York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 21st May
Time: 9:00am – 12:15pm
Venue: Boardroom, 2nd Floor Administration Block, York 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	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 30 April 2025** To be agreed as an accurate record.	Chair	Report	**6**	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	**17**	
6.	**Chair's Report** To receive the report.	Chair	Report	**18**	9:05
7.	**Chief Executive's Report** 7.1 Our Voice Our Future – End of Design Phase To receive the reports	Chief Executive	Report Report	**20** **24**	9:10

Item	Subject	Lead	Report/ Verbal	Page No	Time
8.	**Quality Committee Report** To receive the May meeting summary report.	Chair of the Quality Committee	Verbal	-	9:30
9.	**Resources Committee Report** To receive the May meeting summary report.	Chair of the Resources Committee	Verbal	-	9:40
10.	**Group Audit Committee Report** To receive the May meeting summary report.	Chair of the Group Audit Committee	Report	38	9:50
11.	**Trust Priorities Report (TPR)** March 2025 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	 Chief Operating Officer Medical Director & Chief Nurse Director of Workforce & OD Chief Digital Information Officer Finance Director	Report	39 42 83 102 113 119	10:00
Break 10:50					
12.	**CQC Compliance Update Report** To consider the report.	Chief Nurse	Report	132	11:00
13.	**Maternity and Neonatal Reports (including CQC Section 31 Update)** To consider the report and approve the Section 31 update.	Chief Nurse - Executive Maternity Safety Champion	Report	139	11:10

Item	Subject	Lead	Report/ Verbal	Page No	Time
14.	**Quality Strategy** To approve the strategy.	Chief Nurse	Report	165	11:20
15.	**Guardian of Safe Working Hours Annual Report** To consider the report.	Medical Director	Report	192	11:30
16.	**2025/26 Staff Survey Action Plan** To consider the plan.	Director of Workforce & OD	Report	200	11:35
17.	**Equality and Diversity Annual Report** To consider the report.	Director of Workforce & OD	Report	208	11:50
Governance					
18.	**Emergency Preparedness Resilience and Response (EPRR) Action Plan Update** To consider the report.	Chief Operating Officer	Report	252	12:00
19.	**LIMS and Digital Cell Path Implementation Business Case** To approve the business case.	Chief Operating Officer	Report	261	12:05
20.	**YTHFM Reservation of Powers and Scheme of Delegation and Standing Financial Instructions Revisions** To approve the revisions.	Managing Director	Report	285	12:10
21.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
22.	**Time and Date of next meeting** The next meeting held in public will be on 25 June 2025 at 9:30am at Scarborough Hospital.				

Item	Subject	Lead	Report/ Verbal	Page No	Time
23.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
24.	**Close**				12:15

Minutes
Board of Directors Meeting (Public)
30 April 2025

Minutes of the Public Board of Directors meeting held on Wednesday 30 April 2025 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.20pm.

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 *(Via Teams)*

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

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

In Attendance:
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Julie Southwell, Elected Governor
- Graham Lake, Public Governor (from 1st May 2025)
- Two members of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting with a particular welcome to Mr Norman, Managing Director of York Teaching Hospitals Facilities Management (YTHFM), who was attending his first Board meeting.

2 Apologies for absence

There were no apologies for absence.

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 26 March 2025

The Board approved the minutes of the meeting held on 26 March 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 52 *Progress the use of a Board development seminar for a Board discussion on risk appetite.*
Mr Barkley would find a suitable opportunity in the Board Development Seminar programme for a discussion on risk appetite.

BoD Pub 54 *Explore options to provide more accurate ethnicity data for the Health Inequalities section of the TPR.*
No update was provided on this action.

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 the target should be zero and he would ensure that this was changed in the Trust Priorities Report.

BoD Pub 58 *Seek support from the York and North Yorkshire Mayor with regards to the Trust becoming an Anchor Institution on the East Coast.*
Mr Morritt commented that the action was to progress forming a network with other Anchor Institutions. A meeting with the York and North Yorkshire Mayor was being progressed.

Mr Barkley reported that he had applied to join Scarborough Neighbourhood Board

BoD Pub 61 *Seek further clarification on the "smoking at booking" and "smoking at 36 weeks" metrics in the Scarborough maternity scorecard.*
Mrs Parkes advised that Ms Wells-Munro had included clarification in her report and would expand on this when she presented the paper. The action was closed.

BoD Pub 62 *Ensure that Staff Survey responses are sent directly to all managers and supervisors.*

Miss McMeekin confirmed that this had been completed.

BoD Pub 63 *Present a report on the actions undertaken from the 2024/25 Staff Survey improvement plan.*
This had been circulated to the Board prior to the meeting.

BoD Pub 64 *Email Mr Barkley the data about deaths from strokes for the last four available quarters.*
Mr Barkley advised that he had received this information and had arranged a meeting with Dr Bebb, Assistant Medical Director, for further discussion on the mortality data.

6 Chair's Report

The Board received the report.

Mr Barkley advised that costed proposals for an independent developmental Well Led review had now been received from four organisations. A decision would be made shortly in order for the review to be undertaken at the end of Quarter 1.

7 Chief Executive's Report

The Board received the report.

Mr Morritt highlighted:

- continuing pressures on acute services, compounded by viruses circulating in the community, and paid tribute to staff for maintaining services in the face of these challenges;
- the detail included in his report on national and regional NHS system changes and in particular, the requirement on providers to produce a plan for a 50% reduction in corporate growth recorded since 2018/19;
- the "readiness assessment" currently underway to prepare the organisation for the introduction of a framework for a systemic approach to continuous improvement;
- the size of the capital programme for 2025/26 which exceeded that of 2024/25; Mr Morritt reported that the move into the new Urgent and Emergency Care Centre (UECC) at Scarborough Hospital was now underway.

Board members were, as always, inspired by the Star Award nominations. Mr Barkley was pleased to note the number of colleagues working in administrative roles who had been nominated.

8 Quality Committee Report

Dr Holmberg reported that meetings of the Quality Committee were now reflective of its confidence that appropriate improvement work was being undertaken. He advised that representatives from Care Groups were now attending meetings which would add value to the discussions. He highlighted the key points from the meeting held on 22 April 2025 beginning with the Medicine Care Group's presentation. There had been discussion on the gap against the trajectory of key performance metrics in Urgent and Emergency Care. Support from regional colleagues was in place and trajectories for improvement had been agreed with them. Dr Holmberg expressed some concern that improvement was weighted towards the last two months of the financial year which would add additional pressure.

Dr Holmberg reported that Gastroenterology and Cardiology services were of greatest concern to the Care Group. Cardiology patient pathways, particularly those of the Rapid Access Chest Pain Clinic, would be reviewed to reduce waiting times. Care Group leaders were pleased to report the appointment of a Palliative Care consultant on the East Coast to support the seven day service.

Dr Holmberg reported that the Committee had again discussed the reasons for the high levels of non-elective Caesarean Sections, notably at Scarborough Hospital. He provided details and noted that the Committee had asked for assurance in the form of nationally benchmarked data. The Committee had also discussed how full compliance with the Maternity Incentive Scheme would result in a refund of insurance payments to the Trust of c£1m, and to what extent this would offset the investment necessary for full compliance with the Scheme, particularly in terms of the staff shortfall.

In a correction to Dr Holmberg's report, Mrs Parkes noted that the Quality Strategy had been agreed at meeting, not the Care Strategy.

9 Resources Committee Report

Mr Dillon highlighted the key discussion points from the meeting of the Resources Committee on 15 April 2025:

- the number of 12 hour trolley waits had risen from that recorded in February;
- there were backlogs in the Cardiology service due to recurrent faults in CT equipment; there had been discussion on how this would be addressed;
- the average ambulance handover time had significantly reduced;
- there continued to be reductions in the overall spend on agency staff;
- the pilot Hub established by the Yorkshire Ambulance Service to divert attendances at Emergency Departments to more appropriate settings was being discontinued, due to the prohibitive cost, and other options would be explored.

Mrs Parkes highlighted that the Trust was no longer under a Direct Support Programme for non-registered nursing staff: this was a significant success. She noted that the increase in 12 hour trolley waits had resulted mainly from the number of wards closed to new admissions due to infection control measures.

10 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hansen advised that the improvements in some Urgent and Emergency Care performance metrics resulted from the implementation of tests of change.

In response to a question, Ms Hansen confirmed that the c2000 patients added to the Referral To Treatment (RTT) waiting list had been transferred from the non-RTT waiting list, as a consequence of validation work which had been taking place.

Ms Hansen drew attention to the special cause improvement in the Median Time to Initial Assessment in the Emergency Departments which had fallen to an average of four minutes. The number of Type 1 patients, those most in need of emergency care, waiting more than 12 hours in the Emergency Departments had also reduced to 15.6% of all Type 1 attendances and was the fewest since July 2023.

Dr Boyd noted that the percentage of patients seen by a doctor within 60 minutes of arriving at the Emergency Department was low and questioned the impact of this on prompt treatment for conditions such as sepsis. Dr Stone advise that, as patients were triaged promptly, serious conditions would be identified at this stage. Ms Hansen added that the low percentage of patients seen by a doctor within 60 minutes of arrival was nevertheless a concern. A new acuity tool was being employed which would facilitate quicker assessments by a doctor. Dr Stone flagged some uncertainties around the accuracy of the times of assessment which were being recorded.

Professor Morgan asked about the reasons for the increase in attendances at Emergency Departments and queried whether this was related to the cessation of the Yorkshire Ambulance Service led Hub. Ms Hansen responded the Hub was still in operation but had led to the diversion of only around eight ambulances per day. The next step was to deploy more GPs in the Ambulance Control Centre. The increase in attendances at Emergency Departments was being seen nationally.

In response to a question, Ms Hansen explained that the metrics showed an increase in Emergency Care attendances of all types as this figure reflected an increase in GP out of hours appointments and those offered by Urgent Treatment Centres.

Dr Holmberg raised a concern about the metric relating to patients receiving clinical post take within 14 hours of admission. He sought assurance that patients most in need of this service were receiving it, and the clinical risk was therefore minimised. Ms Hansen explained that there were roster challenges in the medical establishment, leading to a reliance on locums to cover sickness absence. Work was being undertaken to address the issue. The metric had also been impacted by infection control measures. Ms Hansen added that the ongoing work on right sizing the estate would also positively impact on the clinical post take metric. Mrs Parkes emphasised that patients were always under the care of nursing staff who would escalate to clinicians when appropriate.

Mr Barkley drew attention to the community bed occupancy figure which was below the optimum. Ms Hansen responded that the Trust was collaborating with Place colleagues to review the community bed stock, with the aim of increasing the number of patients receiving care for at home.

Mr Barkley asked about the impact of the Multi-Agency Discharge Event (MaDE) which took place from 23 to 30 April. Ms Hansen advised that there had been clear evidence of impact, and she provided some details.

In response to a question, Ms Hansen advised that the Cancer performance figures for March would be better than those reported for February. She highlighted the significant improvement in the Faster Diagnosis Standard and 31-day treatment standard delivered by the Urology Service. Cancer performance in the Colorectal and Gynaecology remained a concern.

Mr Barkley noted the improvements in Cancer performance which had been aided by NHS England recovery funding and asked how these might be sustained. Ms Hansen confirmed that the activity could not be sustained without extra funding but there also needed to be a review of referrals to Cancer services, some of which were not appropriate. Mr Barkley suggested that the Clinical Lead for Cancer and the Head of Cancer Services should be invited to brief the Board, given the importance of the service. Dr Stone would progress this.

Action: Dr Stone

Ms Hansen added that there was still work to do to reduce waiting times for Cancer services; however, the Trust was no longer required to attend tiering meetings with regional and national colleagues as they had confidence in the plans for improvement.

Moving to the Referral To Treatment scorecard, Mr Barkley highlighted that there were still patients waiting over 65 week waits which needed to be addressed. Ms Hansen explained that this was due to demand on the Neurology service, and she explained the plans in place to increase capacity and reduce waiting times.

Ms Charge referred to the narrative on Outpatients and Elective Care and queried the work on the improvement plan for the Rapid Access Chest Pain clinic. Ms Hansen explained that Medicine Care Group leaders had prepared the plan, but she had requested further work before it was presented for approval.

In response to a question, Ms Hansen explained that the Outpatient Follow-up Partial Booking list had increased due to patients being moved from other lists. She was pleased that the national focus was now on the reduction of all waiting lists, as this was the right approach for patients; work via specialty deep dives had already begun on ensuring that all patient pathways were as efficient as possible.

Ms Hansen reported that the Trust had received confirmation that Bridlington Hospital had been awarded Surgical Hub accreditation. The report was very complimentary of the staff and the work of the department. Mrs McAleese and Ms Grantham had attended the visit day and agreed that it had been extremely positive.

Mr Barkley raised a number of queries about the factors impacting diagnostic performance and asked that Ms Hansen bring further details of plans to respond to the next meeting:

- the shortage of healthcare scientists within Cardiology;
- Endoscopy nurse staffing at York Hospital which was challenged due to a mix of vacancies and sickness absence;
- the surveillance backlog causing a sharp decrease in Colonoscopy performance.

Action: Ms Hansen

It was noted that CT performance was impacted by equipment issues. Specifically, a CT scanner at Scarborough Hospital had been decommissioned earlier than expected, before the new Urgent Treatment Centre was open. The new CT scanner in the UECC at Scarborough was now being used. Ms Hansen cautioned that even with all three scanners in operation in Scarborough, capacity would still not meet demand. The capacity gap in York was similar, despite a new arrangement with York St John University to use its facilities.

Dr Boyd drew attention to the 2-hour Urgent Community Response compliancy rate which was above the year end target in March. Ms Hansen explained that the high percentage was being achieved at the expense of other community service waiting times and was therefore not sustainable. A full review of community services was required.

Ms Hazelgrave highlighted the low rate of occupancy of Virtual Ward beds. Ms Hansen explained that this was related to workforce capacity. A review of Virtual Wards was taking place at a regional level.

Quality and Safety
Board members were pleased to note the downward trend in *Clostridioides difficile* cases.

Ms Hazelgrave highlighted the increase in complaints to the Trust. Mrs Parkes responded that one of the main themes was waiting times.

Maternity
Mrs Parkes explained that the *Smoking at booking, at 36 weeks* and *at time of delivery* metrics referred to different cohorts of women.

Ms Hazelgrave queried why the number of births at York Hospital was significantly lower than the number of bookings. Dr Stone responded that the numbers were subject to seasonal variation and to pregnancies not being sustained to term.

Workforce
Miss McMeekin referenced the growth in Whole Time Equivalents in the workforce.

There was some discussion on the government's change to the minimum salary threshold for skilled worker visa applications which had risen to £25k per annum. This equated to the top of the Band 3 range and covered only basic pay. Miss McMeekin noted that many members of staff employed on lower bands had spousal visas and would therefore not be affected.

Miss McMeekin reported that the Trust had successfully moved all its medical agency bookings to Direct Engagement (DE), which would prove more cost-effective and was a significant milestone for the Trust.

Digital and Information Services
Mr Barkley asked for further information about the Environmental Information Regulation (EIR) requests referenced in the report. Mr Hawkins explained that Environmental Information Regulations (EIR) provided public access to environmental information held by public authorities. The regulations ensured that important data related to topics such as air and water quality, pollution, waste management, and land use planning were available to everyone.

Finance
Mr Bertram reported that, after NHS England normalisation adjustments, the Trust ended the 2024/25 financial year with a £9k surplus, from the £38m deficit recorded in Income and Expenditure. Mr Bertram drew attention to the impairment of £28m relating to the new Scarborough Hospital UECC.

Mr Bertram highlighted the positive Elective Recovery Fund performance and the reduction in agency spend.

With regard to the capital programme, Mr Bertram reported that £2m of lease renewals had been brought forward from 2025/26 to 2024/25 following successful negotiation of an additional £2.2m from NHS England. forward

11 CQC Compliance Update Report

Mrs Parkes presented the report. She advised that there had still been no information from the CQC as to when the report of the January inspection would be received. An engagement meeting had been held on 8 April at which no concerns were raised.

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

Ms Wells-Munro presented the report and highlighted the following:

- there had sadly been two antenatal stillbirths in February 2025;
- the Trust's perinatal mortality rate for births in 2023 was detailed in the paper;
- there had been no new cases meeting the criteria for referral to the Maternity and Newborn Safety Investigations (MNSI); of the open cases, two draft reports had been received and any safety recommendations would be shared with the Quality Committee;
- there were no new Patient Safety Incident Investigations (PSIIs) in February 2025;
- the rate of Post-Partum Haemorrhage (PPH) over 1500mls had reduced to 2.4% in February 2025;
- there continued to be concerns around the capacity of the Perinatal Mental Health Team; temporary resource had been secured for the internal team but there remained significant gaps in support from the Tees, Esk and Wear Valley Trust;
- the final report from the latest Local Maternity and Neonatal System (LMNS) visit on 12 February 2025 was still awaited;
- Year 7 of the Maternity Incentive Scheme had been launched on 28 April, along with a new Savings Babies Lives Care Bundle; the implications of both were being worked through.

Ms Wells-Munro drew attention to the smoking cessation data contained in the report and confirmed that the data in the TPR on women smoking at booking, at 36 weeks and at the time of delivery referred to different cohorts. She reported that smoking cessation activities, which had previously been led by Local Authorities, were now being brough in-house, as the funding to Local Authorities had been withdrawn. An options paper was being prepared. Ms Wells-Munro explained that funding for in-house tobacco dependency schemes was provided by the ICB and Maternity Services would now receive an allocation from this.

Returning to the report, Ms Wells-Munro highlighted recent successes, which included a further scan room added to the Antenatal Day Assessment Unit and a further Caesarean Section list. A third Maternity and Neonatal Engagement Day was held on 20 March at which themes were identified which would inform an action plan. The "pebbles in your shoes" activity identified challenges including IT and remote access, parking and administrative support.

Ms Wells-Munro reported that £230k would be transferred into the Maternity Services budget; this funding had been released as a result of the Clinical Education review and would support the appointment of four WTE midwives, two at each hospital. Ms Wells-Munro advised that the Executive Committee had approved the new swipe in and out access for the Maternity Unit at Scarborough Hospital supported by the placement of a nighttime ward clerk for a fixed term of 12 months. A full security review and risk assessment of both units would be undertaken, to be presented to the Executive Committee in June.

Mr Barkley asked Ms Wells-Munro to provide details at the next meeting about recently published changes to national maternity guidelines. Ms Wells-Munro noted that ringfenced funding for Maternity Services had been reduced by NHS England.

Action: Ms Wells-Munro

Mrs Parkes highlighted that PPH rates had stabilised over the last 12 months and were now within the normal range, which was a result of the improvement work undertaken to

reduce them. She advised that the review of maternity scrub nurses was still ongoing; she hoped to have a final recommendation approved in May by the Executive Committee.

The Board approved the CQC Section 31 Update.

13 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports

Miss McMeekin presented the paper, noting that only two actions remain not fully completed in terms of the Workforce Race Equality Standard:

- *Advertise jobs using a variety of recruitment platforms*: a variety of platforms had been explored but most were too costly; the Trust was being supported by Jobcentre Plus to widen its recruitment opportunities;
- *BME representation on recruitment panels*: the logistics of this were being worked through.

Miss McMeekin advised that a six-month review of the BME leadership programme had been undertaken. There had been 30 attendees and 17% had since secured promotion of one or two bands.

Miss McMeekin reported that there were no actions outstanding in relation to the Workforce Disability Equality Standard; new actions had been identified which Miss McMeekin outlined.

14 Trust People Strategy 2025-2030

Miss McMeekin summarised the engagement which had been undertaken to reach the draft version of the People Strategy. She highlighted the five key ambitions which would be the focus of the Strategy and invited comments on the paper.

Ms Hazelgrave queried whether the Strategy would be accompanied by timescales. Miss McMeekin responded that the Strategy would be underpinned by a detailed operational plan, with key metrics. She confirmed that there would be a workforce plan with links to operational planning.

Mrs Parkes asked if the delivery plan would include an ambition for a more diverse workforce and build on strategies in place to improve retention. Miss McMeekin advised that policies were being drafted which would reinforce equality and inclusion, and these elements would be included in the delivery plan.

Mr Barkley asked that the Trust's strategic priorities be cross referenced in the Foreword and suggested that Miss McMeekin's signature be included next to Mr Morritt's. The Strategy also needed to reference organisational development and to include a scorecard.

Mr Barkley queried the fifth key ambition, *Harnessing digital advancements to improve how we work,* in terms of its impact on job satisfaction. There was further discussion. Dr Stone noted that the systems, processes and devices with which staff interacted needed to be the most appropriate and easily accessible, and this in itself would contribute to their job satisfaction. Mrs Parkes added that effective use of data could lead to better staff morale when it demonstrated improvement. Mr Hawkins suggested that a people element could also be added to the Digital Strategy. Miss McMeekin noted that the digital ambition in the Strategy related specifically to HR systems as the Electronic Staff Record was due to be replaced during the lifetime of the Strategy. There would be an expectation that staff

would use manager and self-service functions and there was much work to be done to bridge this gap.

It was agreed that the fifth key ambition would remain in the Strategy, with a revision of the wording and the addition of further context and detail around interactions with digital services in general, not only those relating to HR.

Other amendments agreed were as follows:

- more explicit reference to inclusion in the preamble
- the addition of a scorecard with key metrics.

The Board of Directors approved the People Strategy, subject to the amendments discussed.

Action: Miss McMeekin

15 Trust Digital Strategy 2025-2030

Mr Hawkins presented the Trust Digital strategy and drew attention to the six key priorities. He commented that progress against the priorities would need to be measured against a scorecard, but this would depend on the capacity of the Digital team.

Ms Hazelgrave questioned if there was likely to be any progress in connecting patient records with those of primary care. Mr Hawkins explained that the Trust would continue to use the Yorkshire Humber Care Record, but the Trust was unlikely to lead any initiatives to connect patient records across the system as this would need be informed by discussions across the ICB. There was some discussion on the introduction of a single patient record within the next five years, which Mr Hawkins considered was unlikely.

The following amendments to the Strategy were agreed:

- the deletion of the page entitled Strategic Aims
- the addition of a paragraph describing the digital experience of patients.

In addition, a scorecard would be developed to accompany the Strategy.

The Board of Directors approved the Digital Strategy, subject to the amendments discussed and the development of an accompanying scorecard.

Action: Mr Hawkins

16 2024/25 Q4 Board Assurance Framework

Mr Taylor presented the paper, noting that there had been no movement in scores. Updates were recorded in red text.

There was a brief discussion on the merits of including information about the 2024/25 financial year under PR6 *Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030* and on the fact that the scoring of the risk was the same before and after mitigation. It was noted that the Board would spend time discussing risk appetite at a future Board Development Seminar.

The Board of Directors approved the Q4 Board Assurance Framework.

17 Questions from the public received in advance of the meeting

There were no questions from members of the public.

18 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 21 May 2025 at 9.00am at York 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	
BoD Pub 47 (24/25)	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. Update 26.03.25: 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.	Jun 25 from Feb 25	Delayed
BoD Pub 49 (24/25)	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	On Track
BoD Pub 52 (24/25)	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	Chair of the Board	Update 30.04.25: Mr Barkley would find a suitable opportunity in the Board Development Seminar programme for a discussion on risk appetite.	Feb-25	Delayed
BoD Pub 54 (24/25)	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	Delayed
BoD Pub 57 (24/25)	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. Update 30.04.2025: Mr Hawkins advised that the target should be zero and he would ensure that this was changed in the TPR.	Apr 25 from Mar 25	Delayed
BoD Pub 58 (24/25)	26-Mar-25	6	Chair's Report	Seek support from the York and North Yorkshire Mayor with regards to the Trust joining a network of Anchor Institutions on the East Coast.	Chief Executive	Update 30.04.25: Mr Morritt commented that the action was to progress forming a network with other Anchor Institutions. A meeting with the York and North Yorkshire Mayor was being progressed.	May-25	On Track
BoD Pub 59 (24/25)	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	On Track
BoD Pub 60 (24/25)	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	On Track
BoD Pub 64 (24/25)	26-Mar-25	14	Staff Survey Annual Report	Present the 2025/26 Staff Survey action plan.	Director of Workforce and OD		May-25	On Track
BoD Pub 1	30-Apr-25	10	Trust Priorities Report	Invite the Clinical Lead for Cancer and the Head of Cancer Services to present at a future Board meeting	Medical Director		May-25	On Track
BoD Pub 2	30-Apr-25	10	Trust Priorities Report	Present further details of plans to address: • the shortage of healthcare scientists within Cardiology; • Endoscopy nurse staffing at York Hospital which was challenged due to a mix of vacancies and sickness absence; • the surveillance backlog causing a sharp decrease in Colonoscopy performance.	Chief Operating Officer		May-25	On Track
BoD Pub 3	30-Apr-25	12	Maternity and Neonatal Report	Provide details at the next meeting about recently published changes to national maternity guidelines.	Director of Midwifery		May-25	On Track
BoD Pub 4	30-Apr-25	14	People Strategy	Ensure that the People Strategy is amended as discussed.	Director of Workforce and OD		May-25	On Track
BoD Pub 5	30-Apr-25	15	Digital Strategy	Ensure that the Digital Strategy is amended as discussed and that an accompanying scorecard is developed	Chief Digital and Information Officer		Jun-25	On Track

Report to:	Board of Directors
Date of Meeting:	21 May 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 – May 2025

1. I have continued to visit various wards and services at York, and Scarborough Hospitals and a community team, as well as have several 121s including a meeting with the MP of the Scarborough constituency. Through conversations with colleagues during these visits I pick up valuable insight and issues which I share with relevant Executive Directors as appropriate.

2. I have completed the annual appraisal of the Chief Executive and the appraisals of non-executive Directors of the Board are scheduled to take place over the next 4 weeks. I will undertake these with Rukmal Abeysekera, our Lead Governor.

3. Interviews took place at the beginning of May to select a new Non-Executive Director to replace Dr Holmberg whose second term of office finishes imminently. The Council of Governors approved the recommendation of the appointment panel to appoint Noel Scanlon subject to the usual checks including "fit & proper person" checks. The Council also approved the recommendation to appoint Dr Richard Reece as an Associate NED for 12 months, again subject to the usual checks.

4. I have had introductory 121s with two of our three newly elected Governors. An appointment for me to meet with the third is being arranged. Their terms of office started 1st May. Disappointingly, not all our vacancies have been filled. Further elections will take place in the autumn to try to fill the vacancies and seek new Governors to replace those whose term of office ends in September.

5. Earlier this month I chaired the Trust's Charitable Funds Committee and a week later attended Thank You events held at York Hospital and Scarborough Hospital for Donors. The events gave me the opportunity to thank the donors who attended and even more importantly there were presentations by colleagues in the Trust who work in services whose patients have benefitted from the items that have been bought through their (and others) fundraising activities. A relative also spoke movingly and brilliantly about the importance of the Autumn project which is aimed at improving the experience for patients and their relatives who are very near the end of their life. Our Charitable Funds team organised the events superbly.

6. With our Chief Executive I Chaired the Committee in Common meeting of the acute Trusts in the Humber & North Yorkshire ICS. The main items that were discussed included a provisional end of year report about the work of the Collaborative, the priorities for this new financial/planning year, the handling of a significant reduction in funding of the Collaborative's team, an update on Community Diagnostic Centres and a briefing from the Director of Procurement about savings achieved in 24/25 year and prospects of savings for this new year.

Martin Barkley
Trust Chair
13.05.2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	21 May 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 ☐

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
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☒ 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: an update on the opening of the Urgent and Emergency Care Centre in Scarborough, Bridlington Elective Surgical Hub accreditation, an overview of the Model ICB Blueprint, and the appointment of a new interim Chair for the ICB.

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 (Where the paper has previously been reported to date, if applicable)		
Meeting/Engagement	**Date**	**Outcome/Recommendation**

Chief Executive's Report

1. Scarborough Urgent and Emergency Care Centre opens its doors

I could not be prouder to start my update by reporting that Scarborough's Urgent and Emergency Care Centre is fully open for business.

As a Trust, we have invested £47 million to build the new flagship Urgent and Emergency Care Centre at Scarborough Hospital. Commonly referred to as the UECC, the centre includes a two-storey new build, combining and expanding the current emergency department, same-day emergency care, and the acute medical unit, along with critical care and other services to care for the most critically ill patients.

Services have moved across to the UECC in a phased approach at the end of April, ending with the new emergency department accepting patients from Thursday 1 May.

There are far too many people to thank everyone individually in this report, so many people from every team in the trust have been involved in getting us to this point. It genuinely has been a collective effort, and the approach to solving the challenges and delays we encountered is an example of teamwork at its absolute best. Moving a complex range of 24/7 services is no mean feat, and it is testament to the dedication and focus of the teams when planning these moves and preparing staff in advance that this was a slick operation.

I firmly believe that the new facility will be a genuine healthcare innovation for the people of Scarborough and surrounding areas and will completely transform the experience for our patients and colleagues.

My thanks and congratulations go to everyone involved.

2. Accreditation success for Bridlington Surgical Hub

More good news. We have received confirmation that Bridlington Hospital's elective surgical hub has been accredited by the Getting It Right First Time (GIRFT) programme following a rigorous process culminating in a visit from the GIRFT team on 11 April.

GIRFT's focus is on facilitating the development of surgical hubs, with the aim of improving patient flow and utilisation. This is a tremendous achievement for the team and a real boost for our Bridlington-based services.

Professor Tim Briggs, Chair of GIRFT and NHS England's National Director for Clinical Improvement and Elective Recovery, wrote in his confirmation letter that "the team who visited your hub were impressed with the professionalism and enthusiasm of your staff and it was obvious that they were keen to take advantage of the benefits that the accreditation scheme offers."

As with the UECC moves, the planning, teamwork and attention to detail demonstrated by the team throughout the accreditation process has been exemplary, and everyone involved should be justly proud of this achievement.

Once again, a huge thank you and congratulations to the team.

3. Model ICB Blueprint published

Following the announcement in March of the requirement for ICBs to reduce their running costs by 50%, NHS England has shared a draft Model ICB Blueprint.

The purpose of the draft is to help ICBs develop their plans to achieve the reduction requirement. There will be further refinement to the document and wider engagement will take place with stakeholders over the coming weeks, however the draft should be used to inform the plans that ICBs are in the process of developing to meet the cost-reduction ask.

The document sets out the purpose of ICBs and what their core functions should be to deliver that purpose, the enablers and capabilities required for success, and the support and guidance that will be available for ICBs to manage the transition locally. It lists all current functions provided by ICBs and groups them by the required change that needs to be considered as part of this process, i.e. functions that need to grow to deliver the purpose and objectives, functions that could be selectively retained or adapted, and functions to review for transfer, for example to regional teams or to providers.

The revised running cost envelope has been set at £18.76 per head of population, and plans must be submitted by the end of May outlining how each ICB intends to achieve this. The plans will then go through national moderation (involving a confirm and challenge process) to support consistency of approach and sharing of opportunities. The reduction in ICB costs to meet this target must be delivered by the end of Q3 2025/26 and recurrently into 2026/27.

We are also expecting the publication of a Model Region Blueprint in the coming weeks.

4. New Chair appointed for Humber and North Yorkshire ICB

Jason Stamp has been appointed interim Chair of NHS Humber and North Yorkshire Integrated Care Board, on an initial six-month basis.

Jason has been a Participant member of the Board since its inception and is the strategic lead for the development and integration of the voluntary sector into the work of the Humber and North Yorkshire Health and Care Partnership.

He is also the SRO of the Partnership's Workforce Transformation programme, Breakthrough HNY.

Date: 21 May 2025

Report to:	Trust Board
Date of Meeting:	21 May 2025
Subject:	Our Voice Our Future – End of Design Phase
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Alex Kilbride, Programme Manager Jenny Flinton, Head of Employee Relations and Engagement

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

Approve ☒ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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☒ To create a great place to work, learn and thrive.
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Implications for Equality, Diversity and Inclusion (EDI) *(please document in report)*

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

The report provides an overview of what has been achieved in the Design Phase of the Our Voice Our Future Cultural Change Programme and outlines the next steps being taken as we move into the Delivery Phase of the Our Voice Our Future Cultural Change Programme.

Recommendation:
It is recommended that the Trust Board continues to support the Our Voice Our Future Cultural Change Programme and continue to receive quarterly updates on progress.

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

Our Voice Our Future – End of Design Phase

1. Introduction and Background

Following the 2022 staff survey results, York and Scarborough Teaching Hospitals Foundation Trust (YSTHFT) recognised the need for cultural transformation, acknowledging that strengthening leadership and culture improves patient and staff experiences.

The NHS England (NHSE) Culture & Leadership Programme, a four-stage continuous improvement model, was implemented to help develop a compassionate and inclusive culture through collective leadership. A team of Change Makers was established to 'discover' what it is like to work in the organisation using a range of different tools and stakeholder feedback.

The findings of the Discovery Phase were analysed against the six cultural elements needed for a compassionate and inclusive culture and three key areas for improvement were identified:

1. Values led and inclusive leadership and management
2. Communication and engagement
3. Quality improvement and learning

Each key area for improvement, known through the Design Phase as a pillar, has been assigned support from a Director and the Change Makers have been developing ideas for change. The plans produced have been summarised as 'Plans on a Page' (appendices 1 to 7).

Now the Design Phase is complete the Change Makers, with support, are looking to bring these plans to life in the organisation.

2. Considerations

The Change Makers will now move the Our Voice Our Future Programme into the Delivery Phase, the final stage in the framework. The Delivery Phase of the programme is initially intended to last for twelve months, dependent on the projects to be delivered during this period.

3. Current Position

3.1 Three Pillars Plans on Pages Overview

The Design phase of the NHS England Culture and Leadership Programme has supported the change makers to develop seven plans on pages within three pillar areas.

Pillar 1: Values Led Leadership and Management
(Director Sponsor: Dawn Parkes)

- Ensuring Manager Wellbeing and Peer Support in embedded in everyday practice
- Ensuring Time and Space is protected for Compassionate Leadership

- Accountability and Professional Behaviours in Leadership

Pillar 2: Quality Improvement and Learning
(Director Sponsor: Adele Coulthard)

- Enhancing Learning & Career Development Opportunities
- Making Quality Improvement a Core Element of Change

Pillar 3: Communications and Engagement
(Director Sponsor: Lucy Brown)

- Improving Trust-wide Corporate Communications
- Kind, Values-Based Communication – Trust-wide Approach

Each Director Sponsor has supported the development of the plan on a page for their pillar. The detailed plans on pages can be found in appendices 1 to 7.

As we move into the delivery phase all the plans on pages will be reviewed by all the Director Sponsors to ensure they align to the organisation's strategy and to identify if any similar improvement projects are underway across the organisation which could compliment delivery to reduce duplication.

3.2 Director Sponsors

A meeting took place on Thursday 1 May 2025 with the overarching Executive Director Sponsors and pillar Director Sponsors for programme. The focus of the meeting was to agree the support required from the Sponsors as we move into the 12-month delivery phase of the programme.

It was agreed that the Director Sponsors would:

- Attend the change maker engagement day on 19 May 2025 to outline their support moving into the delivery phase
- Pillar Director Sponsors have agreed to meet with their pillar project groups monthly to support developing the detailed action plans and agree timelines to deliver the plans on pages

3.3 Communications

It has been identified that the Our Voice, Our Future Cultural Change Programme requires a relaunch as we move into the delivery phase.

A change maker engagement day is being held on 19 May 2025 and part of the session will focus on developing the communications plan for the delivery phase of the programme.

The communications development session will focus on:

- Developing immediate key messages for release in May 2025 and June 2025
- Brainstorm communication ideas to feed into the 12-month delivery phase communication plan
- Review and agree the communication outputs required to support delivery of the 12-month delivery phase communication plan
- Draft a governance process to support delivery of the communications plan and provide an escalation route for Change Makers if required

All outputs from the Change Maker engagement day on 19 May 2025 regarding communications will be discussed with the corporate communications team to support further development, finalisation and delivery of the 12-month delivery phase communication plan.

3.4 Recruitment

The NHS England Culture and Leadership Programme recommends that a second recruitment drive takes place as we move into the delivery phase to increase the number of Change Makers.

As part of the Change Maker engagement day on 19 May 2025, we will also have a session focussing on the 2nd recruitment campaign as this will form part of the key communication pieces for May 2025 and June 2025.

The recruitment session will focus on:

- Reviewing the recruitment documentation from the first Change Maker recruitment drive and incorporate feedback from the change makers to improve this for the 2nd recruitment drive
- Agree the Change Maker commitment for the 12-month delivery phase
- Propose a timeline for the 2nd recruitment drive
- Outline a governance process for recruitment and selection of change makers
- Draft key messages and posters to support advertising the opportunity to become a change maker
- Discuss how the programme could develop a ‘Change Champion role’ to support people to be involved in specific pieces of improvement work if they are unable to fully commit to the Change Maker programme, but would still like to be involved

3.5 Detailed Action Plans and Timelines

It was agreed at the meeting with the Director Sponsors on 1 May 2025 that the detailed action plans and associated timelines to deliver the plans on pages will be completed by 31 July 2025. Some plans, such as ‘Improving Trust Wide Communications’, will have commenced prior to this date.

The Programme Lead, Programme Team, Quality Improvement Team and Organisational Development Team will support the pillar project groups to develop the detailed project plans applying quality improvement and project management principles and using documentation and tools used by the organisation.

See appendix 8 for infographic outlining overarching timeline for moving into the delivery phase.

4. Summary

For the next three months, as we move into the delivery phase of the NHS England Culture and Leadership Programme we will:

- Establish monthly meetings with the Director Sponsors and Change Makers to support the delivery phase
- Develop a communications plan for the delivery phase
- Promote a second recruitment campaign for additional Change Makers

- Develop detailed action plans and agree timelines for delivery

5. Next Steps

The Delivery Phase of this programme is recommended to run in a Trust for 12 months. The programme is built on a continuous improvement framework so during this time consideration should be given as to how the Trust wants to take forward ‘Our Voice, Our Future’ beyond 12 months, recognising the time it takes for cultural change in any organisation.

Regular updates and assurance on project plans will be provided to Trust Board on a quarterly basis.

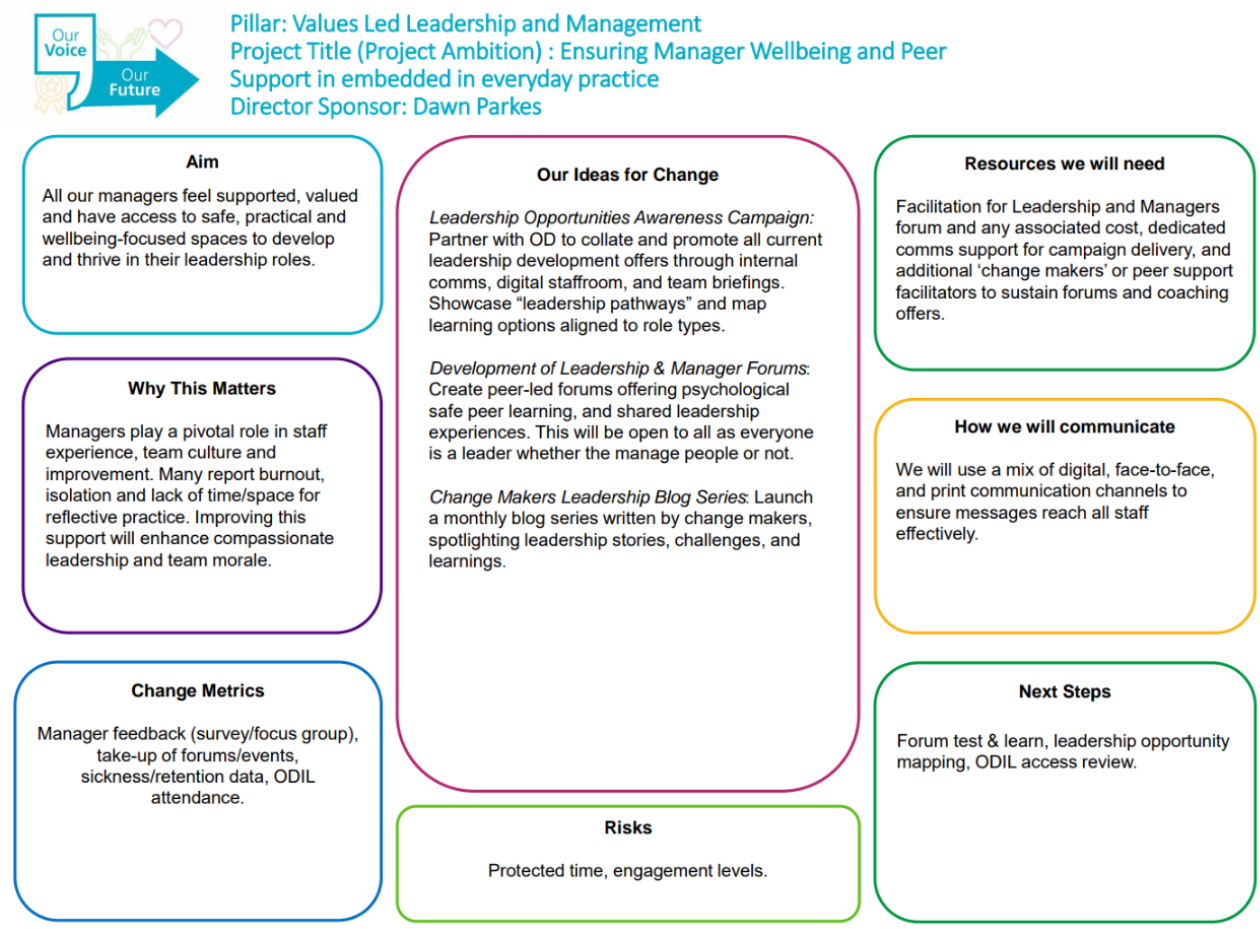
Date: 12 May 2025

Appendices

- Design Phase: Plans on Pages (appendices 1 to 7)
- Infographic of Overarching Timeline for moving into the Delivery Phase (appendix 8)

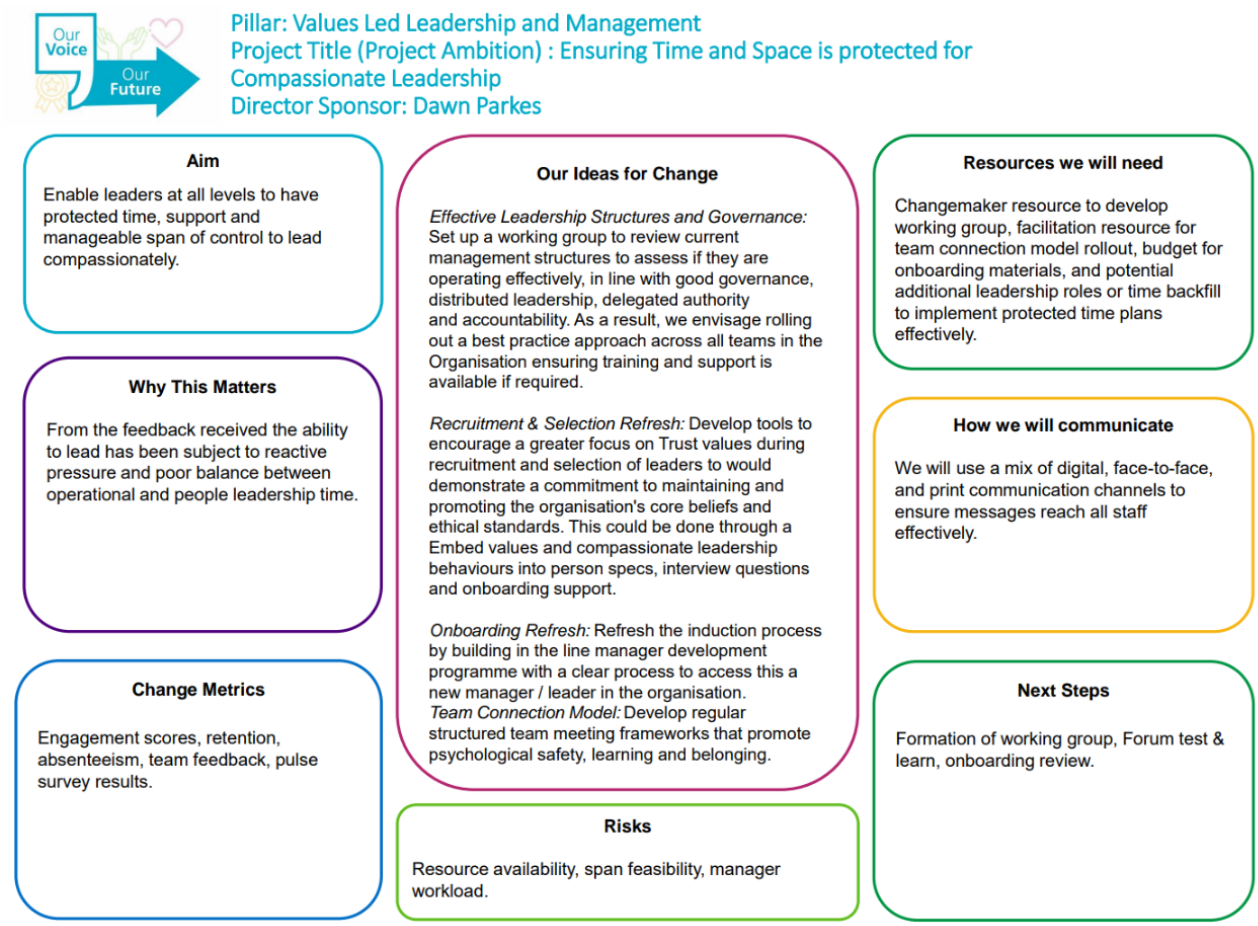
Appendix 1

Pillar 1: Values Led Leadership & Management – Ensuring Manager Wellbeing and Peer Support is embedded in everyday practice Plan on a Page (1 of 3 in Pillar 1)



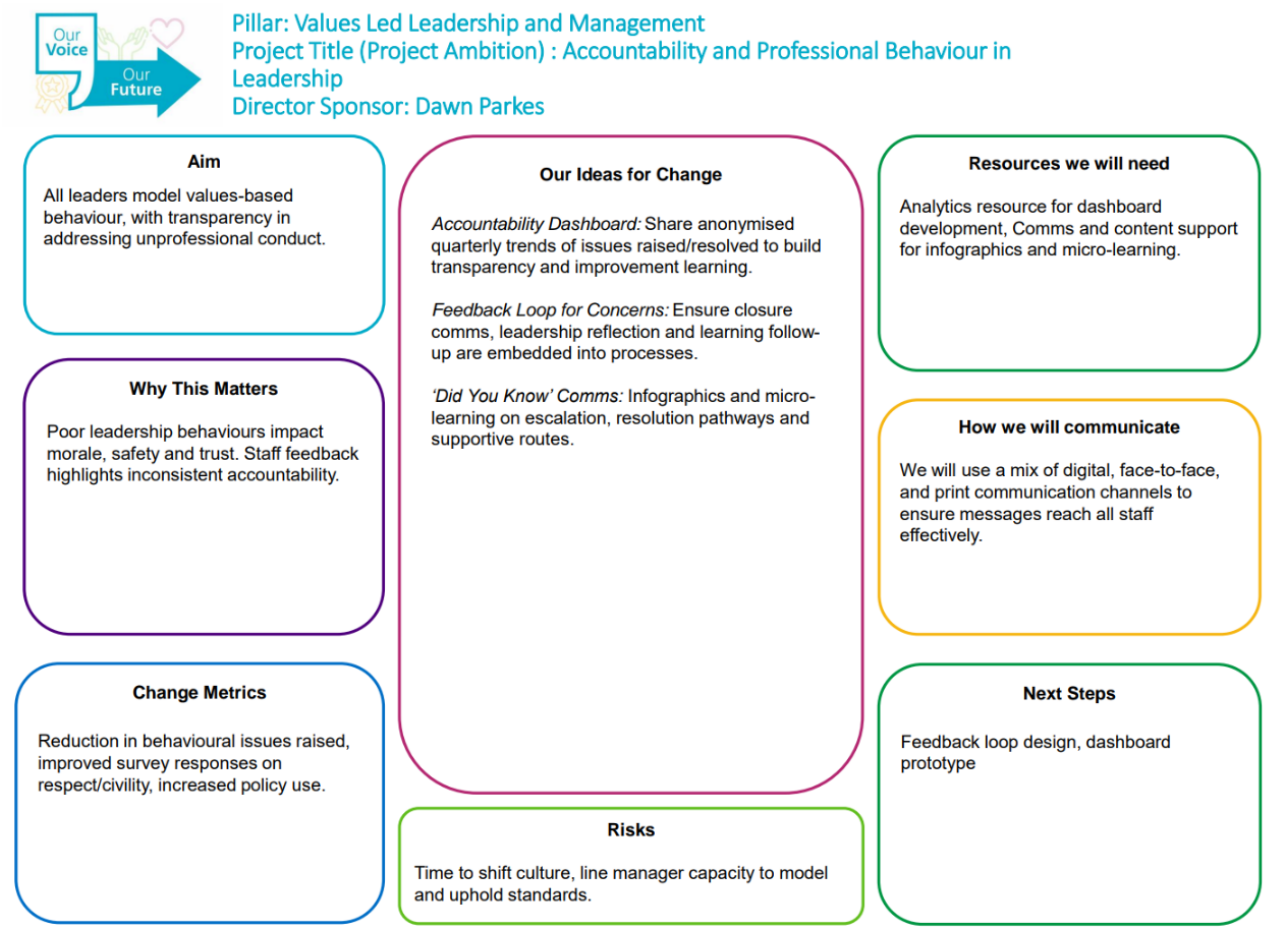
Appendix 2

Pillar 1: Values Led Leadership & Management – Ensuring Time and Space is Protected for Compassionate Leadership Plan on a Page (2 of 3 in Pillar 1)



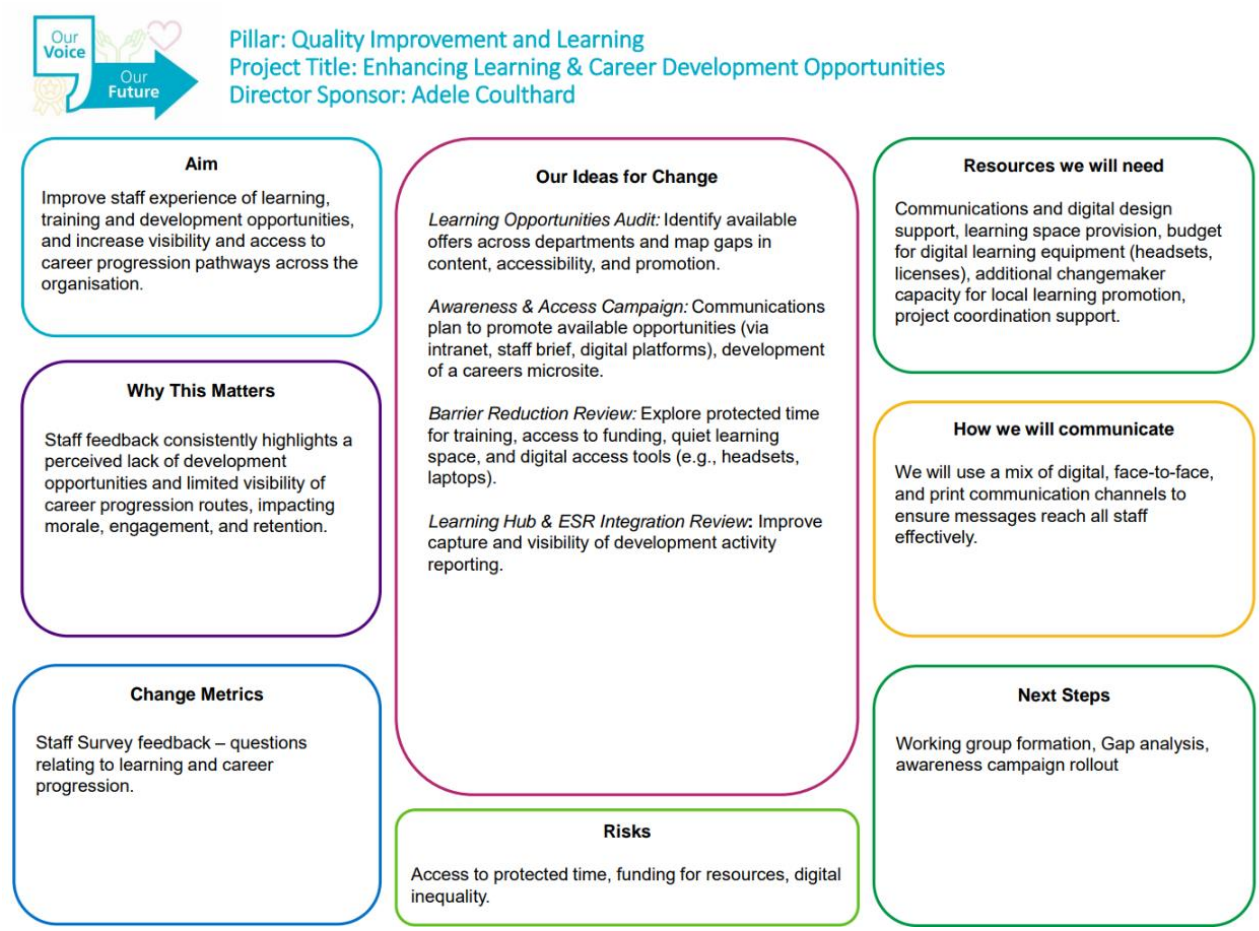
Appendix 3

Pillar 1: Values Led Leadership & Management – Accountability and Professional Behaviour in Leadership Plan on a Page (3 of 3 in Pillar 1)



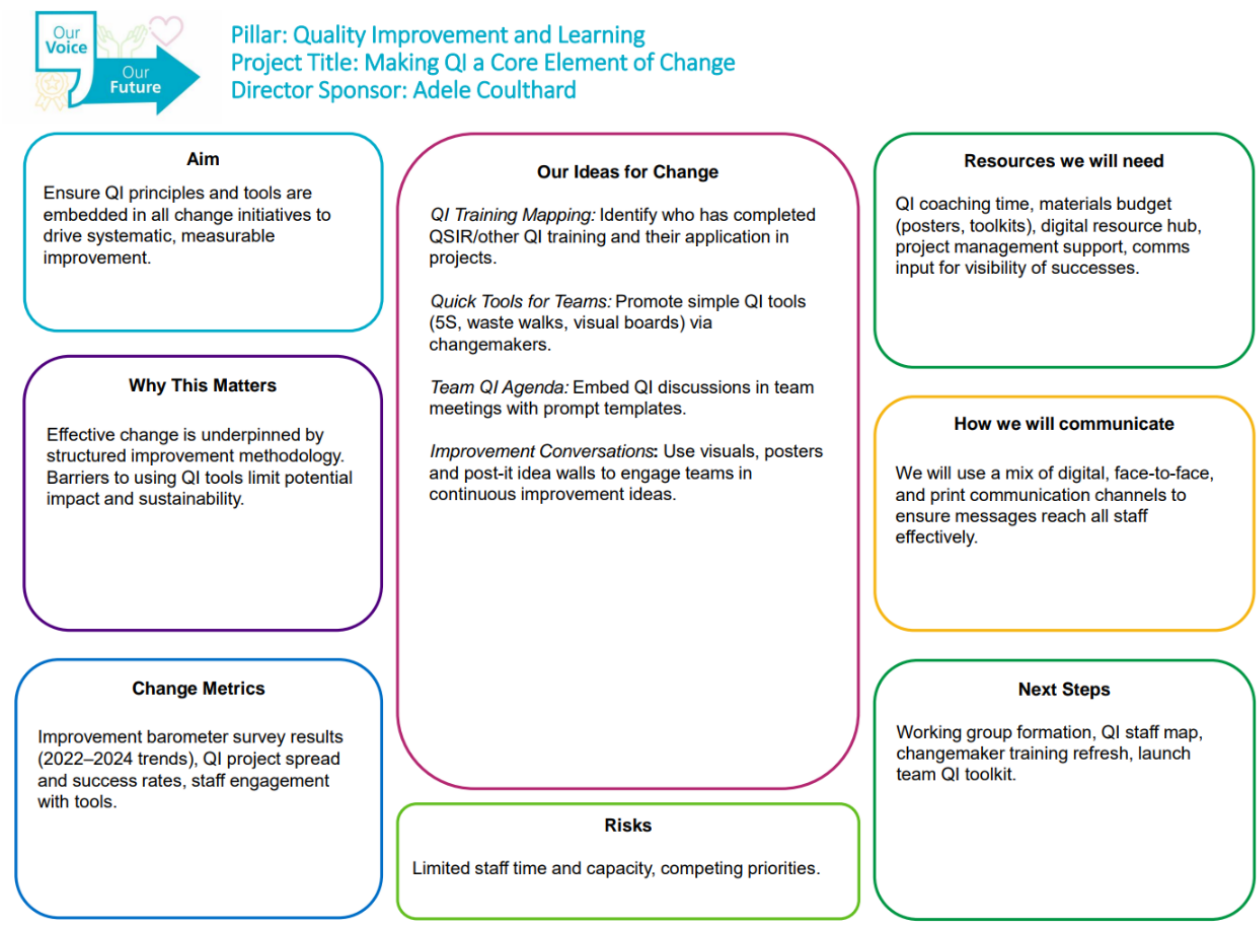
Appendix 4

Pillar 2: Quality Improvement and Learning – Enhancing Learning and Career Development Opportunities Plan on a Page (1 of 2 in Pillar 2)



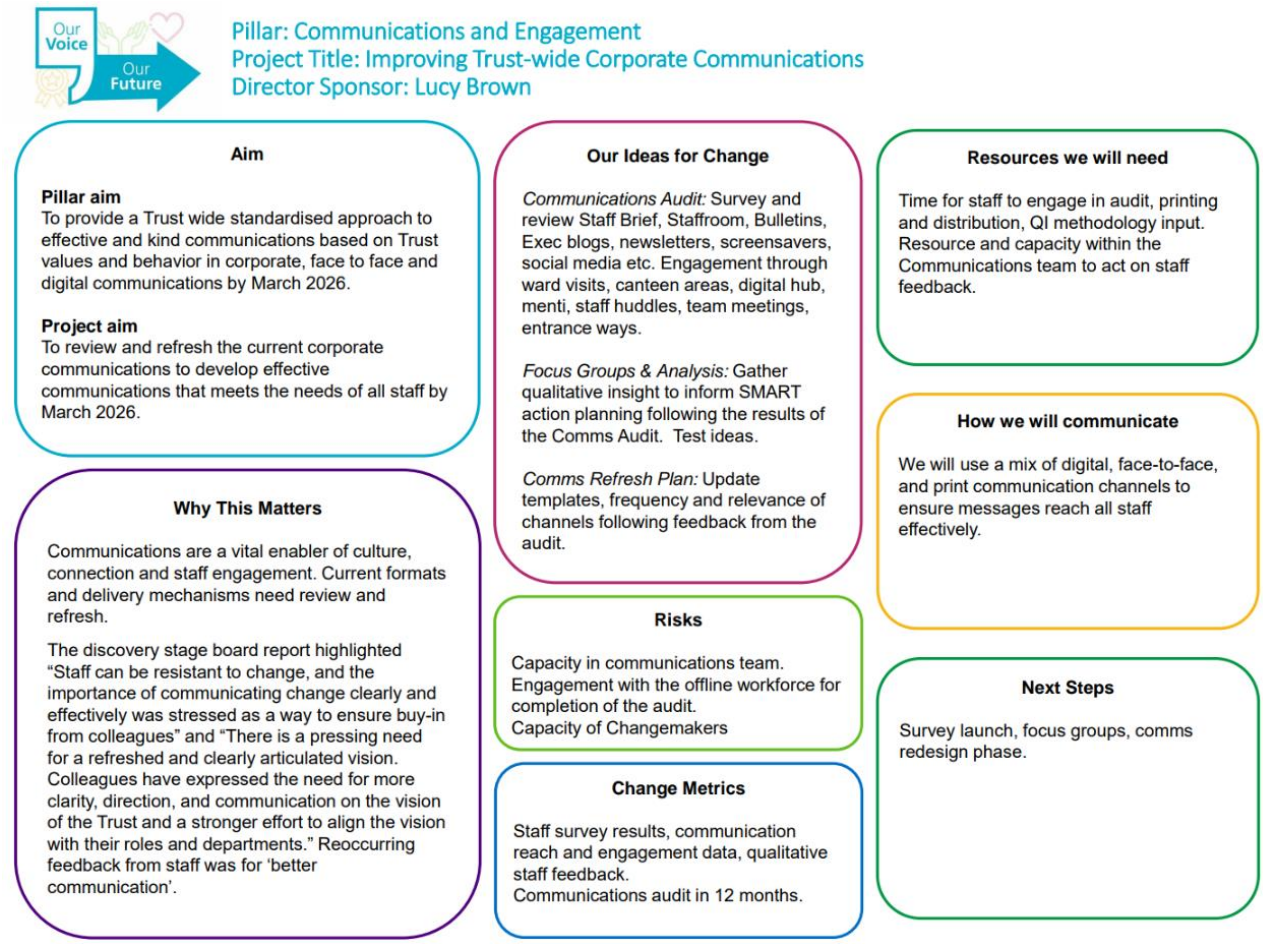
Appendix 5

Pillar 2: Quality Improvement and Learning – Making Quality Improvement a Core Element of Change Plan on a Page (2 of 2 in Pillar 2)



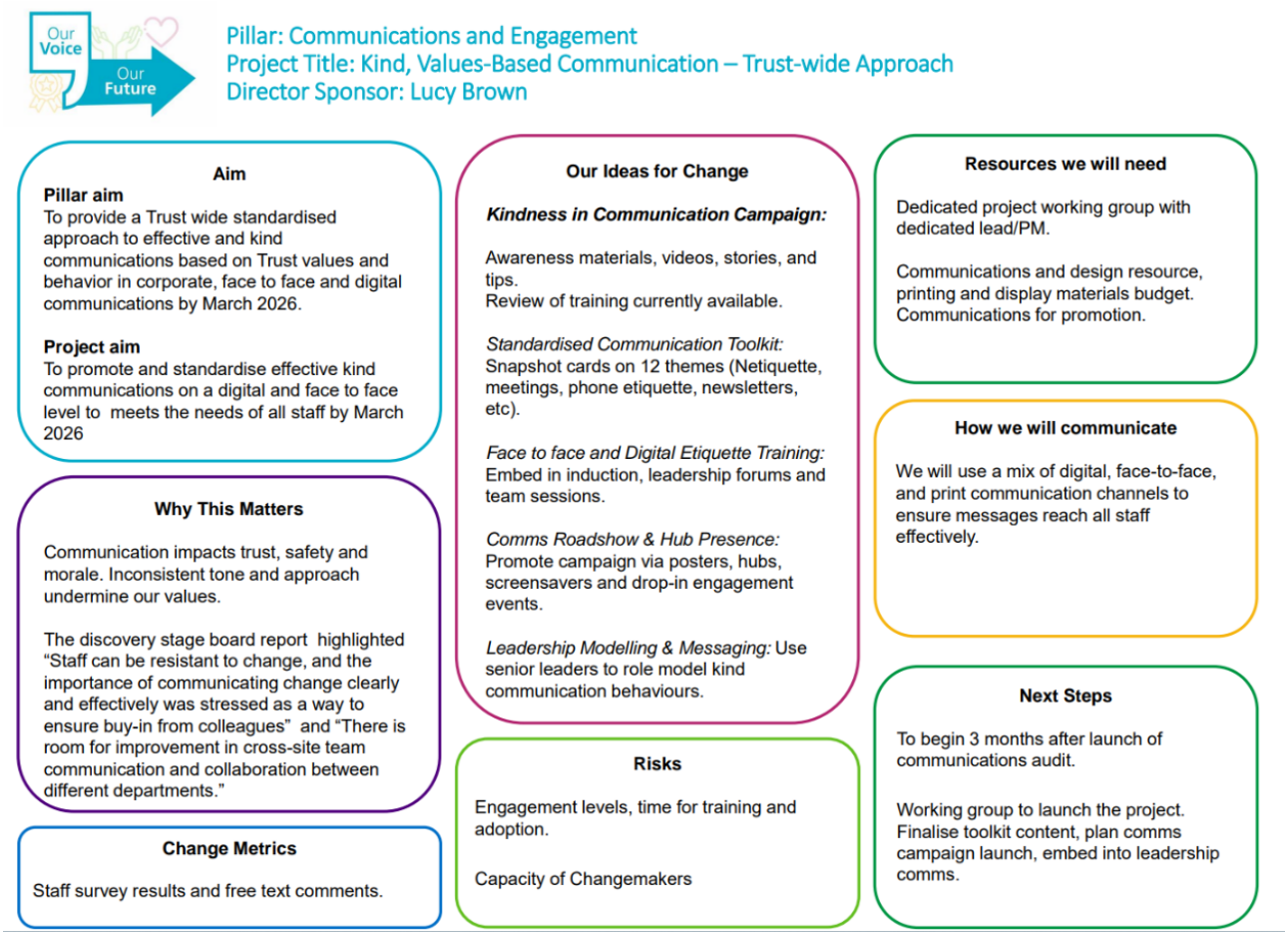
Appendix 6

Pillar 3: Communications and Engagement – Improving Trust-wide Corporate Communications Plan on a Page (1 of 2 in Pillar 3)



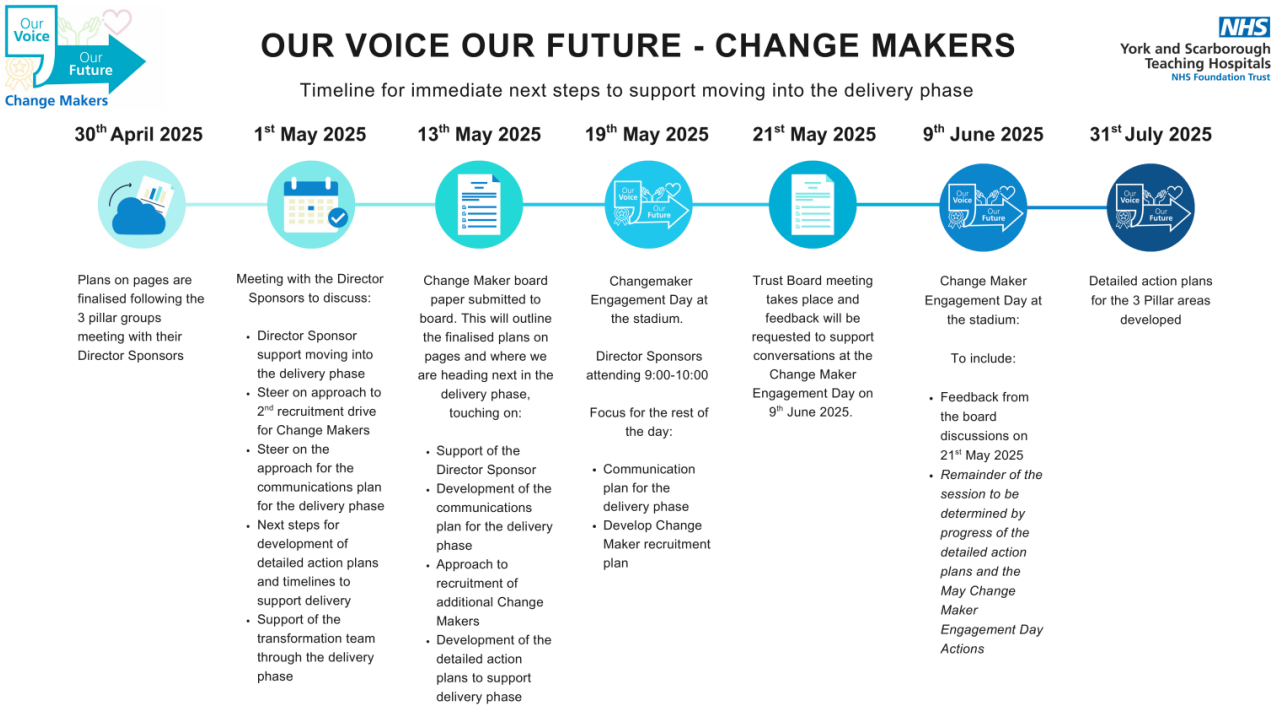
Appendix 7

Pillar 3: Communications and Engagement – Kind, Values-Based Communication (Trust-wide Approach) Plan on a Page (2 of 2 in Pillar 3)



Appendix 8

Infographic of Overarching Timeline for moving into the Delivery Phase



Committee Report

Report from:	Group Audit Committee
Date of meeting:	13/05/2025
Chair:	Jane Hazelgrave

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

ALERT
• YTHFM audit plan has been reprofiled into next financial year. A limited assurance opinion was given for Backlog maintenance mostly associated with timing and implementation of the 6-facet survey. • Trust – 2 reported with limited assurance (OD and continuous Improvement, GDPR)
ASSURE
• Draft AGS and those charged with governance statements reviewed and approved with minor changes. • External audit work in progress. No major concerns were raised at this point. • Internal audit • YTHFM 11 recommendations closed. Significant assurance reported for UECC build project management. • YTHFM Scheme of Reservation was approved noting the changes were mostly associated with the new procurement act and training was advised for committee members. • Trust – 28 actions closed. Three reports with significant assurance (Mortality Rate Analysis, BAF, eRoster).

ADVISE
• Draft Annual report was presented with issues being directed to Mike Taylor outside of the meeting. External Audit confirmed they had received the financial statements and were in the process of auditing. These will form part of the Annual report.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• Impact of overdue IA actions on the Head of Internal Audit opinion. • Role of Group Audit Committee in review of BAF and Risk register and how these fit in with wider governance structures at the Trust.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

TRUST PRIORITIES REPORT

May 2025

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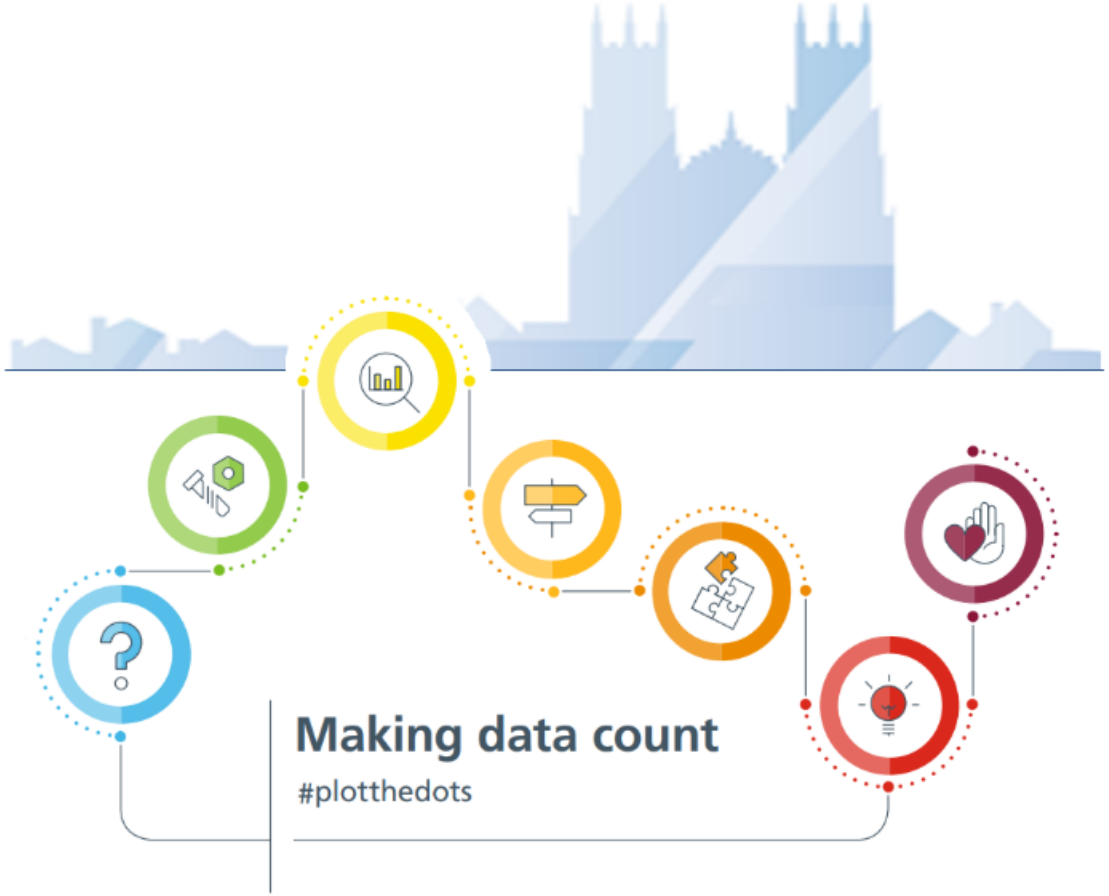
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust



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)	2025-04			34	45	29
ED - Median Time to Initial Assessment (Minutes)	2025-04			4		
ED - Emergency Care Standard (Trust level)	2025-04			63.8%	68.7%	78%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-04			19.8%	17.1%	8.9%
ED - 12 hour trolley waits	2025-04			628		0
Cancer - Faster Diagnosis Standard	2025-03			70.6%	77%	80.1%
Cancer - 62 Day First Definitive Treatment Standard	2025-03			68%	70%	75%
RTT - Total Waiting List	2025-04			49621	48010	38992
RTT - Waits over 65 weeks for Incomplete Pathways	2025-04			38	0	0

Executive Summary:

The April 2025 Emergency Care Standard (ECS) position was 63.8%, against the monthly target of 68.7%.

Average ambulance handover time in April 2025 was ahead of trajectory at 34 minutes 27 seconds. The trajectory was to be below 45 minutes 18 seconds. York ED handover average was 23 minutes 12 seconds, showing real improvement for the second consecutive month since the W45 ambulance handover went live on 5th March 2025.

Please note; in line with national reporting deadlines cancer reporting runs one month behind. The Cancer performance figures for March 2025 saw performance against the 28-day Faster Diagnosis standard (FDS) of 70.6%, this failed to achieve the monthly improvement trajectory of 77%.

62 Day waits for first treatment March 2025 performance was 68% an improvement on the 66.8% seen in February 2025, however the monthly trajectory of 70% was not achieved. The Trust has, as part of the 2025-26 Operational Planning, submitted trajectories to achieve the national ambition of 80% for FDS and 75% for 62 Day waits for first treatment by March 2026.

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

OPERATIONAL ACTIVITY AND PERFORMANCE

May 2025

Headlines:

- The April 2025 Emergency Care Standard (ECS) position was 63.8%, against the monthly target of 68.7%. Statistically this is the 10th consecutive month below the two-year rolling average. In the latest available national data (March 25) the Trust was 99th out of 121 providers of Type 1 ED. For the North East & Yorkshire region the Trust was 18th out of 22 providers.

- Average ambulance handover time in April 2025 was ahead of trajectory at 34 minutes 27 seconds. The trajectory was to be below 45 minutes 18 seconds. Average ambulance handover time is calculated by taking the total combined handover times divided by the number of ambulances that attended the Trust's Emergency Departments. This performance was within the monthly variance that has been seen over the last twenty-four months.

Factors impacting performance:

- The impact of the Norovirus outbreak at York was also felt across the UEC pathway, with reduced flow out of the hospital and less ability to implement continuous flow to the wards from ED.
- W45 ambulance handover went live on 5th March 2025 at York ED which has positively impacted performance.
- The average non-elective Length of Stay (LoS) for patients staying at least one night in hospital was seven days during April 2025. This met the trajectory to have an average LoS for this cohort of less than 7.1 days submitted as part of the 2025/26 annual planning process.
- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) was 87.3%, slightly behind the trajectory of 88% submitted as part of the 2025/26 annual planning process. The average delay (number of days after the DRD that a patient was subsequently discharged) was 3.6 days, just ahead of the submitted trajectory of 3.7 days.
- The number of non-elective admissions continues to be a challenge, above the upper control limit for the second consecutive month.

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 - Emergency Care Attendances * ED - A&E Attendances - Types 2 & 3 * ED - Proportion of Ambulance handovers waiting > 45 mins
COMMON CAUSE / NATURAL VARIATION		* ED - A&E attendances - Type 1 * ED - Proportion of Ambulance handovers waiting > 240 mins * ED - Ambulance average handover time (number of minutes)	* ED - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - 12 hour trolley waits * ED - Emergency Care Standard (Type 1 level)
SPECIAL CAUSE CONCERN			* ED - Emergency Care Standard (Trust level)

More options

Acute Flow (1)
Scorecard

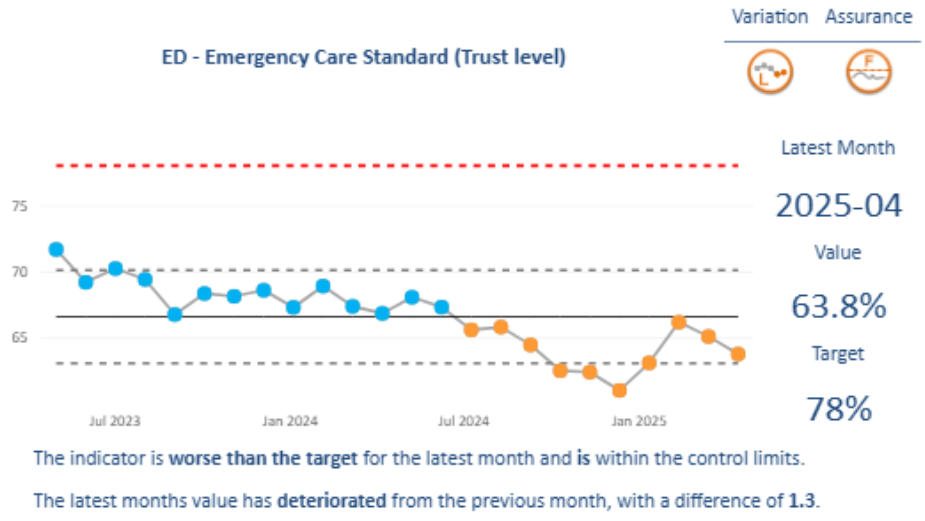
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2025-04	H		72.4%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2025-04			24.4%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-04		F	19.8%	17.1%	8.9%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2025-04			2064		
ED - 12 hour trolley waits	2025-04		F	628		0
ED - Emergency Care Attendances	2025-04	L	F	17739	15942	16377
ED - Emergency Care Standard (Trust level)	2025-04	L	F	63.8%	68.7%	78%
ED - A&E attendances - Type 1	2025-04		?	10390	10707	10999
ED - Emergency Care Standard (Type 1 level)	2025-04		F	41.8%	55%	69.2%
ED - A&E Attendances - Types 2 & 3	2025-04	L	F	7349	5235	5378
ED - Median Time to Initial Assessment (Minutes)	2025-04	L		4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-04			45.6%		
Proportion of SDEC attendances transferred from ED	2025-04			67.7%		
Proportion of SDEC attendances transferred from GP	2025-04			26.4%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-04			49.1%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-04			14.1%		

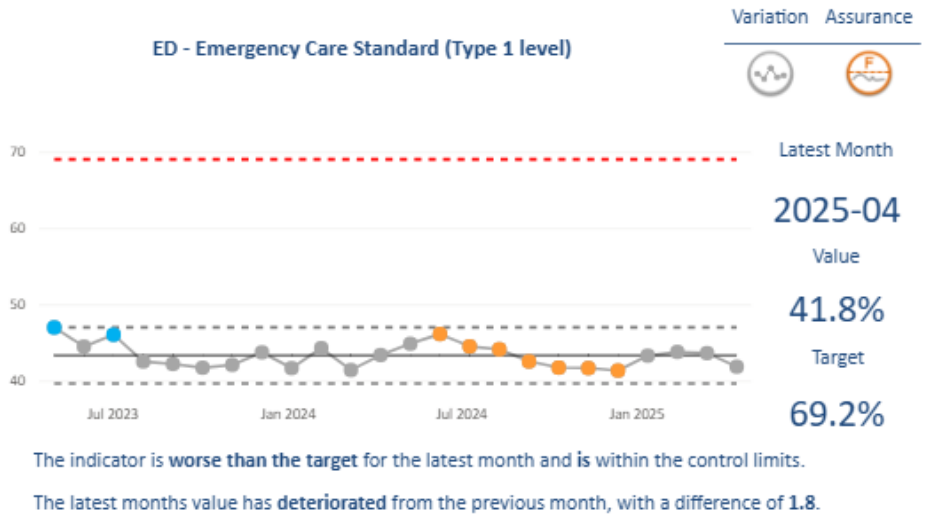
Executive Owner: Claire Hansen

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 **1.3**.



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 **1.8**.

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 2026. **SPC2:** Modelling showed that to achieve 78% as a Trust Type 1 performance needs to be at least 69%.

Actions:

The new clinically-led Task and Finish groups to support improvements at our Front Doors and through our urgent care pathways are operational, as follows:

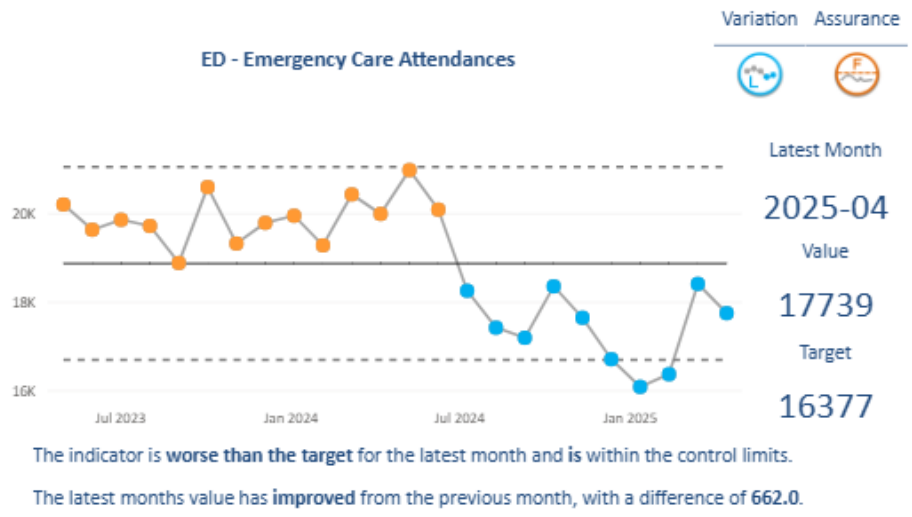
- ED Streaming.
- ED processes (including ambulance handovers).
- Urgent Treatment Centres.
- Emergency Department Ambulatory Care (EDAC).
- Acute Assessment (including SDEC / Integrated Assessment).
- Workforce Modelling.

Using data and frontline expertise, several tests of change have been agreed by the multidisciplinary groups. Planning, communication and engagement activity has taken place, these below changes are being rolled out 1st – 12th May 2025:

- All GP letters direct to SDEC or specialty, not ED.
- All self-presenting patients should be directed to the UTC unless they clearly require ED.
- Additional GP (Minor Illness) hours at York UTC.
- Establish Emergency Department Ambulatory Care (EDAC).

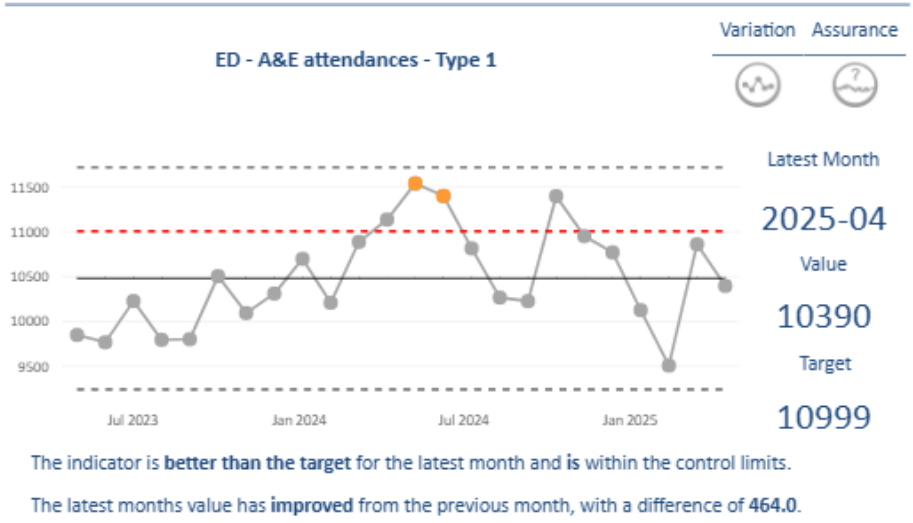
Executive Owner: Claire Hansen

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 **improved** from the previous month, with a difference of **662.0**.



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 **464.0**.

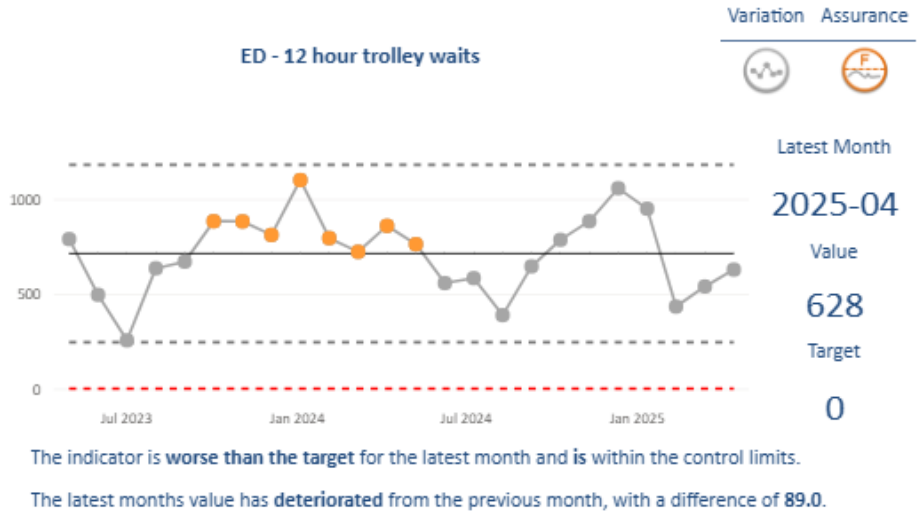
Rationale: SPC1: To monitor demand in A&E. **SPC2:**
Target: SPC1: Monthly activity plan as per chart. **SPC2:** Monthly activity plan as per chart.

Actions:

- The North Yorkshire and York Coordination Hub (led by the Yorkshire Ambulance Service) has now closed. To mitigate this, YAS are planning to increase clinical input to their operational centre and hoping to develop a read-only version of the call stack so that other community partners (for example the York Frailty Hub) can intervene where appropriate. Progress against these ambitions is being reported to the Community Improvement Group (CIG) monthly, attended by multiple community partners and chaired by the Trust's Deputy Chief Operating Officer.

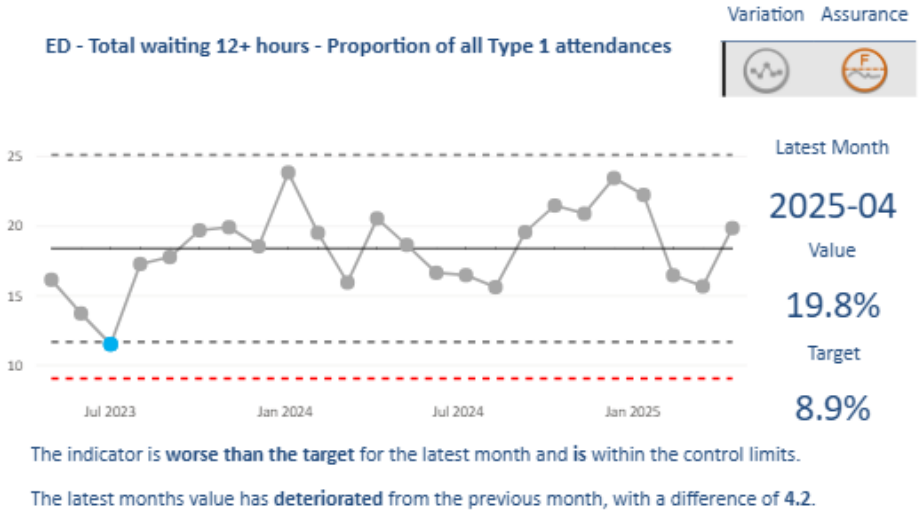
Executive Owner: Claire Hansen

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 **89.0**.



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 **4.2**.

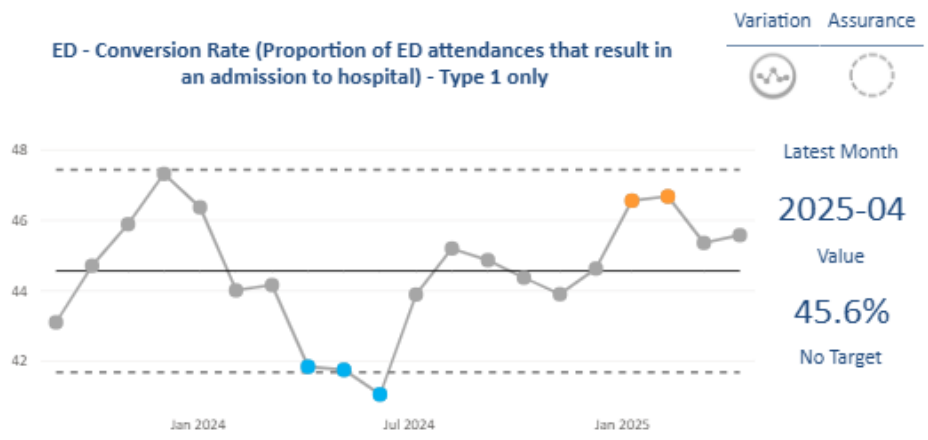
Rationale: To monitor long waits in A&E.
Target: SPC1: Zero patients to wait over 12 hours from decision to admit to being admitted. **SPC2:** Less than 8.9% of patients should wait more than 12 hours by end of March 2026.

Actions:

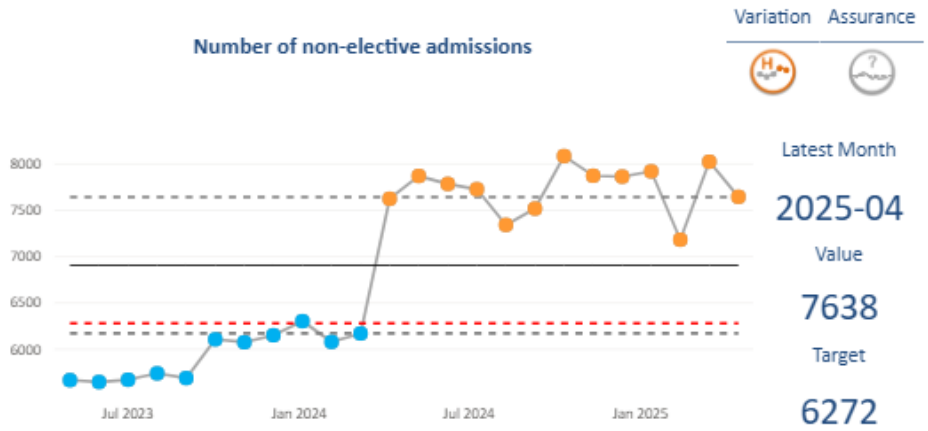
- The proportion of twelve-hour trolley waits (time from decision to admit to time of admission) and Type 1 patients spending over 12 hours in our Emergency Departments deteriorated against the previous month but were within the control limits.
- The reduction in discharges and reduction in open beds during the Norovirus outbreak contributed to this deterioration, though it was already recognised that further improvement to twelve-hour performance is needed and planned through the task and finish groups.
- A set of Quality Standards has been drafted with input from clinical and other frontline colleagues. A schedule of engagement work is now underway to ensure these standards are meaningful to key stakeholders and will then go through a formal governance process for sign-off. The overarching principle of these standards is to keep patients moving forward in their healthcare journey, with a core principle of no 'backwards' movement. Once established and embedded, these Quality Standards should contribute to a reduction in waiting times for inpatient beds.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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



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 **379.0**.

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 Emergency Department Ambulatory Care model is designed to support a reduction in emergency admission rates; it applies an appropriate risk management approach by frontloading senior input into clinical management plans. It is anticipated that this leads to a reduction in diagnostics and admissions.
- Audits are being planned to check the assumptions made in the planning phase, and a quality improvement methodology to continuously improve the services will be applied.

Acute Flow (2)
Scorecard

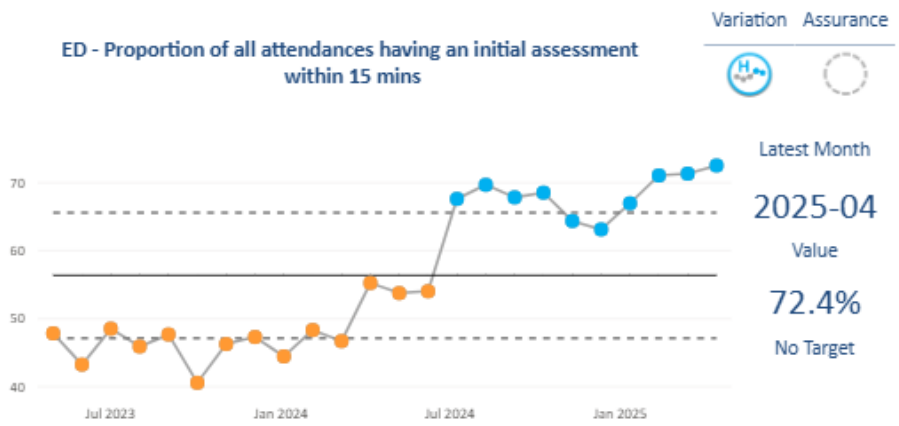
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2025-04			45.6%		
Number of SDEC attendances	2025-04			2452		
Proportion of SDEC attendances transferred from ED	2025-04			67.7%		
Proportion of SDEC attendances transferred from GP	2025-04			26.4%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-04			49.1%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-04			14.1%		
Number of RAFA attendances (York Only)	2025-04			141		
Number of attendances at SAU (York & Scarborough)	2025-04			851		
ED - Proportion of Ambulance handovers within 15 mins	2025-04			29.9%		
ED - Proportion of Ambulance handovers waiting > 30 mins	2025-04			35.8%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2025-04	L	F	16.6%		0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2025-04		?	1.1%		0%
ED - Number of ambulance arrivals	2025-04			4673		
ED - Ambulance average handover time (number of minutes)	2025-04		?	34	45	29

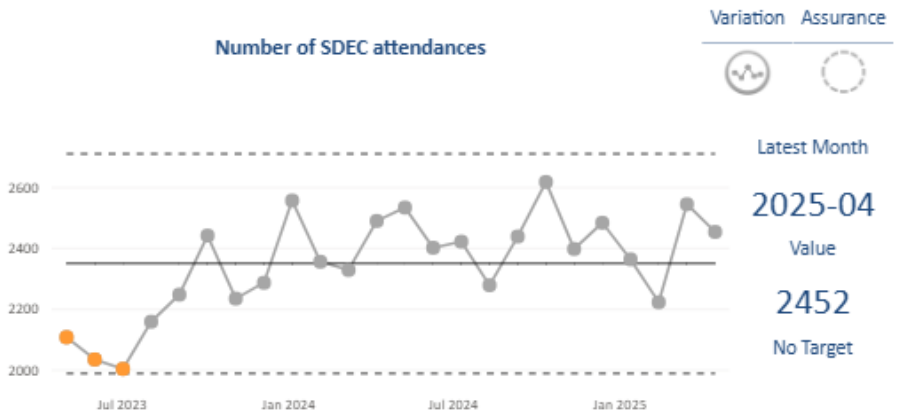
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The indicator is **equal to the baseline** 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 **1.2**.



The latest months value has **deteriorated** from the previous month, with a difference of **91.0**.

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:

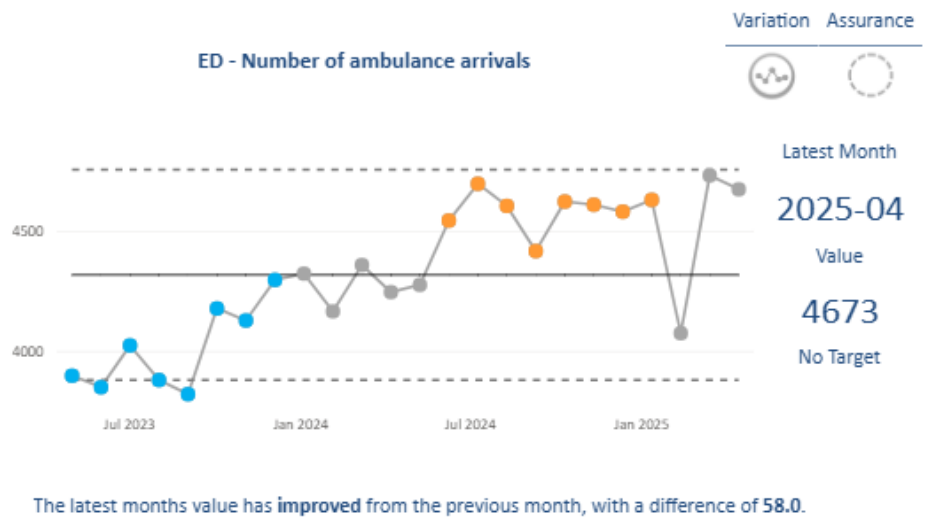
- We continue to see improvement in the proportion of patients having an initial assessment within 15 minutes of arrival to our Emergency Departments, outside the upper control limit for the fourth successive month.

- At Scarborough there has been a reduction in this time to initial assessment since the introduction of Emergency Department Ambulatory Care (EDAC) which coincided with the move to the new build. This will be monitored to understand if a permanent improvement. Patients who are deemed on arrival to need emergency care (more intervention than the UTC - but who are considered unlikely to require admission) are seen promptly in EDAC, with dedicated workforce in daytime hours. After an appropriate settling in period to allow EDAC to embed, audits will be undertaken to determine whether additional focus is required.

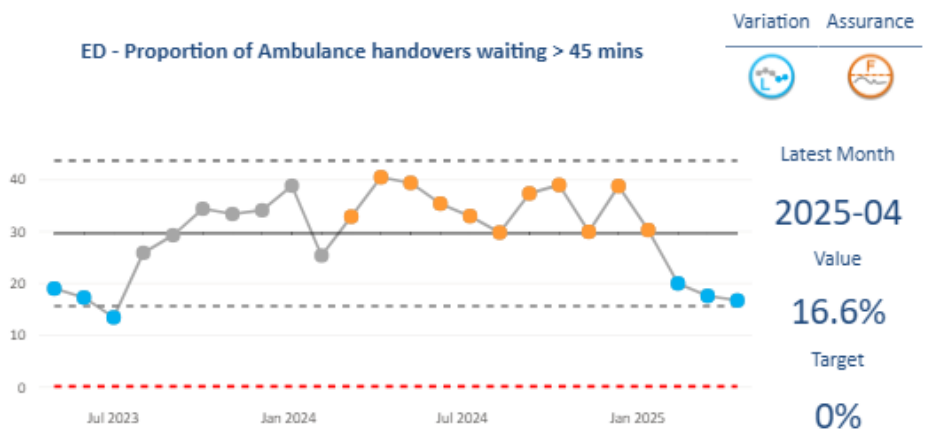
- Recruitment is currently underway for an Acute Physician for Medical SDEC. The Acute Assessment task and finish group is progressing options for removing elective 'bring back' patients from our SDEC units to free up capacity for more unscheduled care. Implementation dates will be proposed and discussed at the next meeting on the 22nd of May. The group is also considering the most appropriate opening hours of Medical SDEC.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **58.0**.



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 **0.9**.

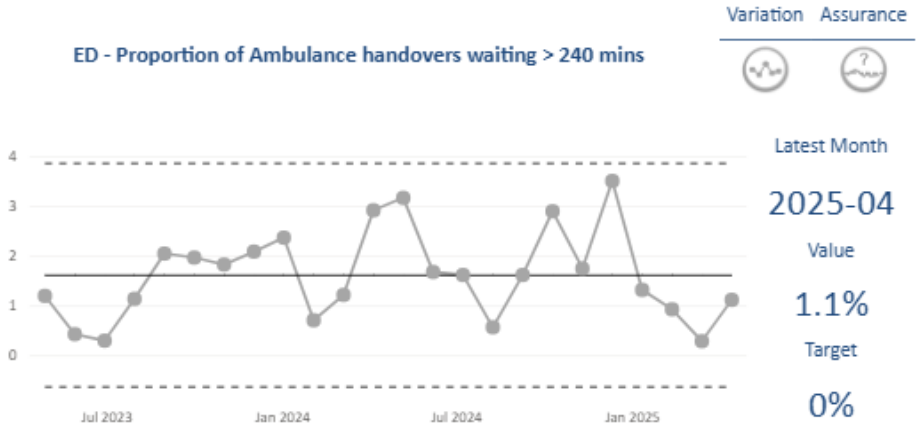
Rationale: SPC1: To monitor Ambulance demand in A&E. **SPC2:** Proportion of ambulances which experience a delay in transferring the patient over to the care of ED staff.
Target: SPC1: No target. **SPC2:** Patients arriving via an ambulance should be transferred over to the care of ED staff within 15 minutes of arrival. 0% should wait over 45 minutes from arrival to handover.

Actions:

- The proportion of ambulance handovers waiting over 45 minutes fell again in April. At York, the W45 initiative, which aims to eradicate handover delays over 45 minutes, has been fully implemented and the average handover time throughout April 2025 was below 24 minutes.
- The W45 initiative is launching in Scarborough on 21st May 2025.

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.

As per previous page

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	* Overnight general and acute beds open	* Number of zero day length of stay non-elective admitted patients	* Patients receiving clinical Post Take within 14 hours of admission * Inpatients - Proportion of patients discharged before 5pm
COMMON CAUSE / NATURAL VARIATION		* Of those overnight general and acute beds open, proportion occupied * Community bed occupancy/availability	* Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside
SPECIAL CAUSE CONCERN		* Number of non-elective admissions	

Acute Flow (3)
Scorecard

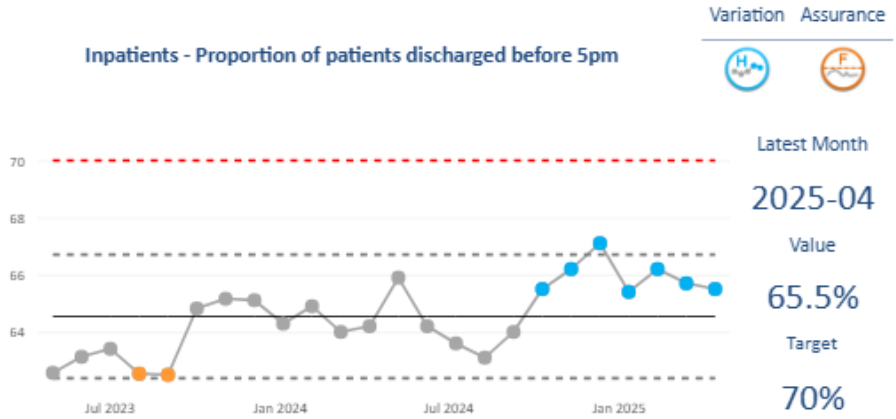
York and Scarborough Teaching Hospitals NHS Foundation Trust

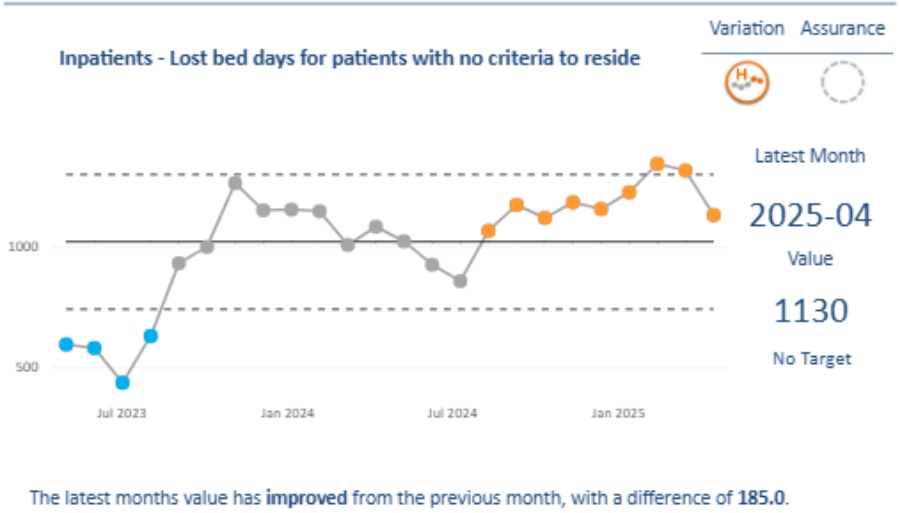
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2025-04	H	F	80.4%		90%
Patients with Senior Review completed at 23:59	2025-04			46.4%		
Inpatients - Proportion of patients discharged before 5pm	2025-04	H	F	65.5%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2025-04	H		1130		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2025-04		F	15.9%	14.9%	12.5%
Number of non-elective admissions	2025-04	H	?	7638	6156	6272
Number of zero day length of stay non-elective admitted patients	2025-04	H	?	2391	2422	2464
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2025-04			122		
Overnight general and acute beds open	2025-04	H	P	875	844	832
Of those overnight general and acute beds open, proportion occupied	2025-04		?	93%		92%
Community bed occupancy/availability	2025-04		?	92%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

Actions:

- The team is planning for a weekly Long Length of stay reviews at both sites via Teams with ward teams to dial in at 10 minute intervals. Will focus on 14-day length of stay, criteria to reside patients. Reviews took place during MaDE week in April 2025. Work underway to ensure all staff groups can attend.
- Lost bed days for patients with no criteria to reside has been above the two-year monthly average since July 2024 despite a reduction in the proportion of patients not meeting the criteria to reside. The Business Intelligence has carried out an in-depth analysis of these figures and concluded the two metrics should not be compared for correlation as they are fundamentally different. More work is being done to understand the data.
- An issue of data quality has been raised, with a percentage of patients not having a criteria to reside code entered. The specialty level data is being reviewed to support teams to input codes more consistently.

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:** No Target. **SPC2:** Internal aim to achieve less than 12.5% by March 2026.

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

Variation Assurance

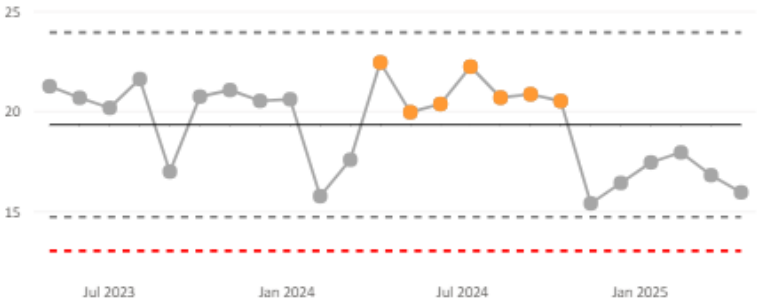
Latest Month
2025-04
Value
122
No Target

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

The latest months value has **improved** from the previous month, with a difference of **4.3**.

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

Variation Assurance



Latest Month
2025-04
Value
15.9%
Target
12.5%

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 **0.9**.

Actions:

- As at week ending 4th May 2025 the NCTR performance shows deterioration to 16.4% against trajectory of 14.7%. Super Stranded ratio of occupancy underachieved at 17.3% against trajectory of 14.8%. Stranded ratio of occupancy at 46.1% achieved against trajectory of 46.4%. One main reason is understood to be impact of Norovirus outbreak.

- A Multi-Agency Discharge Event (MaDE) took place from 23rd to 30th April 2025 inclusive. This coincided with the Norovirus outbreak which limited the impact on quantitative figures however there were positive qualitative outcomes, particularly at Scarborough. A pilot trialling a streamlined notification process (compared with a full Trusted Assessment Form) was successful in facilitating quicker and more effective patient transitions from the DCC to the brokerage in North Yorkshire. This was trialled with 10 patients and resulted in several patients being discharged 1-2 days earlier and one patient being discharged 5 days earlier than traditional methods. This is thanks to multi-agency collaboration. Consideration is being given to the next appropriate steps for this trial, which is a step towards our ambitious Discharge to Assess model.

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

- The Cancer performance figures for March 2025 saw performance against the 28-day Faster Diagnosis standard (FDS) of 70.6%, this failed to achieve the monthly improvement trajectory of 77%.

- 62 Day waits for first treatment March 2025 performance was 68% an improvement on the 66.8% seen in February 2025, however the monthly trajectory of 70% was not achieved. The Trust has, as part of the 2025-26 Operational Planning, submitted trajectories to achieve the national ambition of 80% for FDS and 75% for 62 Day waits for first treatment by March 2026.

- Performance against both targets was above the monthly average for the last two years however there was no statistical change as performance was within the expected variance.

- The Trust has, as part of the 2025 Operational Planning, submitted compliant trajectories to achieve the national ambition of 80% for FDS and 75% for 62 Day waits for first treatment by March 2025.

Factors impacting performance:

- March 2025 saw 2,926 total referrals across all cancer sites in the trust, averaging 94 referrals per calendar day. Colorectal, Breast and Head and Neck had the highest number of referrals per cancer site. Gynaecology saw the highest volume of monthly referrals (284) in two years.
- The following cancer sites exceeded 77% FDS in March 2025: Breast, Haematology, None Site Specific, and Skin pathways.
- The following cancer sites exceeded 70% 62-day performance in March: Breast, Haematology and Skin. Head and Neck, Lung, Upper GI and Urology achieved above their internal trajectories. The expected impact from January and February FDS dip in performance is a contributing factor to 62 day performance in March.
- 31-day treatment standard was 97.3% overall. 292 1st treatments were delivered in March, with 8 patients breaching. Urology had the highest volume of treatments delivered (72) and achieved 100%. Breast delivered 50 treatments and achieved 100%. Colorectal had the largest number of breaches (7).
- At the end of March, the proportion of patients waiting over 104+ days equates to 2% of the PTL size, a consistent percentage trend with February but an increase of 45 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.

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 31 day wait from diagnosis to first treatment	* Cancer - Faster Diagnosis Standard * 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	2025-03		F	70.6%	77%	80.1%
Cancer - 62 Day First Definitive Treatment Standard	2025-03	H	?	68%	70%	75%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2025-04	L		153		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2025-04			7.1%		
Cancer 31 day wait from diagnosis to first treatment	2025-03		?	97.2%		96.1%
Total Cancer PTL size	2025-04	L		2167		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2025-04		F	75%	80.1%	80.2%

KPIs – Operational Activity and Performance

Cancer (1)

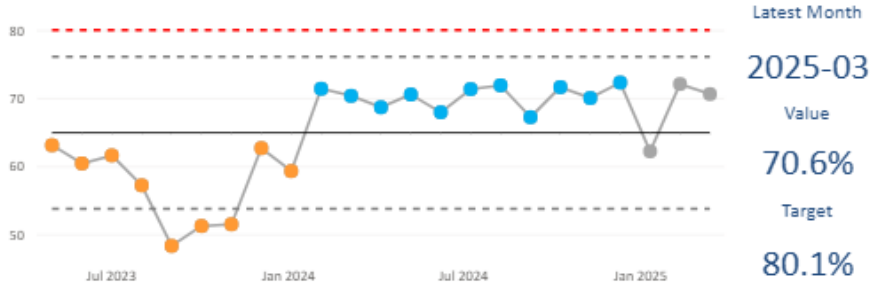
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Cancer - Faster Diagnosis Standard



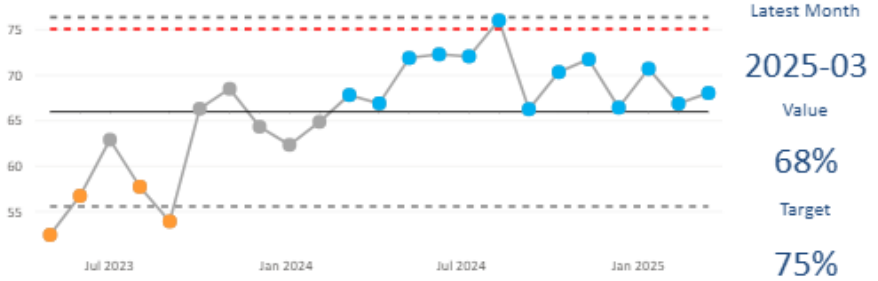
Latest Month
2025-03
Value
70.6%
Target
80.1%

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 **1.5**.

Variation Assurance

Cancer - 62 Day First Definitive Treatment Standard



Latest Month
2025-03
Value
68%
Target
75%

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 **1.2**.

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 2025/25 is to improve performance against the headline 62-day standard.
Target: SPC1: 80% by March 2026. **SPC2:** 75% by March 2026.

Actions:

- Commencement of improvement plans submitted as part of 2025-26 funding, including establishment of frailty pathway in Colorectal, review of Gynaecology capacity and demand and scoping of feasibility of straight to test pathway for haematuria patients.
- Care groups working through action plans for improvement, and high-level cancer demand and capacity for 1st outpatient activity underway by corporate operations team. Review of all TCI dates and breach reasons undertaken at tumour site level and care groups undertaking actions to increase capacity to bring patients forward where clinically appropriate.
- Working through impact and any required changes in processes to ensure the Trust aligns with national changes to Cancer Waiting Times (CWT) standards
- Lung screening programme to commence in Q2 at Bridlington and mobilisation work underway at pace.
- Awaiting written confirmation and SLA of 2025/26 cancer alliance funding.

Operational Activity and Performance

Referral to Treatment (RTT) Narrative

York and Scarborough Teaching Hospitals NHS Foundation Trust

Headlines:

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

- The Trust's RTT Waiting list position ended April 2025 behind the trajectory submitted to NHSE as part of the 2025/26 planning submission: 49,621 against the trajectory of 48,010. However, the Trust is ahead of the trajectory for the proportion of the RTT waiting list waiting under 18 weeks: 56.6% against 53.6%. 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 is ahead of the RTT52 week trajectories submitted within the 2025/26 planning submission; 1,149 waiters and 2.3% of the total RTT Total Waiting list against the trajectories of 1,296 and 2.7%, respectively. By March 2026, the intention is that the percentage of patients waiting longer than 18 weeks for elective treatment will be less than 1% nationally.

- NHSE has introduced a new metric target for 2025/26 with the ambition set for the Trust to have over 67.1% of patients waiting no longer than 18 weeks for a first appointment by March 2026. The Trust is ahead of the trajectory submitted to NHSE as part of the 2025/26 planning submission with performance of 60.3% against the end of April 2025 ambition to be above 54.9%.

Factors impacting performance:

- RTT Total Waiting List metric impacted by ongoing validation work on the Outpatient PTL, resulting in circa 2,800 additional RTT clocks being opened in April. There are no RTT65 week performance risks identified in this work to date.

- Delivery of the 2024/25 elective recovery plan. Initial analysis shows that at the end of April 2026 the Trust was behind the 2025/26 activity plan with a provisional performance of 96% of the Weighted Value Trust Activity Plan submitted to NHSE. From a financial point of view this equates to a provisional performance of 97% against the submitted plan, this is linked to the monetary value of the case mix that has been seen during 2025/26.

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 - Waits over 65 weeks for Incomplete Pathways * RTT - Waits over 52 weeks for Incomplete Pathways * RTT - Proportion of incomplete pathways waiting less than 18 weeks * RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks
COMMON CAUSE / NATURAL VARIATION			* RTT - Total Waiting List
SPECIAL CAUSE CONCERN			

Referral to Treatment (RTT)
Scorecard

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	2025-04		F	49621	48010	38992
RTT - Waits over 65 weeks for Incomplete Pathways	2025-04	L	F	38	0	0
RTT - Waits over 52 weeks for Incomplete Pathways	2025-04	L	F	1149	1296	389
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-04	H	F	56.6%	53.6%	60.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2025-04	L		17.9		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks	2025-04	L	F	2.3%	2.7%	1%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2025-04			60.3%	54.9%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2025-04			1.7%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2025-04			12%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2025-04	L		66.4%		

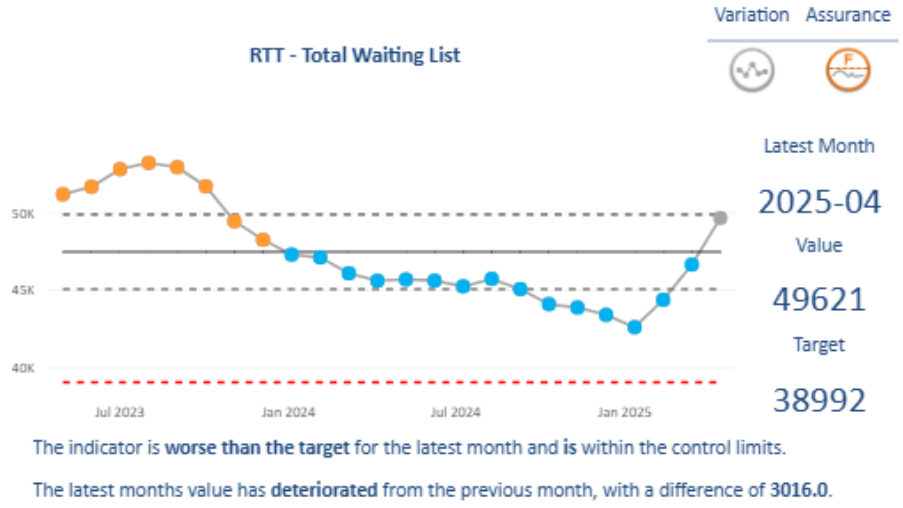
KPIs – Operational Activity and Performance

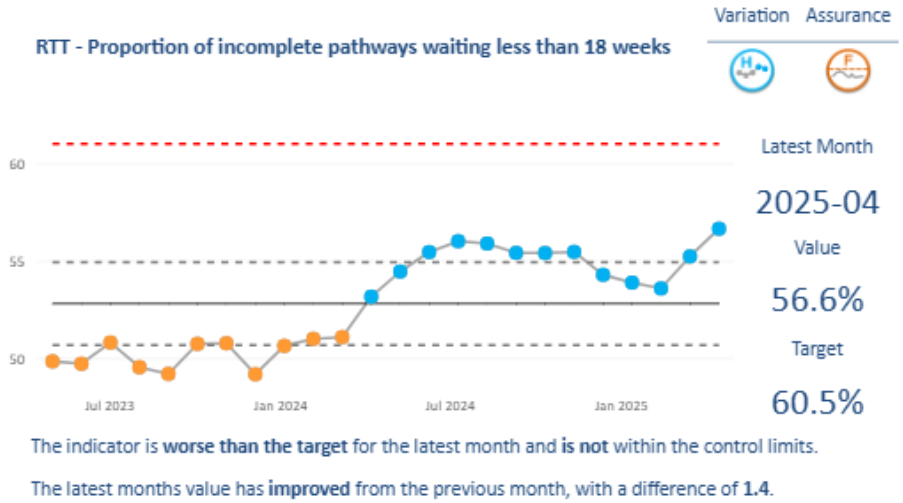
Referral to Treatment RTT (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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

Target: SPC1: Aim to have less than 38,992 patients waiting by March 2026 as per activity plan. **SPC2:** National constitutional target of 92% of patients should be waiting less than 18 weeks. Target for March 2026 is to be above 60.5%.

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 Trust has signed up to participate in the National validation sprint taking place throughout quarter 1 of 2025 initially. This supports overall elective recovery and the commitment in the Elective Reform Plan to:

  NHS England has made 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 baseline provided by NHSE sets the Trust a minimum of 31,543 during Q1. After four weeks of the sprint, the Trust is 2% ahead of the baseline expectation in terms of clock stops.

- 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 reduced the number of RTT patients waiting 52 weeks by 70%, against the average in cohort 2 of a 50% reduction. The Trust continues to do very well on missed appointments, pre referral triage and high level of Advice and Guidance. All these metrics are meeting national standards and more. The Trust is one of 6 Trusts in the North East and Yorkshire region who have agreed to participate in the NHSE accelerating PIFU programme. The PIFU pathways the Trust are developing as part of this programme are Gynaecology, Gastroenterology, Cardiology and ENT. The regional launch of the programme is on the 10th of June 2025.

- The 2025/26 plan has been developed with a greater focus on productivity and efficiency and was presented to Board in April 2025. The programme and progress against the ambitions are managed through the Elective Recovery Board.

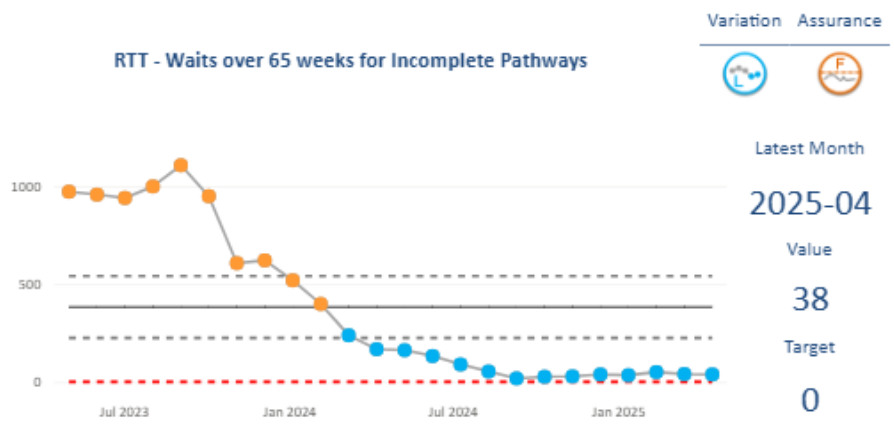
KPIs – Operational Activity and Performance

Referral to Treatment RTT (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

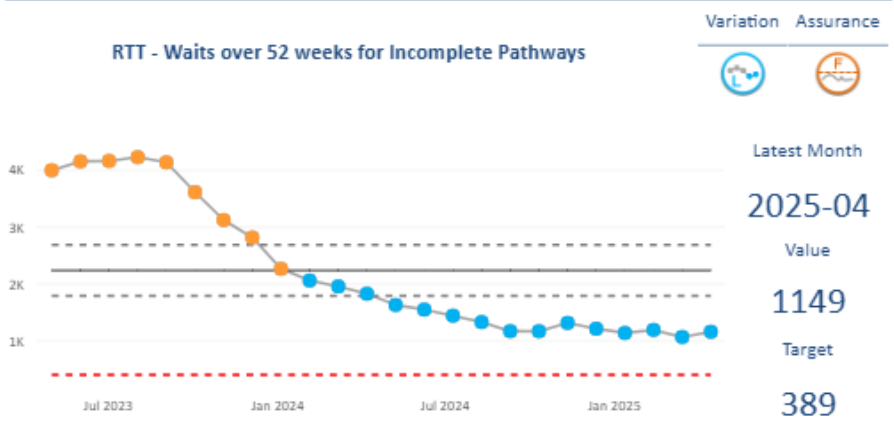
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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 **2.0**.



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 **92.0**.

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 **SPC2:** Aim to have less than 389 patients waiting more than 52 weeks by March 2026 as per activity plan.

Actions:

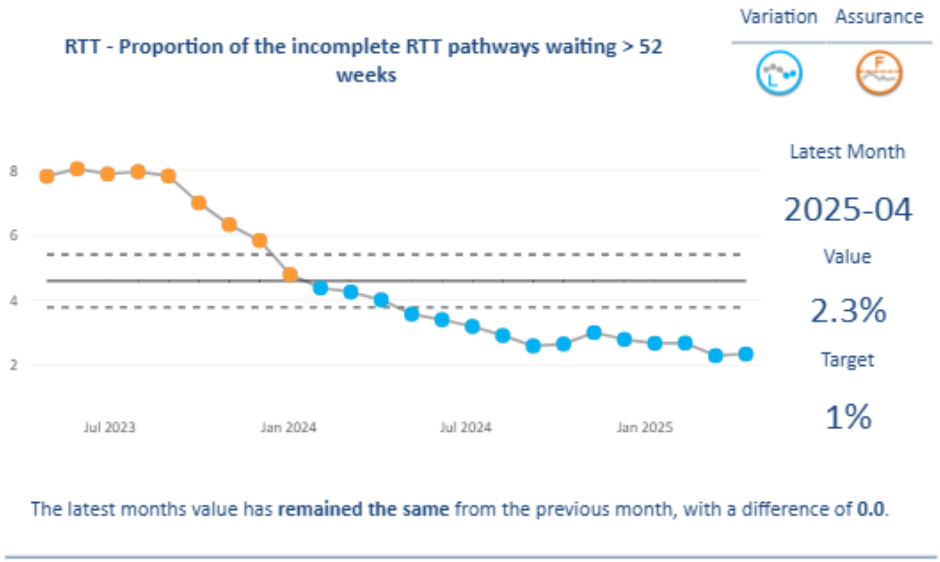
- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectories for RTT52 and RTT65 weeks.
- Internal Elective Recovery Fund (ERF) Process established. In 2024/25 ERF was paid for any activity undertaken above fixed payment baseline and was uncapped, therefore any additional elective activity attracted 100% tariff payment. This year the ERF has been capped, and additional financial governance is required to ensure this funding is spent on activity to deliver the elective improvement trajectories.

  As a result of this change in the way ERF has been allocated in 2025/26 a process to manage the distribution of this funding across care groups has been developed to strengthen the financial and performance governance. To reinforce this, a central process has been developed for Care Groups to apply to access this funding rather than it being allocated at the start of the year and drawn down as per previous years.

  The process includes the identification of the need to undertake additional activity, an application process, an ERF panel and communication of outcome.
- The Trust has seen continued capped theatre utilisation improvement and is the highest performing Trust with utilisation above 85% in March 2025 within the 'Further Faster 2' cohort .

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.
Target: SPC1: National ambition to have no more than 1% of a Trust's RTT TWL waiting over 52 weeks by the end of March 2026.

Actions:

Please see previous page.

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

Headlines:

- At the end of April 2025, the Patient Initiated Follow Up (PIFU) was above the improvement trajectory of 3.9% at 4.1%, this was not a statistical change as the performance was within the monthly variance seen over the last two years.
- Rapid Access Chest Pain (RACP) seen within 14 days was at 12.1% 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 with scrutiny of the impact of the actions 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: 1st Attendances (Activity vs Plan)	
COMMON CAUSE / NATURAL VARIATION	* Proportion of elective admissions which are day case	* Outpatients - DNA rates * Outpatients: Follow Up Attendances (Activity vs Plan) * All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days* * Day Cases (based on Activity v Plan)	* Outpatients - Proportion of appointments delivered virtually (S017a) * Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU) * Electives (based on Activity v Plan)
SPECIAL CAUSE CONCERN			* Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks) * Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)

Outpatients & Elective Care
Scorecard

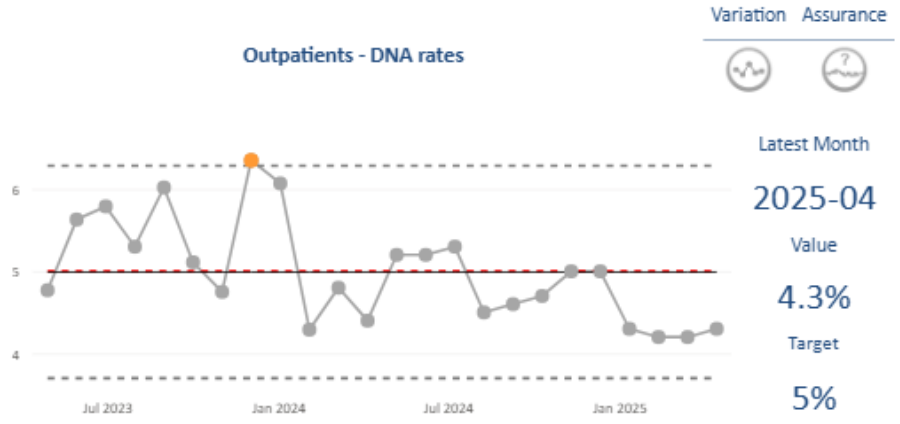
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2025-04		F	20.9%		25%
Outpatients - DNA rates	2025-04		?	4.3%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2025-04	H	?	18534	15915	17494
Outpatients: Follow Up Attendances (Activity vs Plan)	2025-04		?	43059	35738	38846
Outpatient procedures	2025-04			14722		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2025-04	H	F	27231		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2025-04		F	4.1%	3.9%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2025-04	L	F	12.1%		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*	2025-04		?	3		0
Day Cases (based on Activity v Plan)	2025-04		?	7296	7325	8144
Electives (based on Activity v Plan)	2025-04		F	653	674	816
Proportion of elective admissions which are day case	2025-04		P	91.8%		85%

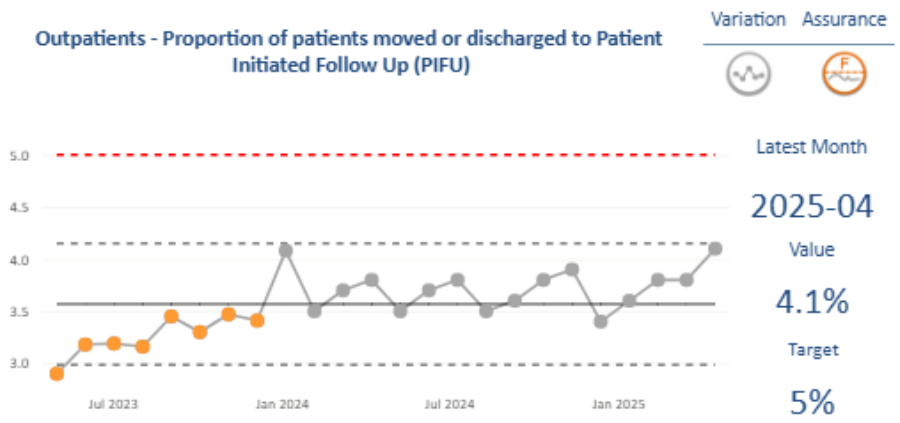
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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 **0.1**.



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 **0.3**.

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 below the two-year average at 4.3% in April 2025. Recent monthly performance shows consistent delivery.

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.

- RACP improvement plan has been developed by the Medicine Care Group with scrutiny of impact of actions undertaken through the Performance Review and Improvement Meetings (PRIM). Plan encompasses:

  York
  - Chest pain nurses have relocated to a stable base, improving continuity.
  - Recruitment underway for 15-hour Band 4 admin post to release nurse time. Maintain consultant support for nurse-led service.
  - Regularly timetable patient bookings to avoid batching.

  Scarborough
  - Full-time locum now in place; recovery trajectory aims for compliance by August 2025.
  - Secure consultant cover and expedite substantive appointment.
  - Reassess outpatient room use to avoid RTT clashes.

Headlines:

- The April 2025 Diagnostic target position for patients waiting less than six weeks at month end was 62.7%, against the trajectory of 68.9%. Performance was below the two year monthly average for the first time since June 2024 but was within the expected variance control limits.

Factors impacting performance:

- CT1 at Scarborough has been permanently decommissioned due to recurrent faults which left just one functional CT. CT2 injection arm at Scarborough developed a fault in April so could deliver limited activity, this has now been fixed but will have impacted performance. Continued intermittent breakdowns of CT1 and 2 at York impact delivery of activity. Acute CT demand continues to impact on capacity for elective work. MRI has also seen a reduction in performance due to increased fast track and RTT >52 week wait escalations, staffing gaps, and a reduction in Nuffield capacity. A review of acute demand is planned with medical and surgical care groups.
- MSK backlog continues to be the main driver of NOUS performance. This is a long-term issue, and a Consultant Radiologist has handed their notice in which will compound the issue from June 2025. Reporting demand continues to outstrip capacity. Reliance on in-house radiologist insourcing and outsourcing to external providers. Locum in place now so should start to address this over the next month.
- Endoscopy; since January 2025 there has been either no consultant or solo locum consultant cover at Scarborough, which has impacted on the ability to deliver planned lists. Elective lists have had to be cancelled on both sites to accommodate York consultants travelling to Scarborough on occasion to provide acute cover. Nurse staffing on both sites has been reduced since January 2025 due to a mix of vacancies and sickness. The service has been unable to staff all job planned and ECP lists in Bridlington.
- Staffing challenges in Cystoscopy have led to last minute cancellations of lists during April 2025.
- Workforce challenges continue at Scarborough within Cardiology and Cardio-Respiratory, with a lack of qualified candidates. Due to issues with our outsourced provider, a cohort of echocardiography patients at Scarborough were identified that required re-scanning, this was carried out in April 2025 with the remaining capacity focused on delivering cancer and acute work which impacted on elective performance.
- Nurse vacancy in Urodynamics continues to impact on capacity to deliver elective activity.
- Sickness in paediatric audiology team affecting capacity with limited locum availability for paediatric audiologist. Data Quality issues with audiology data leading to potential inaccuracies in the DM01 return. Ongoing meetings with BI team to resolve. Reviewing if referral reason and cancellation rules are all being appropriately applied. Inability to recruit to audiology posts due to lack of suitable candidates, especially at the East Coast.

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

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	2025-04		F	62.7%	68.9%	82.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2025-04		F	58.4%	66%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2025-04		?	60.7%	68%	78%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2025-04		?	68.5%	65%	75%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2025-04	L	?	51.1%	80.7%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2025-04	H	?	79.9%	50.9%	67.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2025-04	L	F	47%	76.7%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2025-04	H	F	70.1%	91.9%	95.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2025-04		?	96.4%	90.5%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2025-04	H	?	79.1%	84.3%	94.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2025-04		F	30.2%	54.8%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2025-04		F	55.9%	80.6%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2025-04	H	F	68.6%	81%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2025-04		?	53.8%	83.2%	94.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2025-04		F	74.4%	79.6%	90%

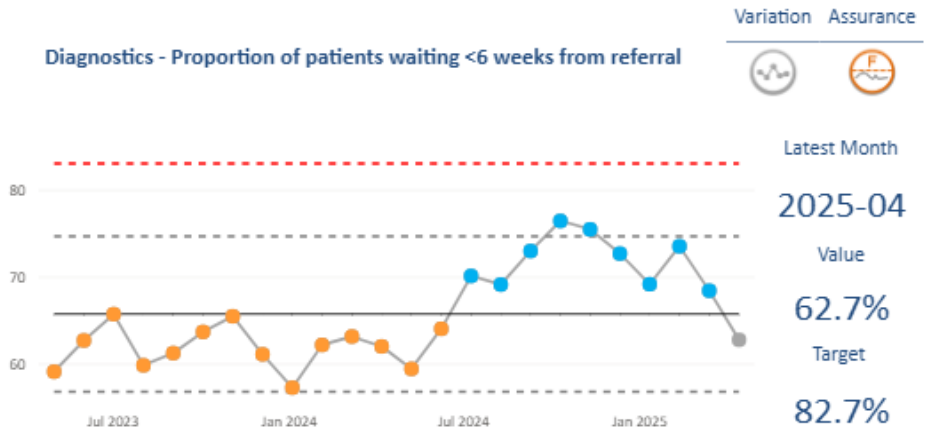
KPIs – Operational Activity and Performance

Diagnostics (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

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 to above 82.7% by end of March 2026.

Actions:

Endoscopy:

- The Scarborough Gastro team are adding another full-time locum, start date is to be confirmed but anticipated to be early May and this will provide an improvement to performance.
- The York Gastro team have also added an additional consultant on a 3-month contract, which will provide a further 2 – 3 endoscopy sessions a week from May.
- Workforce plan in progress for the next 3 years and currently focused on bolstering nurse staffing. York have successfully recruited to 5 RN posts; East Coast staffing remains a challenge.

Imaging:

- Capital programme scheme worked up to replace all 3 scanners at York. CT3 at York will be replaced January 2026. CT1 and CT2 will not be until financial year 2026/27. Contract awarded to deliver cardiac CT to get through backlog, start date TBC but expected to be imminent. This will deliver improved CT performance. Temporary mobile unit was brought in to broach the gap until the new CT in the Scarborough UEC opened. This is now up and running but the mobile unit will remain in place for a further 2 week overlap to provide some additional cover.
- New York MRI (MRI3) 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 2025 start date. Will need insourced radiographer capacity to support roll out due to timescales for recruitment and training
- DEXA recovery is underway, and performance improvement is visible in the April data.
- 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 GI specialist Consultant Radiologist, though start is not anticipated until September 2026 due to fellowship programme.

Physiological:

- A new echocardiographer started in Scarborough in mid-April, and a second will begin mid-May. Recovery plan is in place to fully recover position by the end of the financial year.
- Nurse post recruited to for Urodynamics which will support performance recovery, start date in June. The post will require a 3–6] month training period.
- Requested investment in 3 WTE audiologist posts as part of 25/26 planning to deliver DM01. Order to be placed in May 2025 for 2 x pop-up booths (one for Malton and one for Bridlington) to deliver additional audiology capacity.

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 - Patients waiting over 12 hours in department	* Children & Young Persons: ED - Emergency Care Standard (Type 1 only) * Children & Young Persons: RTT - Total Waiting List * Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks
SPECIAL CAUSE CONCERN			

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

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

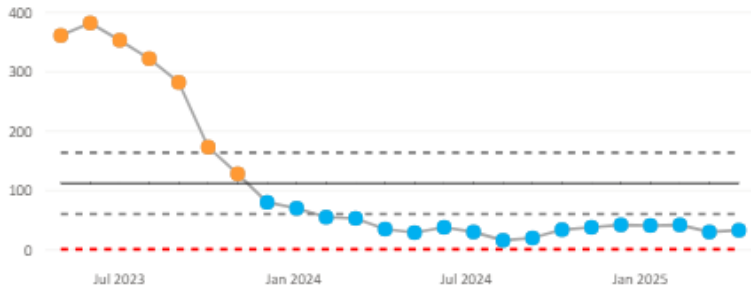
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2025-04			10		0
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2025-04			81.4%		95%
Children & Young Persons: RTT - Total Waiting List	2025-04			4260	3947	3206
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-04			62.2%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2025-04			32	52	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi

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

Variation Assurance



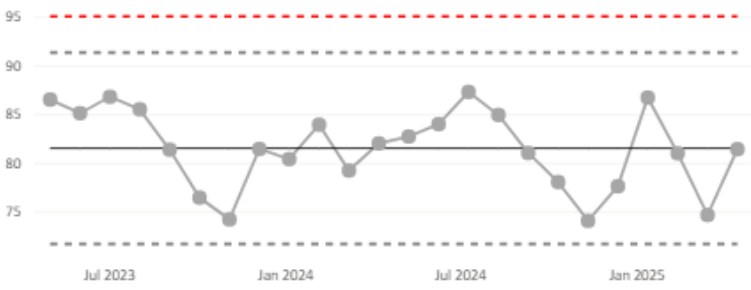
Latest Month
2025-04
Value
32
Target
0

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

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

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

Variation Assurance



Latest Month
2025-04
Value
81.4%
Target
95%

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 **6.8**.

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 by end of September 2025. **SPC2:** NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2026.

Factors impacting performance:

- **SPC1:** The Trust delivered the trajectory for RTT52 weeks wait for patients aged under eighteen with 32 against an external trajectory of 52.
- **SPC2:** ECS performance for CYP deteriorated from 74.6% in March 2025 to 81.4% in April 2025 however this is not a statistical improvement remaining within the unstable variance seen over the last two years.

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 and are planning the same in May. Regular additional day case lists at Scarborough are being explored.
- **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 was 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 open Virtual Ward beds * Total Urgent Community Response (UCR) referrals * Number of people on waiting lists for CYP services per system who are waiting over 52 weeks
COMMON CAUSE / NATURAL VARIATION		* 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	2025-04	H	F	33	33	33
Proportion of Virtual Ward beds occupied	2025-04		?	72.7%	79%	79%
Community Response Team (CRT) Referrals	2025-04	H		502		
Total Urgent Community Response (UCR) referrals	2025-04	H	F	469	522	566
2-hour Urgent Community Response (UCR) care Referrals	2025-04	H		119		
2-hour Urgent Community Response (UCR) Compliancy %	2025-04			79%		
Number of Adults (18+ years) on community waiting lists per system	2025-04			748		
Number of CYP (0-17 years) on community waiting lists per system	2025-04	L		1941		
Number of District Nursing Contacts	2025-04			21376		
Number of Selby CRT Contacts	2025-04			2587		
Number of York CRT Contacts	2025-04			3936		
Referrals to District Nursing Team	2025-04			2109		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2025-04	L	F	699	702	0

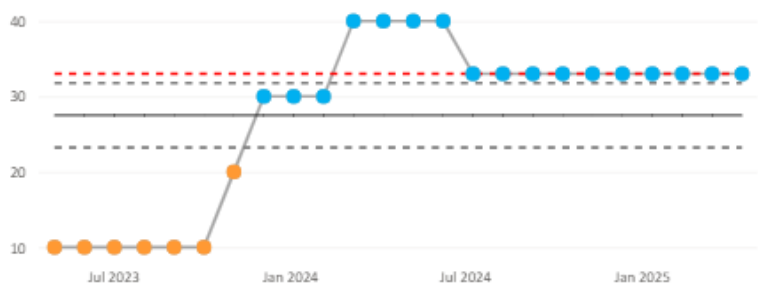
Executive Owner: Claire Hansen

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 79% virtual ward bed occupancy as per activity plan.

Variation Assurance

Number of open Virtual Ward beds



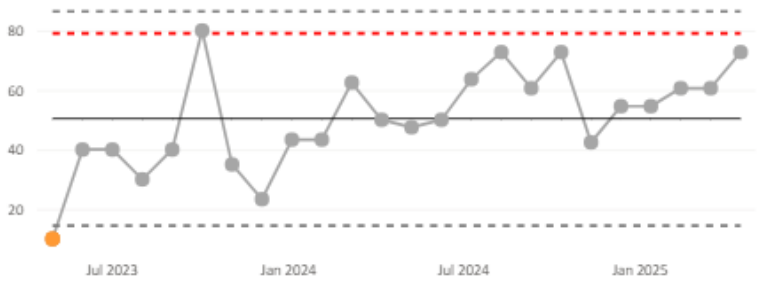
Latest Month
2025-04
Value
33
Target
33

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**.

Variation Assurance

Proportion of Virtual Ward beds occupied



Latest Month
2025-04
Value
72.7%
Target
79%

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 **12.1**.

The ambition for the virtual ward utilisation rate is 79%; at the most recent snapshot occupancy was 72.7%, an improvement on recent months but with no statistical change as performance was within the variance seen over the last two years.

Frailty Virtual Ward (FVW): One key area of focus is building on the weekend model; second Trust grade medic to join 6th May 2025 to support this. The development of a new IV antibiotic and IV frusemide pathways as a step up for patients in their own home is underway, with skills development in progress. This IV antibiotic pathway is yet to be agreed with microbiology.

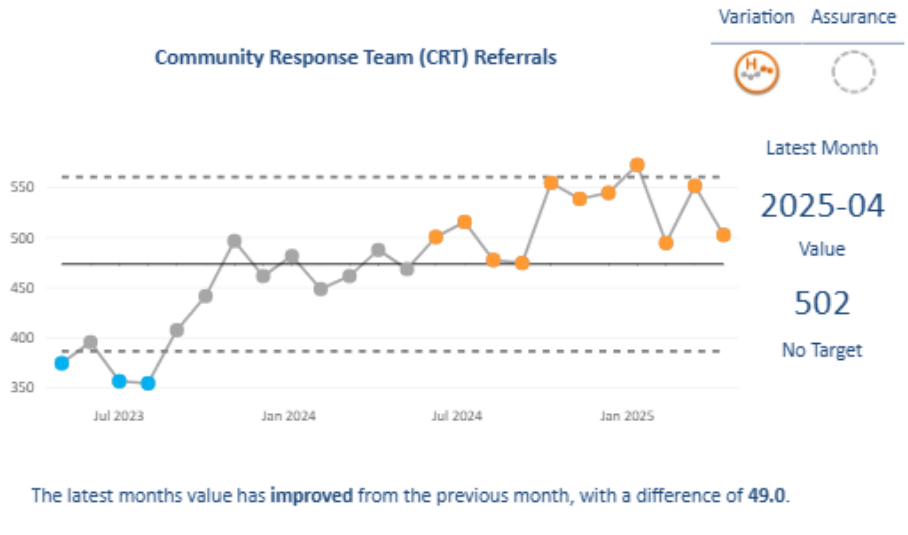
Heart Failure (HFVW): Full model design for the ED in-reach pilot is underway. Two rounds of recruitment have been unsuccessful, decision has been taken to delay until June 2025, while changes in guidance and approach are being agreed. Team met with GIRFT cardiology clinical lead to review the HFVW and now waiting for final GIRFT report. .

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.

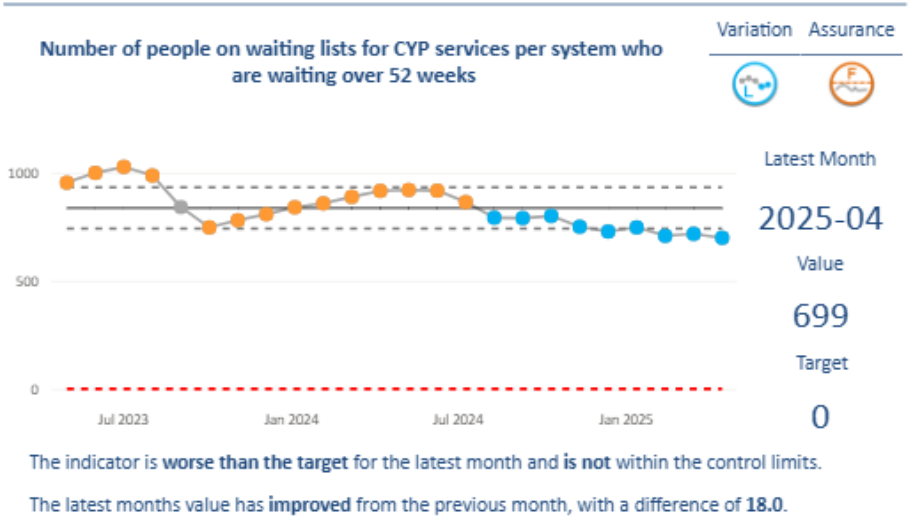
Cystic Fibrosis (CFVW): Some patients benefit from staying at home during a period of being acutely unwell, and the system allows a virtual model of care for up to three patients. There is not 'spare' capacity, the team works differently to support appropriate patients, and numbers will remain low due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

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **49.0**.



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 **18.0**.

Rationale: To monitor demand on Community services.
Target: SPC1: No target. **SPC2:** zero waiting over 52 weeks by end of March 2026 as per activity planning submission.

Factors impacting performance:

- **SPC1:** Referrals to Community Response Teams remain above the average control for the 11th consecutive month. 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 decreased to 699 at the end of April 2025, the 9th consecutive month that it has been below the average control limit with the last three months below the lower control limit. 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. The Community Teams delivered 38,886 care contacts during April 2025, ahead of the trajectory of 37,390 submitted as part of 2025/26 annual planning.
- **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.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

QUALITY AND SAFETY

May 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		* Harmful Incidents per thousand bed days	
COMMON CAUSE / NATURAL VARIATION		* Total Number of Trust Onset MSSA Bacteraemias * Total Number of Trust Onset MRSA Bacteraemias * Total Number of Trust Onset C. difficile Infections * Total Number of Trust Onset E. coli Bacteraemias * Total Number of Trust Onset Klebsiella Bacteraemias * Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias * Pressure Ulcers per thousand Bed Days * Patient Falls per thousand Bed Days * Medication incidents per thousand bed days * Patient Safety Incidents per thousand Bed Days * Monthly SHMI * Monthly HSMR	
SPECIAL CAUSE CONCERN		* Total Number of Never Events Reported	

Quality & Safety
Scorecard (1)

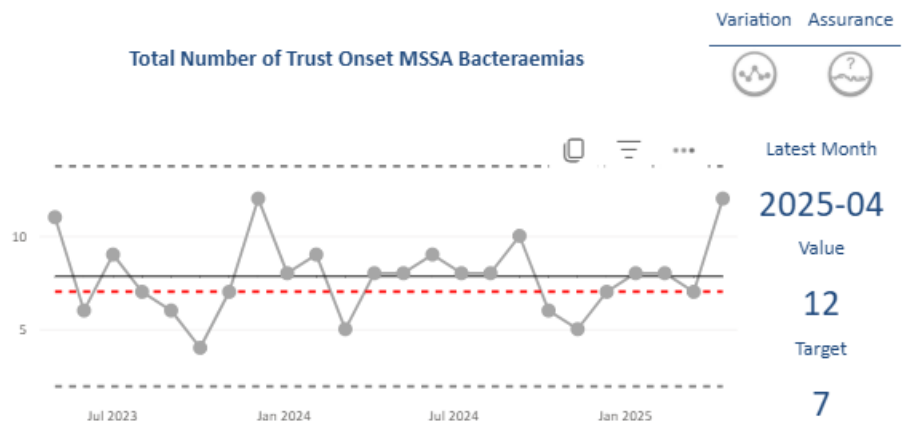
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

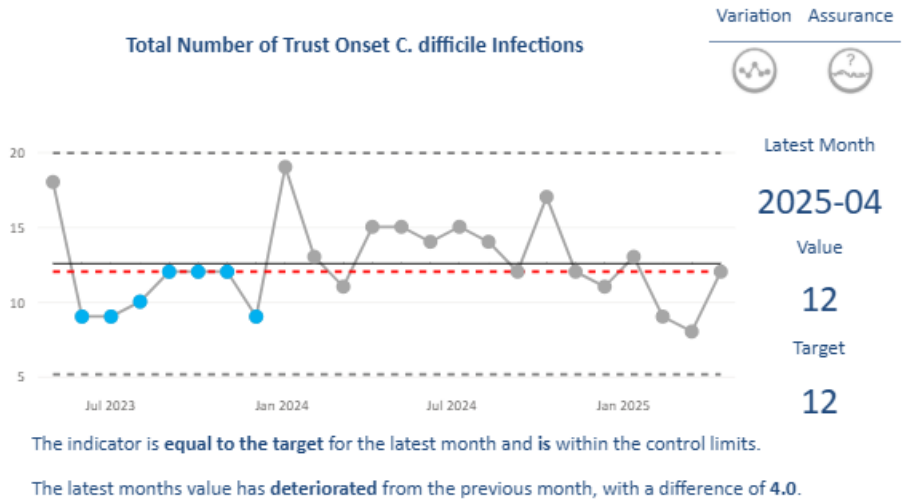
Executive Owner: Dawn Parkes **Operational Lead:** Sue Peckitt

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2025-04			12	7	7
Total Number of Trust Onset MRSA Bacteraemias	2025-04			1		0
Total Number of Trust Onset C. difficile Infections	2025-04			12	12	12
Total Number of Trust Onset E. coli Bacteraemias	2025-04			17	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2025-04			4	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2025-04			1	1	2
Pressure Ulcers per thousand Bed Days	2025-04			3.9		4
Patient Falls per thousand Bed Days	2025-04			6.7		8.7
Medication incidents per thousand bed days	2025-04			5.1		5

Executive Owner: Dawn Parkes

Operational Lead: Sue Peckitt





Rationale: To drive reduction in avoidable health care associated infection (HCAI), facilitate patient safety and improve patient outcomes

Target: National thresholds for 2025/26 have not yet been released but we are assuming this will be a 5% reduction on the 2024/25 year end position.

Factors impacting performance:

- The Trust has equalled or exceeded all of the year-to-date HCAI targets except for Klebsiella bacteraemia
- MSSA bacteraemia - 12 cases recorded in April, 9 cases attributed to Medicine Care Group, 2 attributed to Surgery Care Group, 1 case to the CSCS group. 25% of the cases are attributed to Scarborough Hospital, 17% of the cases are attributed to Community Units and 58% of the cases are attributed to York Hospital. The Trust is 5 cases over the year ton date objective.
- The Trust has recorded 1 MRSA Bacteraemia cases in April against a zero objective. A post infection revie meeting has been held to determine learning and improvement actions.
- 12 Trust attributed Clostridioides difficile cases recorded in April against a trajectory of 12. Of the 12 cases 50% were attributed to York Hospital, 42% attributed to Scarborough Hospital and 8% attributed to the community units.

Actions:

- The care group IPC/AMS meetings are all now established, and they are taking ownership of improvement requirements.
- Clostridioides difficile cases are reviewed using PSIRF approach, learning identified is being addressed via the Care Group IPC/AMS meetings.
- All MSSA/MRSA 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.
- The focus for 2025/26 will be on prevention of avoidable bacteraemia's. An MSSA bacteraemia improvement plan in in development and a drive to improve VIP scoring and documentation has commenced with an educational video being developed for launch in May 2025.
- All care groups will be represented at the forthcoming HNY ICB workshop on Gram Negative Blood Stream Infections.

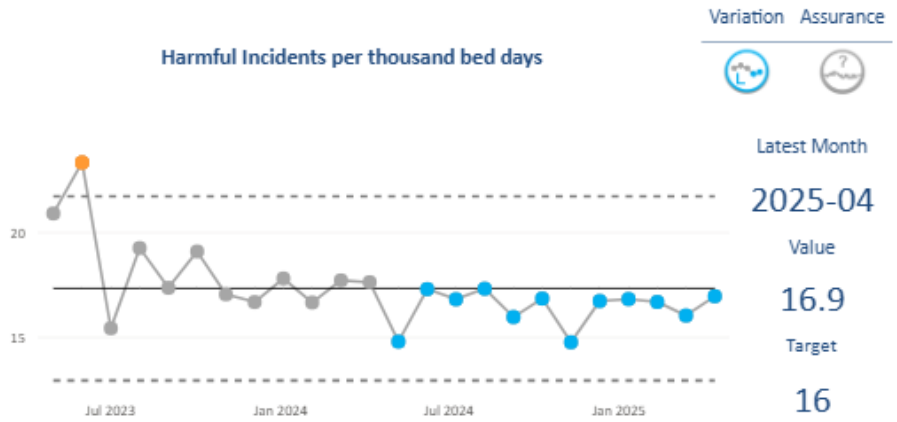
Quality & Safety
Scorecard (2)

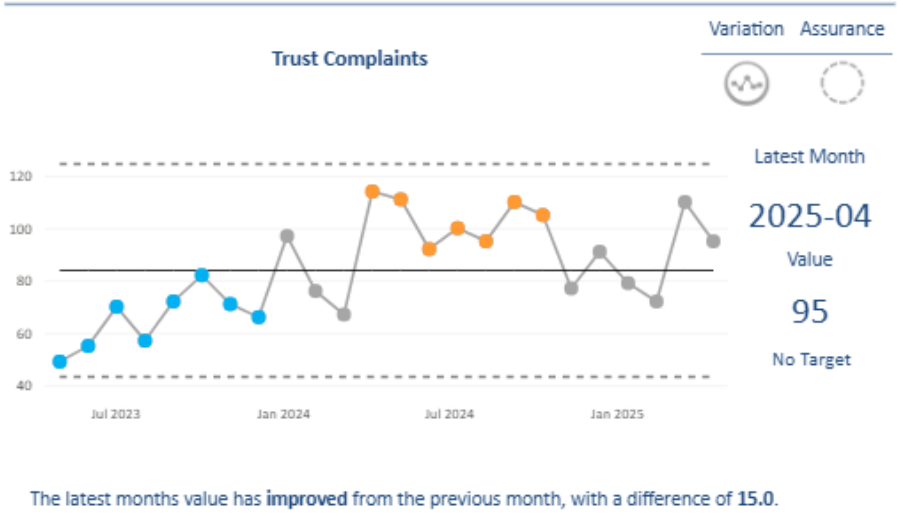
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-04			50.3		53
Harmful Incidents per thousand bed days	2025-04			16.9		16
Total Number of Never Events Reported	2025-04			3		0
In-Hospital Deaths	2025-04			186		
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	2025-04			95		
Antepartum Stillbirths	2025-03			2		
Intrapartum Stillbirths	2025-03			0		
Early neonatal deaths (0-7 days)	2025-03			1		
PPH > 1.5L as % of all women - York	2025-03			2.4%		
PPH > 1.5L as % of all women - Scarborough	2025-03			1.8%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2025-03			38.7%		

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





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 decreased this month. Of the 95 new complaints recorded (versus 110 in March 2025), with 12 being complex complaints:
- ED York (11) - main theme attitude of nursing staff (4) food and hydration (3)
- Frailty assessment unit - main theme attitude of staff (3)
- Emergency Medicine Medical Team York - main theme delay or failure in treatment or procedure (3)
- General medicine medical Team York - main theme delay or failure in treatment or procedure (3)
- Ward 25 - main theme communication with patient (3)

The proportion of twelve-hour trolley waits (time from decision to admit to time of admission) and Type 1 patients spending over 12 hours in our ED's deteriorated against the previous month but were within the control limits.

The impact of the Norovirus outbreak at York impacting the number of open beds negatively impacted patient flow out of the hospital and resulted in less ability to implement continuous flow to the wards from ED. The outbreak also resulted in the closing of wards in York and Scarborough to visitors which negatively impacted patient experience.

Within Endoscopy since limited consultant cover at Scarborough, has impacted on the ability to deliver planned lists. Elective lists have had to be cancelled on both sites to accommodate York consultants travelling to Scarborough on occasion to provide acute cover.

CT1 at Scarborough has been permanently decommissioned and faults with CT2 and continued intermittent breakdowns of CT1 and 2 at York has impacted delivery of the service.

Actions:

Average ambulance handover time in April 2025 was ahead of trajectory at 34 minutes 27 seconds."Withdraw at 45" (W45) will be launching in Scarborough in May 2025.

Communications and complaints writing workshops are being scheduled for delivery in Q1..

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

May 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	* Women affected by suspension - Scarborough * L/W Co-ordinator supernumerary % - Scarborough	* Planned homebirths - Scarborough
COMMON CAUSE / NATURAL VARIATION	* Bookings - Scarborough	* Bookings ≥13 weeks (exc transfers etc.) - Scarborough * Births - Scarborough * No. of women delivered - Scarborough * Maternity Unit Closure - Scarborough * SCBU at capacity - Scarborough * 1 to 1 care in Labour - Scarborough	* Bookings <10 weeks - Scarborough * Anaesthetic cover on L/W - Scarborough
SPECIAL CAUSE CONCERN		* SCBU at capacity of intensive care cots - Scarborough * SCBU no of babies affected - Scarborough	* 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 * Elective caesarean - Scarborough * Emergency caesarean - Scarborough * Induction of labour - Scarborough * HDU on L/W - Scarborough * BBA - Scarborough * HSIB cases - Scarborough * Neonatal Death - Scarborough * Antepartum Stillbirth - Scarborough * Cold babies - Scarborough * Preterm birth rate <37 weeks - Scarborough * Preterm birth rate <34 weeks - Scarborough * Preterm birth rate <28 weeks - Scarborough	
SPECIAL CAUSE CONCERN		* Normal Births - Scarborough * C/S Births - 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	2025-03	L	?	49.1%		57%	Target
Assisted Vaginal Births - Scarborough	2025-03		?	7.1%		12.4%	Target
C/S Births - Scarborough	2025-03	H	?	43.8%		43.4%	Baseline
Elective caesarean - Scarborough	2025-03		?	20.5%		17.8%	Baseline
Emergency caesarean - Scarborough	2025-03		?	23.2%		25.6%	Baseline
Induction of labour - Scarborough	2025-03		?	44.1%		44%	Baseline
HDU on L/W - Scarborough	2025-03		?	2		5	Target
BBA - Scarborough	2025-03		?	1		2	Target
HSIB cases - Scarborough	2025-03		?	0		0	Target
Neonatal Death - Scarborough	2025-03		?	1		0	Target
Antepartum Stillbirth - Scarborough	2025-03		?	1		0	Target
Intrapartum Stillbirths - Scarborough	2025-03		P	0		0	Target
Cold babies - Scarborough	2025-03		?	1		1	Target
Preterm birth rate <37 weeks - Scarborough	2025-03		?	1.8%		6%	Target
Preterm birth rate <34 weeks - Scarborough	2025-03		?	0%		1%	Target
Preterm birth rate <28 weeks - Scarborough	2025-03		?	1.8%		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		* Low birthweight rate at term (2.2kg) - Scarborough * Breastfeeding Initiation rate - Scarborough * Breastfeeding rate at discharge - Scarborough * Smoking at 36 weeks - Scarborough * Smoking at time of delivery - Scarborough * Carbon monoxide monitoring at booking - Scarborough * Carbon monoxide monitoring at 36 weeks - Scarborough * PPH > 1.5L as % of all women - Scarborough * Shoulder Dystocia - Scarborough * 3rd/4th Degree Tear - normal births - Scarborough * 3rd/4th Degree Tear - assisted birth - Scarborough * Informal Complaints - Scarborough * Formal Complaints - Scarborough	
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - Scarborough	2025-03			0.9%		0%	Target
Breastfeeding Initiation rate - Scarborough	2025-03			71.4%		75%	Target
Breastfeeding rate at discharge - Scarborough	2025-03			43.2%		65%	Target
Smoking at booking - Scarborough	2025-03			12.8%		6%	Target
Smoking at 36 weeks - Scarborough	2025-03			7.3%		6%	Target
Smoking at time of delivery - Scarborough	2025-03			8.1%		6%	Target
Carbon monoxide monitoring at booking - Scarborough	2025-03			91.4%		95%	Target
Carbon monoxide monitoring at 36 weeks - Scarborough	2025-03			75.6%		95%	Target
SI's - Scarborough	2023-10			1		0	Target
PPH > 1.5L as % of all women - Scarborough	2025-03			1.8%		2.1%	Baseline
Shoulder Dystocia - Scarborough	2025-03			0		2	Target
3rd/4th Degree Tear - normal births - Scarborough	2025-03			0%		0%	Target
3rd/4th Degree Tear - assisted birth - Scarborough	2025-03			0%		0%	Target
Informal Complaints - Scarborough	2025-03			1		0	Target
Formal Complaints - Scarborough	2025-03			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	2025-03		P	94		169	Target
Bookings <10 weeks - Scarborough	2025-03		F	74.4%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2025-03		?	10.6%		10%	Target
Births - Scarborough	2025-03		?	111		113	Target
No. of women delivered - Scarborough	2025-03		?	111		112	Target
Planned homebirths - Scarborough	2025-03	H	F	2.7%		2.1%	Target
Homebirth service suspended - Scarborough	2025-01	H	F	24		3	Target
Women affected by suspension - Scarborough	2025-03	L	?	0		0	Target
Community midwife called in to unit - Scarborough	2025-03	L	P	0		3	Target
Maternity Unit Closure - Scarborough	2024-12		?	2		0	Target
SCBU at capacity - Scarborough	2025-03		?	4		1	Baseline
SCBU at capacity of intensive care cots - Scarborough	2025-03	H	?	11		4.9	Baseline
SCBU no of babies affected - Scarborough	2025-03	H	?	1		0	Target
1 to 1 care in Labour - Scarborough	2025-03		?	100%		100%	Target
L/W Co-ordinator supernumerary % - Scarborough	2025-03	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 * L/W Co-ordinator supernumerary % - York	
COMMON CAUSE / NATURAL VARIATION	* Bookings ≥13 weeks (exc transfers etc.) - York * Community midwife called in to unit - York * Anaesthetic cover on L/W - York	* Bookings - York * Bookings <10 weeks - York * Births - York * No. of women delivered - York * Planned homebirths - York * Homebirth service suspended - York * Women affected by suspension - York * Maternity Unit Closure - York * SCBU at capacity of intensive care cots - York * SCBU no of babies affected - York * 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	2025-03			287		295	Target
Bookings <10 weeks - York	2025-03			77.7%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - York	2025-03		P	1.4%		10%	Target
Births - York	2025-03			210		245	Target
No. of women delivered - York	2025-03			206		242	Target
Planned homebirths - York	2025-03			0%		2.1%	Target
Homebirth service suspended - York	2025-03			6		3	Target
Women affected by suspension - York	2025-03			1		0	Target
Community midwife called in to unit - York	2025-03		P	0		3	Target
Maternity Unit Closure - York	2025-03			0		0	Target
SCBU at capacity - York	2025-03	L		0		0.2	Baseline
SCBU at capacity of intensive care cots - York	2025-03			29		22	Baseline
SCBU no of babies affected - York	2025-03			3		0	Target
1 to 1 care in Labour - York	2025-03			100%		100%	Target
L/W Co-ordinator supernumerary % - York	2025-03	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		* Induction of labour - York	
COMMON CAUSE / NATURAL VARIATION	* Intrapartum Stillbirths - York	* Normal Births - York * Assisted Vaginal Births - York * Elective caesarean - York * Emergency caesarean - York * BBA - York * HSIB cases - York * Neonatal Death - York * Antepartum Stillbirth - York * Cold babies - York * Preterm birth rate <37 weeks - York * Preterm birth rate <34 weeks - York * Preterm birth rate <28 weeks - York	
SPECIAL CAUSE CONCERN		* C/S Births - 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	2025-03			52.1%		57%	Target
Assisted Vaginal Births - York	2025-03			5.2%		12.4%	Target
C/S Births - York	2025-03	H		42.7%		35.4%	Baseline
Elective caesarean - York	2025-03			19%		14.8%	Baseline
Emergency caesarean - York	2025-03			23.7%		20.6%	Baseline
Induction of labour - York	2025-03	L		37.4%		44.7%	Baseline
HDU on L/W - York	2025-03			7		5	Target
BBA - York	2025-03			2		2	Target
HSIB cases - York	2025-03			0		0	Target
Neonatal Death - York	2025-03			0		0	Target
Antepartum Stillbirth - York	2025-03			1		0	Target
Intrapartum Stillbirths - York	2025-03		P	0		0	Target
Cold babies - York	2025-03			1		1	Target
Preterm birth rate <37 weeks - York	2025-03			5.7%		6%	Target
Preterm birth rate <34 weeks - York	2025-03			3.8%		2%	Target
Preterm birth rate <28 weeks - York	2025-03			0%		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		* Low birthweight rate at term (2.2kg) - York * Smoking at booking - York * Smoking at 36 weeks - York * Smoking at time of delivery - York * Carbon monoxide monitoring at booking - York * PPH > 1.5L as % of all women - York * Shoulder Dystocia - York * 3rd/4th Degree Tear - normal births - York * 3rd/4th Degree Tear - assisted birth - York * Informal Complaints - York * Formal Complaints - York	* Carbon monoxide monitoring at 36 weeks - York
SPECIAL CAUSE CONCERN	* Breastfeeding Initiation rate - York	* Breastfeeding rate at discharge - York	

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	2025-03			0.5%		0%	Target
Breastfeeding Initiation rate - York	2025-03	L	P	66.6%		75%	Target
Breastfeeding rate at discharge - York	2025-03	L		51.9%		65%	Target
Smoking at booking - York	2025-03			4.8%		6%	Target
Smoking at 36 weeks - York	2025-03			4%		6%	Target
Smoking at time of delivery - York	2025-03			5.8%		6%	Target
Carbon monoxide monitoring at booking - York	2025-03			85.4%		95%	Target
Carbon monoxide monitoring at 36 weeks - York	2025-03		F	73.7%		95%	Target
SI's - York	2025-03			0		0	Target
PPH > 1.5L as % of all women - York	2025-03			2.4%		4.1%	Baseline
Shoulder Dystocia - York	2025-03			4		2	Target
3rd/4th Degree Tear - normal births - York	2025-03			1.4%		0%	Target
3rd/4th Degree Tear - assisted birth - York	2025-03			0%		0%	Target
Informal Complaints - York	2025-03			1		0	Target
Formal Complaints - York	2025-03			0		0	Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

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

Workforce
Scorecard (1)

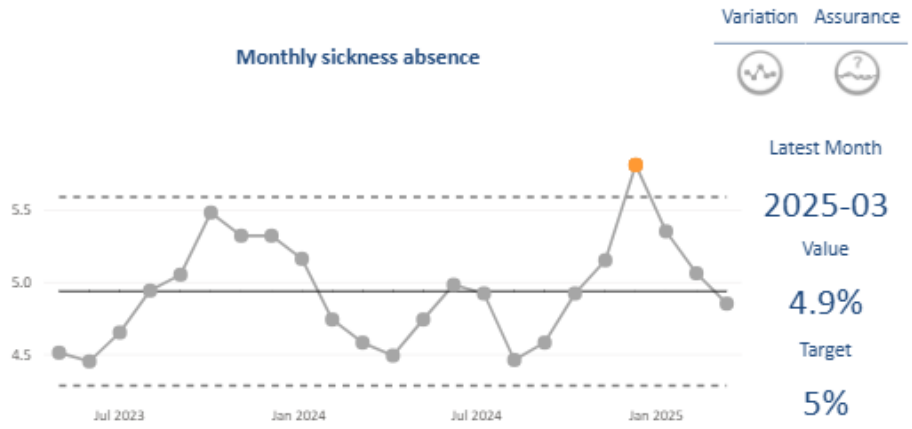
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2025-03			4.9%		5%
Annual absence rate	2025-03	L	F	5%	4.3%	4.3%
12 month rolling turnover rate Trust (FTE)	2025-04	L	P	8.3%		10%
Overall vacancy rate	2025-04			6.5%		6%
HCSW vacancy rate	2025-04	L	F	9.8%		5%
Midwifery vacancy rate	2025-04	H		1.1%		0%
Medical and dental vacancy rate	2025-04			7.7%		6%
Registered Nursing vacancy rate	2025-04			6.3%		5%
AHP vacancy rate	2025-04			8.1%		8.5%
Total Agency Whole Time Equivalent Filled	2025-03	L		108		151
Total Bank Whole Time Equivalent Filled	2025-03			686.5		557
OVERALL: Percentage of rosters approved six weeks before start date	2025-03		F	18.6%		100%
NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent	2025-03	L		3633.1	0	0
NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom)	2025-03		F	31%	22%	22%

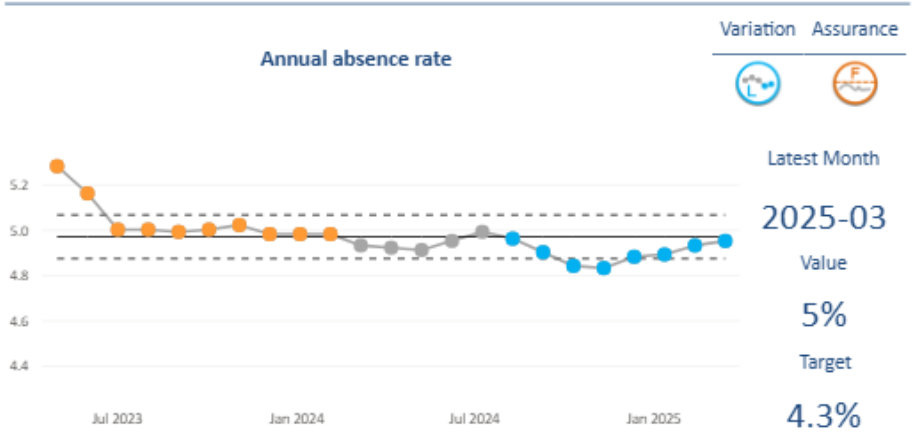
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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 **0.2**.



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 **0.1**.

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

Factors impacting performance and actions:

Monthly sickness decreased slightly from February (0.2% reduction). Anxiety and stress-related illness continued to be the highest contributor to absence with just over a quarter of all sickness being in this category (115.08 WTE). Absence related to gastrointestinal problems rose slightly from 7.9% to 10.1% (36.86 WTE to 45.24 WTE), while cold/'flu accounted for 10% of all absences in March.

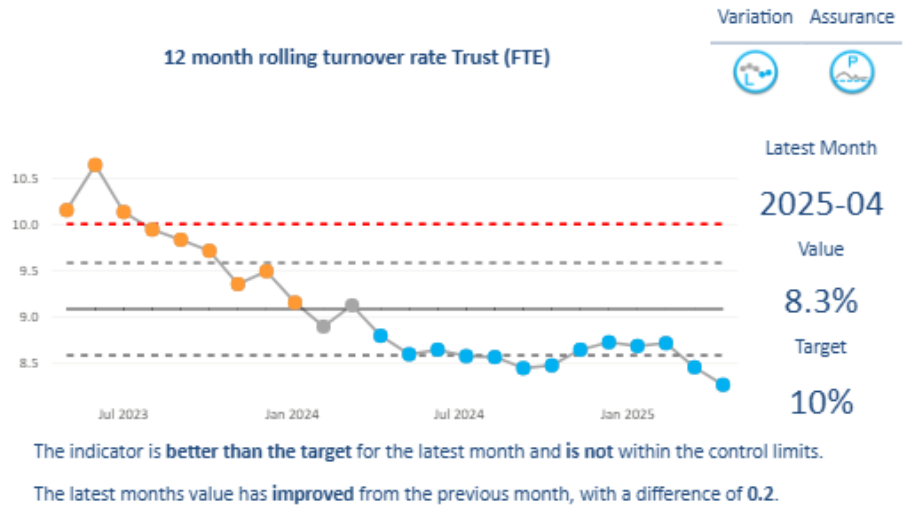
Work is ongoing to reduce absence and support colleagues' wellbeing. Recent developments include:

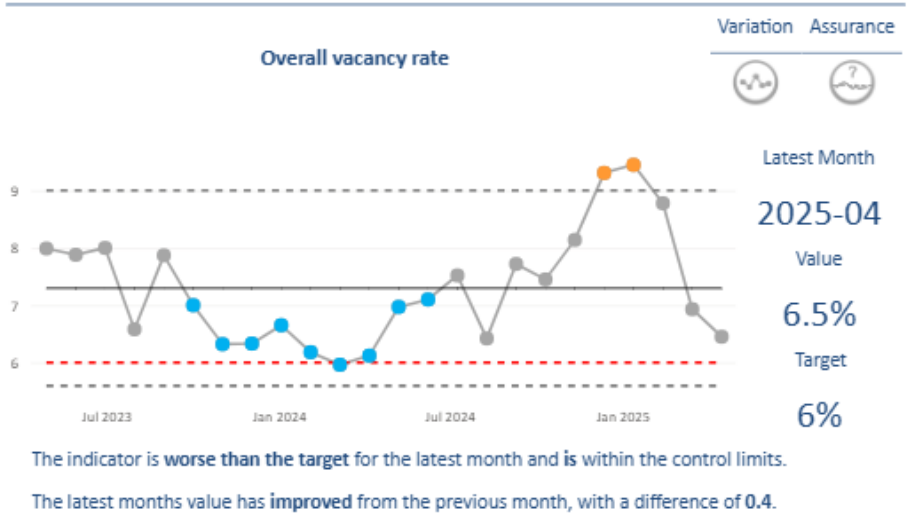
- The introduction of text message reminders for colleagues booked to attend Occupational Health (OH). Although only operational for a few weeks, this already appears to be contributing to a small reduction in DNA rates.
- Our Employee Assistance service now includes an online platform, Ele, which has thousands of supportive resources to encourage colleagues to take time for their health and wellbeing. This is free to access, 24/7, to all colleagues.
- A hybrid model of peer and OH vaccinators has been agreed for the 2025 'Flu Vaccination Campaign, with the incentive of one day annual leave as part of a prize draw to encourage uptake.

The latest results from the National Quarterly Pulse Survey showed a higher response rate amongst Trust staff (8%) than in the previous quarter (6%). The Trust's scores for engagement are below the NHS average; however, there was some improvement including the overall engagement score which was 6.01. It was 5.64 in the previous quarter and 5.42 in April 2024.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

Factors impacting performance and actions:

Recruitment restrictions remain in place through the enhanced vacancy control process. At the end of March 2025, the Trust was 2.3% (226 WTE) above its 2024-25 planned workforce size. This is largely attributable to a combination of filling vacancies and covering absences. The substantive workforce grew by 8 WTE from February. Bank workforce also increased by 13 WTE although this was exceeded by a reduction in agency workforce (14 WTE).

The vacancy reduction in April shown in the chart opposite is attributable to a 29 WTE reduction in budgeted establishments.

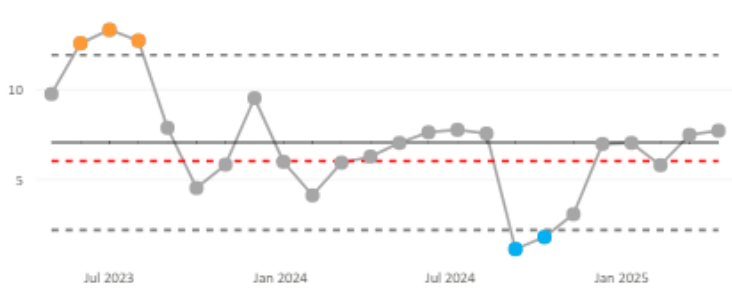
Following new directions from NHS England, the Trust is currently in the process of revising its operational plans for 2025-26. The new instructions include a requirement to achieve a £5.4 million reduction in the cost of corporate services. This forms part of a wider programme of cost improvement that includes commitments to reduce the size of the temporary workforce (bank and agency) by 117 WTE in the 12-months to March 2026.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Variation Assurance

Medical and dental vacancy rate



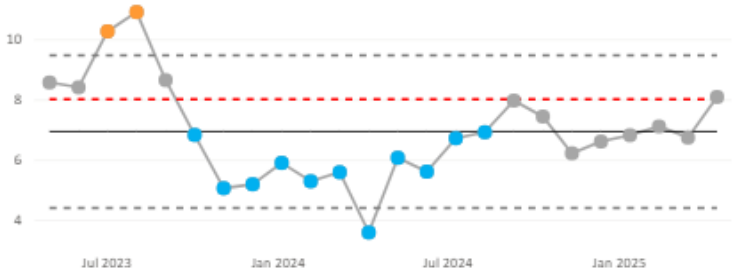
Latest Month
2025-04
Value
7.7%
Target
6%

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**.

Variation Assurance

AHP vacancy rate



Latest Month
2025-04
Value
8.1%
Target
8.5%

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 **1.4**.

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 April, the Trust welcomed 12 new medical staff including four permanent consultants within Gastroenterology, Palliative Care and Dermatology.

In addition, 14 offers of employment in medical posts were made, including five consultant posts, with two being for permanent posts in General Surgery.

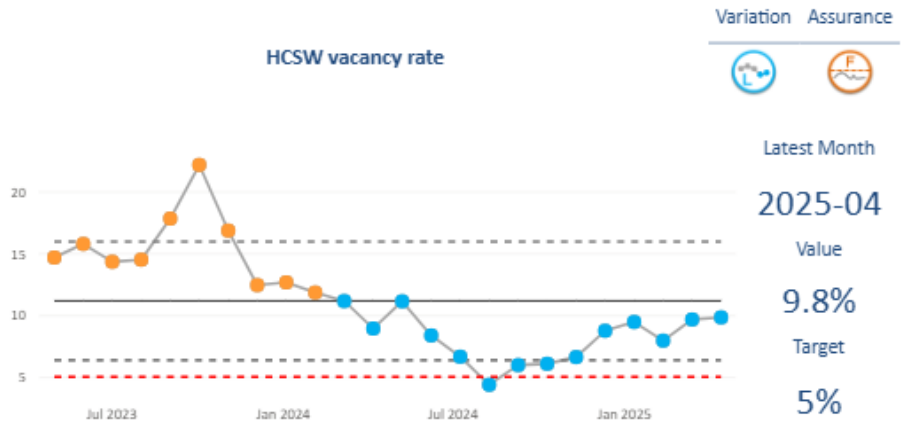
The Trust is starting to receive trainee grids in preparation for August changeover.

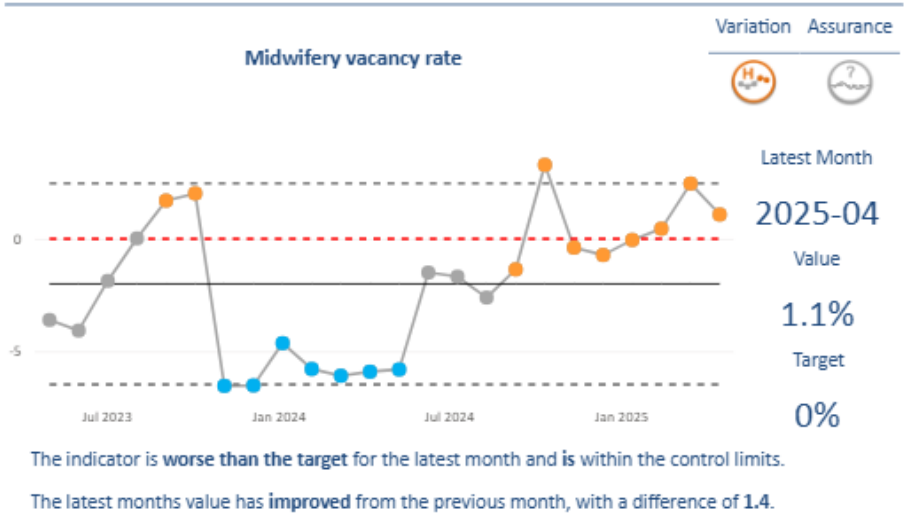
At the start of May, the Trust welcomed six internationally educated nurses following their successful completion of the Bridging Course, created in conjunction with schools of nursing in Kerala, India. The nurses have started their OSCE training and preparing for their exam next month.

17 Pre-Registration Allied Health Professionals are due to join the organisation over the summer months.

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:

Following the recent completion of nursing inpatient establishment reviews, plans are being made to look at increasing use of Long Day shifts on wards. This has the potential to make rosters more efficient and reduce the level of establishments for Health Care Support Workers (HCSWs) and Registered Nurses (RNs). This would allow for some budget to be re-allocated to increase the level of time allocated for ward management. A further impact of the reconfiguration is that it would reduce vacancy rates with HCSW vacancies falling by as many as 41 WTE (-3.2% from the current vacancy rate).

There are currently 26.89 WTE HCSWs undertaking pre-employment checks with the Trust. A further 14.53 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. Although the headcount remains the same between March and April (66) the WTE has increased slightly from 60.07 to 60.67 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								
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
Mar-25	2599.22	125.62	117.04	314.20	71.54	212.90	54.90	25.14
HCA								
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
Mar-25	1278.48	123.17	56.03	292.20	113.00	243.00	0.00	63.80
M&D								
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
Mar-25	1105.25	82.47	47.49	153.00	23.04	93.90	51.60	15.54

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.

The Collaborative Bank has gone live, enabling nursing staff to book shifts across partnering organisations in the region. The Trust is yet to receive any bookings but continues to work with system partners around the development of the Collaborative Bank and increasing staff membership. The next step of the collaborative is to explore expanding the service to cover medical roles.

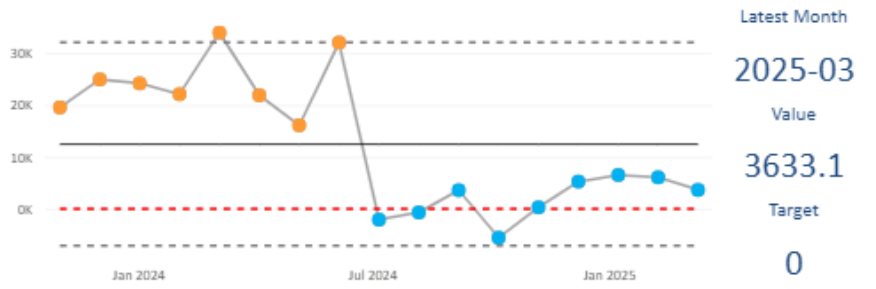
At the end of April, the Trust completed the transition to bring the management of medical agency use in house. Historically, this service has been provided by a master vendor contract, which attracted a service fee for the organisation. By bringing the service in-house, the Trust is predicted save over £120k per annum and will have direct control of the relationship with agency suppliers, supporting the negotiation of rates and helping to reduce agency costs further. Through transition to an in-house service, the Trust has put in place the system and processes to maintain the 100% direct engagement (DE) rate for medical agency bookings. DE is considered the most cost-effective approach for agency bookings.

The Trust has been monitoring the number of administrative bank shifts undertaken each month. 642 shifts were worked in April which is a notable reduction from the previous month, when 732 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



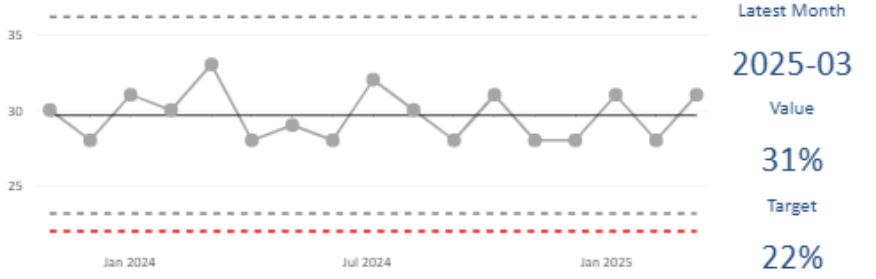
Latest Month
2025-03
Value
3633.1
Target
0

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 **2425.6**.

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

Variation Assurance



Latest Month
2025-03
Value
31%
Target
22%

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

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

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:
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 only 50% of rosters were published on time (down from 85%), with 41% of rosters for non-IPUs (down from 55%). 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	21%	12	33.02%
Non-IPU's	0%	0	41%	46	32%
AHPs	0%	0	95%	53	32%

74% of the workforce are now on HealthRoster. The Trust is aiming to have 90% of the clinical workforce on eRostering by Summer 2025. There are just two staffing groups remaining to achieve this.

Staffing Group	% on Healthroster	Staffing Group	% on Healthroster
Nursing and Midwifery	99%	AHP	99%
Additional Clinical Services	91%	Healthcare Scientists	69%
Sci and Technical	94%	Medical and Dental	58%
Admin and Clerical	55%	Estates and Ancillary	4%

Workforce
Scorecard (2)

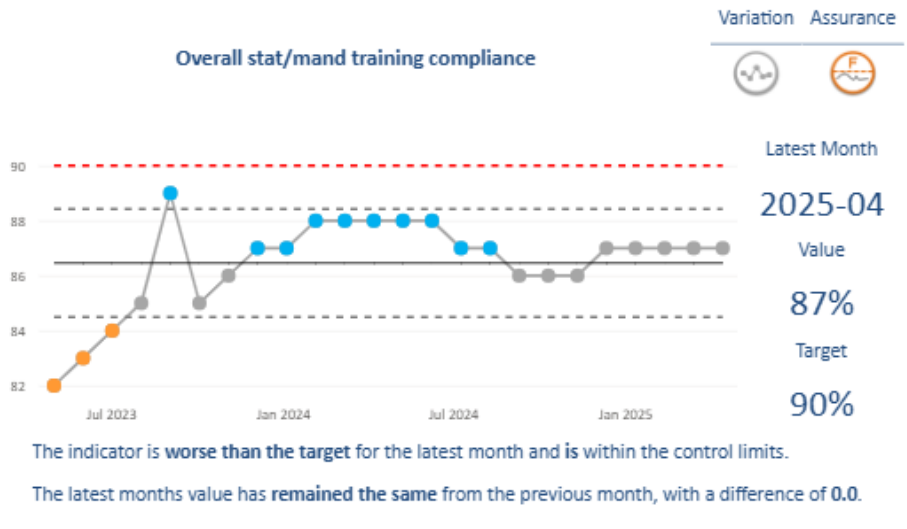
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

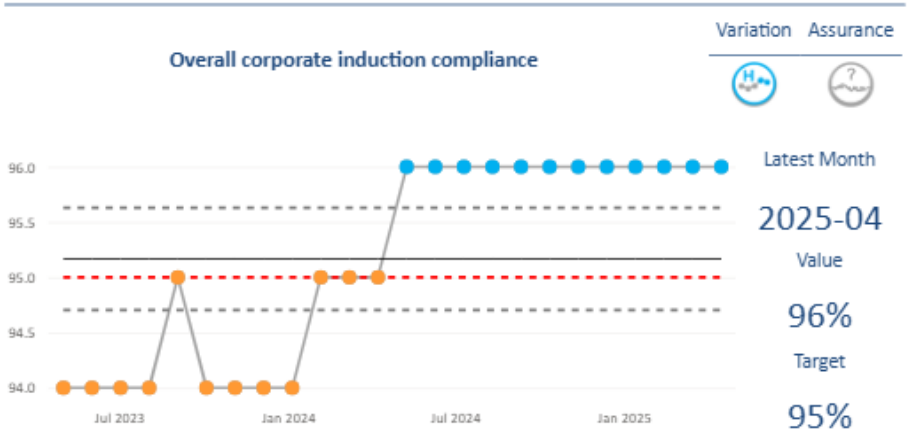
Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2025-04		F	87%		90%
Overall corporate induction compliance	2025-04	H	?	96%		95%
A4C staff stat/mand training compliance	2025-04		F	89%		90%
A4C staff corporate induction compliance	2025-04	H	?	96%		95%
Medical & dental staff stat/mand training compliance	2025-04		F	75%		90%
Medical & dental staff corporate induction compliance	2025-04	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)	2025-04			39.6%		
Percentage recommending the Trust as a place to receive treatment (quarterly - data taken from PULSE, Staff Survey data omitted for Q3)	2025-04			37.3%		

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 adopted a new target for statutory and mandatory training compliance. The 90% target strives for a 3% increase in the level of completion from the current position. 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 in the medium-term.

Within the current compliance position of 87%, classroom-based subjects continue to show a lower-level of completion than those which are provided via elearning. The Level 3 Safeguarding Children (Core) programme, strands of the resuscitation training programme and the higher-level Mental Capacity Act training are all the subject of review due to completion rates which are 15% or more below target.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

DIGITAL AND INFORMATION SERVICES

May 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			
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents* * Percentage of FOIs and EIRs responded to within 20 working days (monthly)	
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

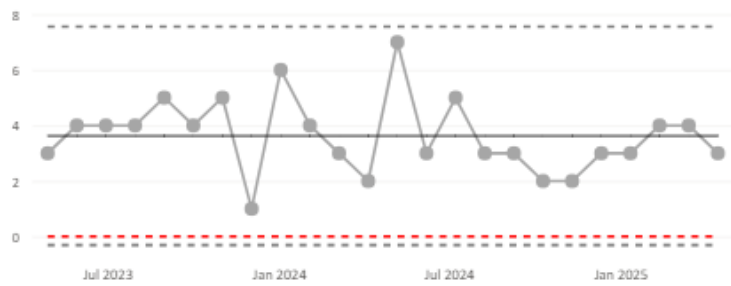
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2025-04			3		0
Total number of calls to Service Desk	2025-04			4322		
Total number of calls abandoned	2025-04			1060		
Number of information security incidents reported and investigated	2025-04			37		
Number of patient Subject Access Requests (SAR) received (monthly)	2025-04			364		
Number of patient Subject Access Requests (SAR) completed (monthly)	2025-04			372		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2025-04			72%		80%
Number of FOIs and EIRs received (monthly)	2025-04			85		
Number of FOIs and EIRs completed (monthly)	2025-04			89		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2025-04			80%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy

Variation Assurance

Number of P1 incidents*

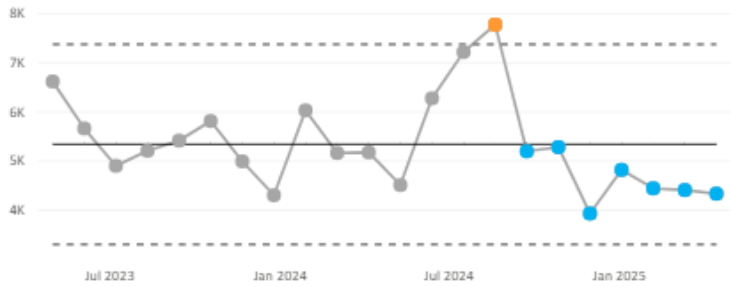


Latest Month
2025-04
Value
3
Target
0

The latest months value has **improved** from the previous month, with a difference of **1.0**.

Variation Assurance

Total number of calls to Service Desk



Latest Month
2025-04
Value
4322
No Target

The latest months value has **improved** from the previous month, with a difference of **74.0**.

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

Target: 0 P1 Incidents

Factors impacting performance:

3x P1 incidents occurred.

1. 4/4 Scarborough Bleep system fault occurred around 0015 and was resolved by 0254. This was not reported to IT Support and dealt with between Switchboard and Multitone Support.
2. 4/4 York Bleep system fault occurred following a site visit by 3rd party support. Identified after they left, workaround implemented using secondary antennae, and then resolved when engineer returned to site.
3. 30/4 Network performance issues affecting external internet-based sites, e.g. Badgernet. Planned technical changes resulted in some unexpected behaviours and caused some users' accounts to become locked out. Duration 2 hours. Workarounds were implemented to minimize disruption on 30/4 and fixes tested and fully applied by 2/5

Actions:

Telephone call performance has stabilised following disruption to staffing levels after internal promotions.

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.

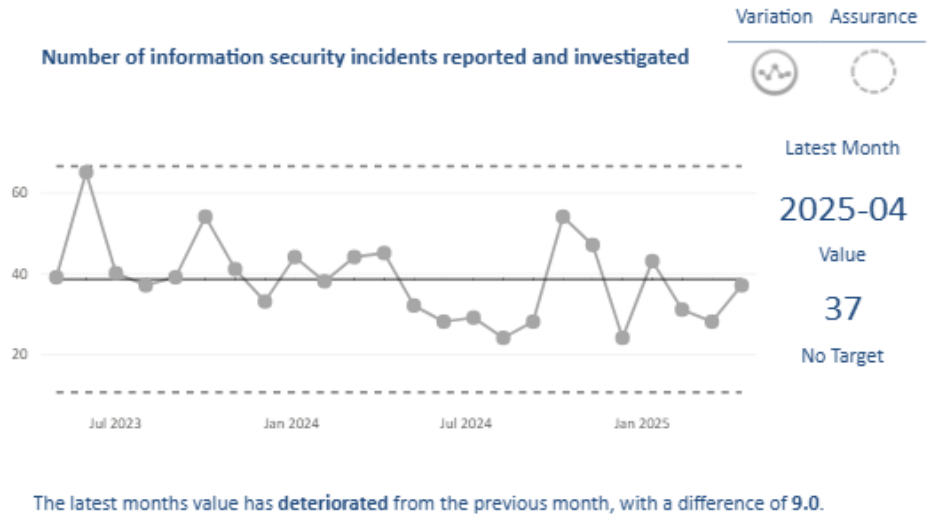
Staff waiting on hold may choose to hang up after hearing the recorded messages if their issue is not urgent and then call later, or may choose to use the IT Self Service route to support instead.

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.

We aim to mitigate any increased support demand related to planned project work by clear communications and directing users to online support routes. E.g. e-mail archives are being migrated from P:\ to the Online Archive, which may result in some support queries.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley



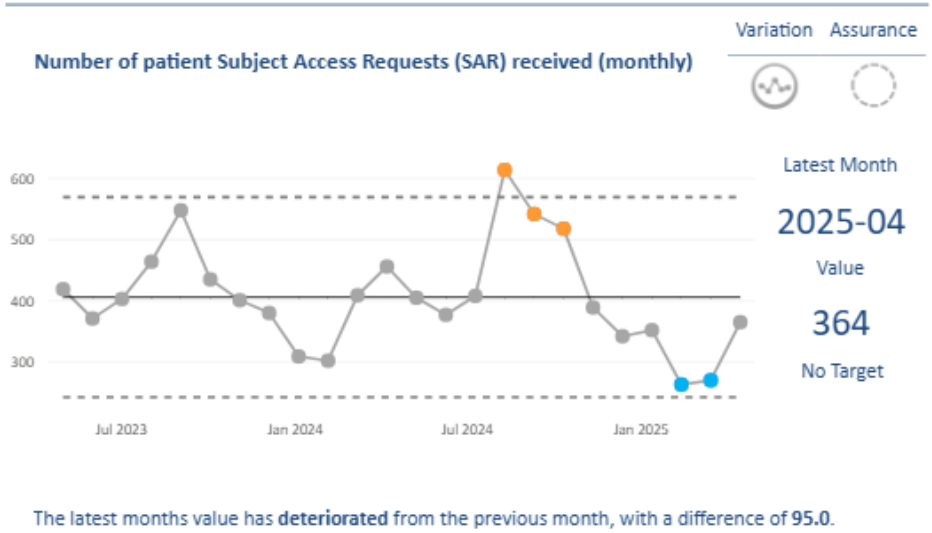
Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

Number of information security incidents reported and investigated

Factors impacting performance:

There has been a small increase in incidents during April.

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



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

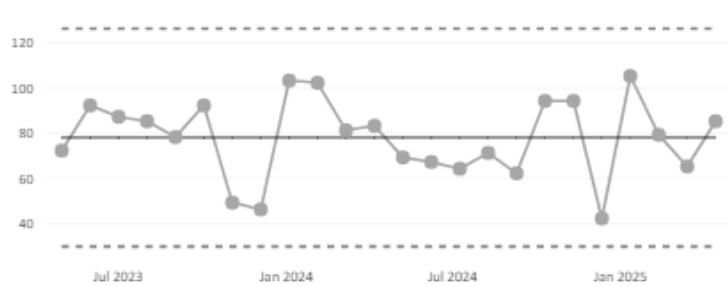
Factors impacting performance:
The reporting for SARs has changed to only include patient access requests. Previous reports have also included police requests, access to health records (deceased patients) and ad hoc external requests which are no longer included in this count.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of FOIs and EIRs received (monthly)

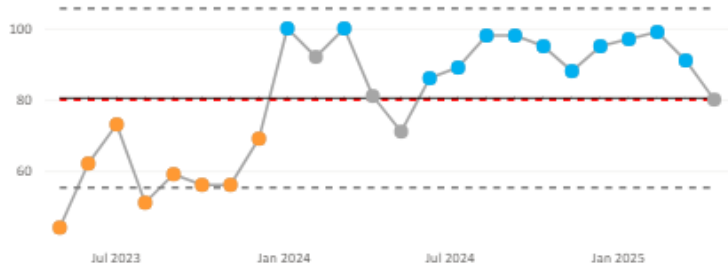


Latest Month
2025-04
Value
85
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **20.0**.

Variation Assurance

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



Latest Month
2025-04
Value
80%
Target
80%

The indicator is **equal to 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 **11.0**.

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 April has increased.

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 but remains on target.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

May 2025

Summary Dashboard and Income & Expenditure

Finance (1)

- The Trust Submitted its Operational Financial Plan to NHSE on 30th April 2025. The plan presented a balanced income and expenditure (I&E) position as per the table opposite.
- The Trust's balanced position forms part of a wider HNY ICB balanced I&E plan.
- The Trust has a planned operational I&E surplus of £1.3m, but for the purposes of assessing financial performance NHSE remove certain technical adjustments to arrive at the underlying financial performance.
- It should be noted that the Trust's projected balanced position is after the planned delivery of a significant efficiency programme of £55.3m.
- The plan is designed to assist the Trust meet all the required performance targets in 2025/26

OPERATIONAL FINANCIAL PLAN 2025/26
SUMMARY INCOME & EXPENDITURE POSITION

	£'000
INCOME	
Operating Income from Patient Care Activities	
NHS England	85,178
Integrated Care Boards	693,623
Other including Local Authorities, PPI etc..	8,780
	787,581
Other Operating Income	
R&D, Education & Training, SHYPS etc..	93,320
Total Income	**880,901**
EXPENDITURE	
Gross Operating Expenditure	-922,635
Less: CIP	55,290
Total Expenditure	**-867,345**
OPERATING SURPLUS / (DEFICIT)	**13,556**
Finance Costs (Interest Receivable / Payable / PDC Dividend)	-12,196
SURPLUS / (DEFICIT) FOR THE YEAR	**1,360**
ADJUSTED FINANCIAL PERFORMANCE	
Net Surplus / (Deficit)	1,360
Add Back	
I&E Impairments	5,000
Remove capital donations / grants I&E impact	-6,360
ADJUSTED FINANCIAL SURPLUS / (DEFICIT)	**0**

Summary Dashboard and Income & Expenditure

Finance (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	n/a	-£0.9m	n/a	n/a
Corporate CIP Delivery Variance to Plan (£26.6m target)	n/a	-£1.0m	n/a	n/a
Core CIP Delivery Variance to Plan (£27.3m Target)	n/a	-£0.9m	n/a	n/a
Business Case CIP Delivery Variance to plan (£1.4m target)	n/a	-£0.1m	n/a	n/a
Variance to Agency Cap	n/a	-£0.3m	n/a	n/a
Month End Cash Position	n/a	£38.1m	n/a	n/a
Capital Programme Variance to Plan	n/a	-£0.4m	n/a	n/a

	Plan	Plan YTD	Actual YTD	Variance	Forecast
	£000	£000	£000	£000	£000
Clinical Income	789,810	65,818	65,952	134	789,810
Other Income	91,090	7,591	6,828	-763	91,090
Total Income	880,901	73,408	72,779	-629	880,901
Pay Expenditure	-607,934	-48,188	-49,260	-1,072	-607,934
Drugs	-76,139	-6,345	-6,484	-139	-76,139
Supplies & Services	-93,893	-7,808	-7,208	599	-93,893
Other Expenditure	-143,139	-11,972	-10,275	1,697	-143,139
Outstanding CIP	53,761	1,975	0	-1,975	53,761
Total Expenditure	-867,345	-72,338	-73,228	-890	-867,345
Operating Surplus/(Deficit)	13,556	1,070	-449	-1,519	13,556
Other Finance Costs	-12,196	-1,016	-817	200	-12,196
Surplus/(Deficit)	1,360	54	-1,265	-1,319	1,360
NHSE Normalisation Adj	-1360	-530	-121	409	-1360
Adjusted Surplus/(Deficit)	0	-476	-1,386	-910	0

The I&E table confirms an actual adjusted deficit of £1.4m against a planned deficit of £0.5m, leaving the Trust with an adverse variance to plan of £0.9m.

At this early stage of the financial year the forecast is that the Trust will take mitigating actions that will successfully deliver a balanced position. This will be kept under review as the year progresses.

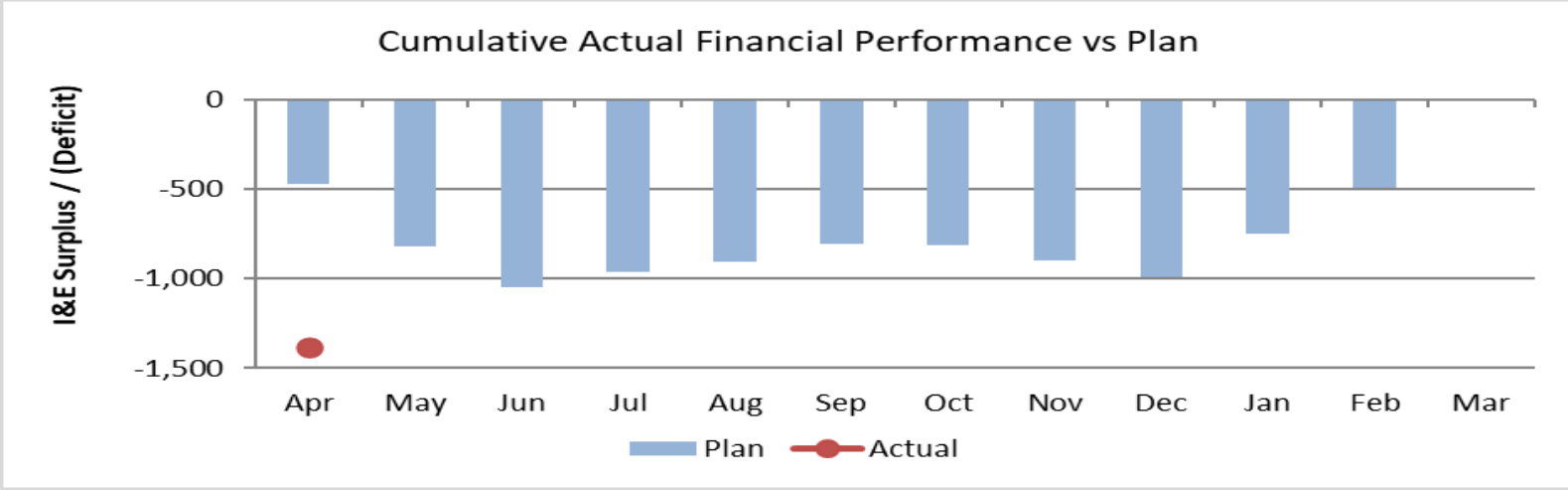
Key Subjective Variances: Trust
Finance (3)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Variance	Favourable / (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	(£2,950)	NHSE under trade linked to services which have been delegated to ICB to commission. There is a corresponding over trade on ICB line below.	Confirm contracting arrangements and ensure plans and actual income reporting align.
ICB Income	£3,053	See above	See above
Employee Expenses	(£1,072)	Agency, bank and WLI spending is ahead of plan to cover medical vacancies.	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.
Clinical Supplies & Services	£599	Favourable variance is linked to a delay in implementation of the Scarborough CDC, lower than anticipated expenditure on consumables in SHYPS and lower than anticipated spend on insulin pumps in Medicine.	To continue to control non-pay expenditure within budget
CIP	(£1,975)	The Corporate Programme is £1.0m behind plan, the Core Programme is £0.9m behind plan and the Business Case Programme is £0.1m behind plan.	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group.
Other Costs	£1,697	Linked to reserve balances and is largely the result of delays to planned initiatives.	To continue to monitor

Cumulative Actual Financial Performance vs Plan

Finance (4)



The income and expenditure plan profile shows an expected cumulative deficit throughout the year with a balanced position achieved in March 2026. The improvement in quarter 4 is due to an expected acceleration of delivery of the efficiency programme.

The actual I&E performance in April 2025 is a deficit of £1.4m compared to a planned deficit of £0.5m. This represents an adverse variance to plan of £0.9m.

Care Group Forecast
Finance (5)

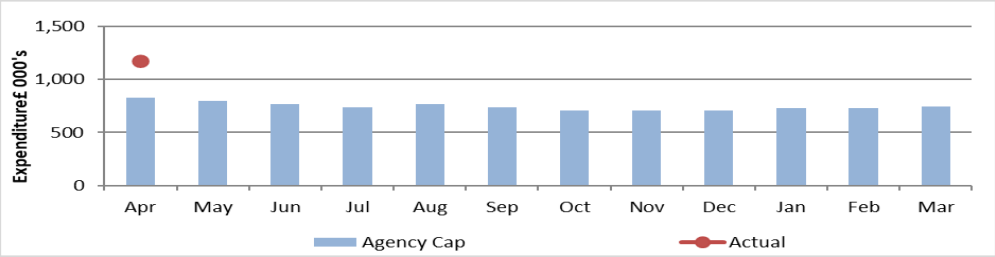
York and Scarborough Teaching Hospitals NHS Foundation Trust

Year to Date 2025/26 Care Group Financial Position							
Care Group	Annual Adjusted Budget	YTD Budget	YTD Actual	YTD Variance	YTD Adjusted Budget	YTD Adjusted Variance	Key Drivers of YTD Adjusted Variance
	£000	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	228,089	19,342	18,403	938	19,360	956	Underspend driven by Scarborough CDC Delay and vacancies in other areas this are partially offset by CIP behind plan and increased expenditure on Outsourced Histopathology and Radiology
Family Health Care Group	84,240	7,111	7,291	-180	7,167	-124	£44k relates to the premium cost of covering medical vacancies, £38k Community Nursing overspend, £177k Midwifery overspend, £121k other pay underspend, £24k unachieved CIP.
Medicine	184,079	15,543	15,968	-426	15,733	-235	£202k relates to the YTD pressure of the unachieved CIP target.
Surgery	156,303	13,189	13,890	-701	13,241	-649	£243k adverse variance relates to Resident Doctors pay costs over budget; £221k WLI spend over budget/ capacity gap £151k unachieved CIP & £42k unfunded nursing cost pressures - Ward 25 & Day Unit.
TOTAL	652,711	55,184	55,553	-368	55,500	-52	

Full Year 2025/26 Care Group Forecast Financial Position						
Care Group	Annual Adjusted Budget	Forecast Prior to Mitigating Actions	Mitigating Actions	Forecast Post Mitigating Actions	Forecast Variance	Key Drivers of Forecast Variance
	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	228,089	227,269	0	227,269	820	Forecast deterioration largely due to expected increase in diagnostic costs (Pathology,Radiology and Endoscopy) based on previous 6 month run rate and CIP planning gap, offset largely by ongoing vacancy expectation.
Family Health Care Group	84,240	86,701	0	86,701	-2,461	£272k relates to the premium cost of covering medical vacancies, £451k Community Nursing overspend, £1.491m Midwifery overspend, £1.2m other pay underspend, £1.450m unplanned CIP.
Medicine	184,079	193,018	-166	192,853	-8,773	£5.1m relates to the CIP planning gap, and £2.2m relates to unachieved Vacancy Factor.
Surgery	156,303	166,844	0	166,844	-10,542	£3m over-spend on Resident Doctors including premium cost of covering vacancies; £2.6m WLI spend over budget including Theatre capacity gap (weekends); £2m unachieved CIP; 2.6m unachieved vacancy factor & £0.5m unfunded nursing cost pressures - Ward 25 & Day Unit.
TOTAL	652,711	673,833	-166	673,667	-20,956	

Agency, Workforce, Elective Recovery Fund

Finance (6)



Agency Controls

The Trust has an agency reduction target of 40% based on 2024/25 outturn. Expenditure on agency staff in April is £1.178m against a plan of £0.831m, representing an adverse variance of £0.347m.

	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,571.29	2,464.09	107.20	12,582	12,809	-227
Scientific, Therapeutic and Technical	1,308.11	1,239.96	68.15	6,359	6,249	110
Support To Clinical Staff	1,939.78	1,707.96	231.82	5,816	5,532	283
Medical and Dental	1,107.94	1022.65	85.29	12,654	13,900	-1,246
Non-Medical - Non-Clinical	3,211.14	2,898.60	312.54	10,942	10,580	362
Reserves				-356	0	-356
Other				192	191	1
TOTAL	10,138.26	9,333.26	805	48,188	49,260	-1,072

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 table illustrates that the key driver for the operational pay overspend position is premium rate spend against Medical and Dental staff.

Trust Performance Summary vs 2025-26 Trust Plan

Care Group Analysis **Activity only in the Scope of ERF (EL, DC, OPFA, OP Procedures, A and G) Excludes LVA ICBs**

Care Group	Trust Plan Weighted Value At 25/26 prices	Weighted Value Trust Plan Month 01 Phase as per NHSE submit	Activity to Month 01 Actual	Variance -
CSCS	£28,204,234	£2,220,644	£2,054,253	-£166,391
Family Health	£13,429,031	£1,057,726	£810,803	-£246,923
Medicine	£24,598,488	£1,937,076	£2,218,334	£281,257
Surgery	£100,315,152	£7,899,243	£7,600,385	-£298,858
Corporate (Advice and Guidance) Est	£10,756,568	£847,430	£658,452	-£188,978
Corporate Adjustment to plan	£62,419	£1,941	£0	-£1,941
All Care Groups	**£177,365,893**	**£13,964,060**	**£13,342,227**	**-£621,833**

Elective Recovery Fund

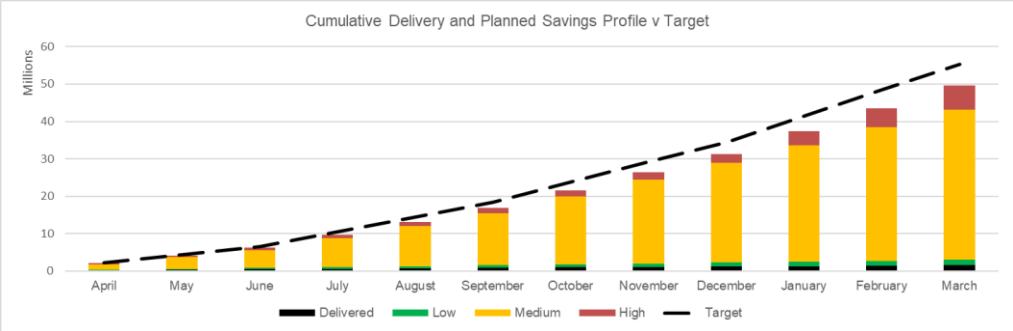
We continue to report on Elective Recovery Performance on an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date before applying average tariff income to the activity. Care Group weighted activity plans for 2025/26 are aligned to the associated elective income within the contract values agreed with Commissioners.

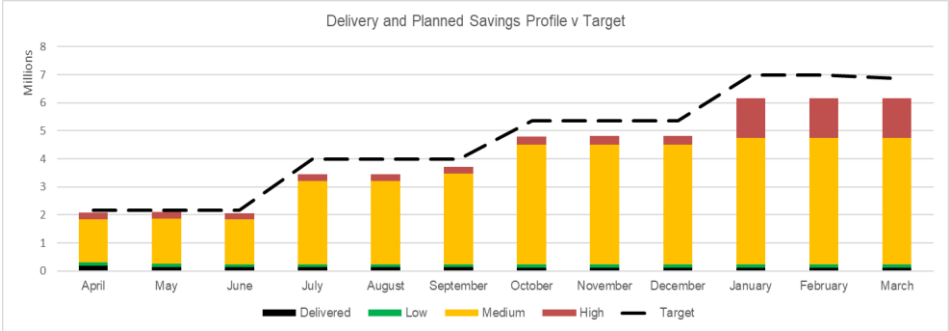
Given the potential limits on Elective Recovery Funding in 2025/26, it is important to closely monitor the position to ensure weighted activity plans are not exceeded at Trust level without ICB Commissioner discussion and authorisation. Additional system funding may become available in year if other system providers are under their agreed plan and elective resource can be redirected.

At Month 1, ERF performance is under the planned level of weighted ERF activity by £622k.

Cost Improvement Programme
Finance (7)

York and Scarborough Teaching Hospitals NHS Foundation Trust





	Full Year CIP Target	April Position			Full Year Position		Planning Position		Planning Risk		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Corporate Programme	26,582	1,040	0	1,040	0	26,582	11,452	15,130	856	6,580	4,016
	26,582	**1,040**	**0**	**1,040**	**0**	**26,582**	**11,452**	**15,130**	**856**	**6,580**	**4,016**
Core Programme											
Medicine	6,039	236	34	202	241	5,797	871	5,167	241	518	112
Surgery	4,524	177	26	151	313	4,212	2,503	2,022	378	2,125	0
CSCS	7,044	276	30	245	363	6,680	5,569	1,474	466	3,498	1,605
Family Health	2,306	90	66	24	246	2,060	856	1,450	280	576	0
CEO	91	4	0	4	0	91	0	91	0	0	0
Chief Nurses Team	653	26	0	26	0	653	10	643	0	10	0
Finance	750	29	0	29	0	750	0	750	0	0	0
Medical Governance	55	2	0	2	0	55	46	9	0	46	0
Ops Management	308	12	0	12	0	308	5	303	0	5	0
DIS	2,219	87	0	87	0	2,219	52	2,167	0	52	0
Workforce & OD	1,377	54	9	45	103	1,275	103	1,275	103	0	0
YTHFM LLP	1,962	77	24	53	284	1,678	1,950	12	284	973	692
Central	0	0	0	0	0	0	24,939	-24,939	334	24,505	100
	27,327	**1,070**	**189**	**881**	**1,550**	**25,776**	**36,903**	**-9,576**	**2,086**	**32,308**	**2,509**
Business Cases	1,382	54	0	54	0	1,382	1,360	22	0	1,360	0
Total Programme	**55,290**	**2,164**	**189**	**1,975**	**1,550**	**53,740**	**49,715**	**5,575**	**2,942**	**40,248**	**6,525**

Efficiency Programme

The total trust efficiency target is £55.3m, £1.6m has been achieved in full year terms and the month 1 YTD position is £2m behind plan. The programme has plans totalling £49.7m giving an unidentified planning gap of £5.6m.

Corporate Efficiency Programme

The Corporate efficiency programme has a Target of £26.6m, no delivery has been achieved in month 1 and it is £1m behind plan YTD at month 1.

Core Efficiency Programme

The Core efficiency programme has a Target of £27.3m, £1.6m has been delivered in full year terms and the month 1 YTD position is £0.9m behind plan.

Business Cases

Business case efficiencies have a Target of £1.4m, no delivery has been actioned in month 1, and it is £0.1m behind plan YTD at month 1.

Current Cash Position and Better Payment Practice Code (BPPC)

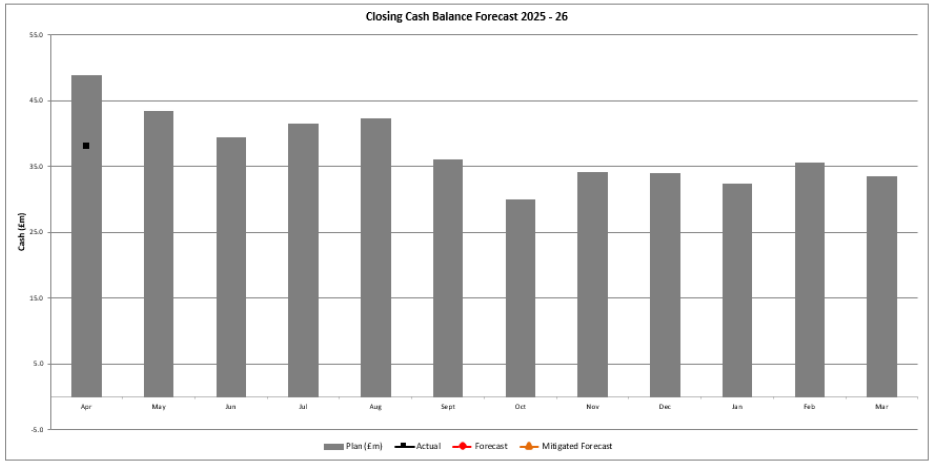
Finance (8)

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Group's cash plan for 2025/26 is for the cash balance to reduce through the year resulting in a closing balance of £33.4m at the end of March 2026.

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	48,728	43,285	39,402	41,443	42,294	35,924	29,962	34,122	33,845	32,386	35,435	33,442
Actual	38,105											



The cash forecast graph illustrates the cash position based on the actual cash balance at the end of April, at £38.1m against a plan balance of £48.7m, which is £10.6m adverse to plan.

This is mainly due to reduction of creditors earlier than planned.

At this stage, we are not expecting a requirement for cash support in 2025/26, however this will be closely monitored alongside the delivery of the Trust's I&E plan and the efficiency program as any slippage will impact cash reserves, and a cash support application may have to be made.

<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 April the Trust managed to pay 90% of its suppliers within 30 days.

Current and Forecast Capital Position

Finance (9)

York and Scarborough Teaching Hospitals NHS Foundation Trust

The board approved capital plan for 2025/26 is £88m. After adjustments for donated & grant funded schemes and the planned disposal of Clarence Street, net CDEL for the year is £80.7m. The main schemes within the plan are:

- £28m - Scarborough RAAC
- £8m – York VIU / PACU / Hybrid Theatre
- £8.4m – Electronic Patient Record
- £4.8m - Scarborough Hospital PSDS4 Decarbonisation Project (Salix Grant)
- £3.5m – Backlog Maintenance
- £1.5m – DIS Investment Programme
- £5m – Capital Prioritisation Process
- £7.8m – Leasing programme Equipment, Vehicles, Buildings

2025/26 Capital Position	Annual Plan £000s	YTD Plan £000s	M1 Actual £000s	Variance to Plan £000s
PDC Funded Schemes	56,525	466	673	207
IFRS 16 Lease Funded Schemes	7,838	-	-	-
Depreciation Funded Schemes	16,626	366	594	228
Charitable & Grant Funded Schemes	7,213	18	4	(14)
Total Capital	**88,202**	**850**	**1,271**	**421**
Less Charitable & Grant Funded Schemes	(7,213)	(18)	(4)	14
Less Sale of Clarence Street	(325)	-	-	-
Total Capital (Net CDEL)	**80,664**	**832**	**1,267**	**435**

The M1 position is £435km ahead of plan.

This is mainly due to the VIU/PACU/HT schemes running ahead of the plan phasing.

There are no significant issues to report at M1.

System Summary – NHSE Efficiency Governance Arrangements 2025/26

Finance (10)

NHSE shared a draft letter regarding 2024/25 closedown and 2025/26 arrangements, focusing on the efficiency programme:

Key deadlines include:

- corporate reduction plans by **end of May**
- no unidentified CIP in plans by **end of May**
- and no high-risk schemes by **end of June**.

Fortnightly reporting on CIP position and monthly oversight meetings will be required.

Plans are categorised by risk:

- high (opportunities)
- medium (plans in progress)
- low (fully developed plans).

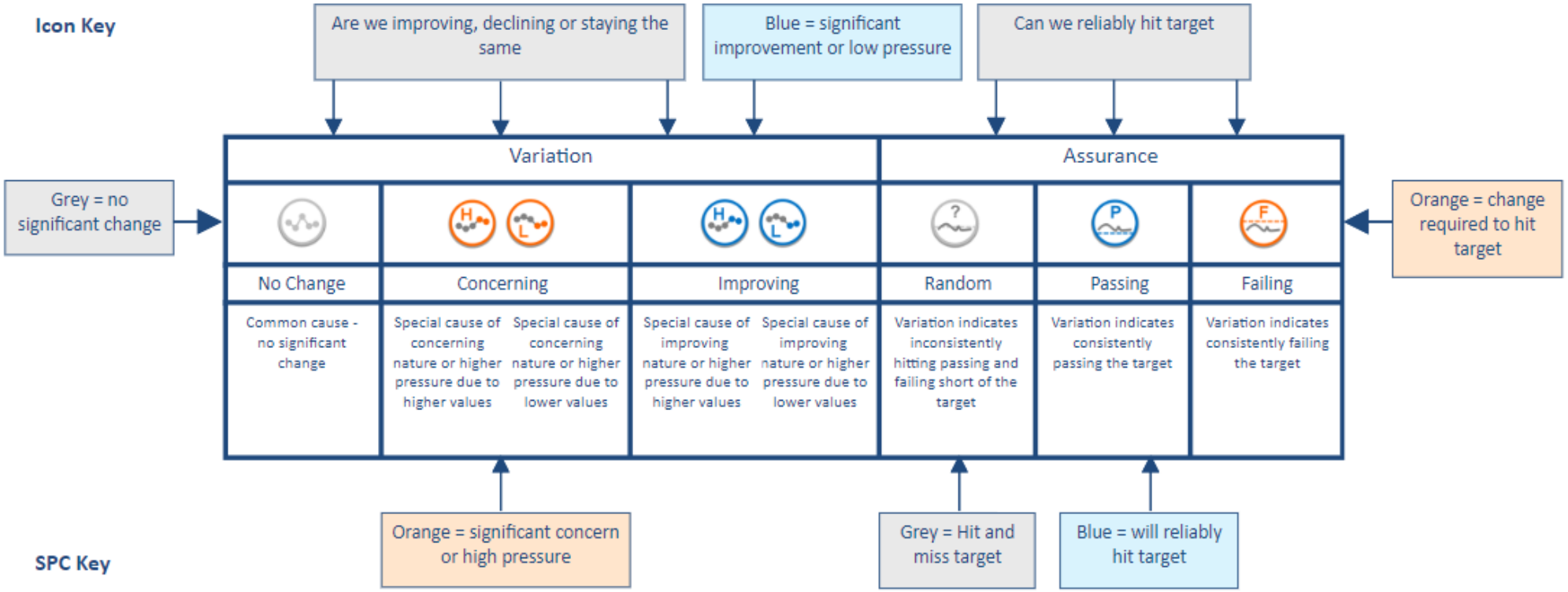
Non-compliance of efficiency governance arrangements by end of Q1 risks losing £16.5m deficit support funding; from Q2 onwards, failure to deliver the plan also risks losing support.

NHSE will not provide cash support in 2025/26

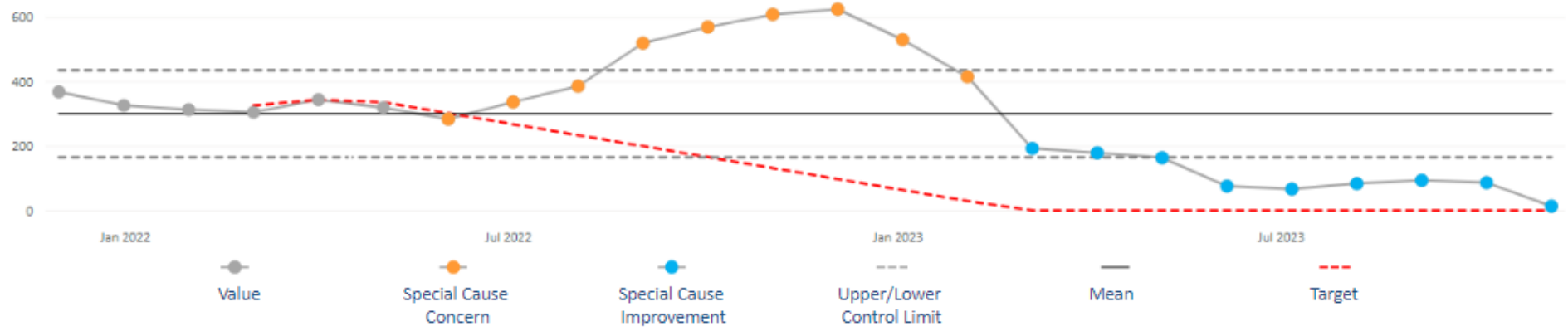
Keys

NHS
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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	21 May 2025
Subject:	Care Quality Commission (CQC) Update Report
Director Sponsor:	Dawn Parkes, Chief Nurse Adele Coulthard, Director of Quality, Improvement and Patient Safety
Author:	Emma Shippey, Head of Compliance and Assurance

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☐ 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 report provides an update on activity linked to the Health and Social Care Regulator, the Care Quality Commission.
At the time of writing this report, the Trust has not received the draft report following the onsite inspection on 14 and 15 January 2025. An improvement plan based on the CQC feedback received, and from review of the evidence sent to support the inspection, is being drafted.
There are three actions which remain open from the 2022/23 inspection. Position statements on all three actions are due to be presented at the Journey to Excellence meeting on 12 May 2025.
There have been no new CQC cases received this month.

Recommendation:
For members of the Board of Directors to note the Care Group clinical audit plans for 2025/26.

Report Exempt from Public Disclosure
No ☒ Yes ☐

Report History		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
Patient Safety and Clinical Effectiveness Sub-Committee	14 May 2025	Not presented at the time of submitting the paper.

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 agreed actions from this session are included in **Appendix A** of this report.

The Trust has yet to receive any further feedback from the CQC following the inspection in January 2025. The Quality Governance team is drafting an improvement plan feedback from the CQC during the inspection, and from review of the evidence requested to support the inspection.

The next CQC engagement meeting is scheduled to take place on Wednesday 28 May.

2. Journey to Excellence Group

The Terms of Reference for the Journey to Excellence Group has been revised and was presented for approval at the meeting on 28 April 2025. Some minor amendments to the membership and attendance were suggested, but the updates included:

- Receiving assurance on the oversight of themes from actions from the CQC Improvement Plan from 2023.
- Progress with the internal and external Well Led assessments and action plan.
- Actions from the January 2025 inspection.
- Updates on the NHS England segmentation process.

There are six actions which remained open from the 2022/23 CQC onsite inspection. The Head of Compliance and Assurance presented a position statement on three improvement actions from the 2022/23 inspection at the meeting held on 28 April 2025. All three actions were approved for closure by members of the Journey to Excellence Group, these were:

- Action 25: The trust must ensure that all staff groups in Medical Care, Maternity and Urgent and Emergency Services complete designated mandatory training sessions. Including:
  - Safeguarding, PREVENT, Adult Life Support and Advanced Life Support (MC York and Scarborough)
  - Theatre recovery training, practical obstetric multi-professional training and saving babies lives version 2 (Mat York and Scarborough)
  - ED Medical Staff, esp. Safeguarding, learning disabilities and dementia (Scarborough)

- Action 29: The trust must ensure that there are sufficient allied healthcare professional, nursing, midwives and medical staff in Medical Care and Maternity to keep people safe.

- Action 35: The trust must ensure that the urgent and emergency service improves compliance in sepsis screening, especially for patients receiving antibiotics within an hour. They must also ensure ED medical staff improve their overall training compliance rate in sepsis screening and all ED staff complete screening for patients at risk of sepsis (to better recognise and respond to warning signs of deterioration).

The position statements have been shared with the CQC. A position statement on the remaining three open CQC improvement actions are scheduled for approval at the meeting on 12 May 2025.

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.

The Trust has not received any CQC cases since the last report was written (31 March 2025).

At the time of writing, the Trust had three open cases / enquiries. The enquiry dashboard can be viewed in **Appendix B.** The three cases are linked to:

- The maternity section 31 monthly update
- A complex complaint relating to the Emergency Department at Scarborough Hospital. An investigation is underway and an update on the investigation will be provided to the CQC in June 2025.
- A Patient Safety Incident Investigation into a never event is in progress and will be shared with the CQC when approved. The report is due to go to the PSII Review Group on 2 July 2025.

4. CQC Updates

Chief Executive Sir Julian Hartley has posted in his latest blog immediate actions that the CQC are taking to improve how they work – including increasing assessments, speeding up registration processes, and responding more quickly to concerns. It also highlights the cultural changes underway, including the development of 'the CQC Way' and their focus on stronger leadership. Julian shares his commitment to building a more effective and trusted regulator, with a clear vision for delivering safe, high-quality care.
Click the link to **Read the blog**

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.

Post CQC Review – After Action Review
1 April 2025

An After Action Review took place following the unannounced CQC onsite inspection at York Hospital on 14 & 15 January 2025. The session was led by the Director of Quality, Improvement and Patient Safety and the Head of Compliance and Assurance.

The session was spilt into three sections:

1. Onsite Inspection
    - Communication upon arrival
    - Management of the Inspection Team
    - Communication during the inspection
    - Feedback from wards / services inspected
    - Staff Interviews

2. Management of the Evidence Request
    - Receipt of evidence request
    - Management of the evidence collation
    - Summary sheets
    - MS Teams and daily check in

3. Communication
    - Use of MS Teams / WhatsApp
    - Verbal feedback following the inspection
    - Reporting through Trust governance

The session was attended staff from the Medicine Care group and Heads of Service e.g. Safeguarding, Health and Safety and Patient Safety. The aim of the session was to learn from the inspection and improve the Trust response to onsite inspection activity.

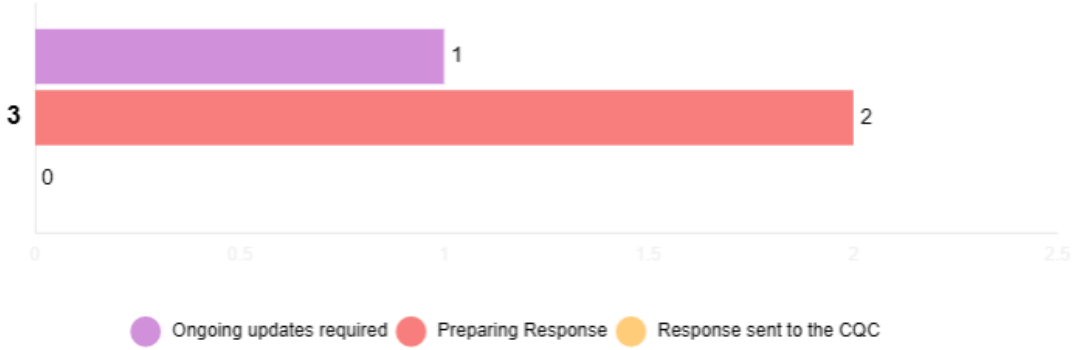
The actions captured following the session are recorded in the table below:

Action	Owner	Timeframe
Clarify with the CQC who can be on their contact list for unannounced inspection activity. This was the Chief Nurse (Dawn Parkes), the Director of Quality Improvement and Patient Safety (Adele Coulthard) , and the Head of Compliance and Assurance (Emma Shippey) at 8am.	AC/ES	May 2025
Clarify with the CQC who can receive the email with the information regarding the inspection. This was the Chief Executive (Simon Morritt), Chief Nurse (Dawn Parkes), the Director of Quality Improvement and Patient Safety (Adele Coulthard) , and the Head of Compliance and Assurance (Emma Shippey) at 8am.	AC/ES	May 2025
Confirm the how it will be communicated that the CQC are onsite (WhatsApp message sent)	AC/ES/DP	May 2025
Clarify those who should be included in the CQC WhatsApp group.	ES/AC/DP	May 2025
Draft standard communications which will be sent when the CQC are on-site.	ES	May 2025
Arrange for the CQC on-site message to be shared on the 8:30 operations management call.	SJ	May 2025

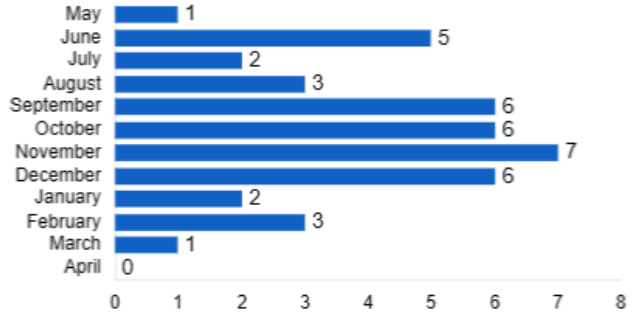
Action	Owner	Timeframe
Clarify what information needs escalating from the Care Group throughout each day of the inspection, and how this should be done, from the areas visited by the CQC. Possible use of action cards.	AC/ES/SJ	June 2025
Arrange for CQC visitor badges, with no access rights, to always be available at the York and Scarborough hospital sites.	SJ	May 2025
Clarify the rooms which need to be booked when the CQC attend the York, Scarborough or Bridlington sites.	SJ	May 2025
Identify if any additional 'standby' resource can be made available for the Care Group and Corporate Teams throughout and in the days following inspection activity.	AC/ES	July 2025
Draft an interview proforma for the CQC to complete documenting who they will need to speak to during and following the inspection, plus the purpose of the meeting.	SJ	May 2025
Agree what information will be communicated internally, and the recipients of that information, during CQC inspection.	AC/ES/DP	May 2025
Ensure sufficient resource is available for a thorough review the CQC evidence request within 24 hours of receipt, and for the timely submission of any items for clarification,	AC/ES	July 2025
Include in the SOP that leads for the evidence request to be confirmed during the daily Teams call.	ES	June 2025
Clarify the CQC evidence request sign off process.	AC/ES/DP	June 2025
Proactively consider the types of information which will be requested by the CQC as part of an evidence submission and identify the lead for this i.e. training figures.	ES/SJ	July 2025
Plan a desktop mock inspection exercise of what would happen on the day and days following a CQC unannounced inspection.	AC/ES	August 2025
CQC SOP to be updated following the agreement and delivery of the actions from the AAR.	ES	June 2025

Appendix B
CQC Cases / Enquiries (1 May 2024 to 30 April 2025)

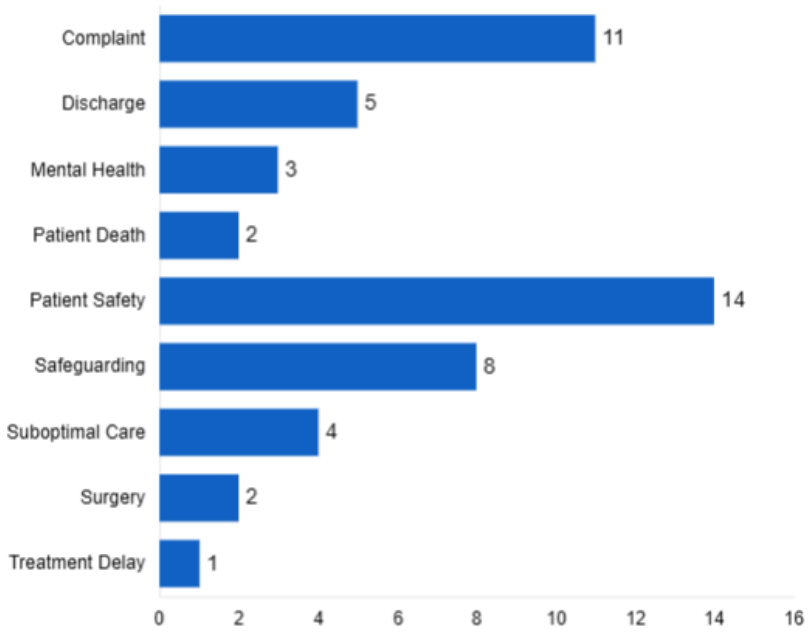
Number of Open CQC Enquiries / Cases



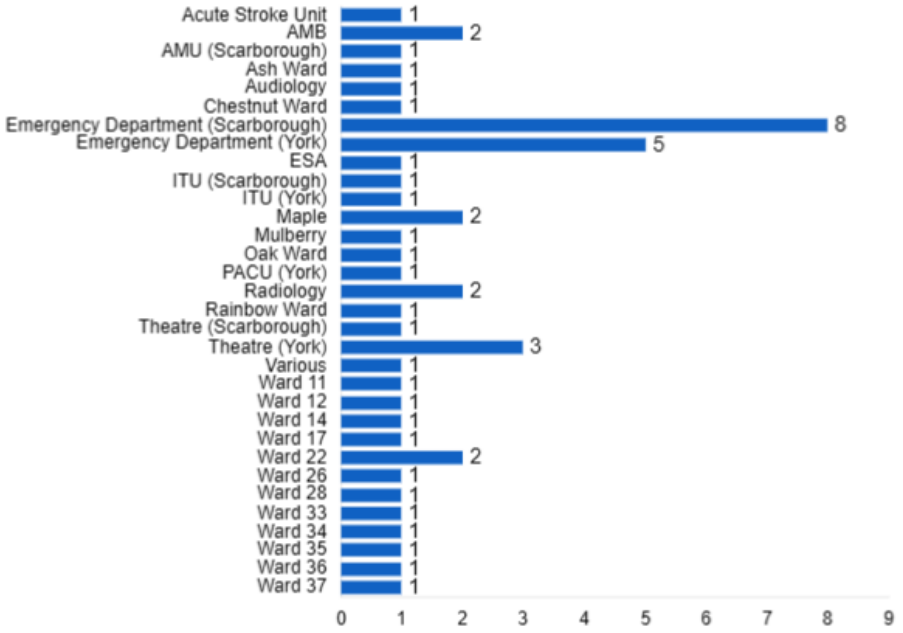
Number of Enquiries Received



Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Item 13

Report to:	Board of Directors
Date of Meeting:	21 May 2025
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Dawn Parkes, Chief Nurse and 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

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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:
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 March 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) 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**
Quality Committee	20/5/2025	1/ To note the progress with the safety actions and improvement work in maternity and neonatal services. 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 March 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 March 2025.

Perinatal Deaths

In March 2025 there was 1 stillbirth at 27 weeks at York and there was 1 neonatal death from a multiple pregnancy at 26 weeks at York.

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.

The eleventh MBRRACE-UK Perinatal Mortality Surveillance Report published in May 2025. The report includes perinatal deaths from 2023.
Key messages:

- Extended perinatal mortality rates decreased across the UK in 2023 (UK extended perinatal mortality rate: 4.84 per 1,000 total births). The long-term reduction in perinatal mortality is driven largely by a reduction in stillbirths.
- Compared with rates in 2022, stillbirth rates per 1,000 total births in 2023 were lower across the UK: 3.22 (UK); 3.27 (England); 2.95 (Scotland); 3.32 (Wales); and 2.51 (Northern Ireland).
- There were decreases in the neonatal mortality rate per 1,000 live births in England, Wales and Northern Ireland compared with 2022: 1.63 (UK); 1.62 (England); 1.61 (Scotland); 1.79 (Wales); and 1.66 (Northern Ireland).

Socioeconomic disparities continued to be a major concern, with stillbirth rates for babies born to mothers from the most deprived areas remaining significantly higher than those from the least deprived areas, despite an 8% decline. Neonatal mortality disparities also widened, with rates increasing for the most deprived populations and decreasing for the least deprived.
Ethnic disparities in perinatal outcomes persisted. Stillbirth rates declined for Black and White babies but increased by 10% for Asian babies. Black babies remained more than twice as likely to be stillborn as White babies. Neonatal mortality rates decreased across all ethnicities but remained highest for Asian and Black babies.
These findings highlight continued progress in reducing perinatal mortality but underscore the need for targeted interventions to address disparities by socioeconomic status, ethnicity, and gestational age. Recent MBRRACE-UK reports have made national level recommendations in support of these aims, but focused work at local provider, network and commissioner level may be required to understand and tackle these issues in an effective manner.

A review of the national findings will be undertaken with a comparison against local data. This will be presented at the Maternity Assurance Group and Quality Committee in June 2025.

Maternity and Newborn Safety Investigations (MNSI)

In the month of March there were no new cases that met the criteria for referral to MNSI for investigation. Of the three open cases one final report has been received, one draft report has been received and the third report is expected late May.

The Trust received 9 Safety recommendations, and an action plan will be developed and submitted to the Patient Safety Learning Response Group (Historically SI group).

Patient Safety Incident Investigations (PSII)

In the month of March there were no new PSIIs declared. There remain four ongoing cases. There are four overdue PSIIs. Two draft PSIIs has been shared with the family, one PSII has been submitted for sign off and one is awaiting approval from the medical director.

Moderate Harm Incidents and above

The postpartum haemorrhage (PPH) rate was 2.8% (9 cases) in March 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.

Quality and Safety

There are 238 incidents overdue, the oldest is July 2024. This is a reduction of 23 There are 11 after action reviews and 4 pathway reviews. There were 2 completed after action reviews in April.
Capacity of the Quality and Governance Lead due to absence within the Family Health Care Group Governance team and a deficit of substantive posts required to the Maternity quality and safety framework is having an impact on timely review of incident and patient safety learning responses.

There are 35 outstanding cases to be reviewed at the avoiding term admissions group. There have been challenges with quoracy at the meeting from Obstetrics and Paediatrics which has contributed to the backlog. This means there are open and overdue incidents which date back to January 2025 which have not had a multidisciplinary review and impacts on Safety Action 3 for the Maternity Incentive Scheme with completing timely reports to be shared with the Safety Champions. There have been 2 sprint days organised to address the backlog.

There are a total of 19 overdue guidelines (decrease 10 since April) and 6 overdue Standard Operating Procedures. This is a signficant improvement since the position in December 2024 of 72 out fo date documents.

CQC Section 31 Progress Update

Annex 2 provides the March 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.

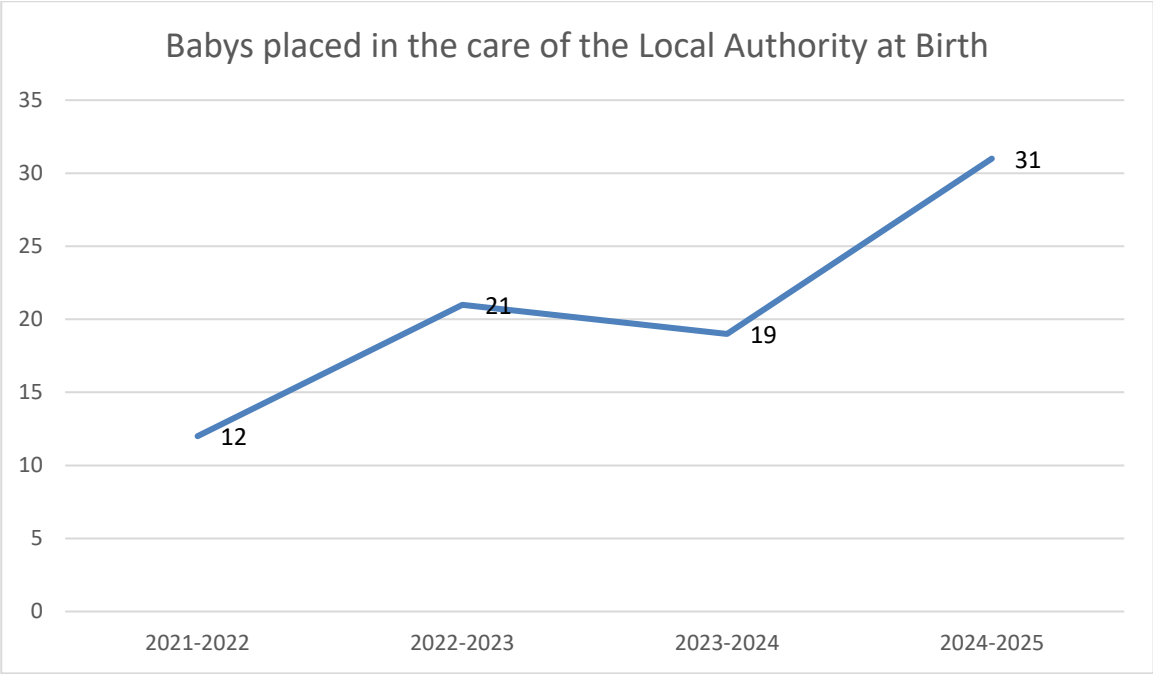
There were no CQC information requests made in March 2025.

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.

Safeguarding

The Maternity Services have seen a significant rise in the number of babies that are placed into the care of the Local Authority from birth. This significant rise in complex safeguarding has increased the organisations statutory duty to meet the Section 11 of the Children Act 2004.
The Children Act (1989 and 2004) and Working Together to Safeguard Children (2018 and 2023) specify that the Trust Board has a legal responsibility to safeguard and promote the welfare of children and young people, and all staff within the organisation have a statutory responsibility to safeguard and promote the welfare of children. In recognition of the increased demand of the safeguarding requirements and in order to mitigate any risk of not being compliant with Section 11 the Maternity Services have recently appointed a Lead Safeguarding Midwife, part of who's role and function will be to ensure the Trust discharge its statutory duty.



NHSE Review and Reset Meeting

On the 28th April 2025 a review and reset meeting took place with the Maternity Services Support Programme, LMNS and the Regional Chief Midwifery Officer. The Trust attendance included the Chief Nurse, Non- Executive Safety Champion, Director of Midwifery, MNVP and other members from the senior midwifery leadership team and specialist midwives. It was acknowledged that the team were aware of the challenges faced especially around the financial challenges aligned to Midwifery staffing and the considerable vacancy gap. It was agreed that a further review and reset meeting would take place in three months to review the progress and improvements especially around the midwifery workforce. It was agreed by all key stakeholders that the service was not ready to transition into the sustainability phase of the programme due to the ongoing risk posed by carrying a large vacancy rate for a complex high risk clinical service. It was agreed to move from six monthly meetings to quarterly in view of the progress made regarding midwifery workforce.

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 which is expected in May/June. 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 was launched on the 28th April 2025.

Overview of Safety Actions:
Safety Action 1: PMRT quarterly report has been submitted to Trust Board in November 2024 and February 2025. Currently on track for compliance for Year 7.
Safety Action: 2: Currently on track for compliance for Year 7.
Safety Action 3: This safety action is non-compliant due to the requirement of no transitional care model in place. Recruited a Transitional Care Nurse, due to commence in post end of February 2025. Business case required for Transitional Care staffing model. Quality improvement project identified for ATAIN.

Safety Action 4 Temporary Staffing team implemented the RCOG guidance on engagement of long-term locums by end of February 2025. Monthly audit of consultant attendance for clinical situations commenced in February 2025. Audit demonstrates full compliance.
Anaesthetic staffing is not compliant with the Safety Action 4 at Scarborough. The standard is a duty Anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising Anaesthetic Consultant at all times. Where the Duty Anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1). At Scarborough the out of hours Anaethetists cover Maternity and Acute Services. This means there are occasions the Anaesthetist cannot attend Maternity immediately and delegate care of their non-obstetric patients.
Safety Action 5: This Safety Action will remain non-complaint for the foreseeable future until the required investment outlined in the midwifery business case is received.
Safety Action: 6: Currently on track for compliance for Year 7.
Safety Action 7: A review the meeting requirements the Maternity and Neonatal Voice Partnership Chair attends is being undertaken due to the additional MIS requirements.
Safety Action 8: Training will be monitored monthly with oversight in the Perinatal Quality Surveillance Model.
Safety Action 9: Maternity and Neonatal Safety Champions meetings and walk rounds have been set up for 2025. First meeting took place in February 2025. The Maternity Claims Scorecard was presented at the Maternity Directorate and Quality Committee in February 2025.
Safety Action 10: Currently on track for compliance for Year 7.

Saving Babies Lives Care Bundle Update

The Saving Babies Lives Care Bundle has been updated to Version 3.2 with several changes to interventions/outcome measures. Version 3.2 has been published in response to evaluation of version 3.1, following feedback from Providers and updates to national guidelines.

Key Changes:

- Element 2: to bring in line with publication of RCOG's Small for Gestational Age and growth restricted fetuses in May 2024. Alongside changes to Element 2, guidance from the Chief Scientific Officer on the use of digital blood pressure monitoring in pregnancy is being refreshed to broaden the range of valid monitors available to Trusts through the supply chain.
- Element 4: to clarify and simplify requirements around clinical review in particular fresh eyes in view of frontline clinical feedback.
- Element 5: updates to interventions and associated measures to match the National Neonatal Audit Programme standards and minimise the need for local audits and to reflect the longer term shortage of validated quantitative fetal fibronectin test kits following hologic decision to discontinue production and remove requirements relating to midwifery continuity of carer in view of revised Cochrane evidence.
- Element 6: replacing requirements around use of continuous glucose monitoring with the use of hybrid closed loop systems for women with type 1 diabetes in line with publication of the diabetes programmes 5 year implementation strategy for hybrid closed loops.

The national team are working on an updated tool which should be available from June 2025. The update will reduce the audit burden for providers. Some audits will be removed/reduced, and some will be aligned with existing data sets (e.g. National Neonatal Audit Programme) to reduce the need for manual audits and evidence collection.

Improvement and Transformation

The York and Scarborough respiratory syncytial virus (RSV) offer, and uptake is 69%. There have been no admissions to Paediatrics Intensive Care Unit (PICU) with Bronchiolitis in the last 12 months and a reduction in admission to paediatrics overall (previously >4 admissions to PICU per year).

Success in March 2025

- Two Governance Co-ordinators commenced in post
- Neonatal Governance Nurse commenced in post
- Cross-site Transitional Care Lead Neonatal Nurse commenced in post
- Community Midwives for Equitable Health commenced in post
- Following a successful recruitment, we appointed to the job-share interim Acute Intrapartum Matron cross-site position for 12-months to cover maternity leave.
- An internal Neonatal BadgerNet kick-off meeting took place on the 24th April to identify key stakeholders to support the implementation of Neonatal BadgerNet cross-site. A meeting with System-C will now be scheduled to discuss next steps with the identified project team.
- Induction of Labour guideline now fully implemented on both sites
- The connectivity issues with the Central Monitoring on the York Site have been addressed following the ports and cables being replaced
- The Standard Operating Procedure for Hope Boxes has been ratified and is now available on Staffroom
- A video has been developed and published on the trust website advising service users of how to access the Maternity unit in Scarborough out of hours through the new Urgent and Emergency Care Centre building https://www.youtube.com/shorts/hzPrMuUSRjA
- All Serious Incidents have now been completed and approved
- The Hot Topics schedule for 2025/26 has launched with good engagement. The hot topics being discussed during Q1 & Q2 are:
  1. Communication and care of mothers when they have babies on the Special Care Baby Unit
  2. Service User Communications
  3. Diabetes Pathway
  4. Emerging topic: Fetal medicine pathway

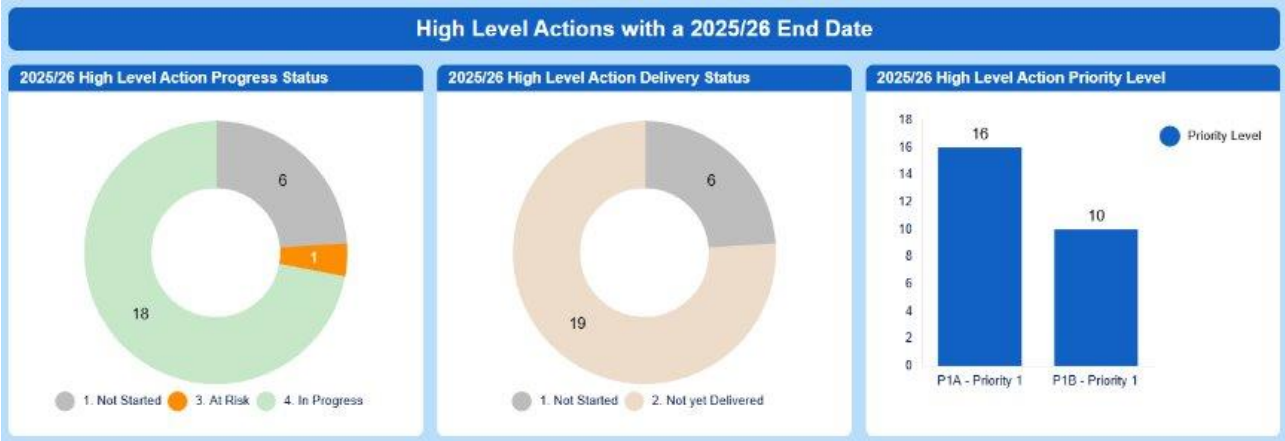
The Maternity and Neonatal Single Improvement Plan (MNSIP)

The 2025/26 delivery dates align to the clinical specialty strategy and focus on priority 1 actions only

- 2 Milestone actions are off track

All actions with delivery dates in Q1 & Q2 have been reviewed to identify if any are at risk

- 1 High Level action has been marked as at risk (details on next slides)
- 4 Milestone actions have been marked as at risk (details on next slides)



Risks

1. A midwifery staffing gap has been identified following the midwifery workforce review and BirthRate+ findings in 2024. There is a risk that staff will not have capacity to continue to support developing and implementing the Maternity and Neonatal Single Improvement Plan. This will result in high-level and milestone actions going off track and will also result in non-compliance with national reporting requirements (MIS/SBLCBV3). 2025/26 prioritisation and delivery dates have been aligned to focus resource on delivery of the priority 1 actions. However, delivery dates were agreed as part of the speciality clinical strategy and annual planning process with the anticipation that investment would be received in 2025/26 to support increasing the midwifery staffing establishment in line with BirthRate+ report (2024). Therefore, the likelihood of actions going off track despite the revised delivery dates remains high.
2. There is a risk that the additional workforce reviews underway will result in gaps being identified in the other staffing establishments (Obstetrics, Neonatal, Operational, Anaesthetics and Admin establishments). If additional workforce gaps are identified, it may result in non-compliance with national staffing standards such as BAPM. Workforce reviews and recommendations are being conducted in line with national best practice standards and initial findings will be shared with the Senior Responsible Owners to escalate to the Trust Senior Leadership Team and agree appropriate action if applicable. A review of the frontline neonatal nursing workforce at York and Scarborough has identified a shortfall of £1,500,000 recurrently to align the services to national safe staffing requirements. Further

reviews are scheduled. Obstetric reviews and operational reviews are scheduled to conclude in 2025/26, and findings will be presented to the Maternity Directorate.

3. There is a risk that the Quality and Patient Safety Framework cannot be fully embedded due to gaps identified in the Midwifery and Quality and Governance establishments**.** The staffing requirements to support full implementation were outlined within the Midwifery Business Case submitted to Board of Directors in 2024; a decision regarding the outcome of the business case has not yet been reached. Therefore, ability to fulfil the national Quality Agenda remains challenged and has an ongoing impact to patient safety.
4. There is a risk that the recent estates structural issues at Scarborough's Maternity Unit may result in delays to the overall progress of the Single Improvement Plan. To ensure standardisation across the service and reduce clinical variation, improvement changes must be applied to both site. The process of where services will be provided during the repairs are still in development and not finalised though will involve staff and service users before any final decisions are made. It is anticipated there will be a reduction in ability to support continued delivery of the improvement plan should the service require decanting.
5. There is a risk the equipment requirements outlined in the Capital Priotisation return 25/26 for maternity and neonates may not be approved during the financial review and therefore planned improvements dependent on funding may not be progressed. The return was submitted in December 24 for financial review. The Trusts Head of Capital Planning has produced a paper that will be shared in Februarys Executive Committee for consideration. The risk will be further understood once the position is shared with operational teams.
6. The programme team have been assigned to take on the oversight and delivery of an additional programme of work within the organisation. This reduces their capacity to support the delivery of the Maternity & Neonatal Single Improvement Plan. As a result, there is a risk that this may impact the programme team's ability to support maternity and neonatal teams to deliver the improvement work in line with the 2025/26 delivery dates. The programme team are monitoring the impact of the additional programme of work and will escalate any issues accordingly.

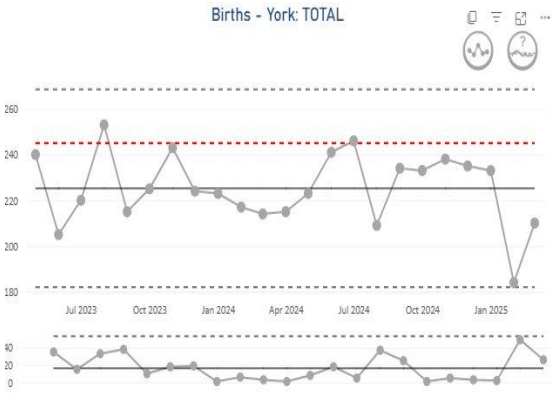
Recommendations to Trust Board

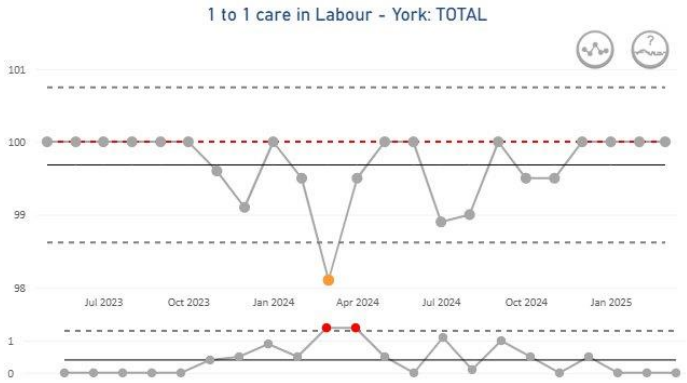
To note the contents of this report and agree the CQC section 31 submission in Annex 2

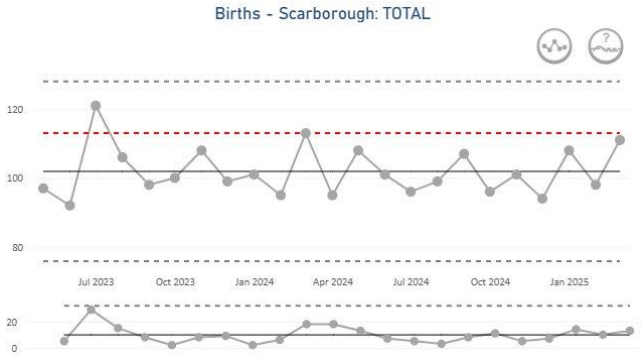
Date: 13th May 2025

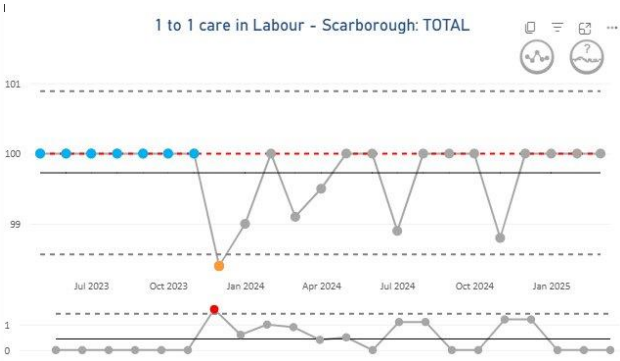
Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery March 2025

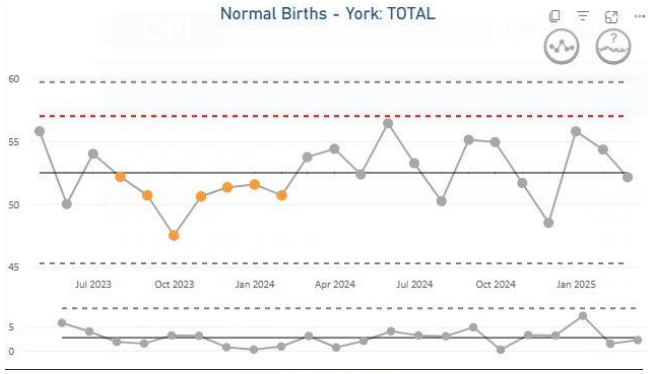
Dashboard

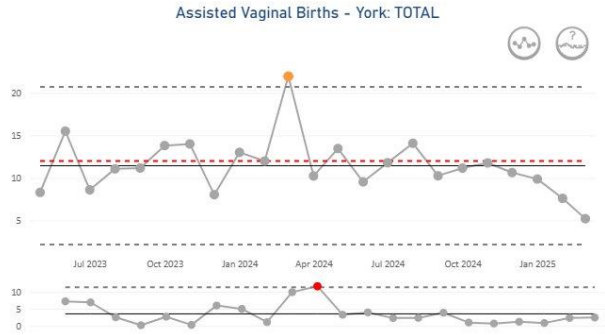


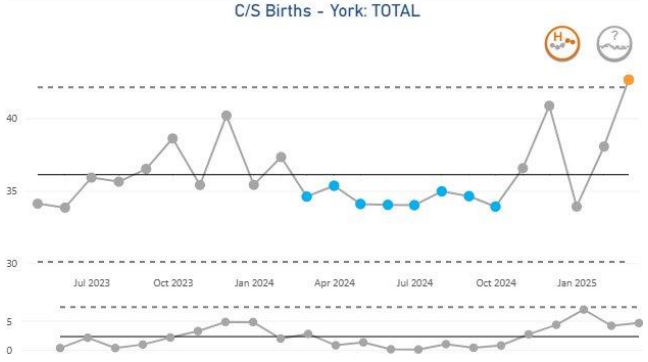


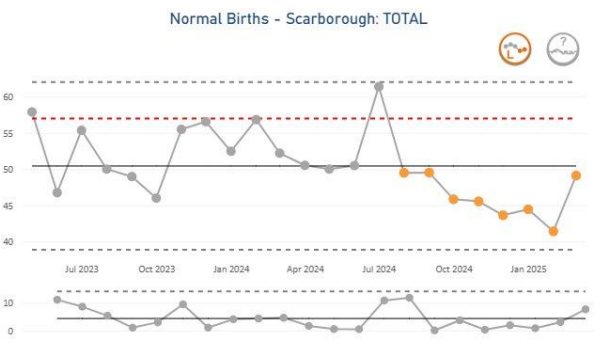


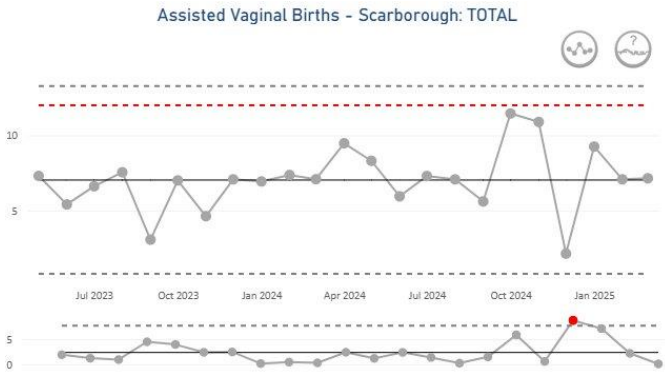


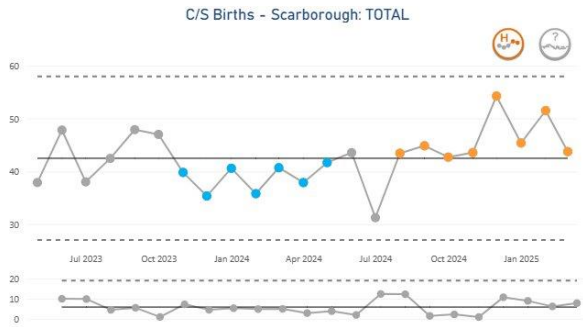


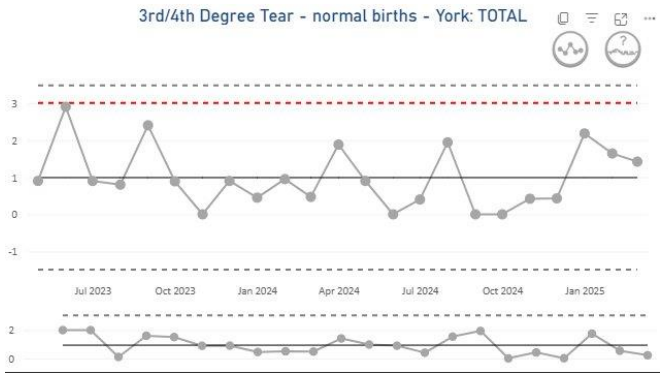


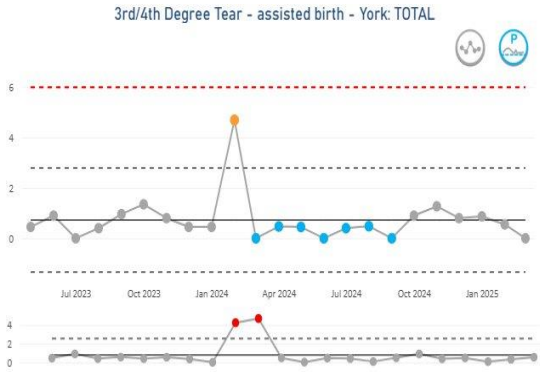


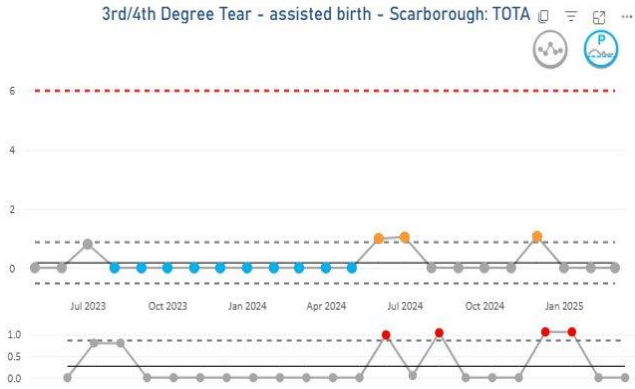


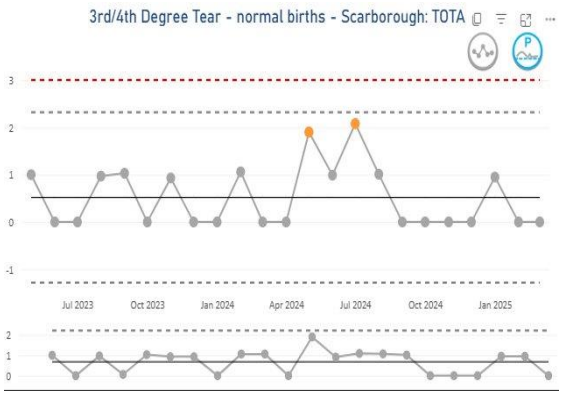

Assisted Vaginal Births - Scarborough: TOTAL
10
5
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
5
0


C/S Births - Scarborough: TOTAL
60
50
40
30
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
20
10
0


3rd/4th Degree Tear - normal births - York: TOTAL
3
2
1
0
-1
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
2
0


3rd/4th Degree Tear - assisted birth - York: TOTAL
6
4
2
0
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
4
2
0


3rd/4th Degree Tear - assisted birth - Scarborough: TOTA
6
4
2
0
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
1.0
0.5
0.0


3rd/4th Degree Tear - normal births - Scarborough: TOTA
3
2
1
0
-1
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
2
1
0

York and Scarborough Teaching Hospitals NHS Foundation Trust

Report to:	Maternity Assurance Group
Date of Meeting:	13th May 2025
Subject:	Maternity CQC Section 31 Update
Director Sponsor:	Dawn Parkes - Chief Nurse & Executive Maternity Safety Champion
Author:	Donna Dennis, Deputy Director of Midwifery Sascha Munro Wells, Director of Midwifery and Strategic Clinical lead for Family Health, Maternity Safety Chamion

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

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

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

Summary of Report and Key Points to highlight:

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.

Recommendation:

- To approve the May 2025 monthly submission to the CQC which provides assurance on progress and impact on outcomes in March 2025.

Report History

Meeting	Date	Outcome/Recommendation

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 March 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 March 2025 are outlined below.

Staff Group	York	Scarborough
Midwives	92% (165/180)	96% (80/83)
Consultants	100% (17/17)	78% (7/9)
Obstetric medical staff	100% (10/10)	71% (5/7)

The were two Obstetric Consultants who were not complaint in March, and this has been escalated to the Clinical Director for Obstetrics and Gynaecology. 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.

Statistical Process Control Charts 1 & 2 demonstrate a special cause for improvement for Midwives on both sites since 2023.

Chart 1

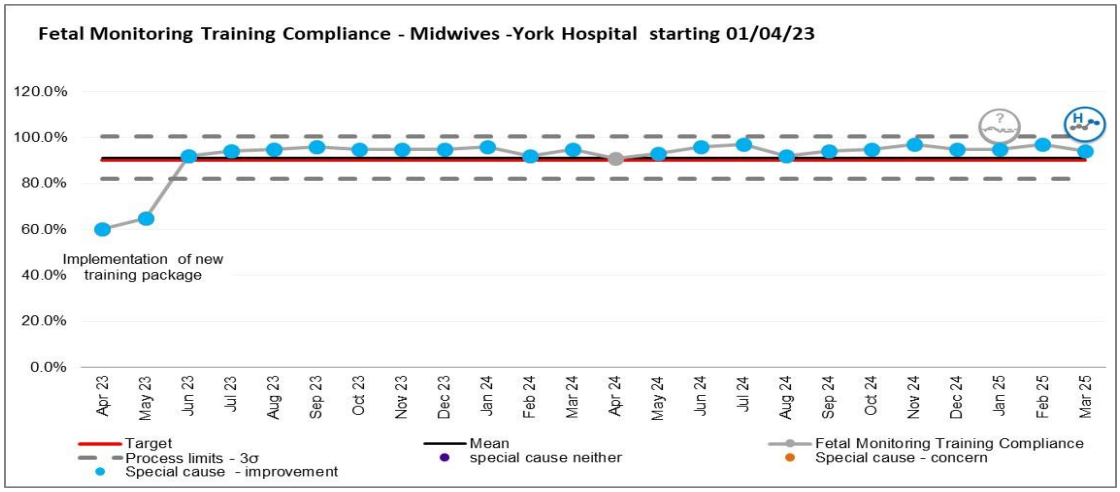
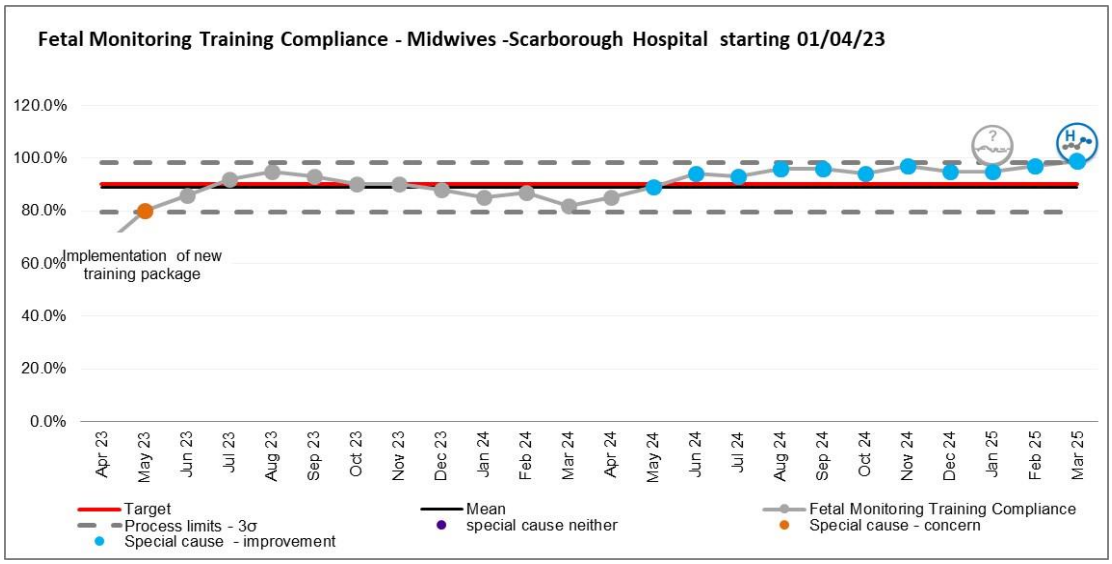


Chart 2



The Consultants fetal monitoring training compliance is shown below in Charts 3 & 4 for both sites. The Scarborough site demonstrates common cause variation and in view compliance remains below the 90% target the Clinical Director of Obstetrics will undertake a review of the Consultants booking process.

Chart 3

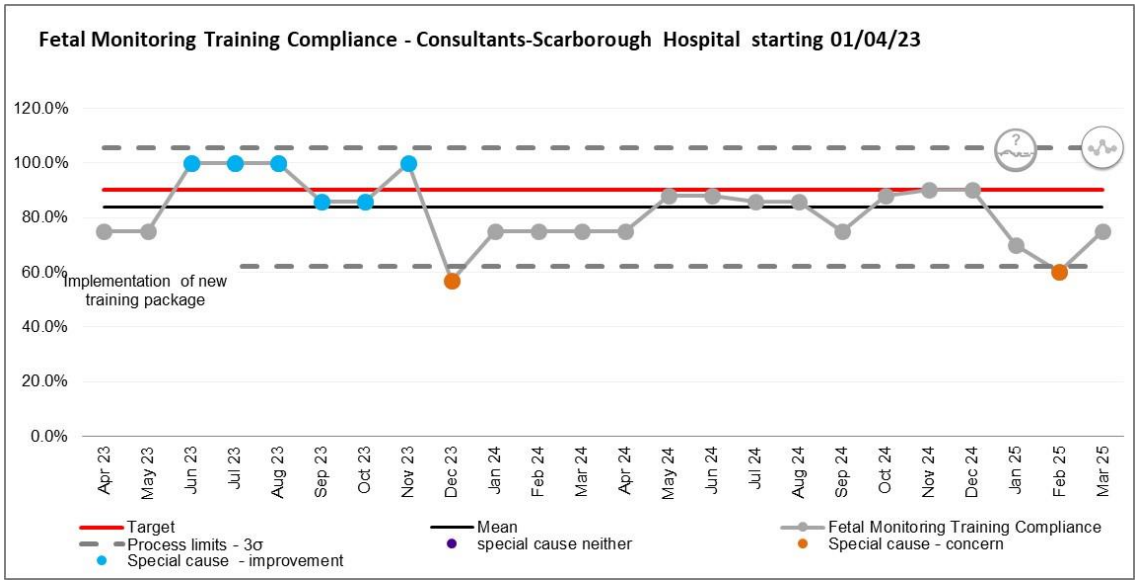
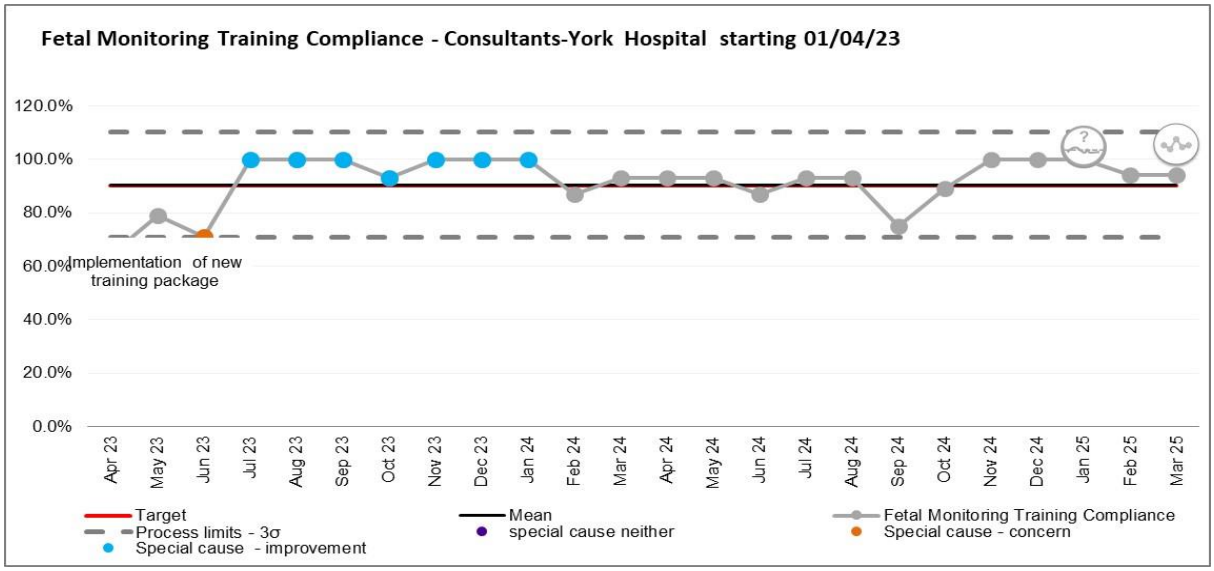


Chart 4



Charts 5 & 6 demonstrate all other Obstetric fetal monitoring compliance. The resident doctor intake during September 2024 has impacted on the obstetric training compliance. A trajectory is in development to ensure that resident doctors are booked onto training sessions. The LMNS has been asked to lead on a passport for mandatory training for Obstetricians and Anaesthetists.

Chart 5

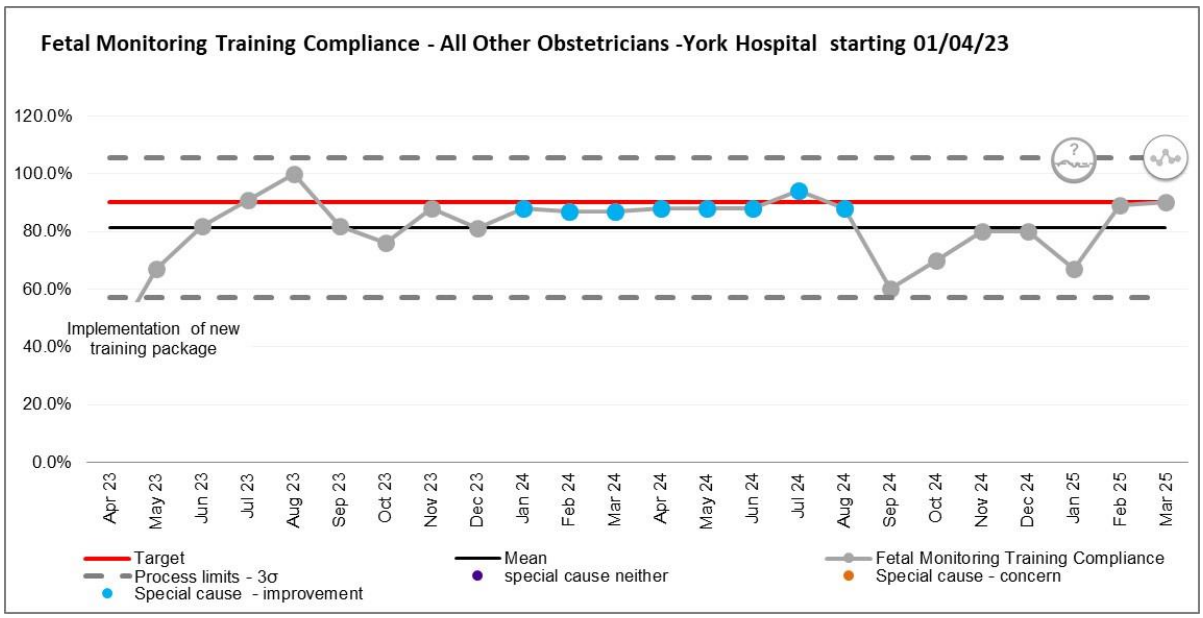
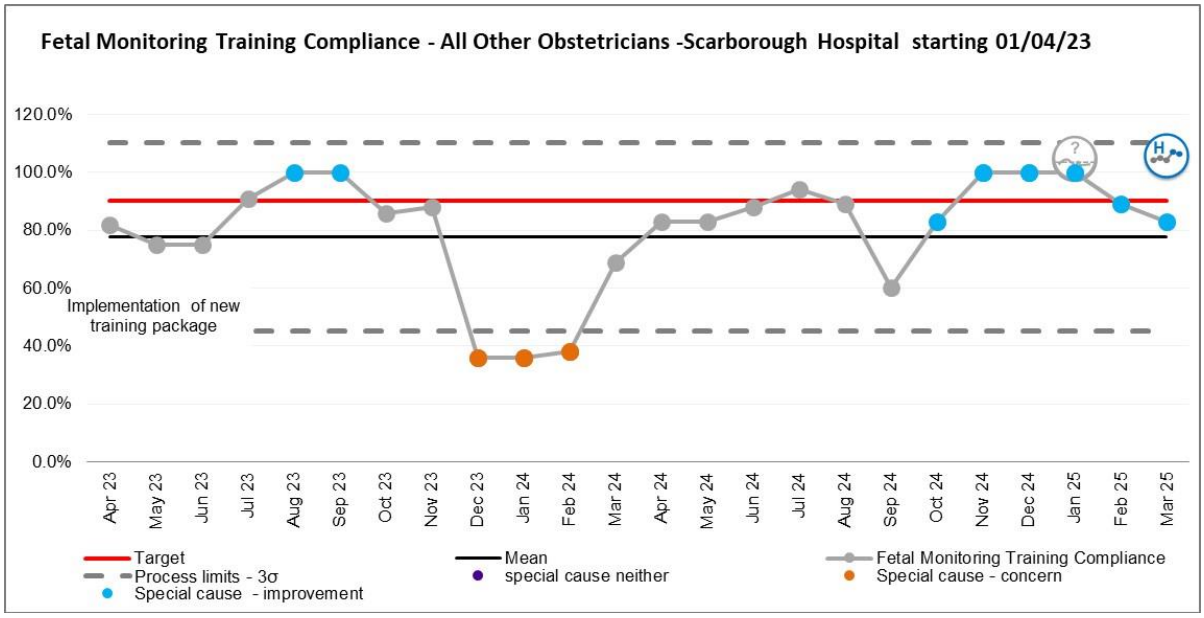


Chart 6



A.2.3 Fresh Eyes

During the November CQC inspection, a review of eleven patient records was undertaken and evidence to support the completion of hourly fresh eyes was found in only one record. It was also noted that staff were not interpreting, classifying, or escalating CTG appropriately. The documentation recorded on CTG's was poor and not in line with NICE guidelines.

Since the inspection, the Maternity services has reviewed the fetal monitoring documentation and aligned this with NICE guideline NG229 (Fetal Monitoring in Labour). The guidance is embedded in BadgerNet, and system changes have been made to support the pathway. Saving Babies Lives V3 states that "At the onset of every labour, there is a structured risk assessment undertaken which informs the clinicians recommendation of the most appropriate fetal monitoring method at the start of labour

Table 1 Compliance with Fresh Eyes

	Compliance with Fresh Eyes for Continuous Fetal Monitoring
Quarter 2 2023/ 24	27%
Quarter 3 2023/24	25%
Quarter 4 2023/24	28%
Quarter 1 2024/25	40%
Quarter 2 2024/25	44%
Quarter 3 2024/25	44%
Quarter 4 2024/25	44%

Table 1 demonstrates slight improvement from the CQC inspection however not a sustainable change in 18 months. The Transformation Lead Midwife and Fetal Monitoring Lead Midwife has developed an action plan in April 2025 with the Fetal Monitoring Lead Midwife to address improvements. This will be monitored at the Maternity Directorate for oversight. The fresh eyes compliance has been monitored as part of the LMNS quality assurance discussions as part of the Saving Babies Lives Care Bundle Version 3

discussions for Safety Action 6 for the Maternity Incentive Scheme Year 6. The monitoring of compliance has been removed for Year 7 of the Maternity Incentive Scheme.

A.3 Risk Assessments and Care Plans

All antenatal risk assessments are recorded on BadgerNet. Table 2 highlights the antenatal risk assessment compliance.

Table 2
Antenatal Risk Assessments

Month	York	Scarborough
January 2025	98%	99%
February 2025	98%	99%
March 2025	98%	98%

BadgerNet has the facility to pull other risk assessment reports. Table 3-8 demonstrates compliance over quarter 4 in 2024/25.

Table 3
Antenatal Booking Risk Assessments

Month	York	Scarborough
January 2025	100%	100%
February 2025	100%	100%
March 2025	100%	100%

Table 4
Intrapartum Risk Assessments

Month	York	Scarborough
January 2025	100%	100%
February 2025	100%	100%
March 2025	100%	100%

Table 5
Risk Assessment for Growth and Pre-eclampsia

Month	York	Scarborough
January 2025	100%	99.1%
February 2025	100%	99.8%
March 2025	100%	100%

Table 6
Venous Thromboembolism Risk Assessment at Booking

Month	York	Scarborough
January 2025	100%	100%
February 2025	100%	100%
March 2025	100%	100%

Table 7
Venous Thromboembolism Risk Assessment on Admission (within 6 hours)

Month	York	Scarborough
January 2025	72%	84%
February 2025	73%	88%
March 2025	76%	86%

Table 8
Venous Thromboembolism Risk Assessment Following Birth

Month	York	Scarborough
January 2025	100%	100%
February 2025	100%	100%
March 2025	100%	100%

The Deputy Director of Midwifery will review the ward process for ensuring antenatal VTE compliance is completed. VTE compliance will be monitored through the Maternity Directorate going forwards.

A.4 Assessment and Triage

There was an increase in red flags noted on Scarborough site for a 2 week period. This was due to a trial of combining Antenatal Day Unit and Maternity Triage. Due to increased red flags, this trial was discontinued and reverted to the previous model of a separating Antenatal Day Unit and Maternity Triage, following which, compliance increased, thus reducing red flags.

Chart 7

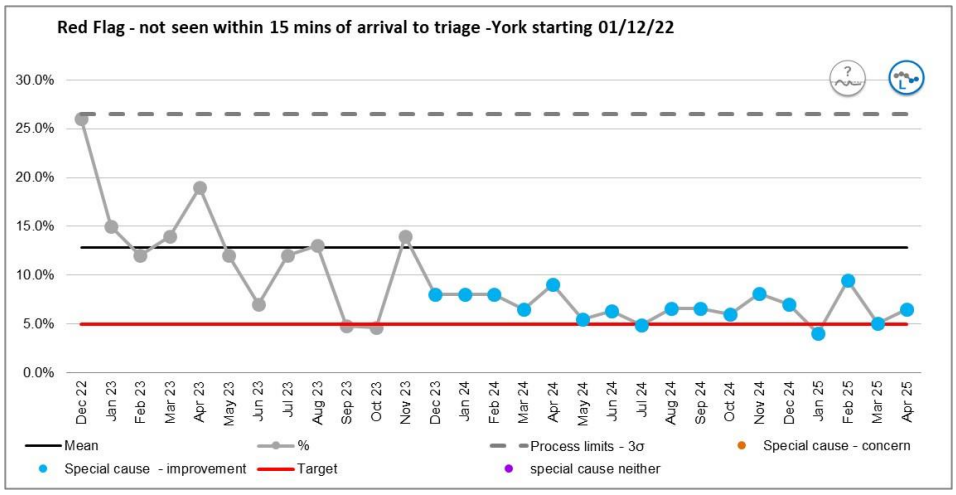


Chart 8

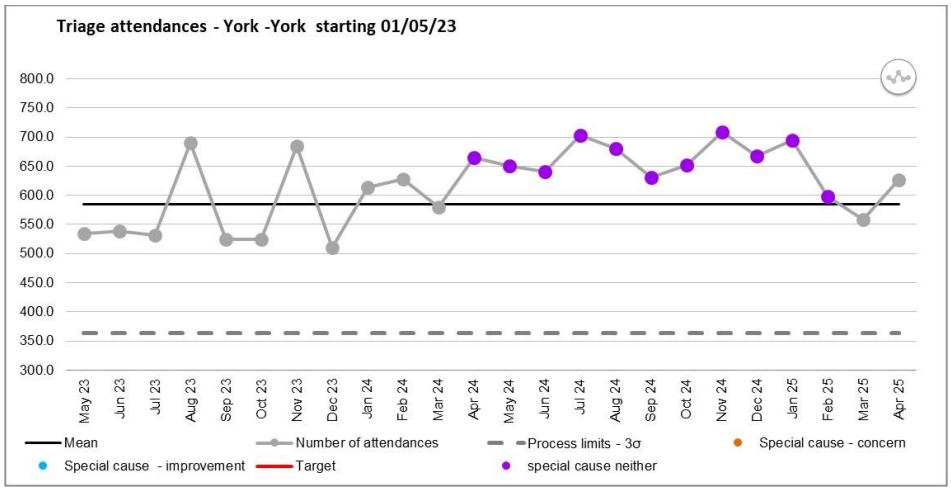


Chart 9

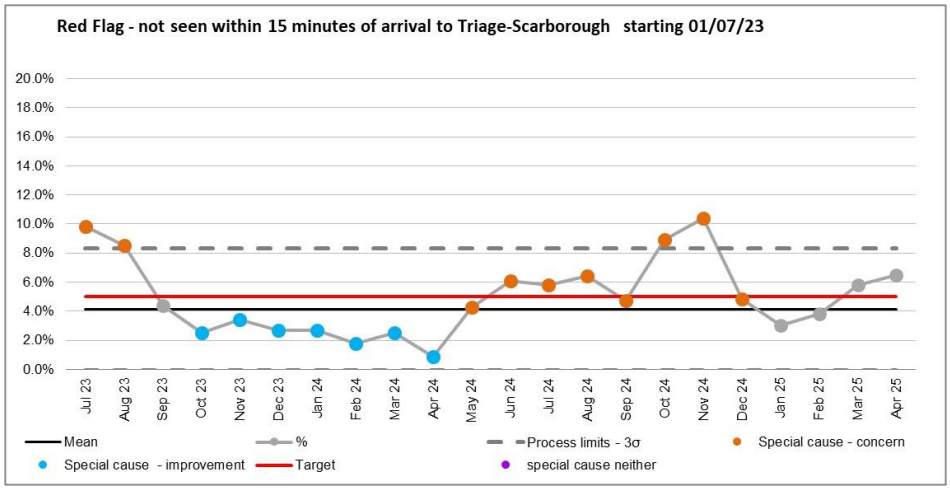


Chart 10

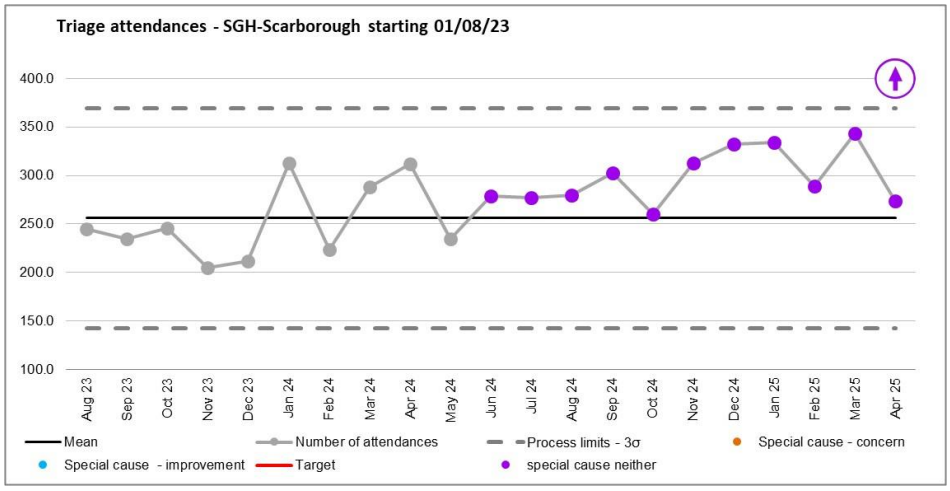


Table 9 Training compliance

	March 2025	April 2025
Midwives	80%	83%
Maternity Support Workers	59%	66%
Consultants	80%	81%
Other Obstetric colleagues	58%	81%

Training compliance is increasing month on month. BSOTS training is mandatory before shifts can be undertaken by Bank or Agency.

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.

The Maternity and Neonatal Safety Champions meetings were re-established in January 2025.

There has been a refresh of the Maternity Directorate meeting, Labour Ward Forum and Senior Midwifery Professional Leads Forum. A Maternity Digital Authority Group was constituted under the authority of the Maternity Directorate in February 2025. The Quality and Safety Framework Policy for Maternity is in development which will replace the Maternity Risk Management Policy.

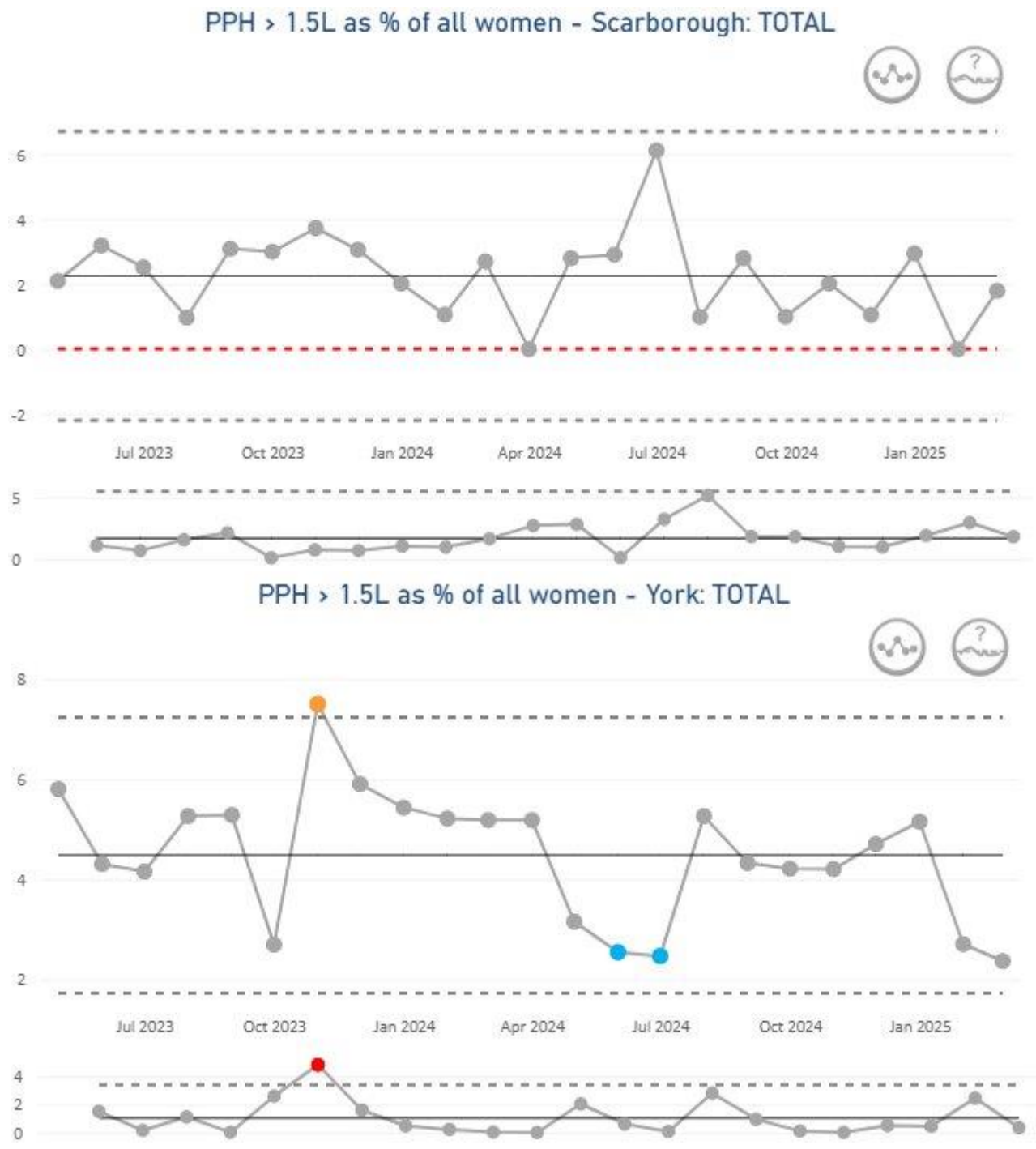
B.2 Postpartum Haemorrhage (PPH)

PPH over 1.5 litres

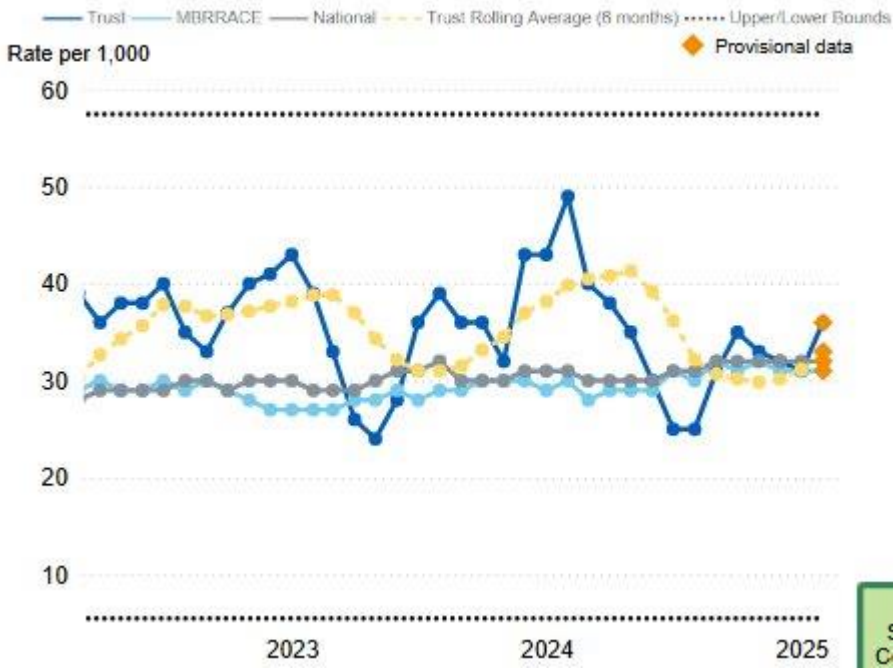
The reduction in the rate of postpartum haemorrhage (PPH) over 1500mls is a key priority for the maternity service. The PPH rate for March 2025 was 2.8% of all deliveries across both sites.

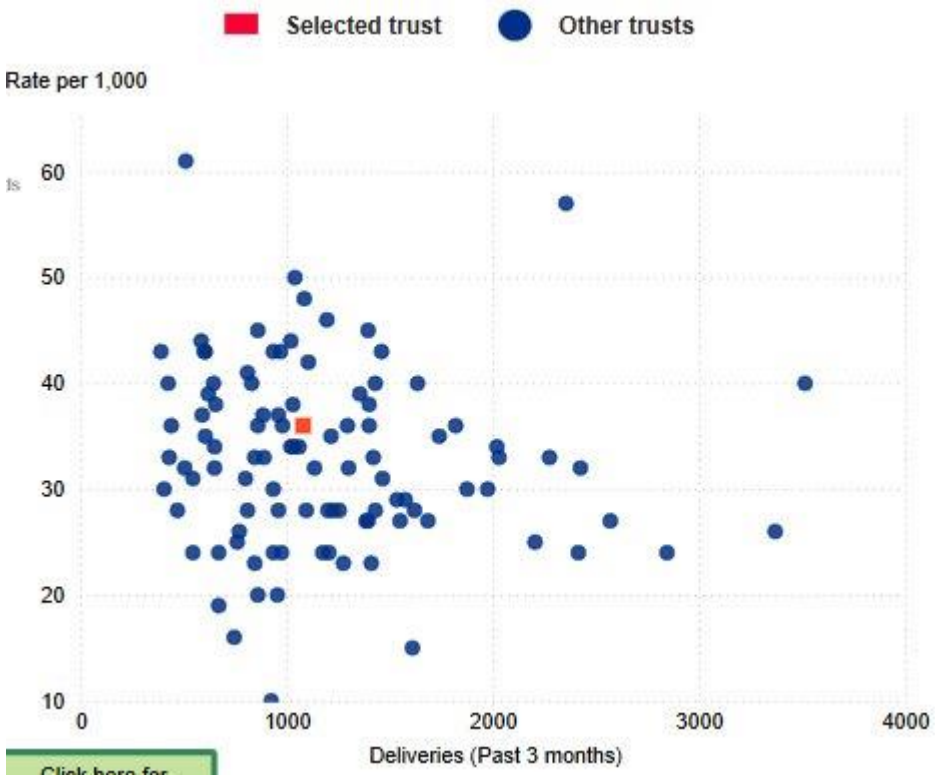
All PPHs are reviewed at the multidisciplinary Maternity Case Review meeting. The themes identified link to the ongoing improvement workstreams identified in the cluster review.

Blood Loss	Number in March 2025
1.5l – 1.9l	7
2l – 2.4l	2
> 2.5l	0



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. All the March 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. 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 February Audit (7 cases)

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.

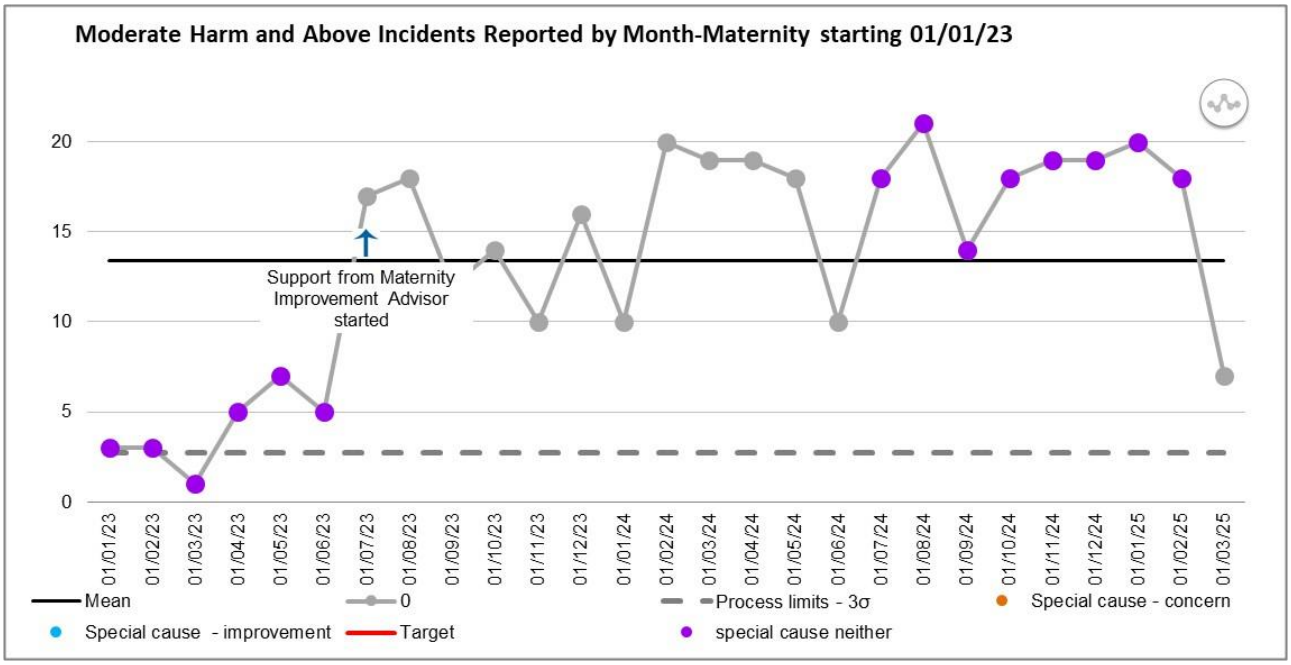
B.3 Incident Reporting

There were 7 moderate harm incidents reported in March 2025.

Datix ID	Incident Category	Outcome/Learning/Actions	Outcome
34051	Neonatal death from a multiple pregnancy (27 week) gestation.	Initial review at Maternity Case Review. No immediate safety actions identified	PMRT will be undertaken

32853 33187 33117 33753 33188	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.
33217	Term admission	Review at ATAIN	Learning included as part of ATAIN action plan

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 are 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.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	21 May 2025
Subject:	DRAFT Quality Strategy 2025/2030
Director Sponsor:	Dawn Parkes, Chief Nurse and Dr Karen Stone, Medical Director
Author:	Dawn Parkes, Chief Nurse and Adele Coulthard, Director of Quality, Improvement and Patietn Safety

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 Trust's Quality Strategy, covering the period 2025–2030, is aligned with the Trust's overarching strategy, Towards Excellence, ensuring a cohesive and complementary approach.

The initial version of the Quality Strategy was prepared and shared with a number of internal stakeholders and groups as detailed in the strategy document, for comments. This was done during February and March 2025. Following feedback, the strategy has been reviewed and adapted. The updated version is now presented alongside this paper for approval.

The Quality Strategy 2025-2030 outlines our commitment to delivering high-quality, safe, and patient-centred care. Key points include:

- **Strategic Framework**: The strategy builds on the 2019-2024 Quality Strategy, emphasising safety, effectiveness, and positive patient experience.
- **Quality Ambitions**: Five key ambitions are defined to guide our improvement efforts.
- **Annual Quality Goals**: Introduction of annual goals to focus on specific improvement areas.
- **Collaborative Approach**: Emphasis on working with partners to address health inequalities and improve population health.
- **Regulatory Alignment:** Incorporation of national priorities and regulatory requirements.

Recommendation:
The Board of Directors is requested to review the revised Quality Strategy and approve its content.

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

Meeting/Engagement	Date	Outcome/Recommendation
Executive Committee	16 April 2025	Recommended for approval
Quality Committee	22 April 2025	Recommended for approval

Quality Strategy 2025-2030

1. Introduction and Background

The Trust's Strategy, 'Towards Excellence' describes the ambitions and objectives of the organisation for the next 5 years. This paper presents the Quality Strategy as a key enabler to support the achievement of the overarching Trust's Strategy.

The Quality Strategy 2025-2030 aims to provide direction for improving the quality of services over the next five years. It builds on the previous strategy and incorporates feedback from various stakeholders. The strategy is aligned with national priorities and regulatory frameworks, ensuring that our services are safe, effective, and patient-centred.

This report presents the final draft of the Quality Strategy.

2. Strategy Development & Engagement

The strategy was developed through a comprehensive engagement process involving:

Stakeholder Consultation: Extensive input was gathered from corporate directors, Care Group Senior Leadership Teams, and other key stakeholders. This included multiple rounds of feedback to ensure the strategy reflects the needs and insights of those involved in delivering and receiving care.

Feedback Integration: Comments and suggestions from the consultation process were meticulously reviewed and incorporated into the strategy. This iterative process ensured that the final document is robust and reflective of collective insights.

Framework Adoption: The strategy is guided by the National Quality Board Shared Commitment to Quality, which provides a structured approach to quality improvement. This framework emphasises the three domains of safety, effectiveness, and positive experience, supported by leadership and sustainable resource use.

Continuous Improvement: The development process itself was iterative, with regular reviews and updates based on ongoing feedback. This approach ensures that the strategy remains dynamic and responsive to emerging needs and challenges.

3. Amendments

This section details the key copy changes made between the versions that have been presented to Corporate Directors and Executive Committee members. The modifications aim to refine objectives, enhance clarity, update incorporate the views of our workforce. Key areas that have been changed following comments received are:

1. To modify the language throughout the document to support the achievement of our ambitions to the level of 'good' as defined by the CQC. This was suggested to be more achievable and more engaging of staff.
2. We have made extensive reference to the 'multidisciplinary team' to emphasise the importance of this group and to align with our way of working at all levels in the Trust and to align with Our Voice: Our Future, our culture development programme.
3. Addressed language to make the report more accessible.

Any further changes made during this approvals process to Board will be captured in a Change Log: Summary of Modifications

4. Alignment with Trust Strategy

The Quality Strategy has been written as an enabling strategy to the Trust's Strategy 'Towards Excellence'. The Quality Strategy complements the Trust's Strategic Objectives and offers supporting ambitions that will move us forward to delivering 'excellent patient experience every time'. It will deliver this through commitment to the five ambitions within the Quality Strategy:

1. Deliver high quality, safe and patient-centred care, each and every time.
2. Deliver quality improvements with our staff, multidisciplinary teams, service users, patients, communities and partners.
3. Embed an evidence-based approach to Quality Improvement
4. Support more people to remain in, or near, their homes whilst receiving care.
5. Strengthen our culture of continuous quality improvement and grow our capability to deliver this.

5. Monitoring Process

The governance of the Quality Strategy 2025-2030 is designed to ensure robust oversight, accountability, and continuous improvement in delivering high-quality care. The governance framework includes the following key components:

Quality Committee: The Quality Committee is the primary board committee responsible for seeking assurance on the delivery of the Quality Strategy. It oversees the implementation of the strategy; monitors progress and ensures alignment with the Trust's strategic objectives.

Sub-Committees and Specialist Groups: Several sub-committees and specialist groups report to the Quality Committee, each focusing on specific aspects of quality improvement.

These include:

- Patient Safety and Clinical Effectiveness Sub-Committee: Monitors patient safety initiatives and clinical effectiveness.
- Patient Experience Sub-Committee: Focuses on improving patient experience and addressing feedback.
- Health and Safety Committee: Ensures compliance with health and safety regulations.
- Infection Prevention and Control Committee: Oversees infection control measures and initiatives.

The Quality Governance Framework provides a two-way 'service to board' assurance mechanism, ensuring that quality improvement efforts are communicated effectively across all levels of the organisation. This framework includes:

- Ward to Board Assurance: Regular reporting from Care Groups to the Board, highlighting progress, challenges, and areas for improvement.

- Quality Assurance Framework: Utilises various qualitative and quantitative measures, such as patient safety metrics, patient experience feedback, clinical audits, and benchmarking data, to monitor and evaluate quality performance.
- Annual Quality Goals: The introduction of annual quality goals provides a focused approach to specific areas of improvement. These goals are reviewed annually by the Quality Committee to ensure they remain relevant and aligned with the Trust's strategic priorities.
- Continuous Improvement and Learning: The governance structure supports a culture of continuous improvement and learning. This includes:
- Executive Deep Dives: Regular in-depth reviews of specific quality issues led by senior executives.
- Quality Rounds and Peer Reviews: Ongoing assessments and peer reviews to identify best practices and areas for improvement.
- Staff Engagement: Encouraging staff participation in quality improvement initiatives through training, workshops, and recognition programs.

External Regulation and Collaboration: The Trust engages with external regulatory bodies, such as the Care Quality Commission (CQC), to ensure compliance with national standards and regulations. Additionally, the Trust collaborates with partners across the health and care system to drive quality improvements and address health inequalities.

Reporting and Accountability: Progress on the Quality Strategy is reported regularly to the Quality Committee, the Trust Board, and other relevant stakeholders. The Trust also publishes an annual Quality Account, detailing achievements, challenges, and future plans for quality improvement.

By implementing this comprehensive governance framework, the Trust ensures that the Quality Strategy 2025-2030 is effectively managed, continuously improved, and aligned with the overarching goal of delivering excellent patient care.

6. Refreshing the Quality Strategy

The Quality Strategy introduces annual quality goals to provide a focus on specific areas of improvement. These will be revisited annually in the Quality Committee to determine if they need to be retired or replaced, and the strategy will be updated accordingly.

7. Recommendations and Next Steps

The Executive Committee is requested to review the revised Quality Strategy, approve its content and enable it to progress for final approval at Trust Board.

On approval at Trust Board, the Strategy will be published, the action plan will be finalised.

Date: 16th April 2025

York and Scarborough Teaching Hospitals NHS Foundation Trust

Quality Strategy for Delivering 'Towards Excellence' 2025 to 2030

Document Control:	
Author(s):	Dawn Parkes – Chief Nurse
Contributors:	Executive Directors Executive Committee Members Care Group Quadrumvirates Director of Midwifery Senior Nurses Senior Allied Health Professionals Medical Director Team Chief Nurse Team Clinical Non Executive Directors
Executive Lead:	Dawn Parkes – Chief Nurse
Version:	Draft v0.6
Date Approved:	
Review Date:	
Circulation:	

Version	Date	Summary of Changes	Author
Working drafts	February 2025	Drafting work to develop a new quality strategy and framework in which we deliver a sustainable and evidenced based approach	D Parkes
	28 Feb	Shared with the corporate directors, Care Group Senior Leadership Teams for comments	
0.6	7 April	Comments received have been incorporated into the document. Added in diagram from NQB and National Quality Strategy.	A Coulthard
0.7	16 April	Comments received have been incorporated.	A Coulthard
0.8	11 May	Final version for Trust Board	A Coulthard

Contents Page

Introduction from our Chief Nurse and Medical Director

Foreword

We are proud to introduce our Quality Strategy for York and Scarborough Teaching Hospitals NHS Foundation Trust — a clear statement of our shared commitment to delivering the very best care for our patients, supporting our colleagues, and continuously improving the way we work.

Every day, across our hospitals and community services, thousands of colleagues demonstrate exceptional dedication, compassion, and professionalism. It is thanks to you that we can make a difference in the lives of so many people. This strategy is built on that strong foundation — a collective drive to ensure our care is consistently safe, effective, and person-centred.

We know that there is much to be proud of, but we also recognise there is more to do. Listening to our patients, families, and staff, we understand where we need to improve. This strategy is our roadmap — not just for addressing challenges, but for creating a culture of curiosity, improvement, and learning. Whether that's making care safer, reducing unwarranted variation, improving access, or strengthening how we listen and act on feedback — the opportunities to do better are also opportunities to come together.

We are especially committed to making sure everyone who works with us feels valued, supported, and empowered to make a difference. The quality of care we provide is directly linked to how we support each other as colleagues, and this strategy reflects that understanding. It's not just about metrics and targets — it's about people. About you, your teams, and the patients and communities we serve.

This work will take time. It won't always be easy. But together, with shared purpose and collective effort, we can deliver meaningful, lasting change. We hope this strategy inspires you to be part of that journey — to think boldly, act with compassion, and keep asking how we can be even better tomorrow than we are today.

Thank you for everything you do.

Dawn Parkes, Chief Nurse and Karen Stone, Medical Director

Quality Strategy 2025 to 2030

1. Introduction

The purpose of this Quality Strategy is to set out our approach and provide direction for driving improvements in the quality of services we provide over the next five years. The strategy outlines the guiding principles that will shape our work, and the steps we will take to put these into practice.

Our approach to quality improvement has been developed over many years, informed by national approaches and provides a developing, supportive and innovative structure to how we improve. The 2019 to 2024 Quality Strategy provided a framework upon which to build, standardise and innovate the delivery of high quality, safe and effective care and the very best patient experience. In this new strategy we aim to rebuild and invigorate our systematic, systemic and evidence-based approach to improving quality to reliably deliver excellent patient experience every time.

The framework we have adopted to support this strategy is based on the National Quality Board: 'A Shared Commitment to Quality'. The diagram below illustrates the three domains of **Safety**, **Effectiveness** and **Positive Experience**, each of which is influenced by leadership (**Well-led**) and resources (**Sustainable use of resources**) to support the delivery of high quality, patient centred care for all.

This framework supports us to deliver care that is:

- **Safe** - delivered in a way that minimises things going wrong and maximises

things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.

- **Effective** - informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical audit.
- **Positive experience** -
    - **Responsive and personalised** - shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.
    - **Caring** - delivered with compassion, dignity and respect

The Care Quality Commission (CQC) inspection in 2023 rated the Trust as "Requires Improvement" overall, with "Good" for 'caring'. This Quality Strategy recognises where we need to improve, provides a framework for how we will do this and sets out the next steps on our journey 'Towards Excellence'. Our aim is to improve to good in all aspects of the inspection framework used by the CQC which will mean that our services are safe, caring, effective, responsive to people's needs and well-led.

The external context that shapes our approach has also changed with an increased expectation that individual organisations will work together as part of systems to deliver care closer to (or at) home where possible and to continue to provide safe and effective care against a backdrop of rising demand, constrained funding growth and increasing patient expectations. This means collaborating with partners across the system to improve the health of our population and reducing health inequalities, making the very most of the funding we receive and attracting, retaining and developing our staff.

In this document we have set out our ambitions for quality in a way that is designed to be meaningful to our staff, our multidisciplinary teams, patients, carers, the integrated care system and other stakeholders. We describe what improving to good means to us and provide an overarching framework to:

- Deliver high quality, safe and patient-centred care, every time.
- Deliver quality improvements with our staff, multidisciplinary teams, service users, patients, communities and partners.
- Embed an evidence-based approach to Quality Improvement
- Support more people to remain in, or near, their homes whilst receiving care.

- Strengthen our culture of continuous quality improvement and grow our capability to deliver this.

1.1 Our Trust

We are an acute and community service provider delivering a comprehensive range of acute hospital, community and specialist healthcare services for more than 500,000 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 including our Community Diagnostic Centres and facilities at the York Community Stadium

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, South Hambleton and Ryedale 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 in excess of £800m 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.

During 2023-24, we provided the following activity:

- 115,414 Accident & Emergency attendances
- 100,613 Urgent Care Centre attendances on our sites
- 160,808 inpatient admissions (adults, including maternity)
- 9,921 inpatient admissions (children)
- 121,700 operations or procedures as an inpatient
- 779,908 outpatient attendances (including telephone and video appointments)
- 3,916 babies delivered
- 43,840 new referrals in adult community services
- 4,100 new referrals in paediatric community services
- 1,120 admissions into community units (St Monica's, Nelson's Court, Selby)

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.

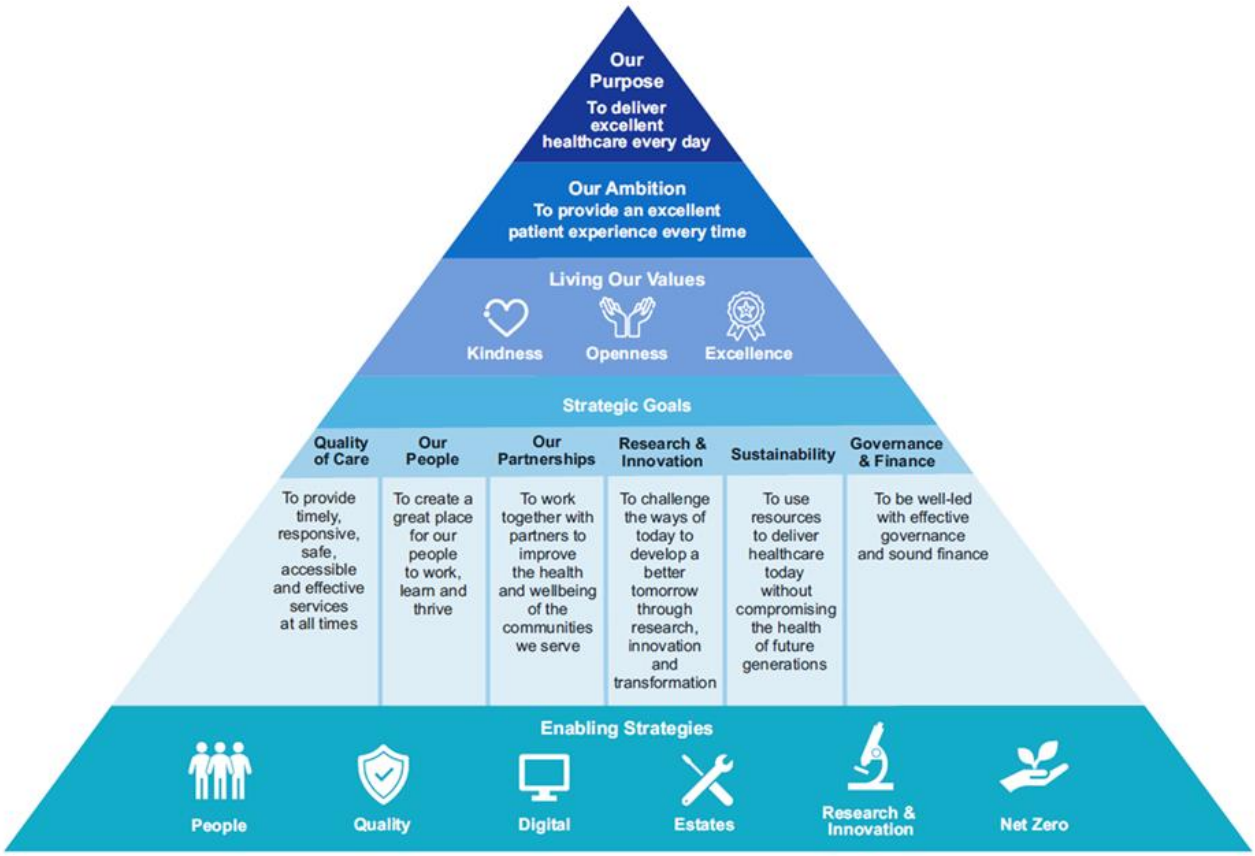
To be successful, our workforce will have a clear understanding of the strategic objectives of the organisation and their role in contributing to their attainment. Our actions and choices, no matter where we work or what we do in the organisation, should be aligned with the Trust's purpose, ambition, 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.

Our Values (how we behave and make decisions at work) are:

- Kindness
- Openness
- Excellence

The way we do things is just as important and what we do. These values have been developed in partnership with our staff. To support staff 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 Quality Strategy supports delivery of all the strategic aims, it will particularly enhance the delivery of two of our strategic goals:

- Quality of Care: to provide timely, responsive, safe, accessible and effective services at all times.
- Our Partnerships: to work together with partners to improve the health and wellbeing of the communities we serve.

The Quality Strategy is one of several supporting strategies and helps to drive our wider programme of quality improvement work. This includes:

- Quality Objectives: each year we select Quality Objectives based on our insight data and in consultation with key stakeholders. These are outlined in our annual Quality Account.
- Thematic Workstreams: improvement workstreams identified from thematic review of data including serious incidents, complaints, and inquests to ensure a Trust-wide approach.

1.3 National Focus and Priorities

There are several factors that influence and inform this Quality 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 support improvements in patient safety, experience and outcomes. They will underpin our work to deliver quality improvements to the services we provide.

This involves providers working more collaboratively to take every opportunity to enhance quality and provide the care our populations deserve. Many quality issues across health and care are a result of miscommunication and inefficient processes because the system is complicated. It is our duty to improve on this, removing waste and complexities by working together.

York and Scarborough Teaching Hospitals NHS Foundation Trust works collaboratively with partners across York and the East Coast, and within the Humber and North Yorkshire Integrated Care System. We are committed to ensuring that we work with colleagues across health and care including the voluntary and community sector, to drive and transform the delivery of quality services, address health inequality gaps and increase the years of life that people live in good health.

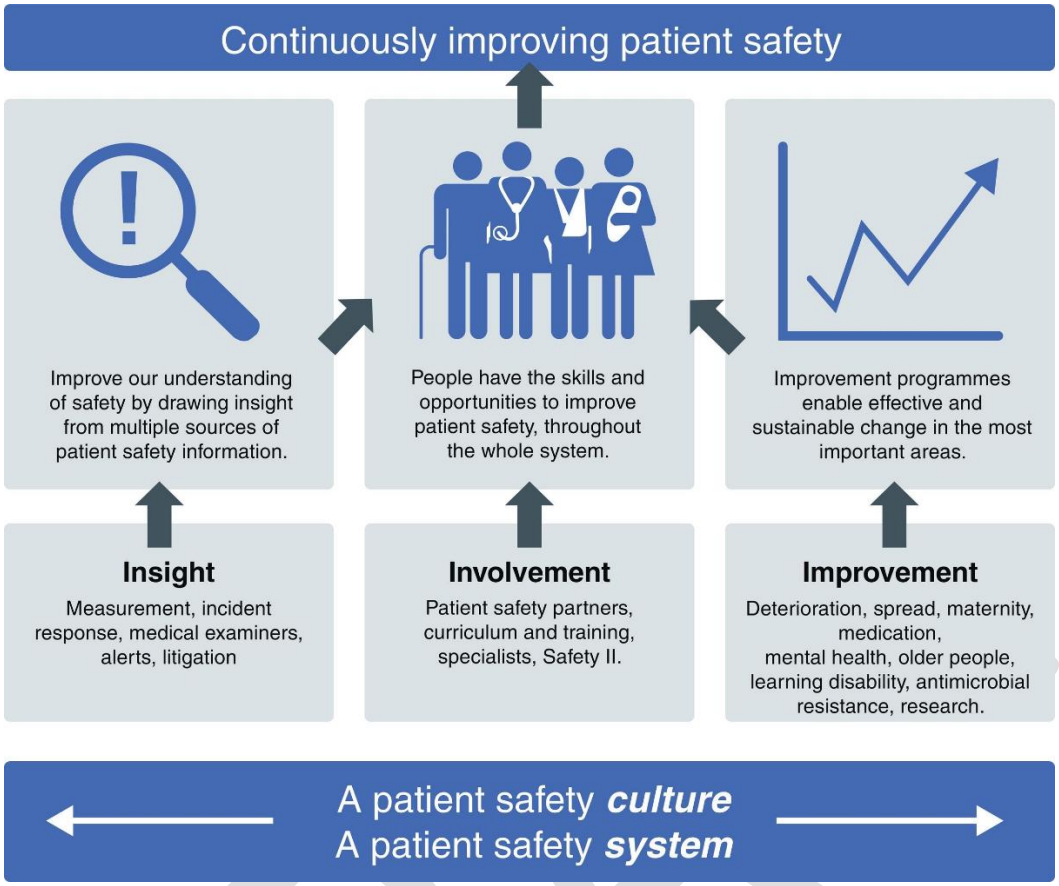
NHS Patient Safety Strategy

There have been significant improvements made in patient safety over the last 20 years, but there is still more to do. The NHS Patient Safety Strategy was published in July 2019 with a vision to improve patient safety, building on two foundations: a patient safety culture and a patient safety system.

The strategy is underpinned by three strategic aims:

- Improving understanding of safety by drawing on intelligence from multiple sources of patient safety information (**Insight**)
- Equipping patients, staff, multidisciplinary teams and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**)

Summary of the NHS Patient Safety Strategy



These three strategic aims are entirely consistent with continuous quality improvement, and we will use this structured approach to ensure we deliver quality improvement in a way that engages our staff, multidisciplinary teams, patients and partners.

- We will monitor progress against the NHS Patient Safety Strategy through our Patient Safety and Clinical Effectiveness Sub Committee to our Quality Committee and Care Group reporting to our Performance Review and Improvement Meetings.
- We will build the improvement capability of our teams, training them in our new Patient Safety Incident Response Framework and Quality Improvement Systems over the next five years.
- We will engage with staff, report on progress and accountability for learning and improvement through our broader quality governance framework and performance management structure.
- We will actively participate and collaborate in Humber and North York Integrated Care Board learning network for Patient Safety.

Regulation

Quality of care is underpinned by external regulation to check that required standards

are being met and that action is taken when they are not.

We will continue to engage with the Care Quality Commission (CQC) through our monthly meetings and with other relevant bodies, including the Medicines and Medical Devices and Healthcare Products Regulatory Agency (MHRA), Health and Safety Executive (HSE) and the clinical professional regulators, including the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Health Care Professions Council (HCPC) and the General Pharmaceutical Council (GPC).

In this new strategy we incorporate the ambitions set out in the revised CQC strategy published in 2021: a new strategy for the changing world of health and social care: that strengthens the commitment to ensuring health and care services provided to people are safe, effective, compassionate, and high quality, with a focus on improvement, based on four themes: people and communities, smarter regulation, safety through learning and accelerating improvement.

2. Our Quality Ambitions

As part of our journey 'Towards Excellence' we will develop an approach to quality and improvement in a structured way using the best management system available to us. The five quality ambitions listed here describe the detail of what improving to good looks like and will be consistent throughout the lifetime of this strategy.

In addition, we are introducing annual quality goals to provide a focus on specific areas of improvement. The Quality Committee will review these annually and determine any changes required.

As an NHS Trust we are required to achieve national quality and constitutional targets, supported by existing governance arrangements. Our work to improve our national and constitutional achievement will continue and complement our relentless focus on our annual quality goals.

We believe by describing what improving to good looks like, supported by understandable and achievable annual quality goals, our patients, staff and stakeholders will clearly understand what our ambition is, what success looks like and how we will get there.

2.1. Quality Ambition 1: Deliver high quality, safe and patient-centred care each and every time.

This means that we will be:

- Meeting and exceeding the set standards for person-centred, effective, well

led and safe care, so that we get it right first time for every patient.

- Encouraging a culture of openness, compassion and transparency where safety and quality incidents are reported, reviewed and learned from, in line with a just and restorative culture.
- Making timely improvements to continuously progress the quality of care we provide.

How will we achieve this?

We will:

1. Sustain and strengthen our focus on developing our quality improvement approach. This will include delivering our Nursing Quality Assurance Framework, quality rounds, senior leader service visits, Getting It Right First Time (GIRFT), benchmarking, peer reviews and clinical audit, executive deep dives and other initiatives.

   This will be measured through our staff survey results in relation to how many staff feel they can share their ideas for improvement and enact them. We will also measure this via our weekly and monthly audits of using the nursing and quality assurance framework and outcomes of peer reviews and accreditations.

2. Support our colleagues to continually improve quality by establishing a York and Scarborough Teaching Hospitals NHS Foundation Trust continuous improvement methodology framework, increasing the number of colleagues trained in the established system and role model compassionate leadership behaviours to sustain and strengthen our safety culture.

   This will be measured by the number of staff trained in our quality improvement approach and the number of quality improvement projects presented in new arrangements to share this work with wider trust staff and multidisciplinary teams

3. Support leaders, managers, clinicians and all our colleagues to explore, identify and deliver improvement opportunities linked to supporting our quality approach, helping us achieve our annual quality goals and address our quality challenges.

   This will be measured using triangulated data from a number of areas to help identify the focus of our improvement areas, supporting staff and multidisciplinary teams to analyse the data to help them understand where their improvement attention should be.

4. Focus on patient safety ensuring we deliver the safety improvement programmes supported by the national patient safety team. The four National

Patient Safety Improvement Programmes are:

- Managing Deterioration Safety Improvement Programme
- Maternity and Neonatal Safety Improvement Programme
- Medicines Safety Improvement programme
- System Safety Improvement Programme

The Trusts current Patient Safety Incident Response Framework (PSIRF) priority areas that are currently part of our PSIRF Plan, are:

- Managing deterioration
- Sepsis care
- Falls prevention
- Pressure ulcer prevention
- Reducing medication errors
- Improving the quality of discharge
- Reducing occurrences of post-partum haemorrhage

This will be measured by the delivery of one thematic review of incidents in each priority area per year to inform improvement work.

5. Listen to and act on the feedback from patients and families, and our staff, delivering high quality patient care aligning improvement activities to outcomes and patient experience of care.

   This will be measured by the number of complaints received and a 10% increase from baseline, year on year of the number of patients who recommend the Trust within their Friends and Family Test response.

2.2. Quality Ambition 2: Deliver quality improvements with our colleagues, service users, patient, communities and partners

This means that we will be:

- Listening to the voice of the patient and our staff as it presents in all parts of our organisation.
- Working with patients, their families and carers, together with our staff and the wider community as partners in the design, development and delivery of services.
- Personalising care so that people feel listened to, respected and cared for.
- Analysing and using available data to help inform our improvement priorities.
- Reducing health inequality gaps and providing care that is equitable.
- Making a conscious effort to hear from and understand the needs of our

seldom heard groups.

How will we achieve this?

We will:

1. Undertake meaningful and inclusive patient and public engagement to involve, collaborate and coproduce quality improvements with our services users, patients and communities.

   This will be measured by: All service improvements articulate via the project outline and the Equality Impact Assessment that patients and families have been involved.

2. Continuously seek to improve patient experience – analysing FFT scores, complaints, and other patient experience measures, and acting on the results.

   This will be measured by evidence from Care Group reports to Patient Experience Sub-committee that demonstrate triangulation of patient experience feedback into quality improvement activity.

3. Listen to our patients; ensuring we hear from voices representative of our diverse patient populations – including underrepresented groups, using a variety of proactive methods to achieve this including digital and online tools.

   This will be measured from the current baseline of patients that access FFT, Patient Advice and Liaison Services (PALS) and complaints processes via digital solutions and making use of reasonable adjustment offers.

4. Contribute and collaborate to place based Health and Care Partnership Experience of Care networks.

   This will be measured by attendance at network meeting by Trust colleagues.

5. Embed and develop leaders that serve our patients, staff and multidisciplinary teams through a framework of Compassionate Leadership.

   This will be measured through the staff survey results where staff report they feel engaged and able to make improvements.

2.3. Quality Ambition 3: Embed an evidence-based approach to Quality Improvement.

This means that we will be:

- Setting ambitious annual quality goals in partnership with our patients and stakeholders, specific to our Trust and, meaningful to our local populations.
- Reviewing these annual quality goals through our assurance framework Ward to Board.

How will we achieve this?

We will:

1. Set annual quality goals based on local and nationally available quantitative and qualitative data.

   This will be measured by having agreed quality goals that are based on available data intelligence.

2. Use the Model for Improvement as our evidence-based approach to continuous improvement. This will incorporate a clear aim, well defined measures and space to think far and wide about change ideas; followed by rapid tests of change using multiple improvement cycles and based on local and nationally available data such as GIRFT, Model Healthcare System, and public health information

   This will be measured by the number of quality improvement projects presented at the new arrangements for sharing our progress and the learning we have had.

2.4. Quality Ambition 4: Support more people to remain in, or near, their homes whilst receiving care.

This means that we will be:

- Creating a world-class clinical environment focused on patient experience and safety.
- Improving health and wellbeing across our population taking a proactive, preventative approach to improving population health.
- Benefiting from the latest estates infrastructure, technology, teaching, research, and innovations.
- Addressing our challenges in sustainability and delivering value by implementing new ideas, services and systems.
- Supporting clinicians and other partners work together to test and deliver quality improvements using continuous improvement methodologies**.**
- A leader in healthcare innovation, teaching and quality improvement.

How will we achieve this?

We will:

1. Work across our Care Groups and multidisciplinary teams, as part of the Humber and North Yorkshire system, to learn from others making sustainable improvements to care, including the Collaboration of Acute Providers, place-based partnerships and local alliances for transformation, which will include placing a priority on developing new models of community service provision.

2. Champion cross-boundary and more integrated neighbourhood pathways to put patients in the centre of their care.

3. Develop and identify innovative and scalable solutions to address our challenges and to improve patient care working through entire pathways of care using a Quality Improvement approach.

4. Exploit the capabilities and opportunities of information technology.

5. Accelerate our research, teaching and development; invest in infrastructure and the clinical environment to pioneer new ways to deliver high quality care.

   All of the above will be measured by evidence of our growing use of technologies, such as artificial intelligence to help with innovations, and the growing use of technology to support more people to remain in their own home rather than come to hospital for care. We will also measure this by the number of new pathways of community-based care that are established.

2.5. Quality Ambition 5: Strengthen our culture of continuous quality improvement and grow our capability to deliver this.

This means that we will be:

- Nurturing and supporting our multidisciplinary teams to have quality improvement skills, knowledge and the tools they need to improve the care they deliver to patients.
- Empowering our multidisciplinary teams, who know their local challenges best, to become skilled in solving problems in their areas to improve care.
- Building a quality improvement community across all professions who support each other to deliver and improve quality.
- Working with other partners across our places to share our approach to

quality improvement.

- Engaging and enthusing all staff, patients and communities to enable then to take part in continuous improvement.
- Supporting leaders and managers across the organisation to coach and role model our Trust values and improvement approach.
- Sharing learning and celebrating success
- Learning from when things go right and view mistakes as a learning opportunity not as failure.

How will we achieve this?

We will:

1. Create opportunities for multidisciplinary, cross-department and pan-system working and cross-pollination of ideas through live improvement work, projects and training.

   This will be measured by the number of quality improvement projects presented at the new arrangements for the Trust to share the improvements we are making and the learning we have had.

2. Expand on our tiered approach to improvement through quality improvement education, training and coaching to build organisational capability and capacity across the multidisciplinary team.

   This will be measured by the number of staff trained in our quality improvement approach, and the levels to which they are trained.

3. Ensure that staff experience leads to more confidence and resilience at work and that we are the employer of choice.

   This will be measured by the staff survey results.

4. Ensure all staff and multidisciplinary teams can be involved with quality improvement Rapid Improvement Events, projects, setting local goals, quality rounds, Schwartz Rounds and the Nursing Quality Assurance Framework recognition awards.

   This will be measured by the number of quality improvement projects presented at the new arrangements for the Trust to share the improvements we are making and the learning we have had.

5. Continue our focus on quality through our embedded quality approach, including executive led deep dives, senior leader links with services and quality ‘temperature checks’.

   This will be measured by reports received in the Quality Governance Assurance Meetings

6. Grow our improvement community to enthuse, empower and enable colleagues to get involved with quality improvement across and with our places, creating a culture that values and actively shares learning across the system.

   This will be measured by the establishment of our internal Quality Improvement Network and the number of staff attending. We will also measure this through an annual event encouraging teams to showcase their improvement work.

7. Use our own case studies to share learning about what works well and where we need to learn from mistakes and failure, recognising the value of sharing our learning across teams, organisations, and systems.

   This will be measured by the number of submissions we make to national and local award structures with the aim of becoming finalists and improvement award winners.

3. Quality Governance

Our Quality Strategy is supported by our revised quality architecture, using our existing and embedded quality assurance framework and governance processes. Quality improvement will be supported through the Trust's governance arrangements, which provides a two-way 'service to board' assurance mechanism, reporting and providing feedback across all areas.

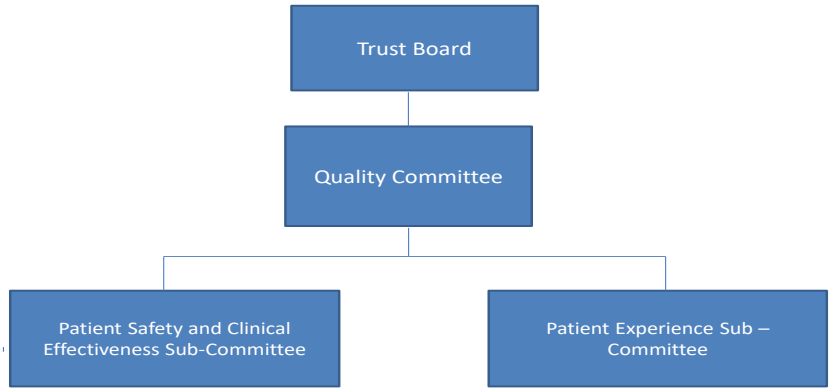
The Quality Committee is the Board Committee with responsibility for seeking assurance on the delivery of the Quality Strategy. Assurance and monitoring evidence is shared with the Committee through the following governance structure highlighted in Figure 3. In support of these high-level committees, we have specialist groups that report through to the Quality Committee and Trust Board and take forward specific aspects of work, for example the Health and Safety Committee and Infection Prevention and Control Committee

The organisations quality ambitions are also supported through a range of key triangulated qualitative and quantitative measures, including:

- Patient safety measures
- Patient experience measures
- Local and national audits
- Corporate reviews with each clinical division
- Getting it Right First Time (GIRFT)
- Trust quality assurance framework and accreditation processes
- Grand rounds
- Leadership visits/back to the floor days

- Clinical audit
- Model Healthcare System data
- Reports of national benchmarking studies and confidential inquiries

Figure 3 High Level Quality Governance Structure



4. Annual Quality Goals

We are introducing the concept of annual quality goals to provide a focus on specific areas of improvement, and we will revisit these annually in the Quality Committee to determine if they need to be retired or replaced. We will report on our progress with delivering our annual quality goals and other important quality measures such as complaints in our annually published York and Scarborough Quality Account.

5. Summary and Next Steps

This York and Scarborough Teaching Hospitals NHS Foundation Trust Quality Strategy, and the introduction of annual quality goals is a bold but appropriate step forward for the Trust in delivering more consistent and reliable care to the people we serve. It will bring clarity to our staff and multidisciplinary teams about our organisation-wide focus for improving quality and support our partnership working with the communities and organisations in York and the East Coast and the wider Humber and North York Integrated Care System.

We will report the improvements we are making and share these with our teams, patients and the public and the Trust Quality Committee and the Trust Board. We will set out our successes and challenges in our Annual Quality Account. We will keep this strategy under constant review and welcome feedback from patients, communities, partners and our staff to strengthen further our approach in delivering for all the communities we serve.

End

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	21 May 2025
Subject:	Guardian of Safe Working Hours 2024-2025 Annual Report
Director Sponsor:	Dr Karen Stone
Author:	Dr Oluwafumbi Olajide

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 Guardian of Safe Working Hours (GOSWH) is a statutory, independent role which exists to ensure compliance with contractual stipulations regarding safe working hours for resident doctors employed by the Trust and provide assurance of this to the board.
- The Guardian role saw a changeover during the year, with a new Guardian who commenced in post in September 2024
- The three key themes in this annual report are:
  - A consistent increase in exception reporting compared to previous years, indicating improved awareness and engagement with the process.

- Staffing shortages remain a key theme across the year, impacting resident doctors' wellbeing and the quality of care provided.
- Exception reports were predominantly submitted for late finishes. There was a rise in missed breaks, inadequate supervision, and missed training opportunities.

Recommendations:

- Note the contents of this 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

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

Meeting/Engagement	Date	Outcome/Recommendation

1. Introduction and Background

This is the 2024/2025 annual report to the Board from the Guardian of Safe Working Hours (GoSWH) as required by the 2016 terms and conditions for doctors and dentists in training. The annual report is for 1 April 2024 to 31 March 2025 and summarises key findings from the Resident Doctor Forum (RDF) and Exception Reporting data.

The primary role of the GoSWH is to ensure compliance with contractual stipulations regarding safe working hours for resident doctors employed by the Trust and provide assurance of this to the board.

The primary source of information about the working hours is from Exception Reporting. All resident doctors are given access to the online Exception Reporting tool and can highlight variation in working hours, missed breaks, and missed training opportunities. These reports are sent directly to the doctor's supervisor who can award Time Off in Lieu (TOIL) or payment for additional hours worked or close the report with no further action.

The Director of Medical Education has access to review reports related to training and supervision.

The GoSWH also holds the position of Chair of the Resident Doctors Forum (RDF). The Forum has core representation from Medical Employment, Medical Deployment, Medical Education, Care Group Management, Local Negotiating Committee and British Medical Association. It is open to all resident doctors working in the Trust.

2. Current Position/Issues

2.1 *Exception reporting trends*

A complete breakdown by Care Group and department is detailed in Table 1 of the Appendix. It is worth noting that **the specialty recorded reflects the doctor's primary base but not necessarily where they worked the shift in question**. This is usually the case in reports related to out-of-hours shifts.

Three hundred and four (304) reports were received in 2024/2025. This has shown a steady increase compared to the past 2 years where we received 287 in 2023/2024 and 254 in 2022/2023 respectively. This suggests better awareness of the process and greater engagement by doctors. However, significant challenges persist, particularly staff shortages, delayed responses to exception reports, and missed training opportunities.

The Medicine Care Group consistently submitted the highest number of reports. This is consistent with this Care Group hosting the highest proportion of Resident Doctors. Reports citing immediate safety concerns were received in each quarter, primarily related to insufficient staffing levels. Foundation Year 1 doctors were the primary reporters, but reporting from Trust Grade doctors and higher trainees increased due to ongoing promotion efforts. Timely resolution of reports remained inconsistent, with an average of 43% reviewed within 7 days across the year.

2.2 *Resident Doctors' Forum (RDF)*

Formerly the Junior Doctors' Forum, the RDF underwent a rebranding in Q3 in line with a national change in terminology from junior doctors to resident doctors.

Key developments include:

- RDF supported awareness campaigns for exception reporting in departments with historical underreporting.
- New vice-chairs and site-specific representatives were appointed to strengthen local engagement.
- 'Swap Shops' launched to support shift flexibility around major holidays like Christmas and Eid.
- Continued advocacy for International Medical Graduates and Locally Employed Doctors (LEDs), including induction improvements.
- Repeated calls for consistent delivery of local induction at non-hospital placements.

2.3 *Exception Reporting Changes*

On 25 April 2025, NHS England announced planned reforms to the framework and processes for exception reporting. These reforms include modifications to reporting structures and oversight mechanisms, aimed at enhancing resident doctors' confidence in submitting exception reports, as well as revisions to the rules governing the issuance of fines. The Trust and the Guardian of Safe Working Hours are currently awaiting further guidance from NHS England, following which the necessary changes will be implemented.

2.4 *Guardian Funds*

The Resident doctor contract stipulates specific breaches to safe working hours and rest should lead to a Guardian fine payable by the relevant Care Group. It also details how the fine should be calculated and shared between the affected doctor and Guardian. The use of Guardian funds are accessible to all residents via the Resident Doctors' Forum.

Ten fines were levied in 2024/2025:

Four were levied against the Family Health Care Group (totalling £310.02, £193.76 going into the Guardian fund), one for Medicine (totalling £89.44, £55.90 going into the Guardian fund) and five against the Surgery care group (totalling £261.24, £163.32 going into the Guardian fund). All ten fines related to shifts that went over the maximum 13 hours.

The predominant reason for exceeding the maximum working hours was handover issues (starting or ending late), as well as two emergency surgeries, and one due to the clocks going forward.

The end of year balance from fines levied is £1,671.44, of which £500.00 has been ringfenced. Details presented below:

Guardian Funds: 2024/2025 activity

Detail	+/-	Balance
Opening balance on 1 April 2024		**£1,493.14**
(+) Guardian fines	+£412.98	£1,906.12
(-) Purchases made in this quarter	*- £234.68*	£1,671.44
Closing balance on 31 March 2025		£1,671.44

Ringfenced funds	+/-	Available Balance
Purchase for York Doctors' Mess	*-£500.00*	*£1,171.44*
Available funds on 31 March 2025		**£1,171.44**

3. Discussion

This annual report presents a detailed picture of the pressures impacting safe working hours for resident doctors, reflected in both the rise in exception reporting and the nature of the issues flagged - primarily persistent staff shortages, late finishes, missed breaks, and delayed supervision.

Recommendations for Consideration:
The following items are areas recommended for action. Many of these will be taken forward by the GOSWH and others are for consideration by the Trust to

3.1 *Promoting Exception Reporting*

The continued rise in exception reporting, reflects growing awareness and engagement. However, underreporting remains an issue in certain departments due to cultural or structural barriers. To further support and normalise the practice of exception reporting:

- Introduce and promote anonymous exception reporting, particularly in departments where discouragement has occurred.
- Sustain awareness campaigns and ensure all new resident doctors, receive clear guidance on exception reporting during induction.
- Reinforce the importance of exception reporting among supervisors and departments

3.2 *Workforce Planning and Deployment*

Staffing shortages remain a recurrent theme, driving late finishes, missed breaks, and insufficient supervision. Exception reporting data offers a valuable lens through which workforce pressures can be analysed.

- Develop a Trust-wide workforce resilience plan to address persistent staffing gaps and prioritise high-risk departments identified through exception reporting trends.
- Integrate exception reporting analytics into workforce planning meetings to inform rota design, recruitment efforts, and shift allocation.
- Finalise and implement terms and conditions for Locally Employed doctors, ensuring consistent recognition and support to stabilise workforce numbers.

3.3 *Resident Doctors' Wellbeing*

The nature of exception reports this year, including increases in reports of missed breaks, inadequate supervision, and missed training highlight sustained pressures that adversely

affect resident doctors' wellbeing. Persistent understaffing remains a critical factor behind these concerns, impacting morale, training, and overall safety.

- Collaborate with workforce and operational leads to ensure safe staffing levels are consistently maintained, particularly during periods of high demand or known workforce deficits, in order to reduce excessive workloads and protect resident doctor wellbeing.
- Ensure structured induction and support for all doctors, including those on non-hospital placements.
- Continue investment in wellbeing initiatives e.g. rest facilities, peer support schemes.

Desired Outcome

- Foster a culture where exception reporting leads to meaningful change, not just documentation.
- Reduce safety-related incidents and burnout by stabilising workforce capacity.
- Improve training quality, morale, and wellbeing among resident doctors.
- Provide the Board with a clearer picture of service pressure points to inform strategic planning.

4. Summary

- Exception reporting rose across all quarters this year, with 304 reports submitted in total.
- The Medicine Care Group remained the primary source of exception reports.
- Doctors' wellbeing and training access are being impacted by poor staffing levels.
- Guardian fines were primarily due to over 13-hour shifts during delayed handovers, emergency cases and service pressures.
- Response delays to exception reports by supervisors remain an issue, with only 43% addressed in the contractually required time.
- The Guardian's role in safeguarding working hours remains vital to ensure quality of care and resident doctors' morale.
- The Trust and the Guardian of Safe Working Hours are awaiting further guidance from NHS England, following which the necessary changes to the Exception Reporting process will be implemented.

Date: 8 May 2025

Appendix 1: Exception reporting data for 2024-2025

Table 1: Exception reports by department			
Care Group/ department	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions open**
Family Health	**44**	**42**	**2**
Obstetrics & Gynaecology	41	39	2
Paediatrics	3	3	0
Medicine	**179**	**179**	**0**
Acute Medicine	32	32	0
Cardiology	48	48	0
Diabetes & Endo	9	9	0
Elderly Medicine	25	25	0
Elderly/Acute	1	1	0
Emergency Medicine	7	7	0
Gastroenterology	20	20	0
General Medicine	1	1	0
Haematology	2	2	0
Palliative Medicine	1	1	0
Renal Medicine	10	10	0
Respiratory	19	19	0
Stroke/Rehab	4	4	0
Surgery	**80**	**80**	**0**
Anaesthetics	3	3	0
Dental Core Trainees	1	1	0
Dental Foundation Trainees	3	3	0
ENT	6	6	0
General Surgery	1	1	0
General Surgery (Colorectal)	8	8	0
General Surgery (Gastro)	8	8	0
General Surgery (Upper GI)	3	3	0
General Surgery (Urology)	2	2	0
General Surgery (Vascular)	9	9	0
Oral & Maxillofacial Surgery	1	1	0
Trauma and Orthopaedics	35	35	0
CSCS	**1**	**1**	**0**
General Psychiatry	1	1	0
Total Raised	**304**	**302**	**2**

Table 2: Exception reports by grade				
Grade	No. exceptions in **previous financial year**	Proportion of reports **financial year**	No. exceptions raised **this financial year**	Proportion of reports **this financial year**
F1	169	59%	144	47%
F2	49	17%	15	5%
CT1-2 / IM1-2/ ST1-2	63	22%	112	37%
IMT3/ ST3+	6	2%	33	11%
Total	**287**	**100%**	**304**	**100%**

Table 3: Exception reports by type				
Type	No. exceptions in **23/24**	Proportion of reports **23/24**	No. exceptions raised **24/25**	Proportion of reports **24/25**
Late finish	218	76%	223	73.3%
Late finish & early start	14	4.9%	0	0%
Early start only	1	0.34%	0	0%
Missed breaks	15	5.2%	27	8.9%
Late finish and missed breaks	16	5.6%	15	4.93%
Difference in working pattern	3	1.03%	4	1.32%
Missed breaks & Difference in working pattern	0	0%	2	0.66%
Unable to achieve minimum 11 hours rest	0	0%	1	0.33%
Inadequate supervision	4	1.4%	10	3.3%
Inadequate supervision & late finish	0	0%	1	0.33%
Inadequate clinical exposure	1	0.34%	4	1.32%
Inadequate supervision & unable to achieve breaks	3	1.03%	4	1.32%
Inadequate supervision & unable to attend scheduled teaching/training	1	0.34%	0	0%
Unable to attend scheduled teaching/training	2	0.7%	7	2.3%
Unable to attend scheduled teaching/training & late finish	2	0.7%	1	0.33%
Unable to attend schedule teaching/training & late finish & missed break	0	0%	1	0.33%
Unable to attend clinic/theatre/session	4	1.4%	3	1%
Unable to attend clinic/theatre/session & missed break	0	0%	1	0.33%
Teaching cancelled	1	0.34%	0	0%
Difficulty completing workplace-based assessments (WPBAs) & Inadequate clinical exposure/experience	1	0.34%	0	0%
Difficulty completing workplace-based assessments (WPBAs) & Inadequate clinical exposure/experience & Inadequate supervision & Lack of feedback	1	0.34%	0	0%
Total	**287**	**100%**	**304**	**100%**

Table 4: Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 3-7 days**	**Addressed in longer than 7 days**	**Still open**
FY1	28	39	76	0
FY2	3	7	5	0
CT1-2/ST1-2	21	18	69	2
IMT3/ST3+	6	9	18	0
Total	**58**	**73**	**168**	**2**

43% addressed within 7 days (59% in 2023/2024)

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Trust Board
Date of Meeting:	21 May 2025
Subject:	Staff Survey Improvement Plan – responding to 2024 results
Director Sponsor:	Polly McMeekin – Director of Workforce & Organisational Development
Author:	Vicki Mallows – Workforce Lead

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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☐ 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:

It is recognised that the survey results show significant gaps in staff experience when comparing our own Trust to that of our peers (including from an equality, diversity and inclusion perspective). The results have relevance to patient experience, patient safety and quality of care, as well as staff experience and retention.

It is also acknowledged that the participation rate has dropped from 43% in 2022 to 36% in 2024 and is 13% below average and 35% below our highest peer Trust i.e. our understanding of what it is like for all staff to work in the Trust is significantly less representative than it could be.

The attached overall Staff Survey Improvement Plan (Appendix 1) incorporates feedback from Staff Networks, Staff Governors, Union Representatives, and Corporate Directors; common themes from plans received from Care Groups, Corporate Directorates, and YTHFM; and some ongoing actions from the last financial year.
Recommendation: The Board is asked to consider the proposed actions and provide feedback. All Directors are asked to take responsibility for the actions that relate to their own staff / areas of delivery; and to hold themselves and each other to account for delivery of this plan.

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

Report History

Meeting/Engagement	Date	Outcome/Recommendation
Executive Committee	07 May 2025	Additional action identified to strengthen the celebration of successes
Resources Committee	20 May 2025	Unknown at the time of submitting this paper

Staff Survey Improvement Plan – responding to 2024 results

1. Introduction and Background

The 2024 Staff Survey results have been shared across the organisation and formally reported to this Board earlier in 2025.

Appendix 1 outlines the proposed overall Trust Staff Survey Improvement Plan which incorporates feedback from Staff Networks, Staff Governors, Union Representatives, and Corporate Directors; common themes from Care Groups, Corporate Directorates, and YTHFM; and some ongoing actions from the last financial year.

2. Considerations

Proposed actions relate to the following key themes:

- Organisational culture (the Our Voice Our Future programme)
- Growing management and leadership capability across the organisation, including team development and effectiveness.
- Ensuring the new Trust strategy is embedded across the organisation with clarity around goals, objectives, roles and responsibilities, at team and individual level.
- Embedding continuous and quality improvement
- Health, safety and wellbeing
- Creating a great place to learn and progress
- Increasing participation in the annual survey to ensure the results are more representative of the whole workforce.
- Increasing the celebration of successes.

3. Current Position/Issues

The organisation has not incentivised completion of the annual survey for the last two years. In that time, we have seen our participation rate drop from a high of 43% in 2022 when we last offered an incentive (2% below average, 26% below our highest peers) to 36% in 2024 (13% below average and 35% below our highest peer Trust).

It is also recognised that the survey results show significant gaps in staff experience when comparing our own Trust to that of our peers (as per the results previously reported to the Board earlier in 2025). The results are applicable to patient experience, patient safety and quality of care, as well as staff experience.

4. Summary

The proposed actions are designed to improve staff experience (and therefore retention), and to increase participation levels to ensure we have a more representative understanding of what it is like for all colleagues to work here.

5. Next Steps

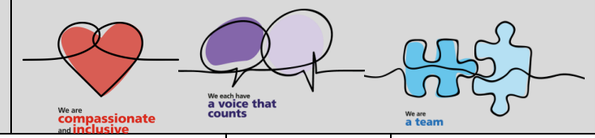
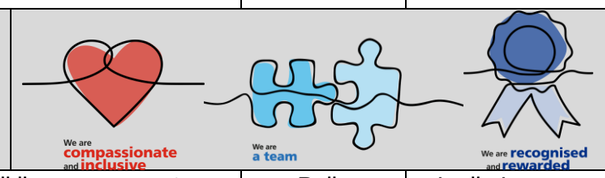
The Board is asked to consider the proposed actions and provide feedback. All Directors are asked to take responsibility for the actions that relate to their own staff / areas of delivery; and to hold themselves and each other to account for delivery of this plan.

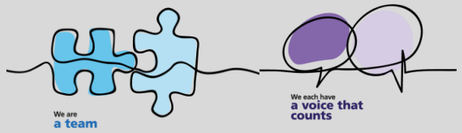
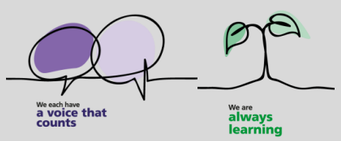
Date: 08 05 2025

2024 Staff Survey Results - Improvement Plan - Listening to Employee Voice: Our Voice Our Future

York and Scarborough Teaching Hospitals NHS Foundation Trust

The actions below have been drawn from the overall Staff Survey results for the organisation, including the themes from the free text comments; and common themes from action plans shared by Care Groups, Corporate Directorates and YTHFM.

ACTION	EXECUTIVE SPONSOR	OPERATIONAL LEAD(S)	MEASURES	TIMESCALES	PROGRESS
Compassionate and Inclusive Culture 					
Create a compassionate and inclusive culture where people want to come to work. Continue with Our Voice Our Future, the NHSE Cultural and Leadership Programme. Implement the Delivery phase of the programme to develop our future culture.	Simon Morritt, Polly McMeekin	Jenny Flinton, Gail Dunning & Alex Kilbride	To improve the staff survey scores in 2025: 'We are compassionate and inclusive' to increase from 6.9 to 7.2 in 2025; and 'Staff Engagement' to increase from 6.3 to 6.8 in 2025 (to match the peer group average scores in 2024). To increase the response to 'I would recommend my organisation as a place to work' from 45% in 2024 to 50% in 2025 and 53% in 2026 (as per scorecard metric). To increase the response to 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' from 43% in 2024, to 48% in 2025 and 51% in 2026 (as per scorecard metric).	Two-year programme for completion 2025/26	Board to review and agree the recommendations of the Design phase in May 2025. Delivery phase to commence in June 2025.
Leadership and Management Capability 					
Further support and development for all line managers to grow management and leadership capability. To include: • Developing team effectiveness (including a sense of 'team'). To support with this fully continue to roll out and utilise the Insights Profiling. • Collaborative working (across teams, CGs/Directorates, and staff groups) • Communicating effectively • Showing respect and appreciation for staff (valuing their contribution) • Ensuring early resolution to staff concerns and complaints	Polly McMeekin	Lydia Larcum & Gail Dunning	To increase the 'Team working' sub-score from 6.3 to 7.1 in 2026 (to match best peer result in 2024) To increase the 'Line management' sub-score from 6.6 to 7.3 in 2026 (to match the best peer result in 2024) To reduce the 'experienced discrimination from managers/team leaders or other colleagues' question from 9.2% to 4.4% in 2026 (to match the best peer result in 2024)	Ongoing 2025/26	As of 28.04.2025 966 people have attended Line Manager Development Training (phase 1). Management Fundamentals Training to commence in July 2025. This will include how to robustly identify and manage capability (performance).
To promote and further embed the line manager toolkit and line manager development programme to ensure managers understand and deliver on their responsibilities.	All directors	Leadership teams in Care Groups, Corporate	To reduce the 'experienced harassment, bullying or abuse at work from Managers' question from 13.2% to 5.2% in 2026 (to match the best peer result in 2024).	Ongoing 2025/26	Further developments and additions made to the Line Manager Toolkit, with a Payroll Booklet also added and a Recruitment specific booklet in development.

To review the Trust's Leadership Framework and associated documentation e.g. 360 feedback to ensure it remains in line with NHS expectations following the publication of the national management and leadership framework expected in the Summer 2025. To promote Managers and leaders each year to have 180-degree feedback against the Trust's Leadership Framework to inform their appraisal and development plan. Strengthen the celebration of successes at organisational, service, team and individual level i.e. recognise and appreciate the contributions of all colleagues.	Lucy Brown	Directorates, and YTHFM Leadership teams in Care Groups, Corporate Directorates, and YTHFM	To increase the response to 'I am confident that my organisation would address my concern' from 35% in 2024, to 40% in 2025 and 42% in 2026 (as per scorecard metric). Increase the response to 'The recognition I get for good work' question from 49% in 2024 to 60% in 2026 (to match peer best in 2024). Increase the response to 'The extent to which my organisation values my work' question from 37% in 2024 to 53% in 2026 (to match peer best in 2024).	September 2025 and ongoing	The Trust's Leadership framework already includes a self-assessment tool which all staff can use for self-reflection and discussion with line manager / coach / mentor etc. OD actively promote the self-assessment on all leadership programmes and include 1:1 or small group discussions on their individual reports & areas of strength and for development.
Delivery of the Trust Strategy, Goals and Objectives					
All managers to ensure that the new Trust vision, purpose and strategy is shared widely and ensure each team has clear shared goals and objectives, each person is clear on the purpose of their role and understanding of own and co-workers' roles and responsibilities. Review of management structures to remove unnecessary bureaucracy including duplication of roles and responsibilities, barriers to effective communication. Increase leadership visibility at all levels to encourage verbal and face to face dialogue thus limiting email communication. Empower staff networks and trade unions by providing reasonable time to support Trust objectives in these roles. Transition the off-line workforce to be online to receive key organisational communications.	All directors	Leadership teams in Care Groups, Corporate Directorates, and YTHFM	To increase the response to 'The team I work in has a set of shared objectives' from 70% in 2024 to 80% in 2026 (to match the best peer result in 2024). To increase the response to 'Team members understand each other's roles' from 68% in 2024 to 76% in 2026 (to match the best peer result in 2024). Feedback through staff survey free text comments Feedback from Trade Unions, Staff Governors and Staff Networks. Digital reporting to monitor uptake.		Review of structures commenced April 2025, actions to be agreed. Back to the Floor Friday to be expanded to include middle management. Diaries to be cleared on Friday mornings. Agreement from Executive Directors that all staff can spend up to 10% of their working time on activities to support wider priorities within the Trust e.g. staff networks. Digital Hub now operational.
Continuous Quality Improvement					
Systematically embed QI methodology. Continuous delivery of introductory and specialist Improvement Training (Five-day QSIR practitioner programme provides more advanced training.)	Dawn Parkes	Adele Coulthard	To increase the response to 'I am able to make improvements happen in my area of work' from 48% in 2024, to 53% in 2025 and to 54% in 2026 (as per scorecard metric).	Ongoing 2025/26	One-day introduction to QI programme available to all staff. Cohort 6 of QSIR training in progress April 2025. Five staff re-accredited by AQuA and licensed to deliver specialist training (QSIR)

Strive for continuous improvement within the workplace and enable individuals to innovate and make change happen. All business cases and process changes to include details of plans for stakeholder and staff engagement.					Agreed to work with an external partner to undertake a readiness assessment of the Trust's ability to use and embed an approach to continuous improvement to support delivery of the Trust strategy and True North objectives. The readiness assessment will be complete by 06.06.2025 when decisions will be made about how to proceed with delivery of our quality management system.
Health, Safety & Wellbeing					
Staff Wellbeing Rooms to be implemented at York, Scarborough and Bridlington Hospitals	Polly McMeekin	Alex Cowman	To improve the 'We are safe and healthy' score from 5.8 in 2024 to 6.1 in 2025 (to match the peer average in 2024)	November 2025	The space at BDH is due to open during May 2025. Spaces identified at SGH & YH but work has not started. YH location relocated to current consultant room. Charitable funds must be used by August 2025.
Revisit multi-disciplinary support provided to teams upon death of a colleague or a patient (and external signposting where someone has a personal bereavement).		Dr Yvonne Doherty		July 2025	Working group established in Sept 2024 to create a more accessible and responsive policy. Bereavement pathway / resources poster near to completion.
Increase confidence in staff that managers will support them with safety concerns relating to workplace violence and sexual misconduct.	All directors	Darren Miller, Jenny Flinton	To reduce 'experienced physical violence from patients' from 15% in 2024 to 6.4% in 2026 (to match best peer in 2024) To reduce 'unwanted behaviour of a sexual nature in the workplace from patients' from 9.6% in 2024 to 0.8% in 2026 (to match best peer in 2024) To reduce 'unwanted behaviour of a sexual nature in the workplace from staff / colleagues' from 5.2% in 2024 to 1.5% in 2026 (to match best peer in 2024)		The Trust has launched the Sexual Misconduct Policy and an anonymous reporting tool. Sexual Misconduct training is available for all to access on Learning Hub.
Every day a healthy main course will be available in the Trust's hospital restaurants that costs (tbc – inflation busting meal price for staff)	Chris Norman	Malcolm Veigas		September 2025	This has been attempted previously [Fix the Basics work post-pandemic]. Food and overhead costs prevented this from being sustained. YTHFM would require subsidy to be able to deliver this.
A new site development plan for York Hospital will be in place by the end of the 25/26 year including where we might locate a purpose-built staff changing and shower facility. It is acknowledged that the absence of such a facility at a major hospital is not acceptable.	All directors				
In the interim – existing York Hospital facilities to be mapped so that availability and access can be promoted; charitable / other funding to be utilised to make minor improvements.	All directors	Sal Katib & Dan Braidley			Scarborough-based staff are able to use the changing and shower facilities in the new UECC building.

Learning, Development & Career Progression					
Create a great place to learn: • Increase awareness of different types of development opportunities that are available and how to access them. • Reduce barriers to learning. • Demonstrate how we invest in staff development – publicise what is being done / stats etc • Provide details of career development opportunities on staff room. • Improve the quality of appraisal conversations by changing the appraisal template, providing further guidance and support for effective appraisals and removing the cascade requirement.	Polly McMeekin, Karen Stone, Dawn Parkes	Will Thornton Rachael Snelgrove Emma George	Increase the 'Development' sub-score to 6.8 in 2025 (i.e. match the best peer result in 2024) Increase the 'Appraisals' sub-score to 5.5 in 2025 (i.e. match the best peer result in 2024)	October 2025	Change Maker project to understand the barriers faced when accessing learning and development opportunities. Professional leads are developing career progression pathways – e.g. nursing 'from acorns to oak trees', Research & Innovation has a map in draft which will not only outline options but signpost to support with those aspirations and development needs.
Timely Resolution of Complaints					
Adjustments to be made to the infrastructure for both the Civility, Respect and Resolution (CRR) and Conduct and Disciplinary policy to ensure investigations into allegations are conducted comprehensively, swiftly and appropriate feedback is provided to key witnesses.	Polly McMeekin	Jenny Flinton	Increase the 'Compassionate leadership' sub-score from 6.7 in 2024 to 7.5 in 2026 (to match best peer result in 2024) To increase the response to 'I am confident that my organisation would address my concern' from 35% in 2024, to 40% in 2025 and 42% in 2026 (as per scorecard metric).	July 2025	The No Excuse for Abuse online reporting form was launched in March to encourage full reporting of all behavioural concerns as survey results indicate that problems are more prevalent than the cases reported via HR/unions/FTSU Guardian etc. The form includes an anonymous reporting function. In addition to the No Excuse for Abuse form we already have the Freedom to Speak Up Guardian in terms of raising concerns and reporting inappropriate behaviours that people feel unable to escalate via their manager. Information will be shared through Trust communications to demonstrate accountability and to highlight any trends in cases.
Staff Voice					
Increase the annual staff survey participation rate to ensure the results are more representative of the whole workforce by using incentives:	All directors	Leadership teams in Care Groups, Corporate	Target – increase from 36% in 2024 to 51% in 2025 (i.e. match the NEY average in 2024)	November 2025	

• A range of weekly prize draws to support individual completion e.g. coffee/meal vouchers, shopping vouchers, one week of annual leave. • A directorate-based incentive based on most increased participation rate (clinical directorates and corporate directorate) – with prizes to be spent on wellbeing. 'Our Voice Our Actions' comms to be produced prior to the next survey at Directorate level to ensure relevance to local areas		Directorates, and YTHFM		September 2025	
Flexible Working					
Improve roster management to increase staff availability and promote flexible working.	Dawn Parkes	Associate Chief Nurses /Amy Messenger	Increase percentage of shifts locked down Self-rostering pilots to be evaluated and learning rolled out.	September 2025 December 2025	The Trust has increased the number of nursing ward rosters being published 6 weeks in advance, recently achieving 96%. Work is underway to improve the percentage for non-inpatient units and to look at the finalisation of shifts for payment. Self-Rostering is being piloted in 3 ward areas with ambition to widen the pilot in 25/26 and look at the use of auto roster functionality as well.
Physical Work Environment					
Introduce a programme of de-cluttering over the summer. Review clinical space usage to ensure services are in the right spaces.	CEO and all directors All directors	Leadership teams in Care Groups, Corporate Directorates, and YTHFM Sal Katib		October 2025 and ongoing	Programme of work led by Sal Katib to ensure that clinical space is appropriately allocated.

Last updated: 08.05.2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	21 May 2025
Subject:	EDI Annual Report (Public Sector Equality Duty) 2025
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development and Dawn Parkes, Chief Nurse
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.
☐ 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 annual report provides the Resources Committee with assurance that the Trust is meeting its legal requirement to comply with the Public Sector Equality Duty (PSED) and gives an overview of the work to meet its Equality Objectives, which are produced every four years. The Trust's objectives cover the period 2024-2028.

The objectives focus on EDI Compliance, Workforce, Services and Building Environments.

The summary in the Annual Report demonstrates that the Trust is meeting its compliance requirements and is either making improvements and/or addressing the disparities as required.
Recommendation: To note the work that has been undertaken to meet the Equality Objectives and compliance with the PSED.

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 Resources Committee 21/05/25		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
N/A		

EDI Annual Report (PSED) May 2025

1. Introduction and Background

This report is being presented to the Resources Committee for assurance before submission to the Trust's Board of Directors for approval, as it is a legal requirement to comply with the Public Sector Equality Duty (PSED.) The Trust has an obligation to produce an annual report stating the work that has been conducted to meet its Equality Objectives, which are produced every four years. The Trust's objectives run from 2024-2028.

The Equality Act 2010 introduced a general equality duty requiring organisations to have due regard in the exercising of their functions, these are to:

1. Eliminate discrimination, harassment, and victimisation
2. Advance equality of opportunity between people who share a protected characteristic and people who do not
3. Foster good relations between people who share a protected characteristic and those who do not

The Public Sector Equality Duty places additional specific duties on public authorities, including NHS Trusts, this is to:

Publish sufficient information to demonstrate compliance with the general duty by 31 January 2012 and thereafter annually.

2. Current Position/Issues

It is evident in the report that significant continuous progress is being made to meet the objectives. Teams are working in collaboration internal and externally and year-on-year analysis will identify the impact being made.

3. Summary

To provide assurance the Trust is compliant in meeting its requirements and is making significant improvement in meeting its Equality Objectives.

4. Next Steps

Continue to implement interventions to meet the Equality Objectives and address areas of improvement.

Date: 24 April 2025

Appendix 1 – EDI Annual Report (PSED) May 2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Equality, Diversity and Inclusion Annual Report April 2025

Public Sector Equality Duty (PSED)

Contents

Glossary of Terms

Accessible Information Standard	AIS
Black and Minority Ethnic	BME
Electronic Staff Record	ESR
Equality Delivery System	EDS 2022/EDS
Equality, Diversity and Inclusion	EDI
Gender Pay Gap	GPG
Integrated Care System	ICS
Lesbian, Gay, Bisexual, Transgender, Questioning and other identities	LGBTQ+
National Health Service	NHS
National Health Service England	NHSE
Public Sector Equality Duty	PSED
Race Equality Network	REN
Very Senior Manager	VSM
Workforce Disability Equality Standard	WDES
Workforce Race Equality Standard	WRES
York Teaching Hospital Facilities Management	YTHFM

Introduction

York and Scarborough Teaching Hospitals NHS Foundation Trust provides a comprehensive range of acute hospital, community and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles.

We manage 8 hospital sites and have a workforce of around 12,000 staff, inclusive of bank, substantive and fixed-term staff, working across our hospitals within the community and York Teaching Hospitals Facilities Management (YTHFM.)

Our hospitals

- 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

York and Scarborough Teaching Hospitals NHS Foundation Trust is a diverse employer and provider of care. Our aim is to create a culture of inclusion where everyone feels valued and respected for who they are and what they bring to our organisation.

Our Public Sector Equality Duty (PSED) Annual Report highlights the progress we have made from April 2024 to March 2025 in line with our Equality Objectives which cover the period 2024-2028.

The Equality Act 2010 and the Public Sector Equality Duty (PSED)

The Equality Act 2010 introduced a general equality duty requiring organisations to have due regard in the exercising of their functions.

These are to:

1. Eliminate discrimination, harassment, and victimisation.
2. Advance equality of opportunity between people who share a protected characteristic and people who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

We are required to do this by:

1. Removing or minimising disadvantages suffered by people due to their protected characteristic.
2. Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
3. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
4. Taking the steps needed in meeting the needs of disabled persons that are different from the needs of persons who are not disabled; and include steps to take account of disabled person's disabilities.
5. Having due regard towards the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it, to tackle prejudice and promote understanding.

The Protected Characteristics covered by the Equality Act 2010 are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

The PSED places additional specific duties on public authorities, including NHS Trusts, these are to:

Publish sufficient information to demonstrate compliance with the general duty by 31 January 2012 and thereafter annually.

The NHS Equality Delivery System (EDS 2022)

Implementation of the EDS 2022 is a requirement on both NHS commissioners and NHS providers.

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing inequalities in health access, experiences, impact and outcomes through three domains: Services, Workforce Health and Wellbeing and leadership. It is driven by data, evidence, engagement and insight and has been amended to be brought into line with the NHS Long Term Plan, and in response to COVID-19.

Organisations must work with partners and stakeholders across the Domains. Each Outcome is to be scored based on the evidence provided. Once each Outcome has been scored an improvement plan is developed and implemented.

EDS Domain 1 - Commissioned or provided services

Outcome 1A: Patients (service users) have required levels of access to the service.
Outcome 1B: Individual patients (service users) health needs are met.
Outcome 1C: When patients (service users) use the service, they are free from harm.
Outcome 1D: Patients (service users) report positive experiences of the service.

EDS Domain 2 - **Workforce health and well-being**

Outcome 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.
Outcome 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
Outcome 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source.
Outcome 2D: Staff recommend the organisation as a place to work and receive treatment.

EDS Domain 3 - Inclusive leadership

Outcome 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.

Outcome 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.

Outcome 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

Our Commitment to Equality, Diversity and Inclusion (EDI)

York and Scarborough Teaching Hospitals NHS Foundation Trust is dedicated to encouraging a supportive and inclusive culture where all our patients can receive high quality, person-centred healthcare which meets their needs. It is within our best interest to promote diversity and eliminate discrimination amongst our workforce in the development of services and our hospital environments. We are working hard to engage and listen to our colleagues to ensure that we continuously support the development of an inclusive culture in line with our Trust Value.

We are committed to taking our responsibilities seriously in providing equity and fairness to all our staff, ensuring we provide no less favourable treatment on the grounds of the 9 protected characteristics.
The aim of this report is to not only meet the requirement of the Equality Act 2010 and PSED, but to also highlight areas of good practice and any gaps that the Trust needs to focus on. It is important for us to comply but also move beyond this by creating a culture of inclusion.

York and Scarborough Teaching Hospitals NHS Foundation Trust commits to:

- Being an organisation that is welcoming and accessible to all.
- Ensuring that there are no barriers to accessing jobs, training or promotion.
- Engaging with patients, communities and colleagues, whilst working collaboratively with our partners and stakeholders.
- Not tolerating any forms of discrimination and will challenge it safely wherever we see it, ensuring that Equality, Diversity and Inclusion (EDI) is everybody's business – continuing to embed our values and behavioural expectations; a 'Just Culture' and learning environments for all.
- Acting on staff feedback.
- Developing interventions which help our staff to understand and support one another for the benefit of each other and patients in our care.

The Trust has made good progress by providing dedicated focus on our EDI agenda. 2025 sees the Trust in a different position to where it was three years ago. We

acknowledge that we are still on a journey but embedding inclusive practices is of great focus for us.

Simon Morritt
Chief Executive

Communication and Engagement

The Trust's Communications and Engagement approach has at its core, several communications principles which are rooted within the organisation's values and behaviours and aims to ensure that EDI influence our communications approach and activities. The Trust's communications team has continued to work with the Head of EDI to ensure internal and external communications continue to be inclusive of people with protected characteristics.

Celebration of Achievement Awards

The Trust's annual recognition awards took place in September 2024 and included for the second year running a category for Excellence in Diversity and Inclusion. Ten nominations were received for an individual or team who had demonstrated an outstanding commitment to valuing and promoting EDI for patients and/or staff in order to create a safe and inclusive culture that helps foster a positive experience for all.

Nominations were judged on the following criteria:

1. Examples of how they have shared knowledge and applied EDI in the workplace.
2. Demonstrated initiating, leading or supporting a service improvement of EDI in the workplace.
3. Evidence of the recognisable impact EDI changes have made.

The winner was Amanda Vipond, Consultant; "Amanda has made significant progress in improving EDI inclusion within the group. She is passionate about this work, and even though it's early days, her efforts will benefit all staff."

Equality Objectives Activity

Equality, Diversity and Inclusion objectives April 2024 – March 2028

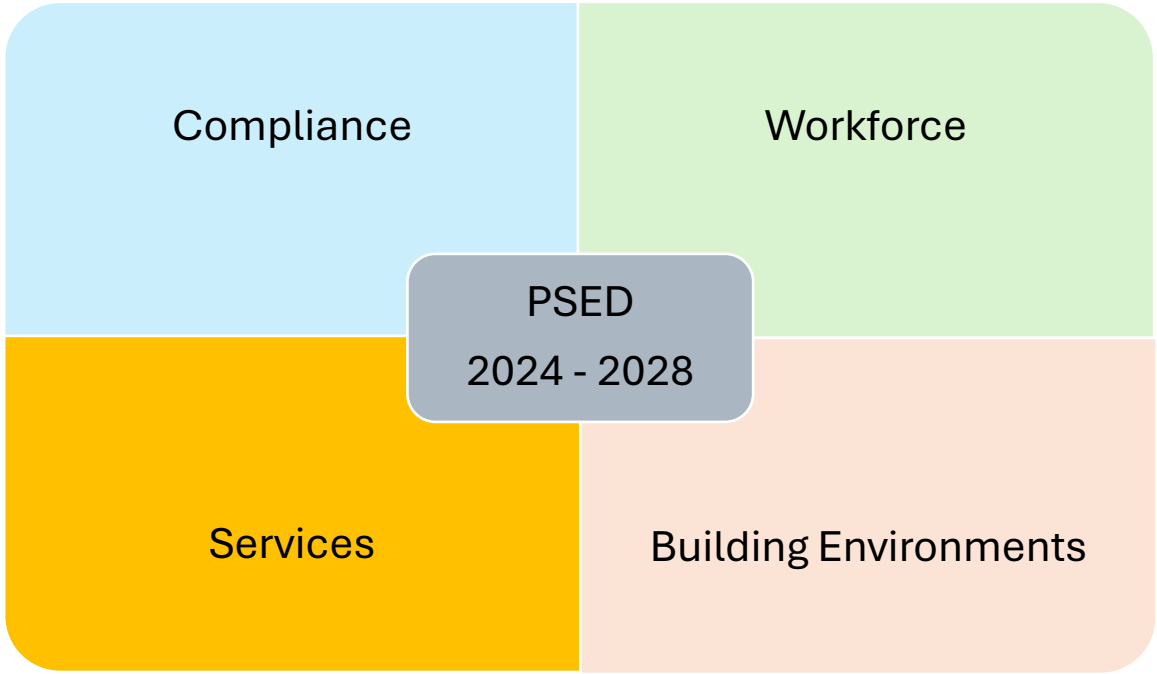
Our Equality Objectives for the period April 2024 - March 2028 are based on areas that we would like to continue to improve and those we know require some development.

The Trust's Inclusion Forum has oversight of the progress we are making with our objectives. The Resources and Patient Experience committees also review progress with the Trust's Board of Directors providing final oversight. Inclusion is integral to our strategies, policies and procedures. Our Trust engages with our staff networks to improve employment practices, supported by their Executive Director Sponsors and the Head of EDI, and are involved in the Trust's decision-making process.

The EDI agenda is embedded into multiple teams' schemes of work and our EDI Workstream has operational responsibility for identifying local actions and solutions.

The Trust will continue to engage with our partners, stakeholders, communities and those in regions further afield to ensure that we listen, involve, learn and act on information, advice and best practice.

2024-2028 Equality Objectives



Aim	Objective	Measurable Outcome
Our services are accessible to all, our workforce has equitable access, experience and outcomes.	Ensure all areas of EDI compliance are met and action plans are implemented to improve experience. NHSE EDI Improvement Plan EDS 2022, Workforce Race and Disability Standards, Accessible Information Standard, Sexual Orientation Monitoring Standard, Gender Pay Gap.	Improvement measures/targets set by the Trust or nationally in relation to the WRES and WDES are met. (Several actions within the 2023-2025 WRES action plan include statistical targets, the one WDES target for this period has been met.) Effectiveness of all improvement interventions is to be analysed through the standards in 2025. *Bank WRES Indicator 1 – 0.6% by 2025 WRES Indicator 2 – achieve a relative likelihood of 1 WRES Indicator 5 – 30.8%, by 2025 WRES Indicator 8 - 2.5%, by 2025 EDS Domain improvement plans are implemented, reassessed and Domain scores improved. Year on year improvement in the Gender Pay Gap. Year on year reduction in patient experience complaints.
To improve the employment experiences of our ethnically diverse, Disabled and neurodiverse staff.	Implement an Anti-racism strategy, Workplace Adjustment policy and guidance on supporting neurodiverse staff.	An improvement in experiences will be measured through the WRES and WDES data within the Staff Survey. *WRES Indicator 5 – annual decrease of 1%

		WRES Indicator 6 – annual decrease of 2% WRES Indicator 8 – annual decrease of 1.5% WDES Indicator 8 – annual increase of 1% (in response to the 2023 Staff Survey) Compassionate and Inclusive engagement scores – annual increase of 1%
To improve in the equality monitoring of people who use our services and the demographics of our communities.	Ensure the Trust's systems can capture equality monitoring information in order to provide insight to improve access, experience and outcomes of our patients.	Data is available and accessible to inform the patient EDI agenda. Evidence of improvement to be measured through an internal audit by Patient Access of patient records to ensure all fields have been completed. Engagement with Patient Access team Q1. Improvement trajectories for each system to be agreed Q2.
Foster a healthcare environment that prioritises equity, inclusivity, and improved health outcomes for all individuals, considering socio-economic, demographic, or other determinants.	Develop a plan that encompasses the overall Trust Inequality Strategy to address and mitigate health disparities within the Trust's catchment area. Implement the plan through Task and Finish groups.	Evidence-based intervention strategies to reduce health inequalities will be in place across the services identified in the Trust's health inequalities plan, endorsed at the Patient Experience Sub-Committee in Q1. Undertake an internal baseline audit of the Accessible Information Standards in Q3. Accessible Information Working Group to develop an improvement plan with clear

		trajectories in Q4 – monitoring of the plan and actions through the Health Inequalities and Population Health Steering Group. Evidence of improvement to be measured through the reduction in the number of complaints and concerns about accessible information – target metrics to be established in Q4. Evidence of improvement to be measured through the reduction of complaints and concerns related to discrimination will decline – target metrics to be established in Q4.
Ensure the Trust complies with the Inclusive and Accessible Build Environment Strategy.	The Trust's annual access audit schedule is progressed, the action plan maintained and workplan implemented.	Access guides are up to date, disability awareness training and the access programme is delivered, and the Trust's access plan implemented.

Inclusive and Accessible Built Environment

Aim: Ensure the Trust complies with the Inclusive and Accessible Built Environment Strategy

The Trust's annual access audit schedule is progressed, the action plan maintained and workplan implemented. Access guides are up to date, disability awareness training and the access programme is delivered, and the Trust's access plan implemented.

Update for Year 2024-2025

Objective	Progress	Further Actions for 2025/2026
The Trust's annual access audit schedule is undertaken in accordance with Appendix 1 of the Inclusive & Accessible Built Environment Strategy.	The objective has almost been fully met with access audits taking place at: Scarborough Hospital, Springhill House, Centurion House, Clementhorpe Health Centre, St Monica's Hospital, Easingwold, Acorn Court, Easingwold, Selby Hospital and Kettlestring Lane. The access audit at Malton Hospital was not completed and will be completed in September 2025.	The access audit at Malton Hospital was not completed and will be completed in September 2025 in addition to the approved 2025-2026 access audit programme.
The Trust's access plan is updated and distributed to stakeholders on a quarterly basis in accordance with the Inclusive & Accessible Built Environment Strategy.	The Trust's Access Plan was in place and has been communicated widely across the organisation with formal distribution to stakeholders on: 29 July 2024 and 23 October December 2024.	The Access Adviser ensured the plan was distributed to key stakeholders in March 2025.

The Access Adviser's Workplan is implemented.	The Access Adviser workplan is in place and was agreed with their Line Manager.	No action required.
Disability Awareness training is provided in line with the agreed KPI.	No KPI was agreed for the year, the training does not form part of core skills training (nationally set) and relies upon voluntary attendance. Thirty sessions were planned and 24 delivered in 2024 at York, Scarborough, and Bridlington Hospital sites, 6 sessions were cancelled due to lack of attendance. 118 Staff and volunteers attended the 24 sessions that were delivered. Staff that attended were mostly from nursing, AHP, Healthcare assistant and patient facing administration roles.	Health & Safety Committee/Equality & Diversity Team to consider making training 'Required Learning' and set appropriate KPI.
Web and app-based Trust Access Guides for use by disabled people and families are available and accurate.	The guides continue to be published at present, a register is in place of any changes that need to be made to Access Guides as and when we alter or extend our built environment.	Access Adviser to monitor changes and report changes via Register to the Access Guide provider throughout the contract.
A current Inclusive & Accessible Built Environment Strategy is in place.	The Inclusive & Accessible Built Environment Strategy is due for review in July 2025.	Access Adviser to review the strategy and present to appropriate group for approval by July 2025.

Compliance

Aim: Our services are accessible to all, our workforce has equitable access, experience and outcomes.

Objective: Ensure all areas of EDI compliance are met and action plans are implemented to improve experience. NHSE EDI Improvement Plan EDS 2022, Workforce Race and Disability Standards, Accessible Information Standard, Sexual Orientation Monitoring Standard, Gender Pay Gap.

- EDS Domain 1 EDS Domain staff guidance developed to inform and support future EDS service reviews.
- EDS Domain 1 reviews conducted for Sexual Health & HIV, Ophthalmology and Endoscopy between August - November 2024 and report published in February 2025.
- Elements of the EDS embedded within new Care Group Patient Experience Groups Terms of Reference.
- AIS policy published and communicated to staff.
- Explored use and provision of communication cards within wards and Urgent and Emergency care. This work will continue into Financial Year 2025/26.
- Co-production, publication and communication of Animals of Trust Property Policy, Transgender and Gender Diverse Communities Policy.
- AIS Baseline Assessment has been carried out, further enhanced with the development of the project plan and compliance review.
- A joint procurement process for interpreting/translation service is underway with North Lincolnshire and Goole and Hull. Tender to go live in April 2025 and service embedded in July 2025.
- Ongoing development of the staff intranet with guidance and resources to support staff with meeting EDI compliance.
- Supported the promotion of disability awareness training. 50 staff attended in person between January 2024 – January 2025.
- Delivered 7 EDI sessions for staff and newly qualified clinical staff (non-medical) as part of the preceptorship programme.
- The EDI, Human Resources and Organisational Development Teams are on track with implementing the NHSE EDI Improvement Plan and inform the Humber and North Yorkshire Health and Care Partnership who monitor this for the region and also update NHSE.
- EDS Domains 2, Workforce Health and Wellbeing and Domain 3, Inclusive Leadership were assessed, and peer reviewed in December 2024. Progress in Domain 2 still requires improvement in 3/4 Outcomes. Domain 3 remains at Achieving Activity and the Trust is working towards Excelling Activity. Improvement Plans continue to be implemented. The EDS full report can be found at: Equality Delivery System (EDS) 2022.

- Data analysis for the WRES, WDES and Pay Gaps took place in 2024 and will recommence this year. The full results will be reported on later this year and in the 2026 EDI Annual Report. From a first glance, WRES Metric 5 has seen a slight deterioration, Metric 6 has seen a slight improvement and there has been no reduction in negative experiences for Metric 8.
- There is no longer a national requirement to report on the Medical WRES. Interventions for the WRES action plan are inclusive of medical staff.
- There is year-on-year improvement with the Gender Pay Gap and there is no Ethnicity Pay Gap in the entire workforce but there is within Medical and Dental. The Medical Human Resources team have devised a plan to address this. The Pay Gaps reports are accessed here: Pay Gaps reports 2025

Workforce

Aim: To improve the employment experiences of our ethnically diverse, Disabled and neurodiverse staff.

Implement an Anti-racism strategy, Workplace Adjustment policy and guidance on supporting neurodiverse staff.

The Trust has a Race Equity Group, which comprises of the Chair and Vice Chair of the Race Equity Staff Network and Global Majority Senior Managers who act as critical friends to members of the Trust Board. Together they have formed a Race Equity Alliance.

In February 2025 the Trust implemented an Anti-Racist Steering Group which is Chaired by the Chief Executive. The purpose of this group is to develop strategies which address, individual, cultural and structural racism across our organisation. The group will have responsibility for co-producing and implementing an Anti-racism strategy or framework. The EDI team have implemented Anti-Racism training, training on Bullying and Harassment and trained Human Resource colleagues on the ‘Too Hot to Handle’ Report.

The Trust now has a Reasonable (Workplace) Adjustment Guidance for colleagues and managers to refer to for support. The entire Reasonable Adjustment process was reviewed and streamlined to be more effective, efficient and supportive. The guidance was co-produced through a Task and Finish Group that included the Enable Staff Network, Director of Finance (the network’s Executive Director Sponsor), representatives of relevant teams and union representatives.

Several colleagues co-produced a Neurodiversity Toolkit for the Trust. This included meeting with the Enable Staff Network to hear colleague’s lived experience. Other

Trust's toolkits were consulted to benchmark against for best practice. The first draft of the toolkit will be completed in May 2025.

Services

Aim: Foster a healthcare environment that prioritises equity, inclusivity, and improved health outcomes for all individuals, considering socio-economic, demographic, or other determinants.

Objective: Develop a plan that encompasses the overall Trust Inequality Strategy to address and mitigate health disparities within the Trust's catchment area. Implement the plan through Task and Finish groups.

Due to a change in direction with how the Trust approaches its health inequalities work, the Steering Group that had responsibility for this is changing its approach. Therefore, new objectives and measurable outcomes will be co-produced and reported on in the 2026 EDI Annual Report.

Objective: Ensure the Trust's systems can capture equality monitoring information in order to provide insight to improve access, experience and outcomes of our patients.

- Engagement with the project team for the new electronic patient record system has taken place to ensure national flags can be implemented.
- Method of reporting on patient Biological Sex and Ethnicity data has been established.
- Standardised equality monitoring information questions have been developed and embedded within patient experience questionnaires.
- Currently reviewing system flag and alert types to ascertain data capturing capabilities.
- FFT captures patient demographics which gives an understanding on the diversity of feedback.

Objective: Develop a plan that encompasses the overall Trust Inequality Strategy to address and mitigate health disparities within the Trust's catchment area. Implement the plan through Task and Finish groups.

- Engagement work undertaken to understand the needs of the local community when accessing the new Urgent and Emergency Care unit in Scarborough and insights embedded into the implementation plan.
- Reviewed concerns, compliments, comments and complaints which relate to EDI issues to understand the circumstances, identify improvements, and share best practice.

- Conducted an audit of the Trust's interpretation tablets to enhance communications and informing staff on how to access the tablets and interpretation service.
- Established an agreement with an alternative interpretation provider for difficult to source languages in order to meet specific service demands.
- We continue to participate in several internal and external groups to champion and better understand the needs of all patients.
- Provided EDI guidance or support to services, feeding into service improvement plans.
- Led on the engagement with patients and stakeholder groups in respect of patient EDI matters, creating and sustaining relationships with external stakeholders and their representative groups.
- Facilitated the co-production of a carer's engagement framework, action plan and contributed to City of York Council carers strategy.
- Contributed to the Trust Health Inequalities Steering group.

Workforce and Patient Equality Monitoring Information

Workforce

The Trust's Workforce Equality Monitoring data can be found at Appendix 1. The data shows the diversity of the staff it employs, which adds to the richness of how it operates and meets the needs of the communities it provides a service to.

We recognise that there is still work to do to encourage staff to share their personal diversity information so we have a more comprehensive picture of the internal demographics and how we can continue to support staff. This is currently being operationalised at a local level through the EDI Workstream.

Patient

The Trust continues to work to improve data capturing to inform the patient EDI agenda. Patient equality monitoring information can be assessed against The Office For Health Improvement and Disparities data (Microsoft Power BI) to better understand the catchment population of the Trust. The Trust reports on patient Sex and Ethnicity data annually. Please see Appendix 1.

Conclusions and Next Steps

This EDI Annual report provides an overview of the activities undertaken to meet our 2024-2028 Equality Objectives and demonstrates the Trust's commitment to embed inclusivity into service provision and employment practices.

Patient EDI Actions for the next financial Year 25/26:

- Publication and promotion of the updated Equality Impact Assessment process.
- Publish guidance for public engagement to support services with engagement activities.
- Accessible Information task and finish group to continue the work as outlined in the AIS action plan. AIS KPIs to be agreed.
- Confirm interpreting/translation contract and embed across the Trust, delivering information sessions and updating communication to staff and public.
- Publication of British Sign Language (BSL) videos and Easy Read of top 5 most accessed patient information leaflets.
- Review of national flags to be agreed so they can be implemented into CPD.
- Review of other patient record systems to be undertaken to ensure national flags are embedded.
- Equality monitoring metrics to be established.
- Establish how current patient record systems pull information from GP records.
- Explore capabilities of FFT to gather insights into the disparity of patient experience.
- Continue to review concerns, compliments, comments and complaints which relate to equality and diversity issues to understand the circumstances, identify improvements, and share best practice.
- Analyse the carers engagement survey results and support the development of a carers improvement plan.
- Support Chaplaincy team in their programme of work to develop a more inclusive service.
- Improve access to animal spending places across the Trust
- Support services with implementing the use of communication cards and menu cards

Workforce EDI Actions for the next financial Year 25/26:

- Implement the Neurodiversity toolkit.
- Develop an Anti-racism statement for the Trust.
- Ensure members of the Trust's Anti-Racism Steering Group complete the Anti-Racism training.
- Review Human Resources and Freedom to Speak Up Cases which have a theme of Race.
- Continue to meet the compliance requirements for the Trust and ensure adequate interventions are in place to improve access, experience and outcomes.
- Continue to focus on the objectives stated above by ensuring they are integrated into current streams of work.

The Trust’s Inclusion Forum, Committees and Board of Directors have oversight, accountability and responsibility for the Trust’s EDI compliance requirements and progress towards meeting its duty under the Equality Act 2010 and PSED.

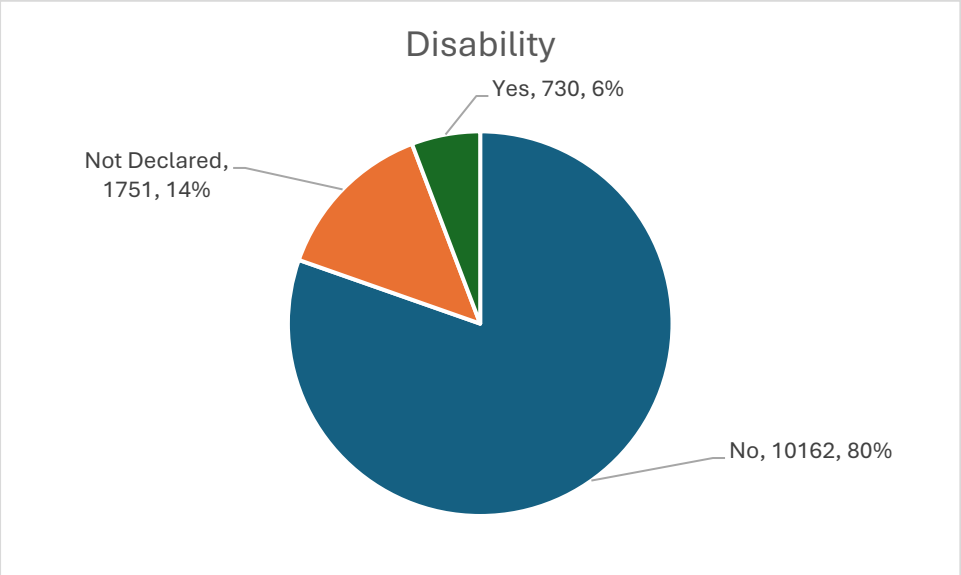
The Trust’s Equality Objectives for April 2024 - March 2028 can be found here: Equality Objectives April 2024- March 2028

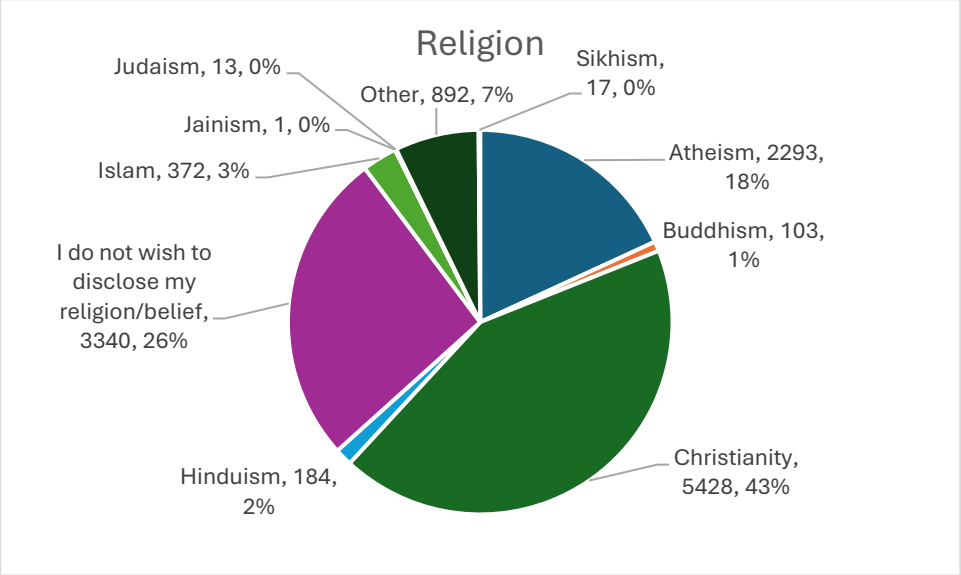
Equality, Diversity and Inclusion Annual Report April 2025 - Public Sector Equality Duty (PSED)

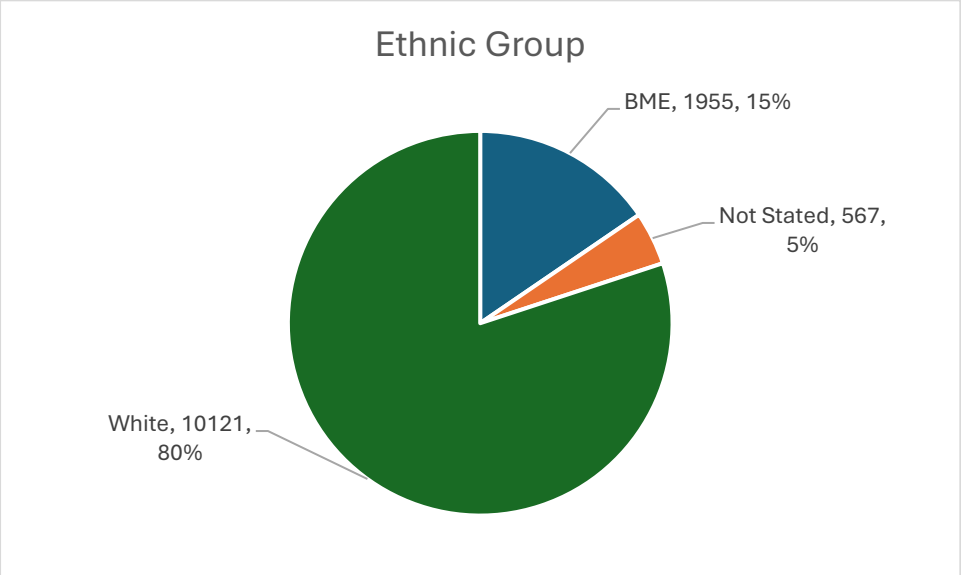
Workforce Equality Monitoring Information

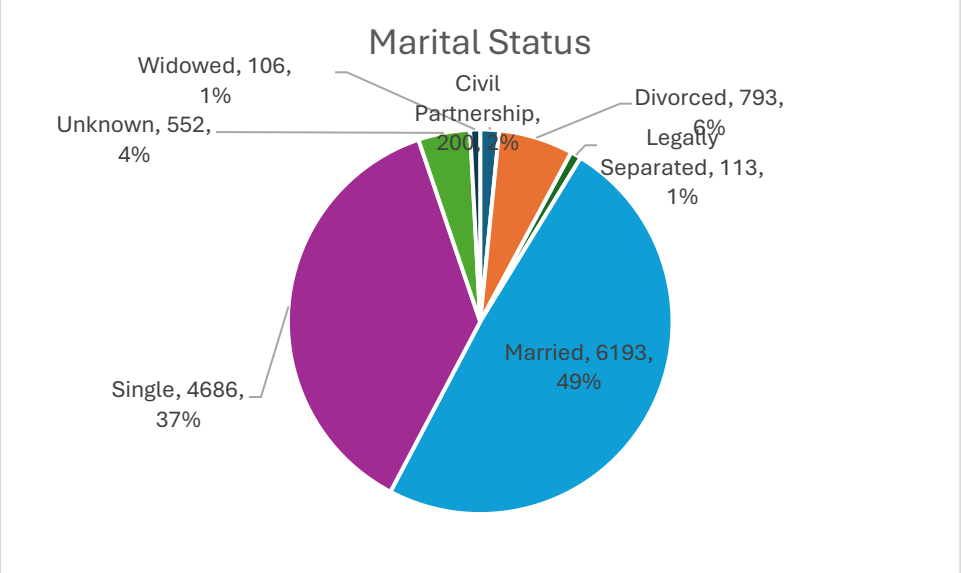
The below data covers York & Scarborough Teaching Hospitals, York Teaching Hospital Facilities Management (YTHFM) LLP and Bank workers.

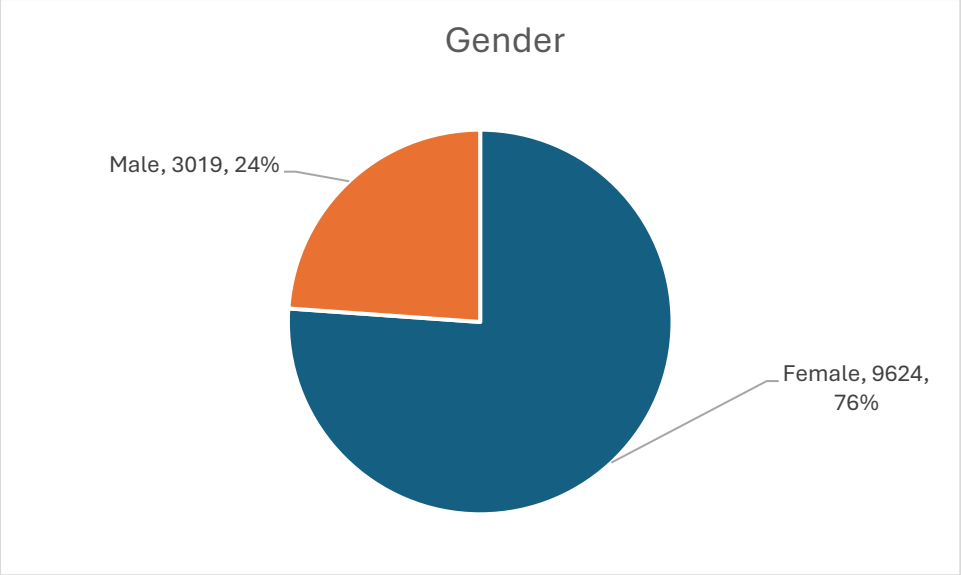
Staff in post headcount = 12,643

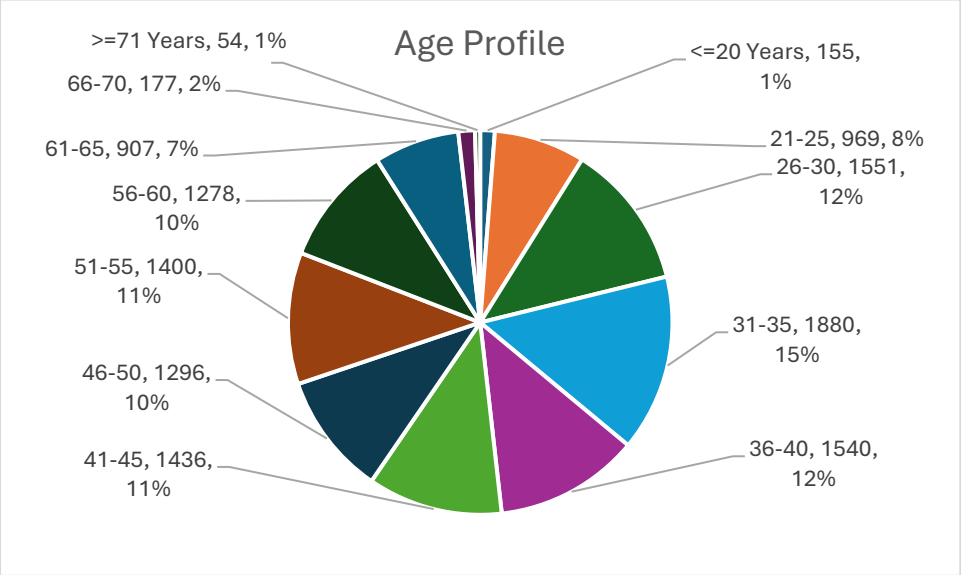


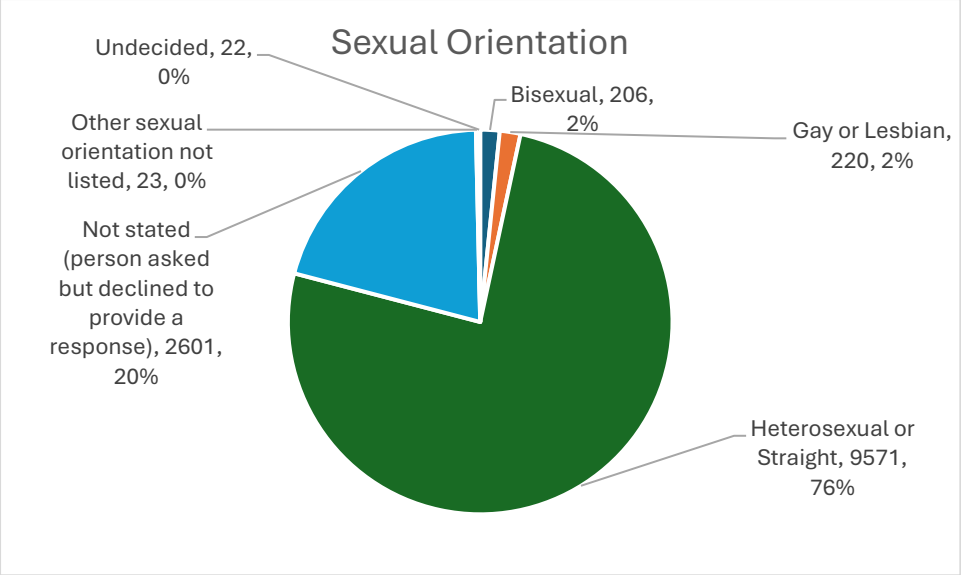



Ethnic Group
BME, 1955, 15%
Not Stated, 567, 5%
White, 10121, 80%


Marital Status
Widowed, 106, 1%
Civil Partnership, 200, 2%
Divorced, 793, 6%
Unknown, 552, 4%
Legally Separated, 113, 1%
Married, 6193, 49%
Single, 4686, 37%


Gender
Male, 3019, 24%
Female, 9624, 76%


Age Profile
>=71 Years, 54, 1%
66-70, 177, 2%
61-65, 907, 7%
56-60, 1278, 10%
51-55, 1400, 11%
46-50, 1296, 10%
41-45, 1436, 11%
<=20 Years, 155, 1%
21-25, 969, 8%
26-30, 1551, 12%
31-35, 1880, 15%
36-40, 1540, 12%



Ethnic Origin	Headcount	Origin vs Total
Any Other Ethnic Group	177	1.40%
Asian British	12	0.09%
Asian Mixed	3	0.02%
Asian or Asian British - Any other Asian background	272	2.15%
Asian or Asian British - Bangladeshi	21	0.17%
Asian or Asian British - Indian	472	3.73%
Asian or Asian British - Pakistani	68	0.54%
Asian Punjabi	1	0.01%
Asian Sinhalese	2	0.02%
Asian Sri Lankan	2	0.02%
Asian Unspecified	7	0.06%
Black British	4	0.03%
Black Mixed	1	0.01%
Black Nigerian	33	0.26%
Black or Black British - African	523	4.14%
Black or Black British - Any other Black background	20	0.16%
Black or Black British - Caribbean	30	0.24%
Black Unspecified	1	0.01%
Chinese	63	0.50%
Filipino	62	0.49%
Malaysian	3	0.02%
Mixed - Any other mixed background	23	0.18%
Mixed - Asian & Chinese	3	0.02%
Mixed - Black & White	1	0.01%
Mixed - Other/Unspecified	23	0.18%
Mixed - White & Asian	52	0.41%
Mixed - White & Black African	52	0.41%
Mixed - White & Black Caribbean	21	0.17%

Not Stated	567	4.48%
Other Specified	3	0.02%
White - Any other White background	374	2.96%
White - British	8979	71.02%
White - Irish	74	0.59%
White Cypriot (non specific)	1	0.01%
White English	361	2.86%
White Greek	5	0.04%
White Italian	3	0.02%
White Mixed	2	0.02%
White Northern Irish	9	0.07%
White Other European	75	0.59%
White Other Ex-Yugoslav	2	0.02%
White Polish	63	0.50%
White Scottish	16	0.13%
White Serbian	1	0.01%
White Turkish	3	0.02%
White Unspecified	149	1.18%
White Welsh	4	0.03%
Grand Total	**12643**	**100.00%**

Care Group vs Employee Gender	Gender Headcount	Gender %
419 CG Cancer Specialist & Clinical Support Services Group	**2303**	**18.22%**
Female	1785	14.12%
Male	518	4.10%
419 CG Chairman & Chief Executives Office	**47**	**0.37%**
Female	38	0.30%
Male	9	0.07%
419 CG Chief Nurse Team	**155**	**1.23%**
Female	117	0.93%
Male	38	0.30%
419 CG Digital Information Services	**260**	**2.06%**
Female	137	1.08%
Male	123	0.97%
419 CG Family Health Care Group	**1563**	**12.36%**
Female	1468	11.61%
Male	95	0.75%
419 CG Medical Governance	**143**	**1.13%**
Female	104	0.82%
Male	39	0.31%
419 CG Medicine	**2578**	**20.39%**
Female	2018	15.96%
Male	560	4.43%
419 CG Operational Finance	**214**	**1.69%**

Female	128	1.01%
Male	86	0.68%
419 CG Operations Management	**264**	**2.09%**
Female	235	1.86%
Male	29	0.23%
419 CG Surgery	**1954**	**15.46%**
Female	1472	11.64%
Male	482	3.81%
419 CG Trust Estates & Facilities	**6**	**0.05%**
Female	5	0.04%
Male	1	0.01%
419 CG Workforce and Organisational Development	**1846**	**14.60%**
Female	1378	10.90%
Male	468	3.70%
419 LLP CG Estates & Facilities	**1310**	**10.36%**
Female	739	5.85%
Male	571	4.52%
Grand Total	**12643**	**100.00%**

Care Group vs Religion	Religious Belief Headcount	Religious Belief %
419 CG Cancer Specialist & Clinical Support Services Group	**2303**	**18.22%**
Atheism	481	3.80%
Buddhism	15	0.12%
Christianity	946	7.48%
Hinduism	23	0.18%
I do not wish to disclose my religion/belief	609	4.82%
Islam	55	0.44%
Judaism	2	0.02%
Other	168	1.33%
Sikhism	4	0.03%
419 CG Chairman & Chief Executives Office	**47**	**0.37%**
Atheism	11	0.09%
Buddhism	1	0.01%
Christianity	22	0.17%
I do not wish to disclose my religion/belief	10	0.08%
Other	3	0.02%
419 CG Chief Nurse Team	**155**	**1.23%**
Atheism	28	0.22%
Buddhism	2	0.02%
Christianity	84	0.66%
I do not wish to disclose my religion/belief	32	0.25%
Islam	1	0.01%
Other	8	0.06%
419 CG Digital Information Services	**260**	**2.06%**

Atheism	60	0.47%
Buddhism	1	0.01%
Christianity	96	0.76%
Hinduism	1	0.01%
I do not wish to disclose my religion/belief	83	0.66%
Islam	1	0.01%
Judaism	1	0.01%
Other	17	0.13%
419 CG Family Health Care Group	**1563**	**12.36%**
Atheism	329	2.60%
Buddhism	8	0.06%
Christianity	709	5.61%
Hinduism	12	0.09%
I do not wish to disclose my religion/belief	352	2.78%
Islam	26	0.21%
Judaism	2	0.02%
Other	123	0.97%
Sikhism	2	0.02%
419 CG Medical Governance	**143**	**1.13%**
Atheism	36	0.28%
Buddhism	3	0.02%
Christianity	55	0.44%
Hinduism	2	0.02%
I do not wish to disclose my religion/belief	30	0.24%
Islam	2	0.02%
Judaism	1	0.01%
Other	14	0.11%
419 CG Medicine	**2578**	**20.39%**
Atheism	371	2.93%
Buddhism	40	0.32%
Christianity	1238	9.79%
Hinduism	70	0.55%
I do not wish to disclose my religion/belief	575	4.55%
Islam	106	0.84%
Judaism	3	0.02%
Other	173	1.37%
Sikhism	2	0.02%
419 CG Operational Finance	**214**	**1.69%**
Atheism	50	0.40%
Christianity	86	0.68%
I do not wish to disclose my religion/belief	55	0.44%
Islam	9	0.07%
Other	13	0.10%
Sikhism	1	0.01%
419 CG Operations Management	**264**	**2.09%**
Atheism	53	0.42%

Buddhism	1	0.01%
Christianity	122	0.96%
I do not wish to disclose my religion/belief	66	0.52%
Other	22	0.17%
419 CG Surgery	**1954**	**15.46%**
Atheism	350	2.77%
Buddhism	7	0.06%
Christianity	820	6.49%
Hinduism	45	0.36%
I do not wish to disclose my religion/belief	545	4.31%
Islam	67	0.53%
Judaism	1	0.01%
Other	117	0.93%
Sikhism	2	0.02%
419 CG Trust Estates & Facilities	**6**	**0.05%**
Atheism	1	0.01%
Christianity	2	0.02%
I do not wish to disclose my religion/belief	1	0.01%
Other	2	0.02%
419 CG Workforce and Organisational Development	**1846**	**14.60%**
Atheism	353	2.79%
Buddhism	21	0.17%
Christianity	690	5.46%
Hinduism	24	0.19%
I do not wish to disclose my religion/belief	527	4.17%
Islam	88	0.70%
Jainism	1	0.01%
Judaism	3	0.02%
Other	133	1.05%
Sikhism	6	0.05%
419 LLP CG Estates & Facilities	**1310**	**10.36%**
Atheism	170	1.34%
Buddhism	4	0.03%
Christianity	558	4.41%
Hinduism	7	0.06%
I do not wish to disclose my religion/belief	455	3.60%
Islam	17	0.13%
Other	99	0.78%
Grand Total	**12643**	**100.00%**

Care Group vs Age Profile	Age Profile Headcount	Age Profile %
419 CG Cancer Specialist & Clinical Support Services Group	**2303**	**18.22%**
<=20 Years	15	0.12%
21-25	144	1.14%

26-30	247	1.95%
31-35	298	2.36%
36-40	319	2.52%
41-45	308	2.44%
46-50	265	2.10%
51-55	272	2.15%
56-60	230	1.82%
61-65	171	1.35%
66-70	25	0.20%
>=71 Years	9	0.07%
419 CG Chairman & Chief Executives Office	**47**	**0.37%**
26-30	7	0.06%
31-35	3	0.02%
36-40	5	0.04%
41-45	9	0.07%
46-50	4	0.03%
51-55	5	0.04%
56-60	8	0.06%
61-65	4	0.03%
66-70	2	0.02%
419 CG Chief Nurse Team	**155**	**1.23%**
21-25	1	0.01%
26-30	6	0.05%
31-35	14	0.11%
36-40	14	0.11%
41-45	25	0.20%
46-50	24	0.19%
51-55	26	0.21%
56-60	31	0.25%
61-65	11	0.09%
66-70	1	0.01%
>=71 Years	2	0.02%
419 CG Digital Information Services	**260**	**2.06%**
21-25	9	0.07%
26-30	25	0.20%
31-35	34	0.27%
36-40	31	0.25%
41-45	33	0.26%
46-50	27	0.21%
51-55	42	0.33%
56-60	29	0.23%
61-65	27	0.21%
66-70	2	0.02%
>=71 Years	1	0.01%
419 CG Family Health Care Group	**1563**	**12.36%**
<=20 Years	3	0.02%

21-25	110	0.87%
26-30	169	1.34%
31-35	222	1.76%
36-40	214	1.69%
41-45	204	1.61%
46-50	170	1.34%
51-55	190	1.50%
56-60	161	1.27%
61-65	101	0.80%
66-70	14	0.11%
>=71 Years	5	0.04%
419 CG Medical Governance	**143**	**1.13%**
<=20 Years	1	0.01%
21-25	9	0.07%
26-30	25	0.20%
31-35	18	0.14%
36-40	21	0.17%
41-45	10	0.08%
46-50	16	0.13%
51-55	23	0.18%
56-60	14	0.11%
61-65	5	0.04%
66-70	1	0.01%
419 CG Medicine	**2578**	**20.39%**
<=20 Years	33	0.26%
21-25	248	1.96%
26-30	387	3.06%
31-35	453	3.58%
36-40	327	2.59%
41-45	262	2.07%
46-50	273	2.16%
51-55	249	1.97%
56-60	197	1.56%
61-65	115	0.91%
66-70	26	0.21%
>=71 Years	8	0.06%
419 CG Operational Finance	**214**	**1.69%**
<=20 Years	1	0.01%
21-25	9	0.07%
26-30	13	0.10%
31-35	33	0.26%
36-40	17	0.13%
41-45	27	0.21%
46-50	21	0.17%
51-55	40	0.32%
56-60	35	0.28%

61-65	17	0.13%
66-70	1	0.01%
419 CG Operations Management	**264**	**2.09%**
<=20 Years	1	0.01%
21-25	8	0.06%
26-30	23	0.18%
31-35	36	0.28%
36-40	29	0.23%
41-45	22	0.17%
46-50	27	0.21%
51-55	44	0.35%
56-60	45	0.36%
61-65	27	0.21%
66-70	1	0.01%
>=71 Years	1	0.01%
419 CG Surgery	**1954**	**15.46%**
<=20 Years	22	0.17%
21-25	161	1.27%
26-30	252	1.99%
31-35	294	2.33%
36-40	221	1.75%
41-45	224	1.77%
46-50	205	1.62%
51-55	220	1.74%
56-60	199	1.57%
61-65	131	1.04%
66-70	20	0.16%
>=71 Years	5	0.04%
419 CG Trust Estates & Facilities	**6**	**0.05%**
26-30	1	0.01%
31-35	2	0.02%
41-45	1	0.01%
46-50	2	0.02%
419 CG Workforce and Organisational Development	**1846**	**14.60%**
<=20 Years	51	0.40%
21-25	207	1.64%
26-30	303	2.40%
31-35	355	2.81%
36-40	197	1.56%
41-45	167	1.32%
46-50	136	1.08%
51-55	124	0.98%
56-60	125	0.99%
61-65	127	1.00%
66-70	42	0.33%
>=71 Years	12	0.09%

419 LLP CG Estates & Facilities	**1310**	**10.36%**
<=20 Years	28	0.22%
21-25	63	0.50%
26-30	93	0.74%
31-35	118	0.93%
36-40	145	1.15%
41-45	144	1.14%
46-50	126	1.00%
51-55	165	1.31%
56-60	204	1.61%
61-65	171	1.35%
66-70	42	0.33%
>=71 Years	11	0.09%
Grand Total	**12643**	**100.00%**

Care Group vs Sexual Orientation	Sexual Orientation Headcount	Sexual Orientation %
419 CG Cancer Specialist & Clinical Support Services Group	**2303**	**18.22%**
Bisexual	43	0.34%
Gay or Lesbian	49	0.39%
Heterosexual or Straight	1725	13.64%
Not stated (person asked but declined to provide a response)	468	3.70%
Other sexual orientation not listed	10	0.08%
Undecided	8	0.06%
419 CG Chairman & Chief Executives Office	**47**	**0.37%**
Bisexual	2	0.02%
Gay or Lesbian	1	0.01%
Heterosexual or Straight	41	0.32%
Not stated (person asked but declined to provide a response)	3	0.02%
419 CG Chief Nurse Team	**155**	**1.23%**
Bisexual	2	0.02%
Gay or Lesbian	5	0.04%
Heterosexual or Straight	127	1.00%
Not stated (person asked but declined to provide a response)	20	0.16%
Other sexual orientation not listed	1	0.01%
419 CG Digital Information Services	**260**	**2.06%**
Bisexual	8	0.06%
Gay or Lesbian	8	0.06%
Heterosexual or Straight	181	1.43%

Not stated (person asked but declined to provide a response)	63	0.50%
419 CG Family Health Care Group	**1563**	**12.36%**
Bisexual	29	0.23%
Gay or Lesbian	25	0.20%
Heterosexual or Straight	1239	9.80%
Not stated (person asked but declined to provide a response)	266	2.10%
Other sexual orientation not listed	3	0.02%
Undecided	1	0.01%
419 CG Medical Governance	**143**	**1.13%**
Bisexual	7	0.06%
Gay or Lesbian	6	0.05%
Heterosexual or Straight	111	0.88%
Not stated (person asked but declined to provide a response)	19	0.15%
419 CG Medicine	**2578**	**20.39%**
Bisexual	40	0.32%
Gay or Lesbian	40	0.32%
Heterosexual or Straight	2020	15.98%
Not stated (person asked but declined to provide a response)	475	3.76%
Other sexual orientation not listed	1	0.01%
Undecided	2	0.02%
419 CG Operational Finance	**214**	**1.69%**
Bisexual	3	0.02%
Gay or Lesbian	3	0.02%
Heterosexual or Straight	166	1.31%
Not stated (person asked but declined to provide a response)	40	0.32%
Other sexual orientation not listed	2	0.02%
419 CG Operations Management	**264**	**2.09%**
Bisexual	3	0.02%
Gay or Lesbian	3	0.02%
Heterosexual or Straight	213	1.68%
Not stated (person asked but declined to provide a response)	45	0.36%
419 CG Surgery	**1954**	**15.46%**
Bisexual	14	0.11%
Gay or Lesbian	23	0.18%
Heterosexual or Straight	1448	11.45%
Not stated (person asked but declined to provide a response)	464	3.67%
Other sexual orientation not listed	2	0.02%
Undecided	3	0.02%
419 CG Trust Estates & Facilities	**6**	**0.05%**

Heterosexual or Straight	5	0.04%
Not stated (person asked but declined to provide a response)	1	0.01%
419 CG Workforce and Organisational Development	**1846**	**14.60%**
Bisexual	44	0.35%
Gay or Lesbian	39	0.31%
Heterosexual or Straight	1338	10.58%
Not stated (person asked but declined to provide a response)	418	3.31%
Other sexual orientation not listed	3	0.02%
Undecided	4	0.03%
419 LLP CG Estates & Facilities	**1310**	**10.36%**
Bisexual	11	0.09%
Gay or Lesbian	18	0.14%
Heterosexual or Straight	957	7.57%
Not stated (person asked but declined to provide a response)	319	2.52%
Other sexual orientation not listed	1	0.01%
Undecided	4	0.03%
Grand Total	**12643**	**100.00%**

Care Group vs Disability	Disability Headcount	Disability %
419 CG Cancer Specialist & Clinical Support Services Group	**2303**	**18.22%**
No	1749	13.83%
Not Declared	404	3.20%
Yes	150	1.19%
419 CG Chairman & Chief Executives Office	**47**	**0.37%**
No	42	0.33%
Not Declared	3	0.02%
Yes	2	0.02%
419 CG Chief Nurse Team	**155**	**1.23%**
No	123	0.97%
Not Declared	19	0.15%
Yes	13	0.10%
419 CG Digital Information Services	**260**	**2.06%**
No	175	1.38%
Not Declared	60	0.47%
Yes	25	0.20%
419 CG Family Health Care Group	**1563**	**12.36%**
No	1277	10.10%
Not Declared	182	1.44%
Yes	104	0.82%

419 CG Medical Governance	**143**	**1.13%**
No	115	0.91%
Not Declared	20	0.16%
Yes	8	0.06%
419 CG Medicine	**2578**	**20.39%**
No	2095	16.57%
Not Declared	362	2.86%
Yes	121	0.96%
419 CG Operational Finance	**214**	**1.69%**
No	160	1.27%
Not Declared	37	0.29%
Yes	17	0.13%
419 CG Operations Management	**264**	**2.09%**
No	209	1.65%
Not Declared	40	0.32%
Yes	15	0.12%
419 CG Surgery	**1954**	**15.46%**
No	1538	12.16%
Not Declared	317	2.51%
Yes	99	0.78%
419 CG Trust Estates & Facilities	**6**	**0.05%**
No	5	0.04%
Not Declared	1	0.01%
419 CG Workforce and Organisational Development	**1846**	**14.60%**
No	1497	11.84%
Not Declared	241	1.91%
Yes	108	0.85%
419 LLP CG Estates & Facilities	**1310**	**10.36%**
No	1177	9.31%
Not Declared	65	0.51%
Yes	68	0.54%
Grand Total	**12643**	**100.00%**

Care Group vs Ethnic Group	Ethnicity Group Headcount	Ethnicity Group %
419 CG Cancer Specialist & Clinical Support Services Group	**2303**	**18.22%**
BME	259	2.05%
Not Stated	77	0.61%
White	1967	15.56%
419 CG Chairman & Chief Executives Office	**47**	**0.37%**

BME	1	0.01%
Not Stated	2	0.02%
White	44	0.35%
419 CG Chief Nurse Team	**155**	**1.23%**
BME	7	0.06%
Not Stated	3	0.02%
White	145	1.15%
419 CG Digital Information Services	**260**	**2.06%**
BME	16	0.13%
Not Stated	6	0.05%
White	238	1.88%
419 CG Family Health Care Group	**1563**	**12.36%**
BME	109	0.86%
Not Stated	35	0.28%
White	1419	11.22%
419 CG Medical Governance	**143**	**1.13%**
BME	11	0.09%
Not Stated	5	0.04%
White	127	1.00%
419 CG Medicine	**2578**	**20.39%**
BME	712	5.63%
Not Stated	112	0.89%
White	1754	13.87%
419 CG Operational Finance	**214**	**1.69%**
BME	15	0.12%
Not Stated	2	0.02%
White	197	1.56%
419 CG Operations Management	**264**	**2.09%**
BME	6	0.05%
Not Stated	6	0.05%
White	252	1.99%
419 CG Surgery	**1954**	**15.46%**
BME	385	3.05%
Not Stated	109	0.86%
White	1460	11.55%
419 CG Trust Estates & Facilities	**6**	**0.05%**
White	6	0.05%
419 CG Workforce and Organisational Development	**1846**	**14.60%**
BME	354	2.80%
Not Stated	146	1.15%
White	1346	10.65%
419 LLP CG Estates & Facilities	**1310**	**10.36%**
BME	80	0.63%
Not Stated	64	0.51%
White	1166	9.22%

Grand Total	12643	100.00%

Care Group vs Marital Status	Marital Status Headcount	Marital Status %
419 CG Cancer Specialist & Clinical Support Services Group	**2303**	**18.22%**
Civil Partnership	33	0.26%
Divorced	145	1.15%
Legally Separated	17	0.13%
Married	1173	9.28%
Single	823	6.51%
Unknown	92	0.73%
Widowed	20	0.16%
419 CG Chairman & Chief Executives Office	**47**	**0.37%**
Divorced	3	0.02%
Married	32	0.25%
Single	12	0.09%
419 CG Chief Nurse Team	**155**	**1.23%**
Civil Partnership	1	0.01%
Divorced	12	0.09%
Legally Separated	1	0.01%
Married	102	0.81%
Single	29	0.23%
Unknown	8	0.06%
Widowed	2	0.02%
419 CG Digital Information Services	**260**	**2.06%**
Civil Partnership	3	0.02%
Divorced	15	0.12%
Legally Separated	2	0.02%
Married	136	1.08%
Single	91	0.72%
Unknown	9	0.07%
Widowed	4	0.03%
419 CG Family Health Care Group	**1563**	**12.36%**
Civil Partnership	21	0.17%
Divorced	125	0.99%
Legally Separated	10	0.08%
Married	849	6.72%
Single	504	3.99%
Unknown	45	0.36%
Widowed	9	0.07%
419 CG Medical Governance	**143**	**1.13%**
Civil Partnership	2	0.02%
Divorced	14	0.11%

Legally Separated	1	0.01%
Married	64	0.51%
Single	55	0.44%
Unknown	7	0.06%
419 CG Medicine	**2578**	**20.39%**
Civil Partnership	38	0.30%
Divorced	133	1.05%
Legally Separated	22	0.17%
Married	1262	9.98%
Single	1001	7.92%
Unknown	100	0.79%
Widowed	22	0.17%
419 CG Operational Finance	**214**	**1.69%**
Divorced	18	0.14%
Legally Separated	1	0.01%
Married	116	0.92%
Single	68	0.54%
Unknown	7	0.06%
Widowed	4	0.03%
419 CG Operations Management	**264**	**2.09%**
Civil Partnership	5	0.04%
Divorced	27	0.21%
Legally Separated	2	0.02%
Married	135	1.07%
Single	82	0.65%
Unknown	11	0.09%
Widowed	2	0.02%
419 CG Surgery	**1954**	**15.46%**
Civil Partnership	22	0.17%
Divorced	100	0.79%
Legally Separated	18	0.14%
Married	1035	8.19%
Single	688	5.44%
Unknown	81	0.64%
Widowed	10	0.08%
419 CG Trust Estates & Facilities	**6**	**0.05%**
Divorced	1	0.01%
Married	1	0.01%
Single	4	0.03%
419 CG Workforce and Organisational Development	**1846**	**14.60%**
Civil Partnership	22	0.17%
Divorced	96	0.76%
Legally Separated	17	0.13%
Married	746	5.90%
Single	848	6.71%

Unknown	100	0.79%
Widowed	17	0.13%
419 LLP CG Estates & Facilities	**1310**	**10.36%**
Civil Partnership	53	0.42%
Divorced	104	0.82%
Legally Separated	22	0.17%
Married	542	4.29%
Single	481	3.80%
Unknown	92	0.73%
Widowed	16	0.13%
Grand Total	**12643**	**100.00%**

Patient Equality Monitoring Information

Sex

Financial Year	2023-24

Row Labels	Sum of Patient Count
Female	58321
Male	52018
Not Known	3
Not Specified	5
Grand Total	**110347**

Ethnicity

Financial Year	2023-24

Row Labels	Sum of No of Patients
British	50325
Unknown	44828
Not stated	7282
Any other White background	6232
Any other ethnic group	350
Indian	233
Any other Asian background	171
African	165
Irish	164
White and Asian	148
Any other mixed background	144
Chinese	127
Bangladeshi	93
White and Black African	91
White and Black Caribbean	91
Pakistani	63
Any other Black background	39
Caribbean	14
Grand Total	**110560**

Item 18

Report to:	Board of Directors
Date of Meeting:	21st May 25
Subject:	Emergency Preparedness, Resilence and Response Core Standards Annual Assurance – Action Plan Progess
Director Sponsor:	Accountable Emergency Officer - Claire Hansen
Author:	Head of EPRR – Richard Chadwick

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 Emergency Preparedness, Resilience and Response Core Standards Annual Assurance process was completed in Dec 2024. The Trust has improved full compliance against the 62 standards from 23% in 2023 to 56% in 2024 although this remains as an organisational grading of NON-COMPLIANT.

An action plan has been developed to remediate the partially and non-compliant standards and this report is the first in 2025 that will chart the progress of work against that action plan.

Significant progress has been made in 2024-2025 in developing the Trust readiness to respond to emergency and business continuity incidents. There is much more to do in addition to maintaining the compliant standards already achieved. It is assessed that this

year the organisational grading will improve to partial compliance with an aspiration to maybe attain substantial compliance. Much will depend on how the non-core activity through the year, i.e. winter planning and incident management, will occupy the EPRR team.

A further progress report will be submitted to the Resource Committee in Sep 25.

Recommendation:

The Board is requested to note the progress of the work conducted against the action plan.

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

Meeting/Engagement	Date	Outcome/Recommendation
Resource Committee	20th May 25	Noted

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS – ACTION PLAN PROGRESS REPORT

1. Introduction and Background

NHSE conduct an annual assurance of the Emergency Preparedness Resilience and Response Core Standards. There are 62 core standards that are grouped into the 10 domains of: Governance, Duty to Risk Assess, Duty to Maintain Plans, Command and Control, Training and Exercising, Response, Warning and Informing, Cooperation, Business Continuity and Chemical, Biological, Radiological and Nuclear. The overall assurance organisational grading is determined as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

The annual assurance for 2023-2024 reported the following:

Domain	Core Standards			Total
	Fully Compliant	Partially Compliant	Non-Compliant	
Governance	1	5	0	**6**
Risk Assessment	0	2	0	**2**
Duty to Maintain Plans	1	10	0	**11**
Command & Control	0	2	0	**2**
Training & Exercising	0	3	1	**4**
Response	3	4	0	**7**
Warning & Informing	1	3	0	**4**
Cooperation	1	3	0	**4**
Business Continuity	3	7	0	**10**
CBRN	4	8	0	**12**
Total	**14**	**47**	**1**	**62**

This was a fully compliant rating of 23% against the 62 standards and therefore was allocated an organisational rating of NON-COMPLIANT.

2. Current Position

The annual assurance for 2024-2025 was conducted within a robust governance and assurance framework coordinated by the Emergency Preparedness, Resilience and Response at the Integrated Care Board as follows:

Date	Action
By 30 Sep 24	Trust submit 1st draft to Integrated Care Board
08 Oct 24	Trust submission subjected to peer review
31 Oct 24	Trust final submission to Integrated Care Board

15 Nov 24	Integrated Care Board and Trust Accountable Emergency Officer confirm Trust submission
19 Nov 24	Local Healthcare Resilience Partnership confirm all Trust submissions within the Integrated Care Board
20 Nov 24	Integrated Care Board submit report on system compliance as part of Regional Emergency, Preparedness, Resilience and Response Team assurance process
02 Dec 24	Regional Healthcare Resilience Partnership confirm final Integrated Care Board submissions in the North East and Yorkshire Region
20 Dec 24	Regional Emergency Preparedness, Resilience and Response Team submit North Region Emergency Preparedness, Resilience and Response Core Standards report to NHS England national team
25 Feb 25	Trust Board of Directors endorse Annual EPRR report

The annual assurance for 2024-2025 reported the following:

Domain	Core Standards			Total
	Fully Compliant	Partially Compliant	Non-Compliant	
Governance	4	2	0	**6**
Risk Assessment	0	2	0	**2**
Duty to Maintain Plans	6	3	2	**11**
Command & Control	2	0	0	**2**
Training & Exercising	4	0	0	**4**
Response	7	0	0	**7**
Warning & Informing	1	3	0	**4**
Cooperation	2	2	0	**4**
Business Continuity	5	5	0	**10**
CBRN	4	8	0	**12**
Total	**35**	**25**	**2**	**62**

This is a fully compliant rating of 56% against total standards and therefore remains NON-COMPLIANT as an organisational rating.

3. Action Plan Progress

The action plan to remediate the partially and non-compliant standards is at Appendix 1. Using the progress to date on the action plan it is assessed that the change to gradings against the annual assurance reported position as of May 25 would be:

Domain	RAG	Feb 25	May 25	Sep 25	Jan 26
Governance	(G)	4	5		
	(A)	2	1		
	(R)				
Risk Assessment	(G)				
	(A)	2	2		
	(R)				
Duty to Maintain Plans	(G)	6	7		
	(A)	3	3		
	(R)	2	1		
Command & Control	(G)	2	**Completed**		
	(A)				
	(R)				
Training & Exercising	(G)	4	**Completed**		
	(A)				
	(R)				
Response	(G)	7	**Completed**		
	(A)				
	(R)				

Domain	RAG	Feb 25	May 25	Sep 25	Jan 26
Warning & Informing	(G)	1	1		
	(A)	3	3		
	(R)				
Cooperation	(G)	2	3		
	(A)	2	1		
	(R)				
Business Continuity	(G)	5	5		
	(A)	5	5		
	(R)				
CBRN / HAZMAT	(G)	4	4		
	(A)	8	8		
	(R)				

4. Points to Note On Progress

- **Risk Assessment.** The Emergency Preparedness, Resilience and Response Risk Management Policy has been written and awaits endorsement by the Emergency Planning Steering Group. In addition, the high scoring risks on the Emergency Preparedness, Resilience and Response risk register need to migrate to the DATIX platform to allow inclusion in Corporate Operations tracking. These actions will be completed this year.
- **Duty to Maintain Plans.** The number of plans that require to be held and reviewed annually is large. The burden on the small EPRR team is significant and action is being taken to move some of the more stable plans to a 2 or 3 year review timetable. The following plans have been written/reviewed and are either on circulation or awaiting governance endorsement:
    - Trust Incident Plan – review awaiting circulation.
    - CBRN / HAZMAT Plan – review awaiting circulation.
    - New and Emerging Pandemic Plan – New plan and on external circulation.
    - EPRR Risk Management Policy – Circulation complete and awaiting endorsement.
    - Major Incident Communications Plan – New plan and on internal circulation.
    - Evacuation Plan – New plan and awaiting endorsement.

  The work above will be completed prior to July 25 and the plans review timetable will continue throughout the reporting period. There are 3 new plans that require external stakeholder engagement (NHS E, UK Health & Security Agency and Local Authority) that will take time to complete; these are Infectious Disease Plan, Mass Fatalities Plan and the Mass Counter Measures Plan. Completion may slip into 2026.
- **Warning & Informing.** A draft Major Incident Communications Plan has been written and is with the Director of Communications for review. This plan will be published this year and will ensure compliance with all standards in this domain.
- **Business Continuity.** The Emergency Planning Manager (EPM) has been tasked with the delivery of Business Impact Analyses and developing Business Continuity Plans to departmental level. This is a significant task and will require a bespoke project that may take 12-24 months to complete.
- **Chemical, Biological, Radiological and Nuclear / Hazardous Material.** The plan has been updated and reformatted. Once published (Jun 25), this will make most of the partially compliant standards compliant.

5. Residual Risks

The residual risks to the completion of the action plan are as follows:

- **Emergency Preparedness, Resilience and Response Team Resources.** The Emergency Preparedness, Resilience and Response Team consists of 3 staff members. Competing “non-core” priorities for the team include responding to incidents such as industrial action, conducting training, and exercising to comply with core standards, managing the annual work schedule and running the Emergency Preparedness, Resilience and Response governance

and assurance processes. To complete the action plan is a significant task that will take time. Mitigation measures for this risk include:

- ED Clinical educators and Hull & York Medical School educators have been identified to assist with elements of Emergency Preparedness, Resilience and Response training such as Chemical, Biological, Radiological and Nuclear / Hazordous Material and High Consequence Infectious Disease.
- NHS E have rolled out a comprehensive Health Commanders training programme that has reduced the training burden on the team.
- The more stable plans and policies are being moved to 2 or 3 yearly review schedules.

- **Staff Availability.** The development and implementation of plans and then the testing of them through training and exercising of them relies on the availability of clinical and nursing staff. Operational pressures limit the ability of the Emergency Preparedness, Resilience and Response Team to engage with subject matter experts and then when it is possible, timelines for completion of tasks are protracted. In addition, when individual training programmes are designed, there is a reliance on colleagues taking the opportunity to sign up for those events. Mitigation measures for this risk include:
  - Training and exercising is targeted at senior managers and clinicians to minimise disruption on the shop floor. Where operation procedures are required to be tested then longer lead in times to roster staff to activity are considered.
  - Work is ongoing to develop training packages that can be delivered on Learning Hub to minimise the time staff take to conduct training and prevent disruption to services. Experience this year has indicated that although the opportunities for individual training have been provided online and in person, the take up from colleagues has been at best limited.
  - Activity conducted when responding to incidents is being recorded on logs to minimise the need for training and exercising events.

6. Summary

Significant progress has been made in 2024-2025 in developing the Trust readiness to respond to emergency and business continuity incidents. There is much more to do in addition to maintaining the compliant standards already achieved. It is assessed that this year the organisational grading will improve to partial compliance with an aspiration to maybe make substantial compliance. Much will depend on how the non-core activity through the year, i.e. winter planning and incident management, will distract the Emergency Preparedness, Resilience and Response team.

A further progress report will be submitted to the Resource Committee in September 25.

Date: 7th May 2025

Appendix 1 – EPRR Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	NHS E Final Grading 2023	ICB Final Grading 2024	Trust Action Plan 2023/2024 Carried Forward	2023/2024 Assessment Recommendations	Trust Action 2025	Actionee	Target Date	Arrayed Grade To Date	Remarks / Updates
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	G	A	3 - The EPRR Core Standards Executive Committee and Board of Directors reports need to adher to the NHS E General Observation. (R)		1 - The EPRR Core Standards Executive Committee and Board of Directors reports need to adher to the NHS E General Observation. (G)	RC	Q4 - 24	G	3 - (03/04/2024) This will not change until Board report is submitted. 3 - (14/11/2024) - Carry forward to next years action plan. 1 - (08/04/25) - Complete.
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	A	A	Nil	Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO	2 - Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	RC	Q1 - 25	A	2 - (08/04/25) - RC to speak to KH and see how this can be taken forward in light of Trust challenges and the political NHSE landscape.
7	Duty to Risk Assess	Risk Assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	A	A	12 - Review EPRR Risk Register and introduce a Risk Assessment form for each serial on the register and include as a thumbnail. Include a check sheet as the first sheet to record checks conducted at the EPSG. (R) 13 - Check that EPRR Risk escalation process is included in the Trust Risk Framework specifically. (R)	Migrate EPRR Risk Register to DATIX - Corporate Ops area	3 - Review EPRR Risk Register and introduce a Risk Assessment form for each serial on the register and include as a thumbnail. Include a check sheet as the first sheet to record checks conducted at the EPSG. (G) 4 - Check that EPRR Risk escalation process is included in the Trust Risk Framework specifically. (G) 5 - Migrate EPRR Risk Register to DATIX - Corporate Ops area (R)	RC / CR CR CR	Q3 - 24 Q4 - 24 Q3 - 25	A	12 (19/12/2023) - Accept that all risk assessment forms will take 2024 to complete therefore EPRR Core Standards likely to remain AMBER with evidence of progress. 12 (03/04/2024) - RC / CR to conduct initial risk assessment on RACC and then review what the target completion against dates should be. 12 & 13 (14/11/2024) - Carry forward to 2025 action plan. 3 (08/04/25) - EPSG Mar 25 directed that this was not required. 4 (08/04/25) - Confirmed not included in Trust Risk Framework. It has been included in EPRR Risk Management Policy.
8	Duty to Risk Assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	A	A	Please see comments for core standard 7					A	
13	Duty to Maintain Plans	New and Emerging Pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	A	R	20 - Review the Pandemic Plan in line with national guidance, the national IPC manual and relevant lessons identified from COVID-19. (A)	Write New and Emerging Pandemic Plan	6 - Review the Pandemic Plan in line with national guidance, the national IPC manual and relevant lessons identified from COVID-19. (G) 7 - Write New and Emerging Pandemic Plan (A)	RC RC	Q3 - 24 Q3 - 25	A	20 (03/04/2024) - RC obtained best practice New and Emerging Pandemic Plan and is amending for Trust use and will then authorise through ID WG. 20 (14/11/2024) - Carry forward to 2025 Action Plan. 7 (08/04/25) - SME Circulation deadline 14 Apr 25.
14	Duty to Maintain Plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	A	R	21 - Capture specific Countermeasures Training in the central training log. (R) 22 - Write a new policy to consider mass vaccination and issue of prophylaxis. (R)		8 - Capture specific Countermeasures Training in the central training log. (R) 9 - Write a new policy to consider mass vaccination and issue of prophylaxis. (R)	CR RC	Q3 - 24 Q4 - 24	R	21 & 22 (14/11/2024) - Carry forward into 2025 Action Plan.
17	Duty to Maintain Plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	A	A	25 - Implement lockdown training and exercises to include: a) Both EDs exercising. b) Table Top exercise for BC Leads and Security. (R)	Update the Lockdown Plan	12 - Implement lockdown training and exercises to include: a) Both EDs exercising. b) Table Top exercise for BC Leads and Security. (R) 13 - Update the Lockdown Plan (A)	CR RC	Q2 - 25 Q1 - 25	A	25 - (07/02/2024) Included on EPM work schedule. Query - delay SGH exercise to conduct in new ED. 25 (14/11/2024) - Carry forward to 2025 Action Plan. 12 (08/04/25) - Engagement from E&F proving challenging. 13 (08/04/25) - Lockdown Aide Memoire issued on opening of UECC to provide an interim solution until plan fiully review.
18	Duty to Maintain Plans	Protected Individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	A	A	26 - Write Trust Protected Individuals Policy. (R)		14 - Write Trust Protected Individuals Policy. (G)	RC	Q2 - 25	G	26 (14/11/2024) - Carry forward to 2025 Action Plan. 14 (08/04/25) - Documents held by CR from Security and Comms cover the requirement.
19	Duty to Maintain Plans	Excess Fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	A	A	27 - Write Trust Excess Fatalities Policy. (R)		15 - Write Trust Excess Fatalities Policy. (A)	RC	Q2 - 25	A	27 (14/11/2024) - Carry forward to 2025 Action Plan. 15 (08/04/25) - RC awaiting plan from Christy Rowley which should meet requirement.
33	Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	A	Nil	Determine 24/7 Comms capability and include in Incident Comms Plan	17 - Determine 24/7 Comms capability and include in Incident Comms Plan (R)	RC	Q3 - 25	A	17 (08/04/25) - Included in draft with Comms Team.
34	Warning and Informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	A	A	40 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercises to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (R)	Write Incident Comms Plan	18 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercises to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (R) 19 - Write Incident Comms Plan (A)	Comms Team RC	Q2 - 24 Q3 - 25	A	40 (14/11/2024) - Carry forward onto 2025 Action Plan. 18 (08/04/25) - RC to include a comms slide in induction training, familirisation training and C2 training. 19 (04/08/25) - With Comms team for comment.
36	Warning and Informing	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	A	A	Nil	Write Incident Comms Plan	20 - Write Incident Comms Plan (A)	RC	Q3 - 25	A	19 (04/08/25) - With Comms team for comment.
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	A	A	Nil					G	
39	Cooperation	Mutual Aid Arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	A	A	43 - Review Trust IRP to include a table under mutual aid that defines by Incident Level (1-4) how, who, when and for long mutual is requested. (R)	Include mutual aid arrangements into Command and Control Plan and include MACA guidance.	21 - Review Trust IRP to include a table under mutual aid that defines by Incident Level (1-4) how, who, when and for long mutual is requested. (A) 22 - Include mutual aid arrangements into Command and Control Plan and include MACA guidance. (A)	RC RC	Q4 - 24 Q4 - 24	A	43 - Carry forward onto 2025 Action Plan. 21 & 22 (08/04/25) - Included in 2025 annual review.

Ref	Domain	Standard name	Standard Detail	NHS E Final Grading 2023	ICB Final Grading 2024	Trust Action Plan 2023/2024 Carried Forward	2023/2024 Assessment Recommendations	Trust Action 2025	Actionee	Target Date	Arrayed Grade To Date	Remarks / Updates
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	A	A	46 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. (A) 46A - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 47 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (R)	Separate project required to develop BIAs	23 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. (A) 24 - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 25 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (R) 26 - Seperate project required to develop BIAs. (R)	CR CR CR CR	Q2 - 24 Q2 - 24 Q2 - 25 Q4 - 25	A	46, 46A & 47 (14/11/2024) - Carry forward to 2025 Action Plan.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	A	A	48 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. (A) 49 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust. (R)	Separate project required to develop BCP	27 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. (A) 28 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust. (R) 29 - Seperate project required to develop BIAs. (R)	CR CR CR	Q2 - 23 Q4 - 25 Q3 - 26	A	48 & 49 (14/11/2024) - Carry forward to 2025 Action plan.
50	Business Continuity	BCMS Monitoring and Evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A	A	Nil	Review required of process and included in Trust BC Plan	30 - Review required of process and included in Trust BC Plan. (R)	CR	Q2 - 25	A	30 (08/04/25) - CR to review completion.
52	Business Continuity	BCMS Continuous Improvement	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A	A	Nil	Review required of process and included in Trust BC Plan	32 - Review required of process and included in Trust BC Plan. (R)	CR	Q2 - 25	A	30 (08/04/25) - CR to review completion.
53	Business Continuity	Assurance of Commissioned Providers / Suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	Nil	Review required of process and included in Trust BC Plan	33 - Review required of process and included in Trust BC Plan. (R)	CR	Q2 - 25	A	30 (08/04/25) - CR to review completion.
56	Hazmat/CBRN	Hazmat/CBRN Risk Assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A	A	Nil	Complete CBRN Tent & PRPS Suit Risk Assessment Complete a Risk Assessment around minimum staffing numbers to respond to a CBRN incident Complete actions provided in the CBRN Audit guidance.	35 - Complete CBRN Tent & PRPS Suit Risk Assessment. (G) 36 - Complete a Risk Assessment around minimum staffing numbers to respond to a CBRN incident. (A) 37 - Complete actions provided in the CBRN Audit guidance. (A)	EC-S EC-S EC-S	Q3 - 25 Q3 - 25 Q3 - 25	A	35 (08/04/25) - completed and held by EC-S. 36 (08/04/25) - RC to review EC-S draft.
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	A	A	55 - Review CBRN Plan. (R)		39 - Review CBRN Plan. (A)	RC	Q3 - 25	A	55 (14/11/2024) - carry forward to 2025 Action Plan.
59	Hazmat/CBRN	Decontamination Capability Availability 24/7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	A	A	Nil	Design an automated system for annotating who is CBRN trained when a incident occurs. Amend CBRN Plan to include guidance provided in CBRN Audit	40 - Design an automated system for annotating who is CBRN trained when a incident occurs. (A) 41 - Amend CBRN Plan to include guidance provided in CBRN Audit (G)	EC-S RC	Q3 - 25 Q3 - 25	A	40 (08/04/25) - Manual process in place whilst automation is explored. 41 (08/04/25) - Guidance included in draft plan.
60	Hazmat/CBRN	Equipment and Supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients	A	A	57 - Review CBRN Plan to include equipment husbandry to include registers, audits and fault finding flow charts. (R) 58 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57. (R)	Submit a full and detailed CBRN equipment inventory to YAS.	42 - Review CBRN Plan to include equipment husbandry to include registers, audits and fault finding flow charts. (A) 43 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57. (G) 44 - Submit a full and detailed CBRN equipment inventory to YAS.	RC RC EC-S	Q3 - 25 Q3 - 25 Q3 - 25	A	57&58 (14/11/2024) - carry forward onto 2025 Action Plan. 42, 43 & 44 (08/04/25) - RC to meet with EC-S and include in plan.
63	Hazmat/CBRN	Hazmat/CBRN Training Resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	A	Nil	CI CBRN to comply with guidance provided in CBRN audit.	47 - CI CBRN to comply with guidance provided in CBRN audit.	EC-S	Q3 - 25	A	
64	Hazmat/CBRN	Staff Training - Recognition and Decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	A	A	Nil	Undertake a full review of the current training course once the TNA has been undertaken.	48 - Undertake a full review of the current training course once the TNA has been undertaken. (A)	EC-S	Q3 - 25	A	48 (08/04/25) - EC-S to confirm acceptable to Corporate Nursing.

Ref	Domain	Standard name	Standard Detail	MHS E Final Grading 2023	ICB Final Grading 2024	Trust Action Plan 2023/2024 Carried Forward	2023/2024 Assessment Recommendations	Trust Action 2025	Actionee	Target Date	Arrested Grade To Date	Remarks / Updates
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	A	A	Nil	Ensure the PRPS suits size selection for individuals aligns to manufacturers guidance.	49 - Ensure the PRPS suits size selection for individuals aligns to manufacturers guidance. (A)	EC-S	Q3 - 25	A	49 (08/04/25) - EC-S to confirm guidance with SB.
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	A	Nil	Complete actions as per CBRN Audit guidance	50 - Complete actions as per CBRN Audit guidance. (R)	EC-S	Q3 - 25	A	

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	21 May 2025
Subject:	Funding to support LIMS and Digital Cell Path Implementation
Director Sponsor:	Mark Quinn, Director – CSCS Care Group
Author:	Alex Sharp, Network General Manager, Scarborough, Hull, York Pathology Service

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 business case is to accept funding of £1,060,000 in capital and £216,000 in revenue via the Digital Diagnostic Capability Program to support the implementation of the new Laboratory IT system (LIMS), and the implementation and associated training for digital cell path.

Recommendation:
The recommendation is to approve the business case

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 The business case was approved at Executive Committee on 7th May		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
Executive Committee	7th May	Approved – due to value to be confirmed at Board

SHYPS Digital Diagnostic Funding to Support LIMS and accelerate Digital Cell Path implementation

1. Introduction and Background

SHYPS has applied for funding from the NHSE Digital Diagnostic Capability Program (DDCP) to support our LIMS (laboratory Information Management System) implementation and the Acceleration of Digital Cellular Pathology.
A value of £1,060,000 in Capital and £216,000 in Revenue has notionally been allocated.
This paper and business case outlines the need for this funding and how the funding will be allocated.

2. Considerations

There is still a significant amount of work to complete in order to achieve the go-live as planned and the continued support of external contractor (Omni-Modi) is critical to achieve this.
The implementation of Digital Cell Path reporting is dependant of the LIMS implementation. Currently all the hardware and infrastructure is in place. The next stage is to integrate the PACS capabilities with the new LIMS to ensure patient information can be securely and accurate linked with the scanned slides/images. This requires the installation of a further Clinisys product (Specimen Processing module). Funding will be used to provide external resource to support this implementation.
Once Digital Reporting capabilities are available, consultants will be required to validate on the new reporting method. This will include a period of double reporting (reporting a case using digital methods and tradition glass slides) to reduce the impact of this on services and patients we will proactively outsource additional activity for a period of 3 months whilst consultants' complete validation on digital methods. This will accelerate the adoption of digital reporting whilst maintaining existing turnaround times.
The existing laboratory systems are "end of life" with limited "best endeavours" support and no further development.

3. Current Position/Issues

Without external funding we will need to either source funding from existing budgets to support the project delivery, or reduce the rate of work and further delay the implementation.

4. Summary

This BC includes as well as the Capital funding, £216k of revenue support from the NHSE DDCP fund this will directly offset training requirements and backfill to develop the Digital Cell Path programme, this is non-recurrent funding in 2025/26 and will all be received and spent within the financial year.

The remaining revenue consequences (£127k) relate to the capital charges from the Capital received.

Both the revenue and Capital elements of this case need to be spent by 31st March and drawdown from NHSE will match this spend profile

5. Next Steps

Once Approved Locally, case will be discussed at an assurance review panel within NHSE before MOU's are raised

Date: 14/05/2025

APPENDIX Ai

Business Case Approvals

- Potential cases should be outlined at Annual Planning
- Business Case Completed (Revenue and/or Capital)
- Care Group Board - Revenue Approval <£50k
- CPMG - Capital Approval <£50k
- Chief Executive, usually through the Executive Committee (Revenue) / CPEG (Capital) - Approval £50k - £500k
- Executive Committee - Revenue & Capital Approval £500k - £1m
- Board of Directors - Revenue & Capital Approval >£1m
- CAP Board / ICB Review of all cases that impact / benefit the wider ICS
- Post Project Evaluation - 12 months after implementation

Stakeholder Considerations

YTHFM LLP	•Is accommodation required? •Is cleaning / maintenance of accomodation required? •Are porters / catering / laundry & linen required? •Is maintenance of medical equipment required?
Digital Information Services (DIS)	•Does the change require a system change? •Does the change require new digital functionality? •Does the change require a new digital solution? •Has the DIS Change Request Process been followed?
Care Groups	•Consider the impact of your business case on other Care Groups - have they been engaged where required? •Mandatory consultation for stakeholder groups is included in section 8 of the business case summary
Sustainability	•Does the business case impact on the Trust's sustainability programme?
Commissioners	•Where additional funding is required this should be discussed with commissioners (i.e the ICB)
Other Providers within the ICS	•Does the business case have an impact or provide a benefit to other provider organisations within the ICS?

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE SUMMARY

1. Business Case Number

2025-26-007

2. Business Case Title

SHYPS Digital Diagnostic Funding to Support LIMS and accelerate Digital Cell Path implementation

3. Sponsorship, Management Responsibilities & Key Contact Point

The Business Case 'Owner' should be the appropriate Care Group or Corporate Director, or where appropriate an alternative lead Clinician nominated by the respective Care Group Director. The 'Author' will be the named manager supporting the owner of the Business Case, who will have responsibility for the development and writing of the Business Case, and will be the key contact point for enquiries.

3.1 Sponsorship Confirmation (where neither are the Owner or Author of the Business Case)

Care Group/ Corporate Director	Name	Date of Agreement
	Mark Quinn	30/04/2025

Care Group Manager	Name	Date of Agreement
	Karen Priestman	30/04/2025

3.2 Management Responsibilities & Key Contact Point

Business Case Owner:	**Dave Oglesby**

Business Case Author:	**Alex Sharp**
Contact Number:	**07419779950**

STRATEGIC CASE

The purpose of the strategic section of the business case is to make the case for change and to demonstrate how it provides strategic fit.

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change.

SHYPS has applied for funding from the NHSE Digital Diagnostic Capability Fund (DDCF) to support our LIMS (laboratory Information Management System) implementation and the Acceleration of Digital Cellular Pathology.
A value of £1,060,000 in Capital and £216,000 in Revenue has notionally be allocated.

The intended go-live in March 25 was not achievable and the new expected go-live date is 30th June.
As of 24th April 2024, this remains an achievable date with UAT expected to be complete on track by 9th May.

There is still a significant amount of work to complete in order to achieve the go-live as planned and the continued support of external contractor (Omni-Modi) is critical to achieve this date.

The delay from March to July has also attracted additional professional fees from Clinisys.

The implementation of Digital Cell Path reporting is dependant of the LIMS implementation. Currently all the hardware and infrastructure is in place. The next stage is to integrate the PACS capabilities with the new LIMS to ensure patient information can be securely and accurate linked with the scanned slides/images. This requires the installation of a further Clinisys product (Specimen Processing module). Funding will be used to provide external resource to support this implementation.

Once Digital Reporting capabilities are available, consultants will be required to validate on the new reporting method. This will include a period of double reporting (reporting a case using digital methods and tradition glass slides) to reduce the impact of this on services and patients we will proactively outsource additional activity for a period of 3 months whilst consultants complete validation on digital methods. This will accelerate the adoption of digital reporting whilst maintaining existing turn around times.

The summary of intended use for this funding is below:

LIMS - CAPITAL

Description	Timescale	Cost	Cost inc. VAT
LIMS Programme Delivery & testing Service plus intensive Go-Live support	April to July	£ 415,500.00	£ 498,600.00

Clinisys CCN, project fees	April to July	£200,000	£240,000.0
		LIMS Total	£ 738,600.00

Digital Cell Path - CAPITAL

Description	Timescale	Cost	Cost inc. VAT
3 months additional (30%) outsourcing to support consultant validation	Jan-Mar '26	£ 200,000.00	£ 240,000.00
Project Management fees	Jun to Oct '25	£80,000	£ 96,000.00
		DCP Total	£ 336,000.00

Digital Cell Path – REVENUE

Resource	Quantity	Cost	Total Cost
Laboratory staff training on Scanners and Digital processes	71 Staff	Revenue	£14,000
Medical staff training – 2nd Stage validation (Digital and Slide)	19 Staff	Revenue	£42,000
6 month Fixed term posts to implement and imbed DCP (4 x B4) lab and admin	4 posts	Revenue	£160,000

5. Capacity & Demand Analysis

Where a key issue raised concerns of the availability of sufficient capacity to meet anticipated demand on the service, it must be supported by a Capacity and Demand analysis to clearly demonstrate the gap in capacity, with the results presented below. Please refer to the Business Case guidance document for the guidance and access to the preferred capacity and demand model. If required, support in completing the model is available through the Corporate Operations team (contact Andrew Hurren on extension 5639).

n/a

6. Alignment with the Trust's Strategic priorities

The Trust has identified four strategic priorities that ensure there is a focus for its emerging priorities and objectives, and assists in the communication to staff, patients and other stakeholders.

Indicate using the table below, to what extent the preferred option is aligned with these strategic priorities. It is expected that the preferred option will align with at least one of the strategic priorities.

Strategic Priority	Describe how the case is aligned to the Strategic Theme
Priority 1 – Our People	By introducing new systems, we provide a modern environment for our highly valued colleagues to work in, which may help with retention and to attract prospective employees also.
Priority 2 – Quality & Safety	A single LIMS will support harmonising work practices and reducing variation, the introduction of Digital Cell Path will track slides better and allow images to be recalled quicker and future use of AI to improve capacity
Priority 3 – Elective Recovery	Both the single LIMs and Digital Cell Path will support improved testing pathways, reduction in reduced testing for patients referred between site and improved turnaround times for histopathology.
Priority 4 – Acute Flow	An improved and more modern LIMS will allow us to track samples throughout their pathway and flag urgent samples that need to be fast-tracked for faster turnaround times.

7. Business Case Objectives

Setting robust spending or investment objectives is essential in making a coherent case for change; the case should identify SMART (Specific, Measurable, Achievable, Relevant, Time bound) to address one or more of the following generic drivers, see page 23 of the guidance for full description of drivers. List the business case objectives and the metrics and measures below:

Description of objective	Metric	Quantity Before	Quantity After
Supporting June/July Go-Live for LIMS	n/a		
Reducing implementation timescale for Digital Cell Path	Number of Months between LIMS go live and 100% Scanning	8 Months	4 Months

How will information be collected to demonstrate that the benefit has been achieved?			

8. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the Business Case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above.

Where external stakeholder support is vital to the success of the Business Case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment. If the Business Case spans more than one Care Group or Directorate the expected/required close collaboration in such circumstances must be evidenced.

Examples of stakeholders include lead clinicians, support services (e.g. Digital Information Services (DIS), Capital Planning re: accommodation, YTHFM LLP re Estates & Facilities support services), Commissioners (e.g. HCV ICB, NHSE, etc.), patients & public, etc.

See page 24 of the guidance for a checklist of potential questions that should be considered when assessing stakeholder involvement.

A 'Not-Applicable' (N/A) response is not acceptable in this section of the case unless accompanied by the name of the relevant stakeholder that has confirmed there is no applicable involvement in the case.

Stakeholder	Confirmation of Stakeholder Support
Mandatory Consultation	
Radiology	No Impact
Laboratory Medicine (SHYPS)	Key Stakeholder
Pharmacy	No Impact
AHP & Psychological Medicine	No Impact
Theatres, Anaesthetics and Critical Care	No Impact
Community Services	No Impact
Digital Information Systems (DIS)	Key Stakeholder
Sustainability	No Impact
YTHFM LLP	No impact
Clinical Coding Team	No Impact

ECONOMIC CASE

The purpose of the economic case is to identify the proposal that delivers the best value for money.

The economic case should identify the preferred option when measured against the issues identified in section 4 of the strategic case, how it closes the capacity gaps identified, how it meets the business case objectives outlined in section 7 and how it meets the Trust's strategic priorities.

9. Options Considered

List, and describe briefly below the alternative options considered to resolve the issue(s) presented in Section 4 above. This should just be a factual description of the option, without at this stage, any comments on the pros and cons of the option. The inclusion of alternative workforce and clinical models should be considered when generating the list of options. Option 1 should always be Business as Usual (BAU) as a comparison to the options considered

Description of Options Considered
Do nothing (no not accept funding) and accept further delay in LIMs & Digital Cell Path implementation
Accept the funding from the DDCF to support additional funding to accelerate the LIMS and Digital Cell Path projects

10. Benefit and Cost Analysis

All identified options must be subject to a Benefit and Cost analysis, using the 'Investment Appraisal Scoring Sheet' (Appendix Aiii) and summarised below:

Summary Benefit Cost Analysis						
	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Objectives Score	0	0	0	0	0	0
	£000	£000	£000	£000	£000	£000
Net Income & Expenditure	0	0	0	0	0	0
Net Present Value	0	0	0	0	0	0
Net Present Value Per Objective Point Scored (£000)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Overall Ranking (manually enter)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

11. The Preferred Option

Detail the preferred option together with the reasons for its selection over the other options. This must be supported with appropriate description and data in demonstrating how it will address the issue(s) described in Section 4 above.

The case for the preferred option should include how the option closes any capacity gaps identified in section 5, with the results of the closed gap after using the preferred capacity and demand model. This section should also confirm that the preferred option meets the business case objectives identified in section 7.

The preferred option should be cross referenced to key attributes identified in the Benefit and Cost Analysis in section 10.

Confirm the preferred option
Accept the funding from the DDCF to support additional revenue and capital spend to accelerate the LIMS and Digital Cell Path projects
Describe how the preferred option addresses any capacity gaps identified in section 5
N/A
Describe how the preferred option meets the Trust's strategic priorities in section 6
The new LIMS and Digital Cell path systems will promote a modern workplace and systems, they will improve quality and safety by providing improved interoperability and integrations with other systems and network and opportunity to adopt AI. Turn around times in Cell Path would be expected to improve with the introductions of digital cell path and the use of high quality barcodes and automatic sample receipt will improve turnaround times for acute tests
Describe how the preferred option meets the Business Case Objectives identified in section 7
Agreeing to accept and allocate the funding will allow the role out of additional zebra printers which are required to facilitate electronic requesting with the new LIMS system. The allocated funding will also support the acceleration for Digital Cell path by funding specific training and staff to adopt and imbed the new (and additional) laboratory processes.
Describe how the outcome of the IASS in section 10 supports the preferred option?
N/A

12. Consultant, and other Non-Training Grade Doctor Impact

*(Only to be completed where the preferred option **increases** the level of Consultant / non-Training Grade input)*

12.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/Non-Training Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the Business Case.

	Before	After
Average number of PAs		
On-call frequency (1 in)		

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**

12.2 Job Plan Approval:

The Medical Director or Deputy, along with the Medical Workforce Manager must review all proposed Job Plans for new Consultant posts, as well as any Job Plans of existing Consultants where the proposed new post would have an impact on current working practices. The date that the Job Plans were approved must be provided below.

Date of Approval	
Comments by either the Medical Director or Deputy, or the Medical Workforce Manager	

13. Accommodation

If the delivery of this Business Case is reliant on the Care Group or Directorate submitting the case being allocated additional space (e.g. to accommodate new staff or to expand its services)

the availability of this additional space should be established prior to the submission of the Business Case for approval.

If assistance is required in assessing the space requirements / availability of space to support this Business Case then help is available from Tony Burns (01904) 721856 or tony.burns@york.nhs.uk).

Does the implementation of the Business Case require additional space to be found and allocated?	**Yes**	**No**
		x
Has the space identified been confirmed available?	**Yes**	**No**
Have the costs associated with maintaining the space been included in the financial analysis?	**Yes**	**No**

Please tick

14. Benefits of the Preferred Option

The identification of the benefit(s) that are expected to arise from the Business Case is crucial to ensuring that a robust evaluation of the progress and delivery of the Business Case objectives is possible during any post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will arise from implementing the preferred option below. The benefits identified must be aligned to the business case objectives in section 7 and be tangible and capable of being evidenced through some form of measurement. The timings of when the benefits will materialise should be realistic.*

It is acknowledged that some benefits may not materialise until at least 6m, dependent on the purpose of the Business Case and, as the Guidance Manual indicates, in a small number of instances there may be a need to consider adjusting the timings of the reviews, dependent on the forecast timeframe for benefit delivery.

				(* from Estimated Implementation date)		
Description of Benefit	**Metric**	**Quantity Before**	**Quantity After**	**At 3m***	**At 6m***	**At 12m***

LIMS and Digital Cell Path progress are reported to NHSE via the DDCF NHS Futures site and specific Benefits survey (6 months post go-live)						

15. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

In light of the difficulties being experienced both locally and nationally in successfully recruiting across a broad range of staff groups, the author should pay particular attention to the risks associated with fully recruiting to any new posts identified in the business case, supported by current market intelligence. Such risks need to be considered in the context of the likelihood (and timeframe) of the need to use agency or locum staff incurring premium costs for the Trust.

*The likelihood of any additional costs of risk **after** mitigation should be acknowledged in this section, and its impact recognised in the financial assessment of the case.*

Identified Risk	Proposed Mitigation	Value of Risk £'000

COMMERCIAL CASE

The commercial case should demonstrate that the preferred option has considered additional approval routes required for the purchase of equipment or that a viable procurement route has been identified where required.

16. Is there a requirement to apply for funding via the Medical Equipment Resources Group (MERG), linked to this Business Case?

If 'yes', the completed and approved MERG form must feature as an attachment to the Business Case document.

Yes	
No	x

Please tick

If 'Yes' please state below what proportion of the overall Capital costs associated with the Business Case (see the Financial Pro-forma), relate specifically to equipment

Overall Capital Costs for the Business Case	1060000
State the value of the Equipment within the above	

17. Is there a requirement to involve or liaise with the Procurement Department with regard to any aspects associated with this Business Case?

Yes	
No	

Please tick

If 'Yes' please provide a brief summary to evidence the involvement and the outcome.

FINANCE CASE

The finance case should demonstrate that the business case is affordable and the relevant source of funding is identified.

18. Financial Summary

18.1 Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the Care Group or Directorate as a result of this Business Case. The figures should summarise the more detailed analysis on the accompanying 'Financial Pro Forma'.

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure (-ve)		-1,075	-1,075
Income (+ve)		216	216
Direct Operational Expenditure (-ve)		-216	-216
EBITDA	0	0	0
Other Expenditure (-ve)		-127	-127
I&E Surplus/ (Deficit)	0	-127	-127
Existing Provisions (+ve)	n/a		0
Net I&E Surplus/ (Deficit)	0	-127	-127
Contribution (%)	#DIV/0!	-1	-1
Non-recurring Expenditure (-ve)	n/a		0

Supporting Financial Commentary:

This BC includes as well as the Capital funding £216k of revenue support from the NHSE DDCP fund this will directly offset training requirements and backfill to develop the Digital Cell Path programme, this is non-recurrent funding in 2025/26 and will all be received and spent within the financial year.

The remaining revenue consequences (£127k) relate to the capital charges from the Capital received.

Both the revenue and Capital elements of this case need to be spent by 31st March and drawdown from NHSE will match this spend profile.

18.2 Estimated Impact on Run Rate

Summarise the impact on current monthly income and expenditure run rate as a result of this Business Case. The current run rate should reference the average monthly income and expenditure over the last six months. Demonstrate how the run rate will change as a

result of this business case in full, and at 6 months and 12 months following approval of the case. Show income as positive figures and expenditure as negative.

	Current Run rate	Revised Run Rate	Change	Change at 6 months	Change at 12 months	Change in later years
	£000	£000	£000	£000	£000	£000
Income (+ve)						
Clinical Income			0			
Non Clinical Income			0	18	0	0
Expenditure (-ve)						
Pay			0	-13.33	0	0
Non Pay			0	-4.67	0	0
Non Operational expenditure			0	-11	-11	-11
Total	0	0	0	-11	-11	-11

Run Rate Supporting Commentary:

The long term Run Rate implications of this Business Case (£11k) relate to the costs of capital. There will be no long term revenue implications from the revenue award and this will all be spent by 31st March 2026.

MANAGEMENT CASE

The management case should demonstrate that robust arrangements are in place for the delivery, monitoring and evaluation of the preferred option.

19. Delivery

Describe the process put in place for successful delivery of the preferred solution, this should include the management of any potential risks, delivery of benefits, recruitment timescales and budgetary changes.

20. Post Implementation Review (PIR)

Provide a self-assessment of the risk score and summarise below to determine whether a PIR is required, this will be validated at the time of approval of the business case, by the approving authority, see section 20 of the business case guidance:

Self-assessment score	Level of Risk	Outcome

21. Estimated Implementation Date

State the estimated implementation date. This will be used as the start point of the review period where the Business Case is selected for Post Implementation Review (PIR).

Estimated Implementation Date	

22. Date of Completion:

Note: This date should be kept current on each occasion that the documentation is refreshed/ updated.

The use of version control is recommended to aid the auditing and tracking of current documentation, particularly if the Case spans more than one Care Group or Directorate with multiple contributors. The 'Final' version must be clearly indicated as such.

Date	
Version No.	

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	**2024/25-56**
TITLE:	**SHYPS Digital Diagnostic Funding to Support LIMS and accelerate Digital Cell Path implementation**
OWNER:	**Dave Oglesby**
AUTHOR:	**Alex Sharp**

Capital

		Total £'000	Planned Profile of Change 2025/26 £'000	2026/27 £'000	2027/28 £'000	Later Years £'000
Capital Investment	(-ve)	-1,075	-1,075			
Equipment	(-ve)					
Property Transactions (Leases)	(-ve)					

Capital Notes *(including reference to the funding source)* :

Capital costs to support LIMS (laboratory Information Management System) implementation Funding available from NHSE Digital Diagnostic Capability Fund

Revenue

		Total Change Current £'000	Revised £'000	Change £'000	WTE	Planned Profile of Change 2025/26 £'000	2026/27 £'000	2027/28 £'000	Later Years £'000
(a) Non-recurring set up costs	(-ve)								
(b) Recurring									
Income									
Income from Patient Care Activities:	(+ve)	0	0	0		0	0	0	0
Other Operating Income	(+ve)	0	0	0		216	0	0	0
Total Income		**0**	**0**	**0**		**216**	**0**	**0**	**0**
Operating Costs:									
Pay									
Medical	(-ve)			0		-56			
Nursing	(-ve)			0					
Other (please list):									
Executive Board & Senior Managers	(-ve)			0					
Support Staff	(-ve)			0					
WLIs	(-ve)			0					
				0					
Total Pay Costs		**0**	**0**	**0**	**0.00**	**-56**	**0**	**0**	**0**
Non-Pay									
Purchase of Healthcare from NHS Bodies	(-ve)			0					
Purchase of Healthcare from non NHS Bodies	(-ve)			0					
Clinical Supplies & Services	(-ve)			0					
General Supplies & Services	(-ve)			0		-160			
Drugs	(-ve)			0					
Establishment	(-ve)			0					
Premises - (incl Business rates)	(-ve)			0					
Transport	(-ve)			0					
LLP Costs (Facilities Mgmt & Estates)	(-ve)			0		0	0	0	0
Other (please list):									
Depreciation	(-ve)								
Rate of return	(-ve)								
Total Non Pay Costs		**0**	**0**	**0**		**-160**	**0**	**0**	**0**
Total Operational Expenditure		**0**	**0**	**0**		**-216**	**0**	**0**	**0**
Impact on EBITDA		**0**	**0**	**0**	**0.00**	**0**	**0**	**0**	**0**
Depreciation	(-ve)		-108	-108		-54	-108	-108	-108
Rate of Return	(-ve)		-19	-19		-10	-19	-19	-19
Lease Ammortisation	(-ve)								
Overall impact on I&E		**0**	**-127**	**-127**	**0.00**	**-64**	**-127**	**-127**	**-127**
									+ favourable (-) adverse
Less: Existing Provisions	(+ve)	**n/a**		**0**					
Net impact on I&E		**0**	**-127**	**-127**		**-64**	**-127**	**-127**	**-127**
									+ favourable (-) adverse

Revenue Notes *(including reference to the funding source)* :

This BC includes as well as the Capital funding £216k of revenue support from the NHSE DDCP fund thsi will directly offset training requirments and backfill to develop the Digital Cell Path programme.

The remaining revenue consequences (£127k) relate to the capital charges from the Capital received.

Both the revenue and Capital elements of this case need to be spent by 31st March and drawdown from NHSe will match this spend profile.

			Board of Directors Only
	Owner	**Finance Manager**	**Director of Finance**
Signed	**Alex Sharp**	**Neil Barrett**	
Dated	29/04/2025	07/05/2025	

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2025/26	2026/27	2027/28	Later Years
Fixed Contract Element							
Non-elective admissions			0				
Outpatient Follow Ups			0				
A&E			0				
High Cost Drugs			0				
Other (please list):							
			0				
Variable Contract Element							
Elective Inpatients			0				
Elective Day Cases			0				
Outpatient First Attendances			0				
Outpatient Procedures			0				
High Cost Drugs			0				

Income (+ve)

		Total Change			Planned Profile of Change			
		Current £'000	Revised £'000	Change £'000	2025/26 £'000	2026/27 £'000	2027/28 £'000	Later Years £'000
Fixed Contract Element								
Non-elective admissions	(+ve)			0				
Outpatient Follow Ups	(+ve)			0				
A&E	(+ve)			0				
High Cost Drugs	(+ve)			0				
Community Services	(+ve)			0				
Other (please list):								
				0				
Variable								
Elective Inpatients	(+ve)			0				
Elective Day Cases	(+ve)			0				
Outpatient First Attendances	(+ve)			0				
Outpatient Procedures	(+ve)			0				
High Cost Drugs	(+ve)							
Other NHS Clinical Income								
	(+ve)			0				
	(+ve)			0				
Non NHS Clinical Income								
Private patient income	(+ve)			0				
Other non-protected clinical income	(+ve)			0				
Total Income from patient care activities		**0**	**0**	**0**	**0**	**0**	**0**	**0**
Other income								
Research and Development	(+ve)			0				
Education and Training	(+ve)			0				
Other (please list):								
NHSE Digital Diagnostic Capability Fund	(+ve)			0	0			
	(+ve)			0				
Total other income		**0**	**0**	**0**	**0**	**0**	**0**	**0**

York and Scarborough Teaching Hospitals NHS Foundation Trust

BUSINESS CASE RUN RATE SUMMARY

		Total Change			Planned Profile of Change		
		Current £'000	Revised £'000	Change £'000	6 months £'000	12 months £'000	Later Years £'000
Income							
Income from Patient Care Activities:	(+ve)			0.00			
Other Operating Income	(+ve)		0.00	0.00	18.00	0.00	0.00
Total Income		**0.00**	**0.00**	**0.00**	**18.00**	**0.00**	**0.00**
Operating Costs:							
Pay							
Medical	(-ve)			0.00	-13.33		
Nursing	(-ve)			0.00			
Other (please list):							
Executive Board & Senior Managers	(-ve)			0.00			
Support Staff	(-ve)			0.00			
WLIs	(-ve)			0.00			
				0.00			
Total Pay Costs		**0.00**	**0.00**	**0.00**	**-13.33**	**0.00**	**0.00**
Non-Pay							
Purchase of Healthcare from NHS Bodies	(-ve)			0.00			
Purchase of Healthcare from non NHS Bodies	(-ve)			0.00			
Clinical Supplies & Services	(-ve)			0.00			
General Supplies & Services	(-ve)			0.00	-4.67		
Drugs	(-ve)			0.00			
Establishment	(-ve)			0.00			
Premises - (incl Business rates)	(-ve)			0.00			
Transport	(-ve)			0.00			
LLP Costs (Facilities Mgmt & Estates)	(-ve)			0.00	0.00	0.00	0.00
Other (please list):							
	(-ve)			0.00			
	(-ve)			0.00			
Total Non Pay Costs		**0.00**	**0.00**	**0.00**	**-4.67**	**0.00**	**0.00**
Total Operational Expenditure		**0.00**	**0.00**	**0.00**	**-18.00**	**0.00**	**0.00**
Impact on EBITDA		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Depreciation	(-ve)		-9	-9	-9	-9	-9
Rate of Return	(-ve)		-2	-2	-2	-2	-2
Lease Ammortisation	(-ve)						
Overall impact on I&E		**0.00**	**-11**	**-11**	**-11**	**-11**	**-11**
Less: Existing Provisions	(+ve)	**n/a**		**0.00**			
Net impact on I&E		**0.00**	**-10.58**	**-10.58**	**-11.00**	**-11.00**	**-11.00**

Run rate notes:

The long term Run Rate implications of this Business Case (£11k) relate to the costs of capital. There will be no long term revenue implications from the revenue award and this will all be spent by 31st March 2026.

Report to:	Board of Directors
Date of Meeting:	21st May 2025
Subject:	YTHFM Revision of the Reservation of Powers and Scheme of Delegations and Standing Financial Instructions
Director Sponsor:	Penny Gilyard, Director of Resources Chris Norman, Managing Director
Author:	Penny Gilyard, Director of Resources

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 purpose of the report is to present to Board of Directors, YTHFM's Reservation of Powers and Scheme of Delegation and Standing Financial Instructions which have been reviewed in line with governance arrangements.

YTHFM reviews the corporate governance documents on an annual basis for recommendation for approval by Management Group and Audit Committee meeting, YTHFM had confirmed there were no material updates to the SoDs and SFIs documentation however, it was agreed to review against the new procurement act changes coming through in March this year. This has now been completed.

The documents are a Reserved Matter and require final approval by Board of Directors.

Recommendation:
The Board of Directors is asked to approve the documents which are available to view in the For Reference folder on the Teams channel.

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
Management Group	December 2024	Approved subject to duplicate wording being removed and change to procurement rules.
Group Audit Committee	December 2024	Verbal Assurance.
Group Audit Committee	13th May 2025	Approved.
Management Group	27th May 2025	
Board of Directors	21st May 2025	

Revision of the Reservation of Powers and Scheme of Delegations and Standing Financial Instructions

1. Introduction and Background

1.1 YTHFM reviews the corporate governance documents on an annual basis for recommendation for approval by Management Group and Audit Committee. YTHFM confirmed there were no material updates to the SoDs and SFIs documentation however, it was agreed to review against the new procurement act changes coming through in March this year. This has now been completed, and the documents are included **(Appendix 1 and 2)** for approval by Board of Directors.

2. Considerations

2.1. Reservation of powers and Scheme of Delegations

2.1.2 The following changes are made to the YTHFM's reservation of powers and scheme of delegations. (Amendments in bold).

Area	Section and amendment
Scheme of Matters Reserved for Management Group	Approval of Management Group banking arrangements. **(SFI 5.1).** (Amendment from SFI 56.1)
All Business Cases revenue investment	Any expenditure over **£30k** must be advertised under UK procurement legislation. (Amendment from £10k). Updated in line with Procurement Act.
Personnel and Pay	**Removed** - Authority to appoint staff to post not on the formal Establishment (duplicate wording)

2.2. Standing Financial Instructions (SFIs)

2.2.1 YTHFM's SFIs have been revised as follows (Amendments in bold).

Area	Section and amendment
Page 26 – 9.2 – Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services	**Updated in line with Procurement Act.**
Page 32 – 9.5 – Tendering, Quotation and Contract Procedure	**Updated in line with Procurement Act.**

3. Recommendation

3.1 Board of Directors is asked to approve the documents.

Date: 13.5.25