York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 24th September
Time: 9:30am – 12:30pm
Venue: PGME Discussion Room, Scarborough Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:30
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 30 July 2025** To be agreed as an accurate record.	Chair	Report	6	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	5	
6.	**True North Report** To consider the report.	Chief Executive	Report	18	9:35
7.	**Chair's Report** To receive the report.	Chair	Report	36	9:45
8.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	39	9:50

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Quality Committee Report** To receive the September meeting summary report.	Chair of the Quality Committee	Report	107	10:10
10.	**Resources Committee Report** To receive the September meeting summary report.	Chair of the Resources Committee	Report	109	10:15
11.	**Group Audit Committee Report** To receive the September meeting summary report.	Chair of the Group Audit Committee	Report	112	10:20
12.	**Trust Priorities Report (TPR)** August 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	114 117 160 179 190 196	10:25
13.	**Q1 Annual Operating Plan Progress Report** To consider the report.	Chief Executive	Report	212	11:15
Break 11:25					
14.	**Freedom to Speak Up Annual Report** To consider the report.	FTSU Guardian	Report	228	11:35

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**CQC Compliance Update Report** To consider the report.	Chief Nurse	Report	247	11:45
16.	**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	251	11:50
17.	**Winter Plan 2025/26** To approve the report.	Chief Operating Officer	Report	278	12:00
18.	**Mortality Review – Learning from Deaths Report** To consider the report.	Medical Director	Report	297	12:10
19.	**Responsible Officer Annual Report** To consider the report.	Medical Director	Report	316	12:15
Governance					
20.	**Emergency Preparedness Resilience and Response (EPRR) Update** To consider the report.	Chief Operating Officer	Report	323	12:20
21.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
22.	**Time and Date of next meeting** The next meeting held in public will be on 22 October 2025 at 9am at York Hospital.				
23.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				

Item	Subject	Lead	Report/ Verbal	Page No	Time
24.	**Close**				12:30

Minutes
Board of Directors Meeting (Public)
30 July 2025

Minutes of the Public Board of Directors meeting held on Wednesday 30 July 2025 in the Trust Headquarters Boardroom, York Hospital. The meeting commenced at 9.00am and concluded at 12.00pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Ms Helen Grantham
- Ms Jane Hazelgrave
- Prof Matt Morgan
- Mr Noel Scanlon
- Dr Richard Reece, Associate Non-Executive Director

Executive Directors
- Mr Simon Morritt, Chief Executive
- Mr Andrew Bertram, Finance Director
- Dr Karen Stone, Medical Director
- Mrs Dawn Parkes, Chief Nurse
- Ms Claire Hansen, Chief Operating Officer
- Miss Polly McMeekin, Director of Workforce and Organisational Development
- 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 Sascha Wells-Munro, Director of Midwifery (For Item 13)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Graham Lake, Elected Governor - Public
- Linda Wild, Elected Governor - Public
- One member of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting, with a particular welcome to Mr Scanlon and Dr Reece who were attending their first Board meeting.

2 Apologies for absence

Apologies for absence were received from:
Mrs Jenny McAleese, Non-Executive Director
Mr James Hawkins, Chief Digital and Information Officer

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 25 June 2025

The Board approved the minutes of the meeting held on 25 June 2025 as an accurate record of the meeting.

5 Matters arising/Action Log

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

BoD Pub 54 (24/25) *Explore options to provide more accurate ethnicity data for the Health Inequalities section of the TPR.*
Mrs Parkes reported that a suite of health inequality metrics were being progressed by the Deputy Chief Operating Officer and the Chief of Allied Health Professionals, with clinical input. These would be presented to the Quality Committee and the Board in September. The action was therefore deferred.

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 reported that the Associate Chief Operating Officer for the CSCS Care Group had provided an update at the recent meeting of the Quality Committee on the actions being taken to address the serious concerns raised by the review. The Committee had asked for regular updates to monitor progress against the actions. The action was closed.

BoD Pub 60 (24/25) *Present an options paper on improvements to Audiology waiting times to the Resources Committee.*
Ms Hansen advised that the paper would be presented in August.

BoD Pub 2 *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.*

A paper describing the workforce plan to address the shortage of healthcare scientists with Cardiology had been previously circulated. Ms Hansen advised that a time out session for the Cardiology team had been scheduled for September to review the specialty's data and to consider proposals for improvement.

Ms Hansen also advised that an improvement plan for Endoscopy, including Colonoscopy, had been developed and was being reviewed through the relevant governance structure. This included a workforce plan which incorporated the training of relevant specialty staff. Ms Hansen expected to see an improvement in Endoscopy capacity from November. The action was closed.

In response to a question, Ms Hansen confirmed that the Cardiology service was led by a consultant level clinical lead and a nursing lead at matron level, but oversight of specialties was one of the aims of an ongoing reconfiguration of Care Groups. Mrs Parkes added that there were issues with governance which were also now being addressed.

BoD Pub 5 *Ensure that the Digital Strategy is amended as discussed and that an accompanying scorecard is developed.*
The Strategy had been amended, and the scorecard would be presented to the Digital Sub-Committee meeting on 1 August. The action was closed.

BoD Pub 7 *Amend narrative summaries in the TPR to show bullet points of highlights and concerns instead.*
Ms Hansen asked for further clarification on the format required and it was agreed that this would be discussed outside of the meeting.

BoD Pub 8 *Report back on progress for options for a new telephony system.*
A progress report had been previously circulated to the Board by email and the action was closed.

BoD Pub 9 *Report to the Board on a full review of Cardiology Services.*
A paper had been circulated prior to the meeting. The action was closed.

BoD Pub 10 *Identify a suitable Board Development Seminar for a presentation from the Director of Midwifery.*
Mr Barkley advised that the Board development seminar on 18 March 2026 had been earmarked for this presentation. The action was closed.

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 options for online training, particularly Level 3 Safeguarding, were being explored with clinical input. She noted that national guidance recommended face to face training for Level 3 Safeguarding, but other providers were using online courses. Dr Stone added that she planned to complete the Level 3 Safeguarding training online to make a judgement on its suitability. The action was closed.

BoD Pub 15 *Work with the authors of the True North report to amend it as suggested.*
This action had been completed.

BoD Pub 16 *Clarify the wording in the True North report around contributing factors to lost bed days.*
This would be referenced under Item 6. The action was closed.

BoD Pub 17 *Ask Mr Scanlon to take on the role of Non-Executive Director Safeguarding lead.*
Mr Scanlon had accepted the role. The action was closed.

BoD Pub 18 *Confirm whether the high number of Cancer referrals to the Head and Neck Service is a result of local GPs withdrawing Dermoscopy services.*
Ms Hansen advised that the Business Intelligence team was providing an analysis of all cancer referrals to the Cancer lead. The number of skin cancer referrals had doubled, which might be a result of the withdrawal of GP Dermoscopy services, but this could not be verified. Ms Hansen noted that a number of GP practices were now not undertaking

routine diagnostic procedures which had previously been in place, and this was leading to more referrals for all cancer sites. GP practices had agreed with the ICB that referrals could now be made without diagnostic input and there seemed no appetite to reverse this decision.
The action was closed.

BoD Pub 19 *Check whether the purchase of audiology booths is included in the capital programme.*
Mr Bertram confirmed that three new audiology booths would be supplied through charitable funding. The action was closed.

BoD Pub 20 *Use the Executive summary section on the report cover sheet to report highlights and concerns in bullet points.*
The format of the Executive summary for the Maternity and Neonatal Report had been amended and the action was closed.

6 True North Report

Mr Morritt reminded the Board that for each True North metric, the narrative in the report was related to the current challenges and also summarised the next steps as set out in the annual plan. A more contemporaneous commentary on the metrics was provided by the Trust Priorities Report (TPR).

Mr Morritt noted that the metric referring to lost bed days had been changed to reflect a national change in the way in which this metric was reported. However, he had agreed with Mr Barkley that the metric for lost bed days originally agreed with the Board should be reinstated in the True North report.

There was some discussion on the level of detail in the True North report. Mr Barkley observed that the True North report should not duplicate the information in the TPR. Ms Grantham noted that the information in both the True North report and the TPR was not sufficiently forward looking, and there was insufficient input from Executive Directors on their principal areas of concern. Mrs Parkes commented that assurance for the Board should be provided by papers presented at the Board's Committees. Mr Barkley reiterated his request for summary pages in the TPR which set out highlights and concerns in bullet points.

Miss McMeekin confirmed that the metrics in the True North report relating to the staff survey were informed by the quarterly Staff Pulse survey which had a much lower response rate than the annual staff survey. Mr Barkley suggested that the metrics should include the annual staff survey results in Q3 each year.

Action: Miss McMeekin

Mr Scanlon queried the metric relating to the reduction of Category 2 pressure ulcers. Mrs Parkes explained that a focus on Category 2 pressure ulcers would also prevent Category 3 and 4 ulcers. The number of Category 3 and 4 ulcers had reduced due to focused work in the previous year, and the relevant metric was reported in the TPR. Mr Scanlon also raised a query about the lack of reference to mattresses, trolleys and beds in the current challenges for this metric. Mrs Parkes explained that there had been a replacement programme for mattresses and beds and the audits of these were now "business as usual".

7 Chair's Report

The Board received the report.

8 Chief Executive's Report

The Board received the report.

Mr Morritt drew out the following points:

- the government's 10 Year Health Plan had been launched on 3 July; there was as yet no plan for delivery;
- Dr Penny Dash had published a review of patient safety across the health and care landscape; Dr Dash had recommended the abolition of the National Guardian's Office and of the local Healthwatch network; Mr Morritt assured the Board that there was no intention on the part of the Trust to scale back the Freedom to Speak Up programme;
- a national maternity and neonatal review had been announced;
- an independent review of Physician Associates and Anaesthesia Associate roles had been undertaken by Professor Leng: the implementation of the recommendations was being progressed by the Trust;
- the CQC report on the inspections which took place in January had been published on 2 July; Mr Morritt observed that the report was evidence of an improvement trajectory although he acknowledged the significant amount of work still to be done;
- the first period of resident doctors industrial action had taken place: Mr Morritt outlined the impact and noted that there would be no resource available to the Trust to support the costs of managing the impact; Ms Hansen reported that doctors' shifts in acute care had been managed well, due to the comprehensive plan in place;
- an Anti-Racism Statement, as advocated by the Anti-Racism Steering Group, had been published on the Trust's website.

Mr Scanlon asked if there had been any reaction locally to the recommendation to close Healthwatch. Mr Morritt confirmed that there had certainly been disappointment and City of York councillors had written to ministers to express this.

Directors referenced the Star Award nominations which, as always, reflected outstanding values and qualities demonstrated by Trust staff. Mrs Parkes added that positive feedback from staff about staff was reported via Greatixes and the Board should consider how these might be shared.

9 Quality Committee Report

Dr Boyd highlighted the key discussion points from the meeting of the Quality Committee on 15 July 2025. The Committee had expressed disappointment that the treatment of medical patients on surgical wards was still being escalated by the Surgery Care Group as there had been limited progress towards a solution; concern was expressed that ward staff may not be using escalation routes, particularly around discharge, due to a lack of response. Weekend coverage was also an issue. The Committee had received assurance that deteriorating patients were escalated appropriately, however. Dr Boyd reported that a Rapid Process Improvement Workshop had been recommended to progress a resolution.

Dr Boyd reported that Surgery Care Group leaders had escalated surgical treatment delays for neck of femur patients. She cautioned that there might be insufficient urgency in addressing the issue given the known negative outcomes which arose from delays to surgery. The Trust's mortality rates for this cohort of patients were, however, in line with the national average
Dr Boyd reported that the Chief Pharmacist had attended the meeting to present an assurance paper around prescribing practice.

Mr Scanlon observed that more assurance was needed around business planning for neck of femur patients and he also noted that a gap in provision in interpretation services had been highlighted in the Patient Experience update.

Ms Hazelgrave highlighted the increase in the number of complaints to the Trust and questioned whether this could be related to the vacancies in the Patient Advice and Liaison Service. Mrs Parkes explained that, following a recent Rapid Process Improvement Workshop, the process for managing complaints and concerns had been streamlined, and the capacity of the team would be reviewed in the light of this.

Mr Barkley stated that he had been informed by theatre colleagues that an emergency weekly list had been converted to an elective list since Covid, which might be contributing to not achieving the best practice standard for undertaking surgery on patients with a fractured neck of femur due to the focus on elective recovery work since the pandemic. Ms Hansen responded that theatre lists were being reviewed to ensure that they met demand.

10 Resources Committee Report

Ms Grantham highlighted the key discussion points from the meeting of the Resources Committee on 15 July 2025:

- challenges to Cancer performance which included the impact of ageing diagnostic equipment; the Committee had discussed the CT scanner replacement plan;
- the growth of the Referral To Treatment list due to the ongoing validation work; there had been discussion on how to ensure that the process of allocating patients to waiting lists was more efficient when the new Electronic Patient Record (EPR) was introduced;
- an update on improvement plans for the Rapid Access Chest Pain clinic had been provided; the Committee would continue to monitor performance;
- the improvement in Urgent and Emergency Care performance was acknowledged as was the positive progress towards Nursing and Associate Health Professional (AHP) priorities;
- the new process for agreeing medical agency spend was noted.

In response to a question, Mrs Parkes explained that the Nursing and AHP priorities were around patient-centred care, well-led, the right approach and involving everyone in decisions.

Miss McMeekin provided a brief update on progress towards creating wellbeing spaces in York and Scarborough Hospitals.

11 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Mr Barkley congratulated the Chief Operating Officer and the relevant teams on the continued reduction in 12 hour trolley waits. He referred to the SPC chart of non-elective admissions and queried the sharp rise in the spring of 2024, which had since been sustained. Ms Hansen responded that the increase was likely to be a result of a change in data collection; she would email the Board to confirm.

Action: Ms Hansen

The Board acknowledged the improvement in the proportion of all patients attending the Emergency Department having an initial assessment within 15 minutes. Ms Hansen explained that the tests of change developed by teams were beginning to impact on performance. It was noted that this improvement was in the context of a continued increase in ambulance arrivals.

Mr Barkley referred to the Cancer performance narrative and commented that none of specialties with challenges were identified. Ms Hansen would ensure that this omission was rectified for the next report.

Action: Ms Hansen

There was some discussion on the current performance of and the large numbers of referrals to Cancer services. Ms Hansen advised that, despite the increase in referrals, the number of cancers diagnosed had not increased. She was asked to share forecasts for the service at the annual business planning meeting scheduled for September.

Mr Barkley noted the improving picture in terms of long waits for Referral To Treatment. Ms Hansen expressed concern, however, about the impact of the rising number of referrals on the waiting list.

Mr Barkley referred to the large capital programme planned for 2025/26 which could impact on elective and theatre capacity. He asked if plans to decant the relevant services were well advanced, given the requirement to spend the project funds by the end of the financial year. Mr Norman agreed to provide a briefing on the decant plans at the Board's meeting in September.

Action: Mr Norman

Ms Hansen commented that forecast operational planning figures would need to be revised based on decisions about relocating services.

Quality and Safety

Mrs Parkes drew attention to the sustained improvement in the numbers of C.difficile infections. She explained that this resulted from a number of factors, including ward managers now having a clear understanding of their role and their level of accountability, better hand hygiene, appropriate sampling, and a multi-disciplinary team approach to antimicrobial stewardship.

Maternity

A query was raised about the capacity of the Special Care Baby Unit (SCBU) at Scarborough Hospital. Mrs Parkes responded that work was in progress to review its usage. She provided further explanation of the SCBU data in the TPR.

Workforce

Mr Barkley asked for an explanation of the last two metrics on the Workforce Scorecard 1. Mrs Parkes explained that the metric of 22% relating to headroom did not include maternity leave. As there was currently a high level of maternity leaves, the figure for

unavailability had risen to 27%. She added that for certain areas, the headroom figures also did not allow for the required specialist training.

Mr Barkley noted that 41 Whole Time Equivalent (WTE) Health Care Support Worker (HCSW) vacancies would be removed from budgeted establishments to account for the use of long day shifts and suggested that this should provide a cost saving. Miss McMeekin advised that the savings were already earmarked for investment elsewhere. Mrs Parkes referenced the areas of nurse staffing which had been identified as priorities for investment.

Ms Hazelgrave highlighted the increase in the AHP vacancy rate. Miss McMeekin advised that there had been an increase in the establishment of 13 WTE, and there had been around 10 WTE leavers.

Mr Barkley queried the reason for the numbers of doctors employed being above the budgeted establishment. Mr Bertram explained that there was work being undertaken with each specialty to determine the reasons for this which would take some time due to the complexities.

Digital and Information Services

There were no comments or questions on this section.

Finance

Mr Bertram reported that, at the end of Quarter 1, the Trust was £2.9m adrift of plan with a variance of £1.9m. He referred to the list of variances detailed in the report, noting that Employee Expenses was a major factor. Finance deep dives were to be undertaken with Care Groups and in many cases, there would be difficult decisions to make.

Referring to the information about the Elective Recovery Fund (ERF), Mr Bertram reminded the Board that the Fund was capped this financial year. At Month 3, the Trust was £2.7m of activity over the funded level. The costs of delivering this extra activity were being closely monitored. Ms Hansen observed that there was a balance to be maintained between the level of elective activity and performance against RTT metrics.

Mr Bertram advised that deficit support funding of £4m per quarter had been paid for Quarters 1 and 2. He cautioned that this would be more difficult to secure in Quarters 3 and 4.

12 CQC Compliance and Journey to Excellence Update Report

Mrs Parkes presented the report. She paid tribute to the staff teams in Urgent and Emergency Care and in Medicine who had contributed to the positive CQC inspection report published on 2 July. She reported that the action plan required by the CQC had been endorsed by the Journey To Excellence Group and had now been submitted to the CQC where it had been perceived positively.

Mrs Parkes reported that the CQC had made an informal visit to the new Urgent and Emergency Care Centre (UECC) and to Maternity Services at Scarborough Hospital on 8 July. CQC officers were very positive after conversations with staff and patients in the UECC but less positive about the built environment in Maternity Services.

There was a brief discussion about compliance with training in relation to the Oliver McGowan Code of Practice which was demanding. Mrs Parkes advised that the Trust was performing well in this regard.

In response to a question, Mrs Parkes confirmed that the Journey To Excellence Group would remain in place and would monitor progress against a new action plan based on gaps identified from the data submissions made to the CQC, as well as the action plan submitted to the CQC.

13 Maternity and Neonatal Reports (including CQC Section 31 Update)

Ms Wells-Munro presented the report and highlighted:

- concerns raised by substantive staff at both York and Scarborough Hospitals regarding safe midwifery staffing levels; there had been an increase in roster gaps since May, but these were being mitigated using agency staff; specialist staff were also being deployed to cover gaps;
- recent concerns regarding support for perinatal mental health had been addressed and the Service would be working collaboratively with Tees, Esk and Wear Valleys Trust (TEWV);
- concerns had been raised by service users about the availability of birthing pools on the York site; work had been undertaken to remedy this position and two of three pools had since reopened;
- the position as regards open incidents had improved and the backlog had been reduced further since the report was published;
- options for the relocation of York Hospital SCBU, whilst the refurbishment project took place, were being considered;
- a summary of compliance with the Maternity Incentive Scheme (MIS) was included in the report.

Professor Morgan referred to the fifth key risk to the delivery of the Single Improvement Plan which referenced the need for key equipment. Ms Wells-Munro advised that the project was progressing with funds from the MIS as the equipment was necessary to fulfil one of the safety actions.

Mrs Parkes reminded the Board of previous discussions around midwifery staffing levels, women and baby safety impacts and concerns related to reduced workforce capacity. Mrs Parkes reminded the Board of its level of accountability to own maternity safety and risk; she then provided an update of the current workforce investments. She referenced the recent review of the Nursing Education team which had now been centralised, releasing funding of £230k, which had been invested in Maternity Services and would fund 4 WTE midwives. A further £142k of MIS funds would be invested in midwifery staffing but this was noted as non-recurrent. Mrs Parkes advised that a paper proposing a reduction in maternity theatre scrub nurse practitioners was due to be presented to the Executive Committee in August. If approved, this proposal would release funding for between 9.5 and 12 WTE midwives, depending on appointed bands. Mrs Parkes summarised that, with the funding outlined above and assuming the scrub nurse proposal was agreed, the original investment requirement for a further 44 WTE midwives would be reduced to around 30 WTE. Recycling and re-prioritising current funding was addressing the first third of the Birth Rate Plus investment requirement. Very recent discussions with NHS England had also resulted in an offer of funding for 12 months from September. The exact value and number of midwives this would support was currently under negotiation but was expected to improve the position still further.

Mrs Parkes reported that 14 midwifery students had been offered employment with the Trust. She cautioned that the service could only support a managed number of Band 5 junior midwives due to the training and supervision requirements to deliver the national maternity standards framework.

Mr Morritt commented that the midwifery staffing gap had been flagged with the ICB as, under fixed contractual envelopes, this was a commissioning issue. However, in the absence of financial support from the ICB, he was of the view that the Board should commit to the necessary investment in Maternity Services over a two to three year period and should recruit midwives as they are available to be recruited, whilst continuing to assess workforce requirements on a regular basis. Mrs Parkes again highlighted the Board's collective accountability for the safety of mothers and babies using its Maternity Services and for ensuring a safe appropriate workforce.

Discussion followed. Directors were supportive of the proposal to invest in Maternity Services to fill the gap of required midwives from the recent staffing review over a three year period with this current year being Year 1, and to commit to ensuring the finances required were made available in the operational planning and budget setting for subsequent years. Mrs Parkes would work with Ms Wells-Munro to map out a realistic two year recruitment plan. Ms Wells-Munro was confident that she would be able to recruit a sufficient number of experienced midwives over this period. Recognising the progress this year, the Board resolved to commit to funding 15 midwives in 2026/27 and the final, circa 15 midwives, during 2027/28 at the very latest (Year 3). Should financial opportunities present to progress this issue at a faster pace, this would be reviewed.

Ms Wells-Munro referred to the Perinatal Quality Surveillance Model which had been included in the report for the first time.

Mr Scanlon asked about the support for perinatal mental health. Ms Wells-Munro responded that she had been encouraged by discussions with TEWV on better collaborative working. Ms Hansen added that the ICB should also be involved in discussions about the allocation of resources for perinatal mental health support.

The Board approved the CQC Section 31 Update.

14 2024/25 Quality Account

Mrs Parkes reported that the Quality Account had been previously endorsed by the Quality Committee. She noted that it referenced the new Quality Strategy. If approved by the Board, the Quality Account would be sent to the ICB and Healthwatch for comment.

Ms Hazelgrave highlighted the Trust's good performance in response to Freedom of Information requests within the required timescales.

The Board of Directors approved the Quality Account.

15 Annual Complaints Report

Mrs Parkes presented the report and began by highlighting the rise in the number of complaints to the Trust which reflected a national trend. She reported that a Rapid Process Improvement Workshop had been held in June to standardise and streamline the response to complaints across Care Groups and Corporate areas. Care Groups had now assumed ownership of complaints and strategies to prevent complaints were being

shared. Mrs Parkes was optimistic that this collaborative approach would reduce the number of formal complaints.

In response to a question, Mrs Parkes advised that the main themes of complaints mirrored those reported nationally, for example, communication and staff attitudes. The key to reducing complaints was to address more specific areas, for example, complaints about communication were often related to discharge processes.

Mr Barkley observed that concerns had reached him about the timeliness of responses to complaints, particularly in relation to the Patient Advice and Liaison Service. Mrs Parkes was confident that the work undertaken as part of the recent Workshop would begin to address these issues.

16 Fit and Proper Persons Test (FPPT) Annual Report

The Board received the report.

17 2025/26 Q1 - Board Assurance Framework

Mr Taylor presented the Board Assurance Framework (BAF). He noted that the score for principal risk 1 *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm* had reduced from 16 to 12 following the implementation of the identified actions.

Following the discussion at the recent Board Development Seminar on risk appetite, Mr Taylor would continue to work with Executive Directors on newly identified risks, risk categories and risk appetite. There was some discussion on where deep dives of BAF risks should take place and whether the Board was sufficiently monitoring the key risks to the organisation, as set out in the BAF.

18 Questions from the public received in advance of the meeting

There were no questions from members of the public.

19 Date and time of next meeting

As this was Professor Morgan's last meeting, he was thanked for his much valued contribution to the work of the Board of Directors.

The next meeting of the Board of Directors held in public will be on 24 September 2025 at 9.30am at Scarborough Hospital.

Action Ref.	Date of Meeting	Item Number Reference	Title (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / comments	Due Date	
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 30.07.25: Mrs Parkes reported that a suite of health inequality metrics were being progressed by the Deputy Chief Operating Officer and the Chief of Allied Health Professionals, with clinical input. These would be presented to the Quality Committee and the Board in September.	Sep 25 from Mar 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	Update 30.07.25: Ms Hansen advised that the paper would be presented to the Resources Committee in August.	Sep 25 from Jul 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	Update 30.07.25: Ms Hansen asked for further clarification on the format required and it was agreed that this would be discussed outside of the meeting.	Sep 25 from Jul 25	Delayed
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
BoD Pub 22	30-Jul-25	6	True North Report	Include the annual staff survey results in tbe relevant True North metric in Q3 each year.	Director of Workforce and OD		Jan-26	On Track
BoD Pub 23	30-Jul-25	11	Trust Priorities Report	Email the Board to confirm that the sharp rise in 12 hour trolley waits in the spring of 2024 was due to a change in data collection.	Chief Operating Officer		Sep-25	On Track
BoD Pub 24	30-Jul-25	11	Trust Priorities Report	Ensure that information about challenged specialties is included in the Cancer performance narrative of the TPR	Chief Operating Officer		Sep-25	On Track
BoD Pub 25	30-Jul-25	11	Trust Priorities Report	Provide a briefing on service decant plans.	Managing Director, YTHFM		Sep-25	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 6

True North Report

September 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’.

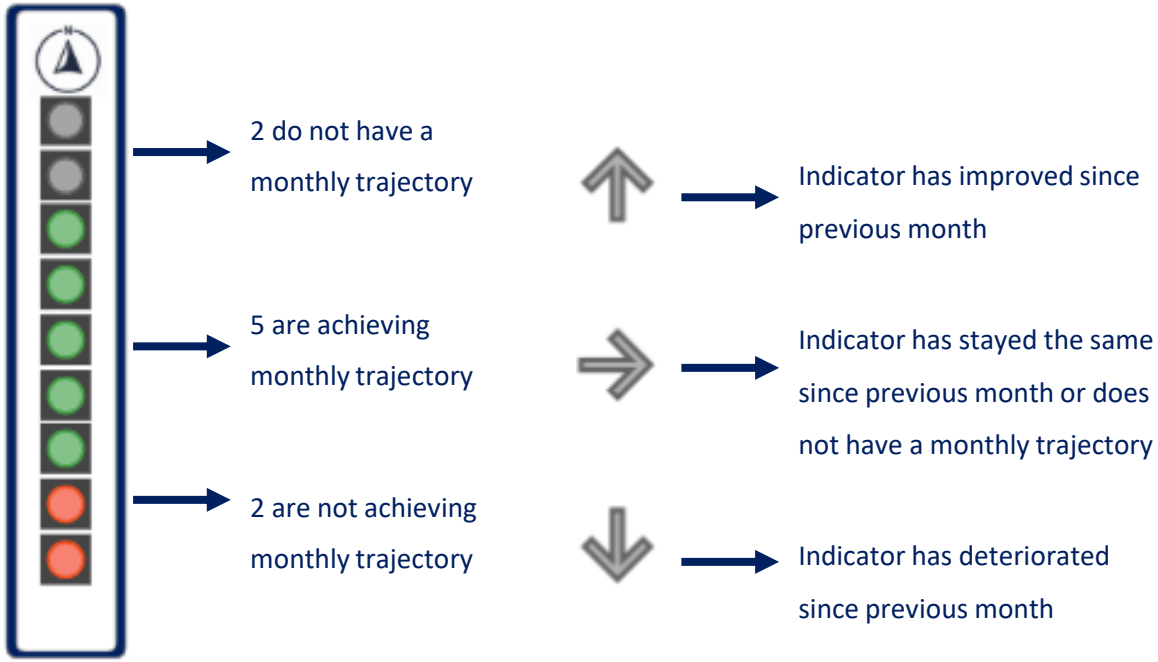
This is the single point of reference to measure our progress.

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 Trust’s key transformational objectives measured by ten key metrics for 2025/26 that have been identified as YSTHFT critical priorities.

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)

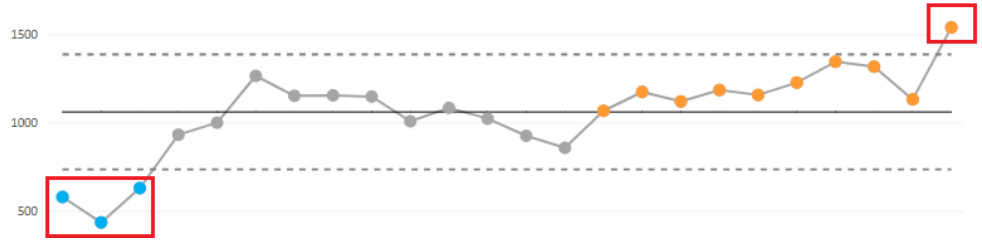
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

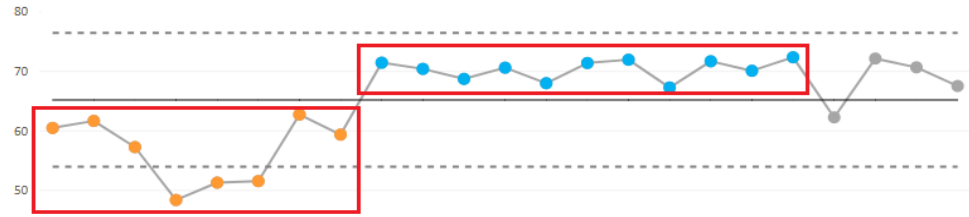
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

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

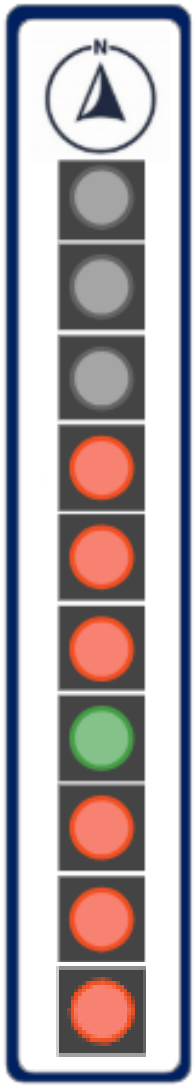


Shift: Counts the number of occasions there is a run of 7 consecutive points above OR below the mean.



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 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

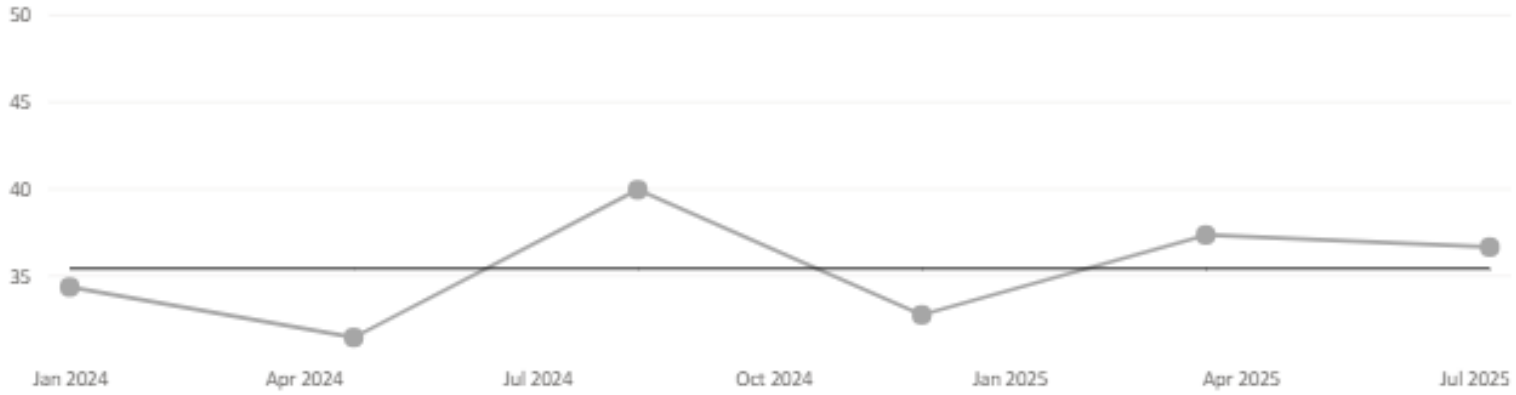
Staff Survey: Recommend Care

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

	Jan-24	Apr-24	Jul-24	Jan-25	Apr-25	Jul-25	Target Mar 2026
Value	34.3%	31.4%	39.9%	32.7%	37.3%	36.6%	49%
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

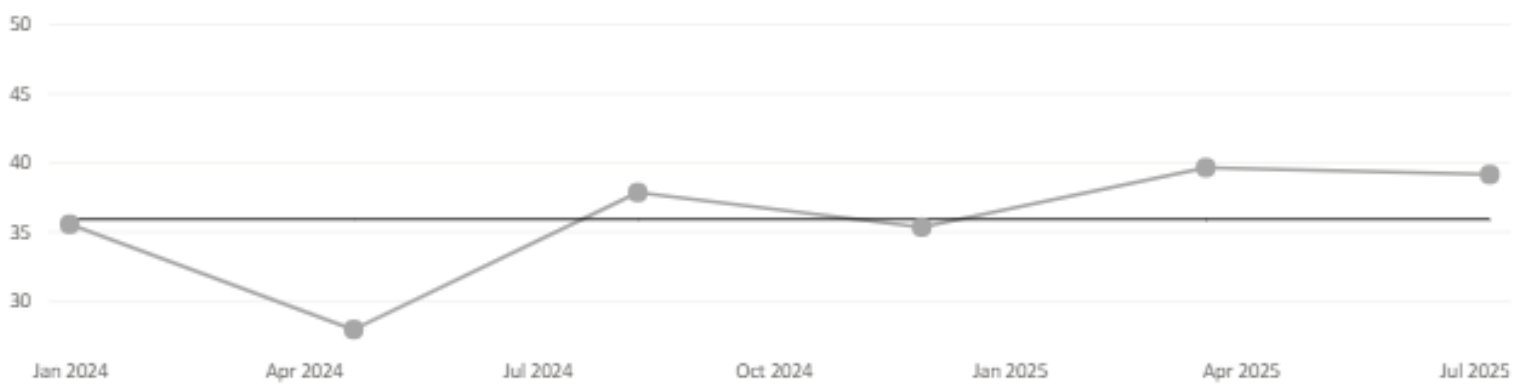
True North Report

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



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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

	Jan-24	Apr-24	Jul-24	Jan-25	Apr-25	Jul-25	Target Mar 2026
Value	35.5%	27.9%	37.8%	35.3%	39.6%	39.1%	50%
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

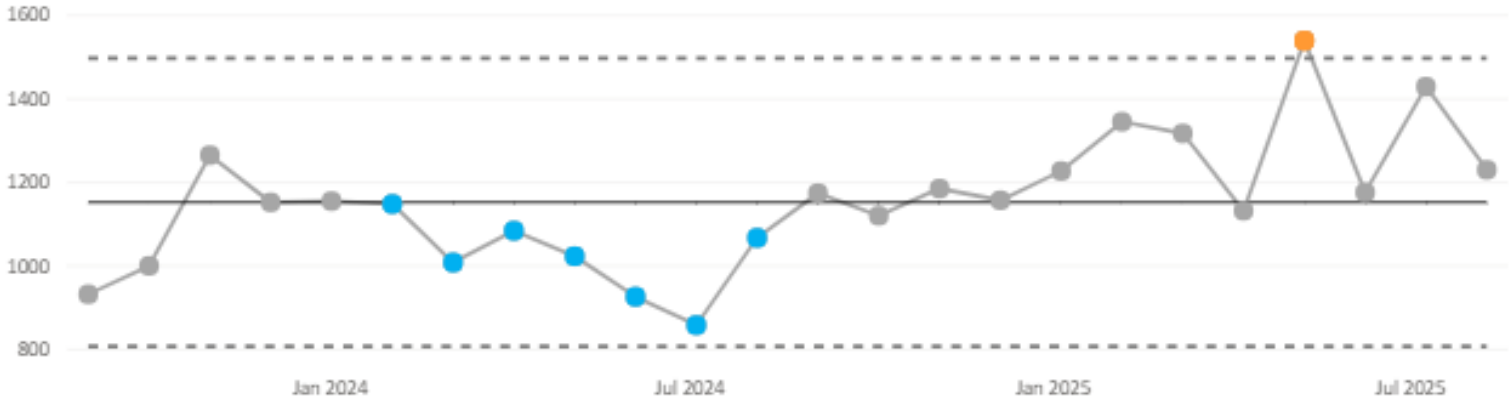
True North Report

Objective Status — No Trajectory

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)?

1 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

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Target Mar 2026
Value	1065	1172	1118	1183	1155	1225	1343	1315	1130	1537	1174	1427	1228	
Trajectory														

What are the organisational risks?

- Patient deconditioning (loss of mobility and independence) and or hospital acquired infections
- Poor flow through our hospitals resulting in mortality/morbidity risks
- A negative impact on Emergency Care Standard and potential overcrowding
- Emergency readmissions due to pressure resulting in rushed discharge planning
- Increased financial pressure
- Moral distress to staff

How are we managing them?

- The Trust's Discharge Improvement Group oversees improvement actions across the system
- First, second and third line escalation meetings continue to happen with system partners. These are used to ensure all partners are aware of the delays and are continuing to proactively seek onward packages of care.

What are the current challenges?

Note: This graph includes all adult (non-elective) bed days including general and acute, non-acute, rehabilitation and community. The BI team is working to separate these activity types.

- Limited capacity for community health and social care
- Workforce challenges, in particular therapists
- Funding challenges

What are we doing about them?

- The high-level future Discharge to Assess model has been established with partners as well as the baseline position. A workshop on 26th September will add detailed requirements, including workforce and number of beds / space requirement.
- This may result in some patients requiring lower levels of care than previously 'prescribed' which could lead to reassignment of capacity to help more patients get the care they need. Modelling work is still to be finalised.

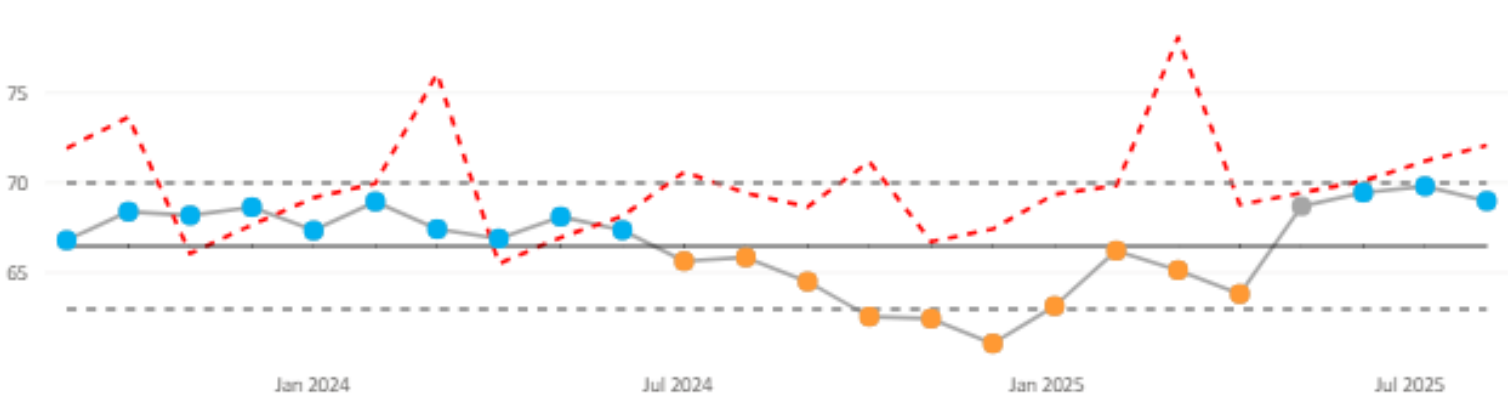
True North Report

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

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Target Mar 2026
Value	65.8%	64.4%	62.5%	62.4%	61%	63.1%	66.2%	65.1%	63.8%	68.6%	69.4%	69.7%	68.9%	78%
Trajectory	69.4%	68.6%	71.1%	66.7%	67.4%	69.3%	69.8%	78%	68.7%	69.4%	70%	71.1%	72%	

What are the organisational risks?

- Increased mortality and morbidity
- Delayed care for critical patients
- Staff burnout and retention problems
- Indication of poor flow elsewhere in the hospital/system
- Financial risk
- Regulatory risk
- Reputational risk
- Risk of negative impact on national oversight framework segmentation as not on planned improvement trajectory

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.

Work includes:

- Effective discharge planning and processes
- Maximising appropriate use of SDEC capacity
- Front door service redesign, eg EDAC pathway
- Recruitment and retention initiatives
- Ambulance handover protocols
- Use of community services including virtual wards
- Review of ED processes including handovers and huddles
- Clear escalation frameworks
- Post breach reviews

What are the current challenges?

- Scarborough performance is most challenged, with ECS typically around 8 percentage points below that in York.
- There is limited capacity to implement and improve at the required pace due to workforce challenges and operational pressures
- There are workforce challenges at both Emergency Departments.

What are we doing about them?

- Recruiting additional Trust grade medics at Scarborough ED which will support increases to rosters and more consistency and stability.
- Training additional Minor Injuries staff in Scarborough with an aim to increase scope and performance.
- Designing future workforce model for both EDs based on predicted demand and considering the pathway changes created this financial year.
- Added GP Capacity to UTC capacity
- Increased streaming to alternatives e.g. UTC and SDEC
- Reducing elective patients seen in SDEC to ensure capacity is optimised for unplanned care.

True North Report

Objective Status ⊗ Down Is Good

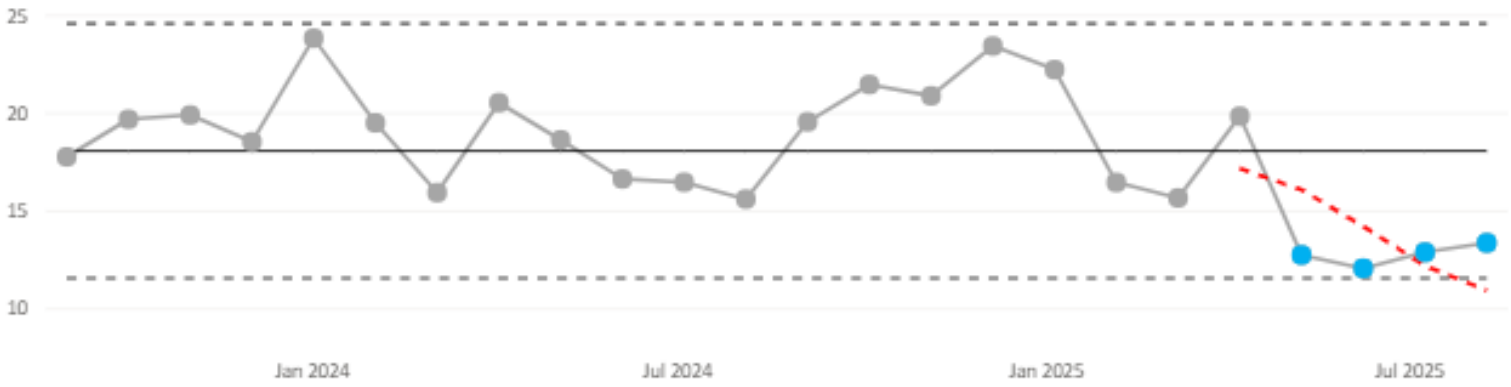
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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



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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

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Target Mar 2026
Value	15.6%	19.5%	21.4%	20.9%	23.4%	22.2%	16.4%	15.6%	19.8%	12.7%	12%	12.9%	13.3%	8.9%
Trajectory									17.1%	16%	14.2%	12.2%	10.9%	

What are the organisational risks?

- Long waits at Emergency Departments have been linked to significant patient harm
- Patients waiting increase the risk of overcrowding and associated hospital-acquired infections
- Persistent breaches of more than 10% of patients waiting over 12 hours can trigger regulatory action
- Reputational risk
- Recruitment and retention issues
- Financial pressures

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 including:
  - Discharge planning
  - SDEC capacity
  - Board rounds and escalation protocols
  - Virtual wards
- 12 hour breach reviews
- Enhanced observations
- Utilising and embedding Continuous Flow policy
- 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

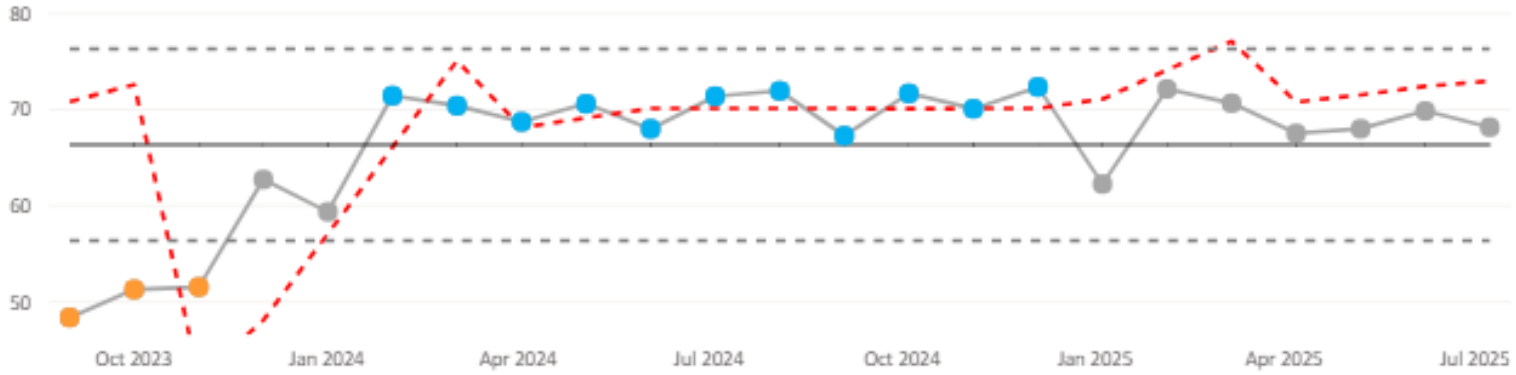
True North Report

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

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Target Mar 2026
Value	71.3%	71.9%	67.2%	71.6%	70%	72.3%	62.2%	72.1%	70.6%	67.4%	67.9%	69.8%	68.1%	80.1%
Trajectory	70%	70%	70%	70%	70%	70%	71%	74%	77%	70.7%	71.4%	72.3%	72.9%	

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
- Increased risk of emergency presentations
- Regulatory and reputational implications
- Potential financial implications
- Reduced organisational credibility
- Retention and recruitment issues
- Risk of negative impact on national oversight framework segmentation as not on planned improvement trajectory

How are we managing them?

- Weekly Trust cancer PTL meeting with a focus on patients breaching FDS with clear escalation routes
- 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.
- Use of transformation funding to support pathways and capacity

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 (3-4wks)
- Increase in suspected cancer referrals month on month from May 2025

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 to impact from Sept 25.
- Discussions with ICB regarding dermoscopy service and scoping service opportunities

True North Report

Objective Status Up Is Good

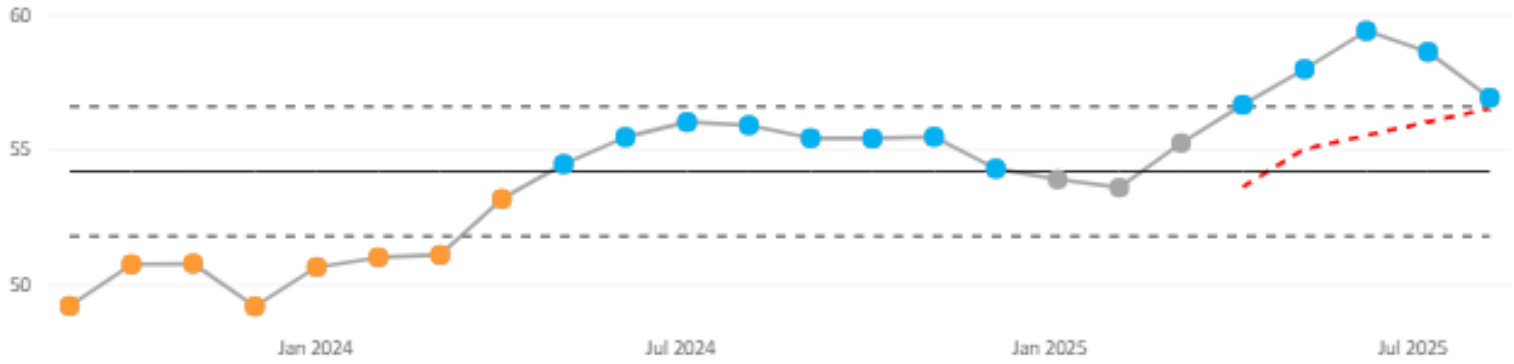
Elective: Improve RTT

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)?

12 found

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

Occurs

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

Occurs

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Target Mar 2026
Value	55.9%	55.4%	55.4%	55.5%	54.3%	53.9%	53.6%	55.2%	56.6%	58%	59.4%	58.6%	56.9%	60.5%
Trajectory									53.6%	55%	55.5%	56%	56.5%	

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
- Higher emergency care utilisation while waiting
- Reputational risk of not meeting improvement trajectories
- Risk of negative impact on national oversight framework segmentation as not on planned improvement trajectory

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
- Risk stratified scheduling and pathway validation
- Staff training
- Use of elective recovery fund monies to support additional activity

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
- Increase in referrals seen in Q1 25/26

What are we doing about them?

- The 2025/26 plan has been developed with focus on productivity and efficiency, progress against the ambitions are managed through the Elective Recovery Board and productivity group.
- NHSE PIFU as standard programme, focused on Gynaecology, Gastroenterology, Cardiology and ENT. Regional launch on 18 June, fortnight internal task and finish group in place expected impact from Q3.
- NHSE RTT validation sprint completed during Q1 2025/26. Sprint 2 commenced in July 2025.
- Analysis ongoing on increase in referrals and discussion with ICB on demand management.

True North Report

Objective Status ⊗ Down Is Good

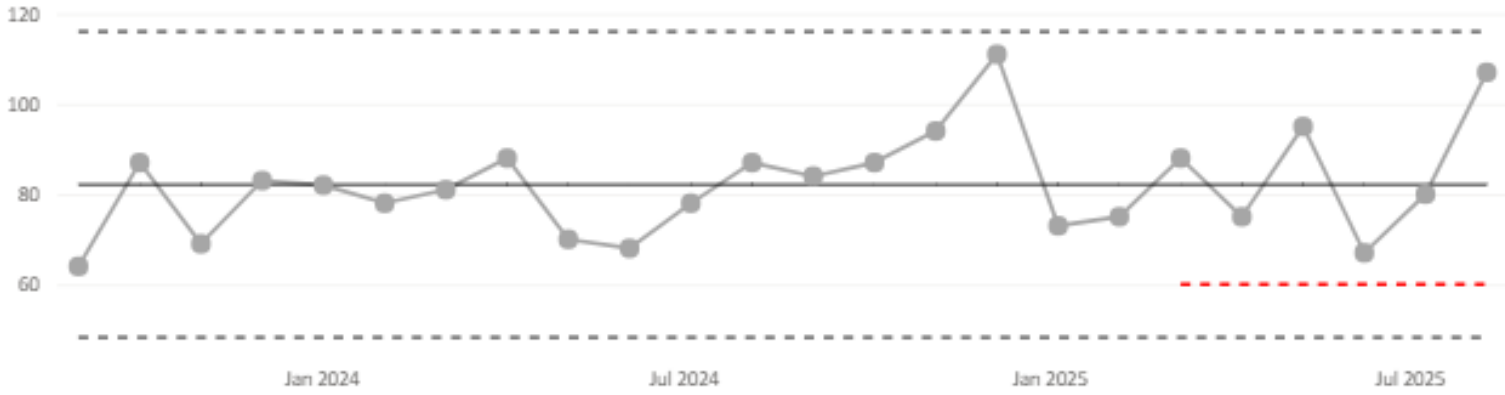
Q&S: Reduce Category 2 Pressure Ulcers

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

Lead Director: Dawn Parkes

Operational Lead: Emma Hawtin

Committee: Quality



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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

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Target Mar 2026
Value	87	84	87	94	111	73	75	88	75	95	67	80	107	60
Trajectory								60	60	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?

- The Monthly Action Delivery Group has been established with representation from all care groups to review Q1 data and commission QI-focused work- overseen by person centred care group into aimed at reducing Category 2 pressure ulcers.
- Virtual education sessions have been delivered by the TVN team over the last three months to improve recognition and accurate categorization of pressure ulcers.
- Request Insight and Intelligence to provide a monthly breakdown of pressure ulcers per ward, to be used alongside the cluster thematic review to guide key work priorities

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
- Updating the current referral process to strengthen and support the service

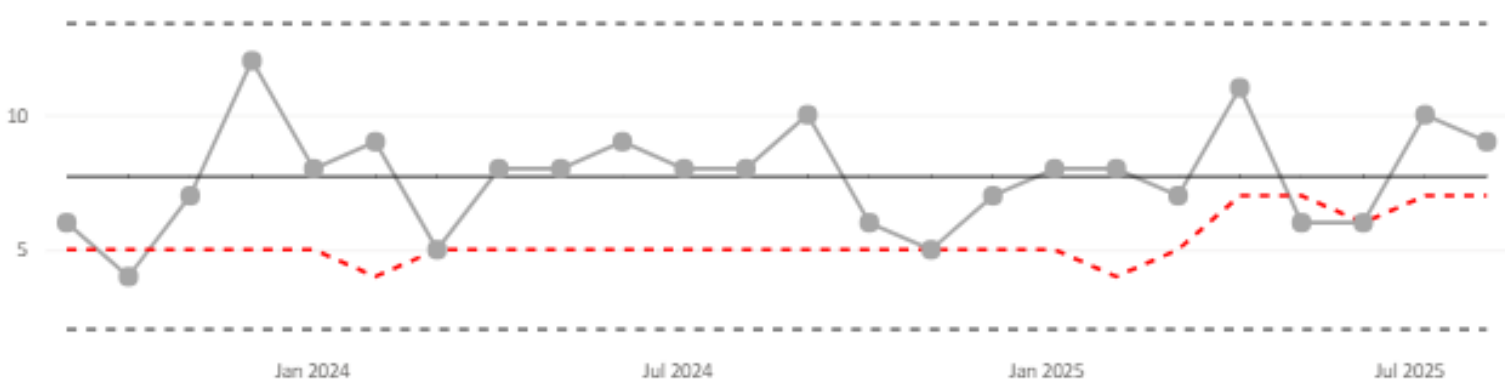
True North Report

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



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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

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

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?

- All cases are reported by the IPC team on Datix to the relevant Care Group Handler.
- Cases are managed locally however there is not a standard process
- The IPC team support the care groups to investigate/manage the patients appropriately.
- MSSA 5% reduction is an objective in the Trust Annual Operating Plan
- A Trust strategic reduction plan is in place.

What are the current challenges?

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

What are we doing about them?

- SOP for reviewing cases has been agreed through IPSAG with Care Groups taking a lead
- Care group reduction action plans in development which will be monitored via IPSAG.
- A standardised Care Group Dashboard and PSIRF/AAR process is being developed with the Care Groups
- Point prevalence survey for urinary catheters was undertaken in August 2025
- Line management, VIP scoring and ANTT education has been refreshed and re-launched
- ICB wide workshop for MSSA reduction is being arranged

True North Report

Objective Status

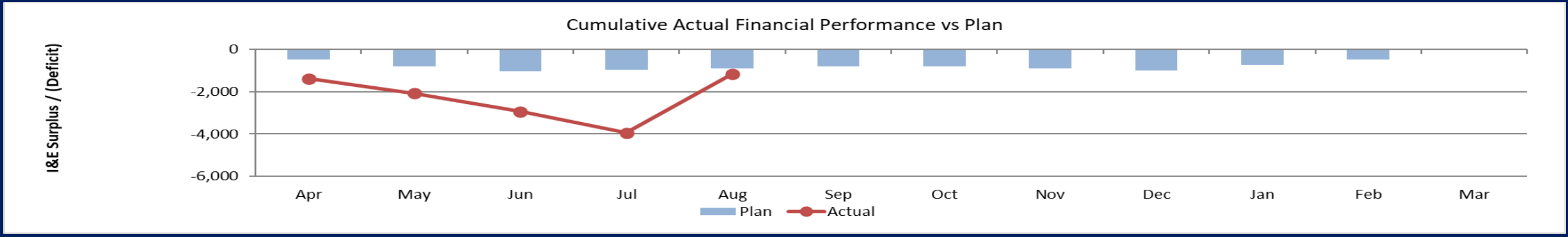
Finance: Achieve Financial Balance

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

Lead Director: Andrew Bertram

Operational Lead: Sarah Barrow

Committee: Resources



Indicator	Target £'000	Apr 25 £'000	May 25 £'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
Meet our obligation to deliver the financial plan for 25/26	0	-476	-820	-1,050	-962	-904	-807	-812	-900	-994	-747	-491	0

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?

- The financial position is deteriorating – current month £0.28m adverse position against a £1m deficit plan (£1.151m actual deficit YTD)
- Control of pay expenditure.
- Delivering the efficiency programme – the planned profile of efficiency delivery is weighted towards the end of the year, at M5 delivery is £4.2m behind plan
- Securing deficit support funding on a quarterly basis – Q3 at risk, 4 metrics to achieve:
  - Overall variance to plan
  - Pay variance
  - Variation against CIP Programme
  - Net risk position

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
- Ongoing increased focus on efficiency delivery
- Deep dive analysis into areas of overspend
- Ongoing recovery plan discussions with ICB

1. EPR Update: Nervecentre Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- Go-live of the first tranche is expected at the end of quarter 1 of calendar year 2026. This tranche includes observations, 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 diagnostic results.
- The team continue to progress the software build with Nervecentre, with focus on the first tranche.
- User Acceptance Testing (UAT) planning is underway. UAT is expected to start in October and continue through to early January.
- EPR Digital Champions are continuing to be recruited to champion the EPR within their wards and specialities throughout the implementation. The EPR Digital Champions network will be officially launched in October.
- Go-live planning continued and will progress over the next few months, with a focus on transition, hyper-case support and business continuity plans.
- Tranche 2 (Order Comms) and tranche 3 (Patient Administration System, Outpatient documentation, Theatres, Endoscopy and eConsent) are also expected to be delivered within 2026. Tranche 3 design sessions have been running over the summer. Tranche 2 will be formally started in October, following delivery of the Trust's new Laboratory Information Management System (LIMS) in September.

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. Have delivered target of 57% in August 2025.

2. Service Reviews - Productivity service reviews completed for neurology, cardiology and paediatrics and a data pack has been developed for each speciality with a focus on key productivity metrics and this this is then presented. MDT workshops are taking place with improvement actions being identified. Improvement plans to be reported back to the productivity group from September 2025.

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 2026. Removing clinics on CPD that are not actively used, focus on booking principles and review clinic template standardisation in line with GIRFT review. Trajectory for removing clinics agreed and to be completed by December 2025.

6. Administrative processes - Project brief developed and approved at executive committee. Focus on patient administration with three key lines of enquiry; standardisation, centralisation (where appropriate) and digitisation. Phase 1 to be completed in Q2 and recommendations to be presented to executive committee in September / October 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. Completed and presented audit in Selby and planning a pilot for electronic outpatient room booking process in Q2 and Q3. Bridlington and Malton audits ongoing.

8. PIFU pathways - Involvement in NHSE PIFU as standard project, commenced with internal task and finish groups. Focus specialities are cardiology, gynaecology and ENT. Cardiology and gynaecology roll out expected from October 2025.

4. Efficiency Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

2025/26 Cost Improvement Programme - August Position											
	Full Year CIP Target	August Position			Full Year Position		Planning Position		Planning Status		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Fully Developed	Plan in Progress	Opportunity
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Total Programme	55,290	14,448	10,220	4,228	15,228	40,063	55,290	0	34,837	20,453	0

Efficiency Delivery

The total Trust efficiency target is £55.3m, £15.2m has been achieved in full year terms and the year-to-date position is £4.2m behind plan.

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, all governance requirements were met.

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.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 September 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 – September 2025

1. I have continued to visit various wards and services at York, Malton and Scarborough Hospitals and nine of our community teams, as well as 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 am delighted that our Council of Governors approved the appointment of Rukmal Abeyeskera as a Non-Executive Director. Rukmal is the nominated person by University of York who will fill the vacancy created by Dr Matt Morgan stepping down at the end of July. Rukmal is of course well known to us in her role as Lead Governor of our Council of Governors. It is likely that Rukmal will formally commence her term of office at the end of October once a new Lead Governor has been elected. In the meantime, I have invited Rukmal to attend all Board events /meetings.

3. The Council of Governors also approved the recommendation made by the appointment panel of Clare Smith becoming our next Chief Executive. She will take up the post on 24th November 2025, two days before our November Board meeting. In the meantime, she is spending 6 days in the Trust to have as many introductory 121s as possible over the next couple of months.

4. All four of our Member/Governor Constituency meetings have been held. Although the number of Members attending is low, those that do attend seem to find the meeting worthwhile and give positive feedback. The timing and venues of this year's meetings have worked well and will repeat next year.

5. Recently the Dept. of Health has published "league tables" of different types of Trusts, and of the 134 acute Trusts we are ranked 118th out of 134 Trusts. This is based on more than 20 different criteria. The main issues that are impacting our ranking are to do with the volume of patients needing our services being greater than our capacity to respond to their needs in a timely way. Even though our costs are in the lowest quartile we are still required to save £50 million and because of this the Trust cannot afford to increase capacity in any significant way. Therefore, the only way forward is for us to become more efficient by having better processes that eliminate waste and reduce non-value adding work. If we could reduce our average length of stay of in-patients by just one day for example it would make a tremendous difference. I see the pressure that so many colleagues experience at work – I certainly do not believe the answer is colleagues having to work harder. Instead, we need improve the way we do things. I absolutely believe that it is the colleagues who work in every team, service and department that know what improvements can and should be made to improve the way things are done (if they need to be done at all) to save time and improve quality at the same time.

6. Jason Stamp has been appointed as Chair of Humber & North Yorkshire Integrated Care Board – he has been the interim Chair since Sue Symington stepped down from that position. Sean Lyons has announced that he will be stepping down as Chair of Humber Partnership (HUTH & NLAG) next month.

7. I had the pleasure of attending the first meeting and launch of the Trust's Quality Improvement Forum. I also had the privilege of presenting certificates to some of our Nurses who had completed their preceptorship and Nurses who are now Registered Nurses having completed their degree apprenticeships. This is an excellent initiative and requires huge commitment and motivation from the participants to complete the degree programme.

8. Sadly, it is the last Trust Board meeting that Simon Morritt will be attending as our Chief Executive. He has served the Trust for 6 years steering it through some very difficult times, none more so than during Covid of course. Huge thanks to Simon for his service and very best wishes to him in the next chapter of his life.

Martin Barkley
Trust Chair
16.09.2025

Report to:	Board of Directors
Date of Meeting:	24 September 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: NHS National Oversight Framework, Planning Framework update, National Inpatient Survey results published, LIMS go live, Integrated Care Board Chair appointment, and the star award nominations received in August and September.

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. NHS National Oversight Framework

The first segmentation scores and associated performance dashboard and league tables from the new NHS National Oversight Framework (NOF) have now been published.

The NOF is the new tool by which all NHS Trusts will be measured. There are 22 metrics within the framework, spread across six domains, which come together to give each organisation a segment rating of between 1 (best performing) to 5.

The results form a league table of NHS Trusts and will be updated and published quarterly, so they will be visible and accessible not just for us, but also for our patients, to see how we are performing against key measures such as access, patient safety and care standards.

We are in segment 4, and rank 118 out of 134 acute trusts. Whilst this is not where we want to be, the metrics used to determine the ratings are reflective of the priority areas we are focused on as a Trust, and as such we have plans in place to make the much-needed improvements in these critical areas.

2. Planning Framework update

The new Planning Framework for the NHS has just been released, reflecting the changes to the planning regime outlined in the NHS Ten Year Plan. At the time of writing we are awaiting further detailed guidance, which we expect to receive imminently, however within the Trust we have already begun our planning process for 2026/27. Key to this is the Annual Business Planning event which took place on 17 September where the Board, alongside the care group leadership teams and other senior leaders, assessed progress to date against the 2025/26 plan and worked collectively on our plan for next year and beyond.

3. National Inpatient Survey results published

On 9 September the Care Quality Commission (CQC) published the results of the 2024 National Adult Inpatients Survey. People were eligible to take part in the survey if they stayed in hospital for at least one night during November 2024 and were aged 16 years or over at the time of their stay.

The results for our Trust indicate a modest improvement in the average experience score from 72.1% in 2023 to 73.9% in 2024.

Overall, the proportion of responses where we score in the bottom 20% nationally remains unchanged at 10 questions, whilst one question placed in the top 20%. The majority (41 questions) remain in the middle 60%.

Several aspects of care saw noticeable improvement when compared with 2023, particularly around the admission and discharge experience.

The report also highlights areas for improvement, for example patients report ongoing issues with noise disturbance and ability to sleep on the wards.

The full results have been shared with the care groups for review through their patient experience groups to identify where actions need to be embedded into the care group improvement plans. The report is also being reviewed to identify
actions that need to be added to the Trust's Patient Experience Improvement Plan.

The full report is available on the CQC's website.

4. LIMS go live

I am pleased to report a major milestone for the Trust with the successful 'go live' of our new Laboratory Information Management System (LIMS) across the Scarborough, Hull, and York Pathology Service (SHYPS).

The new LIMS is a single, shared system across SHYPS, giving us one seamless way of processing pathology tests. For colleagues, it means greater consistency and efficiency in the way we work. For patients, it means safer care and a better experience, meaning no more repeated tests when they move between hospitals and primary care, and a single pathology record that follows them across our Integrated Care System (ICS).

This has taken many months of planning and preparation, and I want to give particular thanks to our SHYPS colleagues, our operational teams, and our colleagues in digital services whose commitment and determination have ensured as smooth a transition to the new system as possible. Thank you to everyone involved.

5. Integrated Care Board Chair appointment

Earlier this month the Secretary of State for Health and Social Care officially confirmed Jason Stamp as the Chair of the Humber and North Yorkshire Integrated Care Board for the next year. He has been Acting Chair since May 2025. Jason has been a Participant member of the Board since its inception and was previously vice-chair of NHS Hull Clinical Commissioning Group. On a national level he was the first independent Chair of NHS England's Patient and Public Voice Assurance Group for Specialised Commissioning.

6. Star Award nominations

Our monthly Star Awards are an opportunity for patients and 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. August and September's nominations are in **Appendix 1A and 1B**.

7. Goodbye and thank you

Finally, this is my last Board of Directors meeting before I retire as Chief Executive. I would like to say thank you to you all, and to former executive and non-executive colleagues, for your support during my time at this Trust.

Clare Smith takes over as Chief Executive on 24 November. I know she is keen to get started, and I am in no doubt that you will afford her the same warm welcome and support you have given me over the last six years.

Date: 24 September 2025

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

August 2025

Sarah Lees, Play Assistant **York** **Nominated by colleague**

Sarah started with the Play Team less than two months ago. Within that time, she has made a profound impact with her delivery and presence towards the patients and staff. Sarah is warm, kind, and welcoming and has so much knowledge. She has made positive changes for the benefits of the patients and is being utilised well.

Bill McIntyre, Patient Services Operative **York** **Nominated by visitor (1) and colleague (2)**

Nomination 1

Bill is one of the PSOs on Ward 34. He is amazing and nothing is too much trouble for him. He does everything he can to ensure patients get the meal they ordered or a substitute if they are sent wrong items or are unable to eat what they ordered. He never stops dashing around. He is friendly and cheerful no matter what.

My partner's mum has been on Ward 34 for ages, and he brightens her day. He makes us all laugh and smile. He remains professional while cheering everyone up.

Nomination 2

Bill is always helpful, polite, and full of energy, consistently going above and beyond in his role. His hardworking and organised approach has made a big difference to the catering staff when serving meals on the ward. He keeps the kitchen area spotless, clean, and well-organised, which helps everything run smoothly. His positive attitude and dedication make him a truly valued member of the team.

Mathew Pepworth, Associate Practitioner **Scarborough** **Nominated by colleague**

Matt is a fantastic member of staff. He always goes above and beyond to make sure all staff are feeling OK. I have watched Matt give CPR many times. After CPR, he always makes sure every member of staff is feeling OK before doing self-reflection and has bags of empathy. He is a selfless person with lots of compassion towards patient care and delivers it to the best of his ability every single day.

Ward 34 Healthcare Support Workers	**York**	**Nominated by colleague (1) and colleague (2)**

Nomination 1:

The healthcare support workers on Ward 34 have truly gone above and beyond to support a young man with a brain injury during his long stay on Ward 34 over the past two months. The patient requires one-to-one support, which is emotionally, mentally, and physically hard work, and has pushed them all to their limits. The need to provide this level of care to this patient for this length of time puts additional pressure on ensuring all other patients are cared for appropriately, but the team has worked non-stop to ensure the standards of care are not affected.

There is no specific support or specialist team to advise to help manage a patient with this condition, and while the team have recognised that they do not have the specific training to support this patient, they have utilised all of their other skills to build therapeutic relationships with him to keep him safe and entertained and progress his rehab when specialist units were not able to manage. The team have shown nothing but kindness, compassion, and resilience during this challenging time, and I am so grateful and proud of them all.

Nomination 2:

As a ward, they have had a bad winter and experienced pressures which have carried on throughout the year. Holding more patients than most wards, this team of healthcare support workers have worked hard to deliver exceptional care and compassion.

Recently they have helped rehabilitate a young patient. The patient came onto the ward non-verbal and behaving aggressively. This team has taken it in their stride and should be proud of themselves. The patient can now talk in short sentences and recognise his behaviours. I have watched the HCSW team teach him new things and now he can count and drink by himself.

As a respiratory ward, you should be proud of yourselves for doing this by yourselves! Exceptional care from the Ward 34 HCSW team, you should be proud of yourselves.

James Ferguson, Emergency Nurse Practitioner	**York**	**Nominated by patient**

I badly injured both feet and ankles after taking a tumble. I went into ED the next afternoon. Jim was caring and professional, explaining possibilities and recommendations clearly and with empathy. He was so efficient too! Thank you, Jim, you were amazing.

Helen Southren, Senior Driver, and Michael Needham, Transport Driver	**York**	**Nominated by colleague**

Over the weekend, we were asked to deliver food from York Hospital to Scarborough Hospital and Helen and Michael volunteered to come in and do this work. It turned out to be a bigger job than anyone had anticipated, but they stuck at it, driving over 250 miles between sites, making sure all food was delivered and ensuring patients' needs were put first.

Jessica Tong, Deputy Sister | **York** | **Nominated by colleague**

Jess is so much more than just an amazing nurse - her compassion and dedication to her patients is inspiring. But what means even more, is the way she shows up for all of us. She makes every person on the team feel genuinely valued, heard, and respected. Working alongside her is not just a privilege, it's a joy.

Sonia Moteea, Specialty Registrar | **York** | **Nominated by colleague (1) and colleague (2)**

Nomination 1:

I am nominating Sonia for her outstanding demonstration of professionalism in every aspect of her work. She consistently upholds the highest standards of integrity, accountability, and respect, serving as a role model to colleagues across the organisation and within ED team. Sonia communicates with clarity and empathy, handles challenges with composure, and always maintains a positive and solution-oriented attitude. This always makes my shift go well, especially during night shifts.

Nomination 2:

Dr Moteea is always kind to patients and their family members. She goes the extra mile to ensure their concerns are addressed. She's an inspiration for all younger doctors.

Ben Williamson, Deputy Team Leader | **York** | **Nominated by colleague**

Ben is a great role model for all. Having originally been a porter many moons ago, through hard work he has achieved much admiration in the department, while still having his feet firmly on the ground. We all appreciate him in the theatres and beyond. Great guy and great team player.

Mark Powell, Operating Department Orderly | **York** | **Nominated by colleague**

Mark has been with the Trust for over eight years and is one of the last remaining original operating department orderlies. He is popular with patients and staff alike, far and wide. He is always happy, cheery, kind, and trustworthy. I want to share my appreciation for mark, for sticking with a sometimes challenging and tiring role, always with a smile.

Maternity Practice Development Team | **Scarborough** | **Nominated by colleague**

Our Practice Development Team have worked tirelessly to create a programme of education and training, ensuring we meet compliance with our regulators and service needs. My experience of undertaking the training week, facilitated by the PDM team, was fantastic. They taught with respect, compassion, and kindness and made sure that everyone got the best out of their training. It was an engaging, educational, and impressive week. Thank you for all you do to support us in learning and developing both individually and as part of a wider MDT.

Emily Maurice, Midwife, Natalie Barker-Dunwell, Specialist Midwife – Antenatal, and Catherine Vollans, Ward Manager – Midwife **York** **Nominated by colleague**

Natalie, Cat and Emily have pulled together as a leadership team to support each other across several sites during staffing shortages in Maternity services. They consistently deliver by working together, ensuring the safety of the service is maintained.

Working together, they have identified processes to guarantee efficiencies and create fail safe measures that can be undertaken, ensuring care is not being missed across any of our sites that they all have access to. I have witnessed team motivation, encouragement, and dividing and conquering amongst the team to play to their strengths during a time of staffing crisis.

I am privileged to work within this team and immensely proud of the positive, kind, and compassionate attitude they have. Thank you all for everything, you are brilliant both individually and as a team.

Jessica Wade, Consultant **Scarborough** **Nominated by colleague**

Dr Wade was the Emergency Physician in Charge when a child presented in a critical condition. Using her wealth of experience and sound clinical expertise, she identified early that the child could have life threatening injuries. She advocated for both the patient and their family through their time in the department.

Jess worked tirelessly to ensure the child received the best possible treatment, navigating difficult decisions and collaborations with different specialities, all while maintaining a calm and reassuring presence. She ensured that she worked remotely with specialist services off-site, including the EMBRACE team to ensure once ready, the patient would be transferred safely to a place of definitive care.

Jacqueline Sanderson and Humberto Reis, Student District Nurses | **Community** | **Nominated by colleague**

I am nominating my two incredible colleagues for the unwavering support they have given me over the past year as I completed my district nursing qualification and the V300 prescribing course.

Undertaking both qualifications while continuing to work in a demanding clinical role has been one of the most challenging periods of my career, but I can honestly say I would not have made it through without their help, encouragement, and belief in me. They consistently went above and beyond to ensure I felt supported, both professionally and personally. From checking in after difficult days, helping with academic work, covering shifts to give me protected learning time, and simply being a listening ear when it all felt overwhelming, their support has been nothing short of extraordinary.

What makes them truly special is that they never made me feel like a burden. Instead, they lifted me up, celebrated every milestone, and reminded me why we do what we do. Their kindness, patience, and genuine desire to see others succeed captures exactly what makes our Trust such a special place to work.

This nomination is my heartfelt thank you to two colleagues who have not only helped me grow as a nurse, but as a person. They are shining examples of compassion, teamwork, and professional excellence, and I can’t think of anyone more deserving of recognition.

Kerry-Anne Carson, Administrator | **Scarborough** | **Nominated by colleague**

I was looking for a colour printer and A3 paper as I am not the most familiar with all of Scarborough Hospital. I passed Kerry in one of the admin offices and asked her for directions. Kerry went above and beyond, taking me to the printing and even giving me a piece of white A3 - a rarity compared to the usual recycled paper.

Later that same day, I appeared again on the hunt for a missing piece of equipment. Kerry took me around the whole department and introduced me to other staff who may be able to help. Despite never meeting me before, Kerry was extremely helpful and kind and couldn't have been happier to help me out. It made me feel welcomed and I was grateful for her support that day. Kerry truly embodies the kindness of the Trust motto.

Joanne Sadler, Midwife | **York** | **Nominated by patient**

Joanne was amazing from the start. I was scared about having a c-section and she reassured me and was so caring. I couldn’t have got through it if it wasn’t for her. She made sure I was OK and kept me calm. She is an amazing midwife, and her dedication, passion, and expertise profoundly impact people's lives. She is a credit to the NHS.

Becca Hunter, Clerical Officer **Scarborough** **Nominated by colleague**

Becca has made a difference by going above and beyond to support the Speech and Language Therapy training workshops. Even with her usual admin workload, she volunteered to take on extra tasks to help make sure everything runs smoothly for the team. She keeps a detailed, colour-coded spreadsheet of all the training dates throughout the year and works closely with the therapists to make sure the right links get shared with participants.

Becca also manages the training email inbox, keeps track of who's attending, and works with the Communications Team to promote the workshops and by sending posts to the relevant settings.

Recently, Becca and Beth found a way to make the whole process easier by using Microsoft Forms for people to sign up, which will save a lot of time. She's done all this while still handling her regular admin duties.

Becca's kindness, openness, and dedication to doing an excellent job really shine through in everything she does, and she's made a positive difference for everyone involved.

Leah North, Specialist MSK Physiotherapist **York** **Nominated by colleague**

Leah has gone the extra mile to provide the MSK team with information, training, and resources to help us to improve our communication with BSL patients. She has organised for the BSL team to come to team meetings and provided individual handouts to individuals who couldn't make the training. These hand outs are also available in clinic rooms. She has gone out of her way to register an iPad for the department to use for BSL translators, which can be easy to use during our busy appointments.

Gillian Locker, Patient Service Assistant **York** **Nominated by colleague**

Gill is relatively new to our team, but is well known to us as her husband, Roy, is a cleaner in ED, and has been for many years. Gill recently transferred from catering, and has already settled in so well, becoming a valued asset to our team.

Change is never easy, but Gill hasn't let that phase her. Watching Gill at work its clear to see the patients love her, she makes friendly chat and treats everyone with dignity and respect and a big smile! Gill often goes above and beyond in her role, taking initiative, seeing a job and getting it done; she is what I would refer to as a "true grafter". If everyone applied Gill's ethos to work, the whole place would be much more efficient.

Play Team **York** **Nominated by colleague**

Leanne, Hollie, and Charlotte helped to organise and support the build-up of a young girl getting to see her mum for the first time in three months due to her mum's critical illness. On the day, Linda pulled out all the stops to greet the family and help settle in the star of the show during her first time inside the hospital. Linda made sure that the little girl and her family were supported to navigate the reunion, turning the day into something everyone was nervous about into the best day. When there was a last-minute hiccup due to being let down by the British weather, the family were welcomed on to the children's ward and into the playroom, which became a fast favourite.

Leanne, Hollie, Charlotte and Linda exemplified the Trust values, showing kindness and compassion to a family that wasn't part of their usual caseload and demonstrating their excellent skills in helping children navigate difficult scenarios. Their help, advice, and support made a nerve-wracking and potentially challenging event into something positive that has helped spur our patient on through the rest of her recovery. As for the little girl, she's armed with her new doctor's kit, courtesy of the Play Team, and is saving all her toys now, and better still, gets to come and see her mum after a long period apart.

Prince Ngwenya, Healthcare Assistant **York** **Nominated by patient**

From the moment I walked on to the ward, Prince made me feel welcome and comfortable. He took my bloods with ease. I didn't even notice the needle go in.

You can tell he genuinely loves his job and is passionate about providing his patients with the very best care. He made a difficult time a lot more pleasant. Prince is an absolute asset to the NHS.

Michelle Cuthbertson, Discharge Liaison Officer **York** **Nominated by colleague**

Michelle works as a Discharge Liaison Officer at York Hospital. One day, Michelle brought a patient down to the Discharge Lounge to wait for transport and medications. We were extremely busy in the lounge and Michelle noticed one of our patients (who was from ED and was waiting for transport) becoming quite vocal, throwing their food around, and hitting out at one of our staff members. Instead of going back to the ward she was working on, Michelle kindly helped, settling the patient, and taking time to calm them down until the transport arrived.

We are not staffed to deal with patients who need one-to-one support when we are busy, and Michelle recognised the situation and automatically helped without being asked. Thank you, we appreciated your support.

Christina Sloper, Healthcare Assistant **York** **Nominated by colleague**

Christina always works hard. She arrives early at work and is ready to start the day. She helps and supports both staff and patients. Nothing is too much trouble for Christina. We have recently had quite a lot of sickness in our team, but Christina has stepped up and been ready to help without complaint. Christina makes such a difference to the team, and I cannot thank her enough.

Children's Therapy Yorkshire Three Peaks Team **Scarborough** **Nominated by colleague**

I would like to nominate the Children's Therapy Yorkshire Three Peaks Team for a Star Award in recognition of their outstanding commitment, teamwork, and dedication beyond their clinical roles. I was proud to be part of the team and to complete the Yorkshire Three Peaks Challenge alongside 11 of my colleagues, taking on a gruelling 24-mile trek over Whernside, Ingleborough, and Pen-y-Ghent.

The challenge was both physically and mentally demanding, with steep climbs, tough terrain, and moments of real exhaustion. But what carried us through was the unwavering team spirit. At every stage, we encouraged, supported, and lifted each other, whether it was pushing through pain, sharing supplies, or simply offering a few words of motivation when it was needed most.

Together, we have raised over £4,200 for our department, with every penny going towards improving therapy services and resources for the children and young people we care for. This experience didn't just test our endurance, it brought us closer as a team and gave a huge boost to morale. It was a true reflection of the compassion, resilience, and collaboration we bring to our work every day. The Children's Therapy Yorkshire Three Peaks Team truly embodied the spirit and values of the NHS, and I believe they deserve to be recognised for their determination, unity, and positive impact.

The colleagues who were part of the team were: Rachel Emerson, Harriet Cousins, Taylor Atkinson, Jessica Simpson, Judith McDowell, Rosie Dyball, Becca Hunter, Cheryl Peplow, Georgie Garry, Abi Saxby, and Hannah Knowles.

Sophie Goodfellow and Chananya Kleaklom-Wilson, Occupational Therapists, and Emma Myers, Physiotherapist **Scarborough** **Nominated by colleague**

Sophie, Chananya (Beam), and Emma embodied Trust values of openness, excellence and kindness with a complex patient on the Orthopaedic Ward.

While providing a good clinical therapy assessment and rehabilitation of a post-op fracture patient, they worked well with family to establish what was important to the patient when he couldn't communicate his needs clearly. They rightly promoted the pathway for an inpatient rehabilitation bed as the patient had demonstrated potential to progress to standing transfers which would reduce the carer need at home and the strain of support for his wife. It would also be more beneficial for the patient to be able to stand and transfer to maintain strength in his legs, pressure relieve and access the toilet more easily. However, the family and patient were extremely keen for discharge straight home.

The therapists were able to engage with conversations effectively, being open and honest that if the patient was discharged as a full hoist there was a significant risk they may not regain standing due to the lack of facilities at home (and the limited community therapy provision in their area) but were also transparent that discharge home may lift the patient's mood. This enabled the patient and family to make an informed decision on their discharge.

Although discharge home came with some risks, the therapists endorsed the Home First principle and were able to negotiate a safe discharge plan, ensuring the family had sufficient carer support. They also went above and beyond with two post discharge visits to ensure the family were trained in the home environment with the equipment they would be using and identifying ways family could support rehab at home while awaiting community therapy to review. They have demonstrated excellent teamwork and patient-centred care daily while working in this speciality, but this example stood out as they supported each other with the challenges the discharge presented, and they considered risks and mitigated them to the best of their ability.

Joanne Severs, Midwife **York** **Nominated by patient**

Jo is an incredible midwife that went above and beyond. She was busy but always found the time to come and check on me and make sure I was comfortable and okay. She ensured that I had the speediest discharge I could have each time I was in hospital with my pre-eclampsia and tried to ensure my continuity of care in every possible way. When my son finally came, she was amazing when helping me with my feeding journey, which has allowed me to carry on with five months of feeding my baby exclusively on expressed breast milk even though his journey started off in SCBU.

Unfortunately, my mum was having a mastectomy at the same time I was in the maternity ward at the same hospital. Jo stepped in and was the mothering figure I needed at that time without even knowing. I will always be grateful for her attention to detail and kindness. She put what I needed and wanted first and tried to tailor the plan around that with what little wriggle room there was, applying logic and all with a sense of humour. She runs a tight ship and is first class!

Jason Angus, Healthcare Assistant **York** **Nominated by relative (1) and colleagues (2)**

Nomination 1:

Jason was the Healthcare Assistant working in paediatric ED. From the moment he greeted us to doing observations and an ECG, he was friendly, warm, and entertaining, not just my daughter, but also to every child there. He brought smiles to children and parents at a stressful time. He made my daughter feel calmer and she hasn't stopped talking about him.

Nomination 2:

We recently collected a child from ED who needed surgery urgently. Jason was looking after them and we thought he was brilliant. He had kept them, and their parents, calm and reassured. He has recently started giving children a 'biscuit barcode' which we thought was brilliant. We could tell how much he loves his job and cares for his patients. He is a credit to ED and deserves this award and recognition.

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

I first met Rachel when I was a newly qualified nurse two years ago. She came onto the ward and introduced herself, as she was a legacy nurse. Rachel not only supported me clinically but emotionally too. Her kindness and openness made me feel like I could contact her when I needed to.

I recently had to ask her for support while performing a procedure, and she was more than happy to help, be patient, and explain everything. I feel that Rachel truly demonstrates the Trust values, and she is asset to newly qualified nurses, all other staff, and patients.

Blood Sciences Team **Hull** **Nominated by colleague**

The Blood Sciences Team at Hull is nominated and appreciated for their teamwork when delivering the acute laboratory service provision during the LabCentre downtime. The on-call staff went over and beyond their roles (staff came early for night shifts and the on-call team had no breaks) and Blood Sciences staff who were not on call for the day came to help at short notice and help organise, collate, and deliver a joint response.

A huge thank you to the entire team for their hard work, professionalism, commitment, and dedication!

Respiratory Secretary Team | **York** | **Nominated by colleague**

I am nominating the Respiratory Secretary Team for a Star Award in recognition of their outstanding teamwork, resilience, and dedication. Despite being short-staffed for several months and recently losing their team leader, the team has continued to support one another and pull together to keep the service running smoothly. They have faced numerous challenges, including ongoing recruitment setbacks and constant change, yet they remain positive, adaptable, and committed to getting the job done.

Their collaborative spirit and unwavering professionalism have been instrumental in ensuring continuity for both staff and patients in the respiratory department. This team truly exemplifies what it means to work together under pressure, and they deserve recognition for their exceptional efforts.

Charlie Turner, Assistant Practitioner | **York** | **Nominated by patient**

I attended Urgent Care following an injury to my knee and had to undergo some x-rays. Charlie was professional and compassionate when she attempted to take the x-rays while working around the limits of the pain I was experiencing. Charlie realised quickly that I was experiencing too much pain to manipulate my leg into the correct positions for x-rays and took me back to Urgent Care where she advocated for me with the medical staff to get stronger pain relief and transfer to a trolley.

She waited with me while the pain relief was administered and then wheeled me back to x-ray, where the x-rays were successfully taken. Charlie was also working with a radiology student that day and she communicated her assessment of the situation to him clearly. I want to thank Charlie for her kindness and excellence in her care towards me.

Kirsten Power, Healthcare Assistant | **York** | **Nominated by patient**

I had an appointment at the Orthotics Department, Belgrave Street, a five-minute walk from the Neurosciences Department. I cycled to Neurosciences with the intention of leaving my bike locked there for security.

After arriving on my bike, my MS symptoms of mobility difficulties flared up. The pain was so severe I walked in with difficulty. There I was met by Kirsten who immediately could see that I was in pain and distress. She helped me to a seat and got me a cup of water. I explained that I had the orthotics appointment. Kirsten helped me to my feet and she without went the extra mile, helping by me to slowly walk, supporting me so I didn't fall. Kirsten was kind, reassuring, caring, understanding and supportive of my needs. She remained with me throughout to my appointment until the staff took over from Kirsten.

I can't thank Kirsten enough for her help. She went above and beyond her day-to-day role and it would be nice for Kirsten to be recognised for a Star Award for her caring, supportive help and assistance with myself as a MS patient.

Emergency Department Nurses **York** **Nominated by patient**

I was in ED when a mother and her young child were brought in. The mother was in quite a bit of pain and distress. The child was physically well but worried about their mother. The nursing staff were wonderful to witness help. They ensured the child had a magazine (Disney's Frozen, I believe) as a means of distracting them. They also made them a certificate of bravery. I wanted to acknowledge their kindness and the ways in which they tried to quell the child's distress.

Adele Kakundi, Staff Nurse **Scarborough** **Nominated by colleague**

I would like to give recognition to Adele Kakundi. I worked a night shift with this Staff Nurse last week, while doing a bank shift on Cherry Ward. We had a patient that was low in mood and didn't want to be here anymore. They had refused all cares, medication, observations, and blood sugars to be done (they were diabetic, and their blood sugar had been too high previously). They had even stopped talking to anyone and became defensive at questions.

Adele sat with this patient, talking to them several times at length and patiently listening to them talk about many issues. She was kind, considerate, and took time to listen to them. She got medical help when the patient suggested that they might harm themselves. She went back several times to talk and reassure the patient.

By the end of the shift, they allowed us to do all their cares, medication, observations, and blood sugars, and were in a better place mentally. They even thanked us both for everything that we did. This nurse was thoughtful and kind. It is nice to see she took the time with this patient, listened, and acted on the information she was given. She is a credit to the job and to this Trust.

G1 Nurses and Healthcare Support Workers **York** **Nominated by colleague**

No matter the challenges, whether they be a new speciality, staff shortages, increased patient demand, or complex patients, this team is consistently steps up and ensures their patients are receiving a high standard of care. They support each other and go above and beyond to make their patients feel heard, valued, and well looked after. This nomination is a recognition of not just for a single moment, but the everyday commitment and hard work that define a team.

Amrutha Sajeev, Staff Nurse **Scarborough** **Nominated by colleague**

Amritha is always willing to help others better themselves. She has always got a big smile on her face and is happy to help anybody who needs her.

Nicola Lloyd-Jones, Lead Diabetes Nurse **York** **Nominated by colleague**

Nic, your dedication, hard work, and compassion to patients is second to none. You work tirelessly during and outside your work hours to ensure our obstetric diabetes patients are all adequately cared for across both sites. I was deeply touched by your recent email to the whole team across both sites, summarising what had been done for each patient and what was outstanding with clear instructions. You always go above and beyond. Thank you for all that you do, Nic. Cheers.

Georgina Ford, Temporary Staffing Recruitment Assistant **Scarborough** **Nominated by colleague**

Georgina always answers the phone with a smile in her voice. She is consistently beyond helpful, and nothing is too much trouble. I would love for her kind professionalism to be recognised as she demonstrates Trust values daily.

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

Nicola is always helpful, polite, and a pleasure to work with. She consistently goes above and beyond, bringing a strong work ethic and a well-organised approach to every shift. Her support has made a big difference to how mealtimes run, improving both efficiency and the overall experience for staff and patients. A truly valued member of the team.

Jenna Hallam, Catering Assistant **York** **Nominated by colleague**

I would like to nominate Jenna for her dedicated work ethic and consistently positive attitude. She is always helpful and polite and goes above and beyond in everything she does. Her commitment and professionalism stand out, and she brings real value to the team each day. A true asset to the department.

Kayleigh Forrest, Catering Assistant **York** **Nominated by colleague**

I would like to nominate Kayleigh for her dedicated work ethic and consistently positive attitude. She is always helpful and polite and goes above and beyond in everything she does. Her commitment and professionalism stand out, and she brings real value to the team each day. A true asset to the department.

David Sellers, Catering Assistant **York** **Nominated by colleague**

I would like to nominate Dave for his dedicated work ethic and consistently positive attitude. He is always helpful and polite and goes above and beyond in everything he does. His commitment and professionalism stand out, and he brings real value to the team each day. A true asset to the department.

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

Rachael’s continued support, professionalism, and patience make a real impact on those around her. She is hardworking and committed and consistently goes above and beyond in her role. Her ability to teach and guide others is a real strength, and she leads by example every day. A truly valued and respected member of the team.

Mike Szpak, Staff Nurse **York** **Nominated by patient**

I was admitted to SDEC with sharp short breaths. Walking onto the ward, Mike quickly reacted to my distress. He was attentive and, although I was in a large waiting room, he kept an eye on me the entire time while running round busily. I began to deteriorate, so he went out of his way to get me on a trolley and quickly had new medication prescribed to stop me from being sick.

Now this may seem like his job as a Staff Nurse, but he truly went beyond with his kindness and compassion. This was a gentleman who is a true credit to the NHS. He put me at ease and explained everything step by step to keep myself and my children calm during a distressing time. The NHS should model their pillars of behaviour on him. He never stopped the entire time I was in there and even stayed beyond his finish time to fetch different anti-sickness medication from another ward. Thank you from a grateful patient.

Dave Donaghy, Patient Services Operative **Scarborough** **Nominated by colleague**

David goes above and beyond for all the patients on Oak Ward to ensure that they are happy and comfortable, catering to all their needs no matter how big or small. He is enthusiastic and takes his job role seriously. I would love for him to see how much he is appreciated by all the staff on Oak Ward.

Maria Gonzales, Staff Nurse **Scarborough** **Nominated by colleague**

Ethel (Maria) is a wonderful nurse. She is always at hand to offer support to both colleagues and patients alike. She has such a positive outlook and sunny disposition that is contagious amongst her teammates. She goes above and beyond every day and I would love her to know how valued she is.

Gemma Nichols, Principal Pharmacist **Scarborough** **Nominated by colleague**

Oxygen is a drug, yet it is readily administered without a prescription. As a Respiratory Team, we have discussed and highlighted the importance of prescribing oxygen but there have been many barriers to this. Gemma has worked with such enthusiasm, excellence, and understanding, managing to overcome these barriers to successfully launch automatic oxygen prescribing on EPMA (CPD).

We know it has been successful as it appears to have been absorbed into daily practice without any issues or concerns. On the first day of being in place, Gemma reported "The benefit is clear already. As of lunchtime today, there are 190 patients across the two main Trust sites with an oxygen prescription on EPMA, compared to 68 patients before the changes were made this morning."

I cannot express my gratitude enough. This will have a huge effect on patient safety (oxygen is a drug with side effects) and staff confidence when prescribing and administering oxygen. I should of course say that Gemma is kind in her approach and caring in her attitude, but, beyond doubt, excellent at her job. This advancement in oxygen prescribing is so far reaching in keeping both patients and staff safe, that Gemma should be recognised for the work she has done. Thank you, Gemma.

Joel Spink, Trust Grade Doctor **York** **Nominated by relative**

I brought my 9-year-old daughter to Ward 18 to see an ENT doctor as she had an earring embedded in her left ear. She had been referred to ENT the previous day after she had been seen in minor injuries (where they had successfully removed the right earring and tried to remove the left one without success). She was scared and nervous as her experience the previous day had been quite traumatic.

Dr Spink was kind to her and put her at ease immediately. His demeaner was so calming and he explained everything that was going to happen in an age-appropriate way. She had the earring removed successfully and she thought Dr Spink was wonderful. She said he was the best doctor she had ever seen! I want to say a massive thank you to him as he turned what was a traumatic experience of hospitals into a positive one. Thanks again!

Sharon Farrow, Clerical Officer **York** **Nominated by colleague**

Sharon received a call from a patient who wanted to cancel their appointment as they had been declined patient transport, and they had no other way of getting to the hospital. The patient is disabled so is unable to use public transport, and they could not afford hundreds of pounds for a taxi, so they were emotional.

Sharon went above and beyond by speaking to patient transport to get more information about why they did not qualify to help the patient understand. She then put them in touch with a local charity who provide heavily subsidised hospital transport for appointments. Due to Sharon's actions, the patient now has a way to attend their appointment.

Sarah Gill, Administrative Co-ordinator **Scarborough** **Nominated by colleague**

Sarah is always professional and helpful. She will strive to answer questions and queries with patience and accuracy. She never complains and will do her best to help, even when I send numerous emails with numerous questions. I wouldn’t be able to support my staff without Sarah navigating me through the systems. Thank you, Sarah, I appreciate your help.

Sandra Milner, Compliance and Development Coordinator **York** **Nominated by colleagues**

I am nominating Sandra Milner for a Star Award in recognition of her outstanding dedication, professionalism, and positive impact on the team. Sandra is consistently helpful, reliable, and approachable, always going above and beyond in her role. Her calm and kind nature makes her a pleasure to work with, and her attention to detail ensures that high standards are always maintained.

Sandra’s support has made a real difference, especially during busy and challenging times. She demonstrates initiative, excellent teamwork, and a genuine commitment to providing the best possible service. Her presence brings stability and reassurance to those around her, and her contribution does not go unnoticed. She truly deserves recognition for everything she brings to the team.

Jimmy Cooper, Training Team Lead **York** **Nominated by colleague**

I occasionally work at a desk near Jimmy. He is always keen to offer his assistance when I ask him many questions and is helpful and kind. He never gets frustrated and remains calm and generally solves my problem, whatever that may be, from computer issues to information I am trying to locate. I know this is the same when Jimmy is dealing with other members of the Trust regarding learning issues or questions they may have. Jimmy remains calm, helpful, and kind and strives to answer questions they may have or solve their issues. Jimmy is a credit to the Trust's educational team and deserves a Star Award, so he knows how much his knowledge, patience, and kindness is appreciated.

Sonia English, Advanced Clinical Specialist Dementia and Frailty **York** **Nominated by colleague**

Sonia has gone the extra mile over the course of the past year in what had been a challenging time for our Elderly Therapy Team. Sonia had combined her Advanced Clinical Specialist role across the hospital and community sites, helping acute wards that had been chronically short-staffed. She has been a shining light the past year and always had a smile on her face.

Sonia is a walking and talking example of how our Trust values should be lived. She is kind and will always listen if anyone has an issue, no matter how trivial or insignificant. I can testify to this as she has listened to me babble on many an occasion. She is open and will always offer constructive feedback in an honest and sensitive manner. She provides excellence in everything she does and will encourage and support our junior members of the Elderly Therapy Team strive to be the best version of themselves.

Sonia is the perfect example of how a member of our Trust should behave and we are fortunate to have her in the team. She deserves a Star Award for turning up every day and providing amazing care, support, and education to all patients, staff, and colleagues within our hospital teams.

Stephanie Tay, Senior Pharmacist **York** **Nominated by colleague**

Steph makes work life easier. She is the nominated pharmacist for Cardiology at York. She regularly reviews patients on CCU and Ward 32 and she'll amend prescriptions where required as she is a prescribing pharmacist and highlight issues she cannot sort.

During the industrial action, she was a massive help by ensuring EDNs were completed in a timely fashion and the drugs came up to the ward quickly so we could get patients home. She is always kind to others and incredibly helpful. I have frequently rung her to source IV medications to allow diagnostic lists to go ahead and she has sorted it, so we did not have to cancel the lists. Her work is of the highest standard, she is excellent in what she does.

Suzi Greening, Community Midwife and Midwife Sonographer **Scarborough** **Nominated by patient**

In November 2024, I was 39 weeks pregnant, and my mum was put on end-of-life care. I broke down to Suzi at my midwife appointment. She was so kind and considerate, and helped me to push for an induction to get my baby here while mum was still alive.

I didn't need one in the end as baby came the next morning, however, Suzi arranged for the midwives on shift to allow me to take baby to the second floor to meet my mum, and, luckily, I was discharged the same day. Mum passed away four days later, and Suzi went above and beyond to check myself and my baby were OK. I never got the chance to thank her properly. She deserves some appreciation!

Communications Team **York** **Nominated by colleague**

I'd like to nominate our incredible Communications Team for a Star Award in recognition of their consistently outstanding contribution to the Trust. This small but dynamic team works with relentless dedication, juggling day-to-day responsibilities alongside fast-moving priorities and emerging issues - often at pace and under pressure. Yet, no matter how busy things get, they never lose sight of the importance of recognising and celebrating our people.

A perfect example of this is their behind-the-scenes work on our annual Celebration of Achievement Awards. This year alone, the team has carefully managed more than 250 nominations - proofreading, logging, editing, and crafting communications to ensure every single colleague or team receives a personal email recognising their nomination. It's thoughtful, kind work that reflects the very best of our culture.

The event itself is a true highlight in the Trust calendar - polished, seamless, and inspiring. But what most people don't see is the sheer volume of planning, creativity, and care that goes into making it all happen. The team never seeks the spotlight, but their contribution is enormous.

In every aspect of their work, they show kindness, openness, and excellence. They bring people and stories to life, help build pride and positivity across the organisation and truly go the extra mile - not just for patients and the public, but for all of us. They deserve to be celebrated every bit as much as they celebrate others.

Emergency Department **York** **Nominated by patient**

The doctors in the Emergency Department took exceptional care of me. They monitored my ECG regularly (every couple of hours) and identified that I was in a critical condition. Thanks to their prompt assessment, they coordinated with Leeds General Infirmary (LGI) for an urgent procedure. I was immediately transferred from York to the LGI lab. The procedure was successfully completed within 30 minutes.

Before I was sent to LGI, one of the ED doctors noticed that my blood pressure remained dangerously high at 197 and wasn't coming down. He recommended increasing my Nitrolingual dosage from 0.6 to 1.2. This was a crucial observation as it helped reduce my pain and made it possible to proceed with the STEMI procedure at LGI without delay.

Throughout my stay, I felt genuinely cared for by both the doctors and nurses. I could see in their faces the concern and dedication; they truly wanted me to recover and undergo the STEMI procedure safely and successfully.

I have a long list of responsibilities yet to fulfil, and an unexpected, unplanned death would have been devastating for my family. My wife and I are parents to four children, including our daughter who is in her third year of medical school. I've now returned to normal life, but I'm committed to taking better care of my health, for myself and my family.

Gayle Wiggins, Healthcare Support Worker, and Kirsten Finn, Nursing Band 7 **Community** **Nominated by colleague**

Kirsten and Gail are supportive and caring people. They go above and beyond even when there are no appointments left to look after patients and squeeze them in to ensure they are getting the correct treatments without delay. They are supportive of educating others and work well with partner agencies, such as general practice. They are always approachable and going the extra mile.

Dawn Turner, Healthcare Assistant **Scarborough** **Nominated by patient**

I visited the hospital while on holiday with a heart condition. I'm probably the most squeamish patient you've ever had. Dawn made me feel calm and looked after me throughout the entire experience. Credit also needs to go to the ED staff and SDEC staff. Thank you all so much!

Rodelyne Demaisip and Cyndrella Christian, Staff Nurses, Andrew Gaskell and Donna Coop, Healthcare Assistants, and Joanne Fisher, Senior Healthcare Assistant	**York**	**Nominated by colleague**

These individuals all demonstrate the Trust values of kindness, openness, and excellence. They worked amazingly as a team when we had a medical emergency that required all hands-on deck. Each staff member delegated, escalated, and communicated well to ensure the patient was the number one priority. When the specialist teams came, they were happy with the teamwork shown and the organisation. You all ensured to check in on one another afterwards, which shows how great of a team you all are. I am proud of every single one of you. Well done!

Kirsten Mack, Consultant in Paediatrics	**Scarborough**	**Nominated by relative**

I am to nominating Dr Mack for the incredible care and compassion she showed to our family during what was one of the most frightening and overwhelming times of our lives. For some time, I felt like something was wrong with my baby. As her mum, my gut instinct told me something wasn't right but despite raising concerns, I was repeatedly dismissed by another Trust. I started to question myself and carry the guilt that maybe I was overthinking, even though deep down I knew something was wrong.

When we met Dr. Mack, everything changed. She took the time to really listen to me, without judgment or rushing. She was calm, kind, and reassuring, and within that first assessment, she carried out an echocardiogram. It was then that she diagnosed our daughter with heart failure and a heart defect. It was a lot to take in, but at the same time, it was a relief to finally have someone acknowledge that my concerns were valid and more importantly, take immediate action. Dr. Mack not only made sure our baby got the urgent care she needed, but she also supported us as parents. She spoke to us in a clear, professional, and incredibly compassionate way. I remember breaking down and asking if I'd done something wrong, if it was somehow my fault. Her response was so gentle and reassuring. She helped ease the heavy mum guilt I'd been carrying for so long.

We'll never forget what she's done for our daughter and for us as a family. Dr. Mack is everything you'd hope for in a doctor: knowledgeable, calm under pressure, genuinely kind, and deeply caring. She made an enormous difference to our lives, and I can't thank her enough. She absolutely deserves to be recognised. We are still under Dr Mack's care for our baby and know we will all be looked after.

Ann Taylor, Healthcare Support Worker	**York**	**Nominated by colleague**

While on a night shift on Ward 14, I could hear a patient shouting from Ward 11. I went over to see if everything was OK and saw Ann going into the room with the patient. From outside I could hear her talking to the patient. Ann provided comfort to someone who was confused and scared. She was reassuring and made sure the patient felt safe and heard. Her comforting words and caring attitude helped the patient in a time of distress. She stayed with the patient for a long period, making sure they were comfortable and had everything they needed. Her kindness helped the patient during a difficult time.

Jezz Kipling, Facilities Supervisor | **Malton** | **Nominated by colleague**

Jezz is always happy and smiling. He does everything he can for patients and staff, taking his time to make everyone feel welcome and looked after.

Chris Hagyard, Colorectal Cancer Pathway Navigator | **York** | **Nominated by patient**

Chris has been helpful, has a kind and friendly voice, and was just what I was needing. He listened to my queries and then tried to give me the answers I required in a timely manner. I feel he went above and beyond for me by keeping in contact, checking back with me, and ensuring my wellbeing, so, I would like to put him forward for recognition.

Tracey O'Brien, Healthcare Support Worker | **Scarborough** | **Nominated by patient**

Tracey took my bloods, ECG, and blood pressure pre-operation. I have a considerable medical trauma response, and my anxiety was incredible when walking into the department. I am autistic and was terrified of having bloods done.

Tracey had a refreshingly good and positive outlook to the care of her patients. She met all the professional standards for equality, diversity, and inclusion with a beautiful empathetic touch. I hardly felt the blood being taken and I have no bruise. I would love if all staff could have her understanding, level of professionalism, and empathy. She is a credit to her profession and the hospital.

Mark Warwick, Cleaning Operative | **York** | **Nominated by patient**

I was an emergency admission on Friday and due to go home on Sunday afternoon, but wasn't quite well enough, so, instead, I was transferred to Ward 11. I noticed the soap dispenser in the toilet of my bay was broken and only a pump bottle of hand sanitiser was available, but you can't wash properly with sanitiser.

Mark was cleaning the floor next to my bed the next morning and I made polite conversation and thanked him. Cleaners do a vital job and rarely get acknowledged. I mentioned the lack of soap, and he immediately put down his mop, checked the toilet, went to the stockroom, and came back with a new litre bottle of mild skin wash and asked me if it was what I wanted.

I was then heading for a wash and commented in passing that there was never anywhere to put clothes and bags in the cubicles, so he moved a plastic chair into the toilet area and showed he me how to get both hot and cold water out of the mixer tap. All these small things allowed me to have a good wash and clean my teeth with ease, making me feel so much better.

Mark's kindness has been of benefit to everyone on my ward. Later that day he stopped off just to ask me if the soap was OK, which it was. I appreciated Mark going that extra mile for me, he's a star!

Nichola Burdett and Elisabeth Hall, Palliative Care CNSs, and Martin Hammond, Chaplain | **York** | **Nominated by colleague**

A patient receiving end-of-life care in ICU expressed a wish to marry their long-term partner, something the couple had spoken about for many years but had never arranged. With the patient's condition deteriorating quickly, time was very limited. Nicky and Lissy discussed the possibility with the patient and their partner, and once both agreed, they contacted Martin from the Chaplaincy team for advice. Together, they coordinated with the patient's consultant and the local registrar to fast-track the arrangements, navigating the necessary processes and paperwork.

Thanks to many hours of collaborative work between clinical teams, chaplaincy, and the registrar's office, the couple were able to marry that same evening in ICU with family present.

This was a touching example of teamwork, compassion, and a 'can do' approach to patient-centred care.

Oreal Cummins, Community Midwife | **York** | **Nominated by patient**

Oreal came to see us for our first home visit following the birth of our little girl. Oreal is a ray of sunshine and is perfect at her job. She is kind, friendly, and knowledgeable. Thankfully, I was feeling well when she came to visit us, but I know that if I hadn't been feeling well, then by the end of her visit I would have been. Oreal's happy, smiley nature is infectious, and she leaves you feeling happy and optimistic. I'm so grateful that Oreal came to see us during those strange, early post-partum days.

Rachel Hand, Community Midwife | **York** | **Nominated by patient**

Rachel was my Community Midwife during my pregnancy with my little girl. I appreciated the care, guidance, and reassurance Rachel gave me, especially as I am quite an anxious person. I normally get anxious about any medical appointment, but I didn't feel this way about my appointments with Rachel. Now that I have been discharged, I think I will miss the appointments! Thank you for everything, Rachel, I will be forever grateful for everything.

Hawthorn Ward **Scarborough** **Nominated by patient**

I am nominating the team working on Hawthorn Ward on Wednesday 25 June 2025. I had an elective c-section on this date, and I was scared. The care I received from all the staff was kind, caring, and understanding. My midwife, Kay, was lovely and looked after me, my partner, and our little girl. Even though I was nervous, she made me feel safe and always cared for.

I also want to thank the theatre staff that helped with my daughter's delivery. Unfortunately, I don't have all their names, but I appreciate them all so much. I struggled with the epidural, but Kay and the theatre staff, Nik and Liz, were kind and kept me talking so I was distracted. They never made me feel silly for being scared. (Sorry, Nik, for squeezing your hand so hard!) I look back on my little girl's birth fondly now because I felt cared for and everyone was lovely.

I would like to thank the midwife, Sophie, and the healthcare assistants working the night shift of the 25 June as they helped me so much. As a first-time mum, I didn't know what to expect or what I was doing, but anytime I needed them, the staff came to help me with patience and lots of kindness. Thank you so much to everyone that helped with the birth of our little girl, we will be forever grateful.

Jessica Savage, Perinatal Mental Health Midwife **York** **Nominated by colleague**

Jess works incredibly hard in her role, supporting women and families who may feel they need extra input during their pregnancies and beyond. The main reason I want to nominate her is because of her approach to supporting staff members. She is always contactable and genuinely cares about her colleagues and the women. She has an amazing aura about her and makes people feel safe when she is around. She listens, talks, and understands, and she will go out of her way at any time to ensure people are safe. Her kindness and compassion run through everything she does, and I could honestly not think of a better person to fit her role.

Amy Herrington, Staff Nurse **York** **Nominated by relative**

My husband was brought to ED by ambulance with a heart problem. ED was busy that day, but the whole experience was flawless. My husband and I were seen quickly, kept informed of what was going on, and treated with the utmost courtesy and compassion. Amy was outstanding not only in her care of us, but in her organisation of the department and other team members. Amy was amazing and always had a smile and time to speak to people, even though she was busy. A credit, not only to the department, but to York Hospital.

Jayne Lenighan, Bank Staff Nurse **York** **Nominated by colleague**

I have worked with Jayne few times. She always goes beyond and above for our patients who come in the clinic. She takes the time to explain and show to all patients who are coming to see her what type of exercises they need to do to relieve the pain and how to use correctly the wrist splint. Jayne is an asset to the team, and she is a lovely person to work with. Thank you for all you do.

Andrea Wall, Endoscopy Coordinator **York** **Nominated by colleague**

When contacting a patient to book them for a procedure, she was advised that there was a Power of Attorney in place, however it was not registered. Andrea took time and used her own personal experience to advise the patient and their family on how to register it. It has now been done and is on CPD, which will take away the frustration and stress for the patient, their family, and any healthcare worker trying to speak with the patient. Andrea went above and beyond.

Donna Graham, Advanced Care Planning Coordinator **Nelsons Court** **Nominated by colleague**

Donna was called by a patient's relative. We had discharged the patient a year ago and we would normally ask for a referral from the GP back to our service. However, after listening to the relative, Donna, despite not being medically trained, was able to establish that the lady sounded acutely unwell and that she may require help urgently.

Donna took the details of the lady and rang me as the triage nurse that day. She asked me if it would be possible to ring the relative as she felt the lady was too unwell to wait. After calling them and the patient it was established that she needed an urgent admission for a possible infection as she was on palliative chemotherapy.

Donna assessed a situation well and recognised that the person required urgent action. She went outside her role and was kind and understanding to the relative who had tried all other sources for help and had not had a response. Although Donna is not medically trained, she understood the need to escalate this quickly outside of agreed processes and went with her instinct, showing kindness compassion, and care.

Jess Latchford, Cystic Fibrosis Specialist Nurse **York** **Nominated by colleague**

I am nominating Jess for a Star Award for her consistent excellence in patient care. Jess in an excellent nurse who is always striving to improve and develop her clinical knowledge so she can support patients who receive their care at the York and Hull Cystic Fibrosis centre. She has an incredible ability to develop a rapport with our diverse range of patients and is always the one member of the team who can make a breakthrough with a patient who is struggling to engage or is feeling overwhelmed by their cystic fibrosis.

If I hear a patient laughing aloud, I know that they are with Jess. She is always appropriate, sensitive, and responsive to the patient's needs. I am consistently impressed with her incredible nursing and care.

Deborah Goldfield, Specialty Doctor Emergency Medicine | **York** | **Nominated by relative**

Debs was truly amazing! We have had quite a few trips to the hospital recently with my Mum due to her cancer and memory issues, and, on this occasion, Debs made my mum feel so cared for. Debs spoke in real terms, listened to what we had to say, and made my mum feel at ease. She did anything and everything to help my mum and we are forever grateful for her assistance and professionalism.

In my 39 years of life, she provided the best service I have ever seen within the NHS. Along with the team working alongside Debs (sorry I didn't remember all the names), she proved how important the NHS is and that in hard times we can still have faith in you all. You could see how much Deb cared for her patients, even to running over as we were leaving to check we were happy with everything. People usually don't have time to do this, but she made sure she made the time.

My mum's health means sadly she won't make a full recovery, but Debs put a smile on her face on this occasion. She doesn't like going to hospital and gets agitated, but this time she was so at ease. Thank you from the bottom of all our hearts. you certainly deserve to be recognised!

Dawn Rhodes and Denise Plowman, Healthcare Assistants | **York** | **Nominated by colleague**

Dawn and Denise make a consistent effort to help patients out of bed, helping to prevent deconditioning on Ward 36. Both are proactive and caring, promoting independence and autonomy. Their help has been incredibly beneficial while the therapy team have been short-staffed on Ward 36.

Paediatric Emergency Department Team | **Scarborough** | **Nominated by colleague**

Following the admission of a child to ED. external safeguarding agencies have asked us to emphasise and reiterated the exceptional care and compassion shown by the Trust, particularly the ED staff. The Tees, Esk and Wear Valleys Trust Matron wanted this recognised as she has had a lot of contact with EDs nationally in her role and has cited the experience in Scarborough as the best she has come across. The CAMHS team have remarked that staff treatment was exceptional and wanted to thank the team for their care and professionalism.

Eye Clinic | **York** | **Nominated by patient**

I am a member of staff who found myself at work with a sudden and awful pain in my eye. I noticed redness and pain, so I went to the Eye Clinic to ask advice on where I should go. I was seen, diagnosed, and given a prescription within 30 minutes. They were amazing, friendly, helpful, and kind. What a great team.

Rehan Nazir, Audiologist **Selby** **Nominated by colleague**

Rehan went above and beyond to help a patient before his shift started. The patient didn't have an appointment but was having trouble using a recently changed hearing aid. The hearing aid was hurting their ears and making them feel dizzy. The patient was going on holiday the following day and didn't have time to get used to the new aids or get another appointment. Before Rehan's intervention the patient was dreading going on holiday, but they left the department with a smile on their face.

Julie Page, Cleaning Operative, and Wendy Purvis, Heart Failure Administrative Assistant **Community** **Nominated by colleague**

Julie and Wendy are both incredibly talented creative individuals. Wendy creates the most amazing works of art with acrylic and/or watercolours and Julie does beautiful embroidery. Inspired by their skills, I sort permission to set up a local talent display in our building and decided to run a creative day for the rest of the building to bring them a little creative wellbeing.

Wendy and Julie both fully supported this and gave up their own time and provided resources to help other staff have a lovely time and realise that they too can enjoy a little creative therapy. Their kindness and support helped make the day a success and I know all that took part are grateful. I wanted to nominate them as a thank you and so they realise how much of a positive difference they have helped make to their colleagues through their efforts.

Lizzie Verity, Labour Ward Coordinator **York** **Nominated by colleague**

Where do I begin? Lizzie is the star of Labour Ward. As a student and junior member of staff, Lizzie has never failed to be the most supportive coordinator we have. Lizzie is calm and collected, supportive of staff learning, and the most encouraging and reassuring person to turn to on shift. It is a sigh of relief knowing you are on shift with Lizzie. I know I am not alone when I safe I feel exceptionally safe with her support.

As a midwife, Lizzie is aspirational; her gentle manner with woman is so genuine and kind and she is a joy to all the women in her care and in our care when she is coordinating. Whilst I am at the beginning of my career, if, one day, I am even half the midwife Lizzie is, I'd feel fulfilled and accomplished. After endless support from Lizzie setting out in my career, it means a lot to me that she believes how wonderful she is!

Helen Hope, Ward Sister **York** **Nominated by patient**

Helen was so supportive to us as we have attended EPAU on more than one occasion and both times with different outcomes, but the same level of anxiety. Helen was honest, level-headed, kind, and considerate and made sure she communicated effectively with us throughout the whole experience. We couldn't have had a better experience thanks to Helen.

Dawn Lowe, Patient Admin Officer **York** **Nominated by patient**

I am nominating Dawn for her exceptional service and unwavering dedication. During a recent phone conversation regarding issues with my appointment, Dawn went above and beyond to ensure everything was resolved efficiently and with genuine care. Her professionalism was immediately evident, she was polite, patient, and incredibly reassuring throughout the call.

Dawn took the time to listen carefully, fully understand the situation, and followed through until everything was sorted, keeping me informed at every step. Her manners were impeccable, and her calm, friendly tone made what could have been a stressful experience feel completely manageable. It was clear she genuinely cared, and her strong work ethic shone through in her determination to help. Dawn is a credit to the NHS, and I'm truly grateful for the support she provided.

Anna Vale, Midwife **York** **Nominated by patient**

I came in for a labour induction on the Friday and on the Saturday, Anna took over my care and helped deliver my second beautiful daughter. She went above and beyond for me throughout the whole process. She was calm and collected and she made me feel comfortable and at ease. She is a one-of-a-kind midwife. I want to say a huge thank you to her and the rest of the team that was on that day and night. You are all amazing! Thank you so much!

Subashini Vasudevan, Staff Nurse **York** **Nominated by colleague**

I had a lady coming in for a PICC line to be inserted, but she could speak very little English, and her husband translated everything for her. I wanted her to have an information leaflet specific to her own language so that she would be able to read this for herself in her own time, so I looked at the Macmillan website for this. Unfortunately, they did not have this lady's particular language, so I copied the information into Google Translate.

Being of a suspicious mind, I wanted someone who knew the language to check it for me, and, after asking around, I was given Subash's name. She willingly looked it over for me and shook her head, it was indeed 'gobbledegook'. She took the original information sheet home with her and spent her evening translating the information leaflet for the lady, carefully adapting it to her regional language. She then emailed it to me so that I could give this information leaflet to her before the line insertion, and I could see the gratitude in the lady's face when she realised it was translated especially for her.

Subash went above and beyond for a patient she didn't know, but her actions made the lady feel included in her treatment process, for which she was appreciative.

Sarath Vayolipoyil, Trust Doctor General Medicine **York** **Nominated by colleague**

Dr Sarath has shown kindness towards patients and has always had a respectful attitude towards all members of staff. He is also exceptional at showcasing his clinical skills and troubleshooting medical issues on the wards.

Gregory Heath, Consultant in Ophthalmology **York** **Nominated by patient**

I would like to nominate Mr Heath for a Star Award because I have received impeccable care from Mr Heath and the whole of the Urgent Eye Centre at York. Since I started with a problem in my left eye over a year ago, I have experienced thorough treatment during all my appointments at the clinic. I have been treated with care and understanding and it did help to restore the normal sight in the eye, although I was advised that the problem could recur at any time, and I was given urgent contact details should this happen. This gave me peace of mind.

The problem did occur again, and I had to return to the clinic a few months later. I was then seen by Mr Heath. During this time, I had been suffering from other medical issues including painful inflammation of the knee and other joints. Mr. Heath listened to my concerns about the inflammation in the rest of my body and saw that it may be affecting my eye. He promptly arranged extensive tests to try to establish the cause. This was the first time that any medical practitioner I have seen recently has taken the care to look further into the possible causes the problem I was having.

I received the results of the tests promptly, which, again, has not been my experience in other departments, and Mr Heath followed the progress and helped to coordinate the different departments which were then involved. This I found helpful as I was finding it difficult to coordinate the results and communicate between the different departments. I cannot thank Mr Heath enough for helping to sort these things out because I had been suffering a lot of pain with the other issues. I was finally referred to a Rheumatologist, who prescribed a course of steroids which has helped to sort out the inflammation and eased the pain.

At my recent appointment with Mr Heath, I was given a thorough eye check and was given the reassurance that my eyes at that time were all well. I am aware that the condition with the eye may still recur, but I know that I will be given the best care should I need to return. It is my experience that Mr Heath and the whole team at the Urgent Eye Care Clinic go above and beyond and treat patients with kindness, openness, and excellence through their behaviours and their actions, and I always sing their praises when speaking to others about the care I have received. I believe Mr Heath thoroughly deserves this award.

Rachel Bissell, Nursing Band 7 **York** **Nominated by colleague**

We had a busy night shift on AMU with high acuity and Rachel was amazing and supportive throughout the night. We had a medical emergency and concerns about the welfare of another patient at the same time and Rachel made sure to manage the situation. She came onto the ward and got in touch with security and relevant partner agencies. Afterwards, she checked on all members of staff, making sure we were all OK. She is an amazing bed manager and is a credit to the Trust. Thank you for all your help that night. Your kindness doesn't go unnoticed!

Dominique Cole, Senior Healthcare Assistant **York** **Nominated by colleague**

Nominated by Mr Chintapatla for being 'really kind and supportive' of one of his patients in an outpatient clinic. Dominique strives to give the best care to our patients and consistently receives positive feedback from her colleagues and patients. Well done, Dominique, a well-deserved recognition.

Holly Murphy, Deputy Sister **York** **Nominated by colleague**

Holly is an exceptional nurse and team member. In a difficult situation with a patient, Holly was able to put the patient first whilst also looking out for the staff in her team. She went above and beyond when debriefing with staff and making sure we were all OK and that we understood the circumstances of the situation. She truly couldn't have done anything more. Apart from this situation, she goes above and beyond for patients and their families and for the team to create a positive environment. Holly shows the perfect example of care and compassion in her work.

Laura Strange, Deputy Sister **York** **Nominated by relative**

My Dad came for an endoscopy after a failed attempt earlier in the week. He was anxious about the procedure and explained this to Laura. She was so patient with him, explaining every detail of the procedure and how they had adapted things to improve his experience this time. Laura gave him lots of time to ask questions and ensure he felt comfortable with everything. She made him feel completely at ease and he was able to have the endoscopy successfully.

Allyson Dale, Senior Healthcare Support Worker **York** **Nominated by relative**

When my daughter attended ED, Allyson immediately put her at ease with her caring nature and smiling face. This made a huge difference as we had experienced terrible care in the days leading up to arriving in ED. Allyson communicated everything that would need to be done and was knowledgeable. She continued to check up on my daughter when she was moved to the next area for antibiotics and escalated our requests to the nurses for pain relief. Allyson also asked for the antibiotics to be started when they hadn't been.

Allyson was caring, professional, polite and communicated information to ensure we felt seen and heard. I thank God that Allyson was on shift. Allyson deserves recognition and praise for her services and for going above and beyond to provide excellent care.

Jacob Calpin, Assistant Systems Accountant **York** **Nominated by colleague**

Jacob has supported me in creating a new ID form online. This process has been a struggle, but he has been there for me, supporting and going above and beyond to get the form complete. Jacob also went out of his way to get the laptop fixed and a new cable so he can access the correct systems. Without Jacob's input with this new project, we would not be at the final stages. Jacob is a credit to his department.

Donna Exton, Trainee Advanced Clinical Practitioner **York** **Nominated by relative**

When we arrived in ED, it was following two unsuccessful and unhappy visits to the out-of-hours GP. Donna was the first nurse my daughter saw, and we were immediately overwhelmed by her kindness and attentiveness. Donna was knowledgeable and examined my daughter to assess her needs. My daughter was in severe pain, had a high temperature, and was distressed. Donna actioned for her blood to be taken, painkillers started, and antibiotics administered via IV.

Despite the department being extremely busy and demanding, Donna remained positive, friendly, and patient-centred throughout. She was a Godsend. Donna continued her care the following day when my daughter hadn't received the CT scan and chased up the care that she needed. Donna deserves praise and recognition for her amazing treatment of patients and relatives. We appreciated her care.

Medical Records Team **Scarborough** **Nominated by colleague**

This last ten months has been extremely difficult for the department, with six people suffering bereavements (approximately a fifth of the department), including myself. The department has pulled together and supported each other, going above and beyond to ensure that all their colleagues are OK and coping.

Everyone has looked out for each other and been there to talk to and listen when needed. It has been such an unprecedented situation that I feel the department needs recognising for the way they have supported each other in a caring and compassionate manner.

Deborah Hull, Advanced Clinical Practitioner **York** **Nominated by colleague**

I'm a trainee Advanced Clinical Practitioner in primary care and I've been shadowing Debs in SDEC. Debs has been an absolute pleasure to work with and she is super knowledgeable. Her teaching displays patience and humour and instils confidence in her students. She explains in a way which is easy to understand, her communication is top notch. Best mentor ever.

Helena Davis, Phlebotomist **Malton** **Nominated by patient**

I have completely avoided blood tests for around 15 years due to fear and anxiety, but I recently needed a blood test. I turned up to the phlebotomy walk-in clinic at Malton and Helena was walking out about to go for her lunch but saw immediately how nervous I was. She insisted on getting me in and getting my bloods done despite this eating well into her lunch break. She was so kind, patient, and fully understood my anxiety. She talked me through the entire process and made me feel completely at ease despite my overwhelming anxiety. She was gentle and made the process easy and manageable.

Helena went above and beyond what I would have expected of her. She has single-handedly got rid of my 15-year fear, and I really cannot thank her enough for that. Thank you so much, Helena.

Cancer Information Team **York** **Nominated by colleague**

For the past three months, the Trust has received the highest volume of suspected cancer referrals on record, with over 3,000 referrals received monthly. This has impacted several teams and services across the Trust at a time when cover can be challenging due to summer leave. The Cancer Information Team have approached the challenge with resilience and positive attitudes, managing the additional workload throughout the team and working in an agile manner to respond and ensure high quality service remains. This has been without additional resource due to financial constraints.

The team have a vital, but sometimes unseen, role in ensuring undiagnosed and diagnosed patients are visible and provide information to teams to move patients along pathways in a timely manner. The increase in referrals has also meant an increase in patients being listed for MDT discussions, which the team also coordinates, and have continued to do so to the best of their ability in a timely manner despite the increase.

Whilst not patient-facing, the Cancer Information Team are integral to ensuring cancer patients have timely and appropriate diagnostics and care, and place patients at the centre of their work. Thank you.

Sally Barratt and Lorraine Vasey, Administrative Assistants **Scarborough** **Nominated by colleague**

Sally and Lorraine recently stepped in to provide some cross-site administration cover for colleagues on an extended period of leave, to ensure that clinical teams in York, Scarborough, Bridlington, and White Cross Court continued to run efficiently. This involved taking on additional work while still completing all their own work, and yet they did so without complaint.

They took action to understand how processes on different sites worked, and problem-solved to make sure they could find ways to support from a distance. They used new IT systems and ways of working and supported each other with excellent communication (and cups of coffee). Both Lorraine and Sally are always willing to offer support to all the AHP teams and help the services run efficiently and do so every day with a smile and a positive attitude. They demonstrate the Trust values every day and are both an asset to the team.

Hannah Howe, Medical Secretary **York** **Nominated by colleague**

Hannah joined our department as a Medical Secretary. Since appointment, Hannah has worked with dedication to improve our department's productivity and to help catch-up on our administrative workload. I've observed her being respectful towards patients and colleagues and she has supported new staff members with their introduction to the department. There's been a professional and caring approach towards patient interactions; typified with both dignity and confidentiality.

Hannah has demonstrated significant insight and exemplifies the Trust values around compassion. She has balanced this with innovations within the office in improving efficiency and helping consultants with clinical administration. Her motivational and organisational skills are first class and continue to improve our service. Please can you consider Hannah for this Award, which I'm confident you'd agree is very much deserved.

Izzy Taylor, Physiotherapist **York** **Nominated by colleague**

The Acute Stroke Unit was under immense pressure due to staff sickness, and a poorly patient had was waiting for a bed bath. Izzy was aware of this and gave the patient a bed bath during planned post-stroke physiotherapy. All members of the MDT are under pressure, and for the nursing team, this meant the world of difference. It can be demoralising to feel that a patient's dignity is not being upheld due to resources.

When a colleague goes the extra mile beyond their role, it should be recognised in line with the Trust's behaviours of kindness and professionalism. More importantly, Izzy always puts the patient's comfort and wellbeing first, and this is everything, especially for this patient who is unable to make their needs known at this time. Thank you, Izzy. You are appreciated.

Zoe Law, Healthcare Assistant **York** **Nominated by colleague**

Zoe has recently joined the team and is an asset. She goes above and beyond to support the patients and her colleagues. No task is too much, if Zoe can help, she always will. In a fast-paced acute environment, this makes a huge difference to staff morale and patient care. Well done, Zoe, a great start. Thank you for all your help.

Shireen Frank, Healthcare Assistant **York** **Nominated by colleague**

Shireen began as a cleaner on the Acute Stroke Unit and then she moved into the PSO role, where her kindness and helpful nature was an asset to the patients she cared for. She has since progressed through the Healthcare Academy and has joined the clinical side of the ward.

Shireen excels as a Healthcare Assistant. The care that she gives is in line with the Trust value of kindness. She treats patients in the way she would treat a relative; they are cared for with love and respect and I have seen how this makes them feel safe. Shireen particularly shines when supporting our end-of-life patients, she is passionate about the care they receive in their final days of life. She ensures regular checks are maintained and her mannerisms with family are impeccable. Well done, Shireen. We are lucky to have you.

Roxanne Tanagras, Theatre Practitioner **York** **Nominated by colleague**

Roxanne consistently demonstrates outstanding technical expertise and serves as a strong role model for the team. She is always proactive, helpful, and dependable, with a consistently positive and diligent approach to her work.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

September 2025

Darianne Atkin, Theatre Support Worker **York** **Nominated by colleague**

I would like to commend Darianne for the pride she takes in her work in the department. She has gone above and beyond on a few occasions, using her own initiative to keep the department tidy and well organised. Her professionalism makes a positive impact on the workplace, and it is truly appreciated. Thank you.

Melissa Cammish, Healthcare Support Worker **Scarborough** **Nominated by colleague**

Melissa always comes to work with a smile and an upbeat attitude. She is a great team player. She demonstrates a caring and compassionate attitude to her patients, and she builds excellent rapport with her patients and their relatives. Melissa has been involved in a quality improvement project looking at preventing patient deconditioning while in hospital and has been enthusiastic and shown a passion in providing high quality care and contributing to the prevention of deconditioning on Cherry Ward. She demonstrates all the Trust values and is an asset to Cherry Ward.

Kimberley Johnson, Healthcare Support Worker **Scarborough** **Nominated by colleague**

Kim has a calm and systematic approach to caring for her patients. Kim will often go above and beyond to ensure assessments and tasks are up to date. Kim is adaptable to change and will contribute to any new initiatives introduced to the ward as part of Cherry Ward's quality improvement, such as the SAFEPAD initiative, a system for recording and storing patient spectacles, hearing aids, etc. She is also a great cake baker and spent time on making cakes for the team on International Nurses' Day. She works within the Trust values and is a valued member of Cherry Ward.

Ashleigh Stanley, Nursing Associate **Scarborough** **Nominated by colleague**

Ashleigh always provides a high standard of individualised nursing care. She has a calm, structured approach to her workload. Feedback from learners is always positive, highlighting her structured approach, care, and compassion. Ashleigh prioritises her workload effectively and ensures assessments and tasks are performed as timely as possible. Ashleigh demonstrates the Trust values. Ashleigh is a valued member of the Cherry Ward team.

Angela McManus, Senior Healthcare Support Worker **York** **Nominated by colleague**

Angela always demonstrates kindness and gives excellent care, but today she went above and beyond in a difficult situation to ensure that a patient's dignity was maintained. The patient had been unwell on their journey to the clinic, and Angela not only looked after the patient but also sourced a change of clothes and found a space they could wait for their appointment privately away from other patients. She ensured they were prioritised so they could get on their way home as soon as possible with minimal waiting. The patient and their child were grateful for the way Angela made a difficult situation more manageable for them. Thanks Ang, you're a star!

Mollie Francis, Pharmacy Assistant **Scarborough** **Nominated by colleague**

On behalf of the chemotherapy team, I wish to nominate Mollie. Mollie works closely with the chemotherapy team and ensures that the medications arrive quickly and promptly to help avoid any delays to patient care. We find Mollie is efficient and her communication skills are excellent. If there are any problems, delays, or concerns she is quick to inform us and, due to this, we can inform the patient of the situation and can plan around these issues.

She is kind and thoughtful and does everything she can to support the nursing team, always going that extra mile. The team and I would like to say a big “thank you” to her and let her know that all these things that she does for us do not go unnoticed.

Kimberley Fernandez, Midwife **York** **Nominated by colleague**

Going into the delivery room, we were uncertain about what was happening due to having extremely high blood pressure and the baby’s heartbeat also being high. From the moment we started care with Kim, it was clear how incredible she was at her job role. Right from the beginning, she went above and beyond for not only myself but also for my partner, making sure he was fed before we began. Kim never left our side and pushed to speak to doctors when she was not happy with observations. She was patient and kind, making the experience so much better.

After my daughter, Nellie, was born, the two days I was in hospital, Kim came to see myself and Nellie. This was lovely as although she had not delivered us, she wanted to see how we were. Our experience was made what it was due to Kim, and we cannot express our gratitude enough. She is an absolute asset to the Maternity Unit, and we believe she went above and beyond for us. This will stay with us for life now and we will be sure to tell Nellie all about Kim when she is older. Thank you again, Kim, what an incredible person you are.

Denise Padley, Administrator **Hull** **Nominated by colleague**

Over the last two to three months, I have been supporting nine departments from SHPYS with their move from their current roster spreadsheets and ESR connect payroll reporting to using Healthroster. Denise is the admin support for several of these areas. I am nominating Denise for this award as at relatively short notice she was able to attend the relevant system-based training sessions and the various department meetings.

Denise was a key person in ensuring the transition to Healthroster has gone smoothly. For example, she has updated the Healthroster system with retrospective and future annual leave for the relevant staff (this is hundreds of staff!). This alone was a large piece of work. She seemingly took all this new work in her stride, and it has been a pleasure to work with her over the months.

Denise continues to work collaboratively with me and the eRostering team to ensure that the new Healthroster processes are in place. I will end the nomination with a big THANKS to Denise for all her hard work and the time she has put in over the recent months.

Charlotte Brown, Child Health Outpatient Manager | **Scarborough** | **Nominated by colleague**

I would love to nominate Charlotte for a Star Award. Every day she comes to work with a smile on her face and is always willing to go above and beyond for everyone. She has been essential in the move to a create a new temporary Children's Clinic. Without her organisational skills and communication this project would not have been able to happen within the tight deadlines we had.

Not only has Charlotte been instrumental in the clinic move, but she has also covered Ward Clerk and Outpatient Admin staffing gaps, as well her own role as Outpatient Manager, not just for Scarborough Hospital but also for York. Her dedication to the department is amazing to see and she is a joy to work with. Thank you, Charlotte!

Gail Tindall, Karen McPherson and Helen Jamieson, Healthcare Assistants, and Gess Charlton, Deputy Sister | **Scarborough** | **Nominated by colleague**

I would love to nominate Gail, Karen, Louise and Gess for all their help with the move into the new temporary Children's Clinic. We had one day to move everything over to the new location, set everything up, and ensure the clinic was operationally ready for the next day for patients.

We had a fantastic day together doing this. Everyone was excited for the new project, supportive, and made it an enjoyable experience. Their passion for the department was great to see and ensured this is a great environment for children. Thank you for all your hard work, it is appreciated, and I hope you enjoy your new home!

Phil Michulitis, Capital Planning Project Manager | **Scarborough** | **Nominated by colleague**

I would love to nominate Phil for a Star Award. Without Phil and his dedication, hard work, organisation and his superb communication skills, we wouldn't have been able to move into our temporary Children's Clinic within a tight deadline.

Nothing was a problem, if we had an issue, he would respond immediately and get this rectified. He was visibly present on the day of the move and helped us, which we were grateful for. In the days after he was always checking in on the team and asking if any more support was required. It was a pleasure to work with Phil on this project. Thank you from us all in Child Health!

Dean Allen, Digital Project Manager, and Lewis Swain, 1st Line IM&T Technician | **Scarborough** | **Nominated by colleague**

I would love to nominate Dean and Lewis for a Star Award. They were a massive help with moving our Children's Clinic within a tight deadline and ensuring we had all the IT systems ready to be operational for patients. They did an outstanding job. They were present on the moving day and no issue was a problem for them. We had IT issues on the opening day and Lewis attended immediately and rectified the issues in a timely manner, which we were extremely grateful for. Thank you for being part of this project!

Ward 16 **York** **Nominated by patient**

Although I would like to particularly name Francis, the whole Ward 16 team were first class in their care dedication and commitment. From admission to the discharge lounge, the hospital was fantastic, including all staff, from the consultants, nurses, cleaners, and staff who prepared food to everyone else, the hospital should be proud of everyone. How small it seems, but all I can say is thanks to all.

Lou Wilcox, Medical Education Service Manager **York** **Nominated by colleague**

I would like to nominate Lou for a Star Award in recognition of her outstanding support and kindness during a particularly challenging time in my training. When unexpected issues arose with my rotation, Lou went above and beyond to guide me through the process, offering practical solutions, reassurance, and consistent follow-up. Her approach was not only professional but also deeply compassionate, ensuring I felt heard and supported throughout.

Thanks to her persistence and advocacy, what began as a difficult situation was resolved with a highly positive outcome. I am sincerely grateful for her dedication and humanity. Her actions made a real difference to my wellbeing and training experience.

Sinead Campbell, Staff Nurse **Scarborough** **Nominated by patient**

After breaking my leg last week, Sinead calmed me down while I was in shock. The next day, on her next shift, she came back to check in and then went above and beyond to make sure I had everything in place to go home. I'll never forget her compassion and kindness; she is a star!

Sian Thompson, Nursing Associate **Community** **Nominated by colleague**

Sian joined the North District Nursing Team a few months back, and since she started, she has been an asset to our team.

As I work closely with her in the same area of our caseload, I have noticed how she goes above and beyond for her patients and their families and our team. Nothing is too much for her, and even if the day is hard and obstacles come her way, she powers through and delivers excellence and compassion. She is thorough in providing efficient care for our patients by acting imminently where escalations or further referrals are needed.

Sian is appreciated and has made a difference. This is also shown through comments made by patients who have mentioned to me how she has had a positive impact on their care. I feel lucky to have Sian as a colleague.

Joanne Radley, Healthcare Assistant **Scarborough** **Nominated by relative**

Jo is an outstanding Healthcare Assistant. Not only is she professional, efficient, and skilled at her job, but she puts patients immediately at ease and brings so much humour to any discourse. She cheers everyone up with her wit yet never ceases to show compassion and care. She was so kind to the families of patients too, always going the extra mile for them.

Despite my dad being poorly, it was fantastic to see Jo make him laugh and have amazing banter with him, distracting him from his pain. Her presence made Dad's stay in the unit so much more pleasant, and we were all gutted when her shift ended. She even took the time to come and speak to all her patients individually before leaving. Jo is one in a million, born to care for people and deserves for this to be acknowledged.

Laura Roughley, Acute NIV Specialist Nurse **York** **Nominated by colleague**

Every shift I work with Laura, she goes so above and beyond. She'll help everyone with every task, whether it’s a bed bath, medication pass, or even a tea round. She is there for everyone and shows so much kindness and understanding for family members. She also recognises when her colleagues are overwhelmed and need a little help. Patients have never had anything but gushing, positive words about her, because she is so helpful and calming.

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

Jason in paediatric ED was superb with our two-year-old son. He goes above and beyond with bubbles, squeaks, stickers, and magic tricks. He kept our son entertained throughout our time and even managed to get a wee sample out of him when we were struggling.

Hannah Ballantyne, Midwife **York** **Nominated by patient**

Hannah has provided a wonderful level of care throughout both of my pregnancies. My first was not straight forward due to me sustaining a cervical fracture following a car accident at 16 weeks gestation. Hannah was so caring and such a massive support at a time when I was worried about the possible impact of the accident on my baby.

During both pregnancies, I felt so lucky to have a community midwife that was not only knowledgeable and practical but who also seemed to genuinely care. Hannah is dedicated and passionate about her work and I am in no doubt that she is an invaluable member of the community team.

Cessi James, Student Midwife **York** **Nominated by patient**

Cessi led our care when our little boy was born. It was a busy shift for her, with a completely full ward, but we were never made to feel like we were being rushed or not monitored closely. Cessi went above and beyond, ensuring we were well cared for and guided through the process of the induction and delivery of our little boy. She explained everything thoroughly and demonstrated an amazing level of knowledge, confidence, and competence for someone early in their career.

A special mention should also be made for Liberty Mayer who was overseeing Cessi. They were a fantastic team, and we were so glad that they were able to deliver our baby before the change of shift.

Frailty Virtual Ward **White Cross Court** **Nominated by colleague**

This team when above and beyond to fulfil a patient's wish to be cared for in their own home. The team worked late into Friday evening and beyond their normal finish time to facilitate the emergency delivery of essential equipment to the person's home. They also worked extra shifts at the weekend to support his care. Without the dedication of the Frailty Virtual Ward team to this patient's care, this person would not have had their final wishes fulfilled.

The patient was eventually admitted to St Leonard’s Hospice, where they spent their last few days. There was no question in the mind of the team about supporting this patient, and I remain in awe of their kindness and dedication to their patients and their colleagues.

Bethany Wilkins, Administrative Assistant **Scarborough** **Nominated by colleague**

I am the senior consultant in Anaesthetics and Intensive Care and there is a new system of requesting leave. Bethany was helpful when guiding me through how to set up Allocate Loop. She dealt with my queries with patience and understanding. This has helped me immensely.

Laura Taylor, Audio Typist **York** **Nominated by colleague**

Laura is always willing to help. Our department is often short-staffed, and Laura is the first person to offer assistance. She is an efficient worker and is thorough and understands the idiosyncrasies of all the cardiology consultants and how they like to work.

Laura is often pulled from Cardiology to help with Respiratory typing too, but she seems to manage her time and be able to prioritise work to enhance the smooth running of our department. She never gets flustered or stressed and is a pleasure to have around the office. Thank you, Laura, for all you do.

Jamie Baxter, Programme Manager | **York** | **Nominated by colleague**

The 2nd floor of the Admin Block is a busy environment as there are many different people and jobs to meet and interact with. As a full-time wheelchair user, many people notice me (especially as I am known to ask for help to reach things off high shelves). Around lunch time one day, I noticed one of my wheelchair tyres was flat and it was making me unbalanced. I didn't have anything with me to help solve the problem until a colleague suggested someone who cycles to work may have a bike pump.

Jamie is known on the floor as being a keen cyclist, so he seemed like an ideal person to ask. I popped over to see him and explained my issue to see if he could help. Jamie was exceptionally kind, pulling out a hand pump, refilling both of my tyres, and checking to make sure he couldn't see any obvious damage to them. Jamie even went as far as saying it was an honour to be asked to help which was truly kind of him. We had a lovely conversation about similarities between wheelchairs and bikes, and how expensive various pieces of equipment can be. The following week, he also checked to see how my tyre was and to make sure it was all sorted.

It seems like a small act, but it made a huge difference. I am extremely grateful for Jamie's help and wanted to highlight him as a true champion and an example of kindness within the Trust. I feel fortunate to work alongside someone so thoughtful and supportive and want to say a huge thank you to Jamie for making my day a little easier.

Jaime Marshall, Staff Nurse, and Bianca Ward, Healthcare Support Worker | **Scarborough** | **Nominated by patient**

I was in ED for many hours and Jane (Jaime) and Bianca were kind to me and kept making sure I was OK as I was in a lot of pain. They were busy but still found time to come and check on me. These ladies deserve some recognition as they worked so hard. I cannot thank them both enough for being kind and helpful to me.

Robert Haythorn, Advanced Podiatrist | **York** | **Nominated by patient**

The skill, knowledge, and experience which Robert Hawthorn, together with his colleague Jo Bradley-Smith from the Plaster Unit, applied to the healing of a deep tissue injury made a huge difference to my wellbeing. The wound, which I had had for a year, meant that no surgeon could even contemplate an operation until it healed.

When taking on this task (which eventually had a successful outcome), Rob kept me informed of its progress, patiently answered all my questions, and was generous when giving me sound advice on related matters. Rob suggested and physically made a strap for my good leg to avoid it getting damaged by the brace on my other, broken leg. He also fashioned from some material like plasticine into an item to separate my toes to avoid a recurring corn or callus, which relieved the considerable discomfort I'd been experiencing. He also went the extra mile in other ways.

In my view, Rob's knowledge and understanding marks him out as a professional who is excellent at his job and of whom York Hospital can be justly proud.

Surgery Flexi Pool Healthcare Support Workers | **York** | **Nominated by colleague**

Recently, as managers, we have taken over the staffing within Surgery and across the Trust. The surgical flexi pool is a team of Healthcare Support Workers (HCSWs) who work across the Surgery Care Group, supporting short falls within staffing.

Recently, on Ward 11, we have required their support in managing the shortfalls given unexpected leave of three substantive HCSWs. Without them, the ward wouldn't have been able to maintain the level of care delivery we have wanted to give to our patients. Every flexi pool worker who has been assigned to us, and other areas within surgery, has been fantastic. Supportive of the needs of our ward and our patients, they have been a joy to work alongside.

Whilst I appreciate on Ward 11, we have not had the pleasure to work alongside them all over the recent weeks, I know when covering staffing how helpful they are at covering last minute sickness and being moved between areas with short notice.

Tracey Butterfield, Maternity Support Worker | **York** | **Nominated by patient**

Tracey was a ray of sunshine at 7am in the morning. She was kind and caring during my glucose tolerance test and made sure that everything was explained to me. Tracey went above and beyond to help relieve my anxiety about further upcoming appointments with fetal medicine. She made sure I went to my next appointment and gave me a delicious slice of toast and jam as I hadn’t eaten in over 14 hours. I will never forget her kindness and bubbly personality; she is a shining star!

Beverley Senturk, Outpatient Services Administrator, and Ross Morton, Outpatient Services Deputy Manager | **Scarborough** | **Nominated by colleague**

Beverley was dealing with a difficult phone call from a distressed patient that was suicidal and threatening to take their life. Beverley escalated it to her line manager, Ross Morton, who then contacted Adult Safeguarding for support.

While Ross was linking with the Safeguarding team, Beverley remained on the phone and kept the patient calm, while also remaining calm herself in this difficult situation. This resulted in the Safeguarding team contacting the emergency services and going to see the patient.

Beverley and Ross demonstrated the Trust values and, although they are not medically qualified, the distressed patient was dealt with in a calm and professional manner until help was sent to them.

Ward 34 Nurses, Healthcare Support Workers, and Patient Service Operatives **York** **Nominated by colleague**

I want to nominate the healthcare support workers, nurses, and patient service operatives on Ward 34 for their dedication, kindness, and support to one of our long-term patients. They are a young adult with complex neurological needs and had been in hospital for nearly four months, most of that time awaiting discharge to a neurological centre.

They required constant one-to-one supervision, and although things haven't always been easy, I cannot fault the care and attention they have received on Ward 34. Especially those who looked after them around the clock, ensuring they had their meals, medications, clean clothes, and, most importantly, a companion to always wander the ward with. They built such a good rapport with them, knowing their likes and dislikes, and keeping their spirits up with music and films. Coming up to discharge time, they fought their corner to make sure they would get the care and treatment they deserved in their new home.

The patient has now been discharged, and the ward will feel strange without them. The team deserve a special mention for everything they have done for this young adult.

Alexandra Jones and Vicky McGrath, Midwives, and Nicole Page, Student Midwife	**York**	**Nominated by patient**

Thank you will never be enough for these incredible ladies! I wanted to share my story for all those women who are nervous going into labour at York as I had the most amazing support, and they deserve recognition as I am forever thankful to them all.

I had a planned induction booked due to having a small for gestational age (SGA) baby. My dad unexpectedly passed the early hours of the morning of my induction, so I was emotional but knew I wanted to get my baby here safely. When I arrived on Labour Ward, I was met by the fantastic Vicky McGrath who was aware about my dad. She made me feel relaxed and calm and answered every question I had. Vicky broke my waters and was there for most of my labour, getting to know me, my husband, and my mum, and taking a genuine interest in our stories. Vicky's shift ended before baby arrived, but she was incredible and I'm so thankful to have had such an attentive, understanding and caring midwife for much of my labour.

When Vicky's shift ended, I had the most amazing pair take over, Student Midwife Nicole Page and Midwife Alex Jones. Nicole is going to be the most amazing midwife, and I was so lucky to have her deliver my baby. Nicole was encouraging, patient, supportive, and a textbook midwife, making sure I knew everything that was going on and every time Alex checked in with her, she knew all the answers. Nicole got me through labour with zero pain relief with her encouraging words. Thank you so much to Nicole, I will forever be grateful that you delivered Finley safely, wish you all the best, and can't wait to see more "thank you"' messages from people about you!

Alex Jones, my absolutely shining star and angel which I'm sure my dad sent to me. Alex was not only incredible during my labour and when supporting Nicole, but I have been fortunate enough for her to do a lot of my post-natal care too. After losing my dad the same day I delivered my baby, the first couple of weeks were tough. Alex has been nothing short of amazing with her check ins, supportive words and just generally being one of the kindest souls I have ever had the pleasure of meeting. She's listened to everything I said, remembered it and checked in with me, and offered support at every stage. It's tough being a new mum and losing your dad on the same day takes it to a whole other level, but I am eternally grateful to have had a Midwife like Alex supporting me as I don't think I would have got through it without her. York Hospital so lucky to have you, Alex, and you should be so proud of what an incredible midwife you are. One in a billion!

Lloyd Villanueva, Staff Nurse	**York**	**Nominated by patient**

The whole team in Vascular Imaging Department were fantastic, reassuring, and helpful and worked professionally as a team. I would like to nominate Lloyd within this department as one who stood out to me as offering the best of nursing and reassurance while also dealing with other patients who needed his help. He even went the extra mile to tie my shoelace after the medical procedure. Well done, Lloyd.

Molly Kellett, Deputy Sister **York** **Nominated by colleague**

Molly has been great, not only towards her patients, but also to her colleagues. She has demonstrated utmost patience and understanding to everyone. She is also knowledgeable and efficient. She does not raise her voice nor show any impatience while at work. No matter how much work she's got lined up, one can always approach her, and she would always have a smile on her face. I hope she gets the recognition she so deserves.

Rachel Hedges, Senior Sister **York** **Nominated by colleague**

The ophthalmology clinics in York had been historically overrun and less efficient over the years. However, since Rachel has joined the department as the Senior Sister, she has led the team effectively and has streamlined the processes. Now clinics run on time and all stakeholders, including patients, staff, and clinicians, are satisfied. Kudos to Rachel's leadership skills and her vision for improving the service so significantly.

Olivia Beaver, Staff Nurse **Scarborough** **Nominated by patient**

I have recently had a hysterectomy, and I was delighted with the care I received from the nursing staff. One nurse in particular, Liv, was wonderful. She looked after me through the night, and as I am a nervous person, she made me comfortable. At only 23 years old, she is sensible and level-headed. An absolute breath of fresh air. Nothing was too much trouble, and it was obvious she loves her job. I would love for her to be rewarded in some way.

Sandra Milner, Compliance and Development Coordinator **York** **Nominated by colleague**

I'd like to nominate Sandra Milner for their outstanding demonstration of the Trust's core values of kindness, openness, and excellence in everything they do.

Sandra is an unseen hero who consistently supports every member of her team. She always treats colleagues with genuine compassion and respect, going the extra mile to make others feel valued and supported. Her kindness is not just seen, it's felt. Sandra is refreshingly open and approachable, creating a space where feelings are heard, not just brushed under the carpet. This honesty and clarity strengthen not just the team, but the individuality within the catering department.

Finally, the excellence she brings to her work is inspiring. Whether it's hands on in the catering department, supporting colleagues, or going above and beyond for every single person they encounter, Sandra sets a high standard and quietly raises the bar for all of us. She embodies what it means to work for York and Scarborough Teaching Hospitals NHS Foundation Trust, and we're all better for having her on the team.

Susan Brewins, Healthcare Assistant **Scarborough** **Nominated by colleague**

Sue always goes the extra mile for her patients. She does this uncomplainingly and with a smile on her face. I have witnessed her kindness on numerous occasions, and nothing is too much trouble for her. She is always trying to make life a little easier for those around her.

Sue is a great colleague, always one step ahead and demonstrating initiative and integrity daily. She is a pleasure to be around, and I hope she knows how valued and respected she is.

Nat Williams, Staff Nurse **York** **Nominated by colleague**

Nat always goes above and beyond in her job role. She is full of energy and always wanting to help others. Little acts of kindness go a long way, and Nat is always there to provide chocolate and a chat after a hard shift.

Recently she came in on her day off, unpaid, to support a colleague going through surgery just so they could have a familiar hand to hold as they suffer with anxiety. This had a huge impact on their experience. She is a real credit to the team and deserves to be recognised.

Abigail Bell, Healthcare Assistant **York** **Nominated by patient**

I was in for a day case operation, and I came in nervous and anxious. I have a diagnosis of autism, which makes these situations overstimulating. Abbie recognised this straight away and, after explaining this to her, instantly adapted her behaviour to accommodate me by offering curtains and asking if I had fidget toys for distraction. She spoke kindly and adapted the way she explained things.

My experience of my operation was made easier by Abbie, and she is a credit to the department.

Steve James, Cleaning and Catering Operative **Scarborough** **Nominated by colleagues**

We appreciate the amount of effort Steve puts in to keeping Springhill House clean and tidy. We can always tell when he is on holiday! He is a superstar and always goes above and beyond his role.

Zach Dolben, Healthcare Assistant **York** **Nominated by colleagues**

Zach went above and beyond, putting himself in a dangerous situation for his nightshift colleagues.

At 1am, a confused and disoriented man kicked our airlock double doors through and entered the ward. The male was angry, upset, and aggressive. Zach immediately took control of the situation, asking the man where he needed to be and how he could help him. Zach attempted to guide the man off the ward and back in the direction he'd come from. The man resisted and started to lash out, kicking at walls and threatening Zach.

The man then made his way to the other side of the ward and threw a chair at a window, continuing to threaten to harm Zach. Zach remained calm and tried to talk the patient down. Eventually, he had no choice but to restrain the man until security came and took over as he continued to try to smash the window.

This was a stressful and scary situation for all involved and it took a long time for us to calm down. We've all agreed that we aren't sure how things would've been if Zach hadn't been there and we are all grateful to him for protecting us. Thanks, Zach.

George Stocker, Physiotherapist **York** **Nominated by patient**

Over my time of being injured, a lot of the doctors and surgeons involved in my care suggested I stopped playing hockey. George was the only one who understood how important it was to me that I get to play. I was a fresher at YSJ hockey when I first got injured, and I am now the club captain of the team.

George’s positive attitude and respect for my decision to keep playing allowed me to get to where I am now. He listened, offered advice, and gave the best care possible during my rehab. When I felt like I was making no progress, he offered encouragement and patience, pushing me to get back on the right track. He is an amazing physio and deserves recognition for it!

Nisha Reynolds, Staff Nurse **York** **Nominated by patient**

Nisha has been brilliant. My husband and I attended the EPAU with bleeding in early pregnancy. The whole team we had contact with were amazing. However, we both felt we needed to recognise how brilliant Nisha is!

This was unfortunately the fifth miscarriage I have had, and being in the EPAU was challenging. Nisha was genuinely lovely, compassionate, and human about the whole process, answering our questions tactfully and supportively. Nisha did not rush us and seemed to “get” us. Nisha was also brilliant at supporting and recognising the loss for my husband as well as myself. When we attended on the second day, the second I heard that Nisha was on shift and going to be speaking to us, I immediately felt more comfortable. The hospital needs more Nishas!

Endoscopy Suite Team **York** **Nominated by patient**

I had a colonoscopy procedure, and have to say that the organisation, care, and service was amazing. The teamwork got my attention, with no hierarchy of importance, just the combined desire to carry out the task. Having been through this procedure before, I have concluded that the most important member of the team is the person who sits by my head and, in addition to their medical duties, talks to the patient and maintains their peace of mind during this uncomfortable process. For this colonoscopy, this person was the ginger-bearded Dan.

I went into the procedure with an anxious state of mind, but by the end this had turned into wondering why I had ever been concerned. A fantastic performance. Please pass on my thanks and admiration to all involved and to every team on duty doing the same for multiple patients.

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

On Wednesday 13 July 2025, I had a colonoscopy at York Hospital. I was dreading this procedure because of the possibility of a cancer diagnosis and a previous colonoscopy I had some time ago had resulted in an error on the part of the surgeon, including excessive bleeding and near death.

On this occasion, everything was carried out professionally and with great kindness, initially from the receptionist when entering the reception area for the procedure, through to completion when I, in the company of my husband, was informed of the diagnosis in a caring and competent way. It was such a relief to me to be treated with such care, competence, and professionalism. I can't thank the staff enough.

The environment deserves mention too: the waiting was clean and bright and the chairs comfortable. The operating theatre was inspirational with its set up and professional appearance, and the friendliness and competence of all the staff. I cannot thank all the staff enough for their care of me on this occasion.

Occupational Health and Wellbeing Team | **Community** | **Nominated by colleague**

I've been Head of Occupational Health and Staff Wellbeing since September 2023, and the constant changes and improvements that the team have made over that time have been fantastic.

The team includes Occupational Health, Staff Health and Wellbeing, and Manual Handling. Given the amount of work that they complete (over 5,000 individual referrals last year), they are a small team and must be adaptable to the ever-changing needs of such a diverse workforce. They're always willing to discuss how we can improve our existing processes, and what additional support we can offer to colleagues whilst in need; whilst consistently maintaining impressive KPIs and a high quality of service. I feel proud to work with them all. They consistently receive positive feedback from colleagues, with the most recent anonymous feedback survey including the following:

"I have been so impressed with the whole process. I really am so happy that I made the referral. I think because of previous experiences (not with the NHS) I wasn't expecting much but was delighted and grateful to have been taken seriously from the start, receiving the telephone consultation so quickly after submitting my referral. The call was so in depth, and I had time to explain my issues, and genuinely helpful solutions were offered to me. I feel genuinely supported by the workplace and so reassured that this service exists in case of future problems. Many thanks to you and thank you for helping me so much."

Dave Collins, Senior Network Specialist, Josh Ward, Deputy PACS Manager, and Lewis Swain, 1st Line IM&T Technician | **Scarborough** | **Nominated by colleague**

These three individuals went above and beyond and demonstrated our Trust values of excellence and kindness. We had 10 days' notice (as opposed to months as is normally required) to arrange, relocate, and set up the entire Scarborough Ultrasound department, which includes four ultrasound scanners requiring PACS connectivity and 10 workstations requiring connecting and setting up. This was a massive challenge in the time frame while ensuring minimal disruption to the ultrasound service and patient appointments.

Dave, Josh, and Lewis helped with the preparation, locating and checking ports, and setting up and ensuring we were back to operation on the day. Due to their due diligence the move went smoothly. I cannot stress how grateful and thankful we are and how much we appreciate how they moved heaven and earth to make the move possible.

Catherine Lomax-Boyeson, Vascular Specialist Nurse, and Jessica Cuthbertson, Deputy Sister and Vascular Specialist Nurse | **York** | **Nominated by relative**

My sister has been looked after by the vascular team, and these two ladies have gone over and above. When she was in hospital, they visited her on the ward to see if she was OK. They made her feel special and did everything they could to help. I can't praise them enough. All the vascular team were lovely to her, but it was these two she talked about all the time. They made her bad situation a whole lot easier. They deserve to be recognised.

Paul Atkinson, Facilities Supervisor | **York** | **Nominated by colleague**

Paul has gone above and beyond to help staff get IT equipped, and it has not gone unnoticed. The feedback from staff is, "Paul has patience and makes me feel at ease". He has also helped those of us in the supervisor team by taking some staff under his wing to get logged on and feeling IT confident. Thank you, Paul!

Catering Team, Food Production Team, and Ellerby's Restaurant Team | **York** | **Nominated by colleague**

I am nominating the Ellerby's Restaurant Team, the Food Production Team, the Catering Team, alongside the managers of Production and Ellerby's and the Compliance Manager for a Star Award in recognition of their outstanding teamwork during a challenging time.

Throughout this difficult period, these teams and their managers have worked tirelessly together, showing exceptional resilience, leadership, and collaboration. The managers provided guidance, support, and direction, while the teams demonstrated flexibility, positivity, and dedication to keeping services running at the highest standard.

By combining their efforts, they ensured that patient, staff, and visitor needs were continuously met, despite the pressures faced. The way they supported one another across different areas showed not only professionalism but also genuine commitment to the Trust's values.

This nomination recognises both the staff and managers for their ability to come together, lead with strength, and demonstrate what true teamwork means in practice. Their combined contribution has made a real and lasting difference, and they are highly deserving of this recognition.

Sasha Egbert, Foundation Doctor, and John Duigan, Healthcare Support Worker | **Scarborough** | **Nominated by relative**

Sasha was dealing with my grandfather. He is profoundly deaf, and it takes a long time to effectively communicate to him. She was patient, compassionate, and handled him brilliantly even though it took a long time. She kept us informed and was pleasant throughout, as were the whole team. John the Healthcare Support Worker was lovely and chatted with great interest and patience throughout, his kindness really helped calm my grandad.

Amanda Langfield, Healthcare Support Worker **Scarborough** **Nominated by visitor**

Mandy went above and beyond to ensure a lady I support with complex care needs was well supported and cared for whilst staying on Maple Ward. I had the pleasure of meeting Mandy when visiting a lady that I normally care for in her own home. Mandy took the time to learn as much as she could about the individual, including her likes and dislikes and her ways of communicating.

Mandy interacted with her, put her at ease, and ensured she was listened to and had her needs met. Even when busy, Mandy made the time to get to know her and reposition and make the lady comfortable before she finished her shift. This was comforting for me too as the lady's usual care staff. Mandy's care, compassion, and general demeanour was outstanding. An amazing member of staff and a true credit to the NHS. A huge thank you to Mandy.

Christine Starr, Staff Nurse **York** **Nominated by patient**

Christine was caring and thoughtful. She ensured I was always comfortable and brought me various foods that were not too heavy on my stomach which stopped my sickness. She was patient and thoroughly guided my parents through how to give anti-blood clotting injections at home.

Christine made me feel at home, checked up on me throughout the entire day, and ensured I never felt worried or scared as it was my first operation. She was also reassuring when I was receiving various injections and never failed to meet my needs whilst reassuring my mum when I was in theatre. She even took care of my sister when she almost fainted towards the end of the day.

Christine was exactly how I pictured a nurse to be; caring, patient, and going above and beyond for her patients. She embodied openness, kindness, and trust. I wanted to thank her for the amazing service she provided as I was made to feel cared for every step of the way with a personal touch.

Malgorzata Banas, Healthcare Assistant | **York** | **Nominated by colleague (1) and colleague (2)**

Nomination 1

Malgorzata (Margaret) stayed behind for over an hour after her night shift finished to comfort a patient and translate for them. The patient was distressed and, although we have other options for translation, Margaret stayed with them to support them as a patient in Resus, despite already working a 12-hour shift and having another shift the following night. This meant so much to the patient and helped what is an incredibly frightening experience feel much easier.

Nomination 2

Margaret provided much needed reassurance to a patient who had deteriorated and needed to have treatment in resus. She stayed after her shift had finished, providing Polish translation, and speaking to the patient in a language they could understand. It was important at this worrying time to have someone at the bedside. Margaret is a naturally helpful, caring, and reliable member of the ED team. She will always go above and beyond when needed and does not always have the recognition she deserves as she puts this extra effort in quietly, regularly, and without fuss.

Thomas Skidmore, Radiology PACS Manager | **York** | **Nominated by colleague**

The Lung Cancer Screening Service would like to nominate Tom for a Star Award due to his outstanding contribution to the creation and roll-out of the Lung Cancer Screening Service. Tom epitomises the Trust values, demonstrating a genuine care and desire to contribute to the improvement of our service.

Over the past six months, our team has thrown every variation of question, problem, and challenge at Tom. Emails from our service must make up 50% of his overflowing inbox! However, Tom always responds with the perfect answer (usually with the problem already fixed).

I acknowledge that singular moments of outstanding care are often take the spotlight for awards. However, Tom should be appreciated for his daily high level of performance, kindness, and drive for excellence. From responses during out-of-work hours to leading on patient safety changes, Tom is an unsung hero who sits behind the scenes facilitating services like ours to improve patient care.

Dale Hick and Ellie Freer, Associate Audiologists, and Sharon Saji, Audiologist | **Scarborough** | **Nominated by colleague**

I am nominating Dale Hick, Eleanor Freer, and Sharon Saji. When the Langdale and Fylingdales fires occurred, the normal route from Scarborough to Whitby was closed. We had four clinics at Whitby on one of the days when the fire had spread across the road and closed the A171.

Dale, Eleanor and Sharon took a long detour to get to Whitby Hospital from Scarborough on time to see their patients and ensure no clinics were cancelled. No patients were cancelled, and they then took the long detour back to Scarborough. All three staff upheld the Trust values of kindness and excellence by ensuring they were at Whitby Hospital for our patients, so no appointments were cancelled, and by providing this excellent service.

Speech and Language Therapy Team | **Scarborough and Bridlington** | **Nominated by colleague**

The Speech and Language Therapy (SALT) Team based in Scarborough and Bridlington hospitals consists of speech and language therapists, SLT assistants, and admin assistants. They are an excellent example of how to demonstrate the Trust values as individuals and as a team.

They are supportive of each other and push themselves and each other every day to provide the best care they can for their patients. They understand the importance of continuous learning, clinical supervision, and kindness to each other when something doesn't go quite to plan.

Over the last year, they have shown resilience in the face of huge amounts of change, including staffing changes, changing IT systems, the introduction of a new service, and changes to processes across all the services they offer. They supported cross-site during a staffing shortfall in another team for several months during Summer/Autumn 2024, without complaint. They show initiative and happily volunteer to be part of wider projects to make sure patients come first, even when they feel stretched.

The whole team deserve recognition for being excellent staff members and overall wonderful people. They make coming to work a joy and are a credit to the Trust.

Carol South, Bereavement Advisor | **Scarborough** | **Nominated by relative**

My mum passed away in Scarborough Hospital, and, although she'd been poorly for over eight years, it was still quite sudden. I spoke to Carol the following morning and she was kind, gentle, clear, and concise as to what we needed to do.

That first call of having to say aloud that your mum (or any other loved one) has passed is so difficult. Having now dealt with the registrar and funeral directors, they all know her and are all complimentary about her. I wanted her to know she is appreciated in her role.

Anisha Talwar, FY1 Resident Doctor | **Scarborough** | **Nominated by colleague**

Dr Talwar commenced on Beech Ward at the start of August, and since she has stepped through the door, she has shown all the Trust values. Each day that she is at work she is enthusiastic, always with a smile upon her face and with a positive outlook towards her day. She is approachable, both with members of the MDT and with patients. Her communication skills are excellent, and she is always polite and respectful.

It has also been noticed by staff that Dr Talwar accepts challenges with ease and uses her knowledge and skills to the best of her abilities. Her general persona has also been recognised by patients and staff alike. She is a breath of fresh air and the kind of person who exemplifies the Trust values of kindness, openness, and excellence.

Janine Edwards, Cleaning and Catering Operative | **Scarborough** | **Nominated by colleague**

When a patient came into the department on Bank Holiday Monday wanting a blood test, Janine went out of her way to make sure they got to the right department. The Phlebotomy department only has skeleton crew on a bank holiday, and Janine escorted the patient to the Cancer Centre as they were anxious and needed bloods doing ready for their chemotherapy the next day.

Jonathan Fahey, Decontamination Operative (HPV/UV-C) | **York** | **Nominated by colleague**

A theatre needed a specialist clean with HPV disinfectant, but no staff were available after the theatre list finished. Jonny Fahey split his shift to be able to come back in the evening to provide this specialised service so the theatre could be back in use the next day. Great service and support from the Domestic team, we could not do our jobs without them.

Karen Heaton, Advanced Therapy Assistant | **York** | **Nominated by colleague**

Karen has worked for the Trust for many years. She always goes above and beyond to support our service. Recently, in Occupational Therapy, we have had reduced staffing and an increased workload. Karen has supported the team and me, in particular, at Applefields School. This has helped ensure that we can still deliver a quality and efficient service for our young people and their families. I couldn't have done it without her.

Rachel Turton, Subject Access Administrator | **York** | **Nominated by visitor**

Rachel has always gone above and beyond with the Subject Access Requests that I have made for our team at TEWV NHS Trust. Our team sees patients who are under a period of extreme crisis for their mental health and, as such, the requests for records are usually urgent.

Rachel often calls the office to confirm what information we need, when we need it, and other things too. For example, a patient had a lot of records so Rachel called to check what exactly we needed and advised it may take a long time if we wanted everything. Rachel is always kind, cheery, and polite and is prompt and thorough in her work. She is clearly an asset to her team.

James Pickup, Learning Administrator **York** **Nominated by colleague**

James helped me so much through the process of being admitted to an apprenticeship programme. He was on hand via email or a phone call to assist me on several occasions. He was always helpful and informative and did his utmost to sort out any difficulties.

Jinto Thomas, Healthcare Support Worker **York** **Nominated by colleague**

Jinto works as Healthcare Support Worker in York ED. He is caring and happy and cheerful every shift, and nothing is too much trouble. He worked in the waiting room alone due to short-staffing, and he never stopped attending to one patient after another and he never complained. He escalated appropriately and fed back issues that needed support.

I was confident that he was there attending to patients' needs. He is an assist to ED. Thank you, Jinto.

Penny Furness, Healthcare Assistant **Scarborough** **Nominated by colleague**

I have been meaning to nominate Penny for this for a while, which reflects her continued behaviours over a long period of time (years). Penny has a "I will help you if I can" attitude to colleagues and patients alike, which makes her a pleasure to work with. She has an inherent kindness and approachability which deserves recognition and a Star Award.

Sue McNeill, Stoma Care Nurse **Scarborough** **Nominated by patient**

During surgery for a hysterectomy in December 2024, complications led to me having an emergency Hartmann's procedure. Due to the unplanned nature of this, I was not prepared for having a colostomy, physically or mentally.

I nervously attended my appointment with Sue, full of anxiety and with 1000 questions that I had swirling around my head, keeping me awake at night. Sue met me with a huge smile and a warm, friendly greeting, which instantly made me relax. She answered every question I had, gave me advice and tips, provided me with information booklets, and gave me the support and reassurance I needed. I left the appointment smiling, with confidence and with a wealth of knowledge and information. Knowing that Sue was only a call or email away if needed, was both comforting and reassuring.

I have had further appointments with Sue, and every time I have been met with the same big smile and warm, friendly greeting and every time I leave, my worries have gone, my questions have been answered, and I have been given new tips and advice. Sue is an absolute credit to the stoma care team. I hope she realises what a positive impact she has on the lives of her patients.

Eleanor Oakes, Midwife **York** **Nominated by patient**

My first labour left me with bad birth trauma, making me worry about how my labour would go this time around. I had El as my community midwife for a little while before she moved to Labour Ward, and when I found out it was her who would be delivering my baby, I was over the moon.

I was induced and El made the whole process so much better. She supported me every step of the way, she hardly left the room, and she stuck to my in-depth birth plan all the way. I was made to feel safe and supported throughout and I couldn't have asked for a better experience this time around.

El made sure to talk to me and my husband about everything in detail and explained exactly what was happening throughout. She deserves recognition for all the hard work and support she put into making my labour perfect.

Day Unit **York** **Nominated by colleague**

My team has seen increased numbers and stresses but are still knocking it out of the park. I feel they all deserve a Star Award for always taking it in their stride. Over 30,000 patients have been through the unit so far this year. With such a wide variety of surgical procedures to look after it's easy to get overwhelmed, but this amazing team members just put their heads down and work.

Beech Ward **Scarborough** **Nominated by relative**

My elderly father was transferred from Malton Hospital to Scarborough ED with a chest infection and then transferred to Lilac Ward overnight (both departments were exceptional, and my dad received outstanding care). He was then admitted to Beech Ward in a weak and ill state. Immediately, we as a family, were made to feel welcome and the exceptional care and attention that my father was receiving as an individual was evident by all staff.

Everyone was friendly, attentive, and considerate to my father and I can only fully praise the delivery of care my father received to help him fully recover in preparation for transfer to the allocated care home in York. A huge thank you to all concerned. Keep up the good work and be proud of your dedication towards others and the profession.

Vicky Hastie, Medical Secretary **Scarborough** **Nominated by colleague**

Vicky is a valued member of the Gynae Medical Secretarial Team, not only by her peers but the consultants and management team alike. Vicky is thorough and dedicated and demonstrates all the Trust values every working day. Vicky is passionate about the service and the service users and goes above and beyond to initiative improvements, ensuring the patient's journey is safe and appropriate as well as being as positive as it can be.

This was recently shown in a letter of appreciation from a patient who has equally appreciated Vicky's kindness and her ability to think outside the box and offer the patient a lovely patient journey, feedback, and attention to detail. I think Vicky needs to be recognised as a member of staff who is the epitome of excellence!

Shelley Cooper, Admiral Nurse **Scarborough** **Nominated by colleague**

Shelley works hard at Scarborough Hospital to provide support to carers and relatives or to people living with dementia. She often works late to provide this support and can be found on the wards assisting our staff, patients, and carers. Her dedication to this role makes a significant impact on the lives of those with dementia and their carers.

Shelley recently had feedback from a relative emailed to Dementia UK to thank her for her support when her mum died in Scarborough Hospital and how this had a significant impact on her at a difficult time. I will copy the email below:

“My Mum passed in Scarborough Hospital, and I wish to pass on my heartfelt thanks to the Admiral Dementia Nurse, Shelley Cooper, at Scarborough. Her care and concern towards my Mum in hospital was fantastic. Visiting Mum on the various wards she was on and spending time with my Mum. She is a true credit. Again, today, Shelley has contacted me to ask how I am. A true credit to the Admiral Nurse Team. Shelley made a difficult time easier. Please pass on my thanks.”

Saffron Snowden, Dietician **York** **Nominated by colleague**

Since starting in the diabetes team, Saffron has shown an eagerness to learn and develop her skills and knowledge, particularly around diabetes technology. Currently we are working to a NICE TA for hybrid closed loop insulin pump systems. We realised that a barrier to people accessing this technology was the waiting list for structured education. Saffron quickly offered a solution to this and has developed half-day group education sessions for carbohydrate counting prior to pump therapy. This will allow significantly more people to receive appropriate and timely training and support prior to starting on diabetes technology.

Saffron is a valued member of the team who is always looking for ways to develop the service to improve patient experience and outcomes.

Joanne Gill, Diabetes Specialist Nurse, and Saffron Snowden, Dietician **York** **Nominated by colleague**

Joanne and Saffron demonstrated exceptional patient-centred care when helping support a patient with complete hearing loss to optimise their hybrid closed loop (HCL) insulin pump system. This patient had numerous face-to-face one-to-one appointments with diabetes specialist nurses and dietitians (with BSL interpreters) but was still struggling to optimise their HCL system and becoming increasingly frustrated with the technology – to the extent that they were wanting to come off the system altogether.

Joanne and Saffron organised a face-to-face session with themselves, the HCL company specialist, and a BSL interpreter on large screen. This session highlighted misunderstandings from previous appointments and enabled a patient-centred team approach that focused on the specific issues this patient was experiencing and allowed for an education refresh. Joanne and Saffron have organised follow-up sessions for ongoing support. HbA1c and glucose levels have improved significantly following this and the patient is much happier and confident with using their HCL system.

Helen Hope, Ward Sister **York** **Nominated by patient**

My husband and I met Helen at our first appointment at EPAU. Unfortunately, we had a pregnancy of uncertain viability which, after subsequent scans, turned out to be missed miscarriage. This is a situation no-one wants to find themselves in. As imagined, this was a distressing time for us both, but Helen guided us through the next steps, investigations, treatments, and emotions with complete professionalism, openness, and genuine compassion.

Due to some underlying health conditions, Helen went out of her way to discuss my case with obstetric and gynaecology consultants to ensure my care was appropriate. Helen is a credit to EPAU and York Hospital and clearly cares deeply about her job and patients. Helen has made such a distressing experience easier to cope with and we cannot thank her enough.

Chris Hagyard, Colorectal Cancer Pathway Navigator **York** **Nominated by patient**

I first received a letter from Chris in July when I had been placed on a Suspected Cancer Fast Track pathway. I contacted him after I had had two colonoscopies and ultrasound guided biopsies. I was anxious as I had not heard anything and contacted Chris. He explained that I had been taken off the fast track as my colonoscopies showed no cancer in the bowel. Although I was no longer under his remit he offered to help.

From that day, he and I have had a few conversations, and he has shown great professionalism all the time and been a great support. One day I rang twice, the second I was in tears at the outset of our conversation. He shows great compassion and excellent care as far as his role permits. He is a pleasure to speak with and has a wonderful calming approach and caring. Today he rang me to say he had received an email from the Malignancy of Unknown Origin Team to say I was now under their remit. I thanked him for all his help and understanding at a time of great stress and anxiety for myself and my family. It has been good for me to have this contact.

I would like Chris to be nominated for a Star Award. Having worked all my career in customer service at all levels, so I know how difficult it can be, and it is good to show appreciation where it is rightly deserved. A lovely gentleman, and I am sure he and I may have a catch-up chat sometime.

Nicoleta Clarke, Healthcare Assistant **York** **Nominated by colleague**

We attended a MET call on the ward, and Nicoleta was the embodiment of professionalism and compassion. When the MET arrived, she was able to give a succinct and clear handover. She clearly knew her patient and advocated for their best interests. She responded to our requests for help and equipment, and when it was sadly futile, she was there for her patient providing support and comfort. She is an absolute asset to the team.

Tom Wyles, Bank Healthcare Assistant **York** **Nominated by colleague**

Tom undertakes bank shifts in theatre and is always polite, kind, and compassionate to staff and patients. This morning, Tom was collecting a patient to bring to theatre and the patient was visibly anxious and upset. Tom was heard talking to the patient showing compassion, encouragement, and reassurance. He was perfectly in alignment with the Trust values and behaviours and made me proud to be his line manager. I feel he should be put forward for a Star Award.

Haematology Nurses **York** **Nominated by relative**

From July 2024 until June 2025, my husband required regular blood transfusions. Initially we were told that he would need to go to a venue away from the hospital, but, in view of his age and frailty, the haematology nurses decided to provide the service in the Magnolia Centre.

We were in the unit for some hours each time and I cannot praise too highly the kind, compassionate, and professional care we both received. Someone always asked how I, as his main carer, was coping. They encouraged me to accept the offer of Patient Transport when I struggled to cope using our own car.

I feel every member of the team consistently demonstrated the Trust values on all our appointments. Sadly, my husband died in August, and I decided to make this nomination in his memory, and I know he would be fully support it.

David Rose and Jenny Westbrook, Healthcare Support Workers **York** **Nominated by colleague**

A long-term patient has moved into a new placement, and this has been a challenging time for them. The patient had struggled initially on the ward but had grown to trust the staff. David and Jenny had gone to visit, taking a big supply of goodies for them to enjoy and spent time with them, helping with the transition. They both decided to do this of their own volition, in their own time and paying for the treats with their own money.

Truly a great example of Trust values and staff who the Trust should be proud of! Well done.

Graham Healey, Facilities Manager **Scarborough** **Nominated by colleague**

Graham started as a supervisor, was quickly promoted to manager, and he has excelled ever since. There was recently an unforeseen medical emergency with a member of my partner's family. He showed kindness to me and my partner while managing a busy shift. Graham was professional but also understanding when handling the situation.

Tina Duncalf, Clinical Skills Educator **York** **Nominated by colleague**

I would like to nominate Tina for her outstanding contributions as a Clinical Skills Educator at Hull York Medical School (HYMS). Tina has demonstrated exceptional initiative, leadership, and innovation in driving forward a vital sustainability project within the department. This is a project that not only aligns with the NHS's greener future goals, but also significantly reduces consumable costs without compromising educational quality.

Recognising the environmental and financial burden associated with single-use medical training supplies, Tina has led a transformative shift in how our department approaches equipment use. She has meticulously sourced alternative solutions that allow us to recycle, repurpose, and reuse a wide range of consumables, including syringes, gauze, IV giving sets, drug vials, and even full catheter packs. These items, which would otherwise be discarded after one use, are now given a second life in a safe and controlled teaching environment.

A key aspect of medical education is ensuring students train with the exact equipment they will encounter in clinical settings. Tina's approach strikes a perfect balance: while sterility is non-negotiable in practice, it is not required in simulation-based education. Through her careful research and consultation with professionals both within and outside of the Trust, Tina has developed a sustainable model that maintains authenticity in training while eliminating unnecessary waste. This initiative is the result of countless hours of Tina's personal time spent researching materials, trialling products, engaging with suppliers, and collaborating across departments and external organisations.

Her work not only enhances our teaching environment but also sets a precedent for what is possible in medical education sustainability. Tina's passion, dedication, and forward-thinking approach make her an exemplary candidate for this nomination. She is not just improving how we teach; she is redefining what responsible, environmentally conscious clinical education can look like.

Jo Bradley-Smith, Orthopaedic Practitioner Lead **York** **Nominated by colleague**

Jo gladly gave up her time and used her own annual leave to go work on the Mercy Ship in Madagascar. The Mercy Ship is a volunteer-run ship that visits various third world countries. While there, she has been treating disadvantaged children with various orthopaedic and trauma related conditions.

Jo has pushed her own boundaries and personal limits to help these disadvantaged children to provide life changing care. I want to let her know that her team thinks she's awesome.

Andrea Trafford and Sharon Thompson, Staff Nurses	**Scarborough**	**Nominated by patient**

Sharon and Andrea were brilliant with me today. After I had been left in limbo when my local GP was unable provide the wound dressing strategy that my hospital discharge letter indicated I needed, I made contact for advice to the Dermatology department. I attended this morning to have the wound checked and redressed and to be given some indication of what to look for and how to self-manage the dressings.

Sharon and Andrea were superb. They took time to explain in detail the aim of dressings and how to do them, as well as keeping the wound clean and the use of creams to promote improvement. The explanation was detailed and clear. Andrea and Sharon went above and beyond with regards to my wound care and future healing process. The dermatology nurses here are a credit to the profession and to the hospital. Thank you.

Nagata Nagata, MSK Physiotherapist	**York**	**Nominated by patient**

I met Nagata for physiotherapy a few days after having a knee operation following an accident. Throughout the five months that he has seen me for physiotherapy, he has been nothing short of wonderful! He listened to my questions no matter how daft they seemed to me and answered them clearly and thoroughly.

He is open, friendly, personable, and encouraging. He gave me so much reassurance and support throughout my initial recovery, which helped me build my confidence after my injury. He was kind, reassuring, and encouraging when I felt like I wasn't making any improvement or progress, and made sure to see me regularly which made me feel supported. I appreciated him doing a thorough recap during our appointments and making sure that I knew and understood what I was doing at every stage of my physiotherapy, with the occasional follow-up email when I had questions outside of our appointments.

His calm, cheerful attitude, along with expressing confidence in my abilities, has helped no end, especially when I have felt a bit low or vulnerable. Thank you, Nagata!

Rebekah Garland, Staff Nurse	**York**	**Nominated by patient**

Becky went above and beyond after my recent stay on Ward 26. I had to have emergency surgery in August and Becky looked after me the day before I had it. She was chasing up doctors to make sure I was seen and that procedures carried out as quickly as possible. She spoke, not just to me, but to every patient, with such care, compassion, and empathy. Everything that should come naturally as a nurse she 100% has.

I was discharged without aftercare paperwork or support information, so, I got in touch with Becky, and once again she went above what she needed to do and got me all the relevant information I needed. Becky is a brilliant example of how nursing should be and deserves to be recognised for it.

Zachariah Evans, Specialty Registrar | **York** | **Nominated by visitor and patient**

Zac has gone above and beyond in his role today for us. He has listened, communicated, and understood all our needs with pain management and past hospital stays, while trying to get the best outcome possible. It has been reassuring having the same person on the case to provide updates and progress, while also having a deep understanding of our needs and explaining it in an easy and cooperative way. Thank you for all your hard work, Zac!

Nataliia Shevko, User Access Technician | **York** | **Nominated by colleague**

Somehow, I had managed to lock myself out of several IT accounts. I needed to access them and had tried several times to overcome this. One morning, tired after a run of night shifts, I made a phone call to the IT department. Natalia was beyond helpful, talking me through the procedure and explaining things step-by-step until we had resolved all the issues.

This took a long time, but not once did she make me feel like a nuisance, despite me being clueless when it comes to modern technology. She was patient and kind, and I hope she knows how much I valued her assistance that morning. Thank you, Nataliia.

Dawn Carr, Maternity Support Worker | **York** | **Nominated by colleague**

Dawn is our Maternity Support Worker, and she is an asset to our team. Last week, I had car troubles and Dawn kindly drove me to visits so I could carry out visits and not let down postnatal ladies expecting home visits. She also brought me some scales today when mine broke at a visit. She is always calm and fair when allocating our work and holds our team together. We can always rely on her to help us.

Adam Brook, Consultant in Gynaecology | **Scarborough** | **Nominated by patient**

Adam Brook was there throughout my miscarriage when my baby died at 20 weeks due to a hematoma. He talked to me throughout my pregnancy, even when things got worse. He also came in and talked to me when I was getting ready to go to surgery when my baby was breech, and I was worried. Even aftercare was amazing in the Snowdrop Room.

When I got pregnant again, he was there, talking through every stage about what was going to happen. Throughout my pregnancy he was amazing, even coming up to the labour ward when I was getting ready to be induced. He was amazing. I cannot thank him enough for everything he has done.

You are a great consultant and knew what was going on even when I had hematoma bleeding. You were there that day, and while it was a slow progress, we got there in the end. Thank you.

Jo Naylor, Staff Nurse **Scarborough** **Nominated by patient**

Jo is amazing and kind to patients in recovery. She goes above and beyond to make sure they are comfortable and have the right pain medication. She accompanies them to the ward to make sure they are settled in OK. She shows excellence, kindness, and openness. I wish all staff were like her.

Ward 36 **York** **Nominated by colleague**

I was recently admitted to Ward 36 with ulcerative colitis and had a stay of nine days. I was then out of hospital for approximately two months before being re-admitted in early August with a flare up and have just returned to work mind-September. From the first morning I was there, I could see how everybody interacted with each other while getting ready for their shift together. There were a lot of smiling faces and getting things ready to start.

My stay in hospital this time was two weeks and one day, and while I was a patient my care was an example of all our values of openness, kindness, and excellence and to a high standard. Without singling staff out for special praise, I will say that every staff member had the same core values in mind, and any job, big or small, did not stop anyone giving their best.

From the domestics, PSAs, HCAs, nurses, doctors, and consultants to the IBD nurses and stoma nurses, every member of staff always had the time to explain my illness and give the best care possible. Each member of staff went above and beyond their duties. They were professional and caring and showed empathy not just to me, but other patients and visitors too. This ward deserves to be nominated for a Star Award.

Ariane Roucoule, Staff Nurse, and Tobi Daniel Adetula, Specialty Registrar **York** **Nominated by relative**

After a stressful Thursday, Ariane and Tobi's actions made Friday a positive day. Ariane was kind and understanding of our situation. She showed two sleep-deprived parents the empathy and warmth we desperately needed. She kept us updated regularly and explained things in a simple and clear way.

Tobi was a great support for Dad during the MRI, a scan which would not have taken place without both Tobi and Ariane's calm professionalism in settling our baby. We are grateful to both and think they should be recognised for their excellent work which we will never forget. Many thanks!

Eniola Ajiboye, Ophthalmology Consultant **Scarborough** **Nominated by relative**

After a recent eye check-up for my son, the optician referred him to the hospital for further tests. After a lot of in-depth tests over a couple of hours, we met Dr Ajiboye, who greeted us kindly and made sure we were comfortable. Dr Ajiboye carried out more tests on my son's eyes and made sure he understood and was comfortable.

Throughout our time spent with Dr Ajiboye, she was calm and collective. She explained everything in full detail, making sure that not just us as parents understood, but also our son. She was happy to re-explain in anything if needed. She put us at ease after feeling nervous about the tests. Dr Ajiboye was running a very busy clinic and did not let this stop her providing fantastic patient care and professionalism. Thank you, Dr Ajiboye.

Christina Sloper, Healthcare Assistant **York** **Nominated by colleague**

On a busy afternoon in the Discharge Lounge, an elderly patient came down on a trolley. Christina first sat with them while their carer went to the toilet. Christina then helped to give them a drink of orange juice, followed by support to eat some food as it looked like they needed food and drink.

Christina checked them over and noticed they were wet. She then looked after the patient's comfort by changing them. Christina said it was a good job she had checked the patient as they had a cannula in as well. Well done, Christina.

Helena Davis, Phlebotomist **York** **Nominated by patient**

I attended the surgery for blood tests, having been discharged from hospital three days prior. I was still feeling vulnerable and unwell. I advised the phlebotomist that I had already been 'attacked' for blood tests, medications, and drips, so venous access might be tricky.

She was utterly professional and reassuring while checking for the best site. The procedure was simple (for her) so there was nothing to worry about in the end! I came away feeling relieved and reassured.

Pauline Adams, Volunteer **York** **Nominated by colleague**

While Pauline was on duty, one of our staff members had to leave due to an emergency. Pauline kindly offered to stay and help. It ended up being a very busy afternoon and Paulines help was appreciated and needed! She ended up staying an extra three hours and most of her time was spent transporting patients by wheelchair to their appointments as the porters were busy.

Pauline is a valued member of our team, and I would like to say a big thank you for the kindness she showed that day and her invaluable help on what turned out to be a busy afternoon.

April Kirk, Bank Healthcare Assistant **York** **Nominated by patient**

April has been the Healthcare Assistant on the night shift while I've been in hospital with cholecystitis, and she is a breath of fresh air, calm, kind, and understanding. She does an amazing job and works hard and never stops. All night I see April running around and tending to her patients, no matter how late it is or tired she gets, she still delivers gold star standard of care, not just to me, but everyone I have seen her interact with. She engages beautifully with her patients and builds an amazing rapport with every single one. No job is ever too big to ask of her, and she never makes you feel like a chore.

April is genuinely one of the most fantastic people I have had the pleasure of meeting, and she made such a miserable experience easier to cope with. She displays appropriate humour to her patients and makes everyone smile. She maintains professional boundaries and always ensures her patients are as happy, looked after, and comfortable as they can be. Her positive approach to everything has made the biggest difference and she deserves the world, such a pure and beautiful person.

Committee Report

Report from:	Quality Committee
Date of meeting:	16th September 2025
Chair:	Lorraine Boyd

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

ALERT
* **Dermatology service** continues to be significantly impacted by the loss of dermoscopic triage, used to maximise safe care and efficient use of resources. In spite of all current mitigations and escalations this is a growing concern and the Care Group anticipate demand and waiting times will keep rising whilst the issue remains unresolved, with increased risk of patient harms. * **Cold store refurbishment delays**, and associated risk of failure with safety and financial impacts, in spite of repeated escalation, was shared. Wider discussion raised questions around the efficacy of processes to escalate safety concerns requiring estates solutions and a need for better assurance around responses and timely and dynamic prioritisation of requests. * **Digital interface systems** emerged as a theme, exemplified by issues around the feasibility of integrating EPMA with the current pharmacy ordering system, and by risks that have resulted from the need for dual entry of clinical information on to Medisight & CPD. The Trust clinical teams utilise a number of bolt on clinical platforms, not all of which will be superceded by Nervecentre. We would like to be assured that the full clinical & safety cost of suboptimal interfaces are considered, particularly in the value engineering decision making processes of business cases. * **Out of Hours Patient Transport** issue remains unresolved. Discussions continue and impact data is being collected
ASSURE
* **Complex Needs Q1 Report** was received and included an outline of the leadership and governance arrangements that are becoming strengthened and embedded, as well as the progress against the planned objectives and NICHE report improvement plan, residual risks and mitigations. It was highlighted that the Trust achieved 87% compliance with Oliver McGowan mandatory training and was nominated as a training hub. * **Quality & Safety Internal Audits** for 2024/25 have been completed and all received significant assurance. The programme of internal audits for 2025/26 and actions from previous IAs are currently on track. * **Learning from Deaths (LfD) Report** was received and there are no escalations to make. The LfD Group continues to meet monthly to review findings and support shared learning. Internal Audit issued a significant assurance report on LfD governance processes.

* **Pressure Ulcer Reduction** initiatives have led to a 15% reduction in newly developed category 2 pressure ulcers in June, with ongoing actions to sustain the improvement. This is a True North Priority Metric.

ADVISE

* **CSCS Care Group** attended and shared their new and ongoing risks& mitigations, along with their progress and successes.

* **LIMS(Laboratory Information & Management System)** successfully went live across the organisation on 1st September.

* **MIS Year 7 Update Report** received. Year 7 position and action plan has been submitted in line with required timescales. Currently on track to comply with 6 of 10 Safety Actions. Work ongoing on remainder and MIS funding to support with delivery of these confirmed. Progress report on MIS action plan will be shared

* **The Maternity Single Improvement Plan** delivery has been slowed down and will focus on business as usual and safety priorities, following a decision by the SLT in response to capacity constraints. Full improvement work will recommence from 1st November.

* **Section 31 Report** was received. Moderate harm incidents were discussed as well as an update on the evolving plan to bridge the maternity workforce gap.

* **The National Maternity Review** TOR have been published. The Trust is not directly involved but plan to review services through the same lens to proactively ensure our Single Improvement Plan aligns with potential recommendations from the review.

* **CQC Update** informed the Committee that the improvement actions in response to the CQC Inspection Report of the visits to York Urgent & Emergency Care and Medical Services have been accepted and quarterly CQC updates will be required. Quality Committee continue to monitor progress through CQC Compliance / Journey to Excellence quarterly report.

* **Q1 Sepsis Report** highlighted the work undertaken to bring greater clarity and understanding of the sepsis pathways, in the context of long standing performance challenges. Some improvements have been seen as a result of the increased scrutiny and focus, but significant challenges remain, particularly in areas outside of ED resuscitation. There is a need to ensure that sufficient resources are allocated to support this work, which is a key contributing mitigation to CRR 48 Response to the Deteriorating Patient.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

* CRR 48 ‘Response to the Deteriorating Patient’, via Sepsis Report
* CRR 50 s31 notice for maternity.
* CRR 601 ‘antenatal scanning’ - evidence shared to support risk score reduction to 8. Removal supported.
* CRR 51 ‘impact of built environment on IPC etc’ - the rationale for removing this risk from the CRR was shared by the Chief Nurse
* CRR 52 ‘failure to observe IPC policies & guidance’ - the recommendation to remove this risk from the CRR needs further discussion and review by IPSAG in September.
* CRR 54 ‘prescribing practice’ was discussed in context of cold store failure risk and EPMA/ Nervecentre interface.
* CRR 58 - ‘ageing infrastructure and backlog maintenance leading to failure of critical systems or accommodation’ was discussed in the context of the cold store failure risk and ventilation failures resulting in compromised endoscopy service in Bridlington, highlighted by CSCS Care Group.

Committee Report

Report from:	Resources Committee
Date of meeting:	16 September 2025
Chair:	Helen Grantham

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

ALERT

- **Diagnostics** – having shown an improving picture in late 24 DM01 performance was deteriorating:
  - 61.7% against trajectory of 72.7% - ranked 134th out of 157 nationally
  - Equipment breakdowns (MRI/CT), colleague resource challenges and infrastructure challenges (e.g. Scarborough CDC). These were discussed in detail and the benefits of good capital planning and sequencing of equipment replacement highlighted.
  - The main areas of concern are MRI, CT, NOUS, colonoscopy and gastroscopy – improvements expected due to endoscopy insourcing, cardiac CT outsourcing and go live of Scarborough CDC, although this will take time to work through the numbers
  - Discussions held with other trusts about assistance, but no capacity available

  See also section under ASSURE below.

- **Cancer** – not meeting trajectory for Faster Diagnosis Standard (FDS) and 62 day waits for first treatment (latter continuing to show a deteriorating position)
  - FDS – 69.8% (behind trajectory of 71.4%) - ranked 130th out of 137 nationally (a declining position)
  - 62 day waits for first treatment – remained at 62.2% against trajectory of 72.9% ranked 110th out of 145 nationally (a deteriorating position)
  - impact of diagnostics – see above and ASSURE section
  - the level of GP referrals for potential cancer remains high and a meeting to be held with the ICS regarding GPs ceasing certain diagnostic activity e.g. dermoscopy.

- **RTT** – total waiting list (TWL) continues to increase due in part to ongoing review of all waiting lists and movement of some patients to RTT list – this work has largely completed
  - 56,815 against trajectory of 45,033 (and ahead of NHSE submission as part of 25/26 planning submission)
  - 46th highest out of 152 nationally for proportion of waiting over 52 weeks
  - 95th out of 152 nationally for waits under 18 weeks (a slightly improving position)
  - Rapid Access Chest Pain clinic performance has improved slightly but remains significantly below target.

- **Acute**
  - ECS for August was below trajectory (91 out of 121 providers nationally)
  - Type 1 12+ hour trolley waits were behind trajectory and had shown a slight uptick after several months of positive improvement
  - actions were being taken in a number of areas to improve paediatric ECS performance.

- **Finance**
- £0.2m adverse variance to plan – discussions on:

- FY risk, cost improvement plan, sparsity and ERF payments
- NHSE approach to deficit funding and associated risk
- The most likely case year-end forecast – actions to return to a balanced plan were being identified and shared with NHSE and would be presented to the Board

ASSURE

- **Diagnostics** – detailed sessions with the CSCS and Medicine Care Groups to update on performance, challenges, where performance was off track plans to reduce waits to no more than 13 weeks and the oversight and governance in place to keep focus on this area and to monitor delivery. Despite current performance against trajectory, management were confident year end DM01 performance target would be achieved if no further equipment, estate or workforce issues where encountered, although targets for some individual tests were at risk - see ALERT for more information on key risk areas. The expected impact of the individual planned improvement schemes on DM01 performance and 13+ week waiter reduction was provided. Various opportunities for partnership working were being progressed and discussed. Additional information was requested.
- **Cancer** – compliant trajectories had been submitted to NHSE to achieve the national ambition of 80% for FDS and 75% for 62 day waits for first treatment
- A review of progress against **Q1 25/26 Annual Operating Plan actions** showed close to 75% had been completed, areas with delays included reduction in NCTR, ECS, workforce and culture and financial plan. Delays mainly relating to operational dependencies, engagement requirements and infrastructure challenges and there was no indication that these delays would compromise delivery of the overall plan.
- On 1 September 2025, the new Scarborough, Hull, and York Pathology Service (SHYPS) Laboratory Information Management System (LIMS) went live across the Scarborough, York and Hull Hospitals without any significant disruption. Good planning and testing had been key to successful roll out which was important to deliver efficiency and consistency across pathology services
- The **Nursing Workforce Report** on five priority areas (workforce efficiency, discontinuing agency work, reducing reliance on bank staff, reviewing nursing establishments, addressing NHSE's employment directive for pre-registered staff and monitoring CHPPD and fill rates as of July 2025) showed positive progress and performance against plans with the vacancy rate for registered nurses at 2.7%(4.2% in Oct 24) and a commitment to cease all agency spend (with limited exceptions) by 3 Nov 2025, with the risks to this timetable and associated mitigations noted.
- The **Winter Plan** was presented and discussed – it being noted that the plan was much improved from 2024 with more detail and scrutiny during production. Financial impact was anticipated to be £3.1m (with an aim to reduce this spend if this was not necessary to provide a safe level of care). The paper was approved for presentation to the Board in September.
- A report was shared on the progress with **eRostering** implementations and eRostering improvement work. Progress was good and the Trust's targets had been achieved. Next steps were to conclude roll out for all clinical roles to be following by admin/clerical and estates and ancillary roles with the entire workforce to be covered by summer 2026.
- The **UEC Update** provided positive assurance relating to NCTR, super stranded ratio and stranded ratio and a broadly steady average ambulance handover time showing much improvement for the trust over the last year and ahead of trajectory (but still some work to do to achieve peer standards). Some areas falling short of trajectory (see ALERT above).
- **YTHFM Business Assurance Report and Q1 Sustainability Report** were provided and discussed. On the whole performance was good, although underperforming on colleague sickness absence and visible cleanliness. The results of the YTHFM six-facet survey were expected shortly and would be reported to the committee, following which there would be a review of capital maintenance plans and potential need to reprioritise. The sustainability report was positive with some further successes in funding bids and no major risks highlighted. The Head of Sustainability was engaging with care groups to support more sustainable clinical practices.

ADVISE
- This was the first meeting following the revised agenda format for the Committee. The majority of time was spent on two deep dives into diagnostics – covering the CSCS and Medicine care groups
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
- The risks to meeting trajectory for some of the key **diagnostic areas** and the potential impact on meeting the **faster diagnosis targets for cancer** (see comments under ALERT and ASSURE above) - Risks to delivery of **financial plan** and the **cost improvement programme** – recent engagement with the ICB on commitment to meet a balanced while highlighting associated risks to delivery - an update would be provided to September Board.

Committee Report

Report from:	Group Audit Committee
Date of meeting:	09/09/2025
Chair:	Jane Hazelgrave

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

ALERT
• There have been delays in the progress of Internal Audit Plan work due to staffing and sickness issues. It is expected the work will be caught up throughout the year. • Three changes have been agreed to the audit plan: (i) combination of 2 planned pieces into one (Separate audits of Elective Operational Toolkit and Non RTT), (ii) Removal of Scarborough UECC Project Post Implementation Review as Deputy COO is undertaking this work already (iii) Staff Change forms – move form Q2 to Q4 • External Audit - not yet been able to issue the usual audit certificate confirming that we have completed all work necessary under the Code of Audit Practice. It is expected that the audit certificate will be issued once confirmation has been received from the National Audit Office that no further work is required on the Whole of Government Accounts. This is a national issue for all external auditors. • One IA report issued with the lowest rating: PKB rating (Low) • One IA report has been issued with a limited assurance rating Pharmacy Stock Process GRNI
ASSURE
• External audit planning has commenced for 2025/26. • YTFM IA : 6 recommendations were closed with satisfactory evidence to support closure. • Trust IA : 45 out of 45 actions closed with satisfactory evidence • Two other reports have been issued Quality Assurance Framework : Significant Data Security and Protection Toolkit: Very High/Medium • Overdue actions fallen from 21 in July to 9 in September. No overdue actions were classed as major. • In light of the upcoming implementation of the Failure to Prevent Fraud offence under the Economic Crime and Corporate Transparency Act 2023, the LCFS is currently undertaking a proactive review to assess organisational preparedness across the organisation. • A presentation was made on the annual FTSU report that will also go to board. • The BAF and risk register were discussed with nothing to escalate to the board • Losses and special payments were reviewed • A treasury management policy was approved.

ADVISE
• Governance, Risk Management and Audit – 26 November 9-12.30pm via MS Teams This, virtual, half day event will cover a range of topics particularly pertinent to Board and

Audit Committee members responsible for overseeing governance and risk management arrangements within their organisations.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• Role of audit committee in review of BAF and Risk register and how these fit in with wider governance structures at the Trust. • The remit of the audit committee and workplan need to be reviewed in light of the clarification of the role of the committee. • Cyber Risks were discussed in light of a recent benchmarking report conducted by Audit Yorkshire The report will go to the digital committee and then to audit committee.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 12

TRUST PRIORITIES REPORT

September 2025

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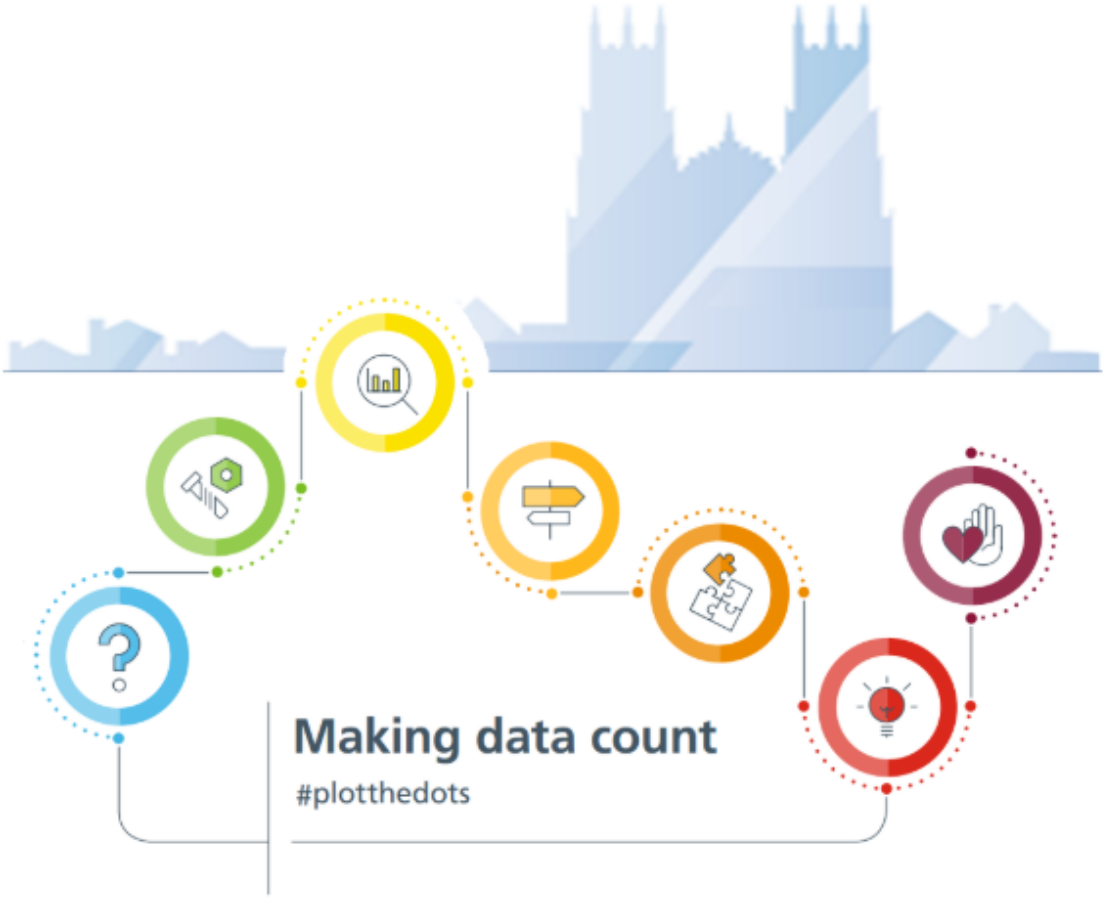


Executive Summary

True North Priority Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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)	2025-07			36.6%		49%
Percentage recommending the Trust as a place to work (quarterly - data source is PULSE, Staff Survey data omitted for Q3)	2025-07			39.1%		50%
Inpatients - Lost bed days for patients with no criteria to reside	2025-08			1228		
ED - Emergency Care Standard (Trust level)	2025-08	H	F	68.9%	72%	78%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-08	L	F	13.3%	10.9%	8.9%
Cancer - Faster Diagnosis Standard	2025-07		F	68.1%	72.9%	80.1%
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-08	H	F	56.9%	56.5%	60.5%
Inpatient Acquired Pressure Ulcers - Category 2	2025-08		?	107	60	60
Total Number of Trust Onset MSSA Bacteraemias	2025-08		?	9	7	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.

TPR metric performance to note:

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"):

- Maternity - Community Midwife called into unit – Scarborough.
- Workforce - Twelve month rolling turnover rate Trust (FTE).

Special Cause Concern – Fail (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 - RTT – Total Waiting List.
- Operational Performance – Children & Young Persons: RTT – Total Waiting List.
- Operational Performance - Diagnostics – Proportion of patients waiting <6 weeks from referral – MRI.
- Operational Performance - Diagnostics – Proportion of patients waiting <6 weeks from referral – Colonoscopy.
- Operational Performance - Diagnostics – Proportion of patients waiting <6 weeks from referral – Gastroscopy.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

OPERATIONAL ACTIVITY AND PERFORMANCE

September 2025

Headlines:

- The August 2025 Emergency Care Standard (ECS) position was 68.9%, against the monthly planned improvement trajectory of 72%. In the latest available national data (July 2025) the Trust ranked 91st out of 121 providers nationally. **ECS performance is a True North metric.**
- Average ambulance handover time in August 2025 was significantly ahead of trajectory at 21 minutes 22 seconds against trajectory of 29 minutes 52 seconds.
- 13.3% of Type 1 patients spent over 12 hours in our Emergency Departments during August 2025, behind the monthly improvement trajectory of 10.9%. **This is a True North Metric.**
- In August 2025, the proportion of patients in our care who no longer meet the criteria to reside was 13.5% ahead of the internal trajectory of 14%.
- The average non-elective Length of Stay (LoS) for patients staying at least one night in hospital was 6.2 days during August 2025 (3,792 spells of care covering 23, 525 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 86.6% (3,283 patients out of 3,790), behind the trajectory of 87.8% 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 2.9 days, ahead of the submitted trajectory of 3.6 days.

Factors impacting performance:

- Scarborough ED performance of Type 1 patients is where our biggest challenge remains, with performance consistently around 8 percentage points behind that of York. Attendances to Scarborough ED are always higher over the summer and have grown significantly year-on-year.

Actions planned in September 2025:

- Recruitment is underway at Scarborough Emergency Department for middle grade medics to reduce the use of bank staff. This will allow a small increase in the current roster while work is underway to determine full roster requirements for the increasing demand.
- Scarborough Minor Injuries has additional staff in training, which should positively impact the service in the coming months, and a pipeline plan for more each year.
- The York Emergency Department Ambulatory Care (EDAC) pathway has a new dedicated space which is pending some final minor works before being available for use in September.
- Job adverts are out for Advanced Care Practitioners at Selby and Malton; more patients will be able to be treated at these sites, and fewer patients will need onward referral to an acute site.
- Further tests of change for streaming and SDEC capacity

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

Acute Flow (1)
Scorecard

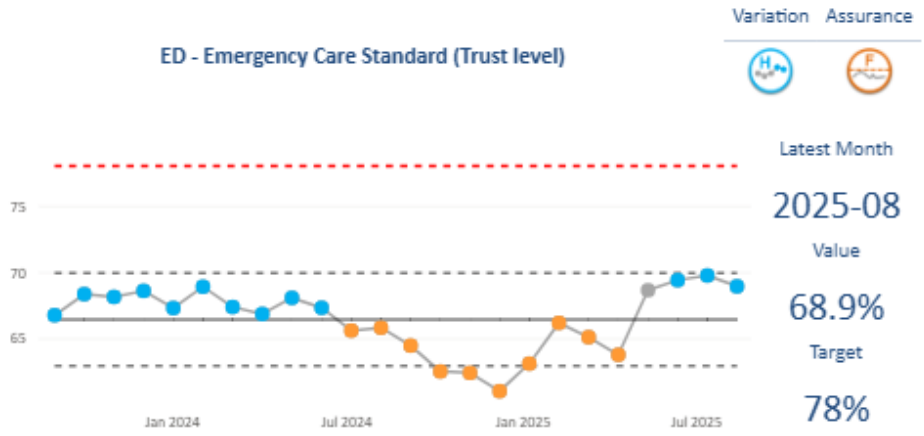
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2025-08			78.9%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2025-08			30%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-08			13.3%	10.9%	8.9%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2025-08			1420		
ED - 12 hour trolley waits	2025-08			315		0
ED - Emergency Care Attendances	2025-08			18939	15880	16377
ED - Emergency Care Standard (Trust level)	2025-08			68.9%	72%	78%
ED - A&E attendances - Type 1	2025-08			10651	10665	10999
ED - Emergency Care Standard (Type 1 level)	2025-08			47.6%	60%	69.2%
ED - A&E Attendances - Types 2 & 3	2025-08			8288	5215	5378
ED - Median Time to Initial Assessment (Minutes)	2025-08			4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-08			44.7%		

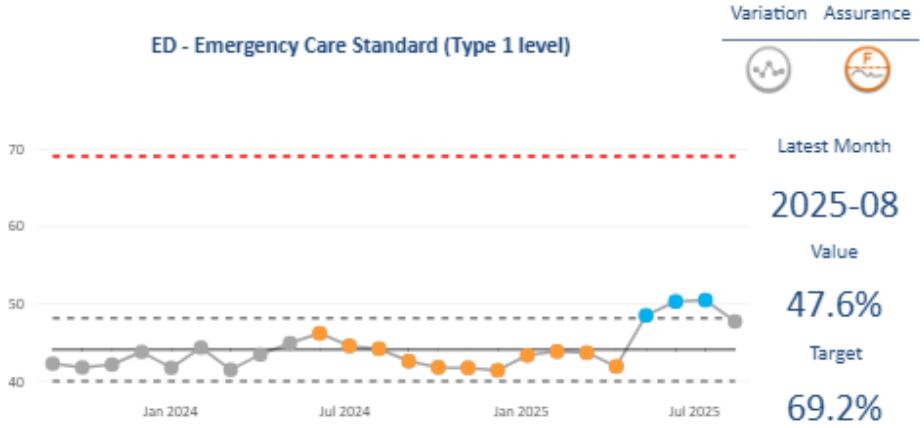
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

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



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 **2.8**.

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?

The focus in September will be to support improvement at Scarborough Hospital Emergency Department in particular:

- Increased streaming to Urgent Treatment Centre and specialties
- Refining Emergency Department Ambulatory Care (EDAC) pathway
- Training additional Minor Injuries staff
- Recruiting additional trust grade medics

At York the focus will be on ensuring EDAC operates well from its new location, and increasing consistency of huddles and board rounds. Interviews will take place for the new Flow Coordinator role which is currently out to advert.

Recruitment will take place for Advanced Care Practitioners at Selby and Malton.

What is the expected impact?

The impact of successfully achieving the above will be improvements in 4hr performance.

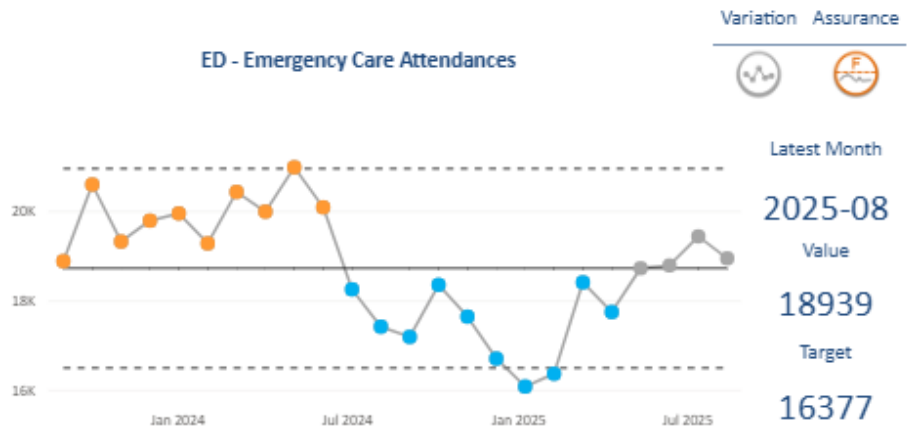
Once newly recruited ACPs are in post at Selby and Malton, more patients will be able to be treated at these sites, and fewer patients will need onward referral to an acute site

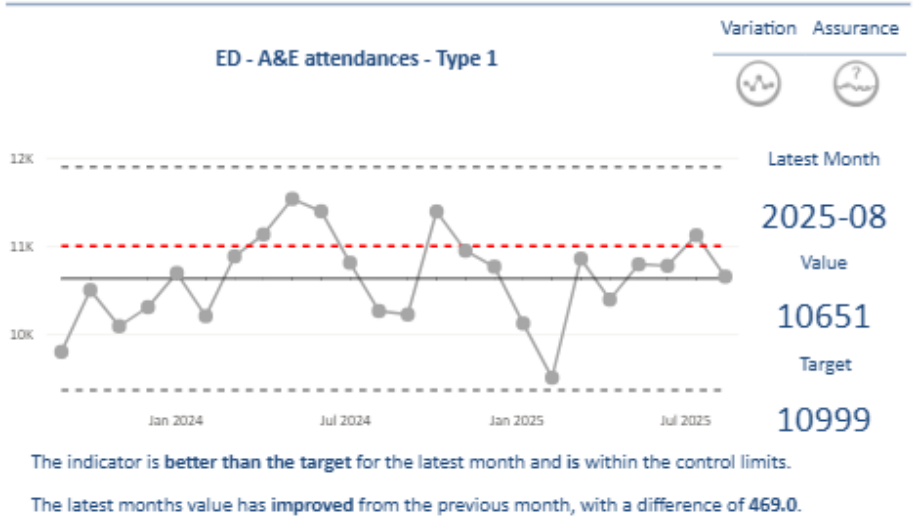
Potential risks to improvement?

There is a risk that recruitment of the outlined posts is not successful, which would delay increase in capacity and capability.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

The antibiotics pathway for Virtual Wards is being developed with Pharmacy and Microbiology.

Yorkshire Ambulance Service are linking with Scarborough frailty services to start developing a direct frailty pathway for crews.

Following recruitment and confirmation of ICB funding, Nimbuscare are continuing to expand the geography of their community initiatives.

Our community team is working with YAS to review Tier 1 falls pathways, with a view to increasing consistency of use and reducing conveyances to acute hospitals.

An audit of patients from East Riding being conveyed to our hospitals is underway by colleagues in the ICB, with a view to identifying themes and opportunities for reduction.

What is the expected impact?

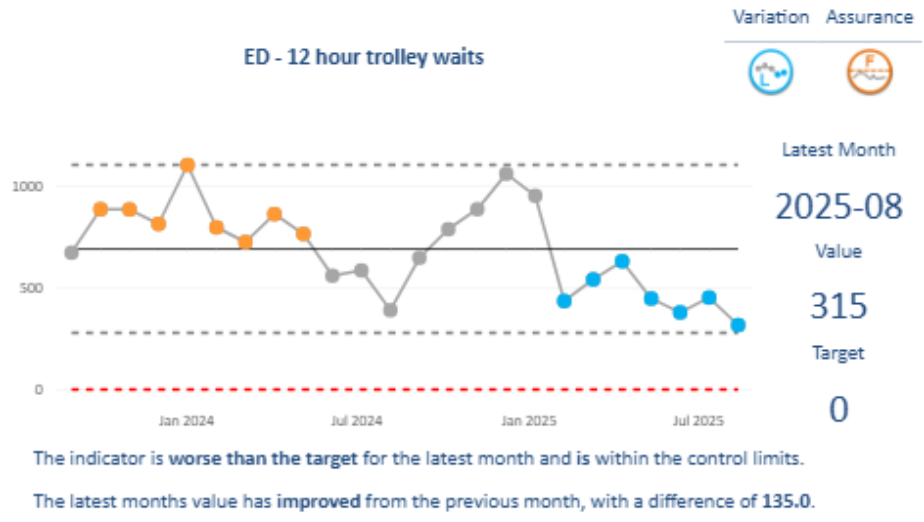
Increasing utilisation of alternative pathways may reduce conveyances to acute sites and could reduce the *proportion* of Type 1 activity. However, attendance numbers could still rise in-line with overall demand.

Potential risks to improvement?

We have insufficient urgent community response capacity to manage more patients at home; more therapists, particularly in York city, are required.

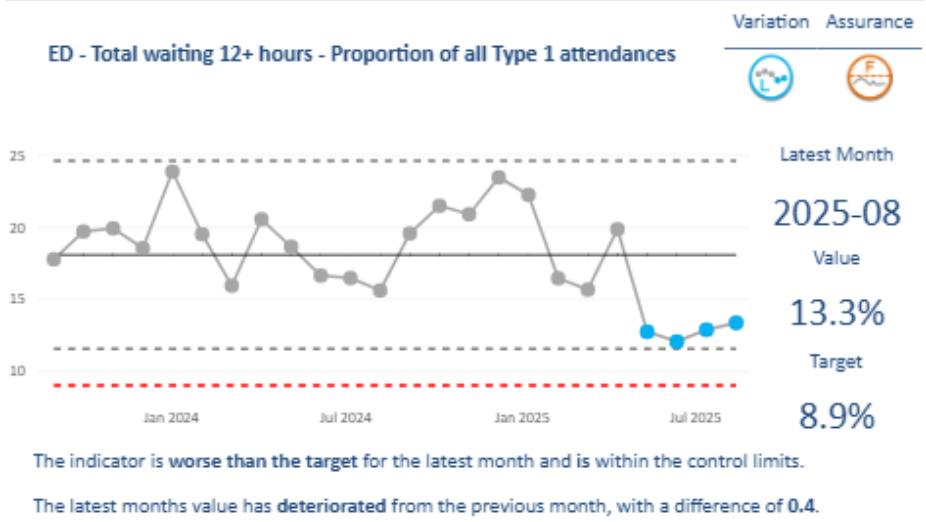
Executive Owner: Claire Hansen

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 **135.0**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **0.4**.

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?

A Rapid Improvement event is being planned by the Quality Improvement team, to review deployment of the Continuous Flow policy and opportunities for further development.

What is the expected impact?

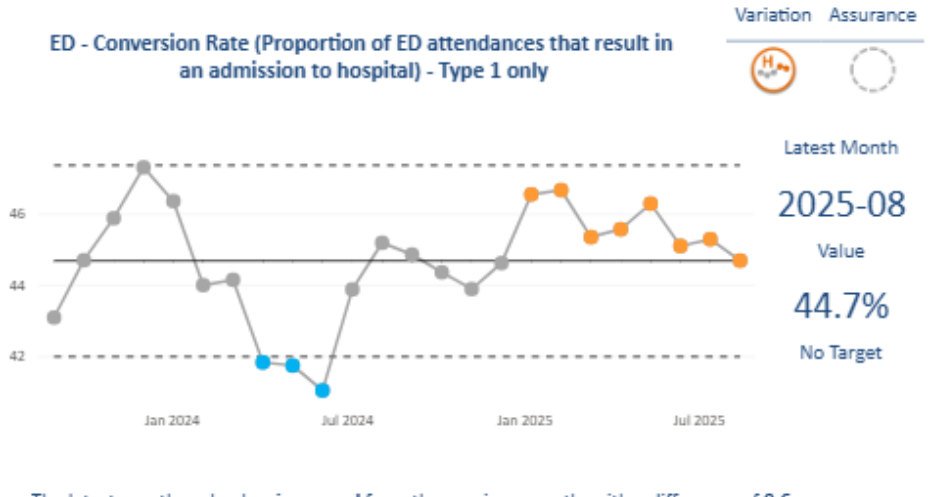
A continued reduction in long waits for admission.

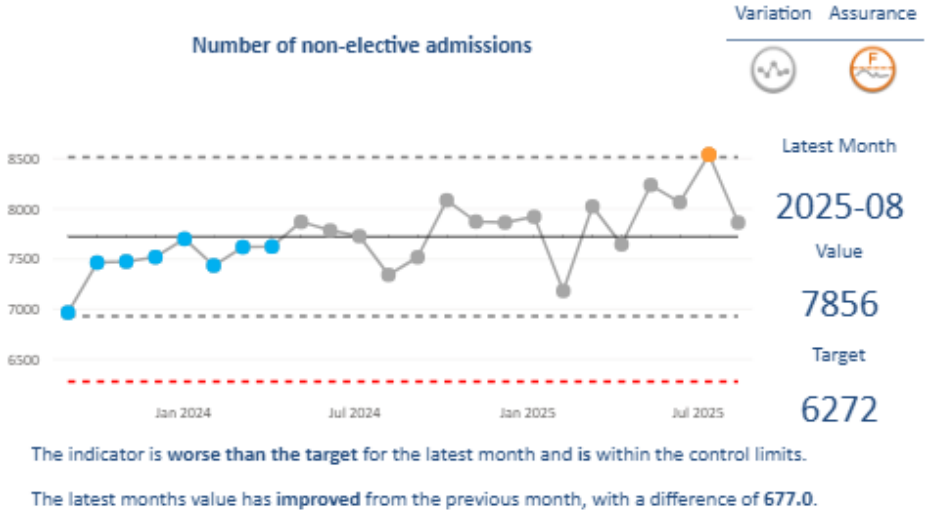
Potential risks to improvement?

When acute hospitals have very high occupancy levels, wards may find it difficult to safely receive 'additional' patients through continuous flow.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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?

A full workforce review is underway for both Emergency Departments, and a business case is being developed accordingly. There is a theory that having more senior decision makers on the roster will lead to fewer diagnostics and admissions, hence creating efficiencies which would fund the workforce plan. Further detailed data analysis will check and challenge this theory before the business case is presented. This is complex modelling work involving clinical leaders, resourcing, finance, operational managers and other supporting teams.

What is the expected impact?

A workforce model fit for current and future demand, which supports a sustainable and supported workforce.

Potential risks to improvement?

There is a risk that the business case for the workforce models at York and Scarborough Emergency Departments cannot find the required resources from efficiencies alone.

Acute Flow (2)
Scorecard

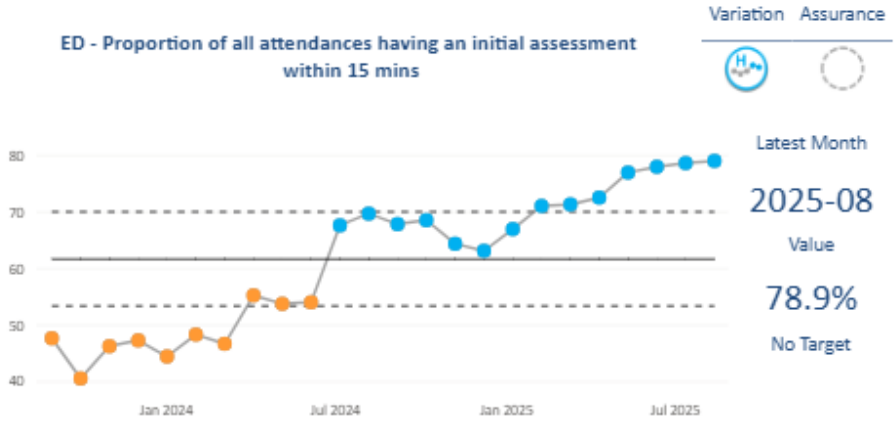
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2025-08	H		44.7%		
Number of SDEC attendances	2025-08			2533		
Proportion of SDEC attendances transferred from ED	2025-08			64.9%		
Proportion of SDEC attendances transferred from GP	2025-08	H		27.4%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-08	H		69.3%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-08			16.5%		
Number of RAFA attendances (York Only)	2025-08			128		
Number of attendances at SAU (York & Scarborough)	2025-08			987		
ED - Proportion of Ambulance handovers within 15 mins	2025-08	H		36.8%		
ED - Proportion of Ambulance handovers waiting > 30 mins	2025-08	L		20.1%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2025-08	L	F	4.8%		0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2025-08	L	?	0%		0%
ED - Number of ambulance arrivals	2025-08	H		4762		
ED - Ambulance average handover time (number of minutes)	2025-08	L	?	21	29	29

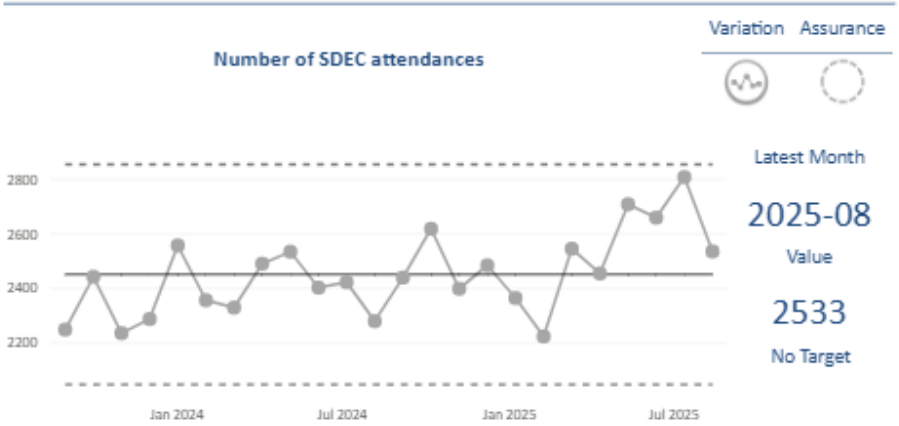
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The indicator is **equal to the baseline** for the latest month and **is not** within the control limits.

The latest months value has **improved** from the previous month, with a difference of **0.4**.



The latest months value has **deteriorated** from the previous month, with a difference of **273.0**.

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

What actions are planned?

Continuing to monitor attendances at SDECs and developing further tests of change which will reduce the number of 'bring back' elective patients and create more capacity for emergency patients.

What is the expected impact?

A 20% reduction in bring back activity in each affected SDEC unit. This will allow for more direct SDEC admissions and quicker movement of patients from ED to SDEC.

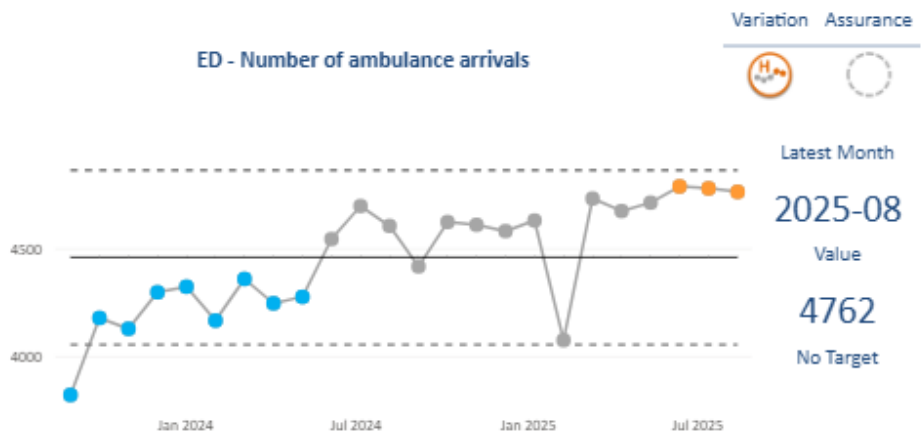
Potential risks to improvement?

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.

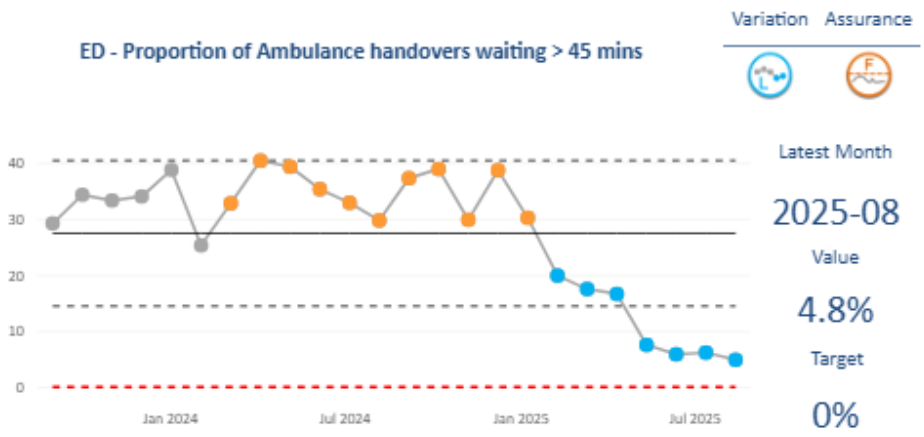
There is a risk that the number of patients impacted by the test of change is higher than expected, putting more pressure on specialty teams who could be unable to find appropriate and safe solutions for seeing their elective patients outside of SDEC.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **16.0**.



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 **1.3**.

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.

What actions are planned?

An audit of all ambulance handovers over 45 minutes at Scarborough Hospital throughout August has been completed. A number of discrepancies between data sets have been identified. The next step is to meet with Yorkshire Ambulance Service colleagues to discuss those discrepancies. The operational team plans to then agree a joint approach to improving data quality.

What is the expected impact?

Higher quality data which better reflects ambulance handover times, and a reduction in the number of handovers over 45 minutes.

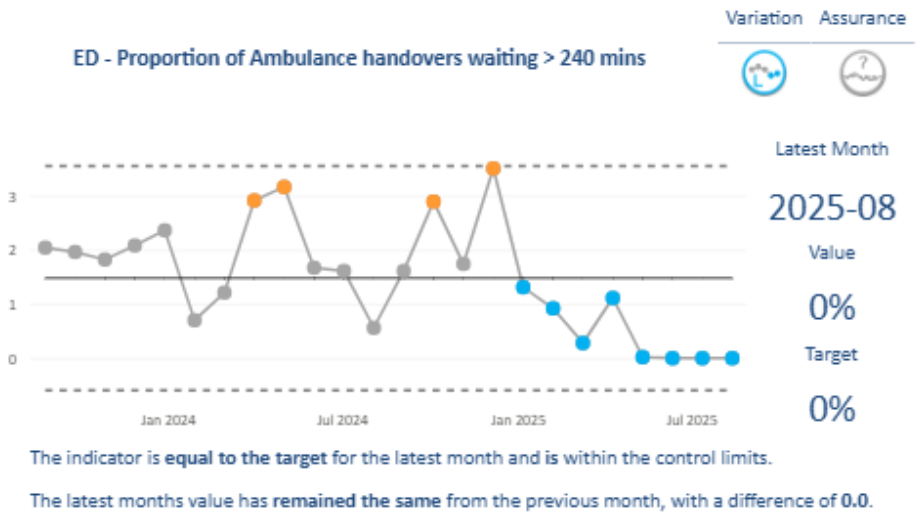
Potential risks to improvement?

There is a risk that we cannot influence ambulance crew behaviours which lead to delays in recording handovers.

There is an issue that we cannot check and challenge YAS data until after the data has been submitted, meaning even if we agree that recording was incorrect we cannot change it.

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

ASSURANCE

VARIATION

	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT		* Of those overnight general and acute beds open, proportion occupied	* Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside
COMMON CAUSE / NATURAL VARIATION	* Overnight general and acute beds open	* Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD) * Number of zero day length of stay non-elective admitted patients * Community bed occupancy/availability	* Patients receiving clinical Post Take within 14 hours of admission * Inpatients - Proportion of patients discharged before 5pm * Number of non-elective admissions
SPECIAL CAUSE CONCERN			

Acute Flow (3)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

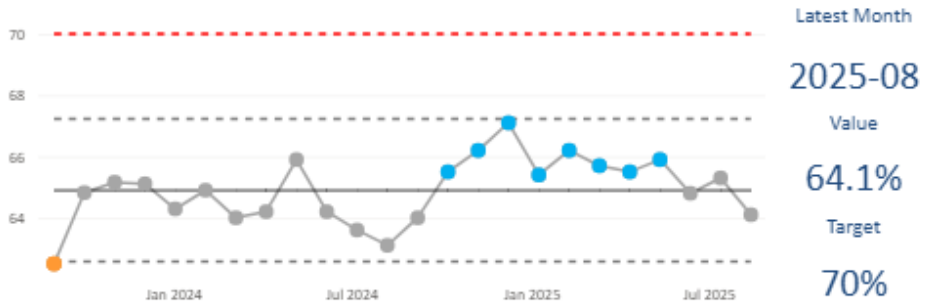
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2025-08		F	76.6%		90%
Patients with Senior Review completed at 23:59	2025-08			46.3%		
Inpatients - Proportion of patients discharged before 5pm	2025-08		F	64.1%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2025-08			1228		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2025-08	L	F	13.5%	14%	12.5%
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2025-07		?	3.8	3.6	3.9
Number of non-elective admissions	2025-08		F	7856	6029	6272
Number of zero day length of stay non-elective admitted patients	2025-08		?	2418	2370	2464
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2025-08			118		
Overnight general and acute beds open	2025-08		P	872	832	832
Of those overnight general and acute beds open, proportion occupied	2025-08	L	?	91.1%		92%
Community bed occupancy/availability	2025-08		?	88.2%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Inpatients - Proportion of patients discharged before 5pm

Variation Assurance



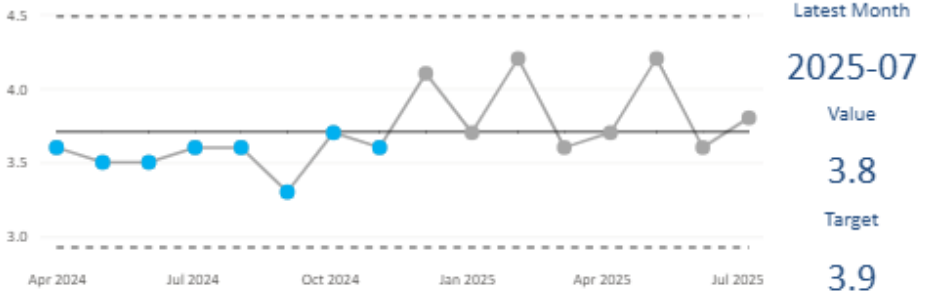
Latest Month
2025-08
Value
64.1%
Target
70%

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 **1.2**.

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

Variation Assurance



Latest Month
2025-07
Value
3.8
Target
3.9

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

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.

What actions are planned?

Multiple workshops and training sessions, run in conjunction with Emergence Care Improvement Support Team (ECIST). These are about discharge processes, risk aversion in clinical management plans, and clinical tools such as criteria-led discharge.

Creating data packs for each ward or specialty, helping frontline teams to understand their indicators and actions which contribute to improving them.

What is the expected impact?

Increased sense of ownership on the wards or within specialties, relating to their discharge performance metrics.

Potential risks to improvement?

There is a risk that increased knowledge does not necessarily change behaviours that contribute to changes.

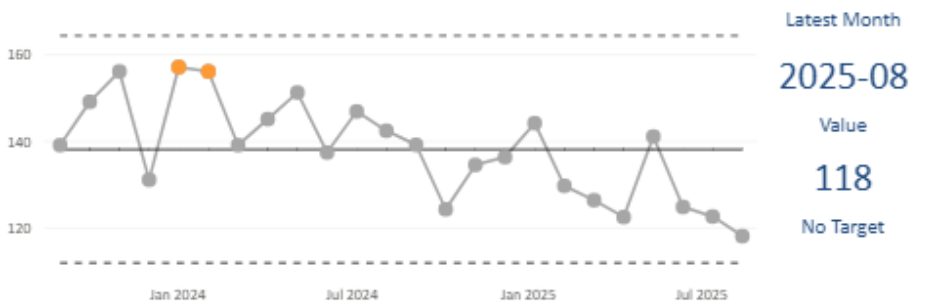
There is a risk of low attendance at training sessions since they are not mandated.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: **SPC1:** No Target. **SPC2:** Internal aim to achieve less than 12.5% by March 2026.

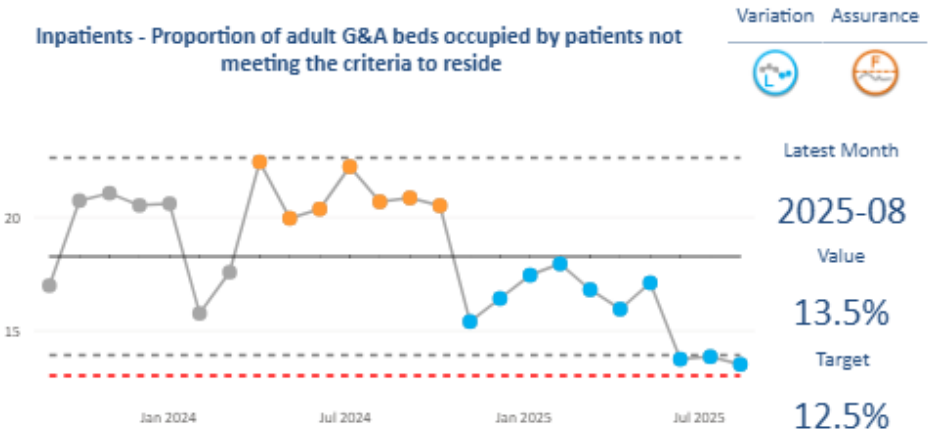
Inpatients - Super Stranded Patients, 21+ LoS (Adult)



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

The latest months value has **improved** from the previous month, with a difference of **4.5**.

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



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 **0.3**.

What actions are planned?

Review of Long Length of Stay (LLoS) reviews to determine use and options for further development of the sessions.

Weekly case reviews of complex patients >21 days which can inform changes to medical plans.

Continued use of escalation processes both internally and with external system partners.

What is the expected impact?

Continued reduction in the number and proportion of patients who do not meet the criteria to reside.

Potential risks to improvement?

There is an issue that some delays to discharges are due to patients needing complex packages of care which cannot easily be sourced; this is escalated appropriately.

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

- The Cancer performance figures for July 2025 saw performance against the 28-day Faster Diagnosis standard (FDS) of 69.8%, failing to achieve the monthly improvement trajectory of 72.9%. In the latest available national data (June 2024) the Trust ranked 130th out of 137 providers nationally (as a comparator, May 2025: 120th). **This is a True North Metric.**

- 62 Day waits for first treatment July 2025 performance was 62.2%, with the monthly trajectory of 71.3% was not achieved. In the latest available national data (June 2024) the Trust ranked 110th out of 145 providers (May 2025: 98th). The HNY cancer alliance footprint remains one of the lowest performing in the country for 62 days.

- Performance against both targets showed 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. As of end of August provisional position, a 15.6% improvement is required to achieve the FDS year end trajectory and a 13.3% improvement is required to meet the 62 days target.

Factors impacting performance:

- July 2025 was the highest referrals received month for urgent suspected cancer referrals in Trust history (3,423). This increase in referrals is impacting on number of patients on patient tracking list and 28 day faster diagnosis. This is the third consecutive month that referrals have been over 3,000. This appears to be a regional trend.
- The following cancer sites exceeded 80% FDS in June 2025: Breast & Skin
    - Gynaecology, Head and Neck, Lung, Skin and Urology achieved above their internal trajectories.
- The following cancer sites exceeded 75% 62-day performance in July 2025: Breast
    - No site achieved above their internal trajectory.
- 31-day treatment standard was 98.3% overall, achieving the national target of 96%.
- At the end of July, the proportion of patients waiting over 104+ days equates to 1.4% of the PTL size with 34 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.
- Diagnostic performance, in particular endoscopy and imaging is impacting faster diagnosis performance due to delays in diagnostic pathways.
- Seasonality has increased patient unavailability impact on faster diagnosis pathway.

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

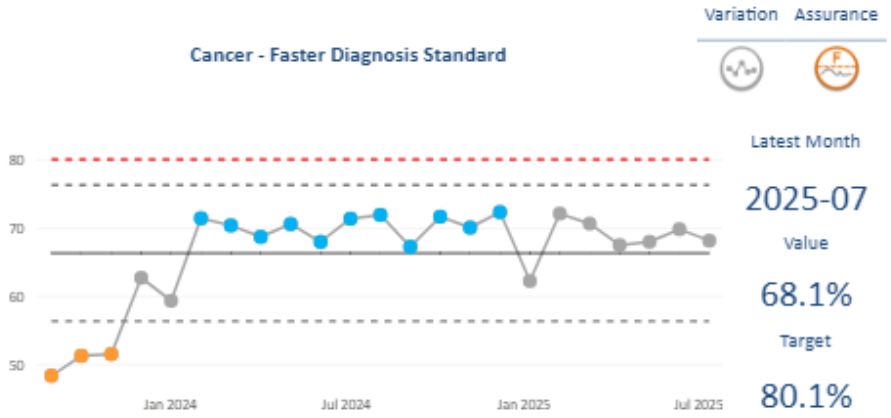
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

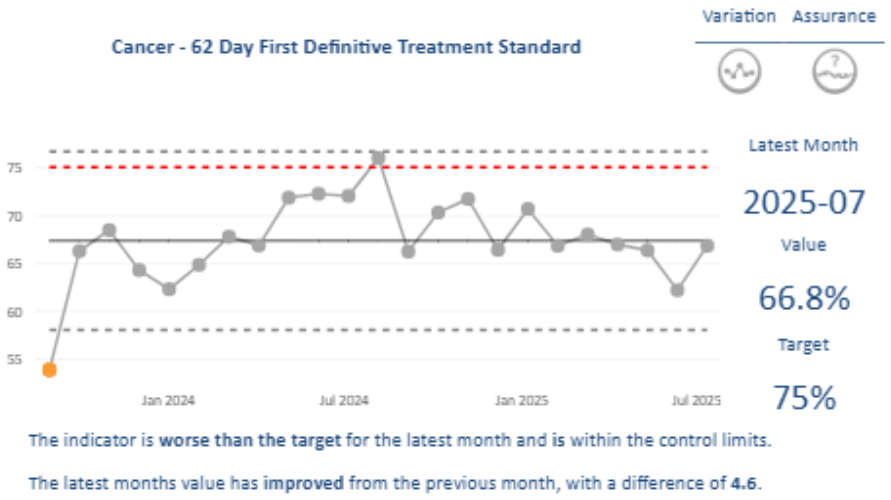
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard	2025-07		F	68.1%	72.9%	80.1%
Cancer - 62 Day First Definitive Treatment Standard	2025-07		?	66.8%	71.3%	75%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2025-08			203		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2025-08	L		7.8%		
Cancer 31 day wait from diagnosis to first treatment	2025-07		?	98.3%		96.1%
Total Cancer PTL size	2025-08			2432		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2025-08		F	70.7%	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?

Cancer PTL Management tool: Tool developed, training taking place across organisation
Breast: Agreed use of one stop clinic slots to bring breach patients forward
Colorectal Plan: Frailty pathway agreed, to be implemented September onwards. Constructive discussion with cancer alliance primary care lead around referral appropriateness and next steps agreed. Ongoing work with Rapid Diagnostic Centre (RDC) redirect pathway for colorectal patients who are suitable. Plans to recover colonoscopy capacity linked to endoscopy actions detailed in diagnostic recovery plan. Continued work on moving MDT day to earlier in week.
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. Review of PSA pathway to understand opportunities for streamlining and efficiencies. Initial conversations planned around scoping potential one stop CDC models for 2026 onwards.
Gynaecology Plan: Locum consultant providing additional sessions to recover position. Agreed implementation date September for PMB pathways 2025. Working through 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?

- Referral volumes across majority of cancer sites exacerbating demand and capacity gap for 1st OPA across all cancer sites
- Industrial action in July; cancer impact mitigated with no D2 or P2 cancellation. Impact on lost outpatient activity and administrative tasks whilst senior medical staff covered acute rotas.
- Cancer performance dependent upon diagnostic capacity and recovery plans
- Skin Pathways: Ongoing discussions with ICB, however due to loss of consultant who had a high FT caseload, dermoscopy service is reviewing ability to offer routine appointments given volume of FT received.
- Seasonality- patient & staff unavailability due to planned holidays/annual leave

Headlines:

- At the end of August 2025, the Trust had thirty **Referral To Treatment (RTT) patients waiting over sixty-five weeks**, an increase on the ten at the end of July 2025.
- The Trust's **RTT Total Waiting list position** ended August 2025 behind the trajectory submitted to NHSE as part of the 2025/26 planning submission: 56,815 against the trajectory of 45,033.
- The Trust is ahead of the trajectory for the proportion of the **RTT waiting list waiting under 18 weeks**: 56.9% against 56.5%. In the latest available national data (June 2025) the Trust ranked 95th out of 152 providers (May 2025: 102nd). 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; 1,988 waiters and 3.5% of the total RTT Total Waiting list against the trajectories of 855 and 1.9%, respectively. In the latest available national data (June 2025) the Trust is 54th in terms of the highest number of RTT52 week waiters (55th at end of June 2025) and is ranked 46th highest out of 152 providers for the proportion of the TWL waiting over 52 weeks (June 2025: 56th). Nationally at the end of June 2025 there were 188,022 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 59.9% against the end of August 2025 ambition to be above 60.3%. There is currently no nationally available comparative data +for this metric.

Factors impacting performance:

- RTT Total Waiting List metric impacted by an increase in referrals in Quarters 1 and 2 of 2025/26 and the update to CPD logic which has resulted in additional RTT clocks being opened since April 2025.
- Delivery of the 2025/26 elective recovery plan; initial analysis shows that at the end of August 2025 the Trust was ahead of the 2025/26 plan with a provisional performance of 103% 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 - Proportion of incomplete pathways waiting less than 18 weeks * RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks
COMMON CAUSE / NATURAL VARIATION			* RTT - Waits over 52 weeks for Incomplete Pathways
SPECIAL CAUSE CONCERN			* RTT - Total Waiting List

Referral to Treatment (RTT)
Scorecard

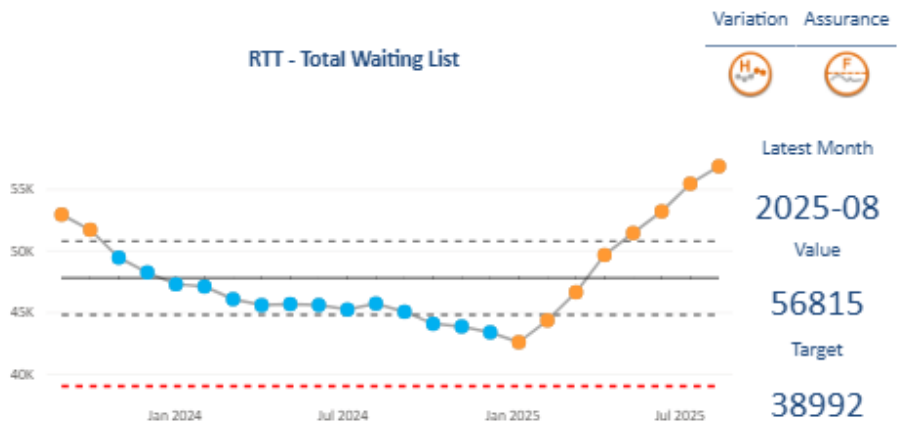
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
RTT - Total Waiting List	2025-08	H	F	56815	45033	38992
RTT - Waits over 78 weeks for incomplete pathways	2025-08	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways	2025-08	L	F	30	0	0
RTT - Waits over 52 weeks for Incomplete Pathways	2025-08		F	1988	855	389
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-08	H	F	56.9%	56.5%	60.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2025-08	L		18.4		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks	2025-08	L	F	3.5%	1.9%	1%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2025-08			59.9%	60.3%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2025-08			1.8%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2025-08	L		11.9%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2025-08	L		66.4%		

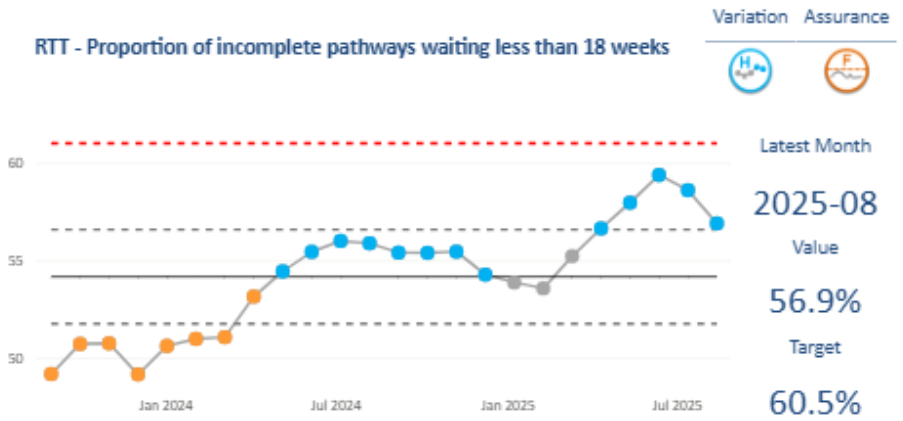
Executive Owner: Claire Hansen

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 **1410.0**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **1.7**.

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 Q2 sprint commenced on the 7th of July with NHSE setting the Trust a target of 29,975 RTT clock stops. At the end of the eighth week, the Trust is 20.7% ahead of the baseline.

- RTT clock change rules have been in place for since late March 2025, and manual validation is effectively completed, therefore it is not anticipated that there will be further impact on the waiting list over and above standard referral volumes.

What is the expected impact?

- Reduction in the TWL or offsetting impact of the ongoing increase in referrals and clock starts.

- 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 referral increase may result in further rises to the RTT TWL. Data quality validation is almost completed and any further impact should be minimal. In order to stabilise the waiting list we need to focus on increasing clock stop activity and validation. This has been communicated to NHSE.

- Increase in referrals in Q1 and Q2 to date of 25/26 compared to same period in 24/25. Discussions with ICB ongoing to identify causes of referral increases.

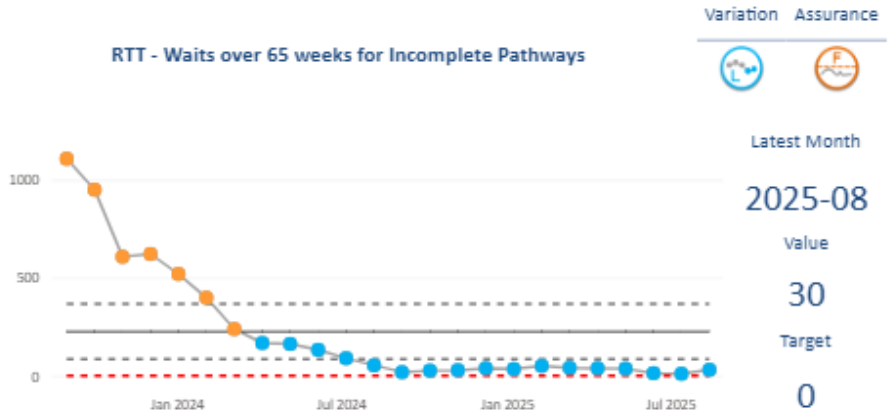
KPIs – Operational Activity and Performance

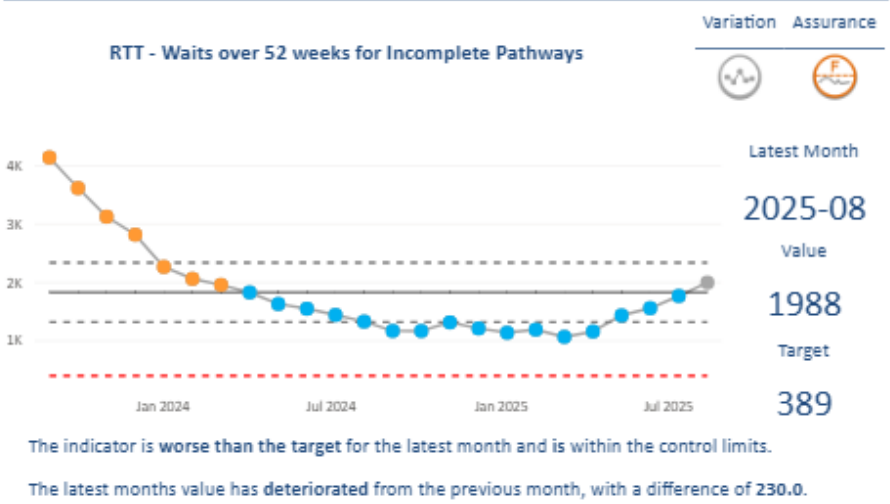
Referral to Treatment RTT (2)

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. Review of spend to date and highest risk specialities at July 25 completed. £3.4million remains available and focus will be on radiology and respiratory.
- 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?

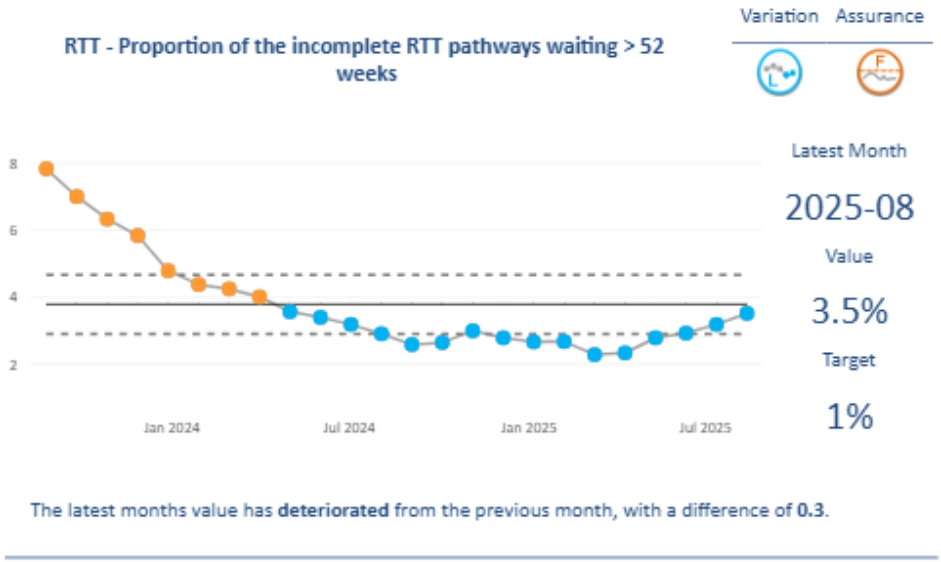
- Reduced RTT long waiters to meet 2025/26 planning trajectories.
- ERF money targeted at specialties most in need.

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 August 2025, the Patient Initiated Follow Up (PIFU) was behind the improvement trajectory of 4.4% with performance of 4.2%. 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 34.3% (July: 25.2%) 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 in 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.
  - Recent instability in locum workforce has impacted capacity and improvement trajectory.

- 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 tp be completed in Q3.
  - Roll out digital clinical letters on pan for Q3.
  - 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) * Electives (based on Activity v Plan)	* Outpatients - Proportion of appointments delivered virtually (S017a) * Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks) * Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)
SPECIAL CAUSE CONCERN			

Outpatients & Elective Care
Scorecard

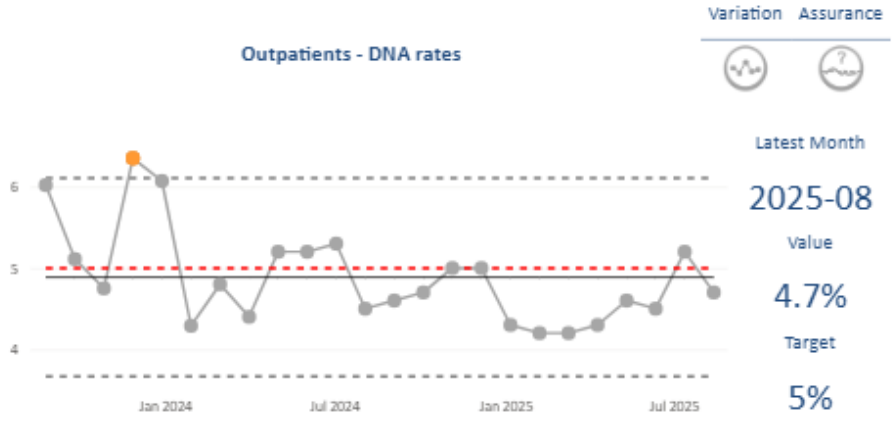
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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)	2025-08		F	21.9%		25%
Outpatients - DNA rates	2025-08		?	4.7%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2025-08	H	?	17836	15591	17494
Outpatients: Follow Up Attendances (Activity vs Plan)	2025-08		?	39374	36422	38846
Outpatient procedures	2025-08			14043		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2025-08		F	27151		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2025-08	H	F	4.2%	4.4%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2025-08		F	34.3%		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*	2025-08		?	7		0
Day Cases (based on Activity v Plan)	2025-08		?	7107	7854	8144
Electives (based on Activity v Plan)	2025-08		?	612	755	816
Proportion of elective admissions which are day case	2025-08		P	92.1%		85%
Outpatients: All Referral Types	2025-08			20982		
Outpatients: Consultant to Consultant Referrals	2025-08			2239		
Outpatients: GP Referrals	2025-08			10183		

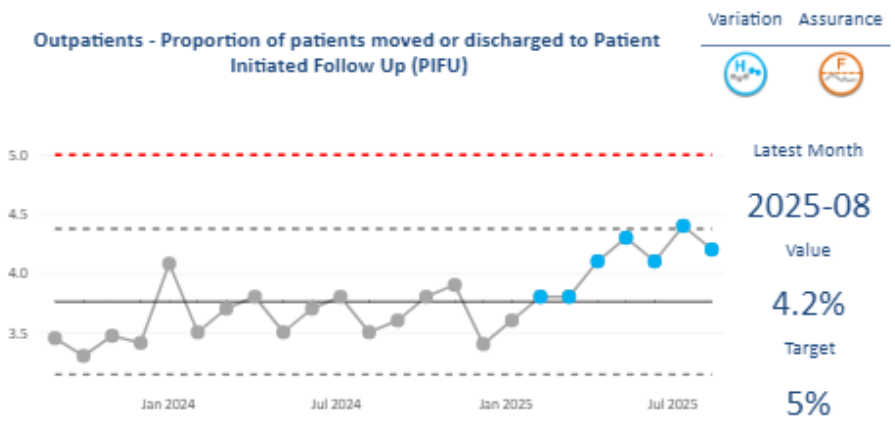
Executive Owner: Claire Hansen

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 **0.5**.



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.
- Weekly RACP meetings have been established with medicine care group. Focused actions are:
    - Additional ad-hoc capacity being scheduled.
    - 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.
    - SGH triage pilot commenced in July 2025, initial evaluation shows a reduction in 20% .

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. Forecast to deliver 5% by end of Q3.
- **RACP:** Improved performance and improved patient experience.

Potential risks to improvement?

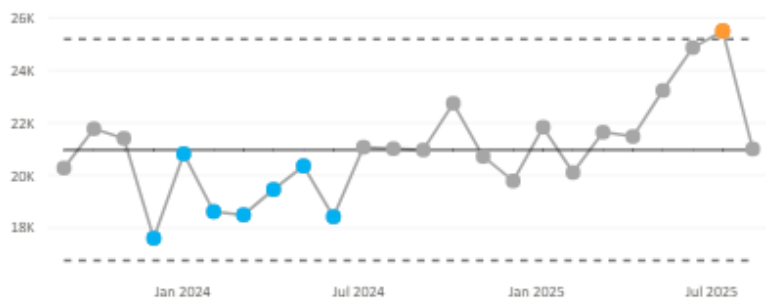
- **PIFU:** There are two challenges to resolve to support PIFU roll out; patient communication mechanism and discharge instruction not carried forward onto pending appointment record on CPD, so FU is booked. Both items are being investigated by Y&S digital.
- PIFU at Scarborough is significantly lower than York (1.8% at SGH / 5.2% at York).
- **RACP:** Medical staffing reduction in July 2025 with loss of locum.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Outpatients: All Referral Types



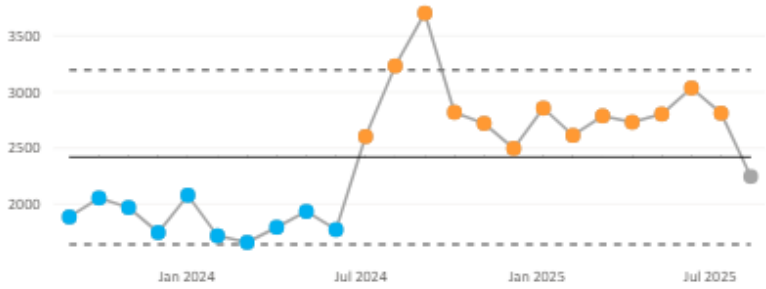
Latest Month
2025-08
Value
20982
No Target

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

The latest months value has **improved** from the previous month, with a difference of **4494.0**.

Variation Assurance

Outpatients: Consultant to Consultant Referrals



Latest Month
2025-08
Value
2239
No Target

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

The latest months value has **improved** from the previous month, with a difference of **565.0**.

Rationale: Number of outpatient referrals received from General Practice, Consultant to Consultant and from other sources.
SPC1: No internal target.
Rationale: Number of outpatient referrals generated internally from Consultant-to-Consultant referral..
SPC1: No internal target.

What actions are planned?

- Working with the ICB on demand management reviewing referrals by speciality and GP practices to understand reasons for increase and required interventions / pathway changes.
- Deep dive into consultant-to-consultant referrals commenced and to be presented at elective recovery board in October 2025.
- BI insights work to be completed in October 25 on suspected cancer referrals and impact on conversion rates to understand impact of referrals on cancer diagnosis.

What is the expected impact?

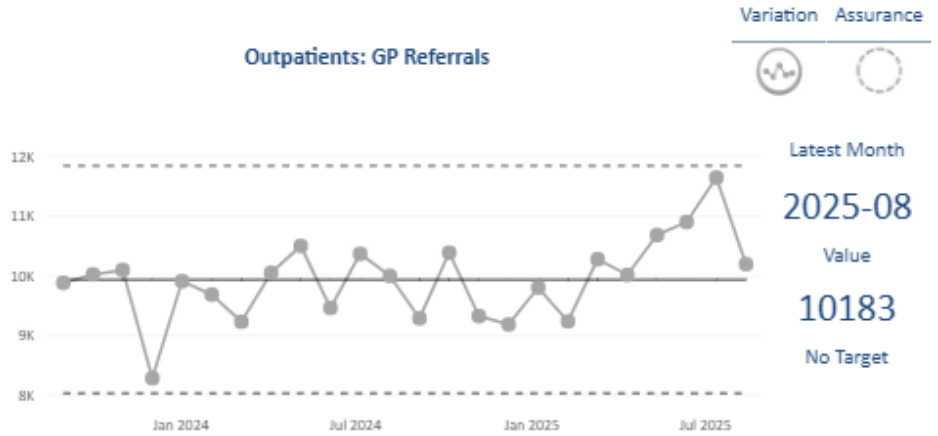
- Stabilisation of GP referrals to reduce impact increase of referrals on RTT total waiting list. Augst reduction is seasonal variation.
- Reduction in consultant-to-consultant referrals.

Potential risks to improvement?

- Organisational barriers in delivering primary / secondary care pathways.
- Workforce challenges across primary / secondary care.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **improved** from the previous month, with a difference of **1452.0**.

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Rationale: Number of outpatient referrals received from General Practice.
SPC1: No internal target.

Please see previous page

Headlines:

- The August 2025 the position for patients waiting less than six weeks at month end was 61.7% against the improvement trajectory of 72.7% , this was within the monthly variance seen over the last two years
- The drop in performance is a result of minor deterioration in multiple modalities. It is important to note however that the overall waiting list has reduced significantly (-4.6%) in August which has impacted DM01 performance but is a positive step in terms of the volume of patients awaiting a diagnostic.
- In the latest available national data (June 2024) the Trust ranked 134th out of 157 NHS providers (May 2025: 131st).

Factors impacting performance:

- MRI continues to be challenged by fast track and RTT >52 week wait escalations. With recent resignations on top of existing vacancies we are currently at 50% staffing against establishment at York. No contrast scans currently able to run at York St John until training is complete. This has impacted on planned activity volumes YTD. Paediatric General Aanaesthetic scans account for many of the longest waiters on the backlog, these can only be done on the static scanner on acute site. Mutual aid sought from Leeds, Hull and Sheffield but unable to assist. Escalated to ICB and at NHSE tiering meeting for support.
- Continued intermittent breakdowns of CT1, CT2 and CT3 at York impact delivery of activity. CT performance being largely driven by cardiac CT backlog. Acute CT demand continues to impact on capacity for elective work.
- MSK backlog continues to be the main driver of NOUS performance. This is a long-term issue. Four sonographer vacancies in York impacting on ability to deliver planned activity
- Echo has returned to full establishment, but posts are in training so not yet delivering full capacity.
- 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. 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.
- A member of the East Coast Respiratory Physiology team was on sick leave, during which time sleep studies were de-prioritised in favour of spirometry (a higher clinical priority). Lead nurse at York has also been on sick leave which has led to reduction in capacity. Capacity is limited by equipment — only two machines are available.
- There are significant challenges in achieving RTT targets in Cardiology and Respiratory meaning capacity must be balanced between avoiding RTT long wait breaches and targeting DM01. While RTT waiters are required to be prioritised for short notice booking this will continue to impact ability to return to DM01 trajectory.
- UDS performance deteriorated in August, this appears to be due to low levels of activity over the month due to annual leave and patient choice.
- Performance deteriorated across all Endoscopy modalities in August. August is historically a low activity month due to annual leave and patient choice. Waiting lists have remained stable so we continue to deliver activity but much of this is for urgent patients who have not yet breached the standard so this impact is not seen in DM01.
- The East Coast gastroenterology locum consultant left the trust at short notice in August and has not yet been replaced, this has reduced capacity and led to cancellation of patients including cancer and Straight to Test (STT). Nurse staffing remains an issue, particularly at York with significant vacancies.
- Ventilation issues continue at Bridlington and sessions have been cancelled in June, July and August due to the high temperatures making the environment unsuitable for both staff and patients. We have tried to minimise cancellations by accommodating activity across York and Scarborough where possible.
- Endoscopy Surveillance backlog leads to large volumes of patients adding to the DM01 backlog each month as their next test becomes due. Almost two thirds of 6 week breaches are surveillance patients.
- **Actions**:
- Performance recovery actions expected to deliver 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
COMMON CAUSE / NATURAL VARIATION		* Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound * Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema * 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 - CT * Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology * Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy
SPECIAL CAUSE CONCERN			* Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI * Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy * Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy

DIAGNOSTICS – National Target: 95%

Scorecard

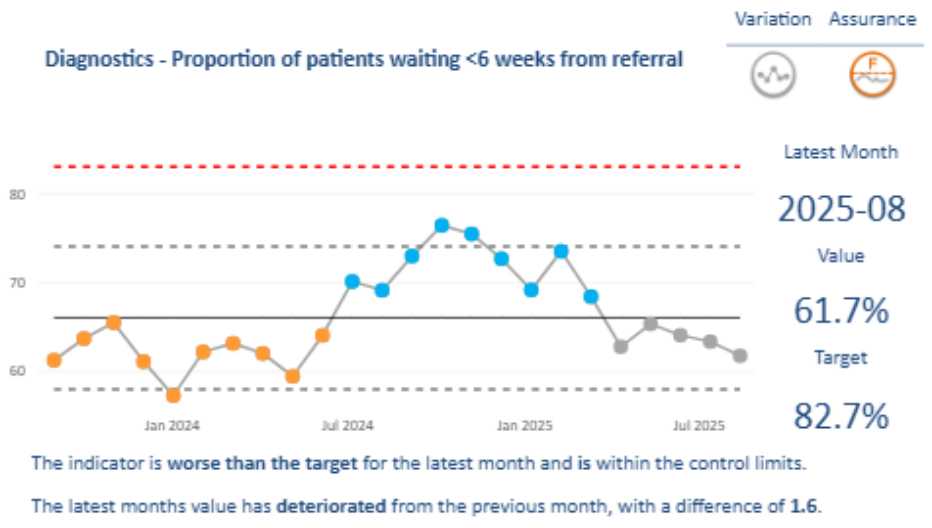
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-08		F	61.7%	72.7%	82.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2025-08	L	F	57.2%	74%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2025-08		F	66.4%	68%	78%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2025-08		?	70%	67%	75%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2025-08		?	65.6%	84.1%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2025-08	H	?	93.7%	58.1%	67.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2025-08		F	48.1%	84.5%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2025-08	H	F	70.2%	95.8%	95.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2025-08	H	?	94.1%	94.3%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2025-08		?	84.3%	89.5%	94.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2025-08	H	F	50.5%	74.7%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2025-08	L	F	43.6%	80.6%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2025-08		F	56.4%	81%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2025-08		?	58.3%	86.8%	94.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2025-08	L	F	52.4%	82.7%	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: From August onwards we are delivering a minimum of 3 days a week in the sixth room at York, with a plan to increase to 5 days a week at latest by December 2025. Insourcing began w/c 18th August delivering a mix of colonoscopy and gastroscopy capacity for circa 60 patients per week. Given the size of the current backlog it is anticipated that it could take up to 6 months to fully clear the long waiters and return to performance trajectory.

Imaging: York St John (YSJ) MRI is running 2 days per week as contracted. Insourcing will start in October to mitigate capacity lost to York vacancies while recruitment is ongoing. Radiographer training for contrast at both YSJ and Scarborough CDC planned for October/November which will improve throughput once completed. Outsourced cardiac CT commenced w/c 1 September 2025, anticipated to clear the backlog within 7 weeks. Advert out for MSK radiologist, interviews booked in October.

Physiological:

Echocardiography: service has returned to full establishment. Capacity at Bridlington has improved with the introduction of a locum which should begin to contribute to performance recovery. Recovery plan is in place to fully recover position by the end of the financial year.

Sleep studies: Templates for the East Coast have been revised with the aim of increasing capacity. Staff member has now returned from sick leave so this will support recovery. Possibilities for insourcing are being explored to get back on top of the testing and reporting backlog.

Audiology: Exploring the possibility of adding a second paediatric room at York which would improve our ability to delivery capacity to support DM01 as well as ENT RTT activity.

Two pop-up booths approved on capital plan to deliver additional audiology capacity.

UDS: Sufficient substantive Urology capacity is available in September and October so it is anticipated that backlog will be cleared by end October. Gynaecology UDS lists have been increased from September to allow an extra patient per list to try to clear long waiters.

What is the expected impact?

Increased capacity leading to increase in activity, reduction in backlogs and improvement to DM01 to trajectory levels. The majority of recovery plans are in place to roll out through Q3 so it is anticipated that it may be late Q3/early Q4 before significant performance improvement is seen.

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			
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 * Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways
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	2025-08			1		0
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2025-08		F	83%		95%
Children & Young Persons: RTT - Total Waiting List	2025-08	H	F	4613	3702	3206
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-08		F	59.6%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2025-08		F	57	9	0

KPIs – Operational Activity and Performance

Children & Young Persons

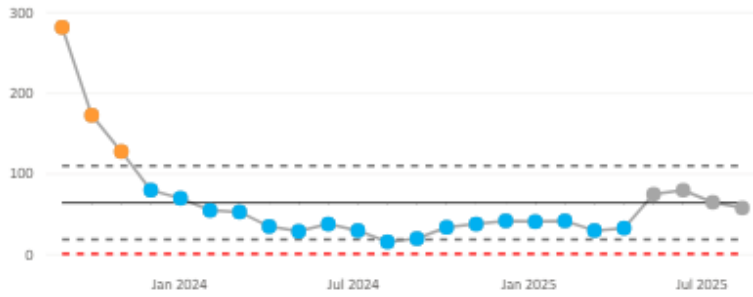
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi

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

Variation | Assurance



Latest Month: 2025-08

Value: 57

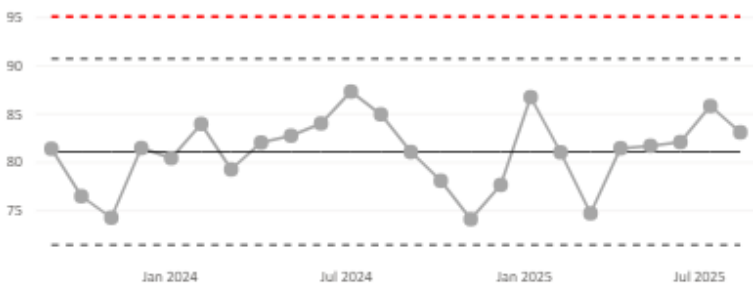
Target: 0

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

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

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

Variation | Assurance



Latest Month: 2025-08

Value: 83%

Target: 95%

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

The latest months value has **deteriorated** from the previous month, with a difference of **2.8**.

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

Target: SPC1: Aim to have zero patients waiting more than 52 weeks by end of September 2025. **SPC2:** NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2026.

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' over the school summer holidays has delivered some improvement.

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

Paediatric ECS Performance

- Triage and Training: Plans to improve triage time to 15 minutes, train staff in updated paediatric sepsis protocol, and ensure appropriate staffing levels.
- Protocols and Patient Flow: Focus on pain management, sepsis and trauma protocol adherence, and improving communication between departments to expedite admissions and transfers.

What is the expected impact?

- Improved ECS for CYP patients.
- To return to RTT52 trajectory and delivery of zero waiters by the end of March 26.

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	2025-08	H	?	33	33	33
Proportion of Virtual Ward beds occupied	2025-08	H	?	75.8%	79%	79%
Community Response Team (CRT) Referrals	2025-08			481		
Total Urgent Community Response (UCR) referrals	2025-08	H	?	455	529	566
2-hour Urgent Community Response (UCR) care Referrals	2025-08			127		
2-hour Urgent Community Response (UCR) Compliancy %	2025-08			88.2%		
Number of Adults (18+ years) on community waiting lists per system	2025-08	L		743		
Number of CYP (0-17 years) on community waiting lists per system	2025-08	L		1639		
Number of District Nursing Contacts	2025-08			21501		
Number of Selby CRT Contacts	2025-08	L		2312		
Number of York CRT Contacts	2025-08	L		3650		
Referrals to District Nursing Team	2025-08			2136		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2025-08	L	F	599	598	0

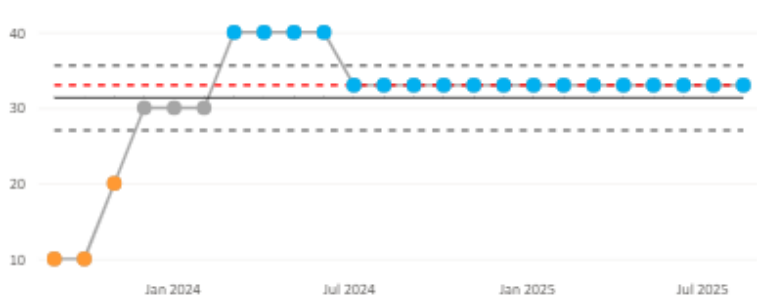
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor demand on Community virtual wards.
Target: SPC1: Trust is commissioned to deliver 33 virtual ward beds. **SPC2:** Aim to achieve 79% virtual ward bed occupancy as per activity plan.

Number of open Virtual Ward beds

Variation Assurance



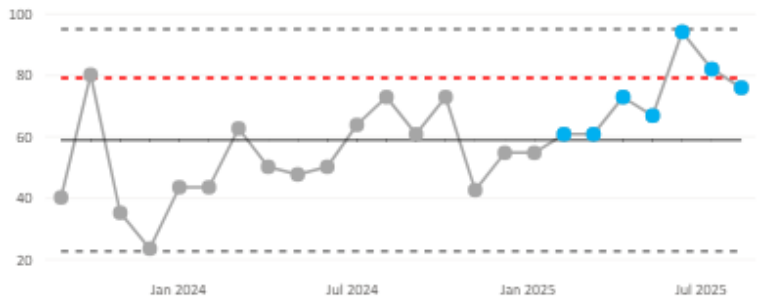
Latest Month
2025-08
Value
33
Target
33

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**.

Proportion of Virtual Ward beds occupied

Variation Assurance



Latest Month
2025-08
Value
75.8%
Target
79%

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

The latest months value has **deteriorated** from the previous month, with a difference of **6.0**.

What actions are planned?

Frailty Virtual Ward - capacity 12
The antibiotic pathway for antibiotic use in a community setting is being developed with Pharmacy and Microbiology. It will be available to Humber for use in Scarborough communities too.

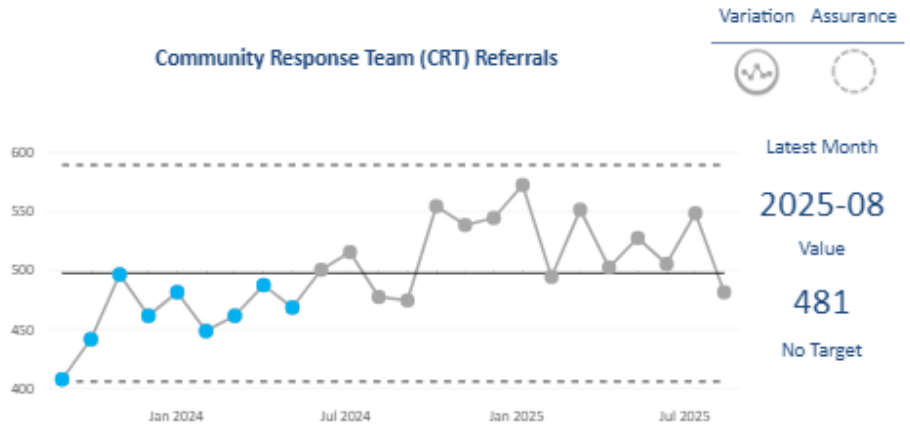
Heart Failure - capacity 10
The admission avoidance pathway can now be finalised and operationalised due to additional medic now in post.

Vascular – capacity 8
The model uses pre-existing resource and often operates at capacity; no improvement actions planned.

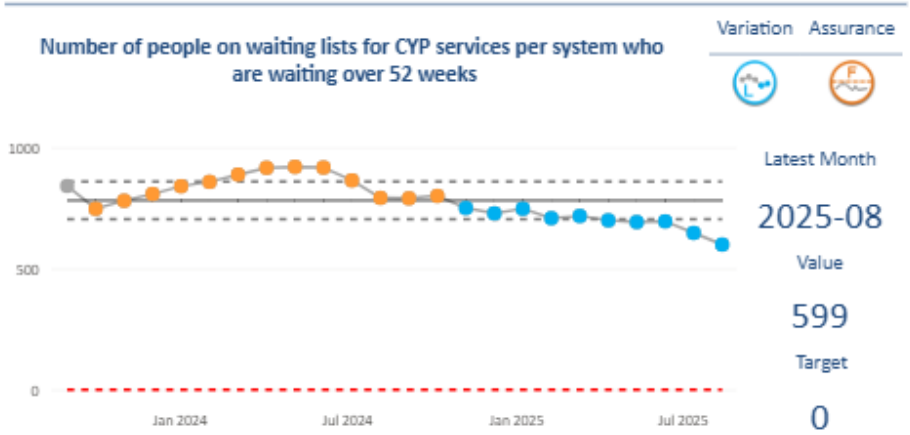
Cystic Fibrosis – capacity 3
The system allows a virtual model of care for up to three patients using existing resource; no improvement actions planned.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **67.0**.



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 **48.0**.

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

SPC1: Referrals to Community Response Teams remain high and there is insufficient community capacity to further increase the number of patients whose needs we can meet at home.

What actions are planned?

SPC1: The Care Group is looking for efficiencies that could support increasing capacity.

SPC2: SLT Leap Into Language initiative ran 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 was 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). The impact of this initiative will be evaluated throughout September and October.

What is the expected impact?

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 2024 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

September 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)

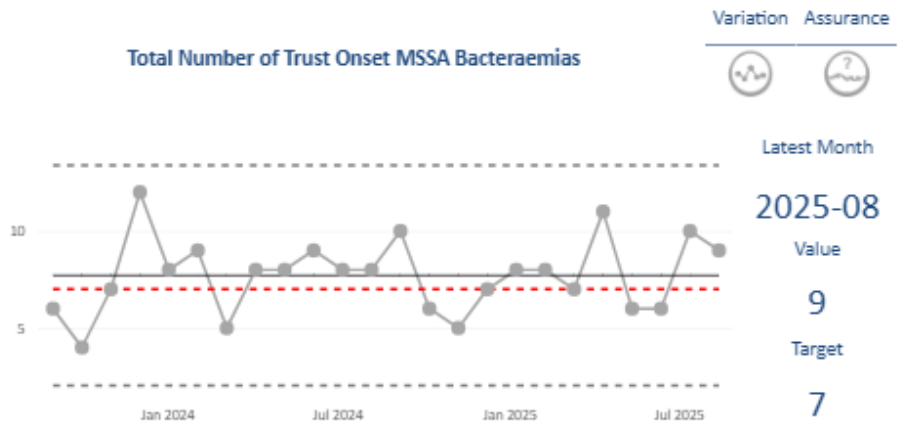
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

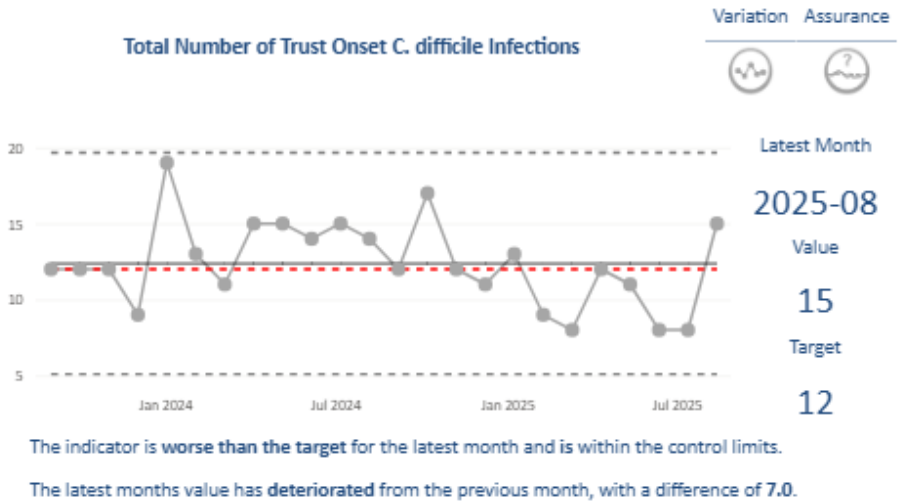
Executive Owner: Dawn Parkes **Operational Lead:** Sue Peckitt

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2025-08			9	7	7
Total Number of Trust Onset MRSA Bacteraemias	2025-08			1		0
Total Number of Trust Onset C. difficile Infections	2025-08			15	12	12
Total Number of Trust Onset E. coli Bacteraemias	2025-08			19	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2025-08			6	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2025-08			4	2	2
Pressure Ulcers per thousand Bed Days	2025-08			4.6		4
Patient Falls per thousand Bed Days	2025-08			6.5		8.7
Medication incidents per thousand bed days	2025-08			5.4		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 remain the same as the previous year except Klebsiella bacteraemia which has reduced by 25 cases. MSSA bacteraemia has an internal 5% reduction on the 2024/25 year-end position. **MSSA is a True North Metric.**

Key Risks:

- MRSA bacteraemia objective breached with 3 cases in 2025/26 against a zero tolerance
- MSSA bacteraemia – The Trust is 8 cases over the YTD objective
- E.coli bacteraemia - The Trust is 10 cases over the YTD objective
- Klebsiella bacteraemia - The Trust is 2 cases over the YTD objective
- Pseudomonas bacteraemia - The Trust is 5 cases over the YTD objective

Key assurances/brilliances:

- CDI - The Trust is 6 cases **under** the YTD objective. Whilst there had been a reduction of Trust attributed cases in the previous 3 months, August has seen a rise in cases which we are ensuring reviews are being undertaken and acted upon.
- The care group IPC/AMS meetings are all now established, and they are taking ownership of improvement requirements. Improvement plans are now in place.
- All cases are subject to after action review and the process for these reviews is being changed to ensure care groups own the reviews and actions.
- The focus for 2025/26 is prevention of avoidable bacteraemia's. A Trust MSSA bacteraemia improvement plan is in place and care groups are developing local MSSA bacteraemia reduction plans to drive improvement.
- Point prevalence survey for Urinary catheters has been undertaken in August to base improvement work on.

- **Next Key Improvements**:
- Complete IPC Board Assurance Framework
- Develop the IPC strategic plan for improvement
- Inform the care group IPC improvement plans
- Deliver the IPC Trust Conference on 9th October 2025
- Year of quality months for IPC – September & October.

Quality & Safety
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patient Safety Incidents per thousand Bed Days	2025-08			53.6		54
Harmful Incidents per thousand bed days	2025-08			18.3		17
Total Number of Never Events Reported	2025-08			0		0
In-Hospital Deaths	2025-08			134		
Quarterly SHMI	2025-03			93.1		100
Monthly SHMI	2025-05			90.6		100
Quarterly HSMR	2025-06			107.6		100
Monthly HSMR	2025-06			116.8		100
Trust Complaints	2025-08			105		
Antepartum Stillbirths	2025-07			2		
Intrapartum Stillbirths	2025-07			0		
Early neonatal deaths (0-7 days)	2025-07			1		
PPH > 1.5L as % of all women - York	2025-07			3.5%		
PPH > 1.5L as % of all women - Scarborough	2025-07			0.8%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2025-07			57.4%		

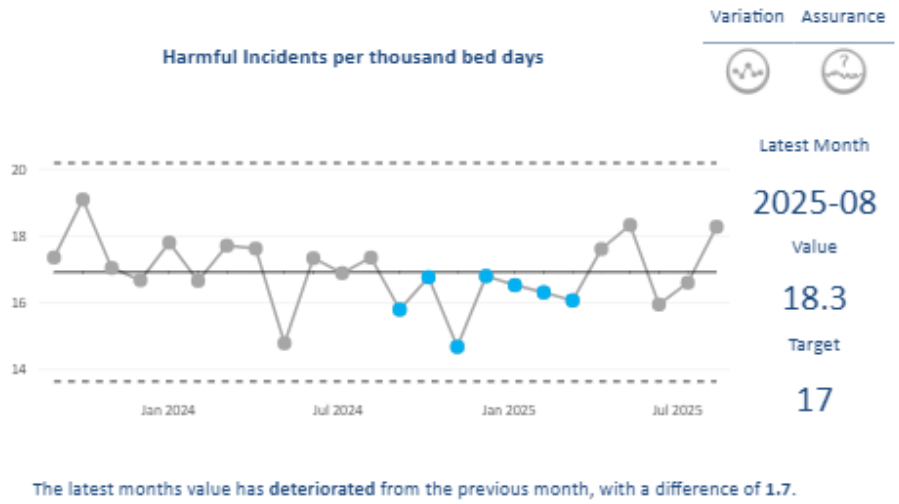
KPIs – Quality & Safety

Q&S (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Adele Coulthard/ Dawn Parkes/Karen Stone

Operational Lead: Dan Palmer/Alice Hunter/Vicky Mulvana- Tuohy



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 SPC chart is no longer showing special cause variation where we were showing a period of reduction in harmful incidents per 1000 bed days over the Q3 and Q4 2024/25 period. This improvement was not sustained, and we are back into common cause variation We continue to have patient safety incidents within our existing normal range.

Throughout the winter period acuity and dependency increased however the number of reported incidents (All incidents) has remained stable, and we did see a reduction in the level of harmful incidents as a proportion of all incidents. On analysis, there are no readily identifiable themes or trends that give us an indication as to why we saw a reduction in harmful incidents during that period and why we have seen an increase, albeit within normal ranges, in the first 5 months of 2025/26.

Factors impacting performance:

The number of new complaints has decreased with 105 new complaints recorded (versus 136 in July 2025, a 23% reduction), with 17 being complex complaints:
- ED Scarborough (13) - Pain management (5) Attitude of nursing staff (4)
- Rainbow Ward (5) - Delay or failure of medical assessment (3)
- Outpatients York (5) - Communication with patient (2) Delay or failure to diagnose (2)

67% of complaints have been closed within the target time scales (versus 79% in July)
36% of complex complaints have been closed within the target timescales (versus 61% in July)

27% of all complaints related to Emergency Medicine (versus 18% in July)

Key risks and emerging risks

- continued high number of complaints and concerns, including issues that are not addressed in the moment e.g. at ward level, with staff continuing to signpost to PALS which has been impacted due to long term absence and no authority to recruit to the FTE PALS administrator vacancy (open since December 2024) with the resulting loss of 109 hours/week

Key assurances

- the RPIW actions being implemented through the 90 days post workshop are making an impact on the time to process complaints
- ward initiatives to improve patient and carer communication - wards implementing these report a reduction in complaints, however they are yet to be embedded across all wards throughout the Trust
- approval to advertise for a 4-month secondment to the role of Concerns and Complaints Officer to provide resource to support the PALS team staffing challenges with shortlisting to take place in September 2025
- one of the members of the PALS team has returned to work following long term sickness (phased return) has meant that we have been able to offer an accessible service with a limited phone service now re-established commencing this month

Next key improvement steps

- RPIW action plan being implemented to further improve the efficiency and effectiveness of complaint management)
- recommendations from the IO survey results to be reviewed and approved by the Chief Nurse team to further improve complaint management
- following the implementation of RPIW actions, we will review and make recommendations to ensure we have the appropriate capacity and capabilities within the PALS team

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

September 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	* Planned homebirths - Scarborough * L/W Co-ordinator supernumerary % - Scarborough	* Homebirth service suspended - Scarborough * Anaesthetic cover on L/W - Scarborough
COMMON CAUSE / NATURAL VARIATION	* Bookings - Scarborough	* Bookings ≥13 weeks (exc transfers etc.) - Scarborough * Births - Scarborough * No. of women delivered - Scarborough * Women affected by suspension - Scarborough * Maternity Unit Closure - Scarborough * 1 to 1 care in Labour - Scarborough	* Bookings <10 weeks - Scarborough
SPECIAL CAUSE CONCERN		* SCBU at capacity - Scarborough * 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		* HDU on L/W - Scarborough * HSIB cases - Scarborough	
COMMON CAUSE / NATURAL VARIATION	* Intrapartum Stillbirths - Scarborough	* Normal Births - Scarborough * Assisted Vaginal Births - Scarborough * C/S Births - Scarborough * Elective caesarean - Scarborough * Emergency caesarean - Scarborough * Induction of labour - Scarborough * BBA - 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	2025-07			53.4%		57%	Target
Assisted Vaginal Births - Scarborough	2025-07			6.8%		12.4%	Target
C/S Births - Scarborough	2025-07			39.8%		43.5%	Baseline
Elective caesarean - Scarborough	2025-07			13.6%		16.2%	Baseline
Emergency caesarean - Scarborough	2025-07			26.3%		27.2%	Baseline
Induction of labour - Scarborough	2025-07			45.2%		45.2%	Baseline
HDU on L/W - Scarborough	2025-07	L		1		5	Target
BBA - Scarborough	2025-07			1		2	Target
HSIB cases - Scarborough	2025-06	L		0		0	Target
Neonatal Death - Scarborough	2025-07			0		0	Target
Antepartum Stillbirth - Scarborough	2025-07			0		0	Target
Intrapartum Stillbirths - Scarborough	2025-07		P	0		0	Target
Cold babies - Scarborough	2025-04			0		1	Target
Preterm birth rate <37 weeks - Scarborough	2025-07			5.9%		6%	Target
Preterm birth rate <34 weeks - Scarborough	2025-07			2.5%		1%	Target
Preterm birth rate <28 weeks - Scarborough	2025-07			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		* Carbon monoxide monitoring at booking - Scarborough * 3rd/4th Degree Tear - assisted birth - Scarborough	
COMMON CAUSE / NATURAL VARIATION		* Low birthweight rate at term (2.2kg) - Scarborough * Breastfeeding rate at discharge - Scarborough * Smoking at booking - Scarborough * Smoking at 36 weeks - Scarborough * Smoking at time of delivery - Scarborough * PPH > 1.5L as % of all women - Scarborough * Shoulder Dystocia - Scarborough * 3rd/4th Degree Tear - normal births - Scarborough * Informal Complaints - Scarborough * Formal Complaints - Scarborough	
SPECIAL CAUSE CONCERN		* Breastfeeding Initiation rate - Scarborough * Carbon monoxide monitoring at 36 weeks - 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	2025-07			1.7%		0%	Target
Breastfeeding Initiation rate - Scarborough	2025-07	L		55.9%		75%	Target
Breastfeeding rate at discharge - Scarborough	2025-07			46.6%		65%	Target
Smoking at booking - Scarborough	2025-07			6.7%		6%	Target
Smoking at 36 weeks - Scarborough	2025-07			4.5%		6%	Target
Smoking at time of delivery - Scarborough	2025-07			5.9%		6%	Target
Carbon monoxide monitoring at booking - Scarborough	2025-07	H		92.3%		95%	Target
Carbon monoxide monitoring at 36 weeks - Scarborough	2025-07	L		4.5%		95%	Target
SI's - Scarborough	2025-06			0		0	Target
PPH > 1.5L as % of all women - Scarborough	2025-07			0.9%		2%	Baseline
Shoulder Dystocia - Scarborough	2025-07			0		2	Target
3rd/4th Degree Tear - normal births - Scarborough	2025-07			0%		0%	Target
3rd/4th Degree Tear - assisted birth - Scarborough	2025-07	L		0%		0%	Target
Informal Complaints - Scarborough	2025-06			0		0	Target
Formal Complaints - Scarborough	2025-06			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	2025-07		P	104		169	Target
Bookings <10 weeks - Scarborough	2025-07		F	66.3%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2025-07		?	5.7%		10%	Target
Births - Scarborough	2025-07		?	118		113	Target
No. of women delivered - Scarborough	2025-07		?	117		112	Target
Planned homebirths - Scarborough	2025-07	H	?	2.5%		2.1%	Target
Homebirth service suspended - Scarborough	2025-06	L	F	11		3	Target
Women affected by suspension - Scarborough	2025-06		?	0		0	Target
Community midwife called in to unit - Scarborough	2025-03	L	P	0		3	Target
Maternity Unit Closure - Scarborough	2025-07		?	3		0	Target
SCBU at capacity - Scarborough	2025-03	H	?	4		1.2	Baseline
SCBU at capacity of intensive care cots - Scarborough	2025-03	H	?	11		5	Baseline
SCBU no of babies affected - Scarborough	2025-03	H	?	1		0	Target
1 to 1 care in Labour - Scarborough	2025-07		?	100%		100%	Target
L/W Co-ordinator supernumerary % - Scarborough	2025-07	H	?	100%		100%	Target
Anaesthetic cover on L/W - Scarborough	2025-07	H	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	* Community midwife called in to unit - York	* Homebirth service suspended - York * SCBU at capacity - York * 1 to 1 care in Labour - York * L/W Co-ordinator supernumerary % - York	
COMMON CAUSE / NATURAL VARIATION	* Anaesthetic cover on L/W - York	* Bookings - York * Births - York * No. of women delivered - York * Planned homebirths - York * SCBU at capacity of intensive care cots - York * SCBU no of babies affected - York	* Bookings <10 weeks - York
SPECIAL CAUSE CONCERN	* Bookings ≥13 weeks (exc transfers etc.) - York	* Women affected by suspension - York * Maternity Unit Closure - York	

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	2025-07			318		295	Target
Bookings <10 weeks - York	2025-07		F	72%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - York	2025-07	H	P	10.1%		10%	Target
Births - York	2025-07			255		245	Target
No. of women delivered - York	2025-07			253		242	Target
Planned homebirths - York	2025-07			1.2%		2.1%	Target
Homebirth service suspended - York	2025-06	L		3		3	Target
Women affected by suspension - York	2025-06	H		9		0	Target
Community midwife called in to unit - York	2025-07	L	P	0		3	Target
Maternity Unit Closure - York	2025-07	H		5		0	Target
SCBU at capacity - York	2025-04	L		0		0	Baseline
SCBU at capacity of intensive care cots - York	2025-03			29		17.1	Baseline
SCBU no of babies affected - York	2025-03			3		0	Target
1 to 1 care in Labour - York	2025-07	H		100%		100%	Target
L/W Co-ordinator supernumerary % - York	2025-07	H		100%		100%	Target
Anaesthetic cover on L/W - York	2025-07		P	10		10	Target

Summary MATRIX 2 of 3

Maternity York

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Induction of labour - York	
COMMON CAUSE / NATURAL VARIATION	* Intrapartum Stillbirths - York	* Normal Births - York * Assisted Vaginal Births - York * C/S Births - York * Elective caesarean - York * Emergency caesarean - 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		* HSIB cases - York	

Maternity York
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Normal Births - York	2025-07			49.4%		57%	Target
Assisted Vaginal Births - York	2025-07			5.4%		12.4%	Target
C/S Births - York	2025-07			40.7%		36.7%	Baseline
Elective caesarean - York	2025-07			17.6%		15.6%	Baseline
Emergency caesarean - York	2025-07			22.4%		21.1%	Baseline
Induction of labour - York	2025-07	L		29.2%		43.3%	Baseline
HDU on L/W - York	2025-07			9		5	Target
BBA - York	2025-07			3		2	Target
HSIB cases - York	2025-07	H		1		0	Target
Neonatal Death - York	2025-07			1		0	Target
Antepartum Stillbirth - York	2025-07			2		0	Target
Intrapartum Stillbirths - York	2025-07		P	0		0	Target
Cold babies - York	2025-04			0		1	Target
Preterm birth rate <37 weeks - York	2025-07			7%		6%	Target
Preterm birth rate <34 weeks - York	2025-07			2%		2%	Target
Preterm birth rate <28 weeks - York	2025-07			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		* Smoking at booking - York * 3rd/4th Degree Tear - normal births - York	
COMMON CAUSE / NATURAL VARIATION		* Low birthweight rate at term (2.2kg) - York * Breastfeeding rate at discharge - 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 - assisted birth - York * Informal Complaints - York * Formal Complaints - York	* Carbon monoxide monitoring at 36 weeks - York
SPECIAL CAUSE CONCERN		* Breastfeeding Initiation rate - York	

Maternity York
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - York	2025-07			0.4%		0%	Target
Breastfeeding Initiation rate - York	2025-07	L		69.4%		75%	Target
Breastfeeding rate at discharge - York	2025-07			57.3%		65%	Target
Smoking at booking - York	2025-07	L		5.3%		6%	Target
Smoking at 36 weeks - York	2025-07			3.4%		6%	Target
Smoking at time of delivery - York	2025-07			4.2%		6%	Target
Carbon monoxide monitoring at booking - York	2025-07			89.6%		95%	Target
Carbon monoxide monitoring at 36 weeks - York	2025-07		F	72.9%		95%	Target
SI's - York	2025-06			0		0	Target
PPH > 1.5L as % of all women - York	2025-07			3.5%		3.8%	Baseline
Shoulder Dystocia - York	2025-07			4		2	Target
3rd/4th Degree Tear - normal births - York	2025-07	L		0.4%		0%	Target
3rd/4th Degree Tear - assisted birth - York	2025-07			0.8%		0%	Target
Informal Complaints - York	2025-06			0		0	Target
Formal Complaints - York	2025-06			2		0	Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

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

Workforce
Scorecard (1)

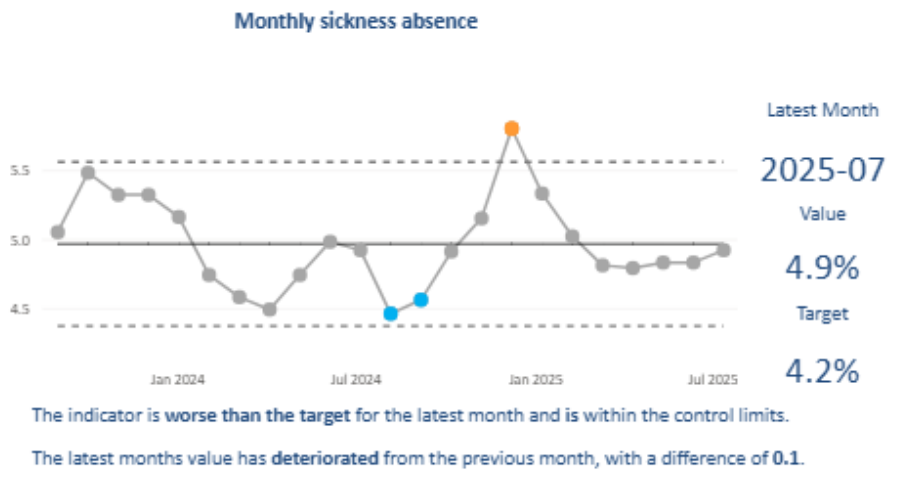
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2025-07		F	4.9%	4.2%	4.2%
Annual absence rate	2025-07		F	5%		4.3%
Total Agency Whole Time Equivalent Filled	2025-07	L	?	94.9		151
Total Bank Whole Time Equivalent Filled	2025-07		?	630		557
OVERALL: Percentage of rosters approved six weeks before start date	2025-07	H	F	52.2%		100%
NURSING & MIDWIFERY: Planned versus delivered hours (net hours) per Whole Time Equivalent	2025-07		?	12197.7		4498.6
NURSING & MIDWIFERY: Percentage of actual clinical unavailability versus percentage of budgeted clinical unavailability (headroom)	2025-07		F	29%		22%
12 month rolling turnover rate Trust (FTE)	2025-08	L	P	8.3%		10%
Overall vacancy rate	2025-08		?	6.7%		6%
HCSW vacancy rate	2025-08		?	6.1%		5%
Midwifery vacancy rate	2025-08	H	?	0%		0%
Medical and dental vacancy rate	2025-08		?	5.7%		6%
Registered Nursing vacancy rate	2025-08	H	?	7.5%		5%
AHP vacancy rate	2025-08		?	7.9%		8.5%

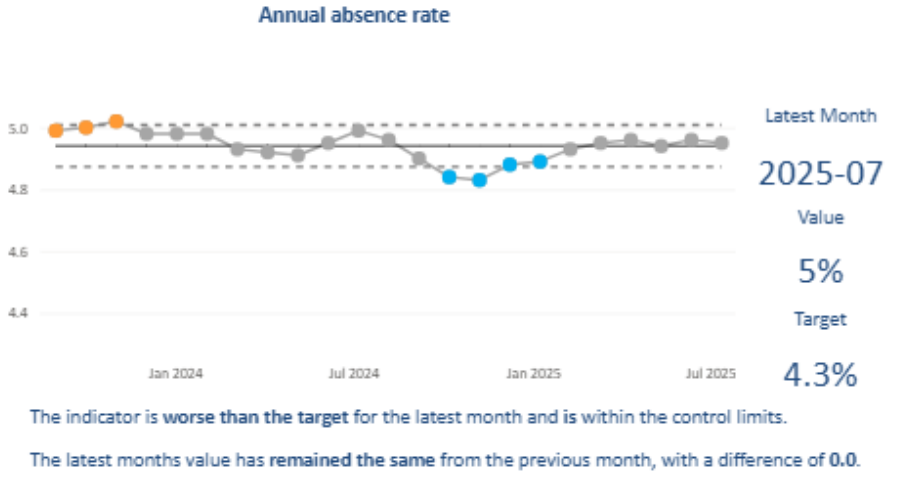
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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

The latest months value has **deteriorated** from the previous month, with a difference of **0.1**.



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

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

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

Factors impacting performance and actions:

July's absence rate saw a small jump compared to June, with absences increasing by 9 WTE to 457. The high-level picture across the 2025-26 financial year to date is of a static Group absence rate, with only 0.1% movement across a period of four-months. Anxiety and stress-related illness continues to be the highest contributing sickness absence reason, with an increase in July (30% of all absences, 136 WTE, compared with 27% and 123 WTE in June). Absence related to gastrointestinal problems continue to decrease, with the proportion for July at 8.6% (a 0.5% decrease from June). Musculoskeletal issues continue to account for 9% of absences.

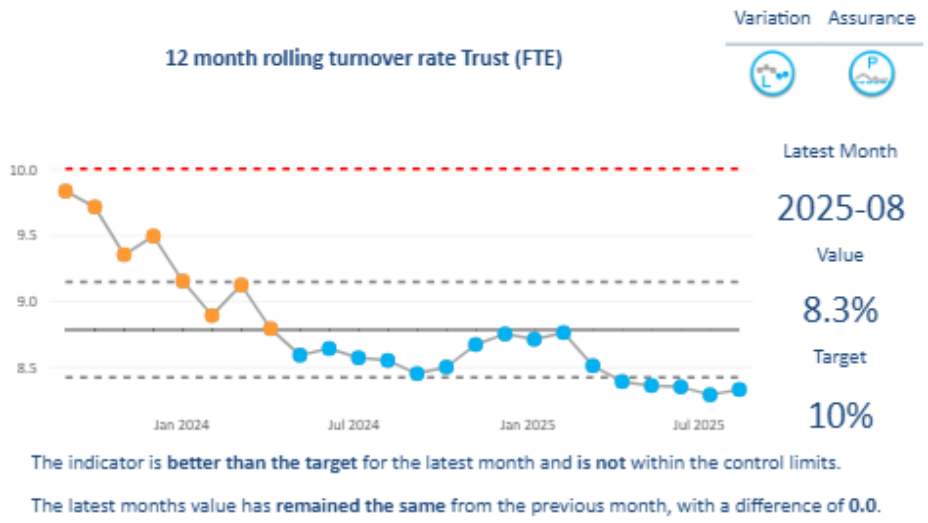
In October and November, the Trust is running on-site clinics for 'flu vaccination at York and Scarborough hospitals, complemented by a peer vaccination campaign. Colleagues will visit workplaces across the hospitals, including Malton, Selby, and Bridlington, to provide vaccinations. The Trust is providing the vaccine at a cost of £11.93 per dose. Although more expensive than previous years, the vaccine has been deemed to be the most effective for protecting colleagues from infection. Colleagues who accept the vaccine will be entered into a draw with a chance to win one of three prizes: a day of annual leave; afternoon tea for two at the Milner Hotel; or Sunday lunch for two at the Marriott Hotel.

The 2025 NHS Staff Survey opens to responses in October. Colleagues completing this year's survey will receive a small thank-you voucher and be entered into a prize draw for an iPad, aimed at boosting historically low participation rates. Paper surveys are being issued to colleagues without active Trust email accounts to ensure the Survey is accessible to all.

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:

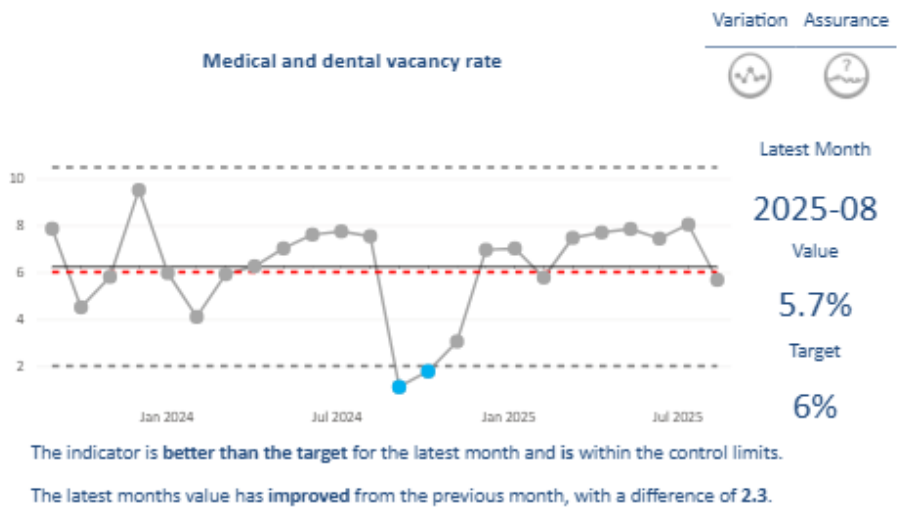
The Group has received its results from the Q2 National Quarterly Pulse Survey. The short pulse surveys, which open for responses three times a year for one month at a time, generally attract a lower response rate than an annual staff survey. In July 2025, 7% of Group colleagues (793) responded to the pulse survey and the Group recorded an overall engagement score of 5.96 out of 10. This ranks below the national average score of 6.29 and was a small reduction from the Group's April score (6.01). In the same period, the national average score reduced by 0.12.

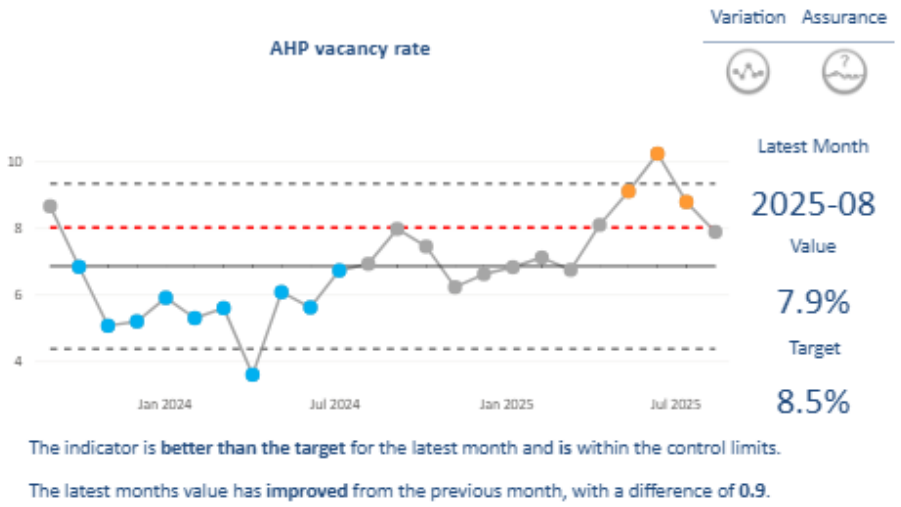
At the end of July, the Group recorded a total workforce position of 10,066 WTE against a plan for 10,025 WTE. This represents an increase of 71 WTE from the total workforce size in June, mostly due to seasonal increase in Bank utilisation (up 65 WTE from June to 630).

The Group have submitted some small changes to its WTE plans for the second half of the financial year, culminating in a planned total workforce position of 10,024 WTE in March 2026. This represents an increase of 15 WTE from the original plan due to an increased maternity workforce (made possible through additional funding from NHS England). Within the total, the proportion of substantive, bank and agency WTE has been re-profiled to provide for an increase to substantive workforce (48 WTE, inclusive of the maternity development) with a 35 WTE reduction in bank and agency. The plan assumes that changes related to the corporate services and Care Group reviews are completed by the end of the financial year.

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:

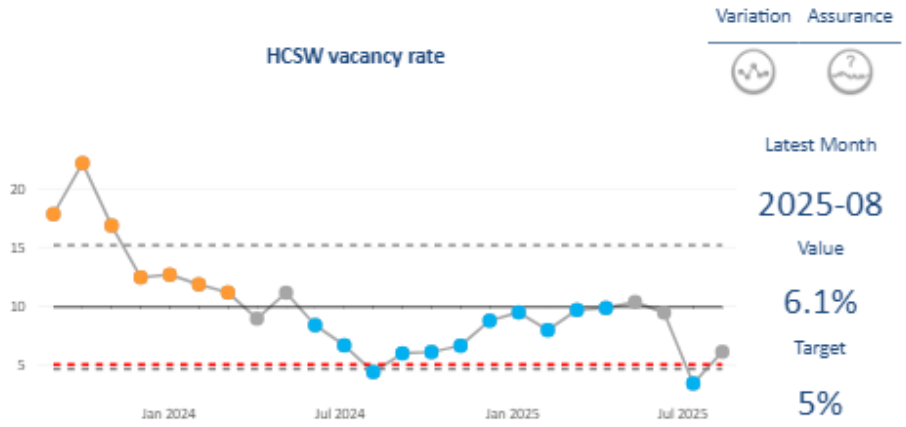
In August, the Trust welcomed 20 new medical colleagues (outside the changeover process) including five permanent Consultants working within Cardiology, Acute Medicine, Anaesthetics and General Surgery and Urology. In addition, 11 offers of employment for medical posts were made, including two permanent Consultant posts in Rheumatology and Paediatrics.

At the beginning of September, a further resident doctors' changeover saw the arrival of 42 new doctors in the Trust. They have taken up a mixture of training and Trust Grade appointments. In addition, 13 Clinical Radiology honorary trainees commenced their placements with the organisation.

During the coming weeks, 16 pre-registered AHPs will take up appointment with the Trust following the formal completion of their training courses.

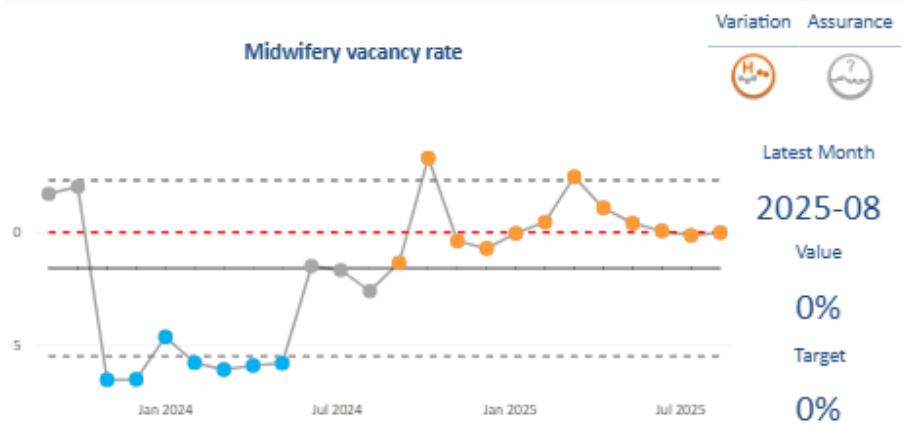
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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

The latest months value has **deteriorated** from the previous month, with a difference of **2.7**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **0.1**.

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

Factors impacting performance and actions:

13 WTE HCSWs commenced employment with the Trust through the September Academy programme. The HCSW recruitment pipeline includes 31 WTE HCSWs undertaking pre-employment checks, and 6 WTE who are booked onto the next Academy in October.

The Trust is preparing to onboard 109 pre-registered nurses in the Autumn. To date, 91 pre-registered nurses have been cleared for work and issued with contracts, with an additional 18 pre-registered nurses undertaking their pre-employment checks. The Trust expects the vacancy rate for registered nurses to reduce to 2.7% as a result.

August saw an increase in nursing associates with 6 new associates in post following completion of apprenticeships. This increased the headcount from 57 to 63.

14 newly qualified midwives are currently undertaking pre-employment checks. The Trust is aiming to recruit a further 5 WTE midwives, with interviews scheduled in early September.

As an aside, the Trust is one of 12 organisations chosen by NHS England to pilot Robotic Process Automation in a small number of workforce administrative processes. The pilot involves the development of 'bots' to complete activities including vacancy long-listing and short-listing. The intention is to drive consistency through processes while reducing the amount of time consumed by repetitive administrative work. The pilot programme began at the start of September, with a February 2026 go-live target.

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								
May-25	2602.28	156.34	100.65	268.40	11.41	183.00	46.30	-27.69
Jun-25	2581.75	157.16	103.86	268.40	7.38	183.00	46.30	-31.72
Jul-25	2604.35	179.10	115.44	287.70	-6.84	190.00	46.60	-57.94
HCA								
May-25	1280.95	132.11	75.25	253.00	45.64	219.40	0.00	12.04
Jun-25	1280.95	120.42	73.60	244.70	50.67	207.20	0.00	13.17
Jul-25	1208.45	73.31	72.99	263.70	117.40	218.00	0.00	71.70
M&D								
May-25	1114.21	87.30	30.09	157.80	40.41	107.90	33.00	23.51
Jun-25	1112.21	76.53	30.18	154.50	47.79	108.70	31.10	33.09
Jul-25	1118.19	63.36	27.53	179.00	88.11	125.10	34.50	68.71

Factors impacting performance and actions:

Pick up through the Collaborative Bank for nursing shifts continues to be low, with no further shifts worked within the Trust. The collaborative steering group are exploring ways to increase membership and awareness. The next step of the collaborative is to explore expanding the service to cover medical roles. The Trust was aiming to make medical shifts available to collaborative partners from October, but other organisations have delayed their commencement, with plans to work towards a November start date instead.

Following the launch of new medical bank rates in August alongside a new process for rate escalation approvals, the Trust has seen a significant reduction in the number of shifts escalated on a weekly basis. In the week prior to the change, 432 shifts were escalated, compared to 53 shifts escalated in the last week of August. Alongside the reduction in rate escalations, there has been a reduction in the number of medical shifts being requested during August too. This is typical for the time of year due to changeover and annual leave, but it will be important to continue to monitor the impact of these changes going forward.

From the start of September, nursing have stopped all ad-hoc requests for agency nurses on a Sunday, to reduce agency reliance and costs by limiting cover on the most expensive day of the week.

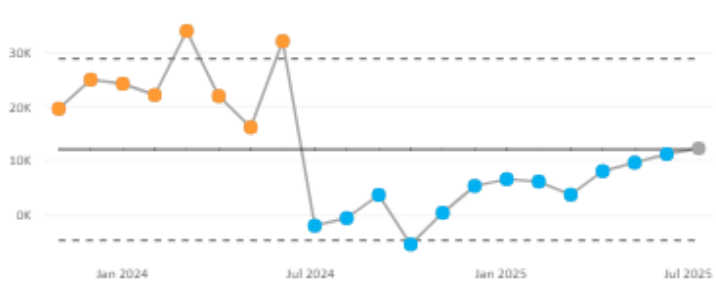
The Trust has been monitoring the number of administrative bank shifts undertaken each month. 777 shifts were recorded in August, which is a reduction from 893 shifts in July. With restrictions in place around vacancy control, the organisation will continue to monitor this activity closely, and monthly reports are being shared with Care Groups to monitor their use and support them to identify opportunities to reduce this.

The Trust has successfully ended some long-term agency registered scientific and technical and AHP bookings following successful recruitment. This includes converting a Biomedical Scientist to a substantive post and ending a Plaster Technician booking that had been in place for over two years.

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

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

Variation Assurance



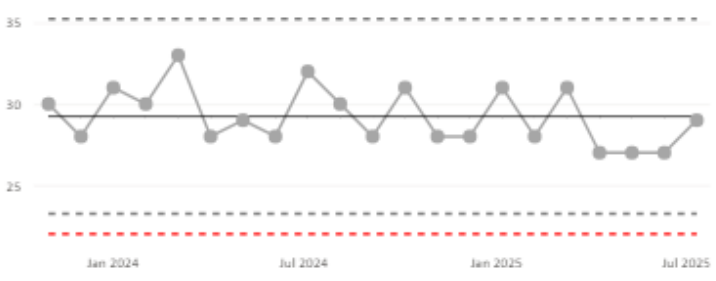
Latest Month
2025-07
Value
12197.7
Target
4498.6

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

The latest months value has **deteriorated** from the previous month, with a difference of **1061.8**.

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

Variation Assurance



Latest Month
2025-07
Value
29%
Target
22%

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

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

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

Factors impacting performance and actions:

There is an aim to publish 100% of rosters with at least 6 weeks' notice. Nursing IPUs achieved 96%, nursing non-IPUs 43% and AHPs 42%. Given AHP's are primarily rostered using set patterns, the Trust is going to explore increasing the use of auto-roster for this group of staff, which should mean rosters can be automatically produced on time.

In addition, work is underway to increase utilisation of self-rostering and the auto-roster function in other areas, to release efficiencies and support a better work life balance for colleagues. Ward 11 and MES are progressing with auto-roster improvement work, and Scarborough Emergency Department and Juniper Ward are progressing with self/team-based rostering.

	% 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	13%	7	55.62%
Non-IPU's	0%	0	46%	54	33.63%
AHPs	0%	0	92%	49	33%

83% of colleagues are on eRostering. In August, Medical and Dental implementations increased to over 90% - a key threshold for the Levels of Attainment Standards. The aim is to have all clinical colleagues on the system by the end of October – there are just 100 clinical colleagues remaining. Admin and Clerical and YTHFM colleagues are due to be implemented after that, with a goal to have everyone on the system by Summer 2026.

Staffing Group	% on Healthroster	Staffing Group	% on Healthroster
Nursing and Midwifery	100%	AHP	99%
Additional Clinical Services	99%	Healthcare Scientists	98%
Sci and Technical	98%	Medical and Dental	91%
Admin and Clerical	63%	Estates and Ancillary	4%

Workforce
Scorecard (2)

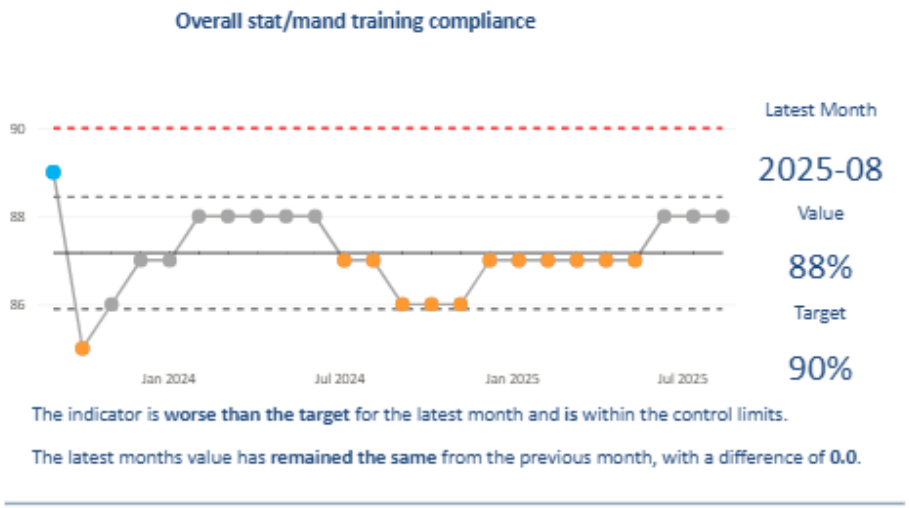
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

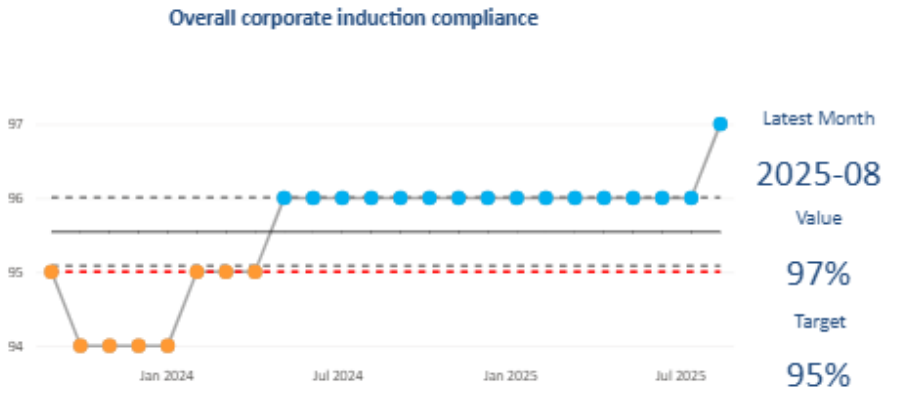
Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2025-08		F	88%		90%
Overall corporate induction compliance	2025-08	H	P	97%		95%
A4C staff stat/mand training compliance	2025-08	H	?	90%		90%
A4C staff corporate induction compliance	2025-08	H	?	97%		95%
Medical & dental staff stat/mand training compliance	2025-08		F	74%		90%
Medical & dental staff corporate induction compliance	2025-08	H	?	95%		95%
Appraisal Activity	2025-08		?	34%	25.3%	95%
Percentage recommending the Trust as a place to work (quarterly - data source is PULSE, Staff Survey data omitted for Q3)	2025-07			39.1%		50%
Percentage recommending the Trust as a place to receive treatment (quarterly - data taken from PULSE, Staff Survey data omitted for Q3)	2025-07			36.6%		49%

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 Group adopted a new target for statutory and mandatory training compliance. The 90% target strives for a 3% increase in the level of completions compared with our previous aim of 87% compliance.

Mandatory training compliance has maintained at 88% in August. This is despite Resident Doctors changeover, which normally contributes to a small reduction in completion rates. The Group also recorded a 1% increase in corporate induction compliance in August.

The Trust is actively contributing to the national development of NHS England's new Management and Leadership Framework, designed to address recommendations from the Messenger and Kark Reviews. Work is underway to align the framework with internal leadership programmes, embedding consistent standards into organisational culture. The Framework launch is expected by late October 2025, with phased implementation over three years.

Between May and July 2025, NHS Elect delivered 12 workshops to 184 colleagues, focusing on enhancing patient, family, and colleague experiences. Feedback highlighted the value of empathetic communication, kindness, and practical tools for managing conflict. Sessions were well-received and considered relevant to daily practice. The initiative supports the Trust's commitment to compassionate, person-centred care.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S Digital

September 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

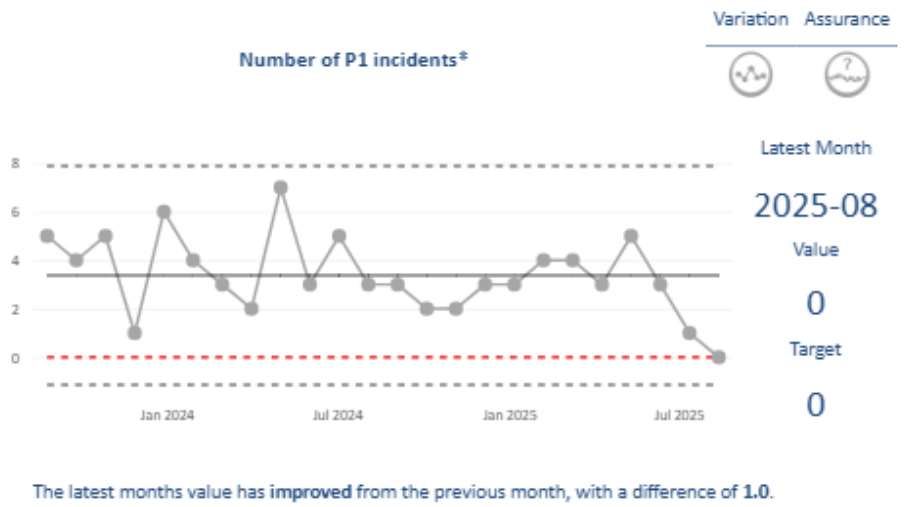
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

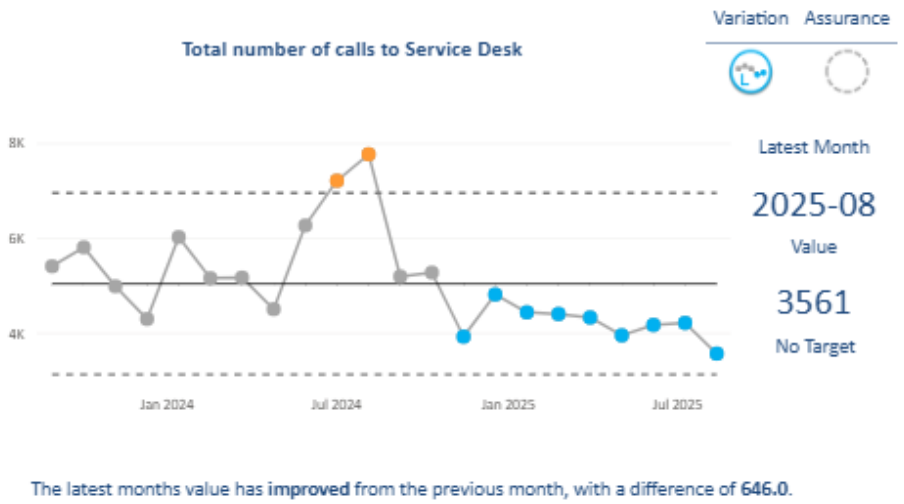
Executive Owner: James Hawkins **Operational Lead:** Steve Lawrie/Rebecca Bradley

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2025-08		?	0		0
Total number of calls to Service Desk	2025-08	L		3561		
Total number of calls abandoned	2025-08			512		
Number of information security incidents reported and investigated	2025-08			37		
Number of patient Subject Access Requests (SAR) received (monthly)	2025-08	L		276		
Number of patient Subject Access Requests (SAR) completed (monthly)	2025-08			235		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2025-08		P	83%		80%
Number of FOIs and EIRs received (monthly)	2025-08			64		
Number of FOIs and EIRs completed (monthly)	2025-08			75		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2025-08		?	99%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy





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

Target: 0 P1 Incidents

Factors impacting performance:

0x P1 incidents occurred.

1. There were no unplanned outages during August.
2. Telephone support demand was low and may be correlated to there being no disruptive outages. The total new tickets was also lower than August 2024.

Actions:

We 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.

Reducing telephone calls for support minimises waiting times for those who require urgent support, and helps support teams balance resources toward existing tickets that are awaiting resolution.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

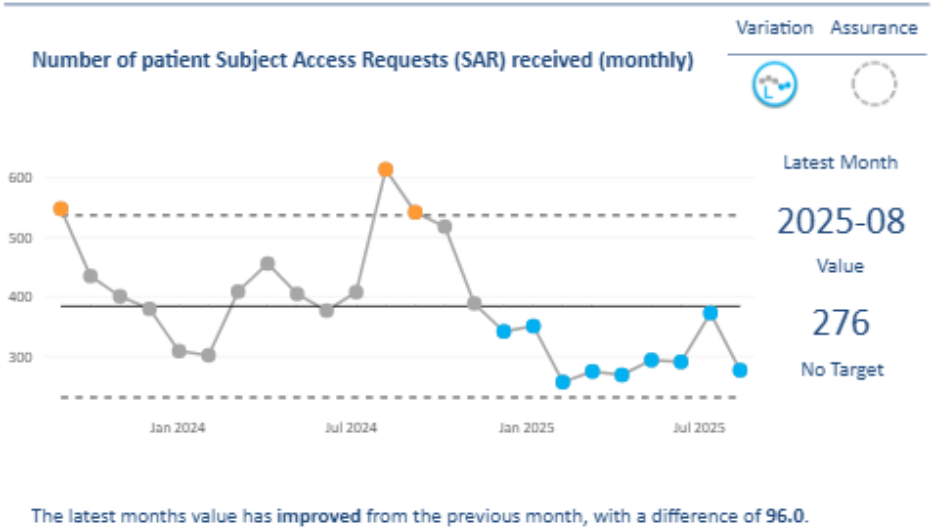
Rationale: Monitoring of information security incidents and ensuring these are investigated and actioned as appropriate.

Number of information security incidents reported and investigated

Factors impacting performance:

There has been a decrease in incidents during August compared to the previous month.

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



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

Number of Subject Access Requests (SAR) submitted by patients

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

Volumes received have increased compared to last month and timeliness of responses has improved, which is achieving target.

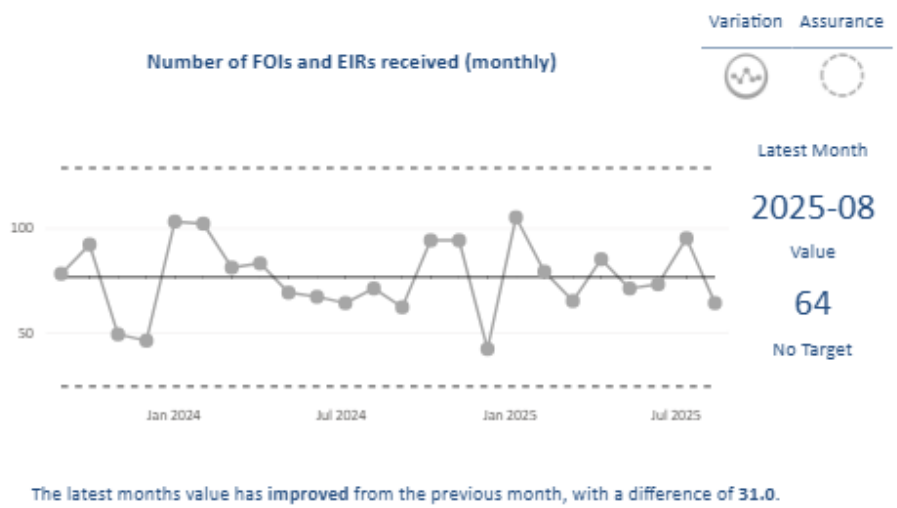
Digital & Information Services (DIS)

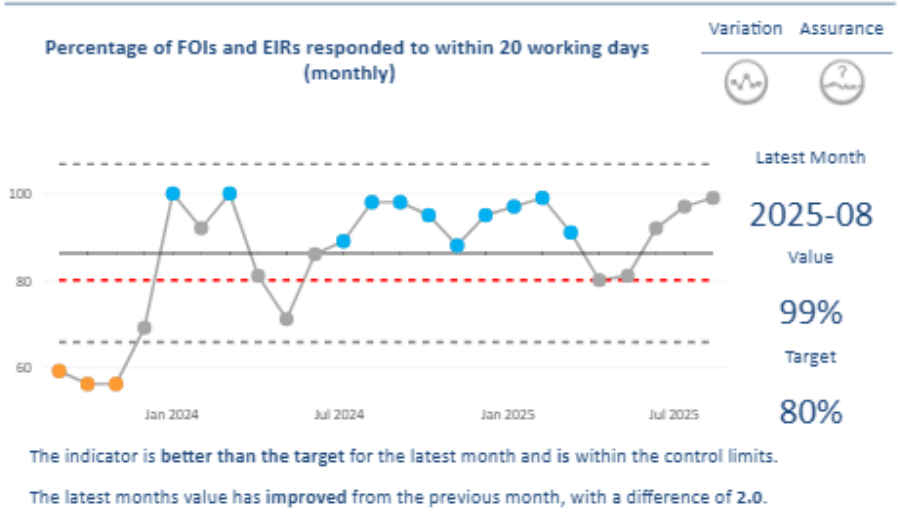
DIS (3)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley





Rationale: Ensuring the Trust responds to % 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 August has decreased.

Actions: N/A

Percentage of FOIs responded to within 20 working days

Requests being sent out on time has increased and is above the target of 80%.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

September 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	-£3m	-£0.2m	↑	Improving
Corporate CIP Delivery Variance to Plan (£29.8m target)	-£5.0m	-£7.6m	↓	Deteriorating
Core CIP Delivery Variance to Plan (£25.5m Target)	£2.0m	£3.4m	↑	Improving
Variance to Agency Cap	£0.7m	£0.5m	↓	Deteriorating
Month End Cash Position	£24.2m	£27.1m	↑	Improving
Capital Programme Variance to Plan	-£4.6m	-£6.3m	↓	Deteriorating

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	794,798	331,166	337,678	6,512
Other Income	95,790	39,927	39,342	-586
Total Income	890,588	371,093	377,019	5,926
Pay Expenditure	-588,664	-247,201	-248,685	-1,484
Drugs	-73,558	-30,667	-33,322	-2,655
Supplies & Services	-96,196	-40,249	-38,086	2,163
Other Expenditure	-158,676	-50,393	-53,161	-2,768
Outstanding CIP	40,063	4,228	0	-4,228
Total Expenditure	-877,032	-364,281	-373,254	-8,973
Operating Surplus/(Deficit)	13,556	6,812	3,765	-3,047
Other Finance Costs	-12,196	-5,082	-4,314	768
Surplus/(Deficit)	1,360	1,730	-548	-2,278
NHSE Normalisation Adj	-1360	-2650	-603	2048
Adjusted Surplus/(Deficit)	0	-920	-1,151	-231

The I&E table confirms an actual adjusted deficit of £1.2m against a planned deficit of £0.9m, leaving the Trust with an adverse variance to plan of £0.2m.

In respect of deficit support funding (DSF), Q1 & Q2 DSF has been secured. Q3 is based on 4 metrics across the system at M5: 1) Balance to plan; 2) CIP delivery; 3) Pay variance to plan; 4) Net risk position. As a Trust, we have achieved metric 1 with a small adverse variance due to the strike action and we have shown improvement in our net risk position, however our pay variance and CIP delivery are still a cause for concern. As a system overall, we are showing an improvement in the position, but the net risk is deteriorating and therefore our Q3 deficit support funding is at risk.

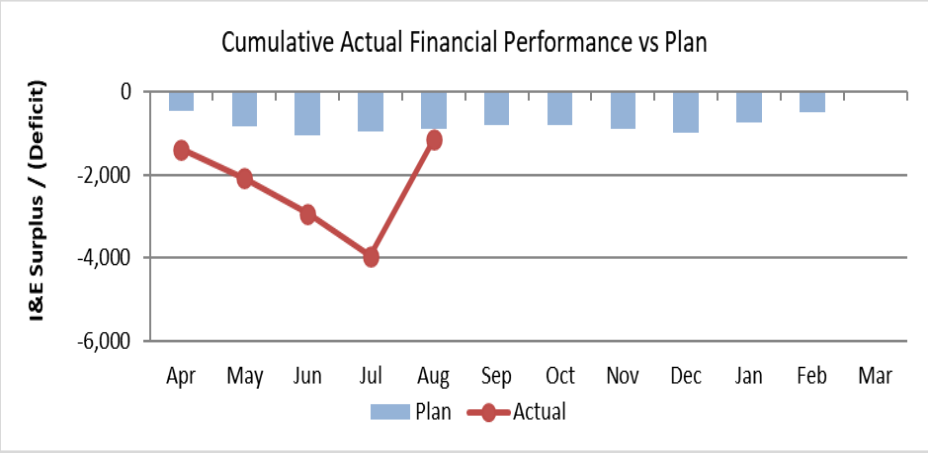
Key Subjective Variances: Trust
Finance (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable / (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	(£15,517)	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	£21,330	ICB over trade linked to services which have been delegated from NHSE to commission. Position also includes £4.5m linked to ERF activity ahead of plan. Although this income is covered by the block contract, £4.5m has been brought forward into the M5 position to recognise activity delivered to date. This action has been agreed by the ICB.	Confirm contracting arrangements and ensure plans and actual income reporting align
Employee Expenses	(£1,484)	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	(£2,655)	Mainly relates to drugs commissioned by ICBs that were previously contracted for on a pass-through basis (£1.1m) 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.	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	(£4,228)	The Corporate Programme is £7.6m behind plan, the Core Programme is £3.4m ahead of plan.	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group.
Other Costs	(£2,768)	Relates to several moderate value cost pressures across the Trust including histopathology outsourcing (£0.2m) hire of vehicles (£0.3m) and charges from the procurement collaborative (£0.6m), the latter costs are offset by pay budget savings in the procurement team.	Identify drivers for increased costs 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 August 2025 is a deficit of £1.2m compared to a planned deficit of £0.9m. This represents an adverse variance to plan of £0.2m.

Forecast			
	Adjusted Surplus/(deficit)		
Scenario	Plan £'000	Forecast £'000	Variance £'000
Likely Case	0	-13,919	-13,919
Best Case	0	0	0
Worst Case	0	-41,837	-41,837

Forecast Scenarios

Best Case

The best-case forecast meets the balanced plan. This assumes that 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, receipt of £5.1m 24/25 ERF overtrade, and additional funding to cover the pay award shortfall, winter pressures and delivery of ERF activity over plan in 2025/26.

Most Likely Case

The most likely case contains the same assumptions identified in the best case above but assumes a shortfall in the delivery of run rate savings of £13.919m

Worst Case

The worst case assumes that none of the mitigations identified in the best case are secured.

Care Group Forecast
Finance (5)

NHS
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	239,086	100,030	98,052	1,978	100,561	2,509	Improved position, due to continued reduction in Drug spend, £2m Underspend on CDC's due to delay at Scarborough, not expected to continue once all sites operational and £0.4m underspend on Lung Health Check, spend will increase to catch up activity numbers.
Family Health Care Group	89,169	37,278	37,942	-664	37,460	-482	£411k relates to the premium cost of covering medical vacancies, £442k Community Nursing overspend, £355k Midwifery overspend, £253k other pay underspend, £371k overachieved CIP.
Medicine	191,403	80,380	84,052	-3,672	80,598	-3,454	£1.8m relates to medical cost pressures in ED and Acute; £1.0m drugs overspend, primarily Gastro and Respiratory.
Surgery	164,219	68,829	71,175	-2,346	68,953	-2,222	Overspend mainly relates to Resident Doctors pay costs over budget - £1.3m & overspends on drugs & CSS spend
TOTAL	683,877	286,517	291,221	-4,704	287,572	-3,649	

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	239,086	238,273	0	238,273	812	Forecast deterioration due to profiling of CIP Target, increased expenditure for Winter diagnostics and opening of all CDC sites by end of financial year. As well as Endoscopy, MRI and CT Insourcing to improve performance.
Family Health Care Group	89,169	91,576	-161	91,414	-2,246	£560k relates to the premium cost of covering medical vacancies, £778k Community Nursing overspend, £853k Midwifery overspend, £497k other pay underspend, £190k under-planned CIP.
Medicine	191,403	201,191	-125	201,066	-9,663	£4.3m relates to medical staffing cost pressures, £2.4m drug overspend and £2.8m shortfall in CIP delivery
Surgery	164,219	168,717	-355	168,362	-4,143	£3.8m over-spend on Resident Doctors mainly relates to premium cost of covering medical vacancies & £0.3m Ward 25 pay costs over budget
TOTAL	683,877	699,757	-641	699,116	-15,239	

Forecast Outturn & Recovery Action Plans

Finance (6)

York and Scarborough Teaching Hospitals NHS Foundation Trust

2025/26 Forecast Outturn & Recovery Actions	
2025/26 Forecast	**£m**
M4 Run Rate FOT	**-11.9**
Winter Plans	-3.0
Redundancy Costs	-2.0
Additional costs re validation (ERF)	-1.8
Run rate efficiencies	1.5
M4 Unmitigated Risk	**-17.2**
M5 Impact of run rate changes	6.3
M5 Impact of CIP delivery changes	-3.0
Revised M5 unmitigated risk	**-13.9**
Recovery Actions	
Medicine Care Group	
Cease Co-horting	0.5
Cease Acute Medical Provision - SGH	1.0
ED Resident Drs - YRK	0.0
CIP Recovery	0.0
Surgery Care Group	
Address medical overspends	1.1
Address unfunded cost pressure - ward 25 & day unit	0.2
Remove unfunded apprentice Posts	0.2
Family Health Care Group	
Community Nursing	0.0
Address Resident Doctors overspend - Child Health	0.1
Corporate	
Discretionary Expenditure Control	0.5
Optimal Residual Risk	**-10.4**

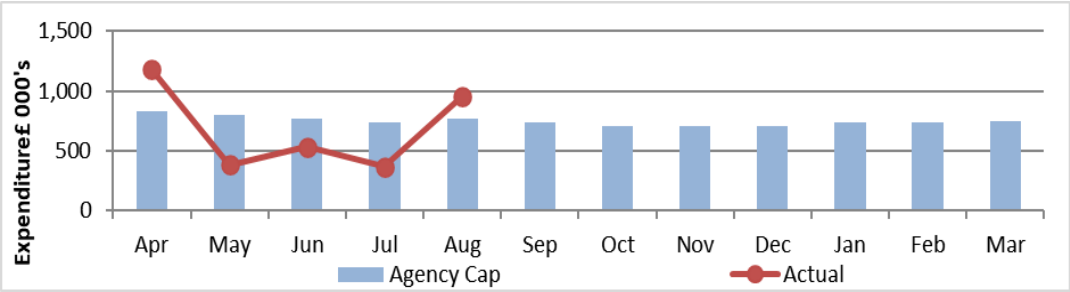
At Month 4, the Trust was required to submit a forecast outturn and recovery action plan. At the time of submission, the Trust had £17.2m unplanned risk. A revised position at M5 due to a reduction in the Pay and Non-pay run rate, and an adverse movement in CIP forecast delivery, reduces the unplanned risk to £14.2m.

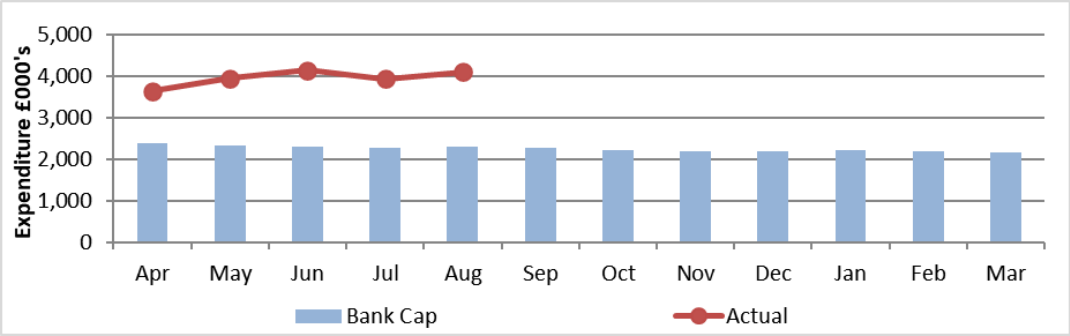
Recovery actions are required to bring the Trust back to balance.

To date there are insufficient actions with a current outstanding risk of £10.7m and it should be noted that some of the current actions are still being validated. The Executive Committee is working on supplementary actions, as is the wider ICB and System. This work includes accelerating delivery of CIP plans (the programme is fully planned but some schemes are slipping), seeking to minimise spend for winter schemes against the total cost estimate of £3m, and the identification of new cost/waste reduction initiatives. The Board will see continual updates on the recovery plan as this work progresses.

Agency, Bank and Workforce

Finance (7)





	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,624.55	2,475.62	148.93	63,396	63,215	181
Scientific, Therapeutic and Technical	1,312.96	1,254.58	58.38	31,072	31,156	-84
Support To Clinical Staff	1,934.15	1,562.77	371.38	26,873	24,901	1,972
Medical and Dental	1,118.84	1204.12	-85.28	66,609	71,776	-5,167
Non-Medical - Non-Clinical	3,232.56	3,031.47	201.09	55,216	56,671	-1,456
Reserves				3,093	0	3,093
Other				942	965	-23
TOTAL	10,223.06	9,528.56	694.5	247,201	248,684	-1,483

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 August is £3.415m compared to a plan of £3.909m, representing a favourable variance of £0.494m.

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 August is £19.756m compared to a plan of £11.575m, representing an adverse variance of £8.181m.

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	Value ERF scope Indicative Weighted Values at 25/26 prices	ERF Month 04 Phase (Av %)	Activity to Month 04 Actual	Variance - (Clawback Risk) M04
Humber and North Yorks	104.00%	£170,198,576	£56,101,622	£60,839,029	£4,737,407
West Yorkshire	103.00%	£1,559,555	£514,068	£529,954	£15,886
Cumbria and North East	115.00%	£222,092	£73,207	£98,630	£25,423
South Yorkshire	121.00%	£181,684	£59,887	£56,727	-£3,160
Other ICBs - LVA / NCA	-				*£0*
All ICBs	***104.02%***	***£172,161,907***	***£56,748,784***	***£61,524,340***	***£4,775,557***
NHSE Specialist Commissioning	113.38%	£4,752,000	£1,566,376	£1,367,719	-£198,656
Other NHSE	104.13%	£303,039	£99,889	£93,578	-£6,312
All Commissioners Total	**104.31%**	**£177,216,947**	**£58,415,048**	**£62,985,637**	**£4,570,589**

Elective Recovery Fund

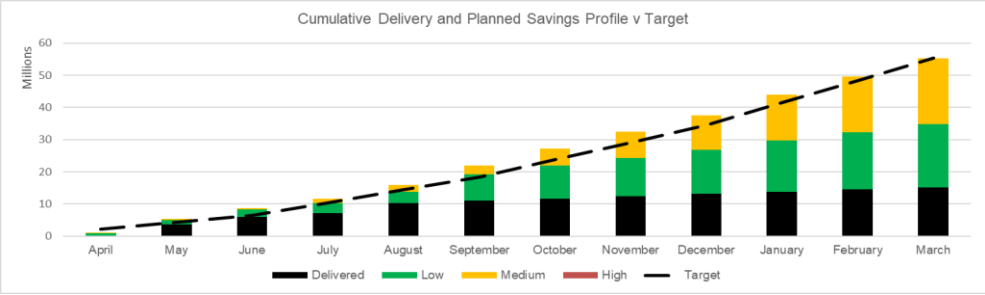
We continue to report on Elective Recovery Performance on an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date before applying average tariff income to the activity.

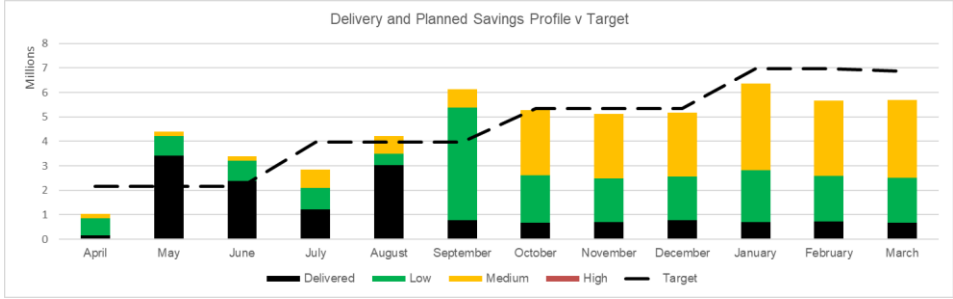
Given the financial limits on Elective Recovery Funding in 2025/26, it is important to closely monitor the position to ensure that the weighted activity undertaken, where it incurs additional costs, does not exceed the planned levels without ICB Commissioner discussion and authorisation. Additional system funding may become available in year. if other system providers, including the Independent sector, are under their agreed activity plan and elective resource can be redirected.

At Month 5, the ERF weighted activity is valued at £4.57m over the funded level of ERF activity within our Commissioner contracts.

Cost Improvement Programme
Finance (9)

York and Scarborough Teaching Hospitals NHS Foundation Trust





2025/26 Cost Improvement Programme - August Position

	Full Year CIP Target	August Position			Full Year Position		Planning Position		Planning Status		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Fully Developed	Plan in Progress	Opportunity
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Corporate Programme	29,789	7,784	163	7,621	392	29,396	14,417	15,371	1,188	13,229	0
	29,789	**7,784**	**163**	**7,621**	**392**	**29,396**	**14,417**	**15,371**	**1,188**	**13,229**	**0**
Core Programme											
Medicine	6,039	1,578	726	852	1,530	4,509	4,203	1,835	2,151	2,053	0
Surgery	4,524	1,182	1,096	87	2,255	2,270	5,564	-1,040	4,026	1,538	0
CSCS	7,044	1,841	1,855	-14	2,291	4,753	8,650	-1,606	7,706	944	0
Family Health	2,306	602	974	-371	1,327	978	2,116	190	2,113	3	0
CEO	45	12	224	-212	537	-493	600	-555	575	25	0
Chief Nurses Team	893	233	55	179	128	764	472	421	128	343	0
Finance	733	191	213	-22	777	-44	841	-109	826	15	0
Medical Governance	62	16	4	12	11	51	56	5	56	0	0
Ops Management	532	139	127	12	299	234	316	216	316	0	0
DIS	601	157	18	139	45	555	605	-5	45	560	0
Workforce & OD	763	199	217	-18	527	236	527	236	527	0	0
YTHFM LLP	1,962	513	946	-434	1,518	444	3,098	-1,136	1,879	1,219	0
Central	0	0	3,602	-3,602	3,590	-3,590	13,823	-13,823	13,301	523	0
	25,502	**6,664**	**10,057**	**-3,393**	**14,835**	**10,666**	**40,873**	**-15,371**	**33,649**	**7,223**	**0**
Total Programme	**55,290**	**14,448**	**10,220**	**4,228**	**15,228**	**40,063**	**55,290**	**0**	**34,837**	**20,453**	**0**

Efficiency Programme

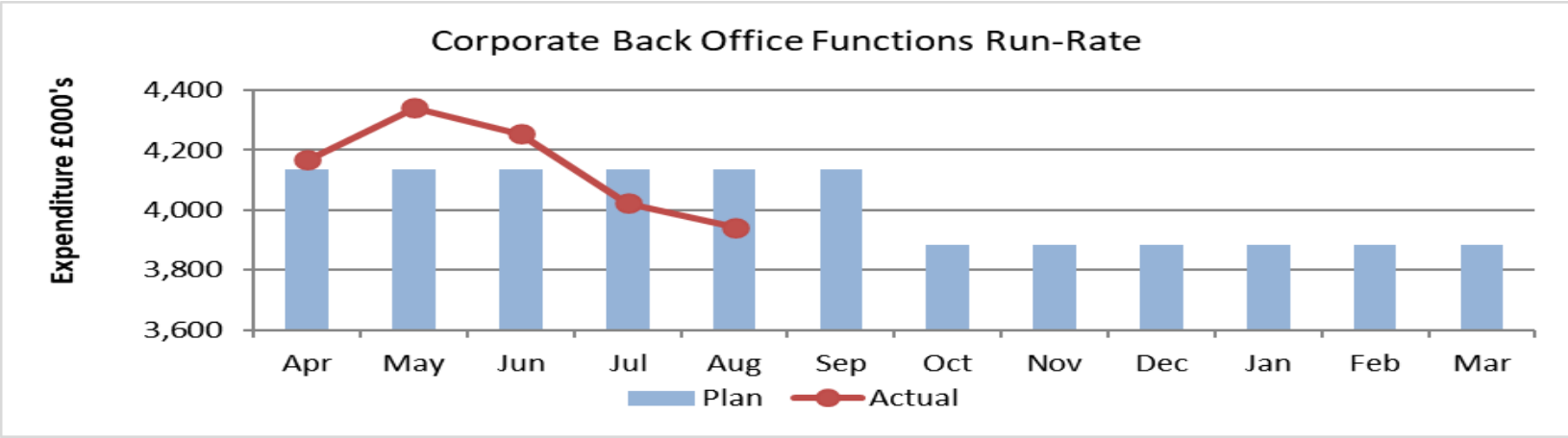
The total trust efficiency target is £55.3m, £15.2m has been achieved in full year terms and the year-to-date position is £4.3m behind plan. The programme is fully planned.

Corporate Efficiency Programme

The Corporate efficiency programme has a target of £29.8m and £392k has been delivered in full year terms. At the end of August, the year-to-date delivery is £7.6m behind plan. Identified plans total £14.4m, leaving a gap of £15.4m.

Core Efficiency Programme

The Core efficiency programme target is £25.5m and £14.8m has been delivered in full year terms. At the end of August, the year-to-date delivery is £3.4m over plan. There are identified plans totaling £40.9m which is £15.4m over the target.



The graph above demonstrates the Trust's progress towards achieving the target to reduce the growth in back-office function costs between 2018/19 and 2023/24, by 50%, effective from October 2025. The Trust's indicative full year target is a £5.4m cost reduction which the Trust has committed to deliver and schemes have been included in Corporate Directorate's CIP Programmes phased between 2025/26 and 2026/27.

The return provided to NHSE on 31 May 2025 identified £2.4m of 'exceptions' that reduced the expected run rate savings in back-office functions to £3m. Run rate savings of £1.5m are expected to be delivered between October 2025 and March 2026 with the full £3m delivered in 2026/27.

The back-office function return is a detailed and complex analysis that is completed annually. NHSE have asked providers to calculate a proxy back-office cost each month to demonstrate a downward trend in expenditure. The graph above demonstrates the calculated corporate back-office function monthly cost in April 2025 at £4.2m and the plan shows that this is expected to reduce by £250k per month from October (£1.5m by March 2026).

The actual calculated back-office costs in the graph above, demonstrate that good progress is being made to reduce the back-office function run rate. The actual spend calculated in August is £3.942m. This needs to reduce by a further £58k per month by October to meet the required run rate reduction.

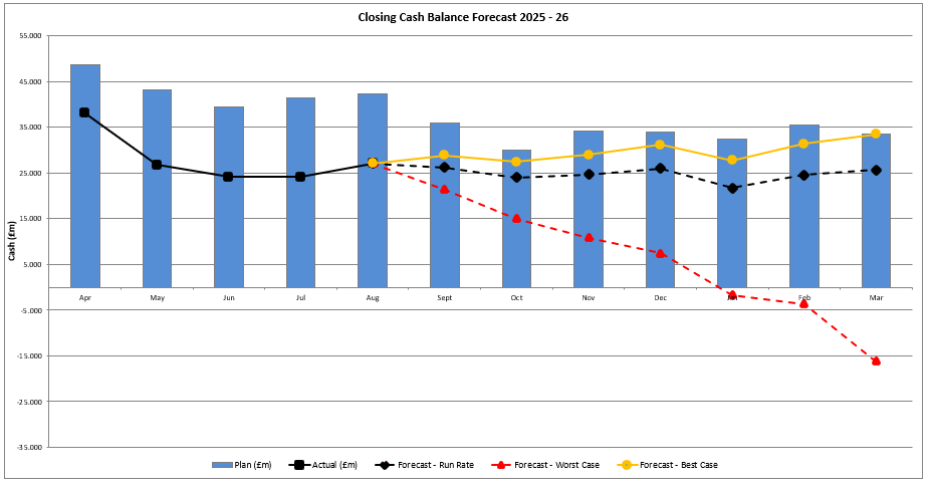
Current Cash Position and Better Payment Practice Code (BPPC)

Finance (11)

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	24,178	27,143							



Cash at the end of August was £27.1m against a plan of £42.3m, which is £15.2m adverse. The significant factors attributing to the variance are:

- £3m – Adverse variance in I&E operating surplus / (deficit).
- £5.5m – Adverse due to payment of capital invoices above plan, £4m relating to PDC funded schemes where NHSE have recently confirmed the reference to allow the funding to be drawn down. This cash will be drawn in September.
- £4.5m – Adverse variance due to creditor balance lower than plan linked to timing of receipt & payment of supplier invoices with no significant issues.
- £2m – Adverse variance in debtors. The HUTH debtor balance reported last month reduced following receipt of £6.2m. The overdue balance is now £2.2m (mainly linked to SHYPS). We are actively chasing for payment in September.

The forecast contains 3 scenarios – all scenarios assume deficit support funding for the full year:

Run rate – Based on continuation of cash receipts & payment run rates in line with April to August levels.

Best case – Based on the Trust recovering to deliver the financial plan.

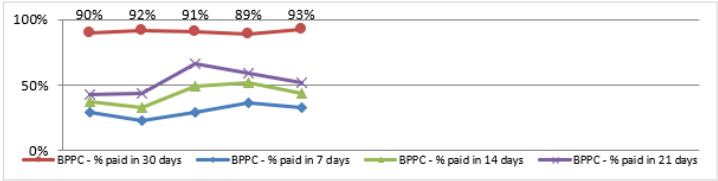
Worst case – Based on the Trust delivering a £41.8m deficit.

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 August the Trust managed to pay 93% of its suppliers within 30 days.



Current and Forecast Capital Position

Finance (12)

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	M5 Actual £000s	Variance to Plan £000s
PDC Funded Schemes	56,525	9,176	4,125	(5,051)
IFRS 16 Lease Funded Schemes	7,838	1,258	451	(807)
Depreciation Funded Schemes	16,626	4,812	4,420	(392)
Charitable & Grant Funded Schemes	7,213	2,010	21	(1,989)
Total Capital	**88,202**	**17,256**	**9,017**	**(8,239)**
Less Charitable & Grant Funded Schemes	(7,213)	(2,010)	(21)	1,989
Less Sale of Clarence Street	(325)	-	-	-
Total Capital (Net CDEL)	**80,664**	**15,246**	**8,996**	**(6,250)**

The M5 position is £6.3m behind the plan.

This is mainly due to the York VIU / PACU / Hybrid Theatre running £1.5m behind the planned profile, the Electronic Patient Record scheme running £0.6m behind the planned profile, the RAAC scheme running £2m behind the planned profile, and various other schemes running £2.2m behind the planned profile.

These schemes are expected to return to plan in future months as projects progress.

System Summary – Month 4

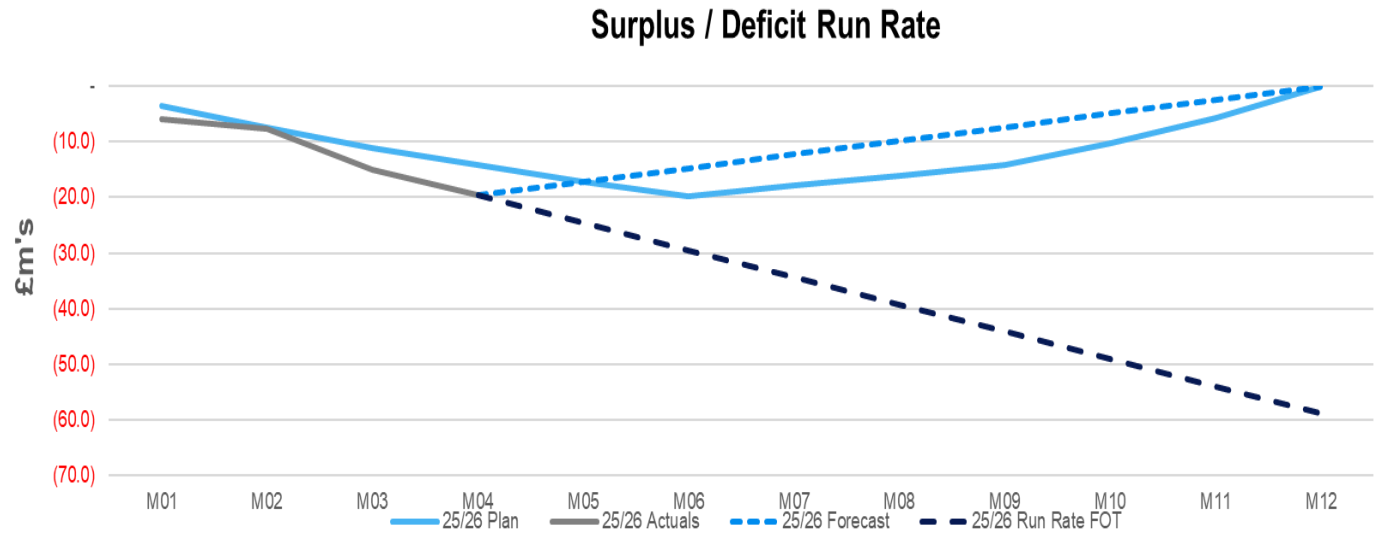
Finance (13)

York and Scarborough Teaching Hospitals NHS Foundation Trust

M4 Position

- ICB £53k overspend YTD, FOT breakeven.
- Providers £5.4m overspend YTD, FOT breakeven.
- Straight line extrapolation of run rate is circa £60m deficit.
- YTD variance is mainly due to slippage against efficiency targets and medical staffing costs partially offset by non-recurrent mitigations.

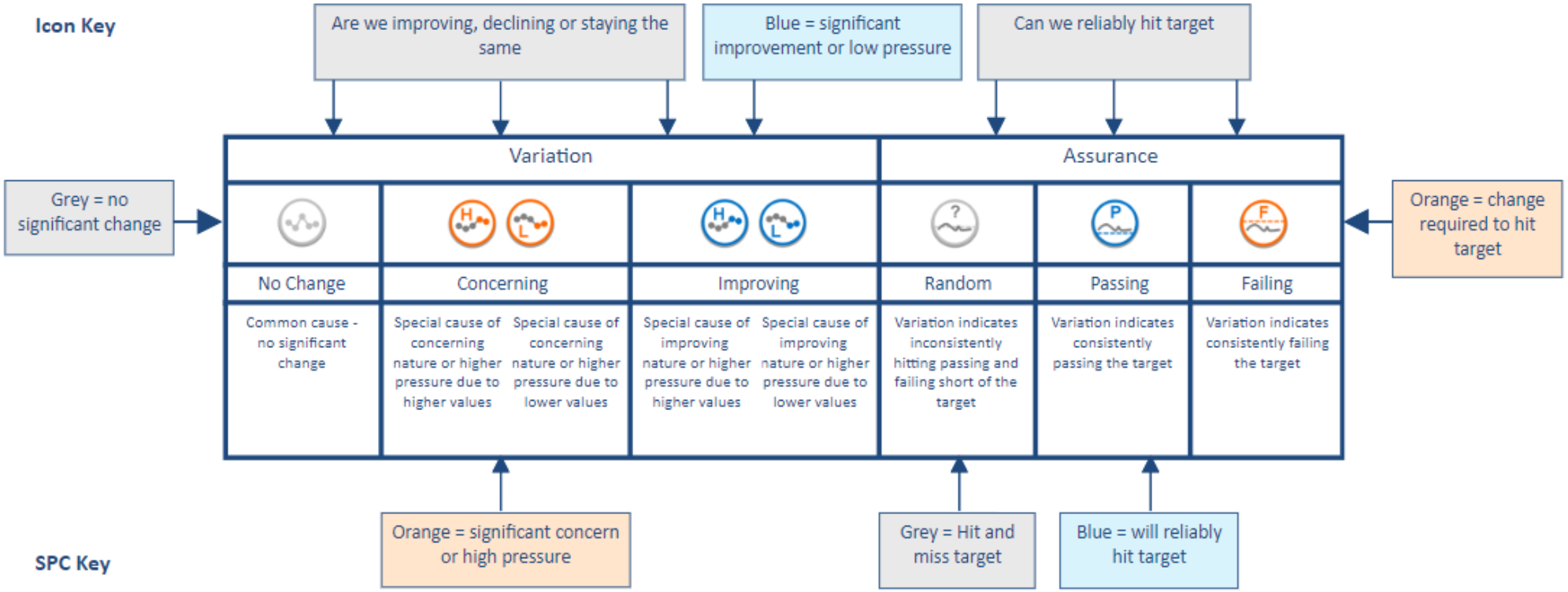
Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Variance Year Ending %
Humber And North Yorkshire ICB	-	(53)	(53)	(0.0%)	-	-	-	0.0%
Harrogate And District NHS Foundation Trust	(3,298)	(5,680)	(2,382)	(1.9%)	-	-	-	0.0%
Hull University Teaching Hospitals NHS Trust	(3,901)	(6,761)	(2,860)	(0.9%)	-	-	-	0.0%
Humber Teaching NHS Foundation Trust	(795)	2,205	3,000	3.4%	-	-	-	0.0%
Northern Lincolnshire And Goole NHS Foundation Trust	(5,268)	(5,438)	(170)	(0.1%)	-	-	-	0.0%
York And Scarborough Teaching Hospitals NHS Foundation Trust	(962)	(3,957)	(2,995)	(1.0%)	-	-	-	0.0%
ICS Total	(14,224)	(19,684)	(5,460)	(0.3%)	-	-	-	0.0%



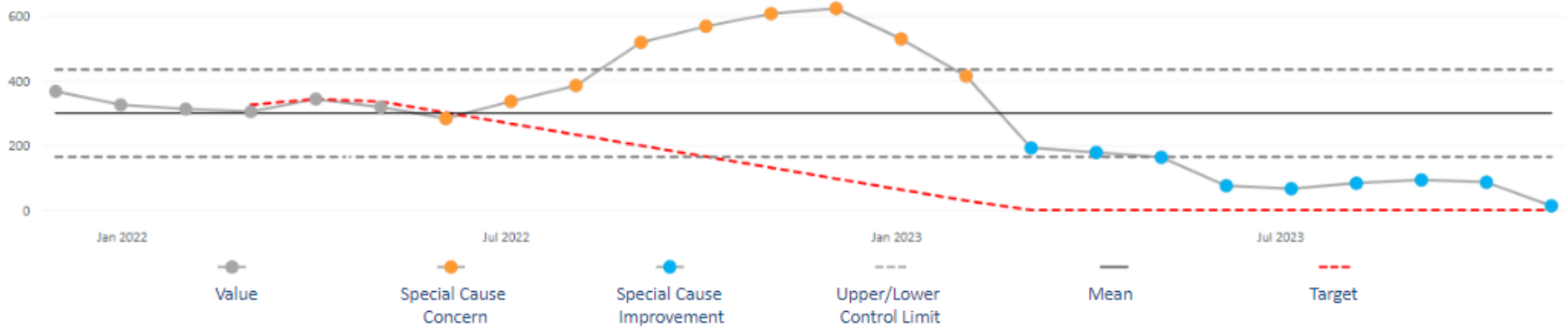
Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key



SPC Key



The orange and blue points indicate either increasing or decreasing trends. The colour will update if 7 points appear either above or below the mean or if 2 out of 3 are near the upper or lower control limit. The target can be either static or moving.

Icon Descriptions

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

Report to:	Board of Directors
Date of Meeting:	24 September 2025
Subject:	Annual Operating Plan Quarter 1 Update
Director Sponsor:	Claire Hansen, Chief Operating Officer
Author:	Tilly Poole, Head of Strategy and Planning

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 this paper is to inform the Board of the progress in relation to the 2025/26 Annual Operating Plan actions. The Board are asked to note the update.

The Annual Operating plan for 25/26 consisted of a total of 272 actions. These included operational actions to address 25/26 priorities.

During July 2025, teams were asked to provide an update on the status of any action highlighted for completion in quarter 1 of which there are 100:

.

- 74 Complete, 4 in part, 21 were not completed in Q1
- 11 were still relevant and delivery quarter has been updated to be Q2
- 6 have been updated to be completed in Q3 and 1 updated to Q4
- 3 actions have been mitigated and no longer require completion
- 1 action is described as ongoing and has been completed for Q1 and will remain monitored each quarter.

Key Themes and Performance

- **Overall progress:** Majority of Q1 actions completed; delays mainly due to operational dependencies, engagement requirements, and infrastructure challenges.
- **Positive trends:**
  - Reduction in patients with *no criteria to reside* in acute beds since April 2025.
  - Month-on-month improvement in Emergency Care Standard (ECS) performance.
  - Improved diagnostic waiting times (6 weeks or less).

Areas with Delays

- **Reduction in No Criteria to Reside:**
  - 15 actions; 6 incomplete (reasons include SOP engagement and physical space expansion).
- **Emergency Care Standard:**
  - 18 actions; 7 incomplete (workforce modelling, SDEC optimisation, UTC usage).
- **Diagnostics:**
  - 7 actions; 4 incomplete due to Scarborough CDC build delays (now Q3).
- **Workforce & Culture:**
  - Leadership and coaching initiatives partially complete; embedding ongoing.
- **Financial Plan:**
  - CIP documentation delayed; focus on de-risking high-risk schemes.

Risks and Mitigations

- **CDC build delay** impacts diagnostic targets; mitigated by revised Q3 go-live.
- **Discharge to Assess model** requires 12-month implementation due to workforce and financial implications.
- **Frailty SDEC extension** paused pending staffing stabilisation.

Overall, no material delay to the annual operating plan objectives.

Next Steps

- Complete deferred actions in Q2/Q3.
- Provide full Q2 update to Board in **November 2025**

Recommendation:

Trust Board members are asked to note the content of 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**
Resources Committee	**16 September 2025**	

Annual Operating Plan – Quarter One Update

1. Introduction and Background

The Annual Operating Plan (AOP) describes the Trust's plans to respond to both national and local planning requirements and supports the delivery of the Trust's Strategy 'Towards Excellence'.

The AOP is supported by detailed action plans, developed by local teams in response to the Trust's strategic objectives within the Trust's Strategy and the planning priorities for 2025-2026. The action plans contain quarterly delivery milestones, key actions and action owners.

2. Purpose

During April 2025, teams across the organisation developed action plans to address the six strategic objectives within the Trust's Strategy in line with the 25/26 trajectory set by Trust Board.

Six Strategic Objectives:

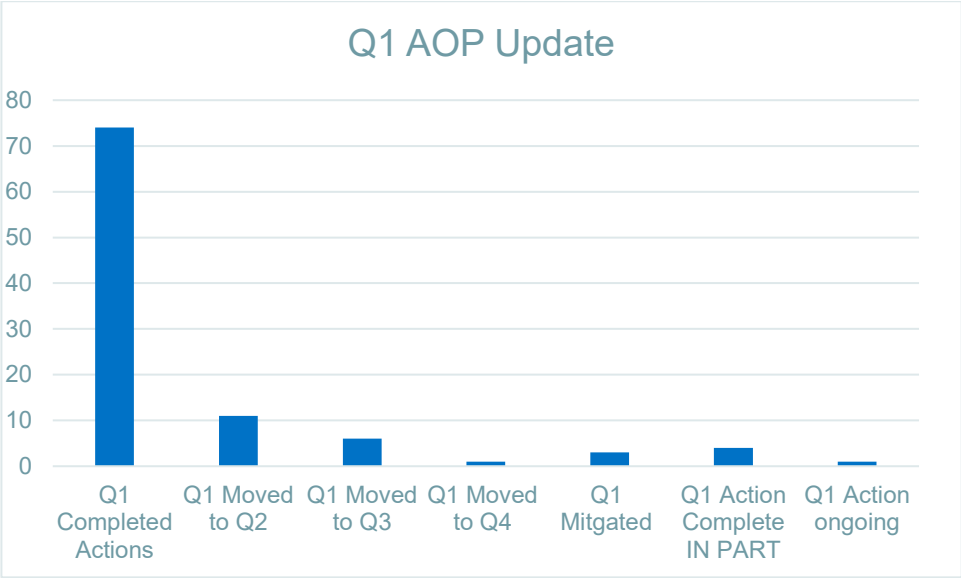
- To provide timely, responsive, safe, accessible and effective
- services at all times
- To create a great place for our people to work, learn and thrive
- To work together with partners to improve the health and wellbeing
- of the communities we serve
- To challenge the ways of today to develop a better 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

At the start of July, updates were provided against the actions marked for completion in the first quarter. This report provides an update on those actions including narrative on the status of those incomplete.

3. Current Position/Issues

The summary status of the 100 Q1 actions is:

- 74 Complete, 4 in part, 21 were not completed in Q1.
- 11 were still relevant and delivery quarter has been updated to be Q2
- 6 have been updated to be completed in Q3 and 1 updated to Q4.
- 3 actions have been mitigated and no longer require completion.
- 1 action is described as ongoing and has been completed for Q1 and will remain monitored each quarter.



The majority of actions incomplete were against four objectives:

- Reduction in no criteria to reside
  - Total of 15 Q1 actions – 6 incomplete
    - 1 will be completed in Q2
    - 2 will be completed in Q3
    - 1 will be complete in Q4
    - 1 mitigated
    - 1 is an ongoing monthly action
- Emergency Care Standard
  - Total of 18 actions – 7 incomplete
    - 6 will be completed in Q2
    - 1 will be completed in Q3
- Improvement in number of patients waiting 6 weeks or less for diagnostic tests:
  - Total of 7 Q1 actions – 4 incomplete
    - 3 will be completed in Q3 due to delay in CDC completion date
    - 1 mitigated
    - 11 will be completed in Q2

It is important to note at the end of Q1:

- There has been a reduction in patients with no criteria to reside occupying acute beds since April 2025.

- The number of people waiting over 4 hours in our emergency departments for admission, treatment and/ or discharge has improved month on month since April 2025.

- There has been an improvement since April on those patients waiting 6 weeks or less for diagnostic tests.

The Annual Operating Plan and associated action plans provide information that describes how the organisation will meet its objectives for 25/26.

The summary update provides an overview of the current achievement against those actions and if actions have been completed, delayed or mitigated.

18 actions for Q1 are still valid and will be completed in the coming months, 4 are partially completed and 3 have been mitigated.

All incomplete actions and narrative have been included in appendix 1.

4. Conclusion

Overall, there has been no material impact on the delivery of the AOP objectives, and performance trends are positive in key areas. Since April 2025, the Trust has seen a reduction in patients with no criteria to reside in acute beds, month-on-month improvement in Emergency Care Standard performance, and progress in reducing diagnostic waits to six weeks or less. Where delays have occurred, these are primarily due to operational dependencies, engagement requirements, and infrastructure challenges.

For example, the Scarborough Community Diagnostic Centre (CDC) build has been delayed, with operational go-live now expected in October 2025 (Q3). Similarly, the Discharge to Assess model requires a phased approach over the next 12 months due to workforce and financial considerations. Some workforce and leadership initiatives are partially complete and will continue into Q2 and beyond.

Financially, work to apply NHSE assurance tests and develop project initiation documentation for CIP schemes has been slower than planned, as focus has been on de-risking high-risk schemes. These actions are now scheduled for completion in Q2.

In summary, while a small number of actions have been deferred, the majority of Q1 commitments have been achieved, and there is no indication that these delays will compromise the overall delivery of the AOP.

5. Next Steps

The quarter 2 report will be issued to Board in November 2025.

Date: 17/07/2025

Reduction in No Criteria to Reside

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative if incomplete	Revised Delivery Quarter	Update provided by (add name)
Improve effectiveness of board rounds	Q1	Cell 1 Leads: Amy Gains / Angela Gruber	Dawn Parkes	No	Trial of the visual boards on 6 wards (3 X York and 3 X Scarborough wards) commenced 23/6 for 2 weeks. ECIST attended board rounds w/c 7th July 2025 and were complimentary about processes. ECIST are running five drop-in sessions on 9th and 10th September about discharge and risk management. ECIST medical lead is providing educational sessions on 'criteria led discharge' and 'clinical criteria for discharge' with dates TBC.	Q2 actions planned + ongoing	Kerry Blewitt
Establish Board Round SOP	Q1	Cell 1 Leads: Amy Gains / Angela Gruber	Dawn Parkes	No	SOP drafted and engagement took place with clinicians; limited support for taking forward in Q1 but Cell 1 of the Discharge Improvement Group will carry out more engagement work and aim to launch this by Q3.	Q3	Catherine Rhodes

Review and maximise Discharge Lounge utilisation	Q1	Sara Kelly	Dawn Parkes	No	Various elements of improvement work happening. Time out day planned, golden patient process being developed, posters, FAQ for wards, clear escalation process for escalation, drug trolley and meds in situ and review of opening hours. The number and percentage of patients being discharged via the lounges at York and Scarborough Hospitals are monitored by Cell 1 of the Discharge Improvement Group.	Q2 + ongoing	Kerry Blewitt
Establish role and requirement of Super Discharge Teams	Q1	Ab Abdi	Dawn Parkes	No	The super discharge team model in York/Scarborough is not continuing but has been replaced with action cards associated with a response to the OPEL scores. On a daily basis and as part of operations meetings, the team monitors the number of discharges by specialty and by ward, against capacity required in the Emergency Departments and consequent predictor. To ensure demand and capacity balance on a daily basis, actions are defined and adjusted throughout each day.	n/a - no longer taking forward	Kerry Blewitt

Identify and improve delays in discharges in pathway 2 and 3	Q1-4	Sara Kelly	Claire Hansen	No	Good progress in terms of improving the number of delays across complex pathways 2 and 3 has been made. On a daily basis (weekdays), 1st line and 2nd line escalation meetings with the system partners have been established that are vital vehicles to ensure delays have been escalated and addressed. The outcomes of 1st and 2nd line meetings (and 3rd line when required) are communicated to the relevant teams regularly during the course of the day / week. Reviews have taken place and feedback has been used to inform the process. A process map has been developed to help consistencies across sites.	ongoing action	Ab Abdi
Support Local Authority partners to establish Discharge to Assess model	Q1	Ab Abdi	Claire Hansen	No	Good progress is being made towards agreeing a Discharge to Assess model and the work is ongoing. Implementing the clinical and workforce model for a true D2A model – where patients are discharged not to an interim care setting but to the place they will call home - is expected to take at least 12 months. This is partly due to the likelihood of workforce consultations and related cross-system financial implications. An additional 10 spaces for interim care settings (which are sometimes	Q4	Ab Abdi

					referred to as D2A beds despite not following a true D2A pathway) have become available in July 2025.		
Expand Discharge Command Centre Physical Spaces to allow space for system partners	Q1	Ab Abdi	Claire Hansen	No	The Scarborough Discharge Hub has expanded by three desks under a Minor Works agreement. Funding has been sourced for further, more extensive works at both sites. A project form is with the Capital Projects team for consideration and options appraisals at both sites. It is expected that the York team will move into the new physical space in Q3 due to the consultation required for staff currently working in that space.	Q3	Catherine Rhodes
Maximise use of Bridging Services - CYC and NYCC to provide number of D2A beds	Q1	Sara Kelly	Claire Hansen	No	At City, procurement of 10 beds across two providers is now complete; these became available in July 2025. There is still scope strategically to further progress towards assessment of patients happening outside the acute sector as much as possible, which is part of the D2A task and finish group work. North Yorkshire have intermediate care beds in Selby and Scarborough areas.	Q2	Ab Abdi

					Additional demand for P2 is met through spot purchased activity. Procurement for intermediate care beds, including D2A, is being developed as part of the Intermediate Care model with NYC – target date April 26.		

Improvement in the Emergency Care Standard

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Set up consistent ED rounds / huddles at both EDs	Q1	T&F group	Karen Stone	No	Full ED Board Rounds should be taking place every day, at least at midday and ideally every four hours. Huddles should then take place more frequently throughout the day. Feedback is that huddles at both sites are taking place more frequently since the introduction of a new Huddle Pro Forma. The daily rhythm is still dependent on who is leading the department and how busy the department is. Therefore, the teams are working towards maintaining full consistency.	Q2	Catherine Rhodes

					A task and finish group brings relevant clinical and operational team members together on a fortnightly basis to review and set actions.		
Productivity scoping work	Q1	Naomi Bennigsen, Nish Jankee	Claire Hansen	No	First stage in reviewing locum productivity is complete. Next step is to review substantive staff and feed into data modelling for capacity and demand.	Q2	Naomi Bennigsen
Review workforce plan for ED and put forward business case for change - Capacity and demand modelling	Q1	Michelle Tipping	Claire Hansen	No	Data and rotas inputted and scrutinisation of model and demand now underway. New dashboard created to continually review demand data and update model as needed.	Q2	Naomi Bennigsen
Maximise Acute Assessment usage - Agree clinical model for acute assessment/SDECs	Q1	Liz Hill	Claire Hansen	No	This is underway for Q2, having visited other sites in the region to see and apply best practice, with support from ECIST	Q2	Naomi Bennigsen
Remove bring backs from surgery and medical SDECs	Q1	Liz Hill	Claire Hansen	No	These are both due to be launched at York in Q2, starting with one or two conditions and scaling up.	Q2	Naomi Bennigsen
Extend opening hours of Frailty SDEC	Q1	Liz Hill	Claire Hansen	No	This is paused until staffing stabilises during core hours.	Q3	Naomi Bennigsen
Maximise UTC usage - Launch test of change for UTC usage at both acute sites	Q1	Neil Storey	Claire Hansen	No	Additional capacity at the York UTC has been very successful, having a significant impact on ECS. This is yet to launch at SGH and will be done in Q2.	Q2	Naomi Bennigsen

Improvement in the number of patients waiting 6 weeks or less for diagnostic tests

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Scarborough CDC 1. Delivery of Capital Build	Q1	Karen Priestman (PM Jamie Baxter)	Claire Hansen	No	Delay to CDC completion date due to capital build and infrastructure challenges. New date for operational go live is October 2025	Q3	Kim Hinton
Scarborough CDC 2. Operational Go Live	Q1	Karen Priestman (PM Jamie Baxter)		No	Delay to CDC completion date due to capital build and infrastructure challenges. New date for operational go live is October 2025	Q3	Kim Hinton
Scarborough CDC 3. Development of pathways	Q1	Karen Priestman (PM Jamie Baxter)		No	Delay to CDC completion date due to capital build and infrastructure challenges. New date for operational go live is October 2025	Q3	Kim Hinton
Review the DM01 logic in CPD 1. Task and finish group established	Q1	Sheena White	James Hawkins	No	This is no longer relevant as needs to be reviewed by modality. The actions will be completed by modality. Audiology has commenced and all speciality on track to be completed in Q2	no longer required	Kim Hinton

Reduction of MSSA

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Review the guidelines for cleaning and decontamination of clinical equipment	Q1	Vicky Christie Keane	Dawn Parkes	No	In Progress will need to go to IPSAG in August for approval prior to implementation.	Q2	Sue Peckitt
Surveillance and monitoring Produce and agree SOP via IPSAG for MSSA case review	Q1	Sue Peckitt	Dawn Parkes	No	SOP presented at IPSAG in June, amendments requested and on IPSAG agenda for 3rd July for final approval	Q2	Sue Peckitt

Improvement in staff survey in workforce recommend Trust as a place to work

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Greater focus on accountability through CRR, disciplinary and performance process. Feedback provided appropriately to staff involved in processes.	Q1	Jenny Flinton	Polly McMeekin	In Part	Updates to processes and documentation have been released but these need embedding and practices reviewed. CRR policy has been reviewed with union colleagues during Q1.	Q2	Jenny Flinton
Mediation.	Q1	Gail Dunning	Polly McMeekin	N/A	0 requests for internal mediation have been received in Q1	Remove as action as ongoing	Gail Dunning /Liz Battye

						offer rather than action	
Our Leadership Framework, self-assessment, 180 and 360	Q1	Gail Dunning	Polly McMeekin	In Part	180 and 360 process launched; hosted alongside Our Leadership Framework on Staff Room. Team Assessment developed and launched against Our LF and V&B framework	Q2	Gail Dunning /Liz Battye
Management & leadership competencies.	Q1	Gail Dunning	Polly McMeekin	In Part	The development of the Management and Leadership Framework for NHS England due for launch in Q3, meanwhile the OD team are starting to design recent programmes against the agreed competencies in readiness. Ongoing Leadership and Management in house training is being provided.	Q4	Gail Dunning /Liz Battye
Coaching skills development – embedding a solution focused coaching culture (Intro to Coaching/Manager as Coach).	Q1	Gail Dunning	Polly McMeekin	In Part	15 colleagues attended coaching skills development sessions in Q1.	ongoing monthly action	Gail Dunning /Liz Battye

Live within our financial means – meet 25/26 financial plan

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
All CIP opportunities to have NHSE 4 tests applied in line with NHSE Closedown letter	Q1	Sarah Barrow	Andrew Bertram	No	Focus has been in relation to de-risking high risk schemes - remaining schemes will follow	Q2	Sarah Barrow
50% CIP plans in progress to have Project Initiation Documentation (PID) initiated in line with NHSE Closedown letter	Q1	Sarah Barrow	Andrew Bertram	No	Focus has been in relation to de-risking high risk schemes - remaining schemes will follow	Q2	Sarah Barrow

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 09 2025
Subject:	Freedom to Speak Up
Director Sponsor:	Simon Morritt
Author:	Stefanie Greenwood, Freedom to Speak Up Guardian

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:

Freedom to Speak Up cases continue to rise against the backdrop of staff survey results, especially around raising concerns, deteriorating. Most concerns relate to inappropriate behaviours, bullying, worker wellbeing and patient safety. Workers raising concerns about detriment are increasing. Administrative and Nursing staff are the most engaged groups; Medical & Dental contacts are increasing, while Midwifery and Estates contacts have declined.

Recommendation:
Discuss and consider:

- Extending the FTSU Guardian's contract to full time, in line with NGO recommendations.
- Appoint a deputy or co-guardian to maintain continuity and support workload, especially during periods of leave and ensure the FTSU service is resilient.
- Incorporate FTSU metrics into leadership performance reviews (e.g. case volumes, resolution timeliness, detriment incidence etc).
- Ensure leaders at al levels visibly champion psychological safety and model respectful behaviours.

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

Freedom to Speak Up

1. Introduction

This annual report provides an overview of the Freedom to Speak Up (FTSU) activity at York and Scarborough Teaching Hospitals NHS Foundation Trust for the year 2024/25. It aligns with national guidance from the National Guardian's Office and supports the Trust's objectives around governance, workforce wellbeing, and patient safety.

2. Background to FTSU

The National Guardian's Office (NGO) and the role of the Freedom to Speak Up Guardian (FTSUG) were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

These recommendations were made as Sir Robert Francis QC found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

There are over 1,200 guardians in NHS and independent sector organisations, national bodies and elsewhere that ensure workers can speak up about any issues impacting on their ability to do their job.

The National Guardian's Office leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts speaking up reviews to identify learning and support improvement of the speaking up culture of the healthcare sector. It also provides challenge and learning to the healthcare system as a whole, as part of its remit.

The guardian acts in a genuine impartial and independent capacity, providing confidential support and guidance on speaking up to all workers, either working for the Trust or on the Trust's premises. The guardian for the Trust was appointed in February 2020 via an open and competitive recruitment process and is contracted substantively to 0.8 WTE.

3. The Role of the Freedom to Speak Up Guardian

"The Freedom to Speak up Guardian will work alongside Trust's leadership teams to support the organisation in becoming a more open and transparent place to work, where all are actively encouraged and enabled to speak up safely." (NGO 2018)

The FTSUG is independent, impartial, and confidential, and there are two main elements to the role.

Reactive: To give independent, confidential advice and support to members of staff who wish to speak up about anything that gets in the way of them providing high quality, safe care to our patients, managing each case, including the initial conversation, and accurately recording themes and actions, following up and feeding back. The guardian ensures the individual is aware of confidentiality and its limitations when there are safeguarding concerns.

Guardians do not get involved in investigations or complaints but help to facilitate the raising concerns process where needed, ensuring organisational policies are followed correctly.

Proactive:

- Communicating the role and making sure there is appropriate training on speaking up.
- Walking the floor.
- Supporting and challenging senior leaders, including through producing regular reports for the senior team or board.
- Looking at barriers to speaking up and working in partnership to help reduce them.
- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions or detriment as a consequence of speaking up/ raising a concern.

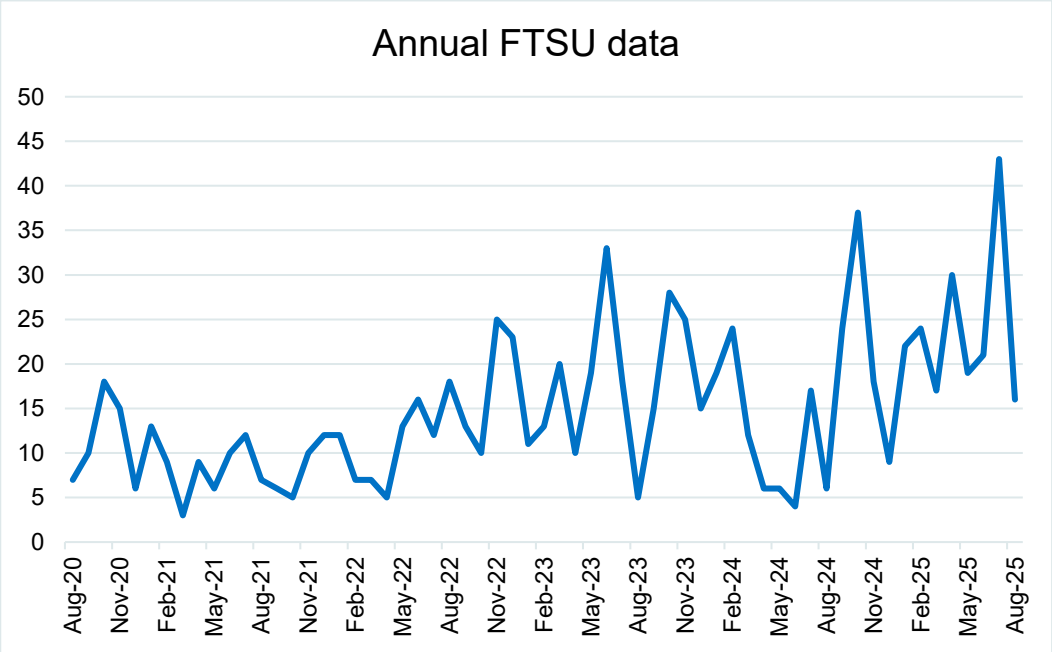
4. FTSU Resource

The Trust's FTSU Guardian is contracted to 0.8 WTE. The guardian has temporarily worked an additional 0.2 WTE for the period April to October 2025 to keep up with demand.

The FTSU Guardian put out Expressions of Interests to the Fairness Champion network for a Vice Chair of the network to support the FTSU Guardian and help drive the network but due to capacity issues in their substantive role, no one was able to offer support.

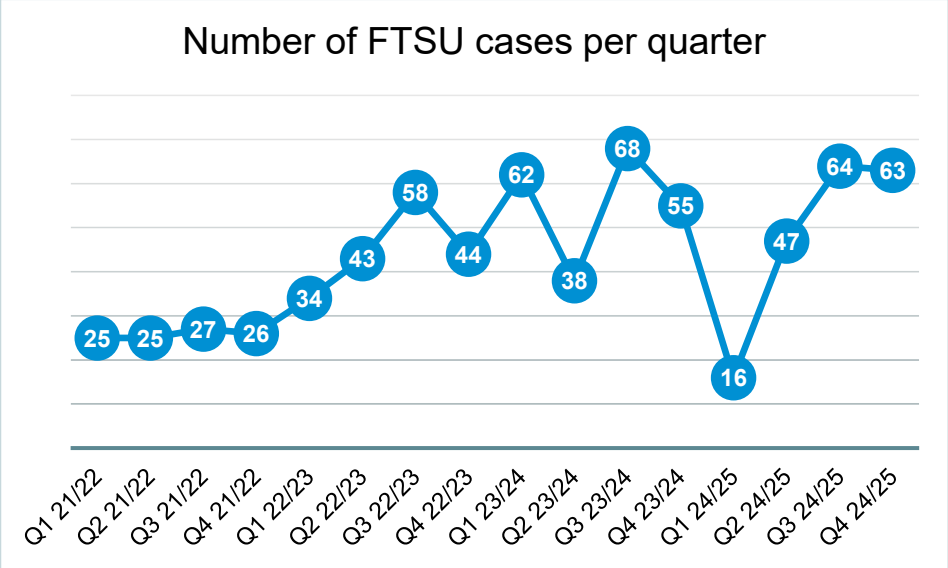
5. FTSU 2024/25 Activity Report

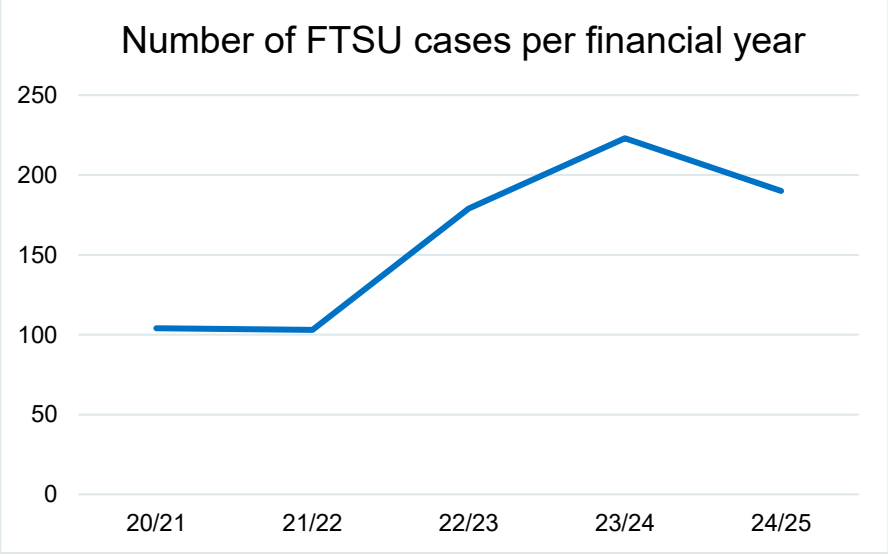
The chart below shows the number of individuals raising concerns with the Freedom to Speak Up Guardian per month, from August 2020 (when the FTSUG officially commenced in post) to August 2025. There's a general upward trajectory, indicating that FTSU cases has increased over the five-year period.



The charts below clearly show the number of FTSU cases has increased significantly over the years, rising from 25 cases in Q1 2021/22 to a peak of 68 cases in Q3 2023/24. A noticeable drop to 16 cases in Q1 2024/25 is visible and aligns with the period when the Freedom to Speak Up Guardian was on unexpected leave, as reported in the previous annual report. This shows how dependent reporting is on guardian visibility and accessibility.

Following the dip, cases rebounded to 47 in Q2 24/25, then stabilised at 64 and 63 in Q3 and Q4 of 2024/25 respectively, indicating restored confidence and accessibility.





As the graph shows a sustained upward trend, it signifies that:

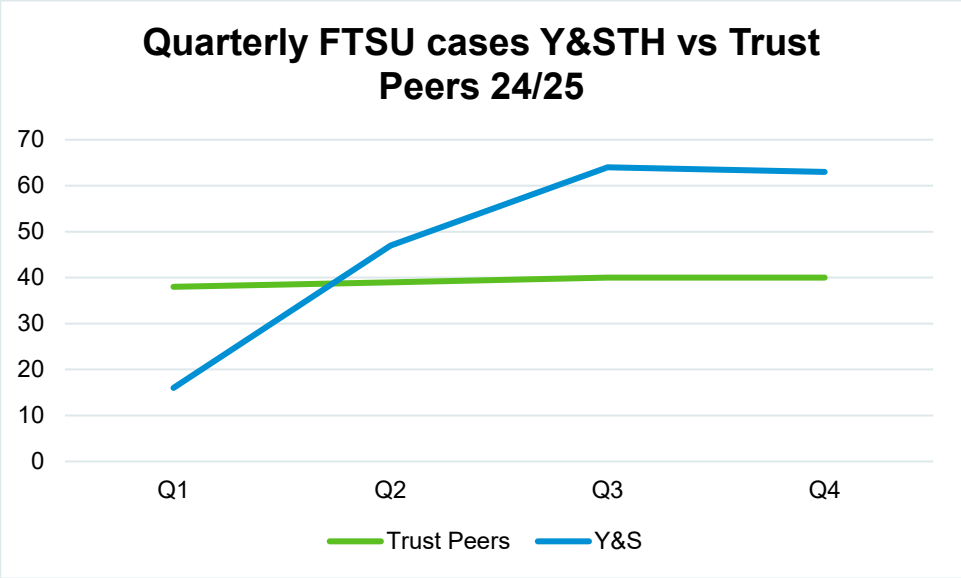
- Staff are increasingly aware of and willing to use the FTSU route.
- Efforts in visibility, training, and cultural diagnostics are having measurable impact.
- Continued investment in guardian support, communication planning, and triangulation with leadership is key to maintaining momentum.

6. Trust data Regional Peers

Nationally, there has been a 27.6% increase in total cases raised to FTSU Guardians in 2024/25, with over 30,000 cases reported, which is the highest ever.

The chart below shows the number of staff contacting the FTSUG (FTSU cases) compared to the average of our peers in Yorkshire and the North East region.

**Peer organisations are categorised by size of organisation and NHS Trust/ Foundation Trust status as per NGO data collection.*



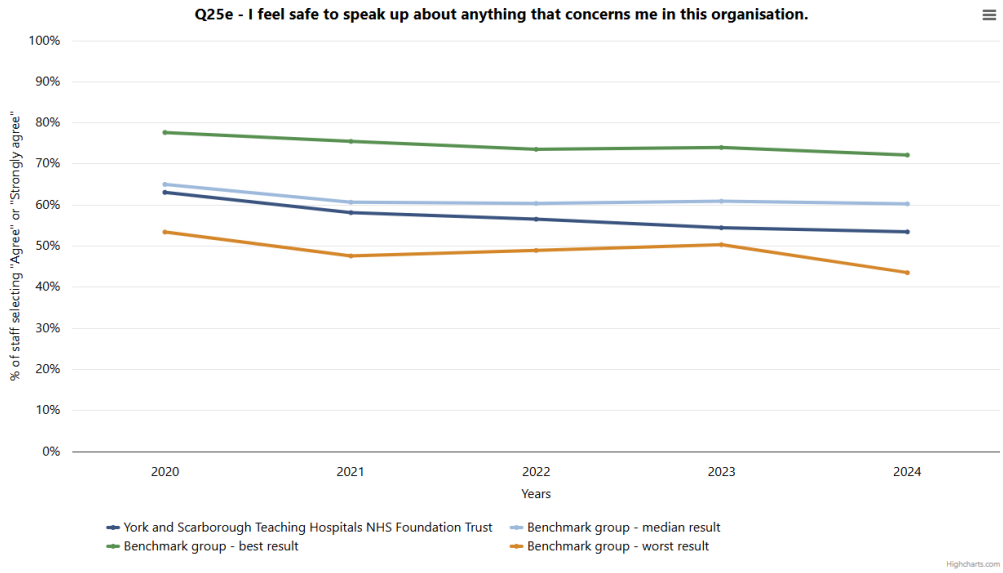
The number of cases being brought to the FTSU Guardian outperforms its peers in Q3 and Q4 24/25 with significantly higher case volumes.

The average number of cases for the Trust's peers is consistent with less dynamic change.

Although there is increasing awareness, willingness and trust in the FTSU process, as shown in the numbers of staff engaging with the FTSU Guardian, according to the latest Staff Survey results, there has been a slight decline in staff confidence in speaking up and having concerns addressed, despite the Trust's high reporting volumes:

- **Q25e – "I feel safe to speak up about anything that concerns me"**:
  - Agree/Strongly Agree: **53.5%** (down from 54.5% in 2023)
  - Disagree/Strongly Disagree: **20.6%** (up from 19.7% in 2023)

- **Q20b – "I am confident that my organisation would address my concern"**:
  - Agree/Strongly Agree: **44.06%** (down from 44.09% in 2023)
  - Disagree/Strongly Disagree: **20.4%** (up from 19.8% in 2023)



The Staff Survey does not reference FTSU Guardian specifically and talks about "raising concerns" in all its forms/ routes i.e. via management.

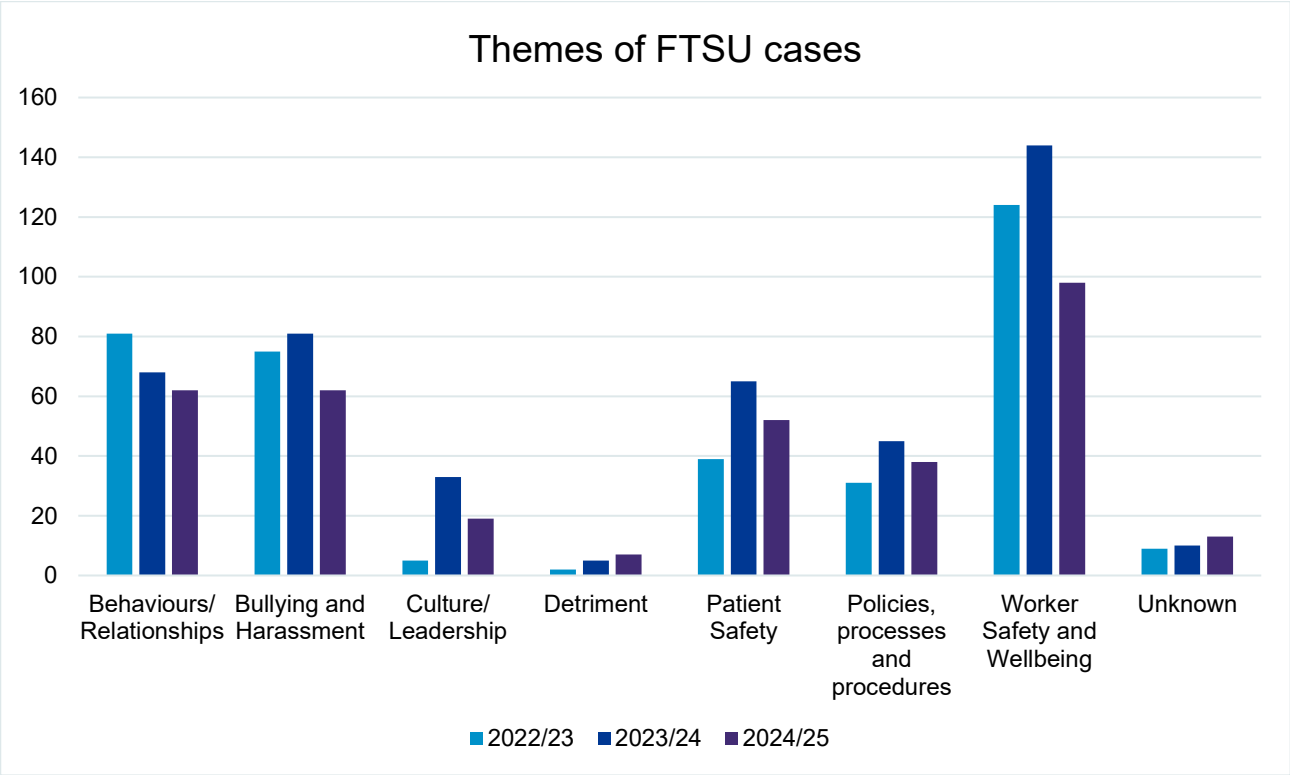
- Staff confidence in speaking up at York and Scarborough has declined by nearly 10 percentage points over five years.
- The Trust consistently scores below the median of its benchmark group, and the gap has widened in recent years.
- This trend suggests that while FTSU infrastructure may be in place, staff perception of safety in speaking up is eroding.
- The results align with national findings that progress has plateaued, and more work is needed to embed speaking up as "business as usual".

This result directly impacts the effectiveness of the Freedom to Speak Up (FTSU) programme:

- It highlights the need for stronger visibility, feedback mechanisms, and managerial responsiveness.
- It supports the case for expanding the Guardian's role and investing in cultural diagnostics, especially in high-reporting areas.
- It reinforces the importance of celebrating successful speaking up stories to rebuild trust.

7. Themes of FTSU Cases

The following chart shows the themes of the FTSU cases brought to the guardian. One case can contain multiple elements, therefore, the sum of cases with an element of patient safety/ quality, worker safety or wellbeing, bullying or harassment, inappropriate attitudes/ behaviours or cases where people indicate that they are suffering detriment as a result of speaking up can be higher than the total number of cases brought to FTSU Guardians.

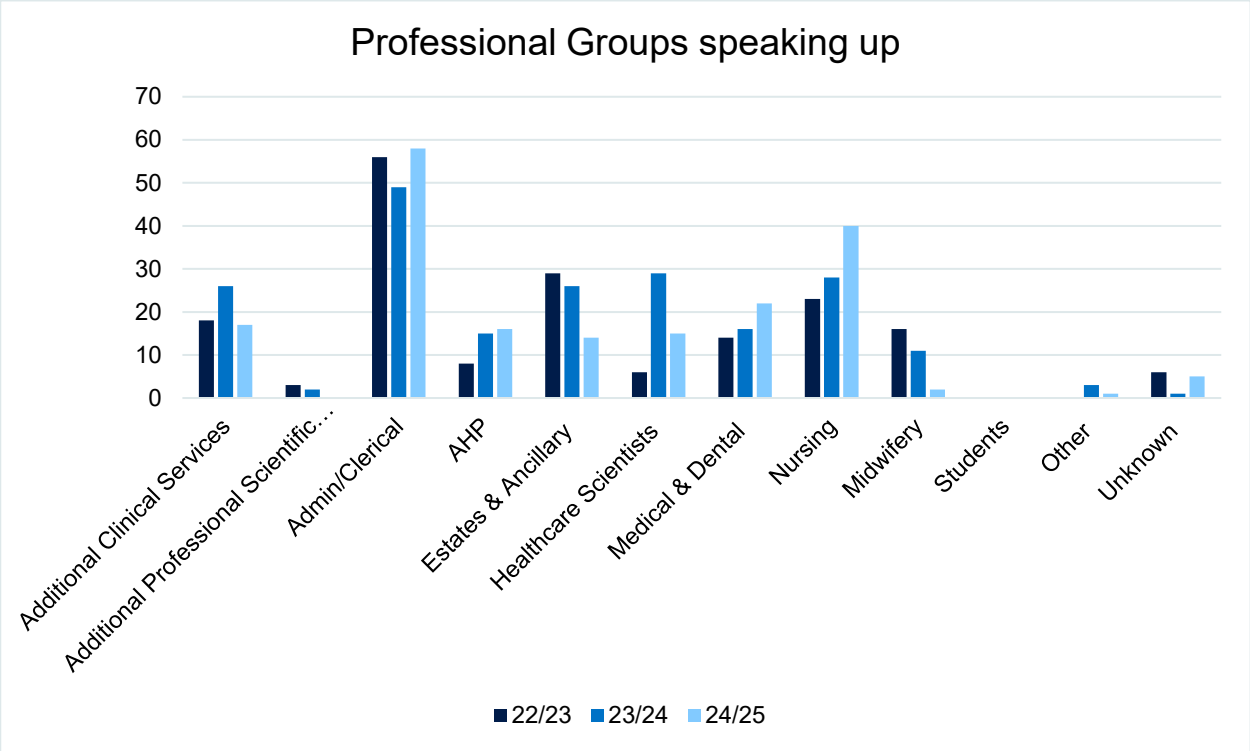


- York & Scarborough reports a higher proportion of cases related to worker wellbeing, bullying, detriment and patient safety than the national average.
- Worker Safety and Wellbeing remains the most common theme, though it dropped in 24/25.
- Culture / Leadership saw a sharp rise in 23/24, then a drop in 24/25.
- Bullying and Harassment peaked in 23/24 but declined in 24/25.
- Patient Safety and Policies & Procedures follow similar patterns, rising in 23/24, then falling slightly.
- Detriment cases though low in volume, are increasing, compared to nationally, which are decreasing (1.1% decrease from 4% in 2022/23), highlighting the need for robust protections for those speaking up.
- Inappropriate behaviours are slightly less prominent locally, possibly due to categorisation differences.

Theme	Local %	National %	Observation
Worker Safety & Wellbeing	51.6%	39%	Higher locally
Bullying & Harassment	33%	18%	Higher locally
Patient Safety	27.4%	18%	Higher locally
Detriment	3.7%	2.9%	Higher locally
Inappropriate Behaviours	33%	40%	Slightly lower

8. Professional Groups accessing FTSU.

The below chart shows the different professional groups contacting the FTSUG for 2024/25:



Admin/Clerical consistently has the highest number of contacts:

- 56 in 2022/23 → 49 in 2023/24 → 58 in 2024/25
- This suggests that staff in administrative roles are regularly engaging with FTSU, possibly due to visibility of processes or workplace dynamics.

Nursing contacts are increasing:

- 23 in 2022/23 → 28 in 2023/24 → 40 in 2024/25
- Saw the largest increase in contacts (+12), indicating rising engagement or concern.

Healthcare Scientists (staff within SHYPS):

- 6 in 2022/23 → 29 in 2023/24 → 15 in 2024/25
- Saw a spike locally however this trend is not highlighted nationally, suggesting it is a localised issue.

Midwifery contacts dropped significantly:

- 16 in 2022/23 → 11 in 2023/24 → 2 in 2024/25
- Midwifery reporting has dropped significantly locally from 16 to 2, while nationally it remains stable but low.
- This could suggest reduced engagement, resolution of prior concerns, or barriers to speaking up. Alternatively, it could reflect growing confidence in escalation of concerns via line managers.

Estates & Ancillary contacts are declining:

- 29 in 2022/23 → 26 in 2023/24 → 14 in 2024/25
- Might indicate improvements, reduced staffing, or barriers to speaking up.

Medical & Dental contacts are rising:

- 14 in 2022/23 → 16 in 2023/24 → 22 in 2024/25
- Medical and Dental staff nationally report fewer cases than nursing and admin but locally show a notable increase in 2024/25.
- Suggests increasing engagement or emerging concerns among clinical staff.

Students:

- Students remain underrepresented both locally and nationally.

There has been a marked increase in FTSU cases from clinical staff groups, demonstrating an increased awareness of FTSU and the FTSU Guardian.

9. Communication, engagement, and training

NHS England aims to ensure everyone working in the NHS feels safe and confident to speak up.

It encourages leaders to learn and improve from concerns raised, using staff experiences to shape policy and guidance.

Speaking up is seen as a learning opportunity for leadership teams to improve culture, care quality, and operational arrangements

Continuous promotion of the Freedom to Speak Up agenda is paramount to ensure all staff know how to raise concerns, the role of the guardian and that “Culture is a patient safety issue”.

The guardian continues to use various formats to communicate the FTSU agenda, the role of the FTSUG and the Fairness Champions. Communications go out via posters, business cards, postcards, CEO’s Week Ahead, Staff bulletins, Staff Matters, etc.

Where capacity allows, the guardian endeavours to attend:

- Team meetings
- Clinical Governance Sessions
- Resident Doctor teaching sessions
- Various Inductions including HCSW/ Nurses Preceptorship/ New Starter Fairs/ Resident Doctor Information Fairs
- The CEO talks about speaking up and references FTSU/ FTSUG in the Corporate Induction
- Staff Benefit Summer Fairs (not attended in 2025 due to capacity)
- FTSU information stalls/ roadshows
- Departmental conferences i.e. SAS Doctor Conference
- Various meetings/ committees e.g. Quality and Safety Meeting, JNCC, Union Representatives Group, LNC, Equality, Diversity and Inclusion Forum, Emotional Wellbeing Group, Resident Doctor Forum and Joining the Dots.
- Continuing to promote ‘Speak up, Listen up, Follow up’ training modules on Learning Hub.

9.1 FTSU and Health and Wellbeing Walkrounds:

The FTSU Guardian and the Health and Wellbeing Lead have been working in partnership, conducting ward/ team visits for the last year, initially as a pilot, but due to their success have maintained them. The purpose of this more “in-reach” approach is to engage more with clinical staff who do not get chance to access emails or leave their clinical areas. The increase in FTSU cases from clinical staff reflects the success of these walkrounds.

The walkrounds/ visits are tailored to the team/ department and provide an opportunity for staff to find out more about FTSU, the role of the Guardian, how it relates to patient

and worker safety, and what Health and Wellbeing support is available to them, both internally and externally.

Feedback from staff about these visits have been hugely positive, with staff stating how helpful and informative they have been, and they are greatly appreciated. Staff state that without these visits they wouldn't know the extent of the support available to them.

These walkounds have led to more tailored forms of support to teams whereby there may have been a large investigation and staff have needed a confidential space to speak to somebody impartial and seek confidential support and guidance.

The demand for this type of tailored support is growing.

10. Fairness Champions

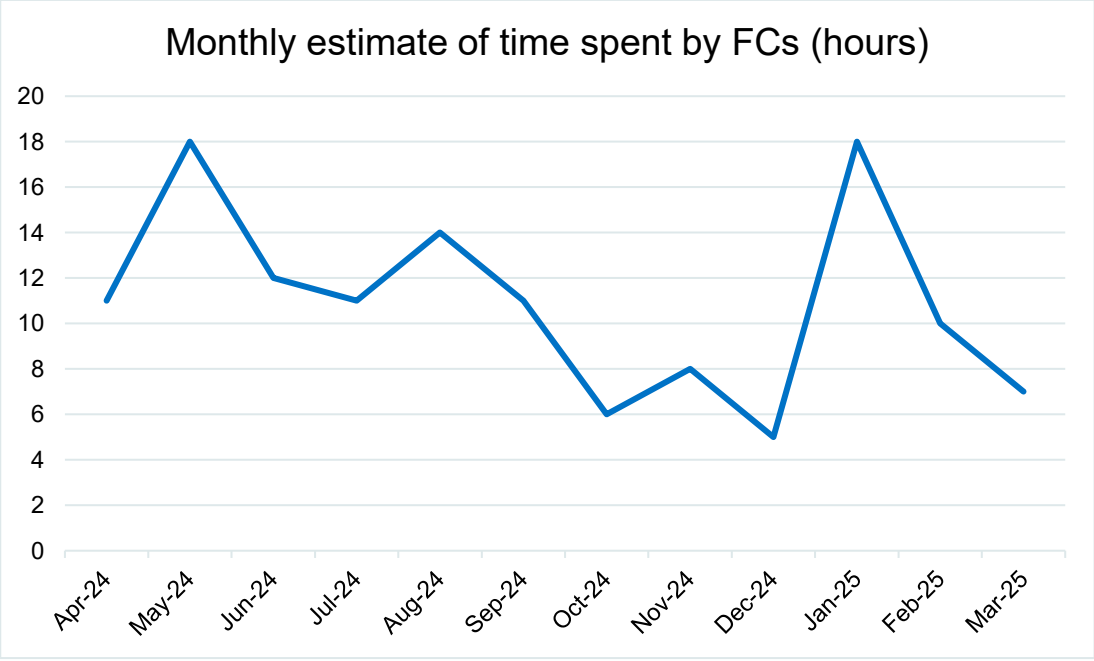
The Fairness Champions work in alignment with the National Guardian Office's "Freedom to Speak Up Champion" Guidance. This means that the role of the Fairness Champion is to:

- Raise Awareness of speaking up, listening up and following up.
- Signposting- Discussing concerns with workers and providing details of speaking up routes as stated in their organisation's Freedom to Speak Up Policy.
- Promoting a positive speaking up culture- Supporting their organisation to welcome and celebrate speaking up.

The National Guardian's Office recommends a clear distinction between the roles of the champion and guardian.

There are 18 Fairness Champions at present with another 20 waiting to receive training.

The chart below shows the number of hours per month Fairness Champions have spent on FTSU related activities. It is important to highlight that Fairness Champions are staff who volunteer and do this role on top of their substantive role.



- May 2024 (18 hours) and January 2025 (18 hours) stand out with the highest hours, indicating peak activity.
- December 2024 (5 hours) shows the lowest engagement.

11. Freedom to Speak Up Policy

The Trust approved and ratified the national Freedom to Speak Up Policy in November 2024, therefore has a review date of November 2027.

12. Freedom to Speak Up Reflection and Planning Tool

NHS England's FTSU Reflection and Planning Tool was completed and approved by the Board of Directors in February 2024. NHS England recommends that the FTSU Reflection and Planning Tool should be done at least every two years, therefore is due early 2026.

This reflection tool in conjunction with the NHS Freedom to Speak Up guide is designed to help senior leaders develop a culture whereby leaders and managers encourage all workers to speak up, and that there is learning and improvement from the concerns being spoken up about.

A Freedom to Speak Up action plan has been drawn up on the back of the reflection and planning tool.

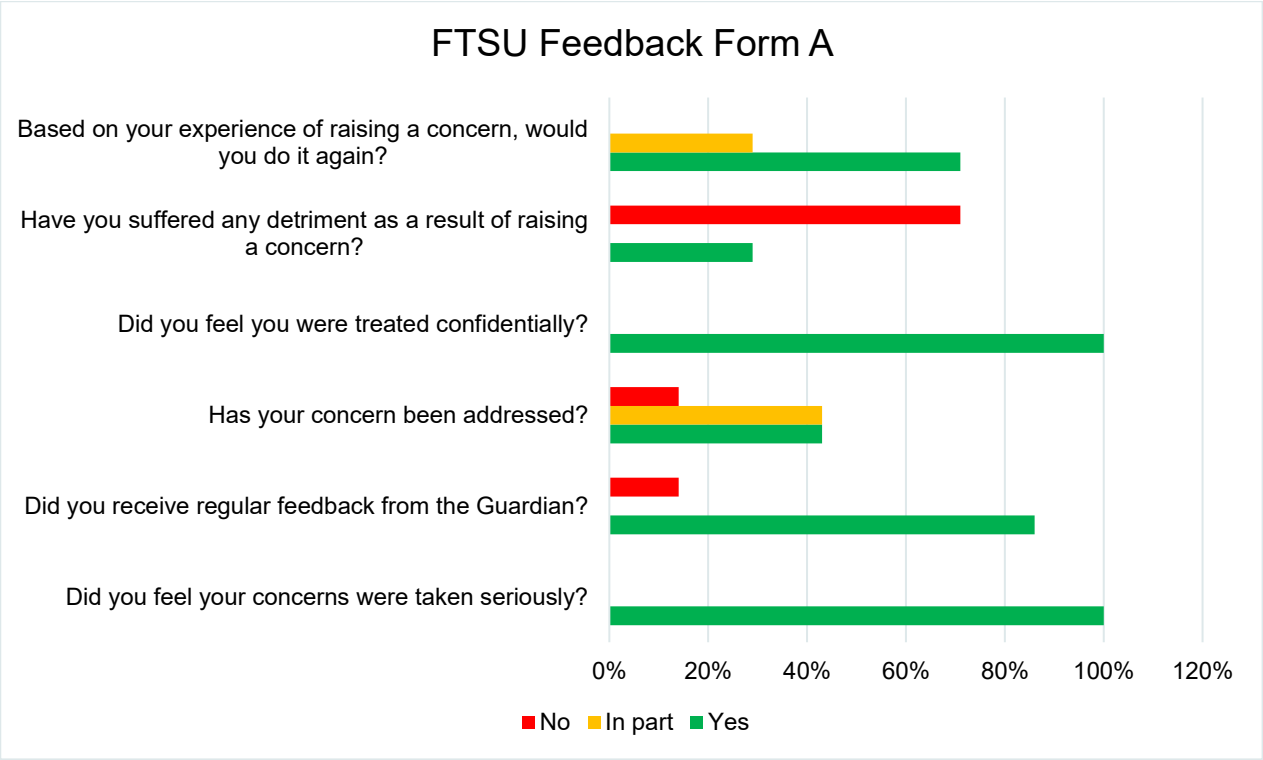
See Appendix A for FTSU Improvement plan.

- Outstanding actions:
    - Quarterly meetings between CEO/ Chair/ SID/ FTSUG have now been agreed and will b booked once new CEO commences in post.
    - Gap analysis to be undertaken by FTSUG in order to:
        - Identify gaps in Speaking Up Culture
        - Reflect on Case Review findings
        - Develop action plans to drive improvement
        - Support FTSU Guardians and Champions
        - Provide assurance for governance and CQC

13. Feedback regarding the FTSU process

A FTSU case is only closed once the guardian is assured that it has been adequately addressed or investigated if appropriate. On the back of the FTSU reflection and planning tool, FTSU feedback forms are now split into two (Form A and Form B). Form A is given out at the beginning of the process to ascertain the person's experience with the guardian. Form B is then sent out at 12 months after first FTSU contact to understand the person's experience of the process overall.

The following chart shows feedback results for Feedback Form A. Feedback Form B's have not been received. Out of 190 FTSU cases only 7 feedback forms were received in 2024/25.



Question	What It Assesses	Observations
1. Would you raise a concern again?	Trust in the process	Majority (71%) answered **Yes**, indicating overall confidence in speaking up.
2. Have you suffered detriment?	Safety and protection	Most answered **No**, but presence of "In part" and "Yes" responses suggest some staff still experience negative consequences.
3. Were you treated confidentially?	Guardian conduct and process integrity	Strong "Yes" response (100%), showing good adherence to confidentiality standards.
4. Has your concern been addressed?	Effectiveness of resolution	Mixed responses, with notable "In part" and "No" answers—indicating room for improvement in follow-through.
5. Did you receive regular feedback?	Communication and transparency	Majority of staff felt they received regular feedback

This chart reflects a positive experience for most staff who raised concerns with the guardian, especially in terms of:

- Feeling safe to speak up again
- Being treated confidentially
- Feeling heard

However, it also highlights areas for improvement:

- Feedback loops: Staff want more consistent updates on their concerns. This can be difficult if processes are ongoing.
- Resolution: Not all concerns are fully addressed. This can be difficult if concerns are around culture/ behaviours.
- Detriment: Even a small number of negative experiences can undermine trust in the system.

Free text comments:

- The freedom to speak up guardian was a confidential space where I could raise my concerns freely, and without judgement. Not only were my concerns heard, and looked into, but there was also an agreed action plan for my own wellbeing. The freedom to speak up guardian was a very good listener, and they did not rush the conversation. It was apparent that the guardian is living by the Trust values, and have a genuine interest in making sure that our workplace is inclusive, and people treated fairly. I am very grateful for the freedom to speak up guardian.
- Professional. Listened to my concerns with empathy.
- Ideally there would be more resources available to deal with concerns (eg more staff) but this is a systemic problem and not reflective of the Guardian. I also think there is a reluctance / lack of awareness about raising concerns about the medical workforce – perhaps it would be helpful for the Guardian to attend resident doctor teaching sessions and proactively ask for their concerns about staffing, supervision, support etc.
- I continue to feel that the situation I raised has not improved and if anything has got worse. I feel more vulnerable and isolated, when I raise any issues, even when trying to aid other staff members and assist the service.
- Unfortunately as only able to offer advice, then nothing has been done from this. I have raised concerns through other channels e.g. HR and Union, however it has been very slow by HR to resolve issues and have continued to leave me in a vulnerable position where I am continuing to experience bullying. As nothing definitive came from this. I do feel as though, although I raised issues, they do not want to be addressed by the Trust and for it to be swept under the carpet.
- Thank you for this, I am really grateful, and I appreciate your time and kindness today.
- Keep up the good work. Thank you for your support.

14. Summary:

1. FTSU Activity Trends

- There has been a sustained increase in FTSU cases over the past five years, peaking at 68 cases in Q3 2023/24.
- A temporary dip in Q1 2024/25 (16 cases) coincided with the Guardian's unexpected leave, highlighting the importance of visibility and accessibility.
- Case volumes rebounded in subsequent quarters, indicating restored confidence.

2. Staff Survey Insights

- Despite high reporting volumes, staff confidence in speaking up has slightly declined:
    - Only 53.5% feel safe to speak up (down from 54.5%).
    - Only 44.06% are confident concerns will be addressed (down from 44.09%).
- The Trust scores below the median of its benchmark group, with a widening gap.

3. Themes of Concerns

- Most common themes: Worker Safety & Wellbeing (51.6%), Bullying & Harassment (33%), Patient Safety (27.4%).
- Detriment cases are increasing locally (3.7%) while decreasing nationally (2.9%).

4. Professional Groups Engaging

- Highest engagement from Admin/Clerical and Nursing staff.
- Notable rise in Medical & Dental contacts.
- Decline in Midwifery and Estates & Ancillary contacts.
- Students remain underrepresented.

15. Recommendations

- Consider extension of FTSU Guardian full time contract, aligning with National Guardian's Office's recommendations.
- Consider appointing a deputy or co-guardian to maintain continuity and support workload, especially given the temporary increase in WTE from April to October 2025. This will ensure consistent presence of a FTSU Guardian, especially during periods of leave, to prevent dips in reporting and provide ongoing support and direction to the Fairness Champion network. It will also build resilience into the FTSU service.
- Consider incorporating FTSU metrics for leadership performance reviews (i.e number of cases raised within the care group, thematic review, resolution timeliness, anonymous reporting rate, detriment incidence etc.
- Ensure leaders at all levels visibly champion psychological safety and model respectful behaviours.

Date: 16 09 2025

Appendix A

Freedom to Speak Up Improvement Plan

Development areas to address	Target date	Comment / Update	Action owner
Expand and develop the Fairness Champion network	Completed	Completed. Fairness Champion network increased from 16 to 38 across the different sites. 1st all day training session completed 31st July. 20/38 FCs trained. 2nd training ?Oct 2024	FTSUG
Consider triangulation meetings with Chair, CEO & SID to ensure confidential concerns raised by FTSUG are acted upon.	In Progress	FTSUG to discuss with CEO at next 1:1 2.10.24 Meetings to be arranged quarterly	CEO/ FTSUG
Further work required to communicate the importance of speaking up and that detriment will not be accepted or tolerated at Y&STH.	Completed	Need communication plan. Stef to meet Emma/ Lucy to discuss how this is woven into the staff comms plan. Embed in the Line Manager training which is in development. Stef to also build into FTSU policy New FTSU Policy. Comms in Staff Matters January 2025 Staff Matters magazine | York and Scarborough Teaching Hospitals re new policy and about the importance of speaking up. FTSUG has comms plan	FTSUG/ DOC
Processes to establish how to identify potential detriment	Completed	Stef to add into the FTU policy that any reported detriment would be referred to DDoW to be investigated. Escalation of suspected detriment added to FTSU Policy	FTSUG
Regular communication required about the new policy and where to find it. Easy access to the policy.	Completed and ongoing	Comms has happened and more will take place with version 2 of the policy. Article re new policy/ speaking up January 2025. Ongoing.	FTSUG/ DOC
Development of FTSU Communication Plan	Completed	Stef to arrange to meet with Comms (EC/LB) FTSUG devised comms plan. Screensaver schedule agreed with comms team	FTSUG/DOC

Appendix A

Regular communication about HEE's Speak Up elearning.	Completed and ongoing	Comms plan	FTSUG/DOC
Ensure speaking up is a fundamental part of the OVOF work, ensuring that speaking up arrangements / culture is clear / explicit with involvement of the FTSUG. This is alongside how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbolic way as a leader.	Completed and ongoing	Ongoing work around this. FTSUG included in all of the OVOF developments. FTSUG to have a catch up with HER&E 14/08/2024	FTSUG/ HER&E
Proactively tackling arising issue/ concerns (part of triangulation group)	Complete and ongoing	Joining the Dots group established in January 2024. Review effectiveness.	DOWOD
To articulate areas of good practice in the annual report to prompt discussion at Board and learning for relevant teams.	Completed	FTSUG to include in next annual Board report	FTSUG
Gap analysis to be conducted using NGO case reviews	Discussion needed- Dependent on FTSU capacity	To be included in the quarterly Resources	FTSUG
Review the self- reflection and planning tool from at least two other Trusts. Identify any best practice applicable to Y&STH and incorporate to a FTSU improvement plan.	Completed	Completed.SG has reviewed Hull and Sheffield's plans and the actions in this document pick up on their best practice.	FTSUG
Trust to look at implementing the NGO's Starting Out, Stepping Down (nationalguardian.org.uk) guidance	Completed	March 2025	FTSUG
More focused work required with our international staff and staff from different cultural groups	Completed and ongoing	SG links in with clinical educators and PNAs. SG to speak to Tony Moffat in Ginni's absence. SG to link in with REN. SG to attend next REN meeting SG provided/ providing joint promotional work with REN chair	FTSUG
More focused work required with clinical teams on wards	Completed and ongoing	Increased FC will help with this. FTSUG regularly conducts FTSU stalls, and walksrounds wards. FTSUG completed SGH wards 8/8/24. FTSUG also attends team meetings. Tea trolley walkrounds being carried out in conjunction with H&W Lead over Speak Up Month (Oct 24) SG attending Op Directorate Meeting COO 2/10	FTSUG
Guardian to invite feedback from workers 12 months after the closure of concern.	Completed/ Ongoing	Started. Devised feedback form A (as soon as met with), and form B (12 months after).	FTSUG
Review the new national policy template and include reference to the process available if a staff member feels subject to detriment.	Completed	Will be included in version 2 of the policy when it is reviewed.	FTSUG
Evaluation required to further develop. This Board self-reflection and planning tool will inform the improvement plan and freedom to speak up policy for the Trust.	Completed/On-going	Ongoing.	CEO

Appendix A

Regularly review the freedom to speak up policy and improvement plan and report on progress updates to the Trust Board on a regular basis.	Annually	Yes and the more frequent sub-board reports should help with this.	FTSUG
Line Management and Leadership Development Training	Completed/ Ongoing	To be included	DOWOD
Consider where FTSU feedback can feed into to drive improvement	Completed	Recommendations to be made via the new quarterly reporting FTSUG raised at Audit Committee 10/9/24. To be discussed by AC. FTSUG to feed any learning into DDOW as per outcome of audit committee.	CEO
Ensure continuous monitoring and compliance of national guidance when providing FTSU reports to Board	Completed/ ongoing	Will be part of new reporting schedule	FTSUG
Determine whether the national speak up training should be mandated for all staff	Complete	Agreed at Board Development session on Speaking up 21/02/24 this would not overcome our barriers and for it not to be mandated. It's covered in the face to face induction from the CEO.	DOWOD
Establish forum to triangulate concerns being raised informally	Complete	Established January 2024	DOWOD
Incorporate the importance of speaking up in the new line manager training	Completed	To be included in the LM training – LL to talk to GD SG discussed with GD in August- SG to attend line manager training on 16/9 and give feedback on content re to raising concerns/ FTSU . Line Management training being delivered.	DDOW
Ensure all the Fairness Champions are trained and supported to undertake the full remit of their roles	Completed and ongoing	1st Cohort trained 31/7/24. 2nd cohort training to be organized finance dependent	FTSUG
Speaking up policy to be ratified by the unions in February 2024 and will be published on the intranet	Completed	Going to LNC on 7th March	FTSUG
Consideration to be given to action learning sets for managers to explore speaking up scenarios / issues	May 2024 Completed July 2024	SG to meet with GD given changing priorities of OD. SG met with GD	FTSUG
FTSUG to attend Board bi-annually	Completed and Ongoing	To be done as part of bi annual – LL to check with PM re frequency.	CEO / Chair
FTSUG to keep up to date with training	Completed/ ongoing	FTSUG is up to date with FTSU training with NGO	FTSUG

Appendix A

Consider seeking feedback (similar to FTSU feedback) from staff who speak up through HR process	May 2024	LL to pick up with JF.	HER&E

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 September 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.
☒ 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 CQC inspection report for York Hospital Urgent and Emergency Care and Medical Care services was published on 2 July 2025. The Trust was required to respond to the six identified breaches in regulation in the form of an improvement response. The improvement responses were submitted to the CQC on 22 July 2025 and approved on 1 August 2025

There are nine open CQC cases.

Recommendation:

- Note the current position regarding the recent CQC inspection activity including the two improvement responses.
- Note the current position of the open CQC cases

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

Meeting/Engagement	Date	Outcome/Recommendation
Quality Committee	16 September 2025	

CQC Update

1. CQC Activity

In response to the CQC inspection report published on 2 July 2025, the CQC have asked for quarterly updates on progress with actions to be provided, the first of which will be due by 31 October 2025.

A standing agenda item in relation to the action updates will also be added to the monthly engagement meetings, the next of which is 23 September 2025. An engagement meeting was not held in August 2025 due to annual leave.

Changes to the CQC leads linked to the Trust are also in progress. There will be one Inspector (currently two) and an Operational Manager working with the Trust.

2. Journey to Excellence Group

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The next meeting of the Journey to Excellence Group is scheduled for 8 September 2025. The inaugural update on the improvement actions from the January 2025 inspection will be provided. This will inform the update provided at the monthly CQC engagement meeting on 23 September, and updates provided in this paper.

3. CQC Cases / Enquiries

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

The Trust received three cases in August 2025. At the time of writing, the Trust had eight open cases / enquiries. The enquiry dashboard can be viewed in **Appendix A**.

4. CQC Updates

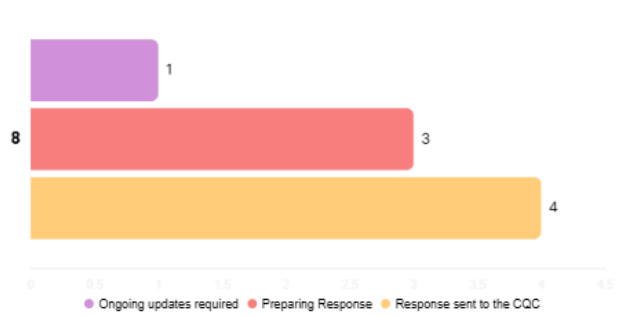
4.1 CQC August update on what they're doing to improve

The CQC have provided an update on delivering more assessments, working with providers to develop proposals for change in how they regulate. For further information **click here**

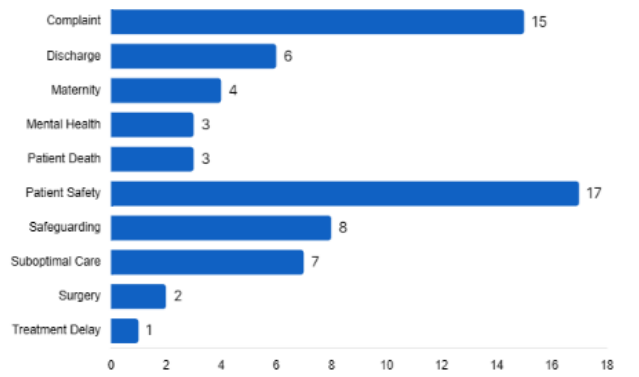
Date: 2 September 2025

Appendix A

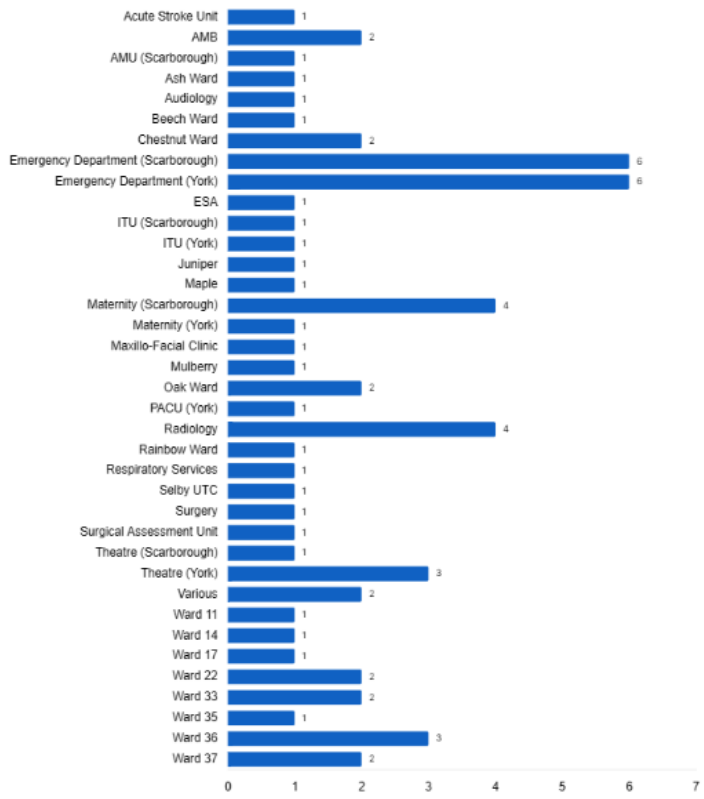
Number of Open CQC Enquiries / Cases



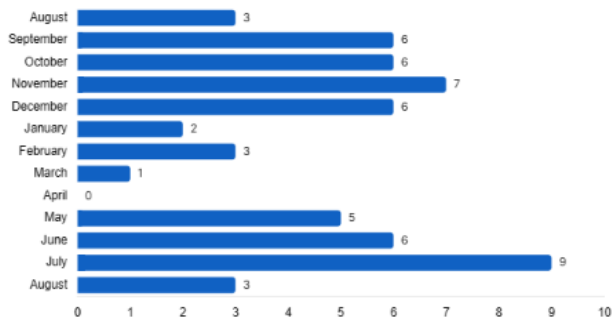
Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Number of Enquiries Received



York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24th September 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 ☐

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)

☐ 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.

Key Assurance

- The Trust perinatal mortality rate is within 5% mortality rate when compared with the group average.

- The Maternity Services are on track for 7 out of 10 safety actions for Year 7 of the Maternity Incentive Scheme
- The postpartum haemorrhage (PPH) rate was 2.9% (10 cases) in July 2025. The data demonstrates there has been a reduction in the Trust rolling average over 12 months for PPH ≥1500mls months from the national digital dashboard.
- A total of 24 WTE Midwives have been recruited. 12WTE Midwives will start in post next month.

Key Risks

- 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/SBLV3).
- There is a risk that the additional workforce reviews underway will result in gaps being identified in the other staffing establishments (Obstetrics, Neonatal, Operational and Admin establishments). If additional workforce gaps are identified, it may result in non-compliance with national staffing standards such as BAPM.
- There is a risk that the Quality and Patient Safety Framework cannot be fully embedded due to gaps identified in the Maternity Quality and Safety Governance Team establishment. The staffing requirements to support full implementation are outlined within the Midwifery Business Case submitted to Board of Directors in 2024; The Maternity Incentive Scheme 2025/26 non-recurrent funding will be used to support creation of some critical roles in 2025/26 (Audit Midwife, Lead PMA and ATTAIN and PMRT Midwife) these will then be funded recurrently from 2026/27 onwards. Remaining roles to support embedding the quality and patient safety agenda will be recruited in 2026/27 onwards. The timescales to support the national Quality Agenda remains challenged and has an ongoing impact to patient safety.
- There is a risk that the 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 sites. 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.
- There is a risk the equipment requirements outlined in the 2025/26 Capital Prioritisation plan for maternity and neonates may not be progressed. Funding for equipment and minor works has been allocated to the Family Health Care Group. The General Manager and Transformation Lead Midwife are overseeing the completion of the required MERGs. Once equipment is in place, risk can be reduced.
- The programme team have been assigned to take on the oversight and delivery of an additional programme of work within the organisation from May 2025. There is a risk that this may impact the programme team's ability to support maternity and neonatal teams to deliver the improvement action plans 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.

Key Concerns

- There is a concern of delayed specialist care and transfer to specialist neonatal units for babies born at Scarborough due to the time and distance for Embrace to reach the maternity unit. This could result in poor outcomes for babies.
- There remains concern raised from substantive staff on both sites regarding safe midwifery staffing levels and the increased use of agency staff. The Director of Midwifery has met with the Labour Ward Co-ordinators on the York site to address concerns.

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	16th September 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 July 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 July 2025.

Perinatal Deaths

In July 2025 there was 1 neonatal death (at 31 weeks) and 1 stillbirth (at 39 weeks gestation) on the York site. There has been a multidisciplinary review of the care for the baby who sadly died at 31 weeks gestation and a decision has been made to conduct a joint patient safety incident investigation with the level 3 tertiary unit who provided most of the antenatal care. The woman had an in-utero transfer due to preterm premature of membranes and went into labour following admission. The baby died at 50 minutes of age.

The 39 week stillbirth met the MNSI criteria and has been referred. The family have consented for an MNSI investigation. Both cases 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 July there were two new cases that met the criteria for referral to MNSI for investigation on the York site. The first referral was to a baby transferred out for cooling to a tertiary level 3 unit. The woman had a waterbirth, the cord snapped, and the baby became hypovolemic and required resuscitation. The second referral was a woman who attended with contractions, there was suspicion of an abruption, and the baby was born stillborn. Both families have consented to an MNSI investigation, been informed about the early notification and have support from the bereavement team.

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. MNSI have responded to the Director of Midwifery and revisions have been made to the final MNSI report.
The Safety Recommendations are:

1. It is recommended that the Trust make early use of the thromboelastogram point of care coagulation testing to enable early replacement of clotting products when a mother has a major post-partum haemorrhage, in line with local guidance.
2. It is recommended that when coagulopathy is suspected and is yet to be confirmed, timely request for and administration of clotting products is needed.
3. It is recommended that the Trust accurately record a fluid balance input and output during an emergency to assist in the holistic overview of mothers.
4. It is recommended that the Trust consistently use their major haemorrhage documentation tool to act as a clinical prompt and documentation tool in the event of a postpartum haemorrhage.
5. It is recommended that the Trust comply with the national standards for blood administration.

An action plan regarding the safety recommendations is in development and will be presented at the Patient Safety Group. The MNSI report will be shared with the coroner.

Patient Safety Incident Investigations (PSII)

In the month of July there was one new PSII declared. The case relates to the 31 week neonatal death and a joint investigation will be undertaken with a level 3 tertiary unit. The woman was booked and received her antenatal care at the level 3 unit however had an in-utero transfer for preterm premature rupture of membranes and went into labour following transfer. The baby died 50 minutes following the birth. The family have bereavement support in place.

There remains one ongoing PSII. The PSII has been presented at the Patient Safety Group and is awaiting Medical Director sign off.

Moderate Harm Incidents and above

The postpartum haemorrhage (PPH) rate was 2.9% (10 cases) in July 2025. The data demonstrates there has been a reduction in the Trust rolling average over 12 months for PPH ≥1500mls months from the national digital dashboard. The local SPC charts show common cause variation for Scarborough and York. 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 is a total of 155 open incidents, the oldest dates back to July 2024. There has been a decrease of 15 incidents closed within the last month. A focused piece of work is going to be undertaken to address the oldest incidents. There is 1 pathway review and 3 After Action Review's to be completed. There are 2 PSIRF learning responses awaiting to be signed off in at the Patient Safety Learning Response meeting in September. There have been challenges in 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.
The Neonatal Consultant lead and Neonatal Clinical Educator have a plan to address medical and neonatal nursing neonatal basic life support training compliance >90% by the end October 2025.

Service User Feedback

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.

There is a theme regarding the timely administration of pain relief and listening to women's concerns. There is a co-produced action plan from the Transformation Lead Midwife and MNVP chair to address service user feedback.

The Maternity Services CQC survey embargoed results for 2025 have been received. The results will be reviewed against the current improvement action plan to identify any new themes. A report and action plan will be presented at the Trust Patient Experience Committee.

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. The Director of Midwifery has met with the Labour Ward Co-ordinators on the York site to address concerns.

CQC Section 31 Progress Update

Annex 2 provides the July 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 July 2025.

New Risk

Availability and accessibility of the Embrace Transport at Scarborough
There is a risk of delayed specialist care and transfer to specialist neonatal units for babies born at Scarborough due to the time and distance for Embrace to reach the maternity unit. This could result on poor outcomes for babies.

Maternity Outcomes Signal System (MOSS)

NHS England has been developing the Maternity Outcomes Signal System (MOSS) in response to the Reading the Signals report on East Kent maternity services.
MOSS presents trend data on term stillbirths and neonatal deaths in maternity units in a new way. Signals of potential safety issues are flagged in units when there has been a recent doubling in the rate of these events compared to what would normally be expected, given the total numbers of births at a given site. Using term events means that MOSS is targeted for use on key elements of safe intrapartum care, as these have an association with intrapartum standards of care not being met. It is important to understand that a signal does not necessarily mean that a service is unsafe, which should be confirmed

through follow up safety checks. NHS England have validated this statistical approach using retrospective data. MOSS has been successful in identifying signals in services which have been subject to recent reviews, in advance of the trigger cases. Development has been led by an expert group, including Dr. Bill Kirkup, author of the report, and piloting has been conducted in a selection of trusts. Subject to further successful testing, MOSS will be made available to all maternity services by the end of November 2025. MOSS will be accompanied by Standard Operating Procedures which will be published alongside the release. These procedures will advise on the necessary actions that maternity services should take when a signal occurs.

MOSS uses data from a passive data collection, the Personal Demographics Service, so there is no additional data collection burden on trusts. In future, MOSS will add term brain injury data provided by the Submit a Perinatal Event Notification service (SPEN), which is being rolled out in a phased way by NHS England over September – November this year. This service will allow trusts to report perinatal mortality and brain injury events to multiple organisations using a single form and will reduce burden.

MOSS is updated in near-real time. Currently, data is updated weekly but will move to a daily update schedule later in the year. This is a recent development in the testing version of MOSS which operationalises the tool and allows live signals to be generated.
There is sufficient confidence in the statistical approach that NHS England would like to inform maternity services who are not part of the national pilot, when signals occur. Standard Operating Procedures are not yet ready to be shared widely, therefore currently this information would be for awareness purposes only and for subsequent action (if any) to be determined locally.

NHS England have agreed the following process with regional colleagues to inform services of signals:

- The national MOSS team in the Maternity and Neonatal Programme, NHSE will inform regional colleagues when a signal has occurred. Regions will then cascade the information to the relevant maternity service, including Maternity Improvement Advisors where a signalling trust is on the MSSP. Standard emails will contain:
    - Date of the signal, statistical confidence (either 95 or 99%) and dates of events that contributed towards the signal
    - A generic description of what the analysis means
    - While the Standard Operating Procedures for the safety check following a signal are being finalised, the national team will offer to meet with the regional and perinatal leadership team to support a discussion about MOSS and an appropriate response during this pilot phase.

Feedback from regions and maternity services will add to learning from the national MOSS pilot.

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.

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. Options appraisal identified there was capacity on labour ward to support two Intensive Care beds however the water committee and infection control identified following a risk assessment the labour ward did not meet required health and safety standards. 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. There are no current plans to utilise space on the maternity wards for the Special Care Baby Unit decant.

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, May and July 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. Options appraisee been written regarding transitional care staffing models. Currently off track due to the SCBU decant.
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 and is included on the PQSM.

Clarification has been sought from NHS Resolutions regarding duty Anaesthetic cover at Scarborough. NHSR have advised the rota will utilised to provide compliance however the risk should be added to the risk register due to episodes of the Duty Anaesthetist having other responsibilities, they are not always able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.

Safety Action 5: Clarification to be sought from NSHR.
Safety Action: 6: Currently at risk for compliance for Year 7. Unable to complete full submission to benchmark against version 3.2 requirements for July 2025 due to capacity within the diabetes team. This is being completed in October, and a full update will be presented following this. On track for implementation of elements 2,3, 4 and 5 of the care bundles. Elements 1 and 6 remain at risk. Delivery group for element 1 has commenced to implement a maternity specific tobacco dependency service by April 2026. Benchmarking taking place against the new Element 6 requirements.

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. On track for compliance for Year 7.
Safety Action 8: Training will be monitored monthly with oversight in the Perinatal Quality Surveillance model. This safety action is 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 and August 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 (-16.6WTE) which is a shift from the Scarborough site (-8.95WTE) 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.

Investment made:
Education review £230k = 4.1WTE
Maternity Incentive Scheme Monies Year 6 £142,405 = 2.6WTE (non-recurrent)
Potential reduction of scrub nurses funding £456k = 9.56WTE
Total funded 16.29WTE
Leaves 27.71WTE to be funded plus 2.6 of non-recurrent MIS posts
Overall total left to fund 30.31WTE

The Trust Board in July 2025 have agreed to fund the staffing gap within midwifery services over three years, with the first year focusing on frontline staffing (2025/26-2027/28).

Following career conversations with the 3rd year students qualifying in September, 12WTE have been recruited. In September Midwifery interviews continued and a total of 24WTE Midwives have been offered jobs.

The unqualified support staff vacancy currently is 14.91WTE. SGH vacancy is 2.08WTE and YGH 12.83WTE. There was a review of the Band 2 and Band 3 job description and following job matching a Band 2 has been uplifted to a Band 3 and a Band 3 uplifted to a Band 4. Engagement sessions took place throughout August, and the beginning of September led by the Director of Midwifery and Human Resources with the Maternity Support Workers, the Maternity Assistants with the support of our trade union colleagues. The review of how many staff have been uplifted to a Band 3 and 4 is nearly completed.

Improvement and Transformation

The Project Group for the Maternity in house smoking cessation service commenced and timelines agreed for delivery of the new service from 01 April 2026.
Successfully trialled a triplet CTG machine .
Developed a proposal for governance around recruitment.
Project brief for infant feeding completed and being presented at the maternity directorate meeting in September 2025.
The 4thengagement day session booked for November 2025 to progress actions within the culture score action plan.

Quality impact assessment and multi-stakeholder review of the SCBU decant
Sustained improvement in complaint responses within the standard targets and a reduction in dissatisfied complaints.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

The impact of operational pressures, vacancy sickness and absence have impacted on the Senior Midwifery Leadership team's ability to progress the Maternity and Neonatal Single Improvement Plan. This has led to the recommendation of the improvement plan focusing on key priorities for 3 months (August, September and October) which will mean there will be limited progress in meeting actions within the timeframe set out.The priority for teams is to support business as usual and quality and safety agenda.

- Key pieces of work which continue to progress are:
    - Recruitment of midwives
    - Finalisation of the Maternity and Neonatal Escalation policy
    - Saving Babies Lives compliance and improvement actions
    - Maternity incentive scheme
    - Engagement with the MNVP and listening to women and families e.g. 15 steps in SGH 10th September
    - Neonatal BadgerNet implementation
    - Progress with implementation of the Transitional Care Project
    - Launch the Personalised care plans and bespoke maternity services survey
    - Telephone triage implementation

The impact of this on the improvement plan is:

- August 2025
    - 5 milestone actions were due to be delivered in August 2025. These have gone off track.
- September
    - 3 high level actions and 28 milestone actions are due to be delivered in September 2025. These will not be delivered in the time frame and will go off track.
- October 2025
    - 5 milestone actions are due to be delivered in October 2025

Due to the high volume of actions due to be delivered in September 2025 it is unlikely the plan will recover and subsequent actions for the remainder of 2025/26 will be impacted.

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/SBLV3). 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 April 2025/26 to support increasing the midwifery staffing establishment in line with BirthRate+ report (2024). At the July 2025 Public Trust Board, it was agreed to fund the midwifery staffing gap in a phased approach over the next three years with this year being year one. However, the likelihood of actions going off track remains high due to the timeline gap/lag in planned vs actual investment.
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 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 Maternity Quality and Safety Governance Team establishment. The staffing requirements to support full implementation are outlined within the Midwifery Business Case submitted to Board of Directors in 2024; The Maternity Incentive Scheme 2025/26 non-recurrent funding will be used to support creation of some critical roles in 2025/26 (Audit Midwife, Lead PMA and ATTAIN and PMRT Midwife) these will then be funded recurrently from 2026/27 onwards. Remaining roles to support embedding the quality and patient safety agenda will be recruited in 2026/27 onwards. The timescales to support the national Quality Agenda remains challenged and has an ongoing impact to patient safety.
4. There is a risk that the 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 sites. 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 2025/26 Capital Prioritisation plan for maternity and neonates may not be progressed. Funding for equipment and minor works has been allocated to the Family Health Care Group. The General Manager and Transformation Lead Midwife are overseeing the completion of the required MERGs. Once equipment is in place, risk can be reduced.
6. The programme team have been assigned to take on the oversight and delivery of an additional programme of work within the organisation from May 2025. There is a risk that this may impact the programme team's ability to support maternity and neonatal teams to deliver the improvement action plans 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.

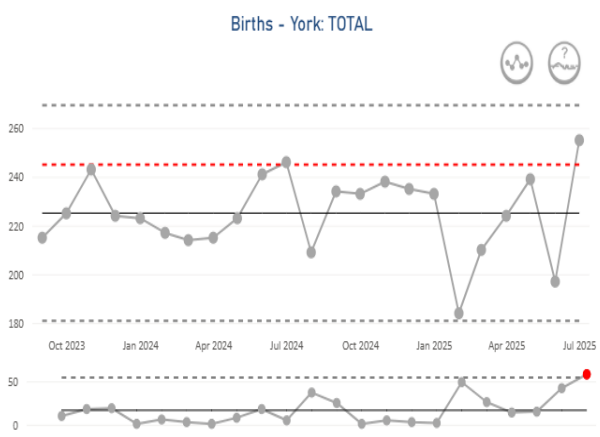
Recommendations to Trust Board

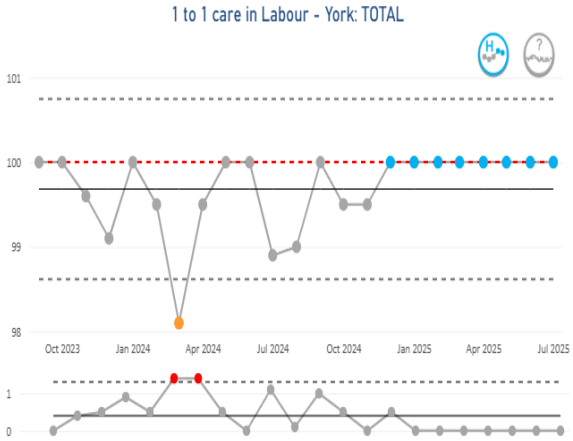
To note the contents of this report and agree the CQC section 31 submission in Annex 2

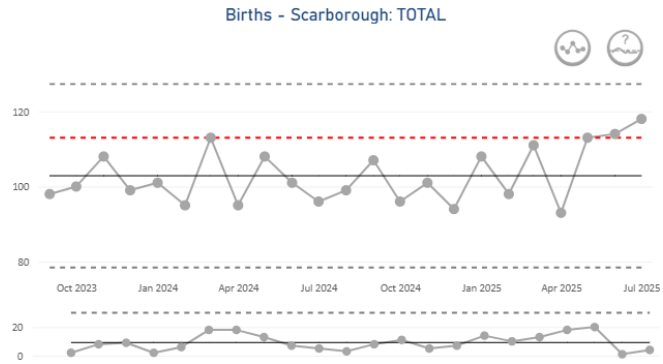
Date: 14th September 2025

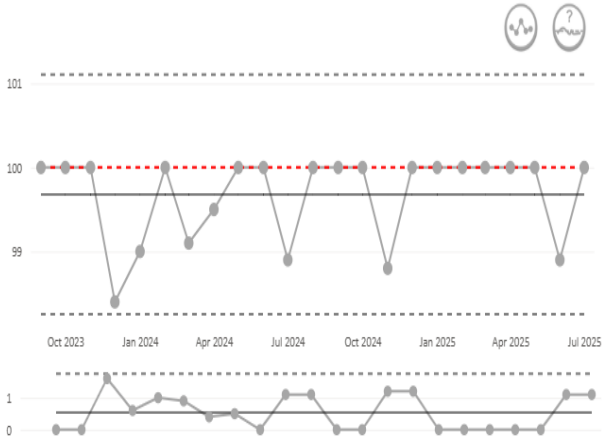
Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery May 2025

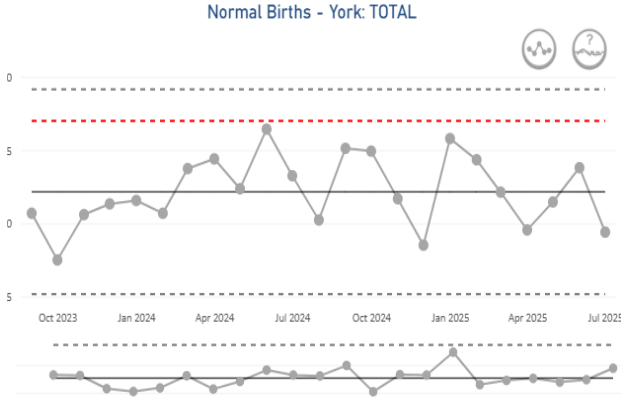
Dashboard

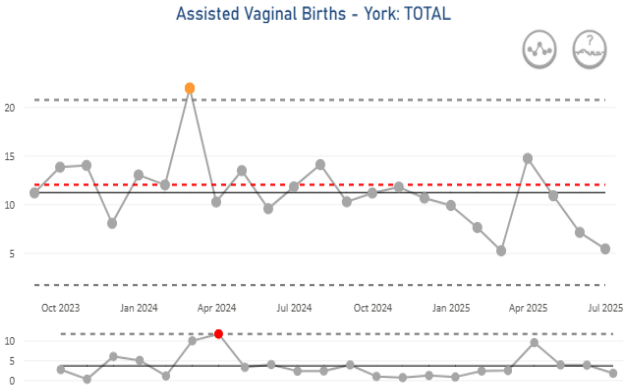


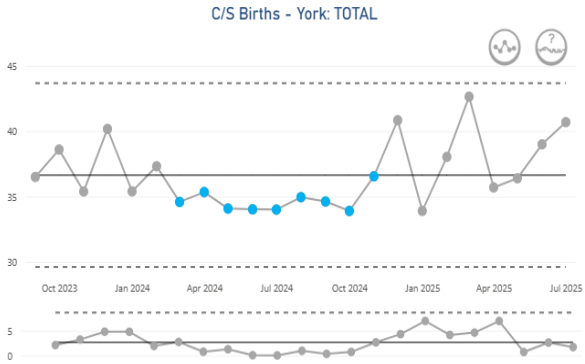


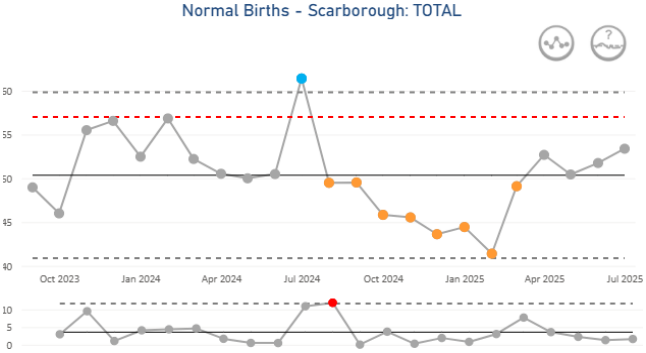




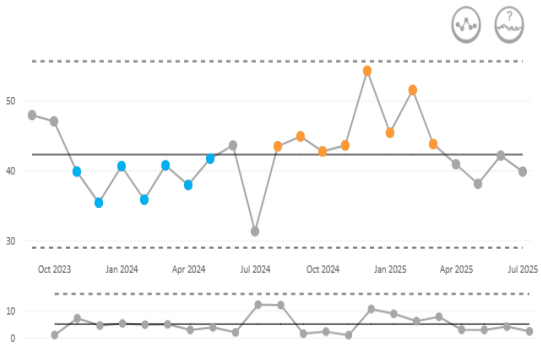




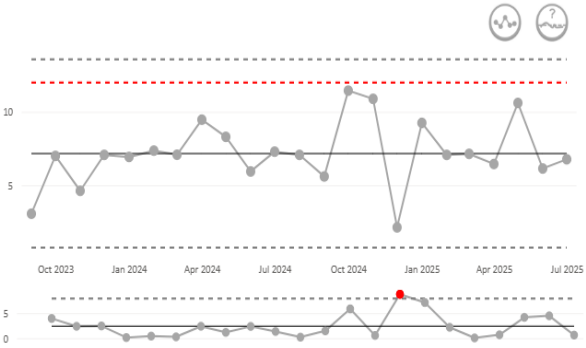




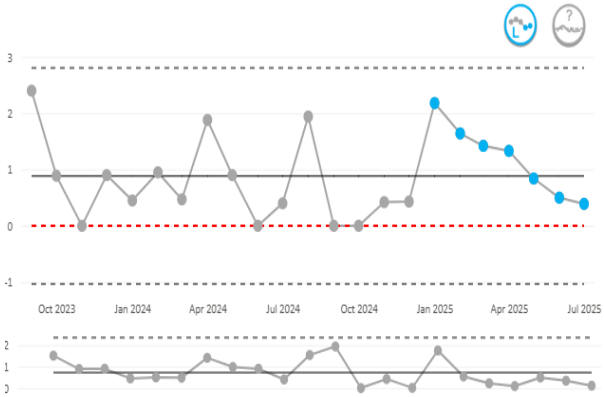
C/S Births - Scarborough: TOTAL



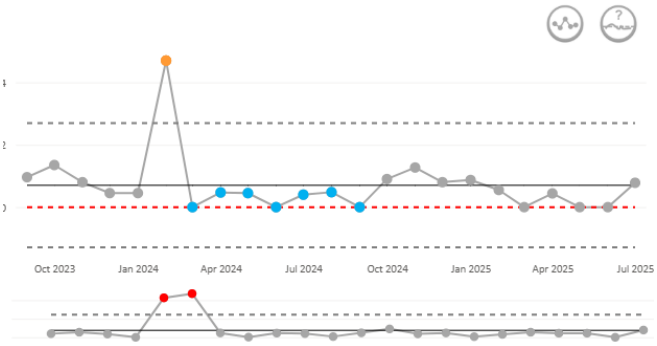
Assisted Vaginal Births - Scarborough: TOTAL



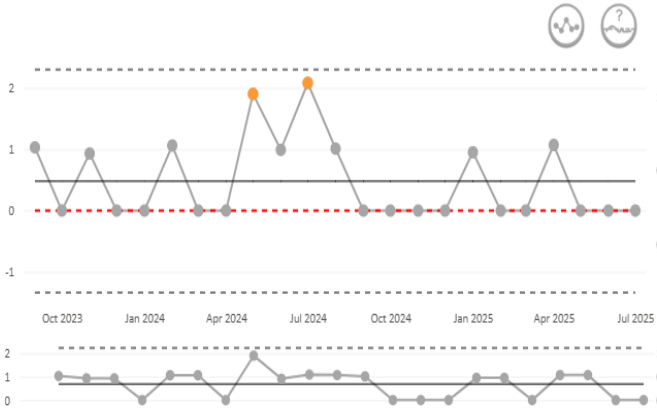
3rd/4th Degree Tear - normal births - York: TOTAL



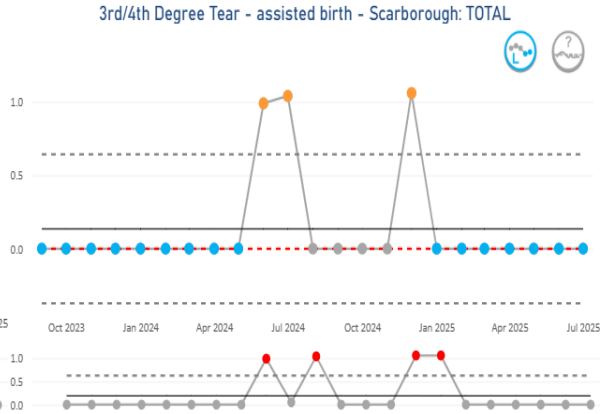
3rd/4th Degree Tear - assisted birth - York: TOTAL



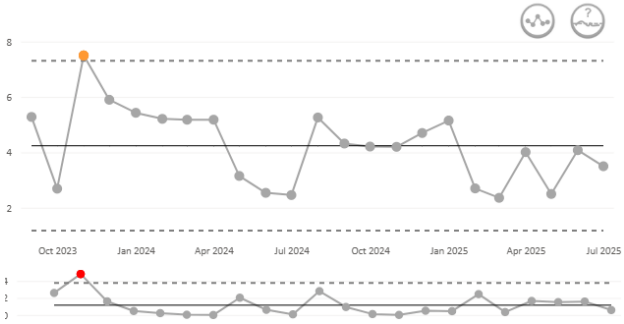
3rd/4th Degree Tear - normal births - Scarborough: TOTAL



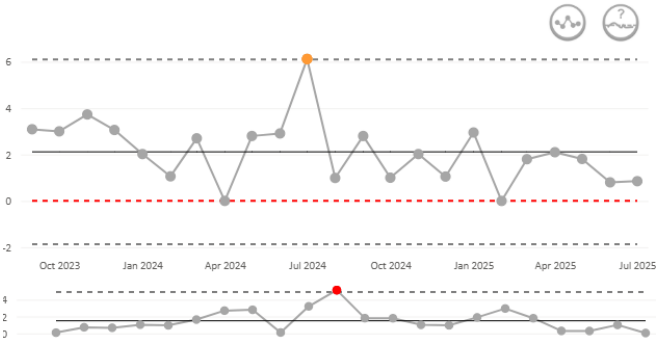
3rd/4th Degree Tear - assisted birth - Scarborough: TOTAL



PPH > 1.5L as % of all women - York: TOTAL



PPH > 1.5L as % of all women - Scarborough: TOTAL



Annex 2

Report to:	Quality Committee
Date of Meeting:	16th September 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% are outlined below.

Table 1

Staff Group	York	Scarborough
Midwives	93% (169/181)	94% (72/77)
Consultants	94% (16/17)	100% (9/9)
Obstetric medical staff	100% (11/11)	100% (7/7)

The one non-compliant Consultant is booked on training in November. 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 2
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%
June 2025	99%	99%
July 2025	99%	99%

BadgerNet has the facility to pull other risk assessment reports. Table 3-7 demonstrates compliance from January to June 2025.

Table 3
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%
June 2025	100%	100%
July 2025	100%	100%

Table 4
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%
June 2025	100%	100%
July 2025	100%	100%

Table 5
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%
June 2025	100%	100%
July 2025	100%	100%

Table 6
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%
June 2025	91%	90%
July 2025	85%	82%

Table 7
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%
June 2025	100%	100%
July 2025	100%	100%

VTE compliance will be monitored in the Maternity metrics going forwards.

A.4 Assessment and Triage

There is special cause for improvement seen in the red flags seen (Chart 1) and common cause variation for attendances (Chart 2) on the York site. There is special cause for concern in the red flags seen (Chart 3) and common cause variation for attendances on the Scarborough site (Chart 4).

There was a noted decrease in compliance on the Scarborough site for the first week of August with meeting the standard of being triaged within 15 minutes. On a review it was identified Triage was relocated to labour ward on 3 occasions throughout that week due to sickness of Maternity Support Workers. On review all women had a review completed within 30 minutes.

Chart 1 Red Flag Incidents not seen within 15 minutes of arrival at Triage at York

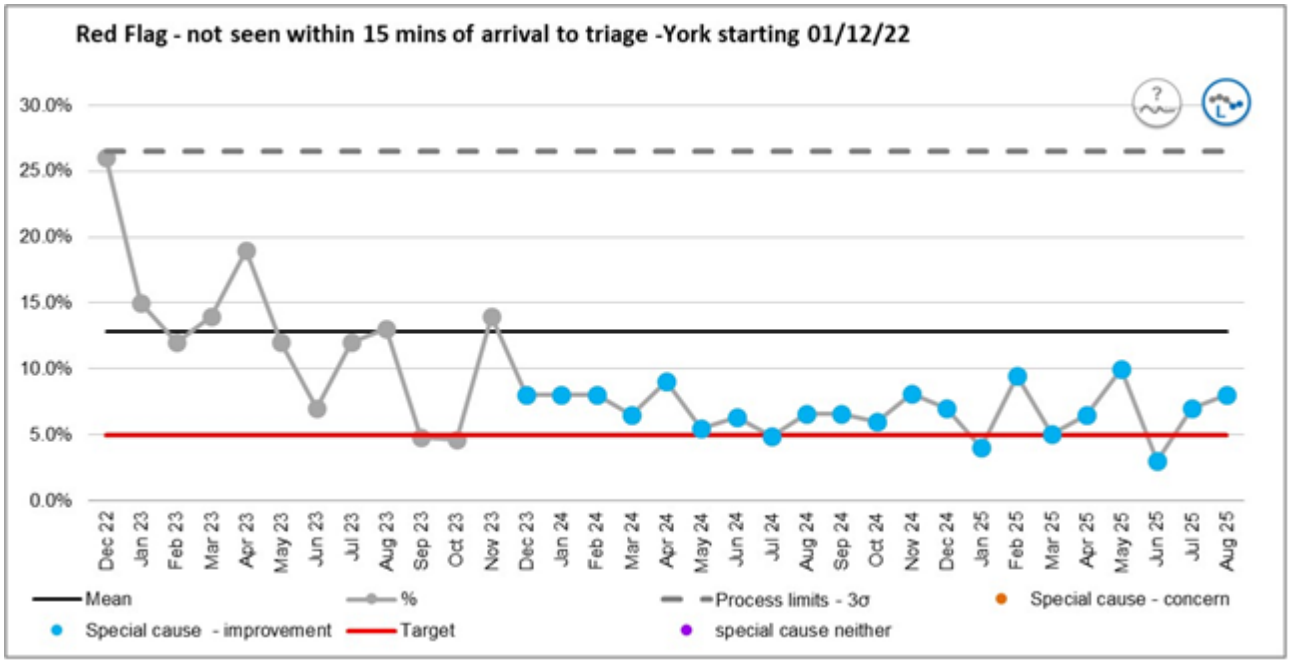


Chart 2 Triage attendances York

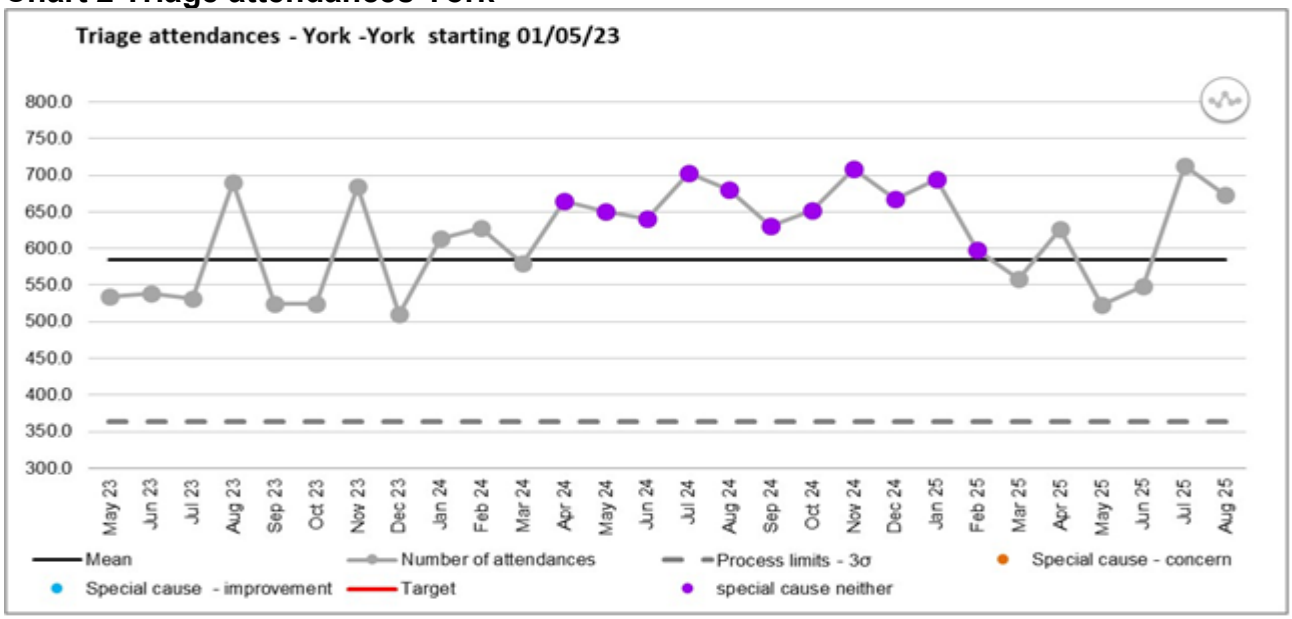


Chart 3 Red Flag Incidents not seen within 15 minutes of arrival at Triage at Scarborough

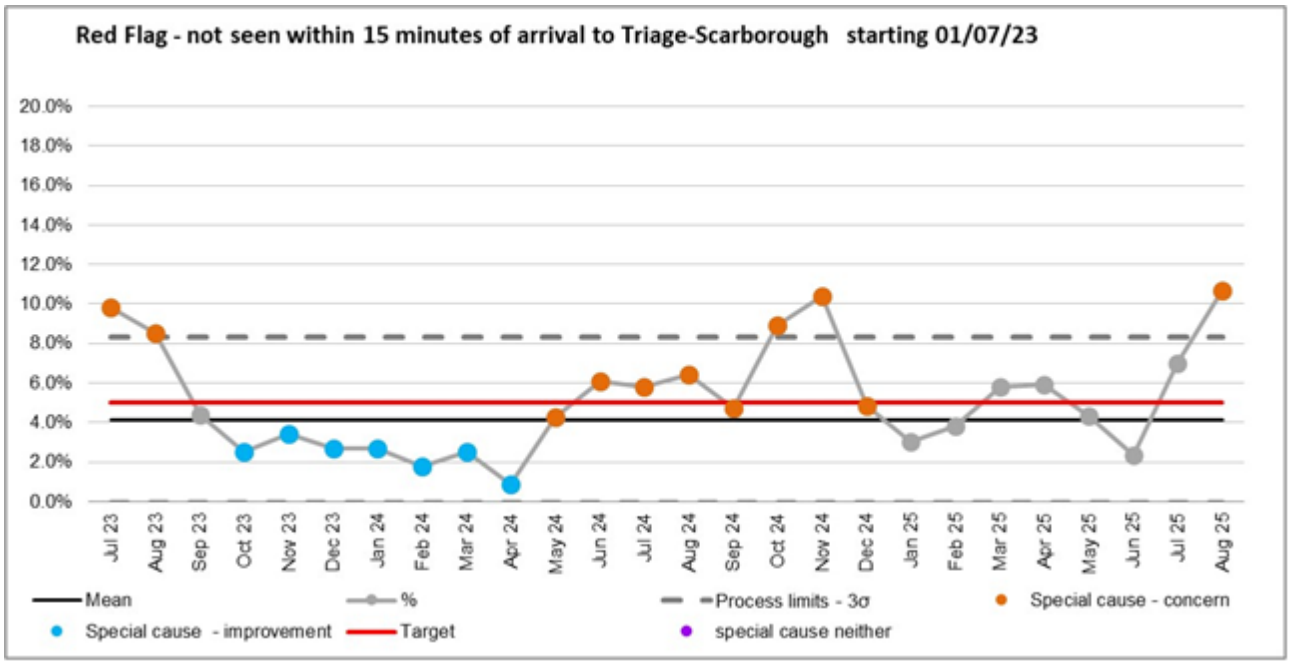
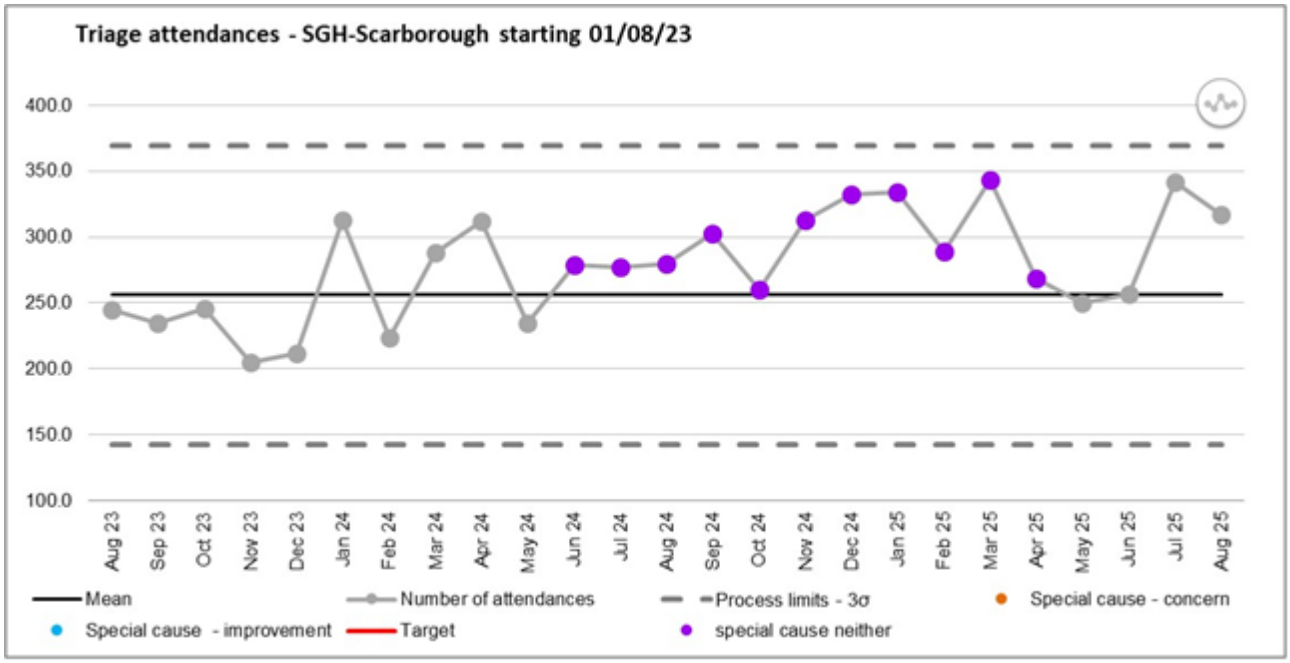


Chart 4 Triage attendances Scarborough



BSOTS Training compliance:

Midwives 87%
Maternity Support Workers/ Maternity Assistants 72%
Consultants 88%
Medical staffing 90%

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 and the next report is due in September. The Perinatal Quality Surveillance Model was implemented in July 2025 and is being presented at Trust Board and the Maternity Safety Champions meetings.

The Maternity and Neonatal Safety Champions meetings were re-established in January 2025, which there have been 6 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)

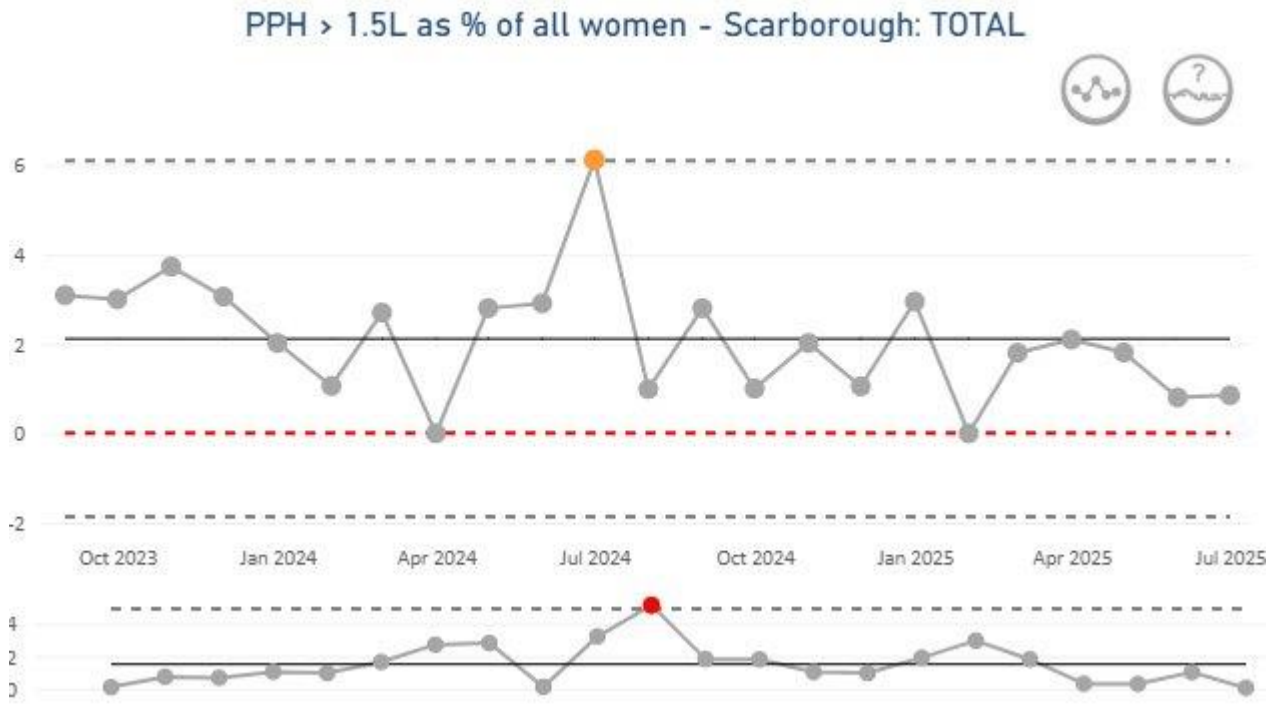
PPH over 1.5 litres

The reduction in the rate of postpartum haemorrhage (PPH) over 1500mls is a key priority for the maternity service. The PPH rate for July 2025 was 2.9% 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.

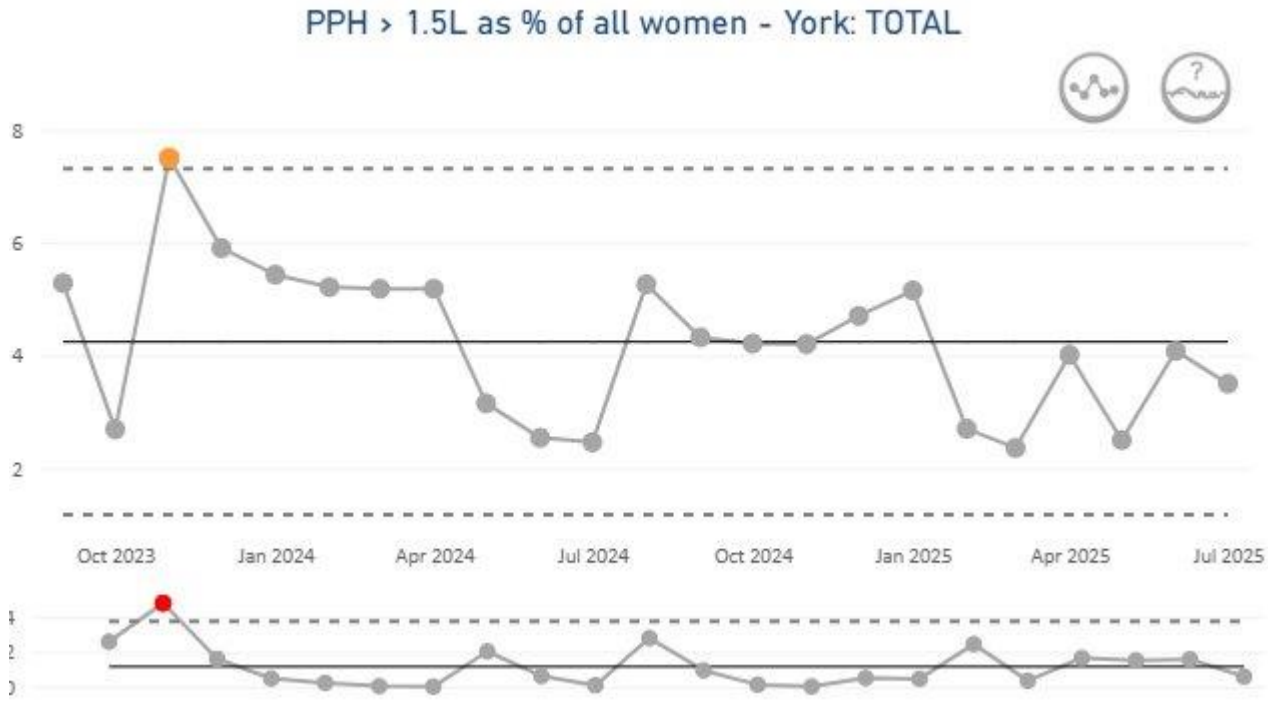
Blood Loss	Number in June 2025
1.5l – 1.9l	7
2l – 2.4l	2
> 2.5l	1

Chart 5



There is common cause variation seen for the PPH≥1500mls for Scarborough and York (Chart 5 and 6).

Chart 6



National Maternity Digital Dashboard
Chart 7

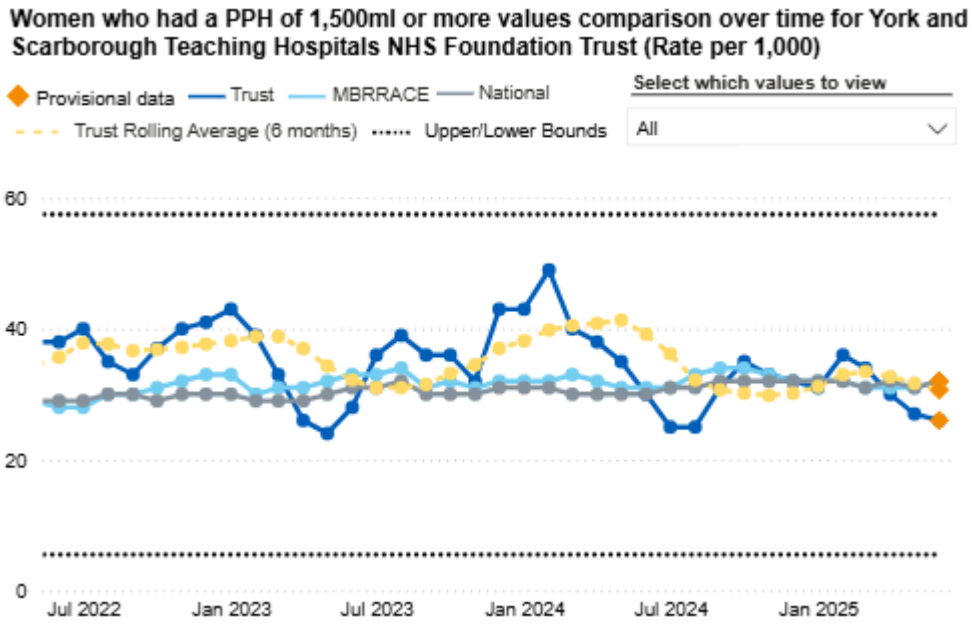
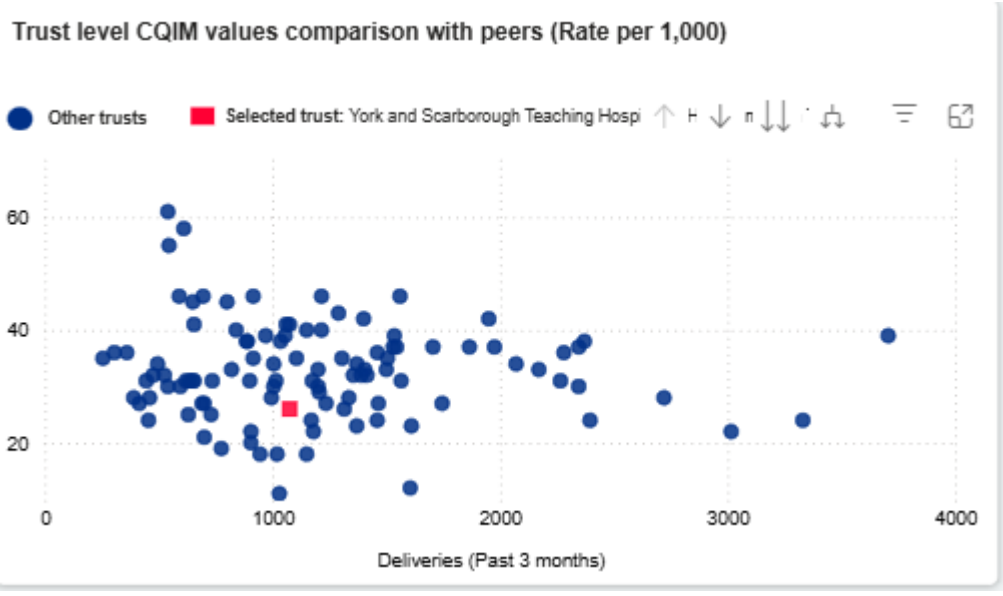


Chart 8



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 5 & 6). All the July cases have been reviewed at the Maternity Case Review and no concerns regarding management was highlighted which would have resulted in a different outcome. The data demonstrates there has been an overall reduction in PPH ≥1500mls when reviewing the Trust rolling average for the 12 months on the national digital dashboard. The national digital chart demonstrates the Trust is not an outlier compared to all Trusts in England. A monthly PPH sprint audit commenced in

January 2025. The monthly PPH sprint audit will be presented at the monthly labour ward forum and Maternity Directorate Group.

Overview of the Monthly Sprint July (10 cases)
The audit includes the number of PPH incident reported in July

Standard	Results	Comments
FBC taken at 28 weeks	100% (10/10)	
Was Haemoglobin managed in accordance with guidance	100% (10/10)	
36-week PPH risk assessment completed	80% (8/10)	
PPH risk assessment completed on admission for birth	100% (10/10)	
Management of third stage of labour	90% (9/10) Active management	
In Caesarean section consider prophylactic use of 1g Tranexamic acid IV after delivery of the baby if moderate to high risk of bleeding	100% (2/2)	
Postnatal oxytocin infusion should be used when there is moderate or high risk of postpartum haemorrhage	100% (10/10)	
PPH proforma fully completed	70% (7/10)	Where the proforma was not completed there was evidence of management written in the healthcare records

8 out of the 10 women had multiple risk factors for PPH. Actions are in place to address areas of partial compliance. All staff receive feedback where proformas have not been completed and shared learning has been included in the safety brief.

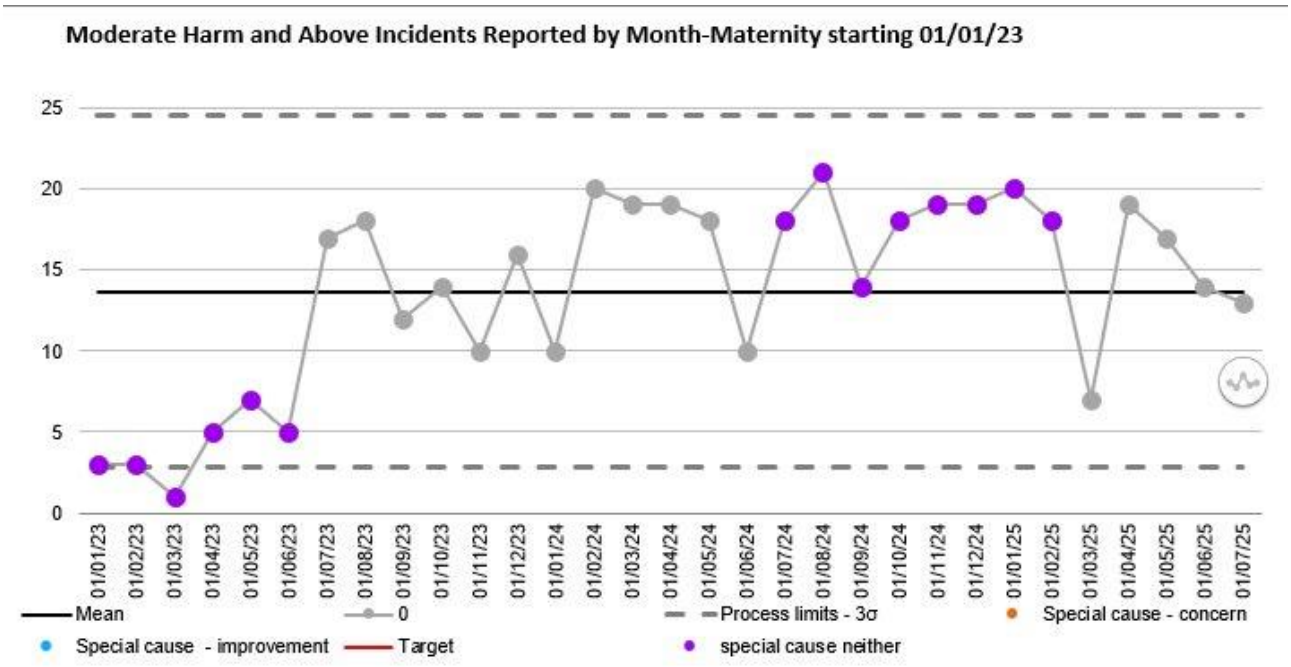
B.3 Incident Reporting

There were 12 moderate harm incidents reported in July 2025.

Datix ID	Incident Category	Outcome/Learning/Actions	Outcome
39584 39896 40114 40296 40298	PPH ≥1500mls	PPH sprint audit started in January 2025. All cases have been reviewed at the MCR meeting	The PPH rate continues to be monitored through the Maternity Assurance Group.
39417	Cord snapped following waterbirth and was transferred out for cooling.	An after action review has been completed. The case has been referred to MNSI.	Learning identified regarding management of hypovolemia in the baby
39551	3b tear following a forceps birth	Reviewed at Maternity Case Review. Risk of 3rd/4th degree tear prior to forceps were discussed. OASI was used during the birth. The tear was repaired in theatre. Management postnatally was appropriate	Review completed. No concerns highlighted
40102	Attended with an abruption and contracting. Maternal PPH 2500mls and antepartum stillbirth	Reviewed at Maternity Case Review. The case has been referred to MNSI. A PMRT will be undertaken. Initial review did not identify any learning which would have changed the outcome	Referred to MNSI
40536	In utero transfer from a tertiary centre with premature rupture of membranes. Woman went into labour following transfer and the baby was born breach. The baby required resuscitation and died at 50 minutes of age.	Joint initial review with the tertiary centre. Plan for a joint Patient Safety Incident Investigation. Family engagement leads have been identified. The family have been provided with bereavement support. A PMRT will also be undertaken.	For a joint PSII and PMRT
40600	34+5 week birth of twins for twin to twin transfusion. Admission to Special Care Baby Unit of twins	Case reviewed at Maternity Case Review.	No concerns highlighted

40362	Term admission	Review at ATAIN.	No concerns highlighted
40789	Anaesthetist gave Oxytocin bolus in theatre before knife to skin. This was in error and should have given Normal Saline. The error was recognised, and baby was born requiring resuscitation	After action review completed. Immediate learning identified and actions implemented regarding not pre-drawing up Oxytocin bolus prior to skin incision. Duty of candour was undertaken by the medical team	Learning identified and immediate actions implemented. Learning shared with wider team

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. There is currently a review

being undertaken to support a workforce model of 24/7 administrative staff for Labour Ward and Hawthorn.

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 September 2025, which if approved will release the equivalent 9.56 WTE Midwives back into the establishment.

Recruitment update:

Position from July 2025:
Scarborough:
Qualified nursing staff and Band 3 staff are fully recruited to.

York:
Qualified nursing staff and Band 3 are fully recruited to.

Maternity Workforce Update

At the July 2025 Public Trust Board, it was agreed to fund the midwifery staffing gap in a phased approach over the next three years with this year being year one.
The current investment made to increase the midwifery establishment:
Education review £230k = 4.1WTE
Maternity Incentive Scheme (MIS) Monies Year 6 £142,405 = 2.6WTE (non-recurrent)
Potential reduction of scrub nurses funding £456k = 9.56WTE
Total funded 16.29WTE
This leaves 27.71WTE to be funded plus 2.6 of non-recurrent MIS posts therefore the overall total left to fund is 30.31WTE.

There are 14 newly qualified midwives (12WTE) who have had career conversations and are appointable to start in late October/November. There are 31 applicants being interviewed throughout September for Band5/6 Midwifery posts.

Perinatal Quality Surveillance Model

NHS
York and Scarborough Teaching Hospitals
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	1 stillbirth at 35 weeks. Graded as B.		
Ethnicity/ Language	3 White and first language English	3 White and first language English	1 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	2 cases referred. 1 baby transfered out for cooling. 1 stillbirth from a placental abruption		
Ethnicity/ Language	2 White and first language English. 1 Bangladeshi and spoke fluent English	N/A	N/A	2 White and first language English		
The number of incidents logged graded as moderate or above	16	18	14	11		
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	British 7 White Other 2 Black Africian 1		
Red flag incidences as per NICE NG4 1.3.5 (see Box 3)	4	7	2	8		
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%	Midwives 82% Consultant Obstetricians 92% All other Obstetricians 73%		
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%	Midwives 93% Consultant Obstetricians 96% All other Obstetricians 100%		
Maternity Emergencies and Multiprofessional training	Midwives 94% MSW 95% Consultants 92% All other Obstetricians 68% Consultant Anaesthetists 82% All other Anaesthetists 73%	Midwives 94% MSW 90% Consultants 88% All other Obstetricians 88% Consultant Anaesthetists 82% All other Anaesthetists 80%	Midwives 92% MSW 89% Consultants Obstetricians 92% All other Obstetricians 91% Consultant Anaesthetists 88% All other Anaesthetists 85%	Midwives 95% MSW 88% Consultant Obstetricians 92% All other Obstetricians 100% Consultant Anaethetists 88% All other Anaesthetists 82%		
Newborn Life Support	Midwives 94% Neonatal Nurses 85%	Midwives 91% Neonatal Nurses 85%	Midwives 93% Neonatal Nurses 83%	Midwives 92% Neonatal Nurses 82% Paediatric Consultants 80% Paediatric Consultants 93%		
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas	100%	100%	100%	100%		
Birth to Midwife Ratio	01:24	01:27	01:24	01:30		
Midwifery Staff average fill rate	74%	78.0%	79.0%	89.50%		
Midwifery bank usage (in hours)	2017	2366	2332	3817.41		
Midwifery agency usage	1201	1593	1643	2390.75		
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%	SGH 102.7% YH 81.6%		
Neonatal bank usage (in hours)	SGH SCBU 384hr YH SCBU 349hr	SGH SCBU 287hr YH SCBU 494hr	SGH SCBU 165hr YH SCBU 202hr	SGH 241hr YH 265.5hr		

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	Not feeling listened to with requests for pain relief. Delays in induction of labour		
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.	Midwifery and MSW staffing. High use of agency at York site.		
MNSI/ NHSR/ CQC or other organisation with a concern or request for action made directly with Trust	No	No	No	No		
Coroner Regulation 28 made directly Trust	No	No	No	No		
Progress in Achievement of CNST	On track 6/10	On track 6/10	On track for 6/10	On track for 7/10		
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.	100 % compliance. 5 out of 5 cases had a consultant present.	100 % compliance. 5 out of 5 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.	100% compliance 45 out of 45 cases had a consultant or senior doctor	100% compliance 41 out of 41 cases had a consultant or senior doctor	
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	5 closures for York. 3 closures for SGH		
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	York- service stood down on 19 occasions, 2 women affected	York- service stood down on 19 occasions, 2 women affected	
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						

Report to:	Board of Directors
Date of Meeting:	24th September 2025
Subject:	• Winter Plan Pack 2025/26 – Overview Paper • Winter Planning 25/26 – Board Assurance Statement (BAS)
Director Sponsor:	Claire Hansen – Chief Operating Officer
Author:	Ab Abdi – Deputy Chief Operating Offcier

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

Approve ☒ Discuss ☐ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

This paper gives an overview of the approach to winter planning, the prioritised additional plans, and the assurance against the national criteria for Trust Board sign off, and a summary of the existing policies that will support operationalisation during winter that exist within the Trust.

Resources Committee have reviewed the plan, an confirmed they are assured that a robust approach to winter planning has been followed and support the plan and the funding proposal.

The Trust's 2025/26 Winter Plan emerges from a robust evaluation of lessons learned during the previous year, sector-wide national guidance, and the urgent requirement to close identified capacity gaps across its acute hospital sites. This plan, underpinned by a data-driven, multi-disciplinary approach, is designed to ensure high-quality, timely, and safe care during the winter period—a season marked by heightened operational pressures on the urgent and emergency care (UEC) pathway.

The post-winter review for 2024/25 identified several critical insights:

- Escalation areas must be proactively planned; ad hoc opening leads to inefficiencies, increased costs, and compromised quality.
- Clear, advance communication with operational staff is essential for effective execution of winter initiatives.
- Short notice costings tend to be inaccurate; robust governance over expenditure is required.
- Annual unplanned expenditures exceeded £1M, with additional hidden costs linked to staffing, consumables, and lost elective activity.

These insights have shaped the methodology and priorities for the 2025/26 Winter Plan with a five-stage framework:

- Review of 2024/25 operational data to set the "bed gap" target and benchmark required capacity increases.
- Compilation of a long list of initiatives, sourced from all care groups and workforce teams, with proposals tagged as cost-neutral or requiring extra funding.
- Detailed costing of initiatives was led by finance managers, ensuring realistic and comprehensive financial appraisal.
- An objective prioritisation process, using a formal scoring matrix, enabled the Trust to rank initiatives by their impact on bed days saved, admissions avoided, ED impact, safety, cost-effectiveness, and feasibility.
- Governance review and board approval.

Six initiatives were classified as HIGH priority:

1. **Winter Escalation Wards and Flu Wards**
   The TRG's operational bed modelling identified a bed deficit of 10–15 for Scarborough and 25–30 for York during winter peaks. Therefore escalation wards are central to the plan, both to provide additional capacity and to cohort patients with flu.

2. **Cohorting and Additional Capacity in ED**
   To expedite ambulance handovers and decompress ED, a dedicated nurse staffing model (1+1) will be implemented in each ED for 24/7 cover (Nov–Feb).

3. **HPV and UV Cleaning**

Investment in the HPV team (2.8 WTE at B3 plus consumable uplift) will accelerate the reopening of closed bays and wards, improving bed availability.

4. **Super Discharge Teams**
   Enhanced Multi-Disciplinary Team (MDT) discharge reviews, including a B2 Transfer Operative working 7 days/week, will ensure swift discharge of long-stay patients (Nov-Feb).

5. **Additional Weekend Acute Operating Lists**
   Acute/trauma lists on key weekends and bank holidays at both York and Scarborough, to maintain prompt surgical care and timely discharges.

6. **Medical Outliers**
   Daily review of medical outlier patients at York (1 Consultant + 1 Resident, 5 days/week for a month).

The financial impact will be £3,126,629 (with an unlikely potential additional financial impact of £1,038,814 for Ward 12 at York if this is available – it is currently being considered as a decant ward for estates works associated with national funding for SCBU therefore is highly likely to be unavailable). This funding will be identified through an increase in non-recurrent savings targets for each Care Group and Corporate areas.

Recommendation:

The Board is asked to:

- Note this paper.
- Approve the recommended approach.
- Approve the financial impact of £3,126,629 (including ward 12 at York hospital the financial impact will be £4,165,443).

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

The Winter Plan Pack 2025/26 has been to the Executive Committee on 03/09/25 and the recommended approach supported to move onto the Resource Committee and the Trust's Board for approval. The pack included the following documents that were approved:

a) Winter Plan Pack 2025-26 Cover Sheet 030925
b) Urgent and emergency care plan 2025-26 (national document)
c) 20250806 UEC Plan and Gap Analysis - Executive Committee
d) 20250813 Winter Initiative Paper - Ab Comments v4 – clean
e) 20250814 25-26 Winter Plans - Long List V5
f) Continuous Flow SOP v5 270825
g) Temporary Escalation Spaces SOP v3 270825
h) 20250827 - Escalation Surge and Full Capacity Protocol v3.1 270825
i) Process for a Call Cascade in Escalation v2 280825
j) RVI Management Winter Plan v1.3 2025-26
k) Flu Vaccination - Review of 24.25 and plan for 25.26 campaign - Exec Committee
l) Quality Impact Assessment - Winter Plan Pack 2025-26

- The Winter Plan 2025/26 paper (minus the above policies) has been to the Resource Committee on 16/09/25 and the recommended approach supported to move onto the Trust Board of Directors for approval.

Winter Plan 2025/26

1. Introduction

The Trust's 2025/26 Winter Plan emerges from a robust evaluation of lessons learned during the previous year, sector-wide national guidance, and the urgent requirement to close identified capacity gaps across its acute hospital sites. This plan, underpinned by a data-driven, multi-disciplinary approach, is designed to ensure high-quality, timely, and safe care during the winter period—a season marked by heightened operational pressures on the urgent and emergency care (UEC) pathway.

2. Context and Strategic Objectives

The winter period consistently brings increased demand, requiring the Trust to manage patient flow, mitigate risks associated with overcrowding, reduce delays, and protect elective and emergency services. The 2025/26 plan specifically supports the Trust in meeting two principal objectives:

- To provide timely, responsive, safe, accessible effective care at all times.
- To work collaboratively with partners to improve the health and wellbeing of the communities served.

The Trust also recognises the necessity of continuous innovation, effective resource management, and strong governance to deliver sustainable healthcare, especially when under seasonal duress.

3. Review of 2024/25: Lessons Learnt

The post-winter review for 2024/25 identified several critical insights:

- Escalation areas must be proactively planned; ad hoc opening leads to inefficiencies, increased costs, and compromised quality.
- Clear, advance communication with operational staff is essential for effective execution of winter initiatives.
- Short notice costings tend to be inaccurate; robust governance over expenditure is required.
- Annual unplanned expenditures exceeded £1M, with additional hidden costs linked to staffing, consumables, and lost elective activity.

These insights have shaped the methodology and priorities for the 2025/26 Winter Plan.

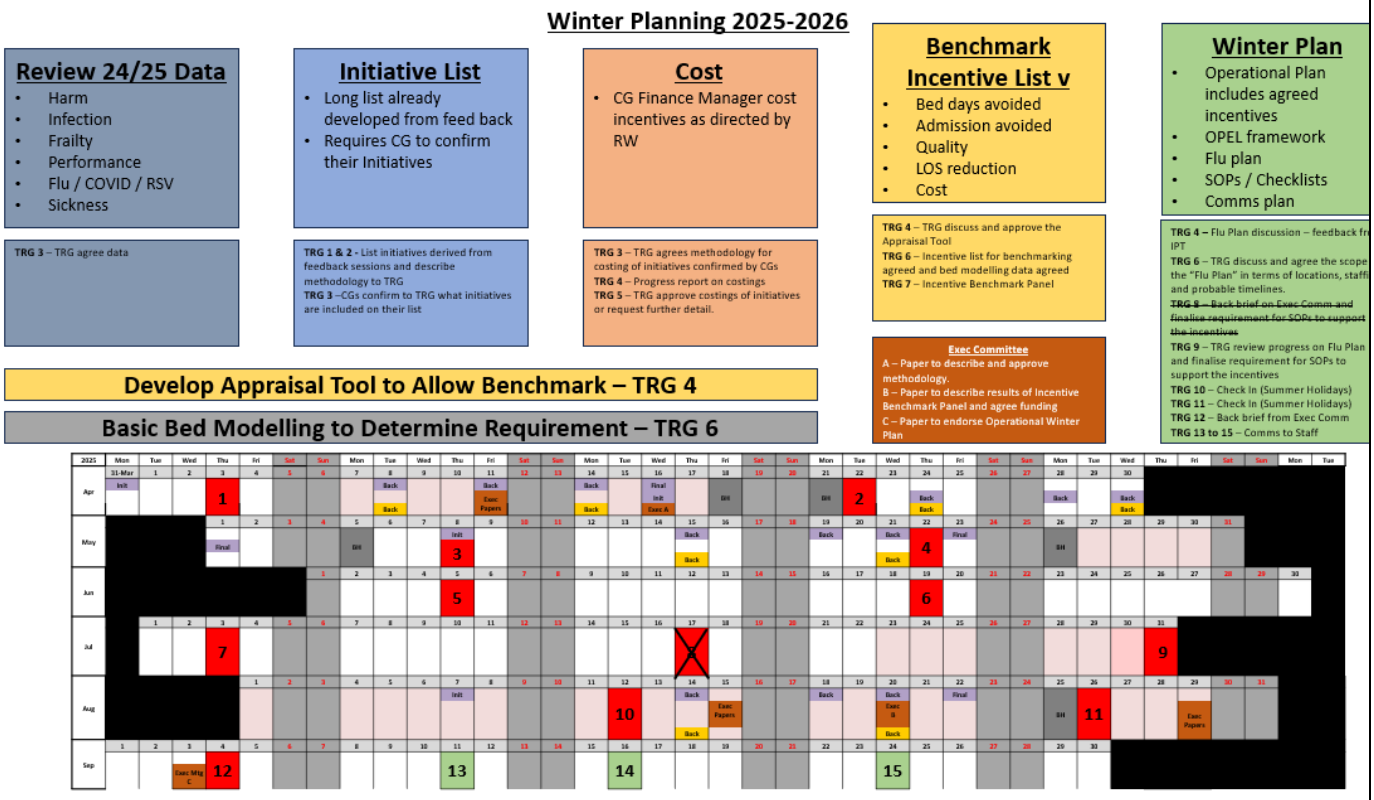
4. Planning Methodology

Winter planning commenced in March 2025 and was coordinated by the Trust Resilience Group (TRG), who adopted a five-stage framework:

- Review of 2024/25 operational data to set the "bed gap" target and benchmark required capacity increases.
- Compilation of a long list of initiatives, sourced from all care groups and workforce teams, with proposals tagged as cost-neutral or requiring extra funding.
- Detailed costing of initiatives was led by finance managers, ensuring realistic and comprehensive financial appraisal.

- An objective prioritisation process, using a formal scoring matrix, enabled the Trust to rank initiatives by their impact on bed days saved, admissions avoided, ED impact, safety, cost-effectiveness, and feasibility.
- Post-approval, the full Winter Plan, including supporting documents such as the Flu Plan, SOPs, and communication strategies, will be submitted for governance review and board approval.

A summary of the stages and timeline is below:



5. Winter Initiatives: Prioritisation and Financials

The TRG's operational bed modelling identified a bed deficit of 10–15 for Scarborough and 25–30 for York during winter peaks. Six initiatives were classified as HIGH priority for closing these shortfalls. These include:

5.1. Winter Escalation Wards and Flu Wards

Escalation wards are central to the plan, both to provide additional capacity and to cohort patients with flu.

5.1.1. York Hospital

- November 2025 – February 2026
  - Ward 25 is used as a winter escalation ward with appropriate funding.
  - Ward 25 is used as the 1st Flu ward.
  - Ward 29 is used as the 2nd flu ward. There is no additional cost associated as it is already established.

- October 2025
  - Ward 29 is used as the 1st flu ward if needed. There is no additional cost associated as it is already established.

- March 2026
  - Ward 29 is used as the 1st flu ward. There is no additional cost associated as it is already established

Ward 12

It is worth noting that ward 12 in York hospital will have a capacity of 22 beds on completion of the refurbishment in October 2025. Long term this is being considered as part of the Integrated Assessment Unit (IAU) programme as assessment and/or short stay capacity for medicine and/or surgery. In the short term due to some national funding for refurbishing SCBY this is being considered as a decant ward. If it were to be used purely as an additional escalation capacity, it would cost additional £1,038,814 to open for the full period of 01 November 2025 to 28 February 2026. Although that is unlikely due to the decant requirements. It has been costed however for completeness as the decision for decant has not yet been made.

5.1.2. Scarborough Hospital

- October 2025 – March 2026
  - LILAC is used as the 1st Flu Ward There is no additional cost associated as it is already established.

- November 2025 – February 2026
  - Mulberry is used as the 2nd flu ward. There is no additional cost associated as it is already established.

- November 2025 – February 2026
  - CCU is proposed as the winter escalation ward with the appropriate funding and sign off of quality impact assessment. (the option of Beech is not recommended due to timeliness for this winter as a result of interdependency with Oak roof work.

5.2. Cohorting and Additional Capacity in ED

To expedite ambulance handovers and decompress ED, a dedicated nurse staffing model (1+1) will be implemented in each ED for 24/7 cover (Nov–Feb).

5.3. HPV and UV Cleaning

Investment in the HPV team (2.8 WTE at B3 plus consumable uplift) will accelerate the reopening of closed bays and wards, improving bed availability.

5.4. Super Discharge Teams

Enhanced Multi-Disciplinary Team (MDT) discharge reviews, including a B2 Transfer Operative working 7 days/week, will ensure swift discharge of long-stay patients (Nov-Feb).

5.5. Additional Weekend Acute Operating Lists

Acute/trauma lists on key weekends and bank holidays at both York and Scarborough, to maintain prompt surgical care and timely discharges.

5.6. Medical Outliers

Daily review of medical outlier patients at York (1 Consultant + 1 Resident, 5 days/week for a month).

6. Financial Assessment

The summary of HIGH priority initiatives a priority order is as follows:

Table 1:

Priority	Initiative	Cost
1	Winter Escalation Wards	York W25, £1,344,769 SGH CCU, £951,399
2	Cohorting and Additional Capacity in ED	£484,789
3	HPV and UV Cleaning	£62,476
4	Super Discharge Teams	£70,320
5	Additional Operating Lists	£18,543
6	Medical Outliers	£194,333
Recommended Totals		**£3,126,629** **(including Ward 12 in York hospital, the financial impact will be £4,165,443)**

The original planning assumption for additional winter costs assumed there would be additional national funding. It has been confirmed that, at this stage, there is no additional funding.

It is highly likely that ward 12 will not feature in the winter escalation plans as this will be necessary to support the SCBU refurbishment project, although this is in the process of being finalised.

Discussions with the Executive Committee recognised that to meet these costs would require further savings actions, including taking non-recurrent opportunities. The Executive Committee supported this action.

Given the general pressure on the financial position, we have prepared a financial recovery plan. This has been formally requested by the ICB and NHSE. The maximum estimated winter costs of £3.1m have been included in this plan along with a commitment to seek to reduce this spend through diverting staff, reconsidering the deployment of corporate nursing and specialist nursing teams and ensuring through robust governance arrangements that capacity is flexed up and flexed down only when necessary.

These winter costs are being managed in totality, alongside the overarching financial pressure the Trust is managing.

It is estimated that the total WTE impact will be approximately 79.52 WTE. This includes a few assumptions about the shifts being filled and includes all staff groups (medical, nursing, AHP, Pharmacy), but does not include YTHFM.

It is recognised that the teams will proactively seek to spend as little as possible and only what is absolutely needed.

To support this aim, in 2025/26 there will be a central financial governance to monitor, manage and support itemised approval of winter funding as follows:

- Any budget that is approved by the Board is held in a central reserve that will be set up.
- The Care Groups seek approval through a defined governance to Deputy Chief Operating Officer that they can spend against an approved scheme and importantly, how much they can spend.
- The Care Group's Head of Finance then, providing evidence of approval, will ask the Deputy Head of Financial Management to draw the approved budget from the central reserve which is then subsequently drawn into their operational budgets. Deputy Head of Financial Management will then update the central tracker (to be saved on teams).
- The Care Group team (with Finance support) should then be in a position to report their actual expenditure against the drawn budget on a monthly basis.
- The above information is collated by Deputy Head of Financial Management and reported to Deputy Chief Operating Officer.

7. Risks and Issues Associated with Non-Approval of Winter Plan 2025/26 Funding

The Trust's Winter Plan for 2025/26 is designed to address the significant operational challenges encountered during the winter period, particularly heightened pressures on urgent and emergency care pathways. The Plan is underpinned by detailed analysis, lessons learnt from previous years, and a robust, multidisciplinary approach. If the recommended funding is not approved, there are several critical risks and issues that the Trust is likely to encounter, which could compromise patient safety, operational effectiveness, and financial sustainability.

7.1. Patient Safety and Quality of Care

Escalation Capacity Gaps: Without the additional escalation and flu wards, the Trust will be unable to close identified bed deficits (10–15 beds at Scarborough, 25–30 beds at York). This would lead to increased overcrowding, delayed admissions, and longer waits for patients in the emergency department (ED), raising the risk of adverse events and compromised safety.

Infection Prevention Shortfalls: The absence of funding for enhanced HPV and UV cleaning could delay the reopening of closed bays and wards, reducing overall bed availability and increasing the risk of hospital-acquired infections, especially during periods of high respiratory virus transmission.

Delayed Discharges and Flow Obstruction: Without investment in Super Discharge Teams and additional weekend operating lists, the Trust will struggle to expedite discharges and maintain patient flow, leading to further congestion and delayed elective and emergency care.

7.2. Operational Pressures and Inefficiency

ED Overcrowding: Failure to fund dedicated nurse staffing models and cohorting initiatives in ED will slow ambulance handovers and impede swift decompression of the department, increasing the likelihood of breaches in national performance targets (e.g., 4-hour waits, 12-hour breaches).

Unplanned, Inefficient Escalation: Lessons from previous years demonstrate that ad hoc escalation (without advance planning and funding) leads to inefficiency, higher costs, and lower quality. This scenario is likely to recur, with increased unplanned expenditure and potentially hidden costs in staffing, consumables, and lost elective activity.

Inadequate Surge Response: Without the resources to implement the Full Capacity Protocol and support escalation spaces, the Trust's ability to respond flexibly to surges in demand will be severely compromised, heightening operational risk.

7.3. Financial Risks

Uncontrolled Expenditure: In the absence of pre-approved funding, any crisis response will likely result in higher, unplanned costs, as seen in previous years when annual unplanned expenditure exceeded £1 million.

Impact on Financial Recovery: Failure to allocate and govern winter funding centrally will undermine the Trust's broader financial recovery plan and efforts to achieve cost improvement targets.

Lost Elective Activity: Overcrowding and delayed discharges will result in the cancellation of elective procedures, impacting both patient outcomes and the Trust's financial position due to loss of income.

7.4. Workforce Wellbeing and Effectiveness

Increased Staff Absence: Without investment, staff absence may rise, further straining workforce capacity during a period of peak demand.

Morale and Burnout: Persistent high-pressure working environments, exacerbated by overcrowding and lack of resources, risk undermining staff morale, increasing turnover, and contributing to burnout.

7.5. Reputational and Regulatory Risks

Failure to Meet National Standards: Inability to deliver timely, responsive, and safe care risks regulatory scrutiny and potential intervention, as well as damage to the Trust's reputation among patients, staff, and partners.

Governance and Assurance Failures: Lack of funding would hinder the Trust's ability to adhere to robust governance processes, undermining Board and stakeholder assurance.

In conclusion, failure to approve the recommended funding for the Winter Plan 2025/26 would expose the Trust to significant risks across clinical, operational, financial, workforce, and governance domains. These risks include compromised patient safety, increased operational inefficiencies, unplanned financial pressures, staff wellbeing concerns, reputational damage, and a failure to meet regulatory and equality standards. Approving the funding is essential to ensure that the Trust can deliver high-quality, safe, and sustainable care during the most challenging period of the year.

8. Policies, Protocols, and Procedures to support Winter

8.1. Patient Flow, Escalation and Surge policy (including full Capacity Protocol)

The Trust's Patient Flow, Escalation and Surge Policy (including Full Capacity Protocol, FCP) aligns with the national OPEL (Operational Pressures Escalation Levels) framework. The policy sets out escalation triggers, command and control roles, and detailed actions at each level of pressure.

Escalation levels are determined using multiple indicators including average ambulance handover, 4-hour ED performance, occupancy rates, delayed discharges, and IPC-related closures.

8.2 The Continuous Flow Model & Temporary Escalation Spaces (TES)

The Continuous Flow Model, detailed in the SOP for Safe and Effective Management of Patient Flow, underpins daily operations and escalation responses. It describes:

- Pre-scheduled transfers from ED to assessment and base wards (with discharge modelling to anticipate available beds).
- Prioritisation of specialty beds, early discharge planning
- The use of escalation beds (green and amber), with clear criteria and risk assessments, to decompress ED and support urgent admissions.
- In extremis, the activation of TES ("Red beds") in corridors or bays, strictly by risk assessment and with defined exclusion criteria (e.g., patients requiring high acuity care, infection isolation, or with safeguarding concerns are not suitable for TES).

A risk assessed approach is deployed when patients are placed in unplanned areas, with hourly checks, documentation, and clear communication to patients and families. Swift de-escalation of TES is prioritised, and all actions are scrutinised through operational meetings and daily reviews.

8.3 Full Capacity Protocol (FCP)

Full Capacity Protocol (FCP) is included in the Patient Flow, Escalation and Surge policy Protocol.
Activation of the FCP requires sign-off by two Executives (COO, Chief Nurse, Chief Medical Officer, or Gold On-Call). FCP is invoked when ED is unable to safely care for additional patients, and all escalation actions have been exhausted.

Key concepts include:

- Extra boarding of patients to wards above escalation beds (by Executive authorisation, for limited periods, with regular review and risk assessment).
- Specialty consultant in-reach to ED and inpatient areas to expedite reviews and discharge.
- Clinical review and possible cancellation of non-urgent elective activity and all non-essential meetings.
- Deployment of additional portering, support services, and consideration of ambulance diversion or critical incident declaration.

8.4 RVI Management Winter Plan

This management plan has three phases:

1.Preparation
2. Active
3. De-escalation

This plan focusses on testing for respiratory virus infection (RVI) and patient placement. It contains limited infection prevention and control (IPC) information. Detailed IPC requirements (e.g. PPE, cleaning, etc) for managing individual patients with suspected / confirmed RVI can be found in the respiratory virus and COVID-19 guidance on the intranet.

This plan does not cover the management and placement of patients in the Emergency Department (ED), Intensive Care Unit (ICU), in paediatrics or maternity. Specific plans for these departments can be found in the appendices.

This plan does not cover any severe or emerging respiratory virus (e.g. Avian influenza (bird flu) and Middle Eastern Respiratory Syndrome (MERS). Refer to the High consequence infectious diseases (HCID) Standard Operating Procedure (SOP) on the intranet.

The plan is designed to be flexible and adaptable. As such, it may undergo changes during the winter period

9 Vaccinations

9.2 Staff vaccinations

In line with the national directive, the Trust is planning to increase staff flu vaccination uptake by 5%. In 2024/25 uptake for York and Scarborough Trust was 31%, meaning we need to achieve 36% this year. Higher vaccination rate could support staff to avoid absence due to cold/flu.

To try and reach this target, Occupational Health (OH) will run on-site clinics at both York Hospital and Scarborough Hospital, over an 8-week period, from Monday 6th October to Friday 28th November. The clinic at York Hospital will run from the main entrance, to make it as accessible as possible for all staff. The clinics at Scarborough Hospital will run from the OH department in Woodlands House.

There's also a cohort of peer vaccinators who will be given a target number to achieve, working across the Care Groups on all sites, managed by a designated member of the Medicines Management team. This is to ensure that staff have easy access to vaccination if they are unable to attend an OH clinic. Specifically identified peer vaccinators are running full day clinics at Malton Hospital, Selby Hospital, and Bridlington Hospital.

There is a communication plan in place, which will advertise the clinics on Staffroom, on screensavers, and on Staff Brief calls; and line managers are being asked to ensure their team are given the time to access vaccination, if they wish to do so.

In 2023, uptake was 34%, meaning a decrease of 3% in 2024, however, in 2023 there was the incentive of receiving a food voucher if they had both their flu and covid vaccinations at the same time. In 2024 we didn't offer covid vaccination, but staff fed back that they felt there should have still been the offer of an incentive. This year we are going to run a prize draw on 4th December (after the campaign has ended), where staff can receive one of three prizes – one day of annual leave, afternoon tea for two at the Milner, or Sunday lunch for two at the Marriott. Uptake will be monitored on a weekly basis, and if there is a need to increase the number of OH clinics, we will be responsive to this and do so wherever staffing resource allows.

In summary:

- Influenza vaccinations for staff will be delivered in the months of October and November.
- Occupational health will provide planned drop-in sessions on the main sites and peer vaccinators will provide access for staff on wards and departments on all sites under a written instruction.
- A promotional campaign will highlight the importance of vaccinations.
- The pharmacy team will distribute the vaccines and maintain cold chain.
- Vaccinations will be documented on the RAVS national vaccination portal.

9.3 Patient Vaccinations

In terms of inpatients, patients with a long-expected length of stay (>21days) or those being discharged to care homes will be targeted for vaccination.

Some high-risk outpatient groups will be offered vaccination including patients planned to start chemotherapy and patients attending the haemodialysis units.

10 Quality, Safety, and Inclusion

The Plan integrates continuous improvement cycles, daily monitoring of key metrics (e.g., ambulance handover times, ECS performance, 12-hour waits), and the rollout of quality standards, including advanced infection prevention and cohorting strategies.

The Trust's commitment to equality, diversity, and inclusion is reinforced in operational policies, ensuring that all services and decisions support the diverse needs of patients, carers, and staff.

11 Governance, Assurance, and Communication

Governance rests with the Executive Committee, Resource Committee, and Board of Directors, with explicit timelines for approvals from August to September 2025 and ongoing assurance through the Trust Resilience Group.

- **20 Aug 25** – Winter Plan Initiative Proposal to Executive Committee.
- **03 Sep 25** – Winter Plan to Executive Committee.
- **16 Sep 25** – Winter Plan to Resource Committee.
- **24 Sep 25** – Winter Plan to Trust Board.

Communications plans ensure operational teams, care groups, and front-line staff are briefed well in advance, with tabletop exercises and briefings forming part of readiness activities.

12 Testing the Winter Plan Pack 2025/26 – Tabletop Exercise

In addition to the system-wide and region-wide testing exercises undertaken on 01/09/25 and 03/09/25 respectively, this winter plan is being tested at the Trust level. The Trust has arranged a Trust wide tabletop exercise in 2 sessions for York and Scarborough hospitals on 2nd and 10th September 2025 respectively.

The objectives include:

- Winter Plan briefing
- OPEL Framework, escalation triggers and responses
- Escalation Spaces and Winter Escalation Capacity

- MDT Super Discharge Team
- Full Capacity Protocol
- Flu Plan, vaccination, outbreak containment, PPE
- Command & Control structures (TRG, Ops Meetings)

Further to above, 5 one-hour communication sessions have been arranged in September and October 2025 to socialise and receive further feedback. Additionally, there will be regular weekly feedback drop-in sessions running form November 2025 to end of February 2026.

13 Conclusion

The 2025/26 Winter Plan for the Trust is a comprehensive, multi-layered framework designed to optimise patient flow, maintain safety and quality, and ensure effective use of resources during periods of peak pressure. It balances robust escalation procedures, a proactive approach to risk management, and responsive, transparent governance. At its heart, the Plan aims to ensure that patients continue to receive high-quality care, irrespective of the operational challenges posed by winter.

Winter Planning 25/26

Board Assurance Statement (BAS)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	York and Scarborough Teaching Hospitals NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Executive Committee 3rd September Resource Committee 16th September Trust Board 24th September
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	QIA is part of the winter plan pack.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Intelligence from Community and Discharge Improvement Groups, which involve system partners, has been used to inform the pack. For example, first, second, and 3rd line (Gold) escalation processes have been developed with system partners.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	North East and Yorkshire testing event took place on 3rd September 2025. The system-wide testing exercise happened on 01/09/25. As a Trust we have conducted two table top sessions and have three Teams briefings for operational teams.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	The Chief Operating Officer (COO) is accountable. Deputy COO Ab Abdi is Winter SRO on behalf of the COO.

Provider:	York and Scarborough Teaching Hospitals NHS Foundation Trust

		There are TRG check ins scheduled throughout the winter. The regular Board reporting schedule will continue over winter, with Urgent and Emergency Care updates provided to Directors at least fortnightly, with escalations to Trust Board as appropriate.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	As outlined in Winter Plan pack 2025/2026. Trust Board 24th September
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	As part of governance approval process, Winter Plan pack 2025/26 has been through executive committee, resources committee. Relevant discussion highlighted risks, issues and mitigations have taken place and assurance reached.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	These are the key principles of the Winter Plan, with trajectories developed.

Provider CEO name	Date	Provider Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Plan in place using last year's performance as baseline. Utilising learning from last year to increase uptake.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	The Trust has completed bed modelling and the outcome of this exercise was presented to the Urgent and Emergency Care Board on 6th August 2025. Winter Plan supporting documentation outlines response to demand.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	At both York and Scarborough Emergency Departments, the rosters are being reviewed to ensure alignment with key times of pressure expected over winter. Additional middle grades being recruited at Scarborough.
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	As part of Discharge Improvement journey the Trust is working on Pathway 0, as well as working with system partners to ensure complex discharges on P1, 2 and 3 are happening effectively and timely. There has

			been sustained improvement in the relevant KPIs.
5.	Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Adjusted profile for winter period to match the demand and pressure.
Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Actively involved in Winter TRG and planning.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	No	We have fit testing available for all staff groups with stock available and the records are placed on the internal learning hub. We are looking to move this to ESR. Fit testing will be happening for identified wards, according to an agreed timetable.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Flu Plan, Temporary Escalation Spaces (TES) and Full Hospital Protocol all socialised in Trust table top sessions.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	Site Management and On Call arrangements are in place, including senior clinical leaders
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	As part of Winter Plan we have reviewed our full hospital protocol and OPEL frameworks in line with national directive.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 18

Report to:	Board of Directors
Date of Meeting:	24 September 2025
Subject:	Quarter 1 Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Owen Bebb- Associate Medical Director for Patient Safety Alice Hunter- Patient Safety Specialist

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

Summary of Report and Key Points to highlight:

This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
  - HSMR (Hospital Summary Mortality Indicator)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:

- Nationally mandated data
- Locally mandated data
- Quality account data

- Learning from deaths – themes, actions and escalations
  - Significant Assurance was given following Learning from Deaths Internal Audit and all actions implemented and completed
  - Poor care was given to 5/19 SJCR's reviewed.
  - Treatment escalation plans, senior decision making and multiple ward moves were highlighted as escalations in June's meeting.
  - SJCR training continues and will be encouraged at the new consultant training
  - Attendance was low at the April meeting, which meant several SJCRs could not be discussed as planned. However, there was a marked improvement in attendance during May and June.
  - Two antepartum stillbirths (twins at 32+5 weeks) occurred within the Trust and will be reviewed using the perinatal mortality review tool.

Metric	Result
Crude mortality	Crude mortality is 2.37% (June 2024 to May 2025) (12 month rolling HES data)
SHMI – HES HED1	SHMI for 12 months (May 2024 to April 2025) is 93.82
SHMI - NHS England2	
	SHMI for 12months (Mar 2024 to February 2025) is 92.84
HSMR3	

[1] SHMI HES HED - Summary Hospital Mortality Indicator 12month rolling, Hospital Episode Statistics and published by Healthcare Evaluation Data for UK Health Data Benchmarking
[2] SHMI NHS England - Summary Hospital Mortality Indicator 12month rolling, NHSE SHMI dataset
[3] HSMR – Hospital Standardised Mortality Ratio

Recommendation:
The Board is asked to note the report and receive the escalations.

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

Meeting/Engagement	Date	Outcome/Recommendation
Learning from Death Group	**11/08/2025**	
Patient Safety & Clinical Effectiveness Subcommittee	**13/08/2025**	
Quality Committee	**16/09/2025**	

1. Y&SH NHS FT mortality rates

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

1.1 Crude Mortality - unadjusted

Crude Mortality rate is the percentage of patients that have died. The crude rate includes all deaths up to 30 days post discharge. The crude mortality rate is the sum of the in-hospital deaths and the out-of-hospital deaths against all discharges. For quarter 1 currently no data is available, the crude mortality (12-month rolling, April 24 to March 25) is 2.55% (National is 2.49%). The rolling 12month trend has increased slightly compared previous. Month by month there was an increase over the winder month and is now falling. For March 2025 was 2.37%.

The crude mortality of all non-elective admissions (12-month rolling, April 24 to March 25) stands at 4.72%. The general trend month by month is that the crude mortality is falling.

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

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

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

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

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

Two risk-adjusted mortality rates are presented:

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

The latest NHS-Digital Summary Hospital Mortality Index (SHMI) to July 2025 (covering Mar 24 to Feb 25) shows the SHMI was 92.84 The SHMI in comparison to other Trusts is displayed below (Figure 1). Compared to Mar 24 we have seen a decrease in the SHMI from 98.27 to 92.84 in Feb 25.

The SHMI HES data reports the SHMI (12 month rolling, May 24 to Apr 25) at 93.82, (Expected deaths 3294, observed deaths 3090) (Figure 2). For in-hospital deaths the numbers were as follows; observed 2131, expected 2285. For out of hospital deaths

observed deaths were 959, expected deaths 1008. These all fall ‘within expected range’ as defined by HED.

Figure 3 shows the SHMI trend by month over the last 12 months. Overall the SHMI continues to improve. Figure 4 shows the rolling 12 month SHMI for the individual sites (April 24 to March 25), York (0.90) has a lower SHMI than Scarborough (0.98). When compared to the previous 12 month period there has been a 0.5 reduction in the SHMI.

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

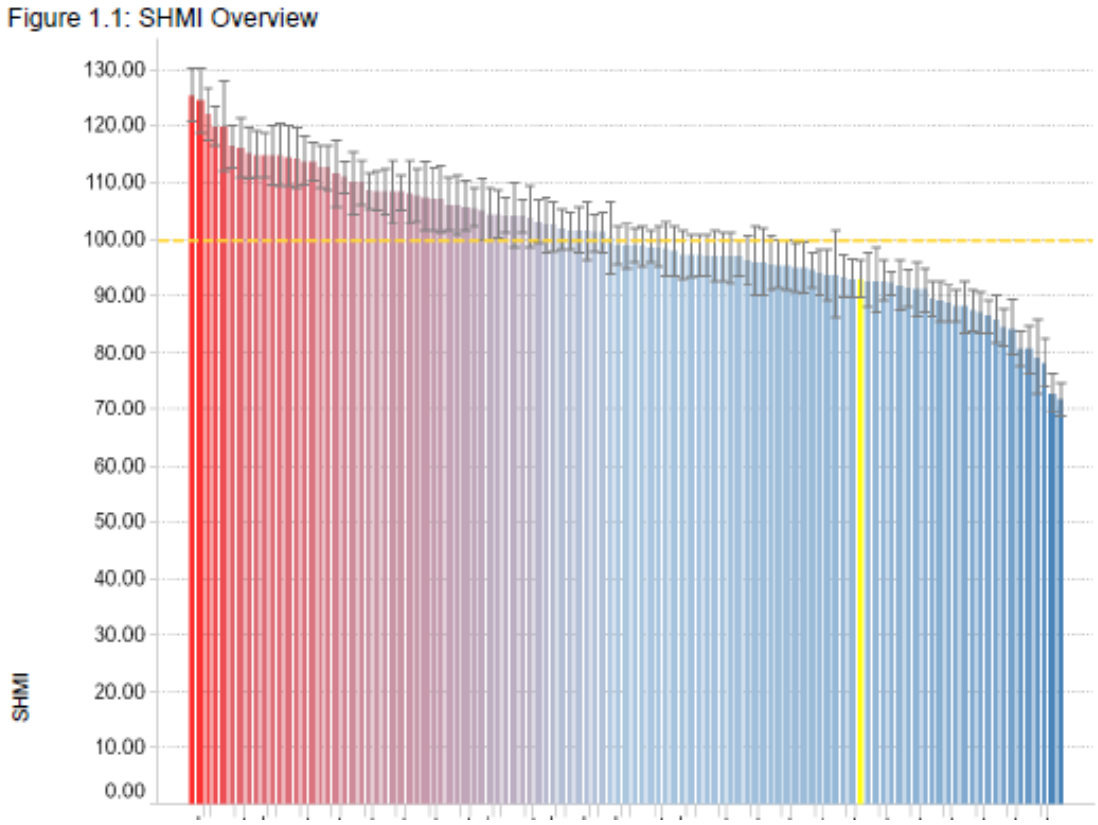


Figure 2 SHMI (HES/HED data) Funnel plots (in comparison with other Trusts)

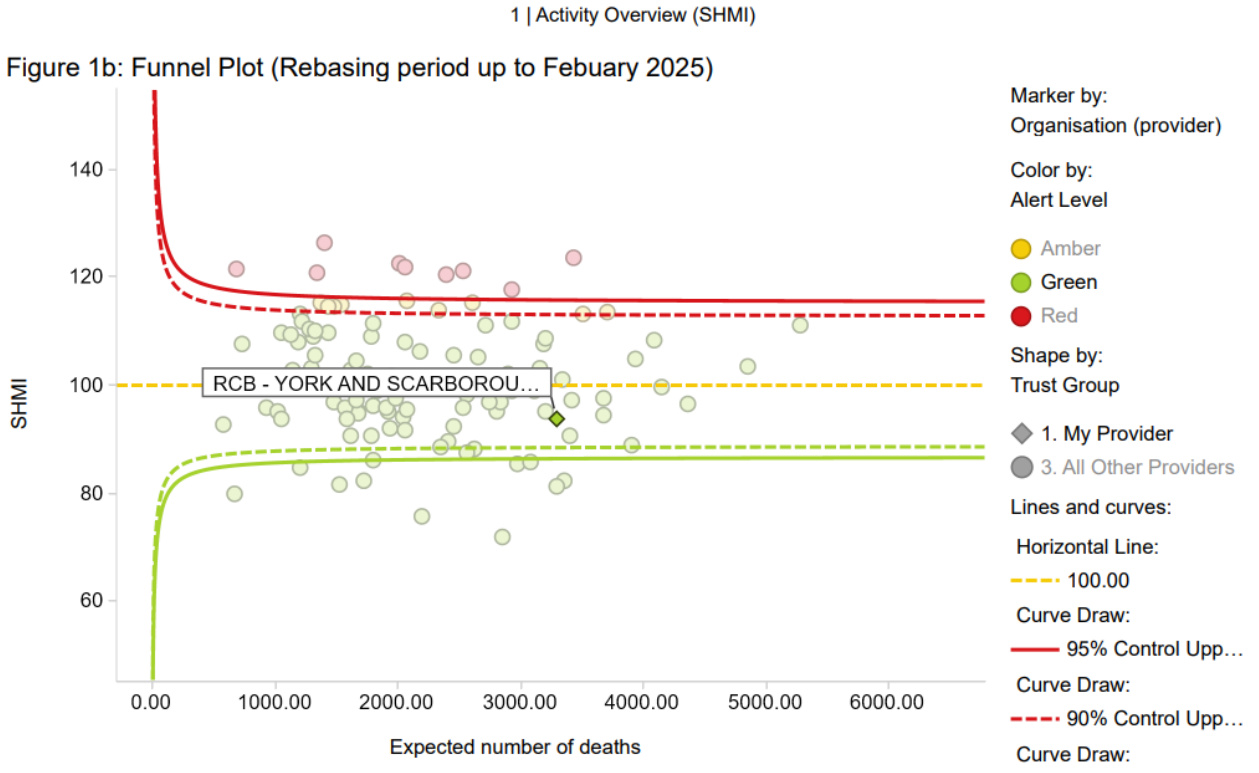


Figure 3: Time series data for SHMI (HES-HED data, to February 25) showing trend over time

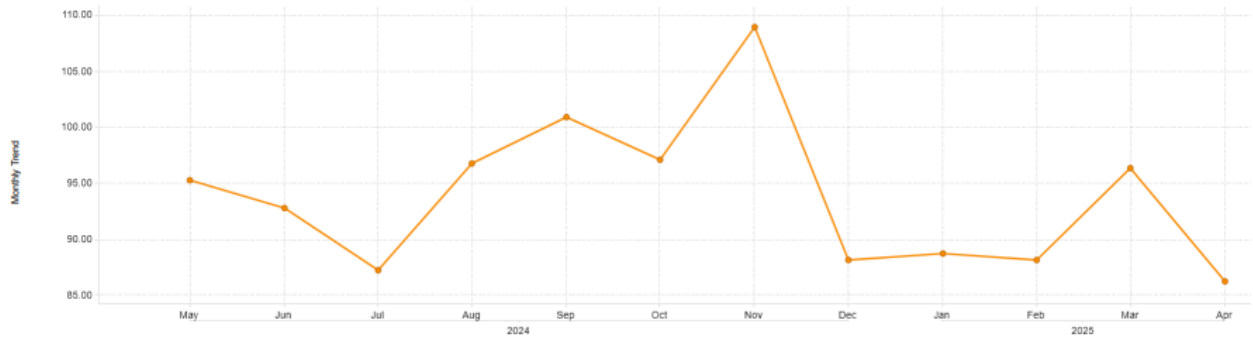
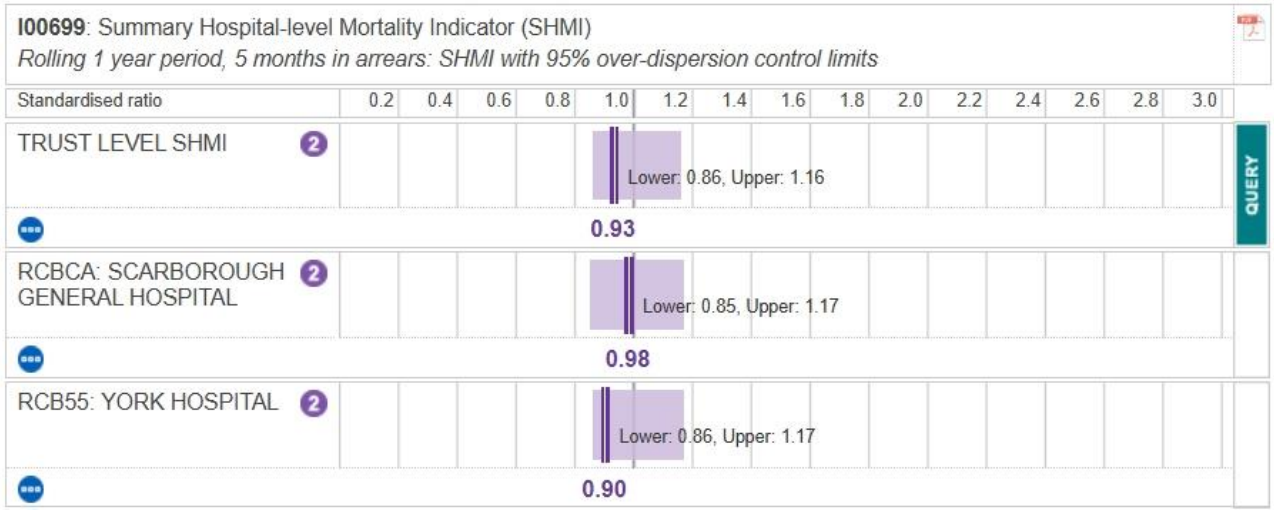


Figure 4 SHMI site comparison



1.3 Hospital Standardised Mortality Ratio (HSMR)

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

The most recent HSMR covers the period to Jun 2025 (covering Jun 24 to May 25) and is reported as follows:

Crude mortality rate 2.72%. (Observed deaths 1728, expected deaths 1595)

HSMR: 108.36

The HSMR remains higher than would be expected and it is unclear at present as to what might be contributing to this. We are continuing to look at the hospital mortality coding to understand potential influences on this rate, and to understand the variability of the reported rate over time. The rolling 12-month HSMR continues to trend downwards.

Figure 5 shows our position in relation to other trusts, figure 6 shows we remain outside expected limits however have moved closer to the upper limit. Figure 6 shows the HSMR on a month by month basis. The overall trajectory is down, there was a marked decrease in December the reason for this is unclear.

Figure 5. HSMR (to May 2025) – in comparison with other Trusts – Y&S Trust :light blue bar

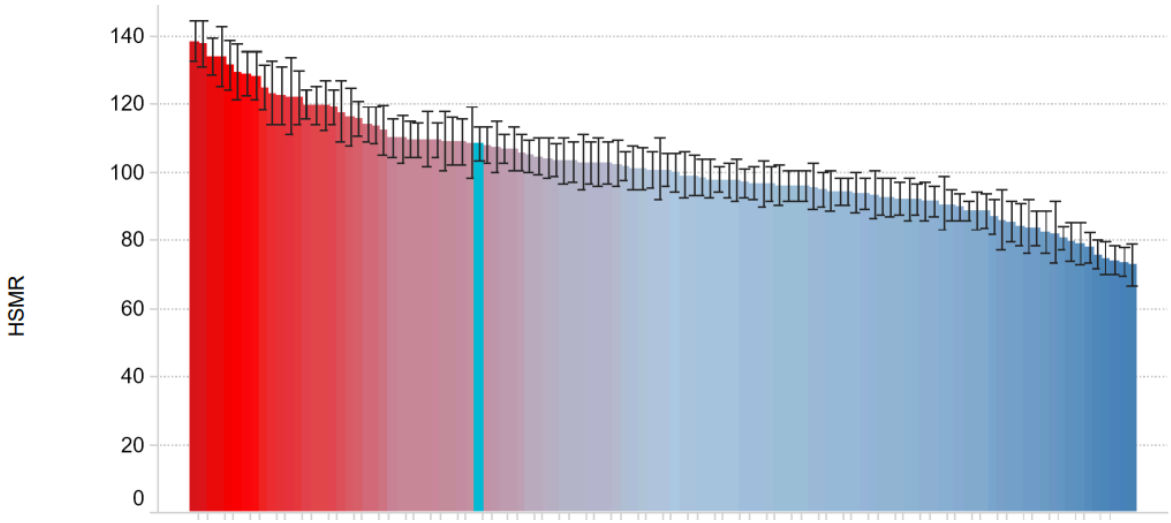


Figure 6 HSMR Funnel Plot (to May 2025)

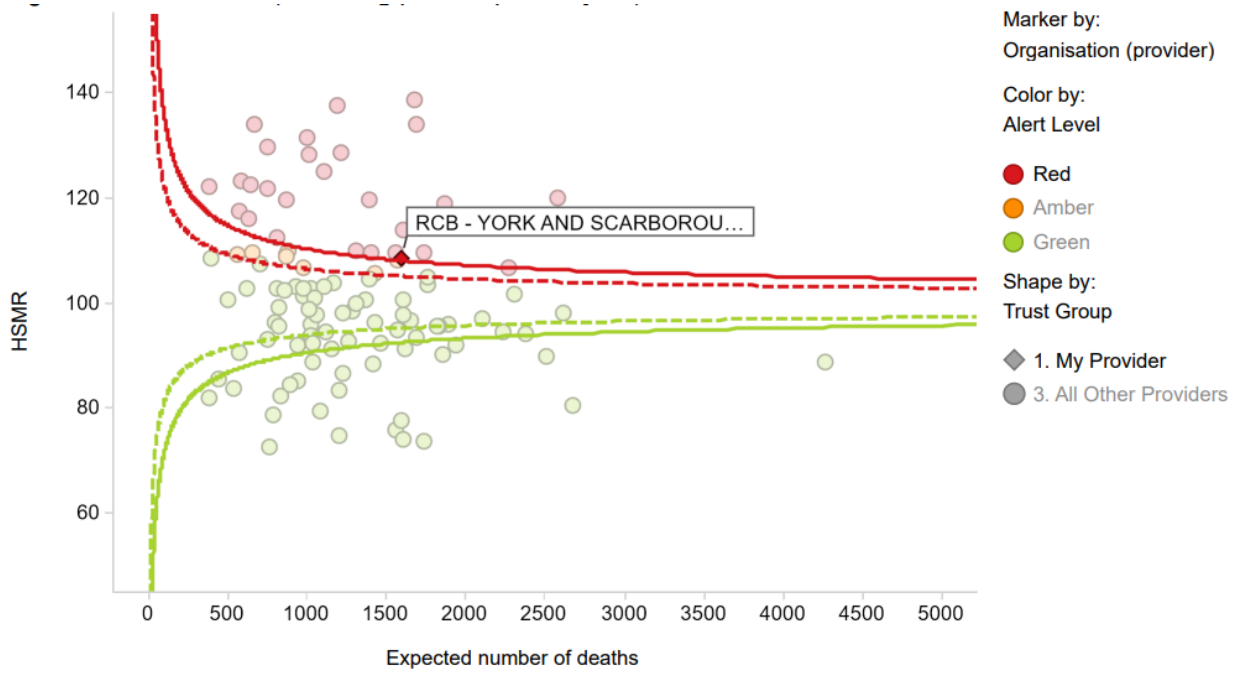
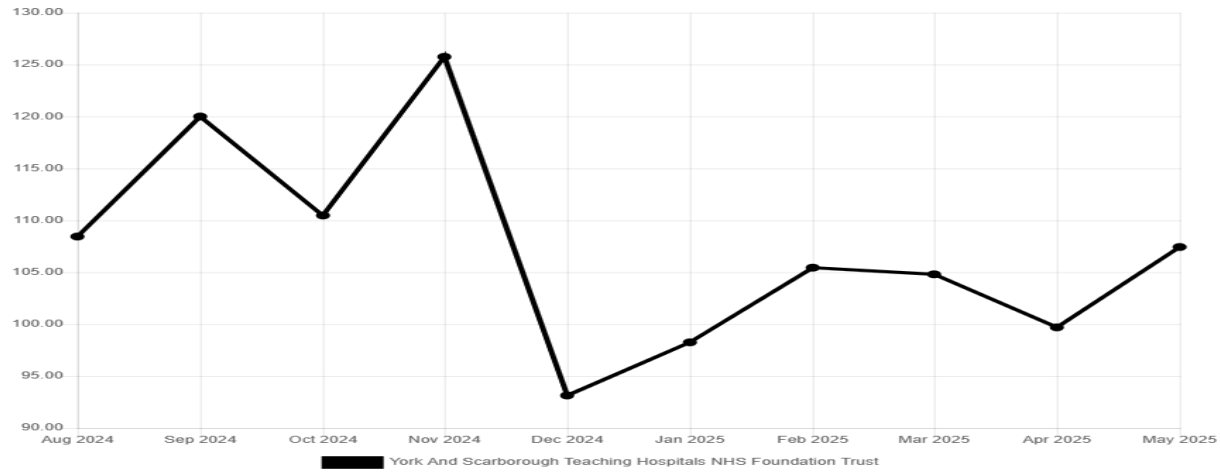


Figure 7 HSMR Time series data



2. Diagnostic groups most contributing to our mortality rates

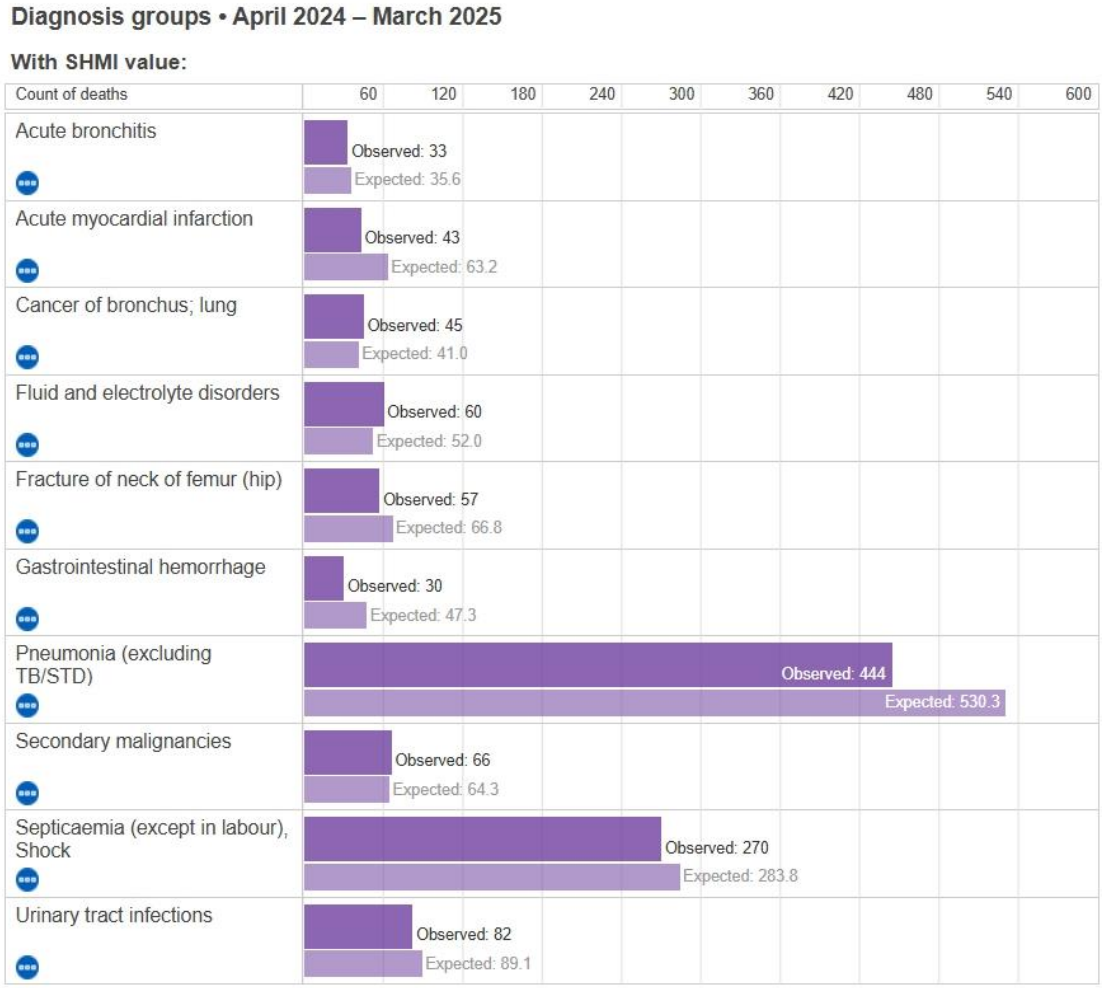
There are 144 diagnostic groups that contribute to the NHS-Digital SHMI aggregate to give each Trust an overall SHMI value.

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

The most recent breakdown of differential SHMI for common diagnostic groups is displayed in Figure 8 below. At present there remain no diagnostic groups causing concern, however this data does triangulate with other patient safety work that we are undertaking. Acute

bronchitis no longer has more deaths than expected so our coding is improving. We may need to look at why having less deaths due to heart attack / pneumonia than expected and is this related to coding or is because our care is better than expected.

Figure 8: SHMI associated with various diagnostic groups (from HES data)



3. Learning from Deaths

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

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

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

Whilst the report focuses on quarter 3 data, some information is provided for quarter 1 and 2 for comparison.

3.1 Nationally mandated data and information

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

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

Table 1 – National data summary

	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 4 (24/25)			Quarter 1 (25/26)		
Total in-patient deaths (inc ED, exc community)	160	179	200	195	216	200	257	211	253	196	187	178
No. SJCRs commissioned for case record review[1]	7	2	4	2	7	11	6	4	7	5	7	3
No. PSII commissioned of deceased patients	1	0	0	2	0	0	0	2	1	2	2	2
No. deaths likely due to problems in care	See tables below		See tables below								See tables below	

1 The SJCRs are those requested in month (adjusted to account for reassignments; and including deaths from 24/25).

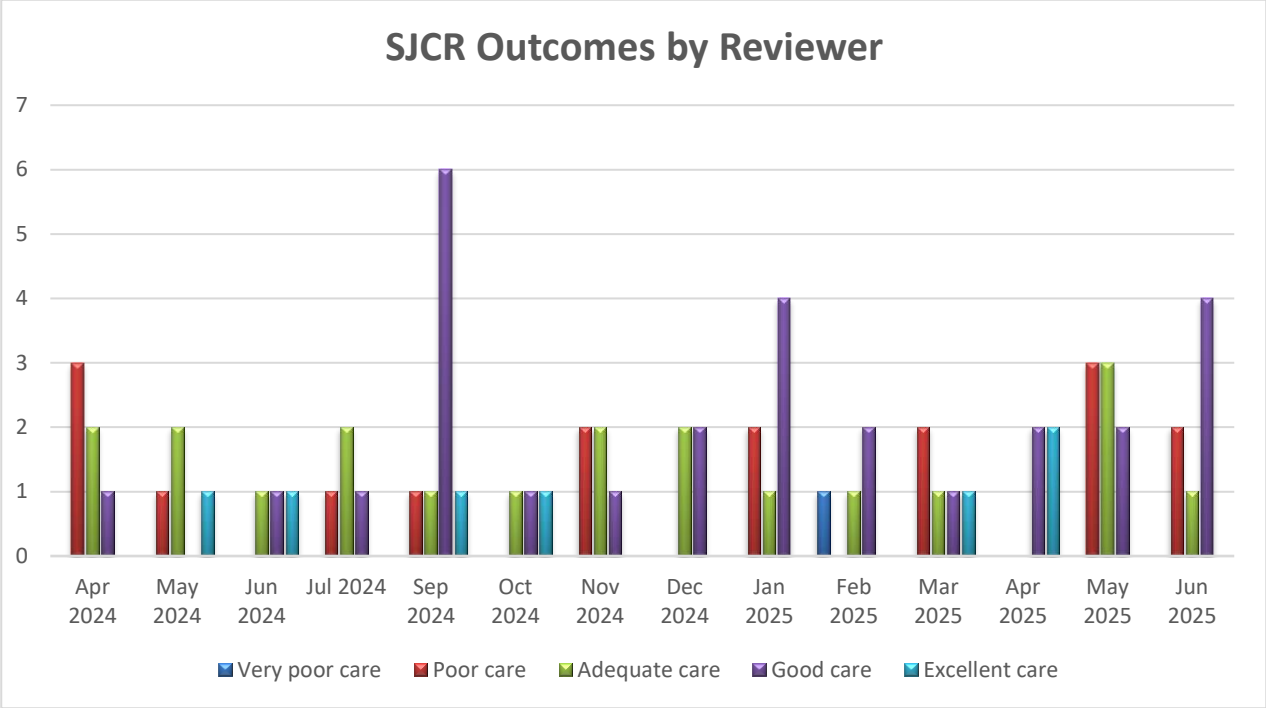
National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Figure 6 shows the outcomes of the SJCRs **completed and reviewed** during Q1, Q2, Q3, Q4 in 24/25 and Q1 in 25/26:

- Figure 6 - the 'overall score' provides the rating from the Reviewer based on their assessment of care during the last admission.
- Figure 7 - the 'degree of harm' agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q1 19 SJCRs were reviewed (16 in Q4):

Figure 6 – SJCR outcomes assigned by the Reviewer (overall score)



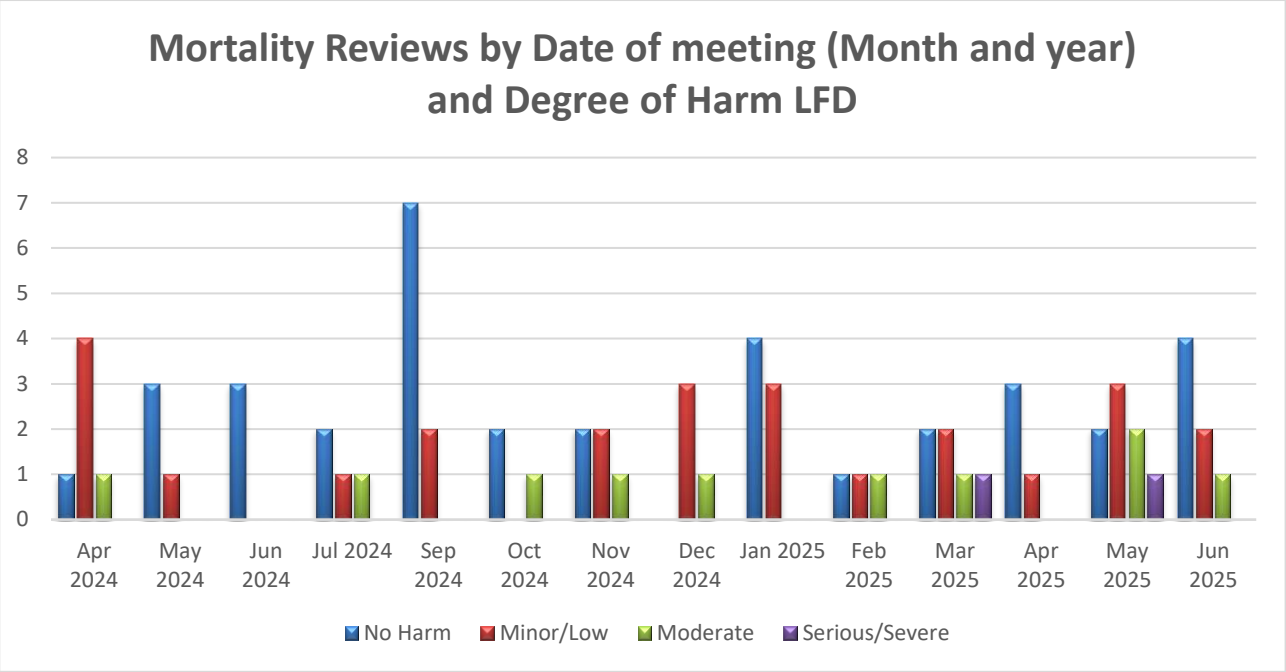
- The overall care score was given in 19 cases.

The Reviewer found there to be:

- Good care in 8/19 cases.
- Excellent care in 2/19 cases
- Adequate care in 4/19 cases
- Poor care in 5/19 cases
- Very poor care in 0/19 cases

The LfD group will decide on the level of harm for the SJCRs presented. The degree of harm levels are No harm, Minor, Moderate, Severe and Death.

Figure 7 – SJCR outcomes following review by LfD Group (degree of harm)



The Learning from Death Group agreed harm leading to death in 0 cases, severe in 1 case, moderate harm in 3 cases, low in 6 of the cases and no harm in 9 cases.

Incident 4000 was agreed Severe harm at the LFD and later discussed at Q&S.
The review identified missed opportunities in patient care, particularly regarding platelet transfusion resistance and lack of haematology involvement before surgery. Documentation gaps and unclear responsibility for care post-operatively were noted, alongside equipment issues. The overall care was rated as poor by LFD due to these multiple lapses. The SJCR was discussed at Q&S, it was updated that the coroner had signed of the case as natural causes, PSII was not required.

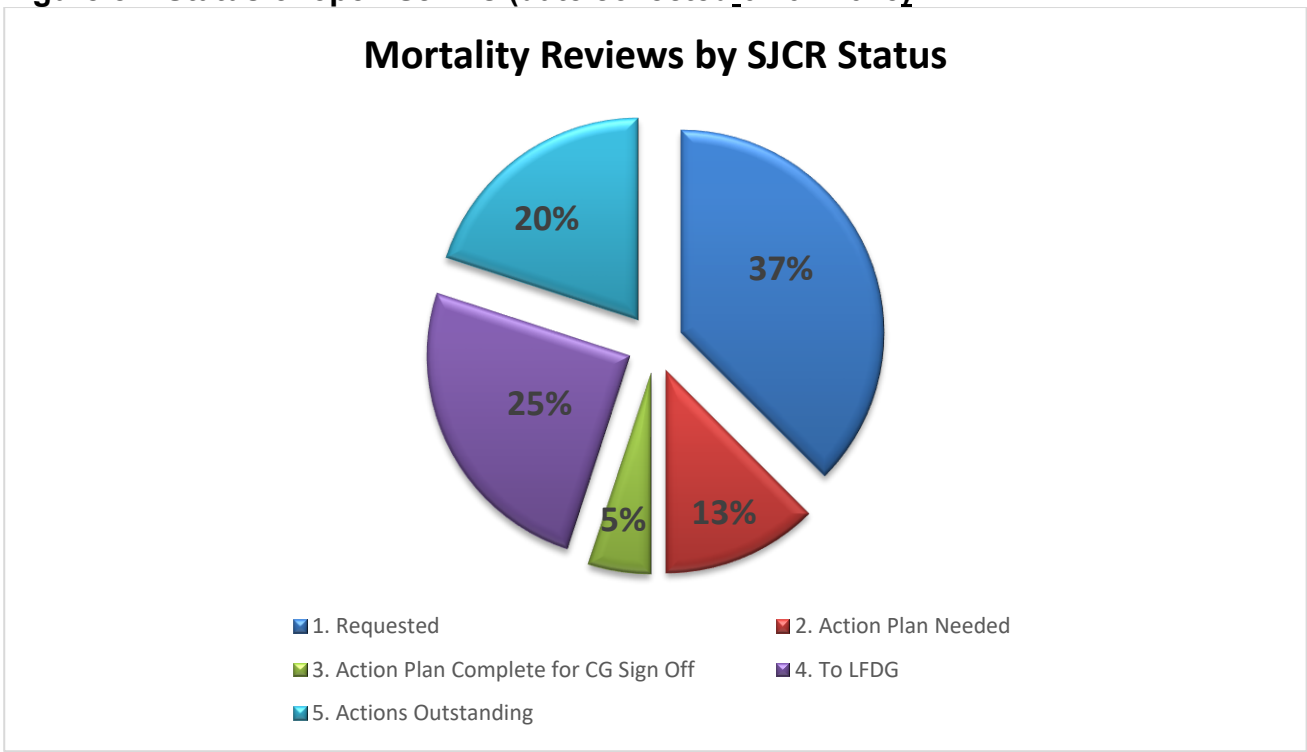
3.2 Locally mandated data

Trust policy requires that the national data is supplemented with locally mandated data to provide a richer picture of performance now Medical Examiners review all deaths; and the timely completion of structured judgement case-note reviews.

Data on progress of investigations at point of reporting (04/07/2025)

Overall no. of SJCRs open 40 (previously 36 as of 24/04/2025)

Figure 8 – Status of open SJCRs (date collected 04/07/2025)



	Q2 (24/25)	Q3 (24/25)	Q4 (24/25)	Q1 (25/26)
Number under review	20	24	17	15
Awaiting action planning	4	4	3	5
Actions outstanding	3	3	1	8
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	18	12	9	8

The status of requested SJCRs has decreased further from previous Quarters. SJCR training is now provided, the first training was delivered in March ’25 and likely a contributing factor to the decrease this month. If the training has the aimed impact we should see these figures continue to decline.

3.3 Quality account data

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The data relates to regulation 27.

Table 2 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2025/26. (please note that the numbering of these relate to the numbering dictated by the Quality Account Report which is why they differ from the rest of the report.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2024/25 but were investigated during 2025/26 and hence not reported in the 2024/25 Quality Account.

	Requirement	**Q1 25/26**			
27.1	Total number of in-hospital deaths	561			
27.2	No. of deaths resulting in a case record review or PSII investigation (requested reviews of patients who died in 24/25 or 25/26)	ME:561			
		SJCRS: 15			
		PSII:6			
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 24/25)	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: 6			
		PSII:5			
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	0			
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	0			

[1] This is where the degree of harm after investigation / SJCR is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group
[2] Reviews completed in 2025/26 after the 2024/25 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. The numbering of these are based on the Quality Account

4. Learning from Deaths - themes and actions

There are certain categories of deaths where a full review is automatically expected:

a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth
d. Stillbirths or perinatal deaths

Local PSII investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs.

The national LfD Framework requires SJCRs to be undertaken when the following criteria are met:

- Where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- Where a patient had a learning disability or severe mental illness.
- Where an 'alarm' has been raised e.g. via an elevated mortality alert, audit or regulator concerns.
- Where people are not expected to die, e.g. elective procedures.
- Where learning will inform the provider's existing or planned improvement work.
- A further random sample of other deaths so that providers can take an overview of where learning and improvement is needed most overall.

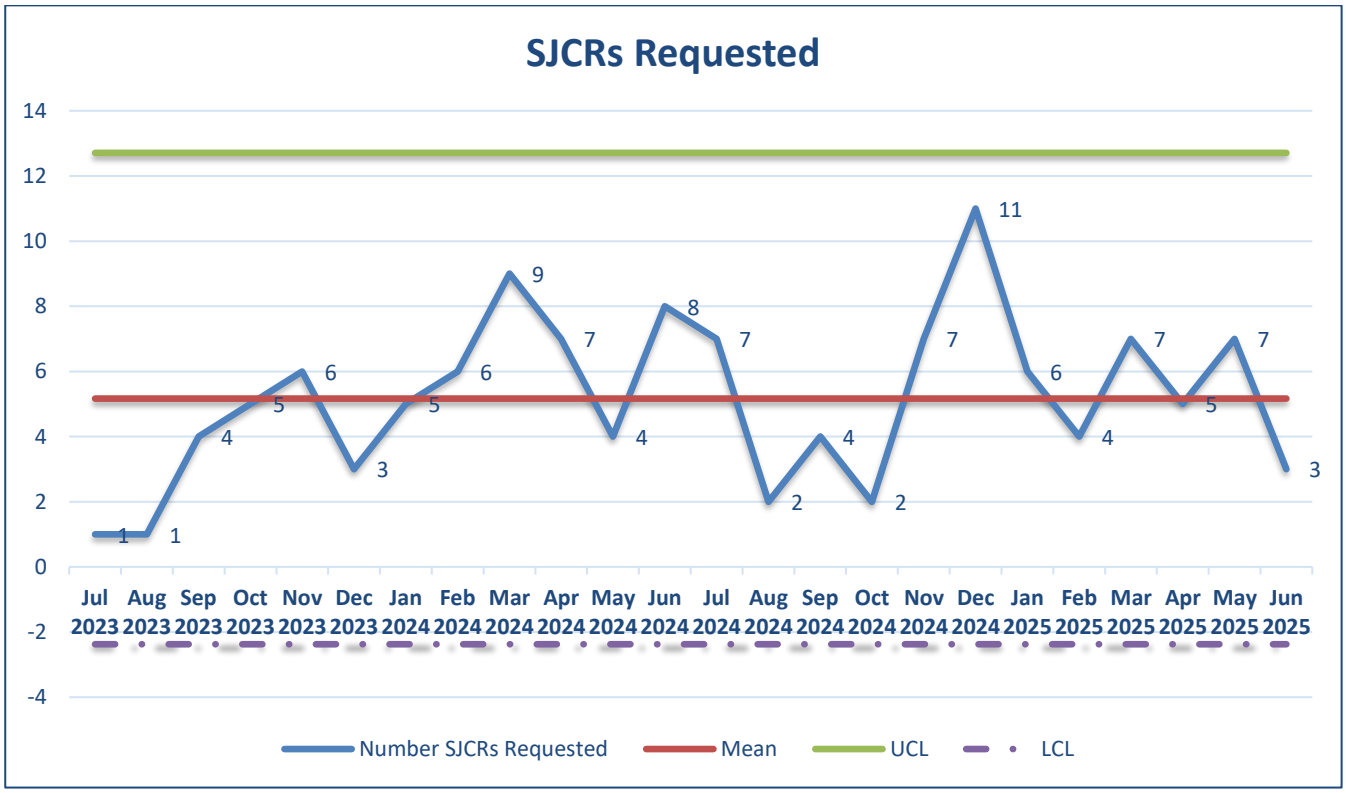
Table 3 below shows the source of SJCR requests for 2024/25 Q2, Q3 and Q4 and 2025/26 Q1; it should be noted that there can be more than one source, however, to avoid duplication only the original inputted source is considered.

Table 3 – Source of request for SJCR

SJCR Request Source	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
1. Care Group	3	2	1	1	3	8	3	1	6	3	3	1
2. Learning Disabilities	4	0	1	1	1	1	0	0	0	1	2	2
3. Medical Examiner Review	0	0	1	0	3	2	2	1	0	0	0	0
4. NoK Concern/ Complaint	0	0	1	0	0	0	0	1	0	0	0	0

5. Initial Mortality Review	0	0	0	0	0	0	0	0	0	0	0	0
6. Elective Admission	0	0	0	0	0	0	0	0	1	1	1	0
7. Q & S	0	0	0	0	0	0	1	0	0	0	1	0

There were 13 requested SJCR's in Q2, 20 in Q3 and 16 in Q4 24/25. 15 were requested in Q1 25/26



4.1 Themes from SJCRs considered by the LfD Group in Q1:

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work.

The introduction of DCIQ and the mortality module has meant that themes and trends identification has had to be updated. During the creation of the mortality module, it was decided that themes would be based on the same ones as the other modules in DCIQ to allow cross comparison and triangulation of data when required.

The themes are identified within the Learning from Deaths meeting. These themes identified are shown in Table 4.

Table 4 – Themes identified

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-26	Apr-25	May-25	Jun-25
Acting on Results	0	0	0	0	0	0	0	0	0	0	0	0
Capacity/Demand	0	0	0	0	0	0	1	1	0	0	0	0
Clinical Assessment	0	0	0	0	0	0	0	0	2	0	0	0
Communication/Documentation	0	0	0	0	0	3	2	1	1	2	4	1
Escalation	0	0	0	0	0	0	0	0	1	0	1	2
Learning Disabilities	0	0	1	0	0	0	0	0	0	0	0	0

Nutrition and Hydration	0	0	0	0	0	1	0	1	0	1	0	0
Pathways/Process	0	0	0	0	0	1	2	0	0	0	3	0
No themes identified	0	0	7	0	1	0	3	0	2	2	1	2
Not listed	0	0	0	0	0	1	0	1	2	0	1*	1
Team Factors	0	0	0	0	0	0	1	0	0	0	0	0
Transfer Issues	0	0	0	0	0	0	0	0	0	0	0	1

*Inappropriate tests carried out
**Senior decision making,
recognising the dying pt.

5.0 Escalations & Learning

5.1 Maternity update Q1

Two antepartum stillbirths (twins at 32+5 weeks) occurred within the Trust and will be reviewed using the perinatal mortality review tool.

5.2 Learning from deaths group overview

April 2025

The Internal Audit on Learning from Deaths was presented during the meeting and Significant assurance was given; all recommended actions have been completed and closed.

Due to attendance constraints, not all SJCRs scheduled for discussion could be addressed. There were no SJCRs identified as poor or below standard in this session.

Feedback was provided on SJCR training, and a review of the master list of SJCR-trained staff has been conducted. Care Group support has been requested to ensure this list remains current.

No escalations were reported.

May 2025

SHMI case-adjusted mortality data shows improvements, with York performing better than Scarborough. LeDeR and safeguarding updates were provided, noting a positive position for SJCRs and reminders for cases 3313 and 4009.

Safeguarding Annual report themes:

MCAs

There have been two completed safeguarding adult reviews that highlighted missed safeguarding opportunities for both patients.

There were 3 Poor Care SJCR's discussed at LFD, these have all been to Q&S:

1. 3080 Rated as poor care with moderate harm. Referred to the End of Life (EOL) group for further discussion. Action to improve joined-up care will be added
2. 2702: Rated as poor care (changed from very poor), low harm. Action to ensure documented plans are followed up and actioned
3. 2517: Rated as poor care with moderate psychological harm. Action to improve communication and documentation

No escalations were reported.

June 2025

LeDeR and safeguarding update

NM talked through the report attached to the agenda.

- 12 LeDeR reviews, 8 pending and 4 awaiting a review.
- 3 domestic homicide reviews upcoming.

There were 3 Poor Care SJCR's discussed at LFD, these have all been to Q&S:

1. 3516: This SJCR was discussed at Q&S in May prior to Junes LFD. No harm was agreed, and escalation was highlighted as a theme. The overall care rating of poor was agreed as the deteriorating patient policy was not followed.
2. 2643: Moderate harm was agreed, and the overall care rating was discussed and asked to be changed from adequate to poor. Discussed at Q&S and to be shared with surgery Care Group. Poor compliance with MCA.

Escalations from the meeting:

- Treatment escalation plans.
- Senior decision making.
- Multiple ward moves.

6. Service developments

6.1 Internal Audit

The audit aimed to provide assurance that the Trust has a robust mechanism for collating, validating, and reporting data related to mortality, scrutinises the available data to identify and understand variations, and takes appropriate action to address potential issues. Significant Assurance was given and all recommendations from the Audit were completed by the target date 30th April 2025.

Key Points:

- **Objective and Scope**: The audit's objective was to ensure that the Trust has effective mechanisms for managing mortality data. The scope included a thematic review across several NHS Trust clients, focusing on mortality governance as a key priority for Trust boards.
- **Significant Assurance**: The audit provided significant assurance on the mechanisms in place for collating and reporting mortality data. While the system is generally well-designed, there may be some weaknesses that need to be addressed.
- **Data Collection and Reporting**: Data is collected and reported in line with National Quality Board requirements. The Trust recorded 3245 actual deaths compared to 3315 expected deaths from June 2023 to May 2024, indicating it was not an outlier compared to similar providers.
- **Mortality Data and Trends**: The Trust's Summary Hospital Mortality Indicator (SHMI) value was 0.98, categorized as expected. The Board of Directors receives monthly data on mortality rates, including SHMI, as part of the Trust's Priorities Report.

Recommendations:

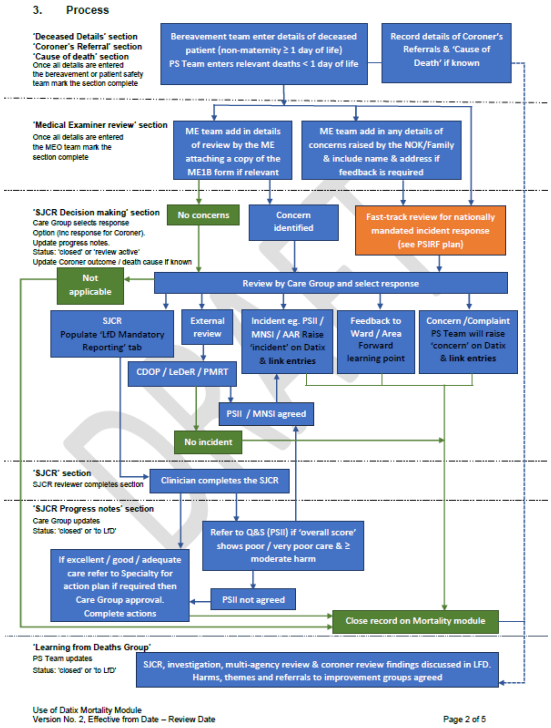
- **Review and Update Terms of Reference:** The Learning from Deaths Group's Terms of Reference should be reviewed and updated to reflect changes in membership and reporting lines.
- **Attendance of Group Members:** Individuals listed in the Terms of Reference as Group Members should attend the Learning from Deaths Group meetings.

- **Policy Updates**: The Learning from Deaths Policy should be updated to include guidance on obtaining legal advice for families, as set out in the National Quality Board's guidance.

6.1 Use of Datix Mortality Module

This was approved in the May's LFD meeting.

The aim of the Standard Operating Procedure (SOP) is to support the use of the Mortality module in Datix to manage the Learning from Death processes for the Trust.
The procedure supports the implementation of the Learning from Deaths (LfD) Policy and the Patient Safety Incident Response Framework (PSIRF). It requires details of all patients who have died within the Trust to be recorded on the mortality module; and for those records to be updated following statutory review by the Medical Examiner or following referral to the Coroner. The mortality module will be used by Care Groups to instigate any further review or investigation deemed necessary as per the Policy and in line with the PSIRF. It will also facilitate onward monitoring by Care Groups and oversight by the Learning from Deaths Group.



7. References

1. Crude Mortality rate is the percentage of patients that died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.
2. NHS-Digital SHMI: SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England. The methodology is transparent, reproducible and sensitivity analysis of SHMI model had been carried out independently. The indicator is produced and published monthly by NHS Digital. University Hospitals Birmingham (UHB) is actively involved in developing and constructing SHMI as a member of Technical Working Group. In comparison to Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster, there are a few of key advantages advocating the use of SHMI -

a. SHMI methodology is completely open and transparent. It is reproducible by third parties and less confusion has been caused within NHS hospitals compared to HSMR.
b. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital, whereas the HSMR only includes 80% of in hospital deaths.
c. SHMI does not account for palliative care (published as a contextual indicator instead) in the model due to coding issues. It could largely reduce the chance of gaming by coding more palliative care to reduce mortality ratio.
d. Death is only counted once in SHMI to the last discharging acute provider. HSMR will attribute one death to all the providers within a chain of spells which are linked together due to hospital transfer (i.e., superspell if existing).

However, due to the limitations of administrative datasets (lack of clinical information in SUS/HES), SHMI-type indicators **cannot** be used to quantify hospital care quality directly and count the number of avoidable deaths.

HED's SHMI (NHSD) Module is built on the *SHMI Dataset* which is created by NHS Digital on a monthly basis. The dataset only includes necessary data fields for the purpose of validating SHMI model.

3. HES-SHMI: The HED team replicate the SHMI methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED SHMI (HES-based) module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more timely and detailed manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets.

SHMI (NHSD) vs. SHMI (HES-based)

1. SHMI (NHSD) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.
3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.

Item 19

Report to:	Trust Board
Date of Meeting:	24 September 2025
Subject:	Annual Medical Appraisal and Revalidation Update
Director Sponsor:	Dr Karen Stone, Medical Director and Responsible Officer for York and Scarborough Teaching Hospitals NHS Foundation Trust, St Leonard's Hospice and St Catherine's Hospice Scarborough
Author:	Paul Whittle, Appraisal and Revalidation Specialist, Medical Directorate Dr Oliver Prince, Medical Appraisal Lead Rob Newton, Associate Director, Medical Directorate

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:

As a Designated Body, the Trust has responsibilities regarding appraisal, revalidation and professional standards of doctors in its employment. The Trust's Medical Director acts as the organisation's Responsible Officer for medical regulation. An increased focus on improving processes and systems in these areas has been put in place by the

Responsible Officer. On 31 March 2025 the Trust achieved 84% compliance for medical appraisal.

Recommendation:

Trust Board is asked to:

- Note the information provided on medical appraisal and revalidation
- Note the ambitions and plans for improvement in in these areas
- Confirm commitment to supporting the discharge of the duties of the Responsible Officer within the Medical Act.

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

Appraisal and Revalidation Update

1. Introduction and Background

Every licensed doctor who practises medicine must revalidate every five years and should have an annual appraisal. The General Medical Council's (GMC) aims for medical revalidation are that it:

- enables licensed doctors to demonstrate that they are up to date and fit to practice
- supports doctors in their professional development, contributes to improving patient safety and quality of care and sustains and improves public confidence in the medical profession
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors

To achieve these aims, the GMC requires that all doctors identify the Designated Body (usually their employer) that monitors and assures their practice. As of 31 March 2025, York and Scarborough Teaching Hospitals NHS Foundation Trust was the Designated Body for 758 doctors. The Trust's Medical Director also acts as Responsible Officer for doctors employed by St Leonard's Hospice, St Catherine's Hospice and Brainkind. The Trust also provides appraisal for clinicians registered with the General Dental Council. Designated Bodies have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations. It is expected that Boards oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisation
- checking there are effective systems in place for monitoring the conduct and performance of their doctors.
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors and
- ensuring that appropriate pre-employment background checks are carried out to the required standard.

This report provides information about how these duties have been discharged and improvement actions for the next twelve months.

2. Medical Appraisal

2.1. Appraisal Process

Doctors are assigned an appraiser by the Revalidation Team. Both parties can request a change in cases of conflict of interest. Appraisees usually stay with the same appraiser for three years and have a maximum of three appraisals with the same appraiser over a six year period. Appraisals can be completed in person or online. The record of appraisal and supporting documentation is held on an online system called L2P.

Appraisees are encouraged to have at least one appraisal per revalidation cycle with an appraiser from a different specialty. To this end, Appraisers are allocated according to availability.

System-generated emails and formal reminder letters are sent at set intervals to encourage completion of appraisal. Care Group management teams are provided with monthly appraisal completion data and this forms part of Care Group accountability reporting.

2.2. Appraisers

Dr Oliver Prince, Specialty Doctor (Anaesthetics) is the Trust's Medical Appraisal Lead. Doctors are required to attend appraiser training to become a Medical Appraiser and existing Appraisers are required to attend annual CPD update training.

There are currently 84 active medical Appraisers within the Trust. Appraisers are expected to complete 6-10 appraisals per year. It is estimated that 115 Appraisers are required with time assigned in their job plans to facilitate timely appraisal for the 750-800 doctors who are assigned to the Trust as their Designated Body[1].
During the past 12 months doctors and dentists have not been able to access timely appraisal due to the shortage in appraiser availability. The shortfall has in large part been filled by Appraisers who go beyond their expected 10 appraisals a year by taking on additional appraisees and responding to individual requests for doctors who need an appraisal at short notice. In addition, during this year a streamlined appraisal process has been introduced for locally employed and bank doctors to reduce the demand on trained Appraisers.

Appeals for new Appraisers are regularly communicated to doctors across the Trust with regular New Appraiser training organised. Care Group Directors and Clinical Directors have been provided with information about the appraiser time made available from their specialties; 15-20% of senior doctors and dentists are required to be Appraisers to achieve the 115 Appraiser target. The majority of doctors who are trained Appraisers have been assigned job planned time but there are currently 19 trained Appraisers who have not been able to have time assigned for appraisal.

2.3. Appraisal Completion Rates

	Number of appraisals	% of appraisals
Total number of doctors with a prescribed connection as of 31 March 2025	738	
Total number of appraisals undertaken between 1 April 2024 and 31 March 2025	621	84%
Total number of appraisals not undertaken between 1 April 2024 and 31 March 2025	117	17%
Total number of agreed exceptions	81	11%
Total number of not agreed exceptions	36	5%

The appraisal completion rate has dropped from 90% in 2024/25 to 84% in 2024/25. This is due to a rise in the number of people with agreed exceptions. This includes people who have not been assigned an appraiser, or are new to the organisation without record of a prior appraisal, or have a period of absence, or experienced a delay due to the change in online system from Prep to L2P. The number of not agreed exceptions has decreased from 54 in 23/24 to 36 in 24/25; these include people who have been assigned an Appraiser within timescales but have not completed an appraisal.

[1] Due to doctors joining and leaving the Trust and doctors moving between training and non-training posts the number of doctors with the Trust as their designated body fluctuates throughout the year.

The change which would make the biggest difference to improving appraisal completion and achieving the target of a minimum of 90% in 2025/26 is more trained Appraisers and more trained Appraisers with job planned time assigned.

2.4. 2024/25 Activities

During the last 12 months the following activity has taken place with regard to Medical Appraisal:

- Procurement and implementation of new L2P Appraisal system, with associated transfer of records
- Design and implementation of a new process for Locally Employed and Bank Doctors, including a streamlined proforma and appraisals undertaken by an Educational or Clinical Supervisor, senior clinician or trained Appraiser.
- Commencing of assurance processes of appraiser activity including feedback to the appraiser
- 3 New Appraiser and 8 Annual Update Training sessions.
- Recruitment of 14 new Appraisers. 7 of whom have had time allocated in their job plan.
- Advertisement and promotion of the Appraiser role to doctors and Medical Leaders
- 10 Appraisers surpassing a cumulative total of 100 Appraisals
- Refresh and Renewal of Medical Appraisal Policy
- Approaching doctors retiring from clinical practice to continue to work or begin work as Medical Appraisers
- Communication with Care Group Clinical Directors and Ops Managers to highlight the appraiser shortage and encourage Job Plan amendments for those already trained as Appraisers without additional SPA and encourage clinicians within their Care Group to become Appraisers

2.5. 2025/26 Improvement Plan

Objective	Action
1. Embedding of L2P Appraisal System	• Continued improved utilisation of existing system including appraiser allocation, reporting, quality assurance and education.
2. Increase the recruitment, retention and utilisation of Appraisers	• Increase communication regarding appraiser recruitment and training • Review appraiser contributions in job planning withing specialties and care groups • Recognition of appraisers who complete a high number of appraisals • Opportunities to continue appraisal for recently retired doctors
3. Improve the timeliness and usefulness of appraisal for Locally Employed Doctors	• Implement adapted appraisal documentation for Locally Employed Doctors • Embed system for more Educational/Clinical Supervisors and senior clinicians to complete appraisal with Locally Employed Doctors
4. Support the improvement in quality of appraisals	• Re-establish system of quality assurance of appraiser activity with feedback to individual Appraisers • Support and educate Appraisers to ensure that the whole scope of a doctors practice is reviewed.

	• Explore potential for partner Trust(s) for peer review
5. Promote opportunities for appraisal to support improvements in care quality and safety	• Guidance on quality improvement activity for appraisers and appraisees. • Continue to promote appraisal as a tool for personal development and reflection

3. Medical Revalidation

3.1. Revalidation Recommendations

Revalidation recommendations are reviewed weekly by the Deputy Medical Director (Professional Standards) and the Appraisal and Revalidation Specialist. Doctor's portfolios are reviewed as to whether they have sufficient evidence to be recommended for revalidation. Where they have sufficient evidence, a positive recommendation is made to the GMC.

If the doctor doesn't have sufficient evidence at the time of recommendation, then their recommendation may be deferred. On rare occasions, doctors do not engage with the appraisal process despite multiple interventions from the Medical Directorate Team. In these cases, a non-engagement notification is made to the GMC, which is a serious intervention and significant efforts are made to avoid this.

For 2024/25 the deferment rate for the Trust was 8% (down from 11% in 2023/24), compared to a national average of 15%.

The most common reason for deferment is a lack of patient and colleague feedback. This should improve with the recent change in the software used for this feedback. The appraisal and revalidation team continue to set the expectation that feedback should be collected during years two and three of the revalidation cycle.

4. Recruitment and Engagement Background Checks

All doctors employed by the Trust are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including bank and locum doctors.

5. Maintaining High Professional Standards (MHPS)

A weekly Responsible Officer Advisory Group is in place, chaired by the Medical Director and attended by a HR advisor, Deputy Medical Director, an Associate Medical Director and Associate Director (Medical Directorate). This group reviews doctors who require investigation, action or support by the Trust internally or by the GMC or for matters concerning conduct, capability and health. Action is taken in accordance with the Trust's disciplinary policies. Where relevant and appropriate, the Board is updated about cases through the Board's Reportable Issues Log. The Responsible Officer maintains regular contact with the GMC's Employee Liaison Adviser and NHS Resolution Practitioner Performance Advice when appropriate.
In 24/25 there has been a significant increase in MHPS cases that has created an unprecedented workload for the Responsible Officer. A Non-Executive Director has responsibility for overseeing the processes and meets monthly with the RO to receive updates on case management. The number of open cases with the GMC creates a further impact on the ROs time as they come to Tribunal hearings. It is anticipated that this will start to impact towards the end of 2025.

6. Policy

The GMC publishes 'Good Medical Practice', which sets out the standards of patient care and professional behaviour expected of all doctors in the UK, across all specialties, career

stages and sectors. These standards have been updated and updated guidance came into effect on 30 January 2024. The GMC also publish supportive guidance.
The Medical Appraisal Policy was reviewed and approved in August 2025.

Cases involving doctors are managed under the Maintaining High Professional Standards Framework, and the Trust's Conduct and Disciplinary Policy and the Civility, Respect and Resolution Policy.

7. Recommendations

Trust Board is asked to:

- Note the information provided on medical appraisal and revalidation
- Note the ambitions and plans for improvement in in these areas
- Confirm commitment to supporting the progress of this work

Dr Karen Stone
Medical Director
Responsible Officer

Date: 28 August 2025

Report to:	Board of Directors
Date of Meeting:	24 September 2025
Subject:	Emergency Preparedness, Resilence and Response Core Standards Annual Assurance – Action Plan Progess
Director Sponsor:	Accountable Emergency Officer - Claire Hansen
Author:	Head of EPRR – Richard Chadwick

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The Emergency Preparedness, Resilience and Response Core Standards Annual Assurance process was completed in Dec 2024. The Board of Directors approved the assurance submission of 56% of the standards being fully compliant in Feb 25 which achieved an organisational grading of NON-COMPLIANT.

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

The assessment in Aug 25 of the 62 standards results in 81% being classified as fully compliant and the organisational grading remaining NON-COMPLIANT. It is assessed

that by Sep 25, when the annual assurance is required to be submitted to NHS E, the compliance rate will be 85% attracting an organisational rating of PARTIAL compliance.

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

Recommendation:

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Resource Committee	20th May 25	Noted
Board of Directors	21st May 25	Noted
Resource Committee	19th Aug 25	Noted

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS – ACTION PLAN PROGRESS REPORT

1. Introduction and Background

NHSE conduct an annual assurance of the Emergency Preparedness Resilience and Response Core Standards. There are 62 core standards that are grouped into the 10 domains of: Governance, Duty to Risk Assess, Duty to Maintain Plans, Command and Control, Training and Exercising, Response, Warning and Informing, Cooperation, Business Continuity and Chemical, Biological, Radiological and Nuclear. The overall assurance organisational grading is determined as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

2. Current Position

The annual assurance for 2024-2025 was conducted within a robust governance and assurance framework coordinated by the Emergency Preparedness, Resilience and Response at the Integrated Care Board as follows:

Date	Action
By 30 Sep 24	Trust submit 1st draft to Integrated Care Board
08 Oct 24	Trust submission subjected to peer review
31 Oct 24	Trust final submission to Integrated Care Board
15 Nov 24	Integrated Care Board and Trust Accountable Emergency Officer confirm Trust submission
19 Nov 24	Local Healthcare Resilience Partnership confirm all Trust submissions within the Integrated Care Board
20 Nov 24	Integrated Care Board submit report on system compliance as part of Regional Emergency, Preparedness, Resilience and Response Team assurance process
02 Dec 24	Regional Healthcare Resilience Partnership confirm final Integrated Care Board submissions in the North East and Yorkshire Region
20 Dec 24	Regional Emergency Preparedness, Resilience and Response Team submit North Region Emergency Preparedness, Resilience and Response Core Standards report to NHS England national team
25 Feb 25	Trust Board of Directors endorse Annual EPRR report

The annual assurance for 2024-2025 reported the following:

Domain	Core Standards			Total
	Fully Compliant	Partially Compliant	Non-Compliant	
Governance	4	2	0	**6**
Risk Assessment	0	2	0	**2**
Duty to Maintain Plans	6	3	2	**11**
Command & Control	2	0	0	**2**
Training & Exercising	4	0	0	**4**
Response	7	0	0	**7**
Warning & Informing	1	3	0	**4**
Cooperation	2	2	0	**4**
Business Continuity	5	5	0	**10**
CBRN	4	8	0	**12**
Total	**35**	**25**	**2**	**62**

This is a fully compliant rating of 56% against total standards and therefore remains NON-COMPLIANT as an organisational rating.

3. Action Plan Progress

The action plan to remediate the partially and non-compliant standards is at Appendix 1. Using the progress to date on the action plan it is assessed that the change to gradings against the annual assurance reported position as of Aug 25 would be:

Domain	RAG	Feb 25	May 25	Aug 25	Oct 25
Governance	(G)	4	5	5	
	(A)	2	1	1	
	(R)				
Risk Assessment	(G)				
	(A)	2	2	2	
	(R)				
Duty to Maintain Plans	(G)	6	7	9	
	(A)	3	3	2	
	(R)	2	1		
Command & Control	(G)	2	**Completed**		
	(A)				
	(R)				
Training & Exercising	(G)	4	**Completed**		
	(A)				
	(R)				
Response	(G)	7	**Completed**		
	(A)				
	(R)				
Warning & Informing	(G)	1	1	1	
	(A)	3	3	3	
	(R)				
Cooperation	(G)	2	3	4	**Completed**
	(A)	2	1		
	(R)				
Business Continuity	(G)	5	5	8	
	(A)	5	5	2	
	(R)				
CBRN / HAZMAT	(G)	4	4	8	
	(A)	8	8	4	
	(R)				
% of standards assessed as fully compliant		56%	61%	81%	

4. Points to Note On Progress

- **Risk Assessment.** Since the last progress report the Emergency Preparedness, Resilience and Response Risk Management Procedure has been published. The work to migrate the Emergency Preparedness, Resilience and Response risk register to the DATIX platform to allow inclusion in Corporate Operations tracking remains outstanding. This action will be completed this year.
- **Duty to Maintain Plans.** The number of plans that require to be held and reviewed annually is large. The burden on the small EPRR team is significant and action is being taken to move some of the more stable plans to a 2 or 3 year review timetable. The following progress has been made since the last progress report:
    - Trust Incident Plan – Published.
    - CBRN / HAZMAT Plan – Published.
    - New and Emerging Pandemic Plan – Published.
    - EPRR Risk Management Policy – Published.
    - Major Incident Communications Plan – New plan and on internal circulation with Director of Communications.
    - Evacuation Plan – Published.

  There are 3 new plans that require external stakeholder engagement (NHS E, UK Health & Security Agency and Local Authority) that will take time to complete; these are Infectious Disease Plan, Mass Fatalities Plan and the Mass Counter Measures Plan. Drafts of the Infectious Disease and Mass Counter Measures Plan have been completed however the requirement for external stakeholders to add to these drafts may see completion slip into 2026.
- **Warning & Informing.** A draft Major Incident Communications Plan has been written and is with the Director of Communications for review. This plan will be published this year and will ensure compliance with all standards in this domain.
- **Business Continuity.** The Emergency Planning Manager (EPM) has been tasked with the delivery of Business Impact Analyses and developing Business Continuity Plans to departmental level. This is a significant task and will require a bespoke project that may take 12-24 months to complete.
- **Chemical, Biological, Radiological and Nuclear / Hazardous Material.** The plan has been published resulting in several standards becoming fully compliant; work will continue to remediate the outstanding standards. It is likely that this work will be completed this year.

5. Residual Risks

The residual risks to the completion of the action plan are as follows:

- **Emergency Preparedness, Resilience and Response Team Resources.** The Emergency Preparedness, Resilience and Response Team consists of 3 staff members. Competing “non-core” priorities for the team include responding to incidents such as industrial action, conducting training, and exercising to comply with core standards, managing the annual work schedule and running the Emergency Preparedness, Resilience and Response governance and assurance processes. To complete the action plan is a significant task that will take time. Mitigation measures for this risk include:
    - NHS E have rolled out a comprehensive Health Commanders training programme that has reduced the training burden on the team. An audit on the progress of colleagues completing their portfolios as evidence of completion is currently underway.
    - The more stable plans and policies have been moved to 2 or 3 yearly review schedules.
- **Staff Availability.** The development and implementation of plans and then the testing of them through training and exercising of them relies on the availability of clinical and nursing

staff. Operational pressures limit the ability of the Emergency Preparedness, Resilience and Response Team to engage with subject matter experts and then when it is possible, timelines for completion of tasks are protracted. In addition, when individual training programmes are designed, there is a reliance on colleagues taking the opportunity to sign up for those events. Mitigation measures for this risk include:

- Training and exercising is targeted at senior managers and clinicians to minimise disruption on the shop floor. Where operation procedures are required to be tested then longer lead in times to roster staff to activity are considered.
- Work is ongoing to develop training packages that can be delivered on Learning Hub to minimise the time staff take to conduct training and prevent disruption to services. Experience this year has indicated that although the opportunities for individual training have been provided online and in person, the take up from colleagues has been at best limited. This has improved with the introduction of portfolios of evidence of completion of training for Health Commanders and conducting a formal audit process.
- Activity conducted when responding to incidents is being recorded on logs to minimise the need for training and exercising events.

6. Summary

Significant progress has been made in 2025 in developing the Trust readiness to respond to emergency and business continuity incidents. There is much more to do in addition to maintaining the compliant standards already achieved. The formal assurance document is due to be submitted to NHS E on 30 Sep 25. It is assessed that the Trust position will be 85% of standards being fully compliant at that date which will attract an organisational grading of PARTIAL compliance. Much will depend on how the non-core activity through the year, i.e. winter planning and incident management, will distract the Emergency Preparedness, Resilience and Response team.

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

Date: 9th September 2025

Appendix 1 – EPRR Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	ICB Final Grading 2024	Trust Action Plan 2023/2024 Carried Forward	2023/2024 Assessment Recommendations	Trust Action 2025	Actionee	Target Date	Assessed Grade To Date	Remarks / Updates
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	G	Nil					G	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent.	G	Nil					G	
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	A	3 - The EPRR Core Standards Executive Committee and Board of Directors reports need to adher to the NHS E General Observation. (R)		1 - The EPRR Core Standards Executive Committee and Board of Directors reports need to adher to the NHS E General Observation. (G)	RC	Q4 - 24	G	3 - (03/04/2024) This will not change until Board report is submitted. 3 - (14/11/2024) - Carry forward to next years action plan. 1 - (08/04/25) - Complete.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises	G	Nil					G	
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	A	Nil	Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO	2 - Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	RC	Q1 - 25	A	2 - (08/04/25) - RC to speak to KH and see how this can be taken forward in light of Trust challenges and the political NHSE landscape.
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	G	Nil					G	
8	Duty to Risk Assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	A	Please see comments for core standard 7					G	(05/06/25) - CR sent Plan on circulation (deadline is 18/6 after which to EPSG OCC endorsement.
9	Duty to Maintain Plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	G	Nil					G	
10	Duty to Maintain Plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	G	Nil					G	
11	Duty to Maintain Plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	G	Nil					G	
12	Duty to Maintain Plans	Infectious Disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	G	Nil					G	
13	Duty to Maintain Plans	New and Emerging Pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	R	20 - Review the Pandemic Plan in line with national guidance, the national IPC manual and relevant lessons identified from COVID-19. (A)	Write New and Emerging Pandemic Plan	6 - Review the Pandemic Plan in line with national guidance, the national IPC manual and relevant lessons identified from COVID-19. (G) 7 - Write New and Emerging Pandemic Plan (G)	RC RC	Q3 - 24 Q3 - 25	G	20 (03/04/2024) - RC obtained best practice New and Emerging Pandemic Plan and is amending for Trust use and will then authorise through ID WG. 20 (14/11/2024) - Carry forward to 2025 Action Plan. 7 (08/04/25) - SME Circulation deadline 14 Apr 25. 7 (12/05/25) - EPSG OOC endorsement deadline 21 May 25. 7 (05/06/25) - Plan published.
14	Duty to Maintain Plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	R	21 - Capture specific Countermeasures Training in the central training log. (R) 22 - Write a new policy to consider mass vaccination and issue of prophylaxis. (R)		8 - Capture specific Countermeasures Training in the central training log. (R) 9 - Write a new policy to consider mass vaccination and issue of prophylaxis. (A)	CR RC	Q3 - 24 Q4 - 24	A	21 & 22 (14/11/2024) - Carry forward into 2025 Action Plan.
15	Duty to Maintain Plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	G	23 - Publish the Mass Casualty Plan. (A)		10 - Publish the Mass Casualty Plan. (A)	RC	Q3 - 25	G	23 - (12/01/2024) this plan is on the MI working group agenda on 24/01/2024. 23 (14/11/2024) - Mass Casualty Aide Memoire published as an interim solution. Carry forward to 2025 Action Plan. 10 (08/04/25) - Draft sent to PD for review to determine way forward.

Ref	Domain	Standard name	Standard Detail	ICB Final Grading 2024	Trust Action Plan 2023/2024 Carried Forward	2023/2024 Assessment Recommendations	Trust Action 2025	Actionee	Target Date	Arrayed Grade To Date	Remarks / Updates
16	Duty to Maintain Plans	Evacuation and Shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	G	24 - Publish the Evacuation & Shelter Plan. (R)		11 - Publish the Evacuation & Shelter Plan. (R)	RC	Q4 - 24	G	24 (14/11/2024) - carry forward to 2025 Action Plan. 11 (08/04/25) - Ready for circulation.
17	Duty to Maintain Plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	A	25 - Implement lockdown training and exercises to include: a) Both EDs exercising. b) Table Top exercise for BC Leads and Security. (R)	Update the Lockdown Plan	12 - Implement lockdown training and exercises to include: a) Both EDs exercising. b) Table Top exercise for BC Leads and Security. (G) 13 - Update the Lockdown Plan (G)	CR RC	Q2 - 25 Q1 - 25	G	25 - (07/02/2024) Included on EPM work schedule. Query - delay SGH exercise to conduct in new ED. 25 (14/11/2024) - Carry forward to 2025 Action Plan. 12 (08/04/25) - Engagement from E&F proving challenging. 13 (08/04/25) - Lockdown Aide Memoire issued on opening of UECC to provide an interim solution until plan fiully review.
18	Duty to Maintain Plans	Protected Individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	A	26 - Write Trust Protected Individuals Policy. (R)		14 - Write Trust Protected Individuals Policy. (G)	RC	Q2 - 25	G	26 (14/11/2024) - Carry forward to 2025 Action Plan. 14 (08/04/25) - Documents held by CR and from Security and Comms cover the requirement.
19	Duty to Maintain Plans	Excess Fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	A	27 - Write Trust Excess Fatalities Policy. (R)		15 - Write Trust Excess Fatalities Policy. (A)	RC	Q2 - 25	A	27 (14/11/2024) - Carry forward to 2025 Action Plan. 15 (08/04/25) - RC awaiting plan from Christy Rowley which should meet requirement.
20	Command and Control	On-Call Mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	G	Nil					G	
21	Command and Control	Trained On-Call Staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	G	Nil					G	
22	Training and Exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	G	Nil					G	
23	Training and Exercising	EPRR Exercising and Testing Programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	G	Nil					G	
24	Training and Exercising	Responder Training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	G	Nil					G	
25	Training and Exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	G	Nil					G	
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	G	Nil					G	
27	Response	Access to Planning Arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	G	Nil					G	
28	Response	Management of Business Continuity Incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	G	Nil					G	
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	G	Nil					G	
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	G	38 - Include exercising of SITREP process in LIVEX 24 exercise objectives. (R)		16 - Include exercising of SITREP process in LIVEX 24 exercise objectives. (G)	RC	Q2 - 24	G	16 (08/04/25) - LIVEX 24 not in format initially intended. SITREP training included in C2 familiarisation and SILVER Command Post exercise.
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty Events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	G	Nil					G	
32	Response	Access to 'CBRN incident: Clinical Management and Health Protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	G	Nil					G	
33	Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	Nil	Determine 24/7 Comms capability and include in Incident Comms Plan	17 - Determine 24/7 Comms capability and include in Incident Comms Plan (A)	RC	Q3 - 25	A	17 (08/04/25) - Included in draft with Comms Team. 17 - (05/06/25) - Chaser sent to LB.

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34	Warning and Informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	A	40 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (R)	Write Incident Comms Plan	18 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (G) 19 - Write Incident Comms Plan (A)	Comms Team RC	Q2 - 24 Q3 - 25	A	40 (14/11/2024) - Carry forward onto 2025 Action Plan. 18 (08/04/25) - RC to include a comms slide in induction training, familirisation training and C2 training. 19 (08/04/25) - With Comms team for comment. 19 - (05/06/25) - Chaser sent to LB.
35	Warning and Informing	Communication with Partners and Stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	G	Nil					G	
36	Warning and Informing	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	A	Nil	Write Incident Comms Plan	20 - Write Incident Comms Plan (A)	RC	Q3 - 25	A	19 (08/04/25) - With Comms team for comment. 20 - (05/06/25) - Chaser sent to LB.
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	A	Nil					G	
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner	G	Nil					G	
39	Cooperation	Mutual Aid Arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	A	43 - Review Trust IRP to include a table under mutual aid that defines by Incident Level (1-4) how, who, when and for long mutual is requested. (R)	Include mutual aid arrangements into Command and Control Plan and include MACA guidance.	21 - Review Trust IRP to include a table under mutual aid that defines by Incident Level (1-4) how, who, when and for long mutual is requested. (G) 22 - Include mutual aid arrangements into Command and Control Plan and include MACA guidance. (G)	RC RC	Q4 - 24 Q4 - 24	G	43 - Carry forward onto 2025 Action Plan. 21 & 22 (08/04/25) - Included in 2025 annual review.
43	Cooperation	Information Sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	G	Nil					G	
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	G	Nil					G	
45	Business Continuity	Business Continuity Management Systems (BCMS) Scope and Objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	G	Nil					G	
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	A	46 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. (A) 46A - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 47 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (R)	Separate project required to develop BIAs	23 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. (G) 24 - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 25 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (G) 26 - Seperate project required to develop BIAs. (R)	CR CR CR CR	Q2 - 24 Q2 - 24 Q2 - 25 Q4 - 25	G	46, 46A & 47 (14/11/2024) - Carry forward to 2025 Action Plan.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	A	48 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. (A) 49 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust. (R)	Separate project required to develop BCP	27 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. (A) 28 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust. (A) 29 - Seperate project required to develop BIAs. (R)	CR CR CR	Q2 - 23 Q4 - 25 Q3 - 26	A	48 & 49 (14/11/2024) - Carry forward to 2025 Action plan.
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	G	Nil					G	Note: The TNA, Trust Training Policy and capture of testing and exercising in a Lessons Identified Template will resole this issue.
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	G	Nil					G	
50	Business Continuity	BCMS Monitoring and Evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A	Nil	Review required of process and included in Trust BC Plan	30 - Review required of process and included in Trust BC Plan. (A)	CR	Q2 - 25	G	30 (08/04/25) - CR to review completion. 30 (05/06/25) - Included in version update of BC Plan and on circulation
51	Business Continuity	BC Audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	G	52 - Confirm and develop the process for conducting BC audits. Include any audits to be completed in the TNA & BCP - Testing & Audit section. (A)		31 - Confirm and develop the process for conducting BC audits. Include any audits to be completed in the TNA & BCP - Testing & Audit section. (G)	CR	Q2 - 24	G	52 - (12/01/2024) meeting with internal auditors on 18/01/2024. 52 (14/11/2024) - carry forward onto 2025 Action Plan. 30 (08/04/25) - CR to review completion.
52	Business Continuity	BCMS Continuous Improvement Process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A	Nil	Review required of process and included in Trust BC Plan	32 - Review required of process and included in Trust BC Plan. (G)	CR	Q2 - 25	G	30 (08/04/25) - CR to review completion. 30 (05/06/25) - Included in version update of BC Plan and on circulation
53	Business Continuity	Assurance of Commissioned Providers / Suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	Nil	Review required of process and included in Trust BC Plan	33 - Review required of process and included in Trust BC Plan. (A)	CR	Q2 - 25	A	30 (08/04/25) - CR to review completion. 33 (14/07/25) - Meeting programmed with IW and review post that meeting.

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55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	G	Nil	Update CBRN Plan to include guidance provided CBRN Audit	34 - Update CBRN Plan to include guidance provided CBRN Audit	RC	Q3 - 25	G	34 (04/08/25) - RC to include skills and drills from CBRN test at SGH UECC and can then put on circulation.
56	Hazmat/CBRN	Hazmat/CBRN Risk Assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A	Nil	Complete CBRN Tent & PRPS Suit Risk Assessment Complete a Risk Assessment around minimum staffing numbers to respond to a CBRN incident Complete actions provided in the CBRN Audit guidance.	35 - Complete CBRN Tent & PRPS Suit Risk Assessment. (G) 36 - Complete a Risk Assessment around minimum staffing numbers to respond to a CBRN incident. (G) 37 - Complete actions provided in the CBRN Audit guidance. (G)	EC-S EC-S EC-S	Q3 - 25 Q3 - 25 Q3 - 25	G	35 (08/04/25) - completed and held by EC-S. 36 (08/04/25) - RC to review EC-S draft. 37 (06/05/25) - Trust to provide additional details on a risk assessment for multiple locations/sites across the site is the only outstanding action
57	Hazmat/CBRN	Specialist Advice for Hazmat/CBRN E	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	G	Nil	Update CBRN Plan to include guidance provided CBRN Audit	38 - Update CBRN Plan to include guidance provided CBRN Audit. (G)	RC	Q3 - 25	G	38 (08/04/25) - Guidance included in draft plan.
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	A	55 - Review CBRN Plan. (R)		39 - Review CBRN Plan. (G)	RC	Q3 - 25	G	55 (14/11/2024) - carry forward to 2025 Action Plan. 39 (14/07/25) - endorsed at EPSG 14/07/25.
59	Hazmat/CBRN	Decontamination Capability Availability 24/7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	A	Nil	Design an automated system for annotating who is CBRN trained when a incident occurs. Amend CBRN Plan to include guidance provided in CBRN Audit	40 - Design an automated system for annotating who is CBRN trained when a incident occurs. (A) 41 - Amend CBRN Plan to include guidance provided in CBRN Audit (G)	EC-S RC	Q3 - 25 Q3 - 25	A	40 (08/04/25) - Manual process in place whilst automation is explored. 41 (08/04/25) - Guidance included in draft plan.
60	Hazmat/CBRN	Equipment and Supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients	A	57 - Review CBRN Plan to include equipment husbandry to include registers, audits and fault finding flow charts. (R) 58 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57. (R)	Submit a full and detailed CBRN equipment inventory to YAS.	42 - Review CBRN Plan to include equipment husbandry to include registers, audits and fault finding flow charts. (G) 43 - Ensure that process after review is included into CBRN WG ToRs and Standing Agenda. Link to 57. (G) 44 - Submit a full and detailed CBRN equipment inventory to YAS. (G).	RC RC EC-S	Q3 - 25 Q3 - 25 Q3 - 25	G	57&58 (14/11/2024) - carry forward onto 2025 Action Plan. 42, 43 & 44 (08/04/25) - RC to meet with EC-S and include in plan.
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	G	Nil	Ensure a preventative maintenance contract is in place for the tent and associated ancillaries.	45 - Ensure a preventative maintenance contract is in place for the tent and associated ancillaries. (A)	EC-S	Q3 - 25	G	45 (08/04/25) - EC-S to chase
62	Hazmat/CBRN	Waste Disposal Arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	G	Nil	Ensure CBRN Plan contains relevant waste and water legislation	46 - Ensure CBRN Plan contains relevant waste and water legislation. (A)	EC-S	Q3 - 25	A	46 (08/04/25) - RC to meet with EC-S & KB and include in plan. 46 (31/07/25) - Waste disposal retainer contract rfequired
63	Hazmat/CBRN	Hazmat/CBRN Training Resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	Nil	CI CBRN to comply with guidance provided in CBRN audit.	47 - CI CBRN to comply with guidance provided in CBRN audit.	EC-S	Q3 - 25	A	
64	Hazmat/CBRN	Staff Training - Recognition and Decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	A	Nil	Undertake a full review of the current training course once the TNA has been undertaken.	48 - Undertake a full review of the current training course once the TNA has been undertaken. (G)	EC-S	Q3 - 25	G	48 (08/04/25) - EC-S to confirm acceptable to Corporate Nursing.

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65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	A	Nil	Ensure the PRPS suits size selection for individuals aligns to manufacturers guidance.	49 - Ensure the PRPS suits size selection for individuals aligns to manufacturers guidance. (A)	EC-S	Q3 - 25	G	49 (08/04/25) - EC-S to confirm guidance with SB.
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	Nil	Complete actions as per CBRN Audit guidance	50 - Complete actions as per CBRN Audit guidance. (R)	EC-S	Q3 - 25	A	