York and Scarborough Teaching Hospitals
NHS Foundation Trust

# Board of Directors – Public

Wednesday 30th April
Time: 9:30am – 12:45pm
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 | - | 9:30 |
| **2.** | **Apologies for Absence**<br><br>To receive any apologies for absence. | Chair | Verbal | - | |
| **3.** | **Declarations of Interest**<br><br>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 26 March 2025**<br><br>To be agreed as an accurate record. | Chair | Report | **5** | |
| **5.** | **Matters Arising / Action Log**<br><br>To discuss any matters or actions arising from the minutes or action log. | Chair | Report | **18** | |
| **6.** | **Chair's Report**<br><br>To receive the report. | Chair | Report | **19** | 9:35 |
| **7.** | **Chief Executive's Report**<br><br>To receive the report. | Chief Executive | Report | **21** | 9:40 |
| **8.** | **Quality Committee Report**<br><br>To receive the April meeting summary report. | Chair of the Quality Committee | Report | **52** | 9:45 |

| Item | Subject | Lead | Report/ Verbal | Page No | Time |
|---|---|---|---|---|---|
| **9.** | **Resources Committee Report**<br><br>To receive the April meeting summary report. | Chair of the Resources Committee | Report | 53 | 9:55 |
| **10.** | **Trust Priorities Report (TPR)**<br><br>March 2025 Trust Priorities Report Performance Summary:<br><br>• Operational Activity and Performance<br>• Quality & Safety<br>• Workforce<br>• Digital and Information Services<br>• Finance | <br><br><br><br>Chief Operating Officer<br>Medical Director & Chief Nurse<br>Director of Workforce & OD<br>Chief Digital Information Officer<br>Finance Director | Report | 55<br><br><br><br>58<br>98<br>117<br>128<br>134 | 10:05 |
| **Break 11:00** | | | | | |
| **11.** | **CQC Compliance Update Report**<br><br>To consider the report. | Chief Nurse | Report | 145 | 11:10 |
| **12.** | **Maternity and Neonatal Reports (including CQC Section 31 Update)**<br><br>To consider the report and approve the Section 31 update. | Chief Nurse - Executive Maternity Safety Champion | Report | 150 | 11:20 |
| **13.** | **Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports**<br><br>To consider the reports. | Director of Workforce & OD | Report | 171 | 11:35 |
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| Item | Subject | Lead | Report/ Verbal | Page No | Time |
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| **14.** | **Trust People Strategy 2025-2030**<br><br>To approve the strategy. | Director of Workforce & OD | Report | **176** | 12:00 |
| **15.** | **Trust Digital Strategy 2025-2030**<br><br>To approve the strategy. | Chief Digital Information Officer | Report | **189** | 12:20 |
| Governance | | | | | |
| **16.** | **2024/25 Q4 – Board Assurance Framework** | Associate Director of Corporate Governance | Report | **202** | 12:35 |
| **17.** | **Questions from the public received in advance of the meeting** | Chair | Verbal | - | - |
| **18.** | **Time and Date of next meeting**<br><br>The next meeting held in public will be on 21 May 2025 at 9:00am at York Hospital. | | | | |
| **19.** | **Exclusion of the Press and Public**<br>'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. | | | | |
| **20.** | **Close** | | | | 12:45 |

# Minutes
# Board of Directors Meeting (Public)
# 26 March 2025

Minutes of the Public Board of Directors meeting held on Wednesday 26 March 2025 in the Trust HQ Boardroom, York Hospital. The meeting commenced at 9.00am and concluded at 12.25pm.



## Members present:

### Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Mr Jim Dillon
- Ms Jane Hazelgrave
- Dr Stephen Holmberg
- Mrs Jenny McAleese *(Via Teams)*
- Prof Matt Morgan
- Ms Helen Grantham, Associate Non-Executive Director

### Executive Directors
- Mr Simon Morritt, Chief Executive
- Mr Andrew Bertram, Finance Director
- Mrs Dawn Parkes, Chief Nurse & Maternity Safety Champion
- Ms Claire Hansen, Chief Operating Officer
- Miss Polly McMeekin, Director of Workforce and Organisational Development
- Mr James Hawkins, Chief Digital and Information Officer

### Corporate Directors
- Mrs Lucy Brown, Director of Communications
- Mr Mike Taylor, Associate Director of Corporate Governance

### In Attendance:
- Miss Nicola Topping, Deputy Medical Director *deputising for* Dr Karen Stone, Medical Director
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

### Observers:
- Dr Gary Kitching, Staff Governor
- Four members of the public
- Three representatives from the Care Quality Council

## 1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

## 2 Apologies for absence

Apologies for absence were received from:
Dr Karen Stone, Medical Director

## 3 Declaration of Interests

There were no new declarations of interest.

## 4 Minutes of the meeting held on 26 February 2025

The Board approved the minutes of the meeting held on 26 February 2025 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 26** *Include in the TPR unvalidated data on operations cancelled on or after the day of admission.*
Mr Hawkins advised that this metric had been included in the TPR and the action was closed.

**BoD Pub 47** *Circulate the action plan for improvement in waiting times for the Rapid Access Chest Pain clinic.*
Ms Hansen advised that the action plan was being progressed by the Medicine Care Group and, once finalised, would be reported to the Quality Committee in April and the Board in June.

**BoD Pub 52** *Progress the use of a Board development seminar for a Board discussion on risk appetite.*
Mr Barkley advised that this was yet to be progressed.

**BoD Pub 53** *Provide more detailed information on the reasons for missed Occupational Health appointments.*
This information had been emailed to the Board and the action was closed.

**BoD Pub 54** *Explore options to provide more accurate ethnicity data for the Health Inequalities section of the TPR.*
Mr Barkley reminded the Board that the issue was with the collection of ethnicity data on the Central Patient Database. Ms Hansen advised that she had requested that the Patient Administration team undertake a process mapping exercise. Mrs Parkes' team was also reviewing the metrics for Health Inequalities which would be reported. Ms Hansen and Mrs Parkes would progress this work and refer to Mr Hawkins with any system changes as appropriate. Mr Hawkins reported that ethnicity data could not be uploaded from primary care sources.

**BoD Pub 55** *Circulate the Staff Survey outcomes to the Board*.
The outcomes had been circulated and the action was closed.

**BoD Pub 56** *Oversee the development of an improvement plan to address the level of abandoned calls to the IT Service Desk.*

Mr Hawkins advised that an improvement plan would be presented to the Digital Sub-Committee; this would also provide further context to the number of abandoned calls to the IT Service Desk. There had been recruitment to the Service Desk team and new members were being trained, which had impacted on the capacity to respond to calls. Mr Hawkins assured the Board that the abandonment of calls did not always signify a negative user experience, as the caller may have taken other options to resolve their issue. The action was closed.

**BoD Pub 57** *Change TPR to show target for 3rd/4th degree tears in assisted births as less than one per cent.*
Mr Hawkins advised that he needed a discussion with Mrs Parkes to determine the correct target or baseline.

## 6 Chair's Report

The Board received the report.

Mr Barkley recorded his thanks to Dr Boyd and Ms Grantham for their continued commitment to the Board as Non-Executive Directors.

Mr Barkley advised that the Council of Governors was supportive of his report on the Trust's role as an Anchor Institution to reduce existing health inequalities and to prevent ill-health. He also reported that the East Coast Constituency event held in Scarborough on 6 March had been well-attended, with a valuable question and answer session. In future, all constituency events would be held during British Summer Time, as Mr Barkley was of the view that light evenings would encourage attendance. The event held in Easingwold would move to Malton.

Mr Barkley had attended the third Maternity and Neonatal engagement event at which Ms Wells-Munro, Director of Midwifery, had provided a detailed update to the staff team including efforts to secure further resource for the service. She had provided an opportunity for staff to share challenges "rocks in my shoes", which Mr Barkley recommended as a strategy for all teams.

Mr Barkley invited questions and comments on his paper entitled *Role of the Trust in relation to preventing inequalities and reducing existing ones,* the aim of which was to inform actions for the Annual Plan for 2025/26 and into 2026/27. The aims set out in the paper should be a constant reference point in line with the appropriate Trust strategic objective. In the discussion that ensued, the following points were raised:

- the Trust needed to support the employment of vulnerable populations; the Health Care Academy was an excellent career route for those without formal qualifications;
- whilst efforts were made to purchase goods and supplies from local businesses, the Trust was bound to NHS procurement contracts;
- other regions had strong networks of Anchor Institutions which the Trust might look to initiate in North Yorkshire and Humber.

On the latter point, Mr Morritt agreed to seek support from the York and North Yorkshire Mayor with regards to the Trust becoming an Anchor Institution on the East Coast.

**Action: Mr Morritt**

## 7 Chief Executive's Report

The Board received the report.

Mr Morritt referenced the recent government announcements around the structural changes of the NHS at regional and national level and advised that there had been no further detail released by NHS England's incoming Transition Chief Executive Sir Jim Mackay. The Trust was on track to submit its annual planning to the ICB on 27 March.

Mr Morritt noted that the national Staff Survey results were due to be discussed later in the meeting: both the response rate and the responses themselves were disappointing. Senior leaders in the Trust shared a commitment to embed a system of continuous improvement which would foster better staff engagement. Mrs McAleese underlined, and directors agreed, that the Staff Survey results were in fact concerning, not merely disappointing.

Mr Morritt was pleased to report that the Trust had received the keys to the new Urgent and Emergency Care Centre at Scarborough Hospital and testing was progressing well. Moves into the new building would begin in the last week of April.

Mr Morritt drew attention to the nominations for Star Awards in March 2025. Directors agreed that, as always, it was humbling and inspiring to read of the acts of kindness and selflessness captured in each nomination.

## 8 Quality Committee Report

Dr Holmberg highlighted the key discussion points from the meeting of the Quality Committee on 18 March 2025. Infection Prevention and Control (IPC) was referenced under both "Alert" and "Assure": there was concern around the level of MSSA infections, particularly on Ward 31 at York Hospital, and rapid work was underway to address this. There had been improvements in the management of other infections which had been supported by Care Group IPC meetings.

Dr Holmberg advised that the Committee was assured that work in Maternity Services was effecting improvement and efforts continued to identify resource from other areas which would fund midwifery posts. Dr Holmberg had expressed some concern at the meeting on the potentially high proportion of Caesarean sections at Scarborough Hospital, particularly those reported as emergency, and had sought further clarification.

Dr Holmberg also highlighted:

- improvement in performance indicators in Emergency Care, particularly the reduction in ambulance handover time;
- more rapid detection of sepsis although there were still delays in doctors seeing patients; a proposal to allow nurses to prescribe broad spectrum antibiotics was being progressed;
- the Committee had received the Inpatient Nurse Staffing Review which had demonstrated the distinction between safe staffing and appropriate staffing levels;
- the Surgery Care Group had presented to the Committee and had escalated the following:
    - continuing issues with medical outliers in surgical beds
    - concerns around the virtual fracture clinic process; the Committee had requested an update at the next meeting;
- the Committee had received a report from the major trauma peer review; the serious concerns raised by the review were not unexpected and were common to acute providers of a similar size; the Committee had requested an assurance paper regarding progress to address the serious concerns and would subsequently update the Board;

**Action: Dr Holmberg**

- in terms of learning from deaths, training around the Mental Capacity Act remained a concern.

Dr Holmberg commented that the Committee now had much clearer oversight of the frontline of the Trust's services. The rotation of Care Groups presenting to the Committee had been in place for a year and the Committee had requested the attendance of a representative from each of the Care Group Senior Leadership team at every meeting.

In response to a question, Ms Hansen clarified the issue affecting the Virtual Fracture Clinic; a more robust process needed to be established. Ms Hansen assured the Board that there had been no harm to patients under the current process, but it did present a risk.

## 9 Resources Committee Report

Mr Dillon summarised the key discussion points from the meeting of the Resources Committee on 18 March 2025:

- the Committee had had a lengthy discussion on the Staff Survey results and the need for a different action plan to address the outcomes; the Trust needed to learn from other organisations with better results;
- there was positive news on ambulance handover times which had seen a significant improvement particularly at Scarborough Hospital; there was an expectation that handover would be completed in under 45 minutes;
- an audit of Emergency Department processes had identified "over medicalisation" of patients which could be addressed by a senior decision maker at the front door;
- staff absence rates were still rising and further work on the reasons for absence was being undertaken;
- the Committee had been pleased to note a reduced number of complaints to the Trust;
- the financial position for year-end and the plan for 2025/26 continued to be dynamic and fast changing.

Mrs Parkes noted that the reference to the Nurse Safe Standard Review in Mr Dillon's report should read "Nurse Staffing Inpatient Review".

Dr Boyd asked for further clarification on which level of staff would be making decisions at the front door of the Emergency Department and what support would they receive. Ms Hansen explained that this would be a substantive senior qualified member of staff, either medical or nursing. The skill mix and experience of staff in the department was currently being reviewed and a training programme had been implemented. This work was being overseen by external clinical support.

## 10 Group Audit Committee Report

Mrs McAleese referred to her escalation report and noted that the issue of report cover sheets had now been resolved.

There were no further questions or comments.

## 11 Trust Priorities Report (TPR)

The Board considered the TPR.

## Operational Activity and Performance

Mr Barkley was pleased to note the 60% reduction in the number of 12 hour trolley waits from December and the reduction in cancer waiting times. These were both significant improvements.

Dr Holmberg asked for clarification of the validation work being undertaken on waiting lists. Ms Hansen reported that there had been c2000 patient added to the Referral to Treatment (RTT) waiting list due to work on reviewing administration and recording processes, and therefore there was some risk that the Trust would not meet its improvement trajectory. There were no patients identified who were not already being treated as patients had been moved from the non-RTT list. Ms Hansen noted that this work would provide greater clarity on the waiting list position and the revised numbers had informed the trajectories for the next financial year. Mr Barkley applauded the decision to carry out the validation work on waiting lists which provided clarity for the Board, despite the inherent risk of failing to meet trajectories. It was very good that the Trust had such a principled Chief Operating Officer.

Ms Hansen drew attention to the improvement in the median time to initial assessment in the Trust's Emergency Departments (ED).

Dr Boyd noted that the improvements in acute flow were based on more rapid treatment of Type 3 patients. She sought assurance that Type 1 patients were receiving a safe level of care. Ms Hansen responded that the work to improve ED had been impacted by the demand, so it was key to ensure that patients were directed to more appropriate sources of care. For those who did attend ED, there were still some issues around delay to admission, but the continuous flow programme was having an impact. Patients needed a clear treatment plan to avoid long waits. There had been additional resource provided to ED to ensure that right level of care was in place.

Mr Barkley referred to the narrative statement about the Frailty Crisis Hub and queried why the number of conveyances it was possible to avoid was capped at c300 a month. Ms Hansen explained that this number referenced the maximum number of patients that could be treated by the community Frailty Crisis Hub. A business case was being developed to expand the service, which would also reduce the number of patients in hospital.

In response to a question, Ms Hansen reported that a decision was still pending on the continuation of the North Yorkshire and York Coordination Hub, led by the Yorkshire Ambulance Service, as the pilot was due to finish on 31 March. Ms Hansen observed that other options were available, should the service be discontinued.

Ms Hansen referred to page 71 of the TPR and highlighted that work to increase the number of patients being treated by the Same Day Emergency Care (SDEC) service was a key priority, whether patients arrived by ambulance or were referred by a GP.

Mr Barkley highlighted the reduction in ambulance conveyances to ED compared to February 2024. Ms Hansen responded that this was a result of work undertaken to reduce the number of conveyances which provided a platform for further improvement. Mr Morritt noted that the funding for projects to reduce ambulance conveyances to ED lay outside of the Trust's control.

Ms Hansen reported that the number of acute and general beds open remained high at 889; this included escalation beds. Pressure on wards had continued past the main winter period. Mr Barkley observed that there was extra pressure from the increase in lost bed days for patients with No Criteria To Reside. Ms Hansen agreed and explained that these

patients tended to be complex cases; the Trust continued to work with Local Authorities to identify more appropriate care settings. Dr Holmberg noted that if conveyances to hospital were being diverted, this was likely to reduce the capacity in the community to receive discharged patients. Ms Hansen confirmed that this was likely to be the consequence, and that resource needed to be redirected to community services which would be a better outcome for patients.

Mr Barkley referred to the Cancer scorecard and highlighted the encouraging metrics for 62 and 31 day waits. Ms Hansen agreed and noted that the reduction in the Faster Diagnosis Standard in January was temporary and the position for February would show an improvement. Ms Hansen attributed the improvements in Cancer metrics to the outstanding work of the new Cancer lead.

There was a brief discussion on the national ambition for RTT patients, specifically that by March 2026, the intention was that the percentage of patients waiting more than 52 weeks for elective treatment would be 1% of a Trust's total RTT waiting list. Ms Hansen noted that the current work on validating waiting lists was key to achieving this ambition.

Referring to the RTT scorecard, Mr Barkley questioned why the number of patients waiting over 65 weeks had increased. Ms Hansen noted that in fact the position had been maintained but there had been no improvement. She explained that the issue was with a particular pathway in the Neurology service; this was also a challenge for other providers. There had been extra resource appointed to the Neurology service in March and discussions were taking place with other providers in the ICB about collaborative efforts to reduce waiting times.

Ms Grantham referred to the Health Inequalities page and observed that the metrics used were not particularly meaningful or informative. Mrs Parkes agreed, noting that it was difficult to identify helpful metrics in terms of health inequalities. The team was working with the Director of Public Health to identify more useful metrics. In response to a question, Ms Hansen explained that waiting lists were based first on clinical priorities and then on waiting times, not on deprivation or ethnicity. There was further discussion on how information on health inequalities could be used to improve patient outcomes. Ms Hansen provided some examples. It was noted that patients from the most deprived quintile range were over-represented on the Trust's RTT waiting list, compared to the representation in the Trust's catchment area; it was agreed that this was a positive indicator. Mr Morritt suggested that the Health Inequalities information on the next version of the TPR should be informed by the internal steering group and the work with the Director of Public Health.

Mr Barkley recorded his thanks to the teams responsible for the positive metrics relating to outpatients and elective care, including the year to date performance of 53% of first and outpatient procedures as a proportion of all outpatient activity. It was noted that the "Did not attend" rate for outpatient appointments was also very low, which reflected excellent work by specialty teams.

Mr Barkley expressed concern at the high proportion of patients waiting more than six weeks from referral for an Audiology appointment and requested that an options paper be presented to the Resources Committee. It was noted that collaboration with external partners could be explored to reduce waiting times.

**Action: Ms Hansen**

Mr Barkley noted issues with the Gastroenterology services at Bridlington Hospital. Ms Hansen explained that the team was under pressure from vacancies and staff sickness.

In response to a question, Ms Hansen advised that the proportion of Virtual Ward beds occupied was impacted by the capacity to deliver this service, whilst the metric itself needed to be amended as it was not reflective of the position. She would progress this with Mr Hawkins. Ms Hansen noted that funding was being received for the Virtual Ward but was not being deployed in a consistent manner due to the number of vacancies.

Referring to the second page of Community Key Performance Indicators, Mr Barkley asked if the Frailty Hub was referring a large number of patients to the Community Response Team. Ms Hansen confirmed that this was the case and would inform the review of Community Services which was being undertaken.

### Quality and Safety

In response to a question, Mrs Parkes confirmed that the metric for pressure ulcers included all types.

Mrs Parkes highlighted the reduction in the number of complaints to the Trust. She advised that Care Groups had now established Patient Experience meetings, where relevant information was reviewed to inform action plans. Actions to improve communication had resulted in a reduction in complaints on inpatient wards.

### Maternity

Mr Barkley was pleased to note that there had been no complaints relating to Maternity Services at Scarborough Hospital.

Mrs Parkes would seek further clarification on the “smoking at booking” and “smoking at 36 weeks” metrics.

**Action: Mrs Parkes**

### Workforce

Miss McMeekin advised that the vacancy rate for Health Care Support Workers had stabilised, but it would continue to be monitored. Mr Barkley queried whether the recruitment and performance management of Health Care Support Workers should be centralised, rather than remain under Care Group control. Miss McMeekin responded that a centralised model was not without challenge, particularly when it came to allocating roles. Mrs Parkes added that local managers wanted to lead recruitment for their teams. The current arrangements would be kept under review.

In response to Mr Barkley’s query about the metric for the approval of rosters, Mrs Parkes explained that there had been significant work to ensure that rosters were signed off in a timely manner as this ensured a better staff experience and promoted efficiency. Thus far, this work had been focussed on inpatient areas but would now move to other areas.

Dr Boyd queried the metric relating to headroom. Mrs Parkes clarified the elements which contributed to this metric and advised that in some areas the budgeted headroom was not correct.

The table of reasons for staff sickness absence was noted in the context of increasing rates of absence and the challenging target for 2025/26.

Professor Morgan queried the levels of statutory and mandatory training compliance for medical and dental staff which had deteriorated. Miss Topping responded that training compliance was one element of the annual appraisal process; new appraisal software had

been introduced which would enable closer monitoring of training and improve compliance. Miss Topping confirmed that failure to complete annual statutory and mandatory training could eventually impact on revalidation.

### Digital and Information Services

There were no comments or questions on this section of the TPR.

### Finance

Mr Bertram reported that the Trust was £12m adrift of plan at Month 11. The focus was now on the outturn position. Mr Bertram advised that the ICB had accepted a deficit year-end position of £18m, and he forecast that the Trust would meet this. Cash income had now been received to support this deficit and the Trust would therefore post a balanced Income and Expenditure position, subject to the usual technical adjustments around impairments.

Mr Bertram highlighted the substantial capital programme of £72m in 2024/25; in Month 11, about half of this had been spent and work was in progress to ensure that the entire capital amount had been spent by year-end. Mr Bertram provided examples of the large capital programmes which had been funded, including the Scarborough Hospital Urgent and Emergency Care Centre, the Vascular Imaging Unit, and the Post Anaesthetic Recovery Unit and a hybrid theatre. Whilst the capital programme was the largest undertaken by the Trust, the funding was still not sufficient to address the levels of backlog maintenance and estate issues, but it would provide a platform for projects in 2025/26.

It was noted that the income received to offset the £18m year-end deficit had contributed to a healthy cash balance which would impact positively on interest received by the Trust.

Mr Hawkins provided a brief update on the expenditure of the income received for the new Electronic Patient Record.

## 12 Maternity and Neonatal Report (including CQC Section 31 Update)

Mrs Parkes presented the report and highlighted the following:

- in January 2025, there had sadly been one antenatal stillbirth and two neonatal deaths from a multiple pregnancy; there had been no concerns highlighted from the immediate internal reviews and the cases would now be reviewed using the National Perinatal Mortality Review Tool;
- the national Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE-UK) report for 2023 had been published which demonstrated that the Trust was not an outlier for stillbirth or neonatal mortality rates;
- there were no new cases in January that met the criteria for referral to Maternity and Newborn Safety Investigations, nor were there any new Patient Safety Incident Investigations declared;
- the postpartum haemorrhage (PPH) rate was 4.4% (15 cases) in January; the Trust's was not an outlier in terms of the PPH rate; a PPH sprint audit been undertaken which had demonstrated that recording of incidents was an area for improvement;
- Perinatal Mental Health remained an area of concern as there capacity issues in both the Trust's own team and in the Tees, Esk and Wear Valleys Foundation Trust's Perinatal Mental Health Team; the Local Maternity and Neonatal System (LMNS) and the ICB were involved in reviewing provision at both Trusts;

- an LMNS assurance visit had taken place on 12 February 2025; Trust leaders had highlighted the requirement for further funding to continue to make improvements;
- the Maternity Incentive Scheme (MIS) report and action plan, which had been approved by the Board in January, had been reviewed by the LMNS and the MIS declaration form had been submitted to NHS Resolution at the beginning of March; Mrs Parkes reminded the Board that the Trust was compliant with four of the ten safety actions;
- 87 of the 230 milestone actions in the Single Improvement Plan had been completed; the status of the outstanding actions was detailed in the report.

Ms Hazelgrave queried whether non-compliance with six of the ten MIS safety actions was a financial risk for the Trust. Mr Bertram clarified that the risk was clinical, not financial. Mrs Parkes assured the Board that the Trust was on track for much improved compliance in 2025/26.

Mr Barkley was pleased to note that a fourth caesarean section list was being implemented and that a new scan machine was now available in the Antenatal Day Assessment Unit. Mrs Parkes agreed that this was positive news; she observed that there was significant improvement work in progress in Maternity Services despite the number of milestones which were off track.

**The Board approved the CQC Section 31 Update.**

## 13 Annual Inpatient Nurse Staffing Review

Mrs Parkes presented the paper, noting that this was the second review of its type and there would be reviews of nurse staffing in other areas. Mrs Parkes advised that there was now an appropriate governance structure and engagement around the review process, and it enabled the Trust to meet the requirements of the National Quality Board and the NHS Improvement Workforce Safeguards. Mrs Parkes outlined the methodology used in the review: professional judgement was the most important element.

Mrs Parkes highlighted the ambition to increase the number of Nursing Associates employed by the Trust, which linked to its role as an Anchor Institution. She drew the Board's attention to the areas of risk and the recommendations identified by the review:

- Stroke Services required an increase of 16.83 Whole Time Equivalents (WTE) to meet the National Clinical Guidelines;
- Rainbow Ward at Scarborough Hospital required an increase in ward staffing of an additional Nursing Associate for the night shift;
- headroom for paediatric inpatient wards needed to be increased from 20% to 22% in line with adult inpatient wards;
- ward manager roles should increase from one to five supervisory days.

Mrs Parkes assured the Board that inpatient ward staffing was safe but was not as effective and productive as it could be. Overall, the recommendation was that inpatient nurse staffing be increased by 120 WTE of which around half should be Registered Nurses and the other half non-registered. She recommended that the Board support the recommendations in the paper, and she would then work with Mr Bertram to identify appropriate resource.

Ms Hazelgrave observed that work to accelerate the discharge of patients with No Criteria To Reside would release nursing staff capacity, as would better management of outpatients. She asked about the Sentinel Stroke National Audit Programme (SSNAP)

score. Ms Hansen reported that a stroke peer review had recently taken place; no serious concerns had been raised but the report had contained workforce recommendations.

Mr Barkley questioned whether the requirement for more Nursing Associates of 13.65 WTE was ambitious enough. Mrs Parkes explained that the aim was to grow the workforce gradually to ensure that quality was maintained.

Mr Barkley asked if there would be leadership and management training/support for Ward Managers given their expanding time commitment to these responsibilities. Mrs Parkes advised that Ward Managers had already accessed the Leadership Development programme and had been prepared for a full-time supervisory role over the past 12 months. Performance would be monitored through the quality assurance framework.

Discussion followed. Directors agreed that the review was extremely valuable and would inform improvements to quality of care, as well as reviews of other services. Mrs Parkes noted that a review should be undertaken each time a ward changed use.

The Board of Directors supported the recommendations in the paper.

## 14 Staff Survey Annual Report

Miss McMeekin presented the report and highlighted:

- the deterioration in completion rates from 39% to 36%, against an improving picture of engagement nationally;
- there had been an increase of 10% in free text comments, but the proportion of positive comments had reduced to just 5%;
- the themes of the free text comments reflected the findings of the Discovery phase of the Our Voice Our Future programme;
- the only improved metric from last year was the one relating to reward and recognition;
- the Trust maintained performance against seven of the questions but had deteriorated in the crucial theme of staff engagement;
- against national performance, the Trust was average for “we work flexibly” but all other scores were below the national average;
- it was apparent from the results that the experience of staff from minority ethnic groups and those with a disability was less favourable than that of non-disabled and White British staff.

Miss McMeekin reported that as directorate and departmental results had been received early, action plans had already been developed. The themes were detailed in the report. Miss McMeekin advised that there already been training and support for leadership and management ability and this, as part of the overall Trust quality improvement strategy, would be beneficial in the long term. Miss McMeekin noted that there was clear understanding at a senior level of the initiatives being put in place, but this was not penetrating down through the layers of management. Support for the work of the Change Makers, as part of the Our Voice Our Future programme, would continue and Executive sponsors were now allocated to the three pillars.

Miss McMeekin underlined the need to increase engagement with the staff survey, as this in itself was likely to improve outcomes; some form of incentive could be considered as incentives were used by the top performing Trusts. She invited comments on how to increase response rates. There was further discussion on the use of incentives, on the means of communicating the outcomes from the staff survey and overall engagement of

staff. It was noted that survey response rates were impacted by a lack of engagement from staff in YTHFM, from the Medicine Care Group and those based on the Bridlington site.

Miss McMeekin observed that the focus needed to be on engaging staff in the work of the organisation as a whole, as the experience for staff currently was overwhelmingly task orientated.

Mr Barkley highlighted the three questions relating to advocacy which were the most important indicators of staff satisfaction in his view:

- Care of patients is my organisation's top priority
- I would recommend my organisation as a place to work
- If a friend or relative needed treatment I would be happy with the standard of care provided.

The Board must create the conditions where staff would feel proud of working for the Trust. This would improve response rates and reflect improvements in the Engagement domain as well as other domains.

It was agreed that all managers and supervisors should receive the Staff Survey responses directly.

**Action: Miss McMeekin**

Mr Barkley requested that the Board receive a report on the actions undertaken from the 2024/25 Staff Survey improvement plan in April and the 2025/26 action plan at the May meeting.

**Action: Miss McMeekin**

## 15 Mortality Review (Learning from Deaths) Q3 Report

Miss Topping presented the paper and advised that the format and content of the report were being reviewed to make it more accessible. She reported that both the crude mortality rate and Summary Hospital-Level Mortality Indicator (SHMI) were within the expected range. The Hospital Standardised Mortality Ratio (HSMR) remained higher than expected; reasons for this were unclear. Miss Topping noted that discussions were taking place nationally about removing the HSMR as an indicator.

Miss Topping referenced the details of Structured Judgement Case-note Reviews (SJCRs) detailed in the report, which were being aligned with the Patient Safety Incident Response Framework. The Trust was training more SJCR reporters to meet the increasing demand. In terms of next steps, the Trust needed to improve on its compliance with the Mental Capacity Act; Care Group Boards were in the process of reviewing their processes.

Dr Holmberg referred to the data on diagnosis groups with excess deaths and noted that the data for *Aspiration pneumonitis; food/vomitus* might relate to poor ward care. Miss Topping responded that this had already been identified and work was underway to address areas of concern. Mrs Parkes added that she had commissioned work to improve the care of patients with nasogastric tubes which would be reported to the Quality Committee.

Mr Barkley asked Miss Topping to email him the data about deaths from stroke for the last four available quarters.

**Action: Miss Topping**

## 16 Vascular Hybrid Theatre Equipment Business Case

Ms Hansen presented the Business Case and explained how this would support capacity in the region to meet the growing level of demand.

**The Board approved the Vascular Hybrid Theatre Equipment Business Case.**

## 17 Corporate Governance Update

- Group Audit Committee Annual Report
- Committee Terms of Reference Amendments
- Board of Directors Work Plan
- Modern Slavery Act Statement

**The Board received and approved the above papers.**

## 18 Questions from the public received in advance of the meeting

There were no questions from members of the public.

## 19 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 30 April 2025 at 9.30am at Scarborough Hospital.

| Action Ref. | Date of Meeting | Item Number Reference | Title (Section under which the item was discussed) | Action (from Minute) | Executive Lead/Owner | Notes / comments | Due Date | Status |
|---|---|---|---|---|---|---|---|---|
| **BoD Pub 47** | 29-Jan-25 | 12 | Trust Priorities Report | Circulate the action plan for improvement in waiting times for the Rapid Access Chest Pain clinic | Chief Operating Officer | Update 26.02.25: Ms Hansen advised that the action plan needed to be reviewed with the Care Group before it was shared with the Board. The action was deferred to March.<br>Update 26.03.25: Ms Hansen advised that the action plan was | Jun 25 from Feb 25 | Amber |
| **BoD Pub 49** | 29-Jan-25 | 13 | Equality Delivery System Report | Keep the Resources Committee apprised of the progress of the EDS action plans. | Director of Workforce and OD | | May-25 | Green |
| **BoD Pub 52** | 29-Jan-25 | 18 | Quarter 3 2024/25 Updated Board Assurance Framework | Progress the use of a Board development seminar for a Board discussion on risk appetite | Associate Director of Corporate Governance | | Feb-25 | Amber |
| **BoD Pub 54** | 26-Feb-25 | 10 | Trust Priorities Report | Explore options to provide more accurate ethnicity data for the Health Inequalities section of the TPR | Chief Operating Officer/Chief Nurse | Update 26.03.25: Ms Hansen and Mrs Parkes would progress work on the collection of ethnicity data and which metrics to report in the Health Inequalities section of the TPR, and refer to Mr Hawkins with any system changes as appropriate. | Apr 25 from Mar 25 | Amber |
| **BoD Pub 57** | 26-Feb-25 | 11 | Maternity and Neonatal Report (including CQC Section 31 Update) | Change TPR to show target for 3rd/4th degree tears in assisted births as less than one per cent | Chief Digital and Information Officer/Chief Nurse | Update 26.03.25: Mr Hawkins advised that he needed a discussion with Mrs Parkes to determine the correct target or baseline. | Apr 25 from Mar 25 | Amber |
| **BoD Pub 58** | 26-Mar-25 | 6 | Chair's Report | Seek support from the York and North Yorkshire Mayor with regards to the Trust becoming an Anchor Institution on the East Coast. | Chief Executive | | Apr-25 | Green |
| **BoD Pub 59** | 26-Mar-25 | 8 | Quality Committee report | Update the Board on progress to address the serious concerns raised by the major trauma peer review report | Chair of the Quality Committee | | May-25 | Green |
| **BoD Pub 60** | 26-Mar-25 | 11 | Trust Priorities Report | Present an options paper on improvements to Audiology waiting times to the Resources Committee | Chief Operating Officer | | May-25 | Green |
| **BoD Pub 61** | 26-Mar-25 | 11 | Trust Priorities Report | Seek further clarification on the "smoking at booking" and "smoking at 36 weeks" metrics in the Scarborough maternity scorecard. | Chief Nurse | | Apr-25 | Green |
| **BoD Pub 62** | 26-Mar-25 | 14 | Staff Survey Annual Report | Ensure that Staff Survey responses are sent directly to all managers and supervisors | Director of Workforce and OD | | Apr-25 | Green |
| **BoD Pub 63** | 26-Mar-25 | 14 | Staff Survey Annual Report | Present a report on the actions undertaken from the 2024/25 Staff Survey improvement plan. | Director of Workforce and OD | | Apr-25 | Green |
| **BoD Pub 64** | 26-Mar-25 | 14 | Staff Survey Annual Report | Present the 2025/26 Staff Survey action plan. | Director of Workforce and OD | | May-25 | Green |
| **BoD Pub 65** | 26-Mar-25 | 15 | Mortality Review (Learning from Deaths) Q3 Report | Email Mr Barkley the data about deaths from strokes for the last four available quarters. | Deputy Medical Director | | Apr-25 | Green |

York and Scarborough Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Date of Meeting:** | 30 April 2025 |
| **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 ☒ Regulatory Requirement ☐

**Trust Objectives**

☒ To provide timely, responsive, safe, accessible effective care at all times.
☒ To create a great place to work, learn and thrive.
☒ To work together with partners to improve the health and wellbeing of the communities we serve.
☒ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☒ To use resources to deliver healthcare today without compromising the health of future generations.
☒ To be well led with effective governance and sound finance.

**Board Assurance Framework**

☒ Effective Clinical Pathways
☒ Trust Culture
☒ Partnerships
☒ Transformative Services
☒ Sustainability Green Plan
☒ Financial Balance
☒ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☐ Yes

☐ No

☒ Not Applicable

**Recommendation:**
For the Board of Directors to note the report.

**Report Exempt from Public Disclosure** (remove this box entirely if not for the Board meeting)

No ☒ Yes ☐

**Report History**
Board of Directors only

**Chair's Report to the Board – April 2025**

1. I have continued to visit various wards and services at Bridlington, York, and Scarborough Hospitals and a community team. Through conversations with colleagues during these visits I pick up valuable insight and issues which I share with relevant Executive Directors as appropriate.

2. The Insight programme candidate the Chief Executive and I were due to meet withdrew from the programme just hours before our scheduled meeting. Interviews for the forthcoming vacant NED position will take place on 2nd May. Four candidates have been shortlisted.

3. On 1st April I had the pleasure of attending the official launch of the SHARC research collaborative. It was a good, well attended event and interesting for me to hear the perspective of St Johns University which is a key partner in the collaborative.

4. Earlier this month I attended a Governance seminar organised by Audit North, our internal Auditor. Several Trusts attended. The focus was the Well Led domain of the CQC Inspection framework, and the value of Trusts commissioning an independent developmental well-led review. The Board will recall that we had commissioned such a review to be carried in December but the selected organisation withdrew from this type of work. We will seek costed proposals for a review to be carried this autumn.

Martin Barkley
Trust Chair
21.04.2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

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|---|---|
| **Report to:** | Board of Directors |
| **Date of Meeting:** | 30 April 2025 |
| **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 ☒ Regulatory Requirement ☐

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**Board Assurance Framework**

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☒ Trust Culture
☒ Partnerships
☒ Transformative Services
☒ Sustainability Green Plan
☒ Financial Balance
☒ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☐ Yes

☐ No

☒ Not Applicable

**Executive Summary:**
The report provides an update from the Chief Executive to the Board of Directors in relation to the Trust's priorities. Topics covered this month include: acute pressures, national and regional system changes, the readiness assessment for an approach to embedding continuous improvement, an update on ongoing capital schemes, and the star award nominations received in the last month.

**Recommendation:**
For the Board of Directors to note the report.

**Report Exempt from Public Disclosure** (remove this box entirely if not for the Board meeting)

| |
|---|
| No ☒ Yes ☐ |
| (If yes, please detail the specific grounds for exemption) |

| **Report History**<br>(Where the paper has previously been reported to date, if applicable) | | |
|---|---|---|
| **Meeting/Engagement** | **Date** | **Outcome/Recommendation** |
| | | |

# Chief Executive's Report

## 1. Acute pressures

The Easter holiday period has been particularly busy for our acute services in both York and Scarborough. High levels of activity through our emergency departments, particularly in Scarborough as is typical for the holidays, and beds closed due to infections circulating in the community (most notably norovirus in York) have made it challenging to maintain flow through the hospitals.

To help to manage this we have continued with our focus on discharge planning and streamlining our processes, and on managing ambulance handover to enable faster turnaround of crews.

Thank you to all of our colleagues who continue work incredibly hard to put patient care first during these periods of high demand. I recognise that it can be particularly challenging during these peak times and everyone's efforts are greatly appreciated.

## 2. National and regional NHS system changes

In my report in March I gave a brief overview of the changes announced by Government relating to NHS England being disestablished and its functions integrated into the Department of Health and Social Care.

Sir Jim Mackey formally became Chief Executive of NHS England on 1 April, and wrote to chairs and chief executives of all providers and Integrated Care Boards on day one to set out some further detail about what these announcements mean in the short-to-medium term.

The letter, *Working together in 2025/26 to lay the foundations for reform,* outlines the strategic priorities and collaborative actions required across the NHS for the 2025/26 financial year, and reaffirms the direction of travel outlined by Sir Jim at the meeting of Chief Executives which I attended last month.

These priorities focus on stabilising NHS finances, embedding a more transparent and collaborative leadership culture, and preparing for long-term service reform.

The key areas of the letter are summarised below.

**Strengthening 2025/26 financial planning:**
Sir Jim thanks all leaders for their work in delivering significant progress in refining the 2025/26 financial plans, with the collective efforts of all teams resulting in a planned headline deficit reduction. He describes the need to go further with these plans, and the ongoing engagement that will be taking place with the regional teams to finalise these and to build delivery confidence.

**Evolving NHS leadership and planning practices:**
The forthcoming 10 Year Health Plan, together with the outcome of the Spending Review, will underpin a shift toward a medium-term planning approach. A structured engagement process will be initiated between June and September 2025 to define planning parameters for 2026/27 and reduce reliance on annual Planning Guidance, enabling a more streamlined planning process in the future.

A return to a ‘fair-shares’ allocation policy is one of Sir Jim’s commitments. An indicative schedule has been shared to show what this would have looked like for this year, whilst an affordable ‘pace of change’ policy is developed to enable a move to new funding arrangements over time.

**Cost reduction in Integrated Care Boards (ICBs) and future strategic role:**
ICBs will be central to delivering future NHS strategy as strategic commissioners. As part of this transition, ICBs are expected to reduce their operating costs by 50% while retaining key staff and enhancing strategic capabilities in areas such as analytics, market management, and contracting.

Areas to look at where duplication may exist (for example in providers, regional teams, and/or local authorities) include assurance and regulatory functions, wider performance management roles, and communications and engagement.

ICBs are required to produce cost-reduced plans by the end of May, with implementation expected during Quarter 3.

**Reducing corporate cost growth in NHS providers:**
Since 2018/19, corporate costs in NHS providers have increased by 40% (excluding pay and pensions). All providers are now expected to deliver a 50% reduction in this growth from October this year. Regional benchmarking data has been provided to Trusts to support this process, and we are working to produce a plan by the end of May describing how we will deliver this ask in our Trust.

**NHS Standard Contract and payment reform:**
New contractual arrangements for 2025/26 will introduce greater flexibility in elective activity planning. The removal of the elective payment limit and strengthened activity management provisions are designed to support collaborative planning between providers and commissioners.

**Streamlining NHS central functions:**
Work is progressing to unify NHS England and the Department of Health and Social Care into a single, aligned centre, with this work being sponsored by Penny Dash (NHSE’s new chair) and Alan Milburn. The new NHS Performance Assessment Framework for 2025/26 will be published following consultation and testing during Quarter 1.

Preparations are also being finalised for the publication of the Urgent and Emergency Care (UEC) Delivery Plan, which will be a critical tool for improving system preparedness ahead of winter 2025/26.

## 3. Readiness Assessment for Embedding Continuous Improvement

Our Board is considering a long-term transformation programme to embed continuous improvement in our Trust.

We know that this is something colleagues feel is a significant barrier to them engaging in their place of work. This was most recently reported in the staff survey but has been a recurring theme for some time.

Key to the successful delivery of our new EPR is having a framework for continuous improvement and a systematic way of doing things, and this is a fundamental enabler to the successful delivery of all major transformation programmes.

Organisations that have a track record of doing this well have several things in common:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

Our new strategy gives us the framework to do this, and to deliver our ambition to provide an excellent patient experience every time, however we have agreed that we need the support of a strategic partner to support us to develop our management system.

As a starting point, we are currently undertaking a 'readiness assessment' to better understand our current position regarding continuous improvement and our ability to undergo such a large programme. This includes gathering insights into our Trust's strategy and transformation capability, as well as the willingness within our organisation to undertake such a large-scale change programme. We are doing this work with an external partner, KPMG, following their successful delivery of similar programmes in other NHS organisations.

The readiness assessment is a rapid, time-limited piece of work to assess our organisation's capability through one-to-one interviews, reviewing key documents, directly observing meetings, and holding focus groups with colleagues.

This will be used to provide an assessment of how best to move forward in embedding a culture of continuous improvement and will inform the Board's decisions as to the next steps in our improvement journey.

## 3. Building for the Future

Despite the extremely challenging financial context, we continue to deliver a growing capital programmes year-on-year, with a good track record in successfully bidding for additional funds to carry out further work in line with our strategic priorities.

As the new financial year begins we have a number of capital schemes underway.

On the York Hospital site we have the new two-storey MRI and hybrid theatre complex scheme. Work on the construction of the building has begun offsite, with the scheme due for completion by the end of 2025. The new complex will consist of an MRI unit on the ground floor and a new hybrid theatre on first floor, along with some additional office space and staff areas.

In addition to the hybrid theatre the Post-anaesthetic Care Unit (PACU) is being upgraded to create a much-improved 18-bay PACU complex. Construction is underway, with phase one due for completion in the summer and phase two in late autumn.

At the other end of the York site in the old physiotherapy department, work is well underway on a new Vascular Imaging Unit (VIU) which will house two cardiac labs and two vascular labs. Work is due to be completed in the autumn with a further phase of works planned to follow.

We also successfully bid for funding under the ACTIF programme, enabling a number of improvements to be made to our estate to help with capacity and flow for acute patients.

This includes the works on ward G1 and the gynaecology assessment area in York which are progressing well. The emergency department works at York are also underway including the minor injuries corridor, additional examination rooms, and re-utilisation of space to include a plaster room.

Improvements to ward 12 in York are also being carried out to include a new sluice and additional side rooms. In total four additional side rooms are being created on the York site to add much-needed single-room capacity to the bed base.

On the East Coast, the Scarborough Community Diagnostic Centre (CDC) is nearing completion. Once fully operational the centre will be the Trust's main CDC Hub, providing additional diagnostic capacity across a range of diagnostic tests, including:

- Pathology/physiology (blood taking, blood pressure monitoring, and 'Point of Care Testing')
- Cardio-respiratory (echocardiograms, electrocardiograms (ECG), FeNO testing (for asthma), Holter fitting/monitoring (for heart activity), lung function testing)
- Imaging (CT scans, DEXA scans (for bone density), MRI scans, and non-obstetric ultrasound scans)

On the Scarborough Hospital site itself, Reinforced Autoclaved Aerated Concrete (RAAC) works are moving at pace and clinical teams are engaged to ensure safe transition. This to address the RAAC that was identified in the theatre plant room, link corridor and pathology building.

Last but by no means least, 28 April is the planned start of 'moving in' week for Scarborough Hospital's new Urgent and Emergency Care Centre, with all areas of the building expected to be fully operational by Friday 2 May.

We are currently finalising our capital programme for the coming year, which is once again likely to be the largest capital programme the Trust has ever undertaken.

## 4. 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. April's nominations are in **Appendix 1**.

**Date:** 30 April 2025

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

# STAR AWARD

# April 2025

**Jayne Young, Occupational Therapy Clinical Lead** **Malton** **Nominated by colleague**

60% of routine referrals into Children's Community Occupational Therapy are for children and young people with sensory processing differences and the waiting list for these referrals has been growing exponentially. Jayne and her team were aware of this so had a vision to create a sensory virtual service that would be accessible for all and to support parents to access support at a time that is right for them, while continuing to support self-care, management, and the understanding of when to ask for further help.

The journey began over a year ago and Jayne has been committed to developing the offer alongside her day job and other significant commitments such as Masters level study and being a mum! February 2025 saw all the hard work come to fruition with the launch and roll out of the programme.

This will increase the capacity of the service to address the needs of those young people referred for universal and targeted therapy, reducing the waiting times and improving the outcomes for these children and young people. This is a commendable improvement piece which will significantly improve the patient and carer experience.

**Mariah Marshall, Healthcare Assistant** **York** **Nominated by colleague**

Mariah is always kind and caring with our patients. She makes time for people, especially confused patients who need one-to-one help. I have witnessed her looking after staff members, relatives, and patients with such understanding and compassion. She also helps to lift the spirit of the team with her happy and upbeat personality. Thank you, Mariah, for all you do and for keeping us all smiling.

**Radiology Medical Secretaries** **York** **Nominated by colleague**

The radiology secretaries have been instrumental in supporting the radiology residents throughout the years, but this has been particularly highlighted during the past six-month rotation. We ask all the leaving residents for feedback, and there was a unanimous "excellent" rating for the support received from the secretarial staff this time around.

They have always gone above and beyond not only in supporting the residents, but also in supporting me and my co-college tutor as we navigate our new role. We would not be able to deliver the high-quality training we do without their support.

**Magnolia Centre** **York** **Nominated by patient**

I had an appointment at the Magnolia Centre, followed by a call from Jackie Pool with my results. Every member of staff that I met was kind, compassionate, polite, and helpful. I have never experienced this level of excellence before, in any setting. The whole team are a credit to the hospital, the NHS, and specifically the people who recruited and trained them.

I do not know all their names, but Jackie, the consultant radiologist and her nurse assistant, the two radiographers, and two receptionists that I saw were wonderful. Jackie also had such an empathetic manner when delivering the news of a cancer diagnosis to me. The team, and Jackie in particular who does a difficult job, are to be highly commended and I hope they get rewarded appropriately.

**Urgent Treatment Centre** **Malton** **Nominated by colleague**

This team are continuously making a difference the local people of Malton and surrounding areas. In times like this, when GPs are busy, this team goes above and beyond to try to help everyone that comes from their door. The staff deserve recognition for the fantastic service they offer and to be appreciated for how valuable they are in the Malton area.

**Joanne Bradley-Smith, Orthopaedic Practitioner Lead** **York** **Nominated by patient**

Jo Bradley-Smith has more than demonstrated the Trust values of kindness, openness, and excellence which she has also engendered in her team. Due to communication problems, I spent some harrowing hours concerned about a deep tissue injury in my heel which I had had for seven months. I then found this godsend who immediately realised the extent of the problem as well as the anxiety associated with it and treated both in a calm and professional manner.

Jo showed an exceptional degree of care and concern when she discovered that I had had what has been described as an ‘ordeal’. She understood that no further surgery on my leg could take place until the wound had healed. She booked me in, and personally supervised weekly reviews of the wound, to the extent that a consultant and colleagues at another hospital involved in my treatment marvelled at the tangible difference she has made to my wound and to my overall health. This included a clearly written explanatory note to the other hospital about current treatment which put my mind at rest about future treatment. She sought further advice from podiatry and the vascular team which increased understanding of my condition.

It is clear from the way her equally professional colleagues approach her for advice on various issues that she is open and willing to share her extensive knowledge with them, which she carries lightly, and when called to do so, with patients. Through her behaviour and actions, Jo demonstrates care, expertise, and professionalism at an outstanding level.

**Pauline Del Rosario, Switchboard Operator** **York** **Nominated by colleague**

Pauline has always shown dedicated and great understanding in her role, but recent events have shown us how she deals with system failures and follows our Business Continuity Plans (BCPs).

With the unfortunate failure of one of our systems, Pauline used her initiative and excellent communication skills to ensure all the relevant people were contacted and updated on the event and then tried to resolve the issue following the BCPs in place. Pauline kept a record of events and ensured all updates were thorough. We would like to thank Pauline for her hard work, and for remaining calm and positive throughout the difficulty of her shift.

**Sam Pope, Switchboard Operator** **York** **Nominated by colleague**

Sam has always shown dedicated and great understanding in her role, but recent events have shown us how she deals with system failures and follows our Business Continuity Plans (BCPs).

With the unfortunate failure of one of our systems, Sam used her initiative and excellent communication skills to ensure all the relevant people were contacted and updated on the event and then tried to resolve the issue following the BCPs in place. Sam kept a record of events and ensured all updates were thorough. We would like to thank Sam for her hard work, and for remaining calm and positive throughout the difficulty of her shift.

**Sarah Gregory, Joanne Davey and Terri Sloan, Midwives** **Scarborough** **Nominated by patient**

These three midwives were amazing during my labour, and I would like to thank them. Sarah and Jo were on call for a home birth and even when their shift was about to change, they decided to stay with me. Terri joined the team and blended in seamlessly.

The care they gave me was amazing. As well as supporting me, they supported my husband and two children. It was a nice, calm, and relaxing atmosphere with the right amount of humour. I can honestly say I had a great time.

My homebirth could not be completed at home, so I had to go to the hospital. They gave me reassurance and kept me calm, keeping me updated with the plan and reasons for transfer to hospital. Due to them, I had a dreamy birth of my daughter even though I had to give birth in hospital. They will always be a part of her story of how she was born.

All the community midwives in Scarborough and surrounding areas deserve recognition for enabling women to get the birth plans they want. A big shoutout to the Scarborough home birthing team and massive thank you to Sarah, Jo, and Terry. You are my superheroes!

**Child Health Team** **York** **Nominated by colleague (on behalf of a relative)**

The team have faced many challenges recently but despite ongoing pressures, they have received lovely feedback which deserves recognition. Please see the below which was sent by a parent to the PALS team:

I would like to say what a wonderful team there is up on Ward 18. I took my little girl in from the GP, and as soon as I arrived on the ward, everyone was helpful. They even got my little girl a bed so she could sleep as she was lethargic. They all went above and beyond, especially when she had her bloods done, which I knew was going to be difficult. They allowed me to wait for my husband and then they got a team of the play team, nurses, doctors, and healthcare assistants to help do the procedure. Although it still was not a nice experience for my daughter, they all tried their hardest. A special to thanks to the Staff Nurse, Sophie, and Healthcare Assistant, Kat (apologies if I have got the name wrong).

I want to also thank the day unit which we went to for a general anaesthetic for an MRI. Everyone up there was fantastic and so supportive of decisions we made, such as not having the cannula put in until she was asleep. The anaesthetist was so good about us choosing this option as I am aware that it is not an option they like to use, but she knew it was the right decision for my child. Hollie the Play Assistant was so good and brought masks over for my little one to see while she explained what happens. She really was amazing.

I know the NHS experience a lot of bad press, but I am grateful for all the staff members that helped me on both occasions. They deserve a Star Award!

**Colin Murray, Consultant VR Surgeon** **York** **Nominated by colleagues**

We are nominating Mr Murray for a Star Award as he deserves recognition for his exceptional kindness and dedication. Mr Murray is an outstanding ophthalmology surgeon, but what sets him apart is his constant kindness and approachability. Whether with patients or colleagues, he always offers support with a friendly, helpful attitude. No matter how much pressure he is under, he remains calm, kind, and ready to assist others. This level of consistency is rare and deeply appreciated by everyone who works with him.

A recent example of his dedication shows just how far he goes for both his patients and colleagues. After losing cover for both elective and acute theatre lists at short notice, Mr Murray immediately stepped in to ensure that both lists were covered. Given that his specialty is vitreo-retinal, where timely treatment is crucial, especially for acute cases, his prompt action ensured patients received the care they needed without delay.

Despite managing his own busy workload, Mr Murray always willingly steps in when needed and goes above and beyond to help. Mr Murray's kindness, helpfulness, and dedication to both his patients and colleagues make him truly deserving of this recognition.

**Anna Clifford, Advance Practitioner Ultrasound** **York** **Nominated by colleague**

Anna is an amazing colleague who works hard to look after all her patients and colleagues. She is always respectful, kind, friendly, and professional. On many occasions, patients have commented on how lovely and caring she is.

Recently, when a colleague was off work sick, Anna scanned her own full list of patients and patients who were due a scan on the other sonographer's list. This is particularly remarkable as many of the patients attending this clinic have mobility issues and need more time. Patients attend hospital worried about what might be found and Anna chose not to cancel scans and went above and beyond to ensure patients attending the Urology Clinic at Malton Hospital for ultrasound received good care. It is typical of Anna to work hard to care for everyone and she deserves thanks and recognition.

**Ward 39 Healthcare Assistants** **York** **Nominated by colleague**

The HCAs on Ward 39 regularly go above and beyond in their roles to ensure the patients receive the best possible care. They take the time to get to know the patients, as well as their relatives, creating a holistic care environment. No task is ever too great for them to undertake, and they demonstrate their passion for caring in every aspect of their role. When they say that healthcare assistants are the backbone of the NHS, this is more than true for the team on Ward 39.

Over the last year, there have been many times that the HCAs on the ward have demonstrated their dedication and kindness to the patients, some examples are:

- They supported a patient to attend their daughter's wedding. They came in early to help with washing and dressing, getting them to the taxi and ensuring they had everything they needed for the day.
- They developed a good rapport with a patient and their relatives, ensuring that the patient was cared for the way their family cared for them at home. The family reported that they felt assured that their relative was in safe hands due to the care and attention they had received as a family.
- They take the time to get to know patients' usual routines so they can support them as they would be supported at home. For example, if they routinely have their hair washed on a Monday then the patient will be supported to have their hair washed on a Monday as an inpatient.
- They are keen to develop their skills and knowledge and work closely with the therapists to ensure that patients get maximum benefit from the ward rehab available to them.
- There was a patient on the ward that was deaf, so lip read and used limited sign language. They utilised the internet to learn basic signs to be able to communicate effectively with the patient to ensure they felt supported within the ward environment.
- During afternoons on the ward, the HCAs support the patients into the ward "Gym" for social interaction with others on the ward, including a game of Bingo, a music session, or a bit of pampering.

There are so many other examples of how the team have gone above and beyond for the patients, but these are a few key ones that I have had the privilege to witness. The ward routinely receives high praise for all HCAs from relatives and patients and you all deserve the recognition for the work you do. You are all so appreciated, and we (the nursing team) are forever grateful for your hard work and dedication to the patients on Ward 39.

**Jenny Linley, Advance Practitioner Ultrasound** | **York** | **Nominated by patient**

Jenny was kind, efficient, professional, and caring during my recent appointment in ultrasound. She assisted me so skilfully and took the time to alleviate my anxiety. Jenny is a credit to the department, hospital, and her profession. I would love her to receive a Star Award to remind her of what a difference she is making.

**Michelle Means, Senior Healthcare Assistant** | **Bridlington** | **Nominated by colleague**

Michelle constantly goes above and beyond for patients and staff. For patients, she does her duties extremely well as well as ensuring the patient is satisfied and their needs are met, whether by offering a drink or by being someone to talk to. Her compassion and professionalism are something that I admire, and I strive to replicate the same level of dedication in my own work.

When it comes to staff, she always has a kind word to say and will go out of her way to help anyone, even when it adds to her workload. She is a fantastic employee, colleague, and friend and is a credit to the team.

**Kristen Bourne, Operational Service Manager** | **York** | **Nominated by colleague**

I had a patient who required hip replacement surgery. The patient has significant psychiatric issues and was on and off the list due to their anxiety. Kristen phoned the patient in the run up to surgery every couple of days to reassure them and make sure they were calm. On the day of surgery, went to sit with the patient on the admissions ward, talking to her and allaying her fears while she waited for the operation.

This was far beyond the call of duty and, once the surgery had proceeded smoothly, the patient was full of gratitude to Kristen, without whom, the surgery may not have gone ahead. Kristen consistently makes the patients her priority and goes above and beyond to ensure patients' needs are met. This one act of sitting with the patient all morning was incredibly kind and made a difference to the patient's experience.

**Ward 39** | **York** | **Nominated by relative**

The staff on Ward 39 were helpful, informative, and friendly.

**Ruth Clegg, Operating Department Practitioner** | **York** | **Nominated by colleague**

Ruthie is passionate about patient care, particularly ensuring that our paediatric patients have a positive theatre experience. She had a range of age-appropriate toys to try to reduce their worries.

Ruthie has gone above and beyond by leading on a project (with the support of the Arts Team) for our anaesthetic rooms to have vibrant and colourful child friendly pictures covering the walls. This makes our clinical setting more child friendly. She is a star and the difference these vibrant wall vinyl have made to our department is worthy of recognition.

**Samantha Kelly, Urgent Care Practitioner** **Selby** **Nominated by patient**

I went to hospital after being attacked by my now ex-partner. The police at the time were not aware. Samantha made me feel safe and cared for and never once made me feel ashamed about what he had done to me. She sorted my injuries and gave me good advice. She ended up contacting the police and making a statement, something I have not been strong enough to do. Without her the police would not be involved and things may have continued to escalate.

I will never forget all the help and support she gave me and will always remember her as the lady that saved me from him.

**Eddie Stevenson, Cleaning Operative** **York** **Nominated by relative**

After a long wait in ED, my child and I were brought up to Ward 18 for her to be monitored. As soon as we walked on to the ward, I could smell how clean it was. I had been awake all night, worried sick about my child, when Eddie popped his head around the door and asked if my little girl wanted a blanket, to which I replied “Yes, please”. He came back with one for my daughter and one for myself, and said to me, "You have got to look after yourself to be able to look after her". He then made me a hot drink which was appreciated after not having a drink for a long time.

Eddie went above and beyond his job role that morning. It may seem little but the kindness this man showed me in one of the most vulnerable times of my life was appreciated. Thank you, Eddie, for being so kind.

**Nicola Wilson, Outpatients Administrator** **York** **Nominated by colleague**

Nicola recently took a phone call from a patient who was suffering from severe anxiety about an upcoming appointment. She ended up meeting the patient on arrival at the hospital and escorting them to the department where their appointment was to take place.

Since then, Nicola has continued to support this patient with their various appointments within our department and others, including ED and radiology, giving her mental and emotional support. During a recent inpatient stay Nicola visited the patient regularly throughout her working day, again offering support. She also left her contact information with the ward staff, should she be contacted at any point if the patient became stressed about their situation.

Nicola has acted as a support system for this patient, working with the medical professionals looking after them by explaining things more clearly, reenforcing what has been said by the healthcare professionals, and giving them reassurance. Unfortunately, the prognosis for this patient is not looking good. They are receiving treatment, and Nicola has agreed to attend further appointments with them as support.

**Claire Ramsay, Ward Sister** **Nelsons Court** **Nominated by colleague**

Claire has had to have some difficult conversations with one of our patients’ relatives who was making demands about what they wanted for their relative. Claire remained professional, even when they were shouting at her. She handled this situation well.

**Holly West, Staff Nurse** **York** **Nominated by relative**

Holly was lovely, thoughtful, and caring with my dad. She hardly left his side in his last hours She was also brilliant with us as his family and looked after us. She gave my dad amazing care while in resus and we could not have asked for anything better. Words are not enough to describe how grateful we are as a family for the care given to my dad.

**Kristie Braviner, Staff Nurse, and Adele Bayes-Warley and Helen Jennison, Healthcare Assistants** **Scarborough** **Nominated by colleague**

Kirstie, Adele, and Helen showed compassion, care, confidence, and common sense while caring for a critical and frail patient with a complex respiratory condition on Beech Ward. This patient was due to be discharged, but due to difficulties managing their oxygen, the discharge was delayed.

Despite the requirement to do their observations regularly, they all recognised the negative impact this was having on both the patient and their partner. They highlighted this to the medical team who appropriately agreed and changed the frequency. They also recognised quickly the signs of hypercapnia, which is not easily recognised by doing observations. Instead, it takes knowing the patient, experience, and confidence. They also highlighted this to the medical team. On acknowledging this, the medical team had a conversation with the patient and partner, explaining the observation and subsequent blood gas. The agreement was to continue to aim for discharge, to monitor and keep the patient comfortable, but to be aware that the patient remains critical and may die. The patient subsequently did die peacefully in their sleep in the early hours of the next morning.

Adele and Helen, as a band 2 and 3, have shown, and always show, how their experience and knowledge of their patient goes well above any grading number they may have. They are a credit to the ward, and they should be proud of their actions, as we are of them. This also demonstrates how well the clinical team and ward team work together, respect each other, and listen when their unified goal is to care for the patient and their family.

**Molly Lees, Medical Secretary** **York** **Nominated by relative**

I am nominating Molly for her outstanding service. Molly has gone above and beyond to help my daughter. My daughter has complex needs which make it difficult for her to attend appointments. Between myself, Dr Abbey, and Molly, appointments have been arranged to support my daughter's needs. Molly has been the most organised person I have ever seen. She ensured all appointments were booked and she checked our availability over several months so that it would not clash with anything.

When we were experiencing problems with communication, Molly, who had been copied into an email, took it upon herself to help chase a response as she understood the need for a response because of my daughter's needs. This meant she helped me get a response direct from the paediatrician and resolved a difficult situation.

Over the years of us working with the hospital I have never had such an excellent service before. Molly is understanding, proactive, and helpful. It feels like Molly appreciates that, as parents, we are co-ordinating our children as care and that we must organise this amongst other appointments. She also understands that we need input from the health team to help us manage care.

I cannot begin to express how amazing it is to have such incredible service from Molly. She is a good example to all. It is a pleasure to work with her and her emails are always warm, caring, and understanding.

**Leigh Shipley, Deputy Sister** **York** **Nominated by colleague**

Leigh has set up a new service in head and neck outpatients to create a one stop biopsy service for patients that present with a potential skin cancer. Leigh has done all the training and research to develop this provision, and it is now a service running weekly, alongside Mr Wotherspoon's skin clinic. This means that patients attending the clinic can have a biopsy taken while attending the consultation, speeding up diagnosis.

Leigh has had amazing feedback from patients about the service. She has worked so hard to develop the service and has undergone training in aspects beyond the specific job role. Leigh has spotlighted how valuable this service is for patients to alleviate the extra stress of waiting for another appointment, to give patients a quicker diagnosis, and to reduce waiting times.

**Lung Cancer Screening Service Development MDT** **York** **Nominated by colleague**

This MDT consists of the following colleagues: Lisa Shelbourn, Radiology Ops Manager, Tracey Doherty, Lead CNS, Nicola Haley, Respiratory Consultant, Nicola Hill, Lung CNS, James Blacker, Lung CNS, Amanda Mullin, Operational Manager, Sarah Good, Operational Manager, Neil Barrett, Finance Manager, Amber Lee, Patient Administration Lead, Tom Skidmore, Radiology IT Systems/PACS Manager, Christine Norris, Cancer Improvement Manager, Bridget Robinson, Corporate Operations Support, and Joy Clarkson, Cancer Support Officer.

Colleagues have worked above and beyond over the past six months to mobilise a new lung cancer screening service at pace. From the business case being approved by Trust Board six months ago, we are now weeks away from formally launching the programme. All colleagues have given time and expertise, on top of their usual day to day activities, and we would not be anywhere close to going live without their support, and the support of other departments and colleagues not listed here.

It has been a collaborative effort across the Trust to get to where we are today, and I want to recognise all the work gone in by individuals and teams to date. Thank you.

**Samantha Chittock, Staff Nurse** **York** **Nominated by relative**

Sam was lovely when I was in ED with my daughter who was experiencing a cluster headache which requires oxygen and is a condition that few people understand. Sam allowed us to explain the situation and she showed empathy, kindness, and compassion, as well as organising the oxygen quickly. Thanks Sam, we really appreciate your care.

**Ward 15** **York** **Nominated by colleagues**

This team make a huge effort to support student nurses, and the Practice Education Team want to nominate them for this. Students comment about how welcomed and supported they felt while on placement on the ward. They also say how welcome the team make bank nurses and other staff on the ward feel and what a positive learning environment it is. Well done to everyone.

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

Dr John Paterson goes above and beyond for his patients. He is easy to approach, has such a gentle and kind manner, and is a caring consultant. He shows every aspect of the Trust values.

He recently saw me as a patient, and I felt so at ease with him. He listened to me and made me feel reassured. He treats all staff and patients with the utmost respect. He is easy to speak to and he explains things thoroughly.

**Maricar Cammish, Bank Healthcare Assistant** **Scarborough** **Nominated by colleague**

I work a night shift with Maricar (Emem) was working a bank shift. I am nominating her for her amazing teamwork and attitude. The other staff on the ward and I were having a difficult shift with poorly patients and patients that needed a lot of attention. Emem got stuck in and helped us so much. She saw what was needed to do and did it. She did so much, taking a lot of pressure off us.

Emem is a wonderful healthcare assistant to patients and staff alike. She is always smiling and shows willing without question or grumbles. It never matters which side of the ward she is on; she will help anyone out without fail. I want to show how grateful we are towards her for the help she gave. Not just last night, but every time I have worked a shift with her, her kindness is unwavering.

**Angela Dalton, Domestic Team Leader** **York** **Nominated by colleague**

If you have complex health issues, having someone who is there, and listens is great. Ange is always there for me, asking how I am and checking in on me. Not matter what is going on in her life, she remains someone I can go to if I need to. I am glad I have Ange to go to. She is an amazing member of this Trust.

**Mojeed Adiat, Trust Doctor Cardiology** **Scarborough** **Nominated by colleague**

Mojeed Adiat has blown us away with his expertise, care, thoughtfulness, compassion, kindness, dedication, and determination to diagnose my husband's complex clinical picture. Mojeed never gave in, time after time and day after day, he went above and beyond for weeks!

We have had such a difficult time over the last six weeks and Mojeed has been there every single step of the way, offering us his time and knowledge when we needed it the most, even when my husband was not directly under his care. Mojeed has always made time for my husband and for me as his wife. He got answers regarding my husband's many health problems and helped my husband as he promised he would.

No words are enough to thank Mojeed for what he has done; we will always remember how selfless, generous and pivotal he has been. He is not only an excellent doctor, but a wonderful man! Thank you, Mojeed, for everything.

**Helen Morley, Transplant Specialist Nurse** **York** **Nominated by colleague**

Helen always encourages people to participate in squats which helps morale and makes people chat and feel better. It is also healthy and beneficial when working at a desk all day. Helen puts in 100% for her patients. She has been a mentor to me and inspires me to be a better nurse.

**Andrea Proctor, Ward Clerk** **Scarborough** **Nominated by colleague**

The ward team had a suspected case of TB in a bay. In the absence of a band 6 on duty, Andrea took it upon herself to contact IPC, bed managers, and facilities, and organise the movement of the patient to a side room. IPC precautions had to be observed by staff, other patients, and visitors, as well as the necessary procedure for the closure of the bay and cleaning requirements. Andrea went above and beyond her role in doing this and she deserves recognition for her efforts.

**Cathy Booth, Orthopaedic Practitioner** **York** **Nominated by colleague**

I started in a new role in the orthopaedic outpatient department in July 2024. This role was something I had not done before, and I felt out of my depth. Cathy has worked as an orthopaedic practitioner for years, so she took me under her wing and was my mentor. She was welcoming and reassuring, especially in the first few months when I wondered if I had made the right decision. She is a great teacher and my biggest champion.

I have seen first-hand how highly regarded she is by the team and by patients. Many patients and their families have known Cathy for years and always remember her and the excellent care she has given them or their family members.

Cathy was supposed to retire last year, but has stayed on to help the department, to help me, and, most importantly, to help patients. I am lucky that I had Cathy to learn from and all her support. She is a friend as well as a wonderful colleague and mentor. I do not know where I would be without her.

**Medical Secretaries** **Selby** **Nominated by colleague**

The team of medical secretaries work together and are such a strong team. Over the past year, they have welcomed three new staff who quickly settled in. Patient care is their top priority, and they provide excellent support to visiting consultants and patients. Nothing is too much trouble where patients are concerned. They cover each other for holidays, etc. and always are obliging when other staff in the hospital pop in the office for help. They all demonstrate the Trust values every day.

**Leanne Officer, Healthcare Support Worker** **York** **Nominated by colleague**

Leanne has been coming up with useful tools to better the department and has been helping anxious patients during induction.

**Williams Acholonu, Healthcare Assistant** **York** **Nominated by relative**

My mum came ED and Williams was so nice to her. She has bad dementia. She went for a CT scan, and he sang to her while pushing her down on the trolley. What an inspiration and truly lovely man he is. He also kept coming to see if she was OK.

Nothing was too much trouble for him. There was always a big smile on his face, and when Mum brought a toy dog in, and he talk to the toy dog and put mum at ease. Thank you, Williams.

**Niamh McDaid, Cardiac Physiologist** | **York** | **Nominated by colleague**

Niamh is in the final year of her Clinical Scientist Training Programme. She has generously used her knowledge and skills to take part in a Pace4Life Mission to Gambia during which she supported the implant of 11 pacemakers. This was the first successful pacemaker implant session in Gambia and Niamh was interviewed by the Gambian media to raise awareness of the need for cardiology resources.

Niamh provided valuable training to local medical personnel and delivered compassionate care to patients, one of whom had been waiting five years for an urgent pacemaker.

**Suzanne Hadfield, Midwife, Raegan Humphrey-Smith, Maternity Support Worker, and Charlotte Birley, Maternity Support Worker** | **Scarborough** | **Nominated by patient**

Came in to get bloods done for a glucose test, but my veins are notoriously bad for getting bloods out of and I get anxious when I get them done. These ladies were amazing and so reassuring when I was getting them done. They were good at distracting from the anxiety and eventually we did get blood and could carry out the test.

I want to say a big thank you to these ladies for being so patient, not giving up, and providing excellent patient-centred care. Also, a shout out to all the staff in the women's unit. Every time I have been in everyone been so helpful and lovely.

**Inpatient Unit OT/GTA Team** | **Selby** | **Nominated by colleague**

Beth, Georgia, and Jules go above and beyond for the holistic needs of patients at Selby Inpatient Unit. This unit consists of individual rooms which can be isolating for some of the patients. Beth, Georgia, and Jules organise Wednesday morning activities for the patients such as spa mornings, games/activities, music groups, etc. This promotes functional activity and mental and social wellbeing.

It is lovely for patients to have access to social situations when they are experiencing a period of ill-health that means they cannot return home to their loved ones. It reminds us that although patients requiring physical rehab also have mental wellbeing needs. The patients really enjoy this, and the activities are always well received.

**Hayley Hunt, Nursing Associate** | **Scarborough** | **Nominated by patient**

Hayley went the extra mile for me. She has old fashioned values with a young head. She is a lovely lady and she the Trust values. Her time and care made my stay much better.

**Carol De'Ath, Audio-typist** **York** **Nominated by colleague**

Carol is an exemplary team member who goes above and beyond for patients every day. Carol delivers a level of care, empathy, and due diligence to the administration of patient care, treating each case with the same care she would towards a close friend or family member. She strives for excellence in all that she does, an example of this being sharing key information with the rest of the admin team of how we can make our service more accessible by signposting us to the Health Warning Cards available in different languages.

Through Carol's keen attention to detail and her openness, demonstrated by her having time to speak to colleagues about issues, work is a much easier place to be. I am grateful for Carol every day, and I know the rest of the team is too!

**Eleanor Katsarelis, Recruitment Advisor** **York** **Nominated by colleague**

I have recently done my first round of recruiting for staff in the Trust and was unfamiliar with working with TRAC and the process of advertising, interviewing, and appointing staff. Eleanor has been so supportive. She has always been happy to help and at the end of the phone for me, no matter how small the question. Her knowledge and experience have been invaluable to me.

Our staff behind the scenes are vitally important to our Trust. Eleanor deserves to be recognised as she has made my learning journey so much easier.

**Kimberly Wright, Medical Secretary** **York** **Nominated by colleague**

Kim has worked for the Trust for many years. She goes above and beyond and ensures all patient queries, whether they are related to oncology or not, are followed up and dealt with in a timely manner. She is approachable and always willing to help. She is a valued member of the team.

**Julia Shannon, Consultant Radiographer** **York** **Nominated by colleague**

The breast imaging unit has had a limited number of radiologists and consultant radiographers due staff sickness and annual leave. Julia has worked tirelessly to keep the service going, coming in early and leaving late so patients get a prompt diagnosis and receive their results without delay. Julia is a valuable member of the team, and we appreciate her.

**Helen Shannon, Consultant Radiographer** **York** **Nominated by colleague**

The breast imaging unit has had a limited number of radiologists and consultant radiographers due staff sickness and annual leave. Helen has worked tirelessly to keep the service going by covering her colleagues' clinics, so patients get a prompt diagnosis and receive their results without delay. Helen is a valuable member of the team, and we appreciate her.

**Jyotirmoy Pal, Consultant in Neurology** | **York** | **Nominated by patient**

I want to say thank you for Dr Pal's professionalism and caring. Also, a thank you to the pleasant and understanding nurse who was there. I have a serious speech impediment, but they were understanding and helpful.

**Ben Steel, Service Co-ordinator** | **White Cross Court** | **Nominated by colleague**

In the face of staff shortages and the service being stretched, Ben has been vital as a service co-ordinator. He has gone above and beyond, working late to ensure the service continues to run smoothly. His hard work has been noticed by more than just me.

**Aseptics Team** | **York** | **Nominated by colleague**

The Aseptics Team received a prescription from eye theatres at 4pm on a Friday afternoon. The prescription was needed urgently as the patient was about to lose their one working eye. Documentation was not in place to make this medication, so the team had to research and liaise with another trust to secure the aseptic method needed to make the product. The team stayed behind their working hours to fulfil the prescription.

**Ward 14** | **York** | **Nominated by relatives**

My son has had four stays on Ward 14 in the last six months. He is quadriplegic with a mild learning disability and needs 1:1 for all physical needs. I always stay with him as it is difficult for staff to provide this support.

I have nominated them as their care and support has been second to none. On days when I have struggled, they have supported me physically and emotionally. They have shown immense understanding and respect for me as a parent of someone with complex needs, which made the experience much calmer for me and my partner. They are an exceptional team who deserve recognition.

**Rebecca Long, Deputy Sister** | **York** | **Nominated by colleague**

Rebecca always goes above and beyond to improve a patient's experience. Rebecca is a credit to the Ward 15 team.

**Sara Stockill, Maternity Support Worker** | **Scarborough** | **Nominated by colleague**

Sara went above and beyond on a shift. A patient had escaped from another ward and security were struggling to get them off the corridor and back to the ward. They were becoming aggressive and stressed.

Sara calmly sat next to them and communicated to them that she understood and was listening to them. Sara safely defused the situation, escorted them back on the ward, and ensured they were safe and listened too. Sara went above and beyond her role and demonstrated her caring and empathetic nature.

**Gabrielle Lawson, Advanced Nurse Practitioner** **Scarborough** **Nominated by relative**

I recently had a late-night trip to ED with my young child about an injury they sustained on their arm. I was greeted at reception by Gabbie who was reassuring, kind, informative, and understanding of having a tired toddler with an injury.

After having a previous traumatic episode at the hospital with my child, Gabbie made me feel heard and reassured and ensured that we were going to be looked after. She was warm and welcoming and made my child giggle. She was professional and ensured we got seen as quickly as possible and then sent home. Gabbie made our experience a lot easier to manage and I felt supported by her. Thank you.

**Aimee Fearby, Sister** **Scarborough** **Nominated by relative**

I arrived at ED with my young child late one evening, and it was Aimee who I saw to consult and evaluate my child. Aimee was amazing with my child and reassured them throughout the examination. She was thorough and professional and kept checking that me and my child were okay.

Aimee was kind and understanding after having a recent traumatic experience at the hospital. She explained everything in detail and made my child laugh. We left the hospital feeling heard, thoroughly checked over, reassured, positive, and cared for. Aimee made a stressful experience a positive one. Thank you.

**Mike Minihan, Community Nurse** **York** **Nominated by relative**

Mike continually goes above and beyond for us. From making sure we can get things such as syringes and medication at a moment's notice, to coming in on his day off to administer chemotherapy to our daughter to save us having to travel to Leeds. He has a kind and caring manner and is always friendly.

We feel lucky to have Mike as our community nurse. We could not ask for a better nurse. He is deserving of this Star Award!

**Ted Maywood, Cleaning Operative** **York** **Nominated by colleague**

Ted was so polite, friendly, and extremely thorough in his work that patients commented to me how good he was. He works hard and takes pride in the work he does to make the hospital nicer for patients.

**Diane Barnham, Catherine Martin and Teresa Bradshaw, Discharge Liaison Officers** | **Scarborough** | **Nominated by colleague**

Diane and Cat have been doing a lot of work in ED to prevent patients being admitted if they are there for social care reasons. They have liaised with different local authorities to get emergency care at home or an emergency placement. They have seen over 434 patients over the past year, and, of those patients, 36 patients went home with care reinstated, 23 returned to care homes or went to a new care home, 10 were admitted to rehab beds, 10 needed new equipment which was delivered same day, and 31 went directly to BCU to await further care.

Teresa is the admin for the discharge command centre, and she supplies all the relevant information to Cat and Di, from changes in condition to research she has done on GP connect. These three exceptional members of the team have made a tangible difference to ED, taking pressures off the staff.

**Charlotte Porthouse, Skin Cancer Clinical Nurse Specialist** | **York** | **Nominated by colleague**

Charlotte has been with the skin cancer CNS team for 16 months. Throughout her time with the team, she has provided excellent support to many patients with advanced skin cancer. While supporting a patient with a young family through their palliative cancer journey, Charlotte maintained regular contact with the patient who was struggling to accept their prognosis and encouraged them to seek support for their partner and young family.

I witnessed Charlotte speaking with the patient on the telephone and showing kindness and support, while also encouraging the patient to acknowledge their potentially short prognosis and helping them to consider options of support for their family. Charlotte has also acted as advocate for the patient several times in relation to symptom control and has made a positive impact on the patient's journey.

**Surgery Day Unit** | **York** | **Nominated by patient**

I had a kidney stone removal operation on Mother's Day. I thought the staff would not be happy to be stuck at work on Mother's Day, but they were all amazing. Megan was my main nurse, along with other nurses on her team, and it felt like I was receiving private health care. They were fabulous, funny, and always smiling. The anaesthetist had a great sense of humour too and put me at ease. He was friendly and welcoming.

Overall, it felt more like a day out than an operation, so thank you to everyone involved in getting me back to being me.

**Jake Taylor, Senior Physiotherapist** **York** **Nominated by colleague**

I am nominating Jake for a Star Award in recognition of his outstanding dedication, professionalism, and kindness. Jake consistently goes above and beyond in his role, demonstrating an exceptional work ethic and commitment to patient care. Jake is an incredibly hardworking individual who not only manages his own caseload, but also willingly takes on additional work to support his colleagues.

Over the past year the team have faced significant challenges and, despite being new to the team, Jake has really carried the clinical work, as well as supporting four students. Jake is always the first to offer help despite being busy himself. His positive attitude and team spirit make him a hugely valued member of the team and his willingness to help others ensures that patients always receive the highest standard of care.

The feedback Jake receives from his patients speaks volumes about the impact he has. Patients describe him as kind, caring, and highly professional. Many have expressed their gratitude via PREMS feedback, stating that his expertise and compassionate approach have significantly improved their wellbeing. I was approached by a patient to pass on feedback that Jake was “an asset to the NHS” and I often overhear positive feedback from his patients as they leave his appointment, including saying that he has “made their day”.

Jake embodies the values of the Trust, consistently putting patients first and ensuring they feel supported and valued. His dedication, compassion, and exceptional service make him truly deserving of this recognition, as he represents the best of what healthcare should be. I do not think you could find a more caring or kinder person in this organisation, nor one with a stronger deadlift!

**Isabel Coe, Clinic Manager** **York** **Nominated by colleague**

Isabel is an exceptional and integral member of the Outpatient Services team, consistently demonstrating expertise, dedication, and professionalism in her role. Her knowledge and work ethic set a high standard, and she consistently delivers outstanding service, ensuring that both patients and care groups receive the highest quality of care. As a result, Isabel has earned a well-deserved reputation for being a reliable, competent, and trusted professional within the department.

In addition to her daily responsibilities, Isabel has been instrumental in driving operational excellence within Outpatient Services. She has played a key role in identifying, conceptualising, and implementing a variety of process improvements aimed at enhancing patient care pathways, inter-departmental collaboration, and overall service delivery. Her ability to document, suggest, and oversee such improvements has significantly advanced patient safety protocols and streamlined workflows, resulting in more efficient and effective patient outcomes. Isabel's leadership extends beyond her formal role, particularly through her exceptional contributions to staff development. As a reverse mentor, she has provided invaluable guidance and support to me as a new team member, offering a wealth of knowledge while embodying the core values of the Trust: kindness, openness, and excellence.

Isabel's contributions reflect not only her technical expertise, but also her unwavering commitment to fostering a collaborative, compassionate, and high-performance work environment. She has demonstrated outstanding leadership, initiative, and a steadfast dedication to the values of patient-centred care, making her an irreplaceable member of the team and a true asset to the organisation. Thank you, Izzy!

**Roman Matusik, Imaging Support Worker** **York** **Nominated by colleague**

Roman is an incredibly polite, kind, and friendly man. He always says hello and asks how people are doing, he checks in with patients and staff to make sure they are okay, and there is no job too big or small. He completes his tasks with excellence, and he never complains. Roman not only upholds the Trust values but exceeds them. He does this even through the little things such as coming up to the desk and telling one of his dad jokes to lift our spirits when it is a busy day, offering to cover his team members, or do favours for others, even during his breaks.

Roman has been a personal source of comfort and joy for me, and we are always happy when we know that Roman is on duty in Radiology as we know that we deal with a hardworking, optimistic, and brilliant colleague.

**Katie Pargeter, Speech and Language Therapist** **York** **Nominated by colleague**

Katie supported the York SCBU team with a pre-shift ward visit to assess feeding safety. She established a safe feeding method and handed over to the nursing team, who praised her knowledge and support. Notably, this service is currently unfunded.

**Dean Ingram, Storekeeper** **York** **Nominated by colleague**

Dean provided his support to the theatre department sourcing specific needles for a pain list. Dean searched many departments in the hospital and successfully located a box which saved a theatre list of fifteen patients from being cancelled.

**Donna Ginders, Sister, Early Pregnancy Assessment Unit** **Scarborough** **Nominated by patient**

Donna has helped me through my current pregnancy and my last pregnancy which ended in miscarriage. When my partner was unable to attend scans last time, she came in with me, so I did not have to face them alone. She was there to hold my hand when I found out my last baby had died. She has been available on the phone for me every time I have been worried about my baby this time. Donna has booked me in for scans to stop me from worrying about my baby. She is kind, caring, and lovely. I could not do pregnancy without her. She is a credit to the team. Everyone who works on the unit are amazing, but not everyone is Donna.

**Marilyn (Marcee) Tenorio, Switchboard Operator** **Scarborough** **Nominated by colleague**

The multitone bleep system went down in Switchboard at Scarborough Hospital overnight and Marcee had to follow the BCP for the first time, in real time. She worked fantastically under pressure, as this meant she needed to contact members of the medical emergency teams to come and collect the back-up radios.

Her communication was excellent, and she kept all the necessary staff informed.

**Isobel Smith, Midwife** **Scarborough** **Nominated by patient**

From the moment Isobel came and introduced herself as our midwife, until the very end when we were taken back to the ward from the operating room, she was amazing. Isobel could not have been more attentive throughout the whole procedure; she recognised I was anxious about the Caesarean and really helped to reassure me all the way through. Both in the operating room and in recovery her care was exceptional, and I cannot thank you enough for making the whole experience just that little bit easier for us. You honestly deserve this Star Award so much and you are an absolute credit to the maternity team.

Thank you so much again for your amazing care.

**Marija Laurineniene, Cleaning Operative** **York** **Nominated by colleague**

Marija was sent from York Hospital to cover a full day shift at Harrogate Renal Unit at the beginning of March 2025.

As a domestic manager for community sites, I often go to those sites to carry out management checks on domestic services, receive feedback from staff and provide any assistance and support from the domestic services perspective where possible to both clinical and domestic staff.

On that day, I happened to visit and meet her. After carefully checking the areas, talking to the admin and some clinical staff on shift, going through trending issues and cleanliness monitoring rectification sheets, I briefed her on what she could focus on during her shift. Her immediate reaction was full of positivity and enthusiasm. Not only that, but she also pointed out other things that could be done to bring improvement in terms of cleanliness. Then she demonstrated how it could be done with limited resources available.

It normally needs a scrubber to clean the hard surfaces, mainly the busy areas such as entrance areas and corridors, as they are quicker and more effective. It often needs to be requested and arranged through the domestic office based at York Hospital, and sometimes it faces logistical challenges, causing delays. But then she kept going on and on until she finished the main entrance and the other areas that were identified. She skipped her usual break, and the result was so impressive that even the staff who witnessed it were amazed.

One of the permanent unit staff, who was once a domestic assistant, was so surprised by her initiative and work ethic. During my initial briefing, I asked her to focus on certain points of the rectification sheet as it would take a few more shifts to complete due to time constraints, as they must carry them out in addition to their normal duties.

I asked her to initial and sign next to each serial once done, and the rest would be continued by the next shift personnel. She said she would try her best to finish them. I was really impressed with her willingness, can-do attitude and positivity. I said I would be super surprised if she did that as well as other things I asked her to do during her shift. But the next day, that rectification sheet was completed and handed in to the domestic office by her. Next time I went there, everything I asked her to do was completed immaculately, and the feedback from the unit staff were commendable. They not only praised but also asked if she could be sent regularly.

The unit looked a lot cleaner and brighter, and the cleanliness inspection result improved. I strongly recommend her to be recognised and receive at least a Star Award.

**Katie Dickson-Wright, Clinical Nurse Specialist** **Community** **Nominated by colleague**

Katie has gone above and beyond when trying to get treatment for one of her long-term patients. This has included getting in touch with other trusts to try and get treatment when this patient was out of area for a short time. Katie has contacted other agencies to always ensure the safety of this patient. She has arranged multiple appointments, even when the patient has struggled to attend or did not attend, she never gave up in getting the correct treatment for her patient. She collected the patient and brought her to treatment appointment s to ensure the patient received the help and treatment she required. She is a credit to her service and is the reason this patient has received the correct treatment.

**Jenifer Simpson, Healthcare Assistant** | **Scarborough** | **Nominated by colleague**

I had the pleasure of working with Jenifer on a long day during a bank shift. Jenifer was so welcoming and extremely helpful with both patients and members of staff. Nothing was too much; Jenifer was thorough with patient care and ensuring all work had been completed and that everything was up to date. Many of the patients under my care that day had mentioned to me how nice Jenifer had been with them, and I agree, Jenifer is a credit to Oak Ward.

**Giss Thomas, Staff Nurse** | **York** | **Nominated by patient**

What an amazing young lady. she has been looking after me on ward 16a. She is tireless and nothing is too much trouble. She is considerate and always carries a torch so when on night shift she does not blind us patients with putting the light on. When she is on duty the ward is peaceful, and everything gets done.

**Kurt Edwards, Healthcare Science Support Worker (Higher)** | **York** | **Nominated by colleague**

Always helpful, going above and beyond with the Dental Nursing team when we need to liaise with the Lab for our patient's lab work. I feel it would be lovely for him to receive his first Star Award.

**Levi Pettit, Community Staff Nurse** | **Community** | **Nominated by colleague**

Levi joined our team as a newly qualified staff nurse in October. Since she joined, she has been consistently wonderful. She is a fabulous nurse and such an asset to our team. Levi works well beyond her level and works thoroughly to help our patients get the best outcome from their care.

She is kind and dedicated and I am so proud of how far she has come.

**Sally Wilson, Maternity Support Worker** | **Scarborough** | **Nominated by a colleague**

Sally has gone out of her way to help support our staff on the Maternity Wards. She has undergone POCT trainer training to be able to train staff on the wards to support the education team who have been unable to facilitate this due to increased capacity. Her dedication to her colleagues and willingness to support the wider team is commendable. Every team needs a Sally.

**Magdalena (Magda) Aleksiuk, Healthcare Assistant** | **York** | **Nominated by colleague**

Magda as we call her on the ward, is an exceptional team member. She sets the bar high for other members of the team by providing high standard of care to patient and their families. She had positive attitude towards work and passionate about patients care. Her communication skills are top notch and committed to patient care and safety. Nothing is too difficult or challenging for her even though she is pregnant. She is disciplined and a loving person to work with.

Ward 16 is privileged to have her as a team member.

**Kirsty Williams, Healthcare Support Worker** **Scarborough** **Nominated by a colleague**

Always there when people need her and always willing to help in any way she can. Makes a hard Ward easier to be on.

**Jason Angus, Healthcare Assistant** **York** **Nominated by relative**

We came into the Emergency Department with our 1-year-old who we were really concerned about in the evening. The whole team were approachable and caring; however, Jason went above and beyond to not only make Louie comfortable and smile but to comfort us as parents as well. He checked in on us multiple times throughout the hours, found that Louie loves bubbles and constantly blew them to cheer him up. Louie's temperature was high, and I was worried about him sleeping in the hot room, Jason did not hesitate to take my concern seriously and brought us a fan for the cubicle immediately. He came with toys, snacks, drinks and anything we could possibly need.

It was so clear to see how much passion he has for helping others, he does anything in his power to try to put a smile on the face of not only the patient but the families, in what can be a scary time.

York Hospital is so lucky to have him as part of their team and if we are to visit again, I would be absolutely delighted to see him as I know we would be in good hands. Thank you, Jason, for making an uneasy time a little easier, you are a pleasure to encounter.

**Evie Newsham, Acute NIV Specialist Nurse** **York** **Nominated by relative**

My dad was admitted into resus with COPD and pneumonia and was not in a good way. There was talk of going to ICU and things were going downhill rapidly. All the team caring for him were excellent.

Evie introduced herself and clearly explained the plan for Dad. She was focused and calm and her professional skills and knowledge were clearly phenomenal. She also found time to keep me fully informed. What really stood out, was when my dad started to respond to treatment, Evie's style of care shifted to what was then needed. From being slick and clinical, she could adapt to being kind and caring. From being clear clinically with me when he was acutely ill, she then took time to make Dad laugh and make him comfortable. She was patient and family-focused, with a human touch. She saved my dad's life and saved my sanity along the way.

**Oncology Junior Medical Team** **York** **Nominated by colleague**

I would like to nominate all the oncology junior doctors, PAs, and pharmacists (Mohamed Abdelmoneim, Benjamin Nelson, Fiona James, Justin Liu, Kiandokht Monjezi, Chloe Robinson, Martin Atkinson, Michal Sladkowski, and Chloe Waterson) for their continual hard work. Over the past six months, staffing has been a challenge, but they have pulled together and worked as a team to make sure our ward, acute services, and outpatient clinics are running, helping support our oncologists with the ever-rising workload. Our junior team are a real asset to the department and deserve to be recognised for their ongoing dedication.

**Women's Unit** **Scarborough** **Nominated by colleague**

This nomination is for the amazing work that the staff do within the Women's Unit. It is also for their kindness, patience, and understanding for both patients and staff that I was privileged to witness during recent spoke days that I attended at the unit.

**Outpatients Department** **Scarborough** **Nominated by colleague**

I am nominating the Scarborough Outpatients Department staff for their hard work every day, ensuring patients receive the care they need. It is also for being welcoming, kind, and understanding during my recent placement with them.

**Marcus Moore, Speciality Doctor, Jade MacKenzie, Operating Department Practitioner, and Elspeth Cairney, Staff Nurse** **Scarborough** **Nominated by patient**

From meeting the team to the end of my caesarean, Marcus, Jade and Elspeth were exceptional and I want to say thank you for making the procedure so much more pleasant for both me and my partner. When I arrived in the operating room, they introduced themselves, explained everything thoroughly, and their general chatting helped to distract me as I was anxious.

Marcus was brilliant, explaining everything he was doing when giving the spinal and again throughout the whole procedure, making sure I knew what was happening and that I was okay. Elsie was dabbing my face with water and utilising equipment by using a sick bowl as a fan which made us laugh. She was also a top photographer to make sure we had those memories of our daughter being born to treasure forever. Jade was fabulous too, reassuring me and again making sure I was okay with her favourite blood pressure cuff.

The care was outstanding, and I cannot thank you enough for making the whole experience more bearable. You are amazing and deserve so much credit for what you do. Thank you so much.

**Facilities Management Helpdesk** **York** **Nominated by colleague**

From start to finish, the Facilities Management Helpdesk team have been amazing to work with. I will be sad to leave such an amazing group of people.

Item 8

# Committee Report

| | |
|---|---|
| **Report from:** | Quality Committee |
| **Date of meeting:** | 22nd April 2025 |
| **Chair:** | Steve Holmberg |

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

| **ALERT** |
|---|
| |
| **ASSURE** |
| **Internal Audit –** Significant assurance from all recent investigations. Results reflective of strengthened relationship between audit and service teams |

| **ADVISE** |
|---|
| **Maternity –** Committee approved Section 31 submission. Committee noted low in-month number of PPH cases and progress on work to strengthen risk assessment. Committee discussed reasons underlying high rate of non-elective LSCS (notably at SGH). Further data requested but Committee noted that some elective procedures become non-elective due to pressure on theatre time. Trust noted to be an outlier in terms of MIS compliance. Potentially, £1M could be refunded to the Trust but this would require that staffing shortfall was funded<br><br>**Nurse Workforce & Fundamentals of Care –** Committee received report and received assurance about progress on care standards<br><br>**Care Strategy –** Committee received and approved latest draft<br><br>**Patient Experience –** Committee received latest report and noted on-going progress |
| **RISKS DISCUSSED AND NEW RISKS IDENTIFIED** |
| **Medicine CG –** UEC: Progress against 4 hour EC standard remains disappointing but Trust plans have been supported by ICS and Region. Metrics being tracked are:<br>Average Ambulance Handover Time<br>10 hour 'stay' in ED<br>No criteria to reside<br>Length of stay<br>Concern that major metric improvements are timed for last 2 months of Q4<br><br>Challenges to services – Gastroenterology medical staffing issues<br><br>Cardiology medical staffing and clinical pathway issues particularly affecting RACP<br>Palliative Care – New consultant appointed at SGH to support 7 day service |

# Committee Report

| | |
|---|---|
| **Report from:** | **Resources Committee** |
| **Date of meeting:** | **15 April 2025** |
| **Chair:** | **Jim Dillon** |

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

| **ALERT** |
|---|
| ▪ March Emergency Care Standard position was 65.1% against a target of 78%.<br>▪ March Type 1 attendances risen to 350 compared to December to February average of 338.<br>▪ Type 1 attendances comparatively low but type 3 attendances increased by 1,000<br>▪ 12 hour plus trolley waits up to 539from 433 In February.<br>▪ Cancer 62 day waits for 1st treatment was 68.8% a deterioration from 70.6% in January however monthly trajectory of 65.1% was achieved.<br>▪ Backlogs in Cardiac care due to recurring faults in CT equipment<br>▪ Health Care Worker recruitment being hindered by changes introduced to the threshold for approving Visa applications<br>▪ £35m efficiency savings to be delivered however only around 40% of these expected to be recurring |
| **ASSURE** |
| ▪ Average Ambulance handover in March reduced significantly to 30 minutes 8 seconds<br>▪ W45 went live on 5th March positively impacting performance<br>▪ Proportion of type1 attendances spending 12+ hours in ED improved to 15.6% which is the best performance since July 2023<br>▪ Improvement in the 28 day Faster Diagnosis Standard for Cancer to 72.1% compared to 62.2% in January.<br>▪ Reduction in overall Agency spend to £14.8m. This is below the Cap of £17.4m for the first time. |

| ADVISE |
| --- |
| ▪ North Yorkshire and York Coordination Hub to be discontinued at the end of April as too costly due to GP expenses.<br>▪ Acute Assessment as part of a number of Task and Finish groups set up to improve patient flow<br>▪ Lost beds due to NCTR continues to increase despite reduction in proportion of patients not meeting the criteria<br>▪ Medical and Dental recruitment challenging due to national situation where not enough consultants to meet demand<br>▪ Action plan to respond to disappointing and concerning staff survey results progressing and to be presented at the next resources committee<br>▪ Trust no longer under a Direct Support Programme for non registered nursing staff. |
| **RISKS DISCUSSED AND NEW RISKS IDENTIFIED** |
| No new significant risks identified |

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 10

# TRUST PRIORITIES REPORT

April 2025

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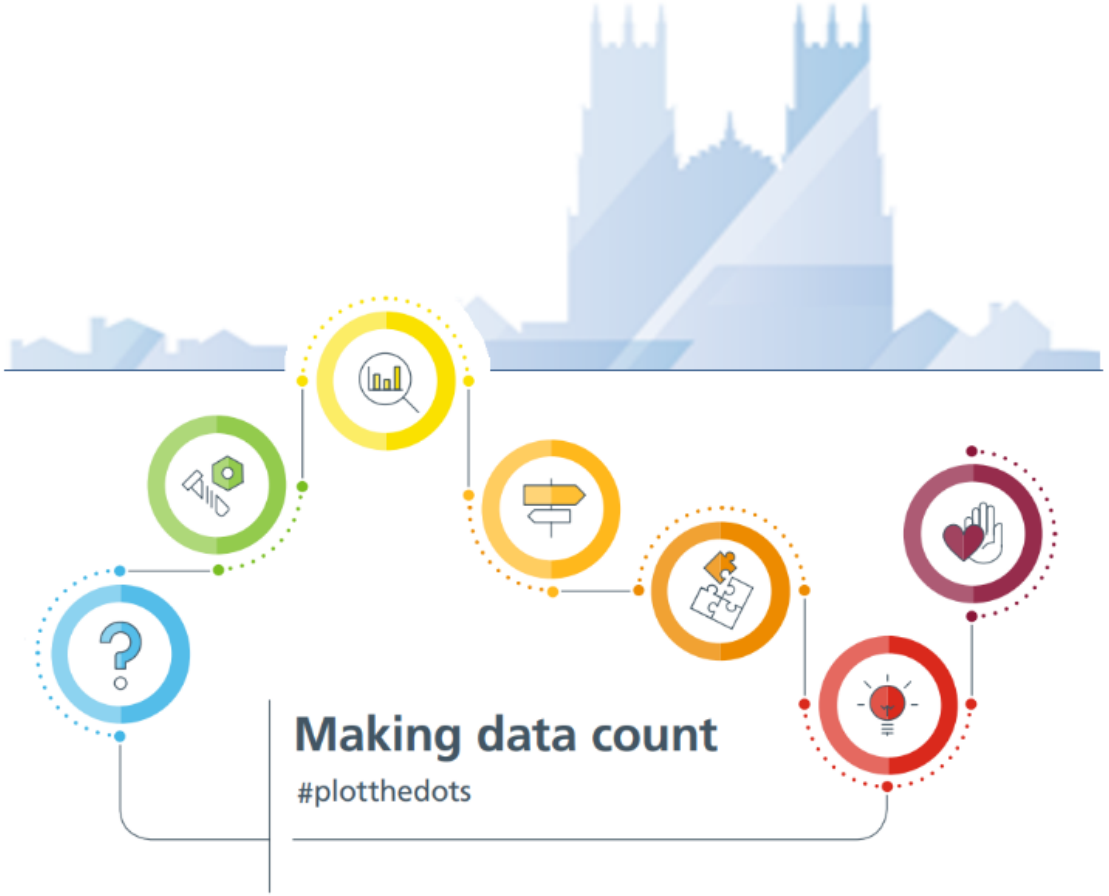
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust





# Executive Summary

## Priority Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| ED - Ambulance average handover time (number of minutes) | 2025-03 | | | 30 | 50 | 50 |
| ED - Median Time to Initial Assessment (Minutes) | 2025-03 | | | 4 | | 18 |
| ED - Emergency Care Standard (Trust level) | 2025-03 | | | 65.1% | 78% | 78% |
| ED - Total waiting 12+ hours - Proportion of all Type 1 attendances | 2025-03 | | | 15.6% | | 7.5% |
| ED - 12 hour trolley waits | 2025-03 | | | 539 | | 0 |
| Cancer - Faster Diagnosis Standard | 2025-02 | | | 72.1% | 74% | 77% |
| Cancer - 62 Day First Definitive Treatment Standard | 2025-02 | | | 66.8% | 65.1% | 70% |
| RTT - Total Waiting List | 2025-03 | | | 46605 | 44663 | 44663 |
| RTT - Waits over 65 weeks for Incomplete Pathways | 2025-03 | | | 40 | 0 | 0 |

**Executive Summary:**

The March 2025 Emergency Care Standard (ECS) position was 65.1%, against the monthly target of 78%.

Average ambulance handover time in March 2025 reduced significantly to 30 minutes 8 seconds. The target was below 50 minutes. York ED handover average was 27 minutes 15 seconds, showing real improvement. Average ambulance handover time is calculated by taking the total combined handover times divided by the number of ambulances that attended the Trust's Emergency Departments.

Please note; in line with national reporting deadlines cancer reporting runs one month behind. The Cancer performance figures for February 2025 saw an improvement in the 28-day Faster Diagnosis standard (FDS) to 72.1% (compared to 62.2% in January 2025) however this failed to achieve the monthly improvement trajectory of 74%.

62 Day waits for first treatment February 2025 performance was 66.8% a deterioration on the 70.6% seen in January 2025, however the monthly trajectory of 65.1% was achieved. 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.

At the end of March 2025, the Trust had forty Referral To Treatment (RTT) patients waiting over sixty-five weeks.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

# OPERATIONAL ACTIVITY AND PERFORMANCE

April 2025

**Headlines:**

- The March 2025 Emergency Care Standard (ECS) position was 65.1%, against the monthly target of 78%.

- Average ambulance handover time in March 2025 reduced significantly to 30 minutes 8 seconds. The target was below 50 minutes. York ED handover average was 27 minutes 15 seconds, showing real improvement. Average ambulance handover time is calculated by taking the total combined handover times divided by the number of ambulances that attended the Trust's Emergency Departments.

**Factors impacting performance:**

- March 2025 saw an increase in the daily average of ambulance arrivals; up to 154 from the December 2024 to February 2025 average of 149.
- W45 ambulance handover went live on 5th March 2025 at York ED which has positively impacted performance.
- March 2025 saw an increase in the daily average of Type 1 attendances at our Emergency Departments; up to 350 from the December to February average of 338.
- There are continued challenges with our local community health and social care capacity.

**Actions:**

- Please see following pages for details.

# Summary MATRIX 1

**Acute Flow:** *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

| VARIATION | ASSURANCE: PASS | ASSURANCE: HIT or MISS | ASSURANCE: FAIL |
|---|---|---|---|
| SPECIAL CAUSE IMPROVEMENT | * ED - Median Time to Initial Assessment (Minutes) | * ED - Emergency Care Attendances<br>* ED - A&E Attendances - Types 2 & 3 | * ED - Proportion of all attendances having an initial assessment within 15 mins |
| COMMON CAUSE / NATURAL VARIATION | * Proportion of SDEC admissions transferred to downstream acute wards | * ED - A&E attendances - Type 1<br>* ED - Proportion of Ambulance handovers waiting > 240 mins<br>* ED - Ambulance average handover time (number of minutes) | * ED - Proportion of all attendances seen by a Doctor within 60 mins<br>* ED - Total waiting 12+ hours - Proportion of all Type 1 attendances<br>* ED - 12 hour trolley waits<br>* ED - Emergency Care Standard (Type 1 level)<br>* ED - Proportion of Ambulance handovers within 15 mins<br>* ED - Proportion of Ambulance handovers waiting > 30 mins<br>* ED - Proportion of Ambulance handovers waiting > 45 mins |
| SPECIAL CAUSE CONCERN | | | * ED - Emergency Care Standard (Trust level) |

# Acute Flow (1)
## Scorecard

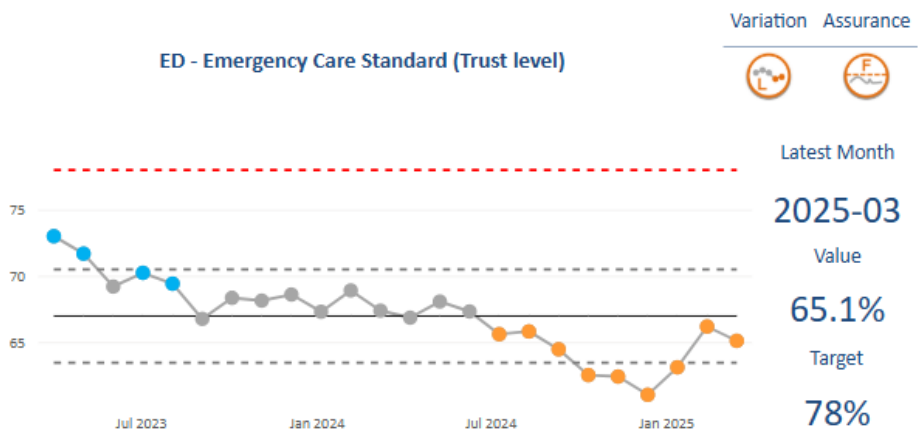
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| ED - Proportion of all attendances having an initial assessment within 15 mins | 2025-03 | H | F | 71.2% | | 66% |
| ED - Proportion of all attendances seen by a Doctor within 60 mins | 2025-03 | | F | 26.5% | | 55% |
| ED - Total waiting 12+ hours - Proportion of all Type 1 attendances | 2025-03 | | F | 15.6% | | 7.5% |
| ED - Total waiting 12+ hours - Actual number of all Type 1 attendances | 2025-03 | | | 1699 | | |
| ED - 12 hour trolley waits | 2025-03 | | F | 539 | | 0 |
| ED - Emergency Care Attendances | 2025-03 | L | ? | 18401 | 17807 | 17807 |
| ED - Emergency Care Standard (Trust level) | 2025-03 | L | F | 65.1% | 78% | 78% |
| ED - A&E attendances - Type 1 | 2025-03 | | ? | 10854 | 10423 | 10423 |
| ED - Emergency Care Standard (Type 1 level) | 2025-03 | | F | 43.6% | 66% | 66% |
| ED - A&E Attendances - Types 2 & 3 | 2025-03 | L | ? | 7547 | 7384 | 7384 |
| ED - Median Time to Initial Assessment (Minutes) | 2025-03 | L | P | 4 | | 18 |
| ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only | 2025-03 | | | 45.3% | | |
| Proportion of SDEC attendances transferred from ED | 2025-03 | | | 66.3% | | |
| Proportion of SDEC attendances transferred from GP | 2025-03 | | | 24.5% | | |
| Proportion of ED attendances streamed to SDEC Within 60 mins | 2025-03 | | | 50.1% | | |
| Proportion of SDEC admissions transferred to downstream acute wards | 2025-03 | | P | 13.7% | | 20% |

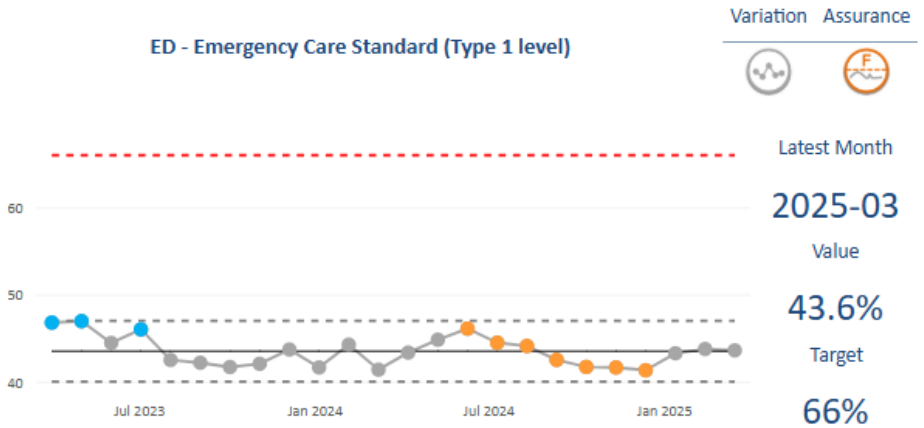
**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi




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 **1.1**.




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 **0.2**.

**Rationale:** To monitor waiting times in Emergency Departments and Urgent Treatment Centres. **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:** Modelling showed that to achieve 78% as a Trust Type 1 performance needs to be at least 66%.

## Actions:

We have refreshed the Unscheduled Care Improvement Programmes (UCIP) and have established a new series of Task and Finish groups to support improvements at our Front Doors and through our in-hospital urgent and emergency care pathways. The groups are as follows:

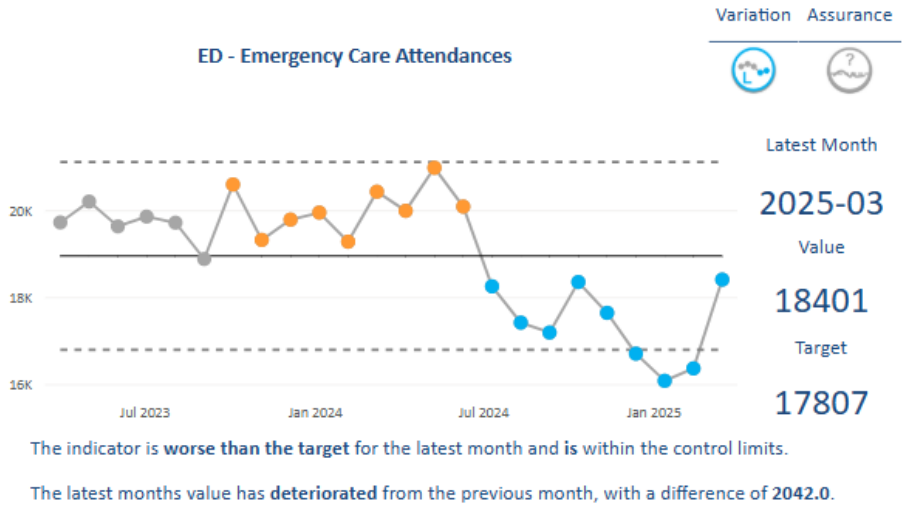
- ED Streaming
- ED processes (including ambulance handovers)
- Urgent Treatment Centres
- Emergency Department Ambulatory Care (EDAC)
- Acute Assessment (including SDEC / Integrated Assessment)
- Workforce Modelling

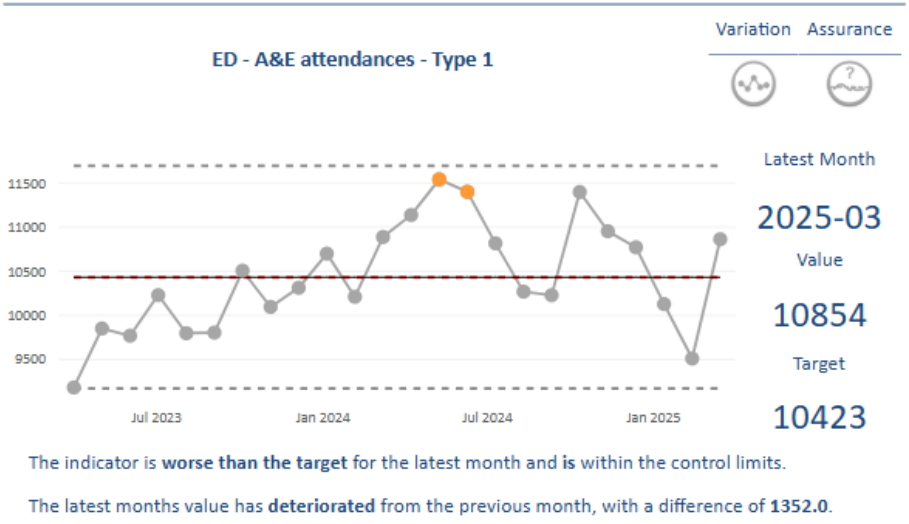
These groups are clinically-led, with multidisciplinary teams from both sites involved in designing and implementing tests of change. Groups will meet at least fortnightly and will be supported by the Programme Management Office. The groups will use hard data alongside frontline views and clinical expertise to make improvements across multiple measures with the goal of improving ECS performance.

An executive-led engagement session has taken place at York to talk through these changes; the Scarborough session is imminent.

**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi




**Rationale: SPC1:** To monitor demand in A&E. **SPC2:**
**Target: SPC1:** Monthly activity plan as per chart. **SPC2:** Monthly activity plan as per chart.

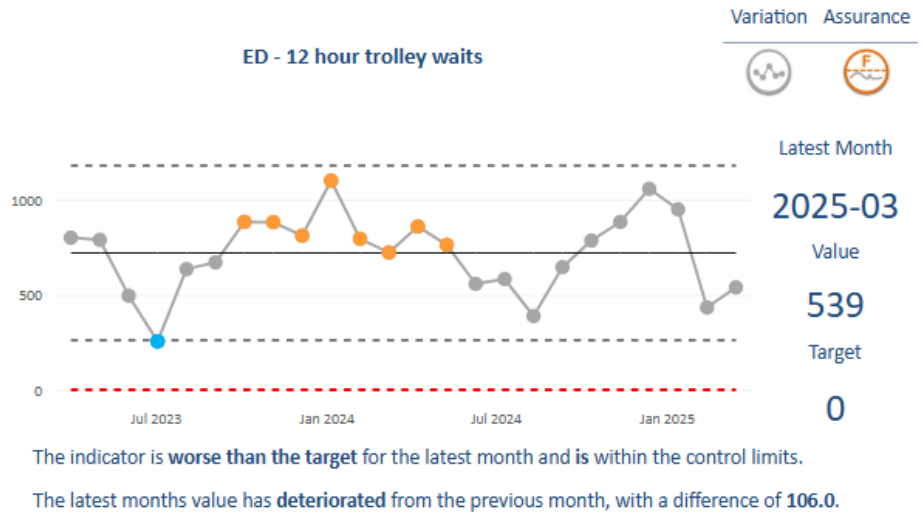
**Actions:**

**Update on the North Yorkshire and York Coordination Hub (YAS-led)**

- The Hub team, led by YAS, was designed as a pilot scheme which takes calls from ambulance crews and gives advice about appropriate alternatives to conveying a patient to the Emergency Department.
- The model demonstrated benefits to multidisciplinary team collaboration but has been costly due to GP expenses.
- Though the proportion of calls leading to an avoided conveyance was high, the overall numbers (<10 per day) were not sufficient for the service to be commissioned on a more permanent basis and the pilot closes at the end of April 2025.
- YAS are putting more clinicians in their operational centre over the next 12 months and are hoping to deploy a read-only version of the clinical stack into partners (e.g. York Frailty Hub) which could provide an opportunity for clinicians in these services to look at the ambulance stack and identify cases they believe would be suitable for their support as and when they have capacity.

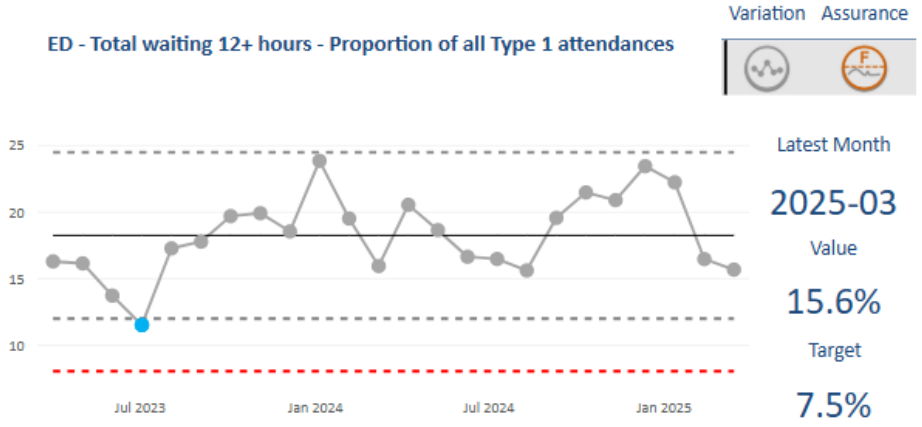
**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi




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 **106.0**.




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 **0.8**.

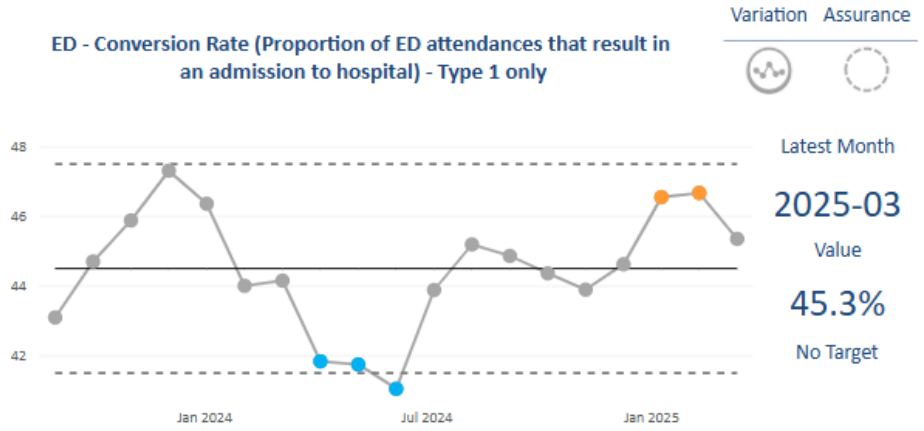
**Rationale:** To monitor long waits in A&E.
**Target:** **SPC1:** Zero patients to wait over 12 hours from decision to admit to being admitted. **SPC2:** Less than 7.5% of patients should wait more than 12 hours.

## Actions:

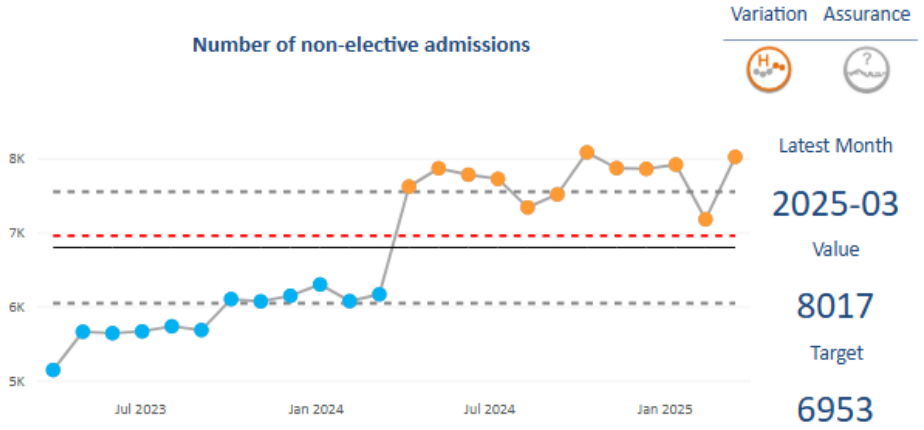
- The proportion of Type 1 patients spending over 12 hours in our Emergency Departments has improved and is in-line with the best performance since July 2023 though further improvement is needed and planned through the task and finish groups.
- Alongside the Continuous Flow standard operating procedure which has been embedded in both acute hospitals, the Trust is planning to design and implement a series of Quality Standards. These standards will focus on keeping patients moving forward in their healthcare journey, with a core principle of no 'backwards' movement, for example no patients being sent 'back' to the Emergency Department after an internal stream or transfer has been agreed.

**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi




The latest months value has **improved** from the previous month, with a difference of **1.4**.




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 **842.0**.

**Rationale: SPC1:** To understand the inpatient demand generated by Emergency Department patients. **SPC2 :** To monitor acute inpatient demand.
**Target: SPC1:** No Target. **SPC2:** Monthly activity plan as per chart.

**Actions**:

- The number of admissions continues to be a challenge; our Acute Assessment task and finish group will support developments to reduce these figures. The group includes clinical and operational representatives from all Care Groups to ensure that the principles of risk sharing are understood and applied across the Trust.

# Acute Flow (2)
## Scorecard

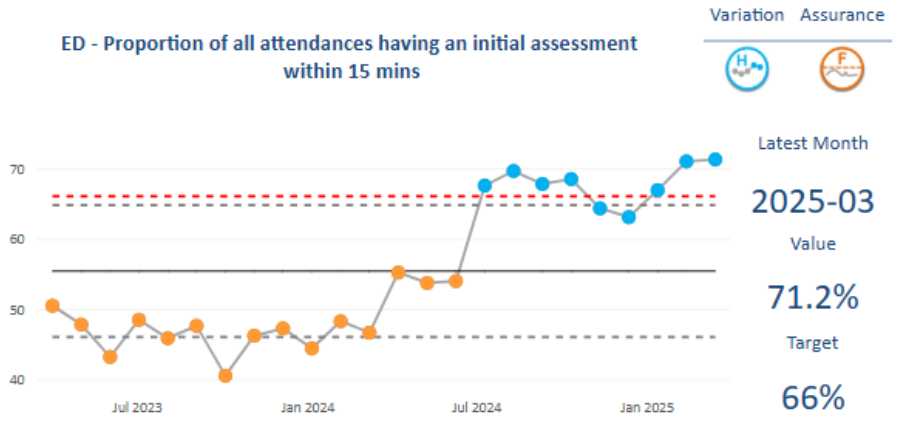
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only | 2025-03 | | | 45.3% | | |
| Number of SDEC attendances | 2025-03 | | | 2543 | | |
| Proportion of SDEC attendances transferred from ED | 2025-03 | | | 66.3% | | |
| Proportion of SDEC attendances transferred from GP | 2025-03 | | | 24.5% | | |
| Proportion of ED attendances streamed to SDEC Within 60 mins | 2025-03 | | | 50.1% | | |
| Proportion of SDEC admissions transferred to downstream acute wards | 2025-03 | | P | 13.7% | | 20% |
| Number of RAFA attendances (York Only) | 2025-03 | | | 164 | | |
| Number of attendances at SAU (York & Scarborough) | 2025-03 | | | 915 | | |
| ED - Proportion of Ambulance handovers within 15 mins | 2025-03 | | F | 32.9% | | 65% |
| ED - Proportion of Ambulance handovers waiting > 30 mins | 2025-03 | | F | 31.6% | | 5% |
| ED - Proportion of Ambulance handovers waiting > 45 mins | 2025-03 | | F | 17.5% | | 10% |
| ED - Proportion of Ambulance handovers waiting > 240 mins | 2025-03 | | ? | 0.3% | | 0% |
| ED - Number of ambulance arrivals | 2025-03 | | | 4731 | | |
| ED - Ambulance average handover time (number of minutes) | 2025-03 | | ? | 30 | 50 | 50 |

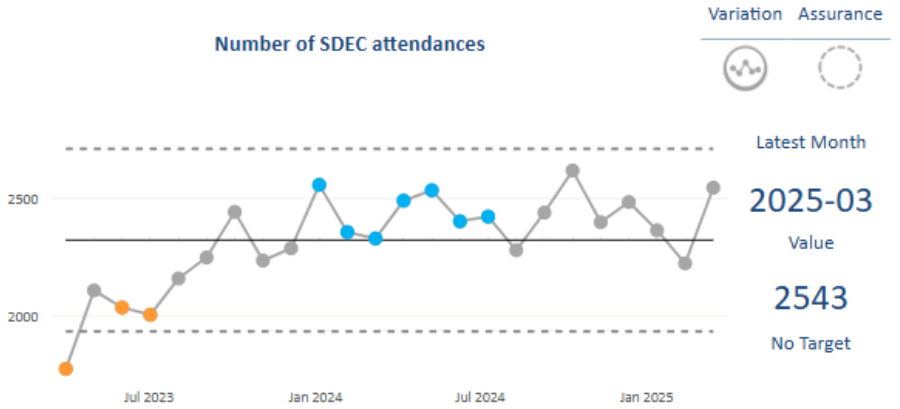
**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi




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

The latest months value has **improved** from the previous month, with a difference of **0.2**.




The latest months value has **improved** from the previous month, with a difference of **322.0**.

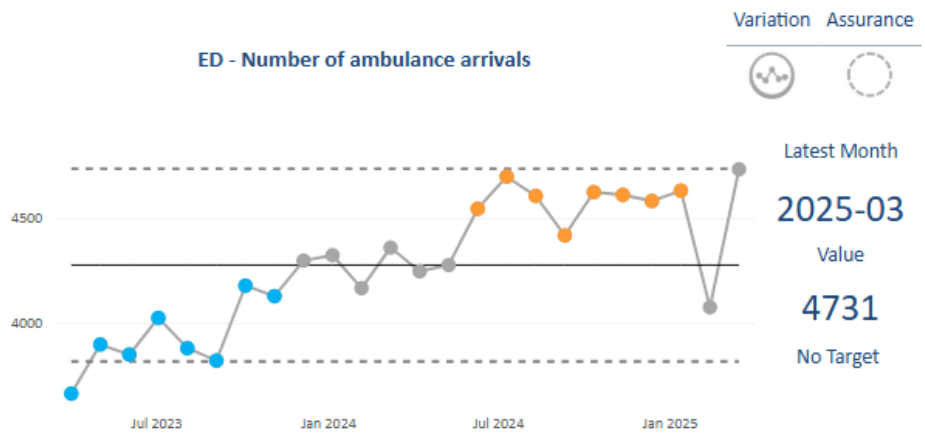
**Rationale: SPC1:** To monitor waiting times in A&E. Patients should be assessed promptly by within 15 minutes of arrival based on chief complaint or suspected diagnosis and acuity. **SPC2:** SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.
**Target: SPC1:** 66% assessed within 15 mins. **SPC2:** No target.

**Actions**:

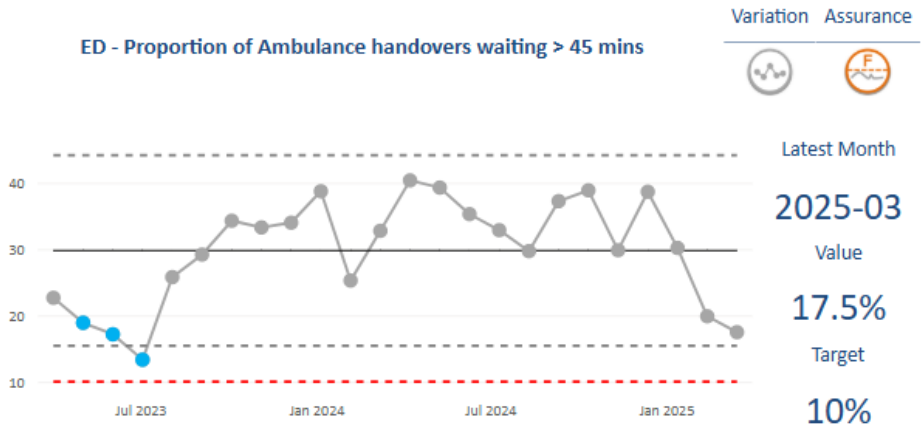
- We continue to exceed the target for the proportion of patients having an initial assessment within 15 minutes of arrival to our Emergency Departments; as the Streaming task and finish group becomes embedded and starts to test changes this figure will be closely monitored.
- Medical SDEC capacity at both sites (but particularly York) continues to be impacted by low numbers of Acute Physicians. The Acute Assessment task and finish group is considering how to start removing 'bringbacks' (i.e. elective) patients from Medical SDEC to free up capacity for more unscheduled care. Workforce support from the regional team to look at rosters, job plans and recruitment is currently being mobilized through trust tiering.
- The Surgical Assessment Unit at York is limited by the facilities available within its footprint. This formed part of the ACTIF estate capital funding, and final configuration to space is being finalized through the acute assessment task and finish group.

**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi




The latest months value has **deteriorated** from the previous month, with a difference of **657.0**.




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 **2.4**.

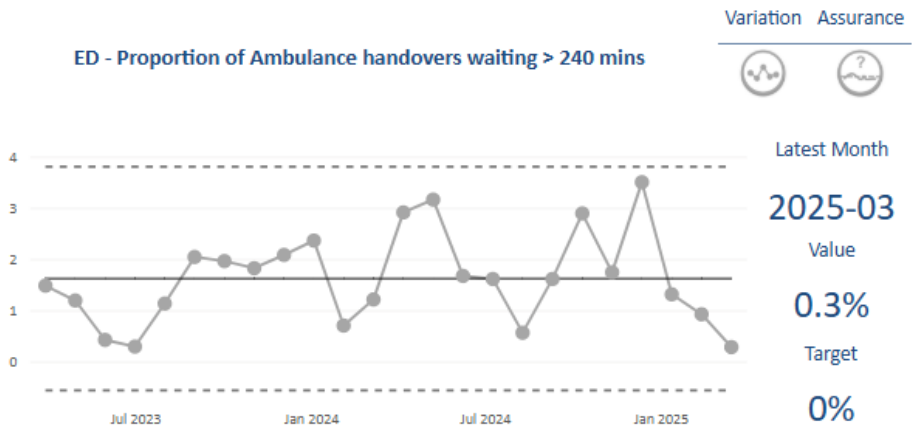
**Rationale: SPC1:** To monitor Ambulance demand in A&E. **SPC2:** Proportion of ambulances which experience a delay in transferring the patient over to the care of ED staff.
**Target: SPC1:** No target. **SPC2:** Patients arriving via an ambulance should be transferred over to the care of ED staff within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

**Actions**:

- March 2025 saw an increase in the daily average of ambulance arrivals; up to 154 compared to the December 2024 to February 2025 average of 149. Despite this pressure, ambulance handover times have decreased significantly. The proportion of handover delays over 45 minutes was the lowest since July 2023.
- The ED Processes task and finish group will include oversight of the ambulance handover processes. As the new trigger points for escalation are introduced at Scarborough and embedded at York, further reductions in handover times are expected.
- Balancing measures are now being considered through the task and finish group; there have been instances of York Emergency Department needing to borrow additional trollies from other parts of the hospital so this unintended impact will be monitored. The Escalation Policy is being amended to add ambulance handover TES spaces to the trigger points for moving to wards.

**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi

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**Rationale: :** Proportion of ambulances which experience a delay in transferring the patient over to the care of ED staff.
**Target:** Patients arriving via an ambulance should be transferred over to the care of ED staff within 15 minutes of arrival, 0% should wait over 240 minutes.

**Actions**:

- As well as the improvements shown on the previous slide, the proportion of ambulance handovers over 4 hours reduced to 0.3% throughout the month. 0.3% equates to 14 ambulances out of 4,731 arrivals during March 2025.

# Summary MATRIX 2

**Acute Flow:** *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

| VARIATION | ASSURANCE: PASS | ASSURANCE: HIT or MISS | ASSURANCE: FAIL |
|---|---|---|---|
| SPECIAL CAUSE IMPROVEMENT | | * Number of zero day length of stay non-elective admitted patients | |
| COMMON CAUSE / NATURAL VARIATION | | * Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside<br>* Overnight general and acute beds open<br>* Of those overnight general and acute beds open, proportion occupied<br>* Community bed occupancy/availability | * Patients receiving clinical Post Take within 14 hours of admission<br>* Inpatients - Proportion of patients discharged before 5pm<br>* Inpatients - Super Stranded Patients, 21+ LoS (Adult) |
| SPECIAL CAUSE CONCERN | | * Number of non-elective admissions | |

# Acute Flow (3)
## Scorecard

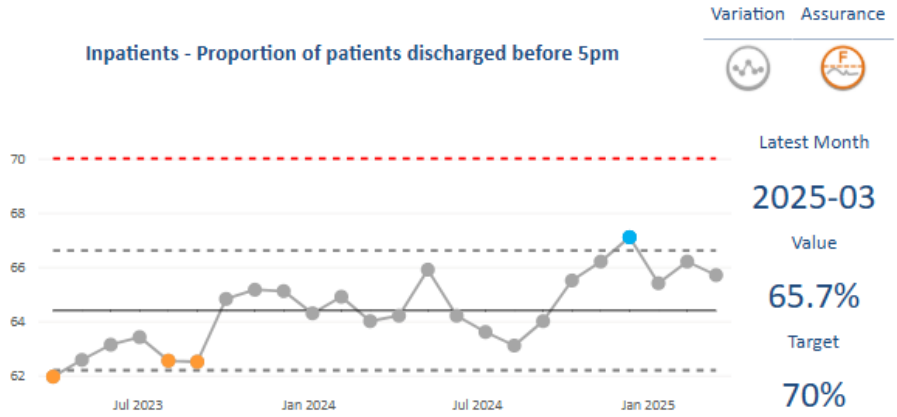
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Patients receiving clinical Post Take within 14 hours of admission | 2025-03 | | F | 80.6% | | 90% |
| Patients with Senior Review completed at 23:59 | 2025-03 | | | 48.3% | | |
| Inpatients - Proportion of patients discharged before 5pm | 2025-03 | | F | 65.7% | | 70% |
| Inpatients - Lost bed days for patients with no criteria to reside | 2025-03 | H | | 1315 | | |
| Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside | 2025-03 | | ? | 16.8% | 15.1% | 15.1% |
| Number of non-elective admissions | 2025-03 | H | ? | 8017 | 6953 | 6953 |
| Number of zero day length of stay non-elective admitted patients | 2025-03 | H | ? | 2623 | 2073 | 2073 |
| Inpatients - Super Stranded Patients, 21+ LoS (Adult) | 2025-03 | | F | 126 | 96 | 96 |
| Overnight general and acute beds open | 2025-03 | | ? | 879 | 838 | 838 |
| Of those overnight general and acute beds open, proportion occupied | 2025-03 | | ? | 93.2% | | 92% |
| Community bed occupancy/availability | 2025-03 | | ? | 89.2% | | 92% |

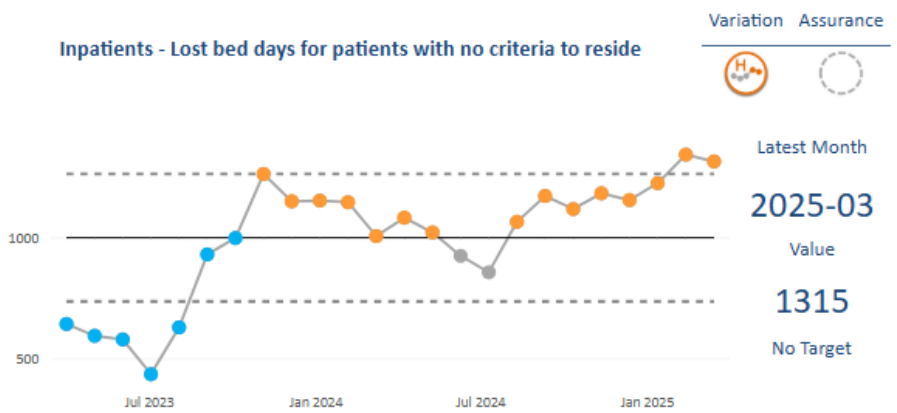
**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi




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 latest months value has **improved** from the previous month, with a difference of **28.0**.

**Rationale:** Understand flow in the acute bed base.
**Target:** **SPC1:** Internal target of 70%. **SPC2:** No target.

**Actions:**

- The Discharge Sprint team worked with eight wards to support effective board rounds, including encouraging improved timeliness of discharges throughout February and March 2025. During times of intensive support some wards were able to make improvements though sustaining those after the removal of intensive support was a challenge. A proposal is being developed to release resource to continue working intensively on ward processes that will support earlier discharges.

- Lost bed days for patients with no criteria to reside has been increasing since July 2024 despite a reduction in the proportion of patients not meeting the criteria to reside. The Business Intelligence team is carrying out an in-depth analysis of these figures to support increased understand of the correlation between the figures, and/or to ensure there is not a data quality issue.

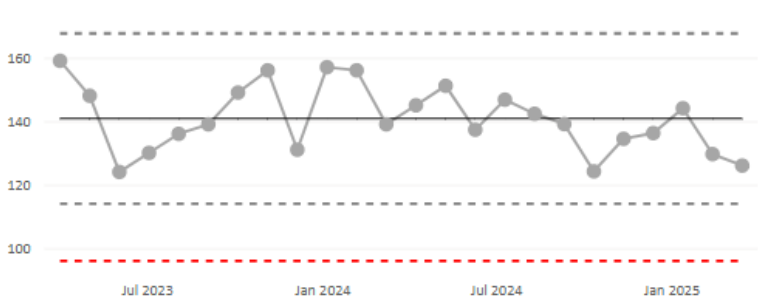
**Executive Owner:** Claire Hansen

**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: SPC1:** Less than 96 Super Stranded patients as per activity plan (March 2025).
**SPC2:** Less than 15% as per activity plan (March 2025).

### Inpatients - Super Stranded Patients, 21+ LoS (Adult)

Variation Assurance



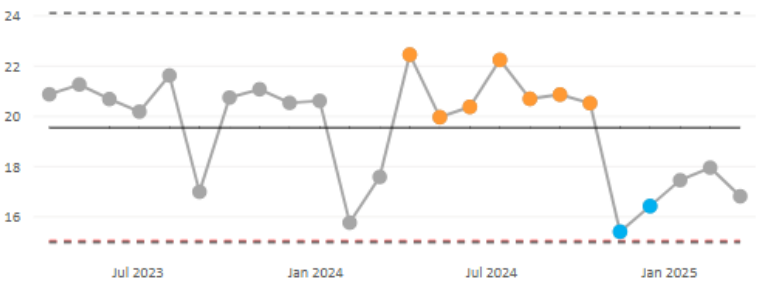

Latest Month
2025-03
Value
126
Target
96

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 **3.6.**

### Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside

Variation Assurance




Latest Month
2025-03
Value
16.8%
Target
15.1%

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 **1.1.**

**Actions**:

- The number and proportion of super-stranded patients reduced in March 2025 and is broadly in line with the lowest figures in recent years.
- During the upcoming Multi-Agency Discharge Event (MaDE) from 23rd to 30th April 2025 inclusive, there will be long length of stay reviews carried out in the Medicine Care Group. These are in place within the Surgical Care Group.

  Clinicians, particularly medics, have limited capacity to lead these reviews given the number of priority actions though they can test approaches for a short-term period during MaDE which could support longer-term proposals. Care Groups are reviewing job plans to ensure senior medics are available on wards in line with the discharge sprint aims.
- In the latest data provided by ECIST (week ending 6th of April) the Trust's proportion of super-stranded patients fell below the average for the North-East and Yorkshire region (14.4% against the regional 18.8%).

**Headlines (please note; in line with national reporting deadlines cancer reporting runs one month behind):**

- The Cancer performance figures for February 2025 saw an improvement in the 28-day Faster Diagnosis standard (FDS) to 72.1% (compared to 62.2% in January 2025) however this failed to achieve the monthly improvement trajectory of 74%.

- 62 Day waits for first treatment February 2025 performance was 66.8% a deterioration on the 70.6% seen in January 2025, however the monthly trajectory of 65.1% was achieved. 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.

- Discussions take place monthly with the ICB, Cancer Alliance and NHS England around the Tiering Status of the trust, and whether performance has improved sufficiently to come out of the tiering system. It is anticipated the Trust will remain in Tier 2 in the new financial year, however due to the level of confidence in the Trust to deliver of improvement trajectories, will not be expected to participate in wider system tiering meetings.

**Factors impacting performance:**

- February 2025 saw 2,723 total referrals across all cancer sites in the trust, the same average as January of 93 referrals per calendar day (compared to 88 average per calendar day in December 24).
- The following cancer sites exceeded 75% FDS in February 25: Breast, Haematology, Head and Neck, Lung, None Site Specific ,Skin and Upper GI pathways. Colorectal and Gynaecology remain below FDS and internal trajectory. Urology achieved 58.5% FDS which is the highest FDS position achieved by the site since FDS was introduced as a national standard.
- The following cancer sites exceeded 70% 62-day performance in February: Breast, Haematology, Skin and Upper GI. Lung and Urology achieved above their internal trajectories. February 62 day performance was impacted by the January FDS dip, and this is expected to continue to have some impact into March.
- 31-day treatment standard was 97.2% overall. 251 treatments were delivered in February, with 7 patients breaching. Urology had the highest volume of treatments delivered (62) and achieved 100%. Breast delivered 48 treatments and achieved 95.8%. Colorectal had the largest number of breaches (3).
- At the end of February, the proportion of patients waiting over 104+ days equates to 2% of the PTL size, at 35 patients, an improvement on January position at 41 patients. Colorectal and Urology are areas with the highest volume of patients past 62 days with/without a decision to treat but are yet to be treated or removed from the PTL. The Urology position also continues to improve, mirroring the January trend, in February the volume of patients over 62 days was the lowest for 7 months.

**Actions:**

- Please see following pages for details.

# Summary MATRIX

**CANCER:** *please note that any metric without a target will not appear in the matrix below*

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 | |
| COMMON CAUSE / NATURAL VARIATION | | * Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL<br>* Proportion of patients waiting 63 or more days after referral from cancer PTL<br>* Cancer 31 day wait from diagnosis to first treatment | * Cancer - Faster Diagnosis Standard<br>* Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result |
| SPECIAL CAUSE CONCERN | | | |

# CANCER
## Scorecard

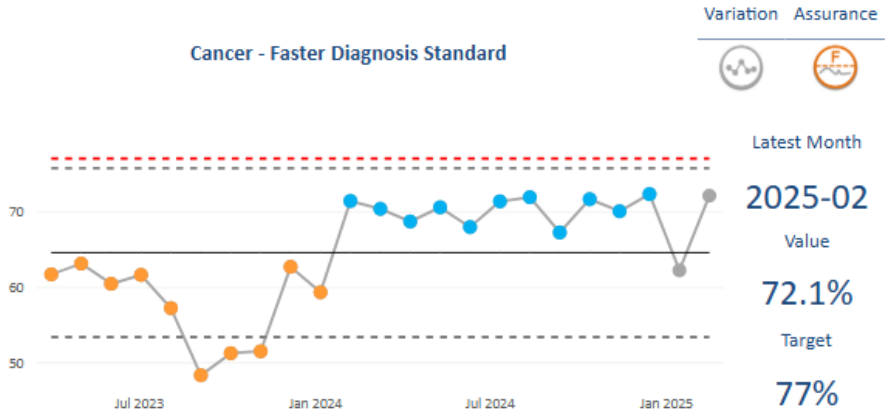
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Cancer - Faster Diagnosis Standard | 2025-02 | | F | 72.1% | 74% | 77% |
| Cancer - 62 Day First Definitive Treatment Standard | 2025-02 | H | ? | 66.8% | 65.1% | 70% |
| Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL | 2025-03 | | ? | 151 | 143 | 143 |
| Proportion of patients waiting 63 or more days after referral from cancer PTL | 2025-03 | | ? | 6.9% | | 12% |
| Cancer 31 day wait from diagnosis to first treatment | 2025-02 | | ? | 97.2% | | 96% |
| Total Cancer PTL size | 2025-03 | L | | 2217 | | |
| Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result | 2025-03 | | F | 72.3% | | 80% |

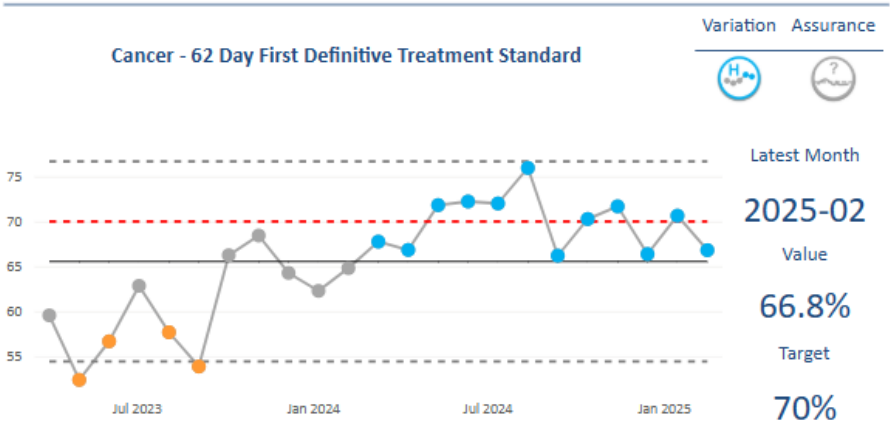
**Executive Owner:** Claire Hansen

**Operational Lead:** Kim Hinton




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 **9.9**.




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 **3.8**.

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

**Actions:**

- Planning for 2025-26 submitted, with national cancer planning pack released early February and improvement trajectories at tumor site and cumulative trust level submitted, compliant with national targets of 80% FDS and 75% 62-day standard by March 2026. Prostate, Gynecology, Skin and Breast identified as national priority pathways for improvement, with cancer alliances and providers to expected to set local priorities and operational improvement plan. High Impact actions developed for each tumor site and enactment of delivery commenced.

- NHSE performance recovery funded schemes implemented at beginning of January and ended March, including additional capacity in Prostate pathway short term change in practice for radiology to increase reporting capacity and reduce turnaround times for most challenged pathways. Prostate pathway FDS position in January 2025 suggests a 25% improvement compared to January 2024, and February FDS position was highest Trust has seen (58.5%). Imaging reporting for all fast-track modalities and tumour sites has improved, and prostate MRI reporting turnaround time remains around 2 days average, despite the volume of scans reported being larger in comparison to previous months.

- Colorectal improvement workshop took place in December 2024 with a short term (Q4 2024-25 delivery) and medium term (Q1 2025-26 delivery) improvement plan agreed. Ongoing discussions around a frailty pathway are in taking place and links made with HUTH who have successfully implemented. Audit taking place into data quality and trends around referrals and percentage of colonoscopies performed without Fit/Fit <10. Gynaecology session took place and actions being worked through at pace to increase hysteroscopy capacity. Urology reviewing actions from improvement plan and progressing options around a STT model for a cohort of haematuria patients.

**Headlines:**

- At the end of March 2025, the Trust had forty Referral To Treatment (RTT) patients waiting over sixty-five weeks.

- The Trust's RTT Waiting list position ended 2024/25 behind the trajectory submitted to NHSE as part of the 2024/25 planning submission: 46,605 against the trajectory of 44,663.

- Proportion of patients with ethnicity coding is 66.3%. A process mapping exercise to understand the areas of improvement has been commissioned.

**Factors impacting performance:**

- All RTT metrics were impacted by ongoing validation work on the Outpatient PTL, resulting in circa 2,500 additional RTT clocks being opened in March. There are no RTT65 week performance risks identified in this work to date.

- The NHS Constitution established that patients "have the right to access certain services commissioned by NHS bodies within maximum waiting times". The RTT standard is a key performance standard indicating how trusts are delivering on a patient's right to receive treatment within 18 weeks of being referred to a consultant-led service. The proportion of the waiting list **waiting under 18 weeks** reduced last month with 55.2% at the end of March 2025 compared to 53.6% at the end of February 2025. The target for this metric is 92% which was last achieved nationally in February 2016. The national ambition as briefed in the Reforming Elective Care Plan published on the 7th of January 2025 states the NHS will meet the 18-week standard by March 2029. By March 2026, the intention is that the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally.

- The Trust were over trajectory for RTT52 weeks; 1,057 against the March 2025 trajectory of 923. Nationally by March 2026, the intention is that the percentage of patients waiting more than 52 weeks for elective treatment will be 1% of a Trust's total RTT Waiting List, currently the Trust is at 2.3%.

- Delivery of the 2024/25 elective recovery plan. Initial analysis shows that at the end of March 2025 the Trust was ahead of the 2024/25 activity plan with a provisional performance of 128% of the Weighted Value Trust Activity Plan submitted to NHSE. From a financial point of view this equates to a provisional performance of 121% against the submitted plan, this is linked to the monetary value of the case mix that has been seen during 2024/25.

**Actions:**

- Please see following pages for details.

# Summary MATRIX

**Referral to Treatment (RTT):** *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

| VARIATION | ASSURANCE: PASS | ASSURANCE: HIT or MISS | ASSURANCE: FAIL |
|---|---|---|---|
| SPECIAL CAUSE IMPROVEMENT | | | * RTT - Total Waiting List<br>* RTT - Waits over 78 weeks for incomplete pathways<br>* RTT - Waits over 65 weeks for Incomplete Pathways<br>* RTT - Waits over 52 weeks for Incomplete Pathways<br>* RTT - Proportion of incomplete pathways waiting less than 18 weeks |
| COMMON CAUSE / NATURAL VARIATION | | | |
| SPECIAL CAUSE CONCERN | | | |

# Referral to Treatment (RTT)
## Scorecard

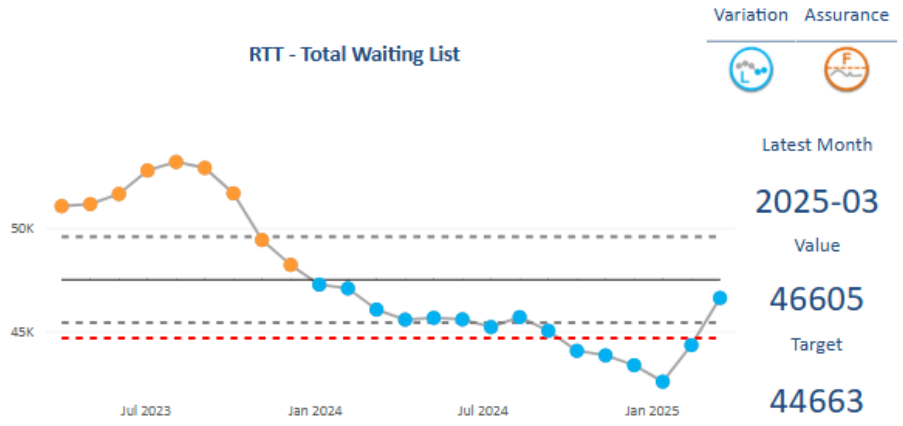
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| RTT - Total Waiting List | 2025-03 | L | F | 46605 | 44663 | 44663 |
| RTT - Waits over 78 weeks for incomplete pathways | 2025-03 | L | F | 0 | 0 | 0 |
| RTT - Waits over 65 weeks for Incomplete Pathways | 2025-03 | L | F | 40 | 0 | 0 |
| RTT - Waits over 52 weeks for Incomplete Pathways | 2025-03 | L | F | 1057 | 923 | 923 |
| RTT - Proportion of incomplete pathways waiting less than 18 weeks | 2025-03 | H | F | 55.2% | | 92% |
| RTT - Mean Week Waiting Time - Incomplete Pathways | 2025-03 | L | | 18.2 | | |
| Proportion of BAME pathways on RTT PTL (S056a) | 2025-03 | | | 1.7% | | |
| Proportion of most deprived quintile pathways on RTT PTL (S056a) | 2025-03 | | | 12.2% | | |
| Proportion of pathways with an ethnicity code on RTT PTL (S058a) | 2025-03 | L | | 66.3% | | |

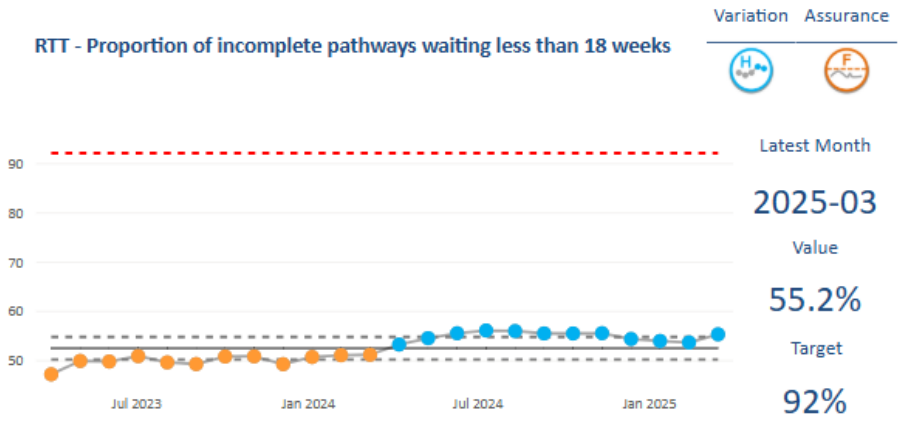
## Executive Owner: Claire Hansen

## Operational Lead: Kim Hinton




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 **2280.0**.




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

The latest months value has **improved** from the previous month, with a difference of **1.6**.

**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:** National constitutional target of 92% of patients should be waiting less than 18 weeks.

**Actions**:

- The ambitions published in the 2025/26 priorities and operational planning guidance included:

'Improve patient and list management, including consistent application of the referral to treatment (RTT) rules suite, utilisation of the national access policy and a strong focus on validation, so that at least 90% of patients waiting over 12 weeks are validated every 12 weeks.'

The National NHS England team are proposing a validation sprint to take place throughout quarter 1 of 2025 initially. This will go live on the 6 April 2025 and run until the end of June 2025. The Trust has signed up to participate. On review of this sprint further sprints may be organised through 2025/26.

This supports overall elective recovery and the commitment in the Elective Reform Plan to:

'Ensure validation is reflected formally as a form of activity within the 25/26 NHS payment scheme' and 'For Validation: develop and test tariffs and payment models in 2025/26 for widespread adoption by commissioners and providers in 2026/27'.

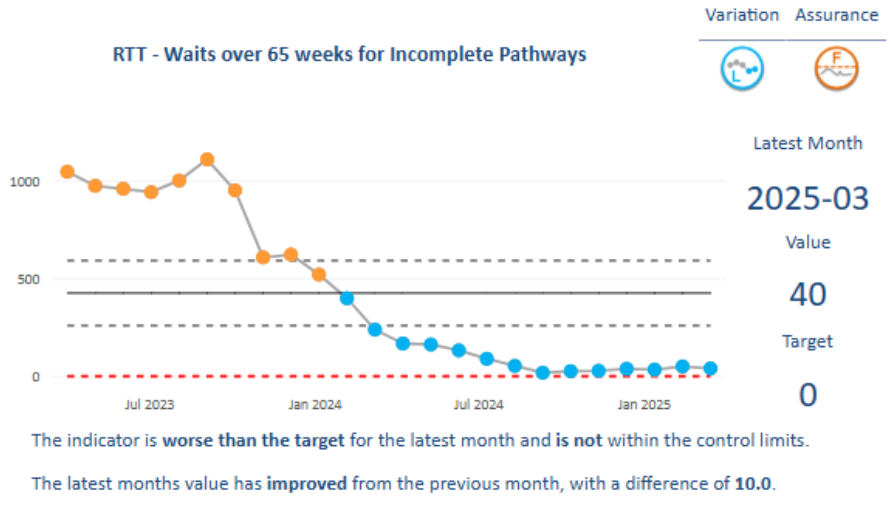
NHS England is making funding available to support providers to increase the validation of patients within the sprint period by undertaking either one of or a combination of technical, admin and clinical validation as required within the identified timescales.

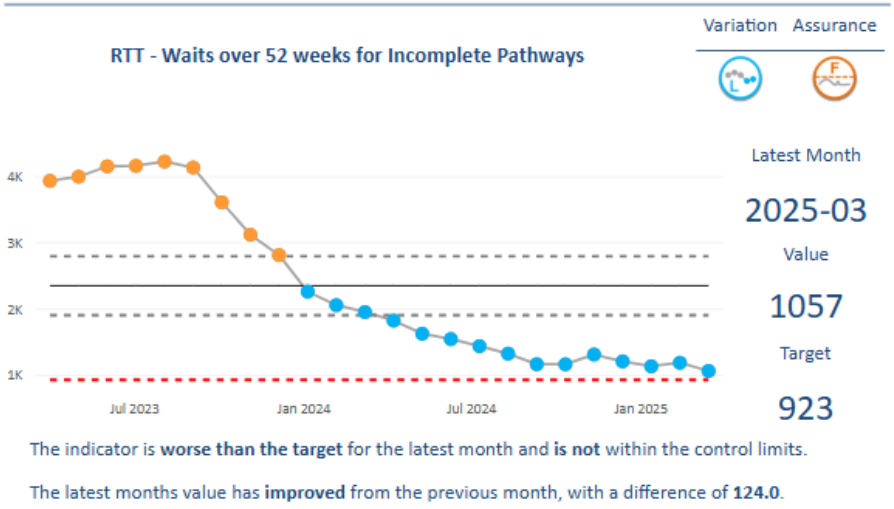
- The Trust is part of cohort 2 of the national Further Faster (FF) Programme, several specialties perform well against the key metrics including the did not attend (DNA) rate, pre-referral triage and advice and guidance. The Trust has been seen a 70.6% improvement since July 23 (baseline month) against 52-week backlog and is the second most improved Trust in cohort 2. It is the most improved Trust for CYP 52-week backlog with an 86.9% improvement, the average improvement for cohort 2 was 56.9%.

- The 2025/26 plan has been developed with a greater focus on productivity and efficiency and will be presented to Board in April 2025.

**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: SPC2:** National ambition to have 0 patients waiting more than 65 weeks by September 2024. **SPC2:** Aim to have less than 923 patients waiting more than 52 weeks by March 2025 as per activity plan.

**Actions**:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectories for RTT52 and RTT65 weeks.
- The Trust's activity plan was aligned to our improvement trajectory to deliver an improvement to have no more than 923 RTT52 week waits by the end of March 2025. At the end of March 2025, the Trust was 134 behind the trajectory (1,057 against 923).
- Independent sector capacity for Neurology agreed. Insourcing clinics began in February 2025 providing an additional 16 clinic slots per week.
- The Trust has seen continued capped theatre utilisation improvement and in further faster 2 cohort is the second highest performing Trust with utilisation above 85% in March 25.

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

**Headlines:**

- At the end of March 2025, the Patient Initiated Follow Up (PIFU) remained at 3.8% against a 2024/25 ambition of 5%.
- Rapid Access Chest Pain (RACP) seen within 14 days was at 23.7% which remains significantly below the target of 99%.
- The number of patients overdue follow up partial booking remains a special cause concern.

**Factors impacting performance:**

- Delays in roll out of PIFU pathways across specialities due to issues with call handling capacity. Alternative patient contact methods being considered.
- The outpatient delivery group is being refreshed as part of the 2025/26 elective recovery plan to put greater focus on PIFU and referral for expert input, which is aligned to the national demand management priority.
- RACP improvement plan has been developed by the Medicine Care Group but further scrutiny of impact of actions to be undertaken through the Performance Review and Improvement Meetings (PRIM).

**Actions:**

- Please see following pages for details.

# Summary MATRIX

**Outpatients & Elective:** *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

| VARIATION | ASSURANCE: PASS | ASSURANCE: HIT or MISS | ASSURANCE: FAIL |
|---|---|---|---|
| SPECIAL CAUSE IMPROVEMENT | | * Outpatients - DNA rates<br>* Outpatients: 1st Attendances (Activity vs Plan) | |
| COMMON CAUSE / NATURAL VARIATION | * Outpatient procedures<br>* Proportion of elective admissions which are day case | * Outpatients: Follow Up Attendances (Activity vs Plan)<br>* 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*<br>* Day Cases (based on Activity v Plan)<br>* Electives (based on Activity v Plan) | * Outpatients - Proportion of appointments delivered virtually (S017a)<br>* Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU) |
| SPECIAL CAUSE CONCERN | | | * Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)<br>* 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

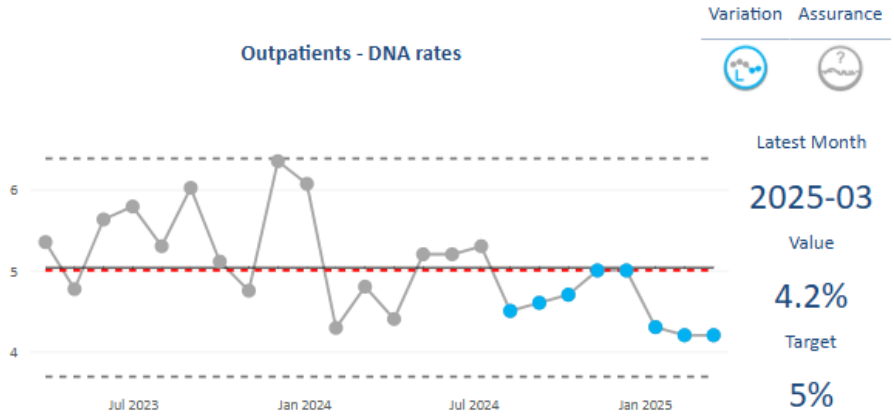
**Executive Owner:** Claire Hansen **Operational Lead:** Kim Hinton

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Outpatients - Proportion of appointments delivered virtually (S017a) | 2025-03 | | F | 20.3% | | 25% |
| Outpatients - DNA rates | 2025-03 | L | ? | 4.2% | | 5% |
| Outpatients: 1st Attendances (Activity vs Plan) | 2025-03 | H | ? | 19165 | 19723 | 19723 |
| Outpatients: Follow Up Attendances (Activity vs Plan) | 2025-03 | | ? | 45083 | 45738 | 45738 |
| Outpatient procedures | 2025-03 | | P | 14954 | 7884 | 7884 |
| Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks) | 2025-03 | H | F | 27189 | | 0 |
| Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU) | 2025-03 | | F | 3.8% | 5% | 5% |
| Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received) | 2025-03 | L | F | 23.7% | | 99% |
| 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* | 2025-03 | | ? | 15 | | 0 |
| Day Cases (based on Activity v Plan) | 2025-03 | | ? | 7636 | 7037 | 7037 |
| Electives (based on Activity v Plan) | 2025-03 | | ? | 756 | 576 | 576 |
| Proportion of elective admissions which are day case | 2025-03 | | P | 91% | | 85% |

**Executive Owner:** Claire Hansen

**Operational Lead:** Kim Hinton

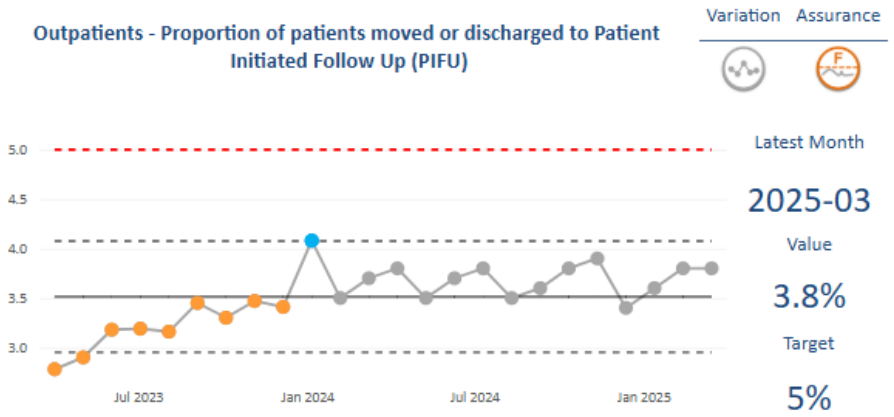
### Outpatients - DNA rates




The indicator is **better 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**.

### Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)




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**.

**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.

**Factors impacting performance**:

- Outpatient bi-directional text messaging continues to positively impact DNA rates which remained at 4.2% in March 2025, the lowest rate in over 2 years.

**Actions**:

- Outpatient Procedure Code (OPCS) project is ongoing to improve outpatient procedure coding with Care Groups using reports to target specific areas where correct recording has not occurred. Significant improvements have been seen in the Surgery and Cancer, Specialist and Clinical support Services Care Group. Further work planned for the Medicine and Family Health Care Groups.

- The Trust delivered the NHSE planning priority of 46% of first and outpatient procedures as a proportion of all outpatient activity in March 2025, with 51%. 2024/25 saw the Trust achieve performance of 53%.

- RACP improvement plan has been developed by the Medicine Care Group but further scrutiny of impact of actions to be undertaken through the Performance Review and Improvement Meetings (PRIM).

**Headlines:**

- The March 2025 Diagnostic target position for patients waiting less than six weeks at month end was 68.4%, against the trajectory of 89.4%. The Trust saw the following modalities achieve their trajectories at month end:

  - Flexi-Sigmoidoscopy
  - Neurophysiology
  - Sleep Studies

**Factors impacting performance**:

- CT performance is being largely driven by cardiac CT backlog. Equipment issues in CT – breakdown of CT1 and CT2 intermittently at York; permanent decommissioning of CT1 at Scarborough due to recurrent faults. Number of breakdowns compounded by delays to replacing equipment.
- MRI has seen a reduction in performance due to increased fast track and RTT >52 week wait escalations, staffing gaps, a reduction in the capacity Nuffield can support with and an increase in GA/acute demand which takes up more scanner capacity. Image quality provided by CDC mobiles limits cohort of studies which can be scanned.
- NOUS backlog due to specialist nature (MSK) – demand outstripping capacity. Long term issue and a Consultant Radiologist has handed his notice in which will compound the issue from June.
- Reporting demand continues to outstrip capacity. Reliance on in-house radiologist insourcing and outsourcing to external providers.
- Workforce challenges continue within Cardiology for healthcare scientists.
- One Gastro consultant at Scarborough on reduced duties. This has impacted on the ability to deliver planned lists and is reflected in the slight decline in February performance. Locum has been recruited to cover acute and elective endoscopy. Where they are not in work the York team provide cross site cover.
- Endoscopy Nurse staffing at York has also been behind plan due to a mix of vacancies and sickness meaning rate of recovery at York has slowed.
- Surveillance backlog cleared through use of insourcing two years ago causing large volumes of patients now to drop onto DM01 backlog as their next test is due. This has caused the sharp decrease in Colonoscopy performance as patients tip over six week wait.

**Actions**:

- Please see page below.

# Summary MATRIX

**Diagnostics:** *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

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

# DIAGNOSTICS – National Target: 95%

## Scorecard

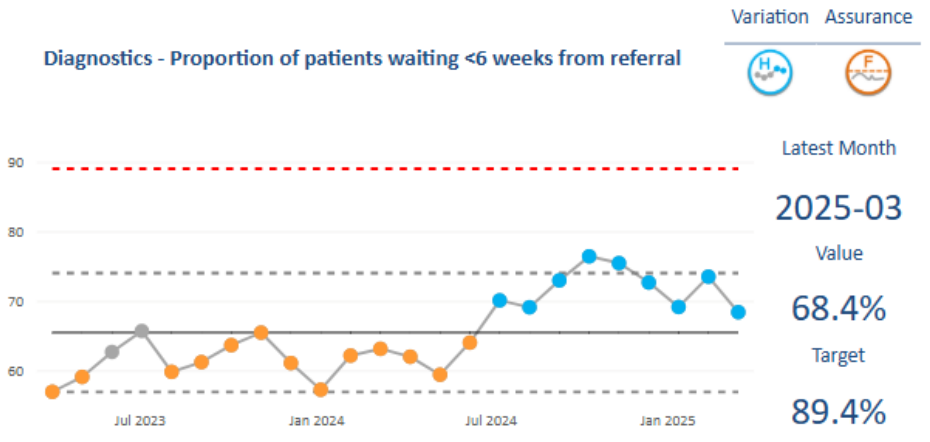
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Diagnostics - Proportion of patients waiting <6 weeks from referral | 2025-03 | H | F | 68.4% | 89.4% | 89.4% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI | 2025-03 | | F | 66.7% | 85% | 85% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - CT | 2025-03 | | F | 63.4% | 85% | 85% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound | 2025-03 | | F | 72.2% | 95% | 95% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema | 2025-03 | | ? | 70.6% | 95.4% | 95.4% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan | 2025-03 | H | F | 79.1% | 95.1% | 95.1% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology | 2025-03 | | F | 46.8% | 95.1% | 95.1% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography | 2025-03 | H | F | 86% | 95.3% | 95.3% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral | 2025-03 | | ? | 97.5% | 95.5% | 95.5% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies | 2025-03 | H | ? | 97.3% | 95.2% | 95.2% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics | 2025-03 | | F | 27.1% | 70.3% | 70.3% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy | 2025-03 | H | F | 66.4% | 95.1% | 95.1% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy | 2025-03 | H | ? | 79.5% | 52.3% | 52.3% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy | 2025-03 | | ? | 68.7% | 95.2% | 95.2% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy | 2025-03 | | ? | 76.9% | 84.8% | 84.8% |

**Executive Owner:** Claire Hansen

**Operational Lead:** Kim Hinton

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**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%.

**Actions**:

**Endoscopy**:

- Gastroenterology have recruited to the East Coast and the new consultant is due to start in April.
- Capacity and demand analysis undertaken which shows significant gap. Review of points per lists carried out to understand impact of surgical consult and scope model; this shows the potential for an additional circa 40 colonoscopies per week across all sites, if consultation removed. Discussion regarding potential way forward is ongoing with General Surgery colleagues.
- Workforce plan in progress for the next 3 years.
- Endoscopy insourcing ceased in January 2025 across both 18–24-month and we are now using only our own workforce (including bank/WLI)
- Core capacity increased in January 2025 as trainee clinical endoscopist has now been signed off to work independently. Additional trainee clinical endoscopist started in post at the end of January and has begun their training programme, with an 18–24-month timeline for completion. There were multiple applicants for the trainee programme which is encouraging for future positions as they come available.

**Imaging**:

- CT recovery plan in progress including insourcing of Cardiac CT. Final tender evaluations completed to award this backlog clearance work to the successful supplier. Due to go live during April/May
- CT3 YH replacement, supplier now agreed. No confirmed timescale yet but anticipated to be circa Autumn 2025. New MRI scanner in 2025 from NHSE funding, order placed; location finalised for South entrance at the back of VIU. MRI scanner should be active by Autumn 2025.
- York St John MRI BC approved - looking at June start date. Will need insourced radiographer capacity to support roll out due to timescales for recruitment and training
- CT – continue to struggle with CT Radiographer staffing at York. Capacity being propped up by WLIs. CT1 at Scarborough has been decommissioned with immediate effect due to unreliability and risk of radiation incidents for patients. Temporary mobile solution in place from w/c 31st March until UEC opens at end of April. CDC at Seamer on track to open in June
- MSK USS – Continuing to try to source locum MSK USS to clear the backlog. Increased in MSK USS lists planned from 14th April. MSK sonographer training being supported to take on soft tissue ultrasound from MSK backlog – aim for go live in June. Successful recruitment of a new sonographer for 3 days per week.
- Successful recruitment of a new GI specialist Consultant Radiologist.

# Summary MATRIX

**Children & Young Persons:** *please note that any metric without a target will not appear in the matrix below*

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 Waits over 52 weeks for incomplete pathways |
| COMMON CAUSE / NATURAL VARIATION | | | * Children & Young Persons: ED - Emergency Care Standard (Type 1 only)<br>* Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks |
| SPECIAL CAUSE CONCERN | | * Children & Young Persons: ED - Patients waiting over 12 hours in department | |

# 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 | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Children & Young Persons: ED - Patients waiting over 12 hours in department | 2025-03 |  |  | 14 | | 0 |
| Children & Young Persons: ED - Emergency Care Standard (Type 1 only) | 2025-03 |  |  | 74.6% | 95% | 95% |
| Children & Young Persons: RTT - Total Waiting List | 2025-03 |  |  | 3927 | | |
| Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks | 2025-03 |  |  | 60.3% | | 92% |
| Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways | 2025-03 |  |  | 29 | 0 | 0 |

# KPIs – Operational Activity and Performance

## Children & Young Persons

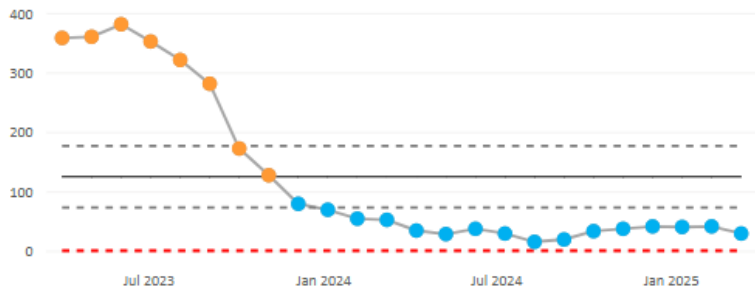
York and Scarborough Teaching Hospitals NHS Foundation Trust

**Executive Owner:** Claire Hansen

**Operational Lead:** Kim Hinton/Abolfazl Abdi

### Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways

Variation Assurance




Latest Month

2025-03

Value

29

Target

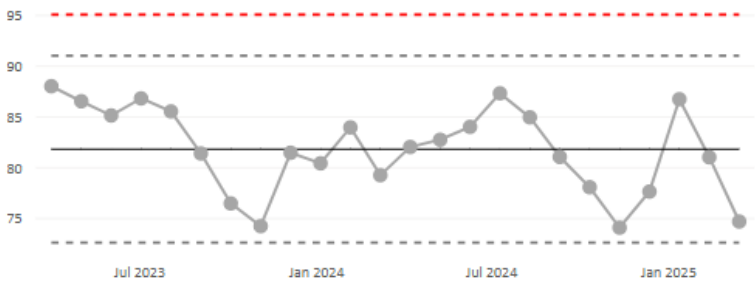
0

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

The latest months value has **improved** from the previous month, with a difference of **12.0**.

### Children & Young Persons: ED - Emergency Care Standard (Type 1 only)

Variation Assurance




Latest Month

2025-03

Value

74.6%

Target

95%

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 **6.4**.

**Rationale: SPC1:** To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients. **SPC2:** To monitor waiting times in A&E and Urgent Care Centres.

**Target: SPC1:** Aim to have zero patients waiting more than 52 weeks (internal target).
**SPC2:** 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**:

- **SPC1:** The Trust did not deliver the trajectory for RTT52 weeks wait for patients aged under eighteen with 29 (down from 41 at the end of February 2025) against an internal trajectory of zero.
- **SPC2:** ECS performance for CYP deteriorated from 81% in February 2025 to 74.6% in March 2025.

**Actions**:

- **SPC1:** The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 weeks wait for patients aged under eighteen. The Trust has submitted plans to NHSE as part of the 2025/26 planning submission to achieve zero by the end of Q2 2025/26.

- **SPC1:** Going further for children waiting times for surgery, Surgical Care Group ran significant volumes of additional CYP capacity in the school half-term holiday during February 2025. Additional daycase lists at Scarborough are scheduled from June 2025.

- **SPC2:** Actions planned:
  - Review of the pathway for children aged 0-17 years requiring admission has been completed to ensure patients are ready for transfer in appropriate timescales and promptly transferred to the appropriate Children/Adult Ward as per the Continuous Flow Model.

  - Paper will be submitted to Executive Committee in April 2025 providing transition plan for responsibility for CYP patients seen in ED to move to the Medicine CG from the Family Health CG.

# Summary MATRIX

**Community:** *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

| VARIATION | ASSURANCE: PASS | ASSURANCE: HIT or MISS | ASSURANCE: FAIL |
|---|---|---|---|
| SPECIAL CAUSE IMPROVEMENT | * Number of people on waiting lists for CYP services per system who are waiting over 52 weeks | | * Number of open Virtual Ward beds |
| COMMON CAUSE / NATURAL VARIATION | * 2-hour Urgent Community Response (UCR) Compliancy % | * Proportion of Virtual Ward beds occupied | |
| SPECIAL CAUSE CONCERN | | | |

# COMMUNITY
## Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Number of open Virtual Ward beds | 2025-03 | H | F | 33 | | 33 |
| Proportion of Virtual Ward beds occupied | 2025-03 | | ? | 60.6% | | 80% |
| Community Response Team (CRT) Referrals | 2025-03 | H | | 551 | | |
| Total Urgent Community Response (UCR) referrals | 2025-03 | H | | 494 | | |
| 2-hour Urgent Community Response (UCR) care Referrals | 2025-03 | H | | 147 | | |
| 2-hour Urgent Community Response (UCR) Compliancy % | 2025-03 | | P | 84.4% | | 70% |
| Number of Adults (18+ years) on community waiting lists per system | 2025-03 | | | 777 | | |
| Number of CYP (0-17 years) on community waiting lists per system | 2025-03 | L | | 1972 | | |
| Number of District Nursing Contacts | 2025-03 | | | 21173 | | |
| Number of Selby CRT Contacts | 2025-03 | | | 2566 | | |
| Number of York CRT Contacts | 2025-03 | L | | 3773 | | |
| Referrals to District Nursing Team | 2025-03 | | | 2101 | | |
| Number of people on waiting lists for CYP services per system who are waiting over 52 weeks | 2025-03 | L | P | 717 | 1056 | 1056 |

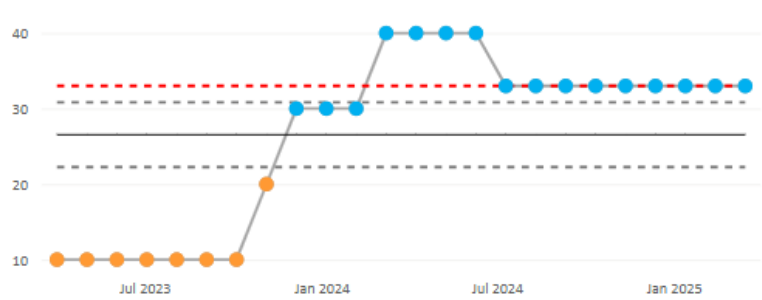
**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi

**Rationale:** To monitor demand on Community virtual wards.
**Target: SPC1:** Trust is commissioned to deliver 33 virtual ward beds. **SPC2:** Aim to achieve 80% virtual ward bed occupancy as per activity plan.

### Number of open Virtual Ward beds

Variation Assurance



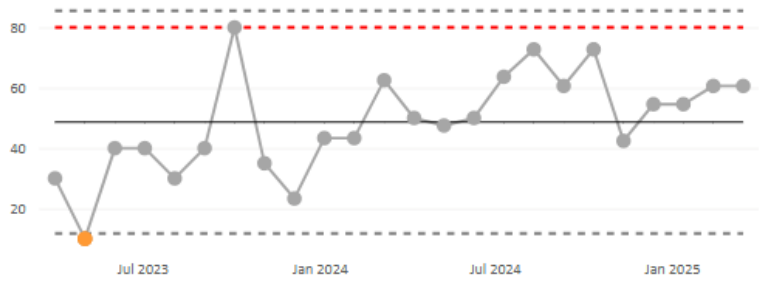

Latest Month
2025-03
Value
33
Target
33

The indicator is **equal to 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**.

### Proportion of Virtual Ward beds occupied

Variation Assurance




Latest Month
2025-03
Value
60.6%
Target
80%

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 ambition for the virtual ward utilisation rate is 80%; at the most recent snapshot occupancy was 60.6% maintaining the position seen in February 2025.

**Frailty Virtual Ward (FVW):** The team has successfully recruited a second trust grade medic, who is due to start in May 2025. This additional clinician will provide a resilient model to provide cover 7 days in continued partnership with CRT. The team is also in conversations with Microbiology about developing an IV antibiotic pathway.

Work is ongoing with Selby Primary Care Network to discuss possible expansion to this location through a collaborative model with primary care and existing community services.

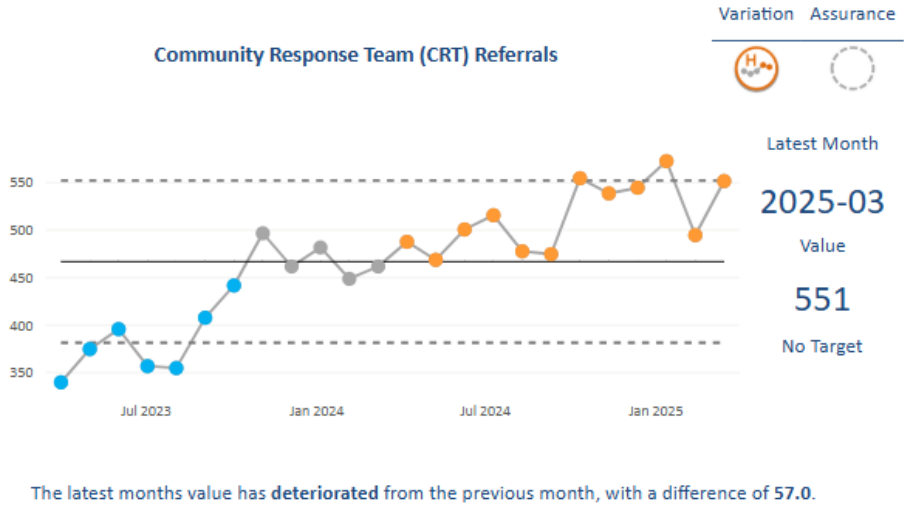
**Heart Failure (HFVW):** The next phase of the in-reach model at York ED is to use charitable funds to appoint a 0.8WTE Band 7 nurse to expand the service. The first round of recruitment was not successful; recruitment is back underway with an anticipated start date early Q2.

**Vascular (VVW):** Capacity is available for patients who can benefit from waiting at home for onward diagnostics or treatment, but it is not expected to be routinely 'full' as it depends on the number of suitable patients. There is not 'spare' capacity, the model uses pre-existing resource.

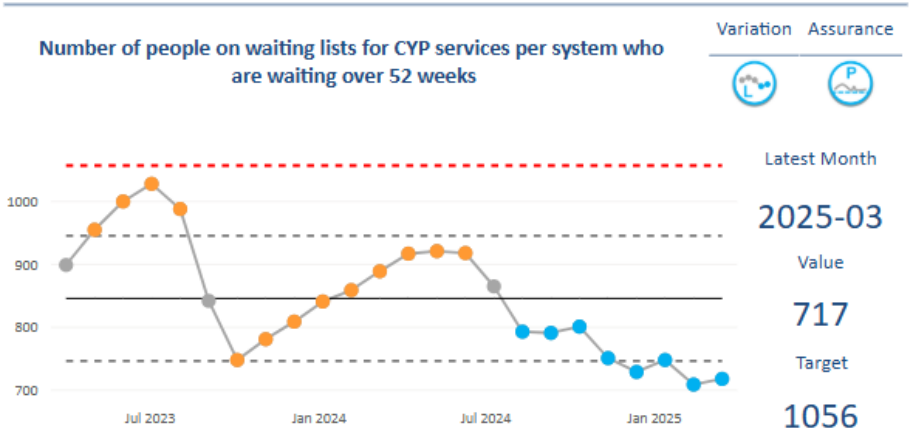
**Cystic Fibrosis (CFVW):** Some patients benefit from staying at home during a period of being acutely unwell, and the system allows a virtual model of care for up to three patients. There is not 'spare' capacity, the team works differently to support appropriate patients, and numbers will remain low due to the niche criteria.

**Executive Owner:** Claire Hansen

**Operational Lead:** Abolfazl Abdi




The latest months value has **deteriorated** from the previous month, with a difference of **57.0**.




The indicator is **better 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 **9.0**.

**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.

**Factors impacting performance**:

- **SPC1:** Referrals to Community Response Teams remain above the average control. The continued development of the Frailty Crisis Hub will likely have further impact on referrals with the YAS pathway developments.
- **SPC2:** The number of Children and Young People waiting over 52 weeks increased from 708 at the end of February 2023 to 718 at the end of March 2025. The Trust has submitted, as part of the 2025/26 planning process, a trajectory to achieve zero against this metric by March 2026.

**Actions**:

- **SPC1:** There is ongoing conversations with the South Hambleton and Ryedale and Selby Primary Care Networks re the UCR model and creating better integration with primary care to ensure better equity of service.
- **SPC1:** Additional therapy resource has been funded by NYCC place to support step down beds and IPU flow in the Selby area only.
- **SPC2:** SLT are discussing an insourcing option with an Independent Sector supplier to provide support for the telephone triage system, further meeting scheduled in May 2025. Recruitment following business case approval has been successful and new starters now in post.
- **SPC2:** Plan for OT service in place to deliver improvement from January 2025. The 'let's make sense together' initiative commenced in February 2025. This offers a different pathway for those on the OT waiting list triaged as 'Sensory Profile'.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

# QUALITY AND SAFETY

April 2025

# Summary MATRIX 1

**Quality and Safety:** *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

| VARIATION | ASSURANCE: PASS | ASSURANCE: HIT or MISS | ASSURANCE: FAIL |
|---|---|---|---|
| SPECIAL CAUSE IMPROVEMENT | | * Patient Falls per thousand Bed Days | |
| COMMON CAUSE / NATURAL VARIATION | | * Total Number of Trust Onset MSSA Bacteraemias<br>* Total Number of Trust Onset MRSA Bacteraemias<br>* Total Number of Trust Onset C. difficile Infections<br>* Total Number of Trust Onset E. coli Bacteraemias<br>* Total Number of Trust Onset Klebsiella Bacteraemias<br>* Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias<br>* Total Number of Never Events Reported<br>* Monthly SHMI<br>* Monthly HSMR | |
| SPECIAL CAUSE CONCERN | | | |

# Quality & Safety
## Scorecard (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

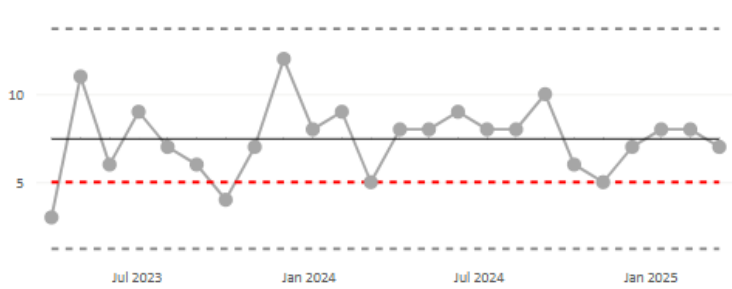
| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Total Number of Trust Onset MSSA Bacteraemias | 2025-03 | | | 7 | 5 | 5 |
| Total Number of Trust Onset MRSA Bacteraemias | 2025-03 | | | 0 | | 0 |
| Total Number of Trust Onset C. difficile Infections | 2025-03 | | | 8 | 10 | 10 |
| Total Number of Trust Onset E. coli Bacteraemias | 2025-03 | | | 12 | 13 | 13 |
| Total Number of Trust Onset Klebsiella Bacteraemias | 2025-03 | | | 2 | 4 | 4 |
| Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias | 2025-03 | | | 4 | | 2 |
| Pressure Ulcers per thousand Bed Days | 2025-03 | | | 4.3 | | |
| Patient Falls per thousand Bed Days | 2025-03 | | | 7.5 | | 8.7 |
| Medication incidents per thousand bed days | 2025-03 | | | 4.2 | | |

## Executive Owner: Dawn Parkes

## Operational Lead: Sue Peckitt

Variation Assurance

### Total Number of Trust Onset MSSA Bacteraemias



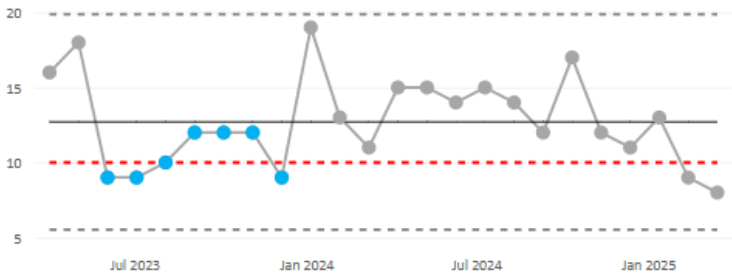

Latest Month
2025-03
Value
7
Target
5

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 **1.0**.

Variation Assurance

### Total Number of Trust Onset C. difficile Infections




Latest Month
2025-03
Value
8
Target
10

The indicator is **better 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 **1.0**.

**Rationale: To drive reduction in avoidable health care associated infection, facilitate patient safety and improve patient outcomes**
**Target:** National thresholds for 2024/25 are a 5% reduction on the 2023/24 year end position.

**Factors impacting performance**:

- MSSA bacteraemia - 8 cases recorded in January, 6 cases attributed to Medicine Care Group, 1 attributed to Surgery Care Group and 1 case attributed to Family Health Care Group 12.5% of the cases are attributed to Scarborough Hospital, 12.5% of the cases are attributed to Family Services Care Group and 75% of the cases are attributed to York Hospital. The Trust is 8 cases over the year- to date trajectory.
- The Trust has recorded 0 MRSA Bacteraemia cases in January but have recorded a total of 4 cases for 2024/25 against a zero target..
- 13 Trust attributed Clostridioides difficile cases recorded in January against a trajectory of 12. Of the 13 cases 54% were attributed to York Hospital, 31% attributed to Scarborough Hospital, 15% attributed to community hospital sites. The Trust is 18 cases over the year to date target.
- Following a period of intensive support Ward 36 has not had a Clostridioides difficile attributed case in January and has reported 1 MSSA bacteraemia, which is a much improved position.

**Actions**:

- The care group IPC/AMS meetings have all now commenced and are reviewing and actioning improvement requirements.
- All MSSA bacteraemia undergo a review using a PSIRF approach, learning identified improvement needed with hand hygiene compliance, IV cannula documentation, ANTT compliance. The move towards care groups leading in these reviews has commenced.
- Clostridioides difficile cases are reviewed using PSIRF approach, learning identified is being addressed via the Care Group IPC/AMS meetings. 75% of all cases have undergone review, a much-improved position on previous years.
- The Trust MRSA/MSSA guidelines have been refreshed and are now published on the Trust intranet

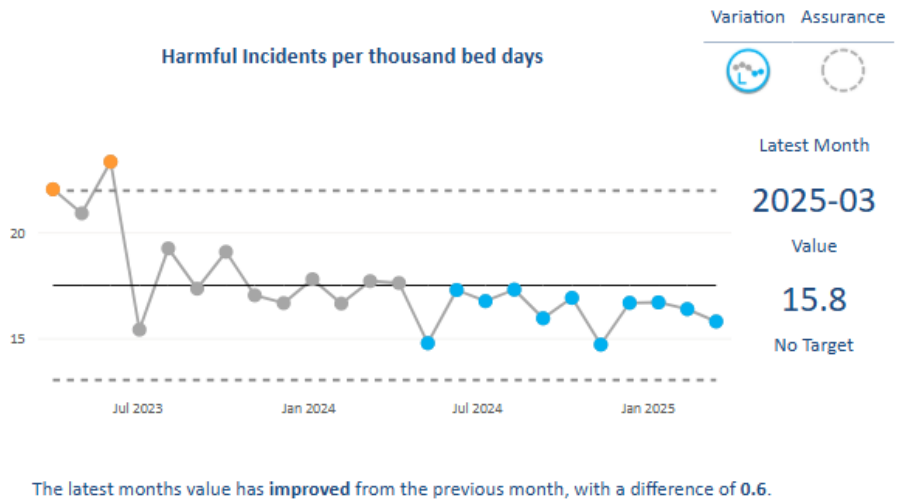
# Quality & Safety
## Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

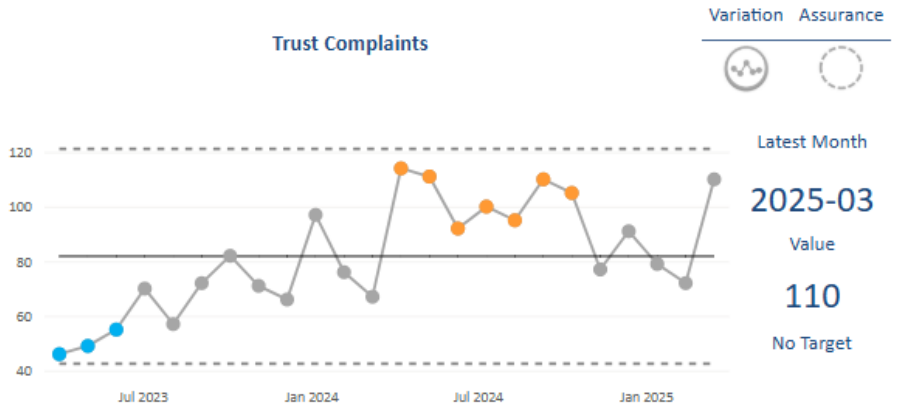
**Executive Owner:** Adele Coulthard/ Dawn Parkes **Operational Lead:** Dan Palmer/ Tara Filby/ Sacha Wells-Munro

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Patient Safety Incidents per thousand Bed Days | 2025-03 | | | 49.2 | | |
| Harmful Incidents per thousand bed days | 2025-03 | | | 15.8 | | |
| Total Number of Never Events Reported | 2025-03 | | | 0 | | 0 |
| In-Hospital Deaths | 2025-03 | | | 204 | | |
| Quarterly SHMI | 2024-09 | | | 96 | | 100 |
| Monthly SHMI | 2024-12 | | | 88 | | 100 |
| Quarterly HSMR | 2024-12 | | | 110.7 | | 100 |
| Monthly HSMR | 2025-01 | | | 100.3 | | 100 |
| Trust Complaints | 2025-03 | | | 110 | | |
| Antepartum Stillbirths | 2025-02 | | | 2 | | |
| Intrapartum Stillbirths | 2025-02 | | | 0 | | |
| Early neonatal deaths (0-7 days) | 2025-02 | | | 0 | | |
| PPH > 1.5L as % of all women - York | 2025-02 | | | 2.7% | | |
| PPH > 1.5L as % of all women - Scarborough | 2025-02 | | | 0% | | |
| Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears) | 2025-02 | | | 52.3% | | |

**Executive Owner:** Adele Coulthard/ Dawn Parkes/Karen Stone **Operational Lead:** Dan Palmer/ Tara Filby




The latest months value has **improved** from the previous month, with a difference of **0.6**.




The latest months value has **deteriorated** from the previous month, with a difference of **38.0**.

**Rationale: The Trust is committed to learning from incidents and complaints and improving the patient experience**
**Target: No target identified as the reporting of incidents/complaints is an indicator of an open reporting culture**

**Factors impacting performance**:

**Harmful Incidents per 1000 bed days:**

The SPD chart demonstrates that there is no special cause reported. The number of incidents has remained below the mean for 12 months.

On this basis we now need to recalculate the control limits to understand where further standardisation and improvement needs to be made.

Throughout the winter period acuity and dependency increased however the number of reported incidents (All incidents) has remained stable. We have not seen an increase in the level of harmful incidents as a proportion of all incidents.

**Factors impacting performance**:

The number of new complaints has increased this month. Of the 110 new complaints recorded (versus 72 in February 2025), the highest number of complaints were in:
- York ED (10) – main theme attitude of nursing staff
- General Surgery Medical Team York (9) – main theme was delay or failure in treatment or procedure
- Oak Ward (8) - main theme was delay or failure in treatment or procedure.

**Actions**:

In line with our 2025/26 priorities and national guidance, with the Yorkshire Ambulance Service, we launched the "Withdraw at 45" (W45) this month. Average ambulance handover time in March 2025 reduced significantly despite an increase in the daily average of ambulance arrivals.

The Discharge Sprint during times of intensive support has resulted in some wards being able to make improvements though more support is required to maintain this when support is withdrawn.

In response to the theme of staff attitude being a theme of complaints, customer service skills training for both clinical and administrative staff is being planned for Q1 2025/26.

Complaints writing workshops are being planned for Investigating Officers to be delivered in the new financial year.

A rapid process improvement workshop for complaints management is being planned to be delivered in Q1 2025/26.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

# MATERNITY

April 2025

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

# 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 | | | |
| COMMON CAUSE / NATURAL VARIATION | * Intrapartum Stillbirths - Scarborough | * Assisted Vaginal Births - Scarborough<br>* Elective caesarean - Scarborough<br>* Induction of labour - Scarborough<br>* HDU on L/W - Scarborough<br>* BBA - Scarborough<br>* HSIB cases - Scarborough<br>* Neonatal Death - Scarborough<br>* Antepartum Stillbirth - Scarborough<br>* Cold babies - Scarborough<br>* Preterm birth rate <37 weeks - Scarborough<br>* Preterm birth rate <34 weeks - Scarborough<br>* Preterm birth rate <28 weeks - Scarborough | |
| SPECIAL CAUSE CONCERN | | * Normal Births - Scarborough<br>* C/S Births - Scarborough<br>* Emergency caesarean - 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 | Current Month | Monthly Trajectory | Year End Target/Baseline | Target/Baseline |
|---|---|---|---|---|---|---|---|
| Normal Births - Scarborough | 2025-02 | L | ? | 41.4% | | 57% | Target |
| Assisted Vaginal Births - Scarborough | 2025-02 | | ? | 7.1% | | 12.4% | Target |
| C/S Births - Scarborough | 2025-02 | H | ? | 51.5% | | 42.1% | Baseline |
| Elective caesarean - Scarborough | 2025-02 | | ? | 17.2% | | 17.8% | Baseline |
| Emergency caesarean - Scarborough | 2025-02 | H | ? | 34.3% | | 24.3% | Baseline |
| Induction of labour - Scarborough | 2025-02 | | ? | 42.4% | | 44.2% | Baseline |
| HDU on L/W - Scarborough | 2024-12 | | ? | 1 | | 5 | Target |
| BBA - Scarborough | 2025-02 | | ? | 1 | | 2 | Target |
| HSIB cases - Scarborough | 2025-01 | | ? | 0 | | 0 | Target |
| Neonatal Death - Scarborough | 2025-02 | | ? | 0 | | 0 | Target |
| Antepartum Stillbirth - Scarborough | 2025-02 | | ? | 1 | | 0 | Target |
| Intrapartum Stillbirths - Scarborough | 2025-02 | | P | 0 | | 0 | Target |
| Cold babies - Scarborough | 2025-01 | | ? | 0 | | 1 | Target |
| Preterm birth rate <37 weeks - Scarborough | 2025-02 | | ? | 3% | | 6% | Target |
| Preterm birth rate <34 weeks - Scarborough | 2025-02 | | ? | 0% | | 1% | Target |
| Preterm birth rate <28 weeks - Scarborough | 2025-02 | | ? | 0% | | 0.5% | Target |

# 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 | | * Smoking at booking - Scarborough | |
| COMMON CAUSE / NATURAL VARIATION | * 3rd/4th Degree Tear - normal births - Scarborough<br>* 3rd/4th Degree Tear - assisted birth - Scarborough | * Low birthweight rate at term (2.2kg) - Scarborough<br>* Breastfeeding Initiation rate - Scarborough<br>* Breastfeeding rate at discharge - Scarborough<br>* Smoking at 36 weeks - Scarborough<br>* Smoking at time of delivery - Scarborough<br>* Carbon monoxide monitoring at booking - Scarborough<br>* Carbon monoxide monitoring at 36 weeks - Scarborough<br>* PPH > 1.5L as % of all women - Scarborough<br>* Shoulder Dystocia - Scarborough<br>* Informal Complaints - Scarborough<br>* 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 | Current Month | Monthly Trajectory | Year End Target/Baseline | Target/Baseline |
|---|---|---|---|---|---|---|---|
| Low birthweight rate at term (2.2kg) - Scarborough | 2025-02 | | | 0% | | 0% | Target |
| Breastfeeding Initiation rate - Scarborough | 2025-02 | | | 63.6% | | 75% | Target |
| Breastfeeding rate at discharge - Scarborough | 2025-02 | | | 39.4% | | 65% | Target |
| Smoking at booking - Scarborough | 2025-02 | | | 4% | | 6% | Target |
| Smoking at 36 weeks - Scarborough | 2025-02 | | | 4.9% | | 6% | Target |
| Smoking at time of delivery - Scarborough | 2025-02 | | | 12.1% | | 6% | Target |
| Carbon monoxide monitoring at booking - Scarborough | 2025-02 | | | 94.8% | | 95% | Target |
| Carbon monoxide monitoring at 36 weeks - Scarborough | 2025-02 | | | 75.5% | | 95% | Target |
| SI's - Scarborough | 2023-10 | | | 1 | | 0 | Target |
| PPH > 1.5L as % of all women - Scarborough | 2025-02 | | | 0% | | 2.2% | Baseline |
| Shoulder Dystocia - Scarborough | 2025-02 | | | 1 | | 2 | Target |
| 3rd/4th Degree Tear - normal births - Scarborough | 2025-02 | | | 0% | | 2.8% | Target |
| 3rd/4th Degree Tear - assisted birth - Scarborough | 2025-02 | | | 0% | | 6.1% | Target |
| Informal Complaints - Scarborough | 2025-02 | | | 0 | | 0 | Target |
| Formal Complaints - Scarborough | 2025-02 | | | 0 | | 0 | Target |

# 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 | Current Month | Monthly Trajectory | Year End Target/Baseline | Target/Baseline |
|---|---|---|---|---|---|---|---|
| Bookings - Scarborough | 2025-02 | | P | 98 | | 169 | Target |
| Bookings <10 weeks - Scarborough | 2025-02 | | F | 78.6% | | 90% | Target |
| Bookings ≥13 weeks (exc transfers etc.) - Scarborough | 2025-02 | | ? | 4% | | 10% | Target |
| Births - Scarborough | 2025-02 | | ? | 98 | | 113 | Target |
| No. of women delivered - Scarborough | 2025-02 | | ? | 97 | | 112 | Target |
| Planned homebirths - Scarborough | 2025-02 | L | F | 0% | | 2.1% | Target |
| Homebirth service suspended - Scarborough | 2025-01 | H | F | 24 | | 3 | Target |
| Women affected by suspension - Scarborough | 2025-01 | | ? | 0 | | 0 | Target |
| Community midwife called in to unit - Scarborough | 2025-01 | L | P | 0 | | 3 | Target |
| Maternity Unit Closure - Scarborough | 2024-12 | | ? | 2 | | 0 | Target |
| SCBU at capacity - Scarborough | 2025-01 | | ? | 4 | | 1 | Baseline |
| SCBU at capacity of intensive care cots - Scarborough | 2025-01 | | ? | 11 | | 5.2 | Baseline |
| SCBU no of babies affected - Scarborough | 2025-01 | H | ? | 1 | | 0 | Target |
| 1 to 1 care in Labour - Scarborough | 2025-02 | | ? | 100% | | 100% | Target |
| L/W Co-ordinator supernumerary % - Scarborough | 2025-02 | H | ? | 100% | | 100% | Target |
| Anaesthetic cover on L/W - Scarborough | 2025-01 | | F | 5 | | 10 | Target |

# 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 | | * SCBU at capacity - York<br>* SCBU no of babies affected - York<br>* L/W Co-ordinator supernumerary % - York | |
| COMMON CAUSE / NATURAL VARIATION | * Bookings ≥13 weeks (exc transfers etc.) - York<br>* Community midwife called in to unit - York<br>* Anaesthetic cover on L/W - York | * Bookings - York<br>* Bookings <10 weeks - York<br>* Births - York<br>* No. of women delivered - York<br>* Planned homebirths - York<br>* Homebirth service suspended - York<br>* Women affected by suspension - York<br>* Maternity Unit Closure - York<br>* SCBU at capacity of intensive care cots - York<br>* 1 to 1 care in Labour - 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 | Current Month | Monthly Trajectory | Year End Target/Baseline | Target/Baseline |
|---|---|---|---|---|---|---|---|
| Bookings - York | 2025-02 | | | 267 | | 295 | Target |
| Bookings <10 weeks - York | 2025-02 | | | 76.4% | | 90% | Target |
| Bookings ≥13 weeks (exc transfers etc.) - York | 2025-02 | | P | 3.4% | | 10% | Target |
| Births - York | 2025-02 | | | 184 | | 245 | Target |
| No. of women delivered - York | 2025-02 | | | 182 | | 242 | Target |
| Planned homebirths - York | 2025-02 | | | 1.7% | | 2.1% | Target |
| Homebirth service suspended - York | 2025-02 | | | 9 | | 3 | Target |
| Women affected by suspension - York | 2025-02 | | | 0 | | 0 | Target |
| Community midwife called in to unit - York | 2025-02 | | P | 0 | | 3 | Target |
| Maternity Unit Closure - York | 2024-12 | | | 0 | | 0 | Target |
| SCBU at capacity - York | 2025-02 | L | | 0 | | 0.2 | Baseline |
| SCBU at capacity of intensive care cots - York | 2025-02 | | | 4 | | 22.2 | Baseline |
| SCBU no of babies affected - York | 2025-02 | L | | 0 | | 0 | Target |
| 1 to 1 care in Labour - York | 2025-02 | | | 100% | | 100% | Target |
| L/W Co-ordinator supernumerary % - York | 2025-02 | H | | 100% | | 100% | Target |
| Anaesthetic cover on L/W - York | 2025-01 | | P | 10 | | 10 | Target |

# 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 | | | |
| COMMON CAUSE / NATURAL VARIATION | * Intrapartum Stillbirths - York | * Normal Births - York<br>* Assisted Vaginal Births - York<br>* C/S Births - York<br>* Elective caesarean - York<br>* Emergency caesarean - York<br>* Induction of labour - York<br>* BBA - York<br>* HSIB cases - York<br>* Neonatal Death - York<br>* Antepartum Stillbirth - York<br>* Cold babies - York<br>* Preterm birth rate <37 weeks - York<br>* Preterm birth rate <34 weeks - York | |
| SPECIAL CAUSE CONCERN | | * Preterm birth rate <28 weeks - 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 | Current Month | Monthly Trajectory | Year End Target/Baseline | Target/Baseline |
|---|---|---|---|---|---|---|---|
| Normal Births - York | 2025-02 | | | 54.3% | | 57% | Target |
| Assisted Vaginal Births - York | 2025-02 | | | 7.6% | | 12.4% | Target |
| C/S Births - York | 2025-02 | | | 38% | | 35.3% | Baseline |
| Elective caesarean - York | 2025-02 | | | 16.3% | | 14.7% | Baseline |
| Emergency caesarean - York | 2025-02 | | | 20.7% | | 20.6% | Baseline |
| Induction of labour - York | 2025-02 | | | 42% | | 44.9% | Baseline |
| HDU on L/W - York | 2023-10 | | | 8 | | 5 | Target |
| BBA - York | 2025-02 | | | 0 | | 2 | Target |
| HSIB cases - York | 2025-02 | | | 0 | | 0 | Target |
| Neonatal Death - York | 2025-02 | | | 0 | | 0 | Target |
| Antepartum Stillbirth - York | 2025-02 | | | 1 | | 0 | Target |
| Intrapartum Stillbirths - York | 2025-02 | | P | 0 | | 0 | Target |
| Cold babies - York | 2025-02 | | | 0 | | 1 | Target |
| Preterm birth rate <37 weeks - York | 2025-02 | | | 4.8% | | 6% | Target |
| Preterm birth rate <34 weeks - York | 2025-02 | | | 2.7% | | 2% | Target |
| Preterm birth rate <28 weeks - York | 2025-02 | H | | 2.2% | | 0.5% | Target |

# 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 | | | |
| COMMON CAUSE / NATURAL VARIATION | * Breastfeeding Initiation rate - York<br>* 3rd/4th Degree Tear - assisted birth - York | * Low birthweight rate at term (2.2kg) - York<br>* Breastfeeding rate at discharge - York<br>* Smoking at booking - York<br>* Smoking at 36 weeks - York<br>* Smoking at time of delivery - York<br>* Carbon monoxide monitoring at booking - York<br>* Carbon monoxide monitoring at 36 weeks - York<br>* PPH > 1.5L as % of all women - York<br>* Shoulder Dystocia - York<br>* 3rd/4th Degree Tear - normal births - York<br>* Informal Complaints - York<br>* 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 | Current Month | Monthly Trajectory | Year End Target/Baseline | Target/Baseline |
|---|---|---|---|---|---|---|---|
| Low birthweight rate at term (2.2kg) - York | 2025-02 | | | 0.5% | | 0% | Target |
| Breastfeeding Initiation rate - York | 2025-02 | | P | 78.1% | | 75% | Target |
| Breastfeeding rate at discharge - York | 2025-02 | | | 64.1% | | 65% | Target |
| Smoking at booking - York | 2025-02 | | | 6% | | 6% | Target |
| Smoking at 36 weeks - York | 2025-02 | | | 5.2% | | 6% | Target |
| Smoking at time of delivery - York | 2025-02 | | | 6% | | 6% | Target |
| Carbon monoxide monitoring at booking - York | 2025-02 | | | 86.9% | | 95% | Target |
| Carbon monoxide monitoring at 36 weeks - York | 2025-02 | | | 79.7% | | 95% | Target |
| SI's - York | 2025-02 | | | 0 | | 0 | Target |
| PPH > 1.5L as % of all women - York | 2025-02 | | | 2.7% | | 4.3% | Baseline |
| Shoulder Dystocia - York | 2025-02 | | | 2 | | 2 | Target |
| 3rd/4th Degree Tear - normal births - York | 2025-02 | | | 1.6% | | 2.8% | Target |
| 3rd/4th Degree Tear - assisted birth - York | 2025-02 | | P | 0.6% | | 6.1% | Target |
| Informal Complaints - York | 2025-02 | | | 0 | | 0 | Target |
| Formal Complaints - York | 2025-02 | | | 2 | | 0 | Target |

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

# WORKFORCE

April 2025

# Summary MATRIX

**Workforce:** *please note that any metric without a target will not appear in the matrix below*

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) | * Total Agency Whole Time Equivalent Filled<br>* Overall corporate induction compliance<br>* A4C staff corporate induction compliance | * Annual absence rate<br>* HCSW vacancy rate<br>* A4C staff stat/mand training compliance<br>* Medical & dental staff corporate induction compliance<br>* Appraisal Activity |
| COMMON CAUSE / NATURAL VARIATION | | * Monthly sickness absence<br>* Overall vacancy rate<br>* Medical and dental vacancy rate<br>* Registered Nursing vacancy rate<br>* AHP vacancy rate<br>* Total Bank Whole Time Equivalent Filled | * Overall stat/mand training compliance<br>* Medical & dental staff stat/mand training compliance |
| SPECIAL CAUSE CONCERN | | * Midwifery vacancy rate | |

# Workforce
## Scorecard (1)

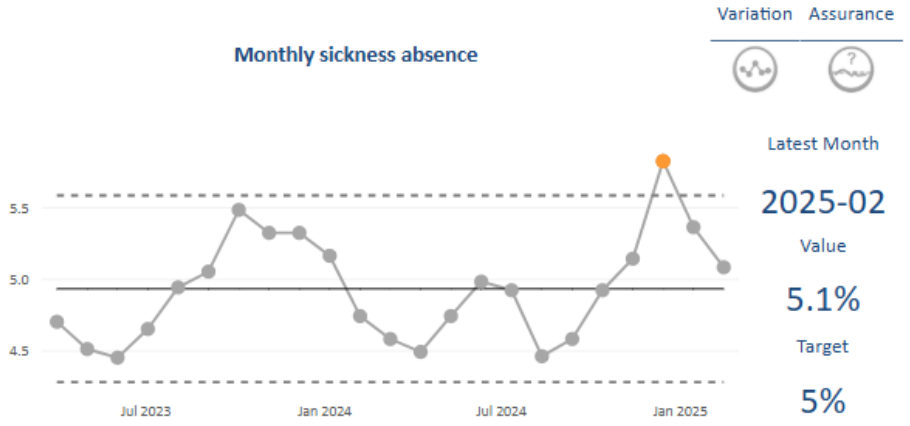
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Monthly sickness absence | 2025-02 | | | 5.1% | | 5% |
| Annual absence rate | 2025-02 | L | F | 4.9% | 4.7% | 4.7% |
| 12 month rolling turnover rate Trust (FTE) | 2025-03 | L | P | 8.4% | | 10% |
| Overall vacancy rate | 2025-03 | | | 6.9% | | 6% |
| HCSW vacancy rate | 2025-03 | L | F | 9.6% | | 5% |
| Midwifery vacancy rate | 2025-03 | H | | 2.5% | | 0% |
| Medical and dental vacancy rate | 2025-03 | | | 7.5% | | 6% |
| Registered Nursing vacancy rate | 2025-03 | | | 6.7% | | 5% |
| AHP vacancy rate | 2025-03 | | | 6.7% | 8.5% | 8.5% |
| Total Agency Whole Time Equivalent Filled | 2025-02 | L | | 121.9 | | 151 |
| Total Bank Whole Time Equivalent Filled | 2025-02 | | | 682 | | 557 |
| OVERALL: Percentage of rosters approved six weeks before start date | 2025-02 | | F | 17.9% | | 100% |
| NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent | 2025-02 | L | | 6058.7 | 0 | 0 |
| NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom) | 2025-02 | | F | 28% | 22% | 22% |

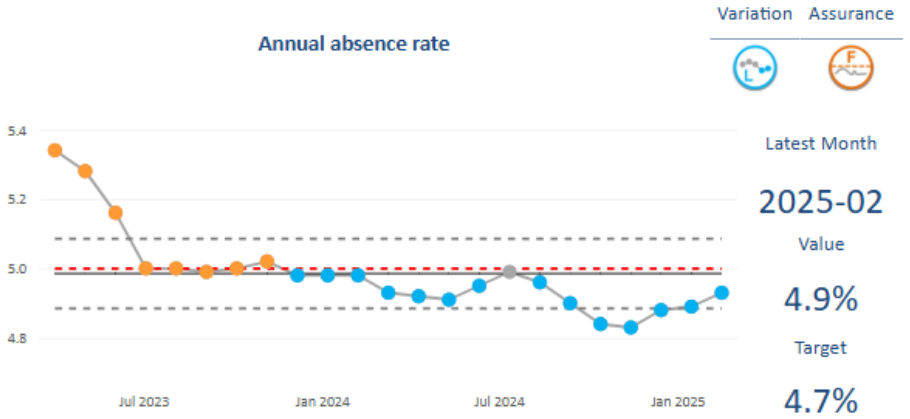
**Executive Owner:** Polly McMeekin

**Operational Lead:** Lydia Larcum




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 **0.3**.




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**.

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

**Factors impacting performance and actions**:

This table below shows a detailed breakdown of reasons for absence in February. It includes the level of WTE lost to each reason and the percentage contribution to total absences. As we move out of the winter pressures, sickness continues to reduce with the overall sickness reducing by 24 WTE in February.

| Absence Reason | WTE Lost | % |
|---|---|---|
| Anxiety/stress/depression/other psychiatric illnesses | 112.78 | 24.1 |
| Cold, Cough, Flu - Influenza | 53.63 | 11.5 |
| Known causes not classified on ESR | 52.89 | 11.3 |
| Other (11 lowest absence reasons combined) | 44.48 | 9.5 |
| Other musculoskeletal problems | 39.42 | 8.4 |
| Gastrointestinal problems | 36.86 | 7.9 |
| Injury, fracture | 22.49 | 4.8 |
| Back Problems | 21.17 | 4.5 |
| Benign and malignant tumours, cancers | 16.16 | 3.5 |
| Pregnancy related disorders | 15.32 | 3.3 |
| Heart, cardiac & circulatory problems | 14.30 | 3.1 |
| Headache / migraine | 14.05 | 3.0 |
| Chest & respiratory problems | 13.75 | 2.9 |
| Genitourinary & gyanecological disorders | 10.64 | 2.3 |

Anxiety and stress and cold and ‘flu remain the two largest causes of staff absence. The 11 causes grouped under the heading “other” includes ear, nose, throat (8.48 WTE), skin disorders (6.28 WTE) and eye problems (5.35 WTE).

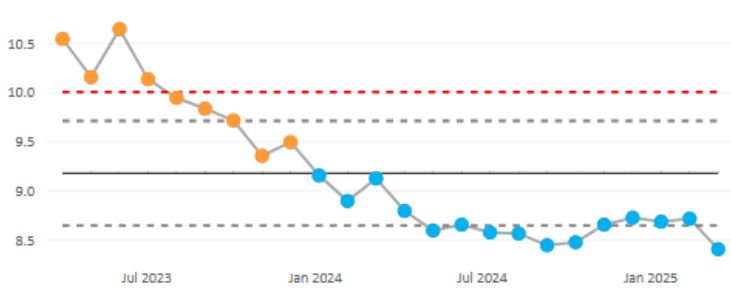
**Executive Owner:** Polly McMeekin

**Operational Lead:** Lydia Larcum

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

Variation Assurance

**12 month rolling turnover rate Trust (FTE)**



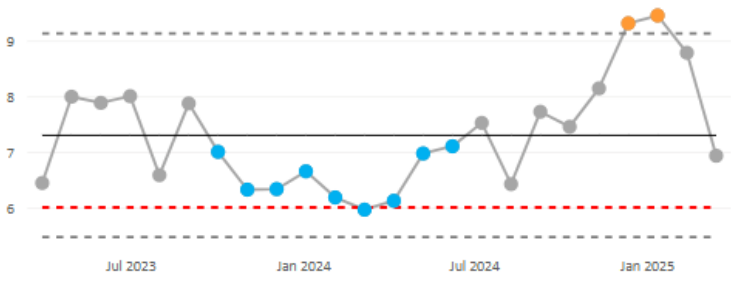

Latest Month
2025-03
Value
8.4%
Target
10%

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

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

Variation Assurance

**Overall vacancy rate**




Latest Month
2025-03
Value
6.9%
Target
6%

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 **1.9**.

**Factors impacting performance and actions**:

The Trust has commissioned training with our employment law solicitors, Hempsons to deliver refreshed training for colleagues sitting on formal panels and appeal panels. The training will take place over the coming months and aims to ensure hearings of all employee relations cases are fair, inclusive and conducted to a consistently high standard.

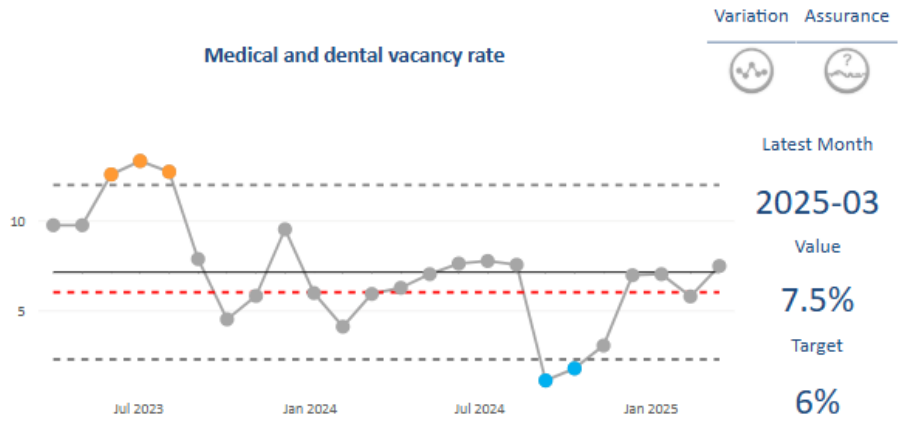
Recruitment restrictions remain in place through the enhanced vacancy control process. At the end of February 2025, the Trust was 2.3% (222 WTE) above its 2024-25 planned workforce size. The substantive workforce grew by 47 WTE from January, while bank workforce usage was up 36 WTE on the previous month. This was attributable to a combination of filling vacancies and covering staff absences. The March vacancy data, however, indicates this position has since improved with contractions in budgeted establishments and the number of staff in post contributing to a significant vacancy reduction.

60 pre-registered nurses linked to partner HEIs had career conversations with the Trust across several Saturdays in March. These nurses are now in the process of being assigned to wards and departments ahead of their start dates in the autumn.

**Executive Owner:** Polly McMeekin

**Operational Lead:** Lydia Larcum

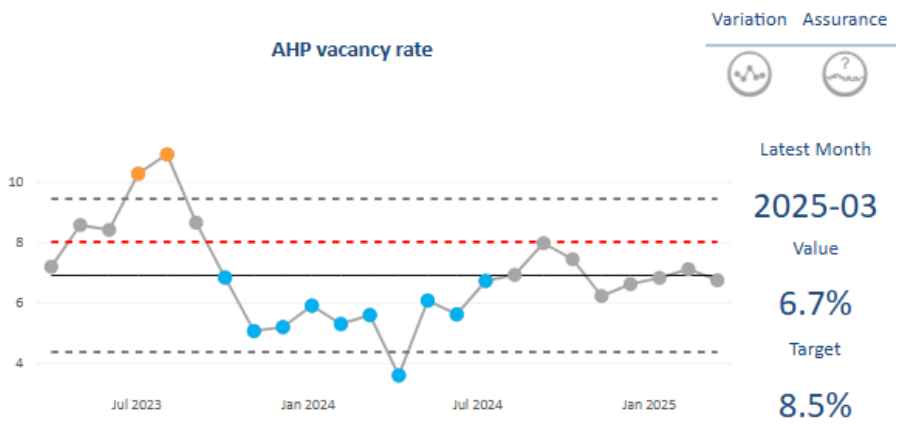
### Medical and dental vacancy rate




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 **1.7**.

### AHP vacancy rate




The indicator is **better 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 **0.4**.

**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**:

In March, the Trust welcomed 13 new medical staff into a range of posts across Emergency Medicine, General Medicine, Obstetrics and Gynaecology, Trauma and Orthopaedics, Anaesthetics and Urology.

In addition, 19 offers of employment in medical posts were made, including five Consultant posts, with two being for permanent posts in Emergency Medicine.

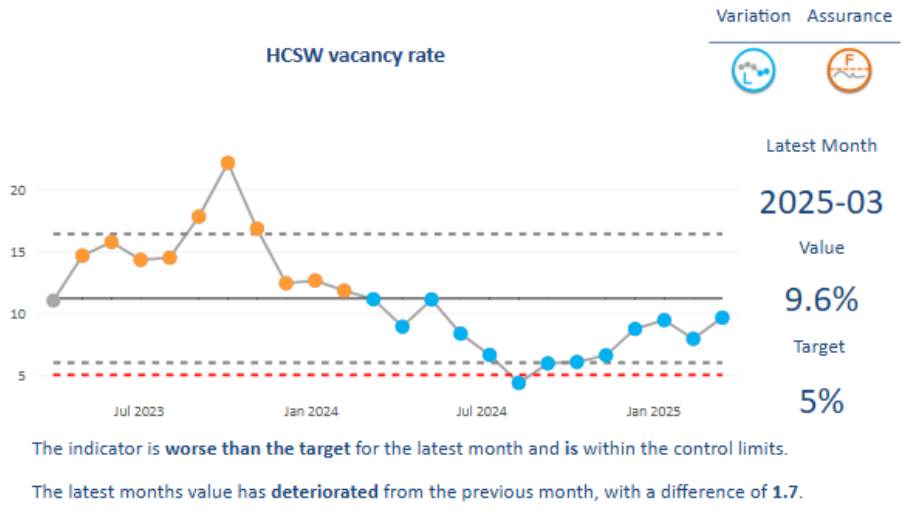
The Trust continues to support its internationally recruited nursing cohorts through their OCSE training, with the cohort of nine nurses that joined the organisation in February recently sitting their OCSE exams, achieving an 89.89% pass rate.

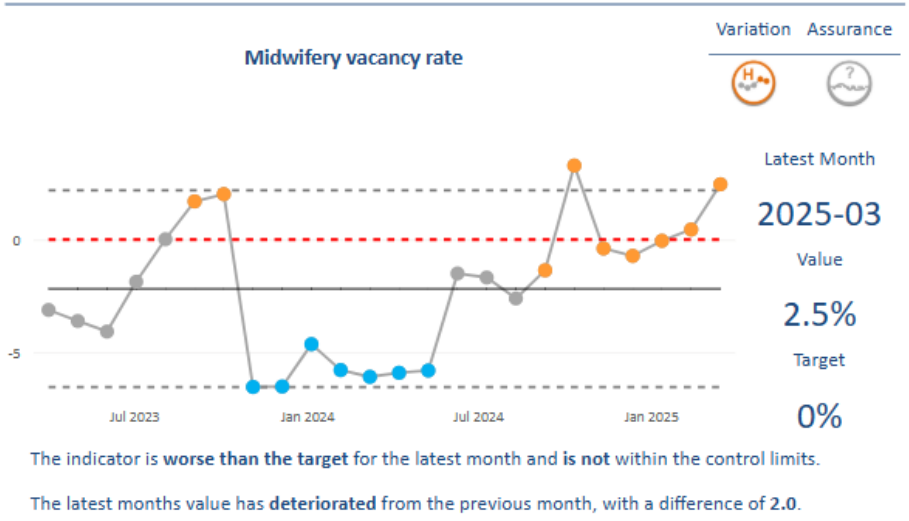
The UK Government has updated the minimum salary floor for skilled worker visa applications. It has risen from £23,200 to £25,000 per year. As a result, the Trust will no longer be able to sponsor employment visas for roles remunerated either at Agenda for Change Band 2 or the starting point of Band 3. This applies to Certificates of Sponsorship (CoS) issued from 9th April. The Trust have identified six existing staff who will be affected by the change and are working with them to bring forward the renewal of their CoS before the new rule comes info effect.

**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**:

In response to the rising HCSW vacancy rate, work is underway to increase the frequency of interviews across care groups and to ensure the optimum number of offers are being made at each interview session. Care groups are being encouraged to consider the forecasted position and plan for future gaps such as the HCSWs that will leave their posts in September to begin their NA apprenticeship.

There are currently 28.26 WTE HCSWs undertaking pre-employment checks with the Trust. A further 20.40 WTE HCSWs are booked onto upcoming Academy programmes.

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. The numbers for Nursing Associates has increased slightly. In February, the Trust had 60 Nursing Associates (55 WTE) and in March those numbers increased to 66 (60.07 WTE).

# 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** | | | | | | | | |
| Dec-24 | 2596.26 | 137.15 | 142.53 | 299.70 | 20.02 | 156.80 | 65.80 | -57.08 |
| Jan-25 | 2599.84 | 143.44 | 128.03 | 333.00 | 61.53 | 176.50 | 74.80 | -20.17 |
| Feb-25 | 2589.30 | 126.35 | 122.54 | 288.80 | 39.91 | 180.90 | 54.90 | -13.09 |
| **HCA** | | | | | | | | |
| Dec-24 | 1277.11 | 111.41 | 69.13 | 276.00 | 95.46 | 208.60 | 0.00 | 28.06 |
| Jan-25 | 1277.11 | 121.98 | 62.43 | 319.80 | 135.39 | 240.80 | 0.00 | 56.39 |
| Feb-25 | 1264.72 | 100.18 | 59.15 | 277.30 | 117.97 | 216.10 | 0.00 | 56.77 |
| **M&D** | | | | | | | | |
| Dec-24 | 1105.74 | 76.81 | 57.92 | 159.68 | 24.95 | 71.20 | 59.65 | -3.88 |
| Jan-25 | 1106.04 | 65.44 | 52.10 | 160.31 | 42.77 | 81.10 | 56.43 | 19.99 |
| Feb-25 | 1103.85 | 63.71 | 49.49 | 147.13 | 33.93 | 78.70 | 49.31 | 14.81 |

**Factors impacting performance and actions**:

The Nursing eRostering Assurance Group and Medical Temporary Staffing Review Group continue to monitor KPIs to ensure temporary staffing use is being managed effectively and to explore opportunities for improvement.

All ad hoc nursing agency shifts within the Trust are now within the NHSE agency price cap. This leaves several agency block bookings within Maternity and Theatres outside the agency price caps. The Trust has proactively worked with these suppliers to reduce the rates below the 50% price cap breach from December onwards and have recently negotiated a further reduction of Theatre rates for 20 workers. The Nursing eRostering Assurance Group will monitor block bookings and explore opportunities to reduce costs moving forward.

In line with the ICB timescales, the Trust has successfully implemented CloudStaff software and has launched the Collaborative Bank to nursing staff in the organisation, with 40 members of staff signing up to work across the collaborative in the region. Unfortunately, partnering NHS Trusts are not at a stage of readiness to support going live, so the organisation remains on standby cost-effective.

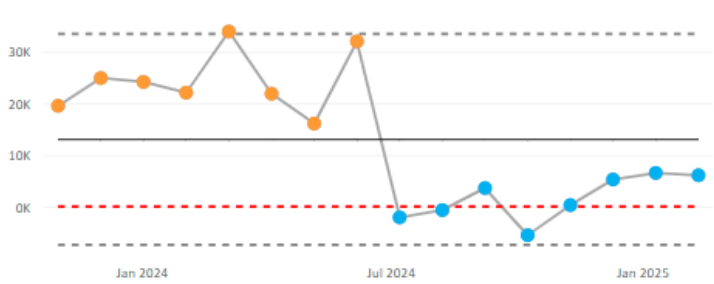
The Trust has successfully moved all its medical agency bookings to Direct Engagement (DE), achieving 100% in line with AHP agency bookings. DE is considered the most cost-effective approach for agency bookings, and it is a significant milestone for the Trust to have achieved this.

The Trust has been monitoring the number of administrative bank shifts undertaken each month. 732 shifts were worked in March which is a reduction from the previous month, when 767 shifts were worked. With further restrictions introduced around vacancy control, the organisation will continue to monitor this activity closely.

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

### NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent

Variation Assurance



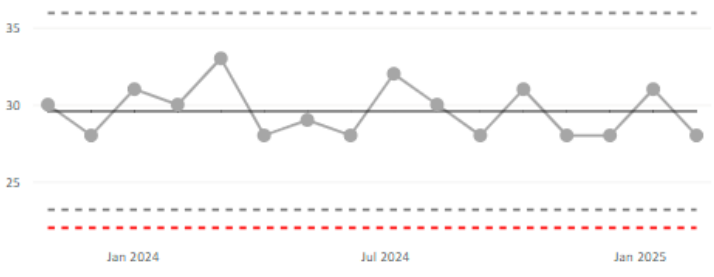

Latest Month
2025-02
Value
6058.7
Target
0

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 **450.2**.

### NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom)

Variation Assurance




Latest Month
2025-02
Value
28%
Target
22%

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 **3.0**.

**Rationale:** Ensure maximum availability of workforce through effective rostering, supporting reduction in temporary staffing reliance.
**Target:** Net hours fewer than 12.5 hours per person.
Clinical Unavailability within budgeted headroom.

**Factors impacting performance and actions**:
A recent audit of eRostering, to review the effective use of staff resources after the introduction of the policy and operational changes to the roster system for nursing has been rated as providing 'significant assurance'. This helps to demonstrate the impact and success the eRoster Improvement Programme is having in the organization.
The Trust has self-assessed at Level 4 of the NHS England Level of Attainment Standards for eRostering within nursing in-patient ward areas.
Within nursing in-patient ward areas, the latest data shows 85% of rosters were published on time, with 55% of rosters for non-IPUs. The aim is to publish 100% of rosters with at least 6 weeks' notice.
The utilisation of self-rostering or the auto-roster function is low at present. Ward 31 have recently stopped piloting self rostering. The Trust is exploring ways to increase take-up, to release efficiencies and support a better work life balance for staff.

| | % of rosters self-rostered | Number of areas self-rostered | % of areas using auto-roster function | Number of areas using auto-roster function | % of rosters auto-rostered where function used |
|---|---|---|---|---|---|
| In-patient Wards | 3.5% | 2 | 25% | 14 | 29.09% |
| Non-IPU's | 0% | 0 | 44.03% | 48 | 28.51% |
| AHPs | 0% | 0 | 95.65% | 44 | 28.02% |

The Trust is aiming to have 90% of the clinical workforce on eRostering by Summer 2025, there are just 2 staffing groups remaining to achieve this.

| Staffing Group | % on Healthroster | Staffing Group | % on Healthroster |
|---|---|---|---|
| Nursing and Midwifery | 99% | AHP | 99% |
| Additional Clinical Services | 90% | Healthcare Scientists | 45% |
| Sci and Technical | 93% | Medical and Dental | 56% |
| Admin and Clerical | 51% | Estates and Ancillary | 4% |

# Workforce
## Scorecard (2)

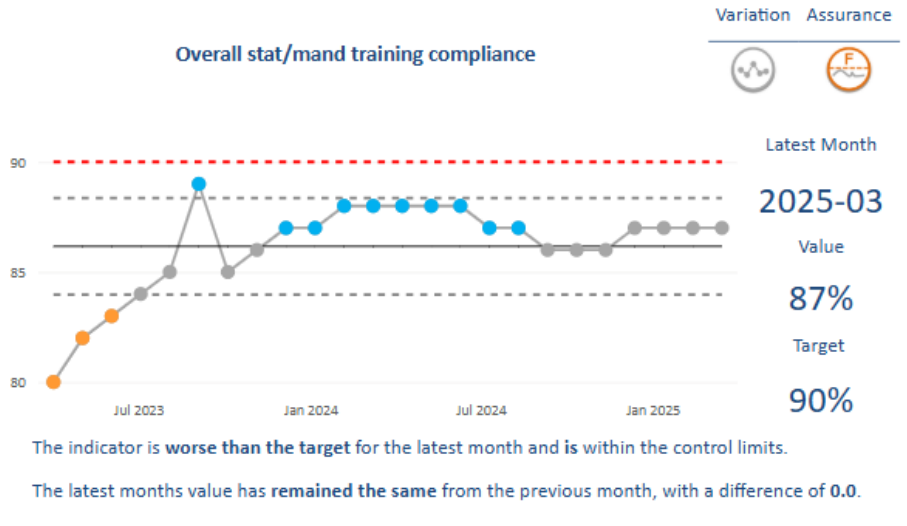
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

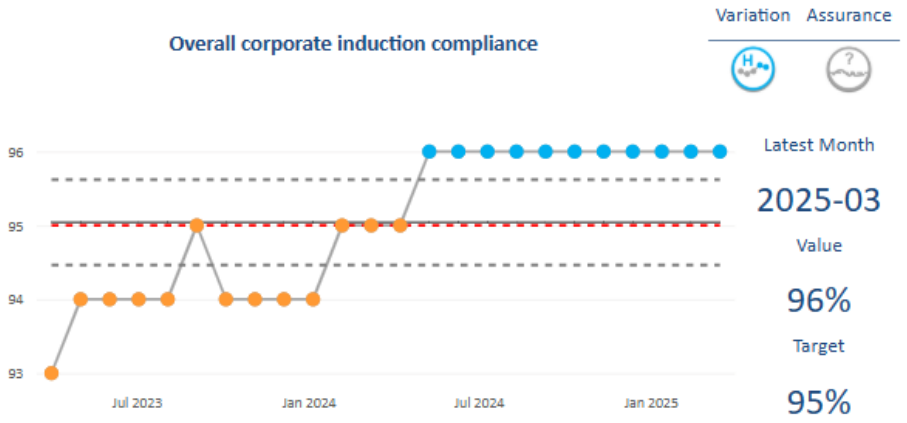
**Executive Owner:** Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Overall stat/mand training compliance | 2025-03 | | F | 87% | | 90% |
| Overall corporate induction compliance | 2025-03 | H | ? | 96% | | 95% |
| A4C staff stat/mand training compliance | 2025-03 | H | F | 89% | | 90% |
| A4C staff corporate induction compliance | 2025-03 | H | ? | 96% | | 95% |
| Medical & dental staff stat/mand training compliance | 2025-03 | | F | 75% | | 90% |
| Medical & dental staff corporate induction compliance | 2025-03 | H | F | 95% | | 95% |
| Appraisal Activity | 2024-12 | H | F | 88.2% | 92.3% | 95% |
| Percentage recommending the Trust as a place to work (quarterly - data source is PULSE, Staff Survey data omitted for Q3) | 2025-01 | | | 35.3% | | |
| Percentage recommending the Trust as a place to receive treatment (quarterly - data taken from PULSE, Staff Survey data omitted for Q3) | 2025-01 | | | 32.7% | | |

**Executive Owner:** Polly McMeekin

**Operational Lead:** Will Thornton & Gail Dunning




**Rationale:** Trained workforce delivering consistently safe care
**Target:** Mandatory Training 90% and Corporate Induction 95%

**Factors impacting performance and actions**:

From April, the Trust has adopted a new target for statutory and mandatory training compliance. The 90% target strives for a 3% increase in the level of completion from current levels. There are some key groups that form the focus of improvement plans, including YTHFM, medical and dental, and bank staff. It is anticipated that the recent national agreement for portability of mandatory training for staff moving between NHS organisations will also support improvements in compliance.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

# DIGITAL AND INFORMATION SERVICES

April 2025

# Summary MATRIX

**Digital:** *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

| VARIATION | ASSURANCE: PASS | ASSURANCE: HIT or MISS | ASSURANCE: FAIL |
|---|---|---|---|
| SPECIAL CAUSE IMPROVEMENT | | * Percentage of FOIs and EIRs responded to within 20 working days (monthly) | |
| COMMON CAUSE / NATURAL VARIATION | | * Number of P1 incidents* | |
| SPECIAL CAUSE CONCERN | * Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly) | | |

# Digital & Information Services (DIS)
## Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

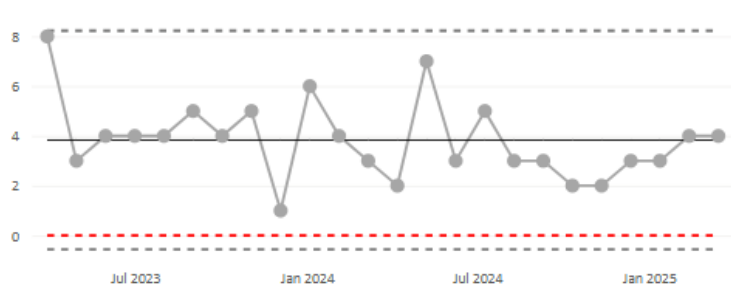
| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Number of P1 incidents* | 2025-03 | | ? | 4 | | 0 |
| Total number of calls to Service Desk | 2025-03 | | | 4396 | | |
| Total number of calls abandoned | 2025-03 | | | 1345 | | |
| Number of information security incidents reported and investigated | 2025-03 | | | 28 | | |
| Number of patient Subject Access Requests (SAR) received (monthly) | 2025-03 | L | | 269 | | |
| Number of patient Subject Access Requests (SAR) completed (monthly) | 2025-03 | | | 273 | | |
| Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly) | 2025-03 | L | P | 60% | | 80% |
| Number of FOIs and EIRs received (monthly) | 2025-03 | | | 65 | | |
| Number of FOIs and EIRs completed (monthly) | 2025-03 | | | 65 | | |
| Percentage of FOIs and EIRs responded to within 20 working days (monthly) | 2025-03 | H | ? | 91% | | 80% |

## Executive Owner: James Hawkins

## Operational Lead: Stuart Cassidy

Variation Assurance

### Number of P1 incidents*

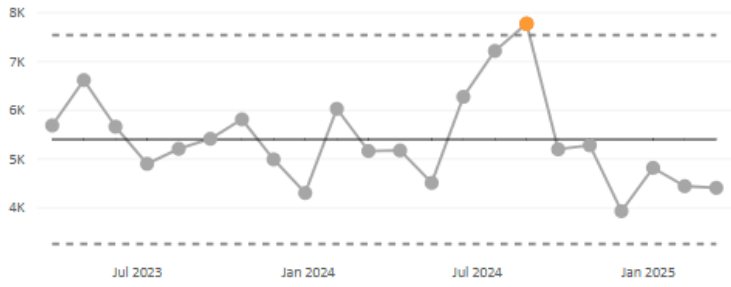



Latest Month
2025-03
Value
4
Target
0

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

Variation Assurance

### Total number of calls to Service Desk




Latest Month
2025-03
Value
4396
No Target

The latest months value has **improved** from the previous month, with a difference of **35.0**.

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

**Target:** 0 P1 Incidents

**Factors impacting performance**:

4x P1 incidents occurred.

1. Saturday 1/3: CT1 scanner at SGH not sending to PACS. Cause = user had turned off a local switch, ignoring a label advising not to power off. Resolved by on-call IT support attending site.
2. Sunday 2/3: Operational Dashboard offline. Staff reporting incident unclear if this is truly a P1 severity incident to be covered for on-call periods, or if staff should be aware of how to use other sources.
3. Thursday 13/3: Nynet issues at Acomb HC resulted in brief loss of network for phones and computers between 12:26 to 12:30 (4 minutes). Cause = core router fault
4. Monday 24/3: AOVPN connection issues affecting some users. Cause = problem affecting 2/6 servers used to handle connections (i.e. 1/3 users attempting to connect in the time period). Duration = 08:08 to 08:47 (39 minutes)

**Actions**:

Telephone call performance has stabilised during February and March with similar levels of calls and abandoned calls to the telephone support queue

The telephone queue provides information on both the caller's place in the queue, and also a "message of the day" for any high-impact incidents, along with encouraging staff to use the online IT Self Service route for non-urgent support.

Staff waiting on hold may choose to hang up after hearing the recorded messages if their issue is not urgent and then call later, or may choose to use the IT Self Service route to support instead.

We will continue to promote the use of IT Self Service as a route to support for non-urgent faults and service requests. This can provide access 24/7 to knowledge articles and request forms that help capture all the relevant details to enable IT support services to be delivered efficiently and effectively.

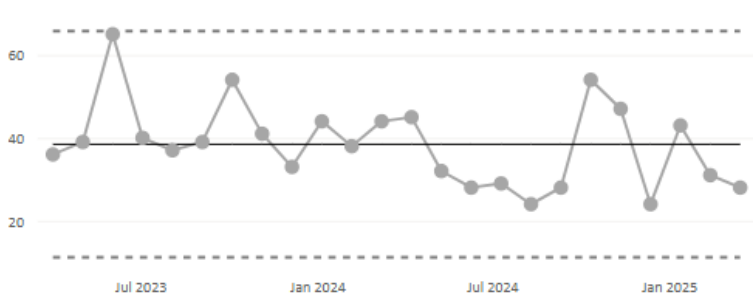
Migrating files from M and G drives to OneDrive is nearly complete. Users are now beginning to have e-mail archives migrated from P:\ to their Online Archive. We aim to mitigate any increased support demand by clear communications and directing users to online support routes.

**Executive Owner:** James Hawkins

**Operational Lead:** Rebecca Bradley

Variation Assurance

### Number of information security incidents reported and investigated




Latest Month
2025-03
Value
28
No Target

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

**Rationale:** Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

Number of information security incidents reported and investigated

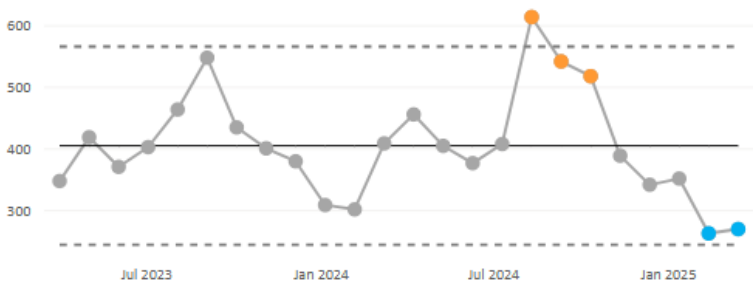
**Factors impacting performance**:

There has been a small decrease in incidents during March.

**Actions:** Trends will be communicated to staff and root cause analysis will be completed on all incident investigations.

Variation Assurance

### Number of patient Subject Access Requests (SAR) received (monthly)




Latest Month
2025-03
Value
269
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **7.0**.

**Rationale:** Monitoring of Subject Access Requests received to ensure the Trust is managing its statutory obligations under the UK GDPR.

Number of Subject Access Requests (SAR) submitted by patients

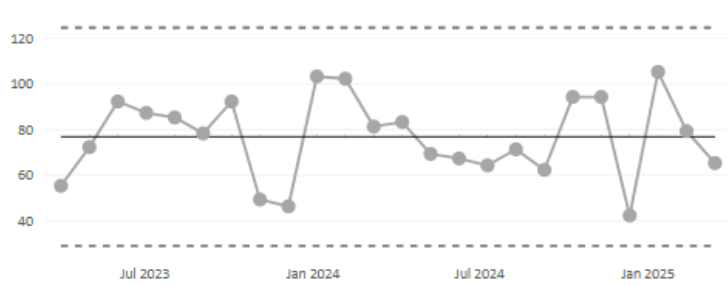
**Factors impacting performance**:
The reporting for SARs has changed to only include patient access requests. Previous reports have also included police requests, access to health records (deceased patients) and ad hoc external requests which are no longer included in this count.

**Executive Owner:** James Hawkins

**Operational Lead:** Rebecca Bradley

### Number of FOIs and EIRs received (monthly)

Variation Assurance

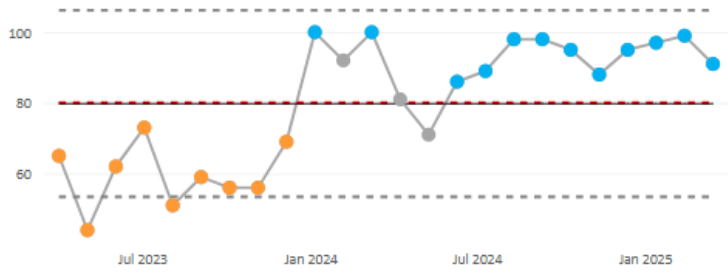



Latest Month
2025-03
Value
65
No Target

The latest months value has **improved** from the previous month, with a difference of **14.0**.

### Percentage of FOIs and EIRs responded to within 20 working days (monthly)

Variation Assurance




Latest Month
2025-03
Value
91%
Target
80%

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 **8.0**.

**Rationale:** Ensuring the Trust responds to % Freedom of Information (FoI) request and Environmental Information Regulation (EIR) requests in line with legislation
**Target:** 80% Freedom of Information (FoI) request and Environmental Information Regulation (EIR) requests responded to within 20 days

**Factors impacting performance**:.

Number of FOIs Received

The number of FoIs the Trust received in March continued to decrease.

**Actions**: N/A

Percentage of FOIs responded to within 20 working days

Requests being sent out on time has decreased; this has been impacted by staff absences within the IG team.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

# FINANCE

April 2025

# Summary Dashboard and Income & Expenditure

## Finance (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

| Key Indicator | Previous Month (YTD) | Current Month (YTD) | Trend | |
|---|---|---|---|---|
| I&E Variance to Plan | -£11.7m | £0m | ↑ | Improving |
| Core CIP Delivery Variance to Plan (£20.0m Target) | £1.5m | £4.1m | ↑ | Improving |
| Corporate CIP Delivery Variance to Plan (£33.3m Target) | -£18.5m | -£22.8m | ↓ | Deteriorating |
| Variance to Agency Cap | £2.2m Below | £2.6m Below | ↑ | Improving |
| Month End Cash Position | £11.2m favourable to plan | £35.3m favourable to plan | ↑ | Improving |
| Capital Programme Variance to Plan | £8.9m behind plan | £22.5m ahead of plan | ↑ | Improving |

| | Plan | Plan YTD | Actual YTD | Variance |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Clinical Income | 745,955 | 745,955 | 813,763 | 67,809 |
| Other Income | 72,215 | 72,215 | 80,856 | 8,642 |
| Total Income | 818,169 | 818,169 | 894,620 | 76,451 |
| | | | | |
| Pay Expenditure | -522,296 | -522,296 | -586,593 | -64,297 |
| Drugs | -68,756 | -68,756 | -77,231 | -8,475 |
| Supplies & Services | -86,381 | -86,381 | -93,038 | -6,658 |
| Other Expenditure | -164,385 | -164,385 | -166,972 | -2,588 |
| Outstanding CIP | 18,703 | 18,703 | 0 | -18,703 |
| Total Expenditure | -823,114 | -823,114 | -923,834 | -100,720 |
| | | | | |
| Operating Surplus/(Deficit) | -4,945 | -4,945 | -29,214 | -24,270 |
| Other Finance Costs | -12,225 | -12,225 | -8,746 | 3,479 |
| Surplus/(Deficit) | -17,169 | -17,169 | -37,960 | -20,791 |
| NHSE Normalisation Adj | 17169 | 17169 | 37970 | 20801 |
| Adjusted Surplus/(Deficit) | 0 | 0 | 9 | 9 |

The I&E table takes into account the additional £18m deficit support funding and presents a balanced plan. From a YTD perspective, the table confirms an actual adjusted deficit of £0m against a planned deficit of £0m.

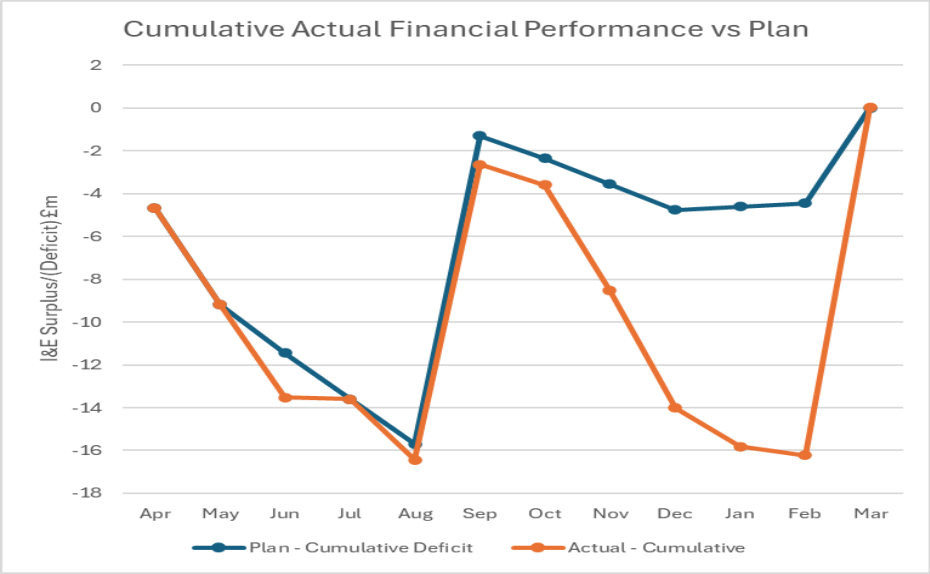
# Key Subjective Variances: Trust
## Finance (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

| Variance | Favourable/ (adverse) £000 | Main Driver(s) | Mitigations and Actions |
|---|---|---|---|
| NHS England income | 30,775 | ERF overperformance, pay award funding and pension contribution | No mitigation or action required. |
| ICB Income | 41,448 | ERF overperformance, deficit support funding & pay award funding | No mitigation or action required. |
| Employee Expenses | (64,297) | Agency, bank and WLI spending is ahead of plan to cover medical vacancies and deliver increased elective activity. Increased cost for additional employers pension contributions offset by income above. | To continue to control agency spending within the cap into 2025/26. Work being led by HR Team to apply NHSE agency best practice controls, continued recruitment programmes (including overseas recruitment). Vacancy control measures now in place. |
| Drug expenses | (8,475) | 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. | Provisional agreement has been reached with ICB and system to release uncommitted ICB provisions to support. |
| Clinical Supplies & Services | (6,658) | 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. | No mitigation or action required – Provisional agreement has been reached with ICB and system to release uncommitted ICB provisions to support. |
| CIP | (18,703) | The Core Programme is £4.1m ahead of plan and the Corporate Programme £22.8m behind plan at M12 | Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group. |

# Cumulative Actual Financial Performance vs Plan

## Finance (3)




In September the Trust received £16.6m deficit support funding and in March the Trust received a further £18m deficit support funding. This represented a stretch ask from NHSE with a requirement to reduce expenditure trends and push delivery of the efficiency programme.

The Trust has been able to control expenditure and accelerate efficiency delivery in the final quarter and has delivered a balanced position, when considering NHSE's normalisation adjustments.

The below table is a detailed breakdown of the NHSE "Normalisation Adjustment" in the I&E presented two slides earlier.

| | £000's |
|---|---|
| SURPLUS/(DEFICIT) | -37,960 |
| Donated Asset Income | 978 |
| Depreciation: donated and government granted assets | -851 |
| Amortisation: Intangibles - donated and government granted assets | -28 |
| Impairments - SGH UEC | -28,415 |
| Impairments - EPR | -6,591 |
| Impairments - Other | -3,063 |
| NHSE Adjusted Surplus/(deficit) | 9 |

The below table summarises the Care Group positions at the end of M12.

| Care Group | YTD Budget | YTD Actual | YTD Variance |
|---|---|---|---|
| | £000 | £000 | £000 |
| Cancer Specialist & Clinical Support Services Group | 189,067 | 191,373 | -2,307 |
| Family Health Care Group | 82,288 | 86,293 | -4,005 |
| Medicine | 186,969 | 201,172 | -14,203 |
| Surgery | 152,962 | 157,738 | -4,776 |
| TOTAL | 611,286 | 636,576 | -25,290 |


## Agency Controls

The Trust's has an agency cap of 3.2% of its overall pay spend in its plan. YTD M12 agency spend is 2.7% of overall pay spend, £14.8m against a plan of £17.4m.

| | Establishment | | | Year to Date Expenditure | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Budget | Actual | Variance |
| | WTE | WTE | WTE | £0 | £0 | £0 |
| Registered Nurses | 2,595.29 | 2,470.99 | 124.30 | 142,931 | 142,517 | 414 |
| Scientific, Therapeutic and Technical | 1,301.58 | 1,240.34 | 61.24 | 71,085 | 70,648 | 438 |
| Support To Clinical Staff | 1,923.07 | 1,706.83 | 216.24 | 64,561 | 67,481 | -2,920 |
| Medical and Dental | 1,105.85 | 1023.83 | 82.02 | 146,470 | 161,984 | -15,514 |
| Non-Medical - Non-Clinical | 3,258.85 | 2,870.08 | 388.77 | 117,723 | 109,854 | 7,869 |
| Reserves | | | | -22,623 | 0 | -22,623 |
| Other | | | | 2,148 | 34,109 | -31,961 |
| TOTAL | 10,184.64 | 9,312.07 | 872.57 | 522,296 | 586,593 | -64,297 |

## 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 position relates to the shortfall in the delivery of the corporate CIP and the 'Other' relates to the increased employers pension contributions which are fully funded. The table illustrates that the key driver for the operational pay position is spend against Medical and Dental staff.

***Trust Performance Summary vs ERF Target Performance***

| Commissioner | 24-25 Target % vs 19/20 | ERF Confirmed Targets Weighted Value at 24/25 PA prices | ERF Month 12 Phase (Av %) | Activity to Month 12 Actual | Variance - (Clawback Risk) | % Compliance Vs 19/20 |
|---|---|---|---|---|---|---|
| Humber and North Yorks | 104.00% | £130,123,659 | £130,123,659 | £161,989,721 | £31,866,062 | 129.5% |
| West Yorkshire | 103.00% | £1,365,316 | £1,365,316 | £1,652,341 | £287,025 | 124.7% |
| Cumbria and North East | 115.00% | £172,009 | £172,009 | £248,233 | £76,224 | 166.0% |
| South Yorkshire | 121.00% | £149,829 | £149,829 | £173,547 | £23,718 | 140.2% |
| *Other ICBs - LVA / NCA* | - | | | | *£0* | - |
| ***All ICBs*** | ***104.02%*** | ***£131,810,813*** | ***£131,810,813*** | ***£164,063,842*** | ***£32,253,029*** | **129.5%** |
| NHSE Specialist Commissioning | 113.38% | £4,100,507 | £4,100,507 | £3,984,041 | -£116,466 | 110.2% |
| Other NHSE | 104.13% | £296,661 | £296,661 | £274,809 | -£21,852 | 96.5% |
| **All Commissioners Total** | **104.31%** | **£136,207,981** | **£136,207,981** | **£168,322,692** | **£32,114,712** | **128.9%** |

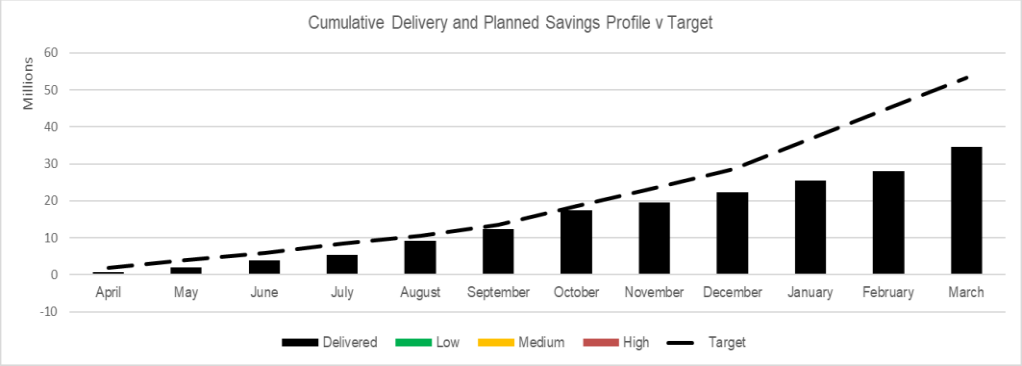
## Elective Recovery Fund

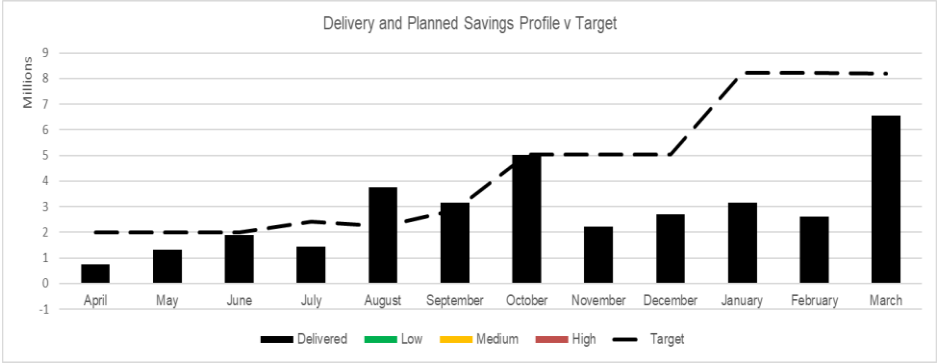
To give an early indication of ERF performance, we have developed an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date before applying average tariff income to the activity. Activity remains significantly up against the ERF Baseline target and following the backdated submission of some coding and counting corrections, it potentially presents an overall £32.1m surplus for the period up to Month 12.

However, the updated FOT on ERF income now exceeds the HNY ICB indicative financial ceiling threshold by over £4.7m. We do not expect this to cause any issues and expect a truing up exercise later in quarter 1 of 2025/26 but there is some residual low-level risk in this position.

# Cost Improvement Programme
## Finance (6)

York and Scarborough Teaching Hospitals NHS Foundation Trust




**2024/25 Cost Improvement Programme - March Position**

| | Full Year CIP Target | Full Year Position | |
|---|---|---|---|
| | | Delivery | Variance |
| | £000 | £000 | £000 |
| Corporate Programme | 33,326 | 10,541 | 22,784 |
| | **33,326** | **10,541** | **22,784** |
| **Core Programme** | | | |
| Medicine | 4,152 | 3,461 | 691 |
| Surgery | 4,120 | 4,384 | -264 |
| CSCS | 6,290 | 8,607 | -2,317 |
| Family Health | 1,797 | 2,217 | -420 |
| CEO | 104 | 129 | -25 |
| Chief Nurses Team | 207 | 557 | -350 |
| Finance | 382 | 439 | -57 |
| Medical Governance | 23 | 520 | -497 |
| Ops Management | 233 | 240 | -6 |
| DIS | 427 | 427 | 0 |
| Workforce & OD | 361 | 754 | -393 |
| YTHFM LLP | 1,840 | 2,288 | -447 |
| Central | 0 | 0 | 0 |
| | **19,936** | **24,022** | **-4,086** |
| **Total Programme** | **53,262** | **34,563** | **18,699** |

Corporate Efficiency Programme

The Corporate efficiency programme has delivered £10.5 towards the £33.3m target, £7.4m of which are recurrent savings. It ended the financial year £22.8m behind plan.

Core Efficiency Programme

The core efficiency programme delivered £24m towards the required £20m target of which £6.8m are recurrent savings. The core programme over delivered its plan by £4.1m.

# Current Cash Position and Better Payment Practice Code (BPPC)

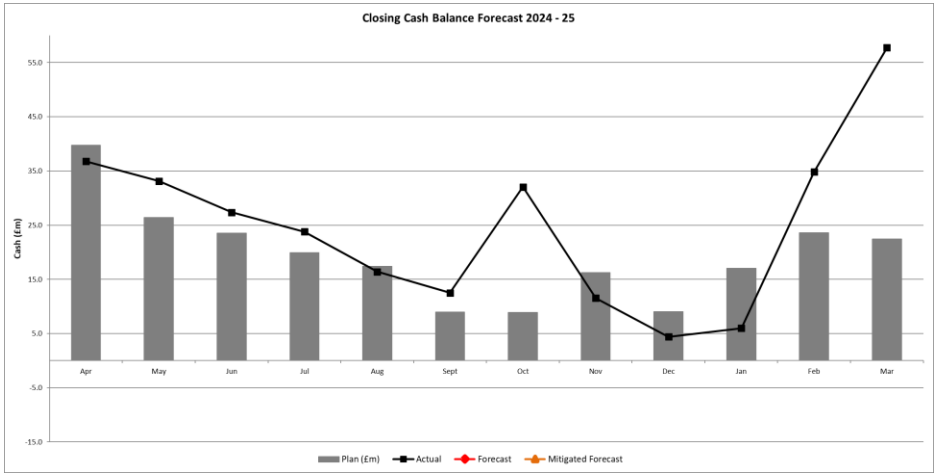
## Finance (7)

York and Scarborough Teaching Hospitals NHS Foundation Trust

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 £22.4m at the end of March 2025, with the planned I&E deficit being a key driver in the reduced balance. The cash balance for March was £35.3m favourable 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 | 39,790 | 26,407 | 23,541 | 19,964 | 17,437 | 9,006 | 8,886 | 16,306 | 9,059 | 17,101 | 23,624 | 22,454 |
| Actual | 36,793 | 33,128 | 27,407 | 23,821 | 16,460 | 12,559 | 32,078 | 11.572 | 4,422 | 5,856 | 34,869 | 57,777 |




The cash forecast graph illustrates the cash position based on the actual cash balance at the end of March, at £57.8m against a plan balance of £22.4m.

March's balance includes PDC drawdowns of £9.8m in readiness for capital expenditure to be incurred in March with invoices becoming due in April/May.

The increase in the March balance to £57.8m is due to PDC mentioned above and £18m of deficit funding from Humber and NY ICB.

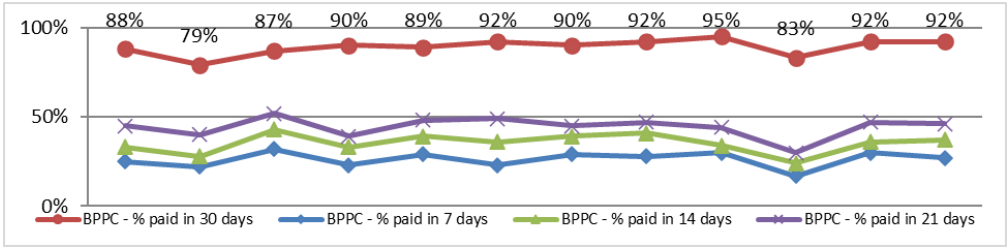
There has been no requirement for cash support during the year.

Cash will remain a focus during Q1 & Q2 of 2025/26 as planning work is finalised.

<u>Better Payment Practice Code</u>

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 graph illustrates that in March the Trust managed to pay 92% of its suppliers within 30 days.



# Current and Forecast Capital Position

## Finance (8)

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

| 2024/25 Capital Position | Plan £000s | M12 Actual £000s | Variance to Plan £000s |
|---|---|---|---|
| PDC Funded Schemes | 21,751 | 41,811 | 20,060 |
| IFRS 16 Lease Funded Schemes | 8,323 | 10,468 | 2,145 |
| Depreciation / Loan Funded Schemes | 20,996 | 21,449 | 453 |
| Charitable Funded Schemes | 800 | 978 | 178 |
| **Total Capital Forecast** | **51,870** | **74,706** | **22,836** |
| Less Charitable Funded Schemes | (800) | (978) | (178) |
| **Total Capital Forecast (Net CDEL)** | **51,070** | **73,728** | **22,658** |

The M12 position is £22.5m ahead of the initial capital plan. This is mainly due to £20m of national PDC awards received during the year, including ACTIF £6m & Scarborough RAAC £4.9m.

Over the past few months, significant work has been completed across all projects, notably York VIU, PACU, Hybrid Theatre and MRI 3. Furthermore, a high volume and value of leases completed which have positively influenced the M12 position.

During March, we have successfully negotiated an additional £2.2m of IFRS 16 CDEL from NHSE.

This has been utilised on equipment during the month and is a great achievement to help mitigate any more pressure on the 25/26 capital prioritisation work which is significantly under pressure for equipment.

The table shows the summarised CDEL position at M12.

The Trust is reporting a minor £66k combined underspend.

It is important to note that this position is after utilising all original allocations and the additional allocations arising in year to deliver a capital investment program of £74m.

| 2024/25 CDEL Position | Allocation £000s | Actual £000s | Variance £000s |
|---|---|---|---|
| Operational CDEL (ICS) | 26,382 | 26,333 | (49) |
| IFRS 16 Lease CDEL | 10,485 | 10,468 | (17) |
| PDC National CDEL | 36,927 | 36,927 | - |
| **Total CDEL** | **73,794** | **73,728** | **(66)** |

# System Summary – Note: M11 System position

## Finance (9)

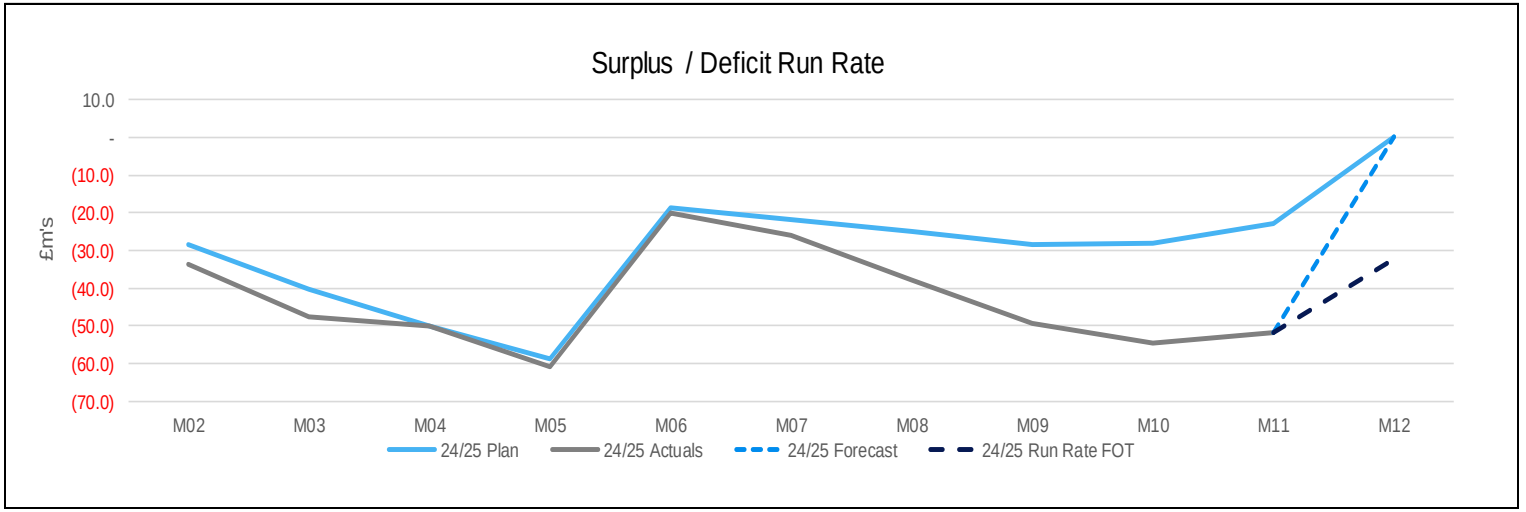
### Year to Date

- ICB £383k adverse variance to plan
- Providers £28.6m adverse variance against plan
- ICS Actual YTD deficit £51.8m (£22.9m plan)

### Forecast Outturn

- ICB Breakeven
- Providers breakeven following NHSE allocation.
- Run rate FOT is at £35m.

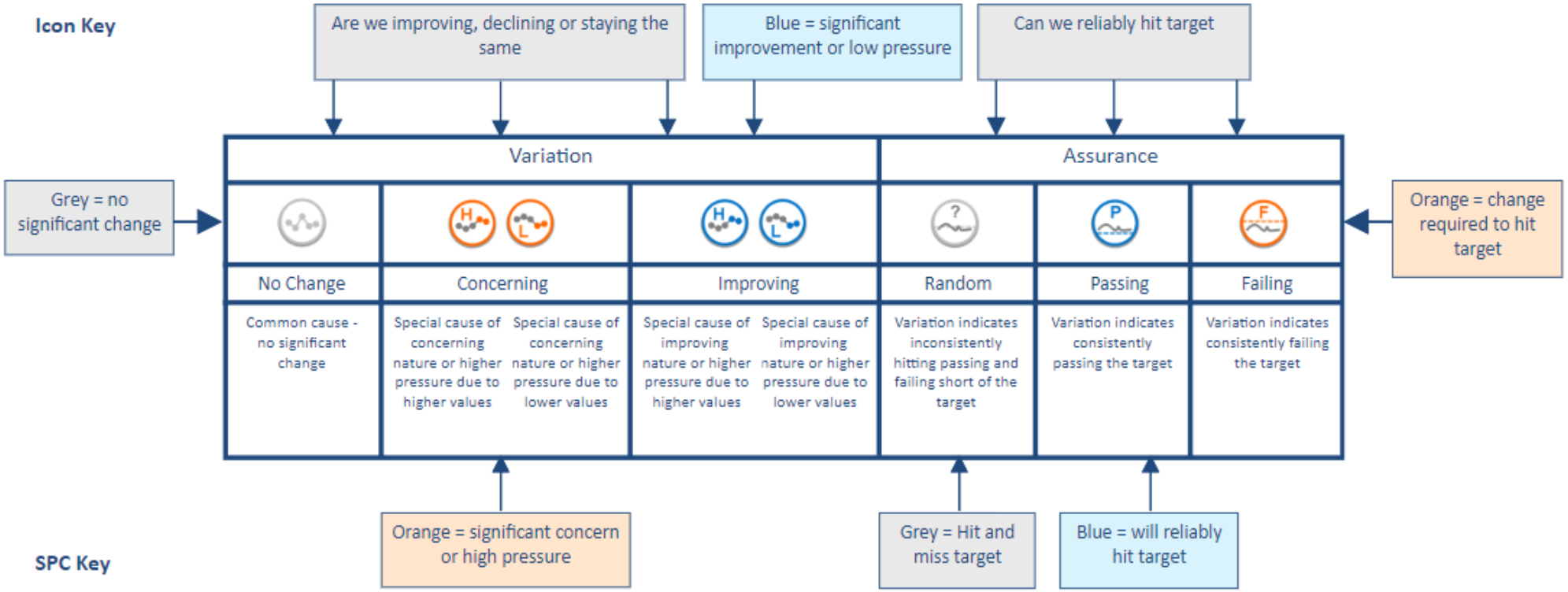
| Organisation | Surplus / (Deficit) - Adjusted Financial Position | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Plan YTD £000 | Actual YTD £000 | Variance YTD £000 | Variance YTD % | Plan Year Ending £000 | Forecast Year Ending £000 | Variance Year Ending £000 | Variance Year Ending % |
| Humber And North Yorkshire ICB | 0 | (383) | (383) | (0.0%) | (0) | (0) | (0) | (0.0%) |
| Harrogate And District NHS Foundation Trust | (2,528) | (16,855) | (14,327) | (4.3%) | - | - | - | 0.0% |
| Hull University Teaching Hospitals NHS Trust | (7,585) | (10,035) | (2,450) | (0.3%) | - | - | - | 0.0% |
| Humber Teaching NHS Foundation Trust | (479) | (479) | 0 | 0.0% | 0 | - | (0) | (0.0%) |
| Northern Lincolnshire And Goole NHS Foundation Trust | (7,804) | (7,809) | (5) | (0.0%) | - | - | - | 0.0% |
| York And Scarborough Teaching Hospitals NHS Foundation Trust | (4,461) | (16,230) | (11,769) | (1.6%) | - | - | - | 0.0% |
| ICS Total | (22,857) | (51,791) | (28,934) | (0.7%) | 0 | (0) | (0) | (0.0%) |



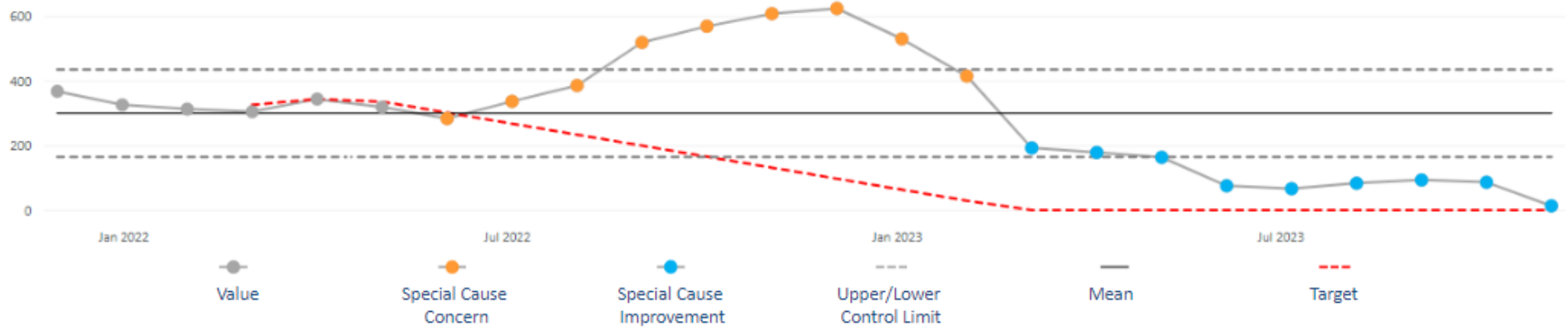
# Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

## 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 are near the upper or lower control limit. The target can be either static or moving.

# Icon Descriptions

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| |  |  |  |
|---|---|---|---|
|  | 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.<br><br>This process is capable and will consistently **PASS** the target. | Common cause variation, no significant change.<br>This process will not consistently HIT OR MISS the target. This occurs when target lies between process limits. | Common cause variation, no significant change.<br><br>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. |

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Date of Meeting:** | 30 April 2025 |
| **Subject:** | CQC Update Report |
| **Director Sponsor:** | Dawn Parkes, Chief Nurse |
| **Author:** | Emma Shippey, Head of Compliance and Assurance |

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

**Trust Objectives**

☒ To provide timely, responsive, safe, accessible effective care at all times.
☐ To create a great place to work, learn and thrive.
☐ To work together with partners to improve the health and wellbeing of the communities we serve.
☐ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☐ To use resources to deliver healthcare today without compromising the health of future generations.
☒ To be well led with effective governance and sound finance.

**Board Assurance Framework**

☐ Effective Clinical Pathways
☐ Trust Culture
☐ Partnerships
☐ Transformative Services
☐ Sustainability Green Plan
☐ Financial Balance
☒ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☐ Yes

☒ No

☐ Not Applicable

**Executive Summary:**

A Trust led after action review of the January 2025 CQC on-site inspection was held on 1 April 2025. The Trust has yet to receive any further feedback from the CQC following the inspection in January 2025.

There has been one CQC case received since the last report, written (28 February 2025). This case was regarding mismatched knee replacements. At the time of writing, the Trust had four open cases / enquiries.

**Recommendation:**

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

**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/Engagement | Date | Outcome/Recommendation |
|---|---|---|
| Patient Safety and Clinical Effectiveness Sub-Committee | 09.04.25 | Presented and accepted. |

## 1. CQC Activity

A Trust led after action review of the January 2025 CQC on-site inspection was held on 1 April 2025. The aim of this session was to obtain learning from when the CQC were on-site, the collation of the supplementary evidence requested by the CQC and the communication during and after the on-site visit. The actions taken following this session will be included in future iterations of this report.

The Trust has yet to receive any further feedback from the CQC following the inspection in January 2025.

The next CQC engagement meeting is scheduled to take place on Tuesday 8 April.

## 2. Journey to Excellence Group

The agenda of the monthly Journey to Excellence Group is currently under review and going forward will focus on:

- Receiving assurance on the sustainability of actions from the CQC Improvement Plan from 2023.
- Progress with the internal Well Led assessment and action plan.
- Actions from the January 2025 inspection.

## 3. 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 patient safety incidents (PSI'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, written (28 February 2025). This case was regarding mismatched knee replacements.

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

## 4. CQC Updates

### a. Rebuilding good regulation – The CQC Way

The CQC have reported that they are now taking immediate action to:

- make sure they can publish reports in a timely way
- increase the number of assessments
- clear the registration backlog
- act promptly on information of concern and notifications.

The CQC asked for feedback on a set of draft proposals for a new framework called the CQC Way. The proposals describe:

- **Why the CQC exists:** Reconnecting to the core purpose of making sure health and social care services provide people with safe, effective, compassionate, high-quality care and encouraging care services to improve

- **What the CQC aim to achieve:** Setting medium and long-term priorities for the assessment and improvement work, addressing immediate needs, while ensuring effective regulation is delivered in the long term
- **How they work:** Setting shared values, and clear behavioural expectations for how CQC colleagues work together and how the CQC works with providers

### 4.2 Dr Arun Chopra appointed as CQC's first Chief Inspector of Mental Health

Dr Arun Chopra, previously Medical Director of the Mental Welfare Commission for Scotland (2020-2024), has been appointed as CQC's first Chief Inspector of Mental Health. Arun is also one of the most recent recipients of the President's Medal, which is awarded annually by the Royal College of Psychiatrists to individuals who have made a significant contribution towards improving the lives of people with mental illness. He has recently returned to frontline clinical work as a Consultant Inpatient Psychiatrist at the Royal Edinburgh Hospital. The creation of this new Chief Inspector role recognises the importance of mental health services in supporting people to lead fuller, healthier lives, and the need for specialist expertise in regulating these services. Dr Chopra will join CQC in May 2025.

### 4.3 Independent review of CQC technology published

An independent review of the technology that supported our transformation has found that the primary cause of our technology failure was a failed organisational transformation. It adds that the technology used for our regulatory platform and provider portal are salvageable but required substantial development and rebuilding work.

The report sets out the scale of the problems that resulted in the failure of our technology and the impact that transformation had across CQC. It makes 23 recommendations, which can be grouped into 5 broad areas covering: culture; data and digital; governance; operating model; and change management.

## 5. Recommendations

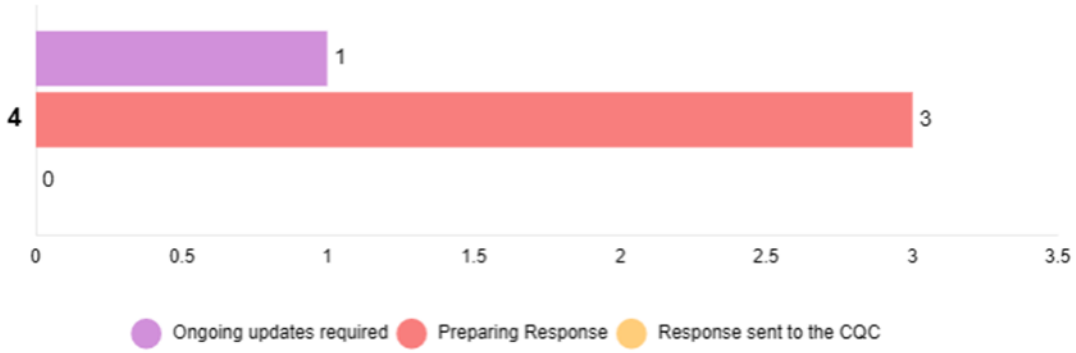
The Board of Directors is asked to:

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

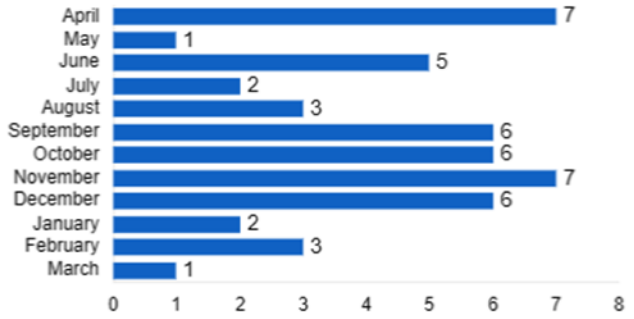
**Date:** 4 April 2025

## Appendix A
## CQC Cases / Enquiries (1 February 2024 to 31 March 2025)

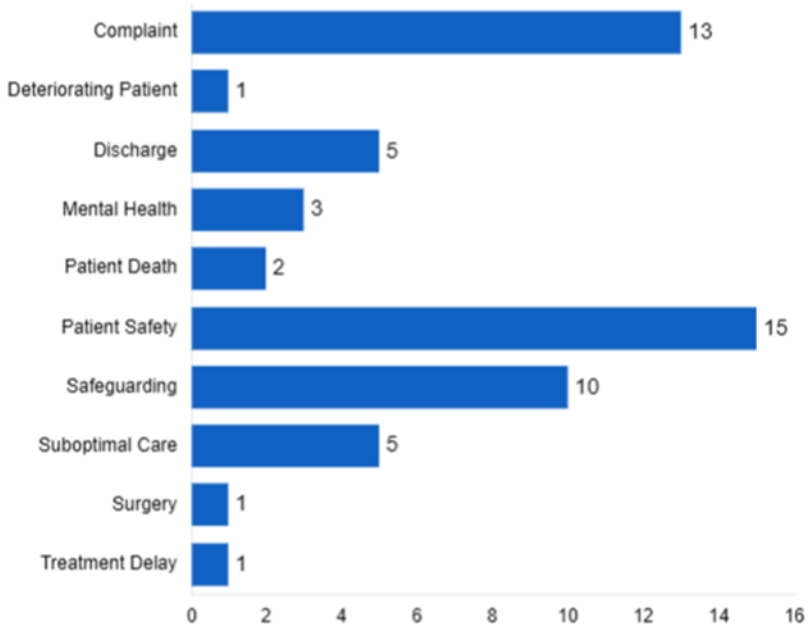
### Number of Open CQC Enquiries / Cases



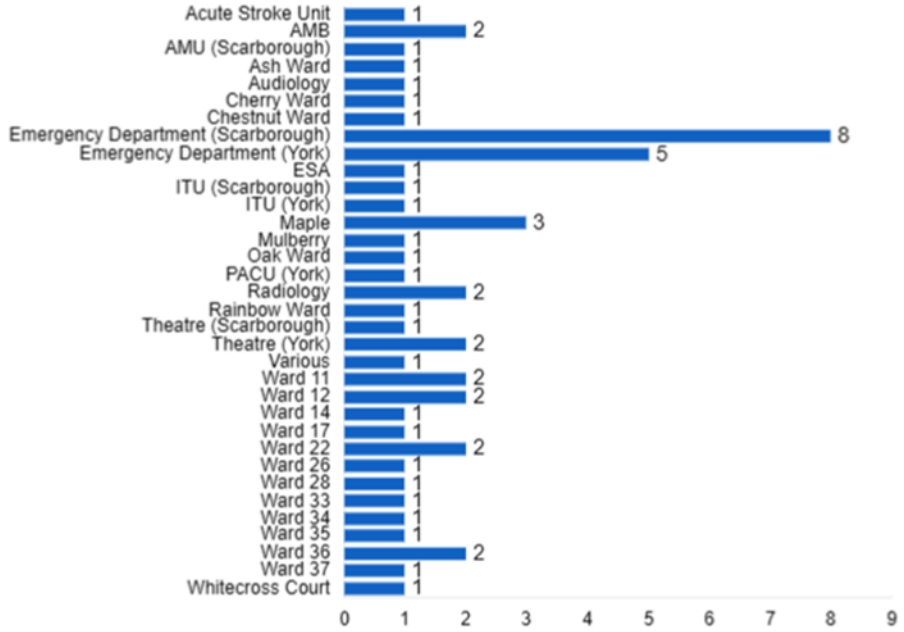

### Number of Enquiries Received




### Number of CQC Enquiries by Theme




### Number of CQC Enquiries by Ward / Dept



| | |
|---|---|
| **Report to:** | Board of Directors |
| **Date of Meeting:** | 30 April 2025 |
| **Subject:** | Maternity and Neonatal Safety Report |
| **Director Sponsor:** | Dawn Parkes, Chief Nurse (Executive Maternity and Neonatal Safety Champion) |
| **Author:** | Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion) |

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

Approve ☒ Discuss ☐ Assurance ☒ Information ☒ Regulatory Requirement ☐

**Trust Objectives**

☒ To provide timely, responsive, safe, accessible effective care at all times.
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**Board Assurance Framework**

☒ Effective Clinical Pathways
☒ Trust Culture
☒ Partnerships
☒ Transformative Services
☒ Sustainability Green Plan
☒ Financial Balance
☒ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☐ Yes

☐ No

☐ Not Applicable

**Executive Summary:**
This report provides an update on the progress of improvements in the maternity and neonatal service as well as provide monthly key quality and safety metrics for the services for the month of February 2025.

**Recommendation:**
The Board is asked to receive the updates from the maternity and neonatal service for February and approve the CQC section 31 report before submission to the CQC.

| **Report Exempt from Public Disclosure** (remove this box entirely if not for the Board meeting)<br><br>No ☒ Yes ☐ |
|---|
| (If yes, please detail the specific grounds for exemption) |

| **Report History**<br>(Where the paper has previously been reported to date, if applicable) | | |
|---|---|---|
| **Meeting/Engagement** | **Date** | **Outcome/Recommendation** |
| Quality Committee | 22 April 2025 | 1/ To note the progress with the safety actions and improvement work in maternity and neonatal services.<br>2/ To formally receive and approve the CQC Section 31 monthly report. |

## Introduction

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the Trust Board and the LMNS Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team.

The maternity and neonatal services continue to review and monitor improvements in key quality and safety metrics and this paper provides the Trust Board with the performance metrics for the month of February 2025.

Annex 1 provides the current delivery position for the service against the core national safety metrics.

## Perinatal Quality Surveillance Model

In line with the perinatal quality surveillance model, we are required to report the information outlined in the data measures monthly to the Trust Board. Data is for the month of February 2025.

## Perinatal Deaths

In February 2025 there was sadly two antenatal stillbirths one at 24 weeks gestation and the other at 25 weeks gestation.

MBRRACE-UK perinatal mortality report for births in 2023 has published. The report concerns stillbirths and neonatal deaths among the 3,910 babies born within the Trust in 2023.
Trust stillbirth rate – 2.88/1000 births, this is within 5% mortality rate when compared with the group average.

- Trust neonatal mortality rate – 0.91/1000 births, this is 5% to 15% lower mortality rate when compared with the group average.
- Trust perinatal mortality rate – 3.78/1000 births, this is within 5% mortality rate when compared with the group average.

Trusts whose mortality rates are up to 5% higher or up to 5% lower than the average group should carry out a review of their data quality and possible contributing local factors that might explain the high rate. The Maternity Services submit a quarterly PMRT report to private Board which includes local factors, themes and action plans.

## Maternity and Newborn Safety Investigations (MNSI)

In the month of February there were no new cases that met the criteria for referral to MNSI for investigation. Of the three open cases two draft reports have been received and the team are reviewing these for factual accuracy. Once finalised the recommendations for the first case will be shared with Quality Committee in May 2025 and the second in June 2025. The investigation into the third cases remains ongoing.

## Patient Safety Incident Investigations (PSII)

In the month of February there were no new PSIIs declared. There remain three ongoing cases. There are two overdue PSIIs. Out of the overdue PSIIs, one draft PSII has been shared with the family and one PSII is scheduled for panel. The third PSII is due for submission to panel at the end of May 2025.

## Moderate Harm Incidents and above

The postpartum haemorrhage (PPH) rate was 2.4% (7 cases) in February 2025. The data demonstrates there has been a reduction in the Trust rolling average over 12 months for PPH ≥1500mls from the national digital dashboard. All cases of PPH over 1500mls have been reviewed at the multidisciplinary Maternity Case Review meeting. A postpartum hemorrhage sprint audit commenced in January 2025 to measure against key quality PPH indicators, and this is the third consecutive month of the audit. The monthly PPH sprint audit is presented at the monthly Labour Ward Forum, Maternity Directorate Group and to the Family Health Care Group Board. A PPH task finish group has been re-established and a business case for Carbetocin will be developed. Carbetocin is recommended to be given to women who have a caesarean section in the prevention of postpartum haemorrhage.

## CQC Section 31 Progress Update

Annex 2 provides the February 2025 monthly update to CQC on the service progress against the Section 31 concerns and key improvement workstreams in place in the maternity and neonatal improvement programme. The Trust Board are asked to approve this submission to CQC.

There were no CQC information requests made in February 2025.

## Perinatal Mental Health

There continues to be capacity issues within the Amethyst Midwifery Perinatal Mental Health Team, although significant work is being undertaken to address this internally and clinical supervision continue to be provided by the Trusts Clinical Psychology team, which is proving hugely beneficial to the team in the absence of the support from Tees Esk and Wear Valley Trust (TEWV). The Local Maternity and Neonatal System along with the Integrated Care Board have undertaken a full review of the TEWV service looking at four key areas: referrals and acceptance rates/thresholds, workforce including. staff capacity and skills, serious clinical incidents, and support to Midwives. Interim measures have been put in place, but unfortunately not with specific perinatal expertise. There remains a delay of up to 12 weeks from referral for women to be assessed by the team, urgent referrals are being seen in and around 6 weeks. There continues to be capacity issues in the team due to high levels of sickness and maternity leave. This means there is a delay in women receiving expert support from TEWV and adding to additional pressure on the Amethyst Perinatal Mental Midwives. This risk is on the risk register with a score of 16.

## LMNS Assurance Visit

There was a Local Maternity and Neonatal System/ Integrated Care Board and Regional Midwifery Team assurance visit on the 12th February 2025. High level feedback recognised the improvements being made despite the ongoing capacity and resource challenge. The draft report has been received for factual accuracy and following comments back to the ICB the final report is awaited. On the 28th April there is a reset and review meeting planned by NHS England to review the progress of the maternity safety support programme and the services ability to meet the exit criteria set out by the programme and enter formally into the sustainability phase.

## Maternity Incentive Scheme

The Maternity Incentive Scheme report and action plan was presented at the Trust Board in January 2025, confirmation is awaited from NHS Resolution as to the funding the Trust will receive to deliver the action plan. This is expected in early May. All funds received have been approved by Board and are directly linked to delivering safety actions to ensure delivery of each MIS standard is achievable, with exception of the risk to the funding workforce gap being achieved. Year 7 of the Maternity Incentive scheme will be formally launched on the 28th April 2025.

## Improvement and Transformation

## Smoking Cessation

Smoking increases the risk of pregnancy complications, such as stillbirth, preterm birth, miscarriage, low birthweight and sudden infant death syndrome (SIDS). Whether or not a woman smokes during her pregnancy has a far-reaching impact on the health of a child throughout their life. Whilst several studies have found that the risk of a number of poor pregnancy outcomes can be reduced to that of a non-smoker if a successful quit is achieved early in pregnancy. Others show increased risk with any smoking in pregnancy and increasing risk with continued smoking. This reinforces the need to support women to quit smoking as early as possible in pregnancy to reduce the risk of poor pregnancy outcomes.

**Table 1 Scarborough Site Quarter 4 2024/25**

| **Scarborough site** | **Q4 24/25** |
|---|---|
| Smoking at booking | 8.5% |
| Smoking at time of delivery | 11% |
| Percentage of smokers at antenatal booking who are identified as CO (Carbon Monoxide) verified non-smokers at 36 weeks | 19% |
| *305 women had their antenatal booking appointment in Q4 at the Scarborough site and of those who booked, 26 women smoked or smoked within 14 days of the booking appointment.*<br>*315 women gave birth in Q4 at the Scarborough site and of those, 35 women smoked.* | |

**Table 2 York Site Quarter 4 2024/25**

| **York site** | **Q4 24/25** |
|---|---|
| Smoking at booking | 4.7% |
| Smoking at time of delivery | 7.2% |
| Percentage of smokers at antenatal booking who are identified as CO verified non-smokers at 36 weeks | 25% |
| *878 women had their antenatal booking appointment in Q4 24/25 at the York site and of those who booked, 42 women smoked or smoked within 14 days of the booking appointment.*<br>*622 women gave birth in Q4 at the York site and of those, 45 women smoked.* | |

The figures on smoking at booking and smoking at delivery are looking at two different cohorts of women and therefore, it is not possible to understand the number of women who are non-smokers by the time of delivery from this data. The data in Table 1 and Table 2 is extracted from BadgerNet. A more accurate way to understand whether women are being supported to achieve a smoke free pregnancy is the percentage of smokers at antenatal booking who are identified as Carbon Monoxide (CO) verified non-smokers at 36 weeks. Saving babies lives' Version 3 outcome indicator 1D requires 15% of women who are smokers at the booking to be verified non-smokers at 36 weeks, for Q4 24/25 this standard was met at the York site at 25% and 19% at the Scarborough site.

The government ambition is to reduce Smoking at Time of Delivery (SATOD) rates to below 6%. Continued improvement work is in progress across the service to achieve this, we are currently onboarding onto the national smoke-free pregnancy incentive scheme. The evidence suggests that the incentive scheme is effective in supporting women to stop smoking during their pregnancy and remain smoke free. The three local authorities have agreed to support the incentive scheme until April 2026. As they are no longer being commissioned to provide this service an options paper is being finalised to agree next steps for the trust and maternity service to implement the NHS long term plan recommendations of an in-house service. Once we onboard on to the incentive scheme, we will be able to have oversight of accurate 4 week quit data for all pregnant women who smoke.

Next steps and implementation include:

- Continue to work with all local authorities and to onboard onto the incentive scheme
- Understand financial element of preferrable option detailed in the options paper for a maternity specific in-house tobacco dependency service
- Develop and agree a project plan for implementation of the agree maternity specific model
- Continued collaboration with the tobacco dependency and midwifery teams, training, engagement, and ongoing education.

**Compliance with element 1 of the Saving Babies Lives Version 3 Care Bundle (Q3 24/25)**

The standards for element 1 are in Annex 3. This element is 40% fully implemented. The trajectory set was for 50% implementation by March 2025, this has not been met due to challenges with obstetric attendance at mandatory training, this is being addressed with support from obstetric leads and the practice development team. Compliance is on track for June 2025 and affects interventions 1.8 and 1.9.

As we have not yet onboarded onto the national smoke free pregnancy incentive scheme and quit data is collected from 3 local authorities and the Tobacco Dependency team, we do not currently have accurate oversight of 4 week quit data and compliance with feedback to Midwives from each local authority due to the multiple systems and not having the resource within the midwifery team to collate the data. Data sharing agreements are however in place therefore the named midwives are informed regarding the woman's engagement. We are currently in the process of onboarding onto the incentive scheme and one central system will be used by all providers meaning access to accurate data for Saving Babies Lives' assurance across the York and Scarborough maternity services. This will enable compliance to be met with interventions 1.6 and 1.7. The agreed trajectory for full compliance with the LMNS is March 2026.

The opt out referral standard (Intervention 1.4) is not met, this was 67% at York and 80% at Scarborough for Q3 24/25. The mandatory training was launched in January 2025 and

has more focus on the opt out referral. The LMNS have been asked if they can support with bespoke training for maternity teams in this area.

The standard for CO monitoring at booking and 36 weeks have been met (see Table 3 for compliance figures). The standard for recording of smoking status at the booking and 36-week appointments for all women and at every appointment for women who smoke have been met (Intervention 1.3). The intervention for ensuring CO testing is offered to smokers at each antenatal appointment (Intervention 1.2) is partially implemented and will be an area of focus now intervention 1.1 has been achieved. See Table 4 for compliance for recording CO measurement and smoking status for smokers for all appointments. The data is monitored monthly by the transformation lead midwife and the community team leaders and actions agreed accordingly.

**Table 3 Compliance with CO monitoring**

| | York | Scarborough |
|---|---|---|
| CO measurement at booking | 89% | 91% |
| CO measurement at 36 weeks | 86% | 86% |

**Table 4 Compliance with recording CO measurement and smoking status at each appointment**

| | Trust | Target |
|---|---|---|
| Percentage of smokers where CO measurement is recorded at all antenatal appointments | 40% | 50% |
| Percentage of smokers where smoking status is recorded at all antenatal appointments | 45.9% | 50% |

Intervention 1.5 and 1.10 are both fully implemented to support the provision of Nicotine Replacement Treatment to pregnant women.

### Success in February 2025

- The 5th scan room on Antenatal Day Assessment Unit opened on 24th March 2025 to support increasing scan capacity in line with saving babies lives version 3 care bundle. This means there is additional third trimester scans available 6 days a week.
- The 4th planned caesarean birth list on the York site went live on 24th March 2025.
- The planned caesarean birth coordinator role has been recruited to and anticipated start date 22nd April and fully operational on 27th May following a period of induction and shadowing team members.
- Following a successful engagement session with Refugee York an information pack is being developed to outline the Maternity Services available. The community midwives for equitable health have commenced in post and will undertake a review of the offering for Scarborough.
- A review of hot topics has been completed and ideas for improvements based on the feedback have been incorporated into the running of hot topics in 2025/26.
- The inaugural Multi-Disciplinary Team Antenatal Clinic and specialist services review meeting took place in March to scope the further improvement work

required in Antenatal Clinic and specialist services in line with national guidance and saving babies lives compliance.

- Prompt training has been taking place at York St John's University following the GAU/EPAU decant into the maternity education room. Feedback for the training teams and the staff attending is that the facilities are fantastic, and it is nice to get off site for training.
- The interviews were held for the recruitment of permanent positions for the previously fixed term and seconded midwifery roles. All specialist midwives' roles were appointed into. Two Matrons were appointed and there remains one acute substantive Matron at Scarborough vacant and a Matrons secondment to cover maternity leave on the York Site.
- The third Maternity & Neonatal Engagement Day was held on 20th March. The focus on the day was to discuss the culture score action plan. The themes identified and discussed were:
    - Leadership
    - Burnout and Poor Behaviours
    - Communication
    - IT & Digital Infrastructure
    - Estates and Equipment
    - Cross-site Working
- The next steps are for the Senior Leadership Team to review the feedback captured on the day and develop a final draft of the culture score survey action plan which will be incorporated into the Maternity and Neonatal Single Improvement Plan for delivery and monitoring.
- Maternity services will be in receipt of funds transferred to the midwifery budget following a review of nurse education capacity requirement and formation of one team, which has released £230K. This funding once transferred will support the appointment of 4/5 WTE Band 6 Midwives across the clinical services.
- At Executive Committee on the 16th April, it was agreed that the new swipe in and out access would be installed with video ability and supported by the placement of an existing nighttime ward clerk for a fixed period of 12 months. Once installed the security support that has been in place can cease. A full security review and risk assessment is to be undertaken, and a paper presented back to the June Executive Committee with its findings and recommendations.

## The Maternity and Neonatal Single Improvement Plan (MNSIP)

- **96 out of the 230 milestone actions have been completed to date** (9 completed in March).
- **11 milestone actions are in progress.**
- **1 milestone action is new and requires approval at the maternity and neonatal oversight group.**
- **98 milestone actions are off track as the delivery date has passed and the action has not been completed** (6 went off track in March 2025).
    - 12 milestone actions have mitigations in place for these to be completed during April 25 – May 25 *(11 x P1, 1 x P2)*
    - 42 milestone actions require a timeline extension as the staffing gap continues to impact upon delivery (See key risks slide for more information and mitigations). These milestone actions are informing the maternity strategy for 2025/26 *(30 x P1, 6 x P2, 6 x P3)*
    - 25 milestone actions cannot progress due to funding constraints (See key risks slide for more information and mitigations) *(18 x P1, 4 x P2, 3 x P3)*

- 19 actions need timelines resetting to National, LMNS or Trust wide projects (awaiting confirmation of timelines to amend these) *(3 x P1, 9 x P2, 7 x P3)*

- **25 milestone actions are not scheduled to start yet**

## Risks

## Safety

1. 39 guidelines are overdue, this is a reduction in 25 since the 30th December 2024. There are now twice monthly guideline meetings in place to address the backlog and 6-month horizon scanning has been implemented. The Deputy Director of Midwifery has taken handover of the portfolio. A monthly exception report will be submitted to the Maternity Directorate.
2. The maternity service does not have a substantive audit midwife, this is recommended mandated post as referenced in the NHS England Maternity self-assessment toolkit. Maternity services have an audit plan in place, but compliance and completion are off track which is impacting on assurance of MIS, Section 31, SBL V3 and SI actions due to having no substantive resource.
3. There has been a significant reduction in the capacity of the trust Midwifery Perinatal Mental Health team due to sickness alongside an increase of referrals into the service with significant and ongoing further reductions of capacity with TEWV (Mental Health Provider). A 1WTE substantive Band 6 Midwife has been approved for recruitment to support the team.
4. Capacity within the Patient Safety Midwife portfolio due to vacancy, sickness and a deficit of gaps within the quality and safety team is impacting on overdue incidents and timely completion of patient safety learning responses.
5. There is a clinical resource gap which is resulting in limited resource which can be released to support service improvement and progress the Maternity & Neonatal Single Improvement Plan actions in the planned timescales, this has led to a significant number of actions becoming off track and at risk.
6. Prompt training has been taking place at York St John's University following the GAU/EPAU decant into the maternity education room. However, the Trust has been notified they will soon be charged for the use of the facilities. Plan to explore Holgate space.
7. Increase in GP surgeries serving notice of the community midwife no longer being able to use rooms. Continued issues remain with GP prescribing with some surgeries following the GP collective action ending.

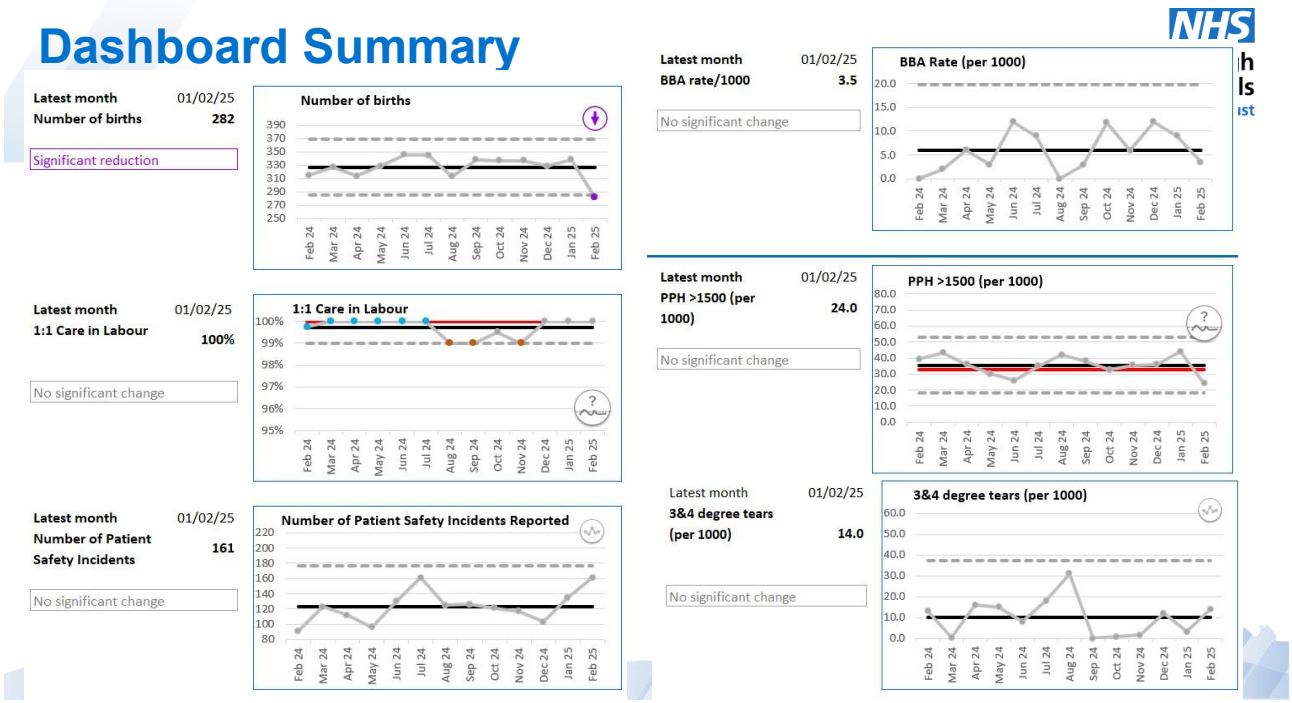
**Recommendations to Trust Board**

To note the contents of this report and agree the CQC section 31 submission in Annex 2

**Date:** 22nd April 2025

## Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery February 2025

### Dashboard



**Annex 2**

York and Scarborough Teaching Hospitals NHS Foundation Trust

| | |
|---|---|
| **Report to:** | Quality Committee |
| **Date of Meeting:** | 22nd April 2025 |
| **Subject:** | Maternity CQC Section 31 Update |
| **Director Sponsor:** | Dawn Parkes, Chief Nurse |
| **Author:** | Sascha Wells-Munro, Director of Midwifery<br>Donna Dennis, Deputy Director of Midwifery |

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☐ Regulatory Requirement ☒

**Trust Objectives**

☒ To provide timely, responsive, safe, accessible effective care at all times.
☐ To create a great place to work, learn and thrive.
☒ To work together with partners to improve the health and wellbeing of the communities we serve.
☒ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☒ To use resources to deliver healthcare today without compromising the health of future generations.
☒ To be well led with effective governance and sound finance.

**Board Assurance Framework**

☒ Effective Clinical Pathways
☒ Trust Culture
☒ Partnerships
☒ Transformative Services
☐ Sustainability Green Plan
☒ Financial Balance
☒ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☐ Yes

☐ No

☐ Not Applicable

**Executive Summary:**

On the 25 November 2022, the CQC, under Section 31 (S31) of the Health and Social Care Act 2008 imposed conditions on the Trust registration in respect of maternity and midwifery services. This Trust updates the CQC monthly on the 23rd of the month with progress against the S31 notice.

This paper provides the key safety and section 31 requirements for the month of February 2025.

| **Recommendation:** |
|---|
| • To approve the April 2025 monthly submission to the CQC which provides assurance on progress and impact on outcomes in February 2025. |

| **Report Exempt from Public Disclosure** (remove this box entirely if not for the Board meeting)<br><br>No ☒ Yes ☐ |
|---|
| (If yes, please detail the specific grounds for exemption) |

| **Report History**<br>(Where the paper has previously been reported to date, if applicable) | | |
|---|---|---|
| **Meeting/Engagement** | **Date** | **Outcome/Recommendation** |
| **Maternity Assurance Group** | **8th April 2025** | **Approved** |

## CQC Section 31 Progress Update

Maternity Services at York and Scarborough NHS Teaching Hospitals Foundation Trust have embarked on a programme of service and quality improvements.

This report provides assurance on the progress to date in delivering against the improvement plan for the purpose of the monthly submission to CQC following the Section 31 Notice.

### A1. Managing and responding to risk

In February 2025 there was a woman who had an arterial line inserted in theatre during her caesarean section. She was cared for on the labour ward by a Midwife who was trained to care for women with arterial lines. The decision was made by a Consultant Anaesthetist for the woman not to be transferred to the High Dependency Unit and the woman was cared for by the Midwife, ODP and Anaesthetist. The arterial line was removed within 12 hours.

### A.2 Fetal Monitoring

### A.2.2 Fetal Monitoring Training

Current Fetal Monitoring compliance figures, by site, set against the target of 85% at the end of February 2025 are outlined below.

| Staff Group | York | Scarborough |
|---|---|---|
| **Midwives** | 97% (177/183) | 97% (75/77) |
| **Consultants** | 94% (17/18) | 66% (6/9) |
| **Obstetric medical staff** | 83% (10/12) | 89% (8/9) |

The three Obstetric Consultants who were not complaint in February, one has completed their training in March 2025 and the other two are booked on in April 2025. Compliance will continue to be monitored at the Maternity Directorate, Quality Assurance Committee

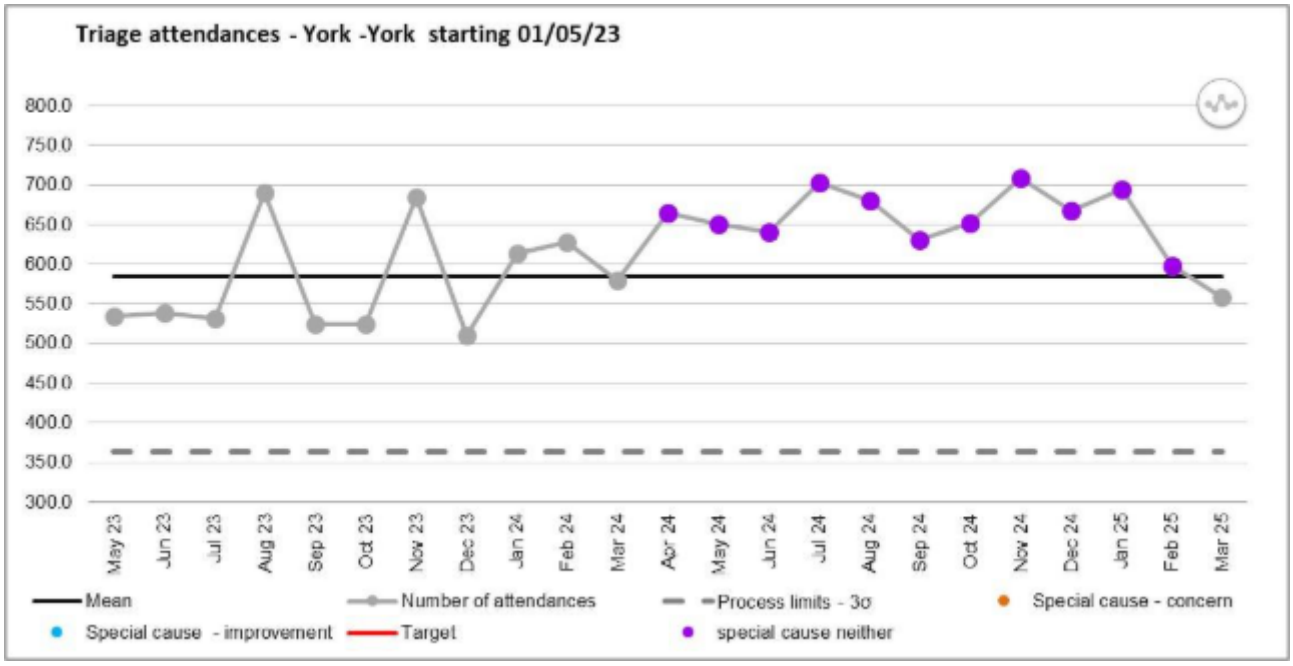
and Trust Board. A review of the process for booking Obstetricians onto the training is being undertaken to ensure training is completed within a 12-month period.

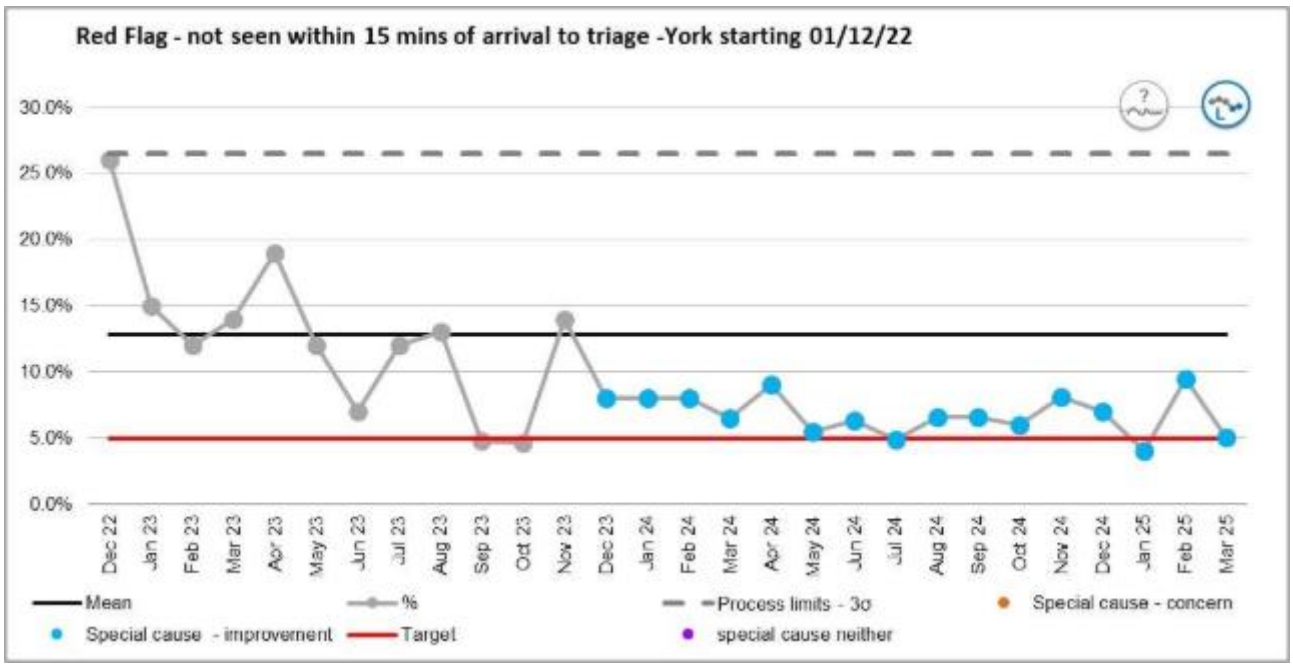
### A.3 Risk Assessments and Care Plans

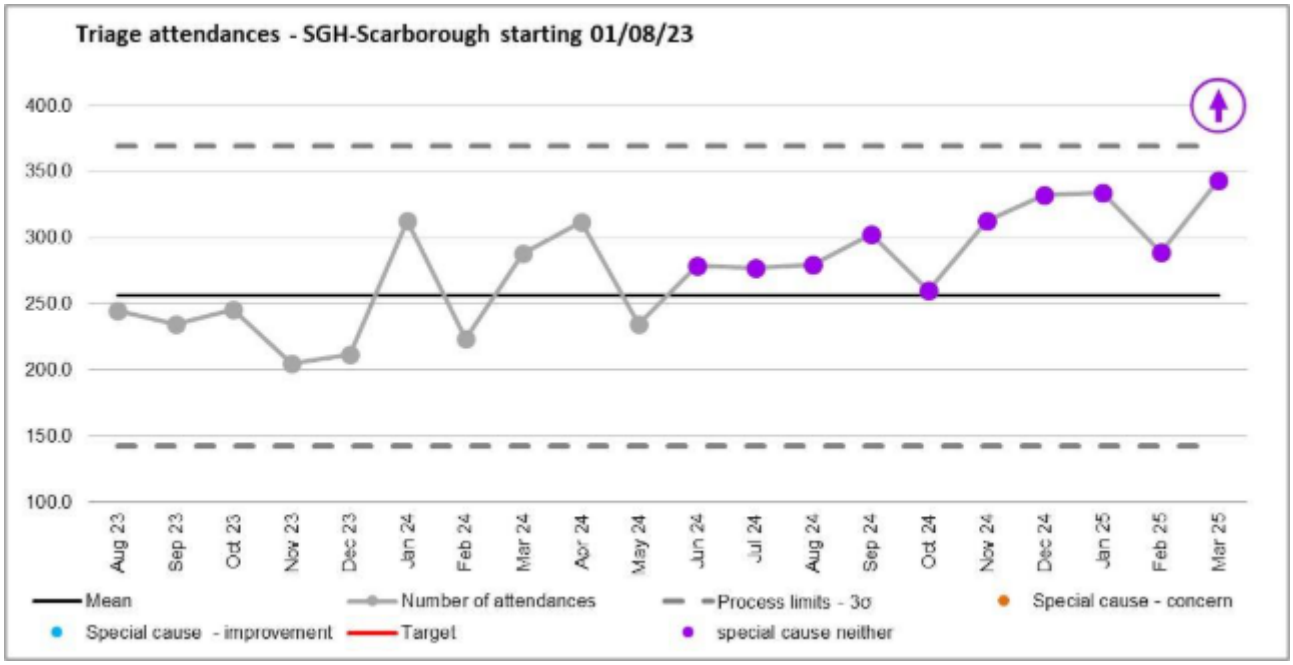
All antenatal risk assessments are recorded on BadgerNet. Table 1 highlights the antenatal risk assessment compliance.

| Month | Antenatal Risk Assessments |
|---|---|
| **September 2024** | 98.5% |
| **October 2024** | 98% |
| **November 2024** | 98% |
| **December 2024** | 98% |
| **January 2025** | 99% |
| **February 2025** | 98% |

### A.4 Assessment and Triage




Red Flag - not seen within 15 mins of arrival to triage -York starting 01/12/22
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Mean
%
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


Triage attendances - SGH-Scarborough starting 01/08/23
400.0
350.0
300.0
250.0
200.0
150.0
100.0
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Mean
Number of attendances
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


Increasing number of attendances in Scarborough Triage has noted a direct correlation with the compliance of rapid assessment. Conversely, the number of attendances in York reduced, showing an increase in compliance with rapid assessment.

BSOTS training is mandatory before shifts can be undertaken by Bank or Agency. A training year to end report will be provided for the next update.

## B. Governance and Oversight of Maternity Services

### B.1 There is oversight at service, division and board level in the management of the maternity services

A schedule of business has been developed for Quality Committee and Trust Board reports for Maternity Services to meet the national reporting requirements for the Maternity Incentive Scheme and the Ockenden recommendations. There have been two quarterly reports for the Perinatal Mortality Review Tool (PMRT) presented at Board and the Maternity claims scorecard has been presented at Quality Committee.

There have been a refresh of the Maternity Directorate meeting and Labour Ward forum.

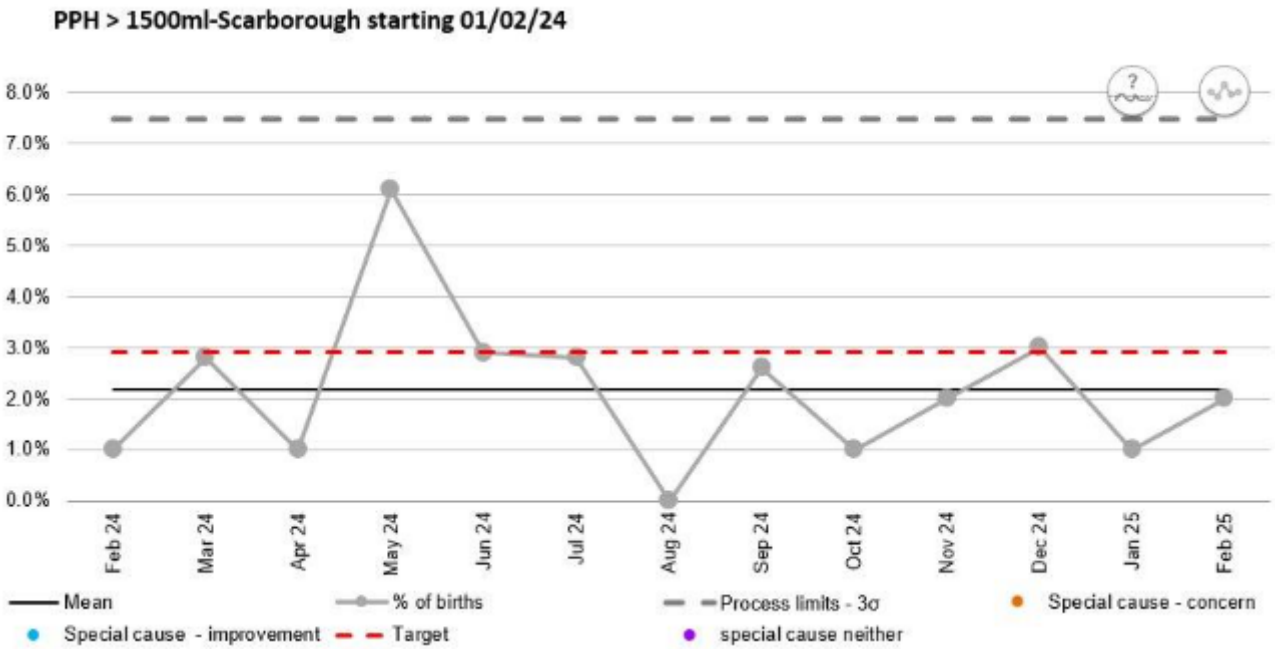
### B.2 Postpartum Haemorrhage (PPH)

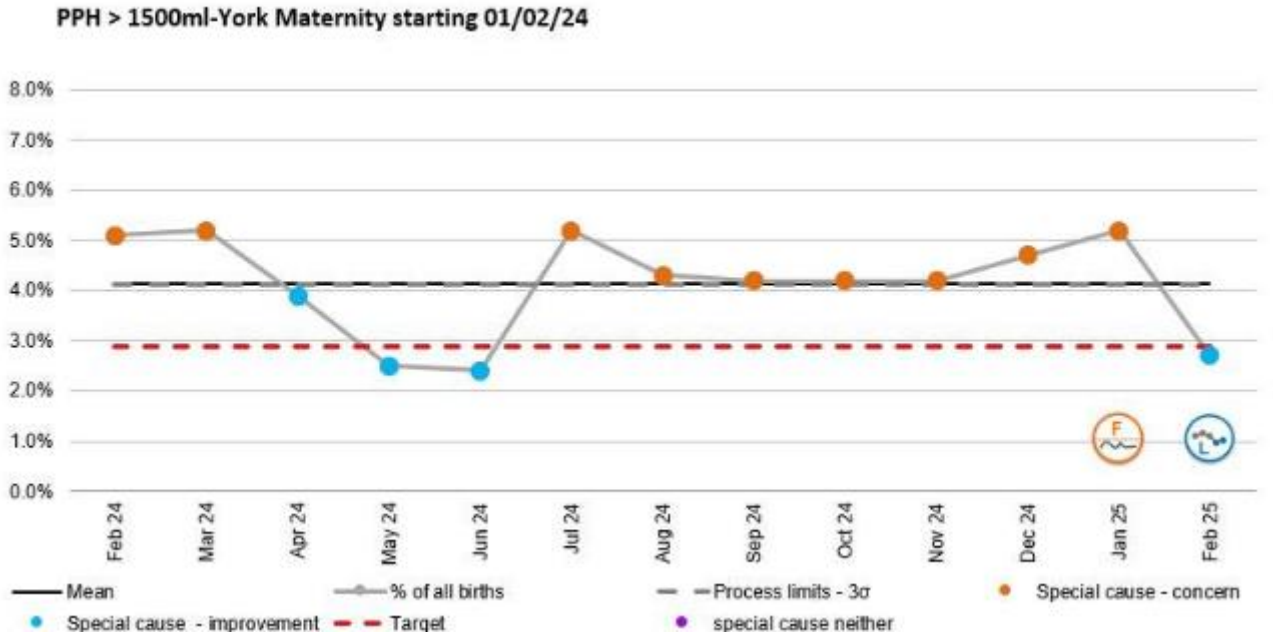
**PPH over 1.5 litres**

The reduction in the rate of postpartum haemorrhage (PPH) over 1500mls is a key priority for the maternity service. The PPH rate for February 2025 was 2.4% of all deliveries across both sites.

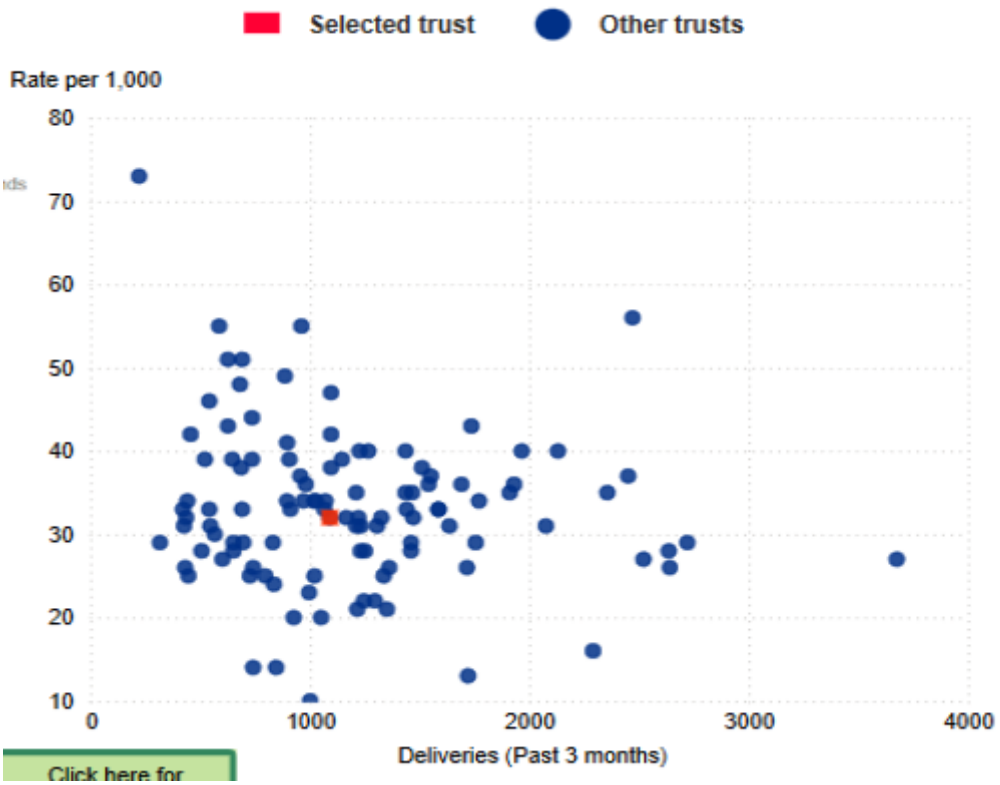
All PPHs are reviewed at the multidisciplinary Maternity Case Review meeting. The themes identified link to the ongoing improvement workstreams identified in the cluster review.

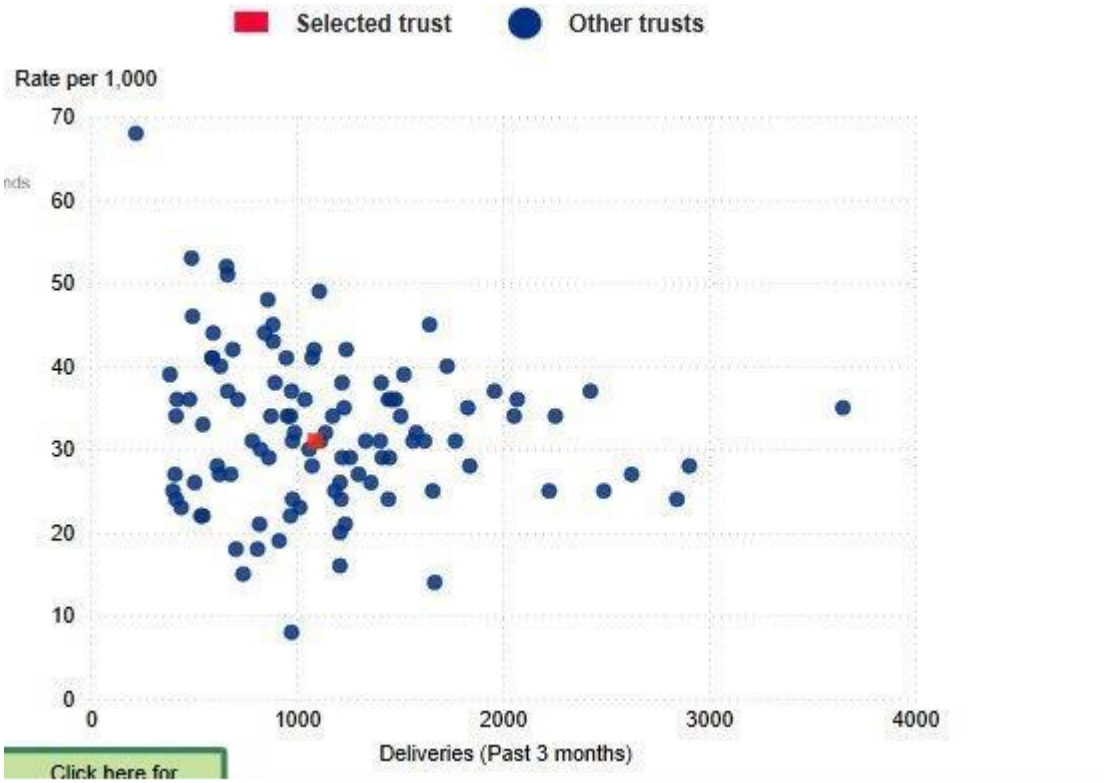
| Blood Loss | Number in February 2024 |
|---|---|
| **1.5l – 1.9l** | 6 |
| **2l – 2.4l** | 0 |
| **> 2.5l** | 1 |

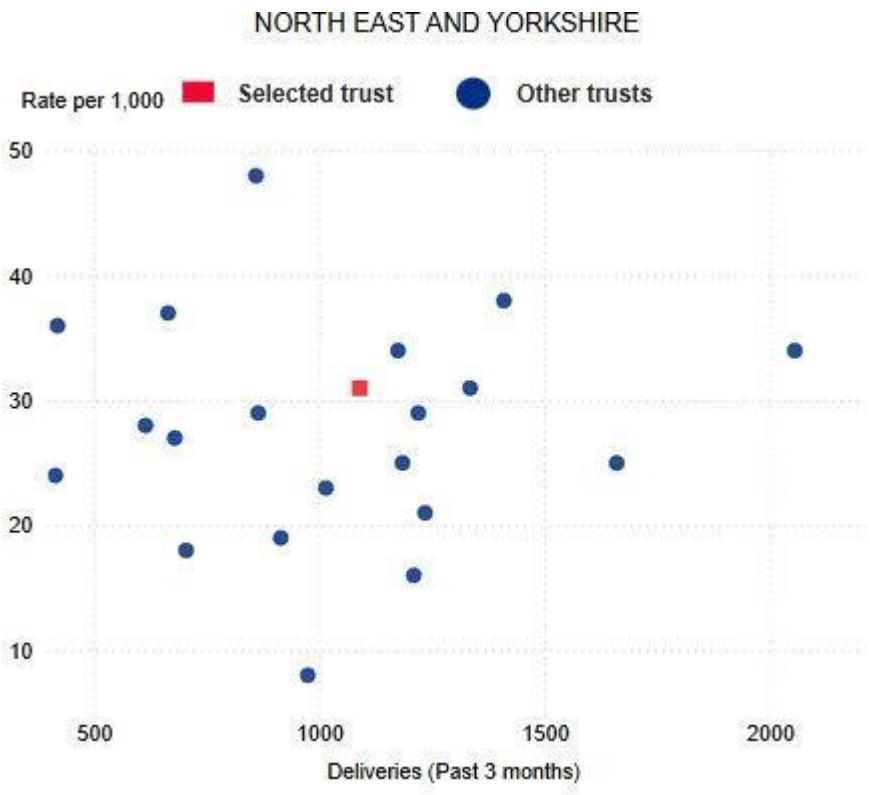


## National Maternity Digital Dashboard






The national digital dashboard demonstrates an overall decline in the Trusts PPH rate over a 12-month period. The local SPC charts show common cause variation for Scarborough and York a special cause for improvement. All the February cases have been reviewed at the Maternity Case Review and no concerns regarding management was highlighted which would have resulted in a different outcome. The data demonstrates there has been an overall reduction in PPH ≥1500mls when reviewing the Trust rolling average for the 12 months on the national digital dashboard. The national digital chart demonstrates the Trust is not an outlier compared to all Trusts in England. In addition, the Trust is not an outlier in the North East and Yorkshire. A monthly PPH sprint audit commenced in January 2025. The monthly PPH sprint audit will be presented at the monthly labour ward forum and Maternity Directorate Group.

There is a thematic review of postpartum haemorrhages being undertaken by a Consultant Obstetrician.

**Overview of the Monthly Sprint Audit**

| Standard | Results | Comments |
|---|---|---|
| FBC taken at 28 weeks | 100% (6/6) | One case excluded as birthed at 24 weeks |
| Was Haemoglobin managed in accordance with guidance | 100% (6/6) | One case excluded as birthed at 24 weeks |
| 36-week PPH risk assessment completed | 60% (3/5) | 2 women had given birth prior to 36 weeks |
| PPH risk assessment completed on admission for birth | 100% (7/7) | |
| Management of third stage of labour | 100% Active management | |

| | | |
|---|---|---|
| In Caesarean section consider prophylactic use of 1g Tranexamic acid IV after delivery of the baby if moderate to high risk of bleeding | 100% (2/2) | |
| Postnatal oxytocin infusion should be used when there is moderate or high risk of postpartum haemorrhage | 100% (2/2) | |
| PPH proforma fully completed | 71% (5/7) | |

6 out of the 7 women had multiple risk factors for PPH. Actions are in place to address areas of partial compliance.

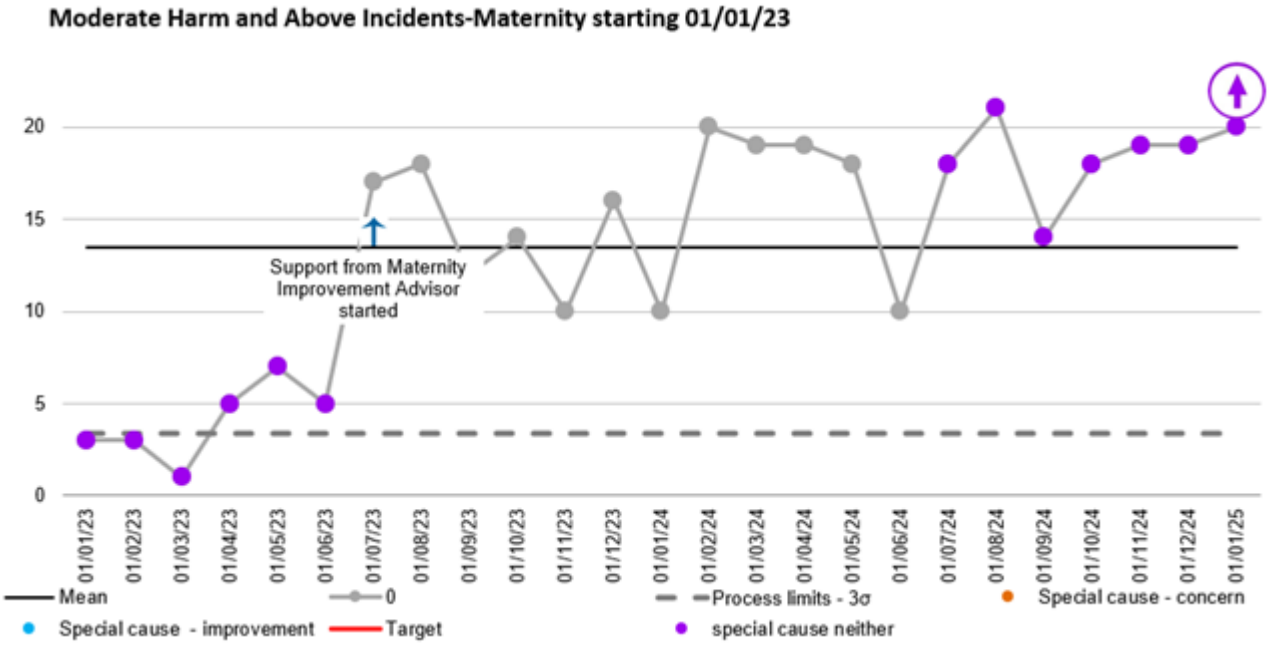
### B.3 Incident Reporting

There were 18 moderate harm incidents reported in February 2025.

| Datix ID | Incident Category | Outcome/Learning/Actions | Outcome |
|---|---|---|---|
| 31536 | Perineal Trauma | Ongoing audit of perineal trauma and the use of the OASI care bundle | Reviewed by the Quality and Patient Safety Midwife, all care was in accordance with guidance and onward referrals made |
| 31688/ 31886/ (reported on two occasions) | Baby born at 23+5 weeks and transferred to Hull | No immediate safety actions | To be reviewed a fetal medicine multidisciplinary meeting |
| 31261<br>31292<br>31897 | Antenatal stillbirth | No immediate safety actions identified | To be reviewed using PMRT |
| 31142 31712<br>31143 32000<br>31218 32298<br>31412 31574 | PPH ≥1500mls | PPH sprint audit started in January 2025 | The PPH rate continues to be monitored through the Maternity Assurance Group. The Trust rolling average rate has reduced over 12 months. |
| 31933 | Transfer to CCU | | Review is currently in progress |

| | | | |
|---|---|---|---|
| 31989 | Transfer to SCBU | Reviewed at ATAIN | Learning included as part of ATAIN action plan |
| 32347 | Anti D prophylaxis not given | | Review is currently in progress |
| 31693 | Management of missed glucose tolerance test | | Review is currently in progress |

Incident grading is reviewed at the Maternity Services daily triage Monday to Friday to ensure it is accurate and in line with national guidance.




## B.4 Management of Risks

### B.4.1.1 Project Updates York

The maternity theatres at York have been refurbished and is operational.

### B.4.1.2 Project Updates Scarborough

The use 24/7 security at Scarborough continues until a permanent solution to the baby tagging issue can be reached.

### B.4.2 Scrub and Recovery Roles

There is collaboration across maternity and surgery to review the national requirements of having two scrub nurses for each list, the potential benefits, and risks in not meeting this standard that may release some staff funding back into maternity services to support recruitment of midwives as an alternative.

Recruitment update:
Position from 1st March 2025:

**Scarborough:**
Qualified nursing staff is fully recruited. There are 4.96 WTE vacancy for a Band 2/3 and interviews have taken place and recruited to 3WTE.

**York:**
Fully recruited to.

**Annex 3: Overview of interventions for Element 1: Reducing smoking in pregnancy (Saving Babies' Lives Version 3)**

1.1 CO testing offered to all pregnant women at the antenatal booking and 36-week antenatal appointment.
1.2 CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209.
1.3 Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.
1.4 Instigate an opt-out referral for all women who have an elevated CO level (4ppm or above), who identify themselves as smokers or have quit in the last 2 weeks for treatment by a trained tobacco dependence treatment adviser (TDA) within an in-house tobacco dependence treatment service.
1.5 Nicotine replacement therapy (NRT) should be offered to all smokers and provision ensured as soon as possible.
1.6 The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree.
1.7 Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional.
1.8 Any staff member using a CO monitor, should have appropriate training on its use and discussion of the result.
1.9 All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g., referral, feedback, data collection).
1.10 Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Date of Meeting:** | 30 April 2025 |
| **Subject:** | Workforce Race and Disability Equality Standards Action Plans 2023-2025 - update |
| **Director Sponsor:** | Polly McMeekin, Director of Workforce and Organisational Development |
| **Author:** | Virginia Golding, Head of Equality, Diversity and Inclusion (EDI) |

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

**Trust Objectives**

☐ To provide timely, responsive, safe, accessible effective care at all times.
☒ To create a great place to work, learn and thrive.
☐ To work together with partners to improve the health and wellbeing of the communities we serve.
☐ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
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**Board Assurance Framework**

☐ Effective Clinical Pathways
☒ Trust Culture
☐ Partnerships
☐ Transformative Services
☐ Sustainability Green Plan
☐ Financial Balance
☐ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☒ Yes

☐ No

☐ Not Applicable

**Executive Summary:**

This report provides an update on the progress made with the 2023-2025 action plans prior to the co-production of the new action plans covering the period, 2025-2027. The new action plans will be shared with the Resources Committee and the Trust's Board of Directors in October 2025 after the 2025 data analysis has been completed and colleague engagement

A RAG rating was used to keep track of progress, Green: Complete, Amber: Begun but not complete, Red: Not yet begun and Blue: a new action.

| |
|---|
| Appendix 1 – WRES, 2023-2025 Action Plan<br><br>Appendix 2 – WDES, 2023-2025 Action Plan |
| **Recommendation:**<br>To assure the Board of Directors the 2023-2025 action plans were implemented as planned. |

| **Report History**<br>(Where the paper has previously been reported to date, if applicable) | | |
|---|---|---|
| **Meeting/Engagement** | **Date** | **Outcome/Recommendation** |
| Resources Committee | 15 April 2025 | N/A |

## Workforce Race Equality Standard Action Plan 2023-2025

**Appendix 1**

| | |
|---|---|
| Red | Not yet begun |
| Amber | Begun but not complete |
| Green | Complete |
| Blue | New |

York and Scarborough Teaching Hospitals NHS Foundation Trust

| Objective | Analysis | WRES Action | Executive Director Lead | Operational Lead | Date | RAG Rating |
|---|---|---|---|---|---|---|
| **WRES Indicator 1 BME representation in the workforce by pay band WRES Indicator 2 Relative Likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointment from shortlisting across all posts** | | | | | | |
| **WRES Indicator 2 Relative Likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointment from shortlisting across all posts** | | | | | | |
| **Indicator 1** has not seen any improvement in the number of BME staff employed in the Trust under Agenda for Change. Therefore, the Trust needs to Increase support and opportunities for career progression | Race Disparity Ratios<br><br>High priority areas for improvement suggested by NHSE WRES Team:<br><br>Career progression in clinical roles (lower to middle levels,)<br><br>Career progression in clinical roles (lower to upper levels)<br><br>· Bands 1-4 = 0.8%<br>· Bands 5-7 = 7.3%<br>· Bands 8-9 = 0.07%<br>· VSM = 0%<br><br>Career progression in non-clinical roles middle to upper levels)<br><br>· Bands 5-7 = 0.5%<br>· Bands 8-9 = 0.1%<br>· VSM = 0.01%<br><br>Lower: band 5 and under<br>Middle: bands 5 & 7<br>Upper: bands 8a and above | Use positive action in targeting BME staff within the race disparity ratios levels to attend the internal development courses to support them with career progression | Director of Workforce and Organisational Development | Head of Organisational Development | Commence in Q4 2024 | |
| **Bank WRES Indicator 1 Percentage of active workers by ethnic group and gender across key grades and staff groups** | | | | | | |
| Increase BME appointments to clinical and non-clinical A4C posts. Increase this by 0.6% for each race disparity ratio level | On examining the Bank data there could be an improvement in the number of BME staff on Bank. | BME staff invited to attend Bank recruitment events. (This should include existing staff) | Director of Workforce and Organisational Development | Bank Recruitment | Commence in Q3 2025 | |
| **WRES, BWRES & MWRES** | Qualitive engagement data states that more visible diversity in the Trust's communications is required. This would encourage BME staff to see themselves in different job roles and see others as role models | Continue to ensure there is visible diversity in the Trust's Communications<br><br>Dedicated equality, diversity and inclusion page in Staff Matters | Director of Communications | Head of Communications and Head of EDI | Commence in Q3 2023 | |
| **WRES Indicator 2 Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts** | | | | | | |
| Improve the relative likelihood of being appointed from shortlisting from 2.5 to 1 for the organisation | Y&S has seen no statistical improvement<br><br>A figure of 1 would mean there is equity | All recruiting managers/panels to attend Inclusive Recruitment Training (whilst this wouldn't be mandatory training, this should be a recruitment requirement) | All Directors | Head of EDI, Medical & Bank Recruitment & HR Recruitment Manager | Q4 2024 | |
| | | BME representation on recruitment panels. Bands 6+ for AfC and Consultant posts (may need to include colleagues from HNY) | Director of Workforce and Organisational Development | Medical Recruitment Manager, Bank Recruitment & HR Recruitment Manager | Q2 2024 | |
| | | Continue to deliver Conscious Inclusion training | Director of Workforce and Organisational Development | Head of EDI | 2023-2024 | |
| | | Workforce Leads to work with CG and Directorates on developing local action plans addressing local data | Polly McMeekin, Director of Workforce and Organisational Development | Workforce Leads | October 2023 onwards | |
| | | Implement interview skills training to support staff pre-interview | Director of Workforce and Organisational Development | Head of EDI | Q3 2024 | |
| | | Encourage recruiting panel to offer all BME job applicants the opportunity of receiving improvement feedback after interview | Director of Workforce and Organisational Development | EDI Workstream supported by Workforce Leads | Q2 2024 | |
| | | Advertise jobs using a variety of recruitment platforms | Director of Workforce and Organisational Development | HR Recruitment Manager, Band and Medical Recruitment | Q2 2024 | |
| **WRES Indicator 5 Percentage of staff experiencing harassment, bullying, or abuse from patients, relatives or the public in the last 12 months** | | | | | | |
| See a year on year decrease in the number of staff experiencing this behaviour. To reach 30.8% by 2025 | There has been a significant deterioration over the last two years with the number of BME staff experiencing unwanted behaviour from those who use our services, this figure is high and is above the Staff Survey benchmark group average of 30.8%. | Review of the Trust's Exclusion Policy | Chief Nurse | | 2023 | |
| | | Implement training for ward staff on how to deal with unwanted behaviour in line with the Exclusion Policy | Chief Nurse | TBA | After implementation of the policy | |
| | | Procedure developed on how to support staff including access to psychological support | Chief Nurse | | 2024 | |
| | | Communications campaign to inform all services users and visitors to the Trust regarding approach to bullying, harassment and violence to staff | Chief Nurse | Head of Communications, Patient EDI Lead and EDI Workstream | 2024 | |
| **Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leaders or colleagues?** | | | | | | |
| For the Trust to see a reduction in people's experiences and the reporting in the Staff Survey by 2.5% by March 2024 | After seeing a steep deterioration in 2022 compared to 2021, there has been little statistical improvement in 2023. The Trust's data is currently above the Staff Survey benchmark group average of 17.3%. | Improve mandatory Equality, diversity and human rights training compliance. Target 85%. | All Directors | EDI Workstream supported by Workforce Leads | Q1 2024 | |
| | | Implement NHS England's Culture and Leadership Programme. Included within this will be the Behavioural Framework implementation, launch of the Civility, Respect and Resolution Policy, the importance of raising concerns and the FTSU remit | Chief Nurse | Head of Employee Relations and Engagement | May 2024-Sep 2025 | |
| | | Examine data collected with ER to determine trends in specific departments, roles or pay bandings<br>• monitor exit interview data to identify any particular trends and issues relating to staff leaving for these reasons. Create local action plans to address the findings | Chief Nurse | EDI Workstream supported by Workforce Leads | Q1 2024 | |
| **Metric 9: BME Board members – Percentage difference between the organisation's Board voting membership and its overall workforce** | | | | | | |
| Increase the number of BME Board members by to be more reflective of the organisation | Metric 9 has seen no statistical improvement in the number of BME staff on the Trust's Board of Directors and as voting board members. The difference in comparison to the rest of the organisation is -4.9% | Associate Director of Governance to engage with staff networks to review Chair and NED recruitment documentation for any barriers | The Trust's Chair | Associate Director of Governance | Oct-23 | |
| | | The Trust to continue to engage with Gatenby Sanderson's Inspiring Leaders Programme to aid diverse recruitment | The Trust's Chair | Associate Director of Governance | Nov-23 | |
| | | Head of EDI to review Chair's JD & PS for any potential barriers | Director of Workforce and Organisational Development | Head of EDI | Jul-23 | |

| | | | | | |
|---|---|---|---|---|---|
| | Career conversation/coaching and mentoring (action also applicable metrics 1, 2 and 4) | Director of Workforce and Organisational Development | OD Facilitator | Mar-24 | |
| | Applications for Non-Executive Director appointments encouraged from a visibly diverse background | Associate Director of Corporate Governance | Associate Director of Corporate Governance | Sep-25 | |
| | Review nomination process for governors to encourage diversity. | Associate Director of Corporate Governance | Associate Director of Corporate Governance | Sep-25 | |

**Author:** Head of Equality, Diversity and Inclusion
**Senior Responsible Officer:** Director of Workforce and Organisation Development
**Publish and Submission Date:** 31 October 2023
Note: BME staff were engaged with via a joint staff network meeting and a survey monkey to obtain their suggestions on the actions required. These actions are designed to address the Workforce, Medical and Bank Race Equality Standards. Where an action has been given a Green RAG rating to indicate complete, the action, where necessary, will be continuously implemented.

**Workforce Disability Equality Standard Action Plan 2023-2025**

**Appendix 2**

York and Scarborough Teaching Hospitals NHS Foundation Trust

| | |
|---|---|
| Red | Not yet begun |
| Amber | Begun but not complete |
| Green | Complete |
| Blue | New |

| Objective | Analysis | WDES Action | Executive Lead | Operational Lead | Date | RAG Rating |
|---|---|---|---|---|---|---|
| **WDES Indicator 1 Staff in AfC pay bands or medical and dental subgroups and very senior managers (Including Executive Board members) compared with the % of staff in the overall workforce** | | | | | | |
| Encourage staff to update their equality monitoring information to help determine who is in the workforce | Indicator 1 has seen various statistical changes in 2023 with five being positive, four statistically static and one deterioration | Last year's action was partly completed and has been updated.<br><br>The Sharing Personal Diversity Guide will be launched along with a targeted campaign to update information on ESR. | Director of Workforce and Organisational Development | Head of EDI, Workforce Data Analyst and EDI Workstream | Commence in Q2 2024 | |
| | | Maintain current Disability Confident level 2 and promote the benefits of this charter to managers | Director of Workforce and Organisational Development | Deputy Head of resourcing | Commence in Q3 2024 | |
| **WDES Indicator 5 Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.** | | | | | | |
| Increase awareness of the support available within the Trust to support Disabled staff in their careers | This has seen a slight negative decrease in 2023 but is equal to the Staff Survey benchmark group average, which has remained the same since 2021. Staff Survey results 2022 52.1%, 2023 51.4%. | Career conversation/coaching and mentoring | Director of Workforce and Organisational Development | OD Facilitator | Commence in Q3 2024 | |
| | | Use positive action in targeting Disabled staff to attend the internal development courses to support them with career progression | Director of Workforce and Organisational Development | Head of Organisational Development | Commence in Q4 2024 | |
| | | Promote the changes in Flexible Working and the Trust's Flexible Working Policy | Director of Workforce and Organisational Development | Workforce Leads and EDI Workstream | Commence in Q3 2024 | |
| **WDES Indicator 9 The staff engagement score for Disabled staff, compared to non-Disabled staff** | | | | | | |
| To engage, listen and support Disabled staff so they feel engaged with and that their needs are taken into consideration and acted upon. | The staff engagement score for the Trust's is 6.5 and the score for Disabled colleagues is below this at 6.1. The Staff Survey benchmark group average for Disabled people is 6.4 and the Trust's is also slightly below this. | Improve mandatory equality, diversity and human rights training compliance. Target 85% | All Directors | EDI Workstream supported by Workforce Leads | Commence in Q1 2024 | |
| | | NHS England's Culture and Leadership Programme will continue. Included within this will be the Behavioural Framework implementation, launch of the Civility, Respect and Resolution Policy, the importance of raising concerns and the FTSU remit | Director of Workforce and Organisational Development | Head of Employee Relations and Engagement | Commence in Q1 2024-Q2 2025 | |
| | | Extend the remit of the Enable Staff Network to include Neurodiversity | Director of Finance | Enable Staff Network Chair | Q2 2023 | |
| | | Continue to implement the Neurodiversity at Work workshop | Polly McMeekin, Director of Workforce and Organisational Development | Head of EDI | Q2 2023 | |
| | | Feature Disabled staff (along with other colleagues with protected characteristics) in the new EDI section of Staff Matters, raising awareness promoting good practice and role models. | Director of Communications | Head of EDI and Communications Team | Commence in 2025 | |
| **Indicator 10 Disabled Board members – Percentage difference between the organisation's Board voting membership and its overall workforce** | | | | | | |
| Increase the number of Disabled Board members to be more reflective of the organisation | This has seen a decrease in the number of staff who identify as Disabled, this is due to an increase in the number of Board members and how they identify. One out of 17 Board Members identify as Disabled | Associate Director of Governance to engage with staff networks to review Chair and NED recruitment documentation for any barriers | The Trust's Chair | Associate Director of Governance | Q3 2023 | |
| | | The Trust to continue engagement with Gatenby Sanderson's Inspiring Leaders Programme to aid diverse recruitment | The Trust's Chair | Associate Director of Governance | Commence in Q3 2023 | |
| | | Head of EDI to review Chair's JD & PS for any potential barriers | Director of Workforce and Organisational Development | Head of EDI | Jul-23 | |
| | | Cohort 3 of the Reverse Mentoring Programme targeted at Disabled staff | Director of Workforce and Organisational Development | OD Facilitator | Commence in Q4 2024 | |
| | | Executive Director Sponsor of Enable to Lead the campaign via a blog to update Personal Diversity Information as in Indicator 1 | Director of Finance | Executive Director Sponsor of Enable and Head of EDI | Commence in Q2 2024 | |
| | | Review nomination process for governors to encourage diversity. | Associate Director of Corporate Governance | Associate Director of Corporate Governance | Sep-25 | |

**Author:** Head of Equality, Diversity and Inclusion
**Senior Responsible Officer:** Director of Workforce and Organisation Development
**Publish Date:** 31 October 2023
Note: Disabled staff were engaged with via a joint staff network meeting and a survey monkey to obtain their suggestions on the actions required. These actions are designed to address the Workforce Disability Equality Standard. Where an action has been given a Green RAG rating to indicate complete, the action, where necessary, will be continuously implemented.

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Date of Meeting:** | 30 April 2025 |
| **Subject:** | Draft People Strategy |
| **Director Sponsor:** | Polly McMeekin, Director of Workforce & Organisational Development |
| **Author:** | Will Thornton, Lead for Workforce Planning & Development |

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☐ Regulatory Requirement ☐

**Trust Objectives**

☐ To provide timely, responsive, safe, accessible effective care at all times.
☒ To create a great place to work, learn and thrive.
☐ To work together with partners to improve the health and wellbeing of the communities we serve.
☐ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☐ To use resources to deliver healthcare today without compromising the health of future generations.
☐ To be well led with effective governance and sound finance.

**Board Assurance Framework**

☐ Effective Clinical Pathways
☒ Trust Culture
☐ Partnerships
☐ Transformative Services
☐ Sustainability Green Plan
☐ Financial Balance
☒ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☒ Yes

☐ No

☐ Not Applicable

**Executive Summary:**

The People Strategy is one of six enabling strategies to deliver the Trust's strategic goals (2025-2030). A draft People Strategy has been developed over a number of months in consultation with our people and has arrived at five core ambitions which connect with our values and context:

- our people consistently live and experience our values so patients can receive the best care
- develop an empowering leadership culture
- our people develop careers in healthcare
- our workplaces become healthier
- digital improves the experience of our people

| |
|---|
| There is a specification for each ambition, accompanied by three to four ‘we will’ statements (high-level actions) and measurements for gauging progress against each ambition. |
| **Recommendation:**<br>Board of Directors are asked to review the draft and confirm agreement with the ambitions and contribute any modifications required for a final draft. |

| |
|---|
| **Report Exempt from Public Disclosure**<br>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/Engagement | Date | Outcome/Recommendation |
|---|---|---|
| Executive Committee | 16 April 2025 | Supportive of the ambitions. A number of small modifications from Executive colleagues have been incorporated into v1.5 |

# Foreword

Our people are the heart of our organisation. Every day, their dedication, expertise, and compassion make a real difference to the lives of their colleagues and the patients, families, and communities we serve. As we look to the future, we know that our colleagues are facing unprecedented challenges, and this can impact on how each of us feel at work.  This makes it more important than ever to help our people feel valued, supported, and inspired to give their best.

This People Strategy sets out our ambition for the next five years, building on the foundations of our Workforce and Organisational Development Strategic Aims and Objectives. It is rooted in the Trust's ambition to provide an excellent patient experience every time. We know that when our people feel engaged, well-led, and supported in their careers and wellbeing, they thrive - resulting in an excellent patient experience.

Taken alongside other feedback, our latest Staff Survey results highlight the very significant scale of our challenge, but they also mark out where we are building from. We are determined to take meaningful action to improve engagement, morale, and the overall experience of working in our Trust. This strategy is not just words on a page—it is a call to action for everyone in the Trust to work together to create the culture and conditions where everyone can excel and enjoy their work.

Over the next five years, we will focus on five key ambitions, developed in consultation with our people via a series of listening exercises:

- Embedding our values into every aspect of working life
- Develop an empowering leadership culture
- Supporting career development and progression
- Ensuring our workplaces are healthy and conducive to positive wellbeing
- Harnessing digital advancements to improve how we work

Achieving these ambitions will require innovation, commitment, collaboration, and to introduce new ways of how  we do things. It will not always be easy, but by staying true to our values of Kindness, Openness, and Excellence, we can create a workplace where everyone feels safe, supported, celebrated and empowered to be their best.

I want to thank every one of our colleagues for the passion and dedication they bring to their roles each day. Your voice, experiences, and ideas will be critical in shaping how we deliver on these ambitions. Together, we can make York and Scarborough Teaching Hospitals a truly great place to work, learn, and thrive.

Simon Morritt
Chief Executive

# People Strategy 2025 to 2030 (Draft v1.5)

## 1. Introduction

The purpose of this People Strategy is to set out the key areas of focus which will shape the experiences of our people over the next five years. We know when we do the right things with and by our people they excel, and so doing this consistently will help fulfil our ambition to provide an excellent patient experience every time.

The strategy outlines the guiding principles that will shape our work, and the steps we will take to put these into practice.

Our Staff Survey results in 2024 and previous recent years show we need change, and we want to do all we can so our people enjoy coming to work. The Trust scored below average in eight of the nine themes on which the survey assesses. In 2024, the scores out of ten for staff engagement (6.31) and morale (5.54), along with the response rate itself (36.16%) were concerning when compared with previous results and those of our peers. Analysis of results by protected characteristics also shows we are not the inclusive employer we want to be. The scores provide a benchmark to gauge the impact of our actions over the next five years. Our ambition is that the 2029 Staff Survey will show we are above average in these themes, reflecting our ambition to be a great place for our people to work, learn and thrive.

The context in which our people work will change over the term of the strategy. By 2030, we will have seen a significant shift to digital ways of working which will impact every role in the organisation. The skillset required within roles and the location of where people work will also alter over time with more health care being delivered closer to (or at) home where possible. These plans are developing against a backdrop of rising demand, constrained funding growth and increasing patient expectations. We must be mindful of this context and the unsettling nature of change, while seizing the opportunities for our people to make positive changes for themselves and patients.

This Strategy describes our ambitions in a meaningful way that is accessible to our people, patients, carers, the integrated care system and other stakeholders. We describe our people ambitions and provide an overarching framework where:

- our people consistently live and experience our values so patients can receive the best care
- develop an empowering leadership culture
- our people develop careers in healthcare
- our workplaces become healthier
- digital improves the experience of our people

## 1.1 Our Trust

We are an acute and community service provider delivering a comprehensive range of acute hospital and specialist healthcare services for more than 800,000 people living in York, North Yorkshire, East Yorkshire and Ryedale - an area covering 3,400 square miles.

Our sites include:

- York Hospital
- Scarborough Hospital
- Bridlington Hospital
- Malton Hospital
- The New Selby War Memorial Hospital
- St Monica's Hospital Easingwold
- White Cross Rehabilitation Hospital
- Nelsons Court Inpatients Unit
- Several community team bases in the Vale of York

We provide a comprehensive range of district general hospital services, in addition to regional and sub-regional services including renal and cystic fibrosis services. The Trust manages community-based services in Selby and District, and the City of York. This includes community nursing and specialist services for both adults and children.

We value being the provider of the community services. This enhances our ability to provide continuity of care, streamlined patient pathways, and improves outcomes by offering us the ability to deliver seamless coordination between hospital and community-based services. This means we can work to reduce unnecessary hospital admissions, facilitate early intervention, and support holistic, patient-centred care for both adults and children.

The benefits of being an integrated acute and community provider means we can promote efficient use of resources, better communication, and collaboration across teams, while addressing public health needs through prevention and population health initiatives.

We have an annual turnover approaching £1b and a workforce of over 10,000 people, making us one of the largest employers in the locality.

We created York Teaching Hospital Facilities Management Limited Liability Partnership (YTHFM) as a subsidiary of our Trust. It has a workforce of over 1,000 people, providing a range of estates and support services, such as catering, cleaning, portering and security.

## 1.2 Our Ambition and Values

## Our Trust Strategic Framework

Our strategy is informed by what our patients, staff and stakeholders, including our regulators, tell us about the services that we currently provide.

We are clear about our purpose, ambition, strategic objectives and our values and behaviours. They are the cornerstone of this new five-year strategy 'Towards Excellence'.

Our Purpose (why we exist) is:

**To deliver excellent healthcare every day**

Our Ambition (where we aspire to get to - our True North) is:

**To provide an excellent patient experience every time**

Our Strategic Objectives (what we will do to achieve our ambition) are:

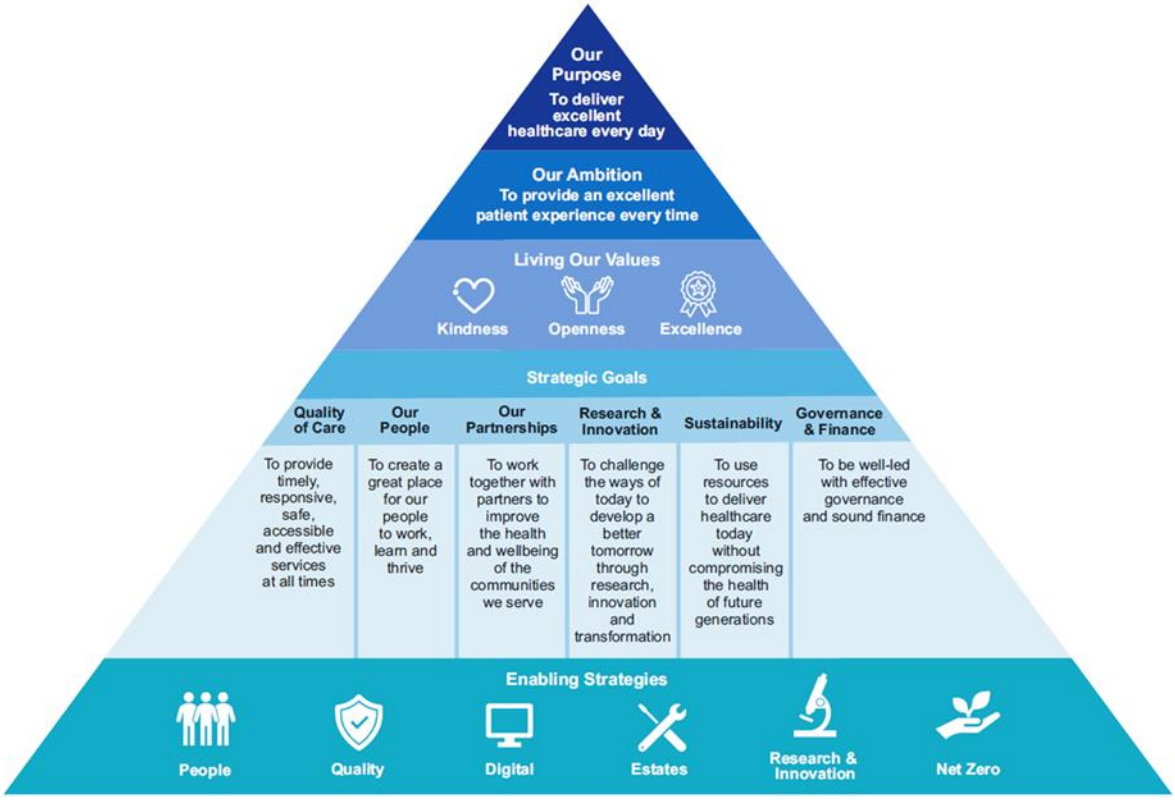
- To provide timely, responsive, safe, accessible and effective services at all times.
- To create a great place for our people to work, learn and thrive.
- To work together with partners to improve the health and wellbeing of the communities we serve.
- To challenge the ways of today to develop a better tomorrow through research, innovation and transformation.
- To use resources to deliver healthcare today without compromising the health of future generations.
- To be well-led with effective governance and sound finance.

To be successful, our people will have a clear understanding of the strategic objectives of the organisation and their role in contributing to their attainment. Our actions and choices, no matter where we work or what we do in the organisation, should be aligned with the Trust's purpose, ambition, and strategic objectives. We believe that every colleague has an important contribution to make and are committed to ensuring they are enabled to provide the services our communities deserve.

The way we do things is just as important as what we do. Our Values (how we behave and make decisions at work), developed with our people are: Kindness, Openness and Excellence.

To support people to live our values every day, we have a behavioural framework, defining the standards we should all expect of ourselves and each other.

The relationship between our Purpose, Ambition, Strategic Objectives, and Values is shown below; this also incorporates the enabling strategies.




Whilst our People Strategy supports delivery of all the strategic aims, it will particularly enhance the delivery of two of our strategic goals:

- Our people: to create a great place for our people to work, learn and thrive.
- Governance & Finance: to be well-led with effective governance and sound finance.

The People Strategy is one of several supporting strategies which helps drive our organisational culture. Our people ambitions are augmented by:

- Partnership working: the Trust works with Trade Union colleagues through its Joint Negotiating Consultative and Local Negotiating Committees to ensure it delivers a supportive, efficient, and high-quality healthcare environment for our people and patients.
- Staff Networks: our relationship with our six networks is one of the cornerstones for engagement with our people and helps us continually re-evaluate our priorities and actions. Our Networks guide us to amplify the voices of our people and help ensure our actions support a fair, open, transparent, compassionate and inclusive culture that is free from bullying, harassment and discrimination

## 1.3 National Focus and Priorities

There are several factors that have helped to inform this People Strategy:

### The new Ten-Year Plan

In anticipation of the new government's Ten-Year Plan for the NHS, the healthcare system needs to shift from:

1. Cure to prevention,
2. Hospital to community
3. Analogue to digital.

These three principles afford opportunity to improve people's experience of work, with long-term potential to recalibrate demand on services. A move to a more collaborative health and care system approach will allow our people to work across pathways, offering them renewed fulfilment in their roles.

York and Scarborough Teaching Hospitals NHS Foundation Trust has already signed a Memorandum of Understanding with other providers in the Humber and North Yorkshire region to enable the movement of our people and support collaboration between organisations. We are committed to ensuring we work with colleagues across health and care and the voluntary and community sector, to drive and transform the delivery of services for the benefit of our patients.

### NHS People Promise

The NHS People Promise is a commitment to creating a positive, inclusive, and supportive working environment for everyone working in the NHS. It outlines key values and behaviours that should define the NHS workplace, ensuring that employees feel valued, respected, and empowered. Central to the promise is a focus on improving leadership, fostering diversity, and encouraging open communication, so that everyone feels their voice is heard and their contributions matter.

The promise is built around seven core themes:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team.

These themes highlight the NHS's commitment to well-being, development, collaboration and inclusive treatment among its people. The goal is to create an environment where everyone can thrive, with fair opportunities for career progression and equity in workplace experiences and a strong emphasis on well-being and mental health support.

By delivering on the People Promise, the NHS aims to improve morale, retention, and overall job satisfaction, ultimately benefiting patient care. The promise serves as a foundation for long-term cultural change, ensuring that the NHS remains a great place to work, where individuals can grow professionally while feeling supported in their roles. This commitment not only enhances the working lives of NHS employees but also strengthens the healthcare system by fostering a motivated and engaged workforce.

We will tailor delivery of the NHS People Promise to support the needs of our people. We will monitor progress with delivery through our Resources Committee, and through focussed reporting to our Executive Committee and our Care Group Performance and Improvement Meetings.

### Regulation

Requirements of our people and services is underpinned by external regulation to check standards are being met and action is being taken when they are not.

We will continue to engage with regulators including the Care Quality Commission (CQC), General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Health Care Professions Council (HCPC) and the General Pharmaceutical Council (GPC) to uphold these standards. In addition, from 2025 we will begin the implementation of the NHS leadership and management framework as the NHS moves towards regulation of managers.

## 2.0 Our People Ambitions

As part of our journey 'Towards Excellence' we will focus efforts on our values and associated defined behaviours to improve the experience of our people. How things are done in the workplace resonates with every person every day. Ensuring our values guide how we approach every situation, every interaction, every decision made will help promote inclusion and equality for all, embrace diversity, and ultimately make the organisation a better place to work and receive treatment.

This begins with making values a core component of our recruitment and selection, extends into how we induct and develop our people and provides for individual consideration throughout employment. It provides a clear behavioural compass, giving rise to celebration when we see the values at their best and guiding us to respond effectively when we see otherwise.

The five ambitions described below connect with our values and context, translating each of them into a series of simple statements, accompanied by actions and measurement for achievement. In describing our ambitions in this way, we hope our people, patients, and stakeholders will understand what our ambition is, what success looks like and how we will get there.

## 1. People Ambition: our people consistently live and experience our values so patients can receive the best care

**What does it mean to live and experience our values?**

This means that we will:

- Attend to the individual needs of our people, showing compassion, understanding and championing fairness and diversity, and supporting them to be themselves.
- Encourage a culture of curiosity, openness, and transparency. One where our people come together to improve decision-making, services and outcomes through sharing of concerns, ideas and balanced feedback.
- Support people to speak up and do the right things by other people and patients.

**How will we achieve this?**

We will:

1. Re-focus recruitment to select the right values and behaviours to serve our people and patients. We will train people to recognise the appearance of values and behaviours when appointing a role, and the importance of alignment with the Trust's ethos. Moreover, we will champion a process which is always fair and inclusive to improve experiences and outcomes.
2. Build leadership and management capability through all levels of the organisation, aligned to a compassionate leadership framework. We will be consistent in our identification of people skills and the willingness and ability to give time to people (e.g. for 1:1s) as fundamental conditions for effective leadership and management.
3. Proactively address unwanted behaviours in pursuit of a safe and inclusive work environment. When unwanted behaviours occur, we will respond quickly and compassionately. We will always strive to ensure people who do the right thing are supported.

Measurements will include the number of staff trained in recruitment and selection and our line manager development programme, and the staff survey scores for staff feeling confident that their concerns will be addressed, engagement and morale.

## 2. People Ambition: develop an empowering leadership culture

**What does it mean to have an empowering leadership culture?**

This means that we will:

- Communicate clearly and regularly with our people: be clear on expectations; actively listen to their ideas; engage and involve them in change.

- Empower our people, as those who know the challenges best, to solve problems in their workplaces and improve care delivered to patients, including by providing quality improvement skills, knowledge and tools.
- Show our people are valued through real-time feedback, appreciation and recognition, taking time to celebrate their achievements regularly.

**How will we achieve this?**

We will:

1. Be explicit about what is required from leaders (i.e. those who lead services) in relation to people. This will emphasise the role they play, including how they are visible to our people, support and develop their ideas for improvement, and manage expectations in their service.
2. Underline the importance of continuous professional development for all our leaders (not just those in the most senior roles), so that they in turn develop people. We will develop compassionate leadership and provide access to coaching and mentoring.
3. Provide all new leaders with training and networks which supports them from the start of employment in their role, including through coaching.

This will be measured by the number of staff trained through our leadership programmes, the numbers accessing coaching and mentoring, and the staff survey score for 'We are compassionate and inclusive'.

## 3. People Ambition: our people develop careers in healthcare

**What does it mean to develop a career in healthcare?**

This means that we will:

- Encourage all our people to look within and beyond their role at opportunities for professional growth and development, and ensure opportunities are taken up by a diverse range of people.
- Identify staff development needs in line with priorities in the 10 Year NHS Plan using Learning Needs Analyses and appraisals.
- Provide roles and programmes that enable development of skills, behaviours and qualifications, equipping people to begin and advance their careers in the NHS.

**How will we achieve this?**

We will:

1. Make clear what progression routes exist for people who want to develop their career. Information that is easy to digest will be provided through digital

channels and staff fairs. We will explore creating talent pools and frameworks to support movement along these routes

2. Provide high quality careers conversations and appraisals, supported by training, which focus on people's strengths and aspirations and provide practical options for development.
3. Champion multi-professional learning and development of common skills and competencies, while also maintaining support for profession-specific requirements.

This will be measured by increasing the number of staff promoted within our organisation annually along with numbers leaving for progression, our WRES and WDES scores for development, and the staff survey score for 'We are always learning'.

## 4. **People Ambition: our workplaces become healthier**

**What does it mean to be healthier?**

This means that we will:

- Strive to foster supportive and sustainable work environments that help people manage the physical, mental and emotional challenges of work.
- Support achievement of a comfortable work-life balance.
- Attend people's immediate as well as long-term wellbeing needs.

**How will we achieve this?**

We will:

1. Make wellbeing conversations a staple of 1:1 meetings and appraisal conversations, encouraging openness and support for all our people.
2. Maintain and promote a range of physical, mental, emotional and financial wellbeing interventions to cater for different needs and health inequalities. We will support people to augment the programme with local team-oriented activities, working to the principle that time on wellbeing is investment in patient care.
3. Strive to improve the working environment, including areas used for rest. This includes enhancing cleanliness and reducing clutter,
4. Be proactive in managing workloads and tackling excessive working. We will support honest conversations about burnout and look at taking difficult decisions (e.g. changing our services) to make workloads balance.

This will be measured through the annual absence rate and the staff survey score for 'We are safe and healthy'.

## 5. People Ambition: digital improves the experience of our people

**What does it mean for digital to improve the experience of our people?**

This means that we will:

- Embrace ‘HR systems’ that are intuitive, easy to use and inclusive which enhance the experience of work. We will continually engage with the people who use them and involve them in procurement when this takes place.
- Support people to master our HR systems through the development of effective training, tools and guidance.
- Always strive to ensure people’s use of HR systems reduces time involved in everyday tasks and/or improves the quality of the output.

**How will we achieve this?**

We will:

1. Increase utilisation of HR systems to incorporate greater ‘self-service’ functionality, including via platforms for rostering, job planning and people data management.
2. Improve the quality of information we hold about people, roles and structures to engender confidence in our standards and decision-making.
3. Develop tools and training which help people to understand and maximise their use of digital systems at work.

This will be measured by the NHS Levels of Attainment for digital people systems and data quality scores.

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Date of Meeting:** | 30th April 2025 |
| **Subject:** | Digital Strategy 2025-2030 |
| **Director Sponsor:** | James Hawkins, Chief Digital and Information Officer |
| **Author:** | James Hawkins, Chief Digital and Information Officer<br>Nicky Slater, EPR Programme Team<br>Siobhan Roberts, EPR Communications & Engagement Lead |

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

**Trust Objectives**

☒ To provide timely, responsive, safe, accessible effective care at all times.
☒ To create a great place to work, learn and thrive.
☒ To work together with partners to improve the health and wellbeing of the communities we serve.
☒ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☒ To use resources to deliver healthcare today without compromising the health of future generations.
☒ To be well led with effective governance and sound finance.

**Board Assurance Framework**

☒ Effective Clinical Pathways
☒ Trust Culture
☐ Partnerships
☒ Transformative Services
☒ Sustainability Green Plan
☐ Financial Balance
☒ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☐ Yes

☐ No

☒ Not Applicable

**Executive Summary:**
This strategy supports the wider Trust Strategy 'Towards Excellence' and sets out how digital and data are key enablers in supporting our staff *'to provide an excellent patient experience every time'.*

The next five years present an exciting opportunity to embed digital excellence across our Trust. By investing in technology, data, and innovation, we will continue to improve patient outcomes, enhance staff experience, and future-proof our healthcare services.

The strategy outlines our six strategic objectives and describes how these will be delivered.

**Recommendation:**
The Board is requested to discuss and approve this Digital Strategy and its strategic objectives.

**Report Exempt from Public Disclosure** (remove this box entirely if not for the Board meeting)

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/Engagement | Date | Outcome/Recommendation |
|---|---|---|
| Digital Sub Committee | 28/03/25 | Recommended |

York and Scarborough Teaching Hospitals
NHS Foundation Trust

# DIGITAL STRATEGY 2025 – 2030

*Digital technology and information will help colleagues provide an excellent patient experience every time*

# FOREWORD

I am delighted to introduce the Trust's Digital Strategy 2025/30. This strategy supports the wider Trust Strategy 'Towards Excellence' and sets out how digital and data are key enablers in supporting our staff *'to provide an excellent patient experience every time'.*

Our ambition is to become a leader in digital healthcare – enhancing patient outcomes, improving colleague experience, and delivering smarter, data-driven, patient-centred care. This digital strategy is therefore unashamedly forward-thinking to ensure that the Trust not only address current needs, but stay ahead of tomorrow's challenges.

The NHS is at a pivotal moment in its evolution, as it embraces the transformative potential of digital and artificial intelligence technologies to meet the needs of patients, colleagues, and communities in the 21st century. Our community teams and hospitals stand as vital cornerstones of this vision, delivering care and innovation with a focus on safety, efficiency, and accessibility.

This digital strategy reflects our commitment to support building a future-ready NHS, where cutting-edge technology enhances patient outcomes, empowers healthcare professionals, and ensures that every individual receives the right care, at the right time, in the right place. It is not just a plan for implementing new systems—it is a roadmap for transforming the way care is experienced by every patient and delivered by every member of staff, embedding digital excellence into the DNA of our healthcare services.

The ambition outlined in this strategy builds on the dedication of our workforce and the trust of the public. It outlines our plans to utilise advances in artificial intelligence, data-driven insights, and connected systems to improve clinical decision-making, streamline workflows, and ensure seamless integration across care pathways. It also prioritises inclusivity, ensuring that digital tools bridge gaps rather than create barriers, and places patient safety, privacy and data security at its core.

The recent acquisition of the Nervecentre Electronic Patient Record (EPR) – will be the biggest transformational change the Trust has experienced. This is an exciting time for the Trust, maximising new opportunities and utilising the wealth of knowledge and expertise from our that colleagues who work in the Trusts digital teams have, to support the change. It will require huge effort and commitment through collaboration, involvement and engagement with our colleagues, partners and stakeholders.

Thank you for your support as we continue this transformational journey together to deliver our ambition.

Simon Morritt

**Chief Executive Officer**

James Hawkins

**Chief Digital and Information Officer**

# Introduction

The Trust recognises the power of technology and data to enhance patient care, improve colleague experience, and create a smarter, more connected healthcare system.

This Digital Strategy 2025-2030 is our roadmap for harnessing digital innovation to deliver outstanding care. It aligns with the Trust's wider vision, 'Towards Excellence,' ensuring that every patient receives the right care, at the right time, in the right place.

With a strong foundation in place—including an extensive digital infrastructure, a dedicated workforce, and a commitment to data-driven insights—we are now poised to take the next step:

- **Empowering staff** with seamless digital tools and automation.
- **Enhancing patient outcomes** through advanced analytics and AI-driven decision-making.
- **Strengthening our systems** with robust cybersecurity and interoperability.
- **Delivering transformation** with the implementation of the Nervecentre Electronic Patient Record (EPR).

As the Trust embarks on this journey, collaboration between our colleagues, partners, and stakeholders is of critical importance. By embracing innovation, the Trust will not only meet today's challenges but anticipate and shape the future of healthcare to build an NHS that is more efficient, resilient, and patient-centred.

# Our Trust

The Trust is an acute and community services provider delivering a comprehensive range of acute hospital and specialist healthcare services for more than 550,000 people living in York, North Yorkshire and East Yorkshire- an area covering 3,400 square miles.

Across 8 sites, with 846 acute beds (plus additional community facilities) and a dedicated workforce of over 10,500 staff, the Trust delivers compassionate, high-quality care to our community. Each year, we care for approximately 160,000 adult inpatients and 10,000 paediatric inpatients, addressing diverse health needs with expertise and empathy. In 2023, our maternity services brought 4,000 babies safely into the world, whilst our surgical teams completed an impressive 122,000 inpatient operations. Outpatient clinics facilitated 780,000 attendances, underscoring our commitment to providing timely and accessible care. Our emergency services responded to 115,414 A&E visits and supported 100,000 urgent care cases, ensuring immediate assistance when it is needed most.

# Y&S Digital

The Trust has a directorate known as “Y&S Digital” which delivers a comprehensive range of services to our workforce, patients and partners, including the technological infrastructure, software, data, training, email, messaging, telephony, cyber and information governance services that ensure the Trust remains connected, our patients safe, and our information secure.

Our Y&S Digital Teams include:

- Business Intelligence and Insights
- Clinical Digital Team
- Clinical Coding
- Clinical Systems Development
- Cyber and Information Security
- Health Records
- Information Governance
- Information Technology Service Management
- Portfolio, Programme and Project Officer (P3O)
- Technical Infrastructure
- Training, Learning and Development

The Directorate has an annual revenue budget approaching £13m and a workforce of circa 250 people. It is committed to continuously improving digital maturity across the Trust, implementing actions to support the delivery of our shared priorities.

The Y&S Digital team plays a key role within the Trust, supporting over 20,000 devices and overseeing approximately 100 critical systems. These numbers highlight the scale of the operation and the commitment of the teams to delivering exceptional support every day.

Recent achievements include:

- Development of ‘Nucleus’ within CPD, which brought digital workflow to nursing, significantly improving efficiency, allowing nurses to spend more time on patient care rather than paperwork.
- Development of digitised Trusted Assessor Form (TAF), transforming the existing nursing and AHP process to facilitate and communicate patients discharge needs more safely, effectively and efficiently.
- Engaged with the Federated Data Platform (FDP) to implement the first phase of OPTICA, to provide transparency in discharge planning with our partner organisations.
- Adoption of NHS.Net Connect, moving from on-premises email to nhs.net email. We have moved to OneDrive and deployed MS Teams which is widely in use throughout the organisation. We are also currently engaged on the MS Copilot trial.

- Effectively integrated with the new NHS e-Referral Service Fast Healthcare Interoperability (FHIR) Application Programming Interfaces (APIs), improving efficiency, and utilising the advice and guidance functionality.
- Proactively addressed risk through the following:

    - Use of Microsoft defender – helps detect, prevent and respond to a wide range of threats
    - Investment in next generation firewalls – a barrier between our internal network and external sources, integrating features such as real-time threat intelligence
    - Proactive patch management – regular security patching across all areas to reduce exposure to cyber threats
    - Multi-Factor Authentication (MFA) – strengthening identity and access security
    - Penetration testing – to identify and remediate vulnerabilities across our digital infrastructure, through controlled tests which are designed to uncover any weakness

- Significant upgrade to the Wireless Network (Wifi) and Local Area Network (LAN) with more than 1000 new Access Points (APs) at different trust locations, and 315 new LAN switches have been installed. This will improve the user experience overall, increase speed and performance, enhance capacity to handle more devices, and increase security.
- Re-launched the way we deliver analytics to support data-driving insights that inform operational decisions and strategic long-term planning.
- Supported over 90 Data Protection Impact Assessments in the last year, ensuring that personal data is being managed lawfully and securely.
- Progressing with digital transformation of paper records and our storage consolidation.

The Trust is assessing options to enhance patient digital communications as part of wider optimisation under the EPR programme. The software system Patient Knows Best (PKB) has been deployed, but this is not yet fully utilised and does not currently offer the ability to rebook or cancel appointments. More work will be carried out to fully utilise the NHS Notify service for both efficiency and patient experience benefits.

The directorate collaborates with clinical and operational colleagues to drive digital transformation and innovation initiatives.

The directorate also collaborates with wider digital teams who focus on Radiology and Pathology, as part of the Trusts broader digital strategy.

The Trusts digital strategy seeks to build on this foundation, ensuring further innovation and improvement to benefit both patients and colleagues.

# Electronic Patient Record (EPR)

The major priority over the next 18-24 months is the transition to a new Electronic Patient Record system (EPR), Nervecentre, which will enable the Trust to be well positioned for the future. The EPR is a major piece of foundational digital infrastructure that influences multiple aspects of quality and safety and provides the opportunity to transform the delivery of patient care and the overall colleague experience as they work in an increasingly digital workplace.

The Clinical Systems Development team are instrumental in this transition, providing invaluable and significant expertise, skill and knowledge in building our current EPR, known as CPD, over the past 25 years, and pivotal in the transition to Nervecentre.

Our current EPR, CPD, is integrated with the Trusts other systems including:

- Badger (maternity)
- Somerset (cancer)
- Metavision (critical care)
- Medisight (ophthalmology)
- YHCR (Yorkshire and Humber Care Record)
- SystmOne (community)
- Soliton (radiology)
- Pathology
- Pharmacy

As we transition to Nervecentre EPR, we will need to carefully manage each phase to ensure we maintain this level of interoperability.

# Our Commitment to Innovation

In addition to the transformation and innovation opportunity that Nervecentre EPR presents to the Trust, Artificial Intelligence (AI) offers an unprecedented opportunity to transform healthcare delivery, making it smarter, safer, and more sustainable. Through embracing AI the Trust has an ambition to be more responsive, more efficient, and better equipped to modernise the way the Trust works and helps patients.

The Trust will adopt AI responsibly, embedding it ethically and seamlessly to enhance—not replace—the expertise of our clinicians and healthcare professionals. The Trust will be guided by three core principles:

1. **Patient-Centric Innovation** – AI will be leveraged to improve patient outcomes, reduce waiting times, and enable more precise, personalised care.
2. **Empowering Our Workforce** – AI will support our teams by reducing administrative burdens, enhancing decision-making, and allowing more time for direct patient care.

3. **Ethical, Safe, and Transparent Implementation** – AI will be developed and deployed with robust governance, ensuring safety, accountability, and alignment with NHS values.

The radiology service has already successfully adopted AI within some areas, including:

- **Stroke patients** – to identify patients who can benefit from transfer for mechanical thrombectomy in Hull
- **Multiple sclerosis** – to review follow up MRIs, where AI helps to identify subtle new lesions or look for enlarging lesions, leading to change in treatment
- **Aneurysm detection** – to identify small aneurysms, we use AI to help identify any vessel abnormalities that could represent an intracranial aneurysm
- **Brain volume in dementia** –to provide a volumetry diagnostic that can help detect neurodegenerative processes at an earlier stage
- **Fractures** – to augment the initial interpretation of radiographs with AI, prior to the final report being issued. This increases diagnostic accuracy, reduces risk of missed fractures and reduces unnecessary referrals to fracture clinic.

The Breast Screening team have applied to be a site for the new national study into AI in breast screening, hopefully going live in 2026.

The Trust is trialling Microsoft Co-pilot, an AI-powered tool, to deliver real-time intelligence that helps our staff work more efficiently, streamline administrative tasks, and enhance patient care. This offers significant opportunities across many different roles, including:

- transcribing and summarising meetings
- generating reports and emails
- providing quick learning resources, retrieving guidance, policies and best practice
- enhancing operational efficiency, by analysing large datasets to support decision making
- improving patient engagement, by translating complex medical jargon into patient friendly language
- assisting with Chatbots – automating responses to common enquiries, freeing up time for front-line staff

The Business Intelligence team plan to leverage the use of MS Co-pilot using the wealth of data we have within the Trust. By harnessing AI-powered analytics and predictive modelling, the Trust aims to reduce wait times, manage waiting lists more effectively, and plan the best use of hospital resources —ultimately delivering better patient care.

Robotic Process Automation (RPA) has been adopted within Accounts Payable in our Finance Department, increasing efficiency and releasing valuable staff time.

# Strategic Aims

Our Digital Strategy outlines how we will be a key enabler in supporting the Trust ambition *"To deliver and excellent patient experience every time".*

Our **Purpose** (why we exist):

- Through technology and data, we help colleagues provide an excellent patient experience every time.

Our **Ambition** (where do we aspire to get to – our True North) is:

- Be a leader in digital healthcare – enhancing patient outcomes, improving staff experience, and delivering smarter, data-driven, patient-centred care.

Our **Priorities** (what will we do to achieve success – our route map) are:

- Deliver safe, secure, and sustainable digital products and services for the staff and the patients we serve.
- Provide data and insights to inform strategic decisions and drive operational improvement.
- Protect the Trust's data with robust information governance and cyber security controls.
- Support the organisation's transformation through new technologies, including the adoption of a new Nervecentre Electronic Patient Record (EPR).
- Improve the digital maturity of our people, through education and training, freeing up time for direct patient care.
- Create an environment where our digital teams can grow and thrive.

# Strategic Priorities

Our **Six Strategic Objectives** are to:

- Deliver safe, secure, and sustainable digital products and services for the staff and the patients we serve.
- Provide data and insights to inform strategic decisions and drive operational improvement.
- Protect the Trust's data with robust information governance and cyber security controls.
- Support the organisation's transformation through new technologies, including the adoption of a new Nervecentre Electronic Patient Record (EPR).
- Improve the digital maturity of our people, through education and training, freeing up time for direct patient care.
- Create an environment where our digital teams can grow and thrive.

# Delivering the Strategy

### Deliver safe, secure and sustainable products and services for the staff and the patients we serve

This means:

- Keep systems, applications, and networks running with minimal downtime, resolving issues proactively.
- Provide fast and efficient IT support to users, minimising disruption and improve service quality.
- Manage clinical risk through clinical safety assurance standards DCB0129, and DCB0160.
- Put patients, families, and colleagues at the centre and ensure our systems are inclusive, accessible, and reliable.
- Support the Trust's Green Plan by championing sustainable digital practices.

### Provide data and insights to inform strategic decisions and drive operational improvement

This means:

- Improve data literacy across the organisation by providing targeted training and self-service BI tools that empower staff to confidently interpret and use data.
- Provide advanced analytics and predictive insights to support population health management, resource allocation, and patient care improvements.

- Upgrade data systems and integrate real-time analytics to enable proactive decision-making and operational agility.
- Strengthen diagnostic analysis and forecasting capabilities through machine learning and AI-driven BI solutions to identify trends, forecast demand, and optimise patient flow.
- Establish a unified data governance framework to ensure data accuracy, security, and accessibility across the Trust.
- Deliver an industry-leading Clinical Coding service that provides highly accurate inpatient data and expert coding advice, adhering to best practices and meeting nationally mandated deadlines.

### Protect the Trust's data with robust information governance and cyber security controls

This means:

- Have appropriate organisational structures, policies, and processes in place to understand, assess and systematically manage risks to the security and governance of information, systems and networks supporting essential functions by achieving the standards set in the NHS England Data Security and Protection Toolkit.
- Protect against cyber-attack and data breaches with proportionate security measures to protect information, systems and networks supporting essential functions.
- Implement capabilities to ensure security defences remain effective and to detect cyber security events affecting, or with the potential to affect, essential function(s).
- Minimise the adverse impact of incidents on the operation of essential functions.
- Ensure that information is used and shared lawfully and appropriately. Including documentation within the Trust Information Asset Register and due diligence checks with all suppliers handing data.

### Support the organisation's digital transformation through new technologies, including the adoption of a new Nervecentre Electronic Patient Record (EPR)

This means:

- Deliver the new EPR system within agreed timelines whilst minimising disruption.
- Improve efficiency through automating workflows, minimising paper, scanning current paper casefiles, and streamlining our administrative processes.
- Enhance patient safety & quality of care through the reducing errors, providing real-time clinical decision support, and ensuring seamless communication across teams
- Collaborate with colleagues across the Integrated Care System (ICS) to drive system-wide efficiencies.
- Implement and integrate Artificial Intelligence (AI) technologies within the trust to enhance clinical decision-making, operational efficiency, and patient outcomes, while ensuring ethical, secure, and regulatory-compliant deployment.

### Improve the digital maturity of our people, through education and training, freeing up time for direct patient care.

This means:

- improve the digital maturity of the Trust's workforce by conducting training needs analyses to identify and address skill gaps.
- offer engaging, accessible, and innovative training and education programmes to enhance digital skills and confidence.
- promote the use of intuitive self-service tools to empower staff with better data insight and decision-making.
- fully adopt Microsoft Office 365 to streamline collaboration, boost productivity, and free up time for direct patient care.

### Create a great digital team where our people can grow and thrive

This means:

- address challenges highlighted in staff surveys by enhancing communication, career growth, and work-life balance to create a more engaged and motivated team.
- invest in skills, training, and education by providing ongoing development opportunities to keep our team skilled, innovative, and future-ready.
- foster partnerships with local education providers by collaborating with universities and colleges to create internships, apprenticeships, and learning opportunities.
- modernise our workplaces by investing in digital tools, flexible work policies, and modern office spaces to enhance collaboration, productivity, and well-being.
- create a supportive, inspiring environment by fostering an inclusive culture, offering career growth opportunities, and ensuring strong leadership support.

# Looking Ahead

The next five years present an exciting opportunity to embed digital excellence across our Trust. By investing in technology, data, and innovation, we will continue to improve patient outcomes, enhance staff experience, and future-proof our healthcare services.

We are committed to working collaboratively across the NHS, leveraging new opportunities, and ensuring our digital journey remains aligned with our core purpose—delivering an excellent patient experience every time.

Through our Strategy we are shaping a future where patients, clinicians, and services benefit from truly integrated, data-driven care, unlocking faster diagnoses, enabling more personalised treatment and care, and proactive health interventions.

This strategy will be continually assessed against its progress, measured through the Strategy Scorecard and colleague feedback routes.

| | |
|---|---|
| **Report to:** | Board of Directors |
| **Date of Meeting:** | 30 April 2025 |
| **Subject:** | 2024/25 Q4 Board Assurance Framework |
| **Director Sponsor:** | Simon Morritt, Chief Executive |
| **Author:** | Mike Taylor, Associate Director of Corporate Governance |

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

**Trust Objectives**

☒ To provide timely, responsive, safe, accessible effective care at all times.
☒ To create a great place to work, learn and thrive.
☒ To work together with partners to improve the health and wellbeing of the communities we serve.
☒ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☒ To use resources to deliver healthcare today without compromising the health of future generations.
☒ To be well led with effective governance and sound finance.

**Board Assurance Framework**

☒ Effective Clinical Pathways
☒ Trust Culture
☒ Partnerships
☒ Transformative Services
☒ Sustainability Green Plan
☒ Financial Balance
☒ Effective Governance

**Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)*

☐ Yes

☐ No

☒ Not Applicable

**Executive Summary:**

The report provides the 2024/25 Q4 Board Assurance Framework.

**Recommendation:**

The Board of Directors is asked to approve the 2024/25 Q4 Board Assurance Framework.

| Report History<br>(Where the paper has previously been reported to date, if applicable) | | |
|---|---|---|
| **Meeting/Engagement** | **Date** | **Outcome/Recommendation** |
| Risk Committee | 4 April 2025 | Approval for updates |

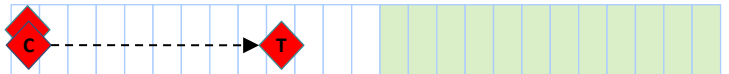
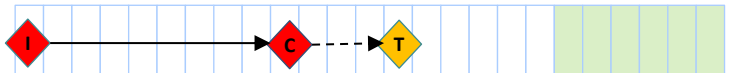
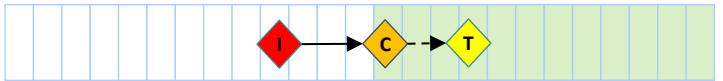
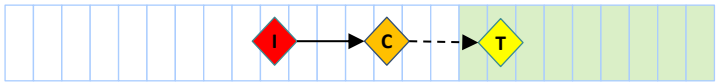
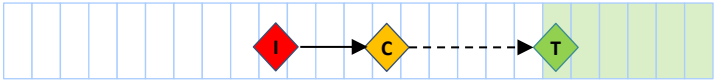
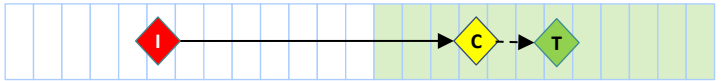
York and Scarborough Teaching Hospitals
NHS Foundation Trust

# Q4 – 2024/25 Board Assurance Framework (BAF)

April 2025

# Q4 - 2024/25 Board Assurance Framework Dashboard

York and Scarborough Teaching Hospitals
NHS Foundation Trust

| Rank/Move | High Level Risk Description | Risk Assessment (Catastrophic / Major / Moderate / Minor / None) | Risk Rating | Actions | Owner | Oversight |
|---|---|---|---|---|---|---|
| 1 | PR6a – Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-30. |  | 25 | 0 0 4 | Director of Finance | Resources Committee |
| 2 | PR1 – Inability to provide consistently effective clinical pathways leading to poor outcomes, experience and possible harm. |  | 16 | 0 0 4 | Chief Nurse | Quality & Resources Committees |
| 3= | PR2 – Inability to nurture a Trust culture that facilitates good staff engagement and development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes. |  | 12 | 0 0 3 | Director of Workforce and OD | Resources Committee |
| 3= | PR5 – Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda. |  | 12 | 0 0 3 | Director of Finance | Resources Committee |
| 3= | PR3 – Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability. |  | 12 | 0 0 4 | Chief Operating Officer | Quality & Resources Committees |
| 4 | PR6b – Failure to demonstrate effective governance to achieve the Trust's strategy. |  | 9 | 0 0 2 | Chief Executive | All Committees |
| 5 | PR4 – Trust service, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients. |  | 6 | 0 0 4 | Medical Director | Quality Committee |

**Key**

- N – New Risk
- Increase in Rank
- Decrease in Rank
- No movement in Rank
- I – Inherent Risk - The measure of risk before controls are considered
- C – Current Risk - The measure of risk after controls are considered
- T – Target Risk - The measure of risk once actions have been completed
- Reliance on controls
- Planned mitigations
- 1 Action on track
- 1 Action delayed by 1-2mths
- 1 Action delayed by 3mths+

Risk Appetite

Minimal - 6
Cautious - 9
Open - 12
Hungry - 20

# Summary of Risks by objective

## Strategic Objective: Quality of Care – To provide timely, responsive, safe accessible, effective care at all times

| REF | Principal Risk | Risk Owner | Assurance Committee | Initial Risk Rating (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status (In / Out of Appetite) | Target Risk (After Actions) | | | Movement from Last Quarter |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | I | L | Rating I x L | I | L | Rating I x L | | | I | L | Rating I x L | |
| PR1 | Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm. | Chief Nurse | Quality & Resources Committees | 5 | 5 | 25 | 4 | 4 | 16 | 6 MINIMAL | OUT | 4 | 3 | 12 | ⟺ |

## Strategic Objective: Our People – To create a great place for our people to work, learn and thrive

| REF | Principal Risk | Risk Owner | Assurance Committee | Initial Risk Rating (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status (In / Out of Appetite) | Target Risk (After Actions) | | | Movement from Last Quarter |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | I | L | Rating I x L | I | L | Rating I x L | | | I | L | Rating I x L | |
| PR2 | Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes. | Director of Workforce & OD | Resources Committee | 4 | 4 | 16 | 4 | 3 | 12 | 12 OPEN | IN | 3 | 3 | 9 | ⟺ |

## Strategic Objective: Our Partnerships – To work together with partners to improve the health and wellbeing of the communities we serve

| REF | Principal Risk | Risk Owner | Assurance Committee | Initial Risk Rating (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status (In / Out of Appetite) | Target Risk (After Actions) | | | Movement from Last Quarter |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | I | L | Rating I x L | I | L | Rating I x L | | | I | L | Rating I x L | |
| PR3 | Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability. | Chief Operating Officer | Quality & Resources Committees | 4 | 4 | 16 | 4 | 3 | 12 | 6 MINIMAL | OUT | 3 | 2 | 6 | ⟺ |

## Strategic Objective: Research, Innovation and Transformation – Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow

| REF | Principal Risk | Risk Owner | Assurance Committee | Initial Risk Rating (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status (In / Out of Appetite) | Target Risk (After Actions) | | | Movement from Last Quarter |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | I | L | Rating I x L | I | L | Rating I x L | | | I | L | Rating I x L | |
| PR4 | Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients. | Medical Director | Quality Committee | 3 | 3 | 9 | 3 | 2 | 6 | 6 MINIMAL | IN | TBC | TBC | 6 | ⟺ |

# Summary of Risks by objective

## Strategic Objective: Sustainability – To use the resources to deliver healthcare today without compromising the health of future generations

| REF | Principal Risk | Risk Owner | Assurance Committee | Initial Risk Rating (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status (In / Out of Appetite) | Target Risk (After Actions) | | | Movement from Last Quarter |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | I | L | Rating I x L | I | L | Rating I x L | | | I | L | Rating I x L | |
| PR5 | Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda. | Director of Finance | Resources Committee | 4 | 4 | 16 | 4 | 3 | 12 | 9 CAUTIOUS | OUT | 4 | 2 | 8 | ⟺ |

## Strategic Objective: Governance and Finance – To be well led with effective governance and sound finance

| REF | Principal Risk | Risk Owner | Assurance Committee | Initial Risk Rating (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status (In / Out of Appetite) | Target Risk (After Actions) | | | Movement from Last Quarter |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | I | L | Rating I x L | I | L | Rating I x L | | | I | L | Rating I x L | |
| PR6 a | Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030 | Director of Finance | Resources Committee | 5 | 5 | 25 | 5 | 5 | 25 | 12 OPEN | OUT | 4 | 4 | 16 | ⟺ |

| REF | Principal Risk | Risk Owner | Assurance Committee | Initial Risk Rating (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status (In / Out of Appetite) | Target Risk (After Actions) | | | Movement from Last Quarter |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | I | L | Rating I x L | I | L | Rating I x L | | | I | L | Rating I x L | |
| PR6 b | Failure to demonstrate effective governance to achieve the Trust's strategy. | Chief Executive | All Committees | 5 | 4 | 20 | 3 | 3 | 9 | 12 OPEN | IN | 2 | 3 | 6 | ⟺ |

# Ref PR1 Board Assurance Framework (BAF)

| Ref: PR1 | Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times | **PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.* | Risk Score: 16 |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

**Consequences** – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients in urgent care pathways
- Regulatory attention
- Poor staff experience, health and wellbeing

**Executive Risk Owner:** Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to 2024/25 BAF:** January 2025

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 5 | 5 | 25 | 4 | 4 | 16 | MINIMAL (1-6) | OUT OF APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 16 | 16 |
| Risk Appetite | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) |

| i) Controls | i) Assurances (inc. Positive) | ii) Controls | ii) Assurances (inc. Positive) | iii) Controls | iii) Assurances (inc. Positive) |
|---|---|---|---|---|---|
| Performance Improvement Review Meetings (PRIM) monthly for all Care Groups | PRIM letter outcomes and next steps reported to Executive Committee Oct-Jan 2025 (Care Group escalation reports previously) | Infection Prevention Strategic Assurance Group (IPSAG) | - IPSAG monthly reporting<br>- Apr 24-Jan 25 TPR reporting to Quality Committee and Board | Sustainable services reviews – internal and with the Collaboration of Acute Providers (CAP) | Internal sustainable services report and CAP reporting through CAP Committee in Common |
| Quality Committee, Patient Safety and Clinical Effectiveness, Patient Experience Sub-Committees, Resources Committee | - Apr 24-Jan 25 Quality and Safety reporting to sub-committees<br>- Apr 24-Jan 25 escalation reports to Quality Committee<br>- Apr 24-Jan 25 Quality Committee delivery of assurance work programme<br>- Apr 24-Jan 25 Board escalations | Programme Management Office schedule of programmes | Specific programmes including:<br>- Urgent and Emergency Care, Electronic Patient Record<br>- Maternity<br>- Culture and Leadership | Humber and North Yorkshire System oversight for diagnostics, cancer, urgent care, finance, workforce and place-based meetings | Collaboration meetings across Executive Portfolios: Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce and OD, Finance Director papers |
| Care Group Board sub-group oversees IPC, escalations made to IPSAC and Assurance Committees | Monthly reporting papers of IPC, Patient Experience and Patient Safety and Clinical Effectiveness | Integrated Quality Improvement Group (IQIG) NHSE oversight | Monthly reporting of Trust Improvement Dashboard, CQC Update, Maternity, risks | Continuous flow and escalation model 3x Op sit rep, proactive management of discharges, proactive communications management with staff and patients, psychological support for staff | - Executive Committee reporting, Board escalations of outcomes and concerns, 3x daily operational sit rep. on-call arrangements in place, proactive management of discharges<br>- Datix field enabled to identify patient safety incidents linked to continuous flow activity. |
| Operations meeting oversight: Elective Recovery Board, Unscheduled Care Board, Maternity Assurance Group | - Monthly reporting papers of Elective and Unscheduled Care Boards<br>- Apr 2024-Jan 2025 Executive Committee<br>- Tiering meetings with NHSE for performance | Corporate Quality Oversight:<br>- Maternity Assurance Group (MAG) single improvement plan<br>- Children's Board<br>~~- Gap – Mental Health single improvement plan~~<br>~~- Gap – Falls and Pressure Ulcer joint working dev~~<br>- Complex Needs Group being established.<br>- Professional Standards Group established | - Monthly reporting papers Maternity Assurance Group<br>- Single Improvement Plan progress report<br>~~Gap – Fundamentals of Care Accreditation~~<br>• Quality Assurance Framework being established to include ward accreditation including fundamentals of care | *Gap – EPRR Core Standards limited compliance*<br>*Gap – Clinical Estates Strategy* | EPR July 2024 Resources Committee and Board reporting<br>EPRR Commander training in delivery<br>Draft clinical estates strategy in place |

# Ref PR1 Board Assurance Framework (BAF) - continued

| Ref: PR1 | Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times | **PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.* | Risk Score: 16 |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

**Consequences** – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients in urgent care pathways
- Regulatory attention
- Poor staff experience, health and wellbeing

**Executive Risk Owner:** Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to 2024/25 BAF:** January 2025

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 5 | 5 | 25 | 4 | 4 | 16 | MINIMAL (1-6) | OUT OF APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 16 | 16 |
| Risk Appetite | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) |

| i) Controls | i) Assurances (inc. Positive) | ii) Controls | ii) Assurances (inc. Positive) | iii) Controls | iii) Assurances (inc. Positive) |
|---|---|---|---|---|---|
| Trust performance report | - Monitored at Quality Committee and associated sub committees<br>- Gap – CPD updates to clinical practice | - Regulation and Assurance visits. | Regulation and Assurance group in place HTA, HNY Trauma network, LMNS, H&S, stroke peer review, CQC | Gaps in Technical Infrastructure and Cyber Security: Limited monitoring of IG policy adherence, lack of access management policy (currently being reviewed), specialist Board cyber security training, wide variety of policies requiring review and update inc cyber protocols, services and endpoint devices require investment, central 3rd party proc register | |

| Mitigating Actions To Address Gaps<br>What actions will further mitigate the risk and its identified rating? | Progress Update<br>What is the current progress to date in achieving the action identified? | Action Owner<br>Who is the action owner? | Target Date<br>When does the action take effect? |
|---|---|---|---|
| Moving individual themed meetings to use a continuous improvement methodology using in the moment data from patient feedback and patient safety incidents | Deputy chief nurse has scoped existing themed meetings and has developed a draft terms of reference for a new complex needs group to be focussed around continuous improvement | Tara Filby | April 2025 |
| Review and refresh the complex needs improvement plan | All existing groups to be brought together under a complex needs development priority | Tara Filby | April 2025 |
| Further develop our quality assurance framework to include ward and department accreditation programmes | A draft QAF that undertakes local monitoring and review. This needs to develop to include external oversight | Tara Filby | June 2025 |
| Development of the EPR programme will address short term inability to update CPD | EPR plan in place for delivery | Adele Coulthard/Tara Filby | April 2025 (review) |

| Target Risk (After Actions Implemented) | | |
|---|---|---|
| I | L | Rating I x L |
| 4 | 3 | 12 |

**Next Review**
Q1 - June 2025

# Ref PR2 Board Assurance Framework (BAF)

| Ref: PR2 | Strategic Objective: To create a great place for our people to work, learn and thrive | **PRINCIPAL RISK 4:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.* | **Risk Score: 12** |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

**Consequences** – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

**Executive Risk Owner:** Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to 2024/25 BAF:** January 2025

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 4 | 4 | 16 | 4 | 3 | 12 | OPEN (10-12) | INSIDE APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 12 | 12 |
| Risk Appetite | OPEN (10-12) | OPEN (10-12) | OPEN (10-12) | OPEN (10-12) |

| i) Controls | i) Assurances (inc. Positive) | ii) Controls | ii) Assurances (inc. Positive) | iii) Controls | iii) Assurances (inc. Positive) |
|---|---|---|---|---|---|
| Our Voice Our Future Programme | - Discovery and Design phase – discovery complete and design phase underway<br>- *Gap – OVOF delivery phase actions*<br>- Q1-Q3 Board Seminar Development reports | Enhanced Vacancy Control Process | - Enhanced Vacancy Control Panel papers May 2024- April 2025<br>- TPR workforce reporting April 2024 – April 2025 | Revised communications approach | - Back to the floor initiative<br>- Senior Leadership blogs<br>- Staff Briefs |
| Delivery of Internal Leadership Programmes in line with Leadership Framework | - Care Group Leadership Development Programme Cohorts phases 1-3 delivered<br>- List of programmes and training programmes on Learning Hub | Implementation of People Strategy<br><br>Freedom to Speak Up Reporting | TPR workforce reporting Apr 2024-April 2025<br>EDS 2022; WRES, WDES & Pay Gap reports<br>FTSU Board report September 2024 | Formal workforce engagement | - JNCC and LNC meeting minutes<br>- Staff Networks ToR<br>- Anti-Racism Group |
| Line Management Toolkit and Training | Toolkit rollout to all Line Managers and training implementation records | Senior Leadership Engagement<br>Gap – engagement with all levels of leadership | - Quarterly Senior Leaders Forum<br>- Senior Clinical Leadership monthly meeting | Wellbeing delivery | - Occupational Health and Wellbeing Annual Report to Resources Committee<br>- Staff Psychologist Therapy |
| - Oversight of establishments and establishment reviews, job planning and medical deep dives<br>- TPR reporting of nursing academy: retention of HCSW and apprenticeships levy | - TPR reporting Apr 2024-April 2025<br>- Nursing workforce Resources Committee reporting Apr 2024-April 2025<br>- Quarterly Medical Workforce Report – Resources Committee Sept 24 – Jan 2025 | *Gap – Financial resources to recruit at the staffing establishments required* | - Annual financial planning Board sign-off April 2025<br>- Staffing business cases<br>- Rostering data | QI Readiness Assessment position when undertaken<br><br>Staff Benefits work programme | |

| Mitigating Actions To Address Gaps<br>What actions will further mitigate the risk and its identified rating? | Progress Update<br>What is the current progress to date in achieving the action identified? | Action Owner<br>Who is the action owner? | Target Date<br>When does the action take effect? |
|---|---|---|---|
| - Our Voice Our Future – Delivery Phase implementation of actions | - Our Voice Our Future Design Phase underway (for completion June 2025), Delivery phase to be launched (for completion June 2026) | Simon Morritt | June 2026 |
| - Staff Survey Improvement Plan and People Promise Programme | - Staff Survey Improvement Plans developed by May 25. People Promise Programme concludes May 25 | Polly McMeekin | Sept 2025 |
| - Required Learning Review and band 5 (RN) competency Framework | - Nursing training and competency review complete with plans to consolidate mode of delivery. | Dawn Parkes | June 2025 |

| Target Risk (After Actions Implemented) | | |
|---|---|---|
| I | L | Rating I x L |
| 3 | 3 | 9 |

| Next Review |
|---|
| Q1 - June 2025 |

# Ref PR3 Board Assurance Framework (BAF)

| Ref: PR3 | Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve | **PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.* | **Risk Score: 12** |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

**Consequences** – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

**Executive Risk Owner:** Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to 2024/25 BAF:** January 2025

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 4 | 4 | 16 | 4 | 3 | 12 | MINIMAL (1-6) | OUT OF APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 12 | 12 |
| Risk Appetite | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) |

| i) Controls | i) Assurances (inc. positive) | ii) Controls | ii) Assurances (inc. positive) | iii) Controls | iii) Assurances (inc. positive) |
|---|---|---|---|---|---|
| Strategic Alignment: Mechanisms in place to ensure alignment of priorities between partners.<br>- Joint Committee in Common<br>- Joint Operational planning meetings with Alliances, ICB and Place Colleagues throughout planning process.<br>- Alignment of Cancer alliance objectives into Y&S Cancer Strategy<br>- Recruitment of Head of Strategy to support partnership working | Shared system performance metrics managed with the ICB and tiering meeting with regional colleagues. ICB performance oversight arrangements.<br>CAP meetings: Elective and UEC – joint leadership arrangements<br>Trust strategy shared with Stakeholders (dec 2024)<br>*Cancer Strategy Workshop – Feb 2025*<br>*Gap: Joint strategic planning sessions with place & partners (not a gap for cancer as this is done collaboratively)* | Training and Development: Increasing the understanding of key Trust leaders in system working and partnership opportunities. | *Gap: Opportunity for leadership development in system collaboration.* | Resources:<br>Senior management representation at core ICB and Place-based forums and alliances.<br>Employment of Head of Strategy as key lead for partnership development | Attendance records at partnership meetings.<br>Recruitment of Head of Strategy to support partnership working.<br>Funding into NHS Benchmarking |
| Communications: Joint committees or forums for collaboration and conflict resolution. | - Trust CEO Committee in Common with other Trust Providers.<br>- Harrogate Board to Board<br>- York Health & Care Collaborative & Joint Delivery Board.<br>- CAP Alliance Representation & clinical leads<br>- Multiple Boards in place where Trust is represented: CAP/ UEC and Place and SOAG.<br>- ICB Board Quarterly meeting minutes<br>- York Health & Care Collaborative & Joint Delivery Board meeting minutes<br>- CAP Quarterly meeting minutes<br>*Gap: Audit of effectiveness of forums for delivering quality partnership working ?* | Data that support partnership working<br>- North Yorkshire Overarching Multi Agency Information Sharing Protocol (MAIS)<br>- Humber sharing charter<br>- Specific sharing agreement with TEWV for them to access our systems as required<br>- Information sharing as part of the Collaborative of Acute Providers Information | MAIS: this is managed by NYCC and is reviewed annually (partners include YAS, NY Police, CYC, Harrogate and District NHS Foundation Trust)<br>*Humber sharing charter:* this is managed by North East Lincolnshire Council and is reviewed annually (partners include HUTH, East Riding council, Humberside Police)<br>TEWV and other agreements managed in line with SLAs<br>CAP: Sharing is managed through the joint working arrangement | - System working to deliver EPR convergence and supporting initiatives around Population Health Management<br>- Partnership working on the Yorkshire and Humber Care Record | - EPR Programme Management<br>- Yorkshire and Humber Care Record Programme Management |

# Ref PR3 Board Assurance Framework (BAF) - continued

| Ref: PR3 | Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve | **PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.* | **Risk Score: 12** |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

**Consequences** – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

**Executive Risk Owner:** Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to 2024/25 BAF:** January 2025

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 4 | 4 | 16 | 4 | 3 | 12 | MINIMAL (1-6) | OUT OF APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 12 | 12 |
| Risk Appetite | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) |

| Mitigating Actions To Address Gaps<br>What actions will further mitigate the risk and its identified rating? | Progress Update<br>What is the current progress to date in achieving the action identified? | Action Owner<br>Who is the action owner? | Target Date<br>When does the action take effect? |
|---|---|---|---|
| Conduct joint strategic planning sessions to align objectives and priorities across key partners (at place most likely). | Cancer Strategic review with partners complete, workshop held for Cancer Strategy 25-30.<br>Collaborative Acute Providers (CAP) 25/26 work programme - awaiting<br><br>Executive Planning Meetings – throughout the national planning round | Beth Eastwood / Jenny Piper<br><br>Simon Morritt / Claire Hansen and Andrew Bertram | **Cancer Strategy:**<br>Cancer Board – 14th May<br>Exec Com – Early June<br>Board June<br>CAP<br>TBC<br>Feb/ May 2025 |
| Audit of effectiveness of forums for delivering quality partnership working. Using partnership maturity matrix across providers / place and alliances | Audit of partnership meetings to be completed<br>Development of maturity matrix for assessing partnership working<br>Application on maturity matrix across partnerships and stakeholders | Tilly Poole | Q1<br>Q1<br>TBC |
| Governance arrangements to demonstrate delivery of primary care collaboration | New Place-based meeting established Q1 2025 - Integrated Primary Health Care Collaborative 2025/26 | To be established on receipt of ToR – first meeting 23/04/25 | Q1 |
| Governance arrangements to demonstrate effectiveness of shared data for decision making | Supporting work of the emerging linked dataset with HNY | TBC | TBC |

| Target Risk (After Actions Implemented) | | |
|---|---|---|
| I | L | Rating I x L |
| 3 | 2 | 6 |

| Next Review |
|---|
| Q1 - June 2025 |

# Ref PR4 Board Assurance Framework (BAF)

| Ref: PR4 | Strategic Objective: Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow | **PRINCIPAL RISK 2:** *Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.* | **Risk Score: 6** |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?
- Failure to transform services sufficiently to within the current resource limits
- Capacity for the EPR programme delivery is not sufficient
- Lack of standard implementation of QI methodology
- Insufficient funds to allow running of services, allowing headroom to affect transformation, plan for the long term and change at pace

**Consequences** – If the risk occurs, what is its impact?
- The EPR programme is not sufficient to realise its full potential
- QI benefits not consistently delivered to transform services

**Executive Risk Owner:** Medical Director | **Assurance Committee:** Quality Committee | **Date Added to 2024/25 BAF:** April 2024

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 3 | 3 | 9 | 3 | 2 | 6 | MINIMAL (1-6) | INSIDE APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 6 | 6 |
| Risk Appetite | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) | MINIMAL (1-6) |

| i) Controls | i) Assurances (inc. positive) | ii) Controls | ii) Assurances (inc. positive) | iii) Controls | iii) Assurances (inc. positive) |
|---|---|---|---|---|---|
| Rollout of Quality Improvement Methodology (QSIR) | - Regular cohorts of QI training<br>- QSIR tools available Trust wide<br>- Governance Half-Days include improvement<br>- Governance outputs reported through Care Group Governance | Implementation of the Nervecentre EPR Programme | - Business case approval<br>- Programme Board<br>- Digital Sub-Committee<br>- HNY EPR Board (ICB joint working)<br>- Project team appointments<br>- Training plan | Building of commercial research team | - Establishment of commercial research team<br>- Collaboration agreements with Contract Research Organisations (CROs) |
| | | | | Research and Innovation Strategy | Approved at February Board of Directors |
| Data for improvement | - Availability of data on Signal<br>- Improvements to Trust Priorities Report | Joint working with partners across ICB for system-wide transformation | - Cancer Board<br>- Elective Recovery Board<br>- Community Improvement Group | Continuation and expansion of Research Delivery | - Partnerships with universities<br>- Research leads and time assigned for Principal Investigators |
| Transformation programmes with programme governance and infrastructure | - Programmes established including:<br>- *Maternity Assurance Group*<br>- *Community Diagnostic Centres*<br>- *Urgent Care Improvement Programme*<br>- *Urgency and Emergency Care Centre* | Annual Planning and Strategy Development | - Annual planning process to develop change and transformation priorities and initiatives in specialties<br>- Joint meetings with ICB and Place during planning round to manage risks and ensure alignment of policy requirements. | Growth of coastal research capacity to create research and implement findings related to inequalities | - Establishment of Scarborough Coastal Health and Care Research Healthcare Collaborative (SHARC)<br>- Partnerships with VCSE organisations |

| Mitigating Actions To Address Gaps<br>What actions will further mitigate the risk and its identified rating? | Progress Update<br>What is the current progress to date in achieving the action identified? | Action Owner<br>Who is the action owner? | Target Date<br>When does the action take effect? |
|---|---|---|---|
| NHS Impact Actions and establishment of continuous improvement culture | Readiness Assessment commissioned from KPMG for the establishment of our management system to deliver our strategic priorities. | Adele Coulthard | Completion of the readiness assessment on 6th June 2025 |
| Resource and focus on innovation | Delivery of Research and Innovation Strategy Action Plan | Lydia Harris/Adele Coulthard | April 2026 |
| Creation and alignment of supporting strategies to Trust Strategy | Supporting Strategies to be updated and published once approved by April Board of Directors. | Executive Owners | May 2025 |
| Development of EPR Programme BAF Risk | EPR Programme BAF Risk under development | James Hawkins | May 2025 |

| Target Risk (After Actions Implemented) | | |
|---|---|---|
| I | L | Rating I x L |
| 3 | 2 | 6 |

**Next Review**
Q1 - June 2025

# Ref PR5 Board Assurance Framework (BAF)

| Ref: PR5 | Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations | **PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.* | **Risk Score: 12** |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

**Consequences** – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

**Executive Risk Owner:** Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to 2024/25 BAF:** January 2025

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 4 | 4 | 16 | 4 | 3 | 12 | CAUTIOUS (8-9) | OUT OF APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 12 | 12 |
| Risk Appetite | CAUTIOUS (8-9) | CAUTIOUS (8-9) | CAUTIOUS (8-9) | CAUTIOUS (8-9) |

| i) Controls | i) Assurances (inc. Positive) | ii) Controls | ii) Assurances (inc. Positive) | iii) Controls | iii) Assurances (inc. Positive) |
|---|---|---|---|---|---|
| External grant and match funding opportunities to help improve capital and infrastructure to better sustainable and energy saving standards | - NHSE and ICB informing of grant opportunities, horizon scanning, for example:-<br>o PSDS<br>o NEEF<br>o Other opportunities including through our local/regional partnerships | Sustainable Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan). | - Senior Lead owner of each Green Plan workstream and theme<br>- Monthly 1-2-1 with the Finance Director in his role as the Executive Sustainability lead<br>*Gap – Development of these workstreams at pace remains a key risk until the Head of Sustainability is assured of these being setup and delivering.* | Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group | - Resources and Executive Committee Reporting every quarter<br>- YTHFM Management Group reporting every quarter<br>*Gap – all workstreams are not currently in place.* |
| Sustainability Team delivering the green agenda across the Trust | - Green Plan approved at Board and published July 2024, progress reported to Resources Committee<br>- Green Champions network<br>- Staff Travel Plan agreed and published, January 2025<br>- Developing external partnerships on public transport<br>- Following external funding sources and support | | | | |
| Sustainable Design Guide | - BREEAM standards embedded in the Capital Team<br>- Scarborough UEC delivery<br>*Gap – the YTHFM Capital Projects' guidance is comprehensive so there needs to be greater understanding* | Delivery of the revised Trust Staff Travel Plan | The travel plan is to set forward a number of initiatives to promote sustainable travel across the Trust<br>*Gap – Staff Travel Plan does not control patient travel but can only influence it. This impacts on our 2045 carbon footprint targets.* | Ongoing staff communications and promotion to keep staff informed and motivated to do what they can to embed sustainability into their work. | - Trust Communication on green plan interventions<br>- York & Scarborough Hospitals Charity partnerships |

| Mitigating Actions To Address Gaps<br>What actions will further mitigate the risk and its identified rating? | Progress Update<br>What is the current progress to date in achieving the action identified? | Action Owner<br>Who is the action owner? | Target Date<br>When does the action take effect? |
|---|---|---|---|
| Staff Travel Plan Implementation | . ICB to review the Patient Transport Service and working with Local Authorities and bus operators to continue with staff bus discount offer with benefits to patients/visitors to travel sustainably. | Daniel Braidley/Graham Titchener | Review April 2025 |
| Review of YTHFM Capital Projects' Sustainability Design Guide against the NHSE Net Zero building Standard | Head of Capital projects supported by a new starter qualified in sustainability to incorporate the best guidance into future Capital Projects. | Andrew Bennett | Review April 2025 |
| Sustainability Quarterly Assurance Reports | Once the workstreams are in place these reports will better reflect the Trusts position in meeting the Green Plan ambitions and targets, further informed with the Green Champions network. | Graham Titchener | Review June 2025 |

| Target Risk (After Actions Implemented) | | |
|---|---|---|
| I | L | Rating I x L |
| 4 | 2 | 8 |

| Next Review |
|---|
| Q1 – June 2025 |

# Ref PR6a Board Assurance Framework (BAF)

| Ref: PR6a | Strategic Objective: To be well led with effective governance and sound finance | **PRINCIPAL RISK 6:** Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030. | Risk Score: 25 |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?

- Failure to achieve the annual financial plan through inadequate income allocations, poor income recovery, lack of expenditure control, non-delivery of the efficiency programme and unaffordable investment decisions.
- Cashflow difficulties
- Inadequate capital funding to meet all infrastructure backlog repair priorities and new investment requirements

**Consequences** – If the risk occurs, what is its impact?

- Trust entering SOF4 arrangements and special measures scrutiny
- Not achieving the Trust's part of the ICB overall financial balance (system failure consequence)
- Externally imposed financial recovery plan
- Potential reduction in service quality and safety
- Reputation impact on the Trust
- Site infrastructure failure
- Loss of autonomy and control

**Executive Risk Owner:** Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to 2024/25 BAF:** January 2025

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 5 | 5 | 25 | 5 | 5 | 25 | OPEN (10-12) | OUTSIDE APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 25 | 25 |
| Risk Appetite | OPEN (10-12) | OPEN (10-12) | OPEN (10-12) | OPEN (10-12) |

| i) Controls | i) Assurances (inc. Positive) | ii) Controls | ii) Assurances (inc. Positive) | iii) Controls | iii) Assurances (inc. Positive) |
|---|---|---|---|---|---|
| Annual business planning process including Board plan sign-off, triangulation with ICB and ICS and ultimate NHSE approval. | - Business plan, Board progress updates<br>- ICB plan working groups<br>- Internal Audit Reports 2025-26 | Expenditure control - business case process<br>*Gap – Unplanned expenditure commitments outside of process* | - Business Case manual and register<br>- Internal audit report<br>- SFI Business Case approval hierarchy | Overspend monitoring against approved scheme sums | - Scheme sum variation process<br>- Scheme expenditure CPEG reports |
| Monitoring and reporting of I&E plan | - TPR Board and Committee reporting 2025-26<br>- PFR monthly NHSE. TPR Resources & Board<br>- Care Group PRIMs and FRMs | Efficiency delivery – managed by Corporate Efficiency Team<br>*Gap – insufficient scheme content* | - TPR Board, Committee and EDG reporting 2025-26 - PFR monthly to NHSE<br>- Care Group PRIMs and FRMs | Management of national PDC schemes to required timelines (year-end cut-off deadlines) | - CPEG reporting 2025-26<br>- ICS/NHSE ad hoc reports |
| Income control - income contract variation process<br>*Gap – unplanned income reduction* | - Income adjustment form register<br>- TPR Board and Committee reporting | Cash flow monitoring. Cash working group. Monthly debtors and creditors review. | - Monthly debtor and creditor dashboard<br>- Trend data and forecast data in TPR<br>- Better Payment Practice in TPR | Backlog maintenance prioritisation<br>*Gap – lack of understanding of full backlog requirements* | - Capital Investment needs schedules<br>- Prioritisation scoring process<br>- EC and Board sign off April 2025 |
| Expenditure control - scheme of delegation, standing financial instructions, segregation of duties. | - SFIs Board approved<br>- Written prime budget holders' approval<br>- System enforcements and no PO no Pay | Capital planning process – preparation and sign off programme | - Capital Investment needs schedules<br>- Prioritisation scoring process<br>- EC and Board sign off April 2025 | Identification of sparsity income stream (£10.3m) | - Formal agreement with ICB to include sparsity income & work on funding<br>- Task & finish group to manage |
| Expenditure control - staff leaver process and Vacancy Control<br>*Gaps – payroll untimely informed of leavers* | - Salary overpayment recovery policy<br>- Staff Reports, REACH reporting<br>- Enhanced Vacancy Control Panel 2025-26 | Routine monitoring and reporting against capital programme | - TPR Board and Committee reporting 2025-26 - CPEG reporting<br>- ICS/NHSE ad hoc reports | Risk share agreed with the ICB for high-cost drug cost pressure | - £6m ICB funding agreed<br>- Area prescribing committee work<br>- ICB strategic commissioner role |

| Mitigating Actions To Address Gaps<br>What actions will further mitigate the risk and its identified rating? | Progress Update<br>What is the current progress to date in achieving the action identified? | Action Owner<br>Who is the action owner? | Target Date<br>When does the action take effect? |
|---|---|---|---|
| Unplanned income or spend change – CG and Corp Dir reminders | As part of the 25/26 budget sign off process a specific reminder will be issued requiring signature | Andrew Bertram | May 2025 |
| Payroll improvement project to tackle under & over payments - Deloitte | Improvement plan prepared. Delivery underway. HR Director chaired working group in place. | Andrew Bertram | September 2025 |
| Insufficient efficiency programme – ICS work, Grant Thornton, NHSE. | ICS-wide System Engine Room governance programme. System leaders group to manage pace and cover | Andrew Bertram | Ongoing for 25/26 plans |
| 6 Facet Survey to be completed to identify full backlog maintenance reqs. | Funding agreed. Work commissioned. Survey work commenced. | A Bertram/Penny Gilyard | Q2 completion. |

| Target Risk (After Actions Implemented) | | |
|---|---|---|
| I | L | Rating I x L |
| 4 | 4 | 16 |

**Next Review**

Q1 - Jun 2025

# Ref PR6b Board Assurance Framework (BAF)

| Ref: PR6 b | Strategic Objective: To be well led with effective governance and sound finance | **PRINCIPAL RISK 6:** *Failure to demonstrate effective governance to achieve the Trust's Strategy.* | **Risk Score: 9** |
|---|---|---|---|

**Causes** – What must happen for the risk to occur?
- Failure to achieve a satisfactory CQC well-led rating
- Inadequate escalation governance processes
- Trust Leadership and staff not held to account effectively
- Poorly structured and defined governance forums from 'Ward to Board'
- Unclear accountabilities and responsibilities of Trust leadership and Staff
- Insufficient grip on the governance of data

**Consequences** – If the risk occurs, what is its impact?
- Regulatory well-led scrutiny on the Trust leadership, staff and governance processes
- Trust resources not used effectively and efficiently in achieving the Trust's strategy
- Quality of patient care and experience is not at the level achieved
- Decision-making not consistent with achieving Trust goals
- Risks and issues not managed effecting patient care
- Poor staff morale

**Executive Risk Owner:** Chief Executive | **Assurance Committee:** All Committees | **Date Added to 2024/25 BAF:** January 2025

| Inherent Risk (Before Mitigation) | | | Current Risk (After Mitigation) | | | Risk Appetite | Status: In or Out of Appetite |
|---|---|---|---|---|---|---|---|
| I | L | Rating I x L | I | L | Rating I x L | | |
| 5 | 4 | 20 | 3 | 3 | 9 | OPEN (10-12) | INSIDE APPETITE |

| Risk Analysis | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) |
|---|---|---|---|---|
| Current Risk Rating | N/A | N/A | 9 | 9 |
| Risk Appetite | OPEN (10-12) | OPEN (10-12) | OPEN (10-12) | OPEN (10-12) |

| i) Controls | i) Assurances (inc Positive) | ii) Controls | ii) Assurances (inc Positive) | iii) Controls | iii) Assurances (inc Positive) |
|---|---|---|---|---|---|
| Monthly Trust Board of Directors reporting | - Approved Standing Orders and work programme (Jan 2024) papers, minutes and action logs<br>- 2024/25 Committee effectiveness reviews and amendments to terms of reference | Patient Experience and Clinical Effectiveness Sub-Committees | - Approved terms of reference and work programmes (Jan 2024)<br>- All Committee reporting papers, minutes, action logs Apr 2024-Jan 2025 | Role job descriptions and annual appraisal processes | - 88% staff appraisals concluded for 2024 |
| Trust constitution and governance framework: Scheme of Reservation and Delegation and Standing Financial Instructions | - Trust constitution and governance framework approved by Board of Directors, delivered through all Committees January 2024 to date | Performance Review and Improvement Meetings (PRIM) with Care Groups | - Monthly letters of meeting outcomes and actions to Care Groups for action<br>- Escalation reporting to Executive Committee for lessons learnt | Line Management Development Programme | - Line managers undertaken the line management training programme as at Jan 2025 |
| - Monthly Quality and Resources Committees<br>- Bi-monthly Executive Committee<br>- Quarterly Audit Committee | - Committees' terms of reference and work programmes (approved January 2024)<br>- All Committee reporting papers, minutes and action logs Apr 2024-Jan 2025 | Committee escalation processes and flow of information across governance forums | - Quality, Resources, and Audit Committee escalation reports to Board of Directors<br>- Care Group reporting escalations to Executive Committee April 2024-Jan 2025 | Business Intelligence data reporting processes | - Signal 'real-time' reporting<br>- Trust Priorities Report (TPR) monthly reporting to Board, Quality, Resources and Executive Committees Apr 2024-to date |
| - Risk Management Strategy and Policy and Datix system<br>- DSPT submission and cyber security management | - Board Approved January 2025<br>- BAF, Corporate Risk, Care Group and speciality risk registers Apr 2024-Jan 2025<br>- SIRO board report Sept 2024 | Care Group governance forums (quality, performance, finance, workforce, risk) | *Gap - Approved consistent terms of reference and work programmes across all Care Groups*<br>- Care Group reporting papers, minutes, action logs Apr 2024-Jan 2025 | CQC 'Journey To Excellence' programme and relationship management meetings | - Journey to Excellence monthly meeting Apr 2024-Jan 2025<br>- Journey to Excellence action plan outcomes evidence submitted to CQC Apr 2024-Jan 25 |

| Mitigating Actions To Address Gaps<br>What actions will further mitigate the risk and its identified rating? | Progress Update<br>What is the current progress to date in achieving the action identified? | Action Owner<br>Who is the action owner? | Target Date<br>When does the action take effect? |
|---|---|---|---|
| Consistent Care Group governance terms of reference for Quality, Performance, Finance and Risk forums | Accountability framework drafted for Care Group engagement<br>Risk and Assurance Workshops conducted with Care Group leadership teams – April | Mike Taylor | May 2025 |
| Well-led external assessment next steps to implement | External well-led assessment currently being commissioned to commence Q2 2025/26 | Mike Taylor | October 2025 |

| Target Risk (After Actions Implemented) | | |
|---|---|---|
| I | L | Rating I x L |
| 2 | 3 | 6 |

**Next Review**
Q1 - June 2025

# Severity/Impact Descriptors

| Severity score (severity levels) and examples of descriptors - this is not an exhaustive list | | | | | |
|---|---|---|---|---|---|
| **Domains** | **1 No Harm** | **2 Minor Harm** | **3 Moderate Harm** | **4 Severe Harm** | **5 Catastrophic Harm** |
| **Impact on the safety of patients, staff or public (physical / psychological harm)** | Minimal injury requiring no/minimal intervention or treatment.<br>No time off work | Minor injury or illness, requiring minor intervention<br>Requiring time off work for >3 days<br>Increase in length of hospital stay by 1-3 days | Moderate injury requiring professional intervention<br>Requiring time off work for 4-14 days<br>Increase in length of hospital stay by 4-15 days<br>RIDDOR/agency reportable incident<br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability<br>Requiring time off work for >14 days.<br>Increase in length of hospital stay by >15 days<br>Mismanagement of patient care with long-term effects | Incident leading to death(s)<br>Multiple permanent injuries or irreversible health effects<br>An event which impacts on a large number of patients |
| **Quality / complaints / audit** | Peripheral element of treatment or service suboptimal<br>Informal complaint /inquiry | Overall treatment or service suboptimal<br>Formal complaint (stage 1)<br>Local resolution<br>Single failure to meet internal standards<br>Minor implications for patient safety if unresolved<br>Reduced performance rating if unresolved | Treatment or service has significantly reduced effectiveness<br>Formal complaint (stage 2) complaint<br>Local resolution (with potential to go to independent review)<br>Repeated failure to meet internal standards<br>Major patient safety implications if findings are not acted on | Non-compliance with national standards with significant risk to patients if unresolved<br>Multiple complaints/ independent review<br>Low performance rating<br>Critical report | Totally unacceptable level or quality of treatment/service<br>Gross failure of patient safety if findings not acted on<br>Inquest/ombudsman inquiry<br>Gross failure to meet national standards |
| **Human resources / organisational development / staffing / competence** | Short-term low staffing level that temporarily reduces service quality (< 1 day) | Low staffing level that reduces the service quality | Late delivery of key objective/ service due to lack of staff<br>Unsafe staffing level or competence (>1 day)<br>Low staff morale<br>Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/ service due to lack of staff<br>Unsafe staffing level or competence (>5 days)<br>Loss of key staff<br>Very low staff morale<br>No staff attending mandatory/ key training | Non-delivery of key objective/service due to lack of staff<br>On-going unsafe staffing levels or competence<br>Loss of several key staff<br>No staff attending mandatory training /key training on an on-going basis |

# Severity/Impact Descriptors (cont'd)

| Severity score (severity levels) and examples of descriptors - this is not an exhaustive list | | | | | |
|---|---|---|---|---|---|
| **Domains** | **1 No Harm** | **2 Minor Harm** | **3 Moderate Harm** | **4 Severe Harm** | **5 Catastrophic Harm** |
| **Statutory duty / inspections** | No or minimal impact or breach of guidance/ statutory duty | Breach of statutory legislation<br>Reduced performance rating if unresolved | Single breach in statutory duty<br>Challenging external recommendations/ improvement notice | Enforcement action<br>Multiple breaches in statutory duty<br>Improvement notices<br>Low performance rating, critical report | Multiple breaches in statutory duty<br>Prosecution<br>Complete systems change required<br>Zero performance rating<br>Severely critical report |
| **Adverse publicity / reputation** | Rumours<br>Potential for public concern | Local media coverage – short-term reduction in public confidence<br>Elements of public expectation not being met | Local media coverage – long-term reduction in public confidence | National media coverage with <3 days service well below reasonable public expectation | National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)<br>Total loss of public confidence |
| **Business objectives / projects** | Cost increase /schedule slippage <1% over project budget /plan | Cost increase /schedule slippage >1<5% over project budget /plan | Cost increase/schedule slippage<br>>5<10 % over project budget /plan | Cost increase/schedule slippage<br>>10<25 % over project budget /plan<br>Key objectives not met | Cost increase /schedule slippage<br>>25% over project budget /plan<br>Key objectives not met |
| **Finance including claims** | Small loss Risk of claim remote | Loss of 0.1–0.25 per cent of budget<br>Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget<br>Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective /Loss of 0.5–1.0 per cent of budget<br>Claim(s) between £100,000 and £1 million<br>Purchasers failing to pay on time | Non-delivery of key objective/ Loss of >1 per cent of budget<br>Failure to meet specification/ slippage<br>Loss of contract / payment by results ,<br>Claim(s) >£1 million |
| **Service / business interruption Environmental impact** | Loss or interruption of >1 hour<br>Minimal or no impact on the environment | Loss or interruption of >4 hours<br>Minor impact on environment | Loss or interruption of >1 day<br>Moderate impact on environment | Loss or interruption of >1 week<br>Major impact on environment | Permanent loss of service or facility<br>Catastrophic impact on environment |

# Likelihood Descriptors

York and Scarborough Teaching Hospitals
NHS Foundation Trust

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Descriptor** | **Extremely Unlikely** | **Unlikely** | **Possible** | **Somewhat Likely** | **Very Likely** |
| **Frequency (general)** How often might it/does it happen | This will probably never happen/recur | Do not expect it to happen/recur but it is possible it may do so | Might happen or recur occasionally | Will probably happen/recur but it is not a persisting issue | Will undoubtedly happen/recur, possibly frequently |
| **Frequency (timeframe)** | Not expected to occur for years | Expected to occur at least annually | Expected to occur at least monthly | Expected to occur at least weekly | Expected to occur at least daily |
| **Probability** Will it happen or not | <5 per cent | 6-25 per cent | 26-50 per cent | 51-75 per cent | 76-100 per cent |