York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 22nd October 2025
Time: 9:00am – 12:10pm
Venue: Board Room, 2nd Floor Administration Block, York Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 24 September 2025** To be agreed as an accurate record.	Chair	Report	5	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log including the Trust's response to meeting the Failure to Prevent Fraud legislation.	Chair	Report Report	15 16	
6.	**True North Report** To consider the report.	Chief Executive	Report	22	9:05
7.	**Chair's Report** To receive the report.	Chair	Report	40	9:10
8.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	42	9:15

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Quality Committee Report** To receive the October meeting summary report.	Chair of the Quality Committee	Verbal	-	9:35
10.	**Resources Committee Report** To receive the October meeting summary report.	Chair of the Resources Committee	Verbal	-	9:45
11.	**Trust Priorities Report (TPR)** September 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	46 49 95 115 126 134	9:55
Break 10:45					
12.	**CQC Compliance and Journey to Excellence Update Report** To consider the report.	Chief Nurse	Report	152	11:00
13.	**Maternity and Neonatal Reports (including CQC Section 31 Update)** To consider the report and approve the Section 31 update.	Chief Nurse - Executive Maternity Safety Champion	Report	157	11:05
14.	**Medical Education Annual Report** To consider the report.	Medical Director	Report	182	11:15

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports** To consider the reports.	Director of Workforce & OD	Report	196	11:25
Governance					
16.	**Premises Assurance Report (PAM)** To consider the report.	YTHFM Managing Director	Report	220	11:40
17.	**Q2 2025/26 Board Assurance Framework (BAF) Report** To consider the report.	Associate Director of Corporate Governance	Report	231	11:50
18.	**2026/2027 Board of Directors Meeting Dates** To approve the 2026/27 meeting dates.	Associate Director of Corporate Governance	Report	248	12:00
19.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	12:05
20.	**Time and Date of next meeting** The next meeting held in public will be on 26 November 2025 at 9am at York Hospital.				
21.	**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.				
22.	**Close**				12:10

Minutes
Board of Directors Meeting (Public)
24 September 2025

Minutes of the Public Board of Directors meeting held on Wednesday 24 September 2025 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.40pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Ms Helen Grantham
- Ms Jane Hazelgrave
- Mrs Jenny McAleese
- 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
- Mr James Hawkins, Chief Digital and Information 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 Stefanie Greenwood, Freedom to Speak Up Guardian (For Item 14)
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 16)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Madelaine Warburton, Observer on behalf of NHS Providers' Well-Led Review
- Ms Rukmal Abeysekera, Lead Governor
- Dr Graham Lake, Elected Governor – Public
- Ms Mary Clark, Elected Governor – Public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting, noting that this was Mr Morritt's last Board meeting as the Trust's Chief Executive.

2 Apologies for absence

Apologies for absence were received from:
Mr Noel Scanlon, Non-Executive Director

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 30 July 2025

The Board approved the minutes of the meeting held on 30 July 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 advised that the Health Inequalities Steering Group was developing a set of metrics to reflect the NHS Performance Assessment Framework. Mr Barkley stressed that the metrics would be of no value if ethnicity data was not collected from patients. He questioned why this administrative process was still not being consistently implemented. Ms Hansen explained that the process had been refreshed but the implementation was not managed consistently. This would be addressed by a reconfiguration of Care Group line management which would be discussed in the Private Board meeting.

Action: Ms Hansen

BoD Pub 60 (24/25) *Present an options paper on improvements to Audiology waiting times to the Resources Committee.*
Ms Hansen advised that this had been addressed as part of a deep dive of Diagnostics undertaken by the Resources Committee and would continue to be monitored by the Committee. The action was closed.

BoD Pub 7 *Amend narrative summaries to show bullet points of highlights and concerns instead.*
This would happen from October reports onwards.

BoD Pub 21 *Ensure that patient quintiles are included in the relevant graphics in the Learning from Deaths report.*
Dr Stone advised that these had not been included in the report as the data could not be presented in any format which would prove valuable. The action was closed.

BoD Pub 23 *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.*

Ms Hansen reported that, in the most up to date SPC chart, the data from the spring of 2024 no longer appeared anomalous. The action was closed.

BoD Pub 24 *Ensure that information about challenged specialties is included in the Cancer performance narrative of the TPR.*
Ms Hansen advised that high level information had been included in the Cancer section of the Trust Priorities Report. The Cancer Board had refreshed its approach to specialty improvement plans, and it was suggested that this should a deep dive area for the Resources Committee. The action was closed.

Action: Ms Hansen/Ms Grantham

BoD Pub 25 *Provide a briefing on service decant plans.*
Mr Norman reported that an options appraisal for the decant of Maternity Services at Scarborough Hospital, due to the roof project, would be discussed on 26 September. He provided further details of some of the options. The roof project would also provide opportunities to improve the environment in Maternity Services which would address concerns raised by the CQC. Mr Norman advised that the recommended decant plan would be presented to the Executive Committee for approval. He assured the Board that the Director of Midwifery and relevant clinical teams had been fully involved in the decant plan and that the plan would deliver in time to access the national funding. Ms Hansen highlighted that the impact on patients of the decant plans would be analysed to determine any impact on performance trajectories. NHS England had been kept fully sighted on the complexities of the project and the potential impact on performance. Mr Norman agreed to update the Board next month.

Action: Mr Norman

6 True North Report

Mrs McAleese expressed concern that the majority of True North metrics were not showing improvement which did not reflect the number of completed actions in the Quarter 1 Annual Operating Plan update and thus raised questions that the actions were not the right ones to address the True North metrics. Ms Hazelgrave also queried whether the trajectories were realistic. Executive Directors were confident that the actions in place would prove successful and Mrs Parkes gave the example of C.Difficile infections which had been significantly reduced over time and the same actions were now being used to reduce MSSA infections. There was also discussion on the trajectories and the thresholds used for the RAG rating.

Mr Barkley noted that the performance metrics for the Scarborough Hospital Emergency Department (ED) were disappointing given the investment in the new Urgent and Emergency Care Centre. Ms Hansen responded that her team held fortnightly performance meetings with the Scarborough ED team; focus for improvement included the model of care and the medical staffing. Ms Hansen was also prioritising 12 hour waits as performance had deteriorated; a Rapid Process Improvement Workshop on continuous flow had been commissioned. Mrs Hansen noted that the ED at York Hospital had also been supporting other Trusts as there had been pressure on EDs across the system.

Mr Barkley congratulated on behalf of the Board all those colleagues who had been involved in the successful go-live of the new Laboratory Information Management System. Ms Hansen added that the smooth implementation was also testament to the partnership working with primary care.

With reference to the Continuous Improvement update, Mr Barkley advised that a Business Case would be presented at the Private Board meeting in October.

7 Chair's Report

The Board received the report. Mr Barkley welcomed the appointment of Ms Abeysekera as a Non-Executive Director. She would join the Board formally once a new Lead Governor had been elected.

8 Chief Executive's Report

Mr Morritt referred to the following:

- the first segmentation scores and associated performance dashboard and league tables from the new National Oversight Framework had been published; as part of this Framework, the Board was required to complete a self-assessment due by 22 October which would be key to the segmentation process;
- the new NHS Planning Framework had been released; further detailed guidance was awaited;
- the National Adult Inpatient Survey results for 2024 had been published; the Trust's outcomes were broadly similar to the previous year; Mrs Parkes confirmed that Care Groups were drafting improvement plans based on the results which would be presented to the Quality Committee;
- Jason Stamp had been appointed as the Chair of the Humber and North Yorkshire ICB;
- Star Award nominations for August and September.

9 Quality Committee Report

Dr Boyd highlighted the key discussion points from the meeting of the Quality Committee on 16 September 2025:

- the impact on the Dermatology Service of the withdrawal of Dermoscopy services by some GP practices;
- the issue of the withdrawal of the out of hours patient transport service was still unresolved;
- evidence was presented of improved compliance with the Mental Capacity Act and Deprivation of Liberty requirements which the Committee welcomed;
- evidence was presented of improvements in the identification and treatment of sepsis;
- the CSCS Care Group had presented to the Committee and had escalated a risk relating to the replacement of the Pharmacy cold store: Executive Directors at the meeting had agreed to progress this project; the Committee had discussed escalation processes and the importance of frequent evaluation of the capital programme in response to changing priorities;
- the Committee had noted a theme from Care Group presentations in relation to the digital interface between specialist software and the new Nervecentre Electronic Patient Record (EPR) and had highlighted the importance of a clear governance structure to underpin the implementation of the new EPR.

Mr Bertram assured the Board that the funding to replace the Pharmacy cold store had been allocated in the 2025/26 capital programme. The delay had arisen from the lack of project management capacity.

Mr Hawkins provided further context to the specific digital interface issues raised at the Quality Committee meeting, which related to the Ophthalmology software, Medisight and to the electronic Prescribing and Medicine Administration System (ePMA). He assured the Board that the retention of current digital interfaces was enshrined in the contract with Nervecentre. All decisions relating to the development of the new EPR were reviewed by the Clinical and Operational Design Authority, with any escalations going to the EPR Executive Steering Group. There would be extensive user testing and the Nervecentre product was a long term resource for the NHS which would be built on.

Mr Hawkins advised that the Digital team was working with both the Chief Pharmacist and the Ophthalmology Department to mitigate issues with the ePMA module on Nervecentre and the Medisight system respectively. An integration engine had also been procured which would support more effective digital interfacing.

Ms Hansen noted that opportunities for the use of Artificial Intelligence were a focus for a number of clinical areas and the Digital team needed to have capacity to respond to developments which would increase productivity. The EPR procured by the Trust would support these opportunities and had capacity to be further developed.

Ms Grantham queried how the cultural changes needed to ensure successful implementation of the new EPR were being managed. Mr Hawkins responded that the Digital team was collaborating with clinical teams to design processes which would be consistent across the Trust's different sites. A team of clinicians had been seconded to the project, but it would be important to manage expectations. In terms of a communication strategy, these clinicians would act as Nervecentre EPR champions in addition to advising on implementation. Mr Hawkins advised that communications on the implementation of Tranche 1 were about to be launched which would increase general awareness.

In terms of Board assurance around the new EPR, it was noted that progress reports were presented to the Digital Sub-Committee, and escalations were to the Resources Committee. Mr Hawkins advised that external assurance was provided by NHS England who undertook formal reviews on a regular basis. These could be shared with the Board for information.

Action: Mr Hawkins

10 Resources Committee Report

Ms Grantham advised that the Committee's agenda had been revised to incorporate deep dives on priority areas. The meeting held on 16 September 2025 had focussed on Diagnostics as performance metrics had been deteriorating. The Committee heard that there were issues with ageing equipment and staffing capacity. Mitigations were discussed along with planning for capital priorities. Ms Grantham noted that the Committee would not review the TPR in detail but would focus on Trust priority metrics which were not meeting their trajectories. The Committee had also discussed the latest financial position and had received positive reports on nursing workforce priorities, the Winter Plan and progress towards full eRostering. Ms Grantham advised that the six-facet survey currently being undertaken would be reviewed by the Committee, along with any impact on capital priorities.

In response to Mr Barkley's question, Ms Hansen agreed to provide the number of patients transferred to the Return To Treatment (RTT) waiting list as a result of the recent validation work.

Action: Ms Hansen

Ms Hansen confirmed that the validation work had been completed but more might arise from the transfer of waiting lists to the Nervecentre EPR. Mr Hawkins agreed that this was likely to be the case but highlighted that the validation work already undertaken been extremely valuable.

Mr Barkley noted the deterioration in Cancer performance. Ms Hazelgrave reported that the Committee had discussed the performance trajectories which had been agreed with NHS England and had requested more detail on in-house trajectories. Ms Hansen advised that there may be an opportunity to review the previously submitted trajectories. Mr Morritt observed that, as Cancer performance metrics varied from month to month depending on a number of factors, he would advise caution when considering changing trajectories.

11 Group Audit Committee Report

Ms Hazelgrave provided a summary of the meeting of the Group Audit Committee held on 9 September 2025:

- the internal audit plan was slightly behind schedule due to capacity issues within Audit Yorkshire; three changes to the audit plan had been agreed;
- auditors could not issue the audit certificate for the 2024/25 external audit until confirmation had been received from the National Audit Office that no further work was required on the Whole of Government Accounts; this was a national issue for all auditors;
- the Committee had received progress reports from the internal auditors; Ms Hazelgrave provided details;
- the Committee had approved the Treasury Management policy and had reviewed losses and special payments;
- the Committee received an update on new legislation which made failure to prevent fraud an offence, and on the work taking place to ensure compliance;
- the role of Committee in reviewing the Board Assurance Framework and the Corporate Risk Register was discussed, and further clarification of roles and responsibilities was sought;
- Mr Hawkins had attended the meeting and contributed to a detailed discussion of Cyber Security; the Digital Sub-Committee would receive a benchmarking report in relation to the Data Security and Protection Toolkit;
- the number of overdue internal audit actions had reduced, which was positive.

There was a brief discussion on the Trust's compliance with the Failure to Prevent Fraud legislation. Ms Hazelgrave noted that the Trust was already compliant with the majority of the standards and, in general, the NHS was successful at recognising and countering fraud. Mr Bertram advised that he had asked the Counter Fraud Manager to prepare a paper for the Board which would provide assurance on the actions being taken and would set out the Board's responsibilities in terms of the legislation.

Action: Mr Bertram

12 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Mr Barkley drew attention to the reduced number of 12 hour trolley waits. Mr Hawkins advised that this was the lowest number since December 2021.

Mr Barkley highlighted the underutilisation of community beds. Ms Hansen explained that the decision by the Yorkshire Ambulance Service (YAS) to cease its out of hours patient transport service at very short notice was hindering use of community beds. This was a significant issue for the Trust. A meeting with YAS and the ICB was scheduled for 30 September. Ms Hansen would update the Board at the next meeting.

Action: Ms Hansen

Ms Hansen agreed with Mr Barkley that the RTT patients waiting over 65 and 52 weeks must be reduced to zero by December in order to achieve this requirement. She assured the Board that each individual patient was being tracked and would provide an update to the Board at the next meeting.

Action: Ms Hansen

Mrs McAleese referred to the "factors impacting performance" in the Outpatients and Elective Care narrative: *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.* Mr Hawkins advised that an upgrade to the telephony system had been procured which would improve capacity in the next few months. Mr Hawkins would provide a more detailed timeline.

Action: Mr Hawkins

Ms Hansen advised that plans to improve waiting times for the Rapid Access Chest Pain Clinic had been refreshed; she was not confident that the improvement evidenced in the metric was sustained.

Mr Barkley queried the origin of outpatient referrals which were not from GPs or consultant to consultant. Ms Hansen explained that these could be from a range of other professionals such as Allied Health Professionals. However, the number was higher than she expected so she would ask for some analysis to be undertaken. Mr Bertram agreed that the referral data reflected a complex picture. Ms Hansen confirmed that referrals were triaged and advised that her team was undertaking a review of elective improvement plans at specialty level. She also confirmed that Care Group directors had been encouraged to reject inappropriate referrals.

Quality and Safety

Mrs Parkes highlighted the significant reduction in the rate of C.Difficile infections which was a success story for the Trust.

Maternity

Workforce

Digital and Information Services

There were no comments or questions on these sections of the TPR.

Finance

Mr Bertram reported that the Month 5 position was an adverse variance to plan of £0.2m which was due to the costs of the recent resident doctors' industrial action. The Trust had undertaken a total of £4.5m of elective activity over the funded level; it was assumed that this income would be received but Mr Bertram cautioned that there may need to be a reduction in elective activity due to financial constraints in the second half of the year.

Mr Bertram advised that, at Month 5, £15m of the £55m Cost Improvement Programme target had been delivered in full year terms. He was increasingly concerned about the number of schemes which were not being delivered within the timescales, and a time out

session with senior leaders had been scheduled with the aim of refreshing the programme to ensure more timely delivery.

Mr Bertram referred to the 2025/26 forecast outturn and recovery action plan which had been required by NHS England and was contained in the report. The recovery actions reduced the residual risk to £5.1m.
Ms Hazelgrave noted that there was a continuing risk around accruing for the sparsity payment for Scarborough Hospital and Elective Recovery Fund income from 2024/25. Mr Bertram agreed that the Elective Recovery Fund income was a concern, but he was working with the ICB to identify resource to support payment of the sparsity fund. Mr Barkley proposed that further discussion on the financial position should be scheduled for the Board Development Seminar in December.

13 Quarter 1 Annual Operating Plan Progress Report

The report was received and noted.

14 Freedom to Speak Up Annual Report

Ms Greenwood joined the meeting to present the report and highlighted the following:

- there had been a steady rise in Freedom To Speak Up (FTSU) cases over the last 5 years;
- culture remained a significant concern across the organisation, with a majority of FTSU cases relating to inappropriate behaviours, bullying, staff wellbeing and patient safety.

Ms Greenwood summarised details relating to staff groups raising concerns which were contained in the report. Given the increase in cases, she recommended an increase in FTSU Guardian capacity.

A query was raised about the closure rate of FTSU concerns. Ms Greenwood explained that a concern would only be closed once the staff member who had raised it was satisfied with the outcome or when a related HR process had run its course.

Miss McMeekin asked if more Fairness Champions could be trained. Ms Greenwood responded that her role did not allow sufficient time for training, and in addition, Fairness Champions had limited capacity to commit to FTSU concerns, as the work was in addition to their substantive roles.

Miss McMeekin noted that the new leadership framework would support managers in addressing concerns, but she queried how managers would be aware of FTSU concerns given the confidential nature. Ms Greenwood explained that general information about FTSU themes could be shared with departmental leads.

Mr Barkley referred to Ms Greenwood's recommendation in her report *Ensure leaders at all levels visibly champion psychological safety and model respectful behaviours* and encouraged Ms Greenwood to refer concerns raised about leaders to the Chief Executive, whilst maintaining the confidentiality of the member of staff raising the concern.

Mrs Parkes questioned why students were included in FTSU data. Ms Greenwood explained that this was in response to a national directive. Students raising concerns about the Trust with their university would be asked to raise them direct with the Trust.

Mrs Parkes noted that it would be helpful for the data on professional groups speaking up to be shown as a percentage of the workforce.

Ms Grantham asked if staff performance reviews covered expectations of appropriate behaviours. Miss McMeekin responded that staff appraisals were in line with Trust values and would be aligned with the national competency framework.

Ms Greenwood was thanked for her report, and she left the meeting.

15 CQC Compliance Update Report

Mrs Parkes reported that, following the CQC inspections in January, the improvement plan developed in response to the six identified breaches of regulations had been submitted to the CQC and had been agreed.

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

Ms Wells-Munro presented the report and highlighted:

- a new risk around delayed specialist care and transfer to specialist neonatal units for babies born at Scarborough due to the time and distance for Embrace transport to reach the maternity unit; this could result in poor outcomes for babies;
- the new Maternity Outcomes Signal System (MOSS) developed by NHS England and currently being piloted by some Maternity Services; Ms Wells-Munro explained the purpose of the new system and how it would operate;
- the Trust was on track to be compliant with seven of the ten safety actions in Year 7 of the Maternity Incentive Scheme;
- recruitment events to increase midwifery staffing levels had taken place at the beginning of September; 24.5 Whole Time Equivalent (WTE) midwives had been recruited to fill the roster gap, and further recruitment would take place; Ms Wells-Munro confirmed that newly appointed Band 5 midwives would be starting on a staggered basis.

There was further discussion on resource to address the midwifery staffing gap. Mrs Parkes reiterated that the 24.5 WTE midwives recently recruited would only fill current vacancies. A further 7 WTE midwives would be recruited in January to begin to address the establishment gap.

In response to Mr Barkley's query about the vacancies for Maternity Support Workers, Ms Wells-Munro explained that the process of reviewing Band 2 and Band 3 job descriptions once complete would inform future recruitment. She outlined the strategies being used to cover the current vacancies.

Returning to her report, Ms Wells-Munro highlighted:

- a fourth engagement day would take place in November to progress actions within the culture score action plan;
- in terms of the Single Improvement Plan, the focus in August, September and October was on "business as usual" key priorities which would impact on progress towards meeting actions within the timeframe set out in the plan; Ms Wells-Munro assured the Board that any deferred actions would not impact on quality or safety.

A question was raised about bereavement services for parents. Ms Wells-Munro advised that, whilst there were bereavement midwives to support parents in the time immediately

after a bereavement, the Trust had no specific internal counselling service staffed by trained counsellors. This was a significant gap which she hoped to address.

Ms Wells-Munro reported that the terms of reference for the national review of Maternity Services had been updated recently. They were being scrutinised with a view to aligning the Single Improvement Plan with them so that any recommendations from the outcome of the review could be pre-empted.

The Board approved the CQC Section 31 Update.

17 Winter Plan 2025/26

Mr Barkley observed that this was a comprehensive and well-developed plan. Ms Hansen advised that the plan had been reviewed by the Resources Committee. The financial impact of the plan was noted and Ms Hansen added that escalation processes would be rigorously managed to keep costs to a minimum whilst maintaining the quality and safety of services. There was further discussion on the details of the plan.

The Board of Directors approved the Winter Plan for 2025/26.

18 Mortality Review – Learning from Deaths

The Board received the report.

19 Responsible Officer Annual Report

Dr Stone presented the report which demonstrated progress and assurance around doctors' appraisal and revalidation. She highlighted that the deferment rate for revalidation in 2024/25 had reduced to 8%, against the national average of 15%. The appraisal rate was challenged by a lack of trained appraisers. Dr Stone advised that the transition to new software for appraisal and job planning earlier in 2025 had been very successful. In response to Mr Barkley's question, Dr Stone explained that there had been a few non-engagement notifications referred to the General Medical Council, but these would appear in the 2025/26 report. Every effort was made to engage with the individual before this process was initiated.

Directors were pleased to note the overall improvement in appraisal and revalidation rates.

20 Emergency Preparedness Resilience and Response (EPRR) Update

The Board extended its congratulations to the Head of Emergency Preparedness Resilience and Response and his team for the improved compliance with the national standards.

21 Questions from the public received in advance of the meeting

There were no questions from members of the public.

22 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 22 October 2025 at 9.00am at York Hospital.

Action Ref.	Date of Meeting	Item Number Reference	Title (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / comments	Due Date	
BoD Pub 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	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. Update 24.09.25: Ms Hansen to provide an update on the collection of ethnicity data.	Oct 25 from Mar 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 Digital & Information 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. Update 24.09.25: This would be in the October version of the TPR.	Oct 25 from Jul 25	Delayed
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 25	30-Jul-25	11	Trust Priorities Report	Provide a briefing on service decant plans.	Managing Director, YTHFM	Update 24.09.25: Mr Norman provided an update and would provide a further update at the next meeting.	Oct-25	On Track
BoD Pub 26	24-Sep-25	5	Matters Arising/Action Log	Schedule a deep dive of Cancer performance for the Resources Committee	Chief Operating Officer/Chair of the Resources Committee		Nov-25	On Track
BoD Pub 27	24-Sep-25	9	Quality Committee report	Share NHSE reviews of the Nervecentre EPR implementation project with the Board for information	Chief Digital & Information Officer		Oct-25	On Track
BoD Pub 28	24-Sep-25	10	Resources Committee report	Provide the number of patients transferred to the Return To Treatment (RTT) waiting list as a result of the recent validation work.	Chief Operating Officer/Chief Digital & Information Officer		Oct-25	On Track
BoD Pub 29	24-Sep-25	11	Group Audit Committee Report	Prepare a paper for the Board to provide assurance on the actions being taken and setting out the Board's responsibilities in terms of the Failure to Prevent Fraud legislation	Finance Director		Oct-25	On Track
BoD Pub 30	24-Sep-25	12	Trust Priorities Report	Update the Board on discssions about the Yorkshire Ambulance Service's Out of Hours patient transport service	Chief Operating Officer		Oct-25	On Track
BoD Pub 31	24-Sep-25	12	Trust Priorities Report	Provide an update on RTT patients waiting over 65 and 52 weeks	Chief Digital & Information Officer		Oct-25	On Track
BoD Pub 32	24-Sep-25	12	Trust Priorities Report	Provide a detailed timeline of the upgrade of the telephony system	Chief Digital & Information Officer		Oct-25	On Track

Report to:	Board of Directors
Date of Meeting:	22 October 2025
Subject:	Failure to Prevent Fraud Offence
Director Sponsor:	Andrew Bertram, Interim Chief Executive
Author:	Marie Dennis, Local Counter Fraud 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

Executive Summary:

This document outlines the introduction and implications of the new offence of failure to prevent fraud under the Economic Crime and Corporate Transparency Act 2023, effective from September 2025, and the steps taken by York & Scarborough Teaching Hospitals NHS Foundation Trust to comply with related fraud prevention recommendations.

Recommendation: Report is for information and to seek approval for incorporating a statement onto the public facing website.

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

Failure to Prevent Fraud Offence

1. Introduction and Background

Legislation

The Economic Crime and Corporate Transparency Bill received Royal Assent on the 26th of October 2023 and introduced a new offence of failure to prevent fraud, which holds organisations to account if they profit from fraud committed by their employees or associated people. It is hoped that this will also encourage organisations to improve their fraud prevention procedures.

The Statutory Instrument was laid on 6th November 2024 and brought the offence into effect on 1st September 2025. The Home Office has published guidance to help organisations understand the sorts of procedures they can put in place to prevent fraud. This can be accessed via the following link: New failure to prevent fraud guidance published - GOV.UK

The offence applies to organisations that meet two out of three of the following:

- More than 250 employees
- Excess of £36million turnover
- £18 million or more in total assets

An organisation can be criminally liable if one or more of their employees, agents or any other associated person commits fraud for the purpose of benefitting the organisation, and there were no reasonable fraud prevention measures in place. An offence may also occur if the fraud is committed to benefit a client of the organisation.

The organisation does not need to receive the benefits. Fraud can be complete before there has been a financial gain - the intention is sufficient to commit the offence.

The offence is also complete if the fraudster's motivation was to benefit themselves or another, but this would also result in the organisation inadvertently gaining. For example, a person on commission mis-sells for their own gain, but this action creates more sales for the organisation.

The benefit does not have to be financial, for example if a fraud was to disadvantage a competitor, it could be within the scope of the offence.

The person / people committing the offence can have done so off their own back, there is no necessity for directors or senior managers at the organisation to have been aware of the frauds.

The offence may sit with another criminal offence, i.e. the person who has committed the fraud may be prosecuted separately and the organisation may be prosecuted for failing to prevent it.

If an organisation has reasonable measure in place to prevent fraud, this will be a defence. If a case does go to court, it will be up to the organisation to prove it had measures in place, and the court decides if these measures are reasonable.

Organisations found guilty may receive a fine. Courts must have regards to the impact a fine would have on organisations which provide a service to the public sector, such as the NHS.

2. Considerations

A fraud prevention framework has been created which is intended to be adaptable to different organisations. This framework is built around the following six principles:

- Top level commitment
- Risk assessments
- Proportionate risk-based prevention procedures
- Due diligence
- Communication (including training)
- Monitoring and review

Based around this, the NHS Counter Fraud Authority has published a list of sixty recommendations which, if in force, should help demonstrate where the organisation has effective processes and measures in place to combat the potential of being prosecuted under this offence.

The Counter Fraud Team is currently undertaking a proactive review of these recommendations which has assisted in identifying areas which require additional work. Whilst this may seem a substantial undertaking, a number of the recommendations are directly aligned to the Counter Fraud Functional Standards where we recorded the organisation as being fully compliant for 2024/25. Furthermore, the NHS counter fraud strategy has been in place for 25 years, so for some of the recommendations we can easily evidence an embedded framework of risk-based counter fraud work.

3. Current Position/Issues

Whilst the way the Counter Fraud Team currently works satisfies these principles, we will need to make some adjustments to be fully compliant.

At the time of writing this report, 35/60 of the recommendations are already in place.

One of the recommendations is "*The chief executive officer (or equivalent) making a statement about the organisation's fraud prevention approach and measures."*

We have drafted the following as a suggested statement if the Board of Directors feels it is appropriate to put this on the Trust's public facing website:

Statement from the Board of Directors on the Bribery Act 2010 and Economic Crime and Corporate Transparency Act 2023 (ECCTA)

The Board of Directors is dedicated to upholding the principles outlined in the Bribery Act 2010 and the Economic Crime and Corporate Transparency Act 2023 (ECCTA), which took effect on 1 July 2011 and 1 September 2025, respectively. These acts aim to combat fraud, bribery, and corruption in both the private and public sectors.

At the Trust, we have established strict controls to prevent unethical practices. However, it is essential that we remain vigilant and ensure that all our employees, vendors, locums, contractors, and any other business partners strictly follow our policies and procedures, especially regarding procurement and sponsorship.

We expect everyone associated with the Trust to understand and follow the standards of behaviour we uphold. These standards, outlined in our policy, describe the ethics, professional conduct, and honesty we demand in business conduct.

If any instances of fraud or bribery are suspected, we would encourage you to report this to the Trust's Counter Fraud Team by emailing yhs-tr.counterfraudyork@nhs.net or reports can be made anonymously to the NHS Counter Fraud Authority. Further details can be found here - Report NHS Fraud | Home | NHSCFA.

A key part of the Bribery Act and the ECCTA is the commitment from the top level of the organisation to prevent fraud, bribery, and corruption. The Board of Directors is fully committed to this and will regularly discuss these issues in Board meetings to ensure the importance of transparency and openness is consistently communicated. A Board member has been appointed to lead our efforts in this area.

On behalf of the Trust, I want to reaffirm our commitment to making sure all staff understand their responsibilities in preventing fraud, bribery, and corruption.

This wording is not mandatory and can be amended, if the Board of Directors are happy for the statement to be published.

In relation to the remaining outstanding recommendations, the Counter Fraud Team will endeavour to achieve these with support from the Trust, the NHS Counter Fraud Authority and by liaising with peers nationally to ensure that we have a thorough understanding of what expectations are.

It is not mandatory to comply with all sixty recommendations - this list has been a suggested approach from the NHS Counter Fraud Authority, and we do not need to formally report back on progress or make any submissions to any regulatory bodies.

Whilst we are not obligated to satisfy all recommendations, the Counter Fraud Team would like to endeavour to do so and be able to provide rationale for any which are not achieved.

4. Summary

This report details the new offence of Failure to Prevent Fraud. The Trust's Counter Fraud Team reports partial compliance with 35 of 60 recommendations implemented, with plans to update policies, training, risk assessments, and monitoring records.
A draft statement for the Board of Directors emphasises commitment to the Bribery Act 2010 and the Economic Crime and Corporate Transparency Act 2023, outlining ethical standards, reporting mechanisms for suspected fraud, and top-level accountability.

While compliance with all NHS Counter Fraud Authority recommendations is not mandatory, the Counter Fraud team aims to meet them, or provide rationale for any gaps, working with national bodies and peers to understand expectations.

5. Next Steps

Further work for the Counter Fraud Team will include:

- Amendments to the Anti-Fraud, Bribery and Corruption policy
- Reviewing the current training programme
- Additions to the Risk Assessments
- Consideration as to how we record that we monitor fraud prevention measures

In relation to the remaining outstanding recommendations, the Counter Fraud Team will endeavour to achieve these with support from the Trust, the NHS Counter Fraud Authority and by liaising with peers nationally to ensure that we have a thorough understanding of what expectations are.

It is not mandatory to comply with all sixty recommendations - this list has been a suggested approach from the NHS Counter Fraud Authority, and we do not need to formally report back on progress or make any submissions to any regulatory bodies.

Whilst we are not obligated to satisfy all recommendations, the Counter Fraud Team would like to endeavour to do so and be able to provide rationale for any which are not achieved.

Date: 07 10 2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 6

True North Report

October 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’.

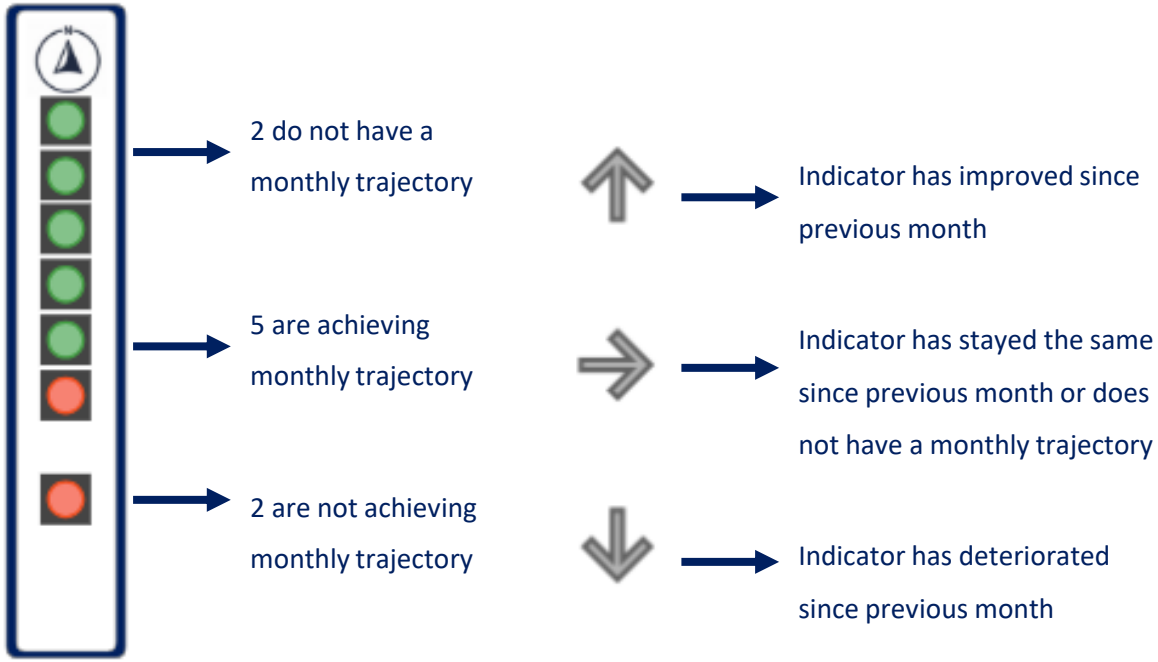
This is the single point of reference to measure our progress.

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)

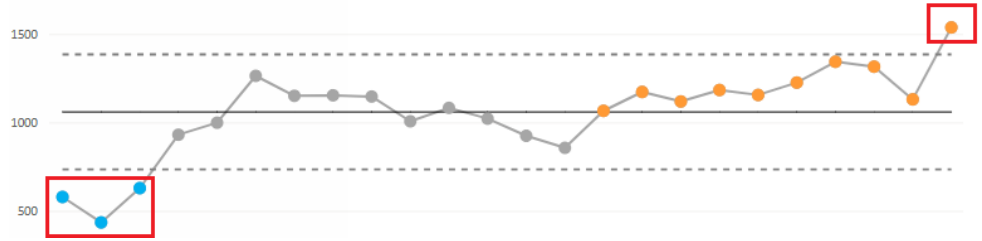
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

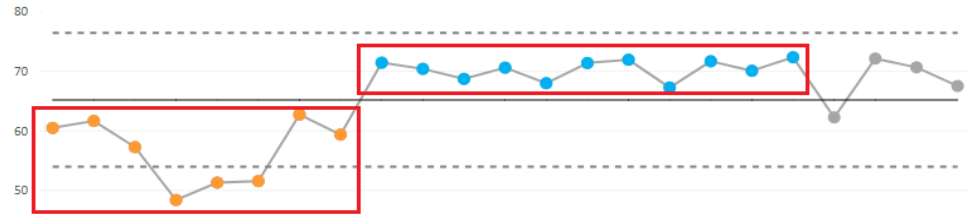
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

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

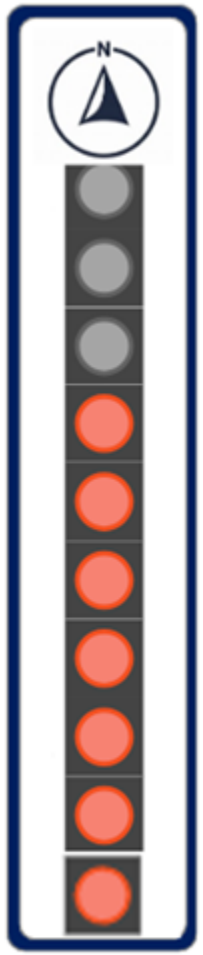


Shift: Counts the number of occasions there is a run of 7 consecutive points above OR below the mean.



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

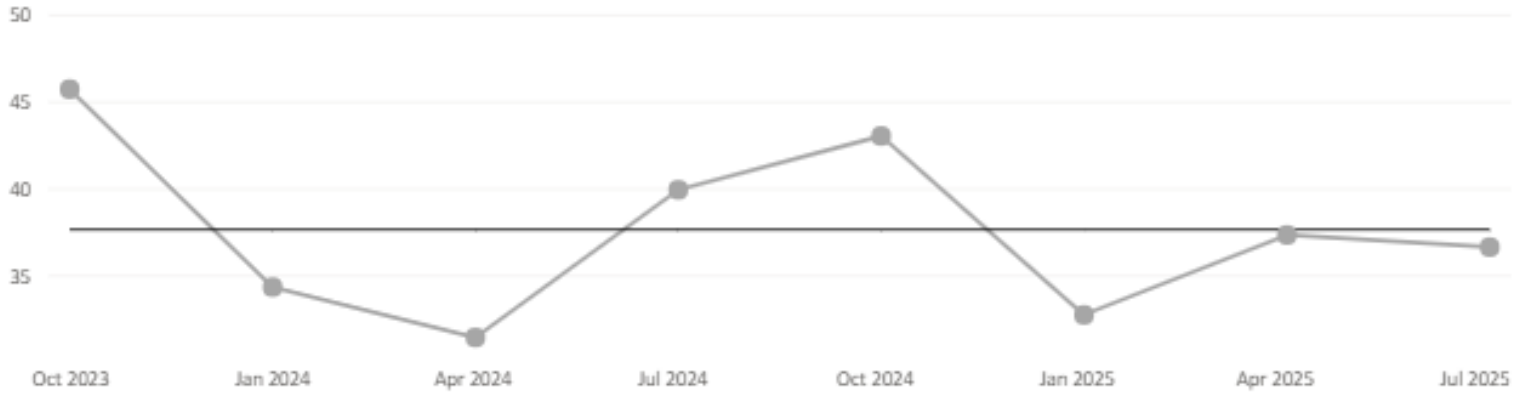
Staff Survey: Recommend Care

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

	Oct-23	Jan-24	Apr-24	Jul-24	Oct-24	Jan-25	Apr-25	Jul-25	Target Mar 2026
Value	45.7%	34.3%	31.4%	39.9%	43%	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

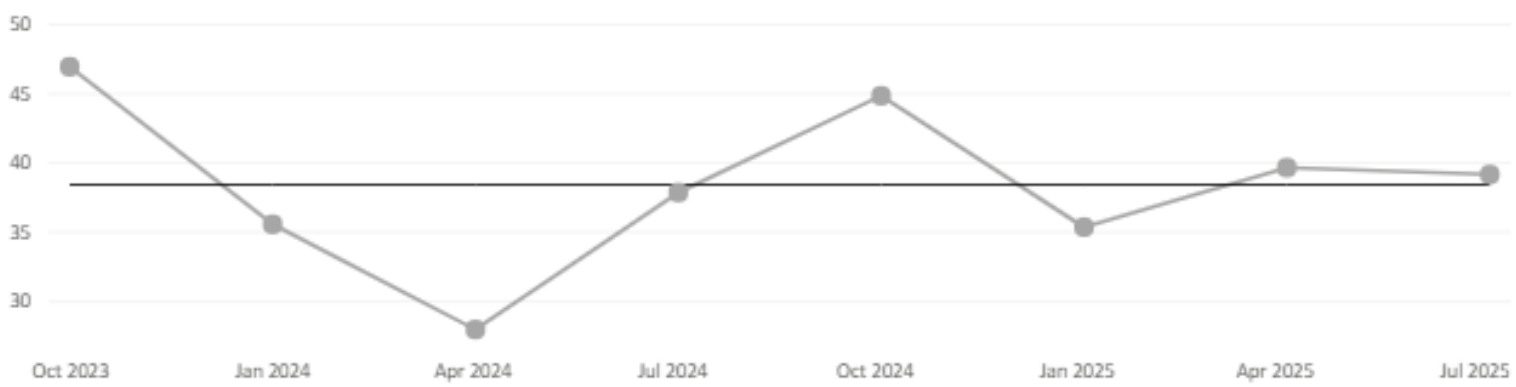
True North Report

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



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

	Oct-23	Jan-24	Apr-24	Jul-24	Oct-24	Jan-25	Apr-25	Jul-25	Target Mar 2026
Value	46.9%	35.5%	27.9%	37.8%	44.8%	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

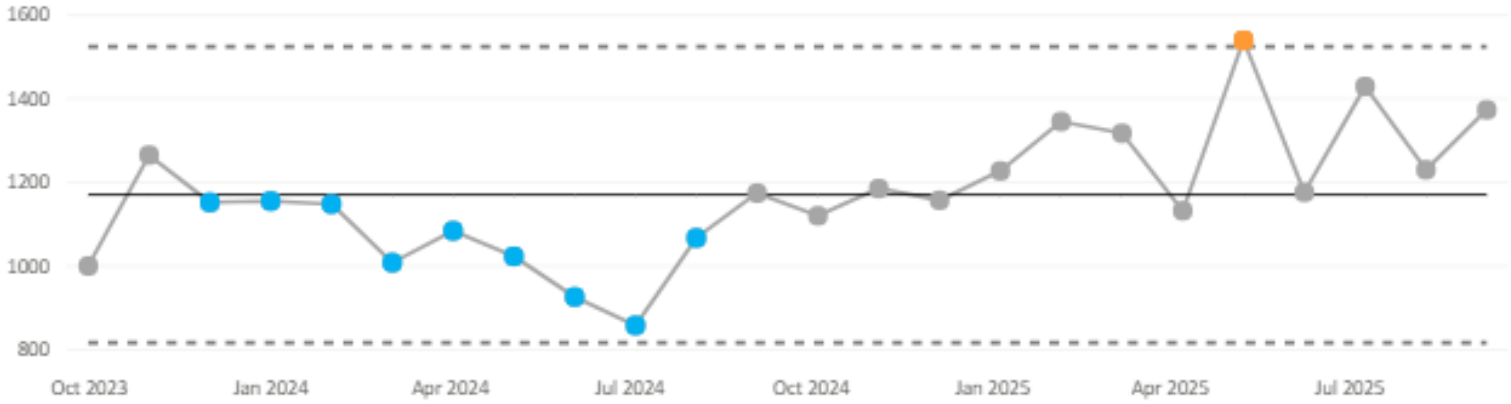
True North Report

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

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Target Mar 2026
Value	1172	1118	1183	1155	1225	1343	1315	1130	1537	1174	1427	1228	1371	
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 Discharge Improvement Group oversees improvement actions across the system
- First, second and third line escalation meetings continue with system partners. These ensure all partners are aware of delays and are continuing to proactively seek onward packages of care.
- In September 2025 we established a second line escalation meeting for community delays.

What are the current challenges?

Note: This graph includes all adult (non-elective) bed days including non-acute, rehabilitation and community. Applying National Oversight Framework criteria (acute bed days) we see the same trend but a significant reduction (~300 fewer days per month).

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

What are we doing about them?

- Multiple training sessions have been delivered. 12 resident doctors attended Discharge Workshop training. 64 AHPs/Nurses booked on to 'Describe, not prescribe training' across 7 sessions at York, Scarborough and Bridlington, providing training for D2A.
- Agreement has been reached to shift two days per week of clinical resource from Medicine Care Group to community response, to enable increased discharge support.

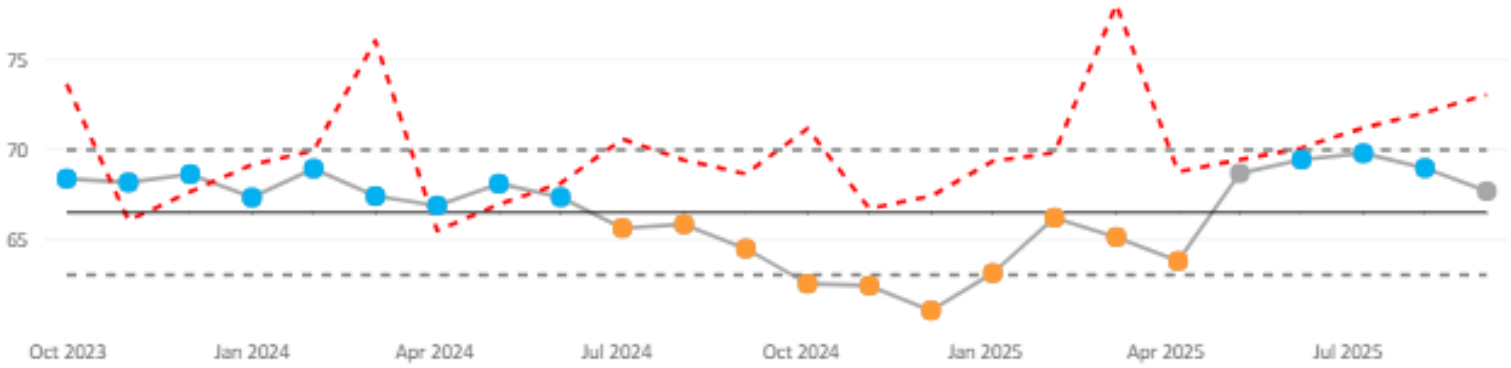
True North Report

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

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Value	64.4%	62.5%	62.4%	61%	63.1%	66.2%	65.1%	63.8%	68.6%	69.4%	69.7%	68.9%	67.6%
Trajectory	68.6%	71.1%	66.7%	67.4%	69.3%	69.8%	78%	68.7%	69.4%	70%	71.1%	72%	73%

Target Mar 2026
78%

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. Attendances to Scarborough Emergency Department were 18% higher in September 2025 compared to September 2024.
- At York the year-on-year increase was 10%.
- 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. Interviews October 2025.
- Continuing to support additional GP capacity at York and Scarborough.
- Increased streaming to alternatives e.g. UTC and SDEC
- Reducing elective patients seen in SDEC to ensure capacity is optimised for unplanned care.
- Relaunched a refreshed version of the EDAC pathway in September 2025 and closely monitoring with a view to further improvements where indicated.

True North Report

Objective Status Down Is Good

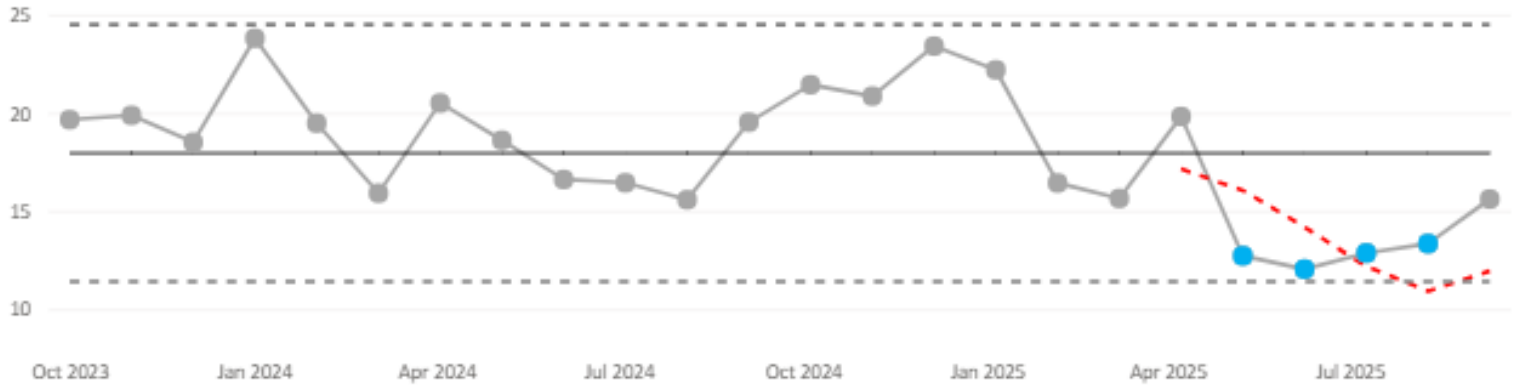
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Target Mar 2026
Value	19.5%	21.4%	20.9%	23.4%	22.2%	16.4%	15.6%	19.8%	12.7%	12%	12.9%	13.3%	15.6%	8.9%
Trajectory								17.1%	16%	14.2%	12.2%	10.9%	11.9%	

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?

- A QI piece of work has been commissioned and the team are considering plans for a rapid improvement week in December, whereby patients will be moving to the next step in their journey in a timely manner.
- The Scarborough EDAC has been reviewed and a reset launched on 24th September 2025. Number of patients has reduced as planned but performance has improved.
- Designing future workforce model for ED teams at both sites.

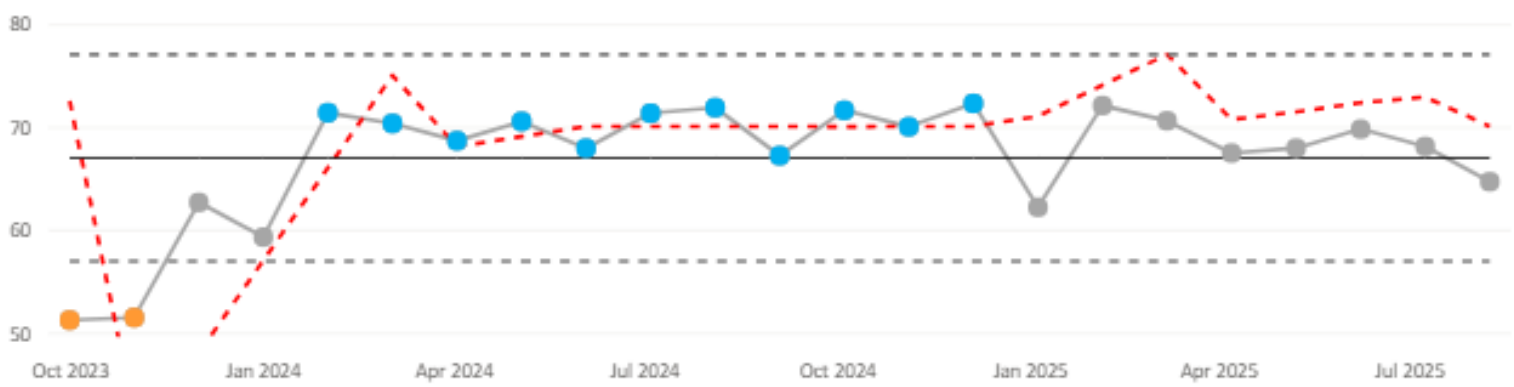
True North Report

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)?

2 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
Value	71.9%	67.2%	71.6%	70%	72.3%	62.2%	72.1%	70.6%	67.4%	67.9%	69.8%	68.1%	64.7%
Trajectory	70%	70%	70%	70%	70%	71%	74%	77%	70.7%	71.4%	72.3%	72.9%	70%

Target Mar 2026
80.1%

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. New PTL Tool launched in Sept 25.
- 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, resulting in increasing demand and deteriorating performance
- 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
- Demand and capacity work for first appointment for all tumour sites completed, actions being developed..
- 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

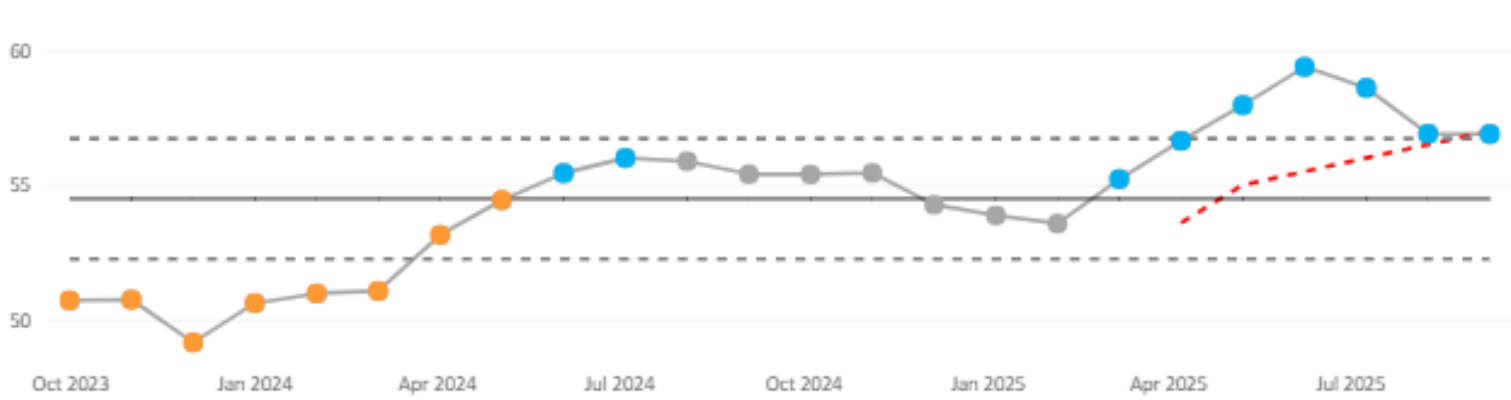
Elective: Improve RTT

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)?

11 found

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

Occurs

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

Occurs

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Target Mar 2026
Value	55.4%	55.4%	55.5%	54.3%	53.9%	53.6%	55.2%	56.6%	58%	59.4%	58.6%	56.9%	56.9%	60.5%
Trajectory								53.6%	55%	55.5%	56%	56.5%	57%	

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 25/26, 8% rise in GP referrals compared to 24/25.

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& Q2 2025/26.
- Analysis ongoing on increase in referrals and discussion with ICB on demand management.

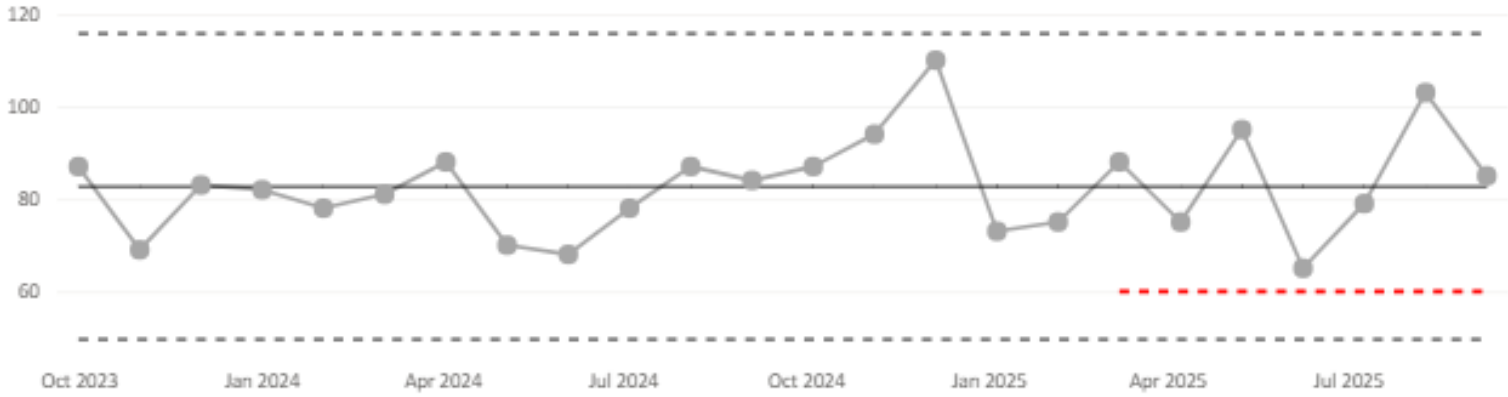
True North Report

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



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Value	84	87	94	110	73	75	88	75	95	65	79	103	85
Trajectory							60	60	60	60	60	60	60

Target Mar 2026
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

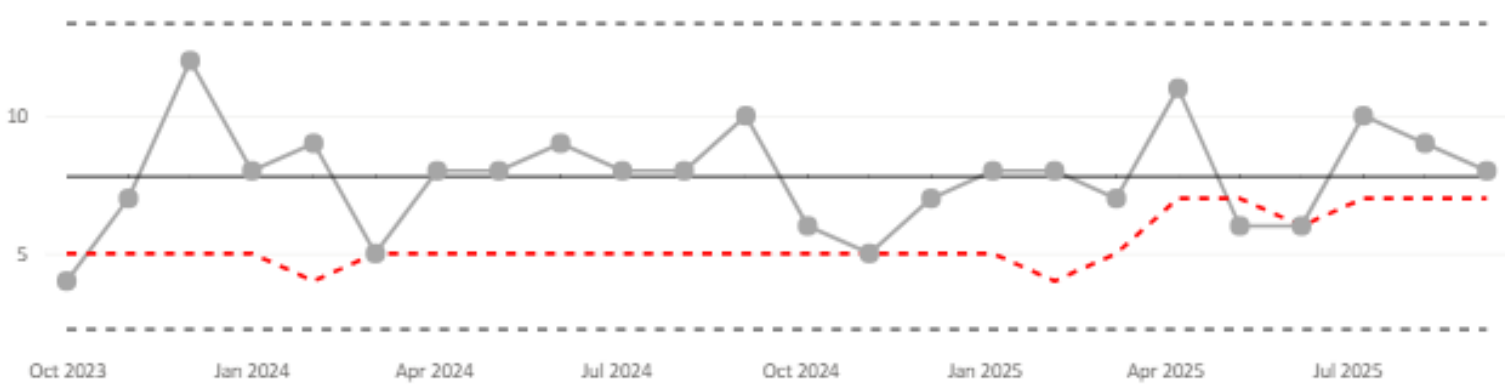
Q&S: Reduce the number of Trust Onset MSSA Bacteremia

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

Lead Director: Dawn Parkes

Operational Lead: Susan Peckitt

Committee: Quality



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Target Mar 2026
Value	10	6	5	7	8	8	7	11	6	6	10	9	8	7
Trajectory	5	5	5	5	5	4	5	7	7	6	7	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
- Line management, VIP scoring and ANTT education has been refreshed and re-launched
- A peripheral cannula care audit is being undertaken in October
- ICB wide workshop for MSSA reduction is being arranged

True North Report

Objective Status

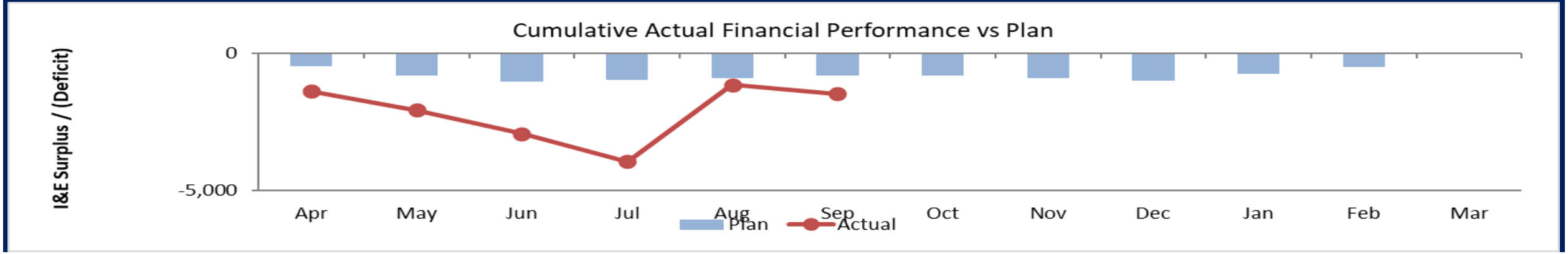
Finance: Achieve Financial Balance

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

Lead Director: Sarah Barrow

Operational Lead: Richard Parker

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
- Recovery action plan in place

What are the current challenges?

- The financial position is close to plan for M6 £0.67m adverse position against a £0.8m deficit plan (£1.484m 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 M6 delivery is £6.1m behind plan
- Securing deficit support funding on a quarterly basis – Q1-Q3 received - Regional NHSE judgement required each quarter as of plan as a system.

What are we doing about them?

- The Trust continues to work closely with the ICB and NHSE to secure deficit support funding . Q1 - Q3 received
- New vacancy control process in place – to include 13-week firebreak on all posts outside of the exceptions list.
- Ongoing increased focus on efficiency delivery
- Line by line budget review; focused look at Medical & Nursing spend; Tightening grip & control re authorised signatories; increased support to Care Groups
- 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 in an iterative, with focus on the first tranche.
- User Acceptance Testing (UAT) started on 7th October with members of the Clinical Digital team. It will be widened to involve many more users from November onwards.
- EPR Digital Champions are continuing to be recruited to champion the EPR within their wards and specialities throughout the implementation.
- 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 2 has now formally started 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 - September Position											
	Full Year CIP Target	September 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	18,426	12,298	6,128	18,917	36,374	55,290	0	34,924	20,366	0

Efficiency Delivery

The Trust has set an efficiency target of £55.3m. So far, £18.4m has been achieved in full-year terms, but the year-to-date position is £6.1m behind plan. To speed up delivery in the second half of the year, key actions include a line-by-line budget review, a review of medicines stock on wards, a focused examination of medical expenditure, a further look at nursing expenditure, tighter control over authorised signatories, and increased support to Care Groups.

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.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	22 October 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 – October 2025

1. I have continued to visit various wards and services at York, Bridlington and Scarborough Hospitals and one of our community teams, as well as undertaking 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. The recent elections of Governors have resulted in seven new Governors being elected and four re-elected for a further 3 years. I will be having introductory meetings with each new Governor. The process for electing a new Lead Governor is underway to succeed Rukmal Abeysekera who joins the Board as a non-executive Director on 1st November.

3. The Trust's Annual General Meeting was held on 2nd October. Despite the meeting being held via MS Teams to facilitate attendance, the actual number of Members and the public was very low. We did however receive in advance of the meeting lots of good questions which were answered (and which will be on our website). However, one question was received as the meeting was closing which we did not see in time to answer, and the questioner will be emailed the answer, and it will again be included on our website.

4. I recently attended a meeting of Yorkshire & Humber Chairs. One of the guest speakers was Fiona Edwards, Regional Director NHS England, who gave a very informative talk. One of the priorities she explained is NHSE holding mid -year reviews with ICBs and Trusts to review progress in the first half of the year and to talk about the Board capability self-assessments which have to be with NHSE on 22nd October 2025. The review of our ICB is taking place on 29th October 2025, including an hour set aside for this Trust. The Chief Executive and I have been invited to attend.

5. The uplifting and inspiring Trust Celebration of Achievements award evening is taking place this year at Scarborough. Whilst we the Board, correctly in my view, spend quite a lot of time focusing on how we resolve the fundamental issue of closing the gap between capacity and demand and in a way that improves what it feels like to work in the Trust, it is very easy to overlook the fantastic work that our workforce does every day. The Celebration event is a brilliant, humbling evening that showcases outstanding examples of great work.

Martin Barkley
Trust Chair
14.10.2025

Report to:	Board of Directors
Date of Meeting:	22 October 2025
Subject:	Chief Executive's Report
Director Sponsor:	Andrew Bertram, Interim Chief Executive
Author:	Andrew Bertram, Interim Chief Executive

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

☒ To provide timely, responsive, safe, accessible effective care at all times.
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☒ Transformative Services
☒ Sustainability Green Plan
☒ Financial Balance
☒ Effective Governance

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides an update from the Chief Executive to the Board of Directors in relation to the Trust's priorities. Topics covered this month include: Interim Chief Executive arrangements, Care Quality Commission (CQC) inspection at Scarborough Hospital, national planning guidance update, Our Voice Our Future programme, Celebration of Achievement Awards and the NHS National Staff Survey.

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. Welcoming our new Chief Executive

I wanted to take the opportunity to place on record my thanks to the Board and the wider organisation for your support as I take on the interim Chief Executive role for these few weeks until Clare Smith joins us on 24 November.

I know that Clare is really keen to get started, and she has been fitting in as many introductory meetings and site visits as she can in advance of her arrival, which will stand her in good stead when she joins us. I have no doubt she will receive a warm welcome from you all.

Thank you also to Deputy Finance Director Sarah Barrow, who is taking over the Finance Director role on an interim basis to allow me to focus my full attention on being Interim Chief Executive until Clare begins.

2. Care Quality Commission (CQC) inspection

A small team of CQC inspectors carried out an unannounced inspection at Scarborough Hospital from 7-9 October. They spent three days on site and were looking at medical care services and urgent and emergency care pathways, with a view to re-rating both services.

We received some high-level verbal feedback at the end of the inspection, and a number of issues were raised which we were able to respond to immediately. As is usual with such inspections, the CQC has also asked for a significant amount of supporting information and documentation, which we are gathering for submission ahead of the deadline later this month.

A formal report will be published detailing their findings and recommendations, however, we do not yet have a date for publication. In the meantime we must thank all colleagues involved in the inspection, who were described by the CQC in their feedback as welcoming, helpful and engaged in the inspection process.

3. Planning guidance update

We are still yet to receive the planning guidance for next year, however within the Trust our planning for 2026/27 is well underway based on what we already understand to be the case, which is that the uplift is likely to be in line with 2025/26 and efficiency will be set at 2%.

4. Our Voice Our Future

I was delighted to attend a time-out session for our Changemakers earlier this month, along with my executive director colleagues. As Board members will be aware, our Changemakers are a group of colleagues from all corners of the organisation who have volunteered their time to drive forward our culture and leadership programme and, ultimately, improve the experience of working in our trust for everyone. We had the chance to work with each of the three groups of changemakers who are taking forward the programmes of work identified through this process so far. Their enthusiasm and energy is truly infectious, and reinforces the view that it is people doing the work who know best how to improve the work. I look forward to their next update to the Board.

5. Celebration of Achievement Awards

At the time of writing our annual staff recognition awards are almost upon us, and I couldn't be more excited to be hosting them this year in Scarborough. A record number of nominations were received this year and I know that our judging panels have had a job on their hands to select winners from such high calibre entries.

I know it will once again be a fantastic occasion and a great opportunity to recognise just some of the many inspiring teams and individuals who make our trust so special. Thank you to everyone who took the time to nominate someone, and congratulations to all of our finalists.

6. NHS National Staff Survey

The NHS Staff Survey is now open. Whilst it is a chance to hear from colleagues about how we can improve and where we need to do better, it is also important that we hear about the experiences of as many people as possible, whatever their views, and use it as an opportunity to recognise and celebrate good practice. In the first week that the survey has been open we have made a good start in terms of numbers of responses, but I am making a plea to encourage as many colleagues as possible to take the time to give their feedback. We have asked all managers to ensure that time is made available for people to complete the survey, and to encourage their teams to do so. Improving the experience of working in our organisation is a key priority for our Board, and we need to do what we can to ensure we are listening to staff and responding to the feedback they give us.

7. 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. Due to the timing of the Board meeting this month, judging for October has not yet been completed, however all nominations for October and November will be shared alongside this report next month.

Date: 22 October 2025

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

TRUST PRIORITIES REPORT

October 2025

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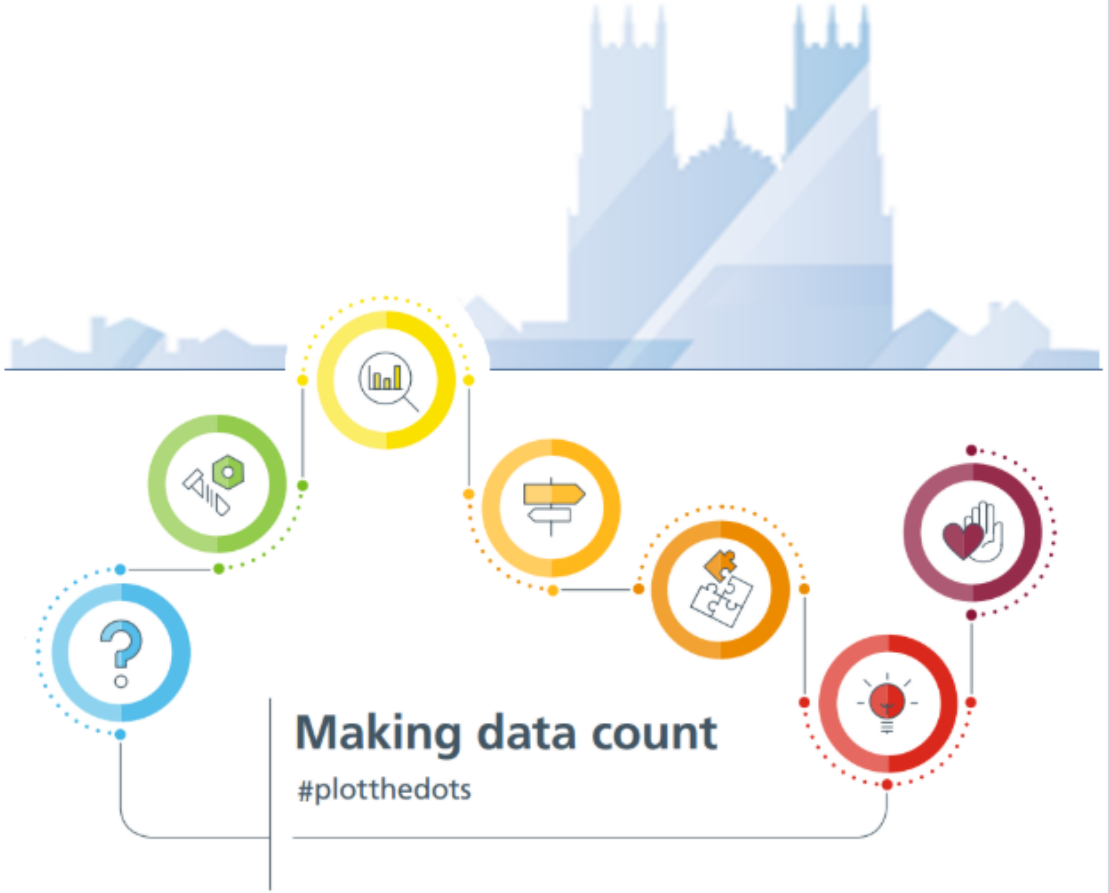


Executive Summary

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 included for Q3)	2025-07			36.6%		49%
Percentage recommending the Trust as a place to work (quarterly - data source is PULSE, Staff Survey data included for Q3)	2025-07			39.1%		50%
Percentage reporting the organisation will address their concern (quarterly - data source is PULSE, Staff Survey data included for Q3)	2025-07			27%		40%
Percentage being able to make improvements happen in their area of work (quarterly - data taken from PULSE, Staff Survey data included for Q3)	2025-07			50%		53%
Inpatients - Lost bed days for patients with no criteria to reside	2025-09			1371		
ED - Emergency Care Standard (Trust level)	2025-09		F	67.6%	73%	78%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-09		F	15.6%	11.9%	8.9%
Cancer - Faster Diagnosis Standard	2025-08		F	64.7%	70%	80.1%
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-09	H	F	56.9%	57%	60.5%
Inpatient Acquired Pressure Ulcers - Category 2	2025-09		?	85	60	60
Total Number of Trust Onset MSSA Bacteraemias	2025-09		?	8	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 – Number of Non-Elective Admissions.
- Operational Performance - RTT – Total Waiting List.
- Operational Performance - RTT – Waits over 52 weeks for Incomplete Pathways.
- Operational Performance - RTT – Proportion of the incomplete RTT pathways waiting > 52 weeks.
- Operational Performance – Children & Young Persons: RTT – Total Waiting List.
- Operational Performance - Children & Young Persons: RTT – Proportion of the incomplete RTT pathways waiting less than 18 weeks.
- 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

October 2025

Executive Owner: Claire Hansen

Highlights:

- Although the National Oversight Framework ranking is not where it needs to be. Evidence that quality oversight has strengthened with recent CQC and Tiering findings acknowledging improvement, although further embedding is required.
- This month Care Groups have continued with their planning for 2026/27 with a draft submission deadline of the 17th of October. The plans are being developed with corporate operational support guiding with data packs and offering confirm and challenge to assumptions based on performance in 25/26.
- Progress on UEC and Elective Care Programmes have continued and remain broadly on track. Additional actions have been developed for UEC to address the recent deterioration in 4 hours and 12 hours, this is expected to have recovered by October to previous months performance of circa 68%, which although still behind trajectory, will demonstrate sustainability. Further planned actions as part of the programme are anticipated to bring this back to trajectory by Q3.
- Elective recovery workshop scheduled for November 2025 to review current position for RTT, Cancer and Diagnostics and additional actions required to bring us back to trajectory in Q4 2025/26.

Concerns/Risks (Top 5):

1. Emergency Department Performance Variability

UEC: ECS 67.6% which is below trajectory; Type 1 12+ hr waits 15.6%. Ambulance handovers average 22:02 with zero >240 mins.
We continue to operate under sustained urgent and emergency care pressure with variable ECS 4 hour and 12 hour in department performance, flow constraints and bed occupancy.
Risk: Inconsistent day-to-day performance and high 12-hour waits, especially at Scarborough ED.
Mitigation: Ongoing recruitment of medics and Advanced Care Practitioners, close monitoring and optimisation of Ambulatory Care pathways, and implementation of new flow coordinators.

2. Cancer Pathway Backlogs

Cancer (August): FDS 64.7%, 62-day 64.5% (diagnostic capacity limiting).
Risk: High volume of referrals causing delays in diagnosis and treatment, especially in colorectal and urology; diagnostic bottlenecks in endoscopy and imaging.
Mitigation: Implementation of Rapid Diagnostic Centre pathways, insourcing to boost endoscopy capacity, recruitment of specialist staff, and escalation of diagnostic recovery plans.

Executive Owner: Claire Hansen

Concerns/Risks – Top 5 – Continued:

3. RTT Long Waiters and Growing Waiting Lists
Elective: RTT total WL 57,450 (above plan); >52w 2,034 (3.5%); >65w 47. %<18w at 56.9%.
Elective recovery remains mixed: strong progress where capacity is ring fenced (e.g. Bridlington Surgical Hub), but specialty pressures persist (notably ENT, Oral Surgery, Cardiology and Respiratory Medicine). Elective RTT waiting list growth is forecast to continue to grow due to an increase in referrals. This is forecast to be circa 500 patients per month. This puts at risk the delivery of the RTT improvement trajectories for 52 weeks and 18 weeks.
Risk: Significant numbers waiting over 52 and 65 weeks, with rising referral volumes impacting total waiting lists.
Mitigation: Intensive validation sprints, weekly recovery meetings, targeted use of Elective Recovery Fund, and enhanced demand management discussions with ICB.

4. Staffing and Capacity Shortfalls in Diagnostics
Diagnostics: DM01 65.5% vs 74.8% trajectory; pressure in MRI, CT, colonoscopy & gastroscopy.
Diagnostic capacity remains challenged from demand, workforce, and equipment failures.
Risk: MRI, CT, and audiology performance affected by vacancies, sickness, and equipment breakdowns.
Mitigation: Insourcing for imaging and sleep studies, ongoing recruitment, training for radiographers, and deployment of additional audiology booths.

5. Workforce and Process Challenges in Outpatients and Community Services
Risk: Delays in PIFU rollout, RACP underperformance, and national shortage of SLT therapists affecting paediatric waits.
Mitigation: Recruitment of administrative and clinical staff, alternative patient contact strategies, and ongoing review and optimisation of referral and therapy pathways.

Actions for the next month (October 2025):

- Complete recruitment processes for Scarborough ED medics and Advanced Care Practitioners at Selby and Malton.
- Monitor and refine the refreshed Ambulatory Care pathway at Scarborough ED.
- Begin onboarding of Flow Coordinators at York site.
- Continue insourcing for endoscopy and imaging to address diagnostic backlogs.
- Deliver further training and data pack rollouts for discharge improvement initiatives.
- Launch new pathways and patient communication methods for PIFU pathways.
- Evaluate impact of SLT ‘Leap Into Language’ initiative and continue targeted reduction of paediatric waits.
- Rollout of ethnicity recording project to increase ethnicity recording at points of entry in ED, outpatients and pre-operative assessment.

Executive Owner: Claire Hansen

Actions for the next three months (Q3 2025/26):

- Implement business case for workforce modelling at York and Scarborough EDs to match capacity to demand.
- Roll out expanded "Describe not Prescribe" and discharge training to additional nursing staff.
- Continue RTT Validation sprints and review impact on RTT waiting list size.
- Advance work on digital clinical letters and operational toolkit embedding for outpatients.
- Evaluate and refine pathways and handover processes in paediatric emergency care.
- Finalise and implement demand management interventions in partnership with ICB to stabilise OP referral rates.
- Maintain weekly RACP meetings and track improvement against agreed actions with the Medicine Care Group.
- Continue to develop and operationalise virtual ward pathways, particularly for frailty and heart failure.
- Elective recovery workshop scheduled for November 2025 to review existing trajectories and additional actions required to return to trajectory in Q4.

Future:
Although mitigations are in place, if demand continue to rise in the same way across all areas, it is likely without some system demand management and additional funding to support recovery, the end of year performance targets are at risk.

Headlines:

- The September 2025 Emergency Care Standard (ECS) position was 67.7%, against the monthly planned improvement trajectory of 73%. In the latest available national data (August 2025) the Trust ranked 90th out of 121 providers nationally (July 2025: 91st). **ECS performance is a True North metric.**
- Average ambulance handover time in September 2025 was significantly ahead of trajectory at 22 minutes 02 seconds against trajectory of 29 minutes 11 seconds.
- 15.6% of Type 1 patients spent over 12 hours in our Emergency Departments during September 2025, behind the monthly improvement trajectory of 11.9%. **This is a True North Metric.**
- In September 2025, the proportion of patients in our care who no longer meet the criteria to reside was 12.6% ahead of the internal trajectory of 13.8%.
- The average non-elective Length of Stay (LoS) for patients staying at least one night in hospital was 6.7 days during September 2025 (3,844 spells of care covering 25,698 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 86.8% (3,316 patients out of 3,819), behind the trajectory of 87.2% submitted as part of the 2025/26 annual planning process. The average delay (number of days after the DRD that a patient was subsequently discharged) was 3.0 days, ahead of the submitted trajectory of 3.3 days.

Factors impacting performance:

- Scarborough ED performance of Type 1 patients is where our biggest challenge remains. Attendances to Scarborough ED have grown by 18% year-on-year (September 2024 compared to September 2025). At York the growth is 10%.

Actions planned in October 2025:

- Medic recruitment at Scarborough Emergency Department is underway, with interviews taking place early October 2025. Successful recruitment would allow a small increase in the current roster while work is underway to determine full requirements for the increasing demand.
- Recruitment continues for Urgent Care Practitioners at Selby and Malton, with four interviews due to take place in October. Once in post, more patients will be able to be treated at these sites, and fewer patients will need onward referral to an acute site.

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

Acute Flow (1)
Scorecard

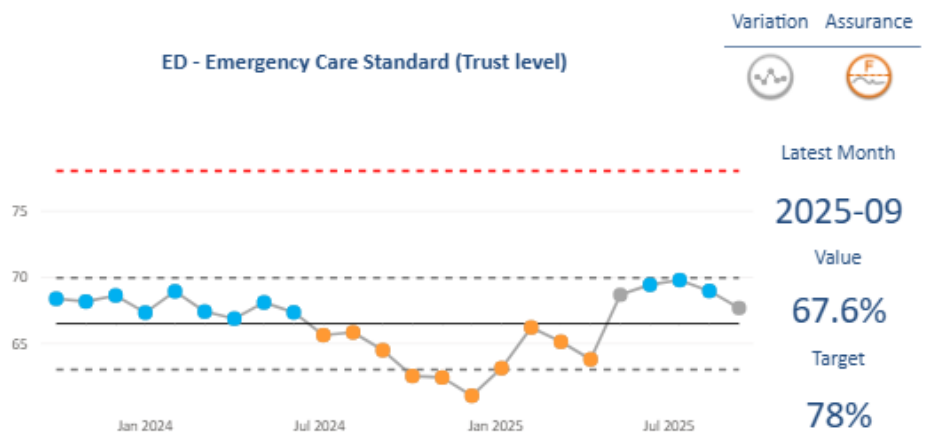
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Proportion of all attendances having an initial assessment within 15 mins	2025-09	H		75.4%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2025-09			31.3%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-09		F	15.6%	11.9%	8.9%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2025-09			1707		
ED - 12 hour trolley waits	2025-09	L	F	535		0
ED - Emergency Care Attendances	2025-09		F	19008	15951	16377
ED - Emergency Care Standard (Trust level)	2025-09		F	67.6%	73%	78%
ED - A&E attendances - Type 1	2025-09		?	10917	10713	10999
ED - Emergency Care Standard (Type 1 level)	2025-09	H	F	47.8%	61.5%	69.2%
ED - A&E Attendances - Types 2 & 3	2025-09		F	8091	5238	5378
ED - Median Time to Initial Assessment (Minutes)	2025-09	L		4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-09			44.6%		

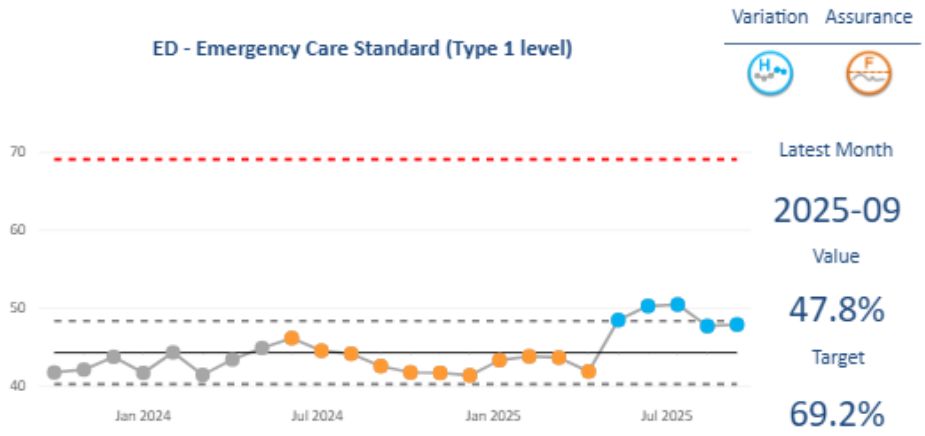
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

The latest months value has **deteriorated** from the previous month, with a difference of **1.3**.



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

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

Rationale: To monitor waiting times in Emergency Departments and Urgent Treatment Centres. **Target: SPC1:** NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 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?

Areas of focus in October are:

- Close monitoring of refreshed Emergency Department Ambulatory Care (EDAC) pathway at Scarborough ED and appropriately increasing patients through this pathway.
- Interviews and appointment of additional trust grade medics at Scarborough Emergency Department.
- Starting the GP letters direct to Surgical Assessment Unit pathway at Scarborough following successful implementation at York.
- Preparation for onboarding two appointed Flow Coordinators in York (start date November TBC)

What is the expected impact?

The impact of successfully achieving the above will be improvements in 4hr performance.

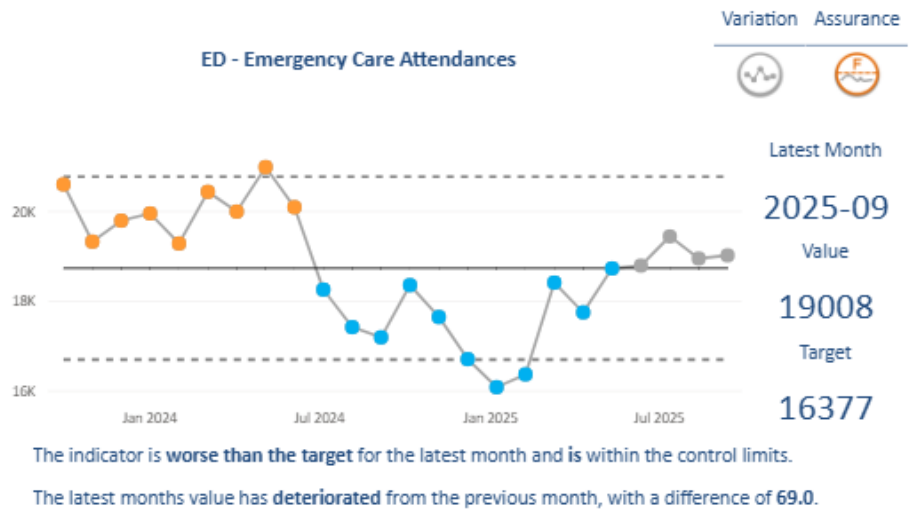
Potential risks to improvement?

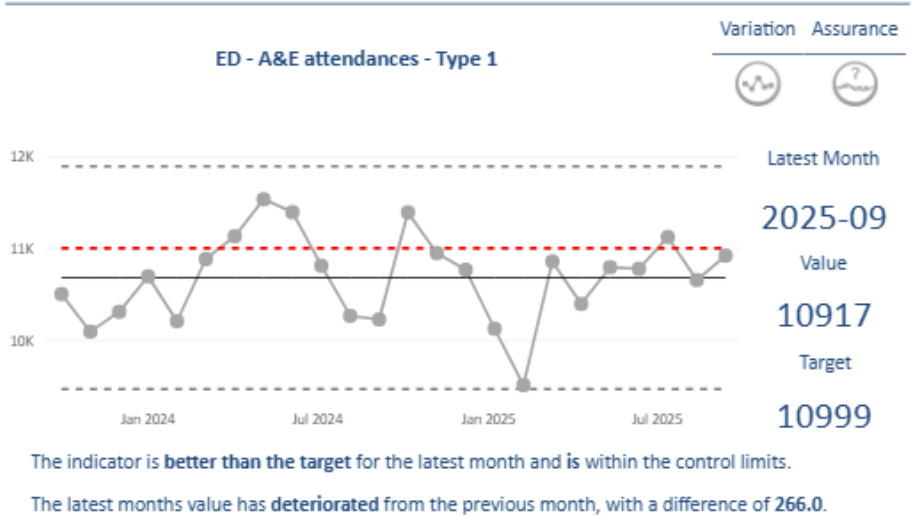
There is a risk that recruitment of the outlined posts is not successful, which would delay increase in capacity and capability.

There is an issue of very inconsistent day-to-day performance levels at our Emergency Departments which makes proactive planning more challenging.

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?

Yorkshire Ambulance Service colleagues are linking with Scarborough frailty services to develop a direct frailty pathway for crews; this has been fully drafted and awaiting final clinical sign off in October 2025.

Our AHP Lead in community services has met with colleagues from YAS and City of York Be-Independent falls managers. Together the group has reviewed and mapped falls pathways, and is now updating these in partnership. A follow up meeting is taking place in October 2025.

To mitigate the issue that Community Response Team (CRT) is at full capacity and unable to support both step-up and step-down demand, an agreement has been reached between Community and Medicine care groups. Medicine Care Group is able to provide additional clinical capacity to CRT 2 days per week.

What is the expected impact?

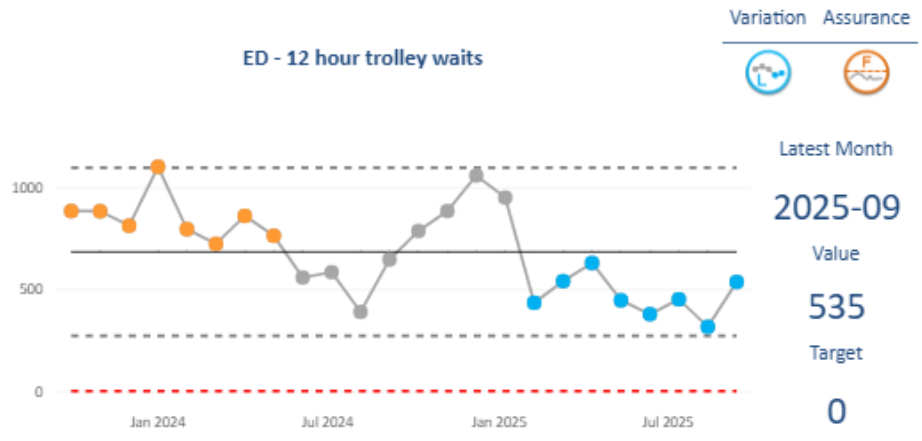
Increasing utilisation of alternative pathways may reduce conveyances to acute sites and could reduce the *proportion* of Type 1 activity. However, attendance numbers could still rise in-line with overall demand.

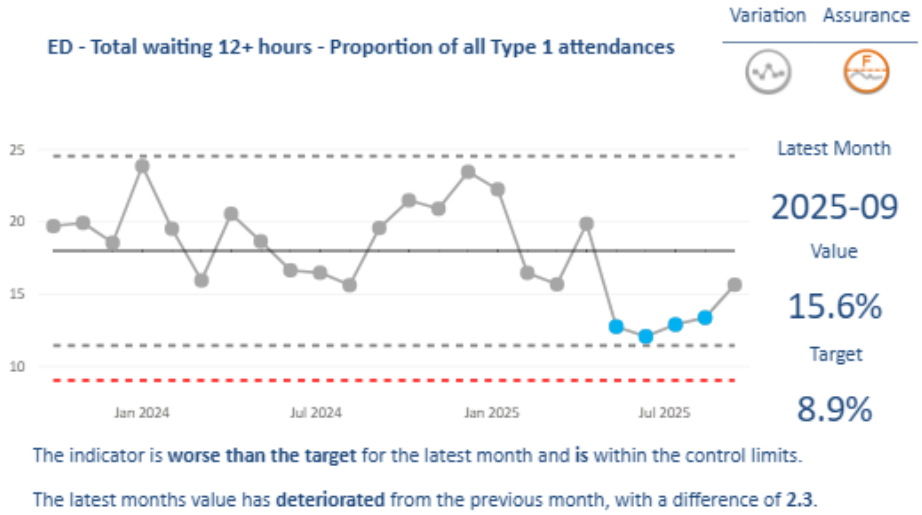
Potential risks to improvement?

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





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?

Led by the Quality Improvement Team and Dr Ed Smith, a rapid improvement event around continuous flow is planned in the coming month.

The main components to be tested are a) whether clinical input into decision making around bed utilisation impacts on outcomes and b) whether we can move from doing continuous flow in 'batches' to it being standard practice.

The aim is to test this on the Scarborough site first and pick two specialties to test against. Orthopaedics and Cardiology have both been consulted with and are supportive of this approach.

What is the expected impact?

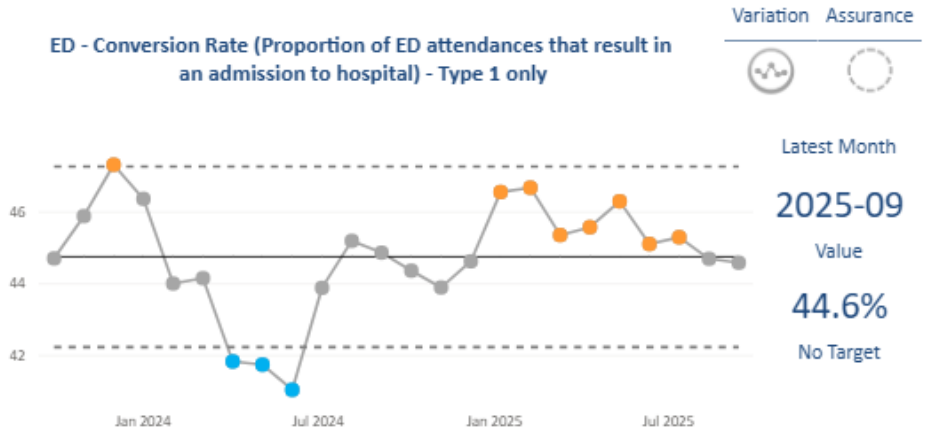
The expected impact is a better understanding of how to continue improving flow through our acute sites.

Potential risks to improvement?

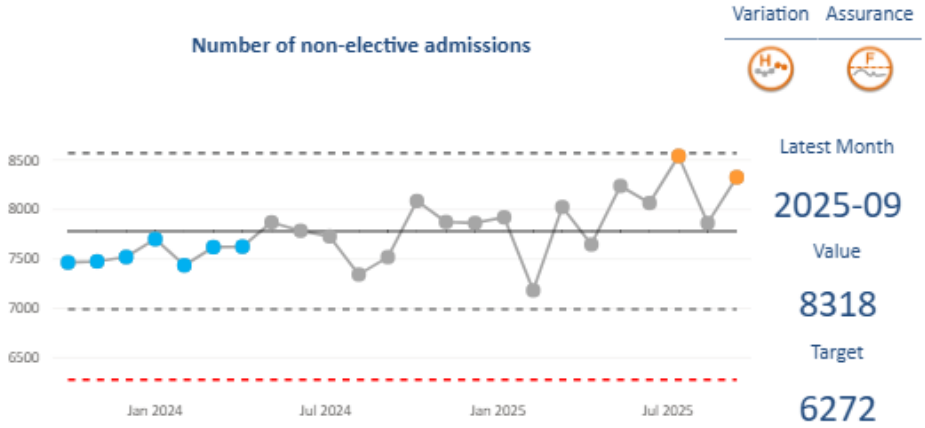
When acute hospitals have very high occupancy levels, wards may find it difficult to safely receive 'additional' patients through continuous flow.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **0.1**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **462.0**.

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

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

What actions are planned?

A review of the workforce model has been completed at both York and Scarborough Emergency Departments.

Heatmaps of activity, existing roster patterns, nationally recommended levels of staffing and expected productivity levels have all been considered. The work has shown that, per weighted activity unit, both departments are lean. That is, we have fewer clinicians rostered on than would be expected.

Despite this - and increasing demand - we are maintaining performance levels and are in an improved position against the same time last year.

Tests of change are aiming to reduce the medical cover gap through working more efficiently however the Care Group does anticipate a need for additional investment, which will be presented as a business case.

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 case for the workforce models at the Emergency Departments cannot find required resources from efficiencies alone.

Acute Flow (2)
Scorecard

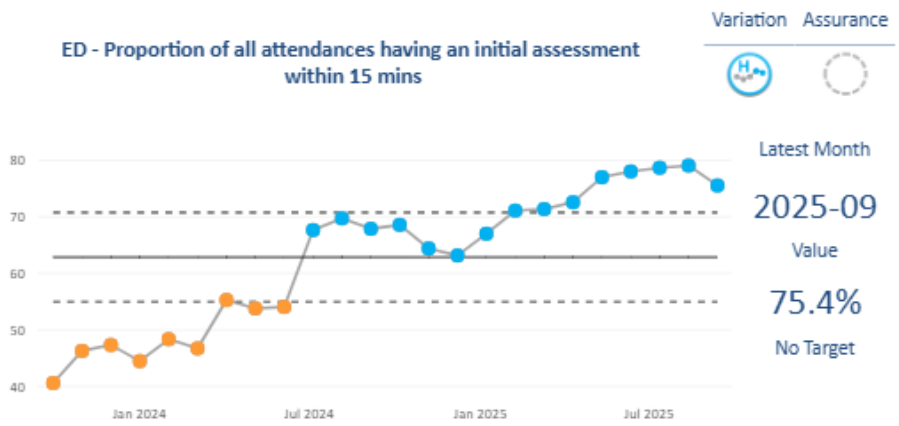
York and Scarborough Teaching Hospitals NHS Foundation Trust

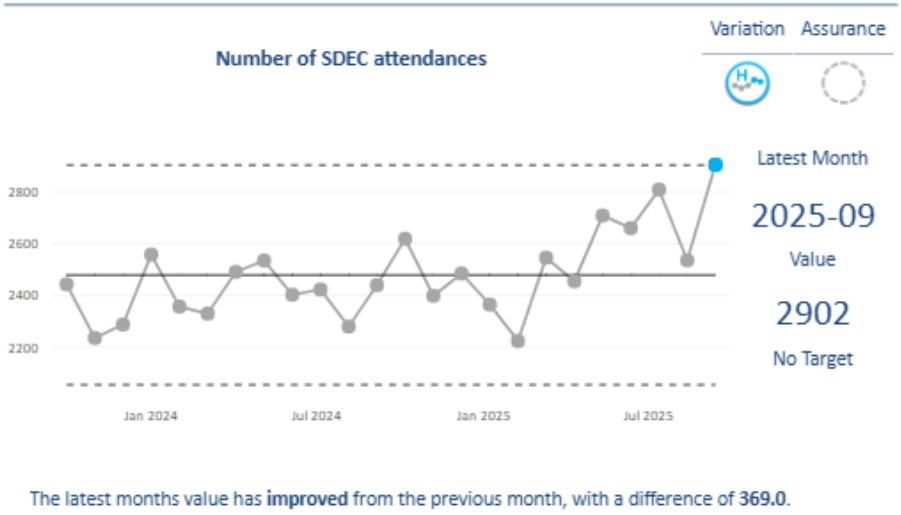
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

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	2025-09			44.6%		
Number of SDEC attendances	2025-09	H		2902		
Proportion of SDEC attendances transferred from ED	2025-09			64.2%		
Proportion of SDEC attendances transferred from GP	2025-09			26.6%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-09	H		64.6%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-09			15.7%		
Number of RAFA attendances (York Only)	2025-09			174		
Number of attendances at SAU (York & Scarborough)	2025-09	H		1103		
ED - Proportion of Ambulance handovers within 15 mins	2025-09	H		34.3%		
ED - Proportion of Ambulance handovers waiting > 30 mins	2025-09	L		22%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2025-09	L	F	4.9%		0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2025-09	L	?	0%		0%
ED - Number of ambulance arrivals	2025-09	H		4793		
ED - Ambulance average handover time (number of minutes)	2025-09	L	?	22	29	29

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

Continuing to reduce elective attendances at SDECs and attendances to SDEC which go via both a GP and the Emergency Department. This is through direct pathways from GP to SDECs and through working with specialties to identify new pathways for 'bring back' elective patients.

What is the expected impact?

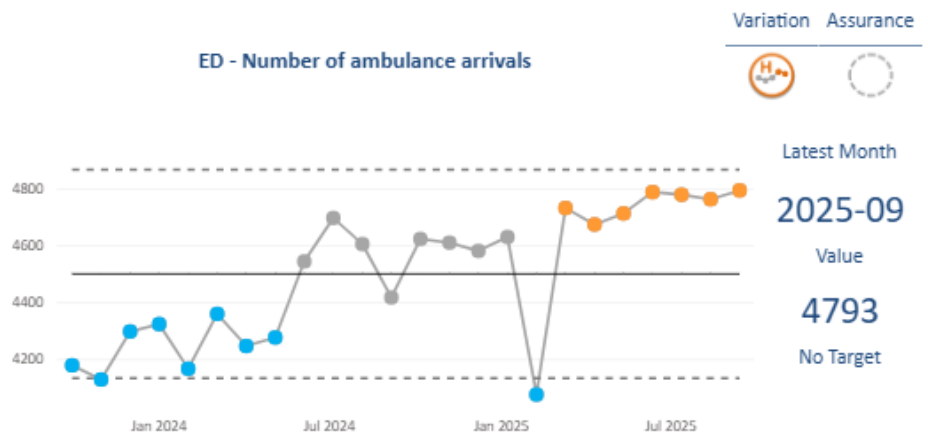
A 20% reduction in bring back activity in each affected SDEC unit this financial year. This will allow for more direct SDEC admissions and quicker movement of patients from ED to SDEC.

Potential risks to improvement?

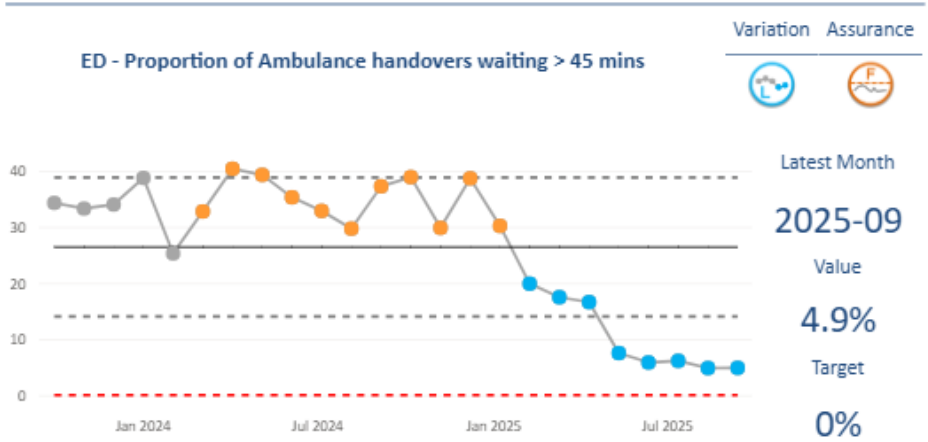
There is a risk that the number of patients impacted by the test of change is lower than expected, which will limit the impact felt in the Emergency Department.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **deteriorated** from the previous month, with a difference of **31.0**.



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 **0.1**.

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?

Meeting with Yorkshire Ambulance Service and colleagues from the ICB to discuss discrepancies identified through audit between handover timestamps.

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?

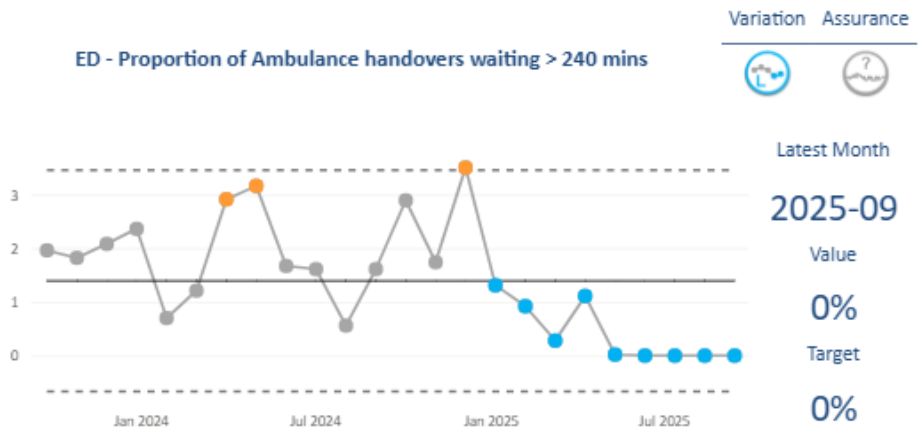
There is a risk that we cannot influence ambulance crew behaviours which lead to delays in recording handovers.

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.

There is a hypothesis that improving ambulance handover times at the acute hospitals may correlate to the conveyance rate of the ambulance service.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

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

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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		* Number of zero day length of stay non-elective admitted patients	* 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) * Of those overnight general and acute beds open, proportion occupied * Community bed occupancy/availability	* Patients receiving clinical Post Take within 14 hours of admission * Inpatients - Proportion of patients discharged before 5pm
SPECIAL CAUSE CONCERN			* Number of non-elective admissions

Acute Flow (3)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

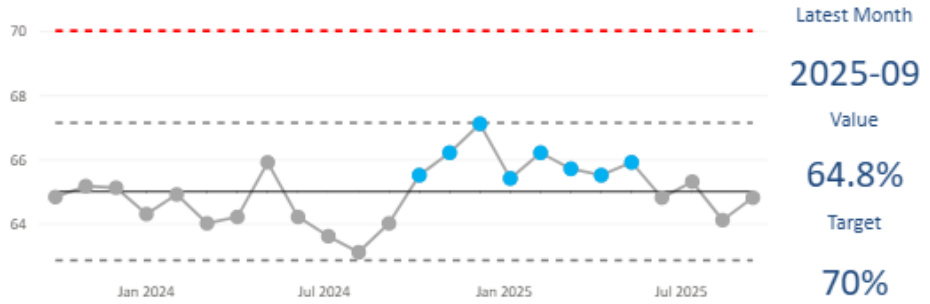
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2025-09		F	79.2%		90%
Patients with Senior Review completed at 23:59	2025-09			47.5%		
Inpatients - Proportion of patients discharged before 5pm	2025-09		F	64.8%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2025-09			1371		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2025-09	L	F	12.6%	13.8%	12.5%
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2025-09		?	3	3.3	3.9
Number of non-elective admissions	2025-09	H	F	8318	5914	6272
Number of zero day length of stay non-elective admitted patients	2025-09	H	?	2814	2324	2464
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2025-09			122		
Overnight general and acute beds open	2025-09		P	878	832	832
Of those overnight general and acute beds open, proportion occupied	2025-09		?	91.9%		92%
Community bed occupancy/availability	2025-09		?	88.2%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Inpatients - Proportion of patients discharged before 5pm

Variation Assurance



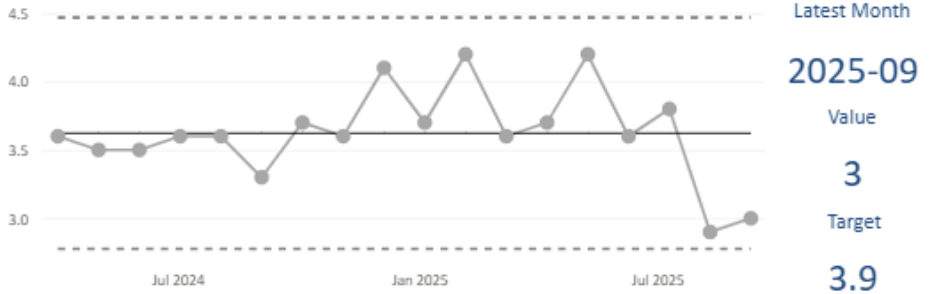
Latest Month
2025-09
Value
64.8%
Target
70%

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

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

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

Variation Assurance



Latest Month
2025-09
Value
3
Target
3.9

The latest months value has **deteriorated** from the previous month, with a difference of **0.1**.

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?

Further roll out of "Describe not Prescribe" training is planned with an expanded target audience to include more nurses.

Creating data packs for each specialty, helping frontline teams to understand their indicators and actions which contribute to improving them.

Trialling a "golden round" at Scarborough and York by Bed Managers daily at 2:30pm. Discharges for that day and the next day will be identified to facilitate early morning discharges through the discharge lounge the following day.

Trial of morning escalation huddles in Medicine care group between Matrons and Operational Manager of the Day to coordinate ward cover and share escalations.

What is the expected impact?

Increased sense of ownership on the wards or within specialties, relating to their discharge performance metrics.

Better coordination of staff to improve efficiency and provide more comprehensive operational grip.

More discharges through the discharge lounge, earlier in the morning.

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

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

Variation Assurance

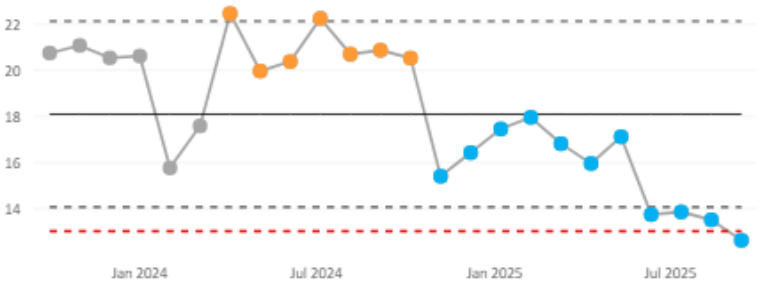
Latest Month
2025-09
Value
122
No Target

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

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

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

Variation Assurance



Latest Month
2025-09
Value
12.6%
Target
12.5%

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 **0.9**.

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: SPC1: No Target. **SPC2:** Internal aim to achieve less than 12.5% by March 2026.

What actions are planned?

Following evaluation of Long Length of Stay review meetings, decision made to continue and collect more detailed data from the sessions to help identify impact and themes/opportunities for improvement.

Audit of medically fit patients over 21 days to be undertaken.

Local plan to support complex rehab patients being explored in meeting in October.

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 August 2025 saw performance against the 28-day Faster Diagnosis standard (FDS) of 64.7%, failing to achieve the monthly improvement trajectory of 70.0%. In the latest available national data (July 2025) the Trust ranked 127 out of 140 providers nationally. **This is a True North Metric.**

- 62 Day waits for first treatment August 2025 performance was 64.5%, with the monthly trajectory of 71.3% was not achieved. In the latest available national data (July 2025) the Trust ranked 100 out of 144 providers nationally. 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:

- May- July was the highest referrals received month for urgent suspected cancer referrals in Trust history (over 3,000 per month). This increase in referrals is impacting on number of patients on patient tracking list and 28-day faster diagnosis. 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 97.7% overall, achieving the national target of 96%.
- At the end of August, the proportion of patients waiting over 104+ days equates to 1.3% 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

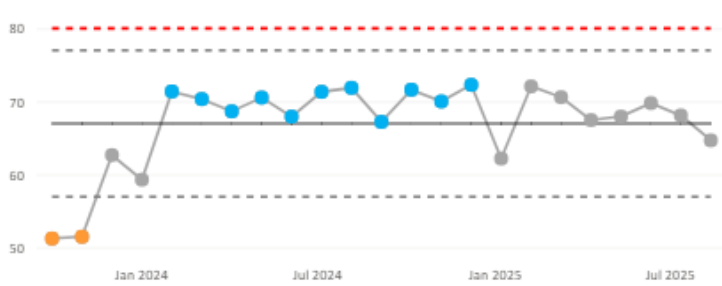
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard	2025-08			64.7%	70%	80.1%
Cancer - 62 Day First Definitive Treatment Standard	2025-08			64.5%	71%	75%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2025-09			251		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2025-09			9.6%		
Cancer 31 day wait from diagnosis to first treatment	2025-08			97.9%		96.1%
Total Cancer PTL size	2025-09			2608		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2025-09			68.4%	80.1%	80.2%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Cancer - Faster Diagnosis Standard



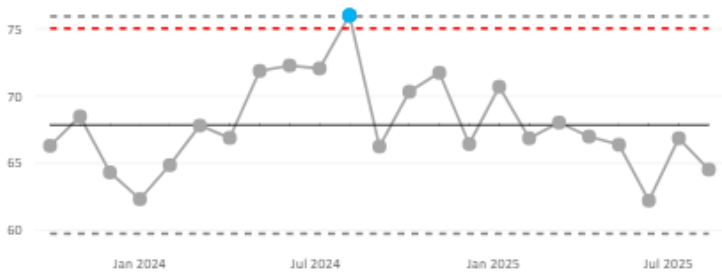
Latest Month
2025-08
Value
64.7%
Target
80.1%

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

The latest months value has **deteriorated** from the previous month, with a difference of **3.4**.

Variation Assurance

Cancer - 62 Day First Definitive Treatment Standard



Latest Month
2025-08
Value
64.5%
Target
75%

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 **2.3**.

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 and launced, 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: Straight To Test 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 prostate pathway to understand opportunities for streamlining and efficiencies. Initial conversations planned around scoping potential one stop Community Diagnostic Centre models for 2026 onwards.

Gynaecology Plan: Locum consultant providing additional sessions to recover position. Agreed implementation date October for PMB pathways 2025. Working through bid for Pipelle clinics in Community Diagnostic Centre with Collaborative of Acute Providers.

Skin plan: Ongoing discussions with ICB and cancer alliance around GP collective action impact on number of referrals in pathway (35% increase April- September 2025 compared to last year). Insourcing being utilised to provide additional capacity.

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
- 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 September 2025, the Trust had forty-seven **Referral To Treatment (RTT) patients waiting over sixty-five weeks**, an increase on the thirty at the end of August 2025.
- The Trust's **RTT Total Waiting list position** ended September 2025 behind the trajectory submitted to NHSE as part of the 2025/26 planning submission: 57,450 against the trajectory of 44,649.
- The Trust is behind the trajectory for the proportion of the **RTT waiting list waiting under 18 weeks**: 56.9% against 57%. In the latest available national data (July 2025) the Trust ranked 100th out of 151 providers (June 2025: 95th). 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; 2,034 waiters and 3.5% of the total RTT Total Waiting list against the trajectories of 803 and 1.8%, respectively. In the latest available national data (July 2025) the Trust is 42nd in terms of the highest number of RTT52 week waiters (54th at end of June 2025) and is ranked 36th highest out of 151 providers for the proportion of the TWL waiting over 52 weeks (June 2025: 46th). Nationally at the end of July 2025 there were 186,967 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 59.6% against the end of September 2025 ambition to be above 61.4%. 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 September 2025 the Trust was ahead of the 2025/26 plan with a provisional performance of 102% 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
COMMON CAUSE / NATURAL VARIATION			
SPECIAL CAUSE CONCERN			* RTT - Total Waiting List * RTT - Waits over 52 weeks for Incomplete Pathways * RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks

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	2025-09	H	F	57450	44649	38992
RTT - Waits over 78 weeks for incomplete pathways	2025-09	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways	2025-09	L	F	47	0	0
RTT - Waits over 52 weeks for Incomplete Pathways	2025-09	H	F	2034	803	389
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-09	H	F	56.9%	57%	60.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2025-09	L		18.5		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks	2025-09	H	F	3.5%	1.8%	1%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2025-09			59.6%	61.4%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2025-09			1.8%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2025-09			12.1%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2025-09			66.6%		

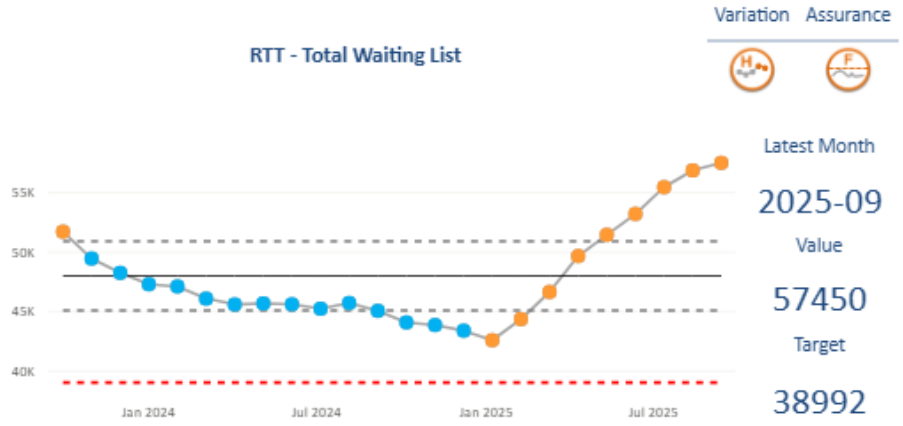
KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

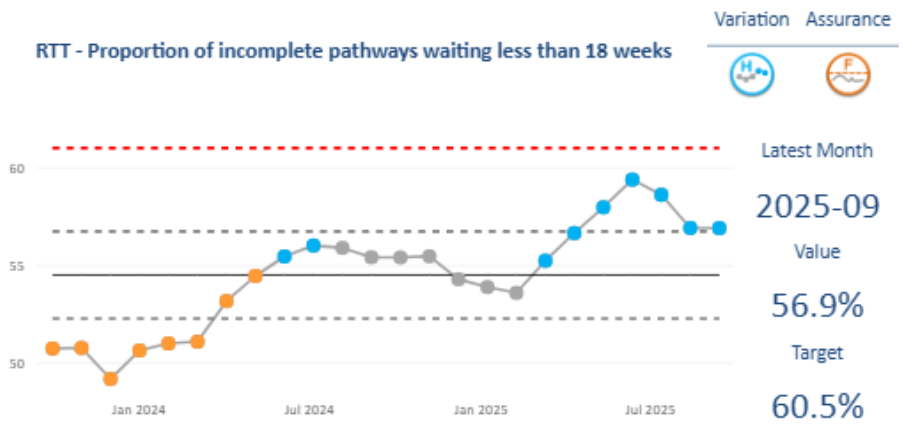
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **deteriorated** from the previous month, with a difference of **635.0**.



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

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

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 sprint, the Trust was 22% ahead of the baseline (circa 6,600 additional RTT clock stops). A Q3 sprint will commence in November running for seven weeks.

- 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. This is supported in the rise in the TWL of circa 500 from the end of August to September, significantly lower that the 1,500 to 2,000 monthly rises seen previously.

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.

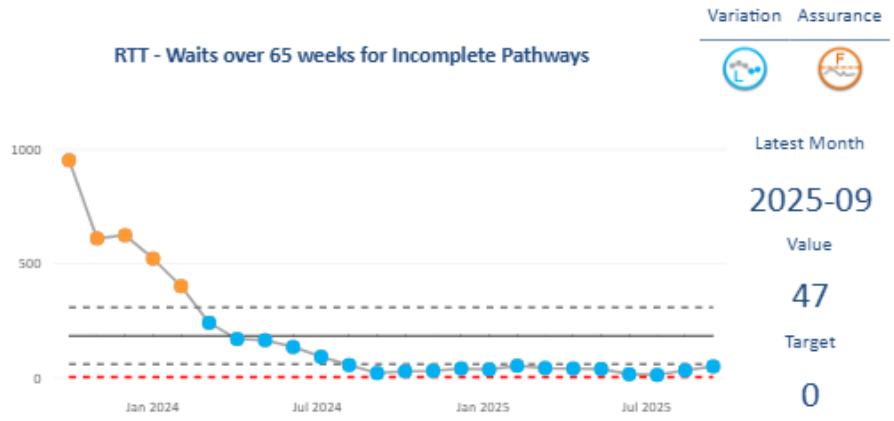
Potential risks to improvement?

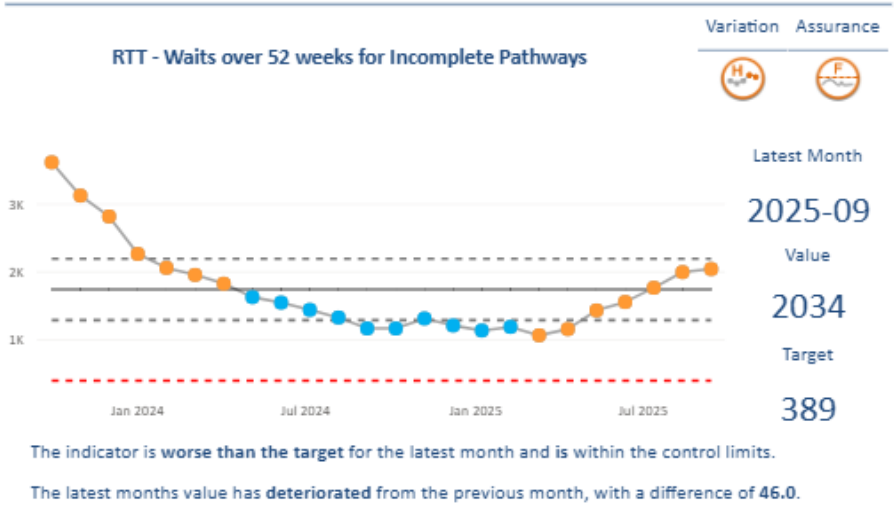
- Despite the sprint, ongoing referral increase may result in further rises to the RTT TWL. To stabilise the waiting list, we need to focus on increasing clock stop activity and validation. This has been communicated to NHSE.

- Increase in GP referrals in Q1 and Q2 to date of 25/26 compared to same period in 24/25 (up 8%). Discussions with ICB ongoing to identify causes of referral increases.

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. Care Groups challenged to make significant RTT52 improvements by the end of Q3.
- 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 specialties at September 25 completed. £2.3million remains available.
- 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.
- Elective recovery workshop scheduled for November 2025 to identify any additional high impact actions.

What is the expected impact?

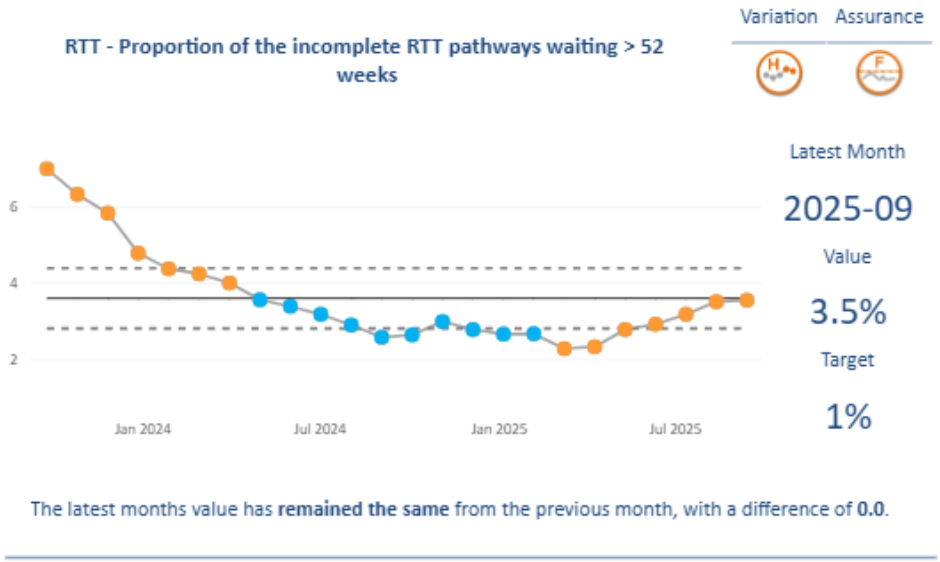
- Reduced RTT long waiters.
- ERF money targeted at specialties most in need.

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 September 2025, the Patient Initiated Follow Up (PIFU) the Trust the improvement trajectory of 4.5% with performance of 4.5%. 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 55.5% (August: 34.3%) which whilst a significant improvement remains below the target of 99%.

Factors impacting performance:

- PIFU as standard project has resulted in improvements in PIFU rates in gynaecology, cardiology and gastroenterology in September 2025.

- 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 and improvements seen in September 2025 as a result of administration staff commencing at York to free up clinical time. Triage pilot evaluation

- 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 to 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) * Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)
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)
SPECIAL CAUSE CONCERN			

Outpatients & Elective Care
Scorecard

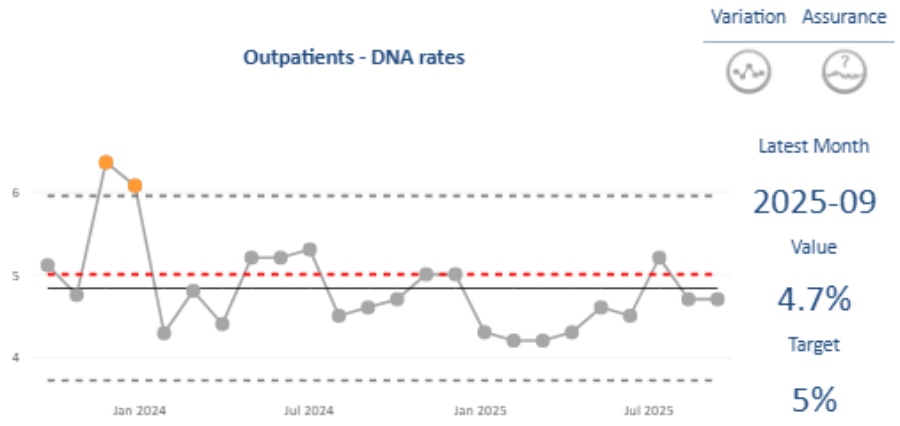
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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)	2025-09		F	21.5%		25%
Outpatients - DNA rates	2025-09		?	4.7%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2025-09	H	?	20756	15838	17494
Outpatients: Follow Up Attendances (Activity vs Plan)	2025-09		?	46131	36759	38846
Outpatient procedures	2025-08			14043		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2025-09		F	27226		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2025-09	H	F	4.5%	4.5%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2025-09	H	F	55.5%		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*	2025-09		?	3		0
Day Cases (based on Activity v Plan)	2025-09		?	7801	7300	8144
Electives (based on Activity v Plan)	2025-09		?	613	726	816
Proportion of elective admissions which are day case	2025-09		P	92.7%		85%
Outpatients: All Referral Types	2025-09			23966		
Outpatients: Consultant to Consultant Referrals	2025-09			2501		
Outpatients: GP Referrals	2025-09	H		10500		

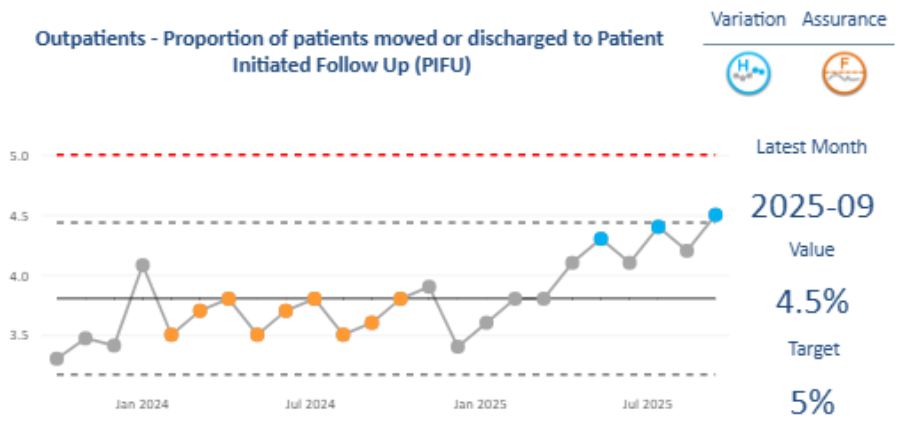
Executive Owner: Claire Hansen

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 **remained the same** from the previous month, with a difference of **0.0**.



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

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

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

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 has been successful. This will free up nursing staff.
    - Job plan review and additional clinics scheduled at Scarborough.
    - Cross site agreement on evaluated urgency for RACP patients and recording on CPD to be agreed and in place.

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.

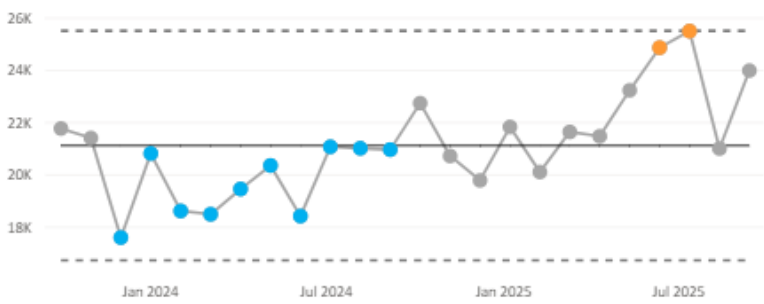
- **Potential risks to improvement?**
- PIFU at Scarborough is significantly lower than York (1.8% at SGH / 5.2% at York).
- **RACP:** Medical staffing at Scarborough.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Outpatients: All Referral Types



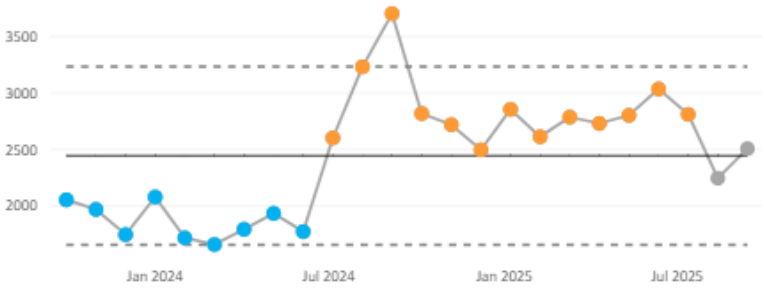
Latest Month
2025-09
Value
23966
No Target

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

The latest months value has **deteriorated** from the previous month, with a difference of **2984.0**.

Variation Assurance

Outpatients: Consultant to Consultant Referrals



Latest Month
2025-09
Value
2501
No Target

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

The latest months value has **deteriorated** from the previous month, with a difference of **262.0**.

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 to be presented at elective recovery board in October 2025. Increase was a result of change in process, this has been amended in July 2025 and reduction seen. Residual increase is as a result of electronic referrals within the same speciality.
- BI insights work to be completed in October 2025 on suspected cancer referrals and impact on conversion rates to understand impact of referrals on cancer diagnosis.

What is the expected impact?

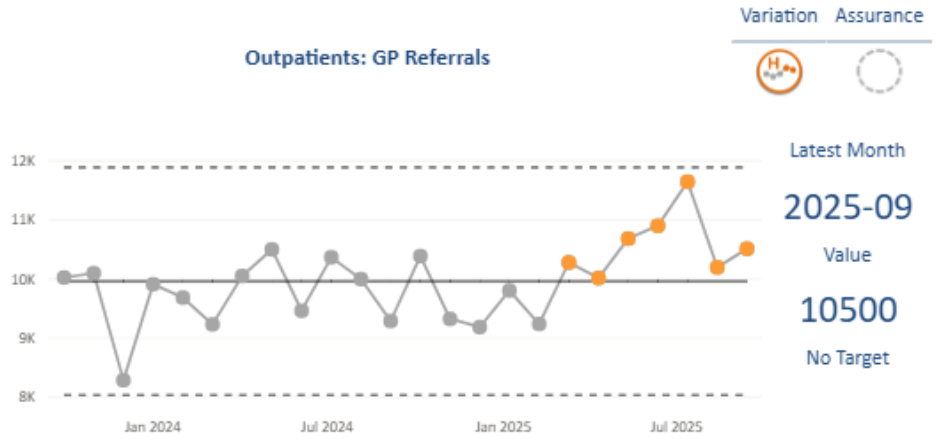
- Stabilisation of GP referrals to reduce impact increase of referrals on RTT total waiting list.

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 **deteriorated** from the previous month, with a difference of **317.0**.

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Rationale: Number of outpatient referrals received from General Practice.
SPC1: No internal target.

Please see previous page

Operational Activity and Performance
Diagnostics Narrative

York and Scarborough Teaching Hospitals NHS Foundation Trust

Headlines:

- The September 2025 the position for patients waiting less than six weeks at month end was 65.5% against the improvement trajectory of 74.8%. This is the highest performance the Trust has had against the DM01 target this financial year.
- Further improvement is required to restore performance to trajectory level however it is a positive step that the total waiting list has continued to reduce, along with 6-week and 13-week breach volumes.
- In the latest available national data (July 2025) the Trust ranked 135th out of 156 NHS providers (June 2025: 134th).

Factors impacting performance:

- MRI continues to be the lowest performing modality in imaging. Staffing issues with resignations at York taking the service down to 50% against establishment.
- YSJ MRI launch slower than anticipated due to training requirements on new scanner. No contrast scans currently able to run until training is complete. This has impacted on planned activity volumes YTD.
- MRI Paeds GA scans account for a cohort of the longest waiters. Sought mutual aid from Leeds, Hull and Sheffield but no uptake. Further meeting scheduled with Hull and Sheffield to discuss options.
- Continued intermittent breakdowns of CT1, CT2 and CT3 at York impacting delivery of activity.
- Delivery of cardiac CT insourcing has significantly improved CT performance in Sept 25.
- NOUS performance continues to be driven by MSK backlog.
- Barium Enema performance deteriorated at the beginning of the financial year due to a retirement and some long-term sickness. Performance has begun to recover, and this is anticipated to continue.
- The largest impact on Audiology performance is due to paediatric patients and tinnitus patients. DNA/WNB rates for paediatric patients in particular increased over the summer.
- Data Quality issues with audiology data are ongoing leading to potential inaccuracies in the DM01 return.
- Sickness and vacancies in paediatric audiology team affecting capacity. Inability to recruit to audiology posts due to lack of suitable candidates, especially at the East Coast.
- Impact of increase in elective demand to support long wait RTT patients in ENT, respiratory and Cardiology against DM01 waiters (audiology, sleep studies & Echo).
- Audiology booth capacity limits delivery of activity.
- We have not seen rise in Endoscopy performance improvement as we were anticipating, the DM01 logic is being urgently investigated by the I&I team as it appears we may not be capturing all relevant activity.
- Flexi-sig performance deteriorated in September; however, this is due to a significant reduction in the overall waiting list with a large proportion of delivered activity being in the 0-5 week wait range for urgent requests and therefore negatively impacting performance but positively impacting volume of patients waiting.
- The East Coast gastro 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 STT.
- 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.
- Increase in referrals for colorectal including more STT, leading to less delivery of D3 and D4 activity.

Actions:

- Performance recovery actions expected to deliver continued improvement by the end of Q3 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 - CT * 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 - 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 - Audiology * Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy
SPECIAL CAUSE CONCERN		* Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	* Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI * Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy * Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy

DIAGNOSTICS – National Target: 95%

Scorecard

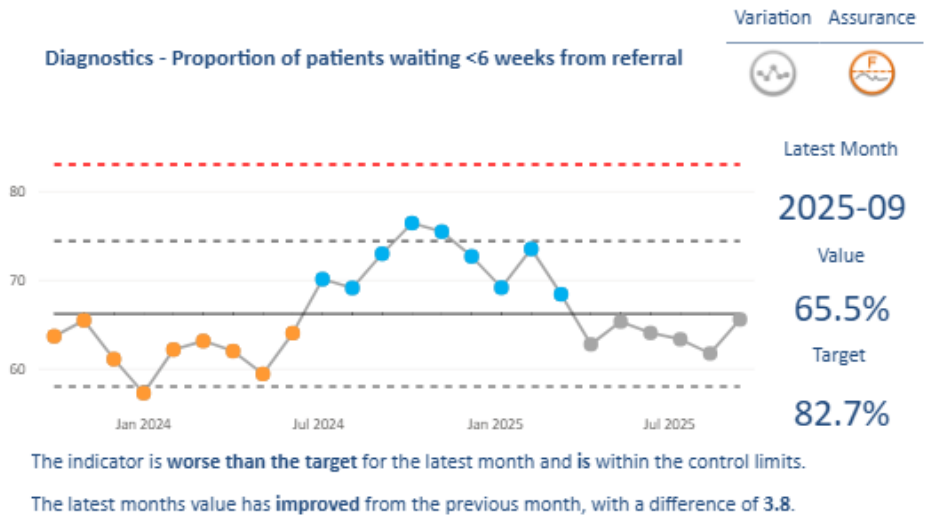
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-09		F	65.5%	74.8%	82.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2025-09	L	F	54.9%	82%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2025-09	H	?	82.2%	68%	78%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2025-09		?	75%	68%	75%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2025-09	L	?	74.7%	85%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2025-09	H	?	98.2%	61%	67.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2025-09		F	48.1%	86%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2025-09	H	F	75.2%	95.8%	95.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2025-09	H	?	98.3%	93.7%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2025-09		?	82.5%	89.6%	94.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2025-09	H	F	69%	78.7%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2025-09	L	F	48.8%	80.6%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2025-09		F	48.9%	81%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2025-09		?	64.9%	87.7%	94.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2025-09	L	F	55.4%	83.5%	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: 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, though a gradual improvement is reflected in the September position.

Imaging: Insourcing began 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. The impact of this has begun to be visible in the September data. Advert out for MSK radiologist, interviews booked in October.

Physiological:

Echocardiography: Capacity has improved with the introduction of a locum which has begun to contribute to performance recovery. Recovery plan is in place to fully recover position by the end of the financial year.

Sleep studies: Possibilities for insourcing are being explored to get back on top of the testing and reporting backlog.

Audiology: New audiology DM01 logic is in test and it is hoped that it will be in place by the time of October reporting. 4 x pop-up booths (two York, one Malton and one Bridlington) planned to deliver additional audiology capacity. Pathway change to introduce audiology on arrival planned by end October.

UDS: Sufficient substantive Urology capacity is available in October so it is anticipated that backlog will be cleared by end October. Gynaecology UDS lists have been increased 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 Waits over 52 weeks for incomplete pathways
SPECIAL CAUSE CONCERN			* Children & Young Persons: RTT - Total Waiting List * Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks

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)

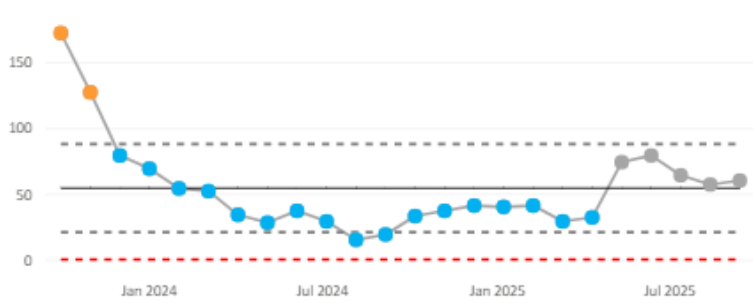
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2025-09			2		0
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2025-09		F	82.6%		95%
Children & Young Persons: RTT - Total Waiting List	2025-09	H	F	4544	3671	3206
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-09	L	F	59.7%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2025-09		F	60	0	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi

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

Variation Assurance



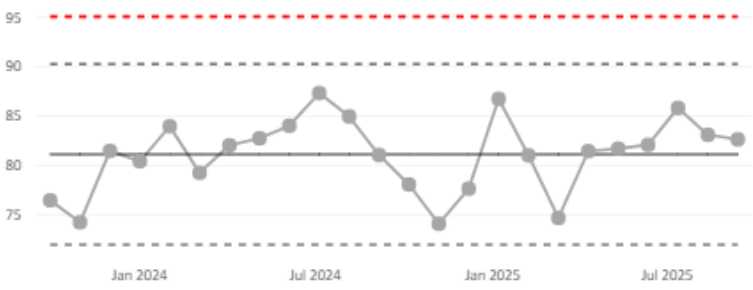
Latest Month
2025-09
Value
60
Target
0

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 **3.0**.

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

Variation Assurance



Latest Month
2025-09
Value
82.6%
Target
95%

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

The latest months value has **deteriorated** from the previous month, with a difference of **0.4**.

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

Target: SPC1: Aim to have zero patients waiting more than 52 weeks 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. Care Groups have except for Head and Neck (due to the volume of long waiters) to deliver zero RTT paediatric patients waiting over forty weeks by the end of Q3 2025/26.

SPC2:

- A training session on breach analysis and breach data has been set up for the paediatric team in the Emergency Departments.
- An opportunity to streamline the pathways from ED to the children's assessment units is being developed. Currently there is both a medic-to-medic and nurse-to-nurse handover; this could be reduced in some cases.
- Missed opportunities audit is underway, with data for three days at each site ready for analysis with a GP and a member of the paediatrics team.
- The ED and Paediatric teams are reconsidering the current front-door triage process; currently all children receive a full triage, but some children may notrequire a full triage and other children may benefit from getting to a doctor quicker rather than waiting for full triage first.

What is the expected impact?

- Improved ECS for CYP patients.
- To return to RTT52 trajectory and delivery of zero RTT40 week waiters (except for Head and Neck) has slipped to March 2026.

Potential risks to improvement?

- Impact of treating RTT65 week waits continues to take priority particularly in Head and Neck.

Summary MATRIX

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

MATRIX KEY

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

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

COMMUNITY
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

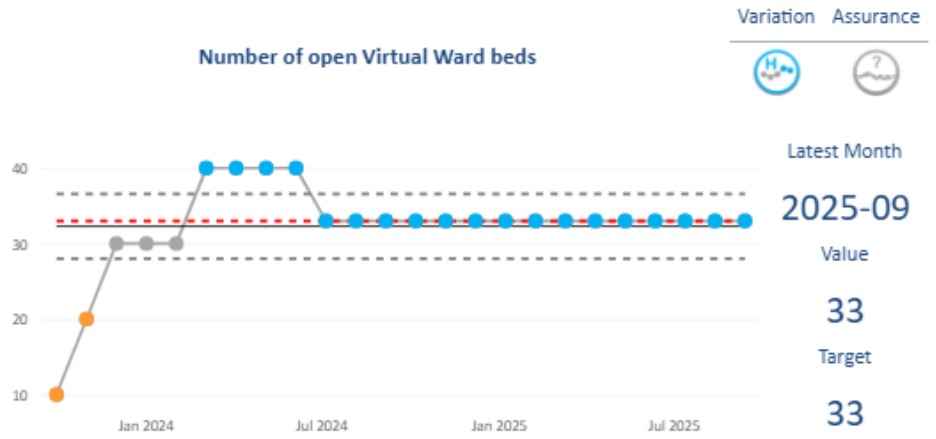
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of open Virtual Ward beds	2025-09	H	?	33	33	33
Proportion of Virtual Ward beds occupied	2025-09		?	51.5%	79%	79%
Community Response Team (CRT) Referrals	2025-09			503		
Total Urgent Community Response (UCR) referrals	2025-09	H	?	501	501	566
2-hour Urgent Community Response (UCR) care Referrals	2025-09			138		
2-hour Urgent Community Response (UCR) Compliancy %	2025-09			81.2%		
Number of Adults (18+ years) on community waiting lists per system	2025-09	L		622		
Number of CYP (0-17 years) on community waiting lists per system	2025-09	L		1530		
Number of District Nursing Contacts	2025-09			20736		
Number of Selby CRT Contacts	2025-09	L		2096		
Number of York CRT Contacts	2025-09	L		3722		
Referrals to District Nursing Team	2025-09			2195		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2025-09	L	F	559	545	0

Executive Owner: Claire Hansen

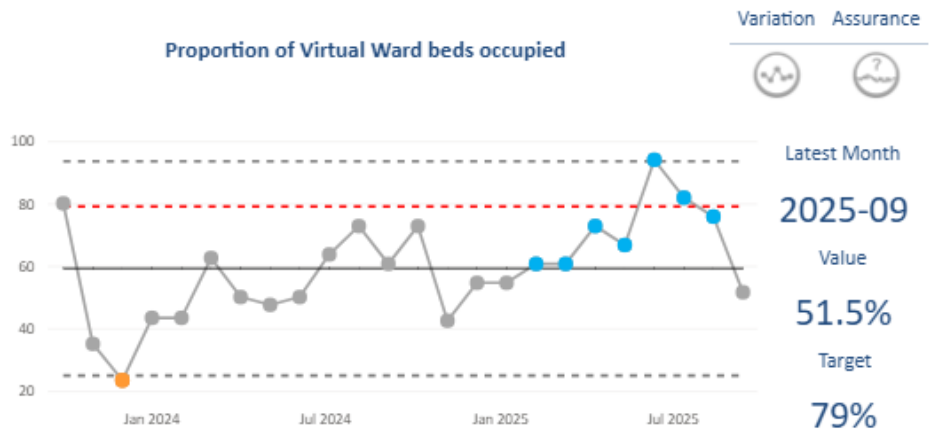
Operational Lead: Abolfazl Abdi

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.



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

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



The indicator is **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 **24.3**.

What actions are planned?

Frailty Virtual Ward - capacity 12, occupancy (snapshot) 5

There has been a data quality issue with identifying patients on the Frailty Virtual ward from both CPD and SystmOne. This is being explored with the Business Intelligence team as actual occupancy is reported to be higher than five.

Heart Failure - capacity 10, occupancy (snapshot) 2

In line with the report carried out by GIRFT and the update given to Trust Board, the heart failure pathways previously captured as Virtual Ward are no longer being classed as such. Therefore as of next month the number of open virtual ward beds will decrease, although these patients are still being cared for in innovative ways at home, away from acute sites.

Vascular – capacity 8, occupancy (snapshot) 10

The model uses pre-existing resource and often operates at capacity; no improvement actions planned.

Cystic Fibrosis – capacity 3, occupancy (snapshot) 0

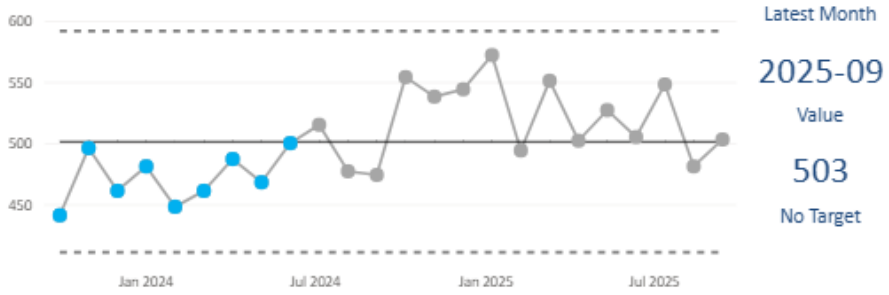
The system allows a virtual model of care for up to three patients using existing resource; no improvement actions planned.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi/Kim Hinton

Variation Assurance

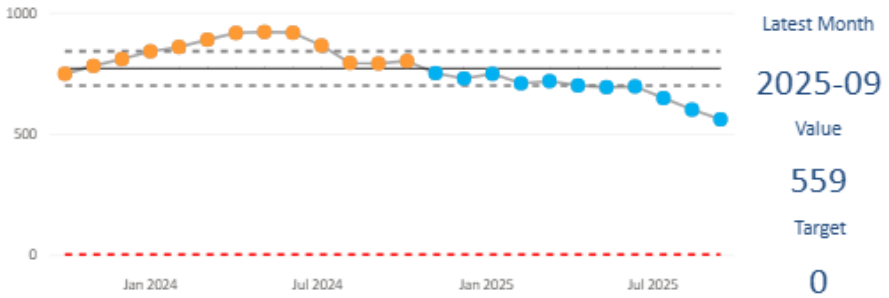
Community Response Team (CRT) Referrals



The latest months value has **deteriorated** from the previous month, with a difference of **22.0**.

Variation Assurance

Number of people on waiting lists for CYP services per system who are waiting over 52 weeks



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 **40.0**.

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.

What actions are planned?

SPC1: The Care Group is looking for efficiencies that could support increasing capacity. Planning for 2026/27 is underway with draft plans to go through Trust's Confirm and Challenge process in October and November.

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. The number waiting over 52 weeks has reduced for the third consecutive month and is just behind the end of September improvement trajectory of 545).

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

October 2025

Executive Owner: Karen Stone and Dawn Parkes

Highlights:

Clostridioides Difficile Infection (CDI) - The Trust is **under** the year-to-date objective by 11 cases. The Trust is no longer an outlier within the region as reported within the UKHSA Healthcare Associated Infections in Yorkshire and Humber Quarterly Report.

Concerns / Risks :

MSSA bacteraemia - The Trust is **over** the year-to-date objective by 9 cases to end of September 2025. The UKHSA Healthcare Associated Infections in Yorkshire and Humber Quarterly Report demonstrates that the Trust MSSA rate per 100,000 bed days is high and the Trust is a regional and national outlier.

E.coli Bacteraemia - The Trust is **over** the year-to-date objective by 13 cases to end of September. The UKHSA Healthcare Associated Infections in Yorkshire and Humber Quarterly Report demonstrate that the Trust E.coli rate per 100,000 bed days is high and has increased since the previous quarter, with the Trust showing as a regional and national outlier.

MRSA

The Trust is over by 5 cases against an objective of 0.

Next Steps:

Trust IPC Improvement plan is being refreshed to include all learning from after action reviews, to be presented to Infection Prevention Strategic Assurance Group on 30th October.

Highlights:

CQC Inspection October 2025:

- CQC undertook an unannounced inspection of Urgent and Emergency Care and Medical Care at Scarborough Hospital on 7-9th October.

Concerns / Risks :

The CQC recognised the need for the Trust to balance risk of overcrowded Emergency Departments and the opportunity to use Temporary Escalation Spaces (TES) within our agreed standard operating plan (SOP).

Next Steps:

To support the implementation of our revised TES SOP and Urgent and Emergency Care Improvement plan.

Data requests from CQC have been received and will be submitted by 24th October 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 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		* Total Number of Trust Onset Klebsiella Bacteraemias	

Quality & Safety
Scorecard (1)

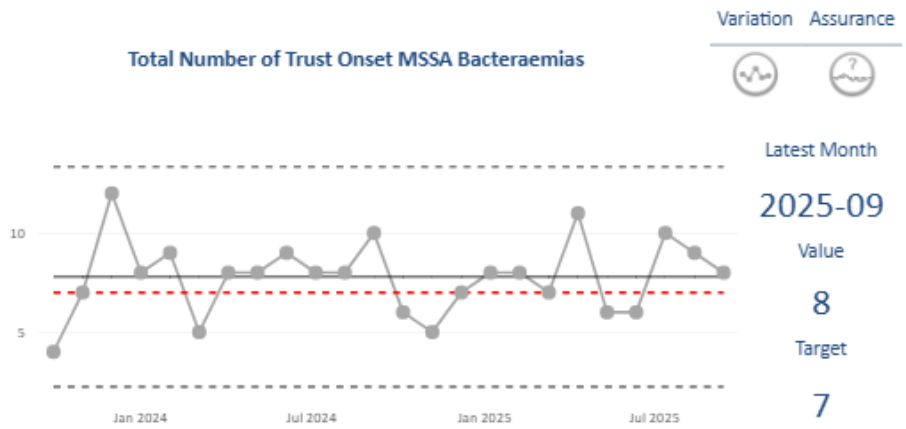
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-09			8	7	7
Total Number of Trust Onset MRSA Bacteraemias	2025-09			1		0
Total Number of Trust Onset C. difficile Infections	2025-09			6	12	12
Total Number of Trust Onset E. coli Bacteraemias	2025-09			11	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2025-09	H		12	6	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2025-09			4	1	2
Pressure Ulcers per thousand Bed Days	2025-09			3.8		4
Patient Falls per thousand Bed Days	2025-09			6.5		8.7
Medication incidents per thousand bed days	2025-09			6.4		5

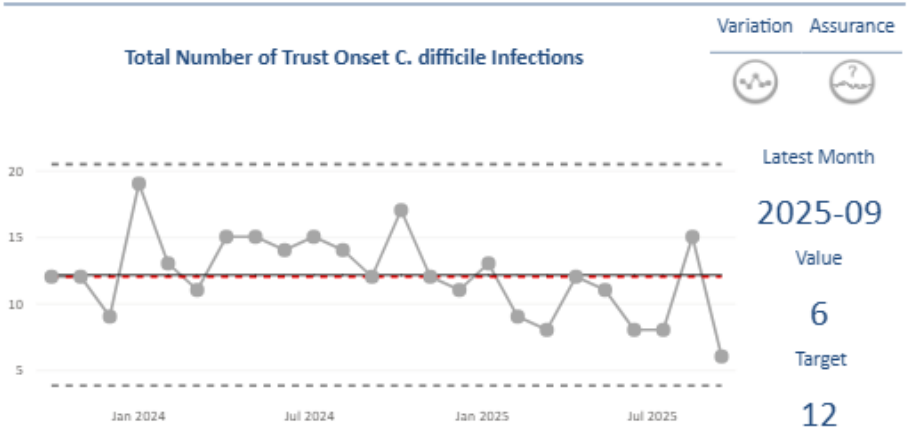
Executive Owner: Dawn Parkes

Operational Lead: Sue Peckitt



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

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



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 **9.0**.

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 4 cases in 2025/26 against a zero tolerance
- MSSA bacteraemia – The Trust is 9 cases over the YTD objective
- E.coli bacteraemia - The Trust is 8 cases over the YTD objective
- Klebsiella bacteraemia - The Trust is 8 cases over the YTD objective
- Pseudomonas bacteraemia - The Trust is 7 cases over the YTD objective

Key assurances/brilliances:

- CDI - The Trust is 11 cases **under** the YTD objective. Whilst August saw a rise in cases, we have recovered the improved position in September.
- 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.
- The IPC team are delivering an internal study day in October and have 75 delegates booked onto the day

- **Next Key Improvements**:
- Present the IPC Board Assurance Framework to IPSAG for approval
- Present the IPC strategic plan for improvement to IPSAG for approval.
- Inform the care group IPC improvement plans
- Year of quality months for IPC – September & October.

Quality & Safety
Scorecard (2)

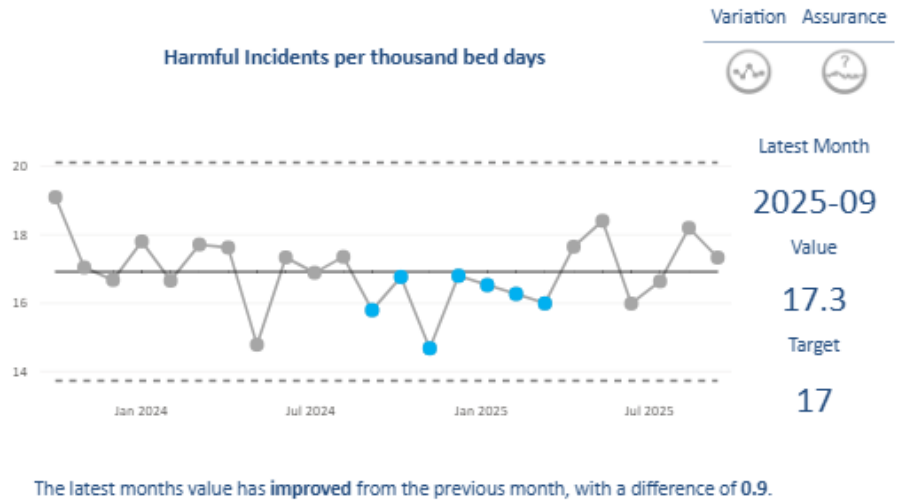
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2025-09			53.7		54
Harmful Incidents per thousand bed days	2025-09			17.3		17
Total Number of Never Events Reported	2025-09			0		0
In-Hospital Deaths	2025-09			178		
Quarterly SHMI	2025-03			93.1		100
Monthly SHMI	2025-06			89.9		100
Quarterly HSMR	2025-06			107.6		100
Monthly HSMR	2025-07			95.5		100
Trust Complaints	2025-09			85		
Antepartum Stillbirths	2025-08			1		
Intrapartum Stillbirths	2025-08			0		
Early neonatal deaths (0-7 days)	2025-08			0		
PPH > 1.5L as % of all women - York	2025-08			4.5%		
PPH > 1.5L as % of all women - Scarborough	2025-08			1.1%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2025-08			27.9%		

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 continues not to show 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 6 months of 2025/26.

Factors impacting performance:

The number of new complaints has decreased with 85 new complaints recorded (versus 136 in July 2025 and 105 in August).

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
- Reduced access to PALS via telephone(impacted due to long term sickness absence)

Key assurances

- the RPIW actions being implemented through the 90 days post workshop are making an impact on the time to process complaints
- Quality of complaint responses is improving following focused training and support
- ward initiatives to improve patient and carer communication continue – initiatives captured on the Trust-wide patient experience improvement plan, presented to Patient Experience Subcommittee September 2025
- Recruitment process underway to secure a 4-month secondment to the role of Concerns and Complaints Officer to provide resource to support the PALS team staffing challenges
- one of the members of the PALS team has returned to work following long term sickness (phased return) – phone lines to re-open 9-12 with the situation being closely monitored by the Head of Patient Experience and Involvement

Next key improvement steps

- RPIW action plan being implemented to further improve the efficiency and effectiveness of 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

October 2025

Summary MATRIX 1 of 3

Maternity Scarborough

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* Community midwife called in to unit - Scarborough	* L/W Co-ordinator supernumerary % - Scarborough	* 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 * Planned homebirths - Scarborough * Women affected by suspension - Scarborough * Maternity Unit Closure - Scarborough * 1 to 1 care in Labour - Scarborough	* Bookings <10 weeks - Scarborough * Homebirth service suspended - 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	2025-08			45.9%		57%	Target
Assisted Vaginal Births - Scarborough	2025-08			5.1%		12.4%	Target
C/S Births - Scarborough	2025-08			48.9%		44.2%	Baseline
Elective caesarean - Scarborough	2025-08			13.3%		16%	Baseline
Emergency caesarean - Scarborough	2025-08			35.7%		28.2%	Baseline
Induction of labour - Scarborough	2025-08			40%		45.4%	Baseline
HDU on L/W - Scarborough	2025-08	L		1		5	Target
BBA - Scarborough	2025-08			0		2	Target
HSIB cases - Scarborough	2025-06	L		0		0	Target
Neonatal Death - Scarborough	2025-08			0		0	Target
Antepartum Stillbirth - Scarborough	2025-08			0		0	Target
Intrapartum Stillbirths - Scarborough	2025-08		P	0		0	Target
Cold babies - Scarborough	2025-04			0		1	Target
Preterm birth rate <37 weeks - Scarborough	2025-08			3.2%		6%	Target
Preterm birth rate <34 weeks - Scarborough	2025-08			1.1%		1%	Target
Preterm birth rate <28 weeks - Scarborough	2025-08			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 Initiation rate - 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	* Carbon monoxide monitoring at 36 weeks - Scarborough
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - Scarborough	2025-08			0%		0%	Target
Breastfeeding Initiation rate - Scarborough	2025-08			85.6%		75%	Target
Breastfeeding rate at discharge - Scarborough	2025-08			64.5%		65%	Target
Smoking at booking - Scarborough	2025-08			3%		6%	Target
Smoking at 36 weeks - Scarborough	2025-08			1.1%		6%	Target
Smoking at time of delivery - Scarborough	2025-08			5.2%		6%	Target
Carbon monoxide monitoring at booking - Scarborough	2025-08	H		91.1%		95%	Target
Carbon monoxide monitoring at 36 weeks - Scarborough	2025-08		F	82.6%		95%	Target
SI's - Scarborough	2025-06			0		0	Target
PPH > 1.5L as % of all women - Scarborough	2025-08			1.1%		1.5%	Baseline
Shoulder Dystocia - Scarborough	2025-08			0		2	Target
3rd/4th Degree Tear - normal births - Scarborough	2025-08			2.1%		0%	Target
3rd/4th Degree Tear - assisted birth - Scarborough	2025-08	L		0%		0%	Target
Informal Complaints - Scarborough	2025-08			0		0	Target
Formal Complaints - Scarborough	2025-08			0		0	Target

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - Scarborough	2025-08		P	101		169	Target
Bookings <10 weeks - Scarborough	2025-08		F	76.8%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2025-08		?	3%		10%	Target
Births - Scarborough	2025-08		?	97		113	Target
No. of women delivered - Scarborough	2025-08		?	95		112	Target
Planned homebirths - Scarborough	2025-08		?	2.1%		2.1%	Target
Homebirth service suspended - Scarborough	2025-07		F	19		3	Target
Women affected by suspension - Scarborough	2025-07		?	0		0	Target
Community midwife called in to unit - Scarborough	2025-08	L	P	0		3	Target
Maternity Unit Closure - Scarborough	2025-08		?	1		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		4.7	Baseline
SCBU no of babies affected - Scarborough	2025-03	H	?	1		0	Target
1 to 1 care in Labour - Scarborough	2025-08		?	100%		100%	Target
L/W Co-ordinator supernumerary % - Scarborough	2025-08	H	?	100%		100%	Target
Anaesthetic cover on L/W - Scarborough	2025-08	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	* SCBU at capacity - York * 1 to 1 care in Labour - York * L/W Co-ordinator supernumerary % - York	
COMMON CAUSE / NATURAL VARIATION	* Bookings ≥13 weeks (exc transfers etc.) - York * Anaesthetic cover on L/W - York	* Bookings - York * Births - York * No. of women delivered - York * Planned homebirths - York * Homebirth service suspended - York * Women affected by suspension - York * Maternity Unit Closure - York * SCBU at capacity of intensive care cots - York * SCBU no of babies affected - York	* Bookings <10 weeks - York
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - York	2025-08			299		295	Target
Bookings <10 weeks - York	2025-08		F	77.9%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - York	2025-08		P	0%		10%	Target
Births - York	2025-08			226		245	Target
No. of women delivered - York	2025-08			223		242	Target
Planned homebirths - York	2025-08			1.8%		2.1%	Target
Homebirth service suspended - York	2025-08			20		3	Target
Women affected by suspension - York	2025-08			3		0	Target
Community midwife called in to unit - York	2025-08	L	P	0		3	Target
Maternity Unit Closure - York	2025-08			0		0	Target
SCBU at capacity - York	2025-04	L		0		0	Baseline
SCBU at capacity of intensive care cots - York	2025-03			29		14.8	Baseline
SCBU no of babies affected - York	2025-03			3		0	Target
1 to 1 care in Labour - York	2025-08	H		100%		100%	Target
L/W Co-ordinator supernumerary % - York	2025-08	H		100%		100%	Target
Anaesthetic cover on L/W - York	2025-08		P	10		10	Target

Summary MATRIX 2 of 3

Maternity York

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION	* Intrapartum Stillbirths - York	* Normal Births - York * Assisted Vaginal Births - York * C/S Births - York * Elective caesarean - York * Emergency caesarean - York * Induction of labour - York * BBA - York * Neonatal Death - York * Antepartum Stillbirth - York * Cold babies - York * Preterm birth rate <37 weeks - York * Preterm birth rate <34 weeks - York * Preterm birth rate <28 weeks - York	
SPECIAL CAUSE CONCERN		* 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	2025-08			53.7%		57%	Target
Assisted Vaginal Births - York	2025-08			7%		12.4%	Target
C/S Births - York	2025-08			39.2%		37.3%	Baseline
Elective caesarean - York	2025-08			16.3%		16.1%	Baseline
Emergency caesarean - York	2025-08			22.9%		21%	Baseline
Induction of labour - York	2025-08			43.5%		41.7%	Baseline
HDU on L/W - York	2025-08			10		5	Target
BBA - York	2025-08			2		2	Target
HSIB cases - York	2025-07	H		1		0	Target
Neonatal Death - York	2025-08			0		0	Target
Antepartum Stillbirth - York	2025-08			1		0	Target
Intrapartum Stillbirths - York	2025-08		P	0		0	Target
Cold babies - York	2025-08			0		1	Target
Preterm birth rate <37 weeks - York	2025-08			2.7%		6%	Target
Preterm birth rate <34 weeks - York	2025-08			1.3%		2%	Target
Preterm birth rate <28 weeks - York	2025-08			0.9%		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 * Smoking at time of delivery - York	
COMMON CAUSE / NATURAL VARIATION		* Low birthweight rate at term (2.2kg) - York * Breastfeeding Initiation rate - York * Breastfeeding rate at discharge - York * Smoking at 36 weeks - York * Carbon monoxide monitoring at booking - York * PPH > 1.5L as % of all women - York * Shoulder Dystocia - York * 3rd/4th Degree Tear - normal births - York * 3rd/4th Degree Tear - assisted birth - York * Informal Complaints - York * Formal Complaints - York	* Carbon monoxide monitoring at 36 weeks - York
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - York	2025-08			0.9%		0%	Target
Breastfeeding Initiation rate - York	2025-08			90.2%		75%	Target
Breastfeeding rate at discharge - York	2025-08			76.1%		65%	Target
Smoking at booking - York	2025-08	L		4.3%		6%	Target
Smoking at 36 weeks - York	2025-08			0.8%		6%	Target
Smoking at time of delivery - York	2025-08	L		0.9%		6%	Target
Carbon monoxide monitoring at booking - York	2025-08			93.9%		95%	Target
Carbon monoxide monitoring at 36 weeks - York	2025-08		F	73.4%		95%	Target
SI's - York	2025-06			0		0	Target
PPH > 1.5L as % of all women - York	2025-08			4.5%		3.9%	Baseline
Shoulder Dystocia - York	2025-08			2		2	Target
3rd/4th Degree Tear - normal births - York	2025-08			1.3%		0%	Target
3rd/4th Degree Tear - assisted birth - York	2025-08			0%		0%	Target
Informal Complaints - York	2025-08			1		0	Target
Formal Complaints - York	2025-08			2		0	Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

October 2025

Executive Owner: Polly McMeekin

1. Highlights

- Vacancy rates for medical and dental (4.1%), midwifery (2.5%) and registered nursing (5.5%) positions remain low, supported by a low-rate of workforce turnover (8.1% in the 12-months to September 2025). This is contributing to a reduction in the Group's agency workforce, which in August was 24 WTE below plan.
- The Trust is concluding a busy period of recruitment, with the arrival of new colleagues as follows:
    - 345 doctors, including 303 Resident and Trust Grade doctors through the changeover process
    - 136 newly qualified Registered Nurses and Midwives
    - 16 newly qualified Allied Health Professionals

2. Concerns

- The Group continues to see a higher sickness absence rate than in pre-pandemic years. The current annual absence rate is 5%, equivalent to 456 WTE, and some way above the 25/26 target of 4.3%.
- It is a concern that the 2025 NHS Staff Survey coincides with the start of a significant programme of organisational change across Care Groups and corporate services. The Trust's morale score in the 2024 survey was in the lowest-performing quartile nationally.
- Related to the organisational change, there is further concern that delays in decision-making will result in a failure to deliver the planned financial savings in 25/26.

3. Future

- The new NHS Management and Leadership Framework is due to be launched in November, designed to address recommendations from the Messenger and Kark Reviews. Work is underway internally to align the framework with internal leadership programmes.
- The Trust has begun the 26/27 operational planning round. From a workforce perspective, it is likely that further reductions in temporary staffing utilisation will be required, as well as commitments to improve workforce productivity.
- A new two-day programme for line managers and supervisors launched recently, aimed at strengthening capability for managing colleagues in line with Trust policies and procedures. The course focuses on practical support strategies, promoting a just and learning culture, and clarifying managerial responsibilities to improve consistency and reduce risks associated with poor management practices.

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

Workforce
Scorecard (1)

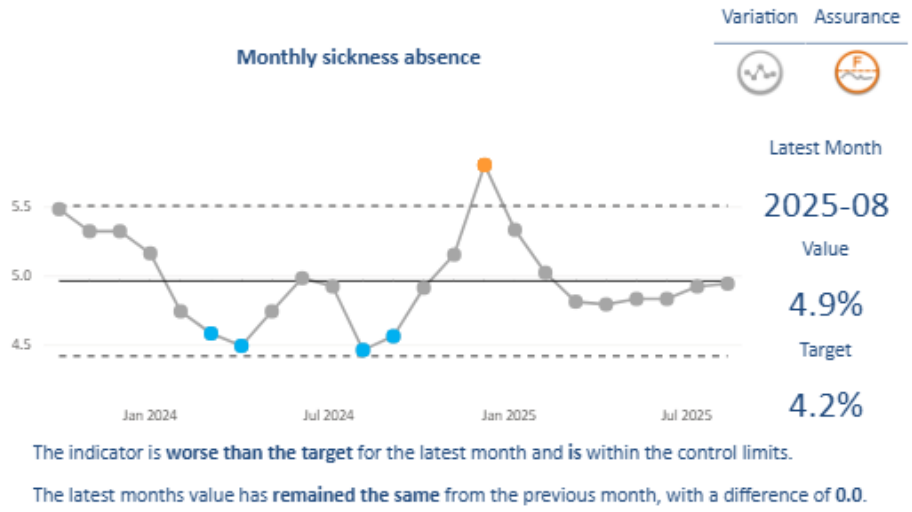
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

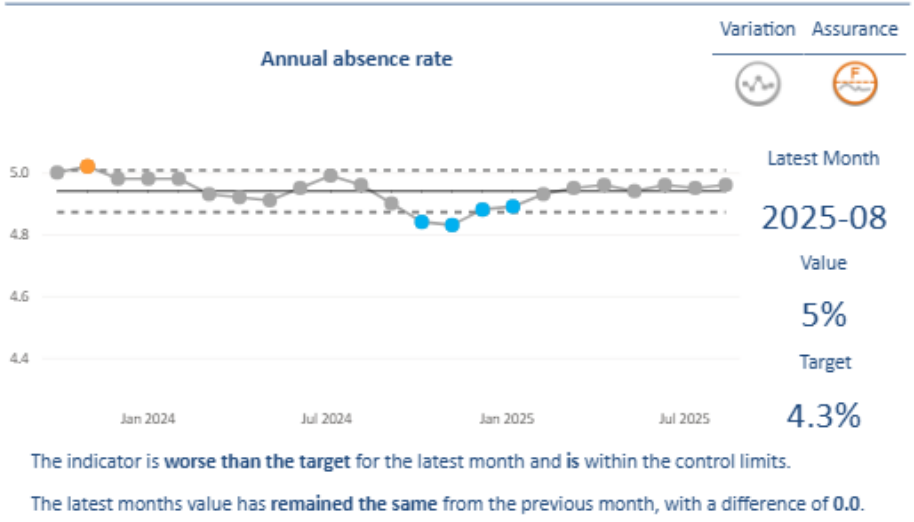
Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2025-08		F	4.9%	4.2%	4.2%
Annual absence rate	2025-08		F	5%		4.3%
Total Agency Whole Time Equivalent Filled	2025-08	L	?	86.7		151
Total Bank Whole Time Equivalent Filled	2025-08		?	621.5		557
12 month rolling turnover rate Trust (FTE)	2025-09	L	P	8.1%		10%
Overall vacancy rate	2025-09	L	?	6.2%		6%
HCSW vacancy rate	2025-09		?	8.1%		5%
Midwifery vacancy rate	2025-09	H	?	2.5%		0%
Medical and dental vacancy rate	2025-09		?	4.1%		6%
Registered Nursing vacancy rate	2025-09		?	5.5%		5%
AHP vacancy rate	2025-09		?	7%		8.5%

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

Factors impacting performance and actions:

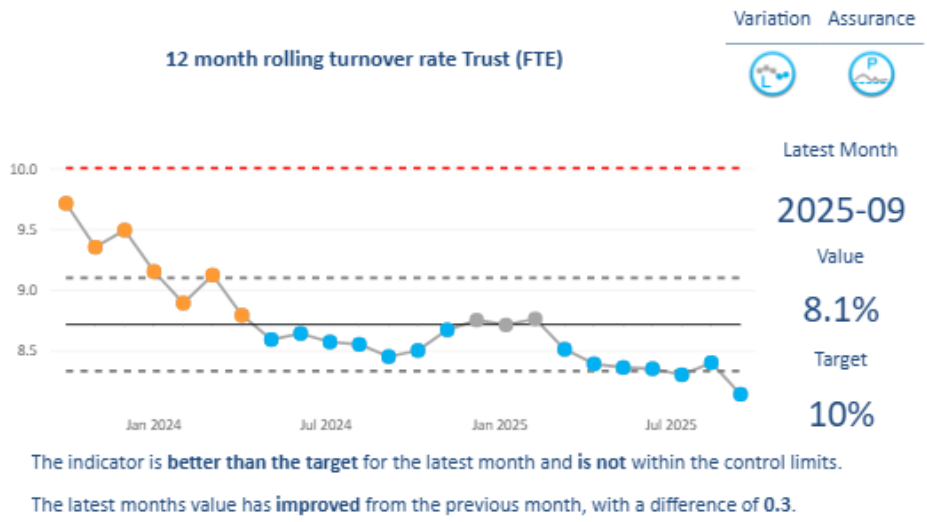
August's absence rate was virtually identical to July's, with absences increasing by 2 WTE to 459. The high-level picture across the 2025-26 financial year to date is of a static Group absence rate, with only 0.1% movement across the April-August period. The reasons for absences in August were consistent with the previous month, with anxiety and stress-related illness (26% of all absences), musculoskeletal problems (10%) and cold/cough/influenza (9%) remaining as the top-three issues.

In October, The Trust began its 2025 'flu campaign' with on-site vaccination clinics and a peer vaccination programme. Following a period of promotion, the campaign has got off to a strong start. During the first six days up to 8th October, 1,291 colleagues took up the offer of vaccination. This represents an increase of 241 (23%) from the first week of the 2024 campaign, and 76 (6%) from 2023. The campaign will conclude in November.

The 2025 NHS Staff Survey opened to responses at the beginning of October. At the end of the first week (9th October), 14.9% of colleagues had completed the Survey, compared with 10.1% in 2024. The Survey will remain open until the end of November and the Trust is aiming to improve on its 36% response rate from last year.

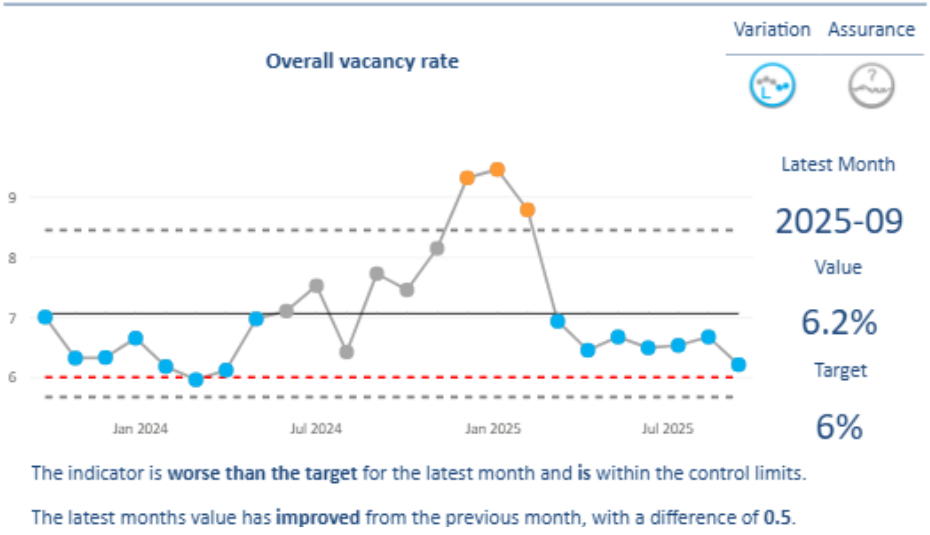
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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

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



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

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

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

Factors impacting performance and actions:

At the end of August, the Group recorded a total workforce position (i.e. substantive, bank and agency combined) that was almost identical to its forecasted position for this stage in the year: 10,036 WTE actual against a plan for 10,030 WTE. This represents a decrease of 30 WTE from the actual workforce size in July when numbers reached their year-to-date peak.

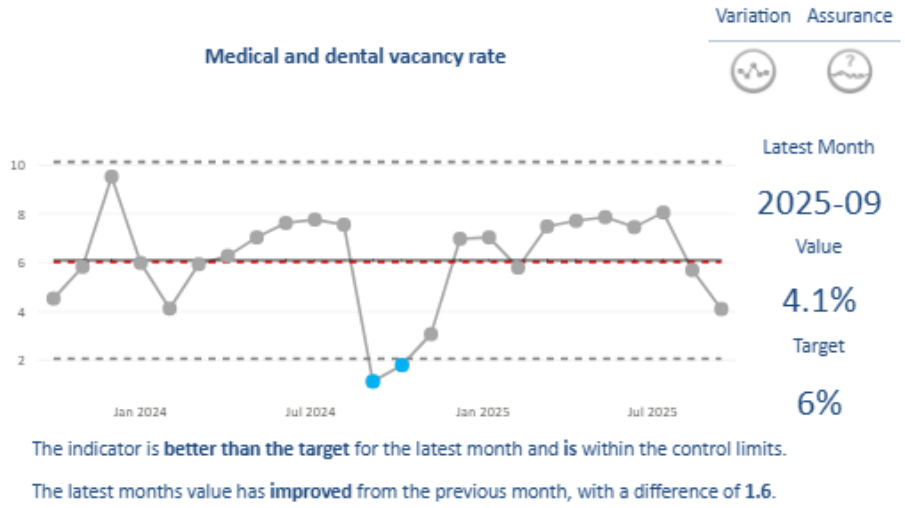
The budgeted WTE establishment for August was 10,205 WTE. At staff group level, the total size of the medical and dental and registered nursing and midwifery groups exceeded establishment levels between June and August. This is influenced in part by higher than planned sickness levels.

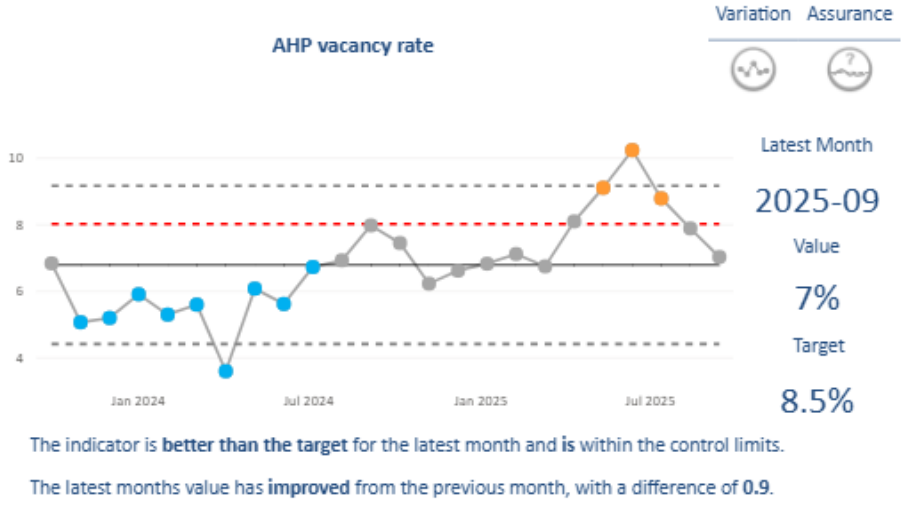
The Trust continues to succeed at reducing agency WTE usage to below the level originally envisaged in its plan for 2025/26. This has been made possible through an increase to the size of its substantive and bank workforce. At present, agency usage is tracking below the Trust's end of year target and there are further plans to cease usage in the nursing group over the coming months.

The total workforce size forecasted for March 2026 continues to assume that changes related to the corporate services review 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 September, the Trust hosted its inaugural Careers Conference at York Hospital, supported by NHS England's Stay and Thrive funding. The event aimed to promote career development across our diverse workforce, with sessions on mock interviews, application writing, and communication skills. Around 20 colleagues from a range of staff groups attended. A second event is planned for Scarborough in the New Year, alongside work to broaden engagement and maximise reach.

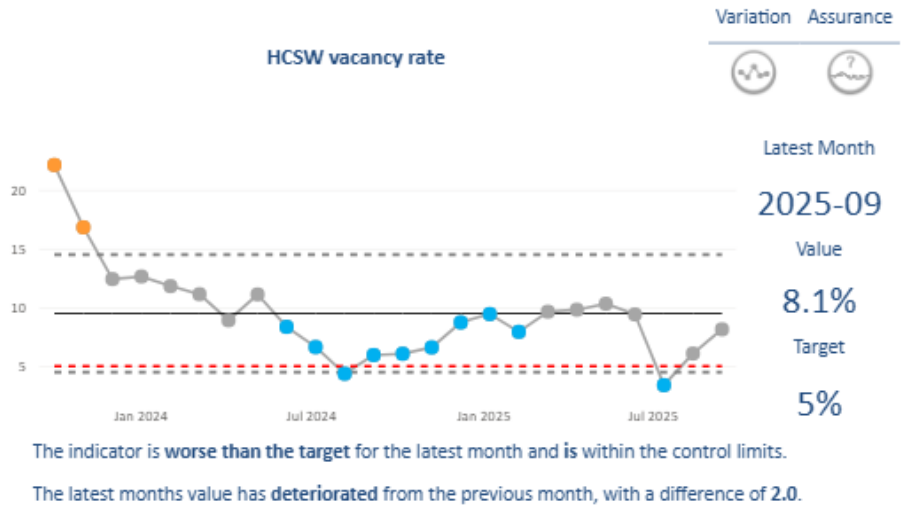
In the same month, the Trust also welcomed 25 new medical colleagues (outside the changeover process) including one permanent Consultant working within Trauma and Orthopaedics. In addition, 11 offers of employment for medical posts were made, including six permanent Consultant posts in Care of the Elderly, Cardiology and Microbiology.

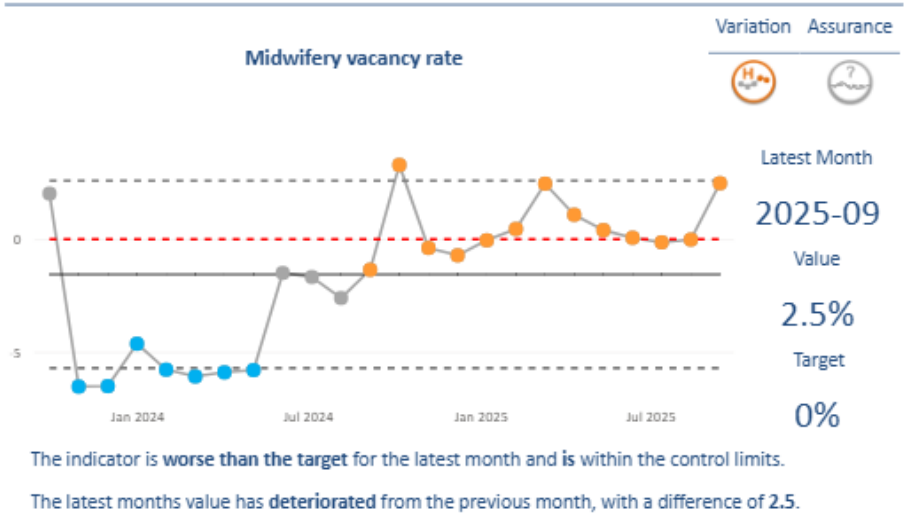
At the beginning of October, a further resident doctors' changeover saw the arrival of 26 new trainee doctors in the Trust.

Altogether, the number of substantive medical and dental colleagues in post has increased by 44 WTE since July, driven predominantly by an increase in resident doctors. Meanwhile, there are now 20 WTE more AHPs in post than in June, including an additional six Operating Department Practitioners and eight Physiotherapists.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

Factors impacting performance and actions:

The HCSW vacancy rate has been impacted by seasonal changes associated with the start of a new academic year. Within the Trust, 24 WTE HCSWs are also about to complete Nursing Associate and Registered Nursing Degree apprenticeships. The HCSW recruitment pipeline itself includes 24 WTE HCSWs undertaking pre-employment checks, and 12 WTE who are booked onto the next Academy in November.

Work continues to finalise the recruitment of pre-registered nurses. 113 have been offered a position, with further applications still being received. The Trust expects the vacancy rate for registered nurses to reduce to 1.8% as a result.

September saw the nursing associate headcount reduce to 56, however, seven nursing associates did qualify to become registered nurses, and a small number of apprentices are about to qualify.

The Trust has recently recruited 23 newly qualified midwives who are planning to join a midwifery preceptorship starting on 20 October. The organisation has also recruited 5 WTE Band 6 Midwives, with a further advert planned to support additional recruitment.

e eRostering and LOA metrics will be reported via a paper to Executives on a monthly basis from

Workforce Table

Workforce (5)

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

	Establishment WTE	Plan: WTE in Post	Actual Staff in Post (WTE)				Variance		
	Funded	Total	Total	Substantive	Bank	Agency	Establishment v Actual	Plan v Actual	Rating
Overall									
Jul-25	10221	10025	10066	9341	630	95	155	-41	SIP under-establishment but over plan
Aug-25	10226	10030	10036	9328	621	87	190	-6	SIP under-establishment but over plan
Sep-25	10205	10037	10004	9356	574	74	201	33	SIP under-establishment and plan
Medical & Dental									
Jul-25	1120	1149	1150	986	127	37	-30	-1	SIP over-establishment and plan
Aug-25	1119	1149	1198	1015	137	46	-79	-49	SIP over-establishment and plan
Sep-25	1120	1176	1177	1008	131	38	-57	-1	SIP over-establishment and plan
Nursing & Midwifery									
Jul-25	2621	2624	2667	2436	185	47	-46	-43	SIP over-establishment and plan
Aug-25	2639	2614	2646	2425	164	57	-7	-32	SIP over-establishment and plan
Sep-25	2625	2622	2689	2471	180	38	-64	-67	SIP over-establishment and plan
Support to clinical staff (includes patient-facing A&C and Estates roles)									
Jul-25	2437	2350	2356	2093	263	0	81	-6	SIP under-establishment but over plan
Aug-25	2357	2348	2328	2060	268	0	29	20	SIP under-establishment and plan
Sep-25	2364	2329	2254	2005	249	0	110	75	SIP under-establishment and plan
NHS Infrastructure (Admin & Estates - non-patient-facing)									
Jul-25	2725	2574	2560	2521	38	1	165	14	SIP under-establishment and plan
Aug-25	2705	2568	2569	2525	43	1	136	-1	SIP under-establishment but over plan
Sep-25	2683	2575	2560	2518	42	0	123	15	SIP under-establishment and plan

Factors impacting performance and actions:

Collaborative Bank uptake for nursing shifts remains low, with no additional shifts worked. Plans to expand the service to medical roles have been paused by partners, with no target date set. The Trust continues to work with system partners to identify ways to reduce agency use across the region.

Following the introduction of new medical bank rates and an updated escalation approval process in August, the number of escalated shifts has fallen significantly—from 432 in the week prior to the change to an average of 85 per week in September. While a seasonal reduction in medical bank requests is typical post-changeover, the impact of these changes will be closely monitored.

Negotiations with agency providers continue, focusing on long-term and high-cost usage. Rate reductions have been agreed with four midwifery suppliers, delivering cost savings from September.

Administrative bank activity remains stable, with 785 shifts in September compared to 777 in August. With vacancy controls in place, this will continue to be monitored, and monthly reports are shared with Care Groups to support reduction opportunities.

Please note: eRostering and Level of Attainment metrics previously reported in the TPR will be reported separately to Executives from November.

Workforce
Scorecard (2)

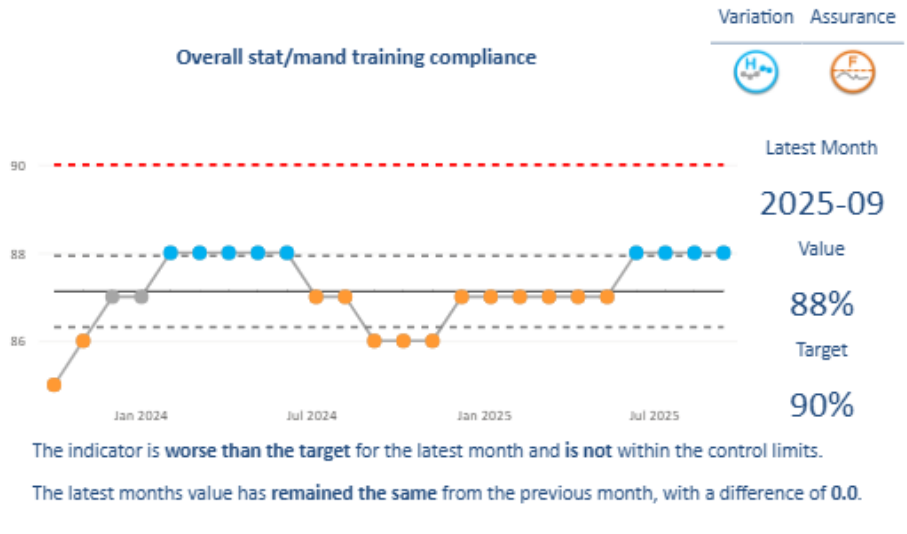
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

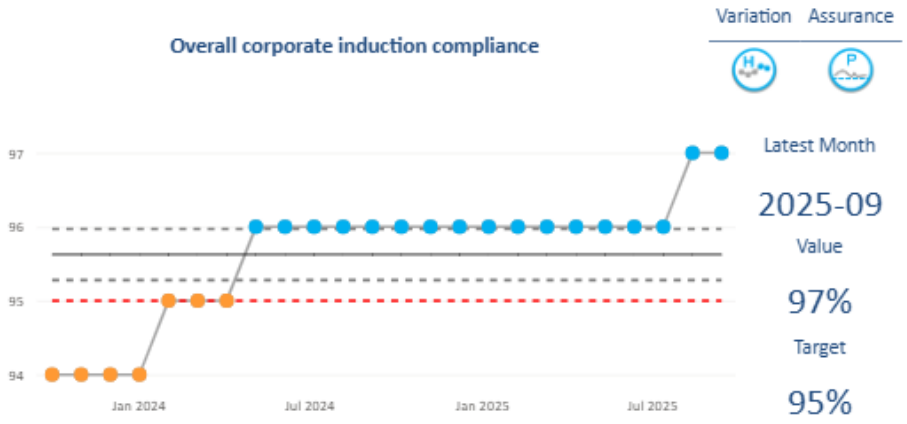
Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2025-09	H	F	88%		90%
Overall corporate induction compliance	2025-09	H	P	97%		95%
A4C staff stat/mand training compliance	2025-09	H	F	90%		90%
A4C staff corporate induction compliance	2025-09	H	?	97%		95%
Medical & dental staff stat/mand training compliance	2025-09		F	74%		90%
Medical & dental staff corporate induction compliance	2025-09	H	?	95%		95%
Appraisal Activity	2025-09		?	82.9%	38.4%	95%

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 for 87% compliance.

Mandatory training compliance has maintained at 88% in September, supported by an improvement in compliance for Bank colleagues. The current rates for Bank workers are 90% for non-medical and 78% for medical. The improvement is the result of a process which restricts colleagues from picking up shifts when their mandatory training has fallen out-of-date.

Of the 25 different subjects and levels which make up the national mandatory training programme, the Trust is achieving 90% in 13 of them, with a further subject (Fire Safety Awareness) only 1% behind the revised target. The remaining 11 courses range in completion rates from 61% (Paediatric Advanced Resuscitation) to 86% (Conflict Resolution). Subject Matter Experts are continuing to review groups where take-up has been poor to help try and target additional course attendance.

Meanwhile, the Group's locally mandated training programme (which is not included in the overall compliance rates) is currently under review. The programme consists of 14 courses supporting different aspects of clinical safety. The overall rate of compliance for locally mandated training in the Group is 85%.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

October 2025

Executive Owner: James Hawkins

Highlights

EPR implementation:

- Currently, progress is in line with plan and go-live of the first Tranche is expected to commence on 27 Feb 2026.
- The first Tranche includes observations, clinical documentation for inpatients, urgent & emergency care, electronic prescribing & medicine administration, bed management and read-only diagnostic results.
- Good progress is being made configuring the Nervecentre product to our needs with a strong focus on the first Tranche.
- User acceptance testing has started and continues through to early January 2026.
- The current plan includes a go-live of Tranche 2 on 30 Jun 2026 and Tranche 3 on 30 Oct 2026.

Wider Digital Portfolio delivery continues with key focus on:

- Multi-year programme of paper records scanning and storage consolidation.
- Windows 11 migration, which is nearly complete.
- Supporting AI trials in both diagnostics and wider trials of Microsoft Co-pilot across the organisation with focus on efficiency opportunities.
- Supporting capital programmes such as hybrid theatres and vascular image unit.
- Optimising the use of the new Pathology Laboratory Information Systems.
- Supporting the Neonatal Badgernet implementation.
- Microsoft Sharepoint adoption.

Concerns / Risks

- Ability of the Trust to continue to engage in design, build and test activities across all the EPR tranches and provide appropriate resources and input to ensure we maximise the opportunity to transform the way we work.
- Ability to manage Y&S Digital business as usual work, whilst delivering the new EPR. The new EPR delivery requires considerable resources.
- Data Security and Protection Toolkit 2025 audit has highlighted known gaps that require multi-year investment and remediation.
- Risk of staff availability for training to achieve the EPR Tranche 1 go live impacting our ability to go live as per the plan.

Executive Owner: James Hawkins

Future / Next Steps

EPR implementation:

- Complete software build for Tranche 1.
- Finalise Tranche 1 cutover planning and gain Executive Committee and Board approval for go-live / implementation approach across our sites.
- Develop detailed cutover plans, including transcribing plans, and how we will undertake the safe go-live of this first Tranche.
- Continue EPR Design and readiness work on Tranches 2 and 3.
- EPR Tranche 2 (which contains full order comms) is due to complete design and build by the end of December 2025.

Wider Digital Portfolio:

- Overall cyber security posture: Track progress against independent Data Security and Protection Toolkit audit actions.
- Review of Digital revenue and capital position for future years.
- Develop business case for upgrading our data warehousing solution.
- Develop plan for greater alignment of departmental IT systems with Y&S digital.
- Consideration of patient portal strategy, including options appraisal.
- Supporting rollout electronic ordering of image diagnostics to primary care.

Summary MATRIX

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

MATRIX KEY

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

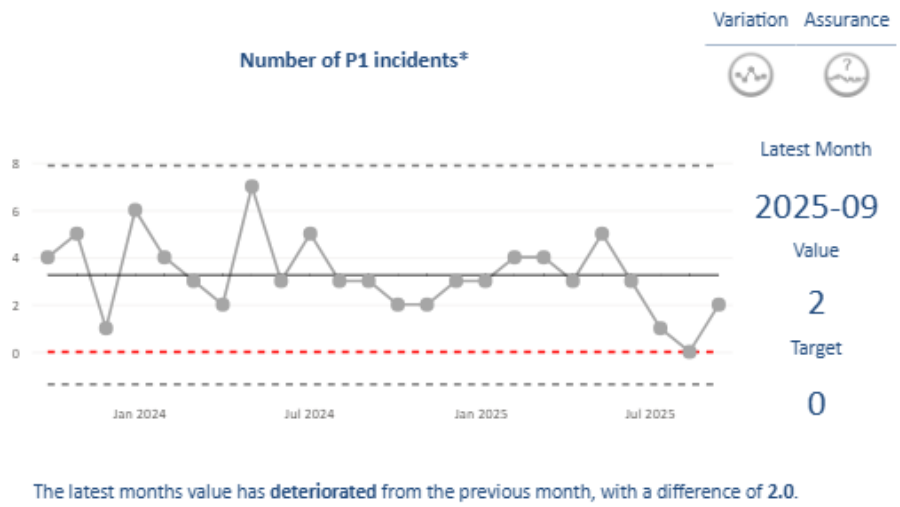
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents* * Percentage of FOIs and EIRs responded to within 20 working days (monthly)	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests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

Executive Owner: James Hawkins

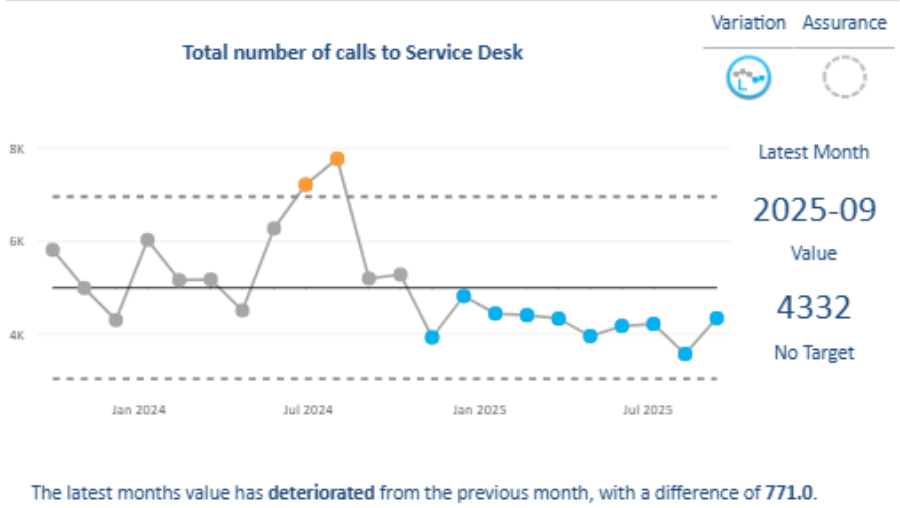
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2025-09			2		0
Total number of calls to Service Desk	2025-09			4332		
Total number of calls abandoned	2025-09			658		
Number of information security incidents reported and investigated	2025-09			48		
Number of patient Subject Access Requests (SAR) received (monthly)	2025-09			324		
Number of patient Subject Access Requests (SAR) completed (monthly)	2025-09			280		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2025-09			67%		80%
Number of FOIs and EIRs received (monthly)	2025-09			50		
Number of FOIs and EIRs completed (monthly)	2025-09			49		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2025-09			98%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy



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



The latest months value has **deteriorated** from the previous month, with a difference of **771.0**.

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

Target: 0 P1 Incidents

Factors impacting performance:

2x P1 incidents occurred.

1. 14/9 St. Monica's Hospital experienced a loss of network and telephone services due to faulty network hardware. This occurred around 0830 on a Sunday, and was fully resolved by 2330. Duration = 15 hours
2. 29/9 CPD label printing services were affected by intermittent issues which began at Midnight on 27/9 (Blood samples, Wristbands, Address labels for casenotes). Services were failed over to an alternate server, but performance issues returned. As demand rose on Monday, various actions were taken during the day which appeared to solve the issue, but the problem returned on Tuesday and there were periods of unavailability or very slow performance when staff sent items to print. This was ultimately resolved at 1500 on 30/9.

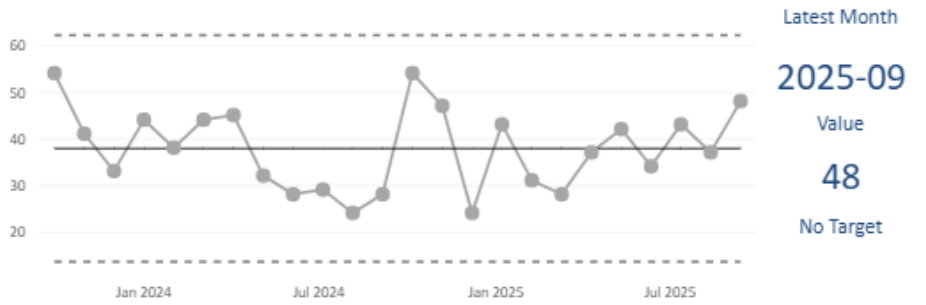
Actions:
Support staff have pro-actively reviewed and enabled NHSmail accounts for infrequent computer users so that they can be ready to receive their annual Staff Survey via e-mail as part of the Board's goal of digital first.
Telephone answering and abandoned performance continues to be monitored and adjustments made where possible. Overall numbers of open tickets for Incidents and Service Requests are continuing to fall during the quarter.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2025-09
Value
48
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **11.0**.

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

Number of information security incidents reported and investigated

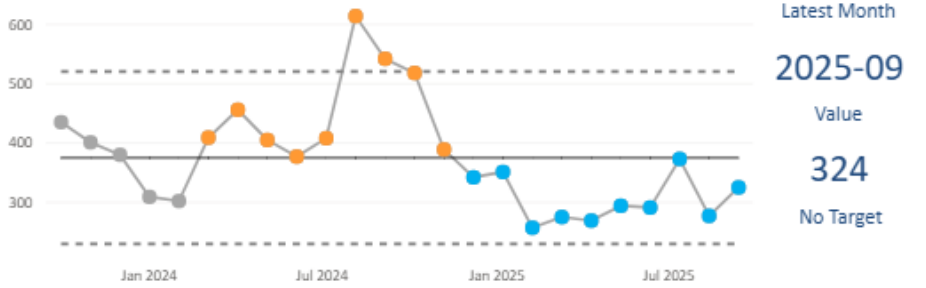
Factors impacting performance:

There has been an increase in incidents during September compared to the previous month.

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

Variation Assurance

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



Latest Month
2025-09
Value
324
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **48.0**.

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

Number of Subject Access Requests (SAR) submitted by patients

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

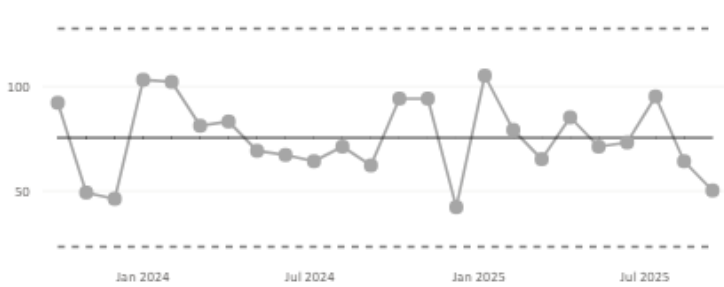
Volumes received have increased compared to last month and timeliness of responses has improved, which is achieving target.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of FOIs and EIRs received (monthly)

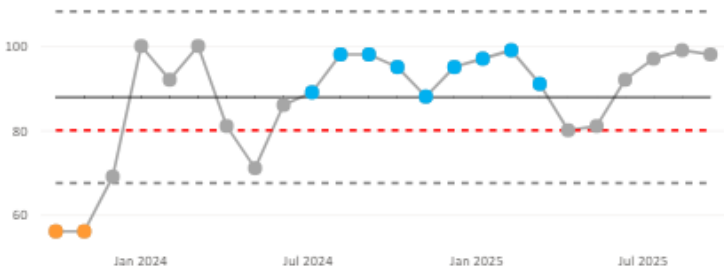


Latest Month
2025-09
Value
50
No Target

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

Variation Assurance

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



Latest Month
2025-09
Value
98%
Target
80%

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

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

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

Factors impacting performance:.

Number of FOIs Received

The number of FoIs the Trust received in September has decreased.

Actions: N/A

Percentage of FOIs responded to within 20 working days

Requests being sent out on time has decreased slightly, but is above the target of 80%.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

October 2025

Executive Owner: Sarah Barrow

Highlights

Income and Expenditure Position

- Month 6 – Actual deficit of £1.5m against a planned deficit of £800k, so we are £700k adversely adrift of plan.
- £400k of the adverse variance is in relation to industrial action – At present, there is no national funding to cover this cost or for the loss of elective income (both of which have been covered in the past)
- ERF income is running £4.5m ahead of our expected plan - we have done £4.5m of elective work above the proportionate element of the annual capped ERF value. In order to achieve financial balance at month 6 we have assumed all this additional income in the position.
- Q3 deficit support funding has been secured for the system following regional assurance that we are doing all we can to balance our position.

Efficiency Programme

- At month 6 we have delivered year to date savings totaling £12.3m against a planned savings trajectory of £18.4m. We are currently falling £6.1m short of the year-to-date target requirement. The full year effect of the savings delivered to date is £18.9m.
- Low risk plans not yet delivered take the programme from £15m delivered to date to £35m and a further medium risk set of plans take the programme to the £55m target requirement.

Cash Position

- The cash balance at the end of September is £23.4m against a plan of £35.9m, which is £12.5m adverse. Key variances include: £3.4m I&E operating deficit, £5.5m creditor balance lower than plan linked to timing of supplier payments and £2.5m adverse variance in debtors.

Concerns / Risks

- A significant element of the additional ERF £4.5m income relates to improved clinical coding made part way through 2024/25. The capped value does not take all these improvements into account so we are introducing a risk into our position here where we may well exceed the ERF cap and not receive payment. This position has to be considered alongside our actual elective (and cancer) performance.
- There remains a risk in relation to 24/25 elective activity and payment under PbR. Our reported income position for 24/25 included £5.1m of additional work done for which payment was reasonably expected. NHSE have not yet confirmed the arrangements for reimbursement of this work. Should there be any retrospective cap application then this would result in a corresponding negative impact to the current year's position.

Executive Owner: Sarah Barrow

Concerns / Risks continued

- The current reported position assumes the sparsity payment of £10.3m (in full year terms) is met by the ICB. As yet the ICB has not identified a source of funding but remains committed to working with the Trust on a solution. This is transparently recognised and agreed by all parties in our plan but securing funding remains a key concern area.
- There is significant risk emerging with the efficiency programme as scheme delivery is slipping. Significant focus is required on delivery in the second half of the financial year, and a clear and documented recovery plan is required.

Future / Next Steps

Income and Expenditure Position

- Current forecast work suggests a most likely outturn of a deficit of £5.1m, following a recovery action plan. This position assumes many of the risks/concerns discussed above do not materialise. This is not acceptable and unsupported; work is underway to go further on a system-wide recovery plan where we are expected to take run-rate reducing measures for the remainder of the financial year.
- The winter requirements are included in this forecast position. It is critical to our financial position that winter spend is minimised and that additional savings are identified to offset the costs.

Summary Dashboard and Income & Expenditure

Finance (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

- 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	-£0.2m	-£0.7m	↓	Deteriorating
Corporate CIP Delivery Variance to Plan (£29.8m target)	-£7.6m	-£9.7m	↓	Deteriorating
Core CIP Delivery Variance to Plan (£25.5m Target)	£3.4m	£3.6m	↑	Improving
Variance to Agency Cap	£0.5m	£0.5m	-	Unchanged
Month End Cash Position	£27.1m	£23.4m	↓	Deteriorating
Capital Programme Variance to Plan	-£6.3m	-£5.8m	↑	Improving

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	794,815	397,408	405,703	8,295
Other Income	95,453	47,742	48,277	534
Total Income	890,269	445,150	453,980	8,830
Pay Expenditure	-599,682	-297,095	-300,568	-3,473
Drugs	-71,923	-36,816	-39,676	-2,861
Supplies & Services	-96,121	-48,258	-45,787	2,471
Other Expenditure	-145,361	-60,639	-62,836	-2,197
Outstanding CIP	36,374	6,128	0	-6,128
Total Expenditure	-876,712	-436,679	-448,867	-12,188
Operating Surplus/(Deficit)	13,556	8,471	5,113	-3,358
Other Finance Costs	-12,196	-6,098	-5,213	885
Surplus/(Deficit)	1,360	2,373	-100	-2,473
NHSE Normalisation Adj	-1360	-3181	-1383	1797
Adjusted Surplus/(Deficit)	0	-808	-1,484	-676

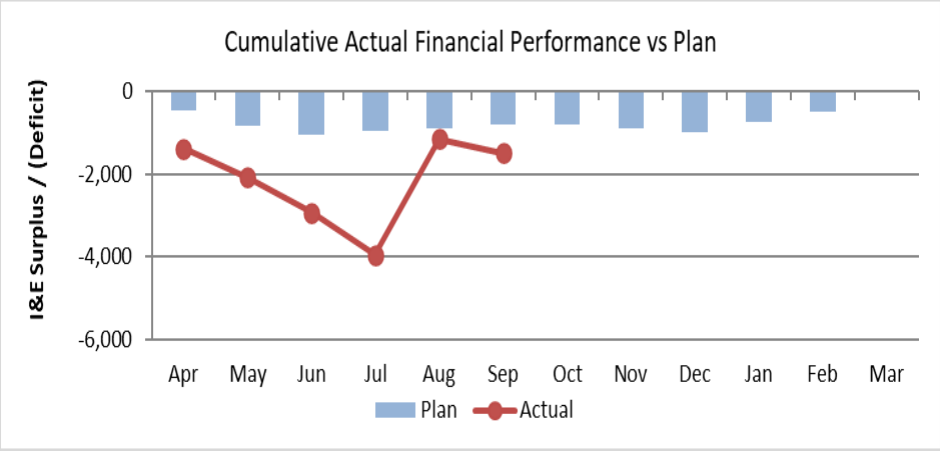
The I&E table confirms an actual adjusted deficit of £1.5m against a planned deficit of £0.8m, leaving the Trust with an adverse variance to plan of £0.7m.

Deficit support funding (DSF), has been secured for Q1 to Q3. Achievement of DSF is based on 4 metrics across the system 1) Balance to plan; 2) CIP delivery; 3) Pay variance to plan; 4) Net risk position. The deterioration in financial performance in month 6 puts the securing of quarter 4 DSF at significant risk. Financial recovery plans are being developed to support the Trust in delivering to plan.

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	(£17,651)	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 in 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	£25,610	ICB over trade linked to services which have been delegated from NHSE to ICBS to commission. The 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 M6 position to recognise activity delivered to date. This action has been agreed by HNY ICB.	Confirm contracting arrangements and ensure plans and actual income reporting align
Employee Expenses	(£3,473)	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	(£2,861)	Mainly relates to drugs commissioned by ICBs that were previously contracted for on a pass-through basis (£1.2m) but are now included in the block payment. In addition, a risk share arrangement was agreed in the 2025/26 plan to reduce expenditure on this group of drugs. Savings have not been delivered at the required rate, and this is contributing to the overall overspend.	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	(£6,128)	The Corporate Programme is £9.7m behind plan, the Core Programme is £3.6m ahead of plan.	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group. CIP Time Out session, lead by CEO, held in October.
Other Costs	£274	Favourable variance on clinical supplies (£2.5m) and services offset by adverse variance on other non pay expenditure (£2.2m).	Identify drivers for increased costs and take corrective action as appropriate.



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 September 2025 is a deficit of £1.5m compared to a planned deficit of £0.8m. This represents an adverse variance to plan of £0.7m.

Forecast			
	Adjusted Surplus/(deficit)		
Scenario	Plan £'000	Forecast £'000	Variance £'000
Likely Case	0	-5,100	-5,100
Best Case	0	0	0
Worst Case	0	-30,600	-30,600

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 HNY ICB in respect of £10m Sparsity funding, delivering an additional £6m savings on high-cost drugs, delivering the efficiency programme in full, receipt of £5.1m 24/25 ERF overtrade income, additional income to cover the 2025/26 pay award shortfall and winter pressures and delivery of activity covered by ERF arrangements to 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 £5.1m

Worst Case
The worst case assumes that none of the mitigations identified in the best case are secured.

Care Group Forecast
Finance (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Year to Date 2025/26 Care Group Financial Position							
Care Group	Annual Adjusted Budget	YTD Budget	YTD Actual	YTD Variance	YTD Adjusted Budget	YTD Adjusted Variance	Key Drivers of YTD Adjusted Variance
	£000	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	238,572	119,940	117,801	2,138	120,462	2,660	Improved position, due to maintained 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	89,594	44,750	45,798	-1,048	45,108	-690	£536k relates to the premium cost of covering medical vacancies, £581k Community Nursing overspend, £476k Midwifery overspend, £159k Sexual Helath underspend, £554k overachieved CIP.
Medicine	191,392	96,655	101,084	-4,429	96,728	-4,356	£2.3m relates to medical cost pressures in ED and Acute; £0.7m drugs overspend relating to Gastro; and £1m shortfall in delivery of the CIP target
Surgery	164,909	82,690	85,269	-2,579	83,129	-2,139	Overspend mainly relates to Resident Doctors pay costs over budget - £1.4m & overspends on drugs & CSS spend.
TOTAL	684,468	344,034	349,952	-5,918	345,427	-4,526	

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	238,572	237,760	0	237,760	811	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	89,594	92,507	-214	92,293	-2,699	£819k relates to the premium cost of covering medical vacancies, £1072k Community Nursing overspend, £952k Midwifery overspend, £191k Sexual Helath underspend, £139k over-planned CIP.
Medicine	191,392	201,316	-113	201,203	-9,811	£4.5m relates to medical staffing cost pressures, £1.4m drug overspend and £3.2m shortfall in CIP delivery
Surgery	164,909	169,640	0	169,640	-4,731	£2.7m over-spend on Resident Doctors mainly relates to premium cost of covering medical vacancies, £0.2m pressure on CSS spend for non elective activity over plan, £0.4m linked to backfill of apprentice posts, £0.4m on other non-pay & £0.4m linked to drug overspend.
TOTAL	684,468	701,223	-326	700,897	-16,429	

Forecast Outturn & Recovery Action Plans

Finance (6)

York and Scarborough Teaching Hospitals NHS Foundation Trust

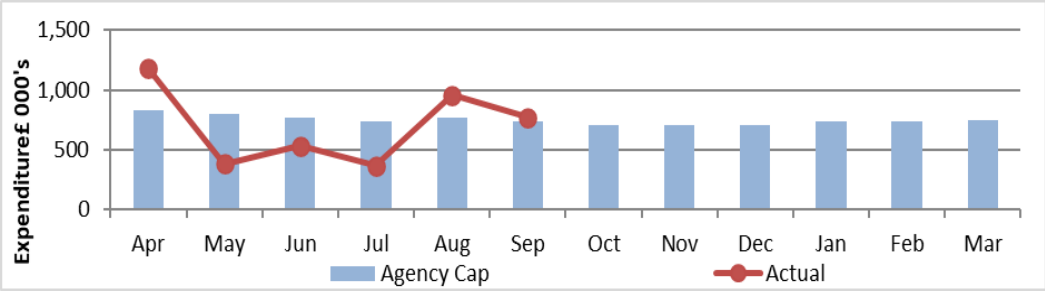
2025/26 Forecast Outturn & Recovery Actions	
2025/26 Forecast	**£m**
M4 Run Rate FOT	**-11.9**
Winter Plans	-3.0
Redundancy Costs	-2.0
Additional costs re validation (ERF)	-1.8
Run rate efficiencies	1.5
M4 Unmitigated Risk	**-17.2**
M5 Impact of run rate changes	6.3
M5 Impact of CIP delivery changes	-3.0
Revised M5 unmitigated risk	**-13.9**
Recovery Actions	
Medicine Care Group	
Cease Co-horting	0.4
Reduce premium rate Acute Medical Provision - SGH	0.4
Reduce premium rate ED Resident Drs - YRK	0.4
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	
Address Resident Doctors overspend - Child Health	0.1
Corporate	
Discretionary Expenditure Control	0.5
Remove bank premium incentive	0.2
Targeted reduction in Winter plans	1.0
Targeted redundancy reductions	1.5
Targeted reduction in ERF expenditure	1.8
EPR Revenue to capital conversion	1.0
Optimal Residual Risk	**-5.1**

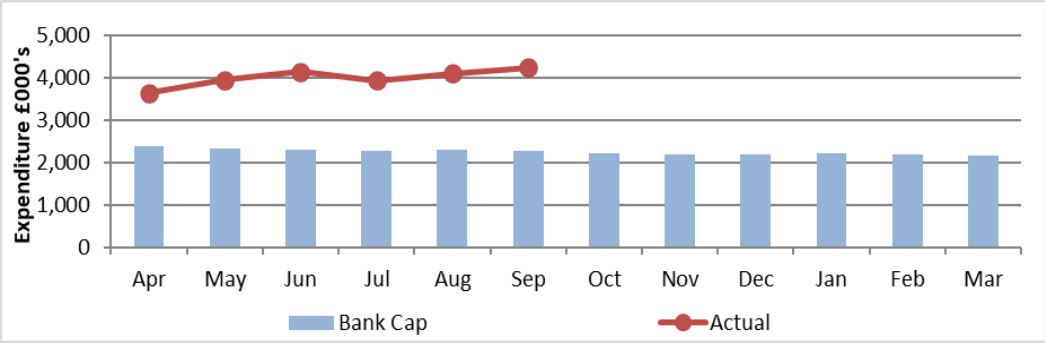
At Month 4, the Trust was required to submit a forecast outturn and recovery action plan. At the time of submission, the Trust had £17.2m unplanned risk. A revised position at M5 due to a reduction in the pay and non-pay run rate, and an adverse movement in CIP forecast delivery, reduces the unplanned risk to £13.9m.

Recovery actions are required to bring the Trust back to balance.

Efforts are underway to validate the current actions within care groups, and the Executive Committee has reviewed additional measures such as reducing winter scheme expenditures and aiming to reduce redundancies. Despite these efforts, there remains an outstanding risk of £5.1m, and some of the current actions, while being validated, are at risk of delay. The Executive Committee, along with the wider ICB and system, is working on supplementary actions. These include accelerating the delivery of CIP plans (although some schemes are experiencing delays) and identifying new cost and waste reduction initiatives. The Board will receive continuous 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	2,628.89	2,499.37	129.52	76,011	76,410	-399
Scientific, Therapeutic and Technical	1,316.00	1,271.51	44.49	37,309	37,596	-286
Support To Clinical Staff	1,926.20	1,470.58	455.62	33,519	30,130	3,389
Medical and Dental	1,121.64	1033.41	88.23	79,855	86,552	-6,698
Non-Medical - Non-Clinical	3,211.38	3,065.44	145.94	67,737	68,681	-944
Reserves				1,548	0	1,548
Other				1,116	1,199	-83
TOTAL	10,204.11	9,340.31	863.8	297,095	300,568	-3,473

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 September is £4.183m compared to a plan of £4.648m, representing a favourable variance of £0.465m.

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 September is £23.994m compared to a plan of £13.837m, representing an adverse variance of £10.151m.

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.

Elective Recovery Fund
Finance (8)

York and Scarborough Teaching Hospitals NHS Foundation Trust

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 06 Phase (Av %)	Activity to Month 06 Actual	Variance - (Clawback Risk) M06
Humber and North Yorks	104.00%	£171,355,927	£85,019,809	£89,856,988	£4,837,179
West Yorkshire	103.00%	£1,570,160	£779,049	£773,946	-£5,104
Cumbria and North East	115.00%	£223,602	£110,942	£140,465	£29,523
South Yorkshire	121.00%	£182,919	£90,757	£86,808	-£3,950
Other ICBs - LVA / NCA	-				*£0*
All ICBs	***104.02%***	***£173,332,608***	***£86,000,558***	***£90,858,206***	***£4,857,649***
NHSE Specialist Commissioning	113.38%	£4,784,314	£2,373,781	£1,976,725	-£397,056
Other NHSE	104.13%	£305,100	£151,378	£163,747	£12,369
All Commissioners Total	**104.31%**	**£178,422,022**	**£88,525,717**	**£92,998,679**	**£4,472,962**

Elective Recovery Fund

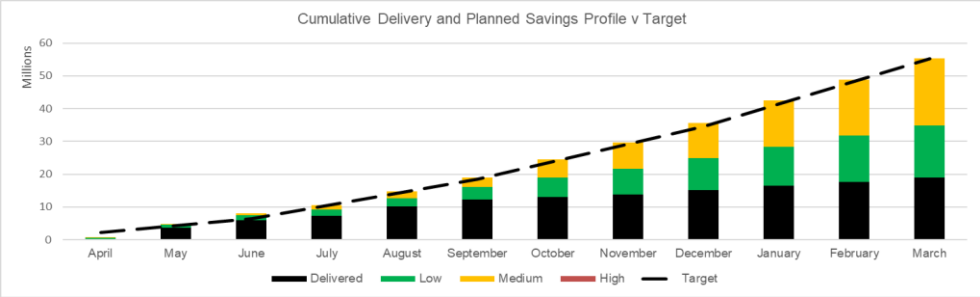
We continue to report on Elective Recovery Performance on an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date before applying average tariff income to the activity.

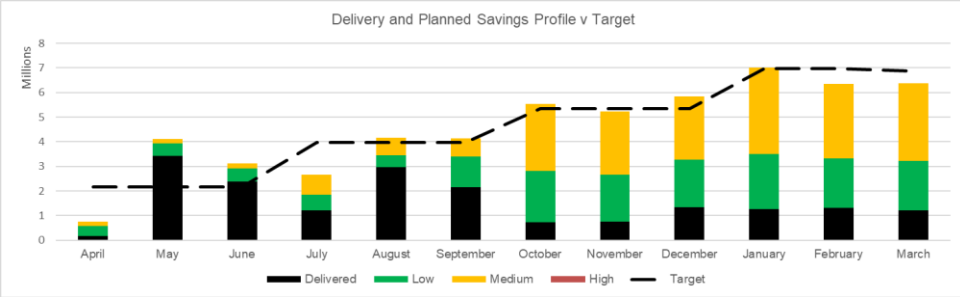
Given the financial limits on Elective Recovery Funding in 2025/26, it is important to closely monitor the position to ensure that the weighted activity undertaken, where it incurs additional costs, does not exceed the planned levels without ICB Commissioner authorisation. Additional system ERF funding may become available in year, where other system providers, including the Independent Sector, are under their agreed activity plan and Elective resource can be redirected into York & Scarborough FT.

At Month 6, the ERF weighted activity is valued at £4.47m over the funded level of ERF activity within our Commissioner contracts. However, we are expecting this overtrade to reduce in the remaining 6 months of the year.

Cost Improvement Programme
Finance (9)

York and Scarborough Teaching Hospitals NHS Foundation Trust





2025/26 Cost Improvement Programme - September Position											
	Full Year CIP Target	September 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	9,928	196	9,731	392	29,396	14,417	15,371	1,188	13,229	0
	29,789	**9,928**	**196**	**9,731**	**392**	**29,396**	**14,417**	**15,371**	**1,188**	**13,229**	**0**
Core Programme											
Medicine	6,039	2,012	1,009	1,004	1,663	4,375	4,184	1,855	2,131	2,053	0
Surgery	4,524	1,508	1,510	-3	2,533	1,992	5,643	-1,118	4,105	1,538	0
CSCS	7,044	2,347	2,386	-38	5,147	1,897	8,194	-1,150	7,321	872	0
Family Health	2,306	768	1,323	-554	1,625	681	2,444	-139	2,441	3	0
CEO	45	15	300	-285	601	-556	601	-556	601	0	0
Chief Nurses Team	893	297	88	209	175	718	472	421	203	268	0
Finance	733	244	396	-151	791	-58	856	-123	841	15	0
Medical Governance	62	21	5	15	11	51	56	5	56	0	0
Ops Management	532	177	152	25	299	234	316	216	316	0	0
DIS	601	200	21	179	45	555	605	-5	45	560	0
Workforce & OD	763	254	261	-7	527	236	527	236	527	0	0
YTHFM LLP	1,962	654	1,028	-374	1,518	444	3,098	-1,136	1,879	1,219	0
Central	0	0	3,622	-3,622	3,590	-3,590	13,877	-13,877	13,270	608	0
	25,502	**8,499**	**12,102**	**-3,603**	**18,524**	**6,977**	**40,873**	**-15,371**	**33,736**	**7,136**	**0**
Total Programme	**55,290**	**18,426**	**12,298**	**6,128**	**18,917**	**36,374**	**55,290**	**0**	**34,924**	**20,366**	**0**

Efficiency Programme

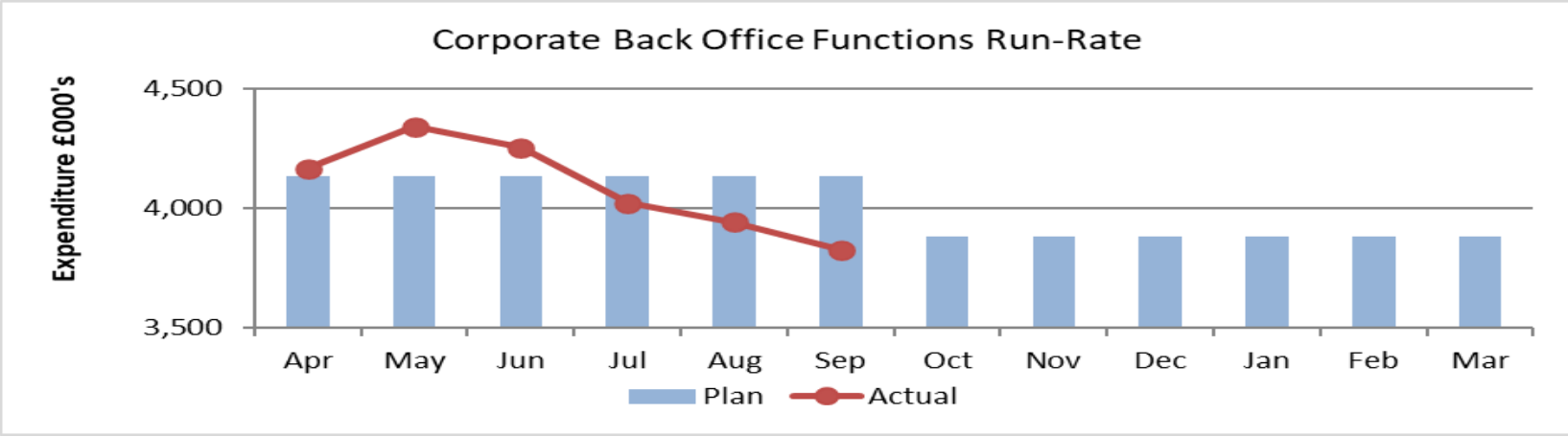
The total trust efficiency target is £55.3m; £18.9m has been achieved in full year terms and the year-to-date position is £6.1m behind plan. The programme is fully planned.

Corporate Efficiency Programme

The Corporate efficiency programme has a target of £29.8m and £0.4m has been delivered in full year terms. At the end of September, the year-to-date delivery is £9.7m 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 £18.5m has been delivered in full year terms. At the end of September, the year-to-date delivery is £3.6m 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 and 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 September is £3.827m. The required run rate reduction has been achieved in September and needs to be maintained for the remainder of the year to meet the target.

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 2	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	23,374						

Closing cash was £23.4m against a plan of £35.9m, which is £12.5m adverse. This is a £2.7m improvement on the variance reported at M5.

The significant factors contributing to the variance are:

- £3.4m – Adverse variance in I&E operating surplus / (deficit).
- £5.5m – Adverse variance due to creditor balance lower than plan linked to timing of receipt & payment of supplier invoices with no significant issues.
- £2.5m – Adverse variance in debtors. The HUTH debtor balance continues to reduce with the overdue balance at £0.7m reduced from the £6.2m reported in previous months. Debt collection remains a focus for the Trust.

The forecast contains 3 scenarios:

Run rate – Based on continuation of cash receipts & payment run rates in line with April to September levels and any known adjustments. Payment run rates have remained high impacting this projection. This highlights the importance of reducing expenditure and increasing efficiency delivery to mitigate the pressure.

Best case – Based on the Trust recovering to deliver the financial plan.

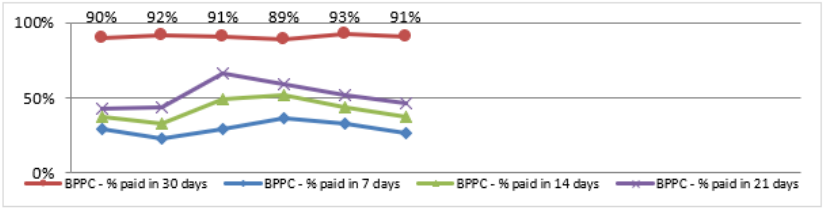
Worst case – Based on the Trust failing to deliver the financial plan.

Delivery of the financial plan & the efficiency program are crucial. Any slippage impacts cash reserves, creating a cash pressure.

<u>Better Payment Practice Code</u>

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

The graph illustrates that in September the Trust managed to pay 91% 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	M6 Actual £000s	Variance to Plan £000s
PDC Funded Schemes	56,525	13,076	8,642	(4,434)
IFRS 16 Lease Funded Schemes	7,838	1,598	926	(672)
Depreciation Funded Schemes	16,626	5,961	5,301	(660)
Charitable & Grant Funded Schemes	7,213	3,112	708	(2,404)
Total Capital	**88,202**	**23,747**	**15,577**	**(8,170)**
Less Charitable & Grant Funded Schemes	(7,213)	(3,112)	(708)	2,404
Less Sale of Clarence Street	(325)	-	-	-
Total Capital (Net CDEL)	**80,664**	**20,635**	**14,869**	**(5,766)**

The M6 position is £5.77m behind the plan.

This is mainly due to the SGH Maternity Roof Replacement Phase 1 running £1.5m behind the planned profile, the Electronic Patient Record scheme running £1m behind the planned profile, the RAAC scheme running £3m behind the planned profile, and various other schemes running £0.2m behind the planned profile.

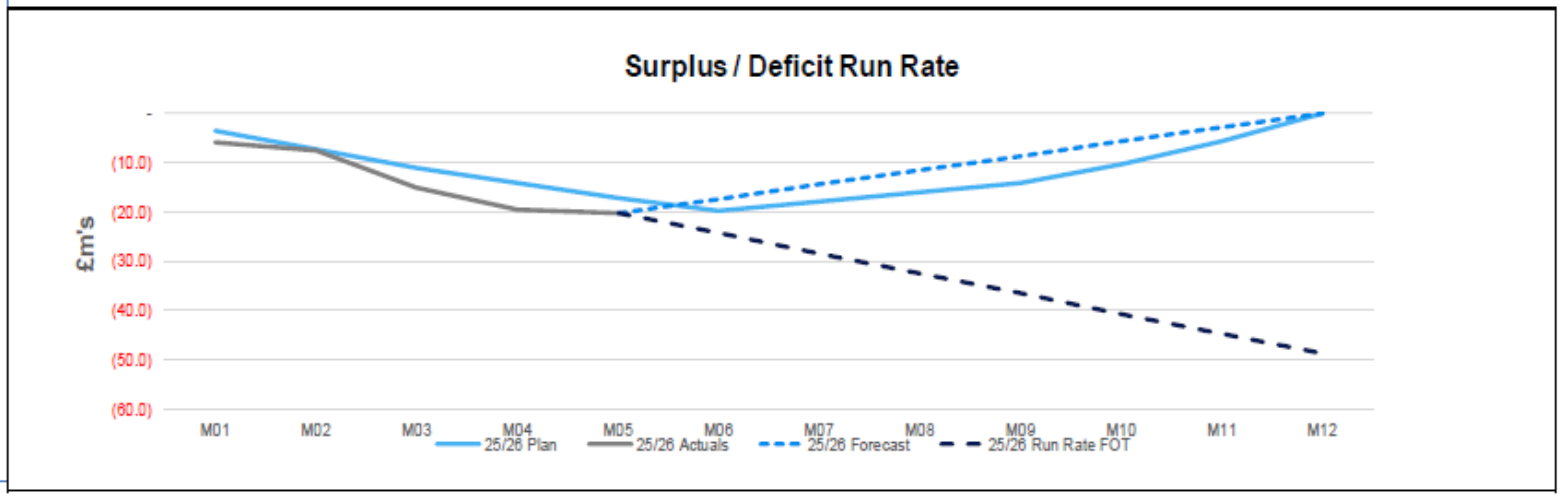
These schemes are not without risk; however, work is underway to review and confirm if the schemes will utilise the full CDEL allocation this financial year.

System Summary – Month 5

M5 Position

- ICB £72k overspend YTD, FOT breakeven.
- Providers £3.2m overspend YTD, FOT breakeven.
- Straight line extrapolation of run rate is circa £49m deficit.
- YTD variance is mainly due to slippage against efficiency schemes, medical staffing, drugs and devices costs partially offset by non recurrent mitigations.

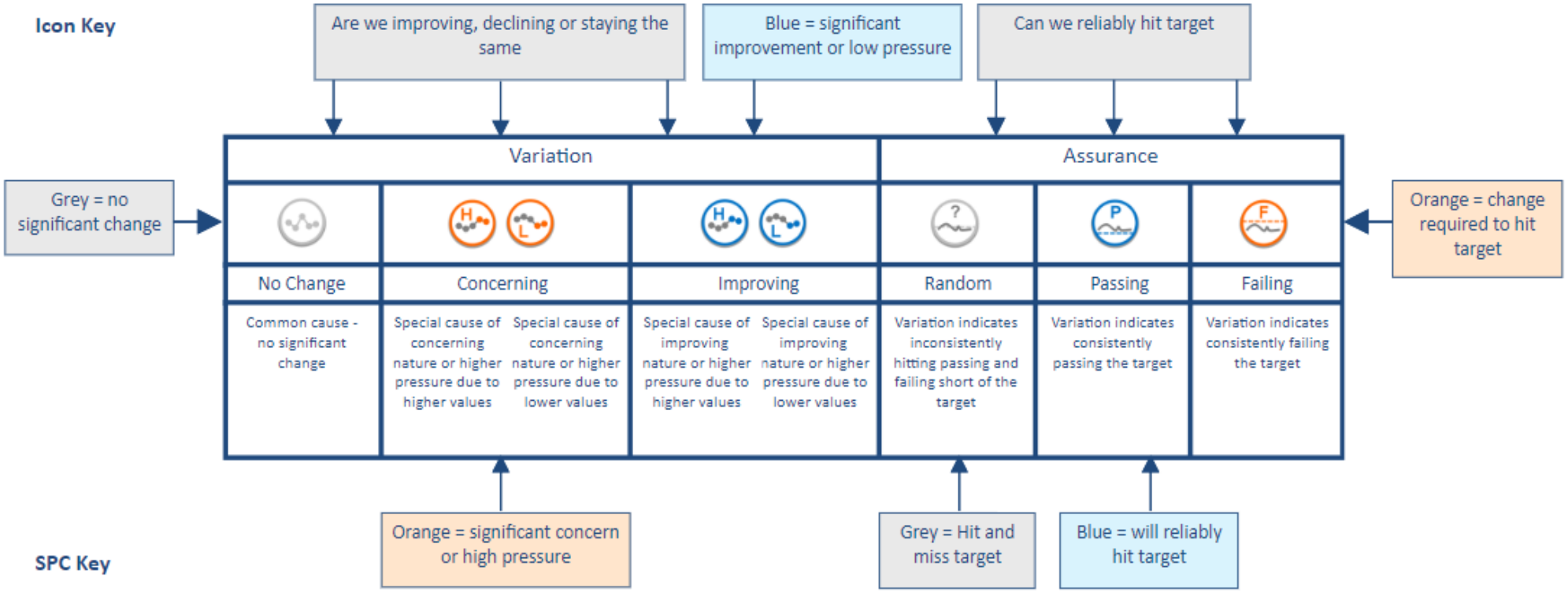
Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD	Actual YTD	Variance YTD		Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£000	£000	£000	%	£000	£000	£000	%
Humber And North Yorkshire ICB	-	(72)	(72)	(0.0%)	-	-	-	0.0%
Harrogate And District NHS Foundation Trust	(4,464)	(7,342)	(2,878)	(1.8%)	-	-	-	0.0%
Hull University Teaching Hospitals NHS Trust	(4,863)	(7,671)	(2,808)	(0.7%)	-	-	-	0.0%
Humber Teaching NHS Foundation Trust	(752)	2,248	3,000	2.7%	-	-	-	0.0%
Northern Lincolnshire And Goole NHS Foundation Trust	(6,174)	(6,401)	(227)	(0.1%)	-	-	-	0.0%
York And Scarborough Teaching Hospitals NHS Foundation Trust	(904)	(1,152)	(248)	(0.1%)	-	-	-	0.0%
ICS Total	(17,157)	(20,390)	(3,233)	(0.2%)	-	-	-	0.0%



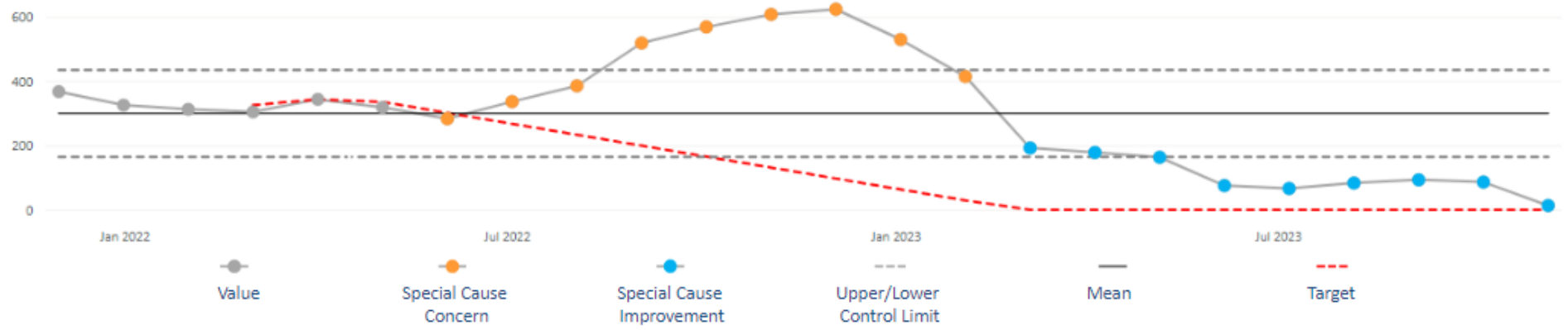
Keys

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
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	22 October 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:

This report outlines key developments in the Trust's engagement with the Care Quality Commission (CQC), including inspection follow-ups, regulatory updates, and ongoing quality assurance activities.

There was an unannounced CQC inspection of Urgent and Emergency Care and Medical Care Services at Scarborough Hospital between 7 and 9 October 2025.

Following publication of the July 2025 CQC inspection report, the Trust is preparing its first quarterly progress update, due by 31 October. At the September engagement meeting, updates were shared on infection control and mental health care in acute settings.

The application to remove Section 31 conditions from York Hospital's maternity services was approved by the Family Health Board and awaits final sign-off by the Executive Committee on 1 October.

In September, the Trust received six new CQC cases, with 13 currently open.

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
Patient Safety and Clinical Effectiveness Sub-Committee	8 October 2025	*Presented and accepted*

CQC Update

1. CQC Activity

Please note: This paper has been updated following CQC inspection activity at Scarborough Hospital between 7 and 9 October 2025 therefore differs to what was presented at the Patient Safety and Clinical Effectiveness sub-committee on 8 October 2025.

Scarborough Hospital Inspection (October 2025)

On Tuesday 7 October, thirteen inspectors from the Care Quality Commission (CQC) arrived at Scarborough Hospital to conduct an unannounced inspection of Urgent and Emergency Care (UEC) and Medical Care Services.

- Urgent and Emergency Care

The UEC inspection team left the Scarborough Hospital site on 8 October 2025. A data request was received on the 9 October 2025 for additional assurance on the triage system within the UEC.

The Trust submitted a response on 14 October 2025 (due 15 October 2025). The CQC confirmed on the 15 October 2025 that *'..we are satisfied with the response from the trust and will pick up anything further as needed upon completion of the final report.'*

- Medical Care

The Medical Care inspection team left the Scarborough Hospital site on 9 October 2025. High leave verbal feedback was provided on Wednesday 8 October, this was confirmed in writing and received on 10 October 2025. The Trust will be submitting a response to this on 17 October 2025.

The CQC has submitted an evidence request to support the inspection, with all documentation due by 24 October 2025.

- Ratings

The CQC confirmed they reviewed all Quality Statements (formerly known as Key Lines of Enquiry) as part of its inspection of both the UEC and Medical Care services. This enables the CQC to rate or re-rate these services as appropriate.

Any new ratings will apply only to the Scarborough Hospital site. Changes to these ratings will not affect the Trust's overall rating of 'Requires Improvement', which will remain in place until a Well-Led inspection is completed.

York Inspection (January 2025)

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.

The monthly CQC Engagement Meeting was held on 23 September 2025. A Trust update on Infection Prevention and Control was provided. The CQC also gave a

presentation on their work on patients with mental health needs in acute hospital settings.

Section 31 Maternity Services

An application for removal of the Section 31 conditions on the Trust registration for Maternity Services at the York Hospital site was approved at the Family Health Care Group Board on 15 September 2025. This is scheduled for approval at the Executive Committee on 1 October 2025. If approved, this will then be submitted to the CQC for consideration *(update to the paper – the application to remove the conditions was submitted to the CQC on 3 October 2025).*

2. 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 six cases in September 2025. At the time of writing, the Trust had thirteen open cases / enquiries. The enquiry dashboard can be viewed in **Appendix A**.

3. CQC Updates

4.1 CQC reports on safe use of radiation in healthcare settings

The Care Quality Commission (CQC) has published its annual report on the enforcement of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) in England for the period 2024/25. The CQC carried out 71 regulatory IR(ME)R inspections during this period, the report shares their key findings including a breakdown of the number and types of errors notified to CQC during this time.

Click here for further information on the report and its findings.

4.2 Chief Inspector update: mental health safeguards and regulatory reform

Dr Arun Chopra, Chief Inspector of Mental Health, posted a new blog, on how the CQC is working to improve outcomes for people using mental health services.

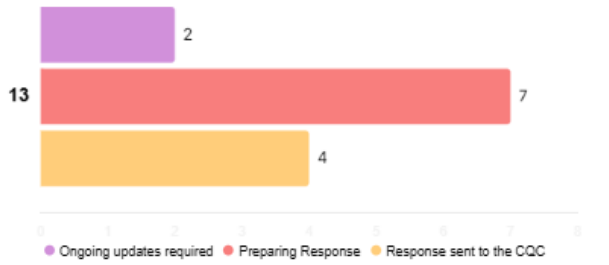
4.3 Results of Adult Inpatient Survey 2024

CQC have published the results of the Adult Inpatient Survey 2024. This survey explores the experiences of people who stayed at least 1 night in hospital as an inpatient. **Click here** to read the results.
The results will be presented through the Patient Experience subcommittee.

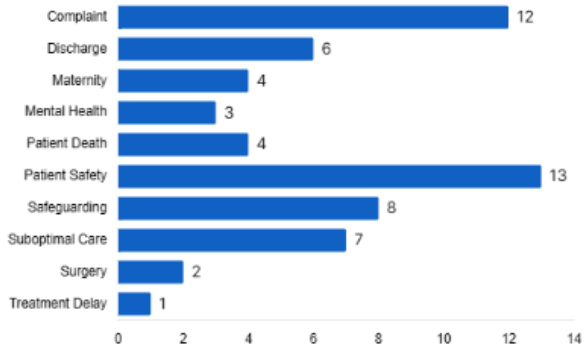
Date: 16 October 2025

Appendix A

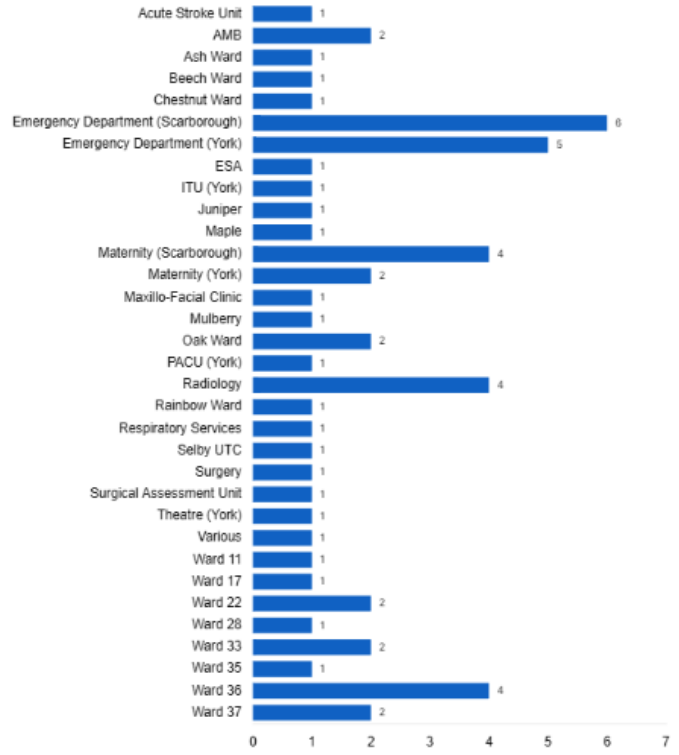
Number of Open CQC Enquiries / Cases



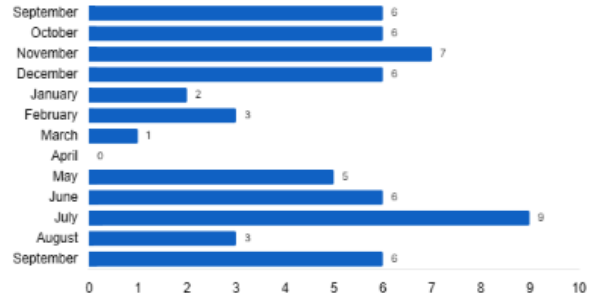
Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Number of Enquiries Received



Report to:	Trust Board of Directors
Date of Meeting:	22nd October 2025
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Dawn Parkes, Chief Nurse (Executive Maternity and Neonatal Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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☒ Transformative Services
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☐ Financial Balance
☐ Effective Governance

Implications for Equality, Diversity and Inclusion (EDI)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:
The purpose of the report is to inform the Trust Board 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 remains 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 3.4% (10 cases) in August 2025. The data demonstrates there has been a stabilisation in the Trust rolling average over 12 months for PPH ≥1500mls months from the national digital dashboard.
- The first newly recruited midwives (12.9 WTE) will commence their preceptorship on the 20th October. With staff returning from Maternity leave and long term sickness this means that once the new recruits totalling 24.6 WTE commence this will take 4.0 WTE off the 44WTE off the Birthrate staffing gap.

Key Risks

- 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 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.
- It has been highlighted that the CTG tocos and transducer cables provided by Huntleigh are made from material that leaves them prone to damage and cracking. This causes an IPC risk and creates a supply problem when replacing broken cables. The Medical Engineering team have checked all machines on both sites and replaced damaged cables from current stock and additional cables have been ordered. A meeting between the Director of Midwifery and Huntleigh has been arranged for w/c 13 October 2025.
- The total roster vacancy is 20.25WTE for midwives, which continues to impact on the ability to meet minimum safe staffing requirements for front line clinical areas and impacts on the wider Quality, safety and improvement agenda for maternity services. However there has been successful recruitment that will start to have a positive impact from the new year.

Key Concerns

- There is a concern regarding the impact of many new initiatives being implemented nationally regards reporting requirements for all Maternity services across England on the current capacity of the team and the ability to meet the strict reporting timeframes.
- The Director of Midwifery is currently working with no Deputy Director of Midwifery or Deputy Head of Midwifery.

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 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 August 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, the service are required to report the information outlined in the data measures monthly to the Trust Board. Data is for the month of August 2025.

Perinatal Deaths

In August 2025 there were 2 neonatal deaths (at 22+3 weeks) and 1 stillbirth (at 24+6 weeks gestation). There has been a multidisciplinary review of each case and no immediate safety concerns have been identified but all cases are subject to a perinatal mortality review using the Perinatal Mortality review Tool.

Maternity and Newborn Safety Investigations (MNSI)

In the month of August there were no incidents that met the reporting criteria and no final reports from MNSI received.

Patient Safety Incident Investigations (PSII)

In the month of August there were no PSII's declared.

Moderate Harm Incidents and above

The postpartum haemorrhage (PPH) rate was 3.4 % (10 cases) in August 2025. The data demonstrates there has been a stabilisation in the Trust rolling average over 12 months for PPH ≥1500mls months from the national digital dashboard.

Quality and Safety

There is a total of 132 open incidents, the oldest dates back to September 2024. There has been a decrease of 15 incidents since September 2025. A focused piece of work is going to be undertaken to address the oldest incidents. There are two pathway reviews to be completed and one After Action Review's to be completed which is in date. There are four PSIRF learning responses awaiting to be signed off in at the Patient Safety Learning Response meeting in September.

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. 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. Neonatal Basic Life Support training for all key staff groups is <90 % in the month of August 2025.

Service User Feedback

Service users feedback from the MNVP has identified a consistent theme of delays to receiving an epidural. Maternity services have instigated an audit to establish the reasons for these delays. This is recorded as a red flag in line with NICE Guidance and findings of the audit will be reported and shared with all key stakeholders.

The Regional MNVP lead asked to interview the York and Scarborough MNVP lead along with the Transformation Lead Midwife and the Director of Midwifery to showcase the work that happens in relation to service user in maternity services to share across the region as an example of good practice. This may also be shared nationally.

CQC Section 31 Progress Update

Annex 2 provides the August 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 August 2025.

National reporting requirements of Maternity Services in England Launching in November 2025 mandated by NHS England

1/ Submit a Perinatal Early Notification Portal (SPEN). The NHS SPEN is a web-based portal designed to streamline the notifications of qualifying perinatal safety events to three national organisations: • MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK) • Maternity and Newborn Safety Investigations (MNSI) • NHS Resolution Early Notification (NHSR EN) scheme. The portal eliminates duplicate data entry by allowing users to input information once and automatically routing it to the appropriate organisation(s) depending on event type.

2/ Maternity Outcomes Safety Signal (MOSS). It was developed by NHS England in response to the first recommendation in the Reading the Signals East Kent report. MOSS aims to identify signals about potential critical safety issues in maternity intrapartum care that could lead to adverse outcomes and is intended to be used as part of routine safety monitoring within the Perinatal Quality Oversight Model (PQOM).It is a new way of monitoring potential safety issues in maternity services using near-real time data.

3/ Regional Heatmap. The Heat Map is an intelligence tool developed to visualise and monitor key health indicators across the region. It supports strategic planning and decision-making by identifying areas of concern and opportunity in maternity services. Key Features include:
• Visual representation of service demand and provision
• Integration of multiple datasets
• Supports ICBs and Trusts in targeting interventions and allocating resources

4/ Daily OPEL/SitRep includes:
• Implement a version of the Midlands OPEL data collection across all regions so services and ICBs have a facility to rapidly check pressures and arrange mutual aid
• Provide data on operational pressures to the NHSE CNO and executive and replace the existing national fortnightly SitRep questionnaire
• Provide data on operational pressures for triangulation with other data and intelligence on safety to inform the Perinatal Quality Oversight Model

Perinatal Mental Health

There continues to be capacity issues within the Team at Tees Esk and Wear Valley Trust (TEWV). This is anticipated to improve in November due to key recruitment within the team. Joint meetings between the Amethyst Midwifery Perinatal Mental Health Team and TEWV are planned in the future to ensure collaborative working across the services to ensure all women are supported by the right team in line with national standards and meets women's individual needs. Clinical supervision continue has been provided by the Trusts Clinical Psychology team, which has been beneficial to the Amethyst team but this is coming to an end. It has been identified that whilst TEWV have provided clinical supervision in the past to the team there is no formal contract in place to support this. This will be addressed between the services in collaboration with the ICB.

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 service remains on track to achieve full compliance in 7/10 safety actions. All evidence will be reviewed by the LMNS on the 22nd of November with a further follow up review in January 2026 before required submission on the 3rd of March 2026 to NHS Resolution by 12.00 midday.

Midwifery Workforce

Total budgeted establishment vacancy:
4.47WTE (York 1.58WTE, Scarborough 2.89WTE)
Absences within Staff in Post (SIP):
15.78WTE (York 9.25WTE, Scarborough 6.53WTE)
Total roster vacancy:
20.25WTE (York 10.83WTE, Scarborough 9.42WTE)

Absence in September comprised of maternity leave (9.8WTE), sickness (3.95WTE) and supernumerary (2.03WTE).
The above figures do not include the below recruitment figures, these will be included in October data.
The Autumn recruitment drive resulted in the recruitment of **24.6WTE** Band 5 and 6 midwives, across York and Scarborough. The first cohort of 14 Band 5s (12.9WTE) will commence their preceptorship 20th October (3.6WTE in Scarborough and 9.3WTE in York). A second cohort of 7.5WTE Band 5s will commence their preceptorship in Feb (2.5WTE in Scarborough and 5WTE in York). There are also an additional 4 Band 6 and 1 Band 5 midwives (4.2WTE) who will commence in post at York in the coming months.

Unregistered workforce (B2&3)
Total budgeted establishment vacancy:
3.74WTE (York 4.49WTE, Scarborough –0.75WTE)

Total roster vacancy:
15.41WTE (York 13.93WTE, Scarborough 1.48WTE)

Recruitment continues with further Band 5 and 6 posts to be advertised shortly, alongside an advert for Band 3 and 4 Maternity Assistants and Maternity Support workers.

Improvement and Transformation In September

Telephone triage go live date confirmed for October 2025.
Perinatal Pelvic Health Service:
Admin role in line with the National Service Specification has been appointed to, awaiting start date.
All physiotherapy positions are recruited to and in post, providing additional support and capacity.
The single point of access referral form across the LMNS has gone live.
Baseline assessment of infant feeding services has been completed to assess capacity vs demand and equity across services. Approval granted to progress to business case stage
15 steps at Scarborough took place in September. The MNVP identified lots of improvements which had been made since the previous 15 steps walk around.
Neonatal BadgerNet due to go live in November 2025
Recruitment across Midwifery workforce.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

September 2025 position:
1 new milestone action has been added to the single improvement plan in September 2025.

- PPHS evaluation of the uptake of the single point of access referral (1 milestone action). Due for delivery in September 2026.

113 out of the 267 milestone actions have been completed to date (8 completed in September 2025)

33 milestone actions are in progress

17 milestone actions have been marked as at risk of delivery in the anticipated time frame

27 milestone actions are off track as the delivery date has passed, and the action has not been completed

(19 went off track in September 2025).

- 11 milestone actions require a timeline review due to the decision to focus on Quality and Safety priorities within business as usual
- 2 milestone action require internal stakeholders to complete the actions
- 1 milestone action needs aligning to trust wide project timelines
- 13 milestone actions are off track but are due to deliver before December 2025.

75 milestone actions are not scheduled to start yet

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.

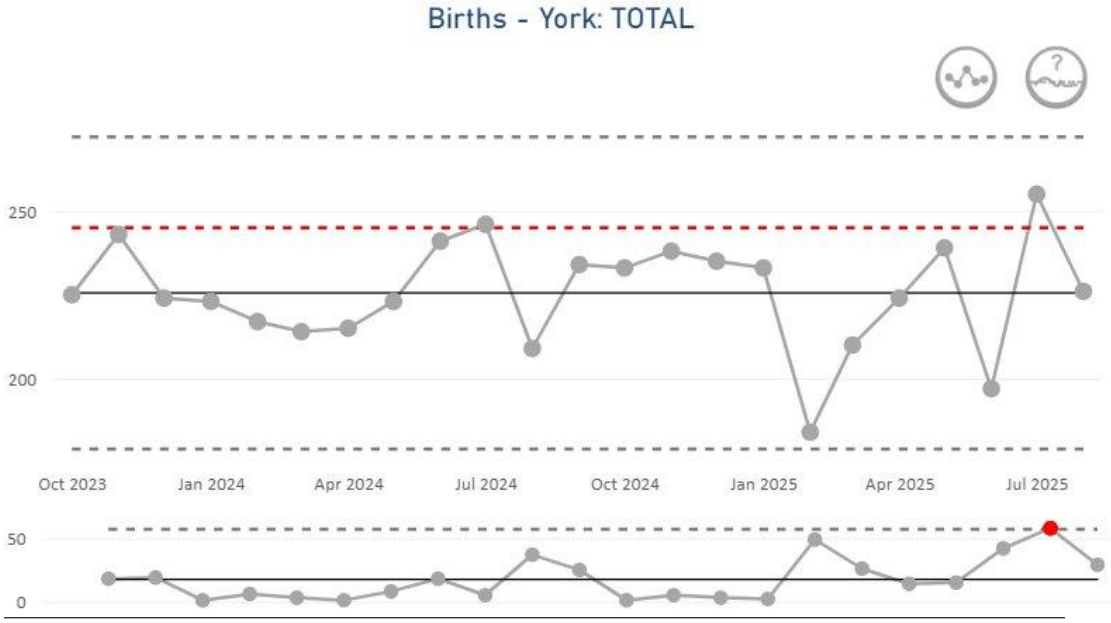
2. There is a risk that the additional workforce reviews underway will result in gaps being identified in the other staffing establishments (Obstetrics, Neonatal, Operational and Admin establishments). If additional workforce gaps are identified, it may result in non-compliance with national staffing 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.

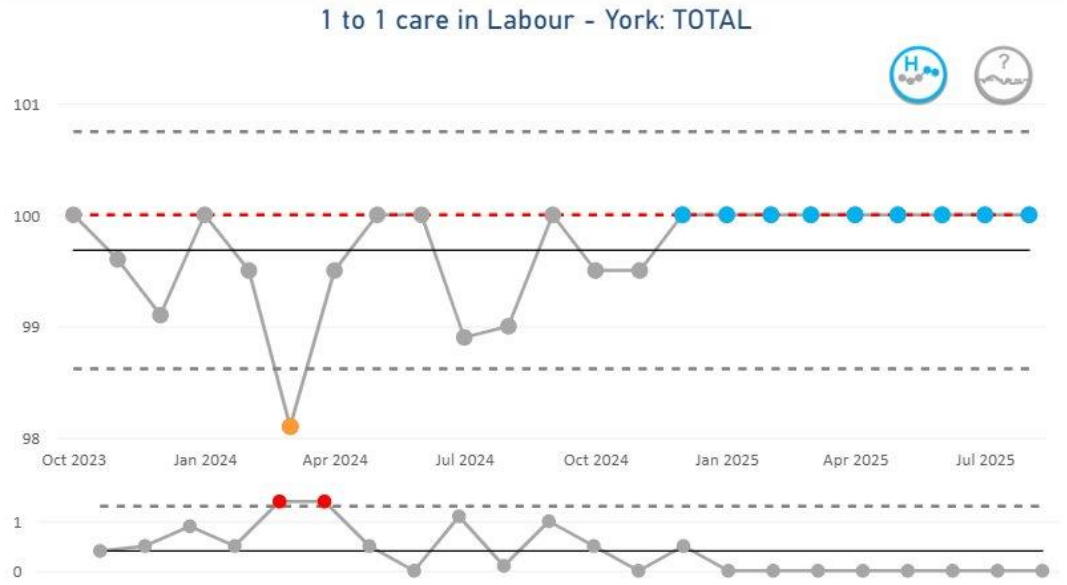
Recommendations to Trust Board

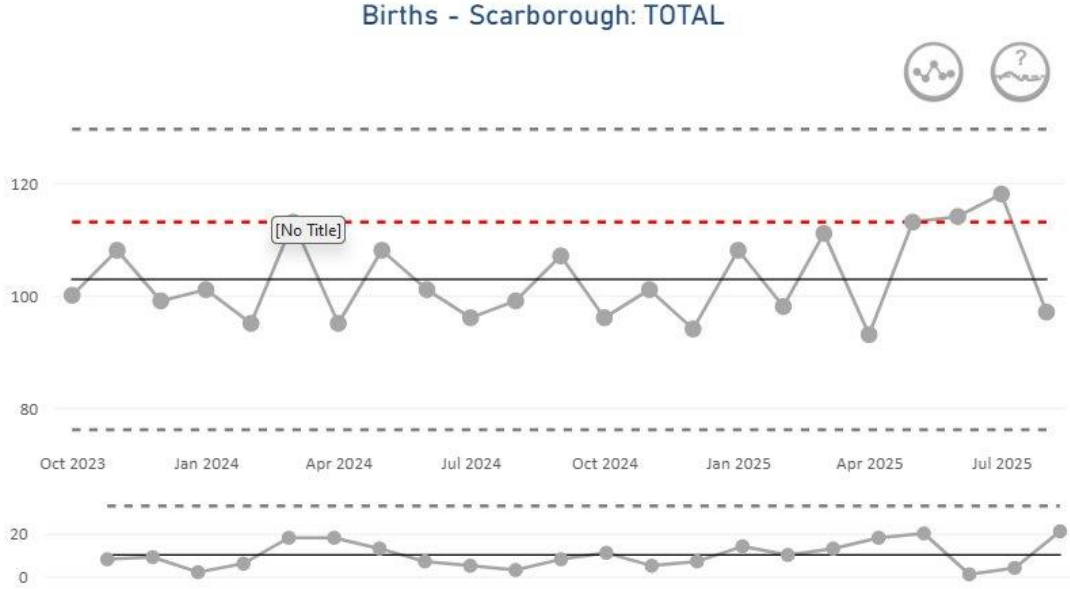
To note the contents of this report and agree the CQC section 31 submission in Annex 2

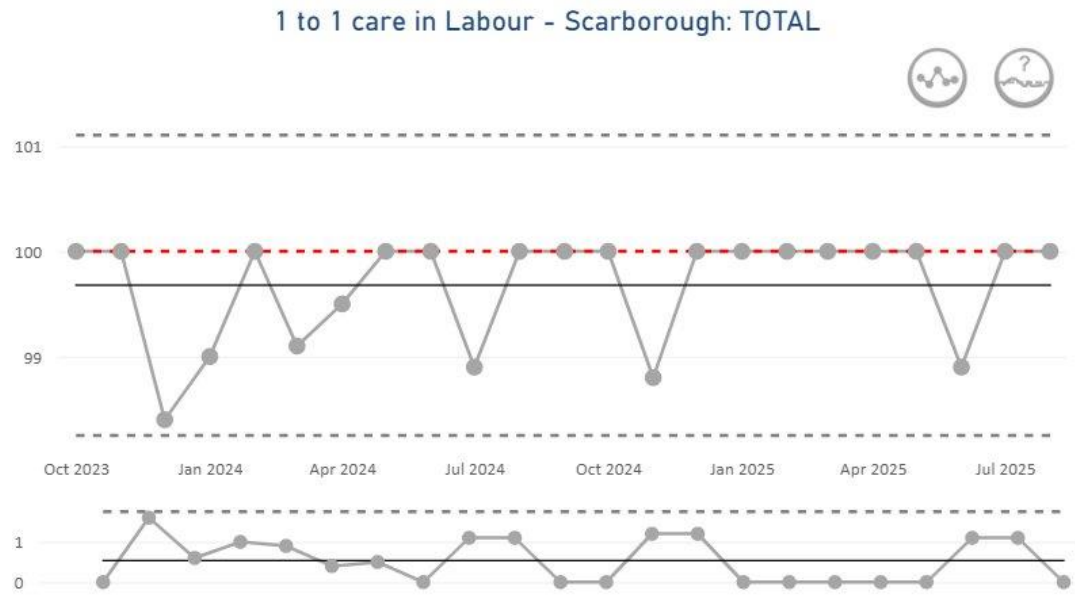
Date: 22 October 2025

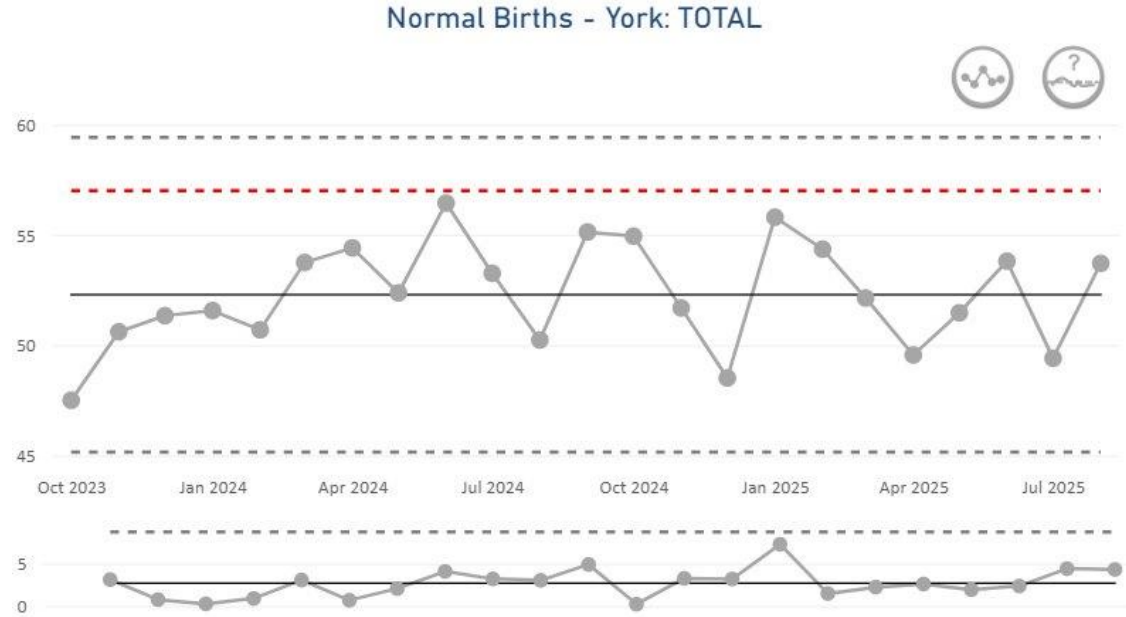
Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery August 2025

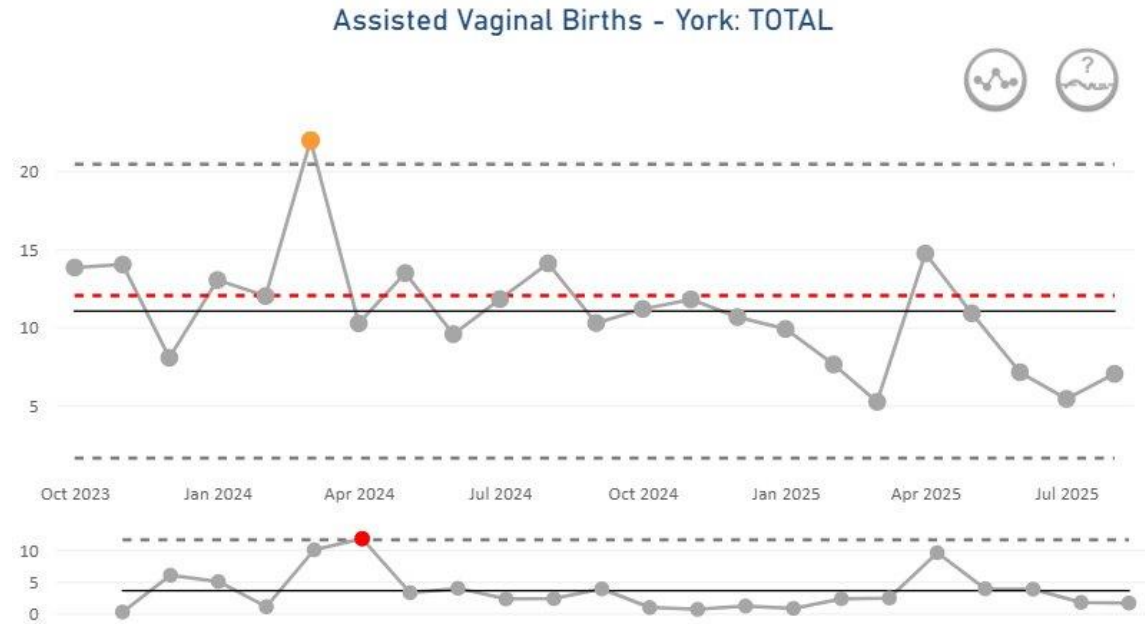


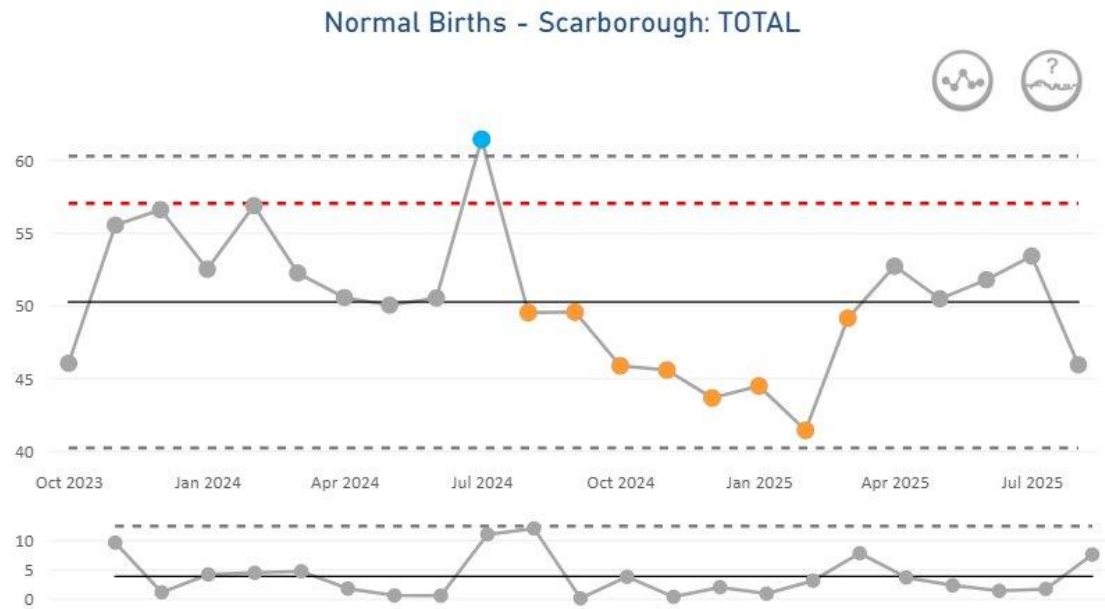


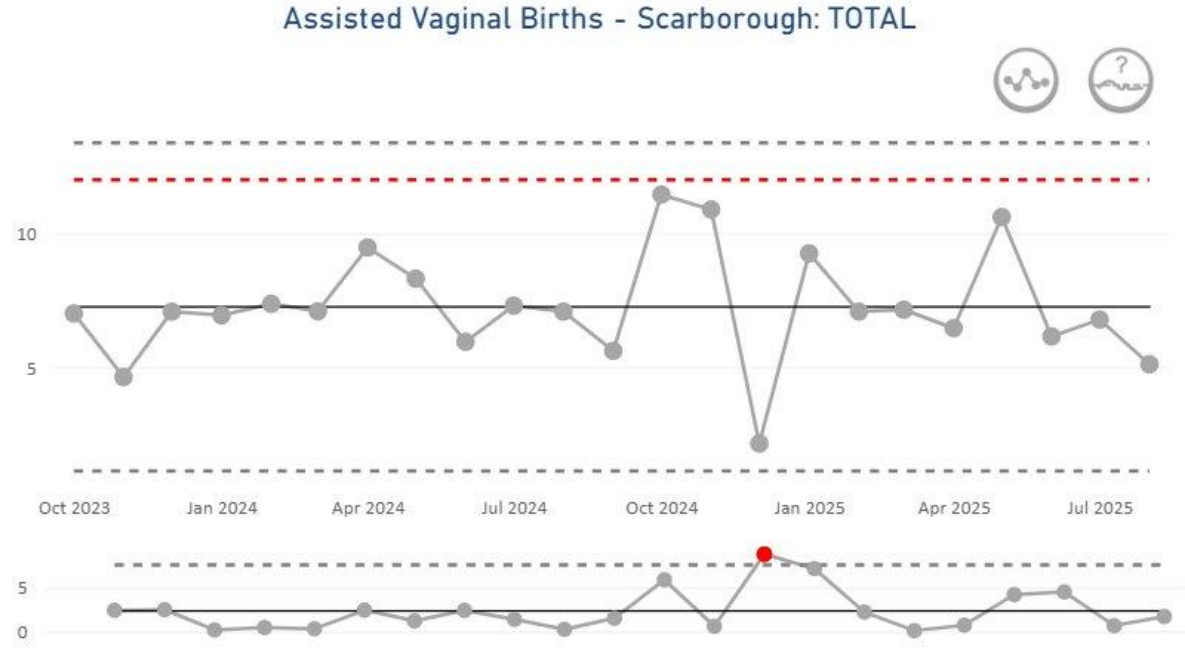


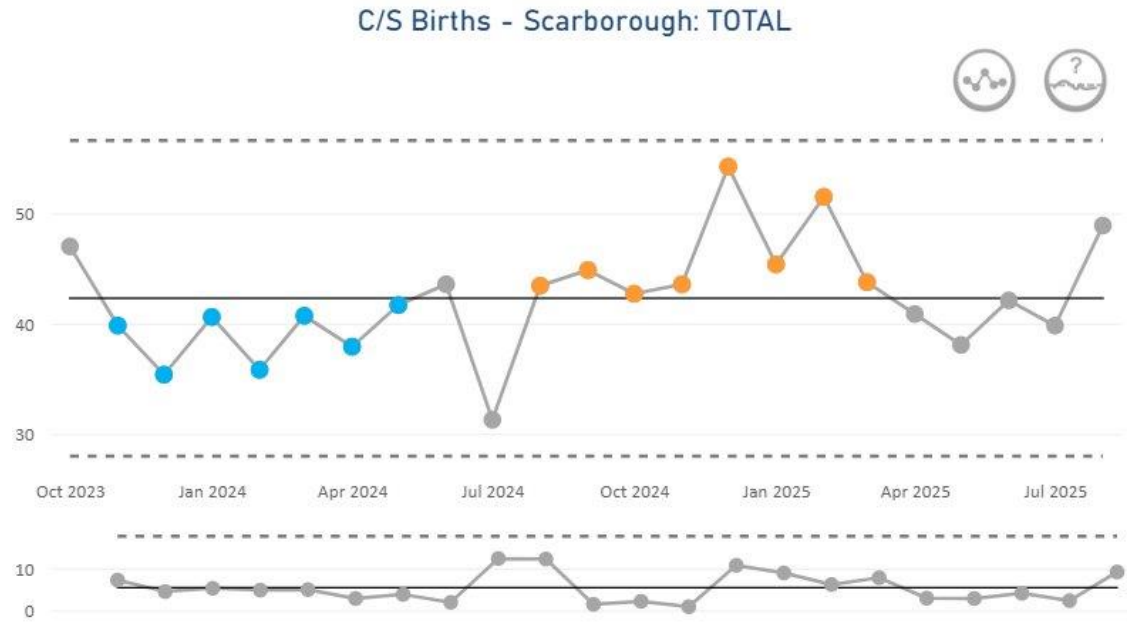

1 to 1 care in Labour - Scarborough: TOTAL
101
100
99
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
1
0


Normal Births - York: TOTAL
60
55
50
45
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
5
0


Assisted Vaginal Births - York: TOTAL
20
15
10
5
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
10
5
0


Normal Births - Scarborough: TOTAL
60
55
50
45
40
Oct 2023
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
10
5
0


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


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

Annex 2 Section 31 Report for August 2025

Report to:	Quality Committee
Date of Meeting:	14 October 2025
Subject:	Maternity CQC Section 31 Update
Director Sponsor:	Dawn Parkes, Chief Nurse & Executive Maternity & Neonatal Safety Champion
Author:	Sascha Wells-Munro, 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 ☒ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

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

Recommendation:

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

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

CQC Section 31 Progress Update

Maternity Services at York and Scarborough NHS Teaching Hospitals Foundation Trust have embarked on a programme of service and quality improvements.

This report provides assurance on the progress to date in delivering against the improvement plan for the purpose of the monthly submission to CQC following the Section 31 Notice.

A.2 Fetal Monitoring

A.2.2 Fetal Monitoring Training

Fetal Monitoring compliance figures for August 2025, by site, set against the target of 85% are outlined below.

Table 1

Staff Group	York	Scarborough
Midwives	94% (170/181)	94% (62/66)
Consultants	94% (16/17)	100% (9/9)
Obstetric medical staff	91% (10/11)	100% (7/7)

The one non-compliant Consultant at York 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 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%
August 2025	97%	96%

BadgerNet has the facility to pull other risk assessment reports. Table 3-7 demonstrates compliance from January to August 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%
August 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%
August 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%
August 2025	99%	98%

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%
August 2025	58%	69%

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%

August 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

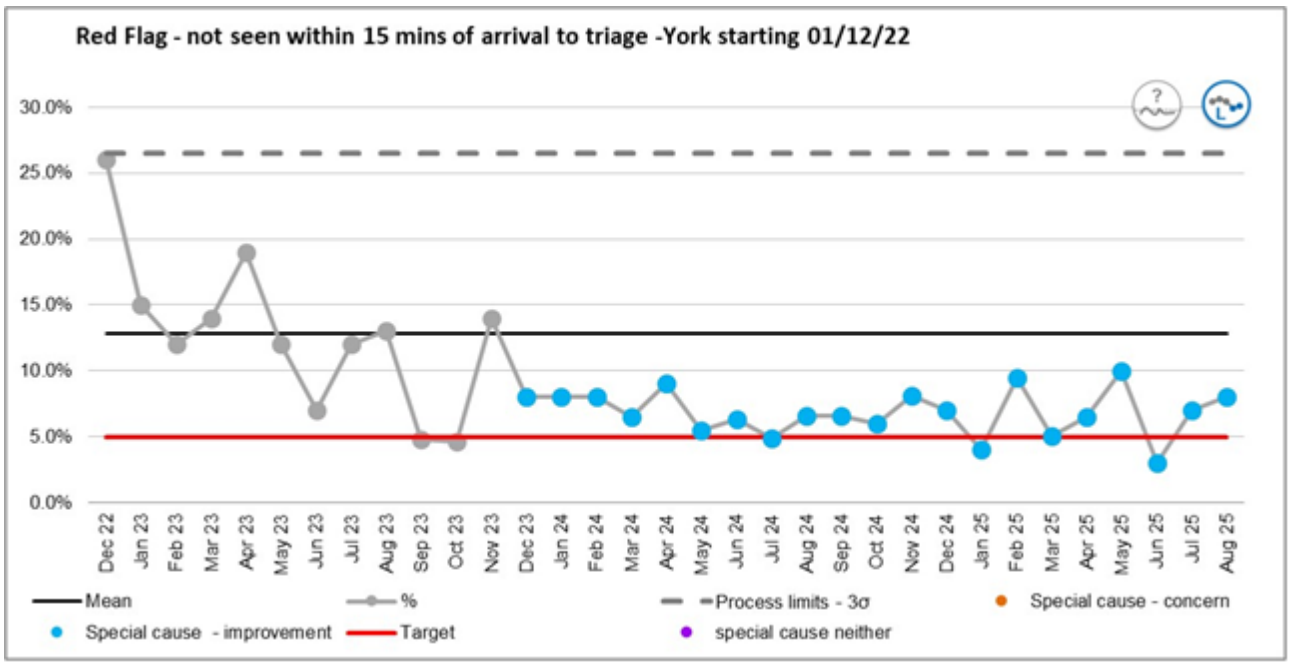


Chart 2 Triage attendances York

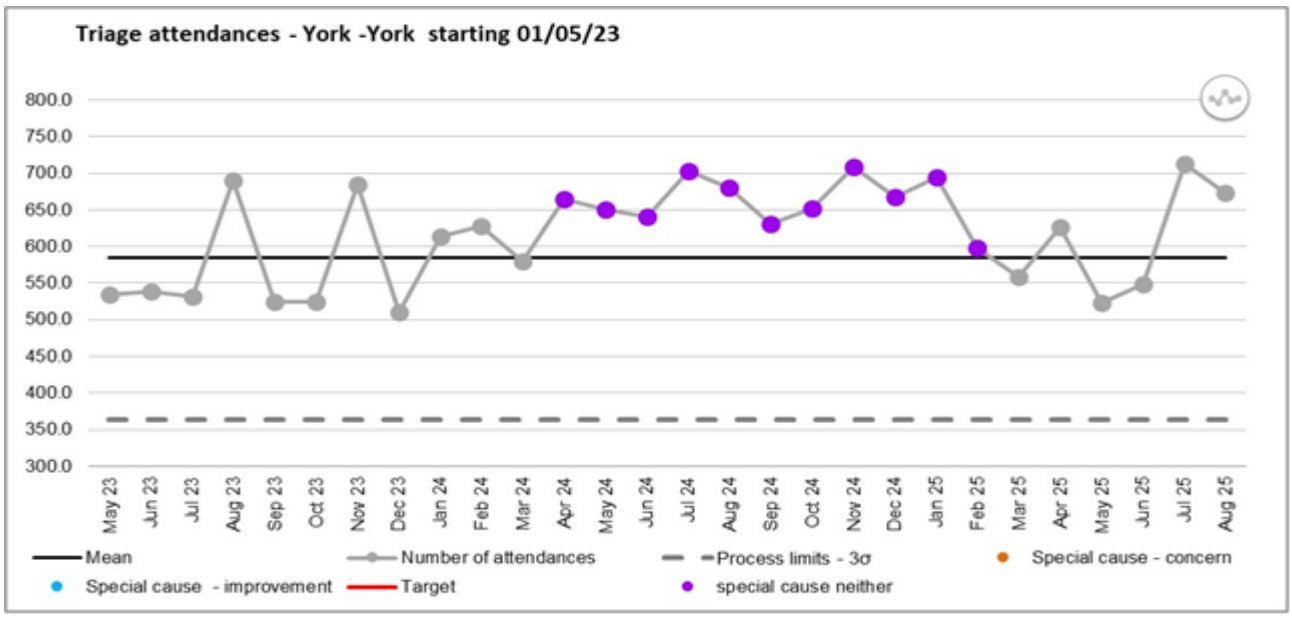


Chart 3 Red Flag Incidents not seen within 15 minutes of arrival at Triage at Scarborough

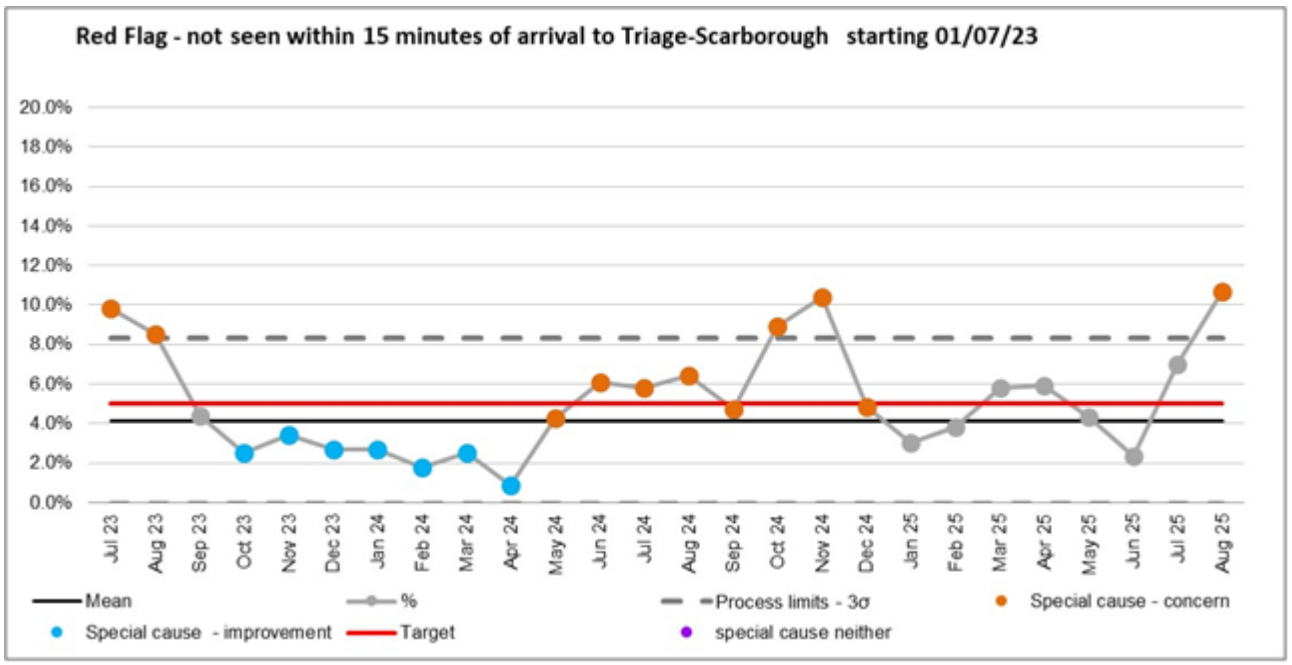
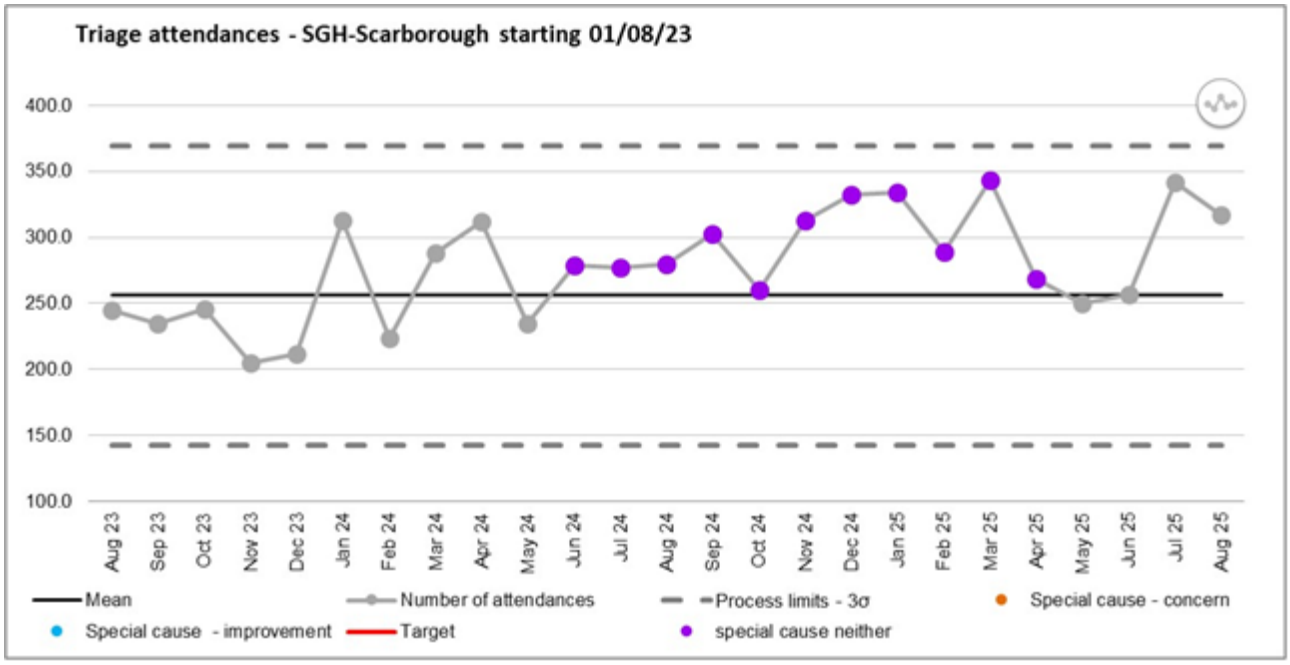


Chart 4 Triage attendances Scarborough



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 further review of the maternity Quality and Safety Framework is underway considering the significant additions of national reporting requirements for maternity services across England in November as well as the development of an in-house maternity and neonatal dashboard. This review will ensure all current operational meetings continue to be required, any new operational meetings added and ensure the lines of reporting continue to provide a robust ward to board assurance framework.

This is due to the implementation of the following National requirements for all maternity services
1/ Submit a Perinatal Early Notification Portal (SPEN). The NHS SPEN is a web-based portal designed to streamline the notifications of qualifying perinatal safety events to three national organisations: • MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK) • Maternity and Newborn Safety Investigations (MNSI) • NHS Resolution Early Notification (NHSR EN) scheme. The portal eliminates duplicate data entry by allowing users to input information once and automatically routing it to the appropriate organisation(s) depending on event type.

2/ Maternity Outcomes Safety Signal (MOSS). It was developed by NHS England in response to the first recommendation in the Reading the Signals East Kent report. MOSS aims to identify signals about potential critical safety issues in maternity intrapartum care that could lead to adverse outcomes and is intended to be used as part of routine safety

monitoring within the Perinatal Quality Oversight Model (PQOM).It is a new way of monitoring potential safety issues in maternity services using near-real time data.

3/ Regional Heatmap. The Heat Map is an intelligence tool developed to visualise and monitor key health indicators across the region. It supports strategic planning and decision-making by identifying areas of concern and opportunity in maternity services. Key Features include:
• Visual representation of service demand and provision
• Integration of multiple datasets
• Supports ICBs and Trusts in targeting interventions and allocating resources

4/ Daily OPEL/SitRep includes:
• Implement a version of the Midlands OPEL data collection across all regions so services and ICBs have a facility to rapidly check pressures and arrange mutual aid
• Provide data on operational pressures to the NHSE CNO and executive and replace the existing national fortnightly SitRep questionnaire
• Provide data on operational pressures for triangulation with other data and intelligence on safety to inform the Perinatal Quality Oversight Model

B.2 Postpartum Haemorrhage (PPH)

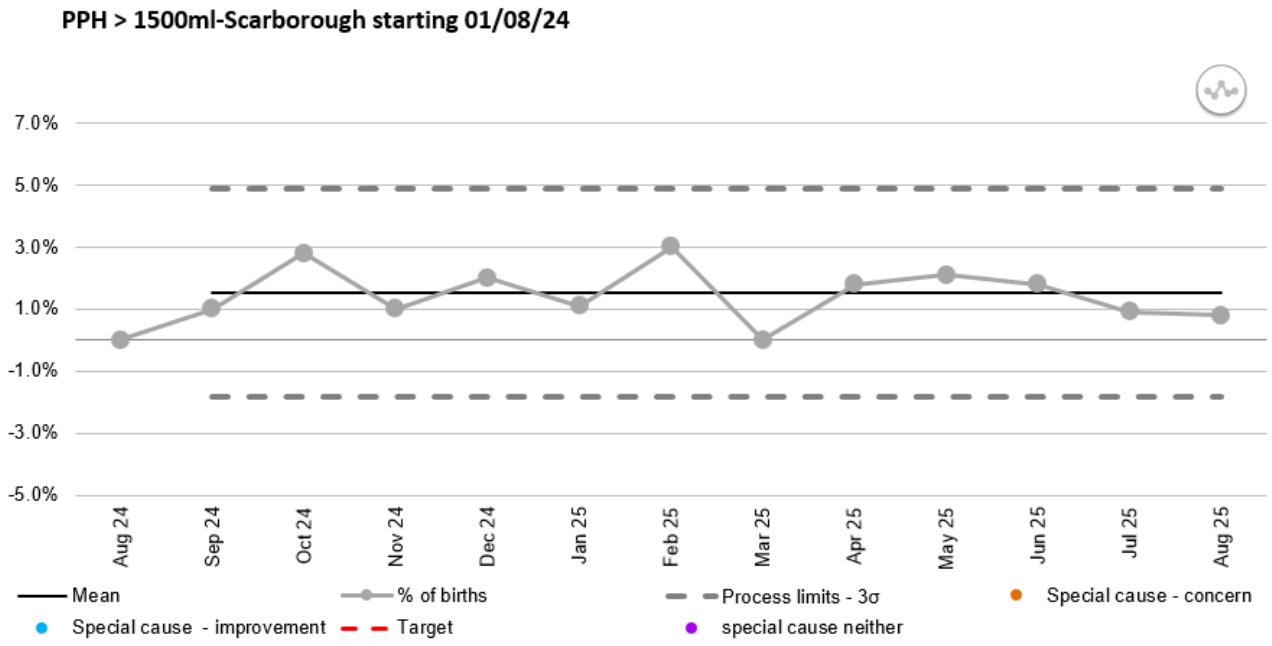
PPH over 1.5 litres

The reduction in the rate of postpartum haemorrhage (PPH) over 1500mls is a key priority for the maternity service. The PPH rate for August 2025 was 3.4% of all deliveries across both sites.

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

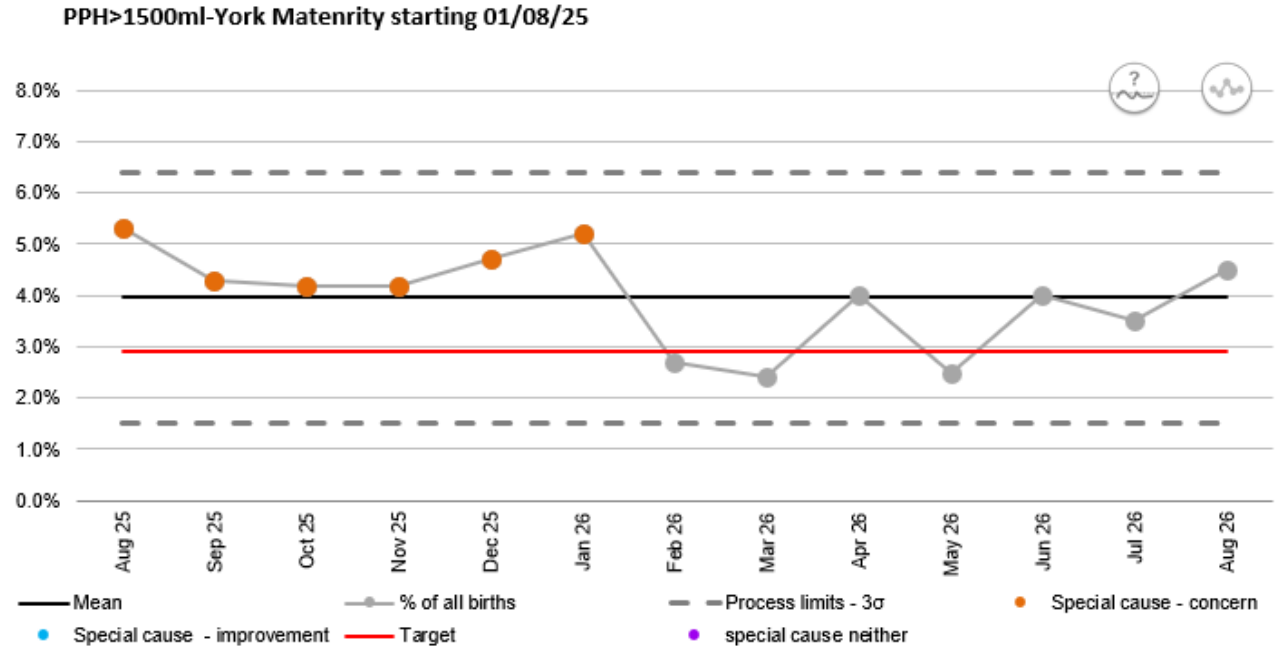
Blood Loss	Number in August 2025
1.5l – 1.9l	6
2l – 2.4l	2
> 2.5l	3

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

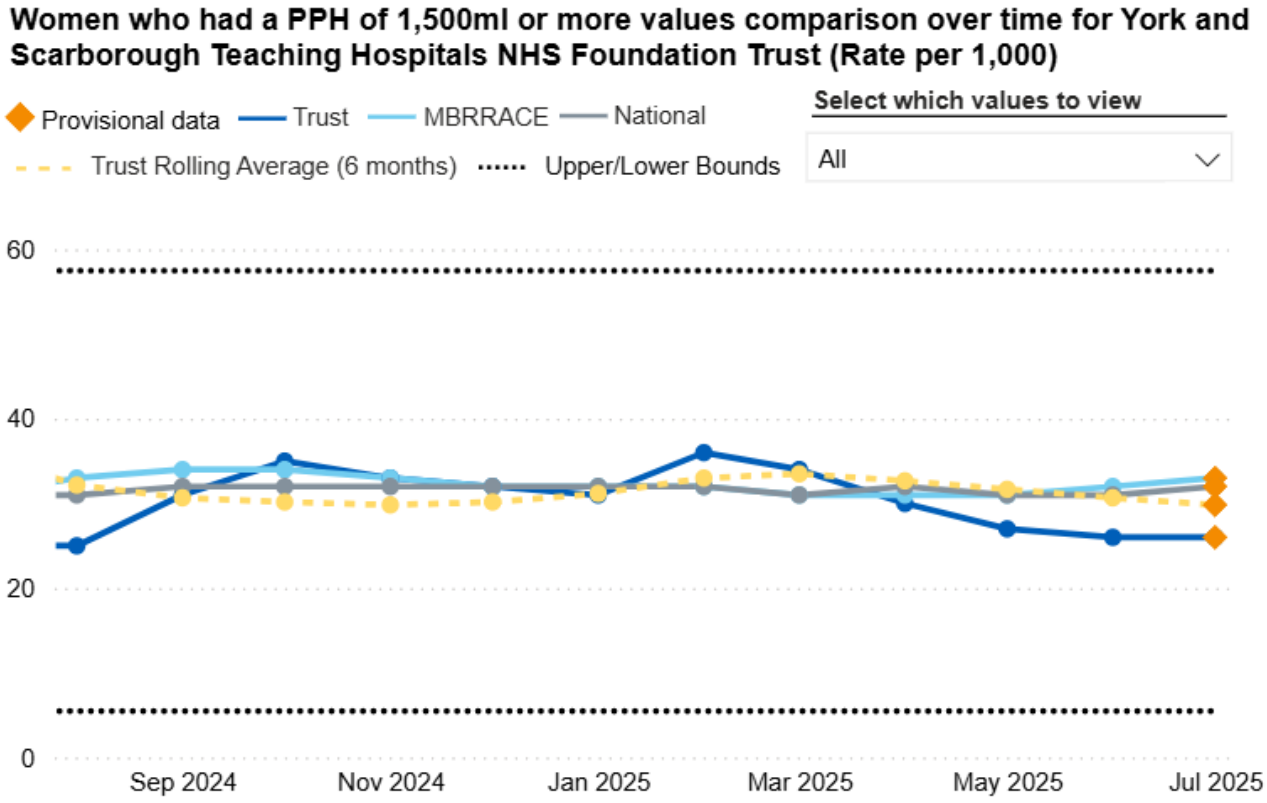
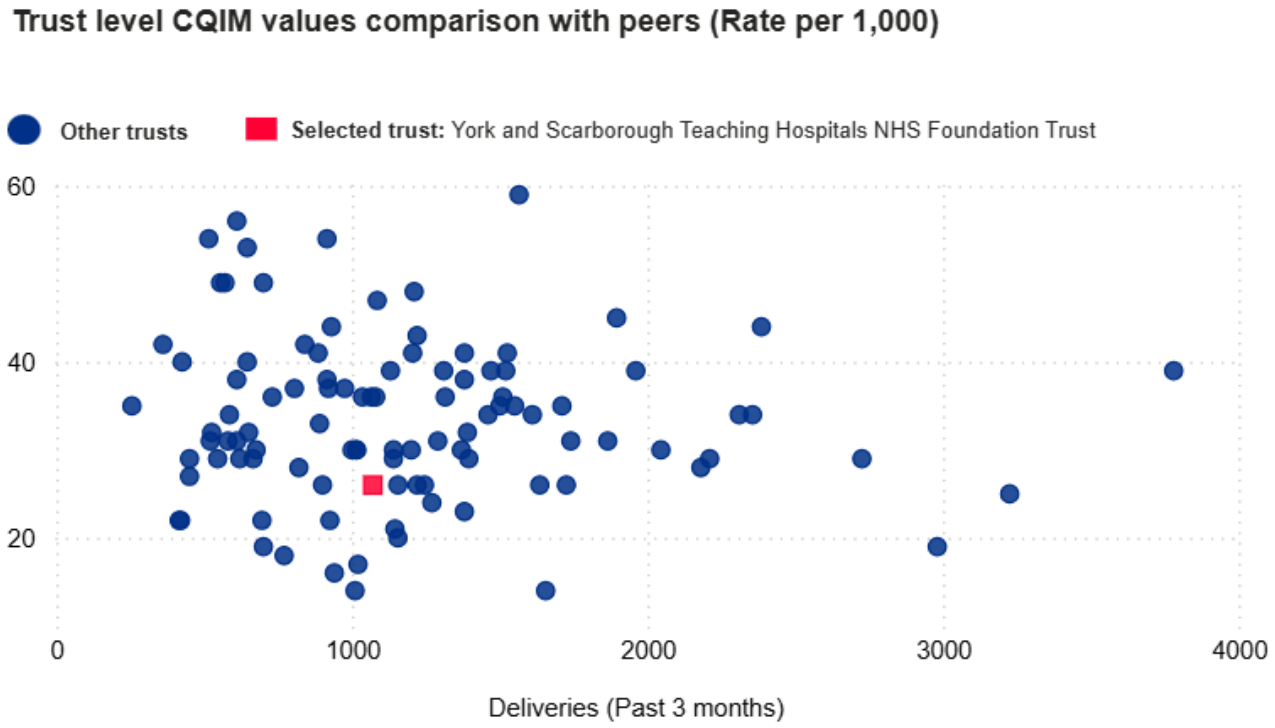


Chart 8



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 August 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.

Overview of the Monthly Sprint August (8 cases audited)
Audit of all PPH >1500ml that occurred in August 2025

Standard	Results	Comments
FBC taken at 28 weeks	100% (8/8)	
Was Haemoglobin managed in accordance with guidance	75% (6/8)	
36-week PPH risk assessment completed	75% (6/8)	
PPH risk assessment completed on admission for birth	100% (8/8)	
Management of third stage of labour	50% (4/8) Active management	
In Caesarean section consider prophylactic use of 1g Tranexamic acid IV after delivery of the baby if moderate to high risk of bleeding	100% (3/3)	
Postnatal oxytocin infusion should be used when there is moderate or high risk of postpartum haemorrhage	88% (7/8)	
PPH proforma fully completed	75% (6/8)	Where the proforma was not completed there was evidence of management written in the healthcare records

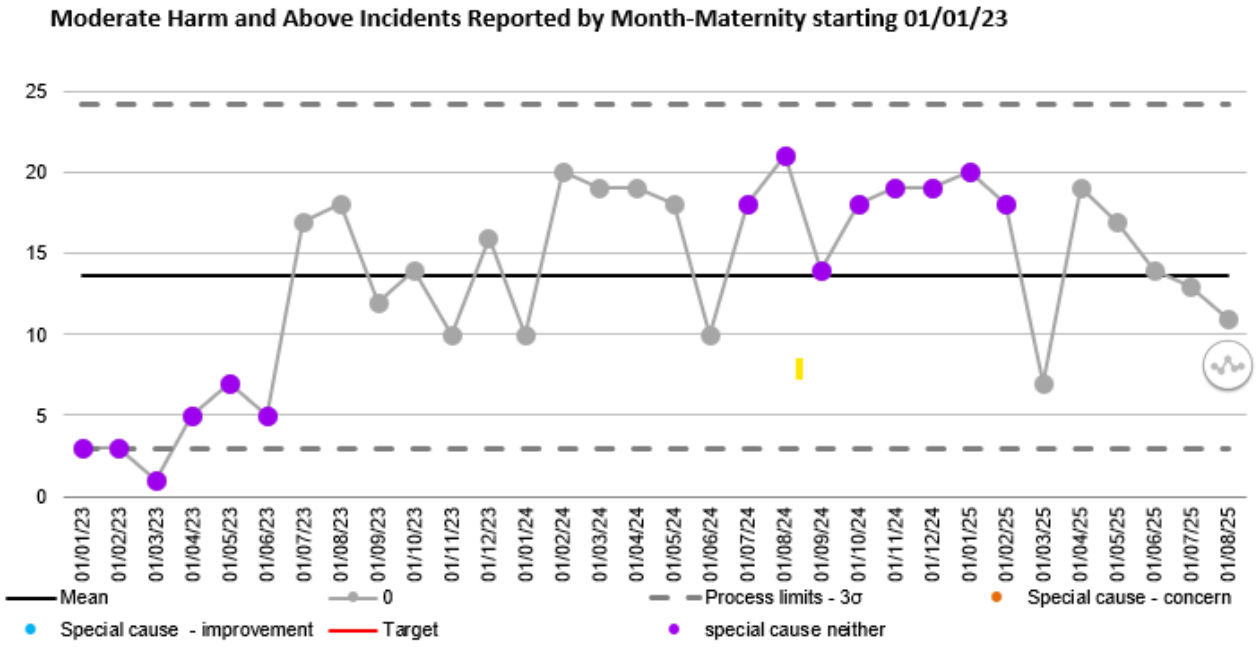
6 out of the 8 women had multiple risk factors for PPH. Actions are in place to address areas of partial compliance. All staff receive feedback where proformas have not been completed and shared learning has been included in the safety brief.

B.3 Incident Reporting

There were 11 moderate harm incidents reported in August 2025.

Datix ID	Incident Category	Outcome/Learning/Actions	Outcome
41122 41259 41509 41512 41649 41713 41787 42103	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.
41375	Admission to ICU.	MDT discussion at Maternity Case Review	No concerns identified
41648	Neonatal death	Reported to MBBRACE-UK for review using the PMRT	

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 and baby X-tag 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. The consultation has commenced with the administrative staff in September 2025.

B.4.2 Scrub and Recovery Roles

There is collaboration across maternity and surgery to review the national requirements of having two scrub nurses for each list, the potential benefits, and risks in not meeting this standard that may release some staff funding back into maternity services to support recruitment of midwives as an alternative. The Director of Midwifery will be presenting a paper at the Executive Committee in 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

Midwifery
Total budgeted establishment vacancy 4.47WTE (York 1.58WTE, Scarborough 2.89WTE)
Absences within Staff in Post (SIP) 15.78WTE (York 9.25WTE, Scarborough 6.53WTE)
Total roster vacancy 20.25WTE (York 10.83WTE, Scarborough 9.42WTE)
Absence in September comprised of maternity leave (9.8WTE), sickness (3.95WTE) and supernumerary (2.03WTE)

The above figures do not include the recruitment figures below; these will be included in the October data.

The Autumn recruitment drive resulted in the recruitment of 24.6WTE Band 5 and 6 midwives, across York and Scarborough. The first cohort of 14 Band 5s (12.9WTE) will commence their preceptorship on 20th October (3.6WTE in Scarborough and 9.3WTE in York). A second cohort of 7.5WTE Band 5s will commence their preceptorship in Feb (2.5WTE in Scarborough and 5WTE in York). There are also an additional 4 Band 6 and 1 Band 5 midwives (4.2WTE) who will commence in post at York in the coming months.

Unregistered workforce (B2&3)
Total budgeted establishment vacancy 3.74WTE (York 4.49WTE, Scarborough – 0.75WTE)

Total roster vacancy	15.41WTE (York 13.93WTE, Scarborough 1.48WTE)

Recruitment continues with further Band 5 and 6 posts to be advertised shortly, alongside an advert for Band 3 and 4 Maternity Assistants and Maternity Support workers.

Report to:	Board of Directors
Date of Meeting:	22 October 2025
Subject:	Medical Education Annual Report 2024/25
Director Sponsor:	Dr Karen Stone, Medical Director
Author:	Rachael Snelgrove, Head of Medical Education

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

☐ To provide timely, responsive, safe, accessible effective care at all times.
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☐ Effective Clinical Pathways
☐ Trust Culture
☐ Partnerships
☐ Transformative Services
☐ Sustainability Green Plan
☐ Financial Balance
☐ Effective Governance

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

This report provides an overview and update on the activities, performance and quality of Medical Education from the training year August 2024 to July 2025.

York and Scarborough Trust support the education and professional development of 520 Undergraduate Medical Students and 436 Resident Doctors in formal training programmes, alongside Locally Employed Doctors (LEDs), Speciality and Specialist Doctors, Consultants and Physician and Anaesthetic Associates.

Undergraduate Education is a formal partnership with Hull York Medical School (HYMS), working in partnership with NHSE Workforce, Training and Education (NHSE WT&E).

Postgraduate Medical and Dental Education within the trust is commissioned by NHSE WT&E with the Trust being the Local Education Provider (LEP). NHSE WT&E are responsible for the management and coordination of Foundation and Specialised training programmes in conjunction with the Speciality Schools and Royal Colleges.

The GMC sets standards for all education and training which are benchmarked by a Quality Monitoring framework outlining the assurance process which includes an annual GMC survey for doctors in formal training posts and the Office for Students issuing the National Student Survey (NSS) each year for undergraduate medical students.

There are many areas of good quality medical education across the trust highlighted in this report, alongside some challenging areas requiring improvement. Local innovative teaching methods have been developed to supplement curriculum requirements to enhance the experience learners receive at our Trust.

Recommendation:

- Trust Board is asked to note the contents of this report.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation

Medical Education Annual Report

1. Purpose

This report provides an overview of the achievements, challenges, and future objectives related to the Medical Education portfolio for Undergraduate Medical, Postgraduate Medical and Dental, including postgraduate Physician Associate (PA) and Anaesthetic Associate (AA) education and training.

2. Undergraduate Medical Education

2.1. Overview

In 2024/2025, HYMS welcomed their largest cohort of Year 5 students, bringing the total student numbers across all year groups to 520, as detailed below:

Year group	York	Scarborough
1	120	X
2	120	X
3	64	32
4	64	32
5	58	30

2.2. Areas of note for 2024/2025

In 2024 the new Medical Licencing Assessment (MLA) was rolled out nationally, to streamline final year assessments. The MLA is now fully embedded into the academic timetable, with the York site responsible for delivering Objective Structured Long Examination Record (OSLER) exams aligned to the MLA content map. Students are supported with MLA-focused revision materials, question banks, and mock exams.

During Summer 2025 the York HYMS team hosted their third cohort of Ukrainian medical students from Kharkiv National Medical University. The initiative provided students with clinical placement experience and on-site clinical teaching sessions, currently unavailable in their home country. Their time provided valuable exposure to the UK healthcare system an enriched our own learning community through cultural exchange and shared perspectives, supporting the development of future doctors in challenging global circumstances.

Notably, published in August 2025, HYMS ranked 3rd among UK Medical Schools in the Guardian and 10th in the Times, newspaper UK University rankings 2026 league tables, out of a total of 39 UK Medical Schools, being recognised for strengths in teaching, learning opportunities, assessment, feedback, and mental wellbeing services.

2026	Institution	Guardian score/100	Satisfied with teaching	Satisfied with feedback	Student to staff ratio	Spend per student/10	Average entry tariff	Career after 15 months	Contin-uation
3	Hull York Medical School	97.1	94.3	85.1	5.1	6	163	100	98.6

Locally the annual HYMS Clinical Teaching Excellence Awards 2025 saw over 30 nominees from York and Scarborough Trust, with a total of 6 nominees being announced as overall winners, as detailed in appendix one.

2.3. Undergraduate Simulation

With the rise in student numbers, innovative ways to deliver education are required. The clinical skills teams are continually reviewing supplementary sessions to offer the students to enhance their clinical skills and communication, teamwork and digital literacy skills. The Scarborough Clinical Skills Educators have developed a clinical Escape Room for Year 3

students, testing students problem solving and teamworking skills. Simulation has been improved with the use of digital resources and interactive tools to support clinical training sessions.

The York Clinical Skills team has initiated a sustainability project to address the significant volume of plastic waste generated through regular teaching sessions. As all training equipment is utilised within a simulation environment and does not come into contact with bodily fluids, it is deemed safe for reuse. The project has expanded to cover a large amount of equipment. The initiative has resulted in environmental benefits and cost savings, without compromising the quality of teaching.

2.4. Research

The York clinical skills team have formed a partnership with the University of Ottawa undertaking research titled “Patterns of stress responses in medical students during clinical management of acutely unwell patients”. The project was an observational study of 5th year medical students. Each participant took part in a clinical simulation where they reviewed and managed an acutely unwell simulated patient, assisted by a nurse.

This partnership has expanded HYMS research capabilities and improved the simulation experiences for our students. The research is now complete, and the project was presented at an international conference in August 2025.

2.5. Faculty and Supervision

To support HYMS clinical faculty annual tutor training days and ad hoc sessions for clinical examinations are held, supplemented by introductory packs and Honorary Lecturer status for new tutors, granting faculty access to University resources. Tutors receive detailed student feedback on their teaching. Tutor contributions have remained consistent throughout the past year, particularly within Phase 1 (Years 1 and 2 of the MB BS programme) where there had previously been challenges in tutor retention.

2.6. Quality and Monitoring - National Student Survey

The annual National Student Survey (NSS) provides Trusts with key indicators of areas for improvement and best practice. NSS data is reviewed alongside local feedback to provide a valuable insight into key themes.

In response to this feedback the teams have enhanced clinical and hands-on exposure for students by introducing volunteer patients into teaching sessions. This initiative has reduced the reliance on tutors to source suitable ward-based patients and has made teaching sessions more interactive and engaging.

Future efforts will focus on educational experiences amid rising student numbers and clinical pressures. HYMS continues to maintain its status among the UK's top medical schools with a strong emphasises on Equality, Diversity, and Inclusion (EDI) through mandatory training and early pastoral and professionalism interventions.

2.7. 2025/2025 Challenges and Priorities

The greatest challenge currently faced is the increase in student numbers.

Increasing pressures on secondary care impact the hospital multi-professional educational environment, with medical students noting busy wards, crowded student presence, and limited staff teaching time. NHS pressures also affect student integration on wards, prompting the expansion of the volunteer patient pool to supplement bedside teaching while maintaining essential ward exposure. Despite these challenges, student exam

performance remains stable, attributed to enhanced simulation sessions and online resources.

Expanding hospital partnerships and tutor involvement, especially in Phase one, have also made sessions more interactive and improved Paediatric education. This has been achieved through seeking a partnership with local pre-school nurseries who provide year 2 students short placements enabling them to gain valuable paediatric experience which reduces dependency on ward-based patients, freeing up capacity for other students and postgraduate learning opportunities.

Space constraints, especially at York, pose challenges for teaching and common areas, with temporary reconfigurations insufficient for anticipated growth. Short-term solutions have been implemented to create additional teaching and study space but this additional space is already being used to capacity. Scarborough currently manages with existing facilities but with expanding student numbers and the increase on clinical skill requirements the space will soon be at capacity.

Traditionally students have rotated between base sites across the Yorkshire and Humber region. This academic year, the University have introduced annual base sites, deigned to increase the consistency of clinical and pastoral experience, rather than multiple rotations across the region students will remain at base sites. This change will be implemented through a three-year staged approach which will see the York property portfolio of student accommodation reduce to zero by August 2028.

3. Postgraduate Medical and Dental Education

3.1. Areas of note for 2024/2025

As shown in appendix two, the numbers of postgraduate doctors continue to rise with an increase of 21 newly established tariff funded training posts during the 2024/2025 academic year.

During the 2024/2025 academic year, 305 doctors participating in formal Postgraduate training programmes achieved successful Annual Review of Competency Progression (ARCP) outcomes, enabling them to advance to the next phase of their training. Adverse outcomes may result from the need for further training or insufficient completion of clinical hours. Medical Education teams collaborate with College Tutors and Educational Supervisors to guide doctors through the ARCP process, with particular attention given to those requiring additional support or extended time to meet progression criteria.

3.2. Postgraduate Simulation

Over the past year, the Medical Education Technology and Simulation Team has made significant progress in strengthening and expanding educational offerings across York and Scarborough sites, with a continued focus on course delivery, simulation sessions, equipment management, and technological innovation.

There are monthly in situ simulations within the Emergency Departments and work in progress to expand this into the Paediatric and General Medicine in Scarborough.

Equipment is continually reviewed to ensure advancing technologies are available. The team have successfully acquired two new ultrasound machines and are purchasing a new high fidelity Paediatric manikin. Simulated training through Laparoscopic and Endoscope training units are available on each site enabling high fidelity tracked training in a safe environment, providing feedback on their performance in real time.

Work continues with the Abdominal Wall Reconstruction (AWR) unit led by Mr Chintapatla, the simulation team and leading industry experts. Through the use of technology and research, innovative ways have been developed to train leading AWR teams from across the UK in York.

3.3. Faculty and Supervision

Recruitment and retention of Educational Supervisors (ESs) remains a persistent challenge across the Trust. Every postgraduate doctor in training (PGDiT) is required to have a named ES responsible for overseeing their educational progress, and all Resident Doctors (Training and LED) are required to have a named Clinical Supervisor (CS). However, the allocation of supervision has been increasingly challenging due to several compounding factors.

Job planning and review of time and funding for non-direct clinical care activities have limited the numbers of doctors with capacity to supervise. This has been exacerbated by the expansion of the medical workforce, including both training and non-training grades, which has led to a higher number of doctors requiring supervision than can be accommodated within current staffing levels. Alongside this, ongoing clinical service demands continue to affect the ability of learner groups to fully engage in training and educational activities. Faculty members frequently report being unable to dedicate the desired level of input to their learners due to competing priorities, including service delivery and other essential planned activities. Protecting time for educational investment remains a significant challenge, with clinical pressures often taking precedence over scheduled training commitments.

To support supervisors the Medical Education team have developed a Supervisor Masterclass programme. This initiative has been designed to ensure supervisors are equipped with the knowledge, skills, and resources necessary to provide high-quality supervision and support to doctors in training.

The programme supports supervisors in understanding the unique challenges faced by Locally Employed Doctors (LEDs) and International Medical Graduates (IMGs), ensuring that supervision is inclusive and responsive to the needs of a diverse medical workforce, alongside topics including, managing doctors in difficulty, understanding moral injury, supporting return-to-training, less-than-full-time trainees, neurodiversity awareness and the ARCP process. Completion of the Masterclass is recognised as part of the Trust's commitment to maintaining GMC-recognised trainer status.

To ensure Postgraduate Medical and Dental supervisors meet national standards, the Medical Education team is implementing a structured five-year revalidation cycle aligned with GMC trainer recognition requirements. Supervisors are provided with a bespoke evidence sheet which allows them to document their training activities, feedback, certificates, and reflections. This document will be reviewed annually by the Director/ Deputy Directors of Medical Education in preparation for appraisal, streamlining the process and ensuring consistency across departments. This approach relieves appraisers from making subjective judgments and ensures that all supervisors are assessed fairly in line with GMC expectations

3.4. International Medical Graduates (IMG)

The Trust delivered its first multi-professional induction for internationally educated staff in March 2025. Previously, the International Recruitment Team has run nursing-specific inductions, but this year the programme was expanded to include doctors and allied health professionals.

A Trust-wide “International Medical Graduate Support Framework” is nearing completion. This framework aims to standardise high-quality onboarding and support across departments, recognising the bespoke needs of IMG doctors joining the NHS for the first time.

3.5. Locally Employed Doctors and Speciality and Specialist (SAS) doctors and dentists

In additional to the Postgraduate Doctors in Training, there are approximately 270 LED and SAS doctors across the Trust.

Since November 2024, study leave entitlement for LEDs has increased from 5 to 15 days per year. This adjustment recognises the ongoing need for professional and personal development among LEDs and is aligned to doctors in formal training posts study leave entitlements.

Additionally, the appraisal process for LEDs has been streamlined. The majority now maintain an e-portfolio rather than utilising the Trust’s appraisal software. To minimise duplication of effort, LEDs are permitted to submit a summary word document, endorsed by their supervisor, directly to the Revalidation Team.

The Trust has a SAS Tutor and an LED Tutor in post.

3.6. Quality and monitoring: National Training Survey (NTS)

Each Spring the GMC run their National Training Survey (NTS) which is the largest annual survey of doctors in the UK. Doctors in formal training posts, alongside their educational supervisors are invited to undertake the survey. The survey is used by the GMC to monitor and report on the quality of Postgraduate Medical Education and Training, placing monitoring conditions on Trusts which are considered below national standards. At present, and for a number of years York and Scarborough Trust have no open conditions.

In 2025, 73% doctors in training posts and 24% of named educational supervisors from our Trust completed the survey.

As highlighted in appendix three, the trust remains within the lower quartile for many of the domains, but improvements are visible within the England rankings and more locally, moving from 17/20 to 13/20. Within the challenges there are positives noted within the provision of on-site facilities for the Doctors Mess/common room facilities, Wi-Fi connectivity and library/study facilities.

Areas of challenge remain the same as previous years with adequate experience and local teaching. Action plans have been created with all speciality areas with below quartile results which are monitored alongside collecting local feedback as trainees rotate internally to correlate results and seek improvements.
Site and specialty specific observations are summarised in appendix three.

3.7. Physician Associates and Anaesthetic Associates

In December 2024, the General Medical Council (GMC) assumed regulatory responsibility for the roles of Physician Associate (PA) and Anaesthetic Associate (AA).

In July 2025, the Leng Review was published, presenting ten recommendations for employers to implement.

To enhance the professionalism and visibility within our healthcare teams the PA and AA roles will have a purple smart-scrub uniform to ensure they are easily identifiable. The

introduction of these uniforms also seeks to promote team cohesion and provide clearer identification for patients and staff.

3.8. Challenges and Priorities in 2025/26

One of the most pressing issues is the tension between the need to release doctors for teaching and the operational demands of clinical service. Departments often struggle to balance these priorities, especially when rotas are stretched due to vacancies or high patient volumes. This is particularly evident in the Scarborough site, where the GP training programme faces a large number of unfilled posts. The resulting rota pressures make it challenging to release trainees for scheduled teaching sessions, despite the educational requirements of their programmes. Similarly, the Internal Medicine Training (IMT) programme presents logistical challenges. IMT cohorts often require multiple trainees to be released on the same day for mandatory regional teaching.

4. Medical Education Finances

Medical Education is funded through the NHSE Educational contract for all clinical placement activity in England.

In the 2024/2025 financial year the Trust received £6.5m for Undergraduate Medical Education and £13.3m for Postgraduate Medical and Dental Education. To reflect national changes in tariff funding, the medical tariff saw an uplift of 5.54%, both in undergraduate and postgraduate medical education alongside the Market Force Factor (MFF) adjustments which fluctuate each year to reflect the differing costs to provide training across the UK, as shown in appendix four.

Two thirds of the Postgraduate funding is allocated for doctor in training salary support, funded at 50% base salary. The remaining funding consists of a placement fee per trainee for delivery and provision of training and education locally.

Study leave for senior medical and dental is administrated by the Postgraduate education teams. During the last financial year medical education received 890 applications and claims to the value of just over £220k as shown in appendix five.

A new study leave policy for Senior Medical and Dental staff is currently under review for implementation in April 2026. This policy will enable a transparent process for applying and claiming study leave entitlements and will see the current paper based system move onto an electronic system.

Appendix One - York and Scarborough Winners of the 2025 Clinical Teaching Excellence Award

Phase Medicine and Medicine with a Gateway Year Tutor of Excellence award:
Dr Joseph Mynett, Clinical Placement Tutor - Clinical Teaching Fellow, York & Scarborough NHS Foundation Trust
"creates a warm and friendly environment to learn in"
"presents hands on interactive sessions, which are always engaging"
"a kind and caring doctor"

Nursing & Allied Health Professions award:
Felicia Holliday, Midwife, York & Scarborough NHS Foundation Trust
"created a really enjoyable learning environment"
"goes completely above and beyond for our teaching"

Medicine Phase II & III Tutor of Excellence Award:
Dr Paul Laboi, Clinical Placement Tutor - Nephrology, York & Scarborough NHS Foundation Trust
"gave useful, constructive feedback, & created a welcoming, safe learning environment"
"we always looked forward to our sessions with him"

Administrative Support award:
Eleanor May, MB BS Coordinator York, York & Scarborough NHS Foundation Trust
"amazingly supportive"
"made the learning environment more positive and efficient"
"went out of her way to make me feel valued"

Team Excellence award:
Clinical Skills Team: Scarborough, York & Scarborough NHS Foundation Trust
"I felt so confident by the end of my rotation in Scarborough and this was entirely because of this team"
"extremely approachable and kind"

Exceptional Contribution to Student Experience award:
Dr Hester Baverstock, Clinical Placement Tutor - Clinical Teaching Fellow, York & Scarborough NHS Foundation Trust
"an amazing teacher who's very friendly and knowledgeable"
"simplifies cardiology and makes it fun"
"I felt empowered and safe enough to talk through any issues"
"her pastoral support was some of the best in the hospital"
"an excellent role model and a pleasure to be taught by"

.

Appendix Two - Postgraduate Resident Medical and Dental Workforce

Postgraduate Doctors in Formal Training posts		
Host site	**2023/2024**	**2024/2025**
York Medical	273	299
York Dental	6	6
Scarbrough Medical	136	131
TOTAL	**415**	**436**

2024/2025 breakdown all Resident and SAS		
Number of Doctors	**Training/Grade**	
148	Foundation	
119	Lower Tier Training	
45	GP Training	
8	Academic Training	
116	Higher Tier Training	
141	Locally Employed Doctors	
131	Speciality and Specialists (SAS)	
708	**TOTAL**	

PA/AA roles - all based in York

Role	**Postgrad Numbers**
Physician Associates	8
Anaesthetic Associates	2
Anaesthetic Associate Students	2

Appendix Three – GMC National Training Survey Results and Action Plans

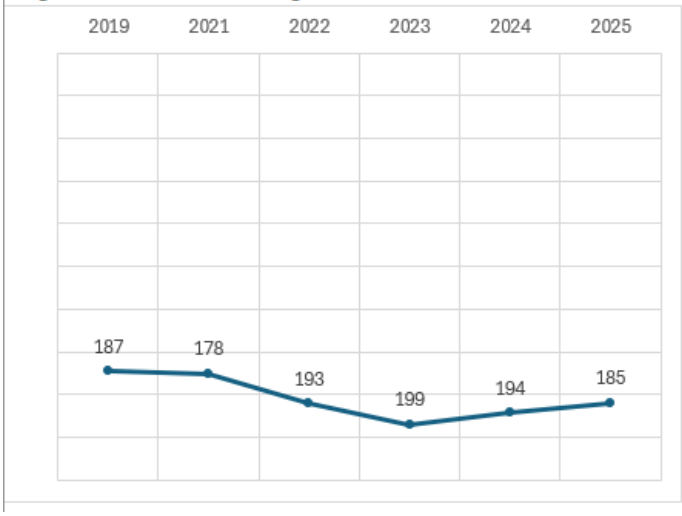
GMC NTS 2025 Trust overview (trainees)

UK-Wide Rankings by 2025
Trusts are ranked 1-226
185

Eng Rankings by 2025
Trusts are ranked 1-197
159

Local Rankings by 2025
Trusts are ranked 1-21
13

Long-term UK-Wide Overall Ranking



UK-Wide Ranking by Indicator (2025)

Indicator	Rank	Out of
Overall Satisfaction	199	226
Clinical Supervision	198	225
Clinical Supervision out of hours	183	220
Reporting systems	174	223
Workload	130	226
Teamwork	179	222
Handover	75	221
Supportive environment	180	226
Induction	145	226
Adequate Experience	202	226
Educational Governance	188	226
Educational Supervision	150	226
Feedback	141	226
Local Teaching	196	225
Regional Teaching	216	225
Study Leave	179	226
Rota Design	160	222
Facilities	47	224

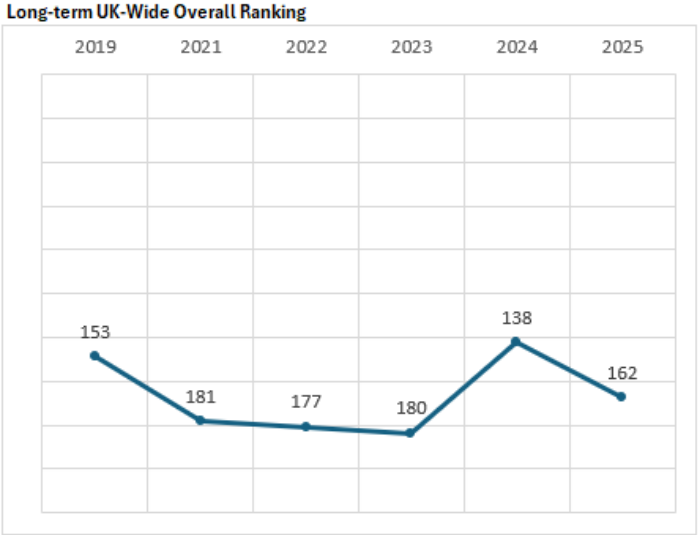
GMC NTS 2025 Trust overview (trainers)

UK-Wide Rankings by 2025
Trusts are ranked 1-220
162

Eng Rankings by 2025
Trusts are ranked 1-192
140

Local Rankings by 2025
Trusts are ranked 1-20
12

Long-term UK-Wide Overall Ranking



UK-Wide Ranking by Indicator (2024)

Indicator	Rank	Out of
Supportive Environment	187	220
Educational Governance	146	220
Professional Development	130	220
Appraisal	165	220
Support for Training	90	220
Time to Train	96	220
Rota Issues	168	219
Handover	141	217
Resources to Train	181	220

GMC NTS trainee action plans

Areas for improvement	
Specialities	**Comments**
O&G York	Reflecting on the 2024 survey results improvements have been made in O&G but there are still some outstanding challenges namely in rota design, access to clinics and supervision. Less Than Full Time trainees has impacted the rota. There is an additional lower tier doctors resulting to increasing the rota to 9 people. Middle Tier also increased this year with an additional LED. Hoping to see change in 2026 results for rota indicator. Action plans for 2025 include, surveying Resident doctors to ask them what they want from teaching. Reviewing core trainees access to Theatre alongside GP trainees where possible. Records are kept of all trainees requirements to ensure trainees are gaining competencies and have access to clinic and theatre, to continue this. Challenge with Registrar's accessing clinic space, working through with clinical leads.
Paediatrics - Scarborough	Results have unfortunately decline between 2024 and 2025 survey. Action plans include; reviewing provision of local teaching focusing on it being Resident doctor led, to review weekly grand round to be more case presentation style to encourage Resident doctor involvement and educational opportunities, establishing regular in-situ simulation, have an established trainee forum to continue this, Implement end of placement feedback forms, challenges with trainee gaps on rota - trainees not allocated to Scarborough backfilled with LEDs but this year have full establishment should see benefits reflected in 2026 results. Trainer results really positive with trainers feeling supported.
General Internal Medicine - York	General Internal Medicine York remains a challenge across several domains. Work has been undertaken with the Medicine College Tutors and clinical leads following the 2024 results and action plans have been updated for 2025 to focus on local teaching opportunities incorporating simulation, implementing regular weekly Acute Medicine teaching alongside a journal club and increasing clinic opportunities for Internal Medicine Trainees (IMT)
Renal - York	Renal York has seen a huge decline across many domains. These declines are multi-factorial mainly due staff vacancies and a n increase in the number of patients resulting in burnout, absence and challenges to attend clinics and learning events. Action plans have been created with the Clinical Lead focussing on weekly teaching opportunities (classroom and clinical skills) and access to clinics in York and Harrogate. Early feedback from the Resident doctors includes feeling supported and they are able to access local teaching opportunities.
T&O - Scarborough	T&O Scarborough reported a significant drop in workload compared to the last three years results. By gathering feedback from the Resident doctors much of the high volume of workload was due to using paper lists on ward rounds. With Nerve centre work is already underway to work with the EPR team to ensure lists are digital which will directly reduce the Residents, and other staffing groups, workload

Notable positive improvements	
Specialities	**Comments**
Radiology - York	Clinical Radiology York continues to excel with consistent above average ratings, with all but one domain scoring above 74%.
Medical Oncology - York	Medical Oncology have been able to transform their 2024 results from below quartile to above quartile showing vast improvements in reporting systems, teamwork, handover and educational governance.
Urology - York	Urology are another speciality who have been able to transform their results, with significant improvements shown in the domains of; teamwork, induction, adequate experience and rota design

Appendix Four – Education Tariff

Education Tariff Prices for Medical training		
Type of Placement	**2023-2024 Tariff placement fee**	**2024-2025 Tariff placement fee**
Medical Undergraduate	£31,937 plus MFF	£34,355 plus MFF
Medical Postgraduate	£12,398 plus MFF, plus 50% contribution to base salary	£13,337 plus MFF, plus 50% contribution to base salary
Inflation uplift	**2%**	**5.54%**

Healthcare education and training tariff: 2024 to 2025 - GOV.UK

Appendix Five - Senior Medical and Dental Study Leave April 2024 – March 2025

Month 2024-2025	Applications Received	Value
April	43	£488.00
May	72	£11,471.03
June	48	£12,134.67
July	69	£20,333.48
August	58	£12,346.69
September	123	£25,895.62
October	97	£36,621.39
November	61	£18,052.10
December	47	£23,994.10
January	78	£17,405.96
February	71	£17,583.02
March	123	£29,497.07

Total	890	£225,823.13

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	22 October 2025
Subject:	Workforce Race Equality Standard Annual Report and Action Plan 2025-2027
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Diversity and Inclusion (EDI)

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

Approve ☒ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

☐ To provide timely, responsive, safe, accessible effective care at all times.
☒ To create a great place to work, learn and thrive.
☐ To work together with partners to improve the health and wellbeing of the communities we serve.
☐ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☐ 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 Workforce Race Equality Standard (WRES) Annual Report is presented to the Trust's Board of Directors for assurance to meet the NHS England (NHSE) WRES mandatory requirements. The approved data was submitted to NHS England (NHSE) by 31 May 2025 and covered the period 1 April 2024-31 March 2025.

The latest WRES findings are deeply concerning and clearly demonstrate that our previous actions have not delivered the progress required. There is an urgent need for a bold, refreshed approach to drive meaningful and sustainable improvement.

A staff engagement event held in August 2025 covered the progress made with the 2023-2025 action plan, the 2023/24 summary report, and the Trust's 2025 data. Indicators that had either deteriorated or where the percentage of colleagues exposed to negative experiences remained high were discussed. These were indicators 2, 5, 6, 7, 8 and 9 (Appendix 1.) A two-year action plan was co-created.

This report provides:

- The Trust's infographics (2024 staff survey and March 2025 payroll data) – Appendix 1
- The 2025-2027 Action Plan – Appendix 2
- An overview of NHS England's 2023/2024 summary report, which benchmarks the Trust regionally, by sector, nationally and provides a rank (Appendix 3)

The access, experiences and outcomes of BME staff across the indicators has shown little improvement in 2025. The negative experiences of staff impact on patient safety and patient outcomes.

Recommendation:
The Board of Directors to note the latest report and support the actions proposed to improve the experiences of BME colleagues.

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

Meeting/Engagement	Date	Outcome/Recommendation
Resources Committee	21 October 2025	

NHS Workforce Race Equality Standard Annual Report, 2025

1. Introduction and Background

The Workforce Race Equality Standard (WRES) is a national annual reporting scheme which York and Scarborough Teaching Hospitals NHS Foundation Trust and York Teaching Hospitals Facilities Management (YTHFM) are required to comply with. This is mandated in the NHS Standard Contract; organisations are required to use this data to develop action plans aimed at improving the experiences of Black and Minority Ethnic (BME) colleagues. This report and action plan is for both organisations.

The WRES covers 9 Indicators/Metrics (used interchangeably) regarding the career progression and work experiences of BME colleagues. The data was collected for the period of 1 April 2024-31 March 2025 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey. Where a metric dictates snapshot data, this is as of 31 March 2025. The Staff Survey data is from the 2024 Staff Survey.

Considerations

Metric 9 – YTHFM Director's details were not recorded on the Electronic Staff Record ESR due to the previous incumbent being contracted. Therefore, they are not included in the data for this metric.

The relative likelihood focuses on a figure of 1 being equity of opportunity. The non-adverse range of 0.8-1.25.

NHS England produced a 2023/2024 summary report for the Trust, which provided an analysis of the data by Trust, region sector, nationally and rank. The tables can be found in Appendix 3.

The 2023/24 summary report stated the high priority areas for improvement for the Trust (to a maximum of three) as:

1. Indicator 6: harassment, bullying or abuse from staff in the last 12 months against BME staff (marginal improvement in 2025).
2. Indicator 7: belief that the trust provides equal opportunities for career progression or promotion.
3. Indicator 8: discrimination from a manager/team leader or other colleagues in the last 12 months against BME staff.

The Area of best performance within the Trust (to a maximum of three): no areas of best performance.

Summary of Findings

This report provides the results of the Trust's 2025 data analysis, which is in the format of an Infographic found at Appendix 1 and, for comparison, the North East and Yorkshire's 2023/24 summary report, (Appendix 3). The co-created 2025-2027 action plan, is at Appendix 2. It is recommended that Appendix 1 is read in conjunction with the summary report.

The 2025 WRES data shows that:

1. The percentage of BME staff has increased from 15.46% in 2024 to 17.92% in 2025. Growth is consistent across all staff groups.
2. Relative likelihood of white staff being appointed from shortlisting compared to BME staff has seen a deterioration in relation to the experience of BME staff. (2.33 in 2024 to 2.54 in 2025).
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff has deteriorated. (1.25 in 2024 to 1.30 in 2025).
4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff is equitable in relation to the experience of BME staff. (0.57 in 2024 to 0.77 in 2025).
5. The percentage of BME staff experiencing harassment, bullying, or abuse from patients, relatives or members of the public in the last 12 months has increased. (29.84% in 2024 to 30.98% in 2025).
6. The percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months has improved. (30.8% in 2024 to 29.75% in 2025).
7. The percentage of BME staff believing that the Trust provides equal opportunities for progression or promotion has deteriorated. (42.26% in 2024 to 40.56% in 2025).
8. The percentage of BME staff who have personally experienced discrimination at work from manager, team leader or other colleagues has increased. (22.08% in 2024 to 22.57% in 2025).
9. The diversity of the Board in relation to ethnicity is static.

The latest WRES findings are deeply concerning and clearly demonstrate that our previous actions have not delivered the progress required. There is an urgent need for a bold, refreshed approach to drive meaningful and sustainable improvement.

2025-2027 WRES Action Plan

To develop the 2025-2027 WRES action plan an invitation was disseminated through Staff Bulletin inviting colleagues to the engagement event. This was held with the Race Equality Staff Network and other colleagues on 29 August 2025. Here the progress made with the 2023-2025 action plan was shared along with the 2025 data and national and regional benchmarking.

Colleagues from Workforce and Organisational Development attended the engagement event. They contributed to discussions regarding the actions required to address the disparities and move the dial in terms of progress.

There was positive discussion in relation to the agenda with specific focus being placed on the indicators that had either deteriorated or where the percentage of colleagues exposed to negative experiences remained high. These were indicators

2, 5, 6, 7, 8 and 9. Following the event a two-year action plan was co-created (see Appendix 2).

It is noted that although the 2023-2025 action plan was successfully implemented, race equality is not making sufficient improvement. The Trust now has an Anti-Racism Steering Group that will steer it towards race equity by implementing the Race and Health Observatory's 7 Anti-Racism Principles.

Next Steps

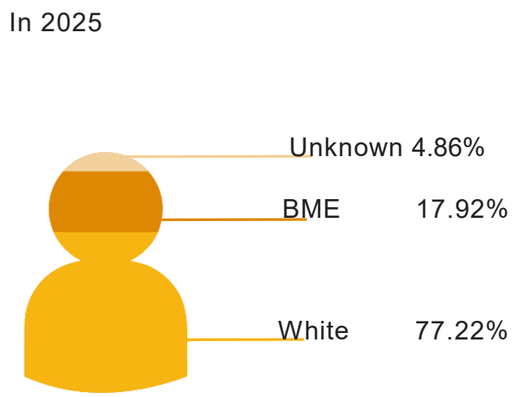
- Deliver the 2025-2027 WRES Action Plan.
- Publish the annual report and the 2025-2027 Action Plan on the Trust's website by 31 October 2025.

Date: October 2025

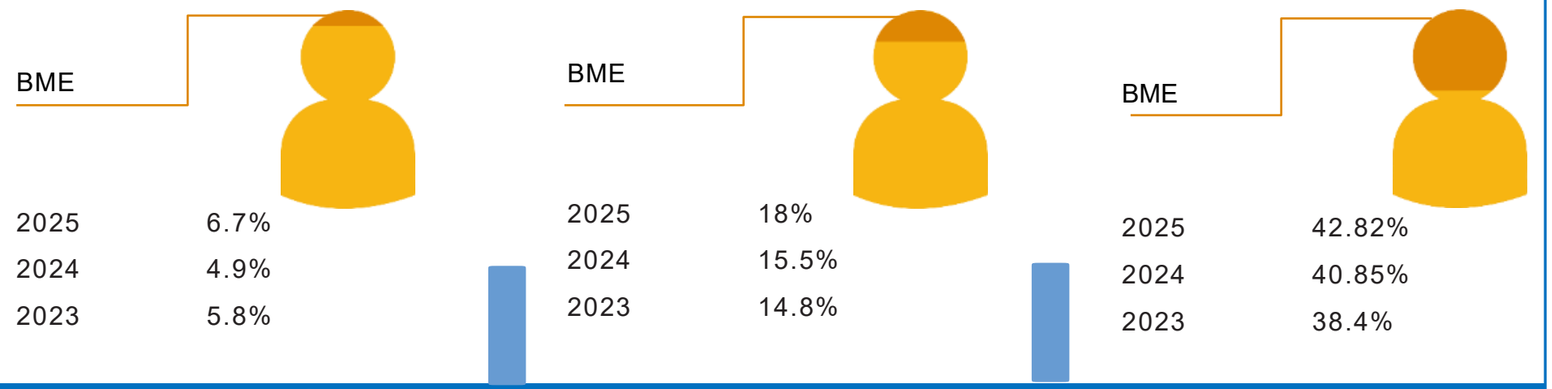
NHS Workforce Race Equality Standard (WRES) 2025

York and Scarborough Teaching Hospitals NHS Foundation Trust

Total number of staff – 12,630 in 2025
Total number of BME staff - 2,263 in 2025
Total % of BME staff - 15.46% in 2024



Metric 1: Percentage of BME staff in the Trust compared with the overall workforce – Improved. The breakdown is:



Metric 2 - Deteriorated

Relative likelihood of white staff being appointed from shortlisting compared to BME staff

In 2023 – 2.02
In 2024 – 2.33
In 2025 - 2.54

Metric 3 – Deteriorated

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff

In 2023 – 0.67
In 2024 – 1.25
In 2025 - 1.30

Metric 4 - equitable

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff

In 2023 – 0 (no data)
In 2024 – 0.57
In 2025 - 0.77

KINDNESS
OPENNESS
EXCELLENCE

The NHS Workforce Race Equality Standard (WRES) provides a framework for ensuring the black and ethnic minority (BME) staff receive fair treatment in the workplace and have equal access to career opportunities.

The data presented here provides an overview of the Trust's performance against the nine WRES standards.

Key

- **Unknown**
- **BME**
- **White**
- **Info taken from ESR**
- **Info taken from Staff Survey**

Metric 5 - Deteriorated

% of staff experiencing harassment, bullying, or abuse from patients, relatives or members of the public in the last 12 months

BME

2025	30.98%
2024	29.84%
2023	32.92%

White

2025	21.74%
2024	21.15%
2023	23.15%

Metric 6 - Improved

% of staff experiencing harassment, bullying or abuse from staff in the last 12 months

BME

2025	29.75%
2024	30.08%
2023	28.17%

White

2025	24.63%
2024	24.19%
2023	22.88%

Metric 7 - Deteriorated

% believing that the Trust provides equal opportunities for progression or promotion

BME

2025	40.56%
2024	42.26%
2023	43.25%

White

2025	53.67%
2024	54.55%
2023	56.15%

Metric 8 - Deteriorated

% of staff who personally experienced discrimination at work from manager, team leader or other colleagues

BME

2025	22.57%
2024	22.08%
2023	19.81%

White

2025	7.27%
2024	7.46%
2023	6.11%

Metric 9 – Static

% difference between the organisation's Board voting membership and it's organisation's overall workforce, disaggregated by voting and executive membership. – 18%

BME	
2025	0
2024	0
2023	1

Total	
2025	17
2024	16
2023	17

Total Board membership

BME	
2025	0
2024	0
2023	0

Total	
2025	16
2024	15
2023	15

Voting membership

Key

- Unknown
- BME
- White
- Info taken from ESR
- Info taken from Staff Survey

Workforce Race Equality Standard Action Plan 2025-2027

APPENDIX 2

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Red	Not yet begun
Amber	Begun but not complete
Green	Complete
Blue	New

Objective	Analysis	WRES Action	Executive Director Lead	Operational Lead	Commence Date	RAG Rating
Metric 2 Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts						
Improve the relative likelihood of being appointed from shortlisting from 2.5, with a long term aim to achieve a score of 1.	There is a trend of year on year deterioration from 2.33 likihood in 2024 to 2.54 in 2025.	Breakdown metric data to identify areas where colleague are less likely to be appointed from shortlisting to identify areas of opportunity for improvement. Work with recruiting managers to review shortlisting and interview practice, promoting best practice and explore ways to increase diversity of recruitment panels across the organisation. **(ongoing from last action plan)**	Director of Workforce and Organisational Development	Deputy Head of Resourcing	Q3 2025-2026	
Metric 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months						
Reduce colleagues from experiencing harassment, bullying or abuse from patients, relatives and the public by 1%.	The percentage of colleagues receiving unwanted behaviour has increased from 29.4% in 2024 to 30.98% in 2025.	Develop a campaign promoting No Excuse for Abuse internally, within external organisation and communities. E.g. Sending campaign posters to GP surgeries etc, Healthwatch, community groups to raise awareness.	Director of Communications	Communications Team	Q3 2025-2026	
		Raise awareness of the Managing Violence and Aggression policy including Exclusion section.	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	
		Engage with internal stakeholders re colleagues uptake onto enhanced conflict management training.	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	
		Review Statutory and Mandatory training Conflict Resolution Training against enhanced conflict management model to ensure receive the essential training they need in this field	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	
Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months						
Reduce the percentage of people experiencing, harassment, bullying or abuse (HBA) by 1%.	2025 has seen less than 1% decrease in unwanted behaviour since 2024. The current percentage is 29.75%, which is above the benchmark average of 24.78%.	Proactive and timely communication about the Trust values and support available when there is societal unrest and riots.	Director of Communications	Communications Team	Q3 2025-2026	
		Management fundamentals training to be delivered to line managers via HR Business partners.	Director of Workforce and Organisational Development	Operational HR Team	Q3 2025-2026	
Metric 7 Percentage believing that the Trust provides equal opportunities for career progression or promotion						

Demonstrate equal opportunities for all through promoting career opportunities and promotion. To increase by 1% annually.	The percentage of colleagues that believe the Trust is an equal opportunity employer has continued to deteriorate year on year. 2025, 40.56% 2024, 42.26% 2023, 43.25%	Develop a Staff Network development book to promote to members about career progression opportunities from NHS Elect, OD courses and Learning Hub.	Director of Workforce and Organisational Development	Race Equality Network	Q4 2025-2026	
		Feature BME colleagues (along with other colleagues with protected characteristics) in the new EDI section of Staff Matters, raising awareness promoting good practice and role models, shadowing, acting up, what's it like being in a senior role.	Director of Communications	Communications Team	Q3 2025-2026	
		Promoting development opportunities to support career progression.	Director of Workforce and Organisational Development	OD Team	Q3 2025-2026	
Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months and Metric 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleague						
		Workforce Leads to work with those responsible for local Staff Survey Action plans in triangulating data from Freedom to Speak Up and Anonymous Reporting Tool reporting HBA and discrimination to target interventions at a local level, e.g. awareness training and support.	Director of Workforce and Organisational Development	Workforce Leads Care Group Quad HR Business partners Freedom to Speak Up Guardian	TBC	
Metric 8. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleague.						
Reduce the percentage of people experiencing, discrimination by 1%.	There has been an increase from 22.08% in 2024 to 22.57% 2025.	Staff Survey action plans to include standing action on reducing discrimination in the workplace.	Director of Workforce and Organisational Development	Workforce Leads Care Group Quad	TBC	
		Blogs/videos/story telling about the impact of discrimination on colleagues and patient care	Director of Workforce and Organisational Development	EDI Team	Q4 2025-2026	
		Promote best practice in line manager training.	Director of Workforce and Organisational Development	OD Team Operational HR	Q3 2025-2026	
		No Excuse For Abuse - more promoting as staff unaware of reporting tool.	Director of Communications	Head of Employee Relations Communications Team	Q3 2025-2026	
		Civility and Respect policy to be reviewed and republished.	Director of Workforce and Organisational Development	Head of Employee Rela	Q3 2025-2026	
		Integrate Management leadership development standard.	Director of Workforce and Organisational Development	OD team	Q3 2025-2026	
Metric 9 BME Board members – Percentage difference between the organisation's Board voting membership and its overall workforce						
Increase the number of ethnically diverse Board members to be more reflective of the organisation.	The % difference in 2025 is -18%. (There are no BME Board members).	Applications for Non-Executive Director appointments encouraged from a visibly diverse background. (Carried forward from last action plan).	Associate Director of Corporate Governance	Associate Director of Corporate Governance	Q3 2025-2026	
All Metrics						

To improve the employment experiences of our BME colleagues. (A Trust Equality Objective)	The majority of the metrics show a deterioration in the workplace experiences and career progression of BME colleagues.	Implement the Race and Health Observatory's 7 Anti-Racism Principles as a strategic framework: 1. Demonstrate leadership by naming racism 2.Understand and acknowledge 3. Meaningfully involve racially minoritised individuals and communities 4. Collect and publish data 5. Identify racial bias 6. Apply a race critical lens 7. Evaluate and reflect.	Chief Executive	Anti-Racism Steering Group	Q3 2025-2026	

Author: Head of Equality, Diversity and Inclusion
Senior Responsible Officer: Director of Workforce and Organisation Development
Publish and Submission Date: 31 October 2025
Note: BME staff were engaged with via a staff network meeting. These actions are designed to address the Workforce Race Equality Standard.
Where an action has been given a Green RAG rating to indicate complete, the action, where necessary, will be continuously implemented.

York and Scarborough Teaching Hospitals NHS Foundation Trust
North East and Yorkshire

Summary for the 2023/24 reporting year

RCB

Trust type: Acute with or without Community

Indicator number and description			Trust	North East and Yorkshire	Acute	National	Rank*
1: BME representation in the workforce by pay band							
Workforce BME representation			15.5%	17.9%	31.1%	28.6%	
Pay band at which %BME drops off	Non-clinical	Band 4 -	Equitable	Band 3	Band 3	Band 3	
		Band 5 +	Equitable	Band 8A	Band 8A	Band 8A	
	Clinical	Band 4 -	Band 3	Band 3	Band 3	Band 3	
		Band 5 +	Band 6	Band 6	Band 6	Band 6	
	Medical		Consultant	Consultant	Consultant	Consultant	
Gap: %BME 8c to VSM - workforce overall		Non-clinical	-1.5%	-4.7%	-6.9%	-5.8%	33%
		Clinical	-15.5%	-10.3%	-19.3%	-16.4%	36%
2: Likelihood of appointment from shortlisting							
		ratio White / BME	2.33	1.74	1.56	1.62	83%
3: Likelihood of entering formal disciplinary proceedings							
		ratio BME / White	1.25	1.07	0.95	1.09	23%
4: Likelihood of undertaking non-mandatory training							
		ratio White / BME	0.57	0.99	1.11	1.06	81%
5: Harassment, bullying or abuse from patients, relatives or the public in last 12 months							
		BME	29.8%	26.7%	27.9%	27.8%	63%
		White	21.1%	23.0%	23.9%	24.1%	31%
6: Harassment, bullying or abuse from staff in last 12 months							
		BME	30.1%	24.3%	25.5%	24.9%	93%
		White	24.2%	18.8%	21.5%	20.7%	83%
7: Belief that the trust provides equal opportunities for career progression or promotion							
		BME	42.3%	50.6%	48.9%	48.8%	92%
		White	54.6%	61.8%	59.2%	59.4%	86%
8: Discrimination from a manager/team leader or other colleagues in last 12 months							
		BME	22.1%	16.0%	15.8%	15.5%	97%
		White	7.5%	5.8%	6.7%	6.7%	70%
9: BME representation on the board minus workforce							
		Overall	-15.5%	-8.4%	-16.9%	-12.2%	68%
		Voting members	-15.5%	-7.1%	-17.8%	-12.1%	63%
		Executive members	-15.5%	-12.5%	-22.3%	-16.8%	53%

* ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator, based on effect size.

Quick guide to colour coding

A quick guide to the colour coding used in the tables of analyses is presented below.

Indicator 1 gap in representation at pay bands 8C to VSM, and indicators 2 to 4: colour coding for the degree of inequality

	Inequality, large degree
	Inequality, medium degree
	Inequality, small degree
	Equity / proportional

Indicators 5 to 8: heat map colour coding for the degree of poor outcome, relative to the benchmark

	Benchmark
	Very high
	High
	Quite high
	Similar to benchmark
	Quite low
	Low
	Very low

Indicator 9: colour coding for the degree of inequality

	Underrepresentation by three or more board members
	Underrepresentation by two board members
	Underrepresentation by one board member
	Equity / proportional representation

Percentile ranks: colour coding

	Best 5%
	Best 10%
	Best 25%
	Middle 50%
	Worst 25%
	Worst 10%
	Worst 5%

A note on interpreting the colour-coding in the summary table:

Regarding the colour coding of the indicators in the summary table on page 2, it is possible that an indicator will be colour-coded green in the "Trust" column, but yellow, orange, or red in the "Percentile rank" column (or vice versa). The colour coding in the "Trust" column conveys whether or not the indicator is different from equity or proportional representation to a statistically significant degree. Sometimes, even a very large value may not be different from equity or proportional representation to a statistically significant degree if it is based on a very small number of people (this is often the case with indicator 3). Meanwhile, the colour-coding in the "Percentile rank" column reflects the percentage of Trusts that had a better value for that indicator when ranked by the size of the deviation from equity or proportional representation. This ranking does not take into account statistical significance. Indicators that are colour-coded yellow, orange, or red in both the "Trust" and "Percentile rank" columns should be a cause for particular concern as this combination denotes that the indicator is both significantly different from equity or proportional representation, and amongst the worst in the country.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	22 October 2025
Subject:	Workforce Disability Equality Standard Annual Report and Action Plan 2025-2027
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Diversity and Inclusion (EDI)

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

Approve ☒ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

☐ To provide timely, responsive, safe, accessible effective care at all times.
☒ To create a great place to work, learn and thrive.
☐ To work together with partners to improve the health and wellbeing of the communities we serve.
☐ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
☐ 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 Workforce Disability Equality Standard (WDES) Annual Report is presented to the Resources Committee for assurance to meet the NHS England (NHSE) WDES mandatory requirements. The approved data was submitted to NHS England (NHSE) by 31 May 2025 and covered the period 1 April 2024-31 March 2025.

A staff engagement event held in August 2025 covered the progress with the 2023-2025 action plan, summary report, and the Trust's 2025 data. The indicators discussed included indicator 1, which has improved but requires more rapid improvement and the

deteriorated indicators, 3, 4, 5 and 9a. (Appendix 1.) A two-year action plan was co-created.

This report provides:

- The Trust's infographics (2024 staff survey and March 2025 payroll data) – Appendix 1
- The 2025-2027 Action Plan – Appendix 2
- An overview of NHS England's 2023/2024 summary report, which benchmarks the Trust regionally, by sector, nationally and provides a rank (Appendix 3)

As with previous WDES reports, it is a mixed picture but clear we are not making the significant progress required. The Trust should continue to focus on improving the experience of those who are Disabled and/or have long term health conditions is required.

Recommendation:
The Board of Directors to note the latest report and support the actions proposed to improve the experiences of Disabled colleagues.

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

Meeting/Engagement	Date	Outcome/Recommendation
Resources Committee	21 October 2025	

NHS Workforce Disability Equality Standard Annual Report, 2025

1. Introduction and Background

The Workforce Disability Equality Standard (WDES) is a national annual reporting scheme which York and Scarborough Teaching Hospitals NHS Foundation Trust and York Teaching Hospitals Facilities Management (YTHFM) are required to comply with. This is mandated in the NHS Standard Contract; organisations are required to use this data to develop action plans aimed at improving the experiences of Disabled colleagues. This report and action plan is for both organisations.

The WDES covers 10 Indicators/Metrics (used interchangeably) regarding the career progression and work experiences of Disabled colleagues. The data is collected for the period of 1 April 2024-31 March 2025 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey. Where a metric dictates snapshot data, this is as of 31 March 2025. The Staff Survey data is from the 2024 Staff Survey.

Considerations

In 2024 Picker (our former staff survey provider) identified an anomaly with the 2023 Staff Survey results for Indicator 4a-d, this was due to the completion of the survey using some models of the iPhone. A resolution was implemented for future surveys along with additional quality assurance.

The implication of this meant the data Indicator 4a-d in the 2024 annual report was incorrect, this has now been corrected for the 2025 report.

Metric 10 – the YTHFM Director's details were not recorded on ESR due to the previous incumbent being contracted. Therefore, they are not included in the data for this metric.

The relative likelihood focuses on a figure of 1 being equity of opportunity. The non-adverse range of 0.8-1.25.

NHS England produced a 2023/2024 summary report for the Trust, which provided an analysis of the data by Trust, region, sector, nationally and rank. (See Appendix 3.)

The 2023/24 summary report stated the high priority areas for improvement for the Trust (to a maximum of three) as:

1. Indicator 9a: the staff engagement score.
2. Indicator 7: satisfaction with the extent to which the organisation values their work.
3. Indicator 4c: harassment, bullying or abuse from other colleagues in the last 12 months.

And highlighted one area of best performance:

1. Indicator 3: likelihood of entering formal capability proceedings (excluding ill health).

Summary of Findings

This report provides the results of the Trust's 2025 data analysis, which is in the format of an Infographic found at Appendix 1 and, for comparison, the North East and Yorkshire's 2023/24 summary report (Appendix 3). The co-created 2025-2027 action plan, is at Appendix 2. It is recommended that Appendix 1 is read in conjunction with the summary report.

The 2025 WDES shows that:

1. There has been a positive increase in the percentage of disabled staff across the organisation (4.86% in 2024 compared to 5.08% in 2025). Growth is consistent across all staff groups except for Medical and Dental staff where there has been a slight decrease.

2. There has been an improvement in the relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting (1.11 in 2024 to 1.03 in 2025).

3. There has been a deterioration in the relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure (1.13 in 2024 to 2.05 in 2025).

4. Harassment, bullying or abuse (HBA) from patients has deteriorated, as it has from Managers, however it has improved in relation to colleagues. Reporting of (HBA) by Disabled staff and their colleagues has deteriorated.

5. There has been a deterioration in the percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. (50.15% in 2024 to 48.10% in 2025).

6. There has been an improvement in the percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. (27.57% in 2024 to 25.14% in 2025).

7. There has been an improvement in the percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. (30.62% in 2024 to 32.57% in 2025).

8. There has been an improvement in the percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (76.29% in 2024 to 79.05% in 2025).

9. There has been a deterioration in the staff engagement score comparison between Disabled staff and non-disabled staff. (6.07 in 2024 to 5.97 in 2025).

10. The diversity of the Board is static.

The experiences of disabled staff across the indicators have been varied. This year's analysis has identified both improvements and deterioration in the data.

Indicator 7, which was a suggested high priority area for improvement for the Trust, has seen an improvement in 2025. Indicator 3, which was previously identified as best practice has deteriorated this year.

2025-2027 WDES Action Plan

To develop the 2025-2027 WDES action plan an engagement event was held with the Enable Staff Network and wider colleagues on 14 August 2025. Here the progress made with the 2023-2025 action plan was shared along with the above 2025 data, national and regional benchmarking was also provided.

There was positive discussion in relation to the agenda with specific focus being placed on the deteriorated indicators, 1, 3, 4 and 5 (above). Following the event a two-year action plan was co-created (see Appendix 2).

Next Steps

- Deliver the 2025-2027 WDES Action Plan
- Publish the annual report and the 2025-2027 action plan on the Trust's website by 31 October 2025

Date: October 2025

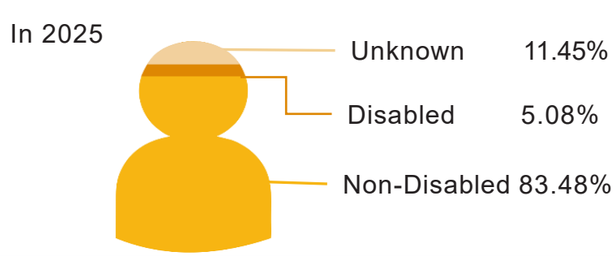
NHS Workforce Disability Equality Standard (WDES) 2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

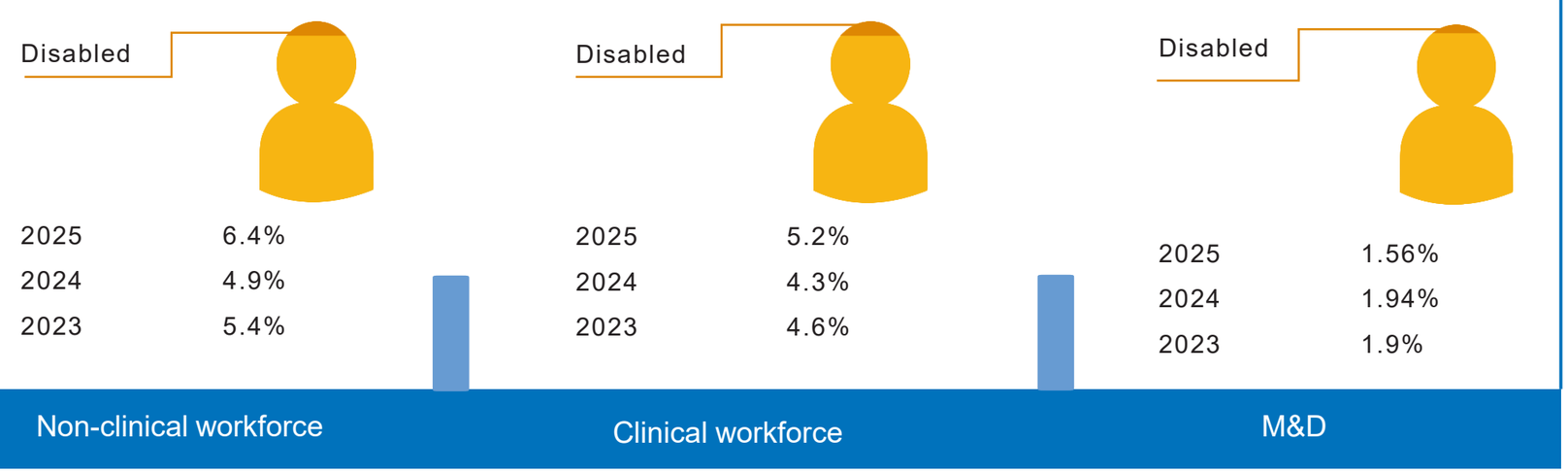
Total number of staff - 12,630 in 2025

Total number of Disabled staff - 641 in 2025

Total % of Disabled staff - 4.86% in 2024



Metric 1: Percentage of Disabled staff in the Trust compared with the overall workforce – Improved. The breakdown is:



Metric 2 - Improved

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

In 2023 – 0.26
In 2024 – 1.11

In 2025 - 1.03

Metric 3 – Deteriorated

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

In 2023 – 0.56
In 2024 – 1.13

In 2025 - 2.05

Metric 4 - Splits into four

Harassment, bullying or abuse from **patients** etc - deteriorated by 2.8% to 27.93%
Managers - deteriorated by 0.8% to 16.28%
Colleagues – improved by 1.4% to 25.87%
Reporting by disabled person or colleague – deteriorated by 6% to 48.90%.

The NHS Workforce Disability Equality Standard (WDES) provides a framework for ensuring that disabled staff receive fair treatment in the workplace and have equal access to career opportunities.

The data presented here provides an overview of the Trust's performance against the 10 WDES standards.

Key

- Unknown
- Disabled
- Non-Disabled
- Info taken from ESR
- Info taken from Staff Survey

Metric 5 - Deteriorated

% of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Disabled

2025	48.10%
2024	50.15%
2023	51.40%

Non-Disabled

2025	54.01%
2024	53.94%
2023	56.29%

Metric 6 - Improved

% of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Disabled

2025	25.14%
2024	27.57%
2023	24.38%

Non-Disabled

2025	19.38%
2024	20.30%
2023	18.62%

Metric 7 - Improved

% of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

Disabled

2025	32.57%
2024	30.62%
2023	31.50%

Non-Disabled

2025	40.34%
2024	38.53%
2023	39.10%

Metric 8 - Improved

% of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

Disabled

2025	**79.05%**
2024	**76.29%**
2023	**80.33%**

Metric 9a - Deteriorated

Staff Engagement Score comparison

Disabled		Non-Disabled	
2025	5.97	2025	6.46
2024	6.07	2024	6.51
2023	6.13	2023	6.63

Metric 10 - Static

% difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting and executive membership – 5%.

Total Board membership

Disabled		Total	
2025	0	2025	17
2024	0	2024	16
2023	1	2023	17

Voting membership

Disabled		Total voting	
2025	0	2025	16
2024	0	2024	15
2023	1	2023	15

Key

- **Unknown**
- **Disabled**
- **Non-Disabled**
- **Info taken from ESR**
- **Info taken from Staff Survey**

Workforce Disability Equality Standard Action Plan 2025-2027

APPENDIX 2

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Red	Not yet begun
Amber	Begun but not complete
Green	Complete
Blue	New

Objective	Analysis	WDES Action	Executive Lead	Operational Lead	Commence Date	RAG Rating
Metric 1 Staff in AfC pay bands or medical and dental subgroups and very senior managers (Including Executive Board members) compared with the % of staff in the overall workforce						
Encourage colleagues to update their equality monitoring information to help determine who is in the workforce. Increase declaration rates by 1% per year.	The number of disabled colleagues in the Trust has increased from 4.86% in 2024 to 5.08% in 2025. Representation across the Trust is equitable, this action is to reduce the % of those 'not stated', which is 11.45%.	The Enable Staff Network will implement actions to encourage members and colleagues within the Trust to share their equality monitoring information.	Executive Sponsor of Enable Staff Network	Enable Staff Network	Q4 2025-2026	
Metric 3 Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure						
Ensure there is equity in the application of the Capability Procedure. Reduce to likelyhood of 1.5.	The likelihood has increased since 2024 and now shows inequality. 1.13 in 2024 to 2.05 in 2025.	Roll out Management Fundamentals training for all line managers. **(Implementation will be ongoing.**)	Director of Workforce and Organisational Development	Head of Operational HR	Q3 2025-2026	
		Review number of colleagues who receive support through the Performance Improvement Policy to establish whether there is a higher number of colleagues with a disability. If a higher number is established review processes for consistency and equity.	Director of Workforce and Organisational Development	Head of Operational HR	Q4 2025-2026	
Metric 4a Percentage of staff experiencing harassment, bullying or abuse from patient/service users, their relatives or other members of the public in the last 12 months						
Reduce the percentage of colleagues experiencing harassment, bullying and abuse from patients, relatives and the public by 1%.	Harassment, Bullying and Abuse (HBA). This has deteriorated for 2025, 27.93% up from 25.13% in 2024.	Develop a campaign promoting No Excuse for Abuse internallly, within external organisation and communities. E.g. Sending campaign posters to gp surgeries etc, healthwatch, community groups to raise awareness.	Director of Communications	Communications Team	Q3 2025-2026	
		Raise awareness of the Managing Violence and Agression policy including the Exclusion section.	Chief Nurse Director of Communications	Darren Miller Communications Team	Q4 2025-2026	
		Triangulate information captured through the Staff Survey with information on Datix to determine the level of reporting.	Chief Nurse Director of Patient Safety	Darren Miller Patient Safety Team	Q4 2025-2026	
Metric 4b Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months						

Reduce the percentage of colleagues experiencing harassment, bullying and abuse from managers by 1% per year.	This has deteriorated from 15.40% in 2024 to 16.28% in 2025.	Workforce Leads to work with those responsible for local Staff Survey Action plans in triangulating data from Freedom to Speak Up and Annoymous Reporting Tool reporting HBA and discrimination. To then target interventions at a local level, e.g. awareness training and support.	Director of Workforce and Organisational Development	Workforce Leads Care Group Director Associate Chief Operating Officers Head of Operational HR Freedom to Speak Up Guardian	TBC	
Metric 4d Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months						
Increase the percentage of disabled colleagues and colleagues reporting HBA by 1% per year.	There has been a deterioration since 2024, 54.99% to 48.90% in 2025.	No Excuse For Abuse - more promoting as colleaugues unaware of reporting tool.	Director of Communications	Head of Operational HR Communications Team	Q3 2025-2026	
		Civility and Respect policy to be reviewed.	Director of Workforce and Organisational Development	Head of Operational HR	Q3 2025-2026	
Metric 5 Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion						
Promote disabled colleagues as role models within the organisation to inspire other colleagues.	This metric continues to see a year on year deterioration. In 2024 it was 50.15% compared to 2025, 48.10%.	Feature Disabled colleagues (along with other colleagues with protected characteristics) in the new EDI section of Staff Matters, raising awareness promoting good practice and role models, shadowing, acting up, whats it like being in a senior role.	Director of Communications	Communications Team	Q3 2025-2026	
		Promote development opportunities to support career progression.	Director of Workforce and Organisational Development	OD Team	Q3 2025-2026	

Author: Head of Equality, Diversity and Inclusion
Senior Responsible Officer: Director of Workforce and Organisation Development
Publish Date: 31 October 2025
Note: Disabled staff were engaged with via a staff network meeting. These actions are designed to address the Workforce Disability Equality Standard.
Where an action has been given a Green RAG rating to indicate complete, the action, where necessary, will be continuously implemented.

York and Scarborough Teaching Hospitals NHS Foundation Trust
North East and Yorkshire

Summary for the 2023/24 reporting year

RCB

Sector: **Acute with or without Community**

Indicator number and description			Trust	Region	Sector	National	Rank*
1: Representation of Disabled staff in the workforce by pay band							
Workforce Disability representation			4.2%	5.9%	5.6%	5.7%	
Disability non-declaration rate			14.4%	12.3%	14.5%	14.3%	63%
Pay band at which %Disabled drops off	Non-clinical	Band 4 - Band 5 +	Equitable Equitable	Equitable Band 8A	Band 4 Band 8A	Band 4 Band 8A	
	Clinical	Band 4 - Band 5 +	Equitable Equitable	Equitable Band 7	Equitable Band 8A	Equitable Band 8A	
	Medical		Equitable	Specialist	Specialist	Specialist	
Gap: %Disabled 8c to VSM - workforce overall		Non-clinical	-3.1%	-2.7%	-2.2%	-1.6%	69%
		Clinical	-1.6%	-1.0%	-1.0%	-1.6%	40%
2: Likelihood of appointment from shortlisting							
likelihood ratio non-disabled / Disabled			1.11	1.02	0.94	0.98	31%
3: Likelihood of entering formal capability proceedings (excluding ill health)							
likelihood ratio Disabled / non-disabled			1.13	1.70	14.38	2.22	5%
4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months							
		Disabled	25.1%	28.4%	29.7%	30.0%	16%
		Non-disabled	20.9%	21.6%	23.5%	23.3%	40%
4b: Harassment, bullying or abuse from managers in last 12 months							
		Disabled	15.4%	12.5%	15.0%	14.6%	62%
		Non-disabled	10.6%	6.6%	8.6%	8.2%	84%
4c: Harassment, bullying or abuse from other colleagues in last 12 months							
		Disabled	27.3%	22.2%	25.4%	23.8%	84%
		Non-disabled	17.2%	13.5%	16.4%	15.4%	79%
4d: Reporting of harassment, bullying or abuse at work							
		Disabled	55.0%	53.1%	50.6%	52.5%	35%
		Non-disabled	47.9%	50.8%	49.4%	51.4%	80%
5: Belief organisation provides equal opportunities for career progression or promotion							
		Disabled	50.1%	55.8%	51.7%	52.2%	67%
		Non-disabled	53.9%	61.8%	57.6%	58.1%	82%

* ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator, based on effect size.

York and Scarborough Teaching Hospitals NHS Foundation Trust
North East and Yorkshire

Summary for the 2023/24 reporting year continued

RCB

Trust type: Acute with or without Community

Indicator number and description	Trust	Region	Sector	National	Rank*
6: Pressure from managers to come to work, despite not feeling well enough					
Disabled	27.6%	26.2%	28.1%	26.6%	57%
Non-disabled	20.3%	17.6%	19.4%	18.5%	73%
7: Satisfaction with the extent to which the organisation values their work					
Disabled	30.6%	36.9%	35.0%	36.9%	87%
Non-disabled	38.5%	47.7%	46.8%	47.8%	94%
8: Disabled staff whose employer has made reasonable adjustment(s)					
Disabled	76.3%	76.1%	73.4%	74.5%	39%
9a: Staff engagement score					
Disabled	6.1	6.5	6.5	6.5	91%
Non-disabled	6.5	7.0	7.0	7.0	94%
10: Disabled representation on the board minus workforce					
Overall	-4.2%	+0.9%	+0.2%	+0.8%	74%
Voting members	-4.2%	+1.1%	+0.3%	+0.9%	67%
Executive members	-4.2%	-0.1%	-0.8%	+0.5%	55%

* ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator, based on effect size.

Quick guide to colour coding

A quick guide to the colour coding used in the tables of analyses is presented below.

Indicator 1 gap in representation at pay bands 8C to VSM, and indicators 2 and 3: colour coding for the degree of inequality

Inequality, large degree
Inequality, medium degree
Inequality, small degree
Equity / proportional

Indicators 4a to 9: heat map colour coding for the degree of poor outcome, relative to the benchmark

Benchmark
Very high
High
Quite high
Similar to benchmark
Quite low
Low
Very low

Indicator 10: colour coding for the degree of inequality

Underrepresentation by three or more board members
Underrepresentation by two board members
Underrepresentation by one board member
Equity / proportional representation

Percentile ranks: colour coding

Best 5%
Best 10%
Best 25%
Middle 50%
Worst 25%
Worst 10%
Worst 5%

Note: Regarding the colour coding of the indicators in the summary table on page 2, it is possible that an indicator will be colour-coded green in the "Trust" column, but yellow, orange, or red in the "Percentile rank" column (or vice versa). The colour coding in the "Trust" column conveys whether or not the indicator is different from equity or proportional representation to a statistically significant degree. Sometimes, even a very large value may not be different from equity or proportional representation to a statistically significant degree if it is based on a very small number of people (this is often the case with indicator 3). Meanwhile, the colour-coding in the "Percentile rank" column reflects the percentage of Trusts that had a better value for that indicator when ranked by the size of the deviation from equity or proportional representation. This ranking does not take into account statistical significance. Indicators that are colour-coded yellow, orange, or red in both the "Trust" and "Percentile rank" columns should be a cause for particular concern as this combination denotes that the indicator is both significantly different from equity or proportional representation, and amongst the worst in the country.

Report to:	Board of Directors
Date of Meeting:	22nd October 2025
Subject:	Premises Assurance Model 2024-25
Director Sponsor:	Chris Norman, Managing Director
Author:	Penny Gilyard, Director of Resources

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

- The NHS Premises Assurance Model (PAM) assessment for the financial year April 2024 to March 2025 has been completed and is scheduled for submission to NHS England on 30th September 2025.
- The assessment was conducted by the Director of Resources supported by an independent consultant. The process involved a series of structured meetings, comprehensive evidence reviews, and in-depth discussions with service and technical leads. All activities were carried out in alignment with the mandatory timescales set by NHS England.

- The 2024/25 PAM assessment reflects a positive trajectory in YTHFM Estates & Facilities performance, with notable gains in “Good” ratings across most domains. However, the increase in improvement-required and “Inadequate” ratings underscores the need for sustained investment, targeted action plans, and continuous monitoring.
- The estimated capital investment required to achieve full compliance is £1.936 million and revenue costs of £694,000. These figures exclude items that come under backlog maintenance or those prioritised through the capital planning process.
- A breakdown of the costs against each of the Self Assessment Questions (SAQ’s) is reported in appendix 1.
- Two new self-assessment question was added to PAM in 2024-25 (SH20 Mortuaries, SS10 Terrorism (Protection of Premises) Act 2025.
- Following the completion of the 2024-25 assessment, it has been recognised that PAM should be embedded within all Service Meetings and regular independent reviews undertaken by the Compliance Team. Action Plans will be developed and presented on a quarterly basis for assurance.

Recommendation:
For the Board of Directors to approve the PAM data submission to NHSE.

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

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Management Group	30th September 2025	Approved

Premises Assurance Model Self-Assessment

1. Introduction and Background

1.1 The NHS Premises Assurance Model (PAM) is a strategic management framework developed by the Department of Health to support a consistent, national approach to assessing the performance of NHS premises. It enables organisations to evaluate their estate against defined national indicators, providing assurance on safety, efficiency, effectiveness, and regulatory compliance.

1.2 The PAM tool is a structured process to ensure a robust approach is adopted for undertaking the assessment against a common set of questions and metrics, otherwise known as Self-assessment questions (SAQ's).

The SAQ's are categorised into the following domains:

- Safety Hard
- Safety Soft
- Patient Experience
- Efficiency
- Effectiveness
- Governance
- Helipad
- Maturity Framework

1.3 This year the following new categories were added SH20 Mortuaries, SS10 Terrorism (Protection of Premises) Act 2025.

1.4 Each SAQ is underpinned by several prompt questions to allow organisations to assess in more details their levels of compliance. There is a standard scoring mechanism in place which allows consistent reporting:

- Not Applicable (Grey)
- Outstanding (Blue)
- Good (Green)
- Requires minimal Improvement (Yellow)
- Requires Moderate Improvement (Orange)
- Inadequate (Red)

1.5 The PAM tool objective is to ensure the outcomes from the SAQ's are reported up to NHS Trust Boards and are embedded in internal governance process to ensure actions are taken where required.

1.6 The NHS PAM Tool provides assurance to services users, commissioners and regulators that robust systems are in place to demonstrate premises and associated services are safe.

2. Considerations

2.1 The NHS PAM assessment data highlights a strong overall performance, with the majority of indicators rated as "Good" across domains.

- **Hard FM – Safety** received the highest number of “Good” ratings (122), though there are areas requiring minimal and moderate improvement**.** Discussions with the Estates Team confirmed work is still required to obtain assurance that Estates and Facilities services are safe and suitable when the organisation is not directly responsible for providing these services (SH18). The Estates Team have confirmed this will be an area of focus and are confident sufficient evidence will be available for the next submission, working collaboratively with NHSPS and other landlords.
- **Soft FM – Safety** shows a broader distribution, including 5 “Inadequate” ratings for meeting National Cleaning Standards, indicating targeted areas for improvement. Cleanliness is the only SAQ reporting inadequate prompt scores. The team advised additional work has been completed outside the reporting period and are confident the inadequate scores will improve within the next submission.
- **Patient Experience** reflects a broadly positive outcome, with 20 indicators rated as “Good,” demonstrating strong alignment with service user expectations. However, 2 indicators were assessed as requiring minimal improvement and 6 as requiring moderate improvement. These findings indicate specific areas where targeted improvements can enhance the overall consistency and quality of patient experience across the estate.
- **Governance** demonstrated consistent performance, with all indicators rated either “Good” or “Requires minimal improvement,” reinforcing confidence in oversight and accountability structures.
- **Efficiency and Effectiveness** both show a mix of “Good” and improvement required ratings, pointing to opportunities for enhanced resource utilisation and service delivery outcomes.
- **The Helipad** domain had no ratings recorded, as they were yes / no questions. The assessment has identified that actions are required to achieve compliance within the Helipad domain. At present, costings for the necessary works have not been established and will need to be determined as part of the next phase of planning. Further evaluation will be undertaken to scope the requirements and inform any associated capital investment.

2.2 A visual representation of this data is provided in the attached (Fig 1.) chart to support further analysis and prioritisation.

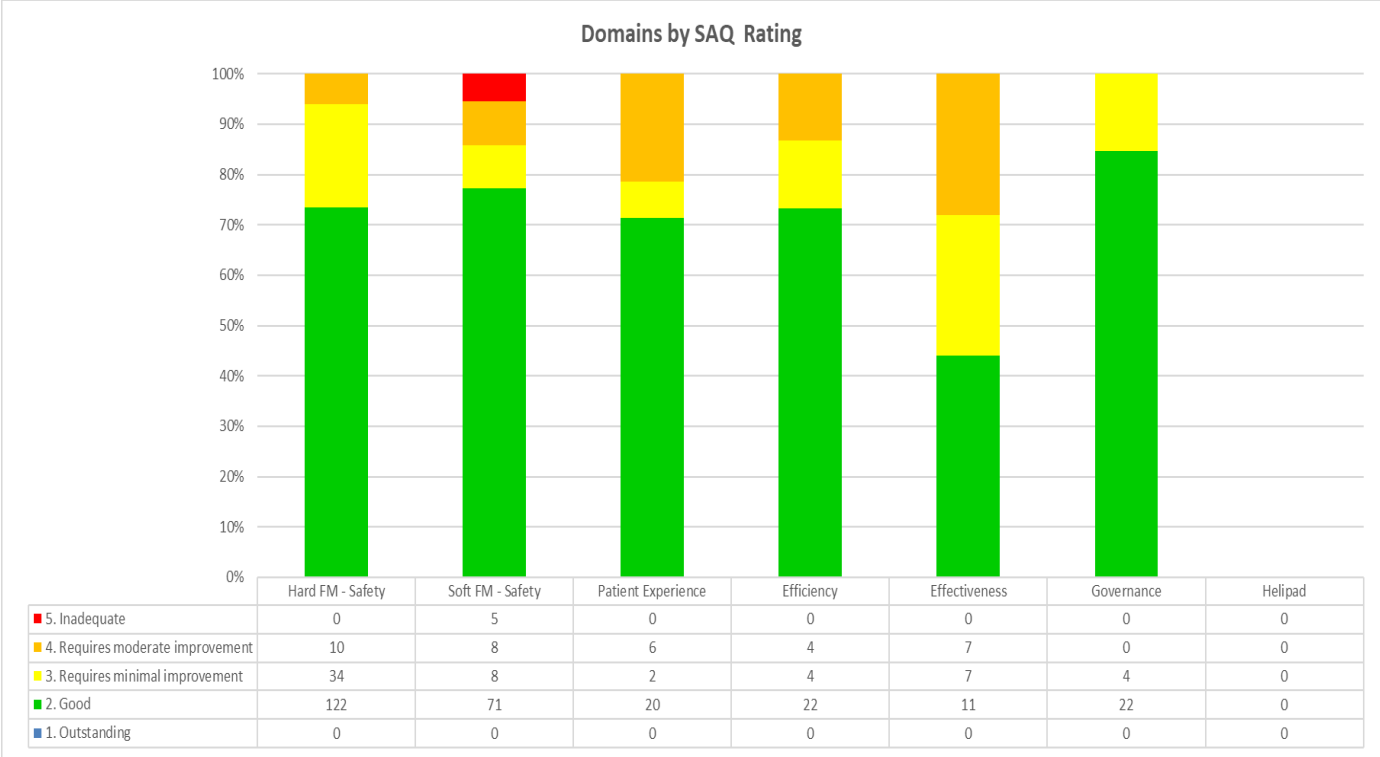


Fig 1. PAM Assessment Scores 24/25

Domain	SAQs Not applicable	Sub-SAQs Not applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate
Hard FM - Safety	0	0	0	122	34	10	0
Soft FM - Safety	0	1	0	71	8	8	5
Patient Experience	0	0	0	23	4	1	0
Efficiency	0	1	0	22	4	4	0
Effectiveness	0	1	0	11	7	7	0
Governance	0	0	0	22	4	0	0
Helipad	0	0	0	0	0	0	0
Total	0	3	0	271	61	30	5

Fig 2. PAM Assessment Scores 24/25

3. NHS PAM Assessment – Year-on-Year Comparison (2023/24 vs 2024/25)

3.1 A comparative analysis reveals encouraging progress in several areas, alongside emerging priorities for improvement.

Performance Trends

- **Overall Improvement:** The number of indicators rated "Good" rose from **244** in 2023/24 to **271** in 2024/25, reflecting strengthened operational standards and targeted interventions.
- **Areas Requiring Attention:** Indicators rated "Requires Minimal Improvement" increased from **52 to 61**, and "Requires Moderate Improvement" rose from **27 to 30**, suggesting that while general performance has improved, consistency across all domains remains a focus.

- **Inadequate Ratings**: A slight increase in "Inadequate" ratings was observed (from **3 to 5**), specifically within the **Soft FM – Safety** domain, indicating the need for corrective action.

Costed Investment Action Plans

3.2 The costed action plan for 2024/2025 is detailed at Appendix 1. Some items identified in the PAM submission for 2023/2024 have been rolled over. The total Capital cost identified is **£1.936 million** and revenue costs of **£694,000** to achieve compliance.

Detailed at Fig 3 is last years costed action plan with an update on items that have been rolled over to the new plan.

SAQ No.	Self- Assesment Question (SAQ) Subject	Domain	Captial cost to acheive compliance	Revenue Concequesnces of achieving	Notes
SH1	Estates and Facilities operational Management	Hard FM - Safety	0	35,000	Support delievered via the Admin Manger
SH6	Medical Gas systems	Hard FM - Safety	35,000	0	Drawings produced
SH7	Natural Gas and specialist piped systems	Hard FM - Safety	30,000	0	Picked up via Backlog programme
SH8	Water safety Systems	Hard FM - Safety	100,000	0	Rolled over into this years action plan
SH14	FIre Safety	Hard FM - Safety	1,000,000	20,000	SH14 updated costings and rolled over on to this year's
SH16	Resilience, Emergency and Buisness continuity plans	Hard FM - Safety	0	80,850	SH16 Trust recruited additional staff member for EPR
SH19	Contractor Managment for Soft and Hard FM services	Hard FM - Safety	85,000	0	SH19 updated costing rolled over on to this year's action
SS1	Catering Services	Hard FM - Safety	250,000	0	SS1 Electronic Meal Ordering rolled over on to this year's
SS3	Waste and recycling management	Hard FM - Safety	0	750,000	SS3 updated costings rolled over on to this year's action plan
SS4	Cleaniliness and infection control	Hard FM - Safety	0	1,240,000	SS4 updated costings rolled over on to this year's action plan
E4	Sustainability	Effectiveness	9,620,000	0	E4 PSDS4 funding and Trust funding secured and work
	Total		11120000	2,125,850	

Fig 3. Costed Action Plan 2023/2024

3.3 It is encouraging to report that funding has been successfully secured for the Sustainability Destemming Project at Scarborough, which is now progressing through the design phase. In parallel, work continues to advance on several key compliance-related initiatives, including the development of updated medical gas drawings, allocation of Emergency Planning resources in the Trust, and targeted support to strengthen regulatory compliance across the estate. These efforts form part of a broader strategy to enhance infrastructure resilience and ensure alignment with national standards.

4. Considerations

4.1 The Management Group has considered the capital and revenue costs required to support the organisation achieving compliance. Financial and resource pressures are a barrier to further progress. See Appendix 1 for a breakdown of costs.

5. Summary

5.1 The 2024/25 PAM assessment reflects a positive trajectory in YTHFM Estates & Facilities performance, with notable gains in "Good" ratings across most domains. However, the increase in improvement-required and "Inadequate" ratings underscores the need for sustained investment, targeted action plans, and continuous monitoring.

6. Next Steps

6.1 To ensure continuous improvement and compliance, all domains currently assessed below “Good” require the development of detailed action plans. These plans must be agreed upon and monitored regularly. Embedding PAM discussions within routine service meetings will enhance organisational awareness and provide assurance that ongoing oversight is in place. The Compliance Team will play a key role in conducting independent reviews of PAM scores and supporting evidence throughout the year, helping to strengthen the process and mitigate potential risks.

The following actions are scheduled as part of the next phase:

- Finalise submission of the PAM assessment to NHS England by 30th September 2025
- Develop targeted improvement plans for domain scores below good
- Scope and cost the works required to achieve compliance within the Helipad domain
- Align capital planning with assessment outcomes
- Update the organisational risk register to reflect PAM-related risks and mitigation strategies.

Date 13th October 2025

Appendix 1 - Capital & Revenue Costs to Achieve Compliance

SAQ No.	Self Assessment Question (SAQ) Subject. Safety Hard FM	Description	Capital	Revenue
SH1	Estates and Facilities Operational Management	None Identified	£0	£0
SH2	Design, Layout and Use of Premises	None Identified	£0	£0
SH3	Estates and Facilities Document Management	None Identified	£0	£0
SH4	Health & Safety at Work	Risk Assessment	£10,000	£0
SH5	Asbestos	Asbestos P405 Training for 2 staff £4K	£0	£4,000
SH6	Medical Gas Systems	None Identified	£0	£0
SH7	Natural Gas and specialist piped systems	None Identified	£0	£0
SH8	Water Safety Systems	Water Safety SGH UEEC Building, & Drawings all sites (£200k)	£440,000	£0
SH9	Electrical Systems	Drawings all sites	£200,000	£0
SH10	Mechanical Systems and Equipment	None Identified	£0	£0
SH11	Ventilation, Air Conditioning and Refrigeration Systems	None Identified	£0	£0
SH12	Lifts, Hoists and Conveyance Systems	None Identified	£0	£0
SH13	Pressure Systems	None Identified	£0	£0
SH14	Fire Safety	Fire Stopping & AE Fire	£750,000	£25,000
SH15	Medical Devices and Equipment	None Identified	£0	£0
SH16	Resilience, Emergency and Business Continuity Planning	None Identified	£0	£0
SH17	Safety Alerts	None Identified	£0	£0
SH18	Externally supplied estate	Risk Assessments & PPM's	£100,000	£0
SH19	Contractor Management for Soft and Hard FM services	Digital sign in system/Contractor Portal	£85,000	£0
SH20	Mortuaries	None Identified	£0	£0
		Totals	£1,585,000	£29,000

SAQ No.	Self Assessment Question (SAQ) Subject. Safety Soft FM	Description	Capital	Revenue
SS1	Catering services	Costs for the new catering structure 1x Band 5 and upgrade of Catering lead to Band 7 - £40K. Electronic meal ordering system (£250k)	£250,000	£40,000
SS2	Decontamination process	2 x Band 6 AP's & training	£0	£180,000
SS3	Waste and Recycling Management	36K Replacement Bins & 25K Maintenance contracts	£61,000	£0
SS4	Cleanliness and Infection Control	Revenue cost pressure 18 posts Band 2 £350K to meet new cleaning standards	£0	£350,000
SS5	Laundry and Linen Services	Extra costs 2021 for Linen & Laundry £40K	£0	£40,000
SS6	Security Management	None Identified	£0	£0
SS7	Transport Services	None Identified	£0	£0
SS8	Pest control	None Identified	£0	£0
SS9	Portering services	Maintenance of Tugs	£30,000	£0
SS10	Telephony and switchboard services	None Identified	£0	£0
		Totals	£341,000	£610,000

SAQ No.	Self Assessment Question (SAQ) Subject. Patient Experience	Description	Capital	Revenue
P1	Engagement and involvement	None Identified	£0	£0
P2	Condition, appearance, maintenance and privacy and dignity perception	None Identified	£0	£0
P3	Cleanliness	None Identified	£0	£0
P4	Access and Car Parking	None Identified	£0	£0
P5	Grounds and Gardens	None Identified	£0	£0
P6	Catering services	None Identified	£0	£0
		Totals	£0	£0

SAQ No.	Self Assessment Question (SAQ) Subject. Efficiency	Description	Capital	Revenue

F1	Performance management	None Identified	£0	£0
F2	Improving efficiency - running	Business Improvement Associate (FM)	£0	£55,000
F3	Improving efficiency - capital	None Identified	£0	£0
F4	Financial controls	None Identified	£0	£0
F5	Continuous improvement	None Identified	£0	£0
		Totals	£0	£55,000

SAQ No.	Self Assessment Question (SAQ) Subject. Effectiveness	Description	Capital	Revenue
E1	Vision and strategy	1.10 Develop Estates Strategy (Consultant Cost)	£10,000	£0
E2	Town planning	None Identified	£0	£0
E3	Land and Property management	None Identified	£0	£0
E4	Sustainability	None Identified	£0	£0
		Totals	£10,000	£0

SAQ No.	Self Assessment Question (SAQ) Subject. Governance	Description	Capital	Revenue
G1	Governance process	N/A	£0	£0
G2	Leadership and culture	N/A	£0	£0
G3	Professional advice	N/A	£0	£0
		Totals	£0	£0

Grand Total	£1,936,000	£694,000

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	22 October 2025
Subject:	2025/26 Q2 Board Assurance Framework
Director Sponsor:	Andrew Bertram, Interim Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides the 2025/26 Q2 Board Assurance Framework

All risk ratings are unchanged from Q1 of 2025/26. All amendments to all risks are provided in red text with identified gaps in blue text.

Three risks remain out of the Trust's risk appetite identified by the Board of Directors:

- PR1 - Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.

- PR3 - Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.
- PR6a - Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030

Recommendation:

The Board of Directors is asked to approve the 2025/26 Q2 Board Assurance Framework.

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

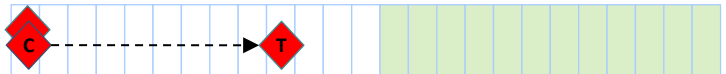
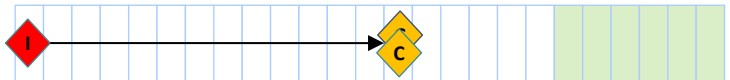
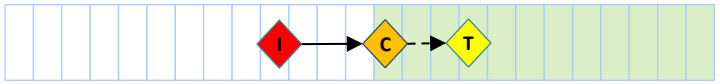
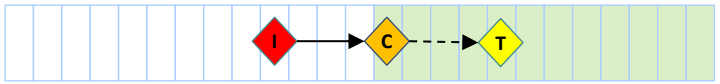
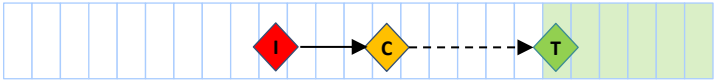
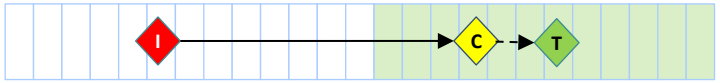
Meeting/Engagement	Date	Outcome/Recommendation
Executive Director Updates	October 2025	Risks reviewed and updated

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Q2 – 2025/26 Board Assurance Framework (BAF)

Q2 - 2025/26 Board Assurance Framework Dashboard

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Rank/Move	High Level Risk Description	Risk Assessment (Catastrophic / Major / Moderate / Minor / None)	Risk Rating	Actions	Owner	Oversight
1	PR6a – Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-30.		25	0 0 3	Director of Finance	Resources Committee
2=	PR1 – Inability to provide consistently effective clinical pathways leading to poor outcomes, experience and possible harm.		12	0 0 0	Chief Nurse	Quality & Resources Committees
2=	PR2 – Inability to nurture a Trust culture that facilitates good staff engagement and development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.		12	0 0 2	Director of Workforce and OD	Resources Committee
2=	PR5 – Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.		12	0 0 4	Director of Finance	Resources Committee
2=	PR3 – Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.		12	0 0 4	Chief Operating Officer	Quality & Resources Committees
3	PR6b – Failure to demonstrate effective governance to achieve the Trust's strategy.		9	0 0 2	Chief Executive	All Committees
4	PR4 – Trust service, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.		6	0 0 1	Medical Director	Quality Committee

Key

- N — New Risk
- Increase in Rank
- Decrease in Rank
- No movement in Rank
- I — Inherent Risk - The measure of risk before controls are considered
- C — Current Risk - The measure of risk after controls are considered
- T — Target Risk - The measure of risk once actions have been completed
- Reliance on controls
- Planned mitigations
- 1 — Action on track
- 1 — Action delayed by 1-2mths
- 1 — Action delayed by 3mths+

Risk Appetite

Low - 6
Moderate - 9
High - 12
Significant -15+

Summary of Risks by objective

Strategic Objective: Quality of Care – To provide timely, responsive, safe accessible, effective care at all times

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR1	Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.	Chief Nurse	Quality & Resources Committees	5	5	25	4	3	12	6 LOW	OUT	4	3	12	⟺

Strategic Objective: Our People – To create a great place for our people to work, learn and thrive

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR2	Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.	Director of Workforce & OD	Resources Committee	4	4	16	4	3	12	12 HIGH	IN	3	3	9	⟺

Strategic Objective: Our Partnerships – To work together with partners to improve the health and wellbeing of the communities we serve

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR3	Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.	Chief Operating Officer	Quality & Resources Committees	4	4	16	4	3	12	6 LOW	OUT	3	2	6	⟺

Strategic Objective: Research, Innovation and Transformation – Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR4	Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.	Medical Director	Quality Committee	3	3	9	3	2	6	6 LOW	IN	3	2	6	⟺

Summary of Risks by objective

Strategic Objective: Sustainability – To use the resources to deliver healthcare today without compromising the health of future generations

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR5	Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.	Director of Finance	Resources Committee	4	4	16	4	3	12	12 HIGH	IN	4	2	8	⟺

Strategic Objective: Governance and Finance – To be well led with effective governance and sound finance

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6 a	Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030	Director of Finance	Resources Committee	5	5	25	5	5	25	12 HIGH	OUT	4	4	16	⟺

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6 b	Failure to demonstrate effective governance to achieve the Trust's strategy.	Chief Executive	All Committees	5	4	20	3	3	9	12 HIGH	IN	2	3	6	⟺

Ref PR1 Board Assurance Framework (BAF)

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients in urgent care pathways
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Performance Improvement Review Meetings (PRIM) monthly for all Care Groups	PRIM letter outcomes and next steps reported to Executive Committee Oct24 – Aug 2025 (Care Group escalation reports previously)	Infection Prevention Strategic Assurance Group (IPSAG)	- IPSAG monthly reporting - Apr 24-Oct 25 TPR reporting to Quality Committee and Board	Sustainable services reviews – internal and with the Collaboration of Acute Providers (CAP)	Internal sustainable services report and CAP reporting through CAP Committee in Common
Quality Committee, Patient Safety and Clinical Effectiveness, Patient Experience Sub-Committees, Resources Committee	- Apr 24-Oct25 Quality and Safety reporting to sub-committees - Apr 24-Oct 25 escalation reports to Quality Committee - Apr 24-Oct 25 Quality Committee delivery of assurance work programme - Apr 24-Oct Board escalations	Programme Management Office schedule of programmes	Specific programmes including: - Urgent and Emergency Care, Electronic Patient Record - Maternity - Culture and Leadership	Humber and North Yorkshire System oversight for diagnostics, cancer, urgent care, finance, workforce and place-based meetings	Collaboration meetings across Executive Portfolios: Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce and OD, Finance Director papers
Care Group Board sub-group oversees IPC, escalations made to IPSAC and Assurance Committees	Monthly reporting papers of IPC, Patient Experience and Patient Safety and Clinical Effectiveness Care Groups have each established an IPC/AMS group to oversee local improvement work re: infection prevention and anti-microbial stewardship	Integrated Quality Improvement Group (IQIG) NHSE oversight	Monthly reporting of Trust Improvement Dashboard, CQC Update, Maternity, risks -Revised measures of assurance agreed by IQIG linked to the original assurance metrics from 2023/24. Updated workplan to support the metrics now in place for IQIG.	Continuous flow and escalation model 3x Op sit rep, proactive management of discharges, proactive communications management with staff and patients, psychological support for staff	- Executive Committee reporting, Board escalations of outcomes and concerns, 3x daily operational sit rep. on-call arrangements in place, proactive management of discharges, oversight through Discharge improvement group - Datix field enabled to identify patient safety incidents linked to continuous flow activity.
Operations meeting oversight: Elective Recovery Board, Unscheduled Care Board, Maternity Assurance Group	- Monthly reporting papers of Elective and Unscheduled Care Boards - Apr 2024-Aug 2025 Executive Committee - Tiering meetings with NHSE for performance	Corporate Quality Oversight: - Maternity Assurance Group (MAG) single improvement plan - Children's Board - Complex Needs Group is now established. - Professional Standards Group established	- Monthly reporting papers Maternity Assurance Group - Single Improvement Plan progress report	*Gap – EPRR Core Standards limited compliance* *Gap – Clinical Estates Strategy*	EPR July 2024 Resources Committee and Board reporting EPRR Commander training in delivery Draft clinical estates strategy in place

Ref PR1 Board Assurance Framework (BAF) - continued

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients in urgent care pathways
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Trust performance report	- Monitored at Quality Committee and associated sub committees	Regulation and Assurance visits.	Regulation and Assurance group in place HTA, HNY Trauma network, LMNS, H&S, stroke peer review, CQC	Gaps in Technical Infrastructure and Cyber Security: Limited monitoring of IG policy adherence, lack of access management policy (currently being reviewed), specialist Board cyber security training, wide variety of policies requiring review and update inc cyber protocols, services and endpoint devices require investment, central 3rd party proc register	
Cyber Security Control Framework to safeguard the confidentiality, integrity, and availability of our systems and data and aligned with NHS policies, the Data Security Protection Toolkit aligned to the NCSC Cyber Assessment Framework	- Digital Sub Committee - Submission of DSPT on a yearly basis - Annual SIRO board report - GAPS: DSPT submission highlighted that the organisation was not meeting standards with 16 out of 47 areas below NHS England's minimum standard.	Quality Assurance Framework	Internal Audit review with significant assurance Operational performance managed via the Performance Review Improvement Meetings (PRIM) - Quality Assurance Framework reviewed and updated with pilot of ward accreditation commenced September 2025 including fundamentals of care - revised QAF for approval October 25	Complex Needs Assurance Group established Complex Needs Assurance Improvement Plan in place in response to the Niche report	Group meets bi-monthly – Chaired by the Chief Nurse Quarterly progress updates to Patient Experience Subcommittee and Quality Committee for assurance

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Actions Implemented – Target Risk Score Achieved			

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	3	12

Next Review
Q3 | Jan 2026

Ref PR2 Board Assurance Framework (BAF)

Ref: PR2	Strategic Objective: To create a great place for our people to work, learn and thrive	**PRINCIPAL RISK 2:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

Consequences – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	N/A	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Our Voice Our Future Programme	- Discovery and Design phase – discovery complete and design phase underway - Q2-Q4 Board Seminar Development reports	Revised vacancy control process – implementation of 13-week firebreak. New medical bank rates from Aug 25	- Vacancy reports (July 25 onwards) - EDG papers – (April 25 onwards) - TPR workforce reporting April 2024 – July 2025	Revised communications approach	- Back to the floor initiative - Senior Leadership blogs - Staff Briefs
Delivery of Internal Leadership Programmes in line with Leadership Framework	- Care Group Leadership Development Programme Cohorts phases 1-3 delivered - List of programmes and training programmes on Learning Hub	Implementation of People Strategy Freedom to Speak Up Reporting	TPR workforce reporting Apr 2024-April 2025 EDS 2022; WRES, WDES & Pay Gap reports FTSU Board report September 2024	Formal workforce engagement	- JNCC and LNC meeting minutes - Staff Networks ToR - Anti-Racism Group
Line Management Toolkit and Training	Toolkit rollout to all Line Managers and training implementation records. Development of Phase 2 Line Management Training.	Senior Leadership Engagement Gap – engagement with all levels of leadership	- Quarterly Senior Leaders Forum - Senior Clinical Leadership monthly meeting	Wellbeing delivery	- Occupational Health and Wellbeing Annual Report to Resources Committee - Staff Psychologist Therapy
- Oversight of establishments and establishment reviews, job planning and medical deep dives - TPR reporting of nursing academy: retention of HCSW and apprenticeships levy	- TPR reporting Apr 2024-July 2025 - Nursing workforce Resources Committee reporting Apr 2024-July 2025 - Quarterly Medical Workforce Report – Resources Committee Sept 24 – July 2025	*Gap – Financial resources to recruit at the staffing establishments required*	- Annual financial planning Board sign-off April 2025 - Staffing business cases - Rostering data - - Nursing workforce establishment review approved, and funding released to support the 3 main priorities agreed	QI Readiness Assessment position when undertaken Staff Benefits work programme	

Ref PR2 Board Assurance Framework (BAF) - continued

Ref: PR2	Strategic Objective: To create a great place for our people to work, learn and thrive	**PRINCIPAL RISK 4:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

Consequences – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	N/A	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
- Our Voice Our Future – Delivery Phase implementation of actions	- Our Voice Our Future - Delivery phase currently underway	Chief Executive	2026
- Staff Survey Improvement Plan and People Promise Programme	- Colleague Engagement Improvement Plans – June 2025.	Polly McMeekin	Sept 2025

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	3	9

Next Review
Q3 - Jan 2026

Ref PR3 Board Assurance Framework (BAF)

Ref: PR3	Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve	**PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

Consequences – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. positive)	ii) Controls	ii) Assurances (inc. positive)	iii) Controls	iii) Assurances (inc. positive)
Strategic Alignment: Mechanisms in place to ensure alignment of priorities between partners. - Joint Committee in Common - Joint Operational planning meetings with Alliances, ICB and Place Colleagues throughout planning process. - Alignment of Cancer alliance objectives into Y&S Cancer Strategy - Recruitment of Head of Strategy to support partnership working	Shared system performance metrics managed with the ICB and tiering meeting with regional colleagues. ICB performance oversight arrangements. CAP meetings: Elective and UEC – joint leadership arrangements Trust strategy shared with Stakeholders (dec 2024) *Cancer Strategy Workshop – Feb 2025* *Gap: Joint strategic planning sessions with place & partners (not a gap for cancer as this is done collaboratively)*	Training and Development: Increasing the understanding of key Trust leaders in system working and partnership opportunities.	*Gap: Opportunity for leadership development in system collaboration.*	Resources: Senior management representation at core ICB and Place-based forums and alliances. Employment of Head of Strategy as key lead for partnership development	Attendance records at partnership meetings. Recruitment of Head of Strategy to support partnership working. Funding into NHS Benchmarking
Communications: Joint committees or forums for collaboration and conflict resolution.	- Trust CEO Committee in Common with other Trust Providers. - Harrogate Board to Board - York Health & Care Collaborative & Joint Delivery Board. - CAP Alliance Representation & clinical leads - Multiple Boards in place where Trust is represented: CAP/ UEC and Place and SOAG. - ICB Board Quarterly meeting minutes - York Health & Care Collaborative & Joint Delivery Board meeting minutes - CAP Quarterly meeting minutes *Gap: Audit of effectiveness of forums for delivering quality partnership working ?*	Data that support partnership working - North Yorkshire Overarching Multi Agency Information Sharing Protocol (MAIS) - Humber sharing charter - Specific sharing agreement with TEWV for them to access our systems as required - Information sharing as part of the Collaborative of Acute Providers Information	MAIS: this is managed by NYCC and is reviewed annually (partners include YAS, NY Police, CYC, Harrogate and District NHS Foundation Trust) *Humber sharing charter: T*his is managed by North East Lincolnshire Council and is reviewed annually (partners include HUTH, East Riding council, Humberside Police) TEWV and other agreements managed in line with SLAs CAP: Sharing is managed through the joint working arrangement	- System working to deliver EPR convergence and supporting initiatives around Population Health Management - Partnership working on the Yorkshire and Humber Care Record	- EPR Programme Management - Yorkshire and Humber Care Record Programme Management

Ref PR3 Board Assurance Framework (BAF) - continued

Ref: PR3	Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve	**PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

Consequences – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Conduct joint strategic planning sessions to align objectives and priorities across key partners (at place most likely).	Cancer Strategic review with partners complete, workshop held for Cancer Strategy 25-30. Collaborative Acute Providers (CAP) 25/26 work programme - awaiting Executive Planning Meetings – throughout the national planning round	Beth Eastwood / Jenny Piper CEO / COO and CFO	**Cancer Strategy:** Cancer Board – 14th May Exec Com – Early June Board June CAP - TBC Sept-Dec 2025
Audit of effectiveness of forums for delivering quality partnership working. Using partnership maturity matrix across providers / place and alliances	Audit of partnership meetings initiated across care groups and directorates Maturity matrix for assessing partnership working developed. Audit completed. There are over 220 partnership meetings listed, over 60 of these are Executive level. It is not possible, nor appropriate to conduct a maturity matrix on all identified partnership meeting. To this end the list will be shared with the executive team for prioritisation. Application on maturity matrix across partnerships and stakeholders	Tilly Poole	Q1 - Initiated Q1 – Matrix completed and being tested Q2-4 – identify priority groups and apply matrix
Governance arrangements to demonstrate delivery of primary care collaboration	New Place-based meeting established Q1 2025 - Integrated Primary Health Care Collaborative 2025/26	To be established on receipt of ToR – first meeting 23/04/25	Q1
Governance arrangements to demonstrate effectiveness of shared data for decision making	Supporting work of the emerging linked dataset with HNY Geomapping exercise initiated by CAP Data-led Planning Approach approved at Exec Com – speciality level data packs complete and shared with specialties in face-to-face meetings throughout September to support planning and clinical service strategy. Next step will be to update following feedback and to collate Trust wide insights – November 2025 Clinical service strategy framework developed in draft form, workshops with care groups planned	Tilly Poole Lynette Smith Tilly Poole Tilly Poole Tilly Poole	Q2-4 Q2&3 Completed Completed Q2

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6
Next Review		
Q3 - Jan 2026		

Ref PR4 Board Assurance Framework (BAF)

Ref: PR4	Strategic Objective: Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow	**PRINCIPAL RISK 4:** *Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.*	**Risk Score: 6**

Causes – What must happen for the risk to occur?
- Failure to transform services sufficiently to within the current resource limits
- Capacity for the EPR programme delivery is not sufficient
- Lack of standard implementation of QI methodology
- Insufficient funds to allow running of services, allowing headroom to affect transformation, plan for the long term and change at pace

Consequences – If the risk occurs, what is its impact?
- The EPR programme is not sufficient to realise its full potential
- QI benefits not consistently delivered to transform services

Executive Risk Owner: Medical Director | **Assurance Committee:** Quality Committee | **Date Added to BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
3	3	9	3	2	6	LOW (1-6)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	6	6	N/A	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. positive)	ii) Controls	ii) Assurances (inc. positive)	iii) Controls	iii) Assurances (inc. positive)
Rollout of Quality Improvement Methodology (QSIR)	- Regular cohorts of QI training - QSIR tools available Trust wide - Governance Half-Days include improvement - Governance outputs reported through Care Group Governance Readiness Assessment commissioned and completed to support the development of the next phase of our QI journey. Business Case produced to support the appointment of a Strategic Partner to support our CQI journey.	Implementation of the Nervecentre EPR Programme	- Business case approval - Programme Board - Digital Sub-Committee - HNY EPR Board (ICB joint working) - Project team appointments - Training plan	Building of commercial research team	- Establishment of commercial research team - Collaboration agreements with Contract Research Organisations (CROs)
				Research and Innovation, People, Digital and Quality Strategies	Approved at February-May 2025 Board of Directors
Data for improvement	- Availability of data on Signal - Improvements to Trust Priorities Report	Joint working with partners across ICB for system-wide transformation	- Cancer Board - Elective Recovery Board - Community Improvement Group	Continuation and expansion of Research Delivery	- Partnerships with universities - Research leads and time assigned for Principal Investigators
Transformation programmes with programme governance and infrastructure	- Programmes established including: - *Maternity Assurance Group* - *Community Diagnostic Centres* - *Urgent Care Improvement Programme* - *Urgency and Emergency Care Centre*	Annual Planning and Strategy Development	- Annual planning process to develop change and transformation priorities and initiatives in specialties - Joint meetings with ICB and Place during planning round to manage risks and ensure alignment of policy requirements.	Growth of coastal research capacity to create research and implement findings related to inequalities	- Establishment of Scarborough Coastal Health and Care Research Healthcare Collaborative (SHARC) - Partnerships with VCSE organisations

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
NHS Impact Actions and establishment of continuous improvement culture	Readiness Assessment commissioned from KPMG for the establishment of our management system to deliver our strategic priorities.	Adele Coulthard	Complete
Resource and focus on innovation	Delivery of Research and Innovation Strategy Action Plan	Lydia Harris/Adele Coulthard	April 2026

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6

Next Review
Q3 Jan 2026

Ref PR5 Board Assurance Framework (BAF)

Ref: PR5	Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations	**PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

Consequences – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	N/A	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
External grant and match funding opportunities to help improve capital and infrastructure to better sustainable and energy saving standards	- NHSE and ICB informing of grant opportunities, horizon scanning, for example:- ○ PSDS ○ NEEF ○ Other opportunities including through our local/regional partnerships	Sustainable Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan).	- Senior Lead owner of each Green Plan workstream and theme - Monthly 1-2-1 with the Finance Director in his role as the Executive Sustainability lead *Gap – These workstreams are in place with identified leads but a minority still need to develop further.* The travel plan is to set forward a number of initiatives to promote sustainable travel across the Trust *Gap – Staff Travel Plan does not control patient travel, which impacts on our 2045 carbon target, where there is a reliance on clinical changes to increase community care and treatment of patients at home.*	Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group Monthly 1-2-1 with the Finance Director in his role as the Executive Sustainability lead	- Resources and Executive Committee Reporting every quarter - YTHFM Management Group reporting every quarter *Gap – all workstreams are now in place but some need to be more effective so a series of 1-2-1's with workstream leads has been put in place, which has helped but a small minority needs to do more, which is due to loss of staff and new staff coming in and work pressures.*
Sustainability Team delivering the green plan and staff travel plan agendas across the Trust	- Green Plan requiring redrafting to better align with new NHSE Green Plan guidance, ICB Green Plan and regional climate change strategies. - Green Champions network established - Staff Travel Plan agreed and published, January 2025 - Developing new external partnerships private & public sectors organisations to support our and their sustainability efforts, following external funding sources and support	Head of Sustainability oversight and lead, Finance Director steer and Sustainability Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan).		Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group. Regular meetings with the Finance Director to update, provide assurances and receive steers from.	
Sustainable Design Guide & NHSE building standards implementation	- BREEAM standards embedded in the Capital Team - Scarborough UEC delivery - Capital Projects' sustainability design guidance is in place. The Head of Capital Projects retains accountability for the broader sustainability improvements via the capital projects they are instructed to deliver, inline with NHS Net Zero Building Standards	Green Plan, Sustainability Development Group & newly established Capital and Estates workstream	*The guidance is now embedded within Capital and supported by a new officer who is experienced in sustainability. Gap – The newly formed workstream for Capital and Estates has only met once but they are aware of a number of items they need to look at including embedding NHSE net zero building standards.*	Ongoing staff communications through the Heads of Capital and Estates to push the embedding of sustainability across their departments.	- Trust Communication on green plan interventions - Capital and Estates teams meetings and communications from the Head of Service with support from the Head of Sustainability.

Ref PR5 Board Assurance Framework (BAF) - continued

Ref: PR5	Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations	**PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

Consequences – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	N/A	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Staff Travel Plan Implementation	A new partnership has been developed between the Trust, both York universities and City of York Council to discuss and implement actions to help improve public and active travel links for our staff and customers, including bus access and car sharing. Bus operators to continue with staff bus discount offer with benefits to patients/visitors to travel sustainably. Funding from North Yorkshire and East Riding Councils and York Hospitals Charity to support new secure cycle parking facilities for York and Bridlington and a bus stop and shelter at Selby. The staff travel survey is underway, and due to close at the end of October, where several hundreds responses have been submitted already. Once complete this will help inform further work of the staff travel plan.	Daniel Braidley/Graham Titchener	Review October 2025
Review of YTHFM Capital Projects' Sustainability Design Guide against the NHSE Net Zero building Standard & chair of newly established Capital & Estates workstream.	Head of Capital projects has an officer who is qualified in sustainability, is ensuring sustainability guidance is incorporated all Capital Projects where possible. The new Green Plan workstream is now up and running, aligning responsibilities between Capital and Estates teams, chaired by the Head of Capital, with the two heads of service leading and ensure better embedding of sustainability policies, especially NHSE Net Zero Building Standards. This includes all existing projects and work to ensure sustainable alternatives are used in new projects and day to day maintenance.	Andrew Bennett	Review October 2025
Sustainability Quarterly Assurance Reports and workstream establishment.	Workstreams are in place but not all being fully effective yet, however following a series of 1-2-1 meetings with all workstream leads, the main 'ask' to develop their update workstream sections for the Green Plan is underway however the Head of Sustainability still has concerns of the progress of some of these, that are due to a combination of work pressures, lack of staff or new staff coming into post. Other work is progressing through the Sustainability team but, while improved, there is still more that needs to be done by these workstreams. Ensuring better data is available to track progress against the newly update 1379t/CO2 saving per annum the Trust needs to make to achieve net zero targets. This is an increase of 1079t/CO2 due to the CHP engine breaking earlier this year. Once the data is more assured, we are aiming to provide a simple dashboard for all staff to show where we are on our CO2 journey.	Graham Titchener	Review October 2025
Trust Green Plan redrafted to better align with new NHSE Green Plan guidance, ICB Green Plan and regional climate change strategies and to include more KPIs/SMART outcomes.	Redraft underway and aiming to send to Exec and Board for approval end of this year or the end of this financial year. This mainly depends on the workstream leads.	Graham Titchener	December 2025

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	2	8

Next Review
Q3 – Jan 2026

Ref PR6a Board Assurance Framework (BAF)

Ref: PR6a	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6a:** Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030.	**Risk Score: 25**

Causes – What must happen for the risk to occur?

- Failure to achieve the annual financial plan through inadequate income allocations, poor income recovery, lack of expenditure control, non-delivery of the efficiency programme and unaffordable investment decisions.
- Cashflow difficulties
- Inadequate capital funding to meet all infrastructure backlog repair priorities and new investment requirements

Consequences – If the risk occurs, what is its impact?

- Trust entering SOF4 arrangements and special measures scrutiny
- Not achieving the Trust's part of the ICB overall financial balance (system failure consequence)
- Loss of Deficit Support Funding
- Externally imposed financial recovery plan
- Reputation impact on the Trust
- Site infrastructure failure
- Loss of autonomy and control
- Potential reduction in service quality and safety

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	5	4	25	OPEN (10-12)	OUTSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	25	25	N/A	N/A
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Annual business planning process including Board plan sign-off, triangulation with ICB and ICS and ultimate NHSE approval.	- Business plan, Board progress updates - ICB plan working groups - Internal Audit Reports 2025-26	Expenditure control - business case process *Gap – Unplanned expenditure commitments outside of process*	- Business Case manual and register - Internal audit report - SFI Business Case approval hierarchy	Overspend monitoring against approved scheme sums	- Scheme sum variation process - Scheme expenditure CPEG reports
Monitoring and reporting of I&E plan	- TPR Board and Committee reporting 2025-26 - PFR monthly NHSE. TPR Resources & Board - Care Group PRIMs and FRMs	Efficiency delivery – managed by Corporate Efficiency Team *Gap – insufficient planning to secure in year delivery*	- TPR Board, Committee and EDG reporting 2025-26 - PFR monthly to NHSE - Care Group PRIMs and FRMs	Management of national PDC schemes to required timelines (year-end cut-off deadlines)	- CPEG reporting 2025-26 - ICS/NHSE ad hoc reports
Income control - income contract variation process *Gap – unplanned income reduction*	- Income adjustment form register - TPR Board and Committee reporting	Cash flow monitoring. Cash working group. Monthly debtors and creditors review.	- Monthly debtor and creditor dashboard - Trend data and forecast data in TPR - Better Payment Practice in TPR	Backlog maintenance prioritisation *Gap – lack of understanding of full backlog requirements*	- Capital Investment needs schedules - Prioritisation scoring process - EC and Board sign off April 2025
Expenditure control - scheme of delegation, standing financial instructions, segregation of duties.	- SFIs Board approved - Written prime budget holders' approval - System enforcements and no PO no Pay	Capital planning process – preparation and sign off programme	- Capital Investment needs schedules - Prioritisation scoring process - EC and Board sign off April 2025	Identification of sparsity income stream (£10.3m)	- Formal agreement with ICB to include sparsity income & work on funding - Task & finish group to manage
Expenditure control - staff leaver process and Vacancy Control *Gaps – payroll untimely informed of leavers*	- Salary overpayment recovery policy - Staff Reports, REACH reporting	Routine monitoring and reporting against capital programme	- TPR Board and Committee reporting 2025-26 - CPEG reporting - ICS/NHSE ad hoc reports	Risk share agreed with the ICB for high-cost drug cost pressure	- £6m ICB funding agreed - Area prescribing committee work - ICB strategic commissioner role

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Unplanned income or spend change – CG and Corp Dir reminders	As part of the 25/26 budget sign off process a specific reminder will be issued requiring signature.	Andrew Bertram	Complete
Payroll improvement project to tackle under & over payments - Deloitte	Improvement plan prepared. Delivery underway. HR Director chaired working group in place.	Andrew Bertram	September 2025
Insufficient efficiency programme – Productivity group / CIP Timeout to accelerate delivery in H2; Recovery action plans.	ICS-wide System Engine Room governance programme. System leaders group to manage pace & cover. Fully planned efficiency programme for 25/26 but need to manage high risk schemes and slippage.	Andrew Bertram	Ongoing for 25/26 plans
6 Facet Survey to be completed to identify full backlog maintenance reqs.	Funding agreed. Survey work completed. Currently being quality checked prior to publishing	A Bertram/Penny Gilyard	November 25

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	4	16

Next Review

Q3 - Jan 2026

Ref PR6b Board Assurance Framework (BAF)

Ref: PR6 b	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6b:** *Failure to demonstrate effective governance to achieve the Trust's Strategy.*	**Risk Score: 9**

Causes – What must happen for the risk to occur?
- Failure to achieve a satisfactory CQC well-led rating
- Inadequate escalation governance processes
- Trust Leadership and staff not held to account effectively
- Poorly structured and defined governance forums from 'Ward to Board'
- Unclear accountabilities and responsibilities of Trust leadership and Staff
- Insufficient grip on the governance of data

Consequences – If the risk occurs, what is its impact?
- Regulatory well-led scrutiny on the Trust leadership, staff and governance processes
- Trust resources not used effectively and efficiently in achieving the Trust's strategy
- Quality of patient care and experience is not at the level achieved
- Decision-making not consistent with achieving Trust goals
- Risks and issues not managed effecting patient care
- Poor staff morale

Executive Risk Owner: Chief Executive | **Assurance Committee:** All Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	4	20	3	3	9	OPEN (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	9	9	N/A	N/A
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances (inc Positive)	ii) Controls	ii) Assurances (inc Positive)	iii) Controls	iii) Assurances (inc Positive)
Monthly Trust Board of Directors reporting	- Approved Standing Orders and work programme (Jan 2024) papers, minutes and action logs - 2024/25 Committee effectiveness reviews and amendments to terms of reference	Patient Experience and Clinical Effectiveness Sub-Committees	- Approved terms of reference and work programmes (Jan 2024) - All Committee reporting papers, minutes, action logs Apr 2024-Jan 2025	Role job descriptions and annual appraisal processes	- 88% staff appraisals concluded for 2024
Trust constitution and governance framework: Scheme of Reservation and Delegation and Standing Financial Instructions	- Trust constitution and governance framework approved by Board of Directors, delivered through all Committees January 2024 to date	Performance Review and Improvement Meetings (PRIM) with Care Groups	- Monthly letters of meeting outcomes and actions to Care Groups for action - Escalation reporting to Executive Committee for lessons learnt	Line Management Development Programme	- Line managers undertaken the line management training programme as at Jan 2025
- Monthly Quality and Resources Committees - Bi-monthly Executive Committee - Quarterly Audit Committee	- Committees' terms of reference and work programmes (approved January 2024) - All Committee reporting papers, minutes and action logs Apr 2024-Jan 2025	Committee escalation processes and flow of information across governance forums	- Quality, Resources, and Audit Committee escalation reports to Board of Directors - Care Group reporting escalations to Executive Committee April 2024-Jan 2025	Business Intelligence data reporting processes	- Signal 'real-time' reporting - Trust Priorities Report (TPR) monthly reporting to Board, Quality, Resources and Executive Committees Apr 2024-to date
- Risk Management Strategy and Policy and Datix system - DSPT submission and cyber security management	- Board Approved January 2025 - BAF, Corporate Risk, Care Group and speciality risk registers Apr 2024-Jan 2025 - SIRO board report Sept 2024	Care Group governance forums (quality, performance, finance, workforce, risk)	*Gap - Approved consistent terms of reference and work programmes across all Care Groups* - Care Group reporting papers, minutes, action logs Apr 2024-Jan 2025	CQC 'Journey To Excellence' programme and relationship management meetings	- Journey to Excellence monthly meeting Apr 2024-Jan 2025 - Journey to Excellence action plan outcomes evidence submitted to CQC Apr 2024-Jan 25

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Consistent Care Group governance terms of reference for Quality, Performance, Finance and Risk forums	Accountability framework drafted for Care Group engagement. Training underway for specialities. Risk and Assurance Workshops conducted with Care Group leadership teams	Mike Taylor	March 2026
Well-led external assessment next steps to implement	External well-led assessment currently underway with interviews, observations, documentation reviews, workshops and survey information gathering.	Mike Taylor	November 2025

Target Risk (After Actions Implemented)		
I	L	Rating I x L
2	3	6

Next Review
Q3 - Jan 2026

Report to:	Board of Directors
Date of Meeting:	22 October 2025
Subject:	2026/27 Board of Directors Meeting Dates
Director Sponsor:	Martin Barkley, Trust Chair
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☐ Discuss ☐ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides the confirmed 2026/27 Board of Directors Meeting dates for the last Wednesday of each month excluding August and December.

Board of Directors Development Seminar meeting dates for each month are also confirmed for 2026/27.

Recommendation:
The Board of Directors is asked to note the meeting dates for 2026/27.

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

2026/27 Board of Directors Meeting Dates

1. Introduction and Background

York and Scarborough Teaching Hospitals NHS Foundation Trust's Board of Directors meet in public 10 times a year on monthly basis, excluding the months of August and December.

These meetings are followed by private meetings due to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

2. 2026/27 Board of Directors Meetings

The dates for the 2026/27 Board Meetings are to be scheduled as follows:

29 April 2026
27 May 2026
24 June 2026
29 July 2026
30 September 2026
28 October 2026
25 November 2026
27 January 2027
24 February 2027
31 March 2027

The dates for the 2026/27 Board of Directors Development Seminar Meetings are to be scheduled as follows:

22 April 2026
20 May 2026
17 June 2026
22 July 2026
19 August 2026
23 September 2026
21 October 2026
18 November 2026
16 December 2026
20 January 2027
17 February 2027
24 March 2027

3. Board of Directors Visits

The Board of Directors will continue to visit Wards and Departments across the Trust following each Board of Directors meeting.