York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 30th July
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 25 June 2025** To be agreed as an accurate record.	Chair	Report	**5**	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	**15**	
6.	**True North Report** To consider the report.	Chief Executive	Report	**16**	9:05
7.	**Chair's Report** To receive the report.	Chair	Report	**34**	9:15
8.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	**37**	9:20

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Quality Committee Report** To receive the July meeting summary report.	Chair of the Quality Committee	Report	71	9:40
10.	**Resources Committee Report** To receive the July meeting summary report.	Chair of the Resources Committee	Report	74	9:50
11.	**Trust Priorities Report (TPR)** May 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	76 79 120 139 150 156	10:00
Break 10:50					
12.	**CQC Compliance and Journey to Excellence Update Report** To consider the report.	Chief Nurse	Report	171	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	178	11:15
14.	**2024/25 Quality Account** To consider the report.	Chief Nurse	Report	202	11:25

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Annual Complaints Report** To consider the report.	Chief Nurse	Report	**287**	11:35
Governance					
16.	**Fit and Proper Persons Test (FPPT) Annual Report** To consider the report.	Associate Director of Corporate Governance	Report	**296**	11:45
17.	**2025/26 Q1 - Board Assurance Framework** To consider the report.	Associate Director of Corporate Governance	Report	**301**	11:50
18.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	12:10
19.	**Time and Date of next meeting** The next meeting held in public will be on 24 September 2025 at 9:30am at Scarborough Hospital.				
20.	**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.				
21.	**Close**				12:15

Minutes
Board of Directors Meeting (Public)
25 June 2025

Minutes of the Public Board of Directors meeting held on Wednesday 25 June 2025 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.05pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Mr Jim Dillon
- Prof Matt Morgan
- Ms Helen Grantham, Associate Non-Executive Director

Executive Directors
- Mr Simon Morritt, Chief Executive
- Dr Karen Stone, Medical Director
- Ms Claire Hansen, Chief Operating Officer
- 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:
- Ms Sarah Barrow, Deputy Finance Director *deputising for* Mr Andrew Bertram, Finance Director
- Ms Sascha Wells-Munro, Director of Midwifery *deputising for* Mrs Dawn Parkes, Chief Nurse
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Rukmal Abeysekera, Lead Governor
- Graham Lake, Elected Governor
- Linda Wild, Elected Governor
- Two members of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

2 Apologies for absence

Apologies for absence were received from:
Ms Jane Hazelgrave, Non-Executive Director
Mrs Jenny McAleese, Non-Executive Director
Mr Noel Scanlon, Non-Executive Director
Mr Andrew Bertram, Finance Director
Mrs Dawn Parkes, Chief Nurse

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 21 May 2025

The Board approved the minutes of the meeting held on 21 May 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 47 (24/25) *Circulate the action plan for improvement in waiting times for the Rapid Access Chest Pain clinic.*
The action plan was presented under Item 5.1. The action was closed.

BoD Pub 59 (24/25) *Update the Board on progress to address the serious concerns raised by the major trauma peer review report.*
Dr Boyd advised that a paper would be presented to the Executive committee and then to the Quality Committee in July. The action was deferred.

BoD Pub 5 *Ensure that the Digital Strategy is amended as discussed and that an accompanying scorecard is developed.*
Mr Hawkins reported that the Digital Strategy had been amended as discussed. A scorecard would be developed and presented to the Digital Sub-Committee meeting in August.

BoD Pub 6 *Undertake a review of the risk reporting processes and would liaise with Executive Directors as part of this.*
Mr Taylor advised that this was complete, and a proposal would be presented at the Private meeting. The action was closed.

BoD Pub 8 *Report back on progress for options for a new telephony system.*
Mr Hawkins explained that the implementation of a new telephony system was dependent on resource being available as it needed to be balanced against other investment priorities. A proposal would be brought to the Digital Sub-Committee meeting in August.

BoD Pub 10 *Identify a suitable Board Development Seminar for a presentation from the Director of Midwifery.*
This action was carried forward.

BoD Pub 11 *Investigate options for statutory and mandatory online training delivery for eg. Safeguarding Level 3 and Mental Capacity Act.*
Miss McMeekin advised that the national guidance indicated that this training should be delivered face to face. However, consideration was being given to delivering the training online and the risks of this were being assessed. An update would be provided in July.

BoD Pub 12 *Re-format the Staff Survey action plan with greater clarity on what new initiatives are being taken as a consequence of the concerning feedback elicited from respondents to the staff survey.*
Miss McMeekin advised that the Staff Survey action plan had been re-formatted and presented to the Resources Committee. The action was closed.

BoD Pub 13 *Review the Public Sector Equality Duty report taking into account the comments made at the meeting and re-present in June.*
The report was presented under Item 15, and the action was closed.

BoD Pub 14 *Provide assurance to the Board that any unintended consequences of the implementation of the LIMS and Digital Cell Path Implementation Business Case have been identified.*
Mr Hawkins reported that he had been assured that the appropriate systems and infrastructure had been upgraded to provide the necessary capacity. The action was closed.

5.1 Rapid Access Chest Pain Update

Mr Barkley invited questions and comments on the paper. Ms Charge queried whether the term “rapid” was likely to raise patient expectations, given that the target was for patients to be seen within two weeks of referral. Ms Hansen responded that the national target for out-patient appointments was 18 weeks and therefore in this context, the national two week target for this particular service was rapid. She advised that work was ongoing with the Cardiology service as a whole to ensure that more patients were seen within the two week standard.

6 Chair’s Report

The Board received the report.

7 Chief Executive’s Report

The Board received the report. Mr Morritt highlighted:

- the launch of the Lung Cancer Screening Programme in Bridlington;
- the government’s Spending Review and the implications for health and care with NHS spending due to increase in real terms by 3% each year over the Review period;
- the successful long service events held in June;
- the Star Award nominations for May and June.

Dr Boyd observed that the government’s focus was on moving more resource from acute into community care and suggested that the Trust, with its provision of community services, might benefit from this. Mr Morritt agreed that this was a possibility although there were no details as yet on the allocation of funding. He cautioned that any growth in funding would need to be offset against costs of, for example, future staff pay awards and the structural changes to the NHS.

7.1 True North report

Mr Morritt introduced the Board's first True North report and invited feedback on the content and format.

Ms Grantham observed that the report did not demonstrate the trajectories towards meeting the targets, or whether the Trust was on track to meet them. It would be useful to be provided with an executive analysis of the trajectories and the actions.

Dr Boyd was of the view that the organisational risks referred to under each metric were too compartmentalised and therefore were not framing discussion effectively.

Mr Barkley noted that this was the first version of the report, and it would be refined with use. There was further discussion on the most effective way to represent forecast trajectories in the report. Ms Hansen suggested that waterfall charts would be more appropriate for some of the metrics.

Mr Morritt would work with the authors to amend the report as suggested above.

Action: Mr Morritt

Mr Barkley questioned why a lack of therapists was contributing to the reduction of bed days lost to patients with no criteria to reside. Ms Hansen explained that there was more work needed to move appropriate patients to discharge to assess, rather than waiting for a therapy assessment, and on providing more therapy services in the community. She would clarify the wording in the report.

Action: Ms Hansen

Mr Barkley highlighted the welcome reduction in the percentage of patients waiting more than 4 hours and more than 12 hours in the Emergency Departments.

Mr Morritt provided an update on the Trust's work with KPMG. The outcomes of the readiness assessment had been presented to senior leaders on 16 June, with follow-up sessions to develop a road map held on 24 June. The Board would need to discuss how to take this forward, with a Business Case to be drafted to resource next steps. It was agreed that the Board would receive and discuss the readiness assessment and the next steps in July.

Referring to the Productivity and Efficiency Group Update, Dr Boyd asked what was involved in the de-risking of cost improvement plans. Ms Barrow explained that this was a governance process set out by NHS England. The Trust had identified £9m of high risk efficiency schemes in the original plan and was completing Equality Impact Assessments and Project Initiation Documents, using NHS England templates for each scheme which were submitted to the ICB on a regular basis. Ms Barrow clarified that the de-risking of schemes was a process, not an outcome.

8 Quality Committee Report

Dr Boyd highlighted the key escalations from the meeting of the Quality Committee on 17 June 2025:

- the Sepsis Report received by the Committee flagged gaps in assurance around the ability to deliver safe and effective care in the Emergency Departments: there were

delays in the time to see a doctor and poor performance against the target to administer antibiotics within an hour of suspected sepsis; the report outlined the work being undertaken to address these issues;
- there was pressure on maternity staffing from an increase in vacancies, particularly at York Hospital, which was impacting on the mitigations already in place to address gaps in staffing;
- the Committee had received the safeguarding update which evidenced significant improvement in compliance with national statutory and mandatory requirements; Dr Boyd referenced the appointment of two Domestic Abuse Practitioners to the Trust who were already having a significant impact;
- the Committee had received a report on Palliative and End of Life Care which had flagged the lack of equality of access to a 7-day service, and the impact on patient choice;
- the Committee had recommended the approval of the Maternity Section 31 monthly submission.

In relation to the identification of sepsis in Emergency Departments, Mr Barkley asked about the role of triage. Dr Stone explained that there was currently a disconnect in pathways for patients arriving in the Emergency Departments. Patients taken directly to the resuscitation area would receive prompt treatment for sepsis. Patients identified as at risk of sepsis by the triage process were not getting treated quickly enough. Dr Stone noted that the data did not demonstrate how close to the threshold treatment had been delivered.

Mr Barkley referenced the lack of capacity in safeguarding staffing highlighted in the escalation report. Dr Boyd explained that this was around named roles and included a Non-Executive Director Safeguarding lead role. Mr Barkley would ask Mr Scanlon to take on this role.

Action: Mr Barkley

9 Resources Committee Report

Mr Dillon highlighted the key escalations from the meeting of the Resources Committee on 17 June 2025:

- performance against the Emergency Care Standard in April was close to the trajectory but was still a concern when benchmarked against other Trusts regionally and nationally, as was performance against Cancer metrics;
- diagnostic performance continued to be impacted by equipment failure;
- average ambulance handover times continued to show significant improvement, and it was clear that initiatives in Emergency Departments were beginning to take effect;
- there had been a discussion on workforce planning and the need to align this with operational planning, efficiency programmes and financial plans;
- the Committee had received the revised Staff Survey improvement plan.

It was noted that the Staff Survey improvement plan, as presented to the Resources Committee, would not be shared in that format with staff. Discussion followed on how to communicate key messages to staff, and it was agreed that a simple document of a “You said, we will” design should be shared with staff, and completed actions communicated as often as possible.

Mr Barkley referred to the escalation around the alignment of workforce planning with other areas and observed that the planning process should cover all elements. He noted

that it had been agreed at the last meeting that plans for most of the cost reduction should be decided by the end of December, and the Board Development Seminar in October would be dedicated to a detailed discussion of the financial plan which would provide more time to align the workforce issues before the next financial year. Miss McMeekin advised that the workforce plan was part of the annual operational plan, and it should align with the financial plan. The main issue was around the medical establishment which must be correct to inform the budget. A paper would be presented to the Resources Committee in July covering the workforce planning process. Dr Stone reported that 90% of job plans had now been signed off and the process of job planning for the medical workforce would commence again for three months in September. This would provide better information about capacity and would more accurately inform workforce, financial and operational planning.

10 Trust Priorities Report (TPR)

The Board considered the TPR.

Mr Barkley welcomed the information on national and regional benchmarking which had been added to this version of the TPR.

Operational Activity and Performance

Mr Barkley noted that a Task and Finish Group was considering future workforce model options for the Emergency Departments and questioned whether this might lead to expectations of further funding. Ms Hansen advised that the work was being led by the team in the Emergency Department based on a national model of staffing. She assured Mr Barkley that the team understood that there would be no further funding to expand the workforce.

The Board was pleased to note that there had been no ambulance handover times over 4 hours in May.

Dr Boyd asked what action was being taken to improve medical presence at reviews of patients with long lengths of stay. Ms Hansen responded that the answer lay in ensuring that rosters and job plans allowed medical staff to attend reviews. Further work to address long lengths of stay was included in discharge plans. Ms Hansen noted that the plan to ensure that ward managers were supernumerary would also support more rapid discharge processes.

Mr Barkley referred to the practice of ward teams dialling in to meetings once a week to discuss patients who were not medically optimised and had been in hospital for more than 21 days and questioned who was involved in the meetings, how had they been received by ward staff and whether there was there an impact from the meetings. Ms Hansen provided further details and confirmed that there had been an impact on the time of discharge. The meetings had been put in place to give senior leaders a better understanding of the issues and also covered preparation for weekend discharges. The meetings involved social care and community teams.

Dr Boyd queried the high number of Cancer referrals to the Head and Neck Service and queried whether this was a result of local GPs withdrawing Dermoscopy services. Ms Hansen could not confirm if this was the main reason but would investigate.

Action: Ms Hansen

Ms Hansen cautioned that the terms of new GP contract was risk for Trust in terms of the likely increase in demand on its service. She also highlighted the risk of delays in patient pathways.

Mr Barkley noted that the Cancer performance as benchmarked against other Trusts was very concerning. Ms Hansen advised that a detailed report on Cancer performance by area was to be presented to the Resources Committee.

Mr Barkley highlighted that the total number of patients on the Referral To Treatment (RTT) waiting list had risen again. Ms Hansen advised that this was in part due to the validation work being undertaken, and also to an increase in referrals from GPs as a result of their new contracts. Dr Boyd confirmed that these were locally agreed contracts and presented a significant risk to the Trust in terms of the impact on its capacity. Ms Hansen added that the risk was also to patients in the form of delays in pathways.

Mr Barkley drew attention to the rise in outpatient activity in May, and asked if there had been a conscious decision to transfer clinical time from elective surgery to outpatient clinics and, if so, what was the impact on Elective Recovery Fund (ERF) income. Ms Hansen responded that this was not a conscious decision but had resulted from a combination of leave and of the new process in place for ERF activity. The new process would ensure that ERF activity was being undertaken by the most appropriate specialties. Ms Barrow confirmed that the Trust was on plan in terms of elective activity funded by the ERF.

Ms Hansen reported that validation sprints for outpatients were being undertaken which resulted in income in Quarter 1 of £120k. Some of this funding would be used to validate non-RTT and follow up waiting lists.

Mr Barkley noted that the capacity of the Audiology service was limited by the number of booths available and questioned whether more could be purchased and installed. Ms Barrow agreed to check whether the purchase of Audiology booths was included in the capital programme.

Action: Ms Barrow

In response to a question about the increase in the number of children and young people waiting over 52 weeks for community services, Ms Hansen advised that further weekend clinics had been put in place.

Dr Boyd referenced the outcome of the Getting It Right First Time report on heart failure patients in virtual ward beds and ask what the impact might be. Ms Hansen responded that the service would continue to be delivered but not under the designation of a virtual ward. There would be no impact on patients, only on the data for the virtual ward.

Quality and Safety

Mr Barkley noted that the narrative around complaints did not reflect the data in the SPC chart.

Maternity

Ms Wells-Munro confirmed that there had been an increase in the number of pre-term babies. She advised that the Maternity metrics in the TPR were being reviewed, and the application of the terms “target” and “baseline” would be considered as part of this.

Workforce

Mr Barkley queried how the increased allocation for Band 5 registered nurses in the York Emergency Assessment Unit was being funded. It was noted that this change had resulted from the nursing establishment review which had been undertaken. Mr Barkley highlighted the increase in the budgeted establishment which was concerning when the Trust was required to maintain static workforce.

Ms Wells-Munro reported that career discussions had been held with the student midwives who were due to qualify in the autumn. However, the current need was for experienced midwives. She was working with the recruitment team to manage the process.

Digital and Information Services

The Board was pleased to note that calls to the Y&S Service Desk had reduced.

Finance

Ms Barrow summarised the Month 2 financial position which showed an actual adjusted deficit of £2.1m against a planned deficit of £0.8m leaving an adverse variance to plan of £1.3m. Ms Barrow reported however that the ICB as a whole was almost in balance which was important for the continued receipt of deficit support funding. The de-risking of cost improvement plans was also key to ensuring this funding was received.

Ms Barrow drew attention to the cash position which was £16.4m adverse to plan mainly due to timing issues. The forecast was for the cash position to return to plan in Month 4. Ms Barrow underlined the necessity of delivering to plan as there would be no cash support this financial year, other than through the ICB.

Ms Barrow advised that the efficiency governance arrangements, as mandated by NHS England, were in place and she highlighted the key deadlines.

Ms Charge referred to the cash position and queried whether the forecasting process should be improved as the variance to plan was so significant. Ms Barrow acknowledged this challenge and would work with the relevant team to improve the process.

There was some discussion on the cost improvement plans, as there were some gaps in the corporate programme. Ms Barrow explained that the profile of the delivery was set when the Cost Improvement Programme was submitted to the ICB, as not all plans were agreed at that time. Planning for next year's efficiency programme would begin earlier this year.

11 CQC Compliance Update Report

Ms Wells-Munro presented the report. She advised that the last three actions had been closed and moved into "business as usual", and she highlighted the new CQC appointments reference in the report.

Mr Barkley congratulated Executive Directors on meeting all the "must do" and "should do" improvement actions from the 2022/23 CQC inspection report and applauded their focus on closing actions only with robust evidence. Further assurance had been provided by the CQC Action Plan internal audit.

It was noted that the final report from the CQC inspections in January had now been received and was due to be published imminently by the CQC.

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

Ms Wells-Munro presented the report which summarised the April data. She highlighted the following:

- there had been no perinatal deaths;
- there had been no new cases which met the criteria for referral to Maternity and Newborn Safety Investigations (MNSI); a final report had been received for two MNSI cases and a draft report received on the maternal death;
- there had been no new Patient Safety Incident Investigations during the month;
- the rate of Post-Partum Haemorrhage over 1500mls in April was 2.6% and the data demonstrated a reduction in the rolling average over 12 months;
- there was a total of 164 open incidents; the Patient Safety Team was supporting in closing these; Ms Wells-Munro assured the Board that any learning from these incidents had been immediately picked up;
- NHS England funding had been received to refurbish the Special Care Baby Unit at York Hospital and a robust plan to temporarily relocate the unit was being developed;
- NHS England had informed the Trust of a coding issue relating to the Maternity Services Dataset; this was a national issue, and the numbers involved would be small.

Mr Barkley suggested that the Executive summary section on the report cover sheet should be used to report highlights and concerns in bullet points.

Action: Ms Wells-Munro

In response to a question, Ms Wells-Munro advised that the drug Carbetocin was very effective in reducing rates of bleeding in women after a Caesarean section, but it was expensive, hence the need for a Business Case.

Professor Morgan asked about the two tables in the Section 31 update showing compliance with fresh eyes for continual foetal monitoring. Ms Wells-Munro explained that the second table showed the data as required by new guidance from the Saving Babies Lives Care Bundle.

The Board approved the CQC Section 31 Update.

13 Infection Prevention and Control Annual Report

Ms Wells-Munro presented the paper. She reported that the Trust had exceeded the annual objectives for all nationally set Health Care Associated Infections, apart from Klebsiella Bacteraemia. The governance of Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS) had been strengthened by the introduction of Care Group IPC/AMS monthly meetings, which were becoming established; Care Group improvement action plans were being developed.

Ms Wells-Munro highlighted the successful quality improvement work in Cherry and Chestnut wards at Scarborough Hospital to reduce rates of C Difficile. Dr Stone advised that the focus of this year's IPC work would be on the reduction of bacteraemia.

The Board recorded its appreciation of the work carried out on Cherry and Chestnut wards to reduce C Difficile infections.

14 Mortality Review – Learning from Deaths Report

Dr Stone presented the report, noting that there had been very little change in the data from previous reports.

A query was raised about the Trust's Hospital Standardised Mortality Ratio (HSMR) which was higher than expected. Dr Stone responded that this was not as useful a metric as the Summary Hospital-level Mortality Indicator (SHMI) which included more diagnostic groups. She advised that the HSMR data had been analysed in depth and nothing of concern had been identified. The SHMI was within normal limits which should provide assurance. There was some discussion on the SHMI data which was split by deprivation quintile. Dr Stone noted that patient quintiles were missing which would clarify the graphics. This information would be added for the next report.

Action: Dr Stone

Dr Boyd reported that the paper had been discussed at the Quality Committee meeting and Mrs McAleese, who sat on the Learning from Deaths Group, had raised the issue of the timely recognition of patients needing palliative care. This was being progressed via a Patient Safety Incident Investigation. Dr Stone added that the Palliative Care team were working with staff to ensure that they made the switch in focus to palliative care earlier, when this was appropriate.

Miss McMeekin referenced the low attendance at the February meeting of the Learning from Deaths Group. Dr Stone advised that it was sometimes challenging for clinicians to attend the meetings due to their clinical work schedule. It was the responsibility of Care Groups to ensure good attendance.

15 Public Sector Equality Duty (PSED) Report

Miss McMeekin advised that the report had been re-formatted at the request of the Board. This version had already been endorsed by the Resources Committee. A more interactive version would be published on the Trust website. Directors agreed that the format was much improved and should be used for future PSED reports.

16 YTHFM Health and Safety Policy

Mr Norman advised that the policy had been reviewed, with only minor amendments made.

The Board of Directors approved the YTHFM Health and Safety Policy.

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 30 July 2025 at 9.00am at York Hospital.

As this was Mr Dillon's last meeting, directors recorded its thanks to Mr Dillon for his much valued contribution to the Board and to the Trust over the past 6 years.

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 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. Update 21.05.25: This was still a work in progress and the due date for the action was deferred to July.	Jul 25 from Mar 25	Delayed
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	Update 21.05.25: Dr Holmberg reported that a paper was due to be presented to the Quality Committee in June. The due date for the action was therefore deferred to June. Update 25.06.25: Dr Boyd advised that a paper would be	Jul 25 from May 25	Delayed
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		Jul-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		Jul-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	Update 25.06.25: Mr Hawkins advised that the Digital Strategy had been amended as discussed. A scorecard would be developed and presented to the Digital Sub-Committee in August.	Sep 25 from Jun 25	Delayed
BoD Pub 7	21-May-25	11	Trust Priorities Report	Amend narrative summaries to show bullet points of highlights and concerns instead.	Chief Operating Officer		Jul-25	On Track
BoD Pub 8	21-May-25	11	Trust Priorities Report	Report back on progress for options for a new telephony system.	Chief Digital and Information Officer	Update 25.06.25: Mr Hawkins explained that the implementation of a new telephony system was dependent on resource being available as it needed to be balanced against other investment priorities. A proposal would be brought to the Digital Sub-Committee meeting in August.	Sep 25 from Jun 25	On Track
BoD Pub 9	21-May-25	11	Trust Priorities Report	Report to the Board on a full review of Cardiology Services.	Chief Operating Officer		Jul-25	On Track
BoD Pub 10	21-May-25	11	Trust Priorities Report	Identify a suitable Board Development Seminar for a presentation from the Director of Midwifery	Chair of the Board	Update 25.06.25: this action was carried forward.	Jul 25 from Jun 25	Delayed
BoD Pub 11	21-May-25	11	Trust Priorities Report	Investigate options for statutory and mandatory online training delivery for eg. Safeguarding Level 3 and Mental Capacity Act.	Director of Workforce and OD	Update 25.06.25: Miss McMeekin advised that the national guidance indicated that this training should be delivered face to face. However, consideration was being given to delivering the training online and the risks of this were being assessed. An update would be provided in July.	Jul-25	On Track
BoD Pub 15	25-Jun-25	7.1	True North Report	Work with the authors of the True North report to amend it as suggested.	Chief Executive		Jul-25	On Track
BoD Pub 16	25-Jun-25	7.1	True North Report	Clarify the wording in the True North report around contributing factors to lost bed days.	Chief Operating Officer		Jul-25	On Track
BoD Pub 17	25-Jun-25	8	Quality Committee report	Ask Mr Scanlon to take on the role of Non-Executive Director Safeguarding lead.	Chair of the Board		Jul-25	On Track
BoD Pub 18	25-Jun-25	10	Trust Priorities Report	Confirm whether the high number of Cancer referrals to the Head and Neck Service is a result of local GPs withdrawing Dermoscopy services	Chief Operating Officer		Jul-25	On Track
BoD Pub 19	25-Jun-25	10	Trust Priorities Report	Check whether the purchase of Audiology booths is included in the capital programme.	Finance Director		Jul-25	On Track
BoD Pub 20	25-Jun-25	12	Maternity and Neonatal Report (including CQC Section 31 Update)	Use the Executive summary section on the report cover sheet to report highlights and concerns in bullet points	Director of Midwifery		Jul-25	On Track
BoD Pub 21	25-Jun-25	14	Mortality Review – Learning from Deaths Report	Ensure that patient quintiles are included in the relevant graphics in the report.	Medical Director		Sep-25	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 6

True North Report

July 2025

True North – Introduction

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Everything we do at YSTHFT should contribute to achieving our ambition of providing an ‘excellent patient experience every time’.

This is the single point of reference to measure our progress.

The main purpose of the True North approach is to provide the Trust with measurement of improvement. It is not a RAG rated performance report – performance against targets will still be available in the Trust Performance Report which will continue to be provided.

The True North Report is a monthly report on the ten key metrics for 2025/26 and the Trust’s key transformational objectives.

True North – User Guide

Understanding the Thermometer Reading (Examples Only):

→ 2 do not have a monthly trajectory

→ 5 are achieving monthly trajectory

→ 2 are not achieving monthly trajectory

→ Indicator has improved since previous month

→ Indicator has stayed the same since previous month or does not have a monthly trajectory

→ Indicator has deteriorated since previous month

Objective Status (top right of indicator page):

The symbol illustrates if the trajectory is being met for the indictor.

The Trust is achieving the monthly trajectory for this indicator for the MOST recent period (last data point)

The Trust is NOT achieving the monthly trajectory for this indicator for the MOST recent period (last data point)

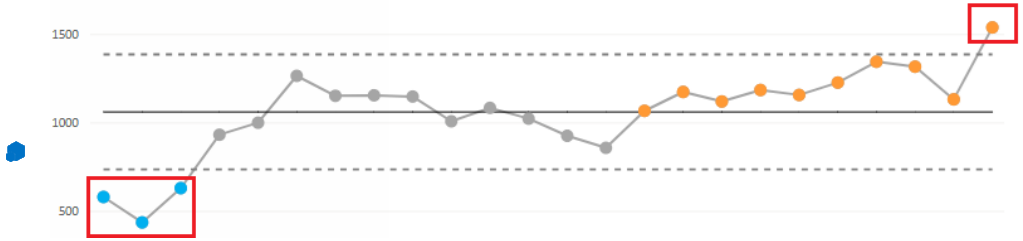
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

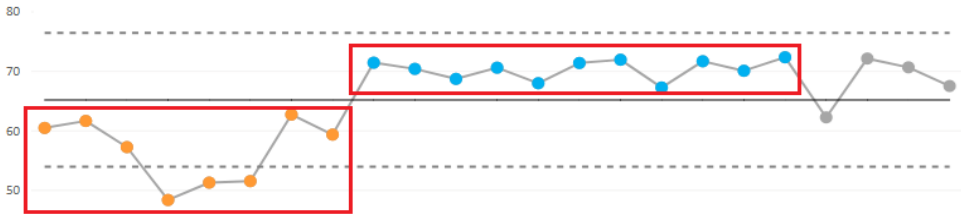
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

Outlier: Counts the number of occasions a single point goes outside the control limits.

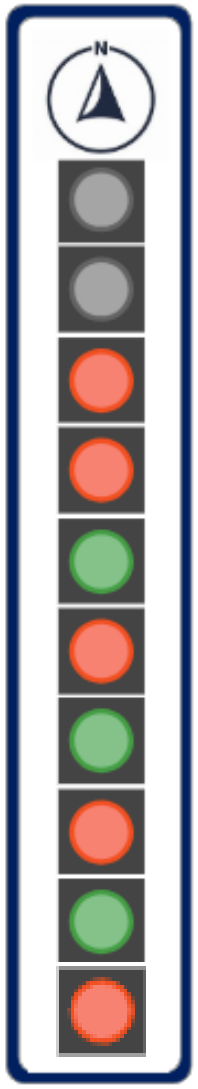


Shift: Counts the number of occasions there is a run of 7 consecutive points above OR below the mean.



Trend: Counts the number of occasions there is a run of 7 consecutive points going in the same direction.

True North Report



Performance Improvement Overview

There are 10 True North objectives set for 25/26 to move us closer to our ambition of achieving excellent patient experience every time. These 10 True North objectives are supported by True North Projects, for which monthly update reports are included in this report.

Staff Survey: Recommend Care

Increase the percentage of staff who would recommend the Trust as a place to receive care to ≥ 48.9%

Staff Survey: Recommend Work

Increase the percentage of staff who would recommend the Trust as a place to work to ≥ 48.9%

Inpatient: Reduce Bed Days Lost to NCTR

Reduce the average number of beds days between the time a patient is assessed and fit for discharge to when a patient returns to the place they call home

Urgent Emergency Care: Improve Emergency Care Standard (ECS)

Decrease the percentage of people waiting 4 hours or more in our emergency departments to achieve ≥ 78% by March 2026

Urgent Emergency Care: Reduce 12 Hour Waits in ED

Reduce the number of people who wait in our EDs for longer than 12 hours to achieve ≤ 8.9% of all type 1 attendances by March 2026

Elective: Cancer: Improve the Faster Diagnosis Standard

Increase the percentage of people who receive diagnosis of cancer, or the all clear, within 28 days of referral to achieve ≥ 80% by March 2026

Elective: Improve RTT

Increase the percentage of incomplete pathways waiting less than 18 weeks to achieve ≥ 60.5% by March 2026

Q&S: Reduce Category 2 Pressure Ulcers

Reduce the number of acquired category 2 pressure ulcers to ≤ 60 per calendar month

Q&S: Reduce the number of Trust Onset MSSA Bacteraemias

Reduce the number of MSSA infections to ≤ 7 per calendar month

Finance: Achieve Financial Balance

Meet our obligation to deliver the financial plan for 2025/26

True North Report

Objective Status No Trajectory

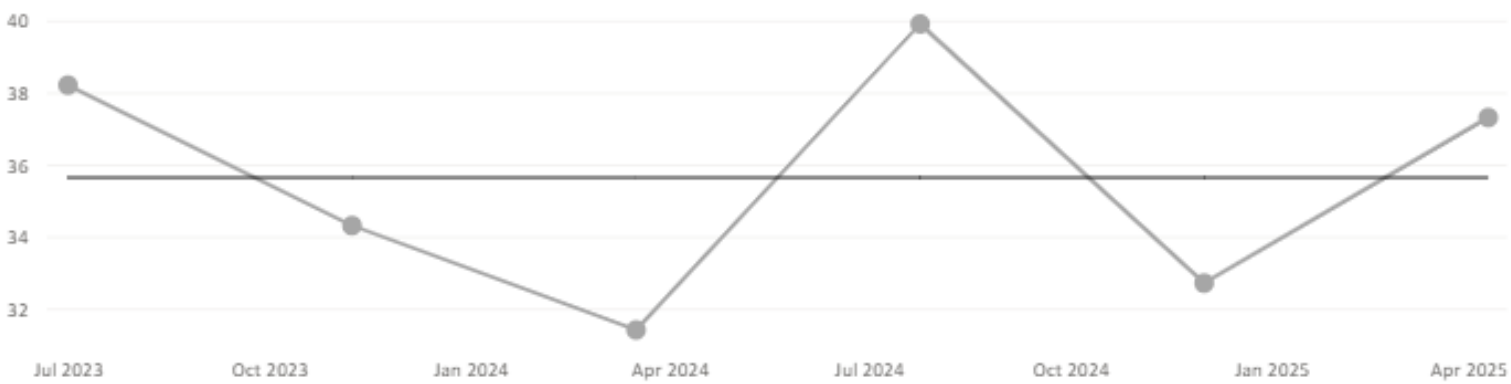
Staff Survey: Recommend Care

Increase the percentage of staff who would recommend the Trust as a place to receive care to ≥ 48.9%

Lead Director: Dawn Parkes & Karen Stone

Operational Lead:

Committee: Resources



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

Not enough data points to produce Control Limits

Shift: 7 points in a row, above or below the Mean?

Does Not Occur

Trend: 7 points in a row, either Ascending or Descending?

Does Not Occur

	Jul-23	Jan-24	Apr-24	Jul-24	Jan-25	Apr-25	Target Mar 2026
Value	38.2%	34.3%	31.4%	39.9%	32.7%	37.3%	
Trajectory							

What are the organisational risks?

- Poor job satisfaction leading to compromised patient care
- Failure to raise concerns
- Increased reliance on temporary staff
- Regulatory intervention

How are we managing them?

- Colleague engagement and responding to feedback
- Acting on Freedom to Speak Up themes
- Management and leadership development
- QI and learning from incidents

What are the current challenges?

- Staff vacancies
- Staff sickness rates
- Poor morale
- Lack of empowerment

What are we doing about them?

- Strengthen management and leadership capability
- Recruit to values and proactively address unwanted behaviours
- Implement EDS22 and PSED recommendations
- Implement colleague engagement improvements
- Embed Quality Improvement
- Implement Speak Up gap analysis recommendations

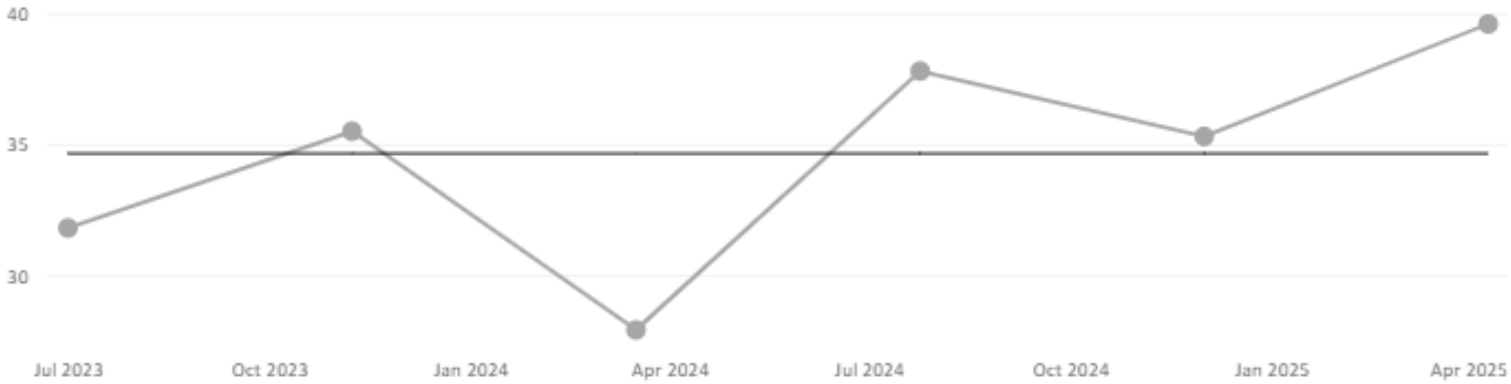
True North Report

Objective Status — No Trajectory

Staff Survey: Recommend Work

Increase the percentage of staff who would recommend the Trust as a place to work to ≥ 48.9%

Lead Director: Polly McMeekin
Operational Lead: Lydia Larcum
Committee: Resources



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

Not enough data points to produce Control Limits

Shift: 7 points in a row, above or below the Mean?

Does Not Occur

Trend: 7 points in a row, either Ascending or Descending?

Does Not Occur

	Jul-23	Jan-24	Apr-24	Jul-24	Jan-25	Apr-25	Target Mar 2026
Value	31.8%	35.5%	27.9%	37.8%	35.3%	39.6%	
Trajectory							

What are the organisational risks?

- Increased staff turnover
- Ability to recruit staff
- Potential of increased temporary staffing costs
- Increased sickness rates
- Negative impact on patient experience

How are we managing them?

- Review equality data – including WRES, WDES, Pay Gap
- Staff Networks, Inclusion Forum, Race Equality Alliance meetings
- Partnership working with our trade unions
- Staff Survey
- Our Voice, Our Future Programme
- Monthly workforce data

What are the current challenges?

- Health and wellbeing of the workforce
- Increased staff absence
- Staffing levels/vacancies
- Colleague morale

What are we doing about them?

- Strengthen management and leadership capability
- Recruit to values and proactively address unwanted behaviours
- Implement EDS22 and PSED recommendations
- Implement colleague engagement improvements
- Embed Quality Improvement
- Implement Speak Up gap analysis recommendations

True North Report

Objective Status — Down Is Good

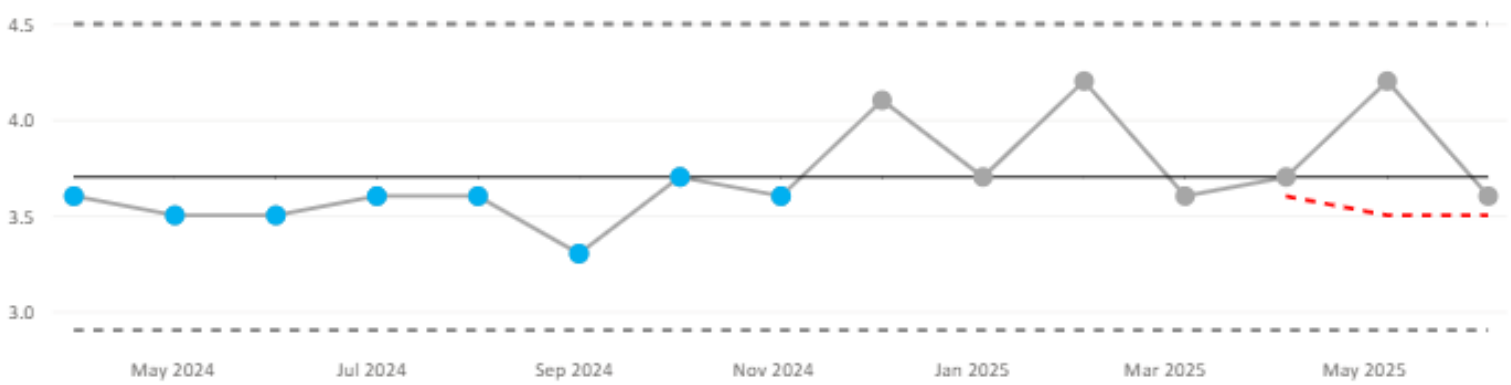
Inpatient: Reduce Bed Days Lost to NCTR

Reduce the average number of beds days between the time a patient is assessed and fit for discharge to when a patient returns to the place they call home

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

0 found

Shift: 7 points in a row, above or below the Mean?

Occurs

Trend: 7 points in a row, either Ascending or Descending?

Does Not Occur

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Target Mar 2026
Value	3.5	3.6	3.6	3.3	3.7	3.6	4.1	3.7	4.2	3.6	3.7	4.2	3.6	3.9
Trajectory											3.6	3.5	3.5	

What are the organisational risks?

If patients are delayed leaving hospital when they have NCTR, there is a risk of:

- Patient deconditioning
- Increased length of stay (LoS)
- Poor flow through our hospitals
- A negative impact on the Emergency Care Standard

How are we managing them?

- The Trust's Discharge Improvement Group oversees improvement actions across the system
- First and second line escalation meetings continue to happen with increased focus

What are the current challenges?

- Limited capacity for community health and social care
- Workforce challenges, in particular therapists
- Funding challenges
- Complexity of bringing multiple stakeholders together from multiple organisations; particularly over summer months.

What are we doing about them?

- Additional step-down community provision for nine patients has been commissioned in City of York with beds becoming available in July 2025
- The first full draft of a Discharge to Assess model has been created with partners, a follow-up workshop to work through additional details is planned in July 2025.

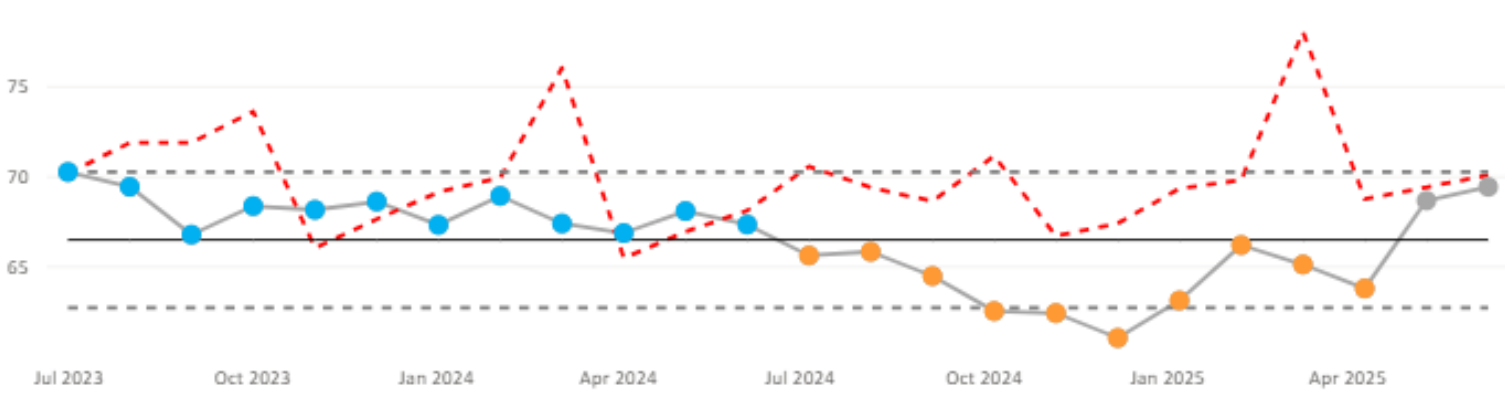
True North Report

Objective Status ⊗ Up Is Good

Urgent Emergency Care: Improve Emergency Care Standard (ECS)

Decrease the percentage of people waiting 4 hours or more in our emergency departments to achieve ≥ 78% by March 2026

Lead Director: Claire Hansen
Operational Lead: Ab Abdi
Committee: Resources & Quality



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

3 found

Shift: 7 points in a row, above or below the Mean?

Occurs

Trend: 7 points in a row, either Ascending or Descending?

Does Not Occur

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Target Mar 2026
Value	67.3%	65.6%	65.8%	64.4%	62.5%	62.4%	61%	63.1%	66.2%	65.1%	63.8%	68.6%	69.4%	78%
Trajectory	68.1%	70.5%	69.4%	68.6%	71.1%	66.7%	67.4%	69.3%	69.8%	78%	68.7%	69.4%	70%	

What are the organisational risks?

- If the Trust does not meet the ECS improvement the national ambition to achieve 78% by March 2026 will not be achieved

How are we managing them?

- Improvements are made and monitored through a series of Task and Finish Groups, reporting to the Urgent and Emergency Care Board.
- Additional GP capacity extended at York and starting in Scarborough in July
- Additional streaming direct to UTCs
- Continue streaming GP letters straight to SDEC/specialty at York and start this practice at Scarborough.
- Removing 'bring back' patients for certain pathways from SDEC units, to increase emergency capacity.

What are the current challenges?

- There is limited capacity to implement and improve at the required pace due to workforce challenges and operational pressures
- Workforce challenges at both Emergency Departments.

What are we doing about them?

- Gathering data on effectiveness of changes to support evaluation and understanding of where to focus efforts to have the biggest impact
- High levels of engagement with frontline teams, ensuring positive impact is celebrated and concerns are listened to
- Designing future workforce model for both EDs based on predicted demand and considering the pathway changes created this financial year.

True North Report

Objective Status Down Is Good

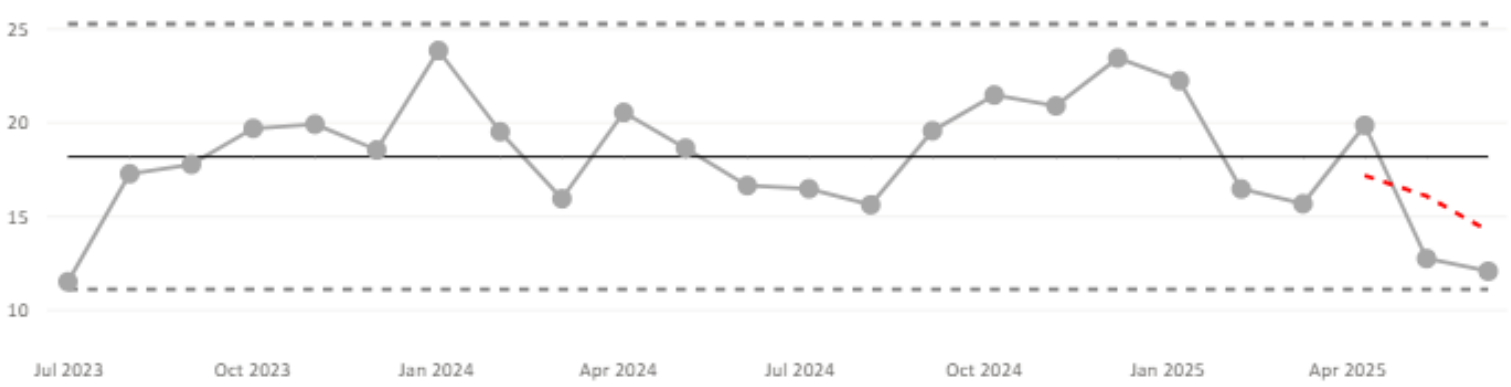
Urgent Emergency Care: Reduce 12 Hour Waits in ED

Reduce the number of people who wait in our EDs for longer than 12 hours to achieve ≤ 8.9% of all type 1 attendances by March 2026

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

0 found

Shift: 7 points in a row, above or below the Mean?

Does Not Occur

Trend: 7 points in a row, either Ascending or Descending?

Does Not Occur

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Target Mar 2026
Value	16.6%	16.4%	15.6%	19.5%	21.4%	20.9%	23.4%	22.2%	16.4%	15.6%	19.8%	12.7%	12%	8.9%
Trajectory											17.1%	16%	14.2%	

What are the organisational risks?

- Long waits at Emergency Departments have been linked to significant patient harm

How are we managing them?

- Established Task and Finish Groups, reporting to the Urgent and Emergency Care Board
- Utilising and embedding Continuous Flow policy
- Continuing discharge improvement work to reduce exit blocks and generate more acute flow.
- Developing Quality Standards to ensure patients always move forward on their care journey

What are the current challenges?

- There is limited capacity to improve at the required pace due to workforce challenges and operational pressures
- Quality Standards need wide engagement and may be met with some resistance

What are we doing about them?

- Gathering data on effectiveness of changes to support evaluation and understanding of where to focus efforts to have the biggest impact
- High levels of engagement with frontline teams, ensuring positive impact is celebrated and concerns are listened to
- Designing future workforce model for ED team

True North Report

Objective Status ⊗ Up Is Good

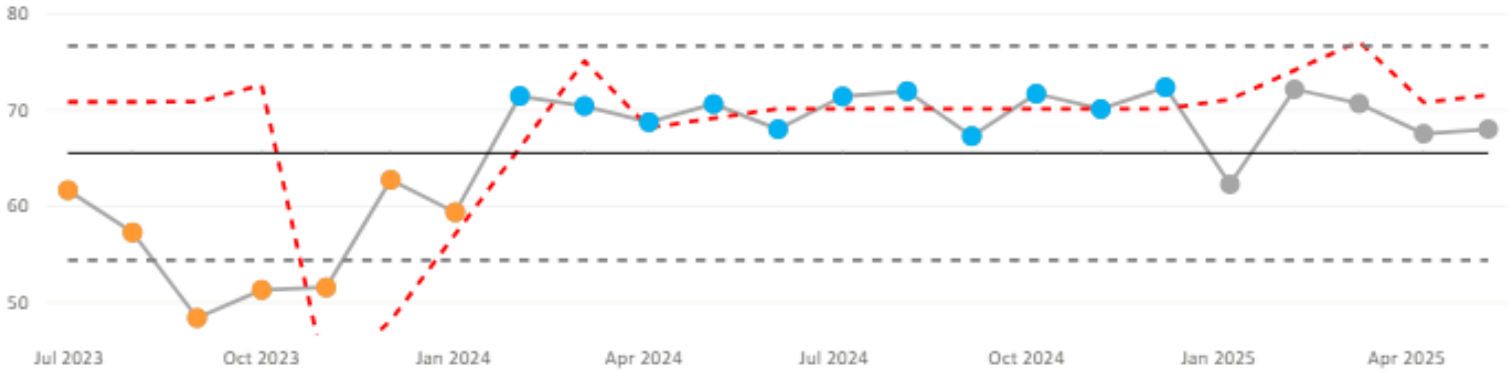
Elective: Cancer: Improve the Faster Diagnosis Standard

Increase the percentage of people who receive diagnosis of cancer, or the all clear, within 28 days of referral to achieve ≥ 80% by March 2026

Lead Director: Claire Hansen

Operational Lead: Kim Hinton

Committee: Resources



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

3 found

Shift: 7 points in a row, above or below the Mean?

Occurs

Trend: 7 points in a row, either Ascending or Descending?

Does Not Occur

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Target Mar 2026
Value	70.5%	67.9%	71.3%	71.9%	67.2%	71.6%	70%	72.3%	62.2%	72.1%	70.6%	67.4%	67.9%	80.1%
Trajectory	69%	70%	70%	70%	70%	70%	70%	70%	71%	74%	77%	70.7%	71.4%	

What are the organisational risks?

- Delay in patient with cancer receiving treatment resulting in poorer outcomes
- Reduced patient experience for patients not being informed of cancer and non-cancer diagnosis
- Reputation risk if improvement trajectory not met

How are we managing them?

- Weekly Trust cancer PTL meeting with a focus on patients breaching FDS
- Monthly cancer delivery group to oversee focused pathway improvement plans for gynaecology, colorectal and urology
- Clinical harm reviews for patients who breach 104 days to identify level of harm and learning
- Weekly diagnostic improvement meeting with modalities.

What are the current challenges?

- Urology, gynaecology and colorectal pathway delays
- Skin referrals not accompanied with picture impacting ability to triage patients effectively because of GP action
- Diagnostic delays in CT (4wks), MRI (4wks) and endoscopy (4wks)

What are we doing about them?

- Best Practice Timed Pathway Implementation: Urology, Gynaecology, Colorectal & Lung. Impact expected in Q4 2025/26
- Development and implementation of Cancer Power BI PTL. to track pathways. Impact expected in Q3
- Demand and capacity work for first appointment for all tumour sites being shared.
- Diagnostic improvement plans for CT, MRI and endoscopy including insourcing for endoscopy
- Discussions with ICB regarding dermoscopy service and scoping service opportunities

True North Report

Objective Status Up Is Good

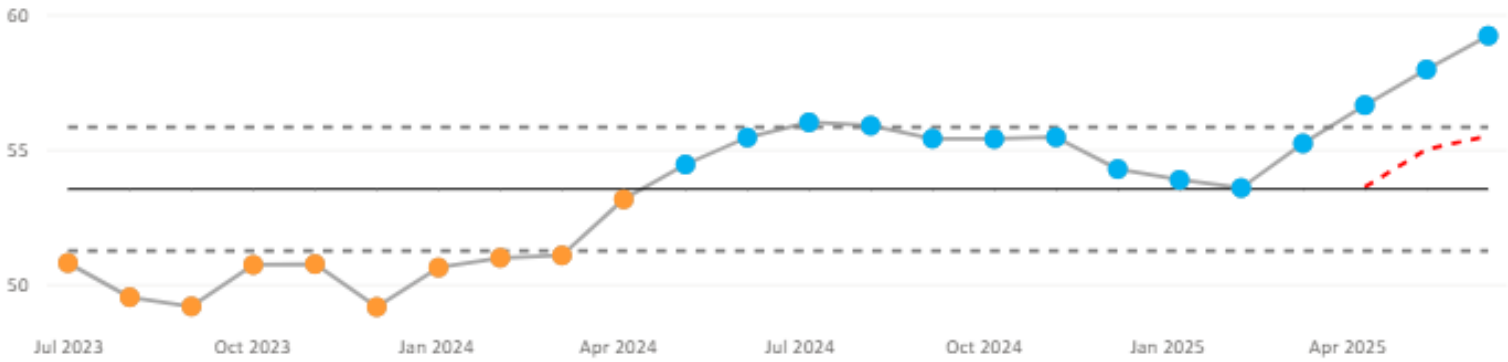
Elective: Improve RTT

Increase the percentage of incomplete pathways waiting less than 18 weeks to achieve ≥ 60.5% by March 2026

Lead Director: Claire Hansen

Operational Lead: Kim Hinton

Committee: Resources



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

14 found

Shift: 7 points in a row, above or below the Mean?

Occurs

Trend: 7 points in a row, either Ascending or Descending?

Occurs

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Target Mar 2026
Value	55.4%	56%	55.9%	55.4%	55.4%	55.5%	54.3%	53.9%	53.6%	55.2%	56.6%	58%	59.2%	60.5%
Trajectory											53.6%	55%	55.5%	

What are the organisational risks?

- Lengthening waits could lead to increase in clinical harm and litigation
- Impact on patient experience resulting in an increase in patient complaints
- Reputational risk of not meeting improvement trajectories

How are we managing them?

- Weekly elective recovery meetings with all specialities to review progress and use of Power BI tool to track all end of month breaches at patient level
- Individual speciality meetings for most challenged specialities
- Weekly diagnostic improvement meeting established
- HNY tactical meeting to identify opportunities for mutual aid

What are the current challenges?

- Validation of non RTT waiting lists resulting in an increase of patients with RTT clock
- Diagnostics delays across radiology, physiology and endoscopy
- Underlying demand and capacity mis match in specialties

What are we doing about them?

- The 2025/26 plan has been developed with a greater focus on productivity and efficiency, progress against the ambitions are managed through the Elective Recovery Board and productivity group.
- NHSE PIFU as standard programme. The PIFU pathways the Trust are developing as part of this programme are Gynaecology, Gastroenterology, Cardiology and ENT. Regional launch on 18 June, fortnight internal task and finish group established.
- National RTT validation sprint completed during Q1 2025/26. Achieved 13.5% above baseline. NHSE announced Sprint 2 due to commence July 2025

True North Report

Objective Status ⊗ Down Is Good

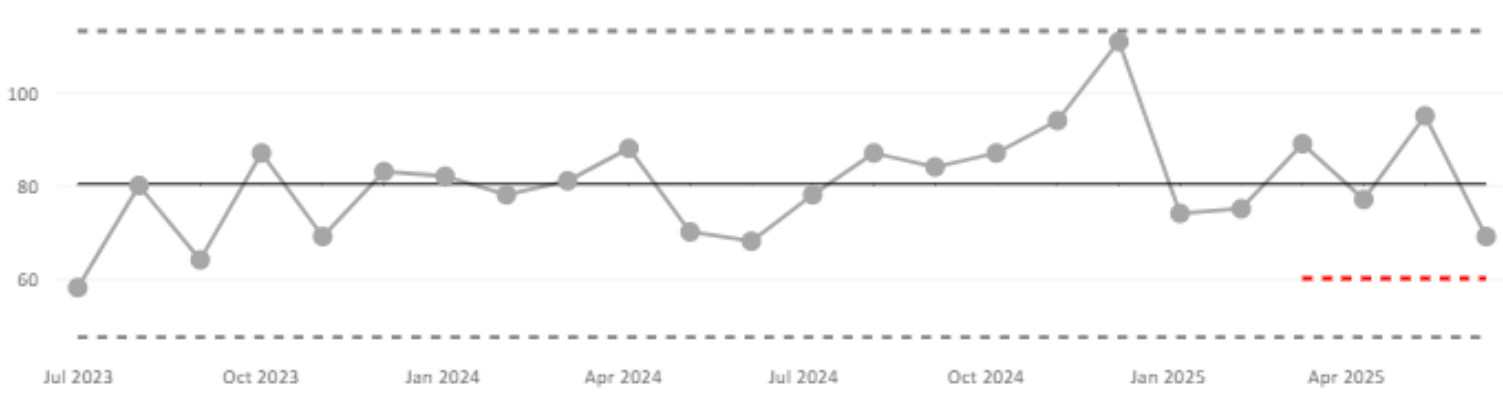
Q&S: Reduce Category 2 Pressure Ulcers

Reduce the number of acquired category 2 pressure ulcers to ≤ 60 per calendar month

Lead Director: Dawn Parkes

Operational Lead: Emma Hawtin

Committee: Quality



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

0 found

Shift: 7 points in a row, above or below the Mean?

Does Not Occur

Trend: 7 points in a row, either Ascending or Descending?

Does Not Occur

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Target Mar 2026
Value	68	78	87	84	87	94	111	74	75	89	77	95	69	60
Trajectory										60	60	60	60	

What are the organisational risks?

- Reduced patient experience for patients those developing a category 2 pressure ulcer within our care
- The potential to deteriorate further resulting in poorer outcomes
- Potential longer length of stay due to increase care needs
- Impact on patient experience resulting in an increase in patient complaints

How are we managing them?

- Bi-monthly meeting currently sits and reviews the data and monitors progress against established objectives
- Development of the person Centred and professional standards group whereby reduction in Cat 2 ulcers is a key objective within the Action delivery Group
- Use of monthly data pack provided by the intelligence team

What are the current challenges?

- Ongoing issues with inaccurate validation and categorisation of Pressure ulcers within clinical areas
- Validation of reporting processes to ensure accurate data entry and prevent double counting of the same pressure ulcer within DATIX
- Appropriate Seating equipment to support patients

What are we doing about them?

- A trust wide seating audit is currently underway
- Care group cluster reviews currently in progress within care groups
- Collaborative work with the DATIX team and insight and intelligence to identify opportunities for improving data quality
- Standardising and formulating an agreed process for validation
- Development of an electronic ASSKIN bundle within the new EPR with integrated photography capabilities

True North Report

Objective Status Down Is Good

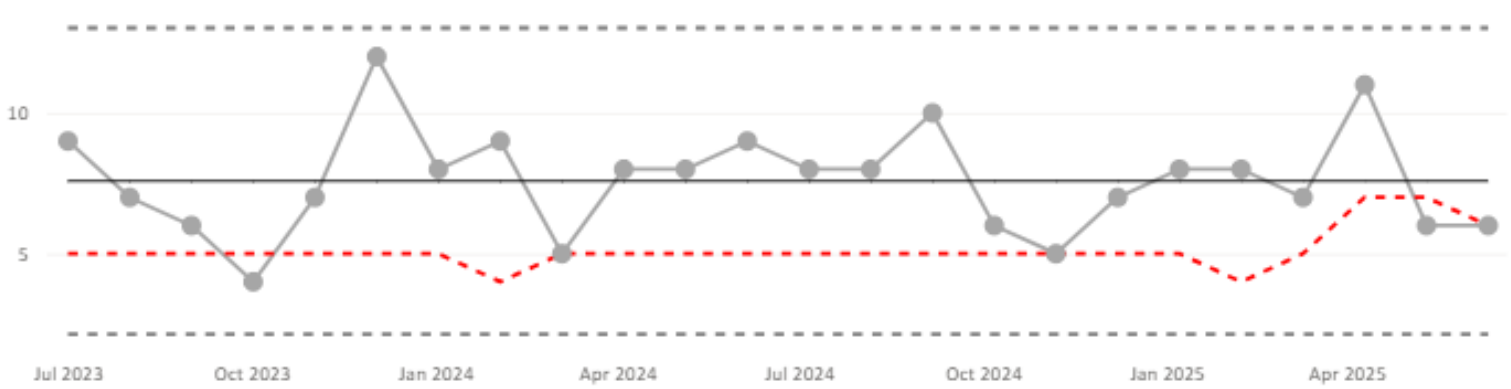
Q&S: Reduce the number of Trust Onset MSSA Bacteraemia

Reduce the number of MSSA infections to ≤ 7 per calendar month

Lead Director: Dawn Parkes

Operational Lead: Susan Peckitt

Committee: Quality



Is there special cause variation?

Outlier: A single point outside of the Control Limits (above or below)?

0 found

Shift: 7 points in a row, above or below the Mean?

Does Not Occur

Trend: 7 points in a row, either Ascending or Descending?

Does Not Occur

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Target Mar 2026
Value	9	8	8	10	6	5	7	8	8	7	11	6	6	7
Trajectory	5	5	5	5	5	5	5	5	4	5	7	7	6	

What are the organisational risks?

- Potential poor outcome for the patient
- Potential longer lengths of stay and increased use of antibiotics to manage the blood stream infection
- Failure to achieve 5% reduction in incidence
- Impact on patient experience which may result in complaints.

How are we managing them?

- Cases are managed locally with or without Consultant Microbiology involvement
- IPC team have had limited involvement

What are the current challenges?

- Cases are not consistently reviewed
- Learning not shared widely across the organisation, limiting overall improvement
- Ownership of the lessons

What are we doing about them?

- MSSA 5% reduction is an objective in the Trust Annual Operating Plan
- SOP for reviewing cases has been agreed through IPSAG with Care Groups taking a lead
- Scoping a Trust wide QI project for reduction of all bacteraemia
- MSSA bacteraemia improvement plan developed and monitored via IPSAG

True North Report

Objective Status

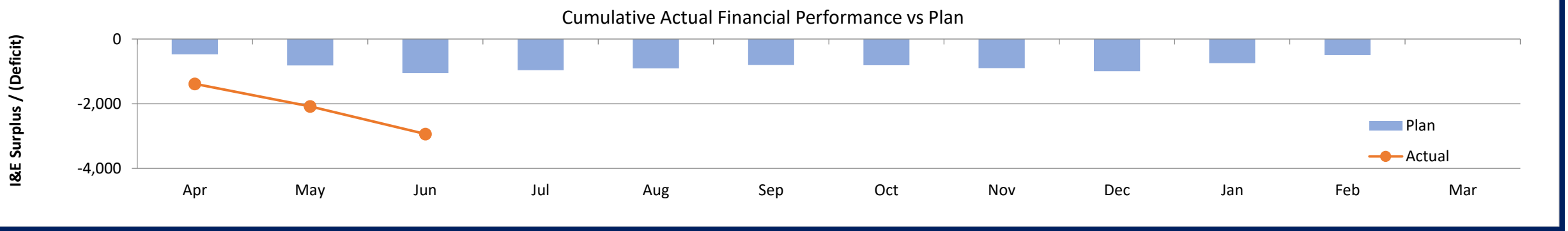
Finance: Achieve Financial Balance

Meet our obligation to deliver the financial plan for 2025/26

Lead Director: Andrew Bertram

Operational Lead: Sarah Barrow

Committee: Resources



Indicator	Target £'000	Jun 25 £'000	Jul 25 £'000	Aug 25 £'000	Sep 25 £'000	Oct 25 £'000	Nov 25 £'000	Dec 25 £'000	Jan 26 £'000	Feb 26 £'000	Mar 26 £'000	Apr 26 £'000
Meet our obligation to deliver the financial plan for 25/26	0	-1,050	-962	-904	-807	-812	-900	-994	-747	-491	0	N/A

What are the organisational risks?

- **Failure to Deliver Financial Balance** - The most critical financial risk is the Trust's potential failure to deliver financial balance in line with the 2025/26 annual plan
- **Efficiency Programme Delivery Risks** – Failure to deliver the required reduction in costs to meet our financial plan

How are we managing them?

- There are several operational controls in place – financial review meetings, PRIM, each budget holder is responsible for living within their agreed budget
- System collaboration re transformation, difficult decisions, risk & gain share approaches, decommissioning strategies
- Increase oversight of efficiency programme

What are the current challenges?

- Delivering to our financial plan on a month-by-month basis
- Control of pay expenditure.
- Delivering the efficiency programme
- Securing deficit support funding on a quarterly basis – to maintain our financial position; 4 metrics to secure Q3:
  - Overall variance to plan
  - Pay variance
  - Variation against CIP Programme
  - De risking of CIP schemes

What are we doing about them?

- The Trust is working closely with the ICB and NHSE to secure deficit support funding . Q1 & Q2 received
- New vacancy control process in place – to include 13-week firebreak on all posts outside of the exceptions list.
- Focus on reduction in bank & agency for both medical and nurse staffing

1. EPR Update: Nervecentre Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- A Contract Change Note to combine the scope of the first two implementation steps into one “tranche” has been agreed with Nervecentre. This is a positive step that is expected to simplify the technical integration required between Nervecentre and the current system CPD and minimise the need for additional process steps for staff throughout the transition.
- Go-live of the first tranche is expected in February 2026. The scope of this tranche includes clinical documentation for inpatients (known as the Patient Safety Bundle and Inpatient Paperless modules within Nervecentre), Urgent & Emergency Care, Electronic Prescribing & Medicine Administration, Bed Management and read-only results.
- The team continue to progress the design and build workstreams at pace, with focus on the first delivery.
- A new EPR Clinical & Operational Design Authority (CODA) is up and running, increasing visibility and engagement with key decision makers across the Trust.
- Go-live planning, for example considering the sequencing of the cutover to Nervecentre, business continuity planning and required support, has started and will continue over the next few months with regular engagement with key Trust forums.

2. Continuous Improvement Update Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Following approval at Trust Board, KPMG were commissioned to conduct a readiness assessment. The KPMG Readiness Assessment for Continuous Improvement is designed to evaluate the Trust's preparedness to implement or enhance continuous improvement (CI) practices. This includes assessing current capabilities, identifying improvement opportunities, and aligning strategic direction with CI principles.

The readiness assessment evaluated the Trust's existing process maturity, operational capability, and cultural alignment with the continuous improvement framework, assessing 10 capability domains including: Strategy, Performance Goals and Operational Planning, Transformational and Step Change Improvement, Operational and Performance Management, Escalation Management, Communications and Engagement, current Improvement Team, HR, Finance, BI and Corporate Functions, Values, Behaviours and Leadership, Daily Management and Continuous Improvement.

The readiness assessment collected information through stakeholder interviews and focus groups gaining insights on current state. A review of elements currently contributing to or supporting delivering the strategy, included:

- Annual Plan and Strategy Scorecard
- Culture work
- Alignment to NHS IMPACT, inc. NHS IMPACT self assessment
- Improvement and Transformation delivery mechanisms and enablers

The outcomes of the readiness assessment were presented to Executives and others on the 16th June with follow-up sessions to develop a road-map against 7 domains held on the 24th June. These include Values, Behaviours & Leadership, Strategy Deployment, Management System, Transformation Projects, Centre of Excellence, BI & Analytics, Comms & Engagement. Exec and lead roles were assigned for each of these domains.

3. Productivity and Efficiency Group Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Operational Productivity Workstreams

The Trust operational productivity group has identified 8 priority workstreams for 2025/26 to improve operational productivity.

1. **Outpatient procedure coding -** Surgery and CSCS have made significant improvements in 2024/25. The focus in 2025/26 is medicine and family health care group. Each care group have presented at the elective recovery board to identify shared learning opportunities.

2. Service Reviews - Productivity service reviews scheduled for neurology, cardiology and paediatrics in Q1. A data pack is being developed for each speciality with a focus on key productivity metrics and this this is then presented and discussed in an MDT workshop to identify opportunities and agree improvement actions.

3. Medical Staffing Rotas - Meetings with each speciality have been undertaken with the chief operating officer and medical director to review medical staffing rotas and job planning. The 2025/26 planning approach has a stronger link with team job planning to understand core capacity.

4. Hot clinics - Opportunities for moving activity from assessment areas such as Same day Emergency Care into outpatient capacity. Opportunities to be identified across specialities as part of the assessment/UCIP workstreams.

5. Clinic utilisation - Clinical utilisation improvement from baseline of 72.6% to 90% by March 2025. Removing clinics on CPD that are not actively used, focus on booking principles and review clinic template standardisation in line with GIRFT review.

6. Administrative processes - Draft project brief developed outlining scope. Focus on patient access, medical secretaries and general administration with a focus on standardisation, centralisation (where appropriate) and digitisation. Scope and approach to be approved at Executive Committee in June 2025.

7. Clinical Estate Utilisation - Clinical Estates lead auditing all outpatient and outpatient procedure capacity to understand utilisation of estates and make recommendations for approach to room booking and principles for use of clinical estate.

8. PIFU pathways - Involvement in NHSE PIFU as standard project, internal improvement plan developed with focus on cardiology, ENT and gynaecology and deep dive into Scarborough pathways.

4. Efficiency Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

	Full Year CIP Target	June 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
Total Programme	55,290	6,492	5,962	531	9,848	45,442	55,290	0	30,999	24,291	0

Efficiency Delivery

The total trust efficiency target is £55.3m, £9.8m has been achieved in full year terms and the year-to-date position is £531k behind plan. The programme is fully planned.

Governance

The Trust is following the recently introduced NHSE enhanced governance expectations for efficiency programs, to provide sound governance and a clear project plan for delivery of each of the efficiency schemes. As at the end of June, governance arrangements are on track, these arrangements are:

- Corporate reduction plans by end of May – Achieved
- No unidentified CIP in plans by end of May – Achieved
- De risk all plans by the end of June – Achieved

Efficiency Delivery Group

The Efficiency Delivery Group (EDG) continues to play a central role in overseeing and assuring the delivery of the Corporate Efficiency and Waste Reduction Program. Future agendas are currently being refined to foster greater engagement in the delivery of efficiency schemes.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	30 July 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 – July 2025

1. I have continued to visit various wards and services at York, Selby and Scarborough Hospitals, as well as have several 121s. 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 attended an excellent Conference hosted by the Royal College of Obstetricians & Gynaecologists organised by Progress in Partnership with the aim of improving the quality including safety of maternity and neonatal services. A lot of Trust Chairs and Chief Executives attended. There was an excellent range of speakers and panel members including the present Secretary of State and the former one Jeremy Hunt. There were lots of practical suggestions and ideas. I have written a briefing note to share with Directors.

3. All of the Non- Executive Directors and I have had their annual appraisal and the necessary outcome of the appraisal documented and agreed with each person ready to send to NHS England.

4. As I mentioned in my previous report to the Board, the issue that has dominated my thoughts the most has been the necessity to recruit an effective and worthy successor to Simon Morritt, Chief Executive following his decision to retire in September. At the time of writing this report the post is currently being advertised with a closing date of 27th July. Shortlisting will take place on 28th July. Shortlisted candidates will give a presentation and take questions from three stakeholder groups on Tuesday 5th August and the formal panel interviews on the following day. The interview panel with consist of me, our Senior Independent Director NED colleague, NHSE Regional Director, External Assessor – an acute Trust FT Chief Executive, and our Lead Governor. An extraordinary meeting of the Council of Governors has been arranged for that afternoon to consider and hopefully approve the recommendation from the panel of who to appoint as our new Chief Executive.

5. Today I welcome Noel Scanlon and Dr Richard Reece to their first Board meeting as our new NED and Associate NED respectively. Helen Grantham on

1st July became a substantive NED and Chairs the Resources Committee from that date.

6. Sadly, it is the last meeting that Dr Matt Morgan will be attending as one of our NEDs. Matt has been an excellent NED as the University of York stakeholder NED. Although we will very much his contribution as a member of the Board, we will continue to have a strong working relationship with him and his team in his role as Dean of the Medical School. Arrangements are at an advanced stage to appoint a successor to him in conjunction with the University of York. Subject to agreement of the Council of Governors it is likely that his successor will formally join the Board on 1st October 2025.

   Martin Barkley
   Trust Chair
   17.07.2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	30 July 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

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☒ 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: A summary of the national report publications and announcements from the past month (including the 10 Year Health Plan, the Dash Review of patient safety-related organisations, the Maternity and Neonatal Review and the Leng Report on Physician Associates and Anaesthesia Associates), our latest CQC report, resident doctors' industrial action, the Trust's anti-racism statement, and the star award nominations received in July.

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. National reports and announcements

Since our last Board meeting there has been a series of announcements and report publications from the Department of Health and Social Care and NHS England as further detail emerges about the Government's strategy for NHS transformation and improvement. These are summarised below.

1a. Fit for the Future: 10 Year Health Plan

On 3 July the Government's 10 Year Health Plan was launched, which marks a significant turning point for the NHS and for all of us working within it.

The plan focuses on the previously-announced three main shifts: from hospital to community, from analogue to digital, and from treatment to prevention. The key areas under each of the three shifts are:

Hospital to Community:

- Improving GP access.
- A GP-led Neighbourhood Health Service to create single and multi-neighbourhood providers and multiprofessional teams organised around groups with most need.
- Care closer to the community with Neighbourhood Health Centres in every community, pharmacy offering more services, more NHS dentists and a focus on prevention.
- Redesigning outpatient and diagnostic services.
- Redesigning urgent and emergency care.

Analogue to Digital:

- Transforming the NHS app to become the 'front door' to the NHS, and the tool to organise care around patient needs, choices, and schedules.
- A Single Patient Record, with patients having control over a single, secure account of their data to enable more coordinated, personalised, and predictive care.
- Improving the digital experience for staff and improving the quality of patient interactions through more accessible information, embracing AI to release time to care, and building a platform for proactive, planned care.

Sickness to Prevention:

- The Tobacco and Vapes Bill will mean that children turning 16 this year or younger can never legally be sold tobacco.
- Tackling the obesity epidemic, new school food standards and reduced junk food advertising aimed at children.
- Giving consumers more information about the health risks of alcohol.
- Helping children to flourish, including the expansion of the mental health support teams in schools and new Young Future Hubs which will provide additional support for children and young people's mental health.
- Moving from a sickness service to a prevention service.

To support delivery of the changes, there will also be a new operating model. The plan also describes how we will make the NHS the best place to work.

Over the coming months, we will learn more about what this means for our Trust, our teams and our patients, but what is clear is that we will play a vital role in shaping this change locally. You can read the full 10 Year Health Plan here.

1b. Review of Patient Safety across the Health and Care Landscape

A few days after the 10 Year Plan's publication, the report by Dr Penny Dash, Chair of NHS England, was published. This review looked at six bodies and how they work within the wider health and care landscape, with a particular focus on patient safety. The six bodies were:

- the Care Quality Commission
- the National Guardian's Office
- Healthwatch England and the Local Healthwatch network
- the Health Services Safety Investigations Body
- the Patient Safety Commissioner
- NHS Resolution

Dr Dash's nine recommendations focus on streamlining the patient safety landscape and improving accountability. These recommendations, which the Government has accepted in full, are:

1. Revamp, revitalise and significantly enhance the role of the National Quality Board.
2. Continue to rebuild the Care Quality Commission with a clear remit and responsibility.
3. Continue the Health Services Safety Investigation Body's role as a centre of excellence for investigations and clarify the remit of any future investigations.
4. Transfer the hosting arrangement of the patient safety commissioner to MHRA, and the broader patient safety work to a new directorate for patient experience within NHS England, transferring to the new proposed structure within the Department of health and Social Care.
5. Bring together the work of Local Healthwatch, and the engagement functions of integrated care boards and providers, to ensure patient and wider community input into the planning and design of services.
6. Streamline functions relating to staff voice.
7. Reinforce the responsibility and accountability of commissioners and providers in the delivery and assurance of high quality care.
8. Technology, data and analytics should be playing a far more significant role in supporting the quality of health and social care.
9. There should be a national strategy for quality in adult social care.

You can read the full report here.

1c. National Maternity and Neonatal Review

A rapid inquiry into maternity and neonatal services has also been announced. The inquiry will be in two parts, the first looking at up to ten trusts where concerns have been raised, the second taking a system-wide look at maternity and neonatal care, drawing together lessons from past inquiries to form a national set of actions to improve care across the NHS.

We do not yet know the extent to which we will be required to participate in this work, but in the meantime, every NHS board with responsibilities relating to maternity and neonatal care to has been asked by NHS England to:

- be rigorous in tackling poor behaviour and poor team cultures,
- listen directly to families that have experienced harm at the point when concerns are raised or identified,
- ensure we are setting the right culture, and working with our maternity and neonatal voice partnership, local women and families,
- review our approach to reviewing data on the quality of our maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both,
- retain a focus on tackling inequalities, discrimination and racism within our services, including tracking and addressing variation and putting in place key interventions.

We will continue to work in close partnership with our regulators, our colleagues and the people who use our maternity and neonatal services to ensure we are responding to feedback and continuously improving what we do.

1d. Independent Review of the Physician Associate and Anaesthesia Associate Roles

Finally, the report by Professor Gillian Leng was published on 16 July. The report draws on evidence and wide engagement from patients, clinicians, and experts.

The review recognises the valuable part these roles play in multidisciplinary care across the NHS, and that is certainly the case here in our Trust.

Several recommendations have been made in the report to strengthen clarity, safety, and support for both colleagues and patients. We are working through these carefully to put them into practice. This includes adopting the new national role titles: physician assistants (PAs) and physician assistants in anaesthesia (PAAs). We will also be aligning how these colleagues are deployed with the national guidance, reviewing roles with line managers where needed, and making sure affected colleagues are fully supported through any changes.

2. CQC report published

The final report following the CQC's inspection of urgent and emergency care (UEC) and medical care services at York Hospital in January 2025 was published on 2 July.

This unannounced assessment focused on key quality domains: safe, effective, caring, responsive, and well-led.

I am pleased to say that the CQC has acknowledged the improvements made across both UEC and medical care services. Inspectors described our staff as welcoming, open, and honest, a reflection of the dedication and values demonstrated across our teams.

Urgent and emergency care has improved from '*inadequate'* to '*requires improvement overall'*. The safe and responsive domains have also moved from '*inadequate'* to '*requires improvement'*, while well-led has notably improved from '*inadequate'* to '*good'*. Both the effective and caring domains are now rated '*good'*.

Both services have been rated '*requires improvement'* overall, marking clear progress since the last inspection. When combined with previous service reviews, the overall rating for York Hospital is now '*requires improvement*'. Significantly, most patients and their families reported feeling treated with kindness and compassion, reinforcing our commitment to person-centred care.

I would like to thank all our colleagues for their continued professionalism, care, and commitment. Together, we are making meaningful progress, and we remain focused on delivering the highest standards of care for the communities we serve.

The report is available on the CQC's website.

3. Industrial Action

At the time of writing, the BMA has announced a period of industrial action by resident doctors, taking place from 7am on Thursday 25 July to 7am on Tuesday 30 July, as part of the ongoing national dispute over pay.

As with previous periods of industrial action, we have stepped up our silver command meetings to ensure we have a co-ordinated, Trust-wide response. Our top priority remains the same: keeping essential services running safely for our patients and supporting our teams throughout.

Once again we are planning for consultants, SAS doctors, and other clinical colleagues to provide cover where needed so that resident doctors can take part in the action if they choose to. Some services may look a little different during this time, and whilst we are doing everything we can to minimise disruption, there may be some unavoidable delays or changes to patient care.

4. Trust Anti-racism Statement

As I have shared in previous reports, we have established an Anti-racism Steering Group. As one of its first actions, the group recently approved an Anti-racism Statement that sets out our Trust's commitment to becoming an anti-racist organisation.

If we are to deliver on our priority of creating a workplace where everyone feels safe and welcome, then it is absolutely critical that we take meaningful action to tackle racism and deal with concerns appropriately.

You can read the full statement here.

5. Star Award nominations

Our monthly Star Awards are an opportunity for patients or colleagues to recognise individuals or teams who have made a difference by demonstrating our values of kindness, openness, and excellence. It is fantastic to see the nominations coming in every month in such high numbers, and I know that staff are always appreciative when someone takes the time to nominate them. July's nominations are in **Appendix 1**.

Date: 30 July 2025

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

July 2025

Millie Priestman, Staff Nurse	**York**	**Nominated by patient, (1) and patient (2)**

Nomination 1:

Millie went over and above to care for me whilst I was a patient on ward 36. She was compassionate and person centred in her nursing approach and advocated for me throughout my stay. She was supportive, understanding and displayed excellent nursing skills.

Nomination 2:

Mollie was tasked to take me as an inpatient to St James in Leeds for an operation planned for 10am. On the journey there, she was friendly and in control, even when we were running an hour and a half behind schedule and she had to reorganise an alternative schedule with Leeds.

The surgery went well, however, when I was discharged, the wrong type of ambulance was provided. Millie recognised this and, after telephone discussion, she explained the rationale and went back to the ward with a view to getting the correct ambulance. This was around 4pm. After pressing the Ambulance Service, she established the possibility of another ambulance arriving at 5pm. This ambulance failed to arrive, as did the next one which had been promised for 7pm. By now, Millie was concerned where this was leading us and rang both matrons at Leeds and York to try to apply pressure to get her patient moving.

Things were not looking good and there was thought that I would be staying in Leeds as by now she had arranged for me to stay in another ward approximately 500 meters away where the staff had the capability to look after me. Not knowing how long I could stay there, but reassured that I was being cared for, she then found an ambulance crew that had the skills and necessary kit onboard to care for me on the journey to York. She put that plan in place and then got a taxi for herself back to York. I eventually arrived back in the ward at York at 2am.

I believe that her dedication to her patient and her professionalism, together with being able to ‘think outside the box’ and engage with her superiors to get the job done deserves recognition.

Chloe Jones, Clinical Lead Occupational Therapist and Laura Nicholle, Occupational Therapy Specialist Practitioner **York** **Nominated by colleague**

Chloe and Laura have been working with a patient with early onset dementia on ward 34. The patient was initially very upset, calling and shouting out, restless and unable to verbalise their pain/worries. Once Chloe and Laura had assessed the patient, they looked at her medications and how this might be hindering the patient's ability to communicate with the staff.

They spoke to the doctors and nurses to try and rectify the situation, and then they spent a few hours with the patient seeing if they could get help her to get out of bed. They saw that they could the patient could be hoisted into a chair, and proceeded to get her out to sit on the ward where she could see people passing by and where she did not feel alone. The patient was so much happier being able to get out of her room.

It was inspiring to see. I hope Chloe and Laura know how much their actions meant to the patient involved, her family and staff who witnessed this. They have shown exceptional care and kindness to the patient and should be proud of themselves.

Olivia Goodwin, Patient Support Officer **York** **Nominated by colleagues**

Nomination 1
Olivia is caring; she is so lovely with the patients and is a great help to us. Olivia helps bring the patients down to the Discharge Lounge, which is a great help to us as sometimes it is extremely busy in the lounge where I work. She ensures the patient is comfortable and offers them a drink which again is a great help to us. She is polite, cheerful and a hard worker who goes above and beyond her role.

Nomination 2
Olivia goes about and beyond what is expected of her. She is a great asset, not only on her own ward the day unit, but to us on the Discharge Lounge also. She takes the pressure off both areas when collecting patient from the day unit to transfer to the lounge - especially when it is busy, and we need her the most. Olivia does this with great care of patients, she is polite, kind and nothing is too much trouble. Olivia hands patients care over to staff in a timely and professional manner. Olivia understands barriers to patients' onward journeys and pre emps problems to ensure they have an acceptable journey through the Trust. She is a great advocate for the Trust and upholds our values to an exceptional degree.

Well-done done Olivia.

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

Eddie goes above and beyond to ensure that the children's wards are thoroughly cleaned for our children, families, and staff. He always has a smile when he is on the ward. Thank you, Eddie, for all your hard work.

Chloe Malarkey, Midwife **York** **Nominated by colleague**

The domestic colleague who works on our ward collapsed in the cleaning cupboard, whilst on the phone to her daughter. Her daughter contacted Chloe who found the domestic, escalated and potentially saved her life. Through her quick thinking and professionalism anything worse was avoided, and we could ensure we got the person appropriate and quick help. Chloe is an asset to the team and works so hard to provide amazing care to the whole team.

Holly Smith and Elizabeth Shore, Medical Laboratory Assistants **Scarborough** **Nominated by colleague**

With the introduction of a new bagging system from GPs and limited computer access for booking in, Holly explored a new approach. By working with Elizabeth and splitting the task across two areas, they were able to move samples to the analyser section more quickly. This improvement will help ensure patient results are reported faster.

Emma Carass, Healthcare Assistant **York** **Nominated by patient**

Nothing has ever been too much for Emma. She is consistently gone out of her way to look after me - nothing has ever been too much trouble. I just want her to be recognised for everything she's doing - thank you so much, Emma, for everything.

Georgia Adams, Midwife **York** **Nominated by patient**

Georgia was my midwife whilst in labour. After having a rocky pregnancy and being told consultants it would be best to have a caesarean section (even though I was adamant I was going to give birth to my daughter naturally unless life threatening). I explained all my wants and wishes, and how strongly I felt on having a vaginal birth despite what consultants were saying.

Georgia took the time to first make myself and my partner feel comfortable at such a crazy time and listen to us and make sure we felt heard and respected. She took the time to really get to know us and understand us which speaks volumes for a health care professional with such a busy job role. Throughout my labour Georgia helped make the experience fun! All of us together had so many laughs, memorable moments and this really helped make the whole experience the best it could be. I think without Georgia’s support, kindness, and fun qualities, I would have most likely become too stressed and resulted in an emergency caesarean section again. Thanks to Georgia, I felt listened to, valued, respected and most of all happy at such a vulnerable time.

We will forever be grateful for Georgia and how she supported us bringing our little girl Ainsley-Sid into the world. I hope that every woman in labour could experience a midwife life Georgia.

Kate Simpson, Specialist Nurse **Scarborough** **Nominated by relative**

We want to extend our deepest gratitude to Sister Kate for the outstanding care she provided recently. Even during one of the busiest times on the ward - short-staffed and under pressure - Kate never let it show. She consistently went above and beyond, showing remarkable compassion, empathy, and dedication. She took the time to understand my husband's needs, never rushing, never making anything seem like too much to ask. Her kindness, calm presence, and professionalism made all the difference. In a world where small gestures can mean everything, Kate showed what true nursing care looks like. Thank you.

Amy Meek, Generic Therapy Assistant **Community** **Nominated by colleagues**

Everyone needs an Amy. In every effective team, there is someone whose impact cannot be measured by titles or statistics - someone who quietly keeps the wheels turning, the spirits lifted, and the hearts full. For our team, that someone is Amy.

A devoted member of the Community Therapy Team for over 16 years, Amy is more than just a Generic Therapy Assistant - she is the heart of the service. A peacekeeper, a listener, a doer, and a fierce advocate for patients and colleagues. Her work ethic is unmatched, her memory astounding - names, faces, addresses, life stories - all held with care and precision in her mind. Amy goes above and beyond without hesitation. She does not just tick boxes - she transforms lives in the quietest, most meaningful ways.

An example of this is when one patient, fragile and disheartened after a long hospital stay, felt lost and disconnected, it was Amy with her colleague Jeannette who made it possible for her to reconnect with her social world. They ensured she was safe getting into a taxi, then met her at the venue, and gently guided her out, ensuring she could spend time with her friends. It was more than logistics - it was dignity, compassion, and hope.

She brings joy with her wherever she goes, always wanting those around her to be happy. She is everyone's secret keeper - trusted implicitly, loved deeply, and yet so often unrecognised for the quiet strength she brings. She is the person who remembers the little things that matter most. But let it be known - Amy may be gentle, but she is nobody's fool. Fiercely protective of her team and those she supports; she will stand her ground when it counts. Fortunately, it is not easy to get on the wrong side of Amy - and once she is in your corner, you will never want to lose her.

She is, simply, one of a kind. And we all agree: Everyone needs an Amy.

Marawan Zaki, Trust Grade SpR Gastroenterology/ Hepatology MBBS MRCP **York** **Nominated by colleagues**

Marawan kindly facilitated the Medical Education ascitic drain course, and the team are hoping it is the first of more! The time and preparation he took to put the session together along with the excellent feedback received from all the attendees made the course a success. Patience, understanding and care for each attendee with questions answered made Marawan perfect for this course. Thank you.

Andy Smith, Generic Therapy Assistant **York** **Nominated by colleague**

Andy went the extra mile for a patient and their partner by undertaking a home visit to fit some furniture equipment for discharge.

The circumstances of the home environment were far worse than had been anticipated. After initial trepidation, the partner allowed Andy inside, where there were soiled bin bags piled up to the windows, furniture buried beneath the rubbish, and a dreadful stench. There would have been no space to mobilise with a walking frame. The partner then broke down in tears saying it was all a mess and everything had got on top of them, and that they needed help but were too embarrassed to let anyone know.

Andy responded to this situation sensitively in a caring and thoughtful way saying reassuringly that there was no judgement involved. Now that the extent of the situation was evident, and that they wanted help he said that the hospital could get help and assistance to sort things out. Andy returned to the ward and spoke to the patient who was relived and grateful and agreed to have help with this. Andy updated the ward staff and completed documentation, all of which took him way over his normal working hours that day.

Andy behaved in a particularly sensitive, thoughtful and caring way, to a difficult and unexpected situation he found himself in. He handled it in a professional way.

Lily Newton, Outpatient Administrator **York** **Nominated by colleague**

We have temporarily moved our scan room whilst some works are being carried out. Since then, despite signage, patients continue to get lost and confused trying to find us. This is a problem because the patient are often elderly women who have been asked to come with a full bladder. They often arrive feeling flustered and either anxious about needing the toilet urgently, or having already emptied their bladder, which can make the scan more difficult to carry out.

Lily thought to send text messages to the patients explaining the location and giving a contact number they could ring. Since then, all our patients have arrived on time. Lily also sent out reminder messages to patients for us for a student assessment which meant they all arrived, and the assessment could go ahead.

Lynn Clegg, Ward Clerk **Scarborough** **Nominated by colleague**

Lynn has helped me several times with a few different things; she is always nice and ready to help.

Rebecca Nisbet, Student Nurse **York** **Nominated by colleague**

While studying as student nurse, Rebecca also dedicated her spare time to working with another organisation. During this time, an urgent recall was issued for specific product codes of oropharyngeal airways (Guedel airways), known as a Field Safety Notice. However, York and Scarborough had not been informed of the alert via the national alert scheme. Thanks to Rebecca's vigilance and proactive approach in notifying the Patient Safety Team, the issue was addressed 24 hours before the formal alert arrived. Given that these airways are stocked in every crash trolley across all wards and departments, her timely intervention potentially prevented delays in resuscitation efforts. Rebecca should be incredibly proud of her swift action and dedication to patient safety.

Diane Atwal, Community Midwife **York** **Nominated by relative**

Diane is a dedicated midwife to the community; she has done this for many years now. She deals with obstacles that come up with professionalism and truly cares about the wellbeing of her patients and their families. She also does on-call, which can mean travelling to situations that require her skills to safely deliver babies.

A true angel.

Phillipa Wood, Staff Nurse **York** **Nominated by colleague**

Phillipa mentored me throughout my initial phase in this department and would often go out of her way to support nurses with patient care, even when she was not assigned to a specific patient. I have seen her provide personal care and assist with washes for patients under someone else's care. I have been impressed by her dedication, professionalism and nursing attributes.

She genuinely cares about every single patient and consistently demonstrates compassion.

Tess Whitelam, Sister **York** **Nominated by colleague (1) and colleague (2)**

Nomination 1:

As someone new to the department, I found her support invaluable. Even though she was not officially assigned as my Band 6 mentor, she consistently offered guidance and a helping hand - not just to me, but to everyone on the team.

She works incredibly hard, never slacks off, and is always willing to answer questions or get involved in the physical aspects of care without hesitation.

Nomination 2:

Tess is an amazing nurse in ICU. She is helpful and approachable. She follows the Trust value of kindness.

Mark Sellars, Radiology Services Administrator **York** **Nominated by colleague**

I would like to nominate Mark for a Star Award in recognition of his outstanding contribution to our department and the wider hospital. Despite navigating personal challenges and during a period of significant staff change both at York and Selby hospitals, Mark has consistently demonstrated exceptional dedication, adaptability, and professionalism.

He has stepped up repeatedly - covering colleagues' annual leave at short notice, training staff, adjusting his work patterns to meet service needs, and being consistently reliable and present for the team. Not only has he shown a strong work ethic, but he has also taken on the challenge of learning a completely new modality, going above and beyond his role to support during a difficult time. His willingness to learn, support others, and placing the needs of the service above his own comfort shows the true values of our organisation in action.

Mark embodies compassion, commitment, and courage. His resilience, empathy, and quiet leadership have made a significant impact on the team and service delivery. It is with immense pride that I submit this nomination - he truly deserves to be recognised. Thank you.

Geraldine Fox, Healthcare Assistant and Caroline Birkinshaw, Patient Services Assistant **York** **Nominated by colleague**

During the hot weather this week, Geraldine and Caroline have devised a hydration station and tuck shop on wheels. They have taken it round throughout the day offering wet wipes covered in ice, ice pops, drinks, complan shakes, and snacks to all the patients. Well done ladies!

Disa Molesbury, HSA Team Leader **Scarborough** **Nominated by patient**

Disa helped my autistic husband this morning as he was experiencing anxiety, on the verge of a panic attack. She was calm, compassionate and kind. She thought outside the box when he needed to lay down in one of the treatments rooms rather than ushering him to the waiting room like the other patients (like the lady doing the scanning did!!) Disa reassured my husband and spoke to the doctor on his behalf to speed up the process. Thank you!

Kat Sherwood, Healthcare Assistant **York** **Nominated by relative**

Having been a regular visitor on Ward 18 due to my son’s regular bloods and complex medical needs we are always happy to be greeted by Kat. Such a warm, gentle, kind woman. She always remembers my son and greets him by name. I cannot say the feeling is mutual and he often signs finished at Kat as he always associates her with his bloods! But we all laugh and after he is always friends with her again! Such a brilliant nurse.

Jane Park, Patient Support Assistant	**Scarborough**	**Nominated by colleague**

Always approachable, always willing to help and always goes above and beyond for patients and colleagues alike. Nothing is too much trouble for Jane, and she is a great person and really hard worker.

Jemini Mistry, Paediatric Audiologist	**York**	**Nominated by colleague (on behalf of a patient)**

Just a quick note to say how much we appreciated the appointment we had with audiologist Jemini Mistry for our young son (X).

Jem took time to make eye contact with all of us and particularly importantly, made a connection with (X); explaining clearly how he could use his new hearing aids. This appointment really helped us to understand clearly how X's hearing aids work and clarified benefits and potential challenges we might all experience. A simple thing, but the pace at which Jem spoke was also suitable for all of us. English is my partner's second language and there has been a lot of information for us all to take in, so this helped us feel clear about choices we have in future re. surgery/grommets for our son.

Checking in with us as to whether we understood key information was also effective in terms of us feeling clear about how we can support X. A big thank you. The above is only one example of the hard work and dedication to paediatric audiology that Jemini shows. She is a hard worker and goes the extra mile to make all the difference to children with hearing loss.

Tom Macleod, Consultant Plastic and Oncoplastic Breast Surgeon and the Plastic Surgery Team	**York**	**Nominated by patient**

Though my operation was minor, Dr Macleod and his team were magnificent. From the initial consultation to the procedure, the care I received was exemplary. Whilst in the theatre, I was constantly reassured, spoken to with care and consideration and was kept informed of what was happening.

The whole team made me feel like they were genuinely interested in me as a person and not just another job to do. I even laughed aloud at one story while being dissected.

Jo Hagan and Isobel Smith, midwives	**Scarborough**	**Nominated by patient**

For being so kind and understanding, and not making me feel like my concerns about my baby's movements were heard. Offering me endless reassurance and monitoring to try to make my worries subside. So proud to call them colleagues as well; it is hard to be vulnerable as a patient in your workplace. They made me feel so listened to.

Maralyn Sotiropoulou, Receptionist-Administrator	**York**	**Nominated by colleague, (1) and colleague (2)**

Nomination 1:

Maralyn always shows such kindness towards the patients and her colleagues, she works a busy reception, but every patient is greeted with such a warm caring smile. Maralyn will go out of her way to help patients especially if she sees they are maybe in distress and will go above and beyond to find a solution.

Nomination 2:

This star award nomination is overdue. Maralyn is the friendliest, kindest, and most generous person, both to her colleagues and patients. Today, I was talking to her when an older patient in a wheelchair returned from their appointment, thanking Maralyn for being helpful and for giving them directions to their appointment. They said she was so friendly and that she does her job so well. They called her a "star". Maralyn downplayed these compliments and simply said she was just doing her job, but I agreed with the patient saying how well she does it.

Maralyn's role can often be challenging and there have been a few times where she has been mistreated and verbally abused by patients. Her professionalism and kind nature helps her persevere. She is an exemplary member of the Outpatient Services' team and the Trust as a whole and she deserves this recognition.

Ben Jones, EUC Analyst (MDE) and Lewis Swain, 1st Line IM&T Technician	**Scarborough**	**Nominated by colleague**

Ben and Lewis are always on hand when I have issues with my computer and other IT problems. They always solve the issue and go above and beyond to help. They are always polite, and both have a good sense of humour which is good for moral on the ward. I find them both approachable and give 100% in helping.

Chloe Howard, Head of Cardiorespiratory	**York**	**Nominated by colleague**

Chloe really helped us out of a difficult situation and prevented a patient having to be re-scheduled unnecessarily.

A locum consultant had refused to see a patient for nerve conduction studies (NCS) as they had an implantable cardioverter defibrillator (ICD) fitted which would need turning off and monitoring during the NCS. The patient had taken time of work and travelled from the coast for their appointment.
I spoke to Chloe who said that monitoring for our patient's situation was not actually necessary, but she would still come to the NCS clinic, turn off the ICD and monitor the patient whilst the consultant did the NCS so that the patient did not have to be cancelled. She was with us within ten minutes, taking herself out of her busy schedule at the drop of a hat without any fuss. The patient was grateful that they could have the NCS that day.

Thank you, Chloe for helping us out at such short notice.

Rachael Hughes, Acute Patient Catering Supervisor **York** **Nominated by colleague**

After an electrical issue on two wards meant that there was no facility to provide hot food provision to patients who, due to the planned maintenance, had only had sandwiches at lunch. Rachael sprang into action and demonstrated fast thinking, great communication skills, teamwork and her patient welfare awareness was a masterclass to watch.

Her and her colleague's actions ensured the patients were given a choice of meals under tight time constraints and lack of resources.

Chris Littlewood, Acute Patient Catering Supervisor **York** **Nominated by colleague**

After an electrical issue on two wards meant that there was no facility to provide hot food provision to patients who, due to the planned maintenance, had only had sandwiches at lunch. Chris sprang into action and demonstrated fast thinking, great communication skills, teamwork and his patient welfare awareness was a masterclass to watch.

His and his colleague's actions ensured the patients were given a choice of meals under tight time constraints and lack of resources.

Shirly Chan, Catering Operative **York** **Nominated by colleague**

After an electrical issue on two wards meant that there was no facility to provide hot food provision to patients who, due to the planned maintenance, had only had sandwiches at lunch. Shirly took on extra work to ensure that patients were given a choice of meals under tight time constraints and lack of resources. She demonstrated great teamwork and commitment to patient wellbeing.

Sally Hobson, Paediatric Orthopaedic Consultant **York** **Nominated by colleagues**

We would like to nominate Miss Hobson for a Star Award in recognition of her outstanding kindness, professionalism, and unwavering support to both patients and the physiotherapy team.

Miss Hobson consistently demonstrates the Trust's core values through her compassionate approach, collaborative spirit, and commitment to high-quality patient care. She is an exemplary Orthopaedic Consultant who goes above and beyond her clinical responsibilities.

Miss Hobson is excellent in managing patients with persistent pain, showing great patience, empathy, and expertise to help them navigate complex and often challenging rehabilitation pathways.

Despite her busy schedule, Miss Hobson is always approachable and willing to provide advice and guidance regarding patient care and rehabilitation. Her support plays a vital role in ensuring seamless multidisciplinary collaboration, ultimately enhancing patient outcomes.

Her dedication does not go unnoticed and is deeply appreciated by all members of the team.

Charlotte Davies, Consultant Radiologist **York** **Nominated by colleague**

I am writing to nominate Dr Charlotte Davies for a Star Award in recognition of her outstanding contribution to patient care and interdisciplinary collaboration.

Dr Davies recently demonstrated exceptional professional commitment by expediting a critical CT report for a pre-operative golden trauma patient. The patient's case was complicated by a query of malignancy, and the surgical planning was entirely dependent on receiving this report promptly. Without hesitation, Dr Davies prioritised this case, understanding the clinical urgency and its impact on patient outcomes.

What sets Dr Davies apart is her unwavering dedication to patient welfare. She recognises that behind every scan is a person waiting for answers and treatment. In this case, her swift action meant our trauma patient could proceed to surgery with a properly informed surgical plan, potentially altering their course of treatment and prognosis significantly.

Dr Davies consistently demonstrates what true interdisciplinary collaboration looks like in modern healthcare. She does not view radiological interpretation as an isolated task but as an integral component of the patient's overall care journey. Her willingness to discuss findings, answer questions, and provide insights has made her an invaluable resource to the Orthopaedic Team.

Dr Davies "steps up to the plate" when needed most. Her reliability is something the entire surgical team has come to depend upon. What makes her truly exceptional is that she maintains this high standard of service not just during routine cases but especially during high-pressure situations when timely radiological input can make all the difference.

Ward 34 **York** **Nominated by colleague**

Ward 34 as a team have gone above and beyond to support a patient admitted in late April, who has acquired brain injury requiring constant 24 hour, one to one support his complex needs. The whole team have been amazing in the care and patience provided, particularly the amazing HCAs providing the hands-on one-to-one care.

On all observations I have seen over this prolonged admission, the HCAs have engaged, interacted, and been amazing in all they do. Unlike many other complex patients in the Trust, the staff on ward have had no formal support. Huge well done to you all in a difficult (at times) situation.

Nina Kidd, Senior Healthcare Assistant **Community** **Nominated by colleague**

I am nominating Nina for a Star Award for her exceptional dedication and consistently high standards. She has a clear understanding of her responsibilities and always goes above and beyond to ensure that everything is completed to the highest standard. She is incredibly hardworking, polite, and deeply caring, towards both her colleagues and the patients she supports.

Nina never hesitates to go the extra mile, often putting in extra effort to ensure the team's success and a smooth patient experience. She is trustworthy, professional, and consistently demonstrates the Trust values. Nina is also a pleasant and positive presence in the workplace, and it is an absolute pleasure to work with her.

Adithyan Rajeev Nair, Staff Nurse **York** **Nominated by patient**

Nothing is too much trouble for this young man. He always has smile on his face, he is empathetic and kind, he is strong and humble, and he gives you confidence to do what the physio needs you to do. There are no words good enough to explain this young man's character; he is a wonderful person and a good nurse.

Annette Jarvis, Cleaning Operative **York** **Nominated by colleague**

Annette is a valued member of the Trust. Every shift she goes above and beyond her duties, and as well as helping staff, she helps patients and relatives with their needs. There are many examples of her dedication to her role, including helping to get patients drinks and helping SAU staff with tasks.

Annette's friendly and helpful personality is appreciated by her colleagues and her work ethic should be highlighted. She encompasses the trust values every day and it is a delight to call her a colleague.

Debbie Bargewell, Staff Nurse **York** **Nominated by patient**

I cannot thank Debbie enough for going above and beyond to help me when I needed somebody most.

Over the May bank holiday weekend, Debbie made sure I felt safe, secure, and cared for, and held my hand throughout what I can only describe one of the scariest times of my life. Debbie came into work and stayed with me, my wife, and Charlotte, the ophthalmologist, offering wonderful cups of tea and lots of laughs, until the early hours when I was able to go home.

When I returned for two follow up appointments, Debbie took time out of her day to see me and check in to see how I was doing. Debbie is a true angel and the best nurse I have ever met. I will never forget all she did for me and my wife that night.

Charlotte Onsiong, FY2 **York** **Nominated by patient**

I cannot thank Charlotte enough for everything she did for me over May bank holiday weekend.

I have a degenerative sight condition and was rushed to York Ophthalmology department with acute angle glaucoma. Charlotte made sure we felt at ease from the moment we arrived. She knew how nervous I was about the possibility of losing my sight and made sure that I was as calm and relaxed as possible throughout the time we were in ED and beyond.

Charlotte was thorough from the start, making sure she explained everything in detail to help me and my wife understand what was happening. She stayed with us until the early hours of the morning and even came to check up on us when we returned for our follow up appointments.

I cannot thank Charlotte enough for the care, compassion, warmth, and understanding she showed throughout. She is amazing at what she does and deserves to be recognised for all she does for her patients. Thank you, Charlotte!

Richard Hanson, Consultant Ophthalmologist | **York** | **Nominated by colleague**

Richard introduced a diabetic screening service (typically offered in the community) into the hospital, aiming to capture patients who have appointments and attend other hospital services on the same day. The aim of this is to improve efficiency and decrease the DNA rate for patients with this blinding eye condition. This also helps to reduce the burden and impact of late presentations, which invariably require more NHS resources.

Jennifer Louth, Facilities Manager | **Scarborough** | **Nominated by colleague**

Jenny has helped me complete a piece of work that I have not done before. Although we work on different sites, she offered to meet me halfway in Malton to guide me. When realising how big the task was, she then offered to take a lot of the work off me as we are short-staffed in York. I appreciate the support she has given me.

Tilli Geaves, Healthcare Assistant | **Scarborough** | **Nominated by patient**

Tilli has gone above and beyond what I would expect to help me when I was in extreme pain during my last visit to ED. She always had a kind word for me.

Jessica Simpson, Paediatric Occupational Therapist | **Scarborough** | **Nominated by colleague**

I am nominating Jess for going above and beyond in both her professional role and in her personal support of a colleague during a challenging time. Jess has demonstrated exceptional initiative in overseeing, delegating, and managing any additional responsibilities with efficiency and care. Her proactive approach has ensured that high standards have been maintained even under pressure.

Beyond her formal duties, Jess has shown genuine compassion and unwavering support to a fellow staff member facing difficult circumstances. Her kindness, empathy, and commitment to team wellbeing exemplify the best of our values.

Lisa Dunwell, Generic Therapy Assistant | **Selby** | **Nominated by colleague**

Lisa visited a patient who had recently undergone hip replacement surgery and was being particularly hard on themselves about the speed of their recovery as they felt they were not making much progress. This was affecting their mood.

Lisa took the time to explain the recovery process to them and reminded them of the progress they had made in a short time and of how their commitment to following the physiotherapist's advice was leading to gradual improvement which they were sustaining over time. The patient stated she had taken a huge weight off their mind and left them with more positive mindset about what they could realistically achieve. They reported that her kindness and understanding had led them to feeling calmer and that they do not need to put themselves under such pressure.

This conversation clearly had a significant impact on the patient’s outlook, confidence, and mood. An achievement worth celebrating and an example of the Trust values in action.

Jenny Westbrook, Healthcare Assistant | **York** | **Nominated by colleague**

I am nominating Jenny as she recently went the extra mile for a patient who had been in hospital for a significant period and was spending their birthday in hospital. Ahead of the patient's birthday, Jenny brought in birthday decorations and a happy birthday headband for the patient's table and bed space. Jenny bought these herself, and took the time to make it look fabulous.

Jenny took time to do this without any expectation for her to do so. She also got the patient their favourite soft drinks as they would be unable to do it themselves. Subsequently, on the day itself, cake was also sourced by other people in the team for the patient. Jenny's actions came from the care she has for her patients beyond the requirements of her role and made a difficult time for a patient who had been in hospital much longer than expected more bearable for them. Jenny is a real asset to the Trust.

Serena Fong, Specialty Registrar | **York** | **Nominated by patient**

Dr Fong has a fantastic bedside manner. She always checked on me to make sure I was OK when she walked past. I felt at ease with this fantastic doctor. She is the type of doctor that goes the extra mile for any patient.

Sonia Moteea, Specialty Registrar | **York** | **Nominated by colleague**

Dr Sonia goes above and beyond with her care. She is friendly and approachable, and her bedside manner is impeccable. She ensures her patients get the best possible care and supports the ward team however she can. Her knowledge and education are outstanding, and she always makes the team smile.

Same Day Emergency Care York Nominated by relative

From arrival to departure, the whole team looked after my mum so well. They were caring and friendly and explained everything clearly. I cannot remember all their names, but the team included Lily, Chloe, and Wendy. The other nurses and doctors were wonderful too. They were an example of everything that is good about the NHS. We are incredibly lucky.

Cara Hayes, Midwife Scarborough Nominated by colleague

As a third-year student midwife, I faced one of the most challenging times of my life when I gave birth during the final year of my degree. My baby was diagnosed with heart failure, and balancing motherhood, personal hardship, and academic demands felt overwhelming.

During this time, Cara became a lifeline. She was my practice assessor, but she also went the extra mile for me. Her unwavering support, kindness, and empathy carried me through some of my darkest days. She not only offered professional guidance, but she also showed genuine care and compassion. She listened, encouraged, and constantly reminded me of my own resilience, even when I struggled to see it in myself.

What sets Cara apart is her ability to lead with both heart and strength. She has been a role model in every sense; showing me the kind of midwife I aspire to become: compassionate, patient, and truly present for others. Her belief in me never wavered, and her support gave me the confidence to keep going when I wanted to give up. I am incredibly grateful to have had her in my corner, both as a mentor and as a person. She exemplifies the best of our profession and is more than deserving of this recognition.

Lauren Haigh, Midwife Scarborough Nominated by colleague

I have had the privilege of working alongside Lauren since my second year as a student midwife, and, from the beginning, she has been a consistent source of encouragement, strength, and inspiration. Over the past two years, Lauren has supported me not only in my professional development, but also through one of the most difficult periods of my life - becoming a mother while completing my degree and navigating the heartbreak of my baby's diagnosis with heart failure.

Throughout it all, Lauren has been unwavering in her support. She has shown me endless empathy, reassurance, and kindness, always making time to check in and uplift me when I needed it most. Lauren's mentorship has shaped me in so many ways. She has modelled what it means to be a truly compassionate and grounded midwife: someone who provides excellent care while never losing sight of the human being in front of them. Her encouragement has helped me grow in confidence, and her belief in me has carried me through some incredibly challenging moments.

It is rare to find someone who consistently shows up with such warmth, professionalism, and genuine care. Lauren has made a lasting impact on both my personal and professional journey, and I will carry the lessons she has taught me throughout my career. I am honoured to nominate her for this recognition, she truly deserves it.

Stephen Hogan, Exercise Practitioner | **White Cross Court** | **Nominated by colleague**

Following some funding from the ISDN, Ste has been developing an exercise practitioner service within the Community Stroke Team. This role has been instrumental in helping patients regain confidence, strength, and function through targeted exercise. Since its start date, we have had an abundance of positive feedback about the amazing work Ste has produced for patients going through recovery after a stroke.

One response stood out above the rest. One of our patients' daughters sent in a powerful video evidencing the incredible work Ste has been doing over the last four months with her dad. It was clear to see what a positive impact he has had on her dad's physical and mental achievements. This gentleman was initially bedbound and is now back to walking his dog and playing golf.

Well done, Ste, we are proud of the service you have developed. You deserve this Star Award.

Acute Medical Unit | **York** | **Nominated by colleague**

AMU had a patient with severe learning disabilities and autism, who had multiple complex needs and was challenging to begin with, due to him being unwell. AMU staff did their absolute best with this young man from the start and adapted their care and communication to accommodate his needs and behaviours.

This patient was on AMU for three months and, in that time, everyone on AMU was incredible with him and with his mum, who was staying with him 24/7. The ward staff went above and beyond with their duty of care for them both and provided the best nursing care and social support they could have done considering the circumstances. AMU is an acute ward and does not have long-term admissions normally, so to have adapted and gone out of their way to make this admission as smooth as possible for the patient has been greatly appreciated.

Staff were making sure he had his favourite foods and drinks in every day and sourcing these to keep him calm. They were looking after mum with such kindness as well. Staff had printed off communication tools to use when mum was not there so they could support him as best as possible as he was non-verbal, and mum was the main interpreter. Staff quickly learnt his favourite things to do and would play and dance and sing with him to keep him entertained. They changed the side room he was in so that he could watch the trains outside, as this is one of his favourite things to do.

Countless reasonable adjustments were thought about and put into place if possible, and every member of staff on AMU, no matter what their role, has worked extremely hard to make this admission the best it could be under difficult and stressful circumstances. Staff were amazing advocates for the patient and mum and would do anything they could for them both. I cannot thank them enough. This is a great example of teamwork and supporting someone with complex needs.

Emma Buckham, Clinical Coding Team Leader | **Scarborough** | **Nominated by colleague**

Emma transferred all the Switchboard rotas electronically to help assist the one call queue on the OneNote platform. This has not only helped us go paperless, but we can also now work off these rotas across sites, which is amazing. Thank you, Emma, for all your hard work!

Emma Sebag-Montefiore, Lead Paediatric Clinical Educator | **York** | **Nominated by colleague**

Emma is an amazing educator, a credit to herself, and valued by the team and the Trust. Emma is role model; she leads by example and always with positivity. She delivers on all expects of her role with precision and care. She takes everything in her stride with calmness, confidence, and conviction.

Michelle Toft, Tissue Viability Specialist Nurse | **York** | **Nominated by colleague**

Michelle has been coming to the Maternity Unit to train midwives on wound assessment and dressing. During this she has been so supportive, kind, and hardworking, going above and beyond to create new guidelines, training, and OSCEs to ensure we have everything we need to be successful in this. This hugely benefits the women who come to our unit needing this service and supports the staff to achieve new skills. Michelle is passionate and enthusiastic about her job and in teaching it to us. I cannot thank her enough.

Christina Devine, Domestic Assistant | **Scarborough** | **Nominated by colleagues**

Tina is passionate about cleaning, and she is brilliant at her job. She is friendly and cheerful, always on the go with her mop. Recently we had to move out of our Children's Community Office as work was being done on the pipes. The room was dirty after the job was done and smelt damp.

The next day we came to work, and Tina had worked her magic and gone the extra mile to have the room fit for use again. We were not expecting this to happen so quickly! Tina is a real star, and we want her to know what a wonderful part of the team she is.

Emma Griffiths, Healthcare Assistant | **York** | **Nominated by colleague**

Emma is amazing. She will go above and beyond for anyone on every shift she does, and she always gives 100%. I want her to be recognised for her amazing work ethic.

Bitto Thomas, Healthcare Assistant | **York** | **Nominated by colleague**

Bitto is one of the hardest working healthcare assistants on AMU. He is kind to all our patients and will help his colleagues whenever he can. He takes initiative with all our admissions and makes sure everything is done in the right order. Bitto is an asset to AMU.

Karen Hayes, Senior Community Nurse | **Community** | **Nominated by colleague**

I am a newly qualified nurse and Karen's dedication to my training and development has been exceptional. She has always been on hand to answer any queries I have had and gone out of her way to meet me on visits to support me in my clinical skills; going above and beyond when she had her own full list of patients.

Karen willingly met me on two visits today to support me with compression, showing patience and understanding and being an excellent teacher. Karen even offered to complete a last visit for me so I would not be late finishing my shift. This was kind of her and another example of her going out of her way to help me.

Karen shows care and compassion to her staff and is an exemplary band 6. I am nominating her for a Star Award for being an exceptional manager, an amazing support, and a genuinely lovely and caring human being.

Jacob Naylor, Healthcare Assistant | **York** | **Nominated by patient**

This young man is a credit to the hospital and to the ward. There is nothing that is too much trouble for him. He is helpful and offers encouragement where he can. Jacob always has a smile and a kind word for everyone. I implore you to give him a Star Award.

Tina Purvis, Healthcare Assistant | **York** | **Nominated by patient**

Tina has been so kind to me and made my stay in hospital a pleasant experience. I have had many falls at home, and I am frightened of having to another fall, but I have been helped by Tina being the epitome of kindness and excellence.

Maisie Sadler, Staff Nurse | **York** | **Nominated by colleague**

A very poorly patient arrived on the ward, without being seen by a doctor in ED, just before handover. Maisie stayed over an hour after her shift had finished to help provide treatment to this patient and assist in all the treatments the doctors wanted actioning.

Maisie had to be prompted to go home at 9pm and her willingness to stay late (the night before her holidays) and help the night staff was appreciated. She liaised with the Critical Care team and the doctors, and provided a thorough handover to the night staff, ensuring nothing was missed for this critically ill patient. Following this, at 5am the next morning, she had checked in with the ward staff caring for this patient, again showing her care, compassion, and commitment.

Eddie Carr, Healthcare Assistant | **York** | **Nominated by patient**

Having experienced awful chemo side effects, Eddie is a bundle of joy, who remembers everyone, how they take they drinks, etc. He is always happy to have a chat about absolutely anything or has a little joke. He makes your time in hospital that little bit more manageable. Thank you, Eddie.

Ward 31 **York** **Nominated by patient**

I have just spent five days on Ward 31, and I could not have asked for better care. Each member of staff was exceptional. A special shout out to Poppy and Margaret who sat and listened when I was upset. Thank to every other member of staff for their constant reassurance, for always doing what they said they would, and for making me and my emotions feel relevant and understandable. I could not have asked for a better team. Thank you.

Clare Scott, Lead Nurse Critical Care Outreach **York** **Nominated by colleague**

I want to take a moment to recognise the incredible work Clare does every single day. Working in outreach is no easy task; it is high-pressure, fast-paced, and emotionally demanding, but Clare goes above and beyond her role without hesitation. She does not just care for critically unwell patients; she looks after the whole team.

Whether it is supporting ward staff so we can take a lunch break, helping with medication rounds, taking observations, or offering a kind word during a tough shift, Clare is always there. Her compassion, calmness, and dedication make such a difference. She never hesitates to offer a debrief after a difficult situation and provides genuine emotional support when it is needed most.

When things feel overwhelming, knowing Clare is around instantly makes you feel more supported and grounded. As a newly qualified nurse, I was incredibly lucky to have her guidance. She never once made me feel like a burden, no matter how many questions I asked, and she took the time to teach, encourage, and build my confidence. Her knowledge is immense, and she is always keen to educate and help us develop our skills. On top of all that, Clare somehow always remembers the little things; checking in with how you are really doing, being available for a quick chat, and lifting everyone's spirits with her smile.

Clare genuinely makes a difference every day, not just clinically (and she does save lives every single day), but emotionally and mentally too. In an emergency, there is truly no one I would rather have by my side. Clare, thank you for everything you do. You are one of a kind, and I am so grateful to work alongside you.

Fritha Tennant, Midwife **Malton** **Nominated by colleague (1) and colleague (2)**

Nomination 1:

Fritha has been an outstanding personal supervisor for a student midwife. She has gone over and above to provide the best learning experience by creating a supportive and welcoming environment. She has encouraged growth and development with her feedback and support.

Nomination 2:

Fritha has been a wonderful personal supervisor throughout my placement as a student midwife. She is amazing at creating a learning environment for students, encouraging me to develop and demonstrate my skills. She is kind and compassionate to students, staff, women, and families.

Lynn Merritt, Advanced Care Practitioner, and Adele Holmes, Senior Healthcare Assistant	**Scarborough**	**Nominated by relative**

Lynn and Adele were fantastic with my fiancé when we came to ED. My fiancé has medical anxiety and becomes stressed about any medical procedure or test. Adele reassured my fiancé perfectly while taking his bloods. Lynn went that extra mile by explaining to him what they believed was going on and gave him options that made him feel heard and reassured for the first time since his problem occurred. These two individuals stood out and fully met the Trust values. Well done and thank you!

Karl Barbaro, Advanced Practice Physiotherapist	**York**	**Nominated by colleague**

A patient with limited mobility arrived by hospital transport three hours early for their appointment. The patient needed to be transferred from their wheelchair to a chair in the waiting area. Karl agreed to see the patient earlier so their wait time was considerably reduced.

Once Karl had finished his consultation, he transferred the patient from the chair to their wheelchair and made sure their needs were met with kindness and empathy. The patient was then able to make their return journey home by hospital transport two hours before their original appointment time. Karl always goes above and beyond, and this example is no exception.

Stephen Cook, Network Engineer	**Bridlington**	**Nominated by colleague**

A colleague based in Hull approached me after suddenly losing access to Staff Room. As Staff Room contains many of our essential policies, procedures, and SOPs, and is a key platform for emergency communication, it is a critical resource for colleagues across all sites.

After several unsuccessful attempts to contact the Y&S digital team to resolve the issue, I reached out to Steve. He immediately recognised the urgency of the situation and took swift action. Steve asked thoughtful questions to fully understand the problem and made it his priority to get it fixed. He worked diligently to identify the root cause and collaborated with partner organisations, such as NHS England and other local trusts, to restore access as quickly as possible.

Throughout the process, Steve was polite, reassuring, and explained everything in a way that was easy for me to understand - even without a technical background. He also followed up after the issue was resolved to make sure it was fixed across all sites, not just the one I had reported. This extra step showed real initiative and care.

Thank you, Steve, for stepping in, grasping how important this was to fix, and resolving it.

Emma Broadley, Waiting List Co-Ordinator, David Sutton, Locum Consultant in Oral Maxillofacial Surgery, and Aidan Adams, Consultant in Oral Maxillofacial Surgery | **York** | **Nominated by patient**

When I was first referred for surgery, Emma took great care to gather all the relevant details of my situation to match my medical needs and my ongoing family responsibilities as an essential carer. She took the time to apply this information and to contact me to secure for me an impending cancellation which, once reallocated, enabled the best, speediest outcome for my referred need for a skilled diagnostic appointment with the relevant consultant, Mr Adams, and the resulting maxillofacial surgery by Mr Sutton.

The preparation, surgery, and after care were excellent, and their skills maximised the treatment provided. I was reassured and provided with necessary detailed information and helpful medical supplies for the recommended ongoing post operative aftercare. This was good for me, and for my husband, who has Waldenstrom's macroglobulinemia. Thank you also for sending me a copy of the feedback letter. I am grateful for the skilled and excellent service I received.

Hope Newman, Staff Nurse | **York** | **Nominated by colleague**

Hope was supportive towards a patient we were scanning. She showed care and compassion and calmed the patient down for their scan.

Kerry Knox, Radiographer Team Manager | **York** | **Nominated by colleague**

Kerry at with me and calmed me down when I was going through a difficult time. She made me feel like my feelings were justified. She was caring and a good listener.

Elizabeth Kaye, Administrator | **York** | **Nominated by colleague**

Lizzie is so valuable to the Children’s Community Nursing Team. She is professional, organised, hardworking and kind, but she is also so much more than that. She is a listening ear for everyone, patients, families and staff. She is empathetic and will always strive to answer questions and queries with patience and accuracy. She never complains and will do her best for everyone. She ensures that all the families on the caseload are safe and will chase us up if she feels things are outstanding.

Lizzie shares a busy office with all the children’s community nurses and children's specialist nurses, and she will greet everyone with a smile and a welcome regardless of how busy she is. We all off-load to her, feeling supported and listened to. Lizzie is the backbone of the team, without whom we would fall apart.

Linda Robinson, Deputy Sister **York** **Nominated by colleagues**

Linda was instrumental in helping the healthcare assistants to achieve their Band 3. She assisted the team by writing a complimentary email about all the clinical tasks that we undertake daily, and the responsibility involved in running the clinic. She is positive on the ward and regularly encourages the staff.

Ward 15 **York** **Nominated by colleague**

I have recently retired as the Ward Sister on Ward 15 and want to highlight what a fantastic, hard working group of staff the ward has. From the senior team onwards, everyone is included and made to feel part of the team.

It has been my privilege to manage this fabulous group of staff, and I really could not have done it without their ongoing support. Trauma and orthopaedics is not an easy speciality and every day brings its challenges, which the team meet head on with a positive can-do attitude.

Monica Dutton, Healthcare Assistant **York** **Nominated by relative**

We were parked in the drop-off zone outside the hospital today and had a stressful time trying to find a wheelchair for my father so he could attend his appointment at the Parkinson's outpatient clinic.

Monica arrived with a patient in a wheelchair and, after ensuring the patient was settled in their transport, she kindly offered to push my father to his appointment. Without Monica's help, my father would not have been able to attend his appointment on time and start the necessary medication. We are grateful for her kindness.

Leanne Crangle, Medicines Management Technician **York** **Nominated by colleague**

I am proud to nominate Leanne Crangle for a Star Award for her outstanding actions that exemplify our Trust values of kindness, openness, and excellence. Her response during a critical situation at the main hospital entrance demonstrated her unwavering commitment to patient care and compassion.

On the day of the incident, Leanne was quick to respond when she heard the screams of a patient who had been knocked down by a vehicle. Without hesitation, she rushed to assist, displaying remarkable bravery. Amid the chaos, she not only provided immediate support to the injured individual but also took the time to collect the patient's glasses, medication, and shoe from the road. This thoughtful gesture ensured that the patient had their essential belongings, which can be overlooked during emergencies.

Furthermore, Leanne handled a delicate situation with exceptional sensitivity when she received a call from the patient's daughter, who was anxiously waiting in the queue to collect her mother. Leanne bravely relayed the unfortunate news about the accident and reassured the daughter that she would personally locate her and escort her to her mother. This action not only calmed the daughter's fears but also embodied kindness by prioritising family connection during a distressing time.

Leanne’s quick thinking and compassionate actions made a tangible difference not only for the patient but also for the daughter, showcasing her dedication to delivering exemplary care. Her ability to remain composed under pressure and her genuine concern for others exemplify the best of our Trust values.

Leanne was deeply affected by this incident, reflecting her empathic nature, yet she continued her fantastic work in pharmacy with unwavering commitment. Her ability to balance her emotional response with professional excellence is commendable. By going above and beyond, Leanne has not only made a significant impact on the individuals involved but has also set a standard for excellence within our team. She is truly deserving of a Star Award.

Daniel Robinson, Administrative Assistant | **York** | **Nominated by colleague (1) and colleague (2)**

Nomination 1:

I am pleased to nominate Dan Robinson for recognition due to his remarkable actions during a recent emergency that had a profound impact on our patients, visitors, and staff. His swift response and dedication truly embodied the Trust's values of kindness, openness, and excellence.

Amid a critical incident, Dan sprang into action, providing immediate medical assistance to a patient in a car. His quick thinking in documenting the scene with photos before any movement was crucial, ensuring essential information was captured for future reference. What truly set him apart was his commitment to enhancing the safety and wellbeing of everyone involved. He expertly retrieved the trauma trolley and cleared safe pathways for patients being transported, showcasing his ability to prioritise patient care under pressure. His efforts to redirect traffic not only ensured the smooth operation of emergency care but also minimised chaos, allowing other staff to focus on their critical roles.

In the heat of the day, Dan went the extra mile by obtaining and distributing water to staff, which was essential for providing comfort and relief during such a stressful situation. This thoughtful gesture demonstrated his genuine concern for the wellbeing of others, aligning perfectly with our value of kindness.

According to those who worked alongside him, his open and collaborative approach in liaising with multi-disciplinary teams facilitated seamless communication and cooperation. By fostering a spirit of teamwork, he ensured that everyone was informed and working effectively together to provide the best possible care.

The tangible difference Dan made today was evident not only in the care provided but also in the sense of calm and support he instilled among patients, visitors, and staff. His outstanding actions exemplify our Trust's mission to deliver excellence in patient care, and I am proud to acknowledge his significant contributions. Thank you, Dan, for your unwavering dedication and for making such a vital impact during a critical moment.

Nomination 2:

While helping with a traffic incident with a medical emergency in the front car park, Dan went to the Staff Shop and, using his own money, purchased water for everyone helping, as it was a stressful experience on an incredibly warm day. This was a kind gesture which I am sure was appreciated by all involved.

Lisa Langton, Patient Pathway Specialist, and Tom Dodd, RTT Patient Pathway Team Leader | **York** | **Nominated by colleague**

As part of our patient waiting list improvement work, there is a significant amount of validation of patients on waiting lists that needs to be done. This is required to ensure that patients are getting the care and treatment they require in terms of next steps on their pathways and to ensure the data quality is improved prior to migration into the new EPR. We have 500,000 open referrals of which identified cohorts need validation.

Lisa and Tom have been working on this project since February 2025, supporting bank staff to undertake administrative validation, linking with operational and clinical teams for clinical validation and providing significant validation capacity themselves and expertise to wider team. This is in additional to their normal roles of RTT validation. Since February, 16,000 patients have been validated in some of our highest risk cohorts.

Tom and Lisa have worked above and beyond their roles to achieve this. They have also supported their wider teams who have been completing additional RTT validation to support the NHSE validation sprint. They have done this with professionalism and kindness, and I wanted to acknowledge the work they are doing to support big improvements in the visibility of patients on our waiting lists and improved data quality.

Catrina Ivel, Specialist Practitioner of Transfusion | **York** | **Nominated by colleague**

A patient who was due to receive a blood transfusion required a cross match taking, however, not enough samples were taken to allow cross matching to take place. The patient needed a new form to have the samples retaken the next day.

This could not be organised locally, so Tina offered to drive to Malton after work to hand deliver the blood form to the patient's home address. This allowed the patient to have their bloods taken the following day therefore not delaying her essential blood transfusion. This is just one example how Tina lives by the Trust values.

Lisa Hinds-Green, Principal Clinical Psychologist | **York** | **Nominated by patient**

I cannot thank Lisa enough for all her help. She is a fantastic psychologist and has supported me through one of the most difficult times in my life.

From day one, she made me feel at ease, and I found it easy to open up to her, something I never thought I would be able to do. Lisa has such a wealth of knowledge and tools that have genuinely helped me move forward, not just emotionally, but also in my career. I have had plenty of sessions with her, and thanks to the strategies she's taught me, I now feel so much more equipped to cope with life's challenges.

What meant the most to me was how she always listened without judgment. I could talk to her about anything, even when I was just venting or feeling at my worst, and I always felt heard, respected, and valued. I am incredibly grateful to have had her support, and I will carry what I have learned with me for the rest of my life.

Hannah Howe, Medical Secretary, and Ash Kumar, Consultant | **York** | **Nominated by relative**

I have been struggling for weeks to get accurate information regarding my husband's prostrate condition for our travel insurance. I did not want to bother the busy staff, but I relented and contacted Hannah. She then asked Mr Kumar, who kindly gave her the information. Hannah sent the required information meaning I can go ahead with the travel insurance. It was lovely that such busy people could take time out to help me so promptly. A massive thank you to Hannah and Mr Kumar.

Lizzie Verity, Midwife | **York** | **Nominated by patient**

Lizzie provided an amazing level of care and kindness to myself and my husband following the premature end of a much-wanted pregnancy. The situation was fraught enough, but complications following delivery meant additional procedures, followed by a surgery, were needed. I was sleep-deprived, scared, in pain, and an emotional wreck. Lizzie took the time to explain in detail what was happening at each stage, making sure I understood and talking through my various concerns.

During the surgery, when my husband could not be with me, she knew I was anxious and did not leave my side. I felt thoroughly supported throughout the whole ordeal. Lizzie later helped us see our baby in a lovely way, which we are grateful for, and we will never forget. We want Lizzie to know how wonderful she is and the difference she made to our experience.

Ruth Popham, Discharge Liaison Officer | **Scarborough** | **Nominated by colleague**

In my role with safeguarding, I can have patients who have been through significant trauma and find their stay in hospital difficult while discharge to somewhere safe is found. Ruth is always an advocate for patients. She is understanding of the difficult situation some of these patients face and is incredibly supportive when finding a safe discharge.

We had a patient who had nowhere safe to go until a refuge placement was found, and as the patient had complex needs it took longer for a place to be accepted. Ruth was always patient, was never pushy, kept in good contact with updates, and was understanding of the situation. She also updated the patient about what we were waiting for when I could not be on the ward. She treated the patient with incredible kindness and understanding and gave her some continuity of care on the ward while she was going through a difficult time.

Ruth exemplifies the Trust values and is credit to safeguarding and the understanding of patients who have suffered significant domestic abuse.

Palliative Care Nurses **York** **Nominated by colleague**

While working on the wards, I found out some upsetting news. Lissy, Kath and Bernie consoled me and helped talk me through things, which was greatly appreciated. They are an incredibly thoughtful team.

The stories they come across daily show just how strong in character and resilient they all are. It amazes me how they can continue being able to practice and work in the manner they do, despite some of the situations they encounter. The palliative care nurses are always there for you to discuss your thoughts and feelings and to have a debrief. They are accommodating and happy to listen to fellow colleagues, patients, and relatives.

The palliative care nurses are a credit to the Trust and have helped me greatly during some tough weeks. They demonstrate the Trust values every day, and I appreciate the kindness that has been shown to me.

Committee Report

Report from:	Quality Committee
Date of meeting:	15th July 2025
Chair:	Lorraine Boyd

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

ALERT
Delays in Medical Review for Outlier Patients were highlighted by the Surgery Care Group as an ongoing issue, with negative impacts on patient experience, flow through the hospital and working relationships and communication. A collaborative, systematic approach will be required to fully understand and address this issue. **Surgical treatment delays following fractured neck of femur** fall well short of the 'within 36 hours' national target (90%) and national average (60 %) at 47% and 55% in York & Scarborough respectively. Business Case for additional trauma lists is in development and, given the poor patient experience and risk of patient harms from prolonged delays, an urgency to addressing this issue was recommended. **Annual Complaints Report** identifies a 49.6% rise in the number of complaints (1221) in 2024/25 compared with 2023/24. Delays in diagnosis and treatment, attitude of nursing and medical staff and poor communication with patients and carers were the outstanding themes. **NICHE report** recommendation that Board level insight into caring for patients with health concerns needs further consideration and strengthening. In addition, significant gaps in assurance relating to training and support for our staff in the care of patients with mental health issues were discussed and will be addressed through the development of comprehensive improvement plans and strengthened collaboration with the mental health provider TEWV. Monitoring will be through Complex Needs Assurance Group reporting into Patient Safety & Clinical Effectiveness who will update and escalate to Quality Committee. Board and CQC will also be kept informed of progress.
ASSURE
3 annual reports and one quarterly report were received and discussed, and an assurance update was provided by Surgery Care Group. **Quality Account,** outlining **a** review of the past year's activity, particularly in relation to the quality and safety of care provided, was presented and reviewed. Progress during the past year towards fulfilling our priority ambitions was outlined and challenges acknowledged. The evidence provided was well aligned to the work of the Quality Committee across the same period. Plans to continue to pursue the aims and ambitions for 2025/26 were outlined and will continue to be monitored through Quality Committee work programme. **Complaints Annual Report** was received, discussed. The Trust meets its statutory obligations for complaints handling. Performance is unchanged from last year with 49% responded to within proscribed timescale in 2024/25. Evidence of improvement work to streamline processes and focus on better learning was shared. Care groups have increasingly taken ownership of this work, with

support, as necessary. Examples of actions taken by the Care Groups to improve services as a result of complaints were provided. Goals to support further improvement in 2025/26 were identified.

Complex Needs Annual Report highlighted the significant progress throughout 2024/25, particularly the development of a clear supporting governance structure and sense of purpose. There remains a significant assurance gap in relation to caring for patients with mental health needs and active plans are in place to address this. Quarterly update reports will come to Quality Committee.

Patient Experience Quarterly Report was received, discussed and approved, highlighting the progress against each of the objectives for patient experience and engagement through Q4 and outlining goals for Q1.

Prescribing Incidents Report was provided to the Committee for the first time to begin to address the gap in assurance around prescribing practice across the organisation.

Major Trauma Peer Review Update was received as requested by the Board. We were presented with an outline of progress to date, mainly focused on current position, and an indication of how further improvements might be made, alongside the supporting business cases that will require to be made and supported. As such an assurance gap remains and a further update was requested.

Nursing Quality Assurance Framework continues to be developed and embedded. Data is triangulated to support understanding of the emerging picture of the clinical area in relation to workforce and quality and the impacts they have on patient care. An Internal Audit report concluded that the framework continues to evolve positively, incorporating a broad and increasingly comprehensive range of data and intelligence sources. Areas for further development were identified and significant assurance was confirmed with respect to the current arrangements.

ADVISE

Critical Care Discharge Delays are impacting on patient experience and an audit is being undertaken to understand the impact of discharge delays on admitting capacity.

Breast Family History Service has been comprehensively reviewed following recent concerns around adherence to NICE guidelines. Appropriate clinical review of potentially affected patients has been undertaken and urgent patients expedited. There is high confidence that the revised service will fully deliver NICE guidance. Improved service is due to commence in September 2025.

Surgical Hub Bridlington achieved GIRFT accreditation following a visit by the national team in April 2025.

Ward G1 refurbishment was completed in June 2025, providing an increased number of side rooms and much improved environment for Urology & Gynaecology patients.

PPH improvement work continues and progress has been made and sustained

Maternity staffing remains an ongoing concern. In addition to the well documented risks to patient experience and staff morale, a significant increase in open incidents, document reviews and priority 1 high level actions in the Single Improvement Plan going off plan, as a result of redeployment to support safe staffing on the frontline. Discussions on funding to close the staffing gap continue.

Maternity CQC Section 31 submission reviewed an Board approval recommended, noting progress on security at the Scarborough site.

Patient experience data is gathered and triangulated It continues to identify the most common threats to the True North goal of excellent patient experience every time as delays in treatment and diagnosis and attitude of (some) staff.

Friends and Family Test uptake remains variable, with a range of 4.28% to 23.04%, and falling. There is currently no effective means of collecting Community FFT data, which represents a significant assurance gap.

Support and oversight of the Volunteering programme was identified as a potential risk. We were assured that the Chief Nurse team are fully aware of this and have a good level of confidence that the programme will be maintained and supported.

The final draft of the NICHE Independent Review of the sad death of a patient under the care of the Trust was discussed, with a focus on how the findings and recommendations will be addressed to ensure appropriate learning and improvement results.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Translation and Interpreting Services is currently undergoing a tender process after exhausted extension periods. There is a recognised risk to patient experience during a transition period.

Patient Experience Facilitator and PALS Administrator roles are currently vacant and remain unfilled due to financial constraints, resulting in a risk to core service provision and to the health and well being of remaining staff, stepping up to cover.

Corporate Risk 727 relating to the non compliance of the Medical Device Outcome Register has reduced following a focussed piece of improvement work.

Refurbishment of maternity estate, including York SCBU, Hawthorn roof repairs and work to deal with RACC in Theatres at Scarborough, all required to be completed by March 2026 to ensure central funding, will increase the risks associated with maternity service. Plans to manage the risk are in development.

Committee Report

Report from:	Resources Committee
Date of meeting:	15 July 2025
Chair:	Helen Grantham

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

ALERT

- Cancer – not meeting trajectory for faster diagnosis standard (FDS) and 62 day waits for first treatment (latter showing deteriorating position)
  - FDS – 67.9% against a trajectory of 71.4% - ranked 128th out of 137 nationally
  - 62 day waits for first treatment – 66.3% against trajectory of 70.1% - ranked 102nd out of 145 nationally
  - risk that year-end target will be missed
  - some positive areas with colorectal, gynaecological and urology particular areas of concern
  - diagnosis hindered by some primary care providers not pre-screening patients (particular issue with dermoscopy)
  - impact of diagnostics – see below

- Diagnostics – deteriorating position
  - 64% against trajectory of 70.5% - ranked 138th out of 157 nationally
  - reviewing phasing of CT replacement to maximise ability to diagnose across clinical areas and potential use of external providers
  - improvement expected in endoscopy following recruitment

- RTT – significant increase in total waiting list (TWL) due to ongoing review of all waiting lists and movement of some patients to RTT list
  - 53307 against trajectory of 46,079 (TWL)
  - 84th out of 152 nationally for proportion of waiting over 52 weeks
  - 102nd out of 152 nationally for waits under 18 weeks
  - explanations provided to NHS England due to NHSE focus on increasing TWL trusts
  - Committee monitoring waiting lists review work - process/training key for non-recurrence

- Rapid access chest pain metric significantly below target – plans in place – being monitored

- Maintaining operational performance over weekends a continuing challenge due to staffing issues – being analysed and plans to mitigate future risks being put in place

- Some areas of concern from national education/training survey for medical colleagues

- Resident doctors have approved strike action – mitigation plans being developed

- Other unions conducting indicative ballots

- Wellbeing rooms – York and Scarborough – delays in staff moves impacting delivery – urgent action needed due to deadline for spend

- Cyber security – see below

- £1.9m behind budget – discussions on FY risk, cost improvement plan, phasing, sparsity and ERF payments and cash

ASSURE

- Good progress on Emergency Care Standard, 12-hour trolley waits and ambulance handover with work still to do
  - ECS 69.4 % against a target of 70% - 87th out of 121 providers nationally
  - Average Ambulance handover times continue to improve ahead of trajectory at 21 minutes and 34 seconds against a trajectory of 36 minutes and 50 seconds
  - 12% of type 1 admissions spent over 12 hours in ED ahead of a 14.2% trajectory
  - Against a backdrop of significant increase in type 2/3 attendances with decrease in type 1

ADVISE

- Positive progress shown on nursing and AHP priorities
- Positive progress on appraisal/revalidation for medical colleagues – more to do on mandatory training
- Process for agreeing medical agency spend noted – Director of Workforce & OD and Medical Director to approve
- Planning ongoing for organisational change – potential timing and budget impact noted
- Committee reviewing approach to agenda/papers to focus on exec delivery in key areas/risks

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Final risk report in current format – future reports will be in line with previous Board discussion
- The risk management report to include updates from Risk Sub-Committee– key items discussed/actions/timing etc
- Cyber security – action to address NHS benchmark – Digital Sub-Committee monitoring
- EPR – delivery of project and realising benefits – proposal for development session at Board
- Cancer faster diagnosis and diagnostics performance – see above

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

TRUST PRIORITIES REPORT

July 2025

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Executive Summary

True North Priority Metrics

NHS
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Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
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%		
Percentage recommending the Trust as a place to work (quarterly - data source is PULSE, Staff Survey data omitted for Q3)	2025-04			39.6%		
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2025-06			3.6	3.5	3.9
ED - Emergency Care Standard (Trust level)	2025-06			69.4%	70%	78%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-06			12%	14.2%	8.9%
Cancer - Faster Diagnosis Standard	2025-05			67.9%	71.4%	80.1%
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-06			59.2%	55.5%	60.5%
Inpatient Acquired Pressure Ulcers - Category 2	2025-06			69	60	60
Total Number of Trust Onset MSSA Bacteraemias	2025-06			6	6	7

Executive Summary:

Everything we do at YSTHFT should contribute to achieving our ambition of providing an 'excellent patient experience every time'. This is the single point of reference to measure our progress.

The Trust has adopted the True North approach. This approach is designed to provide a clear and focused measurement of progress towards achieving the Trust's key transformational objectives for 2025/26. The True North metrics are the core measures that have the highest priority for the Trust's direction of travel.

Ten True North metrics have been identified as part of the development of the Trusts strategy. Nine are displayed here with the tenth: *Achieve Financial Balance* referenced in the Finance section of this report. In June 2025 six True North metrics improved, three were static and one deteriorated.

TPR metric performance to note for June 2025:

Special Cause Improvement – Pass (defined by NHSE Make Data Count methodology as "improving nature where the measure is significantly higher. The process is capable and will consistently pass the target"):

- Operational Performance - Overnight general and acute beds open
- Maternity - Community Midwife called into unit – Scarborough
- Workforce - Twelve month rolling turnover rate Trust (FTE)

Special Cause Concern – Concern (defined by NHSE Make Data Count methodology as "concerning nature where the measure is significantly lower. The process is not capable and will fail the target without process design"):

- Operational Performance – Number of non-elective admissions
- Operational Performance - RTT – Total Waiting List
- Operational Performance – Children & Young Persons: RTT – Total Waiting List
- Operational Performance - Trust waiting time for Rapid Access Chest Pain Clinic seen within 14 days of referral received.
- Operational Performance - Diagnostics – Proportion of patients waiting <6 weeks from referral – MRI.
- Operational Performance - Diagnostics – Proportion of patients waiting <6 weeks from referral – Audiology.

NHS
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OPERATIONAL ACTIVITY AND PERFORMANCE

July 2025

Headlines:

- The June 2025 Emergency Care Standard (ECS) position was 69.4%, against the monthly target of 70.0%. This is the highest monthly performance since August 2023. In the latest available national data (May 2025) the Trust ranked 87th of 121 providers nationally. **ECS performance is a True North metric.**
- Average ambulance handover time in June 2025 was significantly ahead of trajectory at 21 minutes 34 seconds against trajectory of 36 minutes 50 seconds. This was the lowest handover time since monitoring started. There were no handovers over two hours in June 2025; there were 208 in the 6 weeks from the start of April.
- 12% of type 1 patients spent over 12 hours in our Emergency Departments during May 2025, ahead of the monthly improvement trajectory of 14.2%. **This is a True North Metric.**
- In June 2025, the proportion of patients in our care who no longer meet the criteria to reside was 16.6% against the internal trajectory of 14.4%.

Factors impacting performance:

- In June we continued to embed the established Tests of Change at both York and Scarborough Emergency Departments. These include maximising the use of our Urgent Treatment Centres and sending more patients directly to Same Day Emergency Care and specialty wards. These changes correspond with the improvements in ECS performance.
- Maintaining performance on Fridays and Saturdays is a challenge. The Trust was on track to exceed the ECS performance trajectory for June until the final weekend of the month, when performance dropped significantly. A root cause analysis for poor performance on Saturday 28th June 2025 at Scarborough is underway. This is to ensure that lessons are learned which can support avoiding or mitigating future similar incidents.
- The average non-elective Length of Stay (LoS) for patients staying at least one night in hospital was 6.2 days during June 2025 (3,798 spells of care covering 23,725 bed days). This was ahead of the trajectory to have an average LoS for this cohort of less than 7.0 days submitted as part of the 2025/26 annual planning process.
- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) was 87.4% (3,353 patients out of 3,836), behind the trajectory of 87.6% 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, behind the submitted trajectory of 3.5 days. **This is a True North Metric.**
- The number of non-elective admissions continues to be a challenge, above the upper control limit for the second time in three months.

Actions planned in July 2025:

- Scarborough Emergency Department will test increasing UTC capacity, which has worked well in York, as well as streaming GP letters direct to specialty.
- York Surgical Assessment Unit is removing 'bring back' patients, which will free up capacity for emergency presentations.
- Medical SDEC will be trialling removing Gastroenterology and Renal Medicine 'bring back' patients, creating more capacity for unscheduled care.

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

Acute Flow (1)
Scorecard

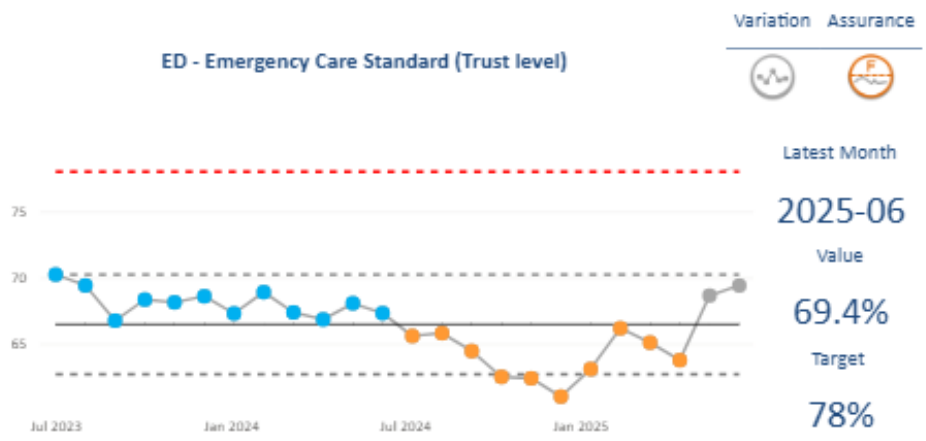
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2025-06	H		77.9%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2025-06			30.8%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-06		F	12%	14.2%	8.9%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2025-06			1299		
ED - 12 hour trolley waits	2025-06		F	377		0
ED - Emergency Care Attendances	2025-06		F	18780	16446	16377
ED - Emergency Care Standard (Trust level)	2025-06		F	69.4%	70%	78%
ED - A&E attendances - Type 1	2025-06		?	10773	11046	10999
ED - Emergency Care Standard (Type 1 level)	2025-06	H	F	50.2%	57%	69.2%
ED - A&E Attendances - Types 2 & 3	2025-06		F	8007	5400	5378
ED - Median Time to Initial Assessment (Minutes)	2025-06	L		4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-06			45.1%		

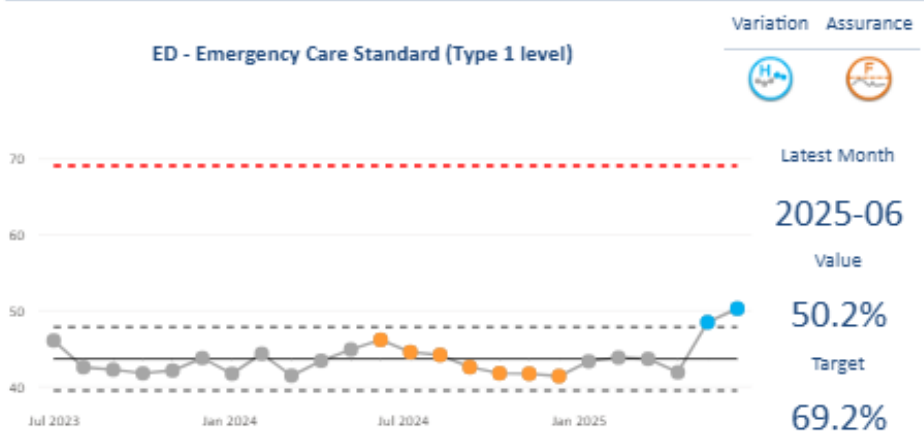
Executive Owner: Claire Hansen

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 **improved** from the previous month, with a difference of **0.8**.



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

The latest months value has **improved** 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. **This is a True North Metric. SPC2:** Modelling showed that to achieve 78% as a Trust Type 1 performance needs to be at least 69%.

What actions are planned?

Alongside continuing to embed the tests of change already established, more changes are planned in July 2025:

- Increase capacity and use of Scarborough Urgent Treatment Centre
- Increase streaming directly to specialty at Scarborough
- Evaluate and develop the new pathway: Emergency Department Ambulatory Care (EDAC) including moving to a new space in York
- Remove bring backs from York Surgical Assessment Unit and Medical SDEC

A root cause analysis into particularly poor performance days is in progress to understand how this can be mitigated in future. The EDAC service has been piloted at both sites with slightly different models. The Scarborough model has been less successful. A review into this model and opportunities for improvement is underway.

We are continuing to embed consistent huddles and board rounds in the Emergency Departments to improve performance.

What is the expected impact?

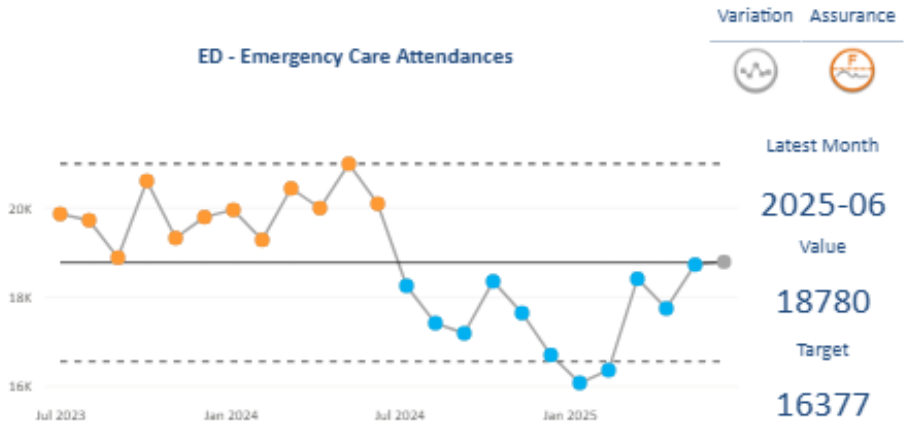
The July 2025 improvement trajectory is 71.1% and teams across all sites will be supported to focus on consistency to ensure we achieve this.

Potential risks to improvement?

There is a risk that while small-scale improvements can still be made, reaching a performance level of 78% may require larger scale changes and financial investment. Additionally, teams may become fatigued by multiple changes or feel they have not had sufficient opportunity to input. The Task and Finish groups continue to encourage high levels of communication and engagement through cascades.

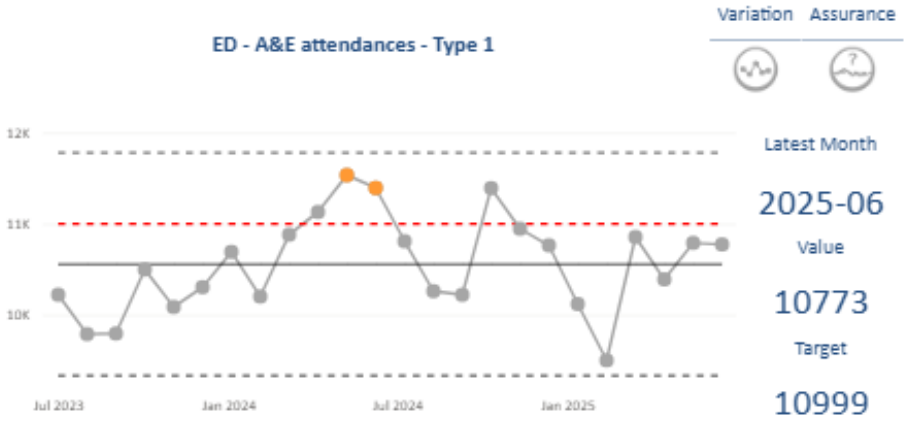
Executive Owner: Claire Hansen

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 **62.0**.



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 **17.0**.

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

What actions are planned?

System partners continue to come together at the Community Improvement Group, to report on and discuss acute-avoidance initiatives.

In June 2025 Yorkshire Ambulance Service finalised their pathways priority plan for this financial year. Included in YAS priorities are increasing use of SDEC, virtual ward and UTC services; the Trust will work with YAS to support this ambition.

What is the expected impact?

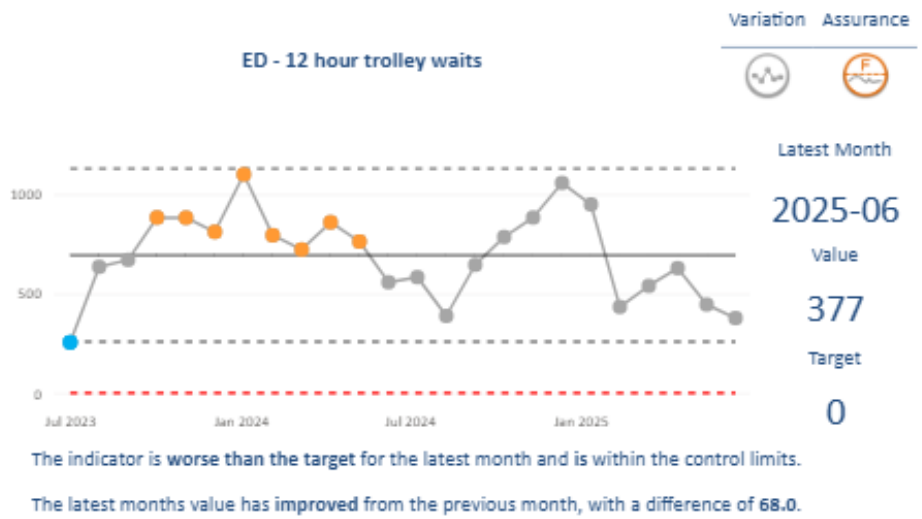
Increasing utilisation of alternative pathways may reduce conveyances to acute sites and could reduce the *proportion* of Type 1 activity. However, attendance numbers could still rise in-line with overall demand.

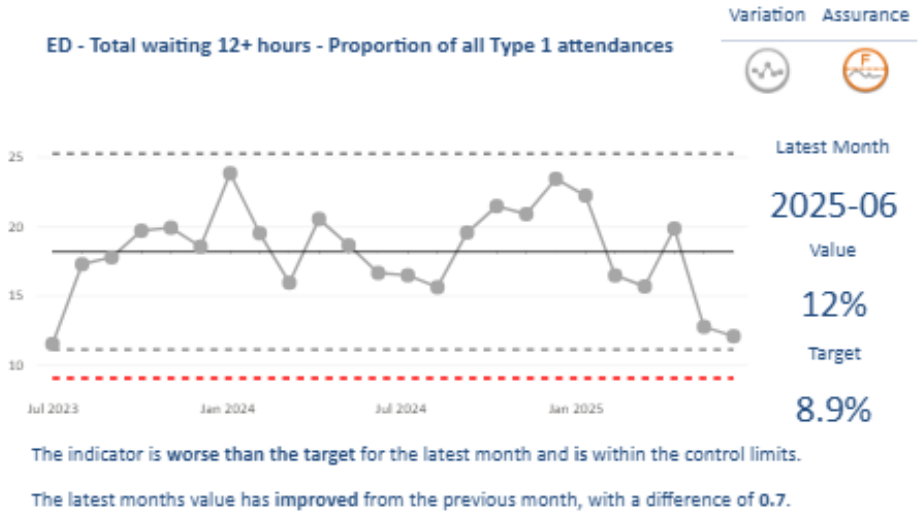
Potential risks to improvement?

We currently have insufficient urgent community response capacity to manage more patients at home; capacity and demand planning is underway and will be presented to the Community Improvement Group in July 2025 with options for next steps.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

Changes made in May 2025 at both acute sites had a significant positive impact on waits in the Emergency Departments. Sustaining improvements in June 2025 reflects the fact that teams are feeling the positive impact of improvements and continuing to support them.

12-hour trolley waits are at their lowest since July 2023, despite high occupancy rates causing delays for an admission bed.

The Quality Standards, which outline professional principles which must be upheld (and escalated when not) will keep patients moving forward in their healthcare journey. These are to be launched ahead of winter.

What is the expected impact?

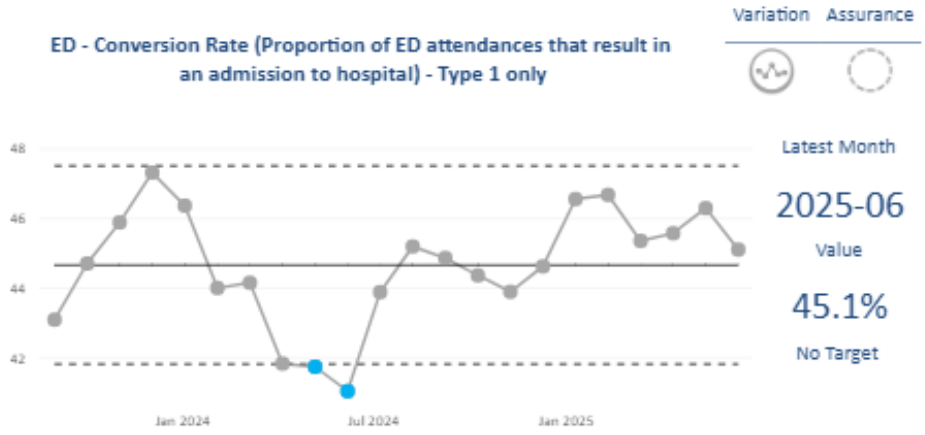
Continuing to use continuous flow, along with discharge improvement work to support improved board rounds and ward processes, will support a continued reduction in long waits for admission.

Potential risks to improvement?

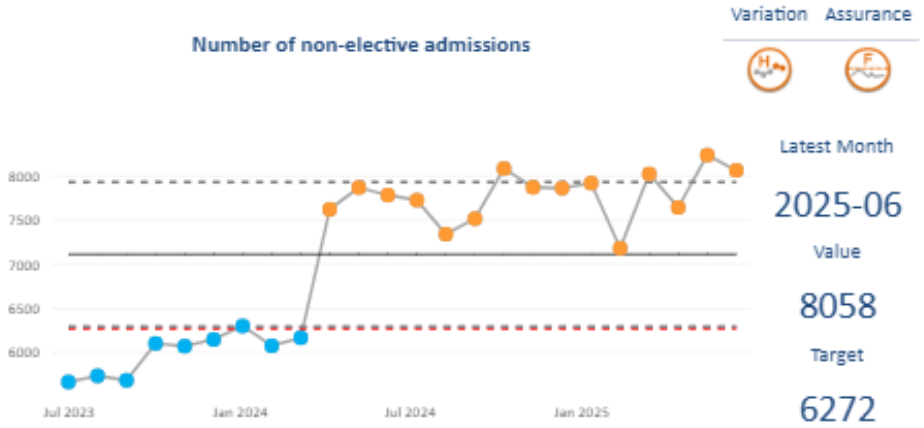
There is a risk that while current improvements should be sustained, further improvements will require more radical change that teams may not be ready to make and/or may require additional investment.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **1.2**.



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 **172.0**.

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.

Note: The data includes admissions to all Same Day Emergency Care (SDEC) units. Work is underway to ensure more appropriate patients are admitted to SDEC from our EDs, therefore increases are not necessarily indicative of an issue.

What actions are planned?

Emergency Department Ambulatory Care (EDAC) is a new Type 1 pathway within each Emergency Department. Where staffing allows, senior expertise is front-loaded to support appropriate risk management and avoid over-medicalising patients who do not require extensive diagnostics and/or admissions.
The success of this model has been varied between the two ED sites. We are undertaking audits to understand the impact of EDAC on waiting times, diagnostics and admissions. This will then support an action plan to improve performance, particularly at Scarborough.

What is the expected impact?

Maximising the use of EDAC should safely reduce diagnostics and admissions.

Potential risks to improvement?

Resus and Paediatrics pathways take precedent over EDAC and when staffing levels do not allow all functions to safely operate, EDAC ‘closes’.

A Task and Finish Group is considering future ED workforce model options. The model and recommendations will be based on data from our Trust, benchmarking data from other Trusts, national guidance, and the changes recently made to functions and processes within the EDs. The model will consider the skill mix and seniority required in the departments at all times of day and night to run all functions safely.

Acute Flow (2)
Scorecard

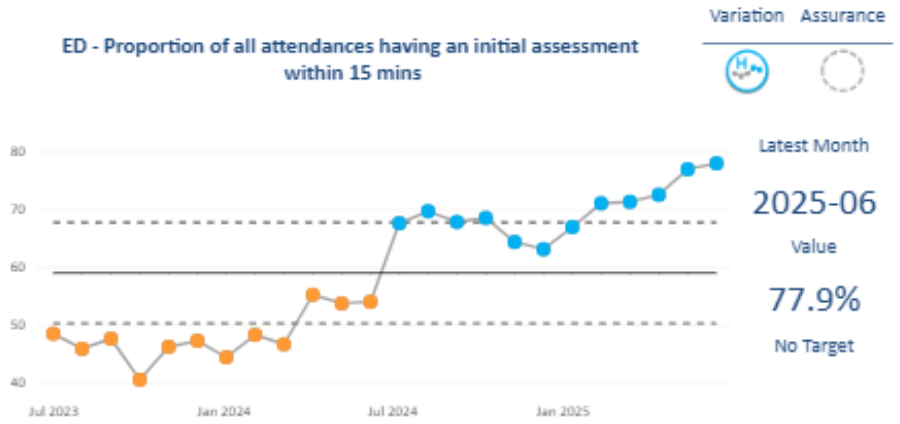
York and Scarborough Teaching Hospitals NHS Foundation Trust

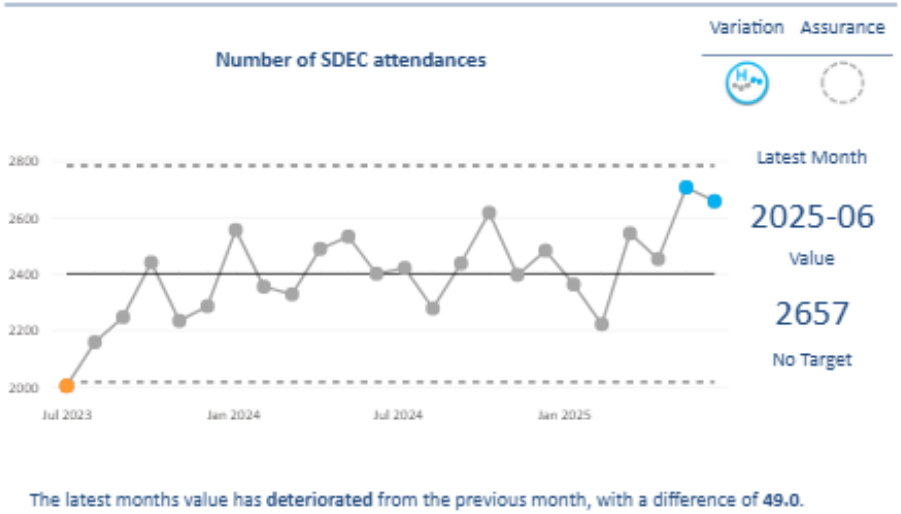
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

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	2025-06			45.1%		
Number of SDEC attendances	2025-06	H		2657		
Proportion of SDEC attendances transferred from ED	2025-06			65.9%		
Proportion of SDEC attendances transferred from GP	2025-06			27%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-06	H		65%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-06			15.3%		
Number of RAFA attendances (York Only)	2025-06			145		
Number of attendances at SAU (York & Scarborough)	2025-06			932		
ED - Proportion of Ambulance handovers within 15 mins	2025-06	H		38.4%		
ED - Proportion of Ambulance handovers waiting > 30 mins	2025-06	L		22.2%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2025-06	L	F	5.8%		0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2025-06	L	?	0%		0%
ED - Number of ambulance arrivals	2025-06	H		4787		
ED - Ambulance average handover time (number of minutes)	2025-06	L	?	22	36	29

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

Further improvements have been made in the proportion of patients having an initial assessment within 15 minutes of arrival.

Two Tests of Change are planned in July 2025. One is to remove 'bring back' patients from York Surgical Assessment Unit for pathways shown to be likely to have a positive impact. The second test of change for July 2025 is to remove Gastro and Renal 'bring back' patients from Medical SDEC at York. These are the first tests, with a view to expand the pilot to cover more inappropriate admissions to SDEC.

In May we launched a Test of Change at York, whereby stable patients arriving to ED with a GP letter advising an SDEC attendance are sent directly to SDEC without an ED triage. An average of 12 patients per weekday have been sent directly to SDECs. In July we aim to roll this out to Scarborough as well.

What is the expected impact?

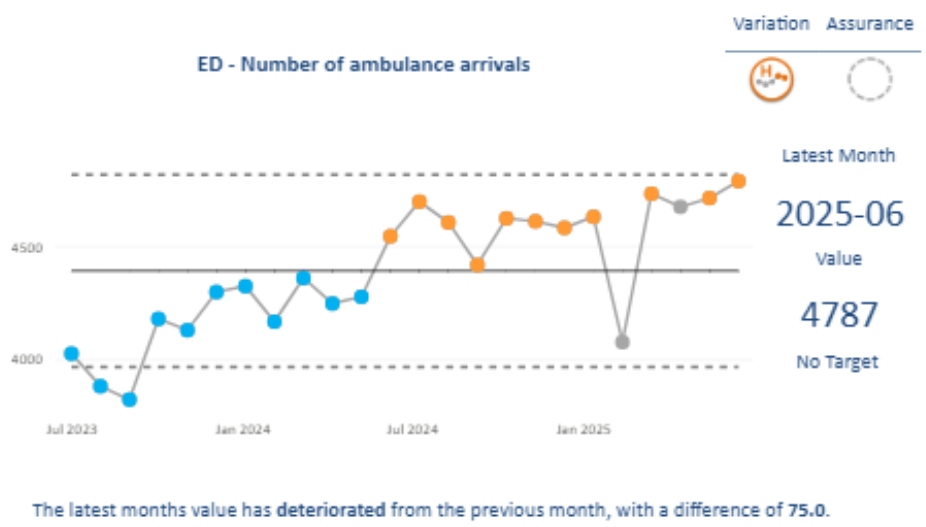
The two tests of change planned for July 2025 should reduce bring back activity by 20% in each unit. This in turn will allow for more direct SDEC admissions and quicker movement of patients from ED to SDEC.

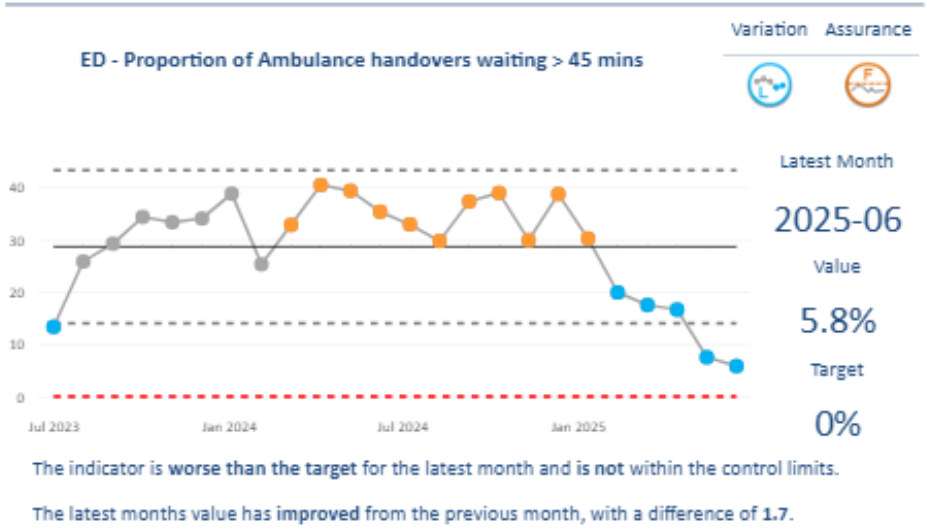
Potential risks to improvement?

There is a risk that the number of patients impacted by the test of change is lower than expected, which will limit the impact felt in the Emergency Department.
There is a risk that the number of patients impacted by the test of change is higher than expected, putting more pressure on specialty teams who could be unable to find appropriate and safe solutions for seeing their elective patients outside of SDEC.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

Despite an increase in ambulance arrivals there was another reduction in ambulance handovers waiting over 45 minutes in June and are significantly out-performing our improvement trajectory for average handover times.

What actions are planned?

The teams at both sites continue to follow processes to limit ambulance handover times as far as possible.

What is the expected impact?

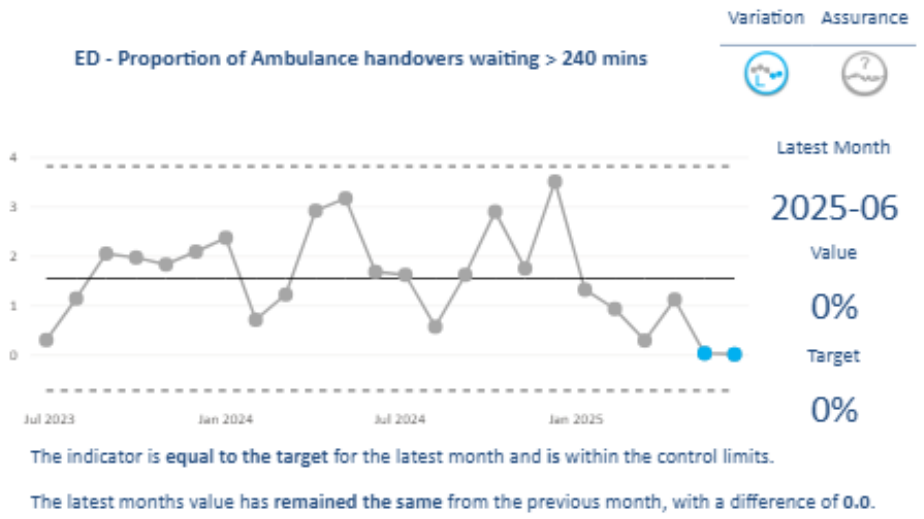
It is expected that we can continue to deliver swift handovers for patients and for Yorkshire Ambulance Service crews, which in turn increases the capacity to respond to 999 calls.

Potential risks to improvement?

There is a risk that ambulance arrivals continue to increase, making safe management of handovers more challenging.

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 • Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside
COMMON CAUSE / NATURAL VARIATION		• Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD) • Of those overnight general and acute beds open, proportion occupied • Community bed occupancy/availability	
SPECIAL CAUSE CONCERN			• Number of non-elective admissions

Acute Flow (3)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

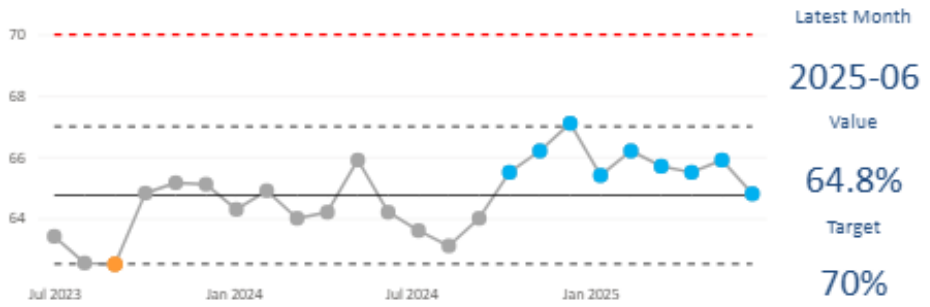
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2025-06	H	F	79.8%		90%
Patients with Senior Review completed at 23:59	2025-06			49.3%		
Inpatients - Proportion of patients discharged before 5pm	2025-06	H	F	64.8%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2025-06	H		1174		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2025-06	L	F	16.6%	14.4%	12.5%
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2025-06		?	3.6	3.5	3.9
Number of non-elective admissions	2025-06	H	F	8058	6365	6272
Number of zero day length of stay non-elective admitted patients	2025-06	H	?	2667	2500	2464
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2025-06			125		
Overnight general and acute beds open	2025-06	H	P	875	832	832
Of those overnight general and acute beds open, proportion occupied	2025-06		?	92.1%		92%
Community bed occupancy/availability	2025-06		?	92.9%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

Inpatients - Proportion of patients discharged before 5pm

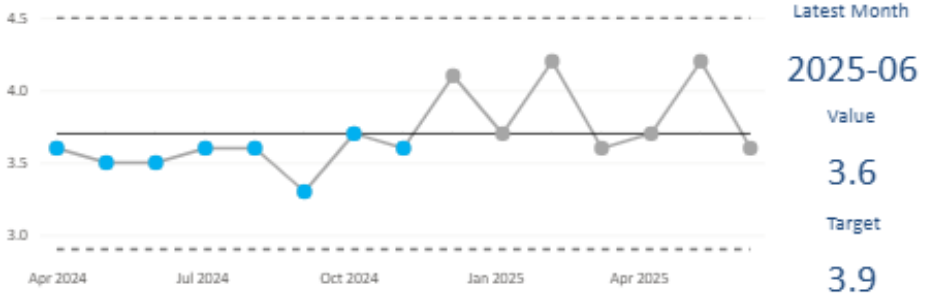


The indicator is **worse than the target** for the latest month and is within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **1.1**.

Variation Assurance

Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)



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

Rationale: Understand flow in the acute bed base.
Target: SPC1: Internal target of 70%. **SPC2:** To reduce the average number of beds days between the time a patient is assessed and fit for discharge to when a patient returns to the place they call home to less than 3.9 days.. **This is a True North Metric.**

What actions are planned?
The new 'visual hospital', which is an output of the Discharge Sprint working earlier in the year, has launched on six wards with support to use the tool. ECIST visits are planned throughout July 2025 to support board round improvements and the ECIST medical lead is supporting education sessions being led by an acute physician at Scarborough.

The first full draft of the Discharge to Assess model has been created with system partners and shared for further input and comment. Further process mapping to add details is scheduled in July 2025.

Additional step-down community provision has been identified in City of York with additional capacity for ten patients becoming available in July 2025.

There is an ambition to increase ward level ownership of key performance indicators, in line with Ward Excellence meetings. Leadership from Head of Nursing and Head of Allied Health Professionals will share key metrics so that teams understand what is being reviewed.

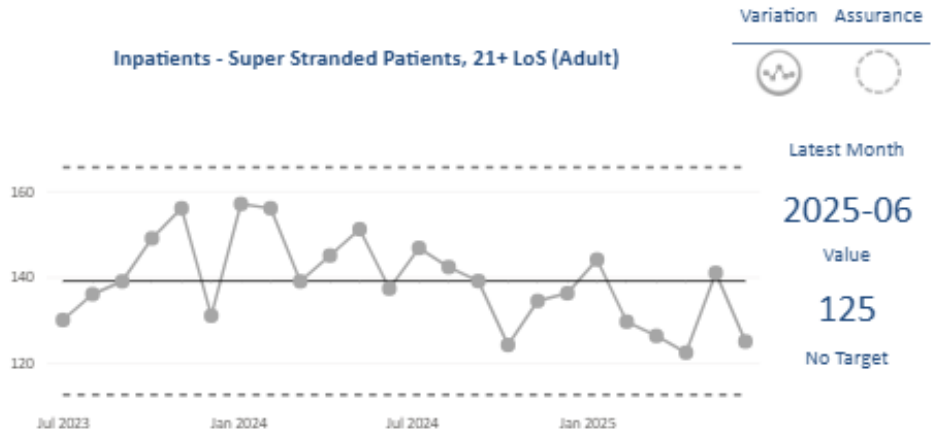
What is the expected impact?
The additional step-down capacity will have a positive impact on our no criteria to reside position and bed days lost.

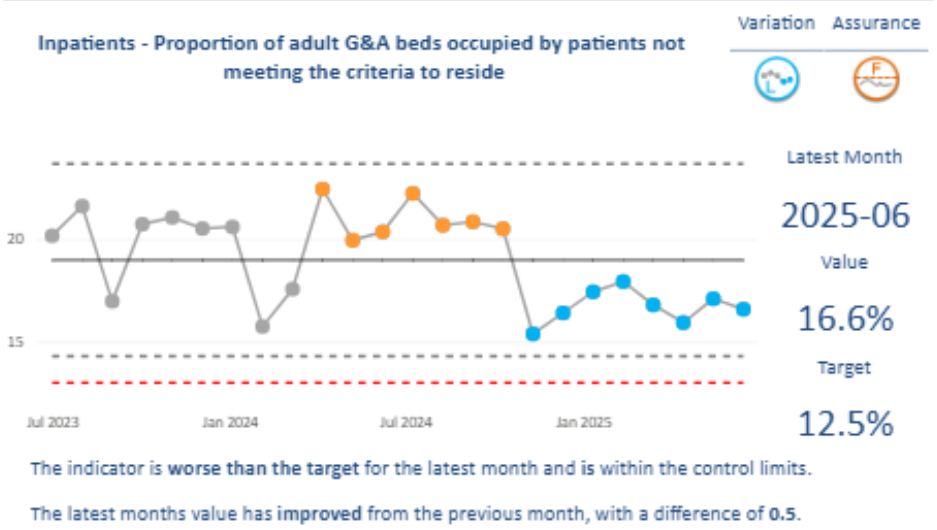
Supporting frontline teams to better understand the key performance indicators may focus attention and improvements in the areas that will have most impact. It will also give ward staff a sense of ownership and a sense of pride when improvements are made.

Potential risks to improvement?
Given the number of different stakeholders that require input into the Discharge to Assess model, there is a risk that over the summer period it will be impossible to bring everyone necessary together to progress at the pace required.

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.

What actions are planned?

The re-launched Long Length of Stay (LLoS) reviews for medical patients continue and feedback is that the format and process is working well, with wards dialing in at allocated time slots. There is good attendance from ward sisters and therapists, with support from the Care Group Director and Associate COO for awareness and understanding of issues. There is a view that support and attendance from ward-based medics would increase tangible outputs and more discharges.

One theme identified is linked to the neurology pathways; this is going to be mapped out to understand possible improvements to support complex neurology patients to receive timely rehabilitation.

What is the expected impact?

As long length of stay reviews continue, and the team starts to reduce the threshold from 21+ days to 14+ days, we should identify more themes which need to be investigated and addressed through improvement work. Successfully doing this will lead to further improvement in the number and proportion of super-stranded patients in our care, which will improve flow through ED.

Potential risks to improvement?

There is an issue that without more medical presence at the meetings, outputs and impact are limited.
There is a risk that uncovering more themes through the reviews will lead to more improvement work than there is resource to undertake. In this case, prioritisation would need to take place using data to understand where to focus efforts.

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

- The Cancer performance figures for May 2025 saw performance against the 28-day Faster Diagnosis standard (FDS) of 67.9%, failing to achieve the monthly improvement trajectory of 71.4%. In the latest available national data (April 2024) the Trust ranked 128th out of 137 providers nationally (March: 134th). **This is a True North Metric.**

- 62 Day waits for first treatment May 2025 performance was 66.3%, with the monthly trajectory of 70.1% was not achieved. In the latest available national data (April 2024) the Trust ranked 102nd out of 145 providers (March: 107th). The HNY cancer alliance footprint remains one of the lowest performing in the country for 62 days.

- 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 2026.

Factors impacting performance:

- May 2025 saw the highest volume of referrals ever seen at the trust, at 3,049. This is the first time the Trust has received over 3,000 referrals in a month and all cancer sites except for lung saw an increase of referrals. Colorectal (626 referrals in May, compared with 510 referrals in April), Breast (502 referrals) and Skin (437 referrals) had the highest number of referrals per cancer site.
- The following cancer sites exceeded 80% FDS in May 2025: Breast, NSS, Skin & Upper GI.
    - Head and Neck, NSS, Skin, Upper GI and Urology achieved above their internal trajectories.
- The following cancer sites exceeded 75% 62-day performance in April: Breast and Skin and Upper GI.
    - Skin and Urology achieved above their internal trajectories.
- 31-day treatment standard was 96.8% overall. 280 1st treatments were delivered in May, with 9 patients breaching. April was the second highest treatment volume month in 12 months; however, May was lower by 46 treatments. Urology had the highest volume of treatments delivered (59) and achieved 98.3%. Breast delivered 42 treatments and achieved 100%. Colorectal and Skin both had the largest number of breaches (3 each).
- At the end of May, the proportion of patients waiting over 104+ days equates to 1.1% of the PTL size with 26 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			
COMMON CAUSE / NATURAL VARIATION		• Cancer - 62 Day First Definitive Treatment Standard • 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

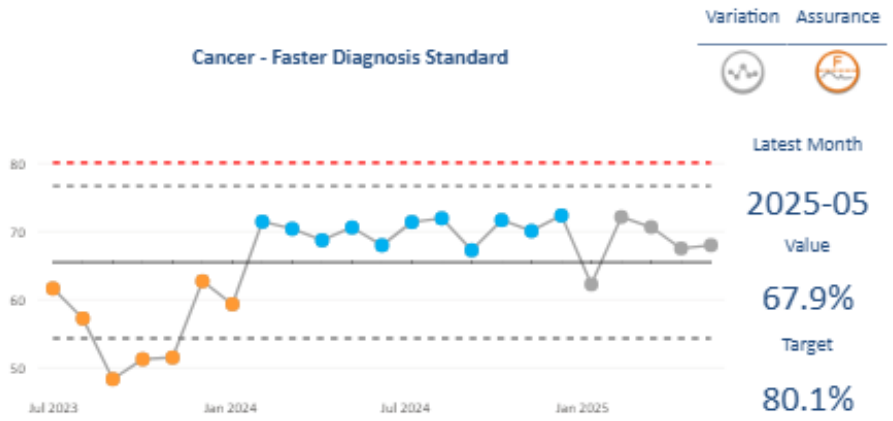
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

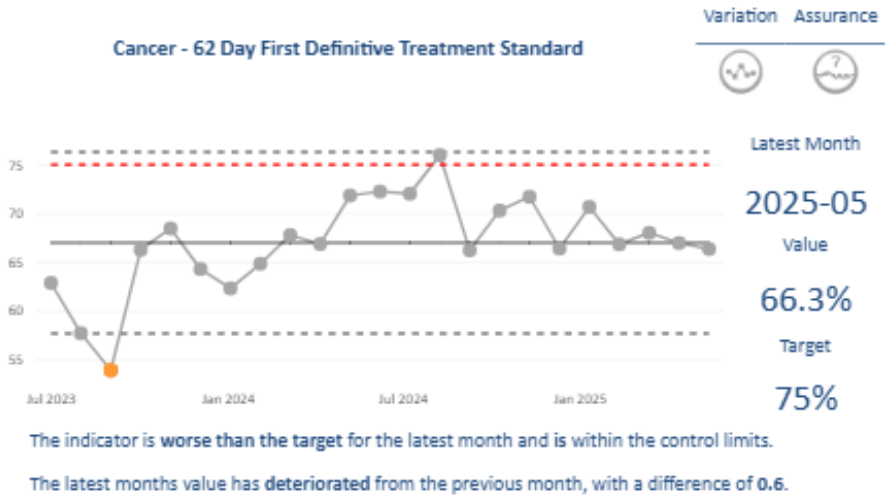
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard	2025-05		F	67.9%	71.4%	80.1%
Cancer - 62 Day First Definitive Treatment Standard	2025-05		?	66.3%	70.1%	75%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2025-06			169		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2025-06			6.7%		
Cancer 31 day wait from diagnosis to first treatment	2025-05		?	96.7%		96.1%
Total Cancer PTL size	2025-06	L		2288		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2025-06		F	69.9%	80.1%	80.2%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





Rationale: SPC1: Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. **This is a True North Metric. 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.

What actions are planned?

- Progressing cancer alliance service development funding SLA to confirm £1.3 million of cancer transformation funding.
- Delivery of targeted improvement plans.

Colorectal Plan

Frailty pathway discussions in progress. Refresh of Rapid Diagnostic Centre (RDC) redirect pathway for colorectal patients who are suitable. Ongoing discussions with clinical lead around widening Straight to Test (STT) criteria. Plans to recover colonoscopy capacity linked to endoscopy actions detailed in diagnostic recovery plan. Additional weekend theatre lists expected to start end of June 2025 to increase surgical treatment capacity.

Urology Plan

STT CT model in haematuria pathway being taken through departmental governance structures however capacity in radiology unable to support at this time. Recruitment of additional Surgical Care Practitioners completed and commenced in role, to be trained on biopsies over coming months.

Gynaecology Plan

Discussions taken place with operational and clinical team, capacity and demand tool completed. Locum consultant to provide additional sessions to recover position. ICB sign off for PMB pathways, estimated implementation date September 2025. Working through a bid for Pipelle clinics in Community Diagnostic Centre with CAP.

What is the expected impact?

Expected impact articulated in waterfall diagrams presented at Trust Board in May 2025. Each cancer site has own trajectory for FDS and 62 day, to achieve month and year end position against national targets.

Potential risks to improvement?

- Cancer performance dependent upon diagnostic capacity and recovery plans.
- Referral volumes across majority of cancer sites exacerbating demand and capacity gap for 1st OPA across all cancer sites.
- Emerging Risk: Skin Pathways- Interim funding from the ICB via a Local Enhanced Service (LES) to ceased on 1st April 2025 for referrals from primary care accompanied by dermoscopy images. Compared to April/ May 2024, 15% year on year increase in referrals. May was the highest number of referrals received in a month ever.
- Seasonality- patient & staff unavailability due to planned holidays/ annual leave.
- East Coast locum provision (lung) wider discussions around locum pay rates.

Headlines:

- At the end of June 2025, the Trust had fifteen **Referral To Treatment (RTT) patients waiting over sixty-five weeks**, a reduction of twenty-one from May 2025. The Trust declared one RTT78 week waiter, this patient was returned to the Trust having previously transferred to Independent Sector provider in December 2023. The patient was not treated in line with the RTT Rules which is being investigated by NHSE. The patient had their clock stopped on the 3rd of July 2025.
- The Trust's **RTT Total Waiting list position** ended May 2025 behind the trajectory submitted to NHSE as part of the 2025/26 planning submission: 53,307 against the trajectory of 46,090.
- The Trust is ahead of the trajectory for the proportion of the **RTT waiting list waiting under 18 weeks**: 59.2% against 55.5%. In the latest available national data (April 2025) the Trust ranked 102nd out of 152 providers (March 2025: 120th). By March 2026, the intention is that the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally. **This is a True North Metric.**
- The Trust is behind the **RTT52 week** trajectories submitted within the 2025/26 planning submission; 1,593 waiters and 3% of the total RTT Total Waiting list against the trajectories of 1,013 and 2.2%, respectively. In the latest available national data (April 2025) the Trust is 63rd in terms of the highest number of RTT52 week waiters (65th at end of March 2025) and is ranked 84th out of 152 providers for the proportion of the TWL waiting over 52 weeks (March 2025: 90th). Nationally at the end of April 2025 there were 186,464 RTT patients waiting over 52 weeks. 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 61.7% against the end of June 2025 ambition to be above 56.6%. There is currently no nationally available comparative data available for this metric.

Factors impacting performance:

- RTT Total Waiting List metric impacted by ongoing validation work on the Outpatient Patient Tracking List (PTL), resulting in circa 2,500 additional RTT clocks being opened in June 2025. There has not been any RTT65 week performance risks identified in this work to date.
- Delivery of the 2025/26 elective recovery plan; initial analysis shows that at the end of June 2025 the Trust was ahead of the 2025/26 plan with a provisional performance of 101% against the funded plan.

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 78 weeks for incomplete pathways • 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			
SPECIAL CAUSE CONCERN			• RTT - Total Waiting List

Referral to Treatment (RTT)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
RTT - Total Waiting List	2025-06	H	F	53307	46090	38992
RTT - Waits over 78 weeks for incomplete pathways	2025-06	L	F	1		0
RTT - Waits over 65 weeks for Incomplete Pathways	2025-06	L	F	15	0	0
RTT - Waits over 52 weeks for Incomplete Pathways	2025-06	L	F	1593	1013	389
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-06	H	F	59.2%	55.5%	60.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2025-06	L		17.6		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks	2025-06	L	F	3%	2.2%	1%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2025-06			61.7%	56.6%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2025-06			1.8%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2025-06	L		11.9%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2025-06	L		66.4%		

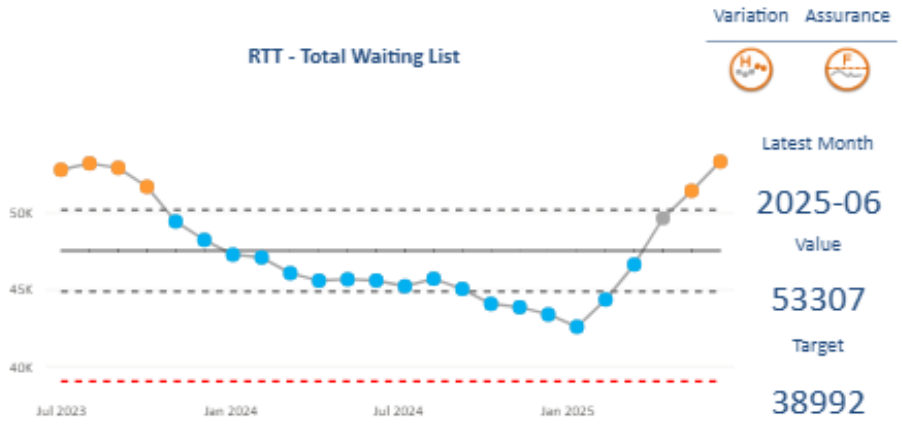
KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

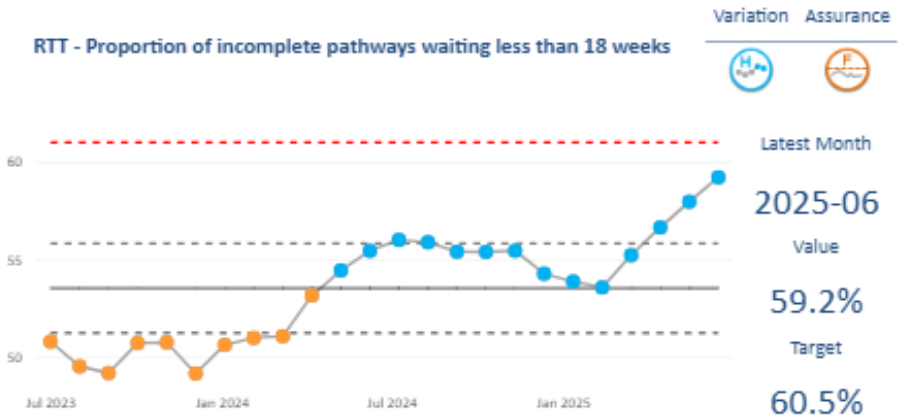
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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 **1903.0**.



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

The latest months value has **improved** from the previous month, with a difference of **1.2**.

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%. **This is a True North Metric.**

What actions are planned?

- 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 set the Trust a minimum target of stopping 31,543 RTT clocks during Q1. At the end of the twelve weeks the Trust stopped 35,751 RTT clocks (4,208 above the baseline). The Q2 sprint commences on the 7th of July with NHSE setting the Trust a target of 29,975 RTT clock stops.

- 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 Operational productivity group. There is a focus on outpatient utilisation which improved to 74.1% in June 2025 which is the highest in the previous 12 months.

What is the expected impact?

- Reduction in the TWL or offsetting impact of the ongoing data quality validation.

- The Trust continues to do very well on missed appointments, pre referral triage and high level of Advice and Guidance in Further faster cohort 2.

Potential risks to improvement?

- Despite the sprint, ongoing data quality validation may result in further rises to the RTT TWL, the number of records requiring data quality validation are known and there is an expectation that the RTT TWL will stabilise in Q2 of 2025/26. This has been communicated to NHSE.

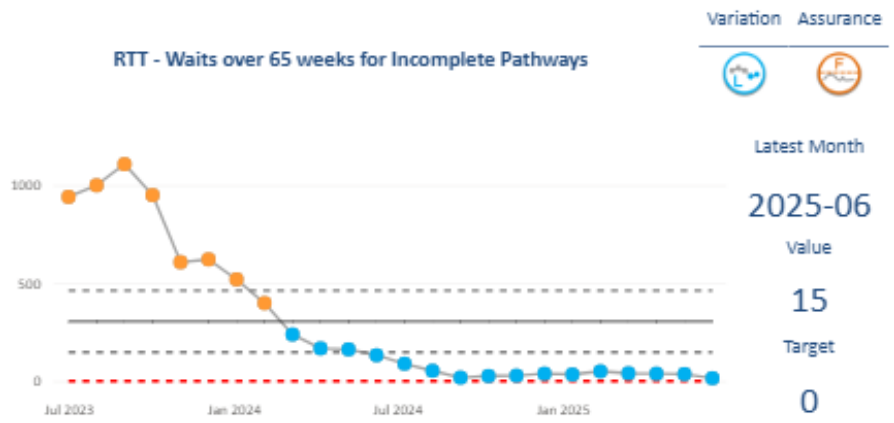
KPIs – Operational Activity and Performance

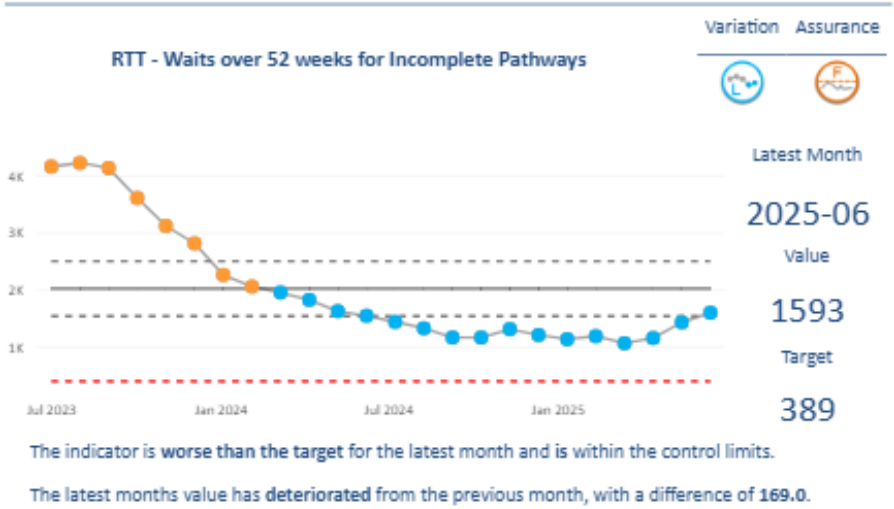
Referral to Treatment RTT (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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

What actions are planned?

- 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 in place with weekly meetings. The Trust's approach has been recognised at ICB level as good practice who are planning to embed within other providers within the HNY ICB.
- Delivery of key workstreams in the 2025/26 elective recovery plan including theatre utilisation, patient initiated follow up (PIFU), new to follow up ratios, prioritisation of children and young people.

What is the expected impact?

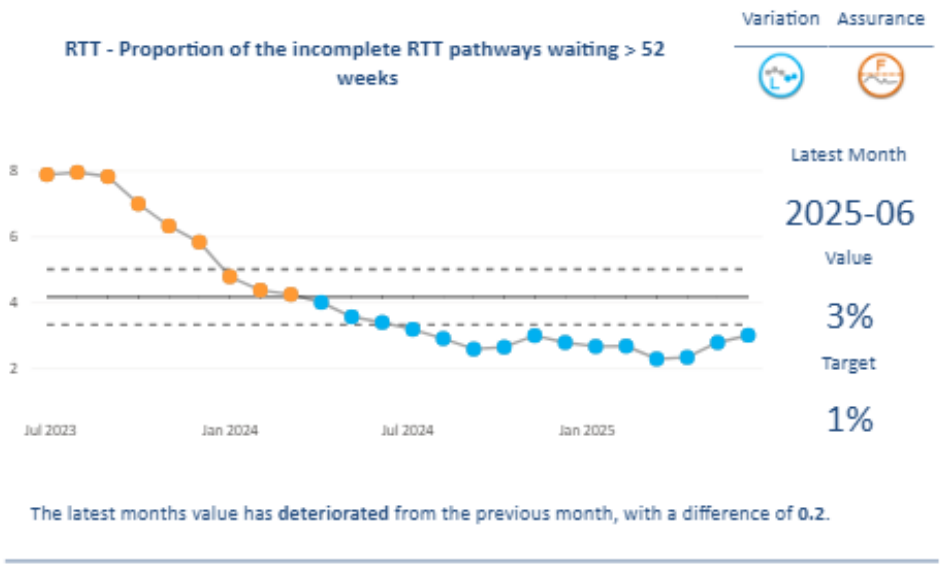
- Reduced RTT long waiters to meet 2025/26 planning trajectories.
- ERF money targeted at specialties most in need.

Potential risks to improvement?

- Patient choice can lead to end of month breaches.
- Diagnostic performance.
- Capital programme (RAAC replacement, CT replacement, Rood replacement)) which could impact on Diagnostic and theatre capacity at Scarborough and York through construction phases.

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.

Please see previous page.

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

Headlines:

- For the month of June 2025, the Patient Initiated Follow Up (PIFU) met the improvement trajectory of 4.1%, this is statistically significant as the performance was a special cause improvement against the monthly variance seen over the last two years. Y&S has three specialties in the upper quartile of Trusts within the NE&Y region (Clinical Haematology, Physiotherapy and Rheumatology).

- Rapid Access Chest Pain (RACP) seen within 14 days was at 13.8% which remains significantly below the target of 99%.

Factors impacting performance:

- Delays in roll out of PIFU pathways across specialities due to issues with call handling capacity. Alternative patient contact methods being investigated by the Y&S Digital team with completion expected during Q2 2025/26.

- 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). Weekly meetings in place with Medicine Care Group to;
  - Understand the current RACP 14-day performance.
  - Recover performance to deliver 99% of RACP being seen within 14 days of referral.
  - Understand factors influencing performance.
  - Identify corrective actions, delivery date and impact and receive updates against agreed actions.

- The outpatient delivery group has been refreshed in May 2025 as part of the 2025/26 elective recovery plan. It has identified four key areas of priority:
  - Increase PIFU rates delivered through the 'PIFU as Standard' project with a focus on gynaecology, ENT, cardiology and gastroenterology in Q2.
  - Increase of Referral for Expert Input. Agreed to review feasibility of cardiology, gynaecology and ENT roll out.
  - Roll out digital clinical letters.
  - PAS readiness validation of non RTT waiting lists and embedding the operational toolkit.

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)	• Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)
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: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks) • Electives (based on Activity v Plan)
SPECIAL CAUSE CONCERN			• Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)

Outpatients & Elective Care
Scorecard

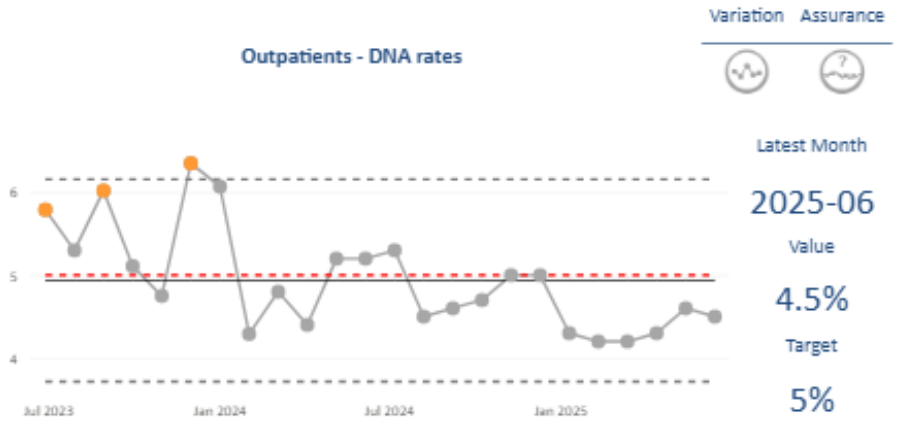
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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)	2025-06		F	21%		25%
Outpatients - DNA rates	2025-06		?	4.5%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2025-06	H	?	20908	17719	17494
Outpatients: Follow Up Attendances (Activity vs Plan)	2025-06		?	46010	38020	38846
Outpatient procedures	2025-06			16125		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2025-06		F	26086		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2025-06	H	F	4.1%	4.1%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2025-06	L	F	13.8%		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*	2025-06		?	22		0
Day Cases (based on Activity v Plan)	2025-06		?	7631	7673	8144
Electives (based on Activity v Plan)	2025-06		F	694	726	816
Proportion of elective admissions which are day case	2025-06		P	91.7%		85%

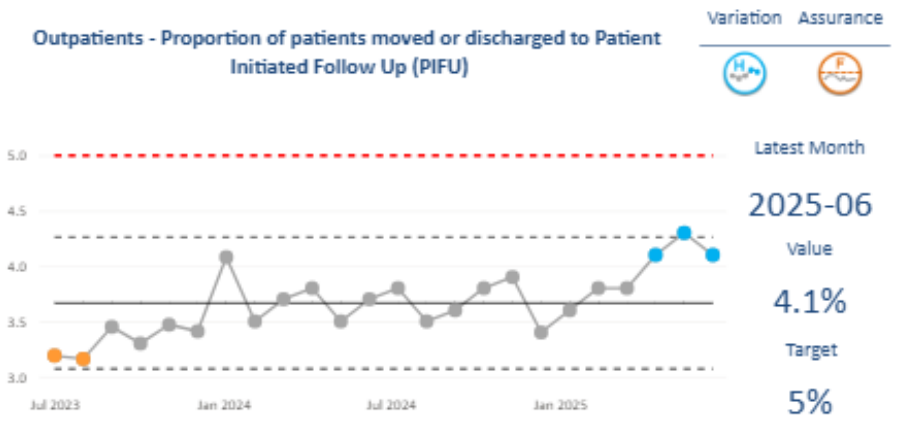
Executive Owner: Claire Hansen

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 **improved** 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 **deteriorated** from the previous month, with a difference of **0.2**.

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.

What actions are planned?

- 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 continues for the Medicine and Family Health Care Groups.
- The Trust is one of 6 Trusts in the North East and Yorkshire region who have agreed to participate in the NHSE 'PIFU as standard' programme. The PIFU pathways the Trust are developing as part of this programme are Gynaecology, Cardiology, Gastroenterology and ENT. Fortnightly task and finish groups set up, further faster guidance being reviewed. Cardiology at Scarborough to be implemented in July 2025.
- Weekly RACP meetings have been established with medicine care group. Focused actions are:
    - Additional ad-hoc capacity in July and August at York
    - Administrative staff recruitment to improve booking processes at York. To be completed by October 2025. This will free up nursing staff. Identify additional RACP clinic space at York so that patents can be seen direct from ED and SDEC rather than book for future appointment
    - Job plan review and additional clinics scheduled at Scarborough from June 2025.
    - Cross site agreement on evaluated urgency for RACP patients and recording on CPD to be agreed.

What is the expected impact?

- **PIFU:** Y&S should see a continued improvement in PIFU through 2025/26. Y&S has one specialty in the lowest quartile of Trusts within the NE&Y region (Gynaecology), involvement in PIFU as standard should result in an improvement in this specialty.
- **RACP:** Improved performance and improved patient experience.

Potential risks to improvement?

- **PIFU:** There are two challenges to resolve to support PIFU roll out; patient communication mechanism and discharge instruction not carried forward onto pending appointment record on CPD, so FU is booked. Both items are being investigated by Y&S digital.
- PIFU at Scarborough is significantly lower than York (1.8% at SGH / 5.2% at York).
- **RACP:** Failure to recruit administrative staff.

Headlines:

- The June 2025 the position for patients waiting less than six weeks at month end was 64% against the improvement trajectory of 70.5% , this was within the monthly variance seen over the last two years
- In the latest available national data (April 2024) the Trust ranked 138th out of 157 NHS providers.

Factors impacting performance:

- Continued intermittent breakdowns of CT1 and 2 at York impact delivery of activity. CT performance being largely driven by cardiac CT backlog. Breakdown of CT1 at Scarborough for 3 days in June. Acute CT demand continues to impact on capacity for elective work.
- Failure of MRI equipment at both York and Scarborough during June. MRI continues to underperform due to increased fast track and RTT >52 week wait escalations, staffing gaps, and a permanent 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.
- Barium Enema performance is significantly below trajectory due to workforce issues at Scarborough, this is an ongoing issue, and recovery may not be seen for a few weeks until activity is restored.
- Nurse vacancy in Urodynamics impacted on capacity to deliver elective activity.
- Echo has returned to full establishment, but posts are in training so not yet delivering full capacity. One Scarborough vacancy remains in pacing.
- Sickness in paediatric audiology team affecting capacity with limited locum availability for paediatric audiologist. Inability to recruit to audiology posts due to lack of suitable candidates, especially at the East Coast. Locum audiologist was due to start in Bridlington in June but was unable to proceed, service is back out to recruitment to support with audiology cover at the coast. Challenging to balance increase in elective demand to support long wait RTT patients in ENT against DM01 waiters. Audiology booth capacity impacts the ability to deliver activity.
- Lack of consultant cover at Scarborough since January 2025 impacted on the ability to deliver planned Endoscopy lists; though workforce is now recovered we continue to see the impact in performance data while activity is restored. Nurse staffing remains an issue, particularly at York with significant vacancies. Use of endoscopy capacity to do scope and consult which reduces the number of points per list.
- Staffing challenges in Cystoscopy led to last minute cancellations of lists during Q1 which impacted performance.

Actions:

Performance recovery actions are beginning to deliver improvements; we anticipate further improvement by the end of Q2 as actions continue to be embedded.

- Please see page below for detail.

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 - Neurophysiology peripheral	• Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography • Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics • 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 - Sleep studies • 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 - 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 - MRI • Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology

DIAGNOSTICS – National Target: 95%

Scorecard

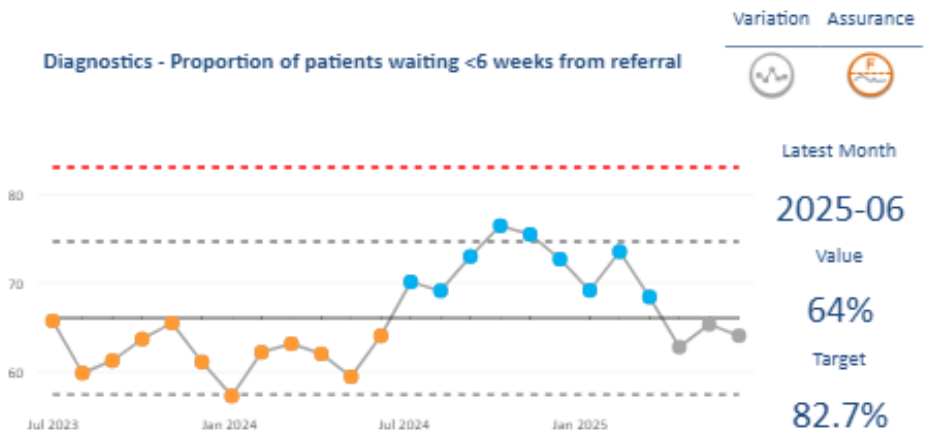
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-06		F	64%	70.5%	82.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2025-06	L	F	56.1%	69%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2025-06		?	68.1%	68%	78%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2025-06		?	68.5%	66%	75%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2025-06	L	?	57.1%	82.1%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2025-06	H	?	88.1%	53.1%	67.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2025-06	L	F	51.5%	80%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2025-06	H	F	87.3%	95.8%	95.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2025-06	H	?	97.2%	92.9%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2025-06		?	58.8%	87.9%	94.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2025-06	H	F	51%	64.7%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2025-06		F	51.1%	80.6%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2025-06	H	F	62.8%	81%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2025-06		?	81.7%	85%	94.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2025-06		F	69.9%	81.2%	90%

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.

What actions are planned?

Endoscopy: York Gastroenterology have added 2 substantive consultants in June 2025; both are job planned for two endoscopy sessions per week. The York Gastroenterology team have also added an additional consultant on a 3-month contract from May 2025, providing a further 2 – 3 sessions a week. From w/c 21st July the service expect to be able to staff 3 of 5 days in the additional room. Insourcing procurement has commenced.

Recruitment within Cystoscopy has allowed introduction of an additional Friday list at Malton which will deliver capacity for another 12 patients a week. Consultant post recruited to from the end of August, with two registrar posts starting in August/September 2025.

Imaging: Permanent mobile CT is in place at Bridlington for acceleration activity until Scarborough CDC is opened. This CT is also supporting delivery of lung health check activity which began in June.

York St John MRI went live on 2nd June and service is now running two days per week.

DEXA recovery is underway, with focus on issues with reporting, list utilisation and communication with ICB around GP referrals

MSK sonographer training being supported to take on soft tissue ultrasound from MSK backlog – training will go live in July 2025 and should start to see impact by the end of 2025.

Physiological:

Echocardiography: service has returned to full establishment. Recovery plan is in place to fully recover position by the end of this financial year.

Urodynamics: From mid-June to end of July additional all day UDS clinics are in place, 7 of 12 lists have been completed to date. These will provide capacity for over 100 patients. Improvement seen in June 2025.

Audiology: Two paediatric locums in Audiology anticipated to begin in August to cover weekends. Continuing to develop Band 4 audiology Practitioner post via apprenticeship route. Two pop-up booths approved on capital plan to deliver additional audiology capacity. Implement pathway change to introduce audiology on arrival pathway (Q2 2025/26)

What is the expected impact?

Increased capacity leading to increase in activity, reduction in backlogs and improvement to DM01 to trajectory levels.

Potential risks to improvement?

Ongoing issues with equipment breakdown and recruitment challenges.

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 - Proportion of incomplete pathways waiting less than 18 weeks
SPECIAL CAUSE CONCERN			• Children & Young Persons: RTT - Total Waiting List

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

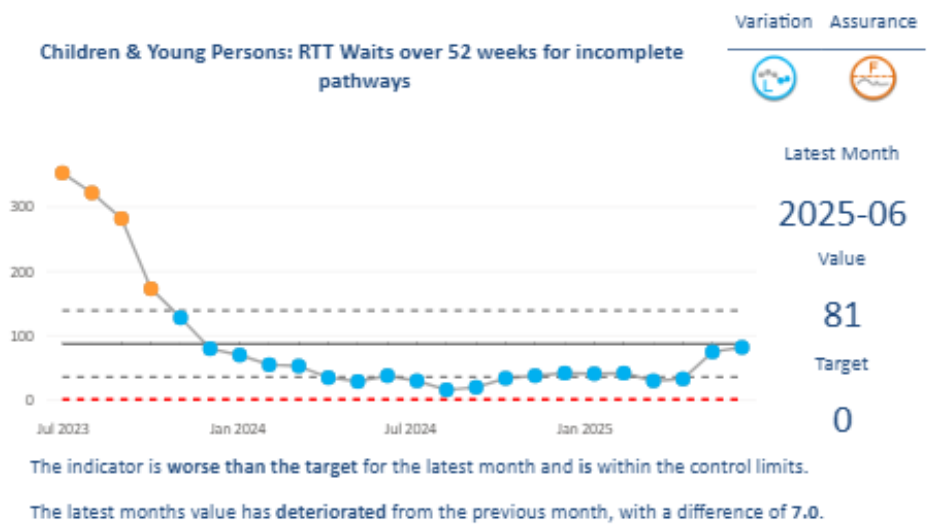
Executive Owner: Claire Hansen

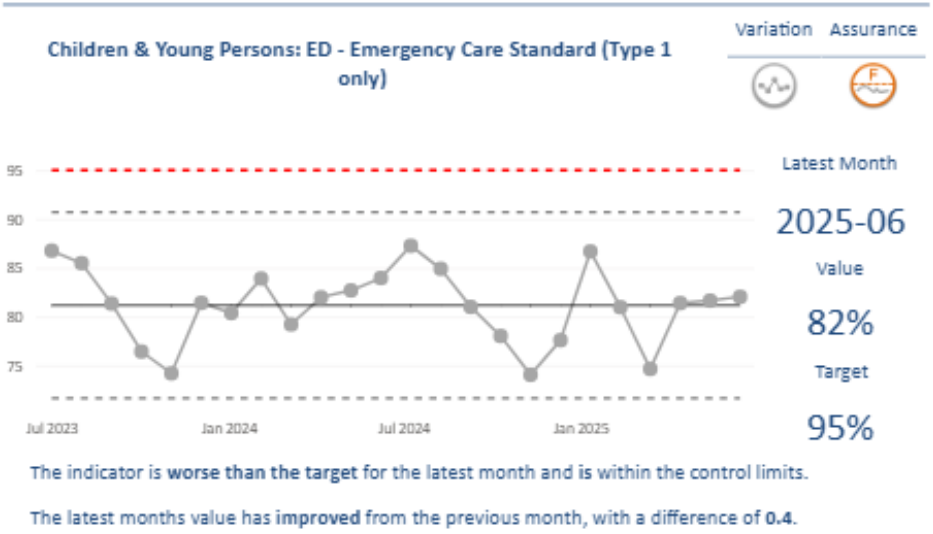
Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2025-06			2		0
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2025-06			82%		95%
Children & Young Persons: RTT - Total Waiting List	2025-06			4463	3789	3206
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-06			64.8%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2025-06			81	29	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi





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.

What actions are planned?

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 Surgical Care Group have validated CYP long waiters and have developed a robust action plan for each patient across Head & Neck areas. Paediatric 'super weekends' have been timetabled to coincide with the school summer holidays.

SPC2:

- Work to be completed to review if opportunity to maximise use of Children's Assessment Unit (CAU) for other specialties who need to assess children outside of ED
- Work is underway to map opportunities or improvement in paediatric ECS. This includes looking at delays in transfer, time to be seen by a doctor and streaming at the front door.

What is the expected impact?

- Improved ECS for CYP patients.
- Ambition is to return to RTT52 trajectory and delivery of zero waiters by the end of September 2025.

Potential risks to improvement?

- Impact of treating RTT65 week waits has taken priority in recent months.

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 • Proportion of Virtual Ward beds occupied	• 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			
SPECIAL CAUSE CONCERN			

COMMUNITY
Scorecard

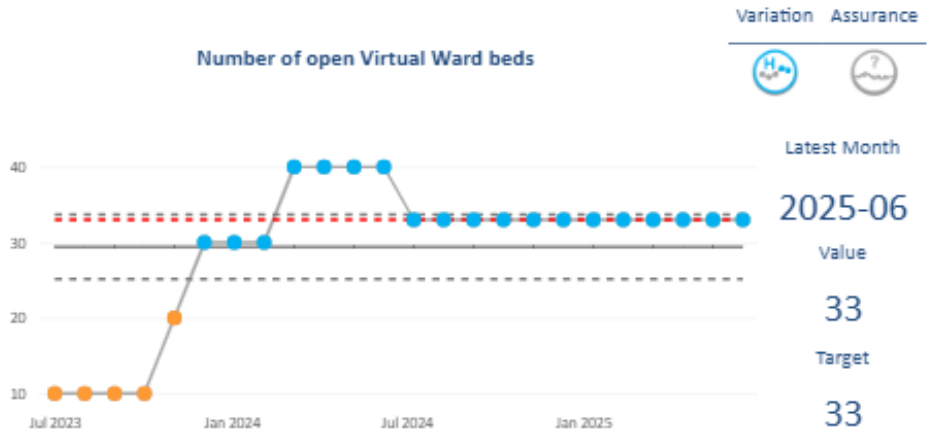
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-06			33	33	33
Proportion of Virtual Ward beds occupied	2025-06			93.9%	79%	79%
Community Response Team (CRT) Referrals	2025-06			505		
Total Urgent Community Response (UCR) referrals	2025-06			490	522	566
2-hour Urgent Community Response (UCR) care Referrals	2025-06			124		
2-hour Urgent Community Response (UCR) Compliancy %	2025-06			78.2%		
Number of Adults (18+ years) on community waiting lists per system	2025-06			763		
Number of CYP (0-17 years) on community waiting lists per system	2025-06			1821		
Number of District Nursing Contacts	2025-06			21003		
Number of Selby CRT Contacts	2025-06			2434		
Number of York CRT Contacts	2025-06			3284		
Referrals to District Nursing Team	2025-06			2219		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2025-06			695	662	0

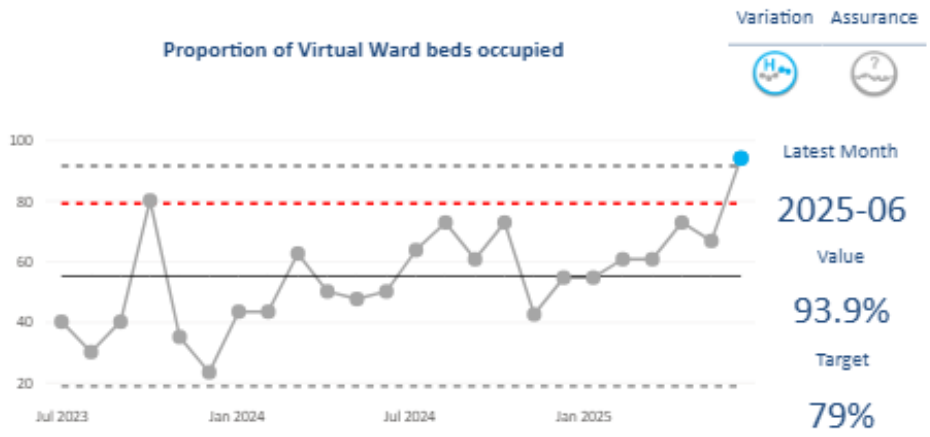
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

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



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

The latest months value has **improved** from the previous month, with a difference of **27.2**.

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.

What actions are planned?

Frailty Virtual Ward - capacity 12 Utilisation has been consistently over 80% (the national suggested ambition) for several months. A step-up IV antibiotic pathway for patients with a Urinary Tract Infection is being developed with support from the Microbiology team.

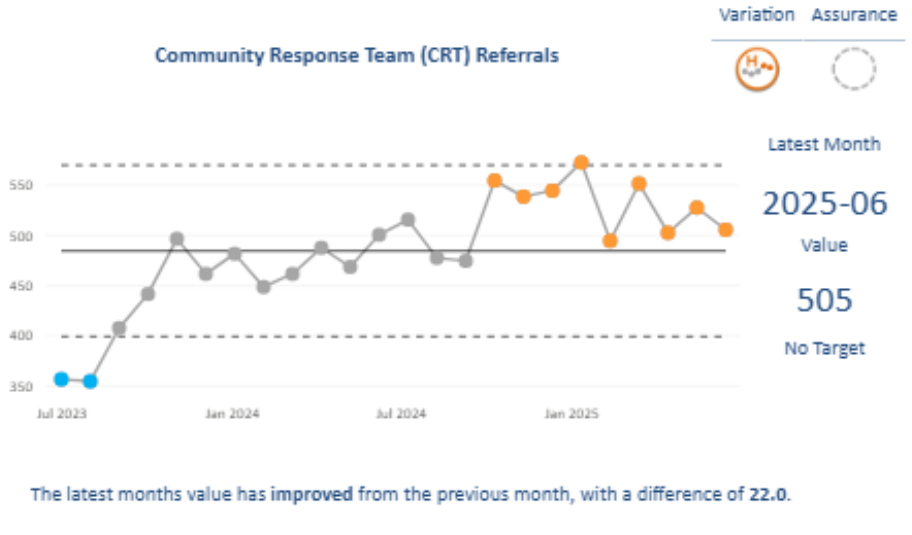
Heart Failure - capacity 10 Options are being considered for the future of this pathway since the GIRFT review indicated it does not fully meet the requirements to be reported as a virtual ward. The team continue to support a reduction in length of stay for acutely unwell patients.

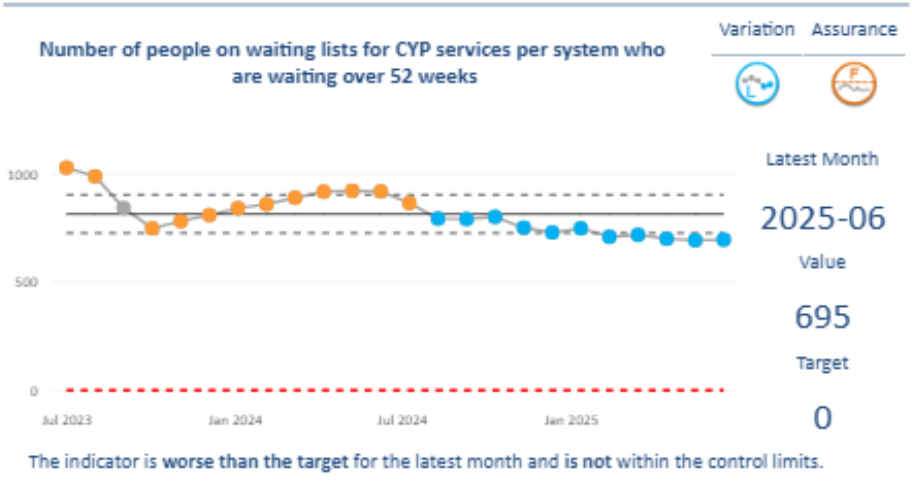
Vascular – capacity 8 There has been a recent influx in patients meeting the criteria for admission; typically, these patients are identified through an outpatient appointment as requiring urgent diagnostics and being acutely unwell, but do not want to be admitted. Instead of admitting a patient, the team send them home on a virtual ward pathway which means their urgent diagnostics are prioritised. The team links regularly with diagnostics colleagues to ensure the impact is not being felt negatively. The model uses pre-existing resource.

Cystic Fibrosis – capacity 3 The system allows a virtual model of care for up to three patients however this is not 'spare' capacity, the team works differently to support appropriate patients and numbers will always be low.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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.

SPC1: Referrals to Community Response Teams remain high; Community Teams delivered 37,483 care contacts during June 2025, ahead of the trajectory of 35,603 submitted as part of 2025/26 annual planning. There is insufficient community capacity to further increase the number of patients whose needs we can meet at home.

What actions are planned?
SPC1: Capacity and demand planning is underway. The scale of the gap will be presented at the July Community Improvement Group, as well as options to reduce that gap.
The Intermediate Care Team (Community Response Team / Community Therapy Team) is looking to increase efficiencies.
The service are undertaking at a skill mix review for Band 3s and Band 4s within the Intermediate Care Team to enable a swift delegation of duty model.
The Intermediate Care Team is involved in the system-wide process mapping exercise to review discharge pathways.

SPC2: SLT Leap Into Language initiative has commenced and will run through to the end of August 2025 consisting of:
Following an initial assessment children will go down 1 of 2 pathways (depending on age):
- Option 1 = PCI pathway with 3 x home visits (primarily SLTAs)
- Option 2 = block of 6 sessions in clinic with a therapist (band 5, 6, and 7)

At the end of summer/first week of the school term there will be a protected slot built in, to follow up with school as appropriate (e.g. admin time to write a report to send, OR to arrange a visit).

What is the expected impact?
Due to the unknown outcome of the capacity and demand review, and the potential scale of the changes required to increase capacity in CRT, impact may not be felt until Q3 or Q4.

Currently circa 40% of the total SLT waiting list are children with 'Language Difficulties' with 60% of those waiting over 1 year. A similar project entitled 'Summer of Speech' which ran June to September 204 saw 25% of patients discharged.

Potential risks to improvement?
- Prioritising the Discharge to Assess pathway could reduce capacity in the Community Therapy Team (which supports planned therapy care) if efficiencies cannot be made.
- National shortage of SLT therapists.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

QUALITY AND SAFETY

July 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			
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 • Harmful Incidents per thousand bed days • Total Number of Never Events Reported • Monthly SHMI • Monthly HSMR	
SPECIAL CAUSE CONCERN			

Quality & Safety
Scorecard (1)

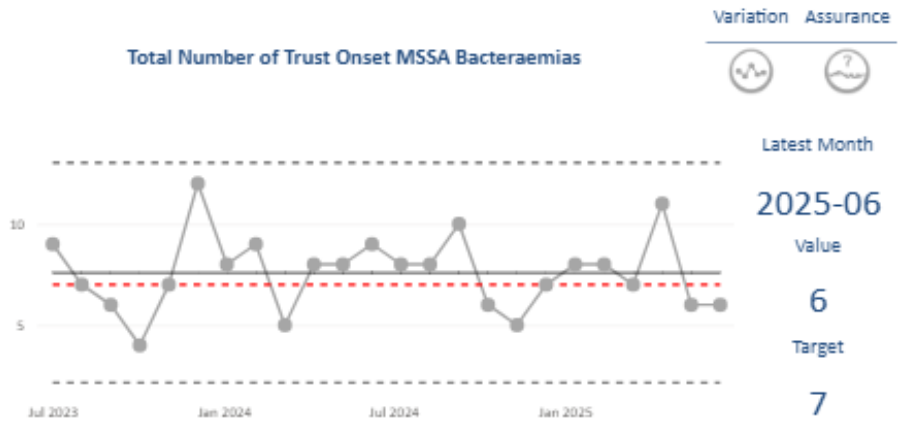
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

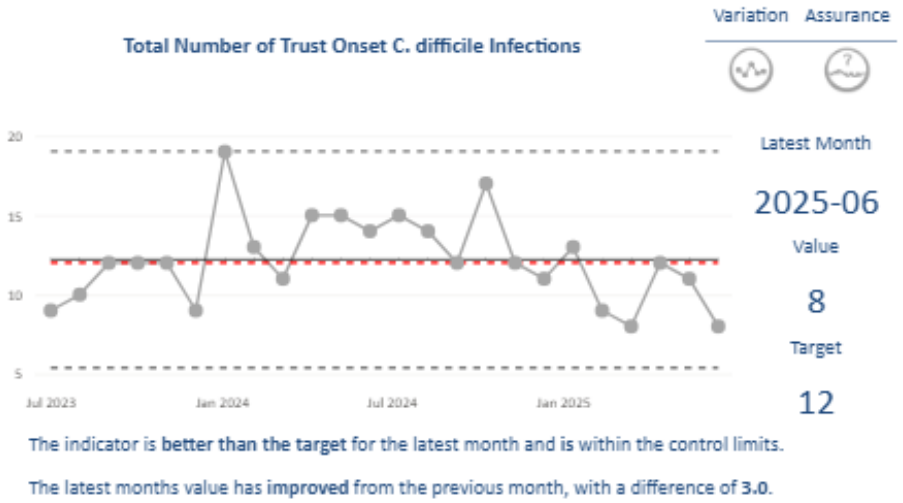
Executive Owner: Dawn Parkes **Operational Lead:** Sue Peckitt

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2025-06			6	6	7
Total Number of Trust Onset MRSA Bacteraemias	2025-06			0		0
Total Number of Trust Onset C. difficile Infections	2025-06			8	12	12
Total Number of Trust Onset E. coli Bacteraemias	2025-06			15	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2025-06			5	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2025-06			2	1	2
Pressure Ulcers per thousand Bed Days	2025-06			3.1		4
Patient Falls per thousand Bed Days	2025-06			7.3		8.7
Medication incidents per thousand bed days	2025-06			5.9		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. **MSSA is a True North Metric.**

Factors impacting performance:

- MSSA bacteraemia - 6 cases recorded in May, improvement on April's performance. 5 cases attributed to Medicine Care Group, 1 case attributed to the CSCS group. 25% of the cases are attributed to Scarborough Hospital, 83% of the cases are attributed to Scarborough Hospital and 17% attributed to the York Hospital. The Trust is 3 cases over the year-to-date objective.
- The Trust has recorded 1 MRSA Bacteraemia cases in April and 1 case in May against a zero objective. A post infection review meeting has been held for both cases to determine learning and improvement actions.
- 11 Trust attributed Clostridioides difficile cases recorded in May against a trajectory of 12. Of the 11 cases 73% were attributed to York Hospital, 27% were attributed to Scarborough Hospital.

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, with the SOP being agreed at IPSAG in May 2025.
- 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.
- A QI project is being scoped regarding the reduction of Gram Negative Blood Stream Infections (GNBSI's) following the Trust attendance at the HNY ICB workshop on GNBSI's in May 2025

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	2025-06			50.9		53
Harmful Incidents per thousand bed days	2025-06			15.8		17
Total Number of Never Events Reported	2025-06			0		0
In-Hospital Deaths	2025-06			173		
Quarterly SHMI	2024-12			95.1		100
Monthly SHMI	2025-03			105.5		100
Quarterly HSMR	2025-03			108.9		100
Monthly HSMR	2025-03			104.8		100
Trust Complaints	2025-06			91		
Antepartum Stillbirths	2025-05			2		
Intrapartum Stillbirths	2025-05			0		
Early neonatal deaths (0-7 days)	2025-05			0		
PPH > 1.5L as % of all women - York	2025-05			2.5%		
PPH > 1.5L as % of all women - Scarborough	2025-05			1.8%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2025-05			38.6%		

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 is now above the mean.

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 slightly reduced with 91 new complaints recorded (versus 91 in May 2025), with 10 being complex complaints:
- ED Scarborough (5) - attitude of nursing staff (3)
- ED York (4) - transfer arrangements (2)
- General Medicine Medical Team York (2) - discharge (2)
- Urgent Treatment Centre Scarborough (2) - attitude of nursing staff (1) delay or failure in treatment or procedure (1)

Factors impacting performance:

Average ambulance handover time in June 2025 was significantly ahead of trajectory at 21 minutes 34 seconds against trajectory of 36 minutes 50 seconds. In June the maximising of the use of our Urgent Treatment Centres and sending more patients directly to Same Day Emergency Care and specialty wards and 12-hour trolley waits being at their lowest since July 2023 is reflective in the reduced number of complaints relating to ED.

Two members of the PALS team are on long term sickness absence and permission has not been given to appoint to the administrative vacancy that has been open since December 2024. This has resulted in a significant backlog in the time patients and carers have to wait for a response to concerns and complaints email enquiries. In addition, it has resulted in the service not being accessible by phone or walk-in.

Actions:

Communications and complaints writing workshops have been delivered in Q1.

A rapid process improvement workshop (RPIW) for concerns and complaints management was delivered during week commencing 23 June 2025 with attendance from across the organisation. Changes were effective the week following the RPIW with additional changes planned to improve complaint management efficiency and effectiveness which will improve patient and carer experience.

A request has been made for a secondment opportunity to support the PALS staffing challenges. The approval to recruit the PALS Administrator is expected as part of the Trust re-organisation plans in the forthcoming weeks.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

July 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	
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 • Planned homebirths - Scarborough • Homebirth service suspended - Scarborough • Anaesthetic cover on L/W - Scarborough
SPECIAL CAUSE CONCERN		• SCBU at capacity of intensive care cots - Scarborough • SCBU no of babies affected - 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	• Normal Births - Scarborough • Assisted Vaginal Births - Scarborough • C/S Births - Scarborough • Elective caesarean - Scarborough • Emergency caesarean - Scarborough • Induction of labour - Scarborough • HDU on L/W - Scarborough • BBA - Scarborough • 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			

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	2025-05			50.4%		57%	Target
Assisted Vaginal Births - Scarborough	2025-05			10.6%		12.4%	Target
C/S Births - Scarborough	2025-05			38.1%		43.9%	Baseline
Elective caesarean - Scarborough	2025-05			15.9%		17.2%	Baseline
Emergency caesarean - Scarborough	2025-05			22.1%		26.6%	Baseline
Induction of labour - Scarborough	2025-05			48.7%		44.1%	Baseline
HDU on L/W - Scarborough	2025-05			2		5	Target
BBA - Scarborough	2025-05			0		2	Target
HSIB cases - Scarborough	2025-05			0		0	Target
Neonatal Death - Scarborough	2025-05			0		0	Target
Antepartum Stillbirth - Scarborough	2025-05			0		0	Target
Intrapartum Stillbirths - Scarborough	2025-05		P	0		0	Target
Cold babies - Scarborough	2025-04			0		1	Target
Preterm birth rate <37 weeks - Scarborough	2025-05			5.3%		6%	Target
Preterm birth rate <34 weeks - Scarborough	2025-05			0%		1%	Target
Preterm birth rate <28 weeks - Scarborough	2025-05			0%		0.5%	Target

Summary MATRIX 3 of 3

Maternity Scarborough

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		• Breastfeeding Initiation rate - Scarborough • Breastfeeding rate at discharge - Scarborough • Smoking at booking - Scarborough • Smoking at 36 weeks - Scarborough • Smoking at time of delivery - Scarborough • Carbon monoxide monitoring at booking - Scarborough • Carbon monoxide monitoring at 36 weeks - Scarborough • 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		• Low birthweight rate at term (2.2kg) - Scarborough	

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	2025-05			1.8%		0%	Target
Breastfeeding Initiation rate - Scarborough	2025-05			75.2%		75%	Target
Breastfeeding rate at discharge - Scarborough	2025-05			55.7%		65%	Target
Smoking at booking - Scarborough	2025-05			6.2%		6%	Target
Smoking at 36 weeks - Scarborough	2025-05			3.8%		6%	Target
Smoking at time of delivery - Scarborough	2025-05			5.5%		6%	Target
Carbon monoxide monitoring at booking - Scarborough	2025-05			94.7%		95%	Target
Carbon monoxide monitoring at 36 weeks - Scarborough	2025-05			71.8%		95%	Target
SI's - Scarborough	2025-05			0		0	Target
PPH > 1.5L as % of all women - Scarborough	2025-05			1.8%		2.2%	Baseline
Shoulder Dystocia - Scarborough	2025-05			1		2	Target
3rd/4th Degree Tear - normal births - Scarborough	2025-05			0%		0%	Target
3rd/4th Degree Tear - assisted birth - Scarborough	2025-05			0%		0%	Target
Informal Complaints - Scarborough	2025-05			0		0	Target
Formal Complaints - Scarborough	2025-05			2		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	2025-05		P	96		169	Target
Bookings <10 weeks - Scarborough	2025-05		F	74%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2025-05		?	11.5%		10%	Target
Births - Scarborough	2025-05		?	113		113	Target
No. of women delivered - Scarborough	2025-05		?	110		112	Target
Planned homebirths - Scarborough	2025-04		F	1.1%		2.1%	Target
Homebirth service suspended - Scarborough	2025-01		F	24		3	Target
Women affected by suspension - Scarborough	2025-04	L	?	0		0	Target
Community midwife called in to unit - Scarborough	2025-03	L	P	0		3	Target
Maternity Unit Closure - Scarborough	2025-05		?	2		0	Target
SCBU at capacity - Scarborough	2025-03		?	4		1.3	Baseline
SCBU at capacity of intensive care cots - Scarborough	2025-03	H	?	11		5.3	Baseline
SCBU no of babies affected - Scarborough	2025-03	H	?	1		0	Target
1 to 1 care in Labour - Scarborough	2025-05		?	100%		100%	Target
L/W Co-ordinator supernumerary % - Scarborough	2025-05	H	?	100%		100%	Target
Anaesthetic cover on L/W - Scarborough	2025-05		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		• Homebirth service suspended - York • Maternity Unit Closure - York • 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 • Births - York • No. of women delivered - York • Planned homebirths - York • Women affected by suspension - York • SCBU at capacity of intensive care cots - York • SCBU no of babies affected - York • 1 to 1 care in Labour - York	• Bookings <10 weeks - 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	2025-05			255		295	Target
Bookings <10 weeks - York	2025-05		F	79.6%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - York	2025-05		P	6.3%		10%	Target
Births - York	2025-05			239		245	Target
No. of women delivered - York	2025-05			237		242	Target
Planned homebirths - York	2025-04			0.4%		2.1%	Target
Homebirth service suspended - York	2025-05	L		3		3	Target
Women affected by suspension - York	2025-05			3		0	Target
Community midwife called in to unit - York	2025-05		P	0		3	Target
Maternity Unit Closure - York	2025-05	L		0		0	Target
SCBU at capacity - York	2025-04	L		0		0.2	Baseline
SCBU at capacity of intensive care cots - York	2025-03			29		19.7	Baseline
SCBU no of babies affected - York	2025-03			3		0	Target
1 to 1 care in Labour - York	2025-05			100%		100%	Target
L/W Co-ordinator supernumerary % - York	2025-05	H		100%		100%	Target
Anaesthetic cover on L/W - York	2025-05		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		• HSIB cases - York	
COMMON CAUSE / NATURAL VARIATION	• Intrapartum Stillbirths - York	• Normal Births - York • Assisted Vaginal Births - York • C/S Births - York • Elective caesarean - York • Emergency caesarean - York • Induction of labour - York • BBA - 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			

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	2025-05			51.5%		57%	Target
Assisted Vaginal Births - York	2025-05			10.9%		12.4%	Target
C/S Births - York	2025-05			36.4%		36.1%	Baseline
Elective caesarean - York	2025-05			17.2%		15.1%	Baseline
Emergency caesarean - York	2025-05			19.2%		21%	Baseline
Induction of labour - York	2025-05			40.5%		43.7%	Baseline
HDU on L/W - York	2025-05			6		5	Target
BBA - York	2025-05			3		2	Target
HSIB cases - York	2025-05			0		0	Target
Neonatal Death - York	2025-05			0		0	Target
Antepartum Stillbirth - York	2025-05			2		0	Target
Intrapartum Stillbirths - York	2025-05			0		0	Target
Cold babies - York	2025-04			0		1	Target
Preterm birth rate <37 weeks - York	2025-05			8.3%		6%	Target
Preterm birth rate <34 weeks - York	2025-05			0.4%		2%	Target
Preterm birth rate <28 weeks - York	2025-05			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 • Breastfeeding Initiation rate - York • Breastfeeding rate at discharge - 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			

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	2025-05			0%		0%	Target
Breastfeeding Initiation rate - York	2025-05			91.1%		75%	Target
Breastfeeding rate at discharge - York	2025-05			74.2%		65%	Target
Smoking at booking - York	2025-05			5.4%		6%	Target
Smoking at 36 weeks - York	2025-05			1.4%		6%	Target
Smoking at time of delivery - York	2025-05			3.3%		6%	Target
Carbon monoxide monitoring at booking - York	2025-05			91.1%		95%	Target
Carbon monoxide monitoring at 36 weeks - York	2025-05		F	68.4%		95%	Target
SI's - York	2025-05			0		0	Target
PPH > 1.5L as % of all women - York	2025-05			2.5%		3.8%	Baseline
Shoulder Dystocia - York	2025-05			2		2	Target
3rd/4th Degree Tear - normal births - York	2025-05			0.8%		0%	Target
3rd/4th Degree Tear - assisted birth - York	2025-05			0%		0%	Target
Informal Complaints - York	2025-05			0		0	Target
Formal Complaints - York	2025-05			2		0	Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

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

Workforce
Scorecard (1)

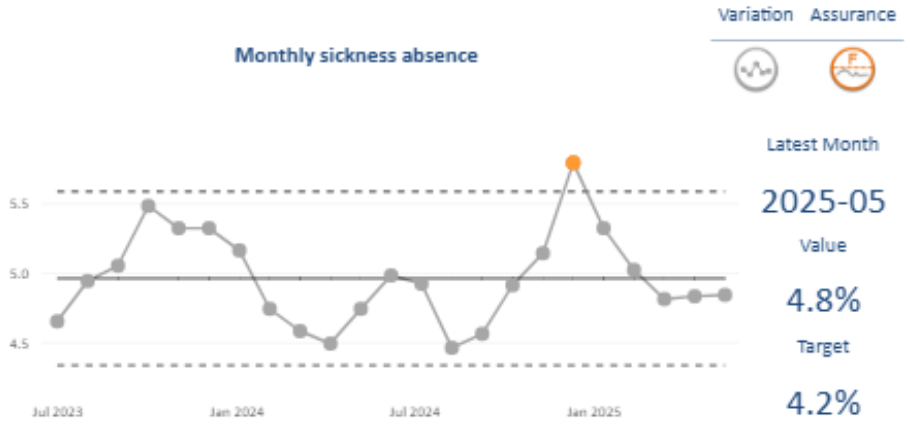
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

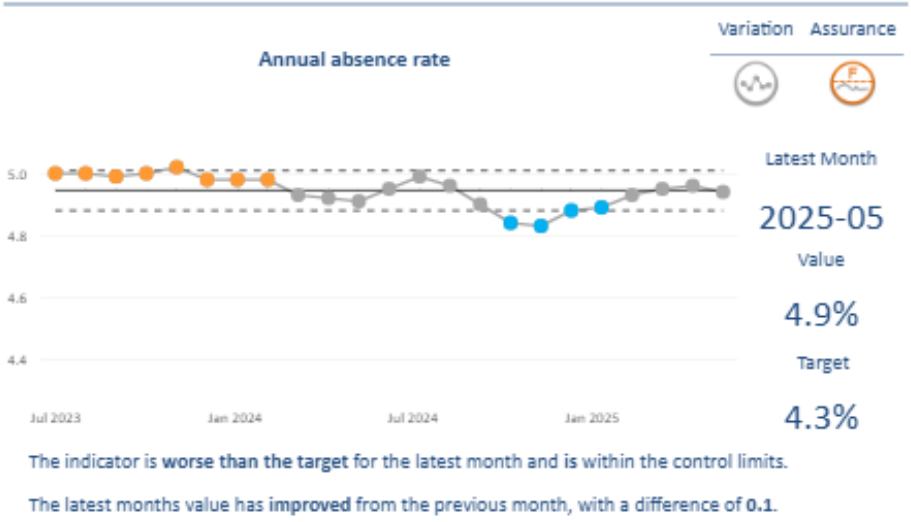
Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2025-05			4.8%	4.2%	4.2%
Annual absence rate	2025-05			4.9%		4.3%
12 month rolling turnover rate Trust (FTE)	2025-06			8.3%		10%
Overall vacancy rate	2025-06			6.5%		6%
HCSW vacancy rate	2025-06			9.4%		5%
Midwifery vacancy rate	2025-06			0.1%		0%
Medical and dental vacancy rate	2025-06			7.4%		6%
Registered Nursing vacancy rate	2025-06			6.6%		5%
AHP vacancy rate	2025-06			10.2%		8.5%
Total Agency Whole Time Equivalent Filled	2025-05			90.3		151
Total Bank Whole Time Equivalent Filled	2025-05			591.5		557
OVERALL: Percentage of rosters approved six weeks before start date	2025-05			43.4%		100%
NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent	2025-05			9563.3		6781.9
NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom)	2025-05			27%		22%

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





Rationale: Reduce absence resulting in greater workforce availability.
Target: **4.3%**

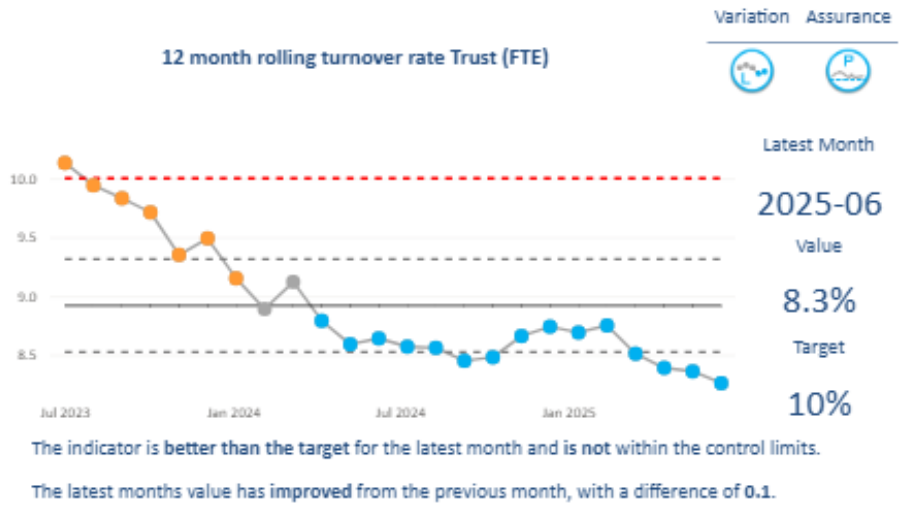
Factors impacting performance and actions:

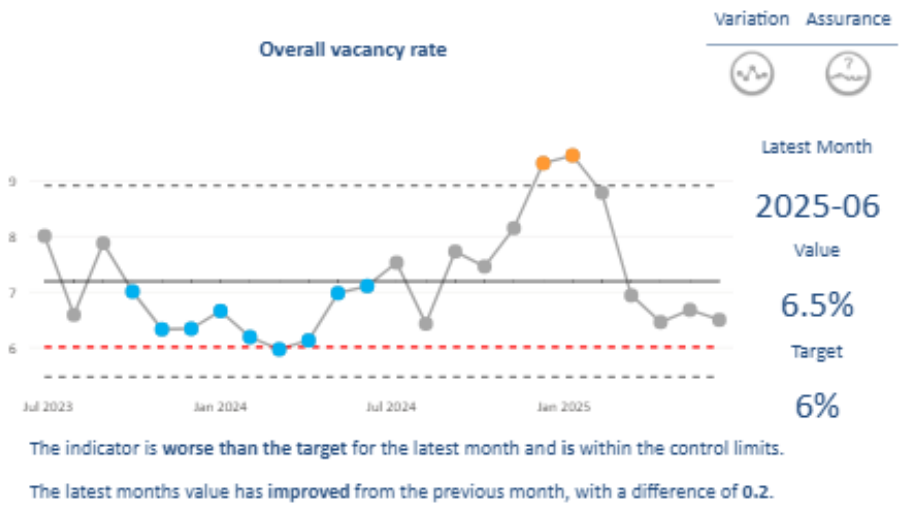
The monthly absence rate held firm at 4.8% for a third consecutive month, though May did see a nominal increase in absences compared with April. Anxiety and stress-related illness was once again the highest contributing sickness absence reason (27.5% of all absences, with an hours lost equivalent to 124 WTE). Absence related to gastrointestinal problems also increased slightly from 10.2% to 11.8% (46 WTE to 53 WTE). Musculoskeletal issues accounted for 8% (36 WTE) of absences.

In July, the British Medical Association announced the result of a ballot for industrial action related to the Resident Doctors Pay Dispute in England. 55% of individuals who were entitled to take part in the ballot voted, and 90% were in favour of action. The result provides the BMA with a mandate for industrial action for six months up to January 2026, though there are likely to be negotiations with the Government to try and avert this. In the meantime, the Trust has commenced planning to maintain business continuity during periods of action, including setting pay rates for required cover.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

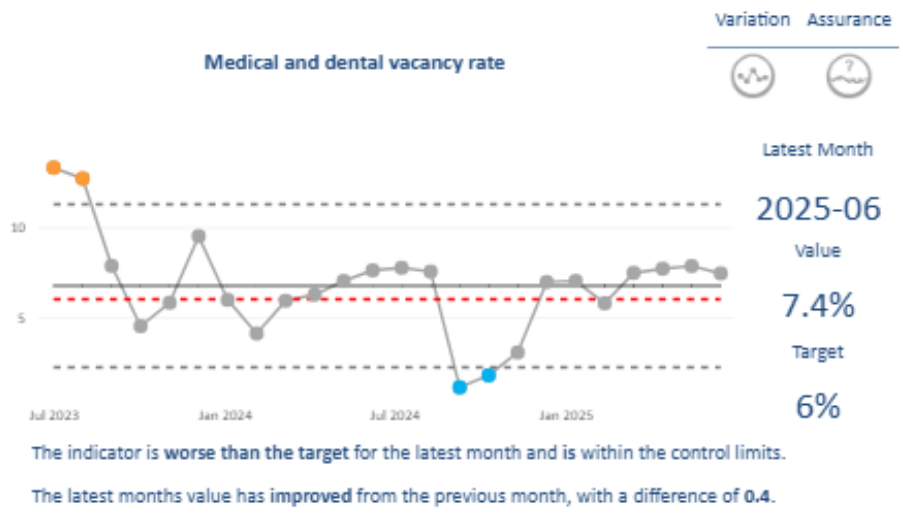
Factors impacting performance and actions:

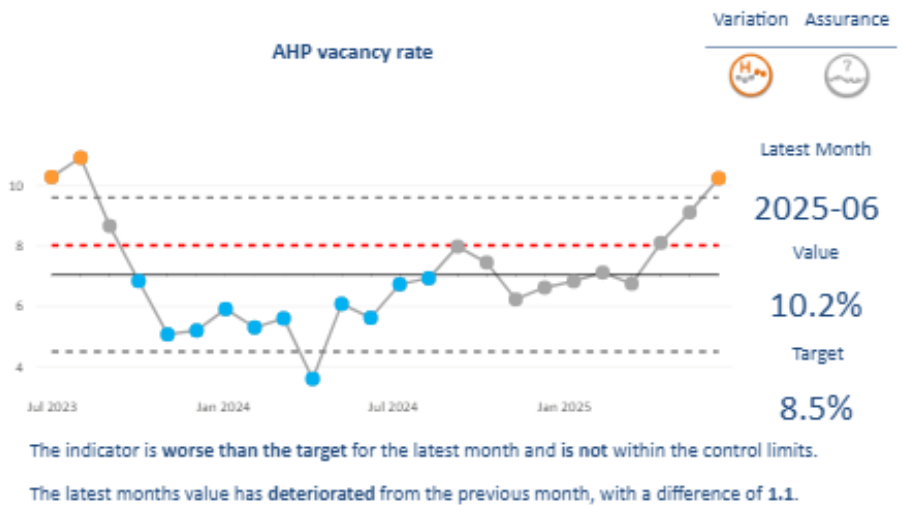
The Trust's centralised enhanced vacancy control process has been replaced with a devolved system through which Care Groups review vacancies in their services and decide whether to recruit. With this change, the Trust has introduced a 13-week 'firebreak' procedure whereby approved vacancies are subject to a standard pause before advertising. There are exempted posts which can proceed without the pause to ensure safety of clinical services.

The Trust is working in partnership with Job Centre Plus and National Employer Training to pilot a new recruitment scheme. Job seekers join a 10-day bespoke programme run by our partners to prepare for a role as a Health Care Support Worker. Once job seekers have completed the programme, they are guaranteed an interview with the Trust. An initial cohort of 10 will join the Healthcare Academy in September. If the pilot is successful, the Trust will look to utilise the pathway to support future Health Care Support Worker recruitment and explore adapting it for other entry level roles, including positions within YTHFM.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

Factors impacting performance and actions:

In June, the Trust welcomed 13 new medical colleagues including four permanent consultants working in Gastroenterology, Emergency Medicine and Acute Medicine.

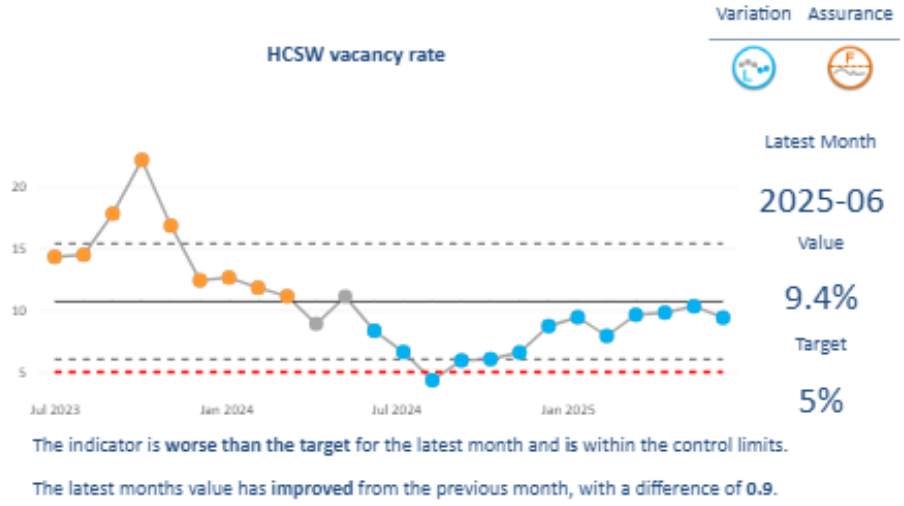
In addition, 26 offers of employment for medical posts were made, including four permanent consultant positions in Respiratory, Oral & Maxillo-Facial Surgery, Oncology and Radiology.

The Trust continues work to prepare for the arrival of 244 new colleagues in August as part of resident doctors' changeover, with pre-employment checks progressing well. This figure is a combination of trainee and Trust Grade posts.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

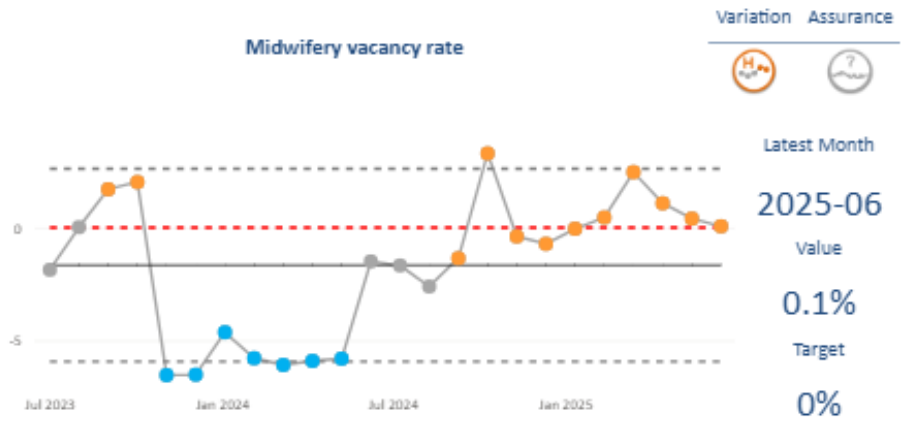
HCSW vacancy rate



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**.

Midwifery vacancy rate



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

Factors impacting performance and actions:

Between May and June, HCSW vacancies reduced by 12 WTE. Although the current vacancy rate is 9%, from July 41 WTE vacancies will be removed from budgeted establishments to account for use of Long Day shifts. If this change were to be applied to the current position, the vacancy rate would reset to 6%.

There are currently 13 WTE HCSWs undertaking pre-employment checks with the Trust. A further 25 WTE HCSWs are booked onto upcoming Academy programmes.

The Trust is preparing to onboard 109 pre-registered nurses in the Autumn. 89 have already been offered roles with the Trust, with another 20 people in the recruitment pipeline.

Although the headcount remains unchanged from May to June at 66, the number of WTE nursing associates has reduced by one to 60 WTE.

Offers have been made to 13 Nursing Associate Apprentices following a recent round of recruitment. The apprenticeships are due to commence in September.

23 Pre-registered Midwives had career conversations with the Trust in June and the Trust is now in the process of allocating people to vacant positions.

Please note, Maternity budgets increased by 15 WTE in June 2024, resulting in the increase in vacancy rate shown in the chart.

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								
Mar-25	2599.22	125.62	117.04	314.20	71.54	212.90	54.90	25.14
Apr-25	2564.22	151.93	115.79	244.00	-23.72	166.90	43.90	-56.92
May-25	2602.28	156.34	100.65	268.40	11.41	183.00	46.30	-27.69
HCA								
Mar-25	1278.48	123.17	56.03	292.20	113.00	243.00	0.00	63.80
Apr-25	1274.47	124.96	55.18	233.20	53.06	207.60	0.00	27.46
May-25	1280.95	132.11	75.25	253.00	45.64	219.40	0.00	12.04
M&D								
Mar-25	1105.25	82.47	47.49	153.00	23.04	93.90	51.60	15.54
Apr-25	1107.34	85.18	47.36	164.70	32.16	96.00	35.60	-0.94
May-25	1114.21	87.30	30.09	157.80	40.41	107.90	33.00	23.51

Factors impacting performance and actions:

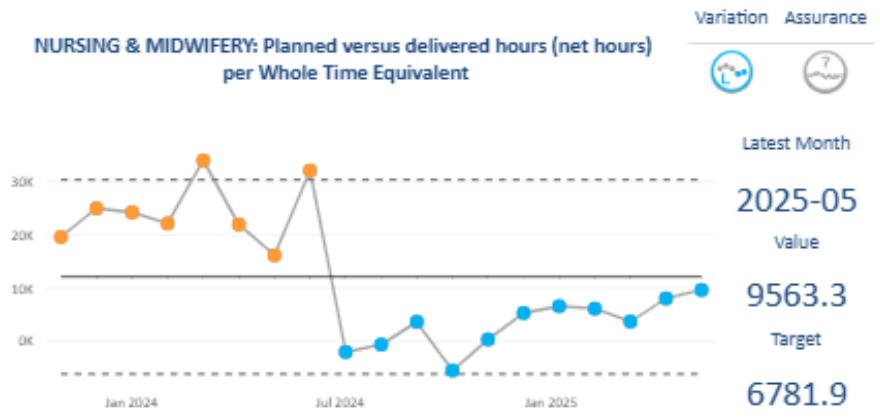
The Collaborative Bank is live, enabling nurses to book shifts across partnering organisations in the region. The first collaborative bank shift was booked and worked on the York site in June, with positive feedback from the worker. Two Trust collaborative bank workers are actively booking shifts in Hull. Work continues with system partners to increase membership. This position will be monitored to ensure the distribution of shifts is balanced and does not disadvantage the Trust. The next step of the collaborative is to explore expanding the service to cover medical roles.

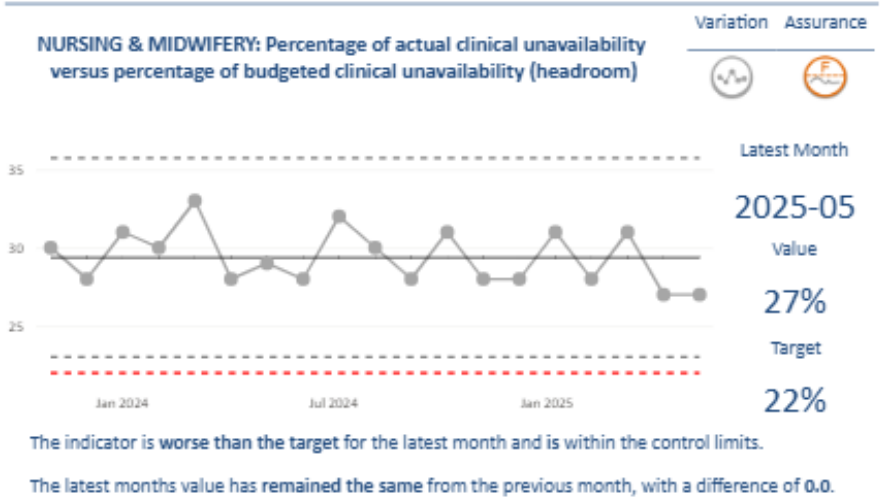
The Trust will launch new medical bank rates in August, introducing an unsocial hour rate for each grade. By moving away from a flat rate card, the Trust is hoping to reduce the need for rate escalations. Alongside the new rates, the Trust will introduce a new process for rate escalation approvals.

The Trust has been monitoring the number of administrative bank shifts undertaken each month. 758 shifts were recorded in June, a reduction from 793 shifts in May. As part of a review into administrative bank, it was identified that not all shifts were being recorded at the point of reporting (the figure originally reported in May's TPR was 737). To ensure greater transparency, all departments have been asked to ensure shifts are added to their rosters prior to being worked. To support with a reduction in bank usage, all departments are being provided with a list of their shifts and authorisation is being sought from appropriate budget holders for any on-going use. This work has already identified opportunities for some bank work to cease. With restrictions in place around vacancy control, the organisation will continue to monitor this activity closely.

Work is on-going to reduce agency rates, through on-going negotiations with agencies to reduce rate cards and reduce individual booking rates. Suppliers are starting to offer midwives within the agency price caps, so work is underway to see if we can replace some of the above price cap block bookings within the department.

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





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 units (IPUs) areas and Level 2 for nursing non-IPUs and AHPs.
An aim is to publish 100% of rosters with at least 6 weeks' notice. The scorecard shows the Trust is at 43% overall, but this figure includes all areas on HealthRoster. Performance within staffing groups undertaking roster improvement work is notably better. Nursing IPUs achieved 96% , nursing non-IPUs 58% (up from 48%) and AHPs 52% (up from 40%).
From 14th July, nursing IPUs will start to publish rosters 12 weeks in advance.
Utilisation of self-rostering or the auto-roster function is low at present. The Trust is exploring ways to increase take-up, to release efficiencies and support a better work life balance for colleagues.

	% 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	3.7%	2	12%	7	15.12%
Non-IPU's	0%	0	41%	46	16.16%
AHPs	0%	0	94%	50	37%

78% of the workforce are now on eRostering. The Trust is aiming to have 90% of the clinical workforce on eRostering by the end of Summer 2025. Medical and Dental are the only staffing group remaining to achieve this.

Staffing Group	% on Healthroster	Staffing Group	% on Healthroster
Nursing and Midwifery	99%	AHP	98%
Additional Clinical Services	98%	Healthcare Scientists	91%
Sci and Technical	97%	Medical and Dental	67%
Admin and Clerical	58%	Estates and Ancillary	4%

Workforce
Scorecard (2)

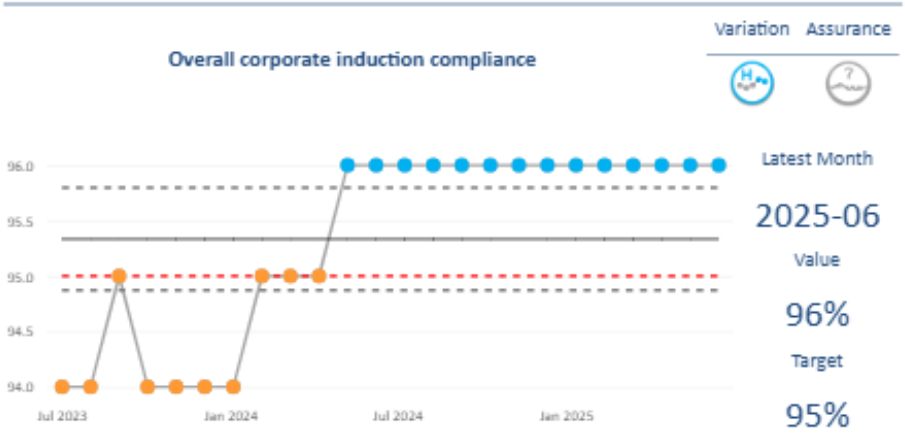
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-06	H	F	88%		90%
Overall corporate induction compliance	2025-06	H	?	96%		95%
A4C staff stat/mand training compliance	2025-06		F	89%		90%
A4C staff corporate induction compliance	2025-06	H	?	97%		95%
Medical & dental staff stat/mand training compliance	2025-06	H	F	77%		90%
Medical & dental staff corporate induction compliance	2025-06	H	F	95%		95%
Appraisal Activity	2025-06		?	6.2%		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 compared with our previous aim of 87% compliance.

In June, there was a 1% increase in compliance to 88%. This was supported by increases in training completion across most subjects and in particular improved rates amongst colleagues on the Bank.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S Digital

July 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	• Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	• Number of P1 incidents* • Percentage of FOIs and EIRs responded to within 20 working days (monthly)	
SPECIAL CAUSE CONCERN			

Digital & Information Services (DIS)
Scorecard

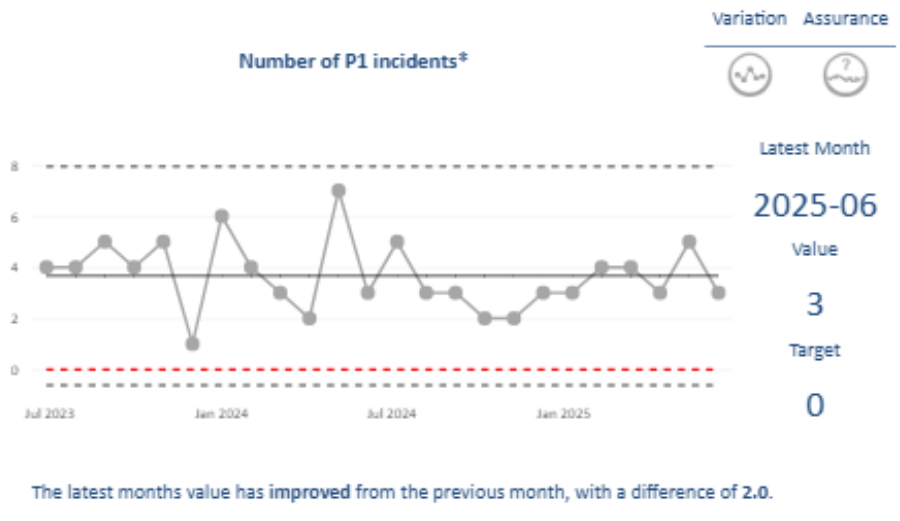
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

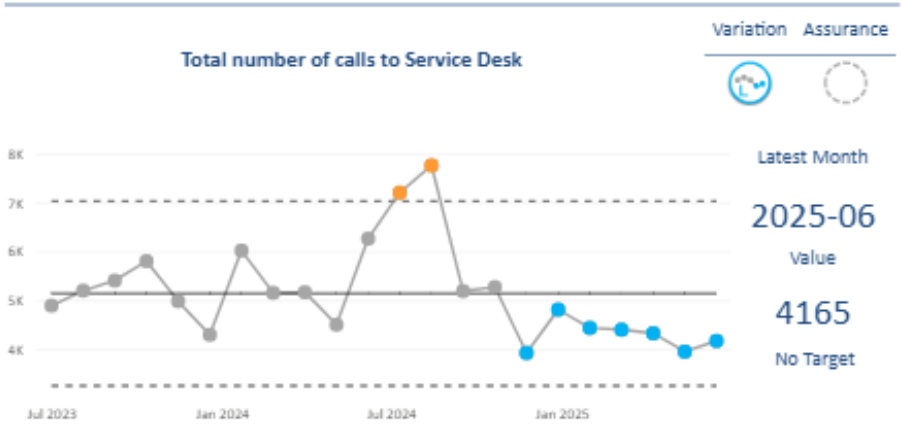
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2025-06			3		0
Total number of calls to Service Desk	2025-06			4165		
Total number of calls abandoned	2025-06			897		
Number of information security incidents reported and investigated	2025-06			34		
Number of patient Subject Access Requests (SAR) received (monthly)	2025-06			290		
Number of patient Subject Access Requests (SAR) completed (monthly)	2025-06			260		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2025-06			93%		80%
Number of FOIs and EIRs received (monthly)	2025-06			73		
Number of FOIs and EIRs completed (monthly)	2025-06			72		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2025-06			92%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy



The latest months value has **improved** from the previous month, with a difference of **2.0**.



The latest months value has **deteriorated** from the previous month, with a difference of **219.0**.

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. 7/6/25 CPD overnight Friday/Saturday not accepting new connections between 0030 and 0600. Database restarted approx. 0400 which would disconnect any connected sessions. Fully resolved by 0600.

2. 18/6/25 Bridlington loss of phones and network connections. Power disconnected in error by external contractors working on cooling systems. Duration <20 minutes

3. 18/6/25 Nelson's Court network offline between 19:10 and 03:20 on 19/6 due to network configuration fault.

Actions:

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

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

Number of information security incidents reported and investigated

Variation Assurance

The latest months value has **improved** from the previous month, with a difference of **8.0**.

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

Number of information security incidents reported and investigated

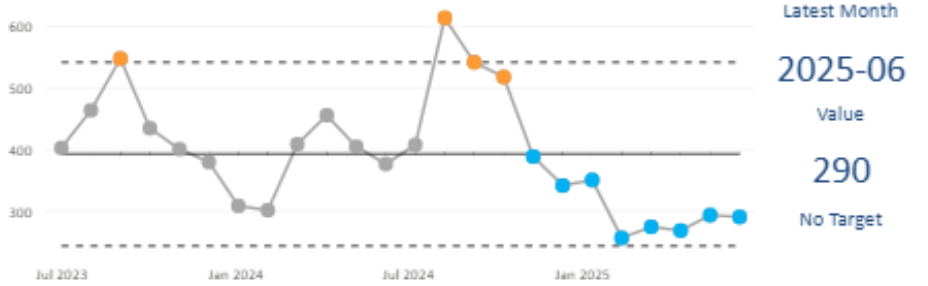
Factors impacting performance:

There has been a decrease in incidents during June compared to the previous month, but this is slightly higher than the same period in the previous year. Misfiles and disclosed in error account for nearly 50% of these incidents.

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

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

Variation Assurance



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

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

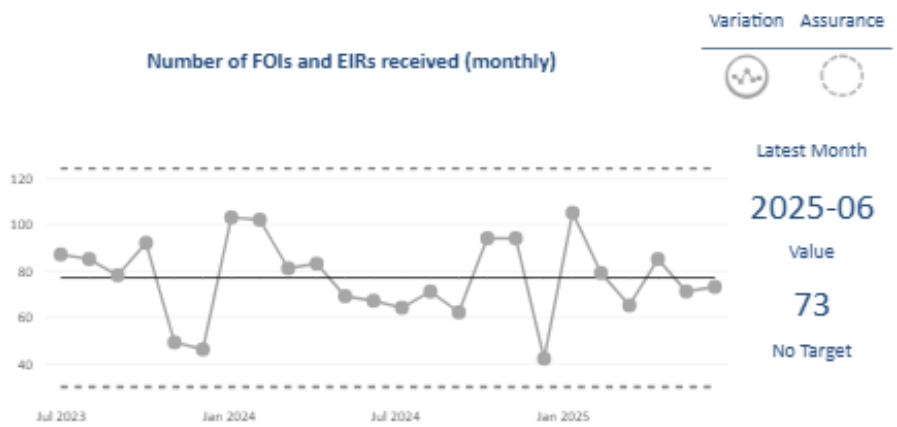
Number of Subject Access Requests (SAR) submitted by patients

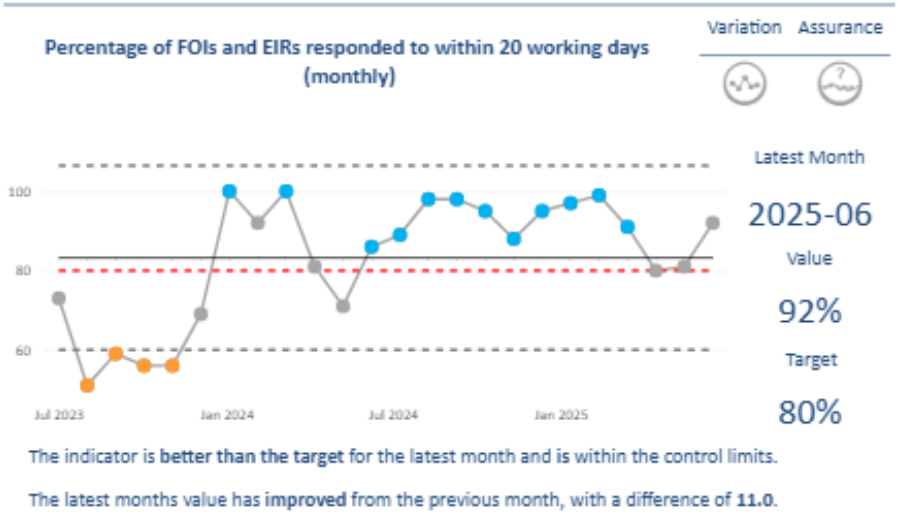
Factors impacting performance:
The reporting for SARs has changed to only include patient access requests. Previous reports have also included police requests, access to health records (deceased patients) and ad hoc external requests which are no longer included in this count.

Volumes received have increased compared to last month and timeliness of responses has improved from 83% last month to 95% in June, which is now achieving target.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley





Trust Priori... . D SPC 3

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 June has increased slightly, but is currently less than requests received at this time last year.

Actions: N/A

Percentage of FOIs responded to within 20 working days

Requests being sent out on time has marginally increased (+12%) and is above the target of 80%. This has improved by 6% compared to the previous year.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

July 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
- The plan includes £16.5m of deficit support funding. This is not guaranteed and can be withdrawn if the Trust and ICB are not meeting their financial obligations.

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)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£1.3m	-£1.9m	↓	Deteriorating
Corporate CIP Delivery Variance to Plan (£26.6m target)	-£2.1m	-£3.1m	↓	Deteriorating
Core CIP Delivery Variance to Plan (£27.3m Target)	£1.5m	£2.7m	↑	Improving
Business Case CIP Delivery Variance to plan (£1.4m target)	-£0.1m	-£0.2m	↓	Deteriorating
Variance to Agency Cap	-£0.3m	£0.3m	↑	Improving
Month End Cash Position	£26.8m	£24.1m	↓	Deteriorating
Capital Programme Variance to Plan	-£0.3m	-£2.6m	↑	Improving

	Plan	Plan YTD	Actual YTD	Variance	Forecast
	£000	£000	£000	£000	£000
Clinical Income	790,045	197,511	200,008	2,496	790,045
Other Income	91,832	22,965	22,926	-38	91,832
Total Income	881,877	220,476	222,934	2,458	881,877
Pay Expenditure	-591,522	-146,504	-148,628	-2,124	-591,522
Drugs	-74,050	-17,513	-20,153	-2,640	-74,050
Supplies & Services	-94,541	-22,868	-23,076	-208	-94,541
Other Expenditure	-153,655	-30,528	-31,145	-616	-153,655
Outstanding CIP	45,447	526	0	-526	45,447
Total Expenditure	-868,321	-216,887	-223,002	-6,115	-868,321
Operating Surplus/(Deficit)	13,556	3,589	-68	-3,657	13,556
Other Finance Costs	-12,196	-3,049	-2,507	542	-12,196
Surplus/(Deficit)	1,360	540	-2,575	-3,114	1,360
NHSE Normalisation Adj	-1360	-1590	-362	1229	-1360
Adjusted Surplus/(Deficit)	0	-1,051	-2,936	-1,886	0

The I&E table confirms an actual adjusted deficit of £2.9m against a planned deficit of £1.1m, leaving the Trust with an adverse variance to plan of £1.9m.

In respect of deficit support funding, Q1 has been received for the system based on a fully planned efficiency program across all providers and the ICB. Q2 funding, based on the progress of CIP delivery, and the month 2 position has also been secured. Although we haven't met all the metrics for Q2 deficit support, the receipt of this has been determined through a judgment by our NHSE regional team based on the progress that has been made in de risking the efficiency programme, there is however a significant risk to the Q3 deficit support funding.

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.

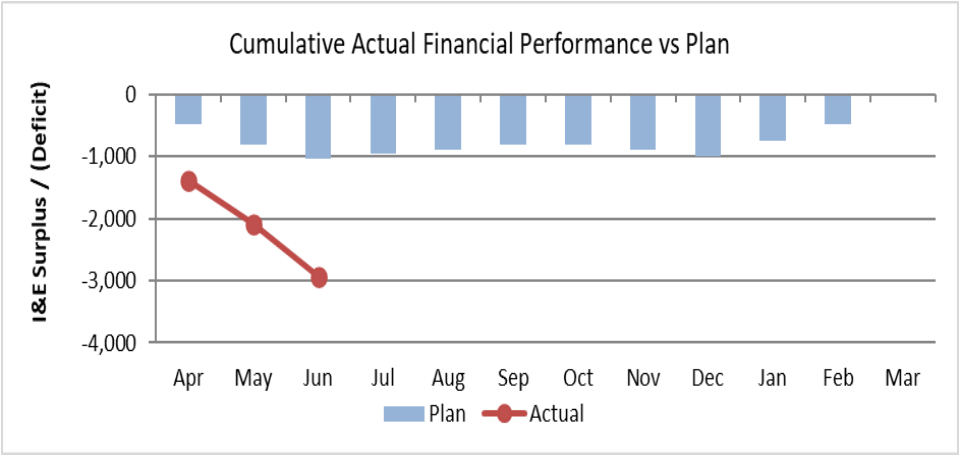
Key Subjective Variances: Trust
Finance (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable / (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	(£7,758)	NHSE under trade linked to services which have been delegated to ICBs to commission. There is a corresponding over trade on the ICB line below. The reduction is NHSE income is partially offset by increased income relating to pass through drugs and devices	Confirm contracting arrangements and ensure plans and actual income reporting align.
ICB Income	£10,038	ICB over trade linked to services which have been delegated from NHSE to commission.	Confirm contracting arrangements and ensure plans and actual income reporting align
Employee Expenses	(£2,124)	Agency, bank and WLI spending is ahead of plan to cover medical vacancies.	To continue to control agency spending within the cap. Work being led by HR Team to apply NHSE agency best practice controls, continued recruitment programmes (including overseas recruitment). Vacancy control measures in place.
Drugs	(£2,640)	Relates to drugs commissioned by ICBs that were previously contracted for on a pass-through basis (£1.6m) but are now included in the block payment. A risk share arrangement was agreed in the 2025/26 plan to manage cost growth in this group of drugs. In addition, growth in drugs commissioned on a pass-through basis by NHS England (£1m).	Identify opportunities to expedite reduction in cost growth including switching to biosimilar products. Work led by Chief Pharmacist to review cost effective use of first line treatment options.
CIP	(£526)	The Corporate Programme is £3.1m behind plan, the Core Programme is £2.7m ahead of plan and the Business Case Programme is £0.2m behind plan.	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group.
Other Costs	(£616)	Growth in unbundled OP Radiology costs that were previously contracted for on a pass-through basis but are now included in the block payment (£0.8m)	Identify drivers for increased demand for OP Radiology and take corrective action as appropriate.

Cumulative Actual Financial Performance vs Plan & Forecast

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 at the end of June 2025 is a deficit of £2.9m compared to a planned deficit of £1.1m. This represents an adverse variance to plan of £1.9m.

Forecast			
	Adjusted Surplus/(deficit)		
Scenario	Plan £'000	Forecast £'000	Variance £'000
Likely Case	0	0	0
Best Case	0	0	0
Worst Case	0	-30,693	-30,693

Forecast Scenarios

Best & Most likely Case

The best and most likely case forecasts meet the balanced plan. These both assume the risks within the position are mitigated through work with the ICB in respect of £10m Sparsity funding, delivering an additional £6m savings in respect of High-Cost Drugs, delivering our efficiency programme and receipt of £5.1m 24/25 ERF overtrade.

Worst Case

The worst case identifies the risk to the position should the above not be resolved.

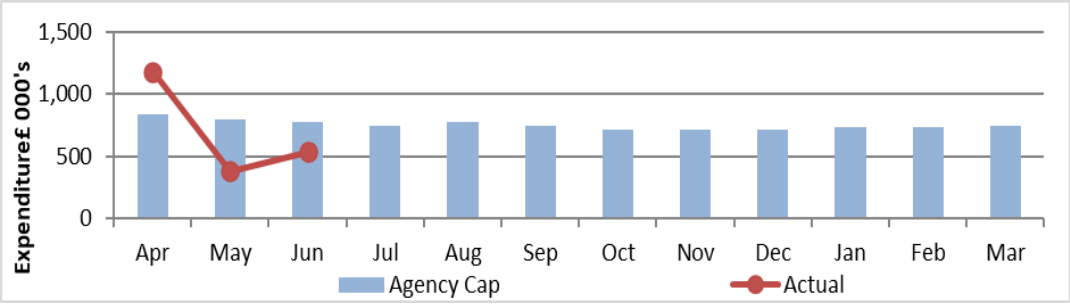
Care Group Forecast
Finance (5)

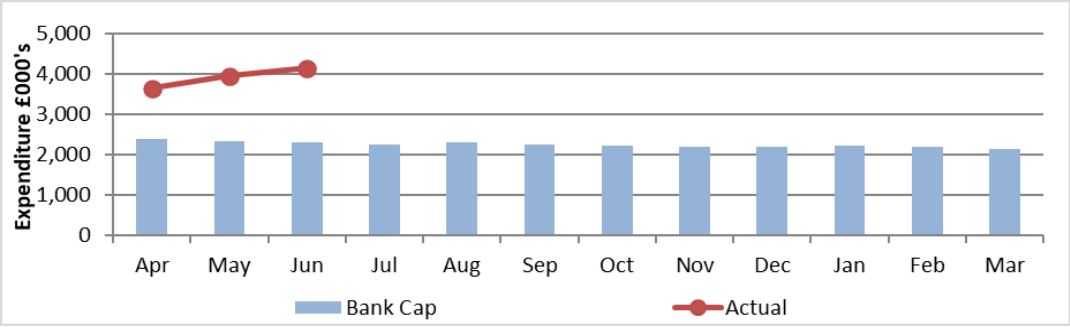
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	232,044	57,615	58,656	-1,041	58,582	-74	Deteriorating position in June caused by £1.3m increase in Drug Spend compared to run rate, CIP £91k behind plan, offset by vacancies mainly due to Scarborough CDC Delay.
Family Health Care Group	85,985	21,804	22,086	-282	22,036	-50	£120k relates to the premium cost of covering medical vacancies, £95k Community Nursing overspend, £204k Midwifery overspend, £153k other non pay underspend, £216k overachieved CIP.
Medicine	183,790	47,168	49,837	-2,669	47,257	-2,580	£1.1m relates to medical cost pressures in ED and Acute; £1.1m drugs overspend, primarily Gastro and Respiratory.
Surgery	159,582	40,393	41,079	-686	40,699	-380	Overspend mainly relates to Resident Doctors pay costs over budget - £0.7m, reduced by non-rec pay savings to be actioned against the planned CIP
TOTAL	661,400	166,980	171,658	-4,678	168,574	-3,084	

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	232,044	232,005	0	232,005	39	Forecast improvement largely driven by expected reduction in drug cost based on previous year trends and continuation of vacancy savings prior to Scarborough CDC go-live, CIP forecast to over deliver by £345k.
Family Health Care Group	85,985	87,055	0	87,055	-1,070	£479k relates to the premium cost of covering medical vacancies, £381k Community Nursing overspend, £814k Midwifery overspend, £474k other non pay underspend, £130k over-planned CIP.
Medicine	183,790	198,359	-150	198,209	-14,419	£4.2m relates to medical staffing cost pressures, £4.4m drug overspend and £3.8m shortfall in CIP delivery
Surgery	159,582	163,987	-257	163,730	-4,149	£2.5m over-spend on Resident Doctors mainly relates to premium cost of covering medical vacancies; £1m Theatre capacity gap/overtime payments; £0.3m Ward 25 pay costs over budget & £0.4m bank & agency backfill for 11 apprentice posts (mainly in TACC)
TOTAL	661,400	681,405	-407	680,998	-19,599	

Agency, Bank and Workforce
Finance (6)





	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,600.02	2,467.33	132.69	40,036	40,122	-87
Scientific, Therapeutic and Technical	1,314.42	1,233.43	80.99	18,450	18,023	427
Support To Clinical Staff	1,948.14	1,632.67	315.47	16,356	15,771	586
Medical and Dental	1,112.86	1030.07	82.79	38,059	41,407	-3,347
Non-Medical - Non-Clinical	3,229.47	2,992.94	236.53	32,340	32,733	-393
Reserves				693	0	693
Other				569	571	-2
TOTAL	10,204.91	9,356.44	848.47	146,504	148,627	-2,123

Agency Controls

The Trust has an agency staffing spend reduction target of 40% based on 2024/25 outturn. The expenditure on agency staff at the end of May is £2.091m compared to a plan of £2.400m, representing a favourable variance of £0.309m.

Bank Controls

The Trust has a bank staffing spend reduction target of 10% based on 2024/25 outturn. The expenditure on bank staff at the end of May is £11.730m compared to a plan of £7.013m, representing an adverse variance of £4.717m.

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 Commissioner ERF weighted Values in Contract.

Commissioner	25-26 Target % vs 19/20	Variable Contract Value ERF scope Indicative Weighted Values at 25/26 prices	ERF Month 03 Phase (Av %)	Activity to Month 03 Actual	Variance - (Clawback Risk) M03
Humber and North Yorks	104.00%	£170,198,576	£41,531,957	£45,329,870	£3,797,913
West Yorkshire	103.00%	£1,394,671	£340,328	£396,856	£56,528
Cumbria and North East	115.00%	£175,707	£42,876	£74,260	£31,384
South Yorkshire	121.00%	£181,684	£44,335	£41,826	-£2,508
Other ICBs - LVA / NCA	-				*£0*
All ICBs	***104.02%***	***£171,950,638***	***£41,959,496***	***£45,842,813***	***£3,883,316***
NHSE Specialist Commissioning	113.38%	£4,752,000	£1,159,586	£27,464	-£1,132,122
Other NHSE	104.13%	£303,039	£73,948	£61,292	-£12,656
All Commissioners Total	**104.31%**	**£177,005,677**	**£43,193,030**	**£45,931,569**	**£2,738,539**

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.

Given the potential limits on Elective Recovery Funding in 2025/26, it is important to closely monitor the position to ensure that the weighted activity undertaken, where it incurs additional costs, does not exceed the planned levels without ICB Commissioner discussion and authorisation. Additional system funding may become available in year if other system providers, including the Independent sector, are under their agreed plan and elective resource can be redirected.

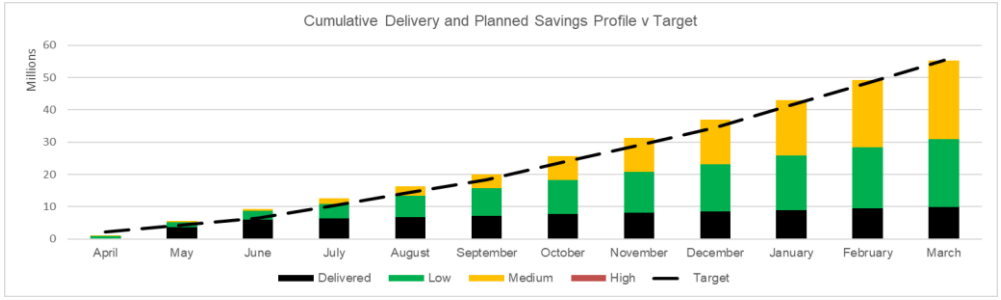
At Month 3, ERF weighted activity is £2.7m over the funded level of ERF activity within the Commissioner contracts.

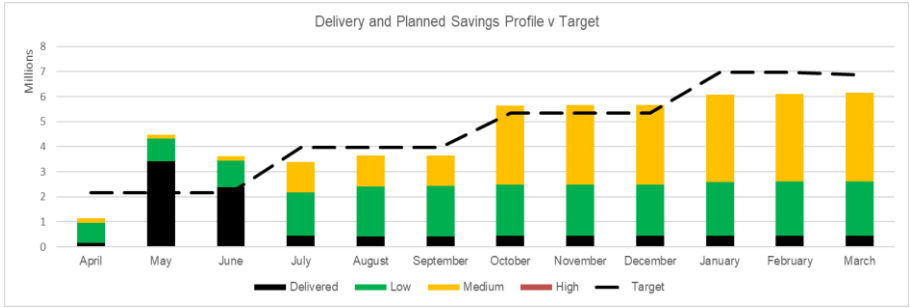
This position moved from last month due to:

- -£923k adjustment to the HNY ERF Target Value
- +£800k of additional activity relating to Ophthalmology not included in the Month 2 reported position.
- +£615k of additional activity above planned levels in Month 3.

Cost Improvement Programme
Finance (8)

York and Scarborough Teaching Hospitals NHS Foundation Trust





	Full Year CIP Target	June 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	3,121	45	3,076	180	26,402	13,162	13,420	1,282	11,880	0
	26,582	**3,121**	**45**	**3,076**	**180**	**26,402**	**13,162**	**13,420**	**1,282**	**11,880**	**0**
Core Programme											
Medicine	6,039	709	276	433	661	5,377	6,249	-211	1,771	4,479	0
Surgery	4,524	531	181	350	725	3,799	4,569	-44	3,031	1,538	0
CSCS	7,044	827	736	91	1,073	5,970	7,389	-345	6,777	611	0
Family Health	2,306	271	483	-212	829	1,476	2,438	-132	2,321	116	0
CEO	91	11	2	9	7	84	70	21	7	62	0
Chief Nurses Team	653	77	28	49	110	542	903	-250	110	792	0
Finance	750	88	93	-5	639	111	733	17	639	94	0
Medical Governance	55	6	4	2	16	39	62	-7	62	0	0
Ops Management	308	36	79	-43	251	57	532	-224	253	279	0
DIS	2,219	261	10	250	41	2,178	601	1,618	41	560	0
Workforce & OD	1,377	162	118	44	472	905	763	615	472	291	0
YTHFM LLP	1,962	230	170	60	680	1,282	1,983	-21	940	1,043	0
Central	0	0	3,736	-3,736	4,162	-4,162	14,479	-14,479	13,294	1,185	0
	27,327	**3,209**	**5,917**	**-2,708**	**9,668**	**17,659**	**40,769**	**-13,442**	**29,718**	**11,051**	**0**
Business Cases											
EPR BC	1,382	162	0	162	0	1,382	1,360	22	0	1,360	0
	1,382	**162**	**0**	**162**	**0**	**1,382**	**1,360**	**22**	**0**	**1,360**	**0**
Total Programme	**55,290**	**6,492**	**5,962**	**531**	**9,848**	**45,442**	**55,290**	**0**	**30,999**	**24,291**	**0**

Efficiency Programme

The total trust efficiency target is £55.3m, £9.8m has been achieved in full year terms and the year-to-date position is £0.5m behind plan. The programme is fully planned.

Corporate Efficiency Programme

The Corporate efficiency programme has a target of £26.6m and £0.2m has been delivered in full year terms. At the end of June, the year-to-date delivery is £3m behind plan. Identified plans total £13.2m, leaving a gap of £13.4m.

Core Efficiency Programme

The Core efficiency programme target is £27.3m and £9.7m has been delivered in full year terms. At the end of June, the year-to-date delivery is £2.7m over plan. There are identified plans totaling £40.8m which is £13.4m over the target level.

Business Cases

The Business case efficiencies target is £1.4m. No savings have been delivered for the first quarter. Plans are in place to deliver £1.4m in full.

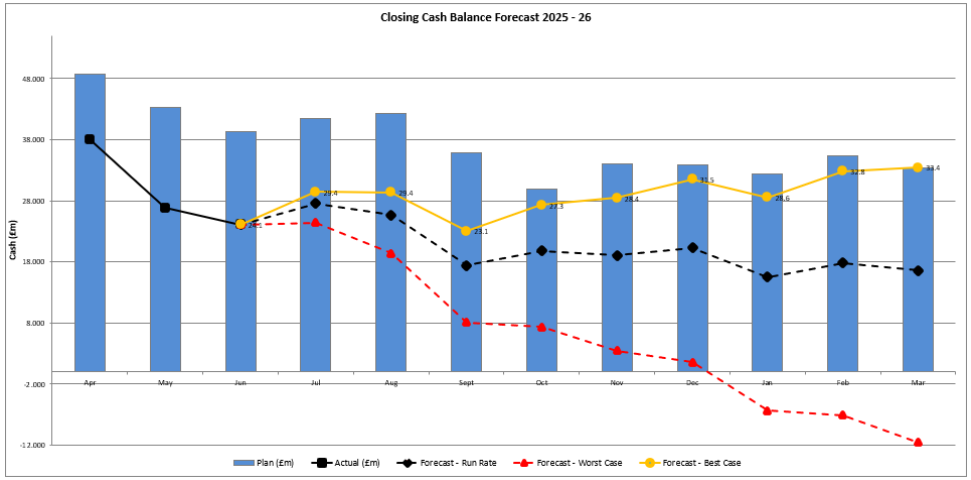
Current Cash Position and Better Payment Practice Code (BPPC)

Finance (9)

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	26,832	24,135									



The graph illustrates the cash balance at the end of June; £24.1m against a plan of £39.4m, which is £15.3m adverse.

The significant factors creating the variance are:

£3.7m – Adverse variance in I&E operating surplus / (deficit).

£4m – Adverse variance due to timing of reclaimable VAT. £2m has been received on 1st July, and a further £1.6m is expected later in July.

£2.8m – Adverse variance due to drug and inventory levels.

£2.3m – Adverse variance in debtors. £1.5m is linked to NHS debtors. We are working to resolve issues and secure receipt of cash.

The forecast contains 3 scenarios:

Run rate – Based on continuation of cash receipts & payment run rates in line with April to June levels.

Best case – Based on the Trust recovering to deliver the financial plan.

Worst case – Based on the Trust delivering a £30.7m deficit.

Delivery of the financial plan & the efficiency program are crucial. Any slippage impacts cash reserves, creating a cash pressure.

Better Payment Practice Code

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

The graph illustrates that in June the Trust managed to pay 91% of its suppliers within 30 days.

Current and Forecast Capital Position

Finance (10)

NHS
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	M3 Actual £000s	Variance to Plan £000s
PDC Funded Schemes	56,525	3,216	857	(2,359)
IFRS 16 Lease Funded Schemes	7,838	260	163	(97)
Depreciation Funded Schemes	16,626	2,664	2,515	(149)
Charitable & Grant Funded Schemes	7,213	374	12	(362)
Total Capital	**88,202**	**6,514**	**3,547**	**(2,967)**
Less Charitable & Grant Funded Schemes	(7,213)	(374)	(12)	362
Less Sale of Clarence Street	(325)	-	-	-
Total Capital (Net CDEL)	**80,664**	**6,140**	**3,535**	**(2,605)**

The M3 position is £2.6m behind plan.

The is mainly due to the York VIU / PACU / Hybrid Theatre running £2m behind the planned profile and the Electronic Patient Record scheme running £0.3m behind planned profile.

These schemes are expected to return to plan in future months as projects progress.

System Summary – NHSE Efficiency Governance Arrangements 2025/26

Finance (11)

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

Weekly reporting on CIP position and monthly oversight meetings have been taking place.

Plans are categorised by risk:

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

Q1 Deficit support funding achieved based on meeting the top 2 criteria above, Q2 achieved based on progress shown in reduction of risk, overall system position and progress on efficiency delivery. Q3 at risk.

System Summary – Note: M2 System position

Finance (12)

HNY System Position - Month 2	Financial Performance			
	Year to Date			FOT Var to Plan
	Plan	Actual	Var	
	£'000	£'000	£'000	£'000
Harrogate	-963	-3,060	-2,097	0
HUTH	-2,310	-2,310	0	0
Humber	-505	2,695	3,200	0
NLAG	-2,866	-2,866	-0	0
Y&S	-820	-2,086	-1,266	0
ICB	804	804	0	0
Total	-6,660	-6,823	-163	0

HNY System Position - Month 2	Risks & Mitigations						
	Plan				Forecast		
	Efficiency Risks	All other Risks	Mitigations	Var	Efficiency Risk	Other Risks/ Mitigations	Var
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Harrogate	-4,500	-8,500	8,000	-5,000	-4,643	0	-4,643
HUTH	-43,172	-16,400	35,623	-23,949	-26,739	11,126	-15,613
Humber	-1,500	-4,067	2,800	-2,767	-1,049	0	-1,049
NLAG	-40,134	-9,050	26,061	-23,123	-21,366	-4,150	-25,516
Y&S	-18,274	-16,506	25,218	-9,562	-22,992	14,448	-8,544
ICB	-40,337	-21,259	37,126	-24,470	-37,873	15,519	-22,354
Total	-147,917	-75,782	134,828	-88,871	-114,662	36,943	-77,719

HNY System Position - Month 2	Efficiencies					
	Year to Date			Forecast		
	Plan	Actual	Var	Plan	FOT	Var
	£'000	£'000	£'000	£'000	£'000	£'000
Harrogate	1,367	1,026	-341	14,467	14,467	-0
HUTH	8,297	5,483	-2,814	68,320	68,320	-0
Humber	1,744	1,723	-21	12,550	12,588	38
NLAG	7,799	5,211	-2,588	61,680	61,680	0
Y&S	4,328	3,628	-700	55,290	55,290	0
ICB	9,479	7,692	-1,787	82,594	82,594	-0
Total	33,014	24,763	-8,251	294,901	294,939	38
Recurrent	18,761	13,676	-5,085	179,644	209,101	29,457
Non Recurrent	14,253	11,087	-3,166	115,257	85,838	-29,419
	33,014	24,763	-8,251	294,901	294,939	38

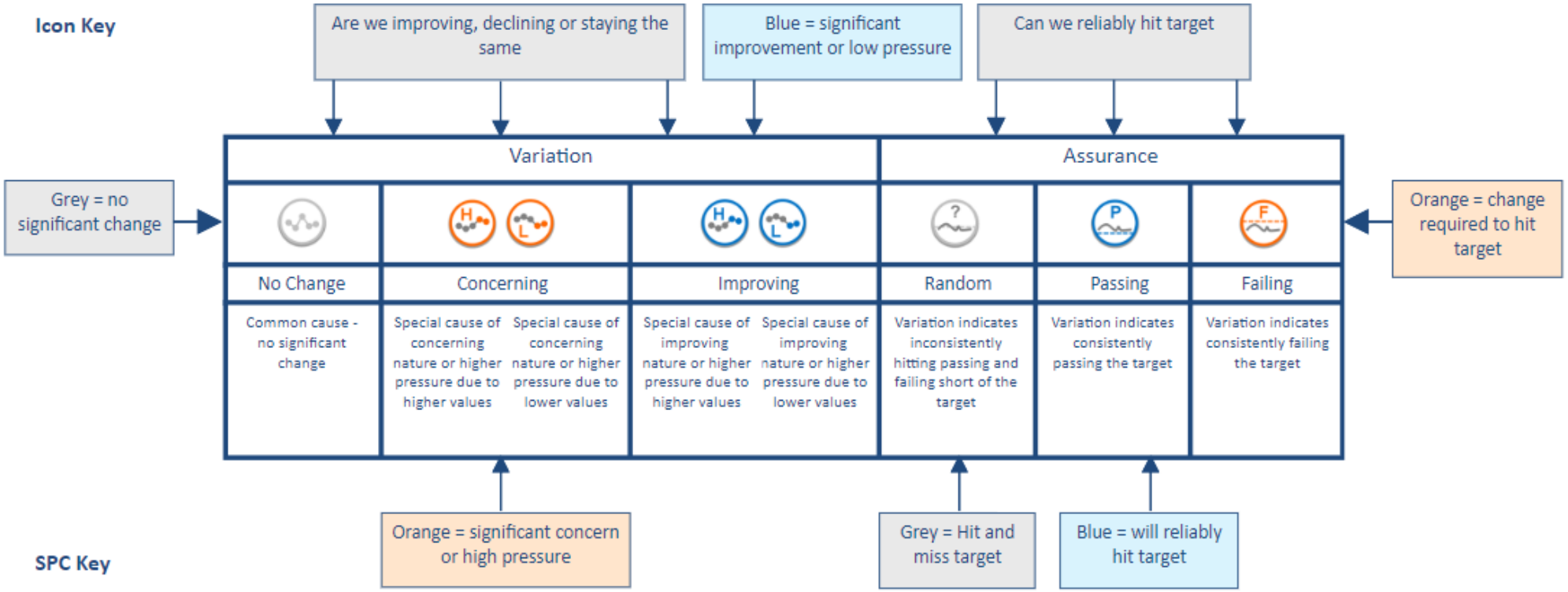
The system closed month 2 with a £163k deficit against a £6.7m deficit plan.

A key focus on our position is our risk & mitigations and our efficiency delivery.

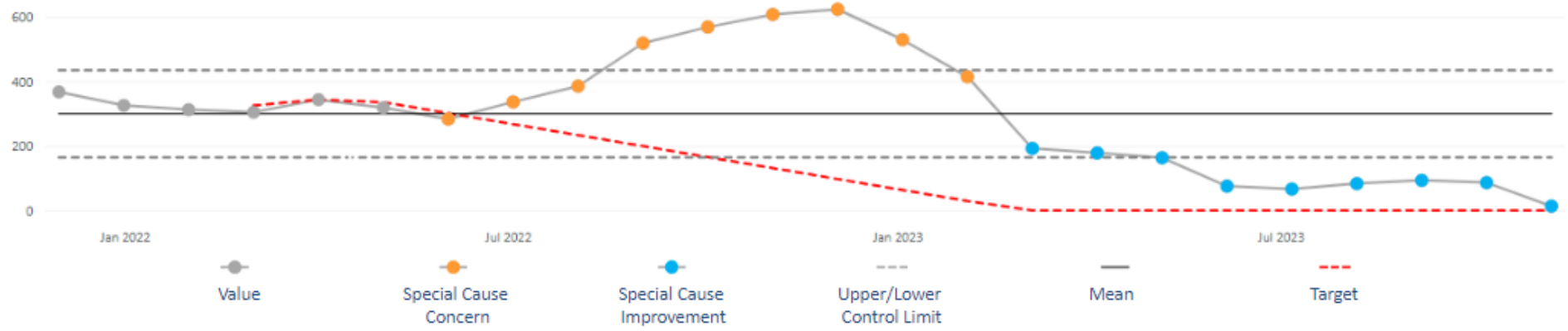
Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key



SPC Key



The orange and blue points indicate either increasing or decreasing trends. The colour will update if 7 points appear either above or below the mean or if 2 out of 3 are near the upper or lower control limit. The target can be either static or moving.

Icon Descriptions

NHS
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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

Item 12

Report to:	Board of Directors
Date of Meeting:	30 July 2025
Subject:	CQC Update
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.
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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:

The CQC inspection report for York Hospital Urgent and Emergency Care and Medical Care services was published on 2 July 2025.

There are 12 open CQC cases.

Recommendation:

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

Report History		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
Patient Safety and Clinical Effectiveness	9 July 2025	*Presented and accepted.*

CQC Update

1. CQC Activity

The CQC inspection report for York Hospital Urgent and Emergency Care and Medical Care services was published on 2 July 2025. The report can be accessed here.

An overview of the ratings following the inspection is as follows:

- Overall, Urgent and Emergency Care has improved from inadequate to requires improvement, as have the ratings for being safe and responsive. Well-led has improved from inadequate to good. Effective and caring have improved from requires improvement to good.
- Medical care has been re-rated as requires improvement overall, as well as for being safe, effective, responsive and well-led. Caring has been re-rated as good.
- The overall rating for the York Hospital has improved from inadequate to requires improvement.

The CQC has requested an action plan for the following breaches of legal regulation:

Regulation 12 Safe Care and Treatment

- Urgent and Emergency Services - The service was in breach of legal regulations in relation to safe care and treatment as care records were not always up to date or completed in full.
- Medical Care - The service was in breach of legal regulations in relation to safe care and treatment as it was not always assessing the risk to the health and safety of patients and ensuring infection, prevention and control standards were followed.

Regulation 15 Premises and Equipment

- Urgent and Emergency Services - The service was in breach of legal regulations in relation to premises and equipment. We found chemical substances in an unlocked room. These tubs of disinfectant are required to be locked according to COSHH (Control of Substances Hazardous to Health' and under the Control of Substances Hazardous to Health Regulations 2002) recommendations. Staff were not completing full resuscitation trolley checklists this meant we could not be assured all specialist lifesaving equipment was stocked and in date in the event of an emergency.
- Medical Care - The service was in breach of legal regulations in relation to premises and equipment as it was not always secure and suitable for the purpose for which it was being used.

Regulation 17: Good Governance

- Medical Care - The service was in breach of legal regulations in relation to good governance as staff did not maintain secure and accurate, complete and contemporaneous records in respect of each patient, including a record of the care and treatment provided to the patient and decisions taken in relation to the care and treatment provided.

Regulation 18: Staffing

- Medical Care - The service was in breach of legal regulations in relation to staffing, as staff were not receiving all the training required, especially medical staff.

The action plan will be submitted for approval at the Journey to Excellence meeting on 14 July 2025 and to the Executive Committee on 16 July 2025. The action plan must be submitted to the CQC by 22 July 2025.

We have invited our CQC colleagues to visit the Scarborough Hospital site to tour the new Urgent and Emergency Care Centre and Maternity Services on 8 July 2025.

2. Journey to Excellence Group

.

The next meeting of the Journey to Excellence Group is scheduled for 14 July 2025. The Quality Governance Team has begun collating key themes from the CQC inspection report, with the associated improvement actions set to be the focus of the discussion.

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.

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

4. CQC Updates

4.1 Chief Inspector Updates

Four Chief Inspectors have been appointed to the CQC:

Dr Arun Chopra has been appointed as CQC's first ever Chief Inspector of Mental Health. To read Dr Arun's blog click here.

Professor Bola Owolabi (MRCGP, MFPH Hon, FRSPH) has been appointed as the new Chief Inspector of Primary and Community Services. Professor Owolabi will be joining CQC from NHS England where she is currently Director of the National Healthcare Inequalities Improvement Programme. As Chief Inspector of Primary and Community Services, Professor Owolabi will lead on CQC's regulation of some of the most frequently used parts of the health and care system – including general practice and dentistry. For more information click here.

Dr Toli Onon has been appointed as Chief Inspector of Hospitals. Dr Onon is currently Joint Chief Medical Officer and Responsible Officer at Manchester University NHS Foundation Trust (MFT). She is a Consultant Obstetrician and Gynaecologist and combines her medical leadership responsibilities with frontline clinical work at Saint Mary's Hospital in Manchester. Further information can be found here.

Chris Badger has been appointed as CQC's Chief Inspector of Adult Social Care and Integrated Care. Chris will lead CQC's regulation of services for older people and adults with complex needs and oversee how local authorities meet their duties under the Care Act 2014.More information can be found **here**

4.2 New CQC Board confirmed

CQC announced on 30 June 2025 that Kay Boycott, Alex Kafetz, Michael Mire, Ruth Owen, Melanie Williams and Richard Barker have been appointed to the CQC Board. For further information **click here.**

4.3 Health and social care support for people with dementia

The CQC has published a report on the experiences of individuals with dementia interacting with health and social care services in England, and how these services are responding. CQC have found that the number of people being diagnosed with dementia is increasing. In February 2025, nearly half a million people in England had a dementia diagnosis. The likelihood of developing dementia, becoming an informal carer or both in a lifetime in the UK is 55% (around 1 in 2). Click here to read the report

4.4 Blog: Julie Stanborough speaks about children and young people's experiences to help improve care

Julie Stanborough, Director of Data and Insight, reflects on the findings from the CQC 2024 Children and Young People's Patient Experience Survey — the first since 2020 and based on responses from nearly 26,000 children, young people, and their families. The results show that most respondents felt well cared for, involved in decisions, and treated with respect. However, the data also highlights areas for improvement, particularly around how concerns are handled and how well the needs of children with mental health conditions, autism, or disabilities are met. These insights will inform the CQC regulatory work and help NHS trusts improve care for all children and young people.

For more information click on the link Read blog

4.5 Oliver McGowan Code of Practice

Since 1 July 2022, all CQC registered health and social care providers have been required by the Health and Care Act 2022 to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people with a learning disability. This should be at a level appropriate to their role.

On 19 June 2025 the Oliver McGowan Code of Practice was published by the department of health and social care. The purpose of the code is to explain what is meant by training that is 'appropriate to the person's role' and to provide guidance on how to ensure all staff receive such training.

Compliance with the standards set out in the code of practice, is expected to ensure that every person receives high quality learning disability and autism training that meets their learning needs and is appropriate to their role. Importantly, this aims to improve the experiences and outcomes of autistic people and people with a learning disability when they access CQC regulated health and social care services.

This means that CQC registered providers must ensure that they provide each member of staff with training that meets the standards set out in the Code in order to deliver the best possible outcomes. CQC will use the Oliver McGowan Code of Practice when considering whether providers are meeting the requirements of the regulation. For more information click on link Read more

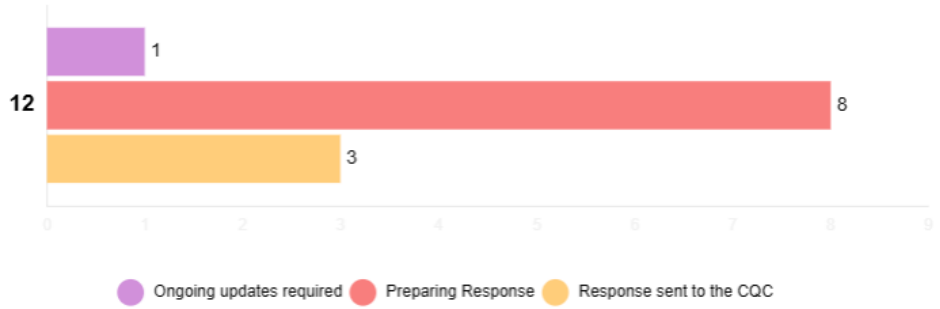
Date: 2 July 2025

Appendix A

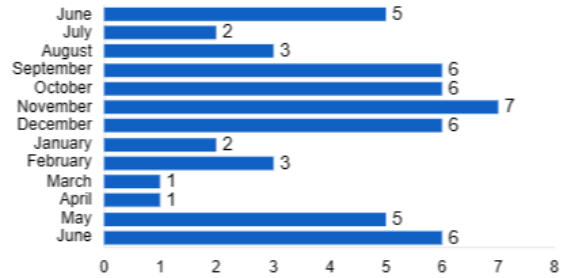
CQC Enquiries over the last 12 months

York and Scarborough Teaching Hospitals NHS Foundation Trust

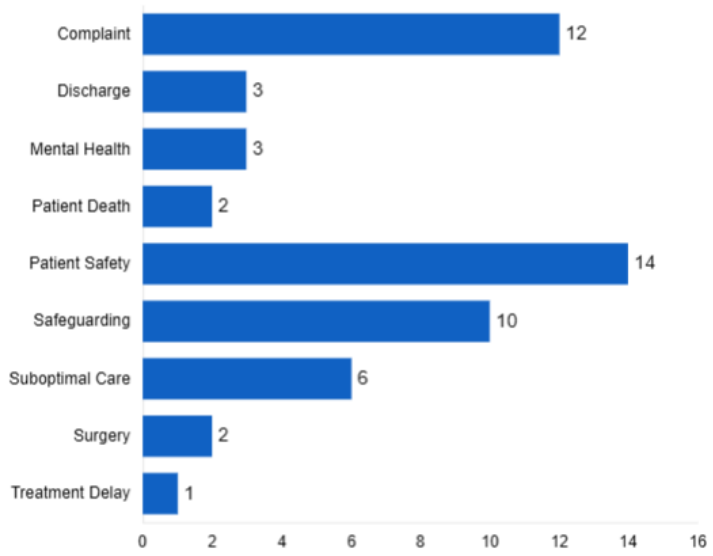
Number of Open CQC Enquiries / Cases



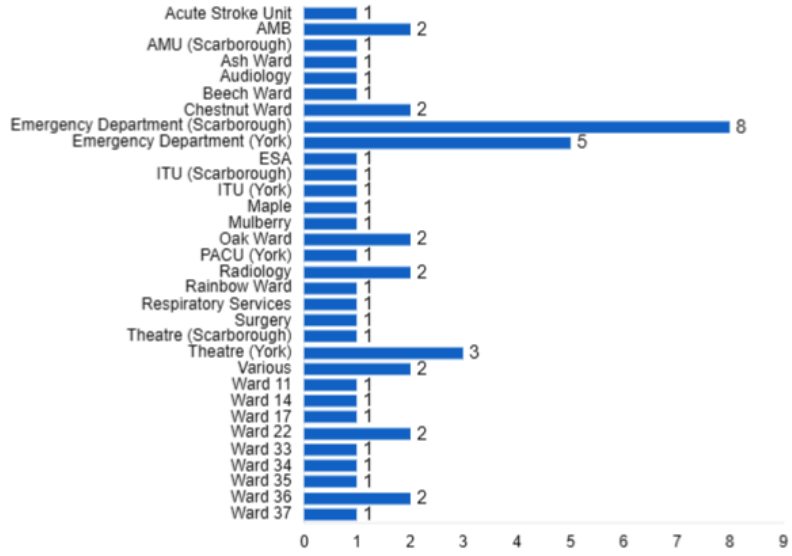
Number of Enquiries Received



Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



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

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

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☒ Transformative Services
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☐ Financial Balance
☐ Effective Governance

Implications for Equality, Diversity and Inclusion (EDI)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

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. There were no newly declared PSII or MNSI cases. There was one antenatal stillbirth, and the case has been reviewed at the Maternity Case Review meeting with no initial concerns. There are a total of 172 open incidents, the oldest dates back to March 2024. There has been a slight increase of 8 overdue incidents since May. A focused piece of work is going to be undertaken to address the oldest incidents. There are 6 pathway reviews and 16 After Action Review's to be completed. There are 2

PSIRF learning responses to be signed off in at the Patient Safety Learning Response meeting. There have been challenges of completing timely reviews of incidents and patient safety learning responses due to sickness and a deficit of substantive posts required within the Maternity quality and safety framework is having an impact on timely review of incident and patient safety learning responses.

There remains concern raised from substantive staff on both sites regarding safe midwifery staffing levels and the increased use of agency staff.
Over the last few months, the vacancy factor has risen at the York site (-15.5WTE) which is a shift from the Scarborough site (-5.26WTE) due to leavers, maternity leave and career progression into other essential posts. The increasing vacancy rate alongside the staffing gap identified by Birthrate plus an additional investment of 44WTE clinical midwives was required to meet minimum safe staffing levels has led to Managers/ Matrons and Specialist Midwives undertaking clinical shifts to mitigate. Following career conversations with the 3rd year students qualifying in September, 13WTE have been recruited. Scarborough have recruited 6.6WTE for SGH and 6.4WTE for York site. A decision is still awaited if the Maternity services can over recruit the newly qualified Midwives therefore not utilising the vacancy rate which accounts for Band 6/7 experienced Midwives. Therefore, the Director of Midwifery has had to use the vacancy to recruit as there were initially 18 newly qualified Midwives and due to delays in offering posts 4 have accepted offers at other trusts.

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 which has increased from 12 weeks to 16 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.

Recommendation:
The Board is asked to receive the updates from the maternity and neonatal service 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	15th July 2025	1. To note the progress with the safety actions and improvement work in maternity and neonatal services.

		2. To note to increased midwifery vacancy at the York site and following no conclusion reached on over recruiting of the newly qualified midwives the existing vacancy of Band 6/7s is being used 3. 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 May 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 May 2025.

Perinatal Deaths

In May 2025 there were no neonatal deaths and one stillbirth. The case has been reviewed at the Maternity Case Review meeting with no initial concerns and will have a Perinatal Mortality Review Tool undertaken.

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.

Maternity and Newborn Safety Investigations (MNSI)

In the month of May there were no new cases that met the criteria for referral to MNSI for investigation. A draft report had been received for the maternal death for factual accuracy. The factual accuracy was returned with a letter on behalf of the Director of Midwifery, Clinical Director for Obstetrics, Anaesthetic Lead for Obstetrics and the Family Health Care Group Medical Director on the 17th June 2025. A response from MNSI is awaited.

Patient Safety Incident Investigations (PSII)

In the month of May there were no new PSIIs declared. There remain three ongoing cases. Three draft PSIIs has been shared with the family, one PSII has been submitted for sign off and two have been shared with the family and require minor amendments.

Moderate Harm Incidents and above

The postpartum haemorrhage (PPH) rate was 2.3% (8 cases) in May 2025. The data demonstrates there has been a reduction in the Trust rolling average over 12 months for PPH ≥1500mls months with a slight increase since January 2025 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.

Quality and Safety

There are a total of 172 open incidents, the oldest dates back to March 2024. There has been a slight increase of 8 overdue incidents since May. A focused piece of work is going to be undertaken to address the oldest incidents. There are 6 pathway reviews and 16 After Action Review's to be completed. There are 2 PSIRF learning responses to be signed off in at the Patient Safety Learning Response meeting. There have been challenges of completing timely reviews of incidents and patient safety learning responses due to sickness and a deficit of substantive posts required within the Maternity quality and safety framework is having an impact on timely review of incident and patient safety learning responses.

Core Competency Training

Fetal monitoring training compliance remains above 90% for all staff groups. Training compliance for PROMPT continues to improve in all staff groups and is on trajectory for 90% for all staff groups to meet the Maternity Incentive Scheme deadline of the 30th November. Going forward there is a plan in place to support Obstetric and Anaesthetic staff groups to maintain >90% with training requirements to be monitored by the Consultant Leads.

Service User Feedback

Concerns have been raised due to the availability of the birthing pools on the York site following three pools/ baths being closed for 4 weeks. Following water tests conducted from the birthing pools at York Hospitals it was identified these did not pass the quality controls. Following work being undertaken from the Estates and Infection Prevention Control team two pools have been reopened.
There is a theme with the care women are receiving following a second trimester bereavement. The Transformation Lead Midwife is leading a quality improvement project with the bereavement midwives.

Staff Feedback from Maternity and Neonatal Safety Walkarounds

There remains concern raised from substantive staff on both sites regarding safe midwifery staffing levels and the increased use of agency staff.

CQC Section 31 Progress Update

Annex 2 provides the May 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 May 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 which has increased from 12 weeks to 16 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. The Director of Midwifery has asked the LMNS to assess if neighbouring Trusts Perinatal Health teams can help support.

New Perinatal Mental Health Service Available for East Riding

There is a new maternal mental health service available to women with a GP in Hull, East Riding, North and North East Lincolnshire.

The maternal mental health service will provide specialist advice, consultation, interventions, and treatment for women experiencing moderate to severe and/or complex mental health problems that are specific to reproductive trauma and loss within maternity context. The service will work collaboratively with maternity, mental health partners and voluntary, community and social enterprise organisations across the patch to deliver a trauma informed approach to care, demonstrating improvements in psychological wellbeing for women.

Special Care Baby Unit Refurbishment on York Site

The Trust has been awarded £2.1 million for the refurbishment of the Special Care Baby Unit on the York site. There is an options appraise being developed to review the most suitable arrangement for the decant options. The Director of Midwifery has included the Operational Delivery Network within the meetings who have advised if the Neonatal service is considering reducing cot capacity during the decant, a reduction from the current capacity of 15 down to 10 would not have an impact in the system. However, anything below a cot capacity of 10 would put additional pressure on Maternity and Neonatal services in the region. A risk assessment of the current options is in progress.

Maternity Incentive Scheme

The Maternity Incentive Scheme report and action plan was presented at the Trust Board in January 2025. NHS Resolution have confirmed the Trust was compliant with 4 out of the 10 safety actions. The lowest compliance in Year 6 of the scheme was 4 out of 10 sections actions by two maternity services. The Trust has received confirmation the funds awarded to support the safety actions in Year 7 is £420,115.60. The funds are 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.

Safety Action 1: PMRT quarterly report has been submitted to Trust Board in November 2024, February and May 2025. Currently on track for compliance for Year 7.
Safety Action: 2: Currently on track for compliance for Year 7.
Safety Action 3: 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. Monthly audit of consultant attendance for clinical situations commenced in February 2025. Audit demonstrates full compliance. Recruit to the vacant Tier 2 Registrar position at York to achieve BAPM standards. Active recruitment underway. Complete a neonatal medical workforce establishment review as per the Maternity and Neonatal Single Improvement Plan timeframes. Develop business case to support findings in the Neonatal Frontline Staffing Establishment paper.

Anaesthetic staffing is not compliant with the Safety Action 4 at Scarborough.
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)
Out of hours Anaethetists cover Maternity and Acute Services. This means there are occasions the Anaesthetist cannot attend Maternity immediately.
Clarification has been sought from NHS Resolutions.

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 of 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. Currently on track for Year 7.
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. Currently on track for Year 7.
Safety Action 10: Currently on track for compliance for Year 7.

Midwifery Workforce

Over the last few months, the vacancy factor has risen at the York site (-15.5WTE) which is a shift from the Scarborough site (-5.26WTE) due to leavers, maternity leave and career progression into other essential posts. The increasing vacancy rate alongside the staffing gap identified by Birthrate plus an additional investment of 44WTE clinical midwives was required to meet minimum safe staffing levels has led to Managers/ Matrons and Specialist Midwives undertaking clinical shifts to mitigate. Following career conversations with the 3rd year students qualifying in September, 13WTE have been recruited. Scarborough have recruited 6.6WTE for SGH and 6.4WTE for York site. A decision is still awaited if the Maternity services can over recruit the newly qualified Midwives therefore not utilising the vacancy rate which accounts for Band 6/7 experienced Midwives. Therefore, the Director of Midwifery has had to use the vacancy to recruit as there were initially 18 newly qualified Midwives and due to delays in offering posts 4 have accepted offers at other trusts. Conversations are being had with the agency midwives regarding applying for substantive posts however many live in the London region and would require relocating.

Office of National Statistics

In 2024, there were 567,708 live births in England and 26,832 live births in Wales. Although this is an increase of 0.7% in live births for England. Several regions in England also experienced a decline in live births: North East, East Midlands, East, South East and South West. The overall increase in births appears to be primarily caused by the numbers of births in the West Midlands and London. Births have remained static at the York site with 2690 births in 2023 and 2682 in 2024. Births have slightly declined at Scarborough with 1177 births in 2023 and 1112 in 2024. However, both sites have seen an increase in the acuity of the patients with increasing induction of labour and caesarean births.

The average age of parents in England and Wales has been increasing steadily for the last 50 years. In 2024, the number of live births for mothers showed:

- a decrease in live births in lower age bands (those aged under 20, those aged 20 to 24 years, and those aged 25 to 29 years)

- an increase in live births in higher age bands (those aged 30 to 34 years, those aged 35 to 39 years, and those aged 40 years and over)
- the largest increase in live births from 2023 to 2024 was for mothers aged 35 to 39 years, where numbers of live births grew by 2.7%
- the largest decrease of live births was seen in those aged under 20 years, declining by 4.6%

When observing mothers' ages by country of birth, only 15.7% of live births for those aged under 20 were to non-UK-born mothers, however for mothers aged 40 to 44 and 45 and over, non-UK-born mothers make up 44.2% and 55.5% of live births, respectively.

The multiple maternity rate (the proportion of maternities with multiple babies) has broadly been decreasing since 2015. Births in 2024 have followed this trend with the multiple maternity rate decreasing by 4.2% from 14.4 in 2023 to 13.8 in 2024.The multiple birth rate on the York site in 2023 was 46 and in 2024 was 44. The multiple birth rate on the Scarborough site was 16 in 2023 and 10 in 2024.

Improvement and Transformation

Neonatal BadgerNet implementation planning is underway, and a process mapping session took place in June to support bespoke tailoring of BadgerNet package.
Transitional Care working group established with key stakeholders and project brief in development. There is a plan to implement transitional care on the York site first.
Learning Needs Analysis and Training Needs Analysis was signed off at the Maternity Directorate in June.
Birthing outside of guidance working group established which includes service users and staff.
Antenatal Clinic referral vetting audit completed to identify if there are any opportunities to create efficiencies.

MNVP and Maternity Services commenced collecting qualitative information from service users with regards to their experience within our diabetic services. The information will inform future service improvements and patient information leaflets.
Development of an action plan to deliver an in house stop smoking in pregnancy service has commenced to support implementation of element 2 SBLV3.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

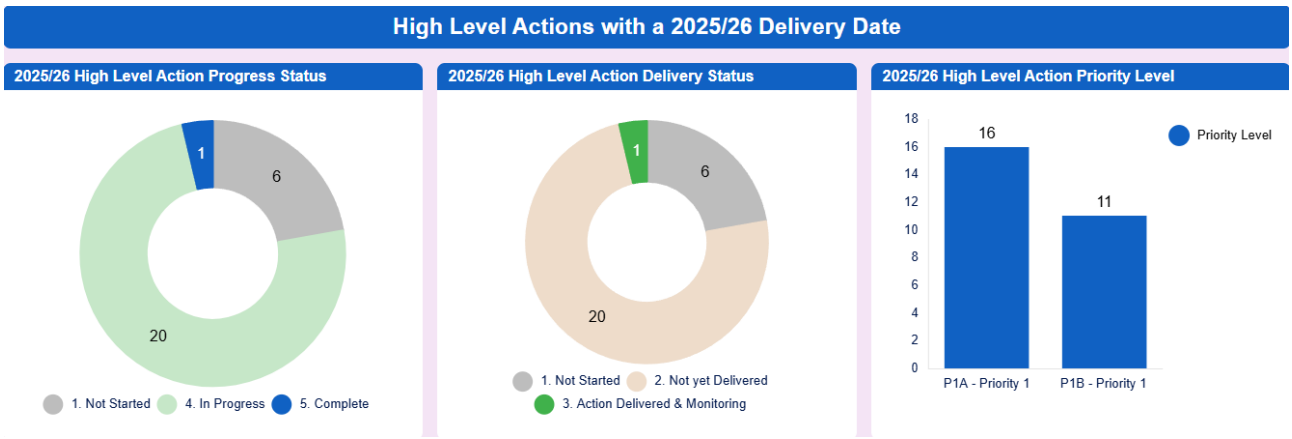
The overview dashboard displays all 41 high level actions and 244 milestone actions. It captures all completed actions to date and priority levels of actions across the entire plan. Timelines for actions yet to be completed have been aligned to the revised delivery dates as per the clinical strategy submission to provide teams with a refreshed picture of the overall health of the delivery of the Maternity & Neonatal Single Improvement Plan.

Priority 1 actions have been prioritised for 2025/26 as per Clinical Strategy Submission

- 27 High Level actions
- 128 Milestones actions

Current position:

- 2 Milestone actions are at risk
- 4 Milestone actions has been marked as off track.



Key Risks to Delivery of the Single Improvement Plan

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.

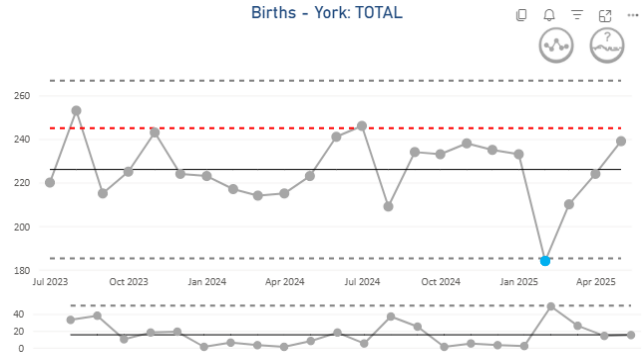
Recommendations to Trust Board

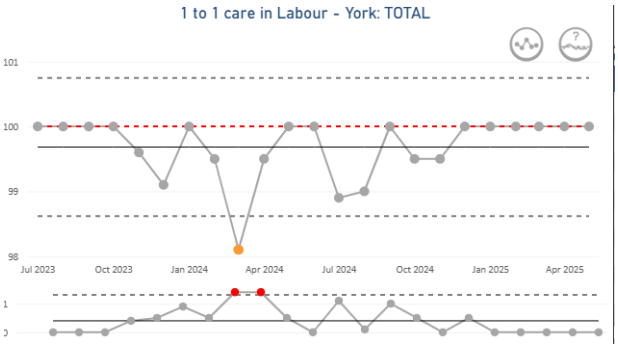
To note the contents of this report and agree the CQC section 31 submission in Annex 2

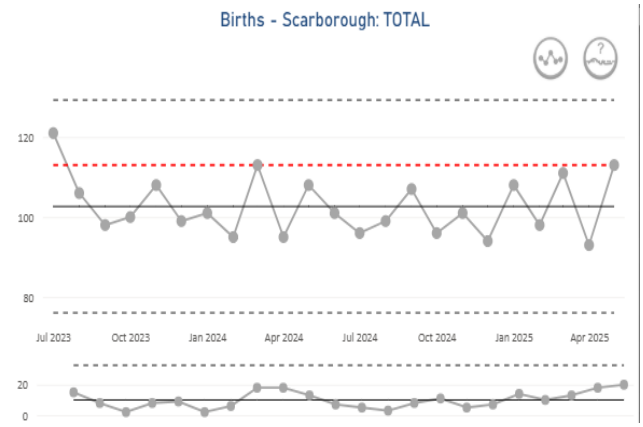
Date: 20th July 2025

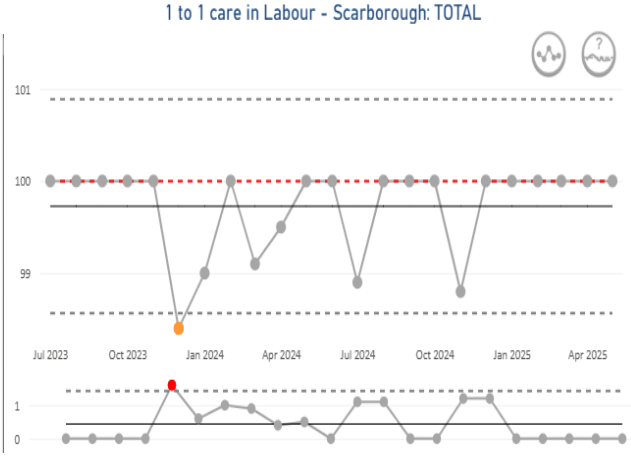
Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery May 2025

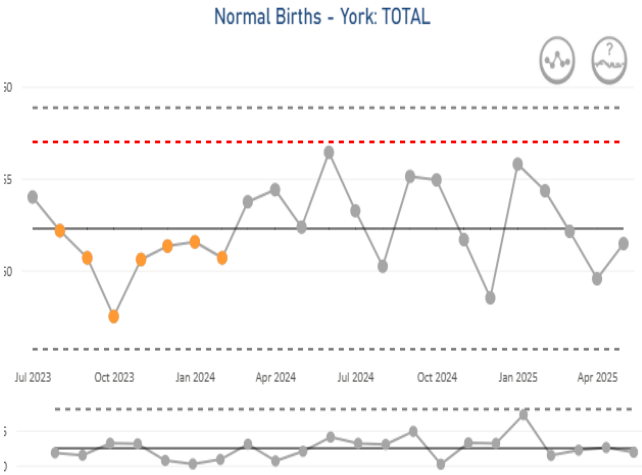
Dashboard

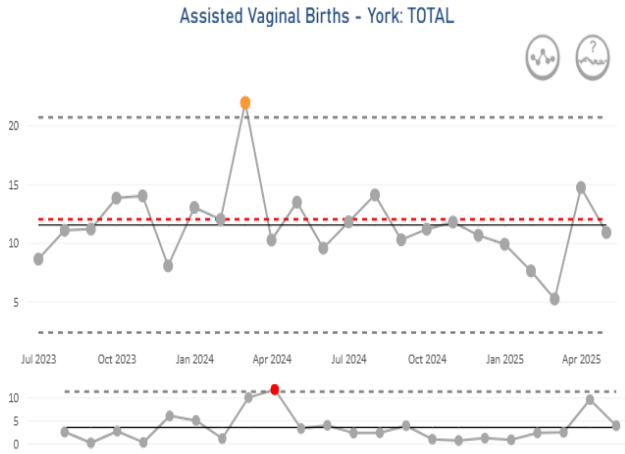


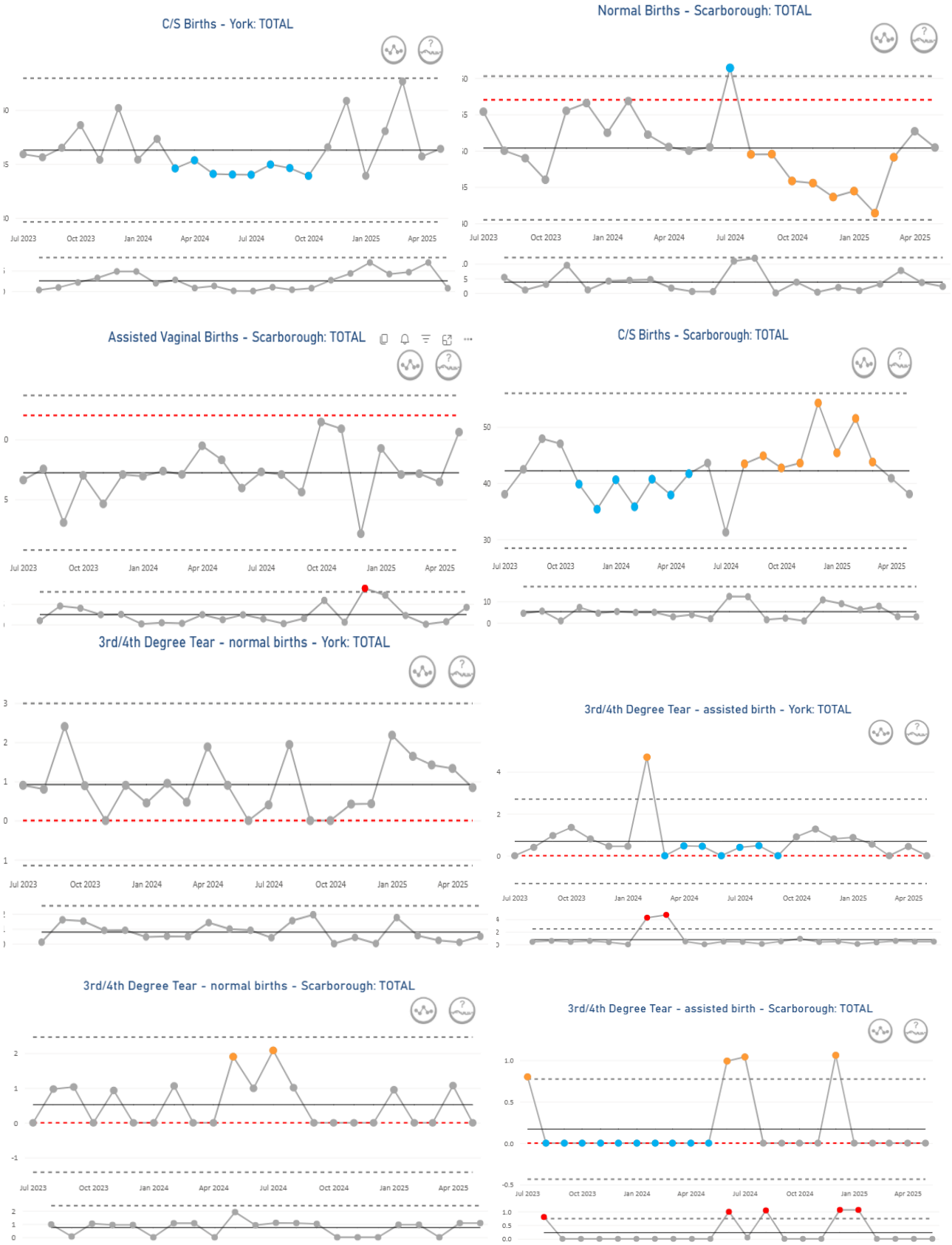











C/S Births - York: TOTAL
Normal Births - Scarborough: TOTAL
Assisted Vaginal Births - Scarborough: TOTAL
C/S Births - Scarborough: TOTAL
3rd/4th Degree Tear - normal births - York: TOTAL
3rd/4th Degree Tear - assisted birth - York: TOTAL
3rd/4th Degree Tear - normal births - Scarborough: TOTAL
3rd/4th Degree Tear - assisted birth - Scarborough: TOTAL
Jul 2023
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025

Annex 2

Report to:	Quality Committee
Date of Meeting:	15th July 2025
Subject:	Maternity CQC Section 31 Update
Director Sponsor:	Dawn Parkes - Chief Nurse Executive 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 July 2025 monthly submission to the CQC which provides assurance on progress and impact on outcomes in May 2025.

Report History

Meeting	Date	Outcome/Recommendation
Maternity Assurance Group	8th July 2025	Discussed and approved

CQC Section 31 Progress Update

Maternity Services at York and Scarborough NHS Teaching Hospitals Foundation Trust have embarked on a programme of service and quality improvements.

This report provides assurance on the progress to date in delivering against the improvement plan for the purpose of the monthly submission to CQC following the Section 31 Notice.

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 May 2025 are outlined below.

Staff Group	York	Scarborough
Midwives	93% (163/180)	90% (75/83)
Consultants	94% (16/17)	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. One Consultant is booked on training in June and the second in July 2025. A training plan has been developed for the Obstetric team to ensure training is undertaken within 12 months which will be monitored by the Clinical Director of Obstetrics. Compliance will continue to be monitored at the Maternity Directorate, Quality Assurance Committee and Trust Board.

A.3 Risk Assessments and Care Plans

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

Table 4
Antenatal Risk Assessments

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

BadgerNet has the facility to pull other risk assessment reports. Table 4-9 demonstrates compliance from January to May 2025.

Table 5
Antenatal Booking Risk Assessments

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

April 2025	100%	100%
May 2025	100%	100%

Table 6
Risk Assessment for Growth and Pre-eclampsia

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

Table 7
Venous Thromboembolism Risk Assessment at Booking

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

Table 8
Venous Thromboembolism Risk Assessment on Admission (within 14 hours)

Month	York	Scarborough
January 2025	72%	84%
February 2025	73%	88%
March 2025	76%	86%
April 2025	52%	76%
May 2025	90.5%	84.56%

Table 9
Venous Thromboembolism Risk Assessment Following Birth

Month	York	Scarborough
January 2025	100%	100%
February 2025	100%	100%
March 2025	100%	100%
April 2025	100%	100%
May 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 has been a special cause for improvement in the red flags seen on the York site (Chart 1). There is common cause seen for red flags at the Scarborough site (Chart 2).

Compliance on the York site is 97% and Scarborough 100% of attendances seen within 15 minutes for rapid assessment. Shift fill now 97% on Scarborough. There is a notable increase in compliance with women being seen within 15 minutes on the Scarborough site

by having a dedicated triage team of midwives with occasional shifts covered by Band 5 and Band 6 Midwives.

Chart 1

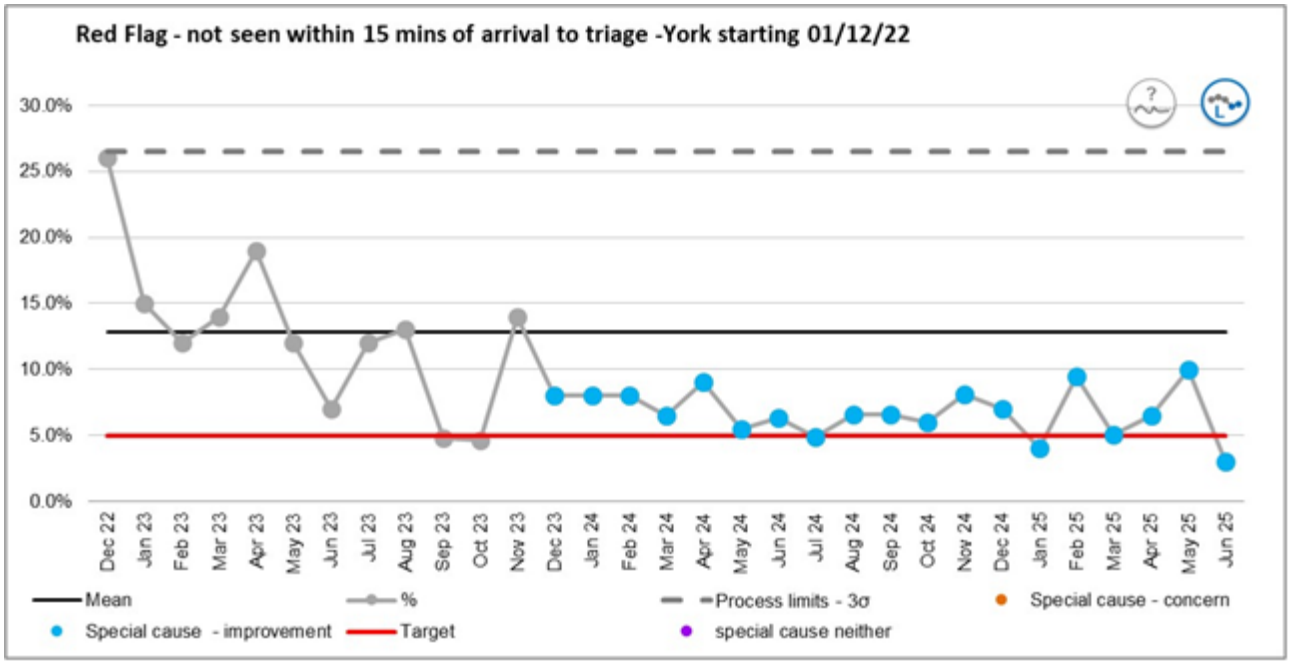


Chart 2

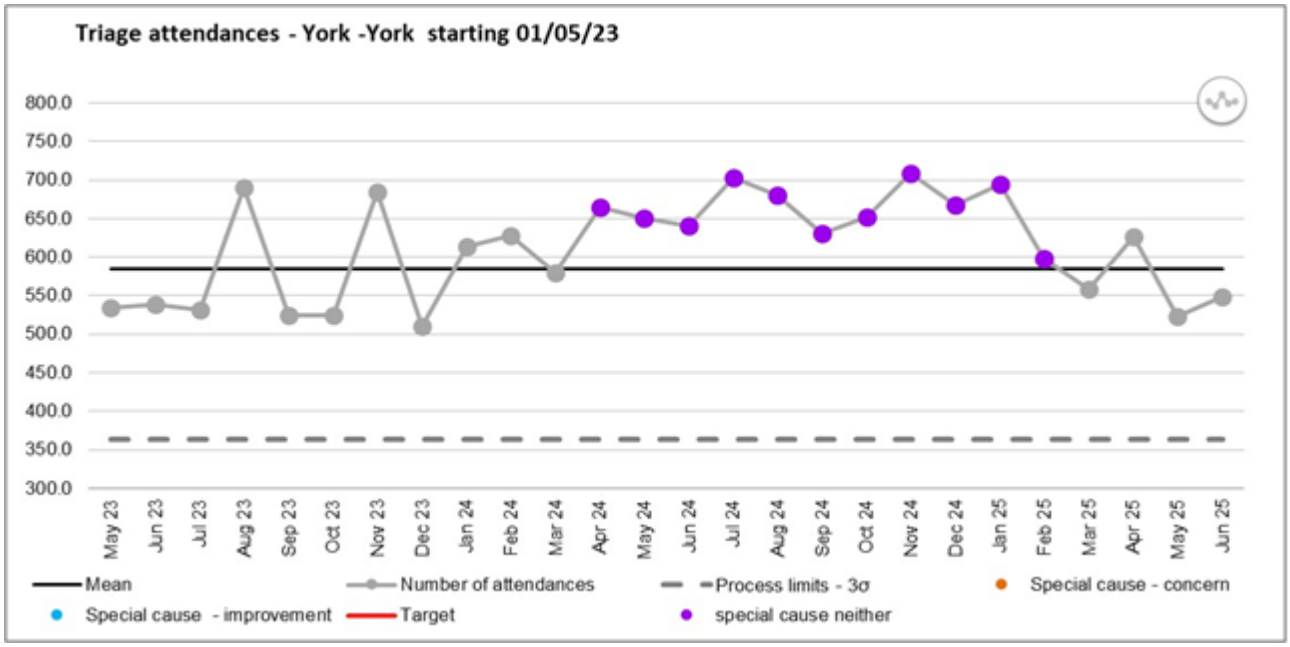
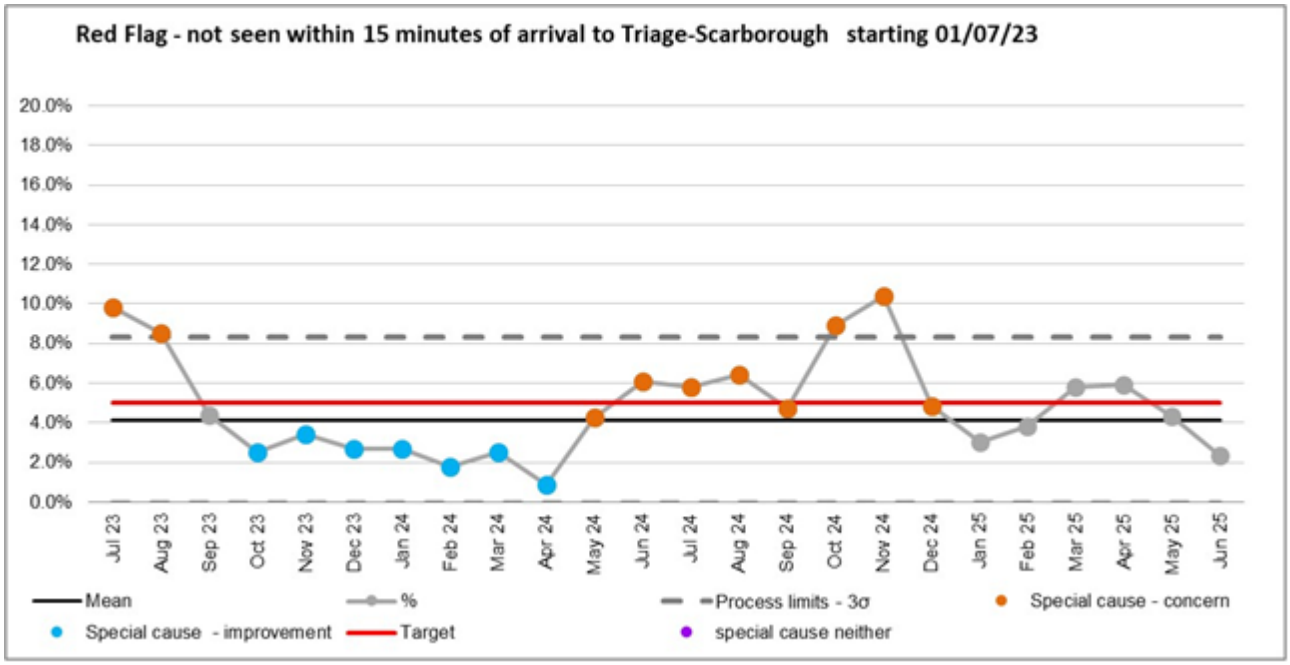


Chart 3



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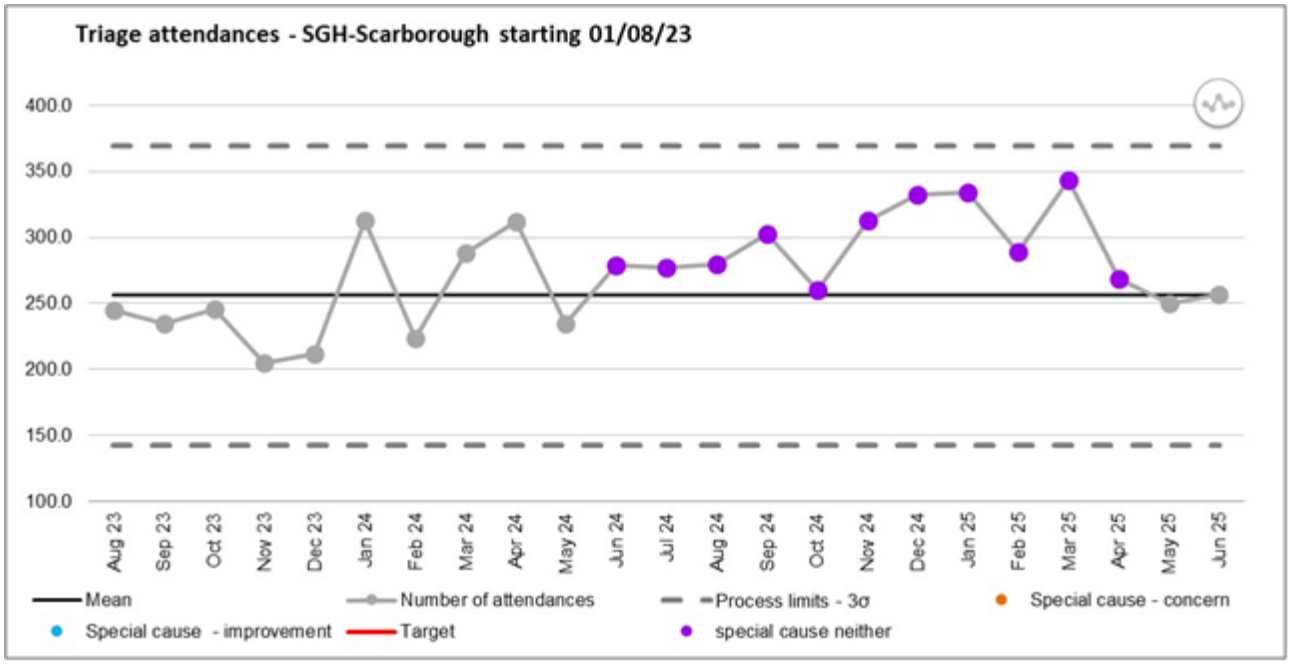


B. Governance and Oversight of Maternity Services

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 three quarterly reports for the Perinatal Mortality Review Tool (PMRT) presented at Board and the Maternity claims scorecard has been presented at Quality Committee. A report was

presented at private trust board on the maternity patient safety learning responses in June 2025.

The Maternity and Neonatal Safety Champions meetings were re-established in January 2025, which there have been 5 meetings.

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 May 2025 was 2.3% 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 May 2025
1.5l – 1.9l	5
2l – 2.4l	3
> 2.5l	0

Chart 7

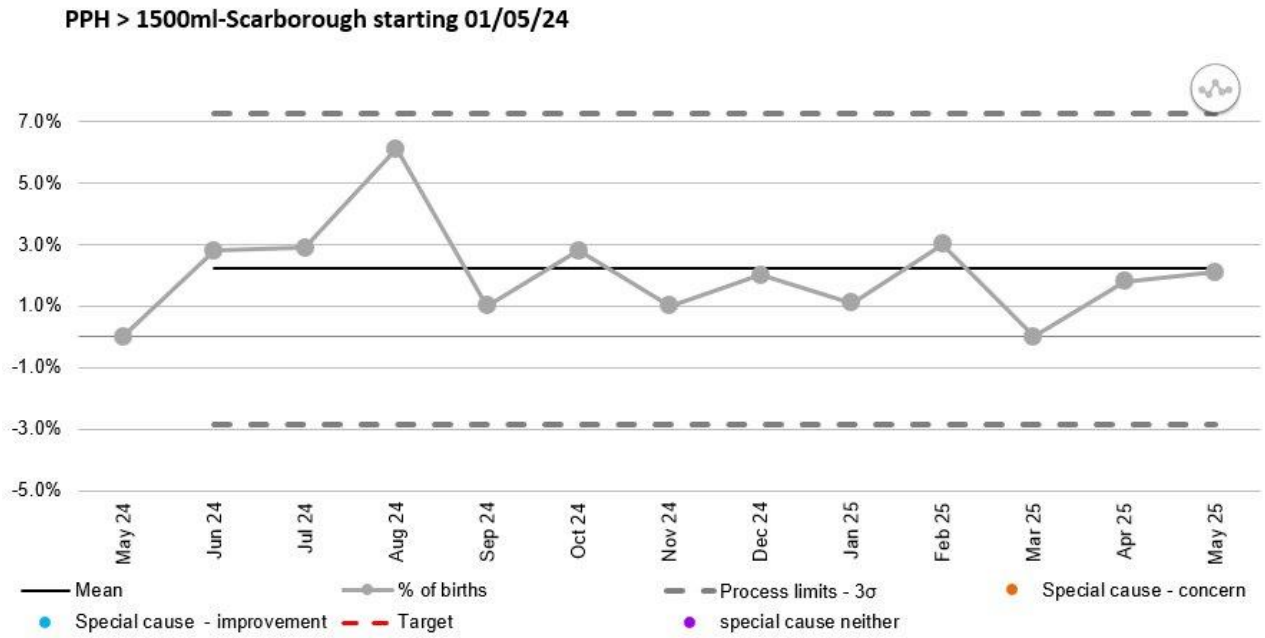
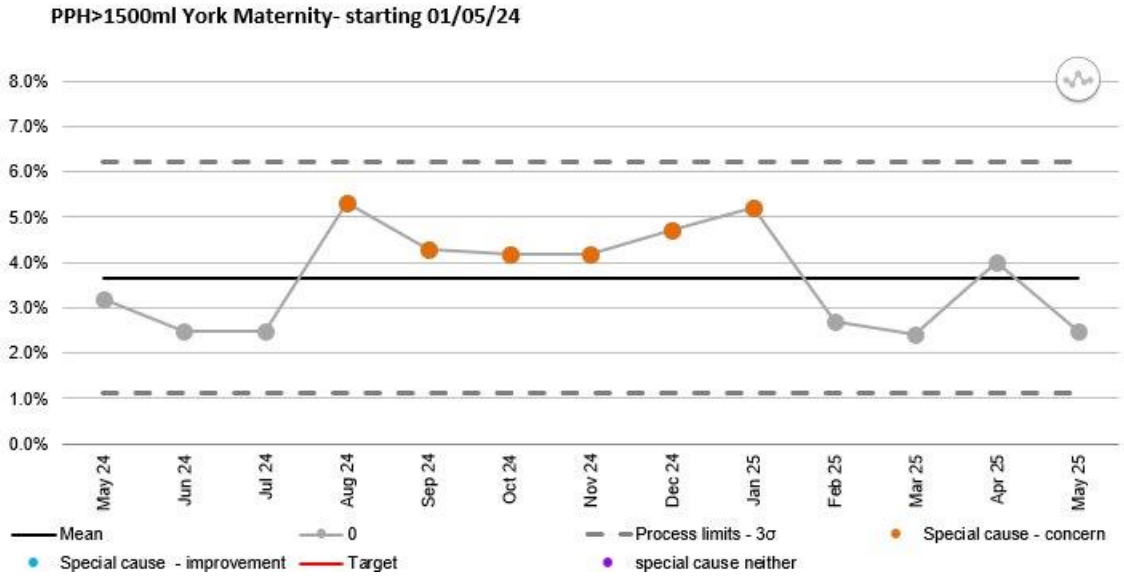
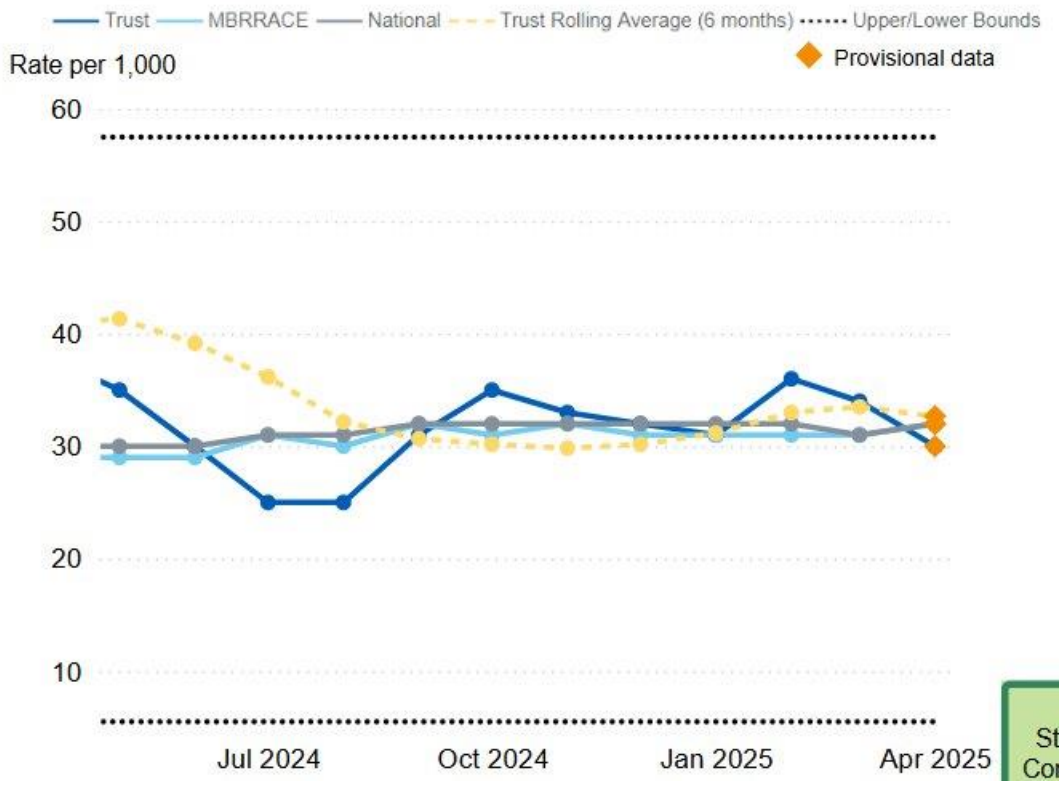
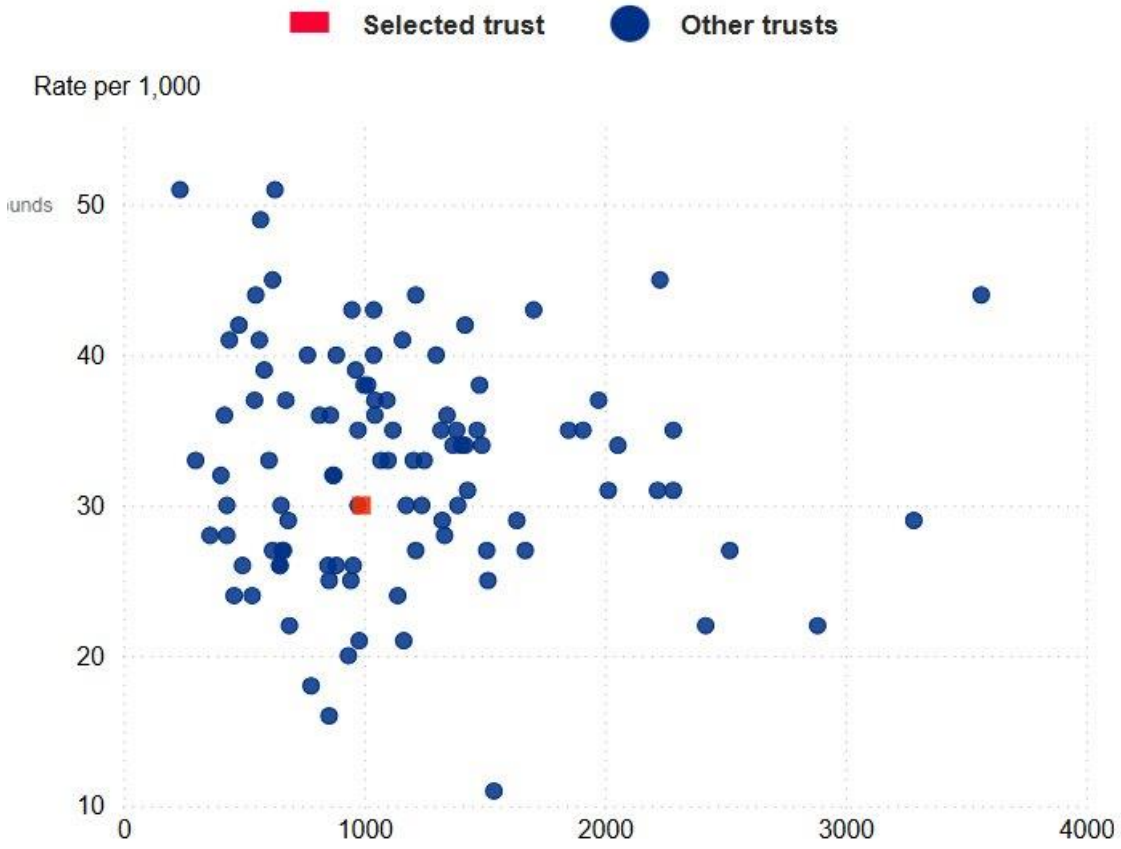


Chart 8



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 (chart 7 & 8). All the May 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, with a slight increase since January 2025 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.

Overview of the Monthly Sprint May (8 cases)

Standard	Results	Comments
FBC taken at 28 weeks	100% (8/8)	
Was Haemoglobin managed in accordance with guidance	100% (8/8)	
36-week PPH risk assessment completed	62.5% (5/8)	3 cases had PPH proformas completed 32 and 34 weeks therefore 100% cases had a risk assessment completed in third trimester

PPH risk assessment completed on admission for birth	87.5% (7/8)	
Management of third stage of labour	87.5% (7/8) 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% (4/4)	
Postnatal oxytocin infusion should be used when there is moderate or high risk of postpartum haemorrhage	100% (8/8)	
PPH proforma fully completed	62.5% (5/8)	Two were partially completed and one was not completed

7 out of the 8 women had multiple risk factors for PPH. Actions are in place to address areas of partial compliance.

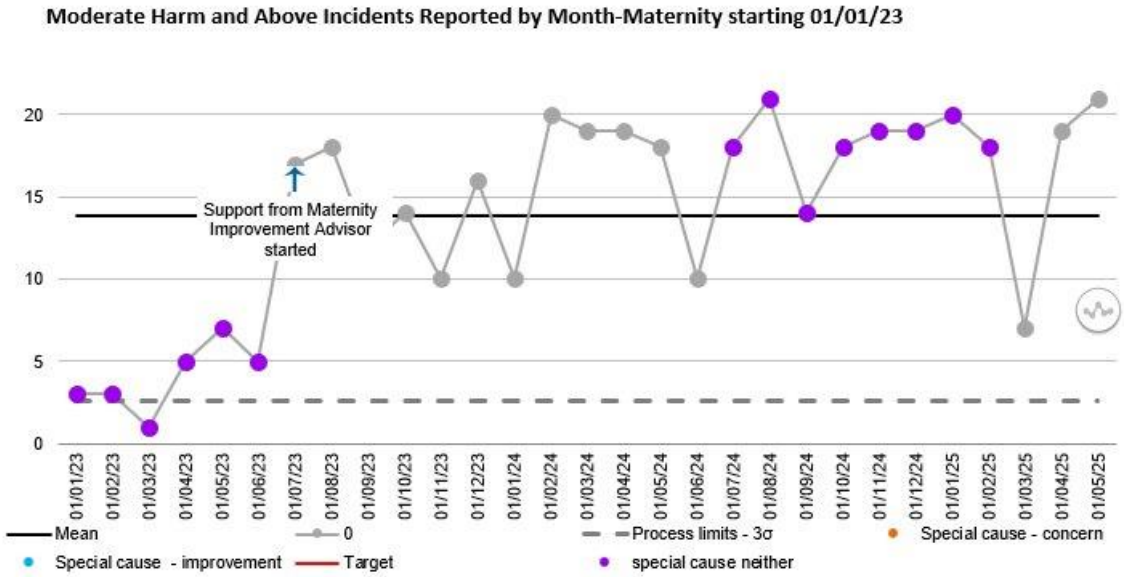
B.3 Incident Reporting

There were 18 moderate harm incidents reported in May 2025.

Datix ID	Incident Category	Outcome/Learning/Actions	Outcome
36080 36229 36230 36231 36492 36496 36525 36927 37325 36266	PPH ≥1500mls	PPH sprint audit started in January 2025	The PPH rate continues to be monitored through the Maternity Assurance Group.
36234	Hysterectomy	Initial review at Maternity Case Review. No immediate safety actions identified	AAR completed and no concerns highted which would have had a bearing on the outcome
36165	Admission discharge process	Initial review at Maternity Case Review. No immediate safety actions identified	
36233	Admission to ITU	Initial review at Maternity Case Review. No immediate safety actions identified	AAR completed and no concerns highted which would have had a bearing on the outcome

37434	Term admission	Review at ATAIN	Learning included as part of ATAIN action plan
36271	Stillbirth	Initial review at Maternity Case Review. No immediate safety actions identified	PMRT to be undertaken
36792 36796	Postnatal readmission	Initial review at Maternity Case Review. No immediate safety actions identified	Review to be undertaken at the Maternity Case Review
36422	3rd/ 4th degree tears	Reviewed at the Maternity Case Review	Following a review no concerns highlighted

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. There has been approval and agreed funding to implement swipe card access on the Scarborough site with 24/7 ward clerk cover. Work will commence in July with a plan to complete in October 2025.

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. The Director of Midwifery will be presenting a paper at the Executive Committee in July 2025, which if approved will release the equivalent 12 WTE Midwives back into the establishment.

Recruitment update:

Position from 1st June 2025:
Scarborough:
Qualified nursing staff are fully recruited to. There is 3WTE vacancy for a Band 3.

York:
Qualified nursing staff are fully recruited to. There is 0.80WTE vacancy for a Band 3.

Perinatal Quality Surveillance Model

NHS
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NHS Foundation Trust

CQC Maternity Rating 2023	Overall	Safe	Effective	Caring	Well-Led	Responsive
York 2023	Inadequate	Inadequate	Requires Improvement	Good	Inadequate	Requires Improvement
Scarborough	Inadequate	Inadequate	Requires Improvement	Good	Inadequate	Requires Improvement

Maternity Safety Support Programme	Yes- Improvement phase

	April	May	June	July	August	September
Findings of review of all perinatal deaths using the real time data monitoring tool	1 late intrauterine death at 23+6 weeks. Case graded as B. 1 neonatal death at 38 weeks. Baby had known abnormalities. Graded as B	1 stillbirth at 35 weeks. Graded as A. 1 stillbirth at 27 weeks. Baby had a known abnormality. Graded as B. 1 stillbirth at 27 weeks. Graded as B.	1 early neonatal death at 38 weeks. Graded as a D. This was an MNSI case			
Ethnicity/ Language	3 White and first language English	3 White and first language English	1 White and first language English			
Findings of the review of all cases eligible for referral to MNSI	0 cases referred. 3 ongoing cases	0 cases referred. 2 reports received and 1 report ongoing. Safety recommendation for the care pathway of gestational diabetes, women who chose care outside of guidance and fetal monitoring during the induction of labour process	0 cases referred. 1 investigation ongoing			
Ethnicity/ Language	2 White and first language English. 1 Bangladeshi and spoke fluent English	N/A	N/A			
The number of incidents logged graded as moderate or above	16	18	14			
Ethnicity/ Language	British - 9 White Other - 6 Mixed Other - 1	British - 9 White Other - 5 Asian - 2 Not Known - 2	British - 9 White Other - 3 Black African - 1 Not Known -2			
Red flag incidences as per NICE NG4 1.3.5 (see Box 3)	4	7	2			
Training compliance for all staff groups in maternity						
SBLCB E Learning	Midwives 71% Consultant Obstetricians 65% All other Obstetricians 65%	Midwives 72% Consultant Obstetricians 73% All other Obstetricians 67%	Midwives 78% Consultant Obstetricians 81% All other Obstetricians 57%			
Fetal Surveillance in Labour	Midwives 93% Consultants 92% All other Obstetricians 88%	Midwives 92% Consultants 88% All other Obstetricians 89%	Midwives 93% Consultants 94% All other Obstetricians 100%			
Maternity Emergencies and Multiprofessional training	Midwives 94% Consultants 92% All other Obstetricians 68% Consultant Anaesthetists 82% All other Anaesthetists 73%	Midwives 94% Consultants 88% All other Obstetricians 88% Consultant Anaesthetists 82% All other Anaesthetists 80%	Midwives 92% Consultants Obstetricians 92% All other Obstetricians 91% Consultant Anaesthetists 88% All other Anaesthetists 85%			
Newborn Life Support	Midwives 94% Neonatal Nurses 85%	Midwives 91% Neonatal Nurses 85%	Midwives 93% Neonatal Nurses 83%			
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas	100%	100%	100%			
Birth to Midwife Ratio	01:24	01:27	01:24			
Midwifery Staff average fill rate	74%	78.0%	79.0%			
Midwifery bank usage (in hours)	2017	2366	2332			
Midwifery agency usage	1201	1593	1643			
Neonatal Unit Staffing fill rate	SGH SCBU 100% YH SCBU 77.7%	SGH SCBU 102% YH SCBU 79.5%	SGH SCBU 99.4% YH SCBU 78.8%			
Neonatal bank usage (in hours)	SGH SCBU 384hr YH SCBU 349hr	SGH SCBU 287hr YH SCBU 494hr	SGH SCBU 165hr YH SCBU 202hr			
Service User Voice Feedback	Review of the diabetes pathway following concerns raised. Review of women who chose to birth outside of guidance to support safe and personalised care plans. Review of the bereavement pathway of second trimester loss. Review of neonatal access for parents of babies on the SCBU	Birthing pools out of use on the York site. Homebirth provision. Bereavement pathway.	Not feeling listened to with requests for pain relief. Availability of antenatal education			
Staff feedback from frontline champions and walk abouts	Midwifery and MSW staffing concerns	Midwifery and MSW staffing concerns. No on midwifery on call facility and lack of senior leadership visibility. Community midwives raised concerns about lone working policy	Midwifery and MSW staffing. High use of agency at SGH site. Concerns with estates and storage of equipment for community midwives.			
MNSI/ NHSR/ CQC or other organisation with a concern or request for action made directly with Trust	No	No	No			
Coroner Regulation 28 made directly Trust	No	No	No			
Progress in Achievement of CNST	On track 6/10	On track 6/10	On track for 6/10			
Situations in which a Consultant MUST ATTEND	100% compliance. 3 out 3 cases had a consultant present.	100 % compliance. 5 out of 5 cases had a consultant present.	87.5% compliance. 7 out of 8 cases had a consultant present.			
Unless the most senior doctor present has documented evidence as being signed off as competent	100% compliance. 26/26 had consultant or signed of doctor present	97.8% 34 out of 35 cases were compliant. Non-compliant was precipitate breech delivery where baby delivered within 20 minutes of arrival.	100% compliance. 26 out of 26 cases had consultant or senior doctor present.			
Unit closures/Service Suspensions	No YGH closures. No SGH closures	2 closures at YGH. 3 closures at SGH	3 closures at SGH. 0 closures at YGH			
Home birth suspended	2 at YGH. 19 occasions for SGH	3 times in YGH . 16 occasions in SGH	19 occasions for SGH. 9 occasions for YGH			
Proportion of Midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment	Trust 33.9% LMNS 47% National 65.3%					
Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (National 79.3%, 2019)	Trust 100% LMNS 94.6% National 77.5%					
Latest available annual figures used (UPDATED)	**York and Scarborough Trust**	**Comparison to the average for similar Trusts and Health Boards**				
Stillbirth Rate	0/91 per 1000 births	Group comparator 0.99 per 1000 births				
Neonatal Death Rate	2.88 per 1000 births	Group comparator 3.90 per 1000 births				
Extended Perinatal Mortality Rate	3.78 per 1000 births	Group comparator 2.91 per 1000 births				
***MBRRACE Perinatal Mortality Report (2024) uses Birth data from 2022**						
Stillbirths after 24 weeks gestation and excluding termination of pregnancy						
Neonatal deaths after 24 weeks gestation						

Item 14

Report to:	Board of Directors
Date of Meeting:	30 July 2025
Subject:	Quality Account
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:

The Quality Account for 2024-25 is attached. The Account provides an update in relation to progress against the 2024-25 quality priorities and provides the priorities for 2025-26.

Following content approval, the document will undergo final formatting before publication.

Recommendation:
The Board of Directors is asked to approve the content of the Quality Account which will also be submitted to the ICB for comment prior to publication.

Report History		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
Executive Committee	2 July 2025	Wording updated slightly in Infection, Prevention and Control section regarding 'exceeding objectives'. Information Governance / DSPT section updated.
Patient Safety and Clinical Effectiveness Sub-Committee	9 July 2025	Presented and accepted.
Quality Committee	15 July 2025	Presented and accepted.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Quality Account

2024 - 2025

Contents

Appendices

Part 1: Chief Executive's Statement from the Board

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.

1.2 Statement on Quality from the Chief Executive

Welcome to the annual Quality Account, where we share with you our achievements, challenges, and successes for the 2024-25 year.
This year has been an incredibly challenging one, as we work to deliver national performance and quality standards and continue on our journey to recover from the impact of the pandemic.
We are making progress in reducing waiting times for appointments, surgery, and diagnostics although some specialties remain challenged. We also improving against the national cancer standards. Urgent and emergency care standards remain the hardest to consistently achieve, as we continue to see increasingly complex patients requiring our services. However, we saw improvements in the final quarter of the year with ambulance handover times and time to assessment, despite a month-on-month increase in ambulance arrivals.
The financial environment we have been operating in has been the most pressured we have ever faced. The level of savings requirement will continue to test us in terms of how we best use our resources, and as a Trust we will clearly need to ensure we are in the best position to respond to these changes and navigate the next few years ahead.
With these performance and resourcing challenges in mind, improving the safety and quality of our services remains a key priority, and the Board committed to refreshing the Trust's strategy throughout 2024, developing proposals for a new purpose, ambition, and strategic objectives.
The strategy was approved by the Board in in January 2025 and has quality at its core, with our purpose to deliver excellent healthcare every day.

As reported in last year's Quality Account, the Care Quality Commission (CQC) carried out an inspection between October 2022 and March 2023. In June 2023, the CQC published its report into this inspection, covering Emergency and Urgent Care, Medicine and Maternity in both York and Scarborough hospitals. It also looked at the 'well-led' key question for the Trust overall. An overall rating of Requires Improvement was given.
In January 2025, the CQC returned to the Trust to carry out an unannounced reinspection of Urgent Care Services at York Hospital. At the time of writing the final report has not been published however feedback given following the visit did not highlight any major concerns and we have continued to make good progress with our actions plans in response to the CQC's recommendations from the 2023 report.
We have continued to make positive progress through our Journey to Excellence improvement programme and with other developments in our services and our estate. These are just some high-level examples, and I encourage you to read more in the rest of this report:

- The £50 million Urgent and Emergency Care Centre at Scarborough Hospital was completed in Spring 2025, transforming the delivery of care for our most critically ill patients on the East Coast.
- Two Community Diagnostic Centres (CDCs) opened at Selby Hospital and Askham Bar in York. These offer a range of services including phlebotomy, ultrasound, cardiorespiratory tests, mobile CT, and MRI. On the East Coast, the Scarborough CDC is due for completion in 2025.
- The Year of Quality programme has continued for a second year, focusing on a different theme each month to increase awareness of, and compliance with, the fundamentals of care.
- Our culture and leadership programme, Our Voice, Our Future, is now in the design phase, where the Change Makers are working with colleagues to develop plans based on their findings from their initial staff engagement work. The plans fall under three pillars, communications and engagement, well-led leadership and management, and quality improvement and learning.
- Our Healthcare Academy reached it's one year milestone, having seen around 350 healthcare support workers graduate from the programme.
- We have launched Great-ix in the Trust and are seeing a steady stream of positive nominations from colleagues.

- We have procured a new Electronic Patient Record system which will be rolled out in phases from Spring 2026.

It is encouraging that throughout this year we have seen progress in quality and safety improvements, and you can read more about the fantastic work that is taking place across the Trust in this report. We know we have further work to do to ensure we are providing the very best care for our patients, and this will continue to be our focus in the year ahead. To the best of my knowledge, the information contained in this Quality Account is accurate.

Simon Morritt, Chief Executive

1.3 Looking Back on 2024/25

May 2024

Accreditation accolade for Audiology

The Audiology Department, which supports patients with hearing loss across North Yorkshire, earned prestigious national accreditation from the United Kingdom Accreditation Service (UKAS).

The recognition highlighted excellence in adult audiology assessment and rehabilitation, placing the department among a select few in the country.

Kate Iley, the Trust's Head of Audiology, said the team had been working towards this goal since 2020. "To receive this accreditation after four years of hard work is marvellous. We were thrilled to hear the news during National Deafness Week. It's never too early to seek support if you suspect hearing loss."

As part of the process, patients shared their positive experiences and the support they received from the clinical team.

July 2024

New palliative care room opened at Selby Hospital

A dedicated room for patients nearing the end of life was opened at Selby War Memorial Hospital.

The Autumn Leaves Palliative Care Suite, funded by the Friends of Selby Hospital, has been created to offer privacy and dignity to patients in their final days. Designed as a calm and comforting space, the room also provides families and visitors with a peaceful retreat away from the busy ward environment.

September 2024

Putting patient safety first

This year's World Patient Safety Day took place on 17 September 2024 and served as a valuable reminder that patient safety remains at the heart of everything we do as a Trust. To mark the occasion, the Patient Safety Team held drop-in sessions across all clinical areas. These provided staff with the chance to meet key colleagues involved in promoting

patient safety, including the Datix reporting team, the medical devices team, and the investigations team.

The sessions also introduced the role of ‘patient safety champions’ - a new position being developed within the Trust to further embed a culture of safety in everyday practice.

October 2024

Endoscopy service commended in Joint Advisory Group (JAG) Accreditation

In October, the Trust’s endoscopy service was awarded prestigious JAG accreditation from the Royal College of Physicians’ Joint Advisory Group on gastrointestinal endoscopy, following a rigorous assessment.

It marked the first joint assessment of the service, which carries out over 20,000 diagnostic and complex procedures annually across Bridlington, Scarborough, and York.

The accreditation confirmed the Trust met the highest standards in endoscopy, with assessors praising its strong clinical leadership, teamwork, and governance.

The team was also commended for its commitment to international recruitment and the contributions of its diverse workforce to patient care.

November 2024

The Healthcare Academy celebrates its first anniversary

Since its launch at Bridlington Hospital in November 2023, a total of 344 healthcare support workers (HCSWs) have graduated from the programme.

The academy is the first of its kind within the Trust, established under the leadership of our Chief Nurse, Dawn Parkes.

The academy aims to train HCSWs - including those new to the care profession - to a high standard, ensuring they have a solid foundation before beginning work in our hospitals. All modules are delivered to a national standard set by NHS England.

Later that year, we celebrated as the Healthcare Academy was named a finalist in the ‘Best Workplace for Learning and Development’ category at the prestigious Nursing Times Workforce Awards.

December 2024

Twenty years of vascular excellence in York

Staff gathered this month to celebrate 20 years of patient care at York Hospital’s Vascular Imaging Unit (VIU).

Since opening on 6 December 2004, the unit has provided life-saving treatment for nearly 3,000 patients annually, supporting a wide range of vascular and cardiac conditions.
This milestone comes as the Trust prepares to relocate the VIU to a larger, purpose-built facility, currently under construction near the Endoscopy Department - set to open in 2025.
The new space will enable the team, which includes over 55 staff, among them 36 dedicated nurses and six specialist consultants, to expand services and meet growing demand, including in cardiophysiology.

January 2025

York Hospital officially welcomes imaging scanner upgrade

In January, York Hospital's Nuclear Medicine Department introduced a state-of-the-art SPECT-CT scanner, improving access to advanced diagnostic services for patients in the region.
The scanner combines two imaging techniques to produce highly detailed images, enabling faster, more accurate diagnoses - particularly for cancer and brain function assessments. It is expected to boost patient capacity by up to a third.

Previously, patients had to travel to Leeds for this service. The installation marks the result of years of planning and collaboration, and was officially opened by Tom Welton, President of the Society and College of Radiographers.

March 2025

Towards Excellence: Our Strategy for 2025-30

In March, we launched a new five-year strategy, developed in collaboration with partners across health and social care. It sets out our purpose, ambition, strategic objectives, and the values that guide our work - all focused on delivering excellent patient care and creating a great place to work.
Chief Executive Simon Morritt said: "As the health and care landscape evolves, we must adapt to meet rising demand, changing needs, and new technologies, while remaining financially and environmentally sustainable. This strategy ensures our efforts, both within the Trust and with partners, are aligned to improve health and wellbeing for our communities."

1.4 Trust Quality Strategy 2025 to 2030

The purpose of the Trust 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 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.

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

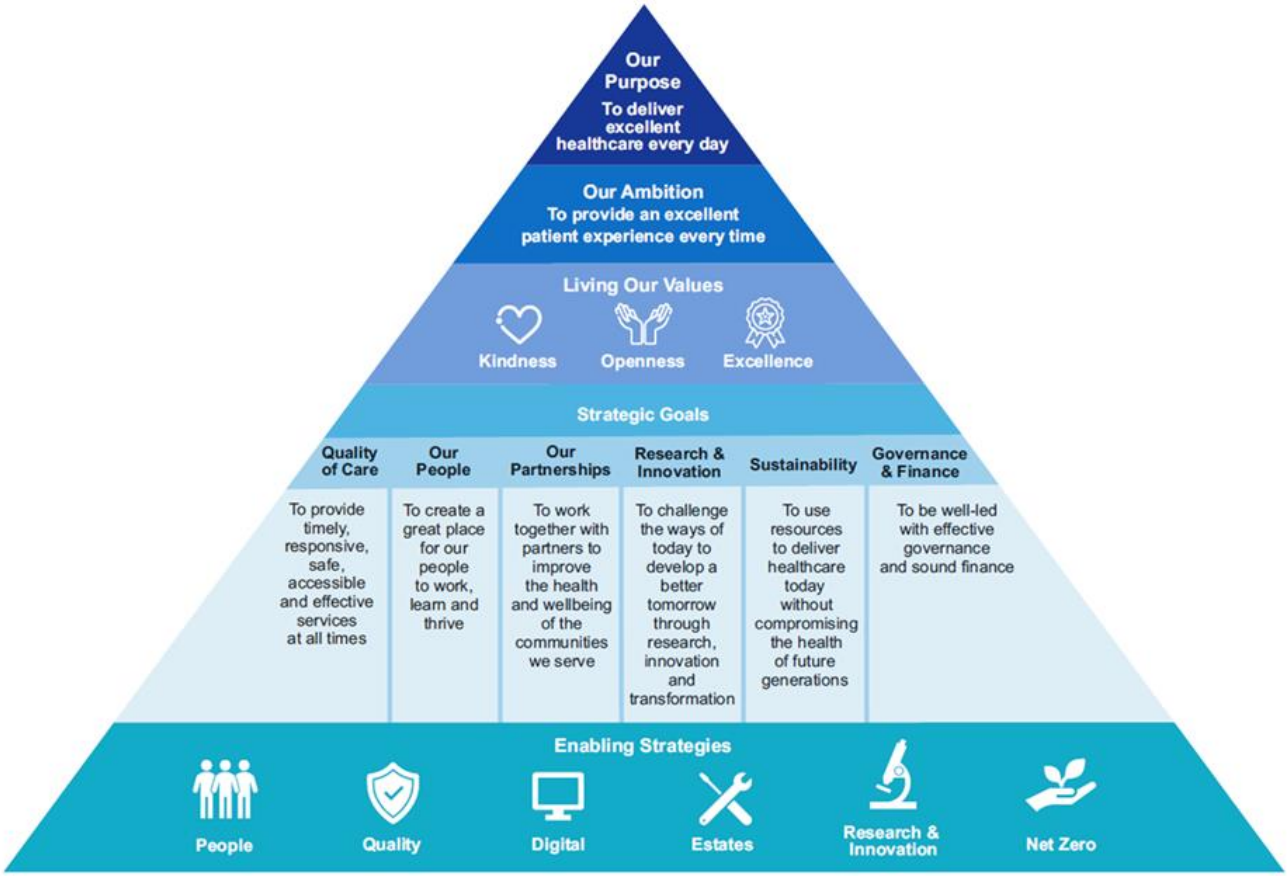
choices, no matter where we work or what we do in the organisation, should be aligned with the Trust's purpose, ambition, and strategic objectives. We believe that every colleague has an important contribution to make and are committed to ensuring they are enabled to provide the services our communities 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.



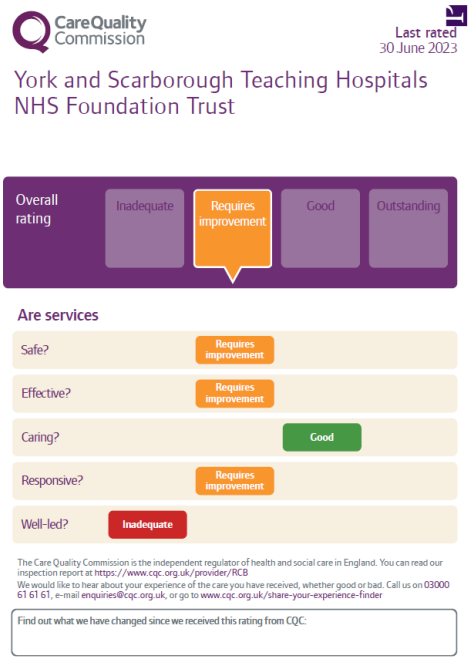
The Quality Strategy is one of several supporting strategies and helps to drive our wider programme of quality improvement work. This includes:

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

Our Quality Objectives are as follows:

- We will deliver a 5% reduction in hospital acquired bacteraemia.
- We will deliver a 15% reduction in category 2 pressure ulcers.
- We will deliver in a 50% improvement in the recording of a VTE risk assessment within 14 hours of an admission to a hospital bed.
- We will improve our average time for a patient, who is suspected of having sepsis, to be reviewed by a Doctor in our Emergency Department to antibiotics being administered (if needed).

1.4 Care Quality Committee Registration and Improvement Journey



York and Scarborough Teaching Hospitals NHS Foundation Trust is registered with the Care Quality Commission (CQC), and its current status is 'Registered with Conditions.' Since January 2020, the Trust has operated under a Section 31 notice to improve mental health risk assessments in emergency care. In response, a paper-based assessment tool was introduced, with compliance reported monthly to the CQC. To further enhance outcomes, the Trust launched an electronic Urgent and Emergency Care risk assessment tool in April 2024, integrating falls, skin, and mental health assessments.

Ongoing efforts include additional staff training, support, and the implementation of a more therapeutic approach to enhanced observation, led by the Trust's Mental Health Improvement Group. The Trust continues to work collaboratively with Tees, Esk and Wear Valleys NHS Foundation Trust to support training delivery.

Between October 2022 and March 2023, the CQC inspected the Trust's Emergency and Urgent Care, Medical Care, and Maternity Services, as well as its overall leadership. All 'must' and 'should' do actions from this inspection have been closed with the CQC. A letter of intent to take urgent enforcement action under Section 31 was issued due to concerns in maternity services. The Trust submits monthly progress updates to the CQC addressing these concerns.

In August 2023, the Trust formally established Journey to Excellence: A Focused Improvement Group, a subgroup of the Executive Committee, to oversee delivery of improvements in response to the inspection and ongoing requirements. The group, comprising all Executive and Corporate Directors, provides the Board with oversight of key improvement workstreams through 2024/25.

The Trust's most recent on-site inspection took place at York Hospital on 14–15 January 2025. The remit of the Journey to Excellence Group is currently under review and will evolve to provide ongoing assurance regarding previous inspection findings, oversee improvements from the January 2025 inspection, and support progress against NHS England segmentation criteria.

Part 2: Improving our Quality of Service

2.1 Patient Safety Priorities

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care.

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

Adverse incidents will and do occur but with a strong safety and learning culture the impact in terms of harm and recurrence will reduce. All staff must feel safe to report patient safety issues without fear of retribution and be empowered to act swiftly to address risk. Celebrating and learning from good practice is essential within a positive safety culture. Bringing into focus aspects of everyday practice is known as Safety II. The Safety II perspective was developed with the recognition that complexity and variability is inherent in healthcare, failure in systems do not necessarily arise from individual components but rather from the structure of the systems within which we operate. Therefore, to improve safety, we need to understand how people manage and overcome complexity and uncertainty.

The Trust Patient Safety priorities for 2024/25 remained as:

- Reducing the incidence and harm from inpatient falls
- Responding to a deteriorating patient
- Improve our delivery and monitoring of Sepsis
- Pressure related skin damage
- Discharge and onward referral
- Nutrition and Hydration
- Medication

Continued development and review of Patient Safety Incident Response Framework (PSIRF) supporting an enhanced patient safety culture.

Background

The Patient Safety Incident Response Framework (PSIRF) is a national approach to managing patient safety incidents. It promotes a shift from reactive investigation to proactive learning and improvement. The key aims of PSIRF are to:

- Ensure proportionate responses to incidents, focusing on learning and system improvement rather than blame or unnecessary investigation
- Align with quality improvement initiatives where themes overlap, reducing duplication and supporting Trust-wide learning
- Engage with staff, patients, and families in a compassionate and supportive manner
- Use systems-based approaches to understand contributing factors, including system design and human factors, rather than focusing solely on individual error

PSIRF provides greater flexibility in how we respond to incidents, encouraging teams to focus on learning opportunities rather than defaulting to formal investigations.
Most incidents can be addressed through local review and sign-off, particularly when they relate to known risks or are already being addressed through existing improvement plans.
Where further response is needed, one of the four structured learning responses may be used:

1. **Hot Debrief** – An immediate team discussion following an incident
2. **After Action Review** – A facilitated, reflective team discussion to understand what happened and why
3. **Pathway Review** – A broader review of the patient's journey across services to identify system-level learning
4. **Patient Safety Incident Investigation** – A more formal process for complex or significant incidents

These learning responses are non-punitive and are designed to involve the teams directly connected to the incident.
Staff are expected to be open and transparent with patients and families when incidents occur, fulfilling the Duty of Candour where moderate harm or greater is identified. Where appropriate, patient and family perspectives should be actively considered in the learning process to ensure meaningful and compassionate responses.

Key Achievements in 2024/25

- Seven Patient Safety Incident Investigations have been completed which have supported improvement in our patient safety themes. Learning from these investigations has been shared through our quality governance structures.
- We have undertaken thematic reviews based on an analysis of our Datix incidents and have developed a refined pathway for early identification of ovarian torsion. We have also established a protocol for the safe and effective management of patients who are

transferred between our two main acute hospital sites.

- A review of the Trust weekly Quality and Safety process has led to greater multidisciplinary oversight of our incidents and a stronger approach to shared learning across our care groups.
- We have introduced Patient Safety Partners to facilitate enabling the patients' voice to be incorporated into patient safety investigations.
- The Patient Safety Team launched a new patient safety course to develop champions in patient safety across the Trust. Over 70 people have now received this training from the patient safety team. The Trust is also above the planned trajectory for staff within the organisation having completed Level 1 Essentials for Patient Safety e-learning.
- The introduction of Great-ix to share examples of staff and teams going above and beyond, for both the safety of our patients and the wellbeing and morale of their colleagues.

Aims for 2025/26

- We will refresh the Patient Safety Incident Response Framework (PSIRF) priorities for 2025/26
- We will evaluate the quality governance structure, including the Care Group governance meetings and sub-committees, which support the patient safety agenda to ensure this is fit for purpose.
- We will maximise the functionality of Datix within the organisation, utilising elements which are currently unused and train staff to extract data. This will be reported throughout the year to the Patient Safety and Clinical Effectiveness sub-committee.
- We will review the data available and how it is used to support the patient safety agenda within the organisation including the patient safety elements of the Trust Priorities Report in conjunction with the Digital and Information System (DIS) to ensure we have appropriate quality and safety metrics performance. This will be included in patient safety reporting to the Care Groups and for assurance through quality governance.
- We will undertake an analysis of what a good patient safety learning system is and have this in place by the year end.
- We will Roll out the Foundations in Patient Safety course to the wider workforce to help promote and increase the understanding of patient safety.

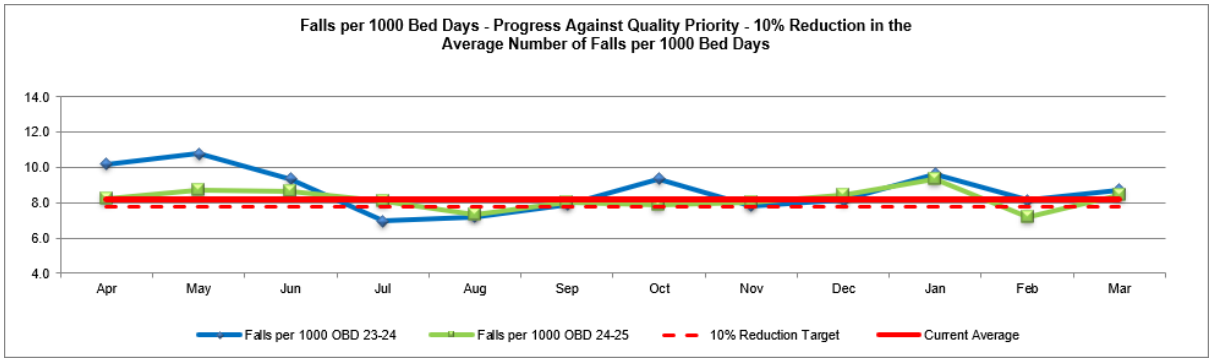
2.2 • Falls

'Reducing the incidence and harm from inpatient falls'

Background

The Trust remains committed to reducing avoidable inpatient falls, with a strategic objective set for 2024/25 to achieve a 10% reduction in the average number of falls per 1,000 occupied bed days (OBD). This translates to a target rate of 7.8 falls or fewer per 1,000 OBD.

A comparative review of data over a two-year period from April 2023 demonstrates a 6.3% reduction in inpatient falls during 2024/25 relative to the previous year. Furthermore, a 6.7% decrease was observed in falls resulting in moderate or severe harm, indicating progress in both prevention and mitigation of injury severity.



In alignment with the National Institute of Clinical Excellence (NICE) Clinical Guideline 161 (2013), which recommends lying and standing blood pressure (LSBP) assessments for all patients over 65. A three-year target was introduced in the Falls Quality Account 2023 - 2026 to improve compliance with this critical assessment:

- Year 1 (2023/24): 50%
- Year 2 (2024/25): 75%
- Year 3 (2025/26): 90%

Quarterly audits, sampling five patients per ward, have been conducted across all inpatient settings. These audits have shown a positive trend in compliance, with average completion rates improving from 54% in 2023/24 to 62% in 2024/25. Continued efforts will be made in 2025/26 to fully embed this assessment into routine practice.

Key Achievements in 2024/25

- Improved assessment and appropriate use of bed rails, supported by updated processes following the National Patient Safety Alert on Bedrails (2023). Assessments now consider entrapment, falls from height, and restraint risks for all inpatients.

- Launch of the Enhanced Therapeutic Care Policy, introducing a person centred assessment of need and ensuring care is delivered based on that specific need.
- Updated and standardised guidance on post-fall neurological observations and head injury management in collaboration with clinical teams, for both inpatient and community settings.
- New outpatient and community post-fall management processes implemented.
- Pilot of pharmacist-led medication reviews following inpatient falls on elderly care wards at the York site.
- Monthly person-centred care study days for healthcare and therapy assistant staff, focusing on topics such as frailty, deconditioning, delirium, dementia, lying and standing blood pressure LSBP assessments, and therapeutic engagement. Feedback indicates a positive impact on practice.
- Monthly 'Shared Learning from Inpatient Falls' infographic distributed Trust-wide, highlighting learning themes and best practices.
- Introduction of 'Activities Volunteer' roles to support person-centred care, prevent boredom, and reduce deconditioning risks.
- The Trust is an active member of the ICB learning collaborative facilitated by AQuA on improvements to reduce the risk of deconditioning in our patients.

Aims for 2025/26

- Standardise slipper socks to ensure consistent product quality and appropriate use, with the added benefit of potential cost savings.
- Develop the Multifactorial Assessment for Optimising Safe Activity, incorporating elements such as vision, delirium, medication, lying and standing blood pressure, continence, and walking aids.
- Shift from a deficit model—which discourages movement due to fear of falls—to a constructive model that supports safe mobilisation. This approach promotes care planning focused on optimising safety while encouraging physical activity, reinforcing a culture where falls are understood rather than feared.
- Further develop learning from deconditioning and falls through Patient Safety Incident Investigation (PSII) and cluster reviews.
- Progress to the next phase of the 'Activities Volunteer' programme, with a focus on recruitment, education, and the implementation of volunteer roles within wards. This initiative is designed to enhance person-centred care, reduce patient boredom, and prevent deconditioning through meaningful engagement and therapeutic activities.

2.3 Deteriorating Patient

'Responding to a deteriorating patient'

Background

Any patient in our care may become acutely ill. The Trust has a duty to ensure that all patients are assessed and treated appropriately in order to reduce the risk of deterioration and potential cardiac arrest.

National and local evidence supports that recognition of acute illness is often delayed and its subsequent management maybe inappropriate, leading to late referral and avoidable admissions to critical care.

Problems associated with the poor recognition of deteriorating patients significantly increase morbidity and mortality.

Key Achievements in 2024/25

- The first phase of our Call 4 Concern initiative has been successfully rolled out across all inpatient areas throughout York and Scarborough hospitals. Call 4 Concern aims to provide a consistent and understandable way for patients and families to seek a review by the Critical Care Outreach Team if they or their loved one's condition deteriorates, and they are concerned this is not being responded to. This aligns to the Martha's Rule campaign, and the Trust was chosen to be part of the first 100 hospitals in the NHS England programme to implement this. Collection of local audit data and submission to national figures has highlighted key themes and learning points which will help guide our ongoing improvement work. We are particularly proud of our Critical Care Outreach Team who have committed to the implementation and improvement work for Call 4 Concern.
- The Deteriorating Patient Group continue to work hard to audit and improve the care of deteriorating patients. Our focus has been in part led by Patient Safety Incident Investigations (PSIIs). These are undertaken to identify new opportunities for learning and improvement, more specifically focusing on improving healthcare systems. NHS England highlight that reviewing systems and processes supporting the NHS to manage acute physical deterioration not only saves lives and prevents patients from becoming increasingly unwell but can also reduce the length of a hospital stay, allowing resources to be available to benefit other patients.
- Staff from all areas were encouraged to be involved in this review and several learning actions were identified. These have provided focus within the Trust's Deteriorating Patient Group, including addressing barriers to recognition and escalation of

deteriorating patients, staff training for specialist blood analysis machines for resident doctors, review, and development of traffic light escalation posters.

Aims for 2025/26

- Opening of the Urgent and Emergency Care Centre which includes an Enhanced Care Unit. This provides specialist medical and nursing support to meet the needs of higher acuity patients throughout Scarborough Hospital.
- The introduction of a new Electronic Patient Record system called Nervecentre which will help provide automatic escalation of patients with deteriorating vital signs to the Critical Care Outreach Team and senior medical colleagues. We also aim to further develop our Hospital Out of Hours team with the launch of Nervecentre.
- Ongoing development of our deteriorating patient teaching programmes to ensure we recognise and address potential health inequalities within our patient cohort.
- Commit to Phase Two of Martha's Rule, developing quality improvement projects to further improve our Call 4 Concern. This will be alongside NHS England collaboration. This includes linking with Patient Partners and Health Watch teams.

2.4 Sepsis

'Improve our delivery and monitoring of Sepsis'

Background

Sepsis is a life-threatening condition that arises when the body's response to infection causes widespread inflammation, leading to organ damage or failure. It is estimated that up to 12% of Sepsis deaths may be preventable. At the Trust we employ standardised protocols, raise staff awareness, and ensure timely interventions such as antibiotics and fluid resuscitation, and by doing so we aim to provide high-quality care for patients at risk. Our commitment to continuous monitoring and learning allows us to refine practices and strive toward excellence in combating this critical health challenge. Sepsis awareness and treatment remain central to our dedication to patient safety and well-being.

Key Achievements in 2024/25

This year has been a significant challenge for all healthcare staff. Operational pressures in our Emergency Departments and across the wider clinical areas have been substantial. Whilst we have made progress our Sepsis metrics have not seen the improvement we aimed for.

This year we have continued to:

- Promote Sepsis six with use of posters, screen savers and Sepsis cards which are the same size ID badges.
- Further develop the Sepsis audit and screening tool which is based about best practice and National Institute for Health and Care Excellence (NICE) guidelines to include ward areas.

Aims for 2025/26

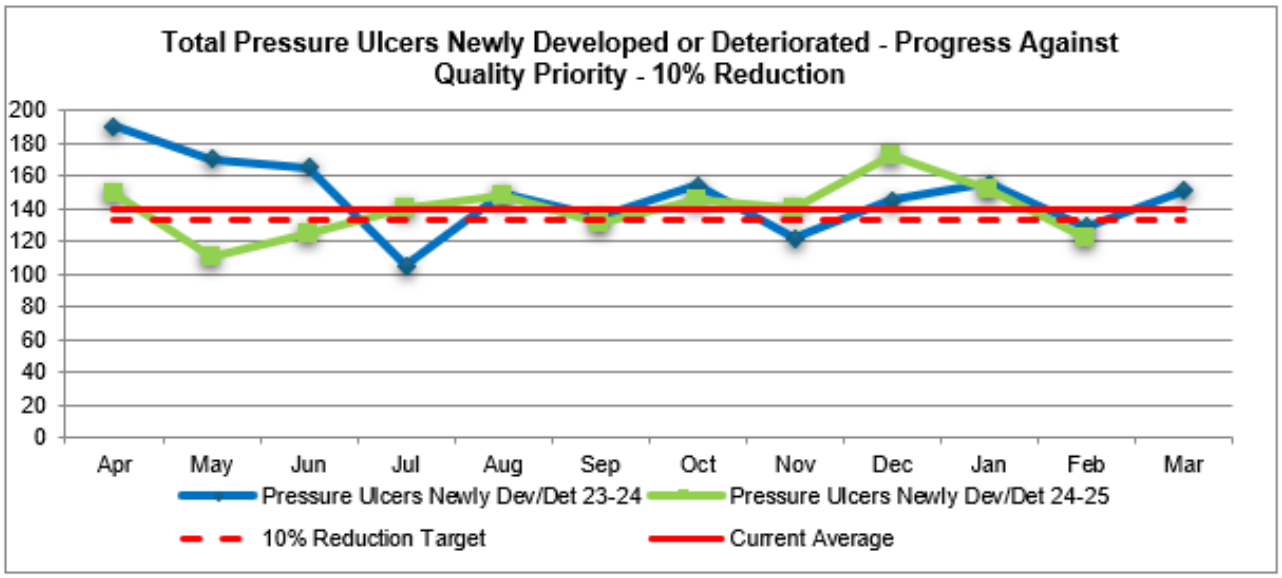
- Work with the digital team to ensure a robust and user-friendly Sepsis assessment tool is created within the new Electronic Patient Record System.
- Staff Training: Expanding education programs to ensure healthcare professionals are equipped with the latest knowledge and skills.
- Public Awareness: Increasing community outreach to help individuals recognise sepsis symptoms early.

2.5 Pressure Related Skin Damage

Background

The Trust is committed to pressure ulcer prevention. To promote this, whilst supporting national targets, quality priorities were agreed by the Pressure Ulcer Improvement Group. The first key priority was to achieve a 10% reduction in all newly developed or deteriorated pressure ulcers across both community and acute settings.

The SPC below illustrates the total number of newly developed or deteriorated pressure ulcers reported during 2024/25. While the data shows periods of improvement, the overall number of incidents remained relatively stable. The target reduction of 10% was not consistently achieved throughout the year. This trend highlights the need for renewed focus and strengthened prevention strategies to address both the development and deterioration of pressure ulcers.



The second key priority focused on maintaining oversight of all newly developed Category 4 pressure ulcers within the organisation, due to the potential for severe and long-term harm to patients. Monitoring this data supports early intervention and targeted learning to prevent recurrence. During 2024/25, 24 newly developed Category 4 pressure ulcers were reported. All have been investigated in detail and learning shared through our Pressure Ulcer Improvement Group.

Key Achievements 2024/25

- The **National Wound Care Strategy Programme (NWCS)** clinical guidelines were successfully embedded into practice across the organisation, aligning care with current national standards.

- A **Trust-wide mattress audit** was completed, and the associated assurance tool was relaunched to support pressure-relieving equipment management and compliance.
- The **Tissue Viability Nurse Virtual Clinic** was re-established for community patients, improving responsiveness in the review and management of Category 3 and 4 pressure ulcers.

- The **Wound Assessment, Planning, and Evaluation Care Plan** was updated to incorporate a skin tone assessment tool, as recommended by the National Wound Care Strategy (NWCS), to support equitable and accurate skin assessments.
- The **Wound Care Passport** was revised and updated to reflect current practice and improve continuity of care.
- We have implemented standardised pressure ulcer training across multiple programmes, including the Healthcare Support Worker Academy, Preceptorship Programme, and Globally Educated Staff Induction.
- As part of the **Year of Quality**, April 2024 focused on pressure ulcer prevention. Virtual teaching sessions using the **aSSKINg tool** (Surface, Skin inspection, Keep your patients moving, Incontinence / increased moisture, Nutrition / Hydration) were delivered, alongside organisation-wide “Stop the Spot” events.
- The organisation participated in **International STOP the Pressure Day** (November 2024). Tissue Viability Nurses engaged with all District Nursing bases, community inpatient units, and acute sites at York, Scarborough, and Bridlington Hospitals, promoting the "Every Contact Counts" message in pressure ulcer prevention.
- In response to the identified theme around unmet nutritional needs and its impact on pressure ulcer development and wound healing, the Tissue Viability Team worked collaboratively with the Trust’s Nutrition and Hydration Lead.

Aims for 2025/26

- The prevention of pressure-related skin damage remains a key organisational priority. Improvement projects outlined within the Pressure Ulcer Improvement Plan are informed by findings from incident investigations and thematic reviews.
- Looking ahead to 2025/26, the strategic focus will shift toward reducing the incidence of low harm Category 2 pressure ulcers. This proactive approach is based on the

recognition that effective early intervention at this level can significantly contribute to a reduction in moderate harm Category 3 and 4 pressure ulcers.

- As referenced in or Quality Objectives, the organisation has set an ambitious target to reduce newly developed Category 2 pressure ulcers by 15% across all care groups by March 2026.

2.6 Discharge and Onward Referral

Background

We have patients in our care who are medically fit and would be more appropriately cared for elsewhere, with the right help. Supporting safe and timely discharges of these patients is beneficial to their outcomes and experiences. It will also improve flow through our hospitals which we know is a key challenge.

Meanwhile we also have patients who do still require our acute intervention but who have been in hospital for longer than expected. We must think innovatively about how we treat these patients and keep them moving towards improved health and towards home.

Strategic work to help people in both these scenarios is being led by a system wide Discharge Improvement Group.

The work of the improvement group falls into three cells:

Cell 1 - Responsible for improving acute and hospital pathways and processes to make sure patient journeys are planned clinically from the outset.

Cell 2 - Responsible for ensuring everything which links our acute hospital processes to our community and local authority partners is high quality and flows fluently.

Cell 3 - Responsible for supporting our community health and social partners to arrange the right onward care for people after they leave the acute setting.

Key Achievements in 2024/25

- The principles of the discharge journey – ‘Why not home?,’ ‘Why not today?’ have been consistently promoted.
- We have reviewed our board round effectiveness to support more effective discharge.
- A Discharge Sprint was undertaken in March 2025 for a period of six weeks to ensure all patients had an estimated date of discharge and a robust clinical management plan as part of effective board rounds.
- Worked in partnership with the City of York and North Yorkshire Councils to implement plans for a Discharge to Assess model for pathway 1 patients. This will be extended to pathways 2 and 3 in a phased approach.
- The Choice on Discharge Policy was introduced in September 2024.
- The use of OPTICA, a communication platform between the acute and community partners for discharge information, was piloted in November 2024 and implemented in full in March 2025.

- There has been a sustained improvement in the no criteria to reside, stranded and super stranded ratios. The Trust achieved these trajectories in 2024/25 and will aim to do so in 2025/26.

Aims for 2025/26

- To continue working to improve the quality and timeliness of discharges.
- To continue in the journey to improve effectiveness of board rounds in all wards.
- To progress towards a criteria led discharge methodology.
- To progress with Discharge to Assess transformational programme on pathways 1, 2 and 3 in conjunction with community health and social partners.
- We, as a system, are aiming to achieve an ambitious no criteria to reside ratio of 10%, super stranded ratio of occupancy of 12% and stranded ratio of occupancy of 40% by end of March 2027.

2.7 Food, Nutrition and Hydration

Background

There is a requirement under the Health and Social Care Act (2008) regulations that Trusts meet nutrition and hydration needs (Regulation 14). The intention of this regulation is to make sure that people who use services have adequate nutrition and hydration to sustain life and good health and reduce the risks of malnutrition and dehydration while they receive care and treatment. The Trust is committed to delivering all the requirements of this regulation through the provision of good food, nutrition, and hydration care for all patients and to the prevention of avoidable patient malnutrition and dehydration and we have an improvement plan to ensure that we are focused in this work.

Key Achievements in 2024/25

Progress has been made against the 2024/25 Quality Account aims as follows:

- We have introduced a more robust risk assessment and care planning tool to support the food, nutrition, and hydration needs of our patients. This is available to all clinical staff through our electronic patient record.
- We have created a swallow care plan and implemented a sip test training video to support safe clinical practice.
- We have relaunched the International Dysphagia Diet Standardisation Initiative (IDDSI) resources to support staff learning.
- We have reviewed all texture modified diets to give wider options to our patients.

Aims for 2025/26

- Publish a Food, Nutrition and Hydration Strategy and associated improvement plan for 2025/26, supported by the recruitment to a new specialist Food Service Dietitian role.
- Work collaboratively with the Trust's digital teams to build effective food, nutrition and hydration-related screening tools, assessments, and documentation into the new electronic patient record.
- Continue quality improvement work in relation to provision of safe and effective care for patients with swallowing difficulties within our hospitals, underpinned by a robust Patient Safety Incident Investigation framework
- Gain documented assurance on the competency, through sign-off against Observed Structured Clinical Examination (OSCE), of all clinical staff who insert and provide ongoing management of nasogastric feeding tubes for adults, children, and neonates. We will publish a new Trust policy for nasogastric and nasojejunal feeding tubes.

2.8 Infection, Prevention and Control

Background

This section highlights the Trust performance against the national 2024/25 healthcare associated infection (HCAI) objectives and the high-level actions that are being taken to reduce incidence of avoidable infection. HCAI annual objectives run 1 April to 31 March, with a focus on reducing Clostridioides difficile infection (CDI) and gram-negative blood stream infections. There was requirement for the Trust to deliver a 5% reduction from the 2023/24 output. Whilst *Staphylococcus aureus* bacteraemia is not detailed with the NHS Contract document, the Trust have continued to focus on their reduction and monitor them against a 5% reducing target. The number of cases exceeded the Trust attributed annual objectives except for Klebsiella bacteraemia, where we completed the year 19 cases below the annual objective. .

Clostridioides difficile infection (CDI):

The Trust attributed annual objective for 2024/25 was set at 144 cases. This includes community-onset healthcare-associated cases (COHA), and hospital-onset healthcare associated (HOHA) cases in patients aged over 2 years. The Trust ended the year with 155 cases, 11 over objective with 84 (54%) attributed to York Hospital, 56 (36%) attributed to Scarborough Hospital and 15 (10%) being attributed to the community in-patient units.

Organisation Name	Code	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Total
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	RCB	15	15	14	15	14	12	17	12	11	13	9	8	155
Total		15	15	14	15	14	12	17	12	11	13	9	8	155

Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia:

The Trust attributed annual objective for 2024/25 was set at zero cases. This includes community-onset healthcare-associated cases (COHA), and hospital-onset healthcare associated (HOHA) cases. The Trust ended the year with 5 cases, with 4 (80%) attributed to York Hospital, 1 (20%) attributed to Scarborough Hospital.

Organisation Name	Code	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Total
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	RCB	1	1	1	0	0	0	1	0	0	0	1	0	5
Total		1	1	1	0	0	0	1	0	0	0	1	0	5

Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia:

The locally agreed 2024/25 objective, based on a 5% reduction was 82 cases. This includes community-onset healthcare-associated cases (COHA), and hospital-onset healthcare associated (HOHA) cases. The Trust ended the year with 90 cases, 8 over objective with 66 (73%) attributed to York Hospital, 24 (27%) attributed to Scarborough Hospital.

Organisation Name	Code	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Total
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	RCB	8	8	9	7	8	9	6	5	7	8	8	7	90
Total		8	8	9	7	8	9	6	5	7	8	8	7	90

Escherichia coli bacteraemia:

The Trust attributed annual objective for 2024/25 was set at 170 cases. This includes community-onset healthcare-associated cases (COHA), and hospital-onset healthcare associated (HOHA) cases. The Trust ended the year with 196 cases, 26 over objective with 121 (62%) attributed to York Hospital, 65 (33%) attributed to Scarborough Hospital and 10 (5%) being attributed to the community in-patient units.

Organisation Name	Code	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Total
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	RCB	16	18	20	15	19	13	23	20	14	10	16	12	196
Total		16	18	20	15	19	13	23	20	14	10	16	12	196

Klebsiella bacteraemia:

The Trust attributed annual objective for 2024/25 was set at 65 cases. This includes community-onset healthcare-associated cases (COHA), and hospital-onset healthcare associated (HOHA) cases in patients. The Trust ended the year with 46 cases, 19 under objective with 31 (67%) attributed to York Hospital, 12 (26%) attributed to Scarborough Hospital and 3 (7%) being attributed to the community in-patient units.

Organisation Name	Code	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Total
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	RCB	2	4	5	4	2	3	2	4	8	4	6	2	46
Total		2	4	5	4	2	3	2	4	8	4	6	2	46

Pseudomonas aeruginosa bacteraemia:

The Trust attributed annual objective for 2024/25 was set at 16 cases. This includes community-onset healthcare-associated cases (COHA), and hospital-onset healthcare associated (HOHA) cases in patients. The Trust ended the year with 26 cases, 10 over objective with 17 (65%) attributed to York Hospital, 8 (31%) attributed to Scarborough Hospital and 1 (4%) being attributed to the community in-patient units.

Organisation Name	Code	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Jan-2025	Feb-2025	Mar-2025	Total
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	RCB	0	2	5	2	3	1	1	1	5	1	1	4	26
Total		0	2	5	2	3	1	1	1	5	1	1	4	26

The Trust considers that this data is as described for the following reasons:

- All cases of infection are reviewed by the Infection Prevention & Control (IPC) Team and reported to the UK Health Security Agency on the monthly basis, through the Data Capture System, in line with national reporting requirements.

- Infection incidence is reviewed within the Trust care groups and assurance provided to the Infection Prevention Strategic Assurance Group (IPSAG), Patient Safety and Clinical Effectiveness Committee, the Quality and Safety Assurance Committee and the Trust Board.

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

- Infection Prevention and Control and Anti-microbial Stewardship groups have been established within each Care Group. These meet monthly to review the care group performance, agree and oversee improvement actions and provide assurance to IPSAG.
- All cases of Clostridioides difficile infection (CDI), Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia and Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia are now reviewed using the Patient Safety Incident Response Framework (PSIRF) framework key learning themes have included:
    - Stool sampling delays
    - Delays in isolating patients
    - Suboptimal documentation
    - Delays in commencing antimicrobial treatment or suboptimal compliance with antimicrobial guidelines
    - Suboptimal compliance with IPC guidelines
    - Suboptimal environmental audits and cleaning scores
- To support improvements, the Infection Prevention Control team have provided feedback on cases to the clinical areas, provided additional face to face training, provided Trust briefings, and participated in Quality Improvement initiatives within the clinical areas.
- Antimicrobial stewardship (AMS) has been improved by increasing AMS ward rounds in wards with increased incidence of Clostridioides difficile infection (CDI) and participation in the CDI reviews providing feedback to prescribers.
- September and October 2024 have been the Chief Nurse Year of Quality months for Infection Prevention Control. The team have co-ordinated several events over the 2 months which have focused on the embedding of high impact actions:

1. Bare below the elbow and effective hand hygiene
2. Appropriate use of Personal Protective Equipment (PPE)
3. When to take stool samples

4. Decluttering the clinical areas, including linen management
5. Effective aseptic non-touch technique.

Throughout the Infection Prevention Control months of quality, the team have used innovative approaches including ward walk rounds with visual aids, fun quizzes, conversation points, campaigns, awareness sessions, new information posters and prompt cards and de-clutter days.

NineteenHealthcare Assistants have successfully undergone NHS England leadership in Infection Prevention Control education this year. These staff are all IPC champions within the clinical areas and will be supporting the Infection Prevention Control team to drive improvements in practice.

2.9 Medication Safety

Background

The Trust Medication Safety Group focuses on improvements in medication safety and ensuring compliance with national standards and alerts relating to medicines. It reviews incidents, claims, complaints, and coroner's concerns relating to medicines along with learning from colleagues regionally and nationally to have an overview of medication related risk. It also oversees implementation of National Patient Safety Alerts (NPSA) and Medicine and Health products Regulatory Agency (MHRA) safety updates in relation to medicines and medicines shortages. It has its own audit program, approving audits and action plans and provides oversight of the medicines management risk register.

Key Achievements in 2024/25

In addition to the routine work as above in 2024/5 we have

- Launched a new three-year medication safety strategy which has four key themes.
    - Improving reporting, investigation and learning form medication incidents in line with Patient Safety Incident Response Framework (PSIRF).
    - Developing a medication safety culture.
    - Commissioning and supporting medicines related improvement projects.
    - Respond to newly identified safety concerns.
- Completed a Patient Safety Incident Investigation (PSII) into administration errors with oral opiates and completed the associated action plan.
- Following Care Quality Commission (CQC) concerns, completed audits into missed doses of medications with key actions being delivered and monitored through the group.
- Oversee implementation of National Patient Safety Alerts (NPSA) relating to Valproate, Topiramate and Oxytocin as well as numerous alerts related to drug shortages and monthly Drug Safety Updates from the Medicine and Health products Regulatory Agency (MHRA).
- Supported a gap analysis in response to the Health Services Safety Investigations Body (HSIB) report on time critical medicines in the Emergency Department.
- Completed a gap analysis and developed an action plan to ensure we have a robust process for supply of steroid emergency kits for steroid dependent patients.

- Developed a medication safety page for staff to access on the intranet.
- Completed scheduled audits on loading doses, the emergency steroid card and liquid medicines for children as well as a new audit to investigate concerns in intravenous iron prescribing.
- Continued to publish monthly Learning from Medication Incidents bulletins.

Aims for 2025/26

- Complete a Patient Safety Incident Investigation (PSII) into missed doses of insulin and support the development of an insulin safety group.
- Complete a thematic review of incidents relating to use of Lorazepam and Haloperidol in sedation.
- Complete the gap analysis and action plan in response to the HSIB report into missed doses of anticoagulants
- Produce guidelines to support staff to challenge others if they are concerned about prescribing issues and commence medication safety walk rounds.
- Explore barriers to medication incident reporting to try and increase our reporting rates.
- Provide updated guidance on second checks for medicines administration.
- Support the annual yellow card week in November.

2.10 Quality Improvement

Background

Quality improvement (QI) is the use of a systematic method to involve those closest to the quality issue in discovering solutions. It applies a consistent method and tools, engages people more deeply in identifying and testing ideas, and uses measurement to see if changes have led to an improvement.

The Quality Improvement Team purpose is to support others to enhance the efficiency, effectiveness, and overall quality of processes, services and patient care through collaboration and continuous improvement. We use data and feedback loops to monitor progress and evaluate outcomes.

Key Achievements 2024/25

- We conducted our first Rapid Process Improvement Workshop (RPIW) focused on environmental issues on the main corridor of York Hospital, which is the arterial route for our patients, staff, and stores to move around the hospital. The aim was to improve the health and safety and environment for both our staff and patients.
- Continuous development and delivery of successful QI training programmes across the Trust for both clinical and non-clinical staff.
- The one day ‘Delivering Improvement’ training has been completed by 372 members of staff. The Quality Service Improvement and Redesign (QSIR) Practitioner five day training has been completed by 111 members of staff.
- Developed and delivered different methods of training.
    - Rapid Process Improvement Workshops
    - 5S (sort, set in order, shine, standardise, and sustain) + Safety
- Provided one to one QI leadership and coaching support to individuals across the Trust..

Priorities for 2025/26

- We will develop and establish a QI Community/Network to promote shared learning. The network will have had its first meeting by September 2025.
- We will review and develop the QI training across the Trust by April 2026 to ensure we understand the benefit realisation from the investment into training.
- We will continue to support the organisation to create a continuous improvement culture through 2025/26 to deliver against the strategy. Our first simple step will be

to conduct a spring clean across the Trust using 5S+safety method. This will introduce a simple tool to staff which they can apply to other aspects of their work.

2.11 Patient Experience Priorities

Background

As a Trust we are committed to ensuring that our patients and their carers have the best possible experience of our care. There are times however, when this experience will not be of the standard that we or the patient and their family would expect to have.

It has been a year of change for the Patient Experience Team, which has seen a number of new appointments to key roles.

We have continued to invest in the recruitment and onboarding of volunteers across the Trust whose roles make a positive impact to patient, family, and carer experience. Our volunteers have supported the strategic priorities of the Trust, predominantly with food, nutrition, and hydration.

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

Our new Trust strategic aim is to deliver excellent patient experience every time, and this means putting patients first and delivering safe and compassionate care at every contact with patients and the communities we serve. Hearing from patients and their families about how we are doing and learning from their feedback is an important part of delivering our strategic aim.

Key Achievements 2024/25

Patient, Carers and Families Experience and Engagement Framework

During this year we co-created a new “Patient, Carers and Families Experience and Engagement Framework” to support us in embedding our vison of excellent patient experience. We want to ensure that when someone comes into York and Scarborough Teaching Hospitals NHS Foundation Trust they are treated with dignity and respect and that the care and treatment is planned in partnership.

This framework will enable us to embed patient experience into our improvement programmes. The five aims of the framework are as follows:

- **Listen** - We will listen to patients and people with lived experience, to understand the needs of those accessing our services.
- **Learn** - We will listen to suggestions on how to improve what we do, act upon what we hear and use your ideas to improve services.

- **Involve** - We will ensure that a diverse range of patients and people with lived experience, are involved in co-production and leading the direction and delivery of our work programmes.
- **Improve** - We will develop responsive services, making changes which support us to improve the quality of care we deliver.
- **Feedback** - We will show that we value your engagement by providing meaningful feedback and sharing outcomes from where we have worked together to improve patient experience.
- In the summer of 2024 as part of the public engagement sessions for the new Scarborough Urgent and Emergency Care facility, we facilitated several patient and carer engagement workshops to access feedback about new environment. The feedback was then incorporated into the programme plan.
- We have further strengthened relationships with external communities including those representing under-represented groups, disabled patients, and carers. The partnerships we have developed including with the three Healthwatch organisations we work with, have been instrumental in the development of new policies that we have published (the Accessible Information Standards policy, Animals of Trust Property Policy and the Gender and Diverse Communities Policy) and other publications including the new Trust carers leaflet.
- We have continued to collaborate with Humber Teaching NHS Foundation Trust to support the Scarborough and Ryedale Patient and Carer Experience Forum. This brings together staff, governors, Healthwatch, patients, carers, and the public from across the Scarborough, Bridlington, and Ryedale region. The forum is coproduced with its members and strives to maintain an informative and relevant agenda. Some of the topics we have covered include patient transport, support for carers and tobacco dependency.
- The Chaplaincy team has recruited new Chaplains and Honorary Chaplains to the team and have worked to establish connections with faith groups to ensure that we are able to meet the needs of all patients and carers. In the year ahead we will continue to explore how the service can support patients and staff of underrepresented faith/belief groups including those with none.

We will develop a suite of resources, to equip members of staff to feel more confident in facilitating patient involvement/engagement

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

- We have delivered patient experience education sessions for staff and newly qualified clinical staff (non-medical) as part of the preceptorship programme. We have continued to update our resources for patient engagement and patient equality, inclusion, and development on the Trust intranet to support Trust staff in learning how to engage and involve patients and carers when implementing and enhancing services.
- We have commenced work on a number of programmes of work that will improve patient and carer experience including the publication of British Sign Language (BSL) videos and Easy Read versions of the top 5 most accessed patient information leaflets and the co-production of a video for patients and carers with sensory needs to support them when visiting York hospital emergency care.
- We have been active contributors to the City of York Carers meeting and have further nurtured our relationships with York Carers, Carers Plus and Carers Resource supporting us in the co-creation of our Carers Improvement Plan. We have undertaken surveys and focus groups to understand what carers want and need when they visit the hospital to support patients and will be using these insights to shape our improvement work.

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

People who access services in the organisation or wish to be involved with improving the patient experience, should be able to access information in a format that is preferable for them. The patient experience pages on the Trust website are an important touchpoint for patients, families, and carers.

- We have continued to embed the Accessible Information Standard including launching the new policy and are engaging with the development team to ensure

that patient requirements can be recorded when we transition to the new electronic patient record.

- We have supported the provision of translation services for British Sign Language and international languages and have worked closely with the external provider to improve the patient experience and fulfilment of the service. We have also provided guidance and training to staff on how to access the service.
- We have refreshed and updated patient experience communications both for print and online materials and have updated the patient information leaflet for our Patient Advice and Liaison Service.
- We recognise that time in hospital can be stressful for patients, their family, and their carers. Our Chaplaincy team offers spiritual and pastoral support to patients, visitors, and staff of all faiths, beliefs, or none, to find strength and meaning in their experience of illness, anxiety, or bereavement. This year we have seen an increase in referrals to the service of 50 percent primarily because of our new electronic referral system.

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

The Trust is committed to learning from and improving the patient experience. It is imperative that we can evidence actions taken in response to feedback, including sharing the learnings to further enhance services alongside recognising and celebrating success where patients have had a positive experience of our services. It is equally important that we ensure outcomes are feedback to those involved.

- We updated the governance and Terms of Reference for the Patient Experience Subcommittee. We have established Care Group Patient Experience Groups to provide oversight and gain assurance, that there are systems, processes, and controls in place to deliver and monitor the achievement of consistently high-quality care.
- We have worked with Care Groups, providing support to assist in the management of responses to overdue concerns and complaints, providing support at Care Group meetings, helping improve the quality of communications through reviewing complaint response letters and providing reports for use at Care Group governance meetings.

- It is essential that patients, carers, and families receive a timely and high-quality response to complaints. To further improve the experience, we have begun to prepare for a rapid process improvement event to develop standard working practices across Care Groups and explore new efficient ways of supporting the complaints process.
- We have reviewed the training provision for complaint management and with effect from the new financial year will transition to the training provided by the Parliamentary and Heath Service Ombudsman. In addition, we have commissioned communication skills training and complaints writing skills training to be delivered in the new financial year.

Aims for 2025/26

- Embedding our new “Patient, Carers and Families Experience and Engagement Framework.”
- Developing and implementing our Carers Improvement Plan.
- Improving patient and carer experience of our concerns and complaints processes.
- Supporting the delivery of the Accessible Information standards through the new electronic patient record system
- Procurement of the new translation and interpretation service provider.
- Procurement of a new supplier for the national patient surveys and the Friends and Family test.

2.12 Friends and Family Test (FFT)

Background

The Friends and Family Test (FFT) remains one of the most widely used tools for capturing timely feedback from patients across the NHS. At York and Scarborough Teaching Hospitals NHS Foundation Trust, we collect FFT data via SMS, paper cards, and quick response (QR) codes, making it accessible to a broad range of patients and carers. Responses are reviewed each month at ward, service, and Care Group levels to celebrate excellence and highlight areas for improvement.

Between April 2024 and January 2025, the Trust received 51,265 FFT responses across five core services. The table below reflects a ten-month summary, ahead of full-year figures:

	Maternity	Community Hospitals	Inpatients	Emergency Department	Outpatients	Total (All Services)
Responses	287	303	17,308	5,120	28,247	**51,265**
Eligible Patients	3,279	36,492	88,585	72,544	587,292	**788,192**
% Response Rate	8.8%	0.8%	19.5%	7.1%	4.8%	**6.5%**

Inpatient services again achieved the strongest response rates, benefiting from consistent engagement by ward teams. Maternity feedback dropped slightly, though remains within the national range. Outpatients, despite the largest response volume, continue to show low proportional engagement. Community services recorded the lowest response rate, largely due to variability in patient flow and limitations in digital access.

Aims for 2025/26

- Implement and embed our new digital-first FFT model, ensuring SMS becomes the primary contact method for most services, while maintaining paper-based options for those who require them.
- Use FFT insight more proactively in service improvement plans, linking feedback directly to actions at ward and Care Group level.

2.13 National Patient Surveys

Background

Alongside real-time feedback through Friends and Family Test (FFT), the Trust participates annually in national patient surveys led by the Care Quality Commission (CQC). These provide a benchmarked and statistically validated view of patient experience across services.

The Trust's FFT contract ended in April 2025. In preparation for the next survey cycle, the Trust has procured a new national survey provider, IQVIA who will begin to work with us from the new financial year. This changed followed a comprehensive review of available options, and a procurement exercise that involved stakeholders. The new platform will provide clear insight reporting and improved support for data submissions.

Adult Inpatient Survey 2023 (published August 2024)

The Adult Inpatient Survey, part of the national NHS Patient Survey Programme, collected feedback from 491 in-patients who received care at the Trust during November 2023. The results, which were formally presented to the Patient Experience Subcommittee in September 2024, offer an essential benchmark for service performance and provide direct insight into patient perspectives at a critical point in their healthcare journey.

This survey showed strong Trust-wide performance in:

- Staff respect and kindness.
- Cleanliness and privacy.
- Discharge communication.

Areas requiring further focus included:

- Medication information at discharge (lowest-scoring question).
- Noise at night, feedback mechanisms, and home circumstance discussions.

Workshops held with clinical teams in October 2024 resulted in several targeted action plans, including improved discharge summaries and ward-level noise-reduction initiatives.

Improvement actions included

- 'Rest Well' initiative launched to address ward noise, with ongoing evaluation.
- Joint work between pharmacy and nursing teams to improve clarity of discharge information, supported by colleagues from the Quality Improvement Team.
- Feedback collection enhanced through the Patient and Community Engagement (PACE) model, piloted in three inpatient areas.

Maternity Survey 2024 (published November 2024)

The 2024 National Maternity Survey, covering births in February 2024, gathered responses from 145 individuals the Trust (49% response rate), a decrease from 56% in 2023.

This survey showed:

- Much better performance than most Trusts for start-of-labour support.
- Better than most performance for mental health and concerns being taken seriously.
- Consistently high scores for kindness and compassion.

Importantly, no questions were rated worse than most Trusts, and our results aligned with or exceeded the national average across all other areas.

A co-produced improvement plan was developed with the Maternity and Neonatal Voices Partnership and embedded into the Trust Maternity and Neonatal Single Improvement Plan. Key areas of work included:

- Partner Involvement: Initial steps to extend visiting hours were underway. Estates constraints remain a key challenge. A partner survey was launched in January 2025 to gather further insight.
- Infant Feeding Support: A cross-site review and process mapping took place in July 2024. Actions included BFI training for staff, review of demand and provision, and peer support expansion. Improvements aim for equity between York and Scarborough sites.
- Discharge Information: A co-produced discharge video was launched in September 2024, complemented by Easy Read guides and updated bedside booklets. Feedback collection on the video began in February 2025.
- Pelvic Health Services: Following business case approval in July 2024, recruitment and rollout began in line with the national specification. As of early 2025, physiotherapists were in post and further recruitment was underway.

This survey and the resulting improvement work were reported to the Patient Experience Subcommittee in February 2025.

Urgent and Emergency Care Survey 2024 (published November 2024)

The Urgent and Emergency Care Survey offers insight into the patient experience within both Type 1 Accident ad Emergency (A&E) departments and Type 3 Urgent Treatment Centres (UTCs) at the Trust. These services, essential to frontline acute care, were

reviewed via 282 and 182 patient responses respectively, capturing real-time feedback on access, environment, communication, dignity, and outcomes. The data, reviewed at the Patient Experience Subcommittee in December 2024, illustrates a service that continues to deliver safe, respectful care, but with notable variation in patient experience between the two service types particularly regarding waiting times and emotional support in Type 1 settings compared to consistently higher satisfaction scores in Type 3.
This year's Urgent and Emergency Care results showed a mixed picture:

- Patients praised staff for discussions about follow-up and care planning.
- Key challenges were identified in privacy, waiting time communication, and basic comfort during long waits.

Improvement Actions:

- Communication boards and digital signage piloted to address waiting time clarity.
- Enhanced pain management protocols with refresher training for frontline staff.
- Improved discharge materials and signposting in both A&E and UTCs.
- Proactive staff presence in waiting areas trialled in Q4 2024/25.

The findings have informed local improvement plans within each urgent care setting. A&E and UTC teams were asked to align service-specific responses with Trust-wide quality goals, particularly those related to communication, pain management, and patient-centred discharge planning.

2.14 Quality Account Participation

The Trust is committed to quality improvement and part of this is learning taken from participation in the national and local audit programme. Participation with the national audit programme is overseen by the Trust Clinical Effectiveness Team. Engagement with the national programme has continued to improve.

The Trust could participate in 68 Quality Accounts for 2024/25. The current trajectory for Quality Accounts participation stands at 93%.

In 2024/25, the provider reviewed national clinical audits, prompting key actions to enhance healthcare quality:

- Clinical Effectiveness Officers arrange multi-disciplinary team meetings upon receiving national audit reports, engaging audit leads and stakeholders to share findings, benchmark against recommendations, and develop action plans where needed.
- Monthly Care Group progress reports highlight any escalations, fostering transparency and accountability.
- The Clinical Outcomes and Effectiveness Group oversees the national clinical audit programme, guiding improvement initiatives following audit results.
- The Clinical Effectiveness Team contact and request support from the Quality Improvement Team for audits which had metrics demonstrating reduced compliance when compared nationally. This resulted in key workstreams being initiated, triangulated with incident data

Quality Accounts National Audit Topic	Trust Participation in 2024-25
BAUS Penile Fracture Audit	No – no cases identified
BAUS Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices (I-DUNC)	No - no information received re data collection date from national provider
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes
British Hernia Society Registry (BHSR)	Yes
CMP Case Mix Programme ICNARC	Yes

Quality Accounts National Audit Topic	Trust Participation in 2024-25
NCEPOD Child Health Clinical Outcome Review Programme - Emergency Paediatric Surgery	Yes
RCEM Emergency Medicine QIPs: Adolescent Mental Health	Data collection not started (pilot from April 2025)
RCEM Emergency Medicine QIPs: Care of Older People	Yes
RCEM Emergency Medicine QIPs: Time Critical Medications	Yes
Epilepsy12 National Audit of Seizures and Epilepsies in Children and Young People	Yes
FFFAP Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls (NAIF)	Yes
FFFAP Falls and Fragility Fracture Audit Programme – National Hip Fracture Database (NHFD)	Yes
LeDeR Learning from lives and deaths of people with a learning disability and autistic people	Yes
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Confidential Enquiries	Yes
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance	Yes
MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme – Maternal Mortality Surveillance and Mortality Confidential Enquiries	Yes
NCEPOD Medical and Surgical Clinical Outcome Review Programme - Blood Sodium	Yes
NDA National Diabetes Audit – Adults – National Diabetes Core Audit	Yes
NDA National Diabetes Audit – Adults – National Diabetes Foot Care Audit (NDFA)	Yes
NDA National Diabetes Audit – National Diabetes Inpatient Safety Audit (NDISA)	Yes
NDA National Diabetes Audit – Adults – National Pregnancy in Diabetes Audit (NPID)	Yes
National Adult Diabetes Audit (NDA) - Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes
National Adult Diabetes Audit (NDA) - Gestational Diabetes Audit	Yes
NACR National Audit of Cardiac Rehabilitation	Yes
NACEL National Audit of Care at the End of Life	Yes
NAD National Audit of Dementia – Care in General Hospitals	Data collection not started (content and

Quality Accounts National Audit Topic	Trust Participation in 2024-25
	format re-design from April 2025)
NBSR National Bariatric Surgery Registry	Yes
NATCAN National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer (NAoMe)	Yes
NATCAN National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer (NAoPri)	Yes
National Cancer Audit Collaborating Centre (NATCAN): National Bowel Cancer Audit (NBOCA)	Yes
National Cancer Audit Collaborating Centre (NATCAN): National Kidney Cancer Audit (NKCA)	Yes
NATCAN National Cancer Audit Collaborating Centre: National Lung Cancer Audit (NLCA)	Yes
National Cancer Audit Collaborating Centre (NATCAN): National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes
National Cancer Audit Collaborating Centre (NATCAN): National Oesophago-Gastric Cancer Audit (NOGCA)	Yes
National Cancer Audit Collaborating Centre (NATCAN): National Ovarian Cancer Audit (NOCA)	Yes
National Cancer Audit Collaborating Centre (NATCAN): National Pancreatic Cancer Audit (NPaCA)	Yes
NATCAN National Cancer Audit Collaborating Centre: National Prostate Cancer Audit (NPCA)	Yes
NCAA National Cardiac Arrest Audit	Yes
NCAP National Cardiac Audit Programme – National Heart Failure Audit (NHFA)	Yes
NCAP National Cardiac Audit Programme – National Cardiac Rhythm Management (CRM)	Yes
NCAP National Cardiac Audit Programme – Myocardial Ischaemia National Audit Project (MINAP)	Yes
NCAP National Cardiac Audit Programme – National Audit of Percutaneous Coronary Intervention (NAPCI)	Yes
NCMD National Child Mortality Database	Yes
NCABT National Comparative Audit of Blood Transfusion: 2023 Audit of Blood Transfusion against NICE QS138	Yes
NCABT National Comparative Audit of Blood Transfusion: 2023 Bedside Transfusion Audit	Yes
NEIAA National Early Inflammatory Arthritis Audit	Yes
NELA National Emergency Laparotomy Audit	Yes
NJR National Joint Registry	Yes
NMTR National Major Trauma Registry (previously TARN)	Yes

Quality Accounts National Audit Topic	Trust Participation in 2024-25
NMPA National Maternity and Perinatal Audit	Yes
NNAP National Neonatal Audit Programme	Yes
NOD National Ophthalmology Database Audit: National Cataract Audit	Yes
NPDA National Paediatric Diabetes Audit	Yes
NPMRT National Perinatal Mortality Review Tool	Yes
NRAP National Respiratory Audit Programme: COPD Secondary Care	Yes
NRAP National Respiratory Audit Programme: Pulmonary Rehabilitation	Yes
NRAP National Respiratory Audit Programme: Adult Asthma (AA) Secondary Care	Yes
NRAP National Respiratory Audit Programme: Children and Young People's Asthma (CYPA) Secondary Care	Yes
NVR National Vascular Registry	Yes
PQIP Perioperative Quality Improvement Programme	Yes
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology & Reconstruction	No – data not submitted
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	No – data not submitted
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	No – data not submitted
Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma Skin Cancers	Yes
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	No – data not submitted
SSNAP Sentinel Stroke National Audit Programme	Yes
SHoT Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes
SAMBA Society for Acute Medicine's Benchmarking Audit	Yes
CFR UK Cystic Fibrosis Registry (Adult & Paediatric)	Yes
UK Renal Registry Chronic Kidney Disease (CKD) Audit	Yes
UK Renal Registry National Acute Kidney Injury (AKI) Audit	Yes

The Trust has annual local audit plans which are managed within individual Care Groups with coordination from Clinical Governance Teams.

Audit activity is now captured on Smartsheet enabling Care Groups and Corporate teams to have oversight of the activity, with learning captured in one place.

For 2025/2026, clinical effectiveness updates will be provided by the Care Groups through the monthly Performance Meetings (PRIM) and at the Clinical Outcomes and Effectiveness Group meetings.

2.15 Research and Development

The aim of clinical research is to increase knowledge about treatments to ensure we are treating based on the best possible evidence. Research offers participants the opportunity to be involved in clinical studies which may or may not be of benefit to them but will allow us to improve and develop treatment for the future.

Yorkshire and Humber is part of the Clinical Research Delivery Network (RDN). Every Clinical Research Network (CRN) is targeted with a figure by the National Institute for Health (NIHR) on the number of patients entered into a clinical trial in a given financial year. Our CRN consists of 22 partner organisations, of which we are one and we are expected to recruit at least 3500 patients a year into clinical trials.

Currently we have approximately 90 research studies open to recruitment. The number of patients receiving relevant health services provided or sub-contracted by the Trust in the period 1 April 2023 to 31 March 2024 is 5051, our largest number of patients recruited into trials in a single year. This is mainly due the success of the Born and Bred in (BaBi) project that is currently being managed and run by our maternity departments.

Key Achievements 2024/25

Research

- We are currently at 145% against our recruitment target for 2024/25. Our strongest recruiting Research Specialties for this period have been Public Health, Gastroenterology, Cancer, Ophthalmology and Trauma and Emergency Medicine. In addition, Critical Care, Surgery, Cancer, Renal and Ophthalmology have the largest portfolios of studies currently open.
- We are ranked in the top three in the Yorkshire and Humber Regional Research Delivery Network for seven specialties.
- The long-term BaBi (Born and Bred in) York and Scarborough study is recruiting very well. This study will see all mothers and babies born in York and Scarborough eligible to participate and it is a study that will capture a routine data from all babies born in our Trust (demographics, health conditions and maternal outcomes); this will later be joined up by wider linked data sources throughout the child's development (e.g. GP, social care, school records) so we can research into areas of child development.

BORN & BRED IN
York and Scarborough

- We have had a great year for grant applications with a total of 32 grants submitted, including nine innovation grants, one internship application and four Fellowship

applications. The total value of grants submitted amounted to £10.3m with £2.3m allocated to the Trust. We were successful in five awards to the value of £340k with £142k being awarded to the Trust.

- Scarborough Hospital, in partnership with the University of Birmingham and the University of York, has secured £1.2 million from the National Institute for Health and Care Research (NIHR) to improve urgent and emergency care in rural coastal areas. The project began set up in February 2025.
- York Hospital, in partnership with the University of Aberdeen, Cardiff University, the University of York and Southampton University secured £3 million last year from the NIHR to deliver the ColoCap study. The study, led by Professor James Turvill, York Hospital, and Professor Angus Watson, University of Aberdeen, aims to determine the diagnostic accuracy of colon capsule endoscopy compared to standard colonoscopy.

- We have grown the Research and Innovation Team as we have recruited a grant development support post to support the current grant writer; due to the volume of grant applications being submitted. We have also recruited a bespoke commercial research delivery team to assist with our increasing commercial portfolio. We have also seconded a Head of Maternity Research and Allied Health Professional Research to the team, so support us in delivering the Research and Innovation strategy.
- Our commercial research portfolio continues to grow and in 2024/2025 we welcomed our very first Commercial Research Team. This team has significantly enhanced our ability to conduct more commercial trials, benefiting our patients. We have successfully opened the first commercial Phase II Intensive Care unit study in 12 years. This explorative study investigating the efficacy of a groundbreaking treatment for patients suffering from severe community-acquired pneumonia. In ophthalmology, a study led by Dr Airody and Professor Gale, focusing on macular oedema and macular degeneration, achieved outstanding results by exceeding its recruitment target by 75%. Looking ahead to 2025/2026, we are thrilled about the promising pipeline of studies and are determined to make a meaningful impact on the lives of patients within our Trust.

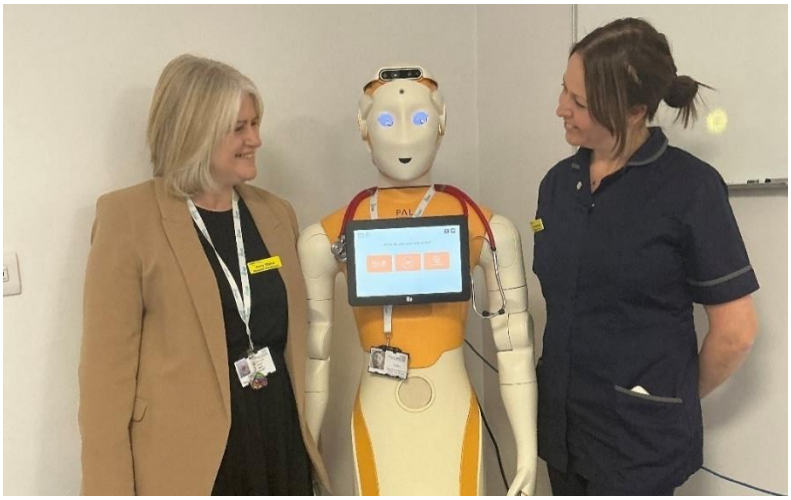
- The Scarborough Coastal Health and Care Research Collaborative (SHARC) launched on the 1 April 2025 in Scarborough. SHARC aims to better address the health and care needs of our coastal populations through high quality collaborative research with community involvement. This project is in collaboration with York St John University, and brings together the charity and volunteer sector, academics, and clinical expertise in health research. Our aim is to better address the health and care needs of our coastal populations through high quality collaborative research with community involvement.
- The team has now become responsible for Research and Innovation, enhancing our portfolio from just Research and Development. The new Research and Innovation strategy for 2025-2028 has now been approved and the delivery of our objectives is now under way, with an annual update being provided to Board.
- The team are utilising the national SORT tool (Self -assessment of Organisational Readiness) to assess where a Trust is at in terms of Nursing Midwifery and Allied Health Professional research readiness to improve research capacity in healthcare.
- We continue to grow strong collaborations with the Institute for Health and Care Improvement at York St John University and have again funded joint research posts and PhD studentships to strengthen these research relationships.
- We are working closely with all the academic institutions in the local area to provide educational sessions in which research careers and pathways are highlighted and discussed. Engaging with the pre-registered workforce enables us to promote innovative career roles, such as research nursing or becoming a healthcare researcher and developing research questions and ideas. Our team visit the universities and deliver sessions which are incorporated into relevant modules to support the curriculum whilst showcasing healthcare research as a career option.
- We have launched our annual writing retreat, jointly run between University of York, University of York St John and Tees Esk and Wear Valleys Trust. We are currently advertising this to our staff to look for early career researchers to participate. The retreat runs for three days in May, and each member of staff gets three days dedicated training and mentorship to write a scientific publication.
- We have held our third Celebration of Research event in November 2024, where over 200 attendees came to listen to our inspiring presentations, The day concluded with an emotive and powerful speech by Professor Bola Owolabi, Director of the

National Healthcare Inequalities Programme at NHS England, which echoed the determination of all us to improve health inequalities across our Trust.

- The Trust continues to maintain a strong publication record. In the last year Trust staff have authored 107 publications across all care groups as returned from a search of MEDLINE (bibliographic database) and Embase Research Database.

Innovation

- We have been meeting with innovation teams from Trusts around the country to start formulating our ideas on how to grow our innovation support to our staff.
- We are actively engaging with local government and facilitating innovation project approaches by local and international small and medium sized enterprises.
- We have submitted nine innovation grants in the last year with the majority being home grown innovation ideas or from ongoing innovation projects we previously supported.
- The DAISY feasibility trial, our home-grown innovation by Dr Ol'Tunde Ashaolu, has started enrolling participants at Scarborough Hospital Emergency Department. DAISY, which stands for Diagnostic AI System for Robot-Assisted Accident and Emergency Triage, is a pilot prototype humanoid device, designed to assist with the initial clinical assessments routinely carried out when patients attend the emergency department. The aim is to explore whether DAISY's advanced digital technology (AI) can enhance these processes. The system provides instructions to patients on how to use medical equipment to measure their own vital signs. DAISY will ask patients a series of health-related questions, gathering important data such as symptoms, body temperature, and pulse rate. All of this information is then compiled into a clinical report, which is intended to support staff in their assessment of the patient.



- Dr Jenny Piper and Dr Theo Issitt have developed an innovative breath biomarker test which we have supported and are awaiting the outcome of their InnovateUK SMART grant. The aim of this is assess the diagnostic accuracy of this tool and

capture cancers early through detection of volatile compounds expressed within the breath. We have supported this project for the past 3 years, from concept to clinical pilot study.

Aims for 2025/26

- To develop our research priorities with the community of Scarborough allowing Scarborough Coastal Health and Care Research Collaborative (SHARC) to establish a full research programme based at Scarborough hospital, working with our local universities.
- To continue to successfully deliver our two large NIHR grants, the Colon Capsule study and ELEVATE and to meet all agree targets.
- To build on recent NIHR grant success to continue to build this income stream for the Trust.
- To build on the growing success of our commercial research trials so we can give our patients opportunity to participate in novel treatments and therapies not yet available through standard NHS care.
- To develop our innovation support services and develop the innovation portfolio, including delivering our first ever “Dragons Den” initiative in 2025.
- To facilitate data access requests to routinely collected clinical data so we can support out Trust staff with developing research ideas and drive operational and patient care improvements.
- To produce a report using the Self-assessment of Organisational Readiness tool (SORT) and report an act on the findings.
- Roll our career development website across the Trust.

2.16 Freedom to Speak Up

Background

Having a speak up culture protects patients and staff. It also improves the working environment, promotes learning and improvement, and improves the culture of the organisation. Freedom to Speak Up is grounded in the everyday behaviours and principles that help organisations work safely and effectively. It is about creating the conditions that prevent harm, resolve issues early, and build lasting Trust. Listening, taking all concerns seriously and acting on them is not only the right thing to morally- it is business critical. Colleagues are often closest to the risk, insights and experiences that affect the safety, culture, and performance of our services.

It is widely acknowledged that what happened in Mid Staffordshire NHS Foundation Trust was caused by a range of factors, not least allowing a culture of fear and poor style of leadership to take hold. Sir Robert Francis highlighted the dangers of losing sight of human concerns in healthcare, the importance of engaging with patients and staff, and the risks to patients when the delivery of care becomes depersonalised. He insisted on the urgent importance of transforming the culture of NHS organisations away from one that is fearful and defensive and towards one that is open, honest, and willing to listen.

Our Trust is committed to the principles of the Freedom to Speak Up (FTSU) review and its vision for speaking up. The Trust has adopted the national Freedom to Speak Up Policy, set out by NHS England, to provide guidance to all workers (employed staff, agency, temporary and students) about how to go about speaking up about anything that gets in the way of them providing high quality care to the patients we serve.
The Trust Board receives a full report from the Freedom to Speak Up Guardian annually which details the numbers, themes and lessons learnt form staff who have spoken up to the Freedom to Speak Up Guardian.

The Freedom to Speak Up Guardian is independent, impartial, and non- judgemental. The guardian reports directly to the Chief Executive, which is in line with best practice, and also the National Guardian's Office, which is sponsored by CQC and NHS England.

Achievements 2024/25

Over the previous 12 months the Freedom to Speak Up Guardian has been working with the Trust's Health and Wellbeing Lead to deliver bespoke sessions around Freedom to Speak Up, the Fairness Champions, and the Trust's Health and Wellbeing offer. The objective of this initiative is to converse with staff who we may not necessarily engage with due to their clinical facing commitments i.e. Theatres, Intensive Care, Maternity etc.
In order to reach a wide variety of staff groups, and hard to reach groups (staff from marginalised groups, students, volunteers, shift workers etc) the guardian has utilised many forms of communication.
Examples include:

- Attending New Starter Fairs and presenting at nurse preceptorship inductions and Healthcare Assistant (HCA) inductions.
- Attending Resident Doctor Fairs.
- Electronic messaging (various communicative bulletins, screensavers, emails etc).
- Posters and postcards for those who may not have regular access to a computer.
- Attends all the Staff Benefit Fairs across multiple sites.
- Working in partnership with the Wellbeing Team, Staff Psychology Services and Staff Side to support awareness weeks.
- Attend team meetings/ clinical governance sessions either in person or virtually.

2.17 Guardian of Safe Working Hours

The 2016 national contract for resident doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came the introduction of a 'Guardian of Safe Working Hours' in organisations that employ, or host, NHS doctors and dentists in training. The Guardian's role is to ensure that issues of compliance with safe working hours are addressed.

The role of Guardian sits independently from the management structure, with a primary aim to represent and resolve issues related to safe working hours for the resident doctors employed by the Trust. The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by NHS England Workforce, training, and education (formerly Health Education England) who oversee the quality of training.

The resident doctor contract has stipulations on the length and frequency of shifts as well as rest breaks. Rosters and work schedules are designed to these specifications. Doctors have access to an online reporting tool that allows them to highlight variations.

Variations include working extra hours (if essential for patient safety), missed teaching or training sessions, missed breaks and unsafe rest periods between shifts.

Outcomes for each report can be closure with no further action (in terms of compensation), the allocation of payment for extra hours worked or time off in lieu (TOIL).

Exception reports can also lead to the host department being fined by the Guardian as well as initiating a review of staffing and rostering to tackle any systemic factors that may be contributing to the breaches. Fines are split between the affected doctor and Guardian funds using nationally established criteria. Resident doctors determine how Guardian funds are utilised via the Resident Doctor Forum.

Key metrics for this reporting period are highlighted below. Values for 2023/24 are contained within [ ] brackets for comparison:

Exception reports received by site:

Site	Number of exception reports
Scarborough Hospital	107 [150]
York Hospital	197 [137]
Total exception reports received	**304 [287]**

Reason(s) for exception report:

Nature	Type	Number of exception reports*	Percentage of total reports*
Hours and rest	Additional hours worked	**242** [251]	79.6%
	Missed breaks	**49** [36]	16.1%
	Difference in work pattern	**6** [3]	2%
	Rest	**1** [0]	0.33%
	Exceeded the maximum 13 hour shift length	**12** [1]	4%
	Unable to achieve the minimum 11 hours rest between resident shifts	**1** [0]	0.33%
Education and training	Inadequate clinical exposure	**5** [2]	1.64%
	Inadequate supervision	**14** [8]	4.6%
	Unable to attend clinic / theatre / session	**4** [5]	1.3%
	Unable to attend scheduled teaching / training	**9** [5]	3%
	Difficulty completing workplace-based assessments (WPBAs)	**0** [2]	0%
	Lack of feedback	**0** [1]	0%
	Teaching cancelled	**0** [1]	0%

** Total does not add up to 304 and percentage does not add up to 100% as individual reports may encompass more than one type of variance*

Hours and rest outcomes:

This is the only category of exception report eligible for time off in lieu or payment. The report must be submitted within 14 days of the event and demonstrate a clear workplace requirement for the overtime. Resident doctors receive paid breaks, thereby, reports relating solely to missed breaks do not garner time off in lieu or payment but trigger a period of monitoring.

Outcome type	Number of exception reports	Hours claimed	Value of hours claimed
Payment for additional hours worked	**114** [155]	**147.75** [187.25]	**£3039.38** [£3291.09]
Time off in Lieu	**126** [70]	**158.25** [85.75]	NA
Other action & pending review	**64** [62]	NA	NA

Guardian fines levied for contractual breaches of safe working hours totalled £660.40.

2.18 Information Governance

Background

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

Information Governance provides a framework to ensure that patient information is fairly obtained, securely handled, properly maintained, and readily accessible to staff with a legitimate reason to access it, to facilitate the provision of high-quality healthcare services. Our commitment to the fundamental principles of data protection, confidentiality and privacy means our patients can be assured that their information will be always handled legally and appropriately.

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

Leadership and Oversight

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

There has been significant work to identify areas which were previously "unknown" which has seen an increase in "not meeting expectations" and "partially meeting expectations." This will allow the Trust to manage the risk associated with these areas.

	2021	2022	2023	2024
Fully meeting our expectation	30%	37%	47%	47%
Partially meeting our expectation	39%	38%	38%	41%
Not meeting our expectation	20%	15%	6%	8%
Not applicable or unknown	11%	10%	9%	4%

Data Security and Protection Toolkit

The Trust measures its performance against the Data Security and Protection Toolkit, a set of standards established by the National Data Guardian (NDG) and the Department of Health and Social Care (DHSC). The Toolkit was updated this year to reflect the Cyber Assurance Framework, introducing more rigorous and comprehensive requirements.

At the final submission in June 2025, the Trust achieved compliance with 31 of the 47 assessed outcomes (66%), falling short on 16 outcomes (34%). While this reflects partial progress, the Trust remains unlikely to achieve full compliance in the next assessment cycle under current conditions.

In response, an improvement plan has been submitted to NHS England. This plan outlines the actions being taken to address the areas of non-compliance and strengthen the Trust's overall data security and protection measures, with the aim of improving performance against the updated Toolkit standards in the future.

Information Asset Register

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

Data Protection Impact Assessments

Work has continued in relation to Data Protection Impact Assessments; these assessments enable the Trust to review any data protection and privacy risks. The Trust has 290+ assessments in place or open for review.

Freedom of Information

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

In the financial year 2024/2025 the Trust processed a total of 856 requests for information and responded to 90% of these within the required 20-day timeframe.

Part 3: Review of Quality Performance

3.1 Reporting Against Core Indicators

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

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

Indicator	Target 2024-25	End of June 2024	End of September 2024	End of December 2024	End of March 2025
ED – Proportion of Ambulance handovers waiting > 45 mins	10%	35.27%	37.23%	38.65%	17.46%
ED – Proportion of all attendances having an initial assessment within 15 mins	66%	53.94%	67.75%	63.04%	71.24%
ED – Total waiting 12+ hours – Proportion of all Type 1 attendances	7.5%	16.60%	19.52%	23.40%	15.63%
ED – Median Time to Initial Assessment (Minutes)	18	10	4	5	4
ED – Emergency Care Standard (Trust level)	78%	67.30%	64.44%	61.00%	65.08%
Cancer – Faster Diagnosis Standard	77%	67.91%	67.19%	72.27%	70.58%
Cancer – Number of patients waiting 63 or more days after referral from Cancer PTL	143	156	189	202	151
RTT – Total Waiting List	44663	45568	45020	43352	46605

Indicator	Target 2024-25	End of June 2024	End of September 2024	End of December 2024	End of March 2025
RTT – Waits over 78 weeks for incomplete pathways	0	0	0	0	0
RTT – Waits over 65 weeks for Incomplete pathways	0	132	18	38	40

3.2 Summary Hospital-level Mortality Indicator

Background

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

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

The Trust considers that this data is as described for the following reasons:

- Information on the Summary Hospital-level Mortality Indicator (SHMI) is reported to and scrutinised by the Quality Committee and Board of Directors when published within the Learning from Deaths report.
- The Trust continues to audit the quality of our clinically coded data for deceased patients as part of our mortality reviews to ensure it is an accurate reflection of the patient's diagnoses and procedures. All clinicians are required to validate the clinical coding of patients who died in hospital to ensure it accurately reflects the main conditions for which the patient was treated and investigated, and that all co-morbidities have been recorded.
- Since September 2024, all deaths are reviewed by the Medical Examiner Service, who escalate any concerns via the Datix incident management system. All Datix concerns are reviewed, and the appropriate level/type of investigation response is taken, in accordance with the governance framework.
- The Trust has taken the following actions to improve this score, and so the quality of its services by:
    - Ensuring that all in-patient deaths are reviewed by a consultant within four weeks of the death occurring.
    - Promoting discussion of learning from mortality review at department governance meetings.
    - Providing a quarterly report on learning from mortality reviews.

- The Learning from Deaths and End of Life Group (LFD) to provide an emphasis on identification, review and learning from avoidable mortality.
- Thematic analysis of learning from serious incidents is undertaken on a quarterly basis with Quality Improvement projects aligned to address the themes.

SHMI (12 month rolling performance)	Trust (Dec 22 to Nov 23)	Trust (Dec 23 to Nov 24)	NHSE (Dec 23 to Nov 24)
Trust score (lower value is better)	0.96	0.97	1.00
Banding	2 – As expected	2 – As expected	2 – As expected

3.3 Learning from Deaths

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

	Requirement	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
27.1	Total number of in-hospital deaths	578	539	603	721
27.2	No. of deaths resulting in a case record review or SI/PSII investigation (requested reviews of patients who died in 23/24 and 24/25)	ME:536	ME:539	ME:603	ME:721
		SJCRS:21	SJCRS: 13	SJCRS: 20	SJCRS: 17
		PSII: 1	PSII: 1	PSII: 2	PSII: 3
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 24/2)	0	0	0	0
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR: 1	SJCR: 0	SJCR: 0	SJCR: 0
		PSII:0	PSII:0	PSII:0	PSII:0
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	0	0	0	0
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	0	0	0	0

1 This is where the degree of harm after investigation / Structure Judgement Case Review is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group.

2 Reviews completed in 2024/25 after the 2023/24 Quality Account was published.

Items 27.4-6 relate to learning from case record reviews and investigations; a description of actions taken and proposed; and an assessment of the impact of the actions. These items are covered in the next section.

Identified Themes and Actions

In 2024, the process of learning from deaths advanced further following the introduction of the Patient Safety Incident Response Framework (PSIRF) and the integration of deaths into the mortality module. PSIRF has enabled a more streamlined approach to ensuring that a Patient Safety Incident Investigation (PSII) is automatically initiated when the harm level is classified as ‘death.’ Additionally, it ensures that where a PSII is not required the most suitable learning response is conducted to capture valuable learning from each incident.

Introduced in 2023, the mortality module initially recorded all adult deaths. From 2024/25, its scope expanded to include neonatal and paediatric deaths. The module has significantly enhanced accessibility to inpatient mortality data, which is now available through 'live' dashboards. Moreover, it facilitates the linkage of all related incidents, claims, and complaints for individual patients, fostering improved communication and more cohesive collaboration across teams.

Structured Judgement Casenote Review (SJCR) Training

SJCR training commenced in March 2025. These are three-hour in-person sessions and are in line with the Royal College of Pathologists and Improvement Academy methodology. The training also includes the patient safety incident review framework and the mortality module on Datix.

To date three of ten sessions have been held and eight reviewers have been trained. The sessions are held at both York and Scarborough sites.

Presently an assessment of the activity of the existing trained reviewers is underway. This will help to better understand the existing capacity for carrying out the reviews and to support inactive reviewers by offering, for example, short refresher training via Teams. New consultants will also be required to undertake the training as part of their induction process from September 2025.

End of Life Care

The End of Life Professional Standards Group operates with a well-defined Terms of Reference and convenes bi-monthly. It reviews themes derived from the Learning from Deaths group, complaints, incidents, audits, surveys, and feedback to guide improvement initiatives.

Identified Themes:

- Limited knowledge of end-of-life care: There is a reliance on specialist palliative care teams for decision-making, even during medical escalations.
- Concerns about patient transfers: Issues have been raised regarding the transfer of patients within the hospital, including during their final hours of life. In response, the out-of-hours SOP has been updated to address the needs of end-of-life patients.
- Individualised care planning: The organisation is an outlier in ensuring that patients identified as dying have personalised care plans to meet their end-of-life care needs. Several improvement activities are underway, led by the group.
- Training gaps: Palliative and End-of-Life Care is not currently included in the essential training programme.

Mental Capacity Act (MCA)

Inadequate Mental Capacity Act Completion: Efforts to improve compliance have included highlighting the importance of Mental Capacity Act adherence in the Safety Spotlight newsletter. Oversight and interventions to address poor practices are managed by the Complex Needs Assurance group. Although compliance levels remain below the desired standard, progress continues to be made.

Improvements in 2024 / 25

- A review of the Learning from Death Policy was conducted. The revised policy incorporated all types of death reviews described within the Patient Safety Incident Response Framework (PSIRF) and the national learning from deaths guidance. This provided an opportunity to centralise maternity and paediatric multi-agency reviews within the Datix mortality module. These reviews included the Child Death Overview Panel and the Peri-natal Mortality Review Tool. Until then, details of these deaths and their reviews had been maintained locally. Centralising onto the Datix mortality module simplified data collection for Learning from Deaths reports and better facilitated discussions at the Learning from Deaths Group meetings. A series of meetings with representatives from family health, bereavement, and patient safety teams informed the mortality module revisions and clarified responsibilities for populating the required fields. The process updates were also included within an accompanying Datix Mortality Module Standard Operating Procedure.

- The autumn project continues to be rolled out across the organisation. As a Trust we aim to ensure all patient and those important to them are treat with dignity and response. The project supports the prevention of unnecessary interventions such as blood tests ad routine observations when these would not enhance care. Our aim is to promote individualised care and good communication, thinking about what matters most to patients and relatives.

- Strengthening partnership working with primary care teams and local hospices as well as other departments through the end-of-life professional standards group.
- The Mental Capacity Act training offer has been increased due to the appointment of two Mental Capacity Act educators. They facilitate bespoke training within wards and departments and have an increased presence in the clinical areas to support improved compliance

3.4 Palliative Care Coding

The data shows the percentage of patient deaths in hospital with specialist palliative care coded at either diagnosis or specialty level. This denotes that the patient had clinical input from a specialist palliative care team during the hospital admission that ended in their death. In some mortality measures, this is considered in the standardisation, making the assumption that a patient who has had specialist palliative care input should not be classified as an unexpected death. A proportion of people who die in hospital will receive specialist palliative care input but the recording of this varies widely between hospitals.

The Trust considers that this data is as described for the following reasons:

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

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

Identification for need for early palliative care involvement during learning from deaths meetings and improve education through palliative care team presence in board rounds. The Trust is part of a regional Palliative and End of Life Group to share best practice, learning and to facilitate system wide improvement.

Trust Dec 22 - Nov 23	Trust Dec 23 - Nov 24	*NHS Average (England) Dec 23 - Nov 24	Highest Trust Dec 23 - Nov 24	Lowest Trust Dec 23 - Nov 24
28	27	44	66	17

3.5 Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering two clinical procedures. The scores below indicate the percentage of patients who reported an improvement in their health. As participation is voluntary, patients can choose not to participate in PROMs. The two procedures are:

- hip replacements
- knee replacements

PROMs have been collected by all providers of NHS-funded care since April 2009.

The Trust considers that this data is as described for the following reasons:

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

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

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

We will:

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

Percentage of Patients Improving scores	Trust Apr 22 - Mar 23	Trust Apr 23 - Mar 24	England Apr 23 - Mar 24	Highest Trust Apr 23 - Mar 24	Lowest Trust Apr 23 - Mar 24
Hip replacement (Primary)	100	100	89.3	100	80
Knee replacement (Primary)	91.7	75	81.1	100	50

3.6 Emergency Readmissions within 30 days

This data looks at the percentage of all patients who are readmitted to hospital as an emergency within 30 days of being discharged. A low percentage score is good.
The Trust considers that this data is as described for the following reasons:

- The data is consistent with that reported locally on the Trust's electronic performance monitoring system.

The Trust considers that this data is as described for the following reasons:

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

We will:

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

Emergency Readmissions within 30 Days of Discharge	Trust Apr 22 – Mar 23	Trust Apr 23 – Mar 24	NHS Average Apr 23 – Mar 24	Highest Trust Apr 23 – Mar 24	Lowest Trust Apr 23 – Mar 24
Percentage of Readmissions aged 0 to 15	16.2	16.5	12.2	19.1	4.6
Percentage of readmissions aged 16 and Over	11.8	12.6	13.9	21.4	9.1

3.7 Staff Experiencing Harassment, Bullying and Abuse

The Trust considers that this data is as described for the following reasons:

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

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

The results of the staff survey reflect the challenging circumstances the Trust has acknowledged and has existing action plans and programmes of work in place to develop improvements. Improvement plans continue to be developed, and more detail is being shared with staff regarding our survey results and the actions we are taking to improve what it feels like to work here. Care Groups, Corporate Directorates, and York Teaching Hospitals Facilities Management (YTHFM) have received their own local results, and senior leaders have shared the results widely with all colleagues and encouraged everyone to get involved with identifying the improvement actions that will make the biggest impact in each team.

We will:

- Continue to focus on our training and support for leaders and line managers, and on delivering our long-term cultural change programme Our Voice, Our Future.
- Continue to work towards embedding a culture where staff feel able to safely challenge if a colleague is not demonstrating behaviours in line with our values. Following the launch of a new Civility Respect and Resolution Policy the Trust signed the Sexual Safety Charter and launched a Sexual Misconduct Policy. In March 2025, an anonymous reporting tool was launched to provide a further route for individuals to raise concerns if it is not possible to raise their concerns through their management structure.
- Work will continue to publicise the Freedom to Speak Up Guardian and the Fairness Champions within the organisation.

	Trust 2023	Trust 2024	NHS Staff Survey Average 2024	NHS Staff Survey Highest (Worst) Trust 2024	NHS Staff Survey Lowest (Best) Trust 2024
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months from Managers*	12.22%	13.18%	10.00%	14.86%	5.22%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months from other colleagues*	20.64%	20.82%	18.49%	23.55%	11.66%

* These results are presented in the context of the best, average, and worst results for Acute and Acute and Community Trusts, taken from the 2024 NHS Staff Survey.

3.8 Staff Career Progression / Promotion, Regardless of Ethnic Background, Gender

The Trust considers that this data is as described for the following reasons:

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

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

The results of the 2024 survey will be used to update the action plan to improve staff experience, engagement and retention, and ultimately patient care within the organisation.

We will:

Continue to work with and support our staff networks and provide a range of training in equality, diversity, and inclusion for all staff members. We will continue to review and update recruitment practices and access to training and development opportunities

Continue to work towards achieving our Equality Actions which will support the Trust in becoming more a more inclusive employer.

	Trust 2023	Trust 2024	NHS Staff Survey average 2024	NHS Staff Survey Highest Trust 2024	NHS Staff Survey Lowest Trust 2024
Percentage of staff believing that the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age?*	52.33%	51.67%	56.02%	67.66%	43.99%

* These results are presented in the context of the best, average, and worst results for Acute and Acute and Community Trusts, taken from the 2024 NHS Staff Survey,

Appendices

Appendix A:

Statement of Directors' Responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 a to prepare Quality Accounts for each financial year.

The Department of Health and Social Care issued guidance on the form and content of annual Quality Accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017. These added new mandatory disclosure requirements relating to 'Learning From Deaths' to quality accounts from 2017/18 onwards.

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

- the Quality Account presents a balanced picture of the Trust's performance over the period covered.
- the performance information reported in the Quality Account is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the board

Xx July 2025 ….....Chair
Martin Barkley

Xx July 2025 .....Chief Executive
Simon Morritt

Appendix B:

Statements from Local Stakeholders

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Statement from NHS Humber and North Yorkshire Integrated Care Board (ICB) for York and Scarborough Teaching Hospitals NHS Foundation Trust Quality Account 2024/25.

Glossary

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

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

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

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

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

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

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

Datix
A patient safety and risk management software for healthcare incident reporting and adverse events.

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

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

dying. Monitoring patients regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

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

Integrated Care Board (ICB)
Clinically led NHS bodies responsible for the planning and commissioning of health care services for their local area.

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

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

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

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

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

National Institute for Clinical Excellence (NICE) quality standards
National Institute for Clinical Excellence (NICE) quality standards are a set of specific, concise statements that act as markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions.
Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with the NHS and social care professionals, their partners and service users,

and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

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

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

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

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

Patient Safety Incident Response Framework (PSIRF)
Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

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

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

Pressure ulcers are graded from 1 to 4 as follows:

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

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT).
The ReSPECT process creates a personalised recommendation for your clinical care in emergency situations, where you are not able to make decisions or express your wishes.

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

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

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

SPC Chart
Statistical Process Control chart. Data is plotted chronologically to see changes over time.

Systems Engineering Initiative for Patient Safety (SEIPS)
A framework for understanding outcomes within complex socio-technical systems.

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

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

Venous thromboembolism (VTE)
VTE is a condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vein can be limited by the clot and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT). An embolism occurs if all or a part of the clot breaks off from the site where it forms and travels through the venous system. If the clot lodges in the lung a potentially serious and sometimes fatal condition, pulmonary embolism (PE) occurs.
Venous thrombosis can occur in any part of the venous system. However, DVT and PE are the commonest manifestations of venous thrombosis. The term VTE embraces both the acute conditions of DVT and PE, and also the chronic conditions which may arise after acute VTE, such as post thrombotic syndrome and pulmonary hypertension, both problems being associated with significant ill-health and disability.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	30 July 2025
Subject:	Annual Complaints Report 2024/25
Director Sponsor:	Dawn Parkes, Chief Nurse
Author:	Justine Harle, Complaints and Concerns Lead

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

- The Trust is meeting its statutory obligations for complaints handling and addressing complaints in accordance with our local policy.
- 1221 complaints were received compared to 816 in 2023/24, an increase of 49.6%.
- The main subjects for complaints related to delays in treatment/procedure, attitude of medical and nursing staff, communication with patients and their relatives/carers and diagnosis delays.
- Performance has remained the same as 2023/24 and 49% of complaint responses were completed within timescales in 2024/25.

- Online training for investigators has been introduced this year as well as writing skills training. The training seeks to embed effective and engaged investigations, empathetic responses, and appropriate and effective learning within the Trust's handling of complaints.
- Priorities for 2025/26 include a focus on better learning from complaints and streamlining processes for greater efficiency.

Recommendation:

The Board is asked to note the contents of the report and continue to support the work being undertaken to improve patient and carer experience.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Patient Experience Sub Committee	11 June 2025	Approved and endorsed to be reviewed at the Quality Committee
Quality Committee	15 July 2025	Approved and endorsed to be reviewed at the Board of Directors

Complaints Annual Report 2024/25

1. Introduction

In managing complaints, the Trust is required to adhere to The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16 – Receiving and acting on complaints.

This is the complaints annual report for the period 1 April 2024 to 31 March 2025. It includes details of numbers of complaints received during this period, performance in relation to responding to complaints, Parliamentary and Health Service Ombudsman (PHSO) investigations and examples of actions the Trust has taken in response to complaints.

The Trust welcomes all feedback from patients, their families and carers about their experience of our services and this information as invaluable in enabling us to learn and improve the experience for patients and carers as well as determining whether changes can be made to the services we provide.

2. The number of complaints which the responsible body received and the number of complaints which the responsible body decided were well-founded

2.1 New complaints

The data contained in this report has been obtained from Datix, our electronic risk management system. 1221 formal complaints were received during 2024/25 compared to 816 in 2023/24, an increase of 50%. This increase is in line with the national trend and equates to a weekly average of 23 complaints. Healthwatch England published their report ‘A Pain to Complain: Why it’s time to fix the NHS complaints process’ in 2025 and highlighted that written complaints in the NHS reached a record high in 2024.

For context, in 2023/24 the Trust had 115,414 A&E attendances, 100,613 attendances in Urgent Care Centres on our sites, 779,908 outpatient attendances (also including telephone and video appointments), 160,808 inpatients (adults, including maternity), 9,921 inpatients (children), 121,700 operations or procedures as an inpatient and 3,916 babies delivered (data taken from the Trust 2025-2030 strategy).

Complaints generally correlate with services as expected (i.e. the higher volume areas receiving more complaints). Some complaints are complex and involve multiple care groups or agencies and require longer to investigate and in June 2024 the category of complex complaint was introduced, giving investigating officers 45 working days to conclude their investigation. These cases accounted for 97 of the overall complaints registered in 2024/25.

New Complaints 2024/25	Q1	Q2	Q3	Q4	Total
York Hospital	244	210	193	169	**816**
Scarborough Hospital	68	92	70	69	**299**
Bridlington Hospital	3	3	1	2	**9**
Total	**315**	**305**	**264**	**240**	**1124**

New Complaints by Care Group	Q1	Q2	Q3	Q4	Total
Medicine	137	127	123	102	**489**
Surgery	80	80	72	72	**304**
Cancer, Specialist & Clinical Support Services (CSCS)	39	46	25	25	**135**
Family Health	46	42	32	33	**153**
Corporate Services	13	10	12	8	**43**
Total	**315**	**305**	**264**	**240**	**1124**

New Complex Complaints 2024/25	Q1	Q2	Q3	Q4	Total
York Hospital	5	24	32	19	**80**
Scarborough Hospital	1	3	5	6	**15**
Bridlington Hospital	0	1	0	1	**2**
Total	**6**	**28**	**37**	**26**	**97**

New Complex Complaints by Care Group	Q1	Q2	Q3	Q4	Total
Medicine	3	17	17	11	**48**
Surgery	1	10	10	6	**27**
CSCS	1	1	7	1	**10**
Family Health	1	0	3	8	**12**
Total	**6**	**28**	**37**	**26**	**97**

2.2 Reopened Complaints

The Trust always seeks to apologise for failings in care and applies the duty of candour principles to the complaints process. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or, in their absence, the Chief Nurse or an Executive Director designated signatory.

In 2024/25, 1203 complaint investigations were concluded, of which 5% (63) were reopened at the request of the complainant and further investigations undertaken. These figures are a small reduction on 2023/24 (6%). Complainants are encouraged to contact the Trust if they have any further questions and almost half of complainants took the opportunity to raise additional questions. 13 of the reopened cases for Medicine (39%) related to Emergency Medicine. No other trends were identified.

Reopened complaints 2024/25	Total
CSCS	**3**
Family Health	**10**
Medicine	**33**
Surgery	**17**
Total	**63**

2.3 Outcome data

The Trust is required under the complaints legislation to record whether the issues were substantiated following investigation. Of the complaints closed this financial year, 1145 had an outcome code provided by the investigating officer at the time of this report. Of

those case, 20% were upheld, 44% were partially upheld and 36% were not upheld. These figures are comparable to previous years.

Outcomes 2024/25	Not upheld	Partially upheld	Upheld	Total
CSCS	36	54	45	**135**
Corporate Services	10	6	23	**39**
Family Health	46	75	30	**151**
Medicine	164	267	82	**513**
Surgery	150	106	51	**307**
Total	**406**	**508**	**231**	**1145**

2.4 Parliamentary and Health Service Ombudsman (PHSO)

Although the Trust makes every effort to resolve formal complaints locally, we understand that this is not always possible. Service users have the statutory right to refer their complaint to the PHSO for an independent review. In 2024/25 the PHSO undertook an initial inspection of eleven complaints and concluded no further action was required. Two PHSO full investigations were registered in 2024/25, and we are currently awaiting the outcome of these along with a case registered in 2022/23.

One case registered in 2021/22 was concluded this year and was partially upheld. It related to confusion that resulted in the patient being discharged from cardiology without being seen for necessary care (this was addressed at the time of the local investigation). This was due to an error in the Clinical Assessment Services and the Trust made some immediate changes to inform patients that they should not attend on the date in the letter, as it was a date for their referral to be triaged. We received several complaints about these “dummy appointments”, and we were able to explain to the patient the work that was underway to remove the need for these appointments to enable a referral into hospital services. The PHSO was satisfied that the Trust had made changes to address their findings.

3. The subject matter of complaints that the responsible body received

The top five themes in 2024/25 are listed in the table below. It should be noted that complainant’s comments are opinions and not always statements of fact and failings were not identified in 36% cases concluded in 2024/25. However, emerging trends or themes are monitored regularly as complaints are received, and any areas of concern are highlighted to the Care Group management teams. Deep dives are undertaken where indicated by the Triangulation of Concerns Forum (Joining the Dots). This group aggregates intelligence and uses this to guide a general overview, to determine specific actions e.g. visits to teams, promotional work, targeted interventions.

Complaint (inc Complex) Top Themes	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Delay or failure in treatment or procedure	23	38	28	21	110
Attitude of medical staff	17	13	16	22	68
Delay or failure to diagnose	9	19	16	16	60
Communication with Patient	16	16	8	14	54
Attitude of nursing staff/midwives	18	11	10	12	51
Total	**83**	**97**	**78**	**85**	**343**

NB: There are often multiple subjects within a single complaint, reflecting the complexity of many complaints.

3.1 Key Themes

As well as communication being the main issue for some complainants, it was often included in a complaint about something else. Some patients told us that they were not informed enough about their diagnosis or treatment options and that staff often lacked the time necessary to provide clear and comprehensive information, resulting in misunderstandings and dissatisfaction and patients feeling “left in the dark” about their treatment plans.

Many individuals are now accustomed to instant access to information and swift responses in their daily lives, leading to higher expectations when they come to hospital. When we fail to meet these expectations, patients are more likely to voice their dissatisfaction, contributing to the increase in complaints that we have seen over the last few years.

Some communication themed complaints related to a lack of communication about how patients should manage their condition and aftercare on discharge from hospital. Prolonged wait times for appointments, diagnoses, and treatment were a frequent source of frustration and complaints often related to the quality of care received, including issues with nutrition, hydration, and overall attention to patient needs.

Our administrative processes can sometimes be convoluted and inefficient. Delays in receiving important information, such as test results, appointments and treatment plans were all commonplace issues having an impact on our patients. These administrative bottlenecks led to frustration and a perception of poor communication, even when the patient acknowledged that clinical care itself was good. Difficulties getting through to wards and departments on the phone remains a theme in complaints as well as letters arriving after appointment dates.

Patients and their families have complained about rude, unprofessional, or indifferent staff members, who make them feel unwelcome, uncomfortable, or unsafe. They also perceive a lack of empathy, respect, or courtesy from the staff and often told us they didn’t feel listened to.

By addressing these issues thoughtfully and proactively, we can improve communication and enhance patient and carer experience and satisfaction. Improving communication is a key theme in Care Group and corporate patient experience improvement plans for 2025/26.

3.2 Communication: Accessible Information Standard

All NHS organisations are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Two formal complaints were received in 2024/25 relating to the Accessible Information Standard. One patient attended an audiology appointment and was not provided with suitable support or advice leaflets in a larger print. This complaint was upheld, and training provided to the member of staff.

In the second case the patient attended Scarborough Hospital for an MRI and no British Sign Language (BSL) interpreter was provided, despite assurance some years ago that he would have access to an interpreter for all his future appointments. His complaint was upheld and resulted in a full review and the team was briefed on how to access and use the translation and interpreting tablet to access the Trust's BSL service.

4. Any matters of general importance arising out of those complaints, or the way in which the complaints were handled.

The national regulations, together with guidance from the Parliamentary and Health Service Ombudsman, indicate that the Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed.' When a response is not possible within the agreed timescale, the investigating officer should inform the complainant of the reason for the delay and a new date is agreed by which the response will be sent.

On average 49% of closed cases met the Trust's response target.

2024/25	2023/24	2022/23	2021/22	2020/21	2019-2020	2018-19
49%	49%	55%	57%	57%	41%	36%

Overall performance in responding to complaints was 49%, the same as in 2023/24 and the focus for 2025/26 will be to improve the quality of our complaint process, investigations, and responses.

An effective complaints process requires a strong partnership between the Patient Advice and Liaison Service (PALS) and Care Group managers and clinicians. For the process to work well, an investigator needs to be allocated quickly by the Care Group leadership team. An investigator must also have the capacity to spend time, both on the investigation itself and on engaging with the complainant. Workforce issues do at times, impact on this process

Plans have been established to host a Rapid Process Improvement Week in June 2025, sponsored by the Chief Nurse, with representatives from PALS, Care Groups and corporate staff, supported by the Trust's Quality Improvement Team with the objective of identifying and implementing changes to improve the effectiveness and efficiency of our complaints processes and procedures.

5. Care Group Actions to improve performance

Medicine Group has extended the current weekly complaint meeting time to enable all investigating officers to attend for support and advice from the senior team. They have changed the way responses are submitted for approval to prevent delays and the senior team members who quality check complaints are working together to standardise advice given to the investigating officers.

Surgery Group has continued with weekly complaint meetings to try and improve response times and support investigating officers. This has helped in building the confidence of investigating officers to contact complainants early and try to resolve concerns informally.

The Deputy Director of Midwifery commenced in post in November 2024 and has implemented a weekly complaint meeting to ensure there is support and guidance for the team. A midwifery staffing gap has been identified of 44 WTE Clinical frontline Midwives following the midwifery workforce review and BirthRate+ findings in 2024. This poses a risk as there is no long-term solution. The short-term solution is to mitigate using bank, agency midwives and redeploy specialist midwives and managers. The redeploying of the midwifery management team and specialist midwives continues to hinder progress in the quality and safety portfolio.

6. Examples of actions that have been taken to improve services as a result of complaints

Communication is a strong theme across incidents, complaints, and concerns and Medicine Group is piloting a bedside handover on ward 33 and 36, which will be rolled out across the organisation. Evidence shows that this improves communication for patients, and reduces risks and incidents, as clinical teams are seeing patients straight away.

Ward 37 introduced a communication log very successfully to keep families up to date and the plan is to roll this out to all wards. Ward 37 has also undertaken a refurbishment of the relative's room with relevant resources in relation to patient pathways and discharges.

Ward 39 created infographics of the patient pathway and a ward/hospital information leaflet. They created a patient/relative space and ward information cards as well as a nutrition board. As a result of these changes, they saw a reduction in the number of complaints and an increase in patient satisfaction.

There has been a review of the streaming and triage process at the front door in response to concerns regarding delays and the Trust has taken part in Emergency Department improvement sprints with regional teams to reduce waiting times.

Surgery Group launched a pilot project for the wards, with a poster and contact details for a dedicated phone number for the matron team so there is always someone available Monday - Friday to speak with patients and their families if required. They have also engaged with IT services to move some of the ENT and Audiology telephone numbers to a queuing system to support patients being able to get through.

Complaints are now used in training modules as part of the maternity core competency framework. In addition, anonymised complaints have now been included in the Maternity unit level meetings to share learning with staff.

The Maternity Services have commenced using the action plan tab on Datix in February 2025 to ensure there is evidence of addressing from complaints going forward. This will support oversight of themes and improvements going forward. Patient feedback is also triangulated from the Maternity CQC survey annual results and a co-produced action plan has been developed by the Maternity and Neonatal Voice Partnerships (MVNP). The action plan was presented at the Patient Experience Subcommittee in February 2025. In addition, the Maternity Service undertakes a triangulation of complaints, incidents and claims on a bi-annual basis. The last report was presented at Quality Committee in February 2025.

The Maternity Services also has a Non-Executive Safety Champion who has oversight of maternity services with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. The MNVP chair is a core member of the Safety Champions meeting. In addition, there is a monthly MNVP meeting.

Over the last 18 months there have been many projects undertaken in Maternity to support themes identified from the NHS claims scorecard, NHS Resolutions thematical review, thematical review from Serious Incidents/ Patient Safety Incident Response Plan and feedback from the CQC women's experience survey, the Friends and Family Test (FFT) and complaints. Examples are Prevention and Management of the Postpartum haemorrhage action plan, documentation on BadgerNet, interpreting services and personalised care plans and consent.

In response to a complaint about the lack of appropriate facilities for an autistic child, paediatrics reviewed the use of flash cards to help ascertain if non-verbal children do feel sick or dizzy and trigger concerns post head injury. There is a plan to link in with the play team to discuss the possibility of the provision of dark glasses, headphones and fidget toys as a further option plan in addition to a quiet space or in the absence of one.

Patient Access has introduced an email address that patients can use as well as a telephone number as a direct result of an autistic person complaining about the lack of options for neurodivergent individuals. The patient was grateful that his concerns had been listened to and constructive changes made.

7. Looking Ahead: Quality Priorities 2024/25

- Streamlining the complaints processes for greater efficiency.
- Introducing the Action module for complaints on Datix across all care Groups so that we have a reportable way of capturing actions taken as a result of complaints and to better share learnings.
- Continue with support and training for investigating officers, including PHSO complaints training, letter writing skills training and customer service training
- Explore ways of garnering complainants feedback about the process of making a complaint.
- Care Groups to continue focus on improving response times.

8. Conclusion and request for the committee

Complaints are often viewed as negative and consume significant resource and time in addition to the emotional impact on both patients and staff. Our refreshed Trust strategy focusses on putting patients first and delivering safe and compassionate care every time. An important aspect of this is the way we respond to feedback from patients, carers and their families. People have the right to raise concerns about their experience and we should endeavour to respond in a timely way, ensuring we learn from feedback.

The Board is asked to note the contents of the report and continue to support the work being undertaken to improve patient experience.

Date: 4 June 2025

Report to:	Board of Directors
Date of Meeting:	30 July 2025
Subject:	Fit & Proper Persons Test – Annual Report
Director Sponsor:	Martin Barkley, Chair
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The purpose of the report is to highlight the assurance of the Board of Directors members adherence to the Trust's Fit and Proper Persons Test Policy (FPPT).

Recommendation:

The Board of Directors is asked to note the assurance provided in compliance with the NHS England Fit and Proper Person Test Framework for Board members.

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

Fit and Proper Persons Annual Assurance 2024/25

1. Introduction

As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'.

2. Background

In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations in the Kark Review, NHS England developed a FPPT Framework to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. This FPPT framework came into effect from 30 September 2023.

The Framework applies to the board members of NHS organisations, irrespective of voting rights or contractual terms.

3. FPPT Process

The Board of Directors members for 2024/25 have each completed a FPPT self-attestation and subsequently the test has been applied in line with the NHS guidance and the Trust Policy approved in January 2024.

The test has been completed both for annual checks and for those board members joining as recruitment checks. The outcome of the FPPT have been saved in respective personnel files and uploaded onto ESR. A summary of this is provided in appendix 1.

The Annual NHSE FPPT submission has been concluded and provided to NHSE as required by the FPPT framework.

Between FPPT checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of the Director of Workforce and OD or the Trust Chair.

4. Recommendation

The Board of Directors is asked to note the assurance provided in compliance with the NHS England Fit and Proper Person Test Framework for Board members.

Appendix 1 - Fit and Proper Persons Register 2024/25

Name, Title / Role	Annual/ Recruitment Checks Complete	DBS Check	Registering Professional Body	Annual Appraisal Conducted	Annual Self Declaration Signed	Disqualified Director Check	Insolvency Service Bankruptcy Register	Charity Trustees Register	Public Domain Search
Non-executive Directors (NEDs)									
Martin Barkley (Chair)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Jenny McAleese (NED)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Jim Dillon (NED) **Leaver – June 2025**	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Lorraine Boyd (NED)(SID)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Lynne Mellor (NED) **Leaver – Dec 2024**	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Matthew Morgan (NED)	Yes	Yes	N/A (for Trust role)	✓	✓	✓	✓	✓	✓
Stephen Holmberg (NED) **Leaver – June 2025**	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Helen Grantham (ANED)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Julie Charge (NED)	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Jane Hazelgrave (NED)	Yes	Yes	CIMA	N/A	✓	✓	✓	✓	✓

Noel Scanlon (NED)	Yes	Yes	NMC	N/A	✓	✓	✓	✓	✓
Executive Directors and Corporate Directors									
Simon Morritt, Chief Executive	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Andrew Bertram, Finance Director and Deputy Chief Executive	Yes	Yes	CIPFA	✓	✓	✓	✓	✓	✓
Claire Hansen, Chief Operating Officer	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Dawn Parkes, Interim Chief Nurse	Yes	Yes	NMC	✓	✓	✓	✓	✓	✓
James Hawkins, Chief Digital & Information Officer	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Karen Stone, Medical Director	Yes	Yes	GMC	✓	✓	✓	✓	✓	✓
Polly McMeekin, Director of Workforce and Organisational Development	Yes	Yes	CIPD	✓	✓	✓	✓	✓	✓
Lucy Brown, Director of Communications	Yes	Yes	N/A	✓	✓	✓	✓	✓	✓
Chris Norman, Managing Director YTHFM	Yes	Yes	N/A	N/A	✓	✓	✓	✓	✓

Report to:	Board of Directors
Date of Meeting:	30 July 2025
Subject:	2025/26 Q1 Board Assurance Framework
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

☒ To provide timely, responsive, safe, accessible effective care at all times.
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☒ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☒ To use resources to deliver healthcare today without compromising the health of future generations.
☒ To be well led with effective governance and sound finance.

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides the 2025/26 Q1 Board Assurance Framework

All risk ratings are unchanged from Q4 of 2024/25 other than PR1 - 'Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm', which has reduced from 16 to 12 following the implementing of identified actions. All amendments to all risks are provided in red text.

Three risks remain out of the Trust's risk appetite identified by the Board of Directors:

- PR1 - Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.
- PR3 - Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.
- PR6a - Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030

Recommendation:

The Board of Directors is asked to approve the 2025/26 Q1 Board Assurance Framework.

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

Meeting/Engagement	Date	Outcome/Recommendation
Executive Director Updates	July 2025	Risks reviewed and updated

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Q1 – 2025/26 Board Assurance Framework (BAF)

July 2025

Q1 - 2025/26 Board Assurance Framework Dashboard

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Rank/Move	High Level Risk Description	Risk Assessment (Catastrophic / Major / Moderate / Minor / None)	Risk Rating	Actions	Owner	Oversight
1	PR6a – Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-30.		25	0 0 4	Director of Finance	Resources Committee
2=	PR1 – Inability to provide consistently effective clinical pathways leading to poor outcomes, experience and possible harm.		12	0 0 0	Chief Nurse	Quality & Resources Committees
2=	PR2 – Inability to nurture a Trust culture that facilitates good staff engagement and development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.		12	0 0 3	Director of Workforce and OD	Resources Committee
2=	PR5 – Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.		12	0 0 3	Director of Finance	Resources Committee
2=	PR3 – Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.		12	0 0 4	Chief Operating Officer	Quality & Resources Committees
3	PR6b – Failure to demonstrate effective governance to achieve the Trust's strategy.		9	0 0 2	Chief Executive	All Committees
4	PR4 – Trust service, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.		6	0 0 4	Medical Director	Quality Committee

Key

- N – New Risk
- Increase in Rank
- Decrease in Rank
- No movement in Rank
- I – Inherent Risk - The measure of risk before controls are considered
- C – Current Risk - The measure of risk after controls are considered
- T – Target Risk - The measure of risk once actions have been completed
- Reliance on controls
- Planned mitigations
- 1 Action on track
- 1 Action delayed by 1-2mths
- 1 Action delayed by 3mths+
- Risk Appetite
  - Low - 6
  - Moderate - 9
  - High - 12
  - Significant -15+

Summary of Risks by objective

Strategic Objective: Quality of Care – To provide timely, responsive, safe accessible, effective care at all times

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR1	Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.	Chief Nurse	Quality & Resources Committees	5	5	25	4	3	12	6 LOW	OUT	4	3	12	↓

Strategic Objective: Our People – To create a great place for our people to work, learn and thrive

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR2	Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.	Director of Workforce & OD	Resources Committee	4	4	16	4	3	12	12 HIGH	IN	3	3	9	↔

Strategic Objective: Our Partnerships – To work together with partners to improve the health and wellbeing of the communities we serve

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR3	Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.	Chief Operating Officer	Quality & Resources Committees	4	4	16	4	3	12	6 LOW	OUT	3	2	6	↔

Strategic Objective: Research, Innovation and Transformation – Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR4	Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.	Medical Director	Quality Committee	3	3	9	3	2	6	6 LOW	IN	3	2	6	↔

Summary of Risks by objective

Strategic Objective: Sustainability – To use the resources to deliver healthcare today without compromising the health of future generations

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR5	Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.	Director of Finance	Resources Committee	4	4	16	4	3	12	12 HIGH	IN	4	2	8	⟺

Strategic Objective: Governance and Finance – To be well led with effective governance and sound finance

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6 a	Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030	Director of Finance	Resources Committee	5	5	25	5	5	25	12 HIGH	OUT	4	4	16	⟺

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6 b	Failure to demonstrate effective governance to achieve the Trust's strategy.	Chief Executive	All Committees	5	4	20	3	3	9	12 HIGH	IN	2	3	6	⟺

Ref PR1 Board Assurance Framework (BAF)

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	**Risk Score:** 12

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients in urgent care pathways
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	N/A	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Performance Improvement Review Meetings (PRIM) monthly for all Care Groups	PRIM letter outcomes and next steps reported to Executive Committee Oct-Jan 2025 (Care Group escalation reports previously)	Infection Prevention Strategic Assurance Group (IPSAG)	- IPSAG monthly reporting - Apr 24-Jan 25 TPR reporting to Quality Committee and Board	Sustainable services reviews – internal and with the Collaboration of Acute Providers (CAP)	Internal sustainable services report and CAP reporting through CAP Committee in Common
Quality Committee, Patient Safety and Clinical Effectiveness, Patient Experience Sub-Committees, Resources Committee	- Apr 24-Jan 25 Quality and Safety reporting to sub-committees - Apr 24-Jan 25 escalation reports to Quality Committee - Apr 24-Jan 25 Quality Committee delivery of assurance work programme - Apr 24-Jan 25 Board escalations	Programme Management Office schedule of programmes	Specific programmes including: - Urgent and Emergency Care, Electronic Patient Record - Maternity - Culture and Leadership	Humber and North Yorkshire System oversight for diagnostics, cancer, urgent care, finance, workforce and place-based meetings	Collaboration meetings across Executive Portfolios: Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce and OD, Finance Director papers
Care Group Board sub-group oversees IPC, escalations made to IPSAC and Assurance Committees	Monthly reporting papers of IPC, Patient Experience and Patient Safety and Clinical Effectiveness	Integrated Quality Improvement Group (IQIG) NHSE oversight	Monthly reporting of Trust Improvement Dashboard, CQC Update, Maternity, risks	Continuous flow and escalation model 3x Op sit rep, proactive management of discharges, proactive communications management with staff and patients, psychological support for staff	- Executive Committee reporting, Board escalations of outcomes and concerns, 3x daily operational sit rep. on-call arrangements in place, proactive management of discharges - Datix field enabled to identify patient safety incidents linked to continuous flow activity.
Operations meeting oversight: Elective Recovery Board, Unscheduled Care Board, Maternity Assurance Group	- Monthly reporting papers of Elective and Unscheduled Care Boards - Apr 2024-Jan 2025 Executive Committee - Tiering meetings with NHSE for performance	Corporate Quality Oversight: - Maternity Assurance Group (MAG) single improvement plan - Children's Board - Complex Needs Group is now established. - Professional Standards Group established	- Monthly reporting papers Maternity Assurance Group - Single Improvement Plan progress report - Quality Assurance Framework being established to include ward accreditation including fundamentals of care	*Gap – EPRR Core Standards limited compliance* *Gap – Clinical Estates Strategy*	EPR July 2024 Resources Committee and Board reporting EPRR Commander training in delivery Draft clinical estates strategy in place

Ref PR1 Board Assurance Framework (BAF) - continued

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	**Risk Score:** 12

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients in urgent care pathways
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	N/A	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Trust performance report	- Monitored at Quality Committee and associated sub committees	Regulation and Assurance visits.	Regulation and Assurance group in place HTA, HNY Trauma network, LMNS, H&S, stroke peer review, CQC	Gaps in Technical Infrastructure and Cyber Security: Limited monitoring of IG policy adherence, lack of access management policy (currently being reviewed), specialist Board cyber security training, wide variety of policies requiring review and update inc cyber protocols, services and endpoint devices require investment, central 3rd party proc register	
Cyber Security Control Framework to safeguard the confidentiality, integrity, and availability of our systems and data and aligned with NHS policies, the Data Security Protection Toolkit aligned to the NCSC Cyber Assessment Framework	- Digital Sub Committee - Submission of DSPT on a yearly basis - Annual SIRO board report - GAPS: DSPT submission highlighted that the organisation was not meeting standards with 16 out of 47 areas below NHS England's minimum standard.	Quality Assurance Framework	Internal Audit review with significant assurance Operational performance managed via the Performance Review Improvement Meetings (PRIM)	Complex Needs Assurance Group established Complex Needs Assurance Improvement Plan in place ins response to the Niche report	Group meets bi-monthly – Chaired by the Chief Nurse

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Actions Implemented – Target Risk Score Achieved			

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	3	12

Next Review
Q2 - Sept 2025

Ref PR2 Board Assurance Framework (BAF)

Ref: PR2	Strategic Objective: To create a great place for our people to work, learn and thrive	**PRINCIPAL RISK 4:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

Consequences – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	N/A	N/A	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Our Voice Our Future Programme	- Discovery and Design phase – discovery complete and design phase underway - Q2-Q4 Board Seminar Development reports	Revised vacancy control process – implementation of 13-week firebreak. New medical bank rates from Aug 25	- Vacancy reports (July 25 onwards) - EDG papers – (April 25 onwards) - TPR workforce reporting April 2024 – July 2025	Revised communications approach	- Back to the floor initiative - Senior Leadership blogs - Staff Briefs
Delivery of Internal Leadership Programmes in line with Leadership Framework	- Care Group Leadership Development Programme Cohorts phases 1-3 delivered - List of programmes and training programmes on Learning Hub	Implementation of People Strategy Freedom to Speak Up Reporting	TPR workforce reporting Apr 2024-April 2025 EDS 2022; WRES, WDES & Pay Gap reports FTSU Board report September 2024	Formal workforce engagement	- JNCC and LNC meeting minutes - Staff Networks ToR - Anti-Racism Group
Line Management Toolkit and Training	Toolkit rollout to all Line Managers and training implementation records. Development of Phase 2 Line Management Training.	Senior Leadership Engagement Gap – engagement with all levels of leadership	- Quarterly Senior Leaders Forum - Senior Clinical Leadership monthly meeting	Wellbeing delivery	- Occupational Health and Wellbeing Annual Report to Resources Committee - Staff Psychologist Therapy
- Oversight of establishments and establishment reviews, job planning and medical deep dives - TPR reporting of nursing academy: retention of HCSW and apprenticeships levy	- TPR reporting Apr 2024-July 2025 - Nursing workforce Resources Committee reporting Apr 2024-July 2025 - Quarterly Medical Workforce Report – Resources Committee Sept 24 – July 2025	*Gap – Financial resources to recruit at the staffing establishments required*	- Annual financial planning Board sign-off April 2025 - Staffing business cases - Rostering data - - Nursing workforce establishment review approved, and funding released to support the 3 main priorities agreed	QI Readiness Assessment position when undertaken Staff Benefits work programme	

Ref PR2 Board Assurance Framework (BAF) - continued

Ref: PR2	Strategic Objective: To create a great place for our people to work, learn and thrive	**PRINCIPAL RISK 4:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

Consequences – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	N/A	N/A	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
- Our Voice Our Future – Delivery Phase implementation of actions	- Our Voice Our Future - Delivery phase to be completed (for completion June 2026)	Simon Morritt	June 2026
- Staff Survey Improvement Plan and People Promise Programme	- Colleague Engagement Improvement Plans – June 2025.	Polly McMeekin	Sept 2025
- Required Learning Review and band 5 (RN) competency Framework	- Nursing training and competency review complete with plans to consolidate mode of delivery. – completed	Dawn Parkes	June 2025

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	3	9

Next Review

Q2 - Sept 2025

Ref PR3 Board Assurance Framework (BAF)

Ref: PR3	Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve	**PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

Consequences – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	N/A	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. positive)	ii) Controls	ii) Assurances (inc. positive)	iii) Controls	iii) Assurances (inc. positive)
Strategic Alignment: Mechanisms in place to ensure alignment of priorities between partners. - Joint Committee in Common - Joint Operational planning meetings with Alliances, ICB and Place Colleagues throughout planning process. - Alignment of Cancer alliance objectives into Y&S Cancer Strategy - Recruitment of Head of Strategy to support partnership working	Shared system performance metrics managed with the ICB and tiering meeting with regional colleagues. ICB performance oversight arrangements. CAP meetings: Elective and UEC – joint leadership arrangements Trust strategy shared with Stakeholders (dec 2024) *Cancer Strategy Workshop – Feb 2025* *Gap: Joint strategic planning sessions with place & partners (not a gap for cancer as this is done collaboratively)*	Training and Development: Increasing the understanding of key Trust leaders in system working and partnership opportunities.	*Gap: Opportunity for leadership development in system collaboration.*	Resources: Senior management representation at core ICB and Place-based forums and alliances. Employment of Head of Strategy as key lead for partnership development	Attendance records at partnership meetings. Recruitment of Head of Strategy to support partnership working. Funding into NHS Benchmarking
Communications: Joint committees or forums for collaboration and conflict resolution.	- Trust CEO Committee in Common with other Trust Providers. - Harrogate Board to Board - York Health & Care Collaborative & Joint Delivery Board. - CAP Alliance Representation & clinical leads - Multiple Boards in place where Trust is represented: CAP/ UEC and Place and SOAG. - ICB Board Quarterly meeting minutes - York Health & Care Collaborative & Joint Delivery Board meeting minutes - CAP Quarterly meeting minutes *Gap: Audit of effectiveness of forums for delivering quality partnership working ?*	Data that support partnership working - North Yorkshire Overarching Multi Agency Information Sharing Protocol (MAIS) - Humber sharing charter - Specific sharing agreement with TEWV for them to access our systems as required - Information sharing as part of the Collaborative of Acute Providers Information	MAIS: this is managed by NYCC and is reviewed annually (partners include YAS, NY Police, CYC, Harrogate and District NHS Foundation Trust) *Humber sharing charter: T*his is managed by North East Lincolnshire Council and is reviewed annually (partners include HUTH, East Riding council, Humberside Police) TEWV and other agreements managed in line with SLAs CAP: Sharing is managed through the joint working arrangement	- System working to deliver EPR convergence and supporting initiatives around Population Health Management - Partnership working on the Yorkshire and Humber Care Record	- EPR Programme Management - Yorkshire and Humber Care Record Programme Management

Ref PR3 Board Assurance Framework (BAF) - continued

Ref: PR3	Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve	**PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

Consequences – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	N/A	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Conduct joint strategic planning sessions to align objectives and priorities across key partners (at place most likely).	Cancer Strategic review with partners complete, workshop held for Cancer Strategy 25-30. Collaborative Acute Providers (CAP) 25/26 work programme - awaiting Executive Planning Meetings – throughout the national planning round	Beth Eastwood / Jenny Piper Simon Morritt / Claire Hansen and Andrew Bertram	**Cancer Strategy:** Cancer Board – 14th May Exec Com – Early June Board June CAP - TBC Feb/ May 2025
Audit of effectiveness of forums for delivering quality partnership working. Using partnership maturity matrix across providers / place and alliances	Audit of partnership meetings initiated across care groups and directorates Maturity matrix for assessing partnership working developed Application on maturity matrix across partnerships and stakeholders	Tilly Poole	Q1 - Initiated Q1 – Matrix completed and being tested Q2-4
Governance arrangements to demonstrate delivery of primary care collaboration	New Place-based meeting established Q1 2025 - Integrated Primary Health Care Collaborative 2025/26	To be established on receipt of ToR – first meeting 23/04/25	Q1
Governance arrangements to demonstrate effectiveness of shared data for decision making	Supporting work of the emerging linked dataset with HNY Geomapping exercise initiated by CAP Data-led Planning Approach approved at Exec Com Clinical service strategy framework developed in draft form	Tilly Poole Lynette Smith Tilly Poole Tilly Poole	Q2-4 Q2&3 Completed Completed

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6

Next Review
Q2 - Sept 2025

Ref PR4 Board Assurance Framework (BAF)

Ref: PR4	Strategic Objective: Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow	**PRINCIPAL RISK 2:** *Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.*	**Risk Score: 6**

Causes – What must happen for the risk to occur?
- Failure to transform services sufficiently to within the current resource limits
- Capacity for the EPR programme delivery is not sufficient
- Lack of standard implementation of QI methodology
- Insufficient funds to allow running of services, allowing headroom to affect transformation, plan for the long term and change at pace

Consequences – If the risk occurs, what is its impact?
- The EPR programme is not sufficient to realise its full potential
- QI benefits not consistently delivered to transform services

Executive Risk Owner: Medical Director | **Assurance Committee:** Quality Committee | **Date Added to BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
3	3	9	3	2	6	LOW (1-6)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	6	N/A	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. positive)	ii) Controls	ii) Assurances (inc. positive)	iii) Controls	iii) Assurances (inc. positive)
Rollout of Quality Improvement Methodology (QSIR)	- Regular cohorts of QI training - QSIR tools available Trust wide - Governance Half-Days include improvement - Governance outputs reported through Care Group Governance	Implementation of the Nervecentre EPR Programme	- Business case approval - Programme Board - Digital Sub-Committee - HNY EPR Board (ICB joint working) - Project team appointments - Training plan	Building of commercial research team	- Establishment of commercial research team - Collaboration agreements with Contract Research Organisations (CROs)
				Research and Innovation, People, Digital and Quality Strategies	Approved at February-May 2025 Board of Directors
Data for improvement	- Availability of data on Signal - Improvements to Trust Priorities Report	Joint working with partners across ICB for system-wide transformation	- Cancer Board - Elective Recovery Board - Community Improvement Group	Continuation and expansion of Research Delivery	- Partnerships with universities - Research leads and time assigned for Principal Investigators
Transformation programmes with programme governance and infrastructure	- Programmes established including: - *Maternity Assurance Group* - *Community Diagnostic Centres* - *Urgent Care Improvement Programme* - *Urgency and Emergency Care Centre*	Annual Planning and Strategy Development	- Annual planning process to develop change and transformation priorities and initiatives in specialties - Joint meetings with ICB and Place during planning round to manage risks and ensure alignment of policy requirements.	Growth of coastal research capacity to create research and implement findings related to inequalities	- Establishment of Scarborough Coastal Health and Care Research Healthcare Collaborative (SHARC) - Partnerships with VCSE organisations

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
NHS Impact Actions and establishment of continuous improvement culture	Readiness Assessment commissioned from KPMG for the establishment of our management system to deliver our strategic priorities.	Adele Coulthard	Completion of the readiness assessment on 6th June 2025
Resource and focus on innovation	Delivery of Research and Innovation Strategy Action Plan	Lydia Harris/Adele Coulthard	April 2026
~~Creation and alignment of supporting strategies to Trust Strategy~~	~~Supporting Strategies to be updated and published once approved by Board of Directors.~~	~~Executive Owners~~	~~May 2025~~
~~Development of EPR Programme BAF Risk~~	~~EPR Programme BAF Risk under development~~	~~James Hawkins~~	~~May 2025~~

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6

Next Review

Q2 - Sept 2025

Ref PR5 Board Assurance Framework (BAF)

Ref: PR5	Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations	**PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

Consequences – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	N/A	N/A	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
External grant and match funding opportunities to help improve capital and infrastructure to better sustainable and energy saving standards	- NHSE and ICB informing of grant opportunities, horizon scanning, for example:- o PSDS o NEEF o Other opportunities including through our local/regional partnerships	Sustainable Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan).	- Senior Lead owner of each Green Plan workstream and theme - Monthly 1-2-1 with the Finance Director in his role as the Executive Sustainability lead *Gap – Development of these workstreams is now in place but some needing to be more effective.*	Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group	- Resources and Executive Committee Reporting every quarter - YTHFM Management Group reporting every quarter *Gap – all workstreams are now in place but some need to be more effective so a series of 1-2-1's with workstream leads will be put in place.*
Sustainability Team delivering the green plan and staff travel plan agendas across the Trust	- Green Plan requiring redrafting to better align with new NHSE Green Plan guidance, ICB Green Plan and regional climate change strategies. - Green Champions network established - Staff Travel Plan agreed and published, January 2025 - Developing new external partnerships private & public sectors organisations to support our and their sustainability efforts, following external funding sources and support	Head of Sustainability oversight and lead, Finance Director steer and Sustainability Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan).	The travel plan is to set forward a number of initiatives to promote sustainable travel across the Trust *Gap – Staff Travel Plan does not control patient travel but can only influence it. This impacts on our 2045 carbon footprint targets.*	Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group. Regular meetings with the Finance Director to update, provide assurances and receive steers from.	
Sustainable Design Guide & NHSE building standards implementation	- BREEAM standards embedded in the Capital Team *Gap – implementation of NHSE net zero building standards etc across YTHFM Capital and Estates teams to create greater understanding and buy in.*	Green Plan, Sustainability Development Group & newly established Capital and Estates workstream	*Gap - Delivery outcomes from the Sustainable Development Group and workstreams in its infancy*	Ongoing staff communications and promotion to keep staff informed and motivated to do what they can to embed sustainability into their work.	- Trust Communication on green plan interventions - York & Scarborough Hospitals Charity partnerships

Ref PR5 Board Assurance Framework (BAF) - continued

Ref: PR5	Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations	**PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

Consequences – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	N/A	N/A	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Staff Travel Plan Implementation	. ICB to review the Patient Transport Service and working with Local Authorities and bus operators to continue with staff bus discount offer with benefits to patients/visitors to travel sustainably.	Daniel Braidley/Graham Titchener	Review July2025
Review of YTHFM Capital Projects' Sustainability Design Guide against the NHSE Net Zero building Standard & chair of newly established Capital & Estates workstream.	Head of Capital projects supported by a new starter qualified in sustainability to incorporate the best guidance into future Capital Projects. New workstream better aligns responsibilities between Capital and Estates teams with the 2 heads of of service leading and ensure better embedding of sustainability policies	Andrew Bennett	Review July 2025
Sustainability Quarterly Assurance Reports and workstream establishment.	Workstreams are in place but not all being fully effective yet so starting a series of 1-2-1 meetings with all workstream leads. Ensuring better data is available to track progress against the now established 1200t/CO2 saving per annum the Trust needs to make to achieve net zero targets.	Graham Titchener	Review July 2025
Trust Green Plan redrafted to better align with new NHSE Green Plan guidance, ICB Green Plan and regional climate change strategies and to include more KPIs/SMART outcomes.	Redraft underway and aiming to send to Exec and Board for approval end of this year.	Graham Titchener	December 2025

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	2	8

Next Review
Q2 – Sept 2025

Ref PR6a Board Assurance Framework (BAF)

Ref: PR6a	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6:** Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030.	Risk Score: 25

Causes – What must happen for the risk to occur?

- Failure to achieve the annual financial plan through inadequate income allocations, poor income recovery, lack of expenditure control, non-delivery of the efficiency programme and unaffordable investment decisions.
- Cashflow difficulties
- Inadequate capital funding to meet all infrastructure backlog repair priorities and new investment requirements

Consequences – If the risk occurs, what is its impact?

- Trust entering SOF4 arrangements and special measures scrutiny
- Not achieving the Trust's part of the ICB overall financial balance (system failure consequence)
- Loss of Deficit Support Funding
- Externally imposed financial recovery plan
- Reputation impact on the Trust
- Site infrastructure failure
- Loss of autonomy and control
- Potential reduction in service quality and safety

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	5	5	25	OPEN (10-12)	OUTSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	25	N/A	N/A	N/A
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Annual business planning process including Board plan sign-off, triangulation with ICB and ICS and ultimate NHSE approval.	- Business plan, Board progress updates - ICB plan working groups - Internal Audit Reports 2025-26	Expenditure control - business case process *Gap – Unplanned expenditure commitments outside of process*	- Business Case manual and register - Internal audit report - SFI Business Case approval hierarchy	Overspend monitoring against approved scheme sums	- Scheme sum variation process - Scheme expenditure CPEG reports
Monitoring and reporting of I&E plan	- TPR Board and Committee reporting 2025-26 - PFR monthly NHSE. TPR Resources & Board - Care Group PRIMs and FRMs	Efficiency delivery – managed by Corporate Efficiency Team *Gap – insufficient planning to secure in year delivery*	- TPR Board, Committee and EDG reporting 2025-26 - PFR monthly to NHSE - Care Group PRIMs and FRMs	Management of national PDC schemes to required timelines (year-end cut-off deadlines)	- CPEG reporting 2025-26 - ICS/NHSE ad hoc reports
Income control - income contract variation process *Gap – unplanned income reduction*	- Income adjustment form register - TPR Board and Committee reporting	Cash flow monitoring. Cash working group. Monthly debtors and creditors review.	- Monthly debtor and creditor dashboard - Trend data and forecast data in TPR - Better Payment Practice in TPR	Backlog maintenance prioritisation *Gap – lack of understanding of full backlog requirements*	- Capital Investment needs schedules - Prioritisation scoring process - EC and Board sign off April 2025
Expenditure control - scheme of delegation, standing financial instructions, segregation of duties.	- SFIs Board approved - Written prime budget holders' approval - System enforcements and no PO no Pay	Capital planning process – preparation and sign off programme	- Capital Investment needs schedules - Prioritisation scoring process - EC and Board sign off April 2025	Identification of sparsity income stream (£10.3m)	- Formal agreement with ICB to include sparsity income & work on funding - Task & finish group to manage
Expenditure control - staff leaver process and Vacancy Control *Gaps – payroll untimely informed of leavers*	- Salary overpayment recovery policy - Staff Reports, REACH reporting - Enhanced Vacancy Control Panel 2025-26	Routine monitoring and reporting against capital programme	- TPR Board and Committee reporting 2025-26 - CPEG reporting - ICS/NHSE ad hoc reports	Risk share agreed with the ICB for high-cost drug cost pressure	- £6m ICB funding agreed - Area prescribing committee work - ICB strategic commissioner role

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Unplanned income or spend change – CG and Corp Dir reminders	As part of the 25/26 budget sign off process a specific reminder will be issued requiring signature	Andrew Bertram	July 25
Payroll improvement project to tackle under & over payments - Deloitte	Improvement plan prepared. Delivery underway. HR Director chaired working group in place.	Andrew Bertram	September 2025
Insufficient efficiency programme – ICS work, Grant Thornton, NHSE.	ICS-wide System Engine Room governance programme. System leaders group to manage pace & cover. Fully planned efficiency programme for 25/26 but need to manage high risk schemes and slippage	Andrew Bertram	Ongoing for 25/26 plans
6 Facet Survey to be completed to identify full backlog maintenance reqs.	Funding agreed. Work commissioned. Survey work commenced.	A Bertram/Penny Gilyard	Q2 completion.

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	4	16
Next Review		
Q2 - Sept 2025		

Ref PR6b Board Assurance Framework (BAF)

Ref: PR6 b	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6:** *Failure to demonstrate effective governance to achieve the Trust's Strategy.*	**Risk Score: 9**

Causes – What must happen for the risk to occur?

- Failure to achieve a satisfactory CQC well-led rating
- Inadequate escalation governance processes
- Trust Leadership and staff not held to account effectively
- Poorly structured and defined governance forums from 'Ward to Board'
- Unclear accountabilities and responsibilities of Trust leadership and Staff
- Insufficient grip on the governance of data

Consequences – If the risk occurs, what is its impact?

- Regulatory well-led scrutiny on the Trust leadership, staff and governance processes
- Trust resources not used effectively and efficiently in achieving the Trust's strategy
- Quality of patient care and experience is not at the level achieved
- Decision-making not consistent with achieving Trust goals
- Risks and issues not managed effecting patient care
- Poor staff morale

Executive Risk Owner: Chief Executive | **Assurance Committee:** All Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	4	20	3	3	9	OPEN (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	9	N/A	N/A	N/A
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances (inc Positive)	ii) Controls	ii) Assurances (inc Positive)	iii) Controls	iii) Assurances (inc Positive)
Monthly Trust Board of Directors reporting	- Approved Standing Orders and work programme (Jan 2024) papers, minutes and action logs - 2024/25 Committee effectiveness reviews and amendments to terms of reference	Patient Experience and Clinical Effectiveness Sub-Committees	- Approved terms of reference and work programmes (Jan 2024) - All Committee reporting papers, minutes, action logs Apr 2024-Jan 2025	Role job descriptions and annual appraisal processes	- 88% staff appraisals concluded for 2024
Trust constitution and governance framework: Scheme of Reservation and Delegation and Standing Financial Instructions	- Trust constitution and governance framework approved by Board of Directors, delivered through all Committees January 2024 to date	Performance Review and Improvement Meetings (PRIM) with Care Groups	- Monthly letters of meeting outcomes and actions to Care Groups for action - Escalation reporting to Executive Committee for lessons learnt	Line Management Development Programme	- Line managers undertaken the line management training programme as at Jan 2025
- Monthly Quality and Resources Committees - Bi-monthly Executive Committee - Quarterly Audit Committee	- Committees' terms of reference and work programmes (approved January 2024) - All Committee reporting papers, minutes and action logs Apr 2024-Jan 2025	Committee escalation processes and flow of information across governance forums	- Quality, Resources, and Audit Committee escalation reports to Board of Directors - Care Group reporting escalations to Executive Committee April 2024-Jan 2025	Business Intelligence data reporting processes	- Signal 'real-time' reporting - Trust Priorities Report (TPR) monthly reporting to Board, Quality, Resources and Executive Committees Apr 2024-to date
- Risk Management Strategy and Policy and Datix system - DSPT submission and cyber security management	- Board Approved January 2025 - BAF, Corporate Risk, Care Group and speciality risk registers Apr 2024-Jan 2025 - SIRO board report Sept 2024	Care Group governance forums (quality, performance, finance, workforce, risk)	*Gap - Approved consistent terms of reference and work programmes across all Care Groups* - Care Group reporting papers, minutes, action logs Apr 2024-Jan 2025	CQC 'Journey To Excellence' programme and relationship management meetings	- Journey to Excellence monthly meeting Apr 2024-Jan 2025 - Journey to Excellence action plan outcomes evidence submitted to CQC Apr 2024-Jan 25

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Consistent Care Group governance terms of reference for Quality, Performance, Finance and Risk forums	Accountability framework drafted for Care Group engagement Risk and Assurance Workshops conducted with Care Group leadership teams – April concluded	Mike Taylor	September 2025
Well-led external assessment next steps to implement	External well-led assessment currently being commissioned to commence September 2025	Mike Taylor	September 2025

Target Risk (After Actions Implemented)		
I	L	Rating I x L
2	3	6

Next Review
Q2 - Sept 2025