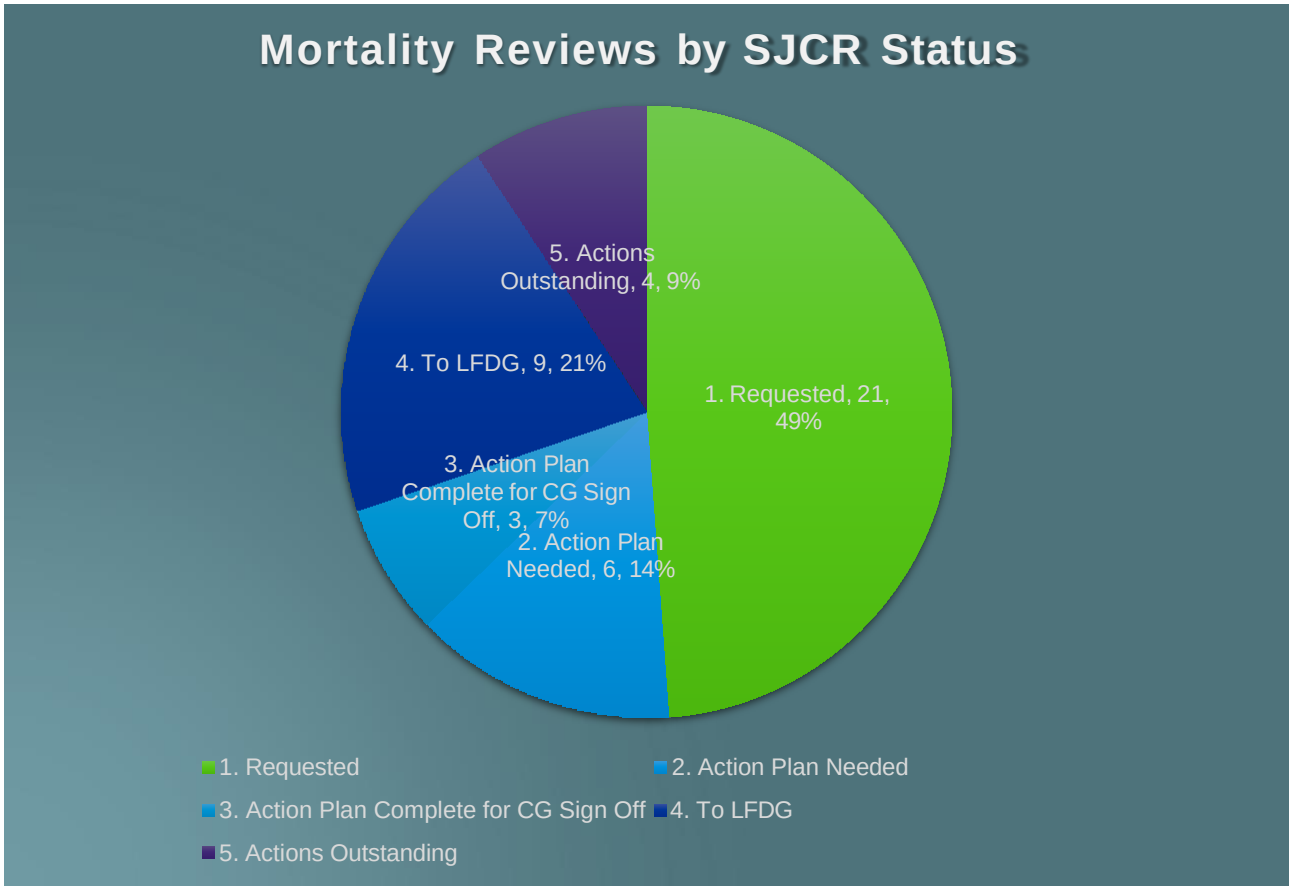
Points to note:

Following the introduction of the Mortality Module it is no longer possible to provide a breakdown of site data due to the amalgamation of the care groups and how investigations and deaths are managed.

Data on progress of investigations at point of reporting (11/04/2024)

Overall no. of SJCRs open 43: (previously 77 as of 13 March 2024)

Figure 6 – Status of open SJCRs (date collected 11/4/24)



	Q3 Report	Q4 Report
Number under review	26	21
Awaiting action planning	4	3
Actions outstanding	37	4
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	22	10

3.3 Quality account data

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The data relates to regulation 27.

Table 6 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2022/23. (please note that the numbering of these relate to the numbering dictated by the Quality Account Report which is why they differ from the rest of the report.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2021/22 but were investigated during 2022/23 and hence not reported in the 2021/22 Quality Account.

Item	Requirement	Q1	Q2	Q3	Q4
27.1	Total number of in-hospital deaths	568	505	666	669

27.2	No. of deaths resulting in a case record review or SI investigation (requested reviews of patients who died in 22/23 and 23/24)	ME:506 SJCRS:14 SI:13	ME: 440 SJCRs:6 SI:10	ME: 556 SJCRS: 15 SI:11	ME:588 SJCRS:20 PSII: 0
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 23/24)	0	1	2	0
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR:18 SI:1	SJCR: 4 SI: 1	SJCR: 6 SI: 0	SJCR: 6 SI:4
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	1	0	0	2
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	Previously stated: 5 Updated total: 6	1	2	2

[1] This is where the degree of harm after investigation / SJCR is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group

[2] Reviews completed in 2023/24 after the 2022/23 Quality Account was published

Items 27.4-6 relate to learning from case record reviews and investigations; a description of actions taken and proposed; and an assessment of the impact of the actions. These items are covered in the next section.

4. Learning from Deaths - themes and actions

There are certain categories of deaths where a full review is automatically expected:

a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth
d. Stillbirths or perinatal deaths

Local SI/PSII investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs. A specific report is escalated to Patient Safety and Clinical Effectiveness with summarised learning.

The national LfD Framework requires SJCRs to be undertaken when the following criteria are met:

- Where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- Where a patient had a learning disability or severe mental illness.
- Where an 'alarm' has been raised e.g. via an elevated mortality alert, audit or regulator concerns.
- Where people are not expected to die, e.g. elective procedures.
- Where learning will inform the provider's existing or planned improvement work.

- A further random sample of other deaths so that providers can take an overview of where learning and improvement is needed most overall.

Table 7 below shows the source of SJCR requests for Q3 & Q4, it should be noted that there can be more than one source however to avoid duplication only the original inputted source is considered in this table.

Table 7 – Source of request for SJCR

SJCR Request Source	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03
1. Initial Mortality Review	0	0	0	1	0	0
2. Medical Examiner Review	1	1	2	1	1	0
3. Learning Disabilities	2	4	1	1	3	3
4. NoK Concern/Complaint	1	0	0	0	0	0
5. Care Group	2	1	0	2	2	6

4.1 Themes from SJCRs considered by the LfD Group in Q4:

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work.

Assessment against five themes, collated over many months as part of the SJCR, are shown as per Datix dashboard in Table 8. Q4 suggests there was an increase in source of request coming from the Care Groups however review of these has shown that this was due to the SJCR being initially logged as Care Group and then being adjusted to ME/NoK concerns.

The introduction of DCIQ and the mortality module has meant that themes and trends identification has had to be updated. During the creation of the mortality module it was decided that themes would be based on the same ones as the other modules in DCIQ to allow cross comparison and triangulation of data when required.

The themes are identified within the Learning from Deaths meeting. These themes identified are shown in Table 8.

Table 8– Themes identified

	Jan 2024	Feb 2024	Mar 2024	Total
Acting on Results	0	0	0	0
Clinical Assessment	0	0	0	0
Communication/Documentation	0	0	1	1
Delayed Diagnosis/Treatment	0	0	1	1
Learning Disabilities	0	0	1	1
No Themes Identified	1	1	1	3
Not listed (please specify)	1	0	4	5
Nutrition and Hydration	0	0	0	0
Pathways/Process	0	0	0	0

The number of themes identified within the SJCRs is currently low, this is something that will be addressing in order to better identify trends for further review (see section 5.1 for further details).

See below further information on the themes discussed in Q4.

Sepsis

- Whilst discussing SJCRs in Q4 it was felt that there was a theme of delayed in identifying the need or administration of antibiotics for query sepsis.
- A search of Mortality module in DCIQ and Datix covering April 23-April 24 was conducted. 14 results produced, these SJCRs were then reviewed.
- Reference was made in 9 of a delay in either identifying possible sepsis or antibiotics being administered. In no cases the delay in antibiotics was identified as the reason for the patient death.
- This snapshot audit gave further evidence that another form of investigations in the form of SJCR has produced similar findings and reaffirms the need for improvement work around sepsis. This information was therefore fed into the ongoing work being carried out within the organisation in response to our management of sepsis.

MCA/DNACPR

Following on from Q3, the themes identified by LeDeR are family awareness of DNACPR and MCA compliance.
LFD March meeting discussed RESPECT and this is more about family engagement around advanced care planning. The DNACPR / TEP group will be adapting into the RESPECT implementation group.

5. Service developments

5.1 Patient Safety Team Role in Learning from Death

In preparation for 2024/25, the Patient Safety Team will take the responsibility of theming the SJCRs, picking up themes during the LfD meetings but also conducting analysis outside of these meetings. This will ensure that a more thorough theming will take place, rather than just being reliant on discussions within the meetings. This will increase the number of themes identified and help facilitate further analysis when required. The Patient Safety Team will also pick up any other significant concerns or topics brought to light from SJCRs, therefore ensuring that any themes outside the standard list are captured and can be cross-matched. This will give further assurance that any repeated trends are identified and discussed.

When potential themes are identified or escalations made from meetings, the patient safety team will carry out further deep dives into areas to them bring back to the following meeting and be included in the Patient Safety Team report that is presented to the monthly Patient Safety and Clinical Effectiveness Subcommittee. The first example of this can be in the previous section of this report concerning sepsis.

6. References

1. Crude Mortality rate is the percentage of patients that died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.
2. NHS-Digital SHMI: SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England. The methodology is transparent, reproducible and sensitivity analysis of SHMI model had been carried out independently. The indicator is produced and published monthly by NHS Digital. University Hospitals Birmingham (UHB) is actively involved in developing and constructing SHMI as a member of Technical Working

Group. In comparison to Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster, there are a few of key advantages advocating the use of SHMI -

a. SHMI methodology is completely open and transparent. It is reproducible by third parties and less confusion has been caused within NHS hospitals compared to HSMR.
b. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital, whereas the HSMR only includes 80% of in hospital deaths.
c. SHMI does not account for palliative care (published as a contextual indicator instead) in the model due to coding issues. It could largely reduce the chance of gaming by coding more palliative care to reduce mortality ratio.
d. Death is only counted once in SHMI to the last discharging acute provider. HSMR will attribute one death to all the providers within a chain of spells which are linked together due to hospital transfer (i.e., superspell if existing).

However, due to the limitations of administrative datasets (lack of clinical information in SUS/HES), SHMI-type indicators **cannot** be used to quantify hospital care quality directly and count the number of avoidable deaths.

HED's SHMI (NHSD) Module is built on the *SHMI Dataset* which is created by NHS Digital on a monthly basis. The dataset only includes necessary data fields for the purpose of validating SHMI model.

3. HES-SHMI: The HED team replicate the SHMI methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED SHMI (HES-based) module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more timely and detailed manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets.

SHMI (NHSD) vs. SHMI (HES-based)

1. SHMI (NHSD) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.
3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.