York and Scarborough Teaching Hospitals
NHS Foundation Trust

Agenda

Council of Governors (Meeting held in Public)

Wednesday 10 September 2025

Malton Rugby Club, YO17 7EY
at 10.00am

COUNCIL OF GOVERNORS MEETING

The programme for the next meeting of the Council of Governors will take place:

On: Wednesday 10 September 2025

Venue: Malton Rugby Club, YO17 7EY

TIME	MEETING	LOCATION	ATTENDEES
09.15 – 10.00	Governors meet General Public	Malton Rugby Club	Council of Governors Members of the Public
10.00 – 13.00	**Council of Governors meeting held in public**	**Malton Rugby Club**	**Council of Governors** **Non-executive Directors** **Executive Directors** **Members of the Public**
13.30 – 15.00	Private Council of Governors	Malton Rugby Club	Council of Governors Non-executive Directors

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Council of Governors (Public) Agenda (10.09.25)

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Introduction, apologies for absence and quorum** To receive any apologies for absence	Chair	Verbal	-	10.00 – 10.05
2.	**Declaration of Interests** To receive any changes to the register of declarations of interest	Chair	Enclosed	5	
3.	**Minutes of the meeting held on 11 June 2025** To receive and approve the minutes from the above meeting	Chair	Enclosed	10	
4.	**Matters arising from the minutes and any outstanding actions** To discuss any matters or actions arising from the minutes	Chair	Enclosed	19	
5	**Chief Executive's Update** To receive a report from the Chief Executive, including a report from the Anti-racism Steering Group	Chief Executive	Enclosed	21	10.05 – 10.20
6	**Chair's Report** To receive a report from the Chair	Chair	Enclosed	26	10.20 – 10.30
7	**Independent Auditors Report** To receive and discuss the Independent Auditors Report	Forvis Mazars	Enclosed	28	10.30 – 10.50

	SUBJECT	LEAD	PAPER	PAGE	TIME
8	**Performance Report** To receive the latest Performance Report	Chief Operating Officer / Chief Nurse	Enclosed	34	10.50 – 11.15
	BREAK 11.15 – 11.30				
9	**Chief Nurse Update** 9.1 CQC Update 9.2 IPC Annual Report 9.3 Complaints Report (half-yearly)	Chief Nurse	Enclosed	 44 49 78	11.30 – 12.00
10	**NHSE 10 Year Plan** To discuss the recent publication	Chair	Verbal	-	12.00 – 12.15
11	**Reports from Board Committee Chairs** 11.1 Quality Committee 11.2 Resources Committee	Chairs of the Committees	Enclosed	87	12.15 – 12.35
12	**Governor Activities Report** To receive a report from the governors on their activities including an update re Patient Experience Group	Governors	Enclosed	99	12.35 – 12.45
13	**Items to Note** 13.1 CoG Attendance Register 13.2 NED Attendance Register	Chair	 Enclosed Enclosed	 103 106	12.45 – 12.50
14	**Any Other Business**	Chair	Verbal		12.50 – 13.00
15	**Time and Date of Next Meeting** The next Council of Governors meeting will be held on Wednesday 10 December 2025				**13.00**

Register of Governors' interests
Sept 2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Additions: **Cllr Tim Norman**

Deletions:

Modifications:

2

Register of Governors' interests 2025/26

York and Scarborough Teaching Hospitals NHS Foundation Trust

Governors	Relevant and material interests						Other
	Directorships including non -executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks.	Any connection with other organisations.
Rukmal Abeysekera (Public: York)	Nil	Nil	Nil	Nil	Nil	Nil	**Employee** of University of York
Vacancy (Appointed: East Riding Council)							
Rebecca Bradley (Staff: Community)	Nil	Nil	Nil	Nil	Nil	Nil	Temporary secondment alongside current post as Matron with NHS England
Bernard Chalk (Public: Scarborough & Bridlington)							
Mary Clark (Public: City of York)	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Cllr Liz Colling (Appointed: NYCC)	Nil	Nil	Nil	**Councillor** - NYCC	**Councillor** - NYCC	**Councillor** - NYCC	**Trustee**: CAB NY **Governor & VC:** Childhaven Nursery School Scarborough **Chair:** NY Constituency Ctte Scarborough & Whitby **VC:** NYCC Scrutiny of Health Committee **Member:** Scarborough Town Deal Board
Beth Dale (Public: York)	Nil	Nil	Nil	Nil	Nil	Nil	**Member** of the York Sight Loss Council
Abbi Denyer (Staff: York)	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Adnan Faraj (Staff: Scarborough & Bridlington)	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Paul Gibson (Public: East Coast)	Nil	Nil	Nil	**Chair** for Humber Primary Care PPG	Nil	Nil	**Member** Bridlington Health Forum
James Hayward (Public: East Coast)	**NED** Government Facilities Services Ltd Engineering	James D Hayward Building Services	Yes	Nil	Nil	Nil	Nil
Graham Healey (Staff: Scarborough & Bridlington)							
Gary Kitching (Staff: York)	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Graham Lake (Public: Ryedale & EY)	Nil	**Nil**	Nil	**Education Lead:** RCN NY Branch **Member:** TEWV NHS **Member:** Derwent PPG	Nil	Nil	**Member:** European Lung Fd PAG

Wendy Loveday (Public: Selby)	Nil	**Shareholder** in Fleetways Taxis which is on the Trust's procurement system.	Nil	Nil	Nil	Nil	Nil
Elaine McNicoll (Public: East Coast)	**Nil**	Nil	Nil	Nil	Nil	Nil	Nil
Elizabeth McPherson (Appointed: CarersPlus)	**CEO** - CarersPlus	Nil	Nil	**CEO** - CarersPlus	**CEO** - CarersPlus	Nil	Nil
Cllr Tim Norman (Appointed: ERYC)	**Director - Coast Holidays Ltd &** **Quilt Sandwich Ltd**	Nil	Nil	Nil	**Trustee & Treasurer:** Bridlington Health Forum **Councillor:** ERYC	Nil	Nil
Jill Quinn (Appointed: Dementia Forward)	**CEO** – Dementia Forward	Nil	Nil	**CEO** – Dementia Forward **Trustee** – The Place in Settle	**CEO** – Dementia Forward	Nil	**As stated**
Gerry Richardson (Appointed: University of York)	Nil	Nil	Nil	Nil	Nil	Nil	**Employee** of University of York
Michael Reakes (Public: City of York)	Nil	Nil	Nil	Nil	Nil	Nil	**Member** - Patient feedback panel of the Priory Medical GP Practice (Friends of Priory). **Member** - Patient and Public Involvement at the University of York, researching Health Inequality. **Lay Member** – Trust's Research & Development Panel
Cllr Jason Rose (Appointed: CYC)	Nil	Nil	Nil	**Councillor** – NYC	**Councillor** – NYC	**Councillor** - NYC	Nil
Ros Shaw (Public: York)	Director of Conbrio Ltd	Nil	Nil	Nil	Nil	Nil	Nil

Julie Southwell (Staff: York)	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Catherine Thompson (Public: Hambleton)	Nil	**Director** of Catherine Thompson Consulting Ltd.	Nil	Nil	Nil	**Employed** by West Yorkshire & Harrogate Health Partnership	**Member:** NICE Technology Appraisal Committee.
Franco Villani (Staff: Scarborough & Bridlington)	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Linda Wild (Public: East Coast of Yorkshire)	Nil	Nil	Nil	Nil	Nil	Nil	**Councillor**: Whitby Town. **Chair** of Finance, Policy & General-Purpose Committee (WTC) **Chair** of Human Resources Committee (WTC) **Chair** of Pannett Art Gallery Committee (WTC) **Chair** of Trustees Whitby Lobster Hatchery **Trustee** of United Charities, Board **Member** - Whitby Town Deal Board, **Member** of Esk Valley Medical Practice Patient Participation Group RNLI volunteer

York and Scarborough Teaching Hospitals
NHS Foundation Trust

ITEM 3

Minutes
Public Council of Governors Meeting
11 June 2025

Chair: Martin Barkley

Public Governors:
Rukmal Abeysekera, City of York; Mary Clark, City of York; Ros Shaw, City of York; Michael Reakes, City of York; Linda Wild, East Coast of Yorkshire; James Hayward, East Coast of Yorkshire; Paul Gibson, East Coast of Yorkshire; Bernard Chalk, East Coast of Yorkshire; Elaine McNicholl, East Coast of Yorkshire; Catherine Thompson, Public Governor Hambleton

Appointed Governors: Gerry Richardson, University of York; Cllr Jason Rose, CYC; Elizabeth McPherson, Carers Plus; Cllr Liz Colling, NYCC; Gary Kitching, Staff Governor York; Rebecca Bradley, Staff Governor Community

Staff Governors: Abbi Denyer, York; Julie Southwell, York; Franco Villani, Scarborough/ Bridlington

Attendance: Simon Morritt, Chief Executive; Claire Hansen, Chief Operating Officer; Lucy Brown, Director of Communications; Polly McMeekin, Director of Workforce & Organisational Development; Helen Grantham, ANED; Jenny McAleese, NED; Julie Charge, NED; Lorraine Boyd, NED; Jim Dillon, NED; Jane Hazelgrave, NED; Noel Scanlon, NED; Mike Taylor, Assoc. Director of Corporate Governance; Tracy Astley, Governor & Membership Manager

Presenters: Sarah Crossland, General Manager, Surgery Care Group (item 9)

Public: 5 members of the public attended

Apologies: Wendy Loveday, Selby; Beth Dale, City of York; Graham Lake, Ryedale & EY; Jill Quinn, Dementia Forward; Graham Healey, Scarborough/Bridlington; Adnan Faraj, Scarborough/Bridlington; Andrew Bertram, Finance Director; Dawn Parkes, Chief Nurse

25/18 Chair's Introduction and Welcome

Mr Barkley welcomed everybody and declared the meeting quorate.

25/19 Declarations of Interest (DOI)

The Council acknowledged the changes to the Declarations of Interest.

25/20 Minutes of the meeting held on the 13 March 2025

The minutes of the meeting held on the 13 March 2025 were agreed as a correct record.

25/21 Matters arising from the Minutes

Action Log

The Council acknowledged that all actions have been completed.

25/22 Chief Executive's Report

Mr Morritt gave an overview of his report which had previously been circulated with the agenda and highlighted the following.

- Scarborough's Emergency Care Centre and Critical Care Unit are now open and have been fully functioning for the past few weeks.
- Accreditation success for Bridlington Surgical Hub. Congratulations!
- NHS England (NHSE) is being abolished and integrated into the Department of Health and Social Care. There will also be changes to Integrated Care Boards (ICBs), based on the model published by NHSE, and who will be required to cut their running costs by 50% by Quarter 3 of 2025/26.
- As part of the corporate cost reductions, which form part of our wider £55 million CIP programme, we effectively completed our plan for that work.
- The government's spending review results have been published today. The NHS has been highlighted positively with the government funding an "NHS Fit for the Future".
- The Readiness Assessment for embedding a systemic method of Continuous Improvement is almost complete which will effectively tell us what we need to do to make that a reality.

Mr Morritt then gave feedback on the recent Anti-racism Steering Group meeting, which he chairs, the outcome of which is to produce an Anti-racism Statement by the end of June. This will be done in consultation with colleagues across the organisation.

The Council referred to the £18.76 per head of population and asked if the Trust would lose out if the data from MSOA is used to define our constituencies, specifically if we omit chunks of population in an area because they might use another hospital. Mr Morritt replied that the Trust would not lose out as funds are not allocated on a per head of population basis, but by the cost of activities and services provided by the Trust.

The Council highlighted that part of the reform was a reduction in duplication of communications engagement. What does that mean in practical measures? Mr Morritt replied that a number of things are being done multiple times within the system, including communication and engagement with the population. Mrs Thompson added that in practical terms it means functions will be transferred to a different part of the system, either local trusts, regional organisations or to the Department of Health & Social Care.

The Council referred to racism within the Trust and asked if it was directed at a specific group. Mr Morritt replied that it was not specific but the behaviour of patients to staff and staff to staff is not where it should be and this needed tackling. Cllr Rose highlighted the Council's cross party anti racist committees and added that at each meeting new people who have just been put in charge of anti-racism in their organisation are attending and there is no continuity. Mr Morritt replied that he will get back to him on this point.

The Council referred to the conversations previously where the Board were asked to sign up to a large amount of cuts and the board effectively said no to the government on that. What was the consequence/outcome of that? Mr Morritt replied that they have signed up to it and will give the best endeavours to try to deliver the £55 million efficiency target. They have identified plans to do that and are in the middle of assessing the risks. The Trust must live within its means this year and they are working really hard to minimise any risk to service delivery. It is challenging year on year. Ms McMeekin advised that she is now a member of the City of York Anti-racism group and will be representing the organisation going forward.

The Council:

- **Received the report and noted its contents.**

25/23 Chair's Report

Mr Barkley gave an overview of his report which had previously been circulated with the agenda and highlighted the following.

- Changes to Board:
  - Mr Morritt will retire at the end of September 2025.
  - Mr Holmberg will complete his tenure on 31st May 2025
  - Mr Dillon will complete his tenure on 30 June 2025
  - Mr Morgan will step down on 31 July 2025
  - Dr Reece will become an ANED for a 12 month period from 1 July 2025
  - Mrs Grantham will become a substantive NED on 1 July 2025

- NED Reviews:
  - All reviews have been completed apart from Mrs Charge who will have her review at the end of June.

No questions were asked.

The Council:

- **Received the report and noted its contents.**

25/24 WRES & WDES Action Plans

Ms McMeekin gave an overview of the report which had previously been circulated with the agenda. With support from the Head of Equality, Diversity and Inclusion, a two-year action plan was implemented, 2023-2025, in place of annual targets, recognising that some initiatives require a longer timeframe. This report reflects progress in Year 2 of the plan, with new actions to follow in October 2025. She explained the RAG rating system to track completion, with green indicating completed actions. Some challenges remain, particularly around improving racial diversity on senior interview panels and addressing underrepresentation of ethnic diversity at the board and senior leadership levels.

It was emphasised the importance of increasing diversity to better reflect and serve both patients and staff. One challenge discussed was implementing a planned action to diversify recruitment panels for senior roles. As panel composition is not managed centrally by the recruitment team this issue is trickier to resolve. The team is seeking support from the Race Equality Staff Network to help resolve this. A second challenge was promoting vacancies more widely across multiple platforms to attract a broader range of applicants. Although financial constraints have limited this approach, close collaboration with Jobcentre Plus and other partners is ongoing to improve outreach.

The Council asked what the underlying barriers were - whether structural or self-imposed - that may be preventing greater racial diversity in senior leadership roles, despite a diverse patient and staff population. Ms McMeekin replied that it was a bit of both and that is why they decided to launch a BME leadership development programme last year in response to concerns about limited diversity in senior roles. The programme proved highly popular and was oversubscribed, with positive outcomes noted during the recent six-month post-course review—17% of participants have since secured promotions by one or two pay grades. The initiative is viewed as a key driver in boosting confidence among underrepresented groups to apply for senior positions. However, there was acknowledgment that the current application process, which relies heavily on digital platforms such as NHS Jobs, may inadvertently exclude some candidates, particularly those with limited digital access. They will explore more inclusive, flexible application methods moving forward.

The Council referred to the significant deterioration in behaviour over the last two years with the number of BAME staff experiencing unwanted behaviour and asked what ultimate power does the Trust have in its exclusion policy for people who don't behave appropriately? Ms McMeekin replied that the exclusion policy addresses inappropriate behaviour from patients towards staff—a concern that has notably increased since the pandemic. Although initially difficult to navigate, the policy now forms a key part of the organisation's "No Excuse for Abuse" campaign launched in July last year. Emphasis was placed on the importance of clinician support in redirecting patients whose behaviour is deemed unacceptable. Where patients have capacity but continue to display abusive behaviour, the policy allows for the possibility of ceasing treatment—though this is recognised as a complex clinical decision. To ensure appropriate implementation, the Medical Director played a key role in developing the policy, with treating consultants also given oversight to help navigate such cases.

The Council:

- **Received the report and noted its contents.**

25/25 Performance Report

Mr Barkley gave a summary of the report which had previously been circulated with the agenda and highlighted the following:

- **Diagnostics** – there is a significant way to go to reach the 83% standard by the end of March 2026. The new Community Diagnostics Centre opening in Scarborough should bring additional capacity and reduce the number of patients waiting for scans, etc. It is expected that the new Centre will open in the autumn.
- **Acute Flow -** April was adversely affected**,** particularly because of the outbreak of norovirus. A large number of beds were closed for a period of time.
- **Cancer –** see discussion below.
- **Referral to Treatment (RTT) -** the increase in the number of people on the waiting list is not for negative reasons, but due to transferring a couple of thousand patients from the non RTT list to the RTT waiting list.
- **Children's Scorecard –** the 52 week wait has almost been eliminated.
- **Workforce –** see discussion below.

The Council asked why there was a significant issue with diagnostics. Mr Barkley replied that it was due to capacity and demand, the lack of trained staff, and unexpected equipment failure. They are looking at the situation with their wider system partners around demand management, productivity and efficiency. Ms Hansen added that a contract has been

agreed with GPs, with some additional incentives, to undertake diagnostics within primary care and some of them will wish to take that up and others will not. This will really support the Trust with improving patient waiting times.

Referring to the 2 week Urgent Referral Pathway, a discussion took place around the telephone calls received from the hospital to patients having no caller ID. Some patients will not answer anonymous telephone calls and are therefore unaware that the hospital is trying to contact them. This causes a delay. A letter is then sent to the patient with a future date that is outside the two week timeframe. Ms Hansen replied that she would look into this as she thought the letter was sent at the same time as the telephone calls were being made. Mrs Boyd added that some patients do not want their relatives or friends to know about their health and the no caller ID gives them that confidentiality.

Regarding the waiting lists, the Council wanted assurance that these were being managed appropriately. Ms Hansen replied that there were a number of waiting lists, RTT – for patients waiting for treatment, and also other waiting lists where patients had been treated and were on other management plans. Full validation of these is ongoing as part of the preparation for moving to the new electronic patient record, and is also good governance as part of data quality checks.

The Council asked about the workforce retention rate. Ms McMeekin replied that the Trust is fairing quite well. The overall turnover rate is 8.6% which is one of the lowest in our ICS. It is monitored really closely.

The Council asked if those leavers had exit interviews to find out why they are leaving. Ms McMeekin replied that a standard exit questionnaire is provided to departing staff, which is intended to gather feedback and support ongoing improvement. While employees are encouraged to complete the form and are also offered the option of an exit interview, the current response rate is disappointingly low, hovering just below 10%. Efforts to increase participation, such as placing QR codes around the organisation for easier access, have had limited success. The team values the insights gained from this feedback, particularly when patterns emerge in relation to high staff turnover in specific teams, and agreed that further exploration of barriers to uptake is needed.

The Council:

- **Received the reports and noted their contents.**

Action: Going forward Mr Barkley will provide comparative information on performance this year with performance at the same time last year.

Action: Ms Hansen will look into the Urgent Referral process around telephone calls/letters to patients.

25/26 Bridlington Surgical Hub

Mrs Crossland gave a presentation, and it was noted that the Bridlington Hospital elective surgical hub has been accredited by the Getting It Right First Time (GIRFT) programme. This is the outcome of a rigorous assessment process culminating in a visit from the GIRFT team on 11 April. This marks a significant achievement for the Bridlington site and reflects the ongoing work and dedication of the surgical team, who performed exceptionally during the visit. The positive feedback received—both on the day and in the formal report—highlighted areas of excellence. It was emphasised that the accreditation was granted based on current activity, underscoring the strength of existing practices at the site. The Committee

formally acknowledged the team's efforts and the importance of maintaining this standard moving forward.

The Council was informed that a hub optimisation plan has been completed and will be submitted by the end of the day. This plan outlines key areas for improvement and proposed actions to support ongoing development. Progress will be monitored through a series of scheduled reviews: a three-month check-in with Professor Bryce, Chair of GIRFT, in September, followed by further evaluations at one, two, and three-year intervals. These reviews aim to ensure that the standards already achieved are maintained and that commitments made in the optimisation plan are being delivered. For Bridlington, the plan recognises the significant work already underway and offers a framework to support increased activity and operational efficiency. The importance of delivering improvements within the constraints of the current budget was emphasised.

Mrs Crossland discussed the need to improve efficiency in patient pathways across the network, ensuring that individuals—particularly those from Bridlington, Scarborough, York, and Hull—can access pre-assessment appointments locally. This aligns with the wider goal of delivering the right care in the right place at the right time through a collaborative network approach. To support this, there is a focus on increasing capacity, with an aspiration to extend surgical activity to 10-hour operating days, six days a week. Currently, Bridlington operates three 10-hour days, and expansion is needed to meet demand. A business case is being prepared to outline the associated resource requirements for this proposed development.

There are outlined plans to establish new procedure rooms at Bridlington, designed to accommodate patients who require interventions more complex than outpatient treatments but not necessitating full theatre settings. This development aims to boost capacity and ensure that patients receive care in the most appropriate environment. The overarching goal is to increase access for a broader range of specialties and ensure that specialists are matched to the right procedures in the right settings. The primary focus of the hub is on high-volume, low-complexity cases, with efforts ongoing to ensure sustainability and efficiency.

The Council heard that the strategic move to shift appropriate patients away from acute sites to cold sites—particularly those from the local community or facing long waits—is helping to improve efficiency and reduce unnecessary travel. This approach aligns with the wider transformation agenda and reflects positively on the Trust's progress. In particular, praise was given to the Bridlington team for their outstanding work in driving this forward, with personal recognition of the team's achievement and its significance to the wider Trust.

The Council queried whether there was sufficient transportation from the catchment areas to Bridlington Hospital. Mrs Crossland replied that transport is part of the optimization plans to look at and engage with a wider network within our footprint.

The Council:

- **Thanked Mrs Crossland for the presentation and noted the achievements at the Bridlington site.**

25/27 Reports from Board Committee Chairs

Quality Committee

Mrs Boyd advised that she had become Chair of the Quality Committee from Dr Holmberg who has left the Trust as he had served his tenure. She advised that during the past quarter

the committee had received updates from the CSCS Care Group, Medicine Care Group, and the. Surgery Care Group. These updates have really grown in importance as they provide the committee with a deeper insight into how care groups operate, including their successes, challenges, and risks. Members noted the value of inviting care group representatives as this strengthens collective understanding and promotes assurance on how the system functions collaboratively.

Urgent and emergency care remains a significant challenge, particularly around performance, waiting times, and the knock-on effect on planned care and patient experience.

One case was highlighted involving a patient who tragically died while under the Trust's care. This case was first identified through internal reporting mechanisms and has since undergone internal review and broader investigation. For additional assurance, the Trust commissioned an independent external review to assess how the case was managed and to surface key learning. The external report, received last month, outlined the Trust's response and identified areas for improvement and best practice, particularly in the context of complex mental health care. The findings will be used to inform wider organisational learning and ongoing improvements in patient safety. The recommendations of the external reviews have been acknowledged and understood, and a high level mental health care and treatment plan has been developed.

Governance structures in this area have been strengthened through the establishment of a newly convened Complex Needs Assurance Group, supported by relevant staff and focused on managing, delivering, and embedding the necessary training. Ongoing oversight will be provided by the Patient Safety & Clinical Effectiveness Subcommittee, which will continue to report progress and impact to the Quality Committee. Any concerns or risks related to delivery will be escalated to the Board to ensure transparency and accountability.

Concerns were raised about ongoing challenges within the dermatology service, particularly around image-based referrals which have proven effective in streamlining patient triage and care. Ms Hansen replied that approximately nine practices are currently not submitting images with referrals, and this issue is growing. Discussions are underway with the ICB to address this with primary care partners, and several options are being explored. These include enabling GPs to triage cases directly where feasible and providing training for nurses or healthcare assistants to support image capture within a 'one-stop shop' model. Funding remains a significant consideration, and if these issues are not resolved, limitations on service provision may need to be considered due to increasing demand. The matter remains under active review.

A discussion took place around the scheduling of diabetic eye screening whilst patients were attending other services and asked if this was working well. If it was, can it be extended across other areas to reduce the multi-appointments that some patients have to attend. Ms Hansen replied that anecdotally it is working well but she is yet to see evidence of this.

The Committee highlighted the improvement in ambulance handover and asked the reasons for this. Ms Hansen replied that it was due to internal processes being put in place in ED and also ED staff working with ambulance colleagues to refine the handover process. It has worked well and patients are being seen in a timelier manner.

The Committee were concerned about the issues raised in Major Trauma and asked for assurance that these are being reviewed. Ms Hansen replied that there is a plan that the trauma team are working through that is going to be presented through the Executive

Committee and to Board. There are a number of things that are being looked at in the way the patients are identified for trauma and also the way that the theatres are scheduled to enable that to be improved. The details are yet to be presented.

Resources Committee

Mrs Hazelgrave discussed the Staff Survey response draft plan recently presented by Ms McMeekin. It will result in change to make a difference. She explained that the committee will continue to actively monitor progress.

Audit Committee

Mrs McAleese briefly reflected on her final meeting as Committee Chair, noting that the focus was on wrapping up the year's work and approving plans for 2025/26. A specific point was raised regarding the audit fee of £125k – an increase of £30k on last year. This increase is comprised of two elements: the additional work associated with the revised ISA 600 on group accounts and the alignment of the fee with the market for NHS external auditors.

The Council:

- **Received the report and noted its contents.**

25/28 Governors Activities Report

Ms Abeysekera gave a summary of her report which had previously been circulated with the agenda and highlighted the following:

- **Governor Involvement in NED Appointments** - A couple of governors were actively involved in the recent NED appointment process. The NomRem Committee oversaw the selection and appointments of new NEDs, ensuring all relevant guidelines and protocols were followed.

- **Appraisal of Non-Executive Directors** – Most of the appraisals have been completed satisfactorily. One is scheduled to be completed at the end of the month.

- **New Governor Appointments** - Several new governors have recently been appointed. An induction session for new governors was successfully held in May. Buddying arrangements have been implemented for all new governors.

Mr Barkley thanked Mr Reakes for updating the Council on the Membership meeting and Constitution Review Group meeting he chairs. Mr Reakes will be leaving the Council on 30 September 2025 as his tenure will be complete. Governors were asked to put their names forward if they would like to chair any of the two groups.

No questions were asked.

The Council:

- **Received the report and noted its contents.**

25/29 Items to Note

The Council noted the following items:

- CoG Attendance Register

- NED Attendance Register

25/30 Time and Date of the next meeting

The next meeting is on Wednesday 10 September 2025 at Malton Rugby Club

Council of Governors

Action Log

BRAG ratings:		= Action is Complete
		= Action is not on Track
		= Action in jeopardy of missing due date
		= Action is on Target

Committee / Group	Ref No.	Date of Meeting	Action	Responsible Officer	Due Date	Updates
Public CoG	25/25	11.06.25	Going forward Mr Barkley will provide comparative information on performance this year with performance at the same time last year.	Mr Barkley	Sept'25	On agenda. **Action complete.**

Council of Governors

Action Log

Committee / Group	Ref No.	Date of Meeting	Action	Responsible Officer	Due Date	Updates
Public CoG	25/25	11.06.25	Ms Hansen will look into the Urgent Referral process around telephone calls/letters to patients.	Ms Hansen	Sept'25	In terms of the telephony, we have agreed to trial a proof of concept for the main outpatients telephone number. This currently has a call queue, which allows patients to wait in a queue, and it will be rebuilt on a newer platform which will give us the potential for enhanced functionality as we move forward. This is currently in procurement with the network team and we are hoping to deploy this in Autumn. If this is successful it will give us the opportunity to bring in other call queues, and importantly, other patient facing numbers into a queuing function so that patients have a better experience. Currently not all patient facing teams have a call queue and this has been difficult to provide due to the expertise and time it takes to build them in the old system, however, this cloud based platform should make this easier. We completed a re-build of the call queue for outpatient services earlier this year, to direct patients directly to Head & neck or ophthalmology, rather than sitting in our queue. This in addition with being flexible with staffing at peak periods has helped us to improve our call handling from a low of 24% in December 2024 to a high of 75% in July. We know that there is more to do, and we are continuing to focus on call handling.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 5

Report to:	Council of Governors
Date of Meeting:	10 September 2025
Subject:	Chief Executive's Report
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Simon Morritt, Chief Executive

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

Approve ☐ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

☐ 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 an update from the Chief Executive to the Council of Governors in relation to the Trust's priorities. Topics covered include: an overview of national reports and announcements, the publication of our latest Care Quality Commission report, an update on industrial action, and an update on the Trust's anti-racism statement.

Recommendation:

For the Council of Governors to note the report.

Chief Executive's Report

1. National reports and announcements

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

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

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

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

Hospital to Community:

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

Analogue to Digital:

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

Sickness to Prevention:

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

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

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

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

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

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

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

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

You can read the full report here.

1c. National Maternity and Neonatal Review

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

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

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

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

2. CQC report published

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

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

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

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

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

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

The report is available on the CQC's website.

3. Resident Doctors' Industrial Action

Resident Doctors once again participated in a period of industrial action from 25 July to 30 July, as part of the ongoing national dispute over pay.

Consultants, SAS doctors, and other clinical colleagues provided cover so that resident doctors could take part in the action if they chose to, and to enable to sustain as many of our services as possible to avoid disruption and delay for patients.

The BMA's legal mandate for strike runs out in January 2026, however at the time of writing no further dates for action have been announced.

4. Trust Anti-racism Statement

Following my update at the last Council of Governors meeting, I can confirm that the Anti-racism Steering Group has approved an Anti-racism Statement that sets out our Trust's commitment to becoming an anti-racist organisation.

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

You can read the full statement here.

5. Goodbye and thank you

Finally, as this will be my last Council of Governors' meeting as Chief Executive, I would like to say thank you to you all, and to former Governors, for your support during my time at this Trust.

The new Chief Executive Clare Smith is due to start on 24 November. I know she is keen to get started, and I'm sure you will give her your full support.

Date: 10 September 2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 6

Report to:	Council of Governors
Date of Meeting:	10 September 2025
Subject:	Chair's Report
Director Sponsor:	Martin Barkley, Chair
Author:	Martin Barkley, Chair

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

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

Trust Objectives	**Board Assurance Framework**
☐ Timely, responsive, accessible care ☐ Great place to work, learn and thrive ☐ Work together with partners ☐ Research, innovation and transformation ☐ Deliver healthcare today without compromising the health of future generations ☐ Effective governance and sound finance	☐ Quality Standards ☐ Workforce ☐ Safety Standards ☐ Financial ☐ Performance Targets ☐ DIS Service Standards ☐ Integrated Care System ☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction. This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

The council of Governors is asked to note the report.

Chair's Report to September 2025 Council of Governors meeting.

Since the previous meeting of the Council of Governors I wish to update the Council of Governors about the following:

1. A key issue for me has been leading the recruitment process for a new Chief Executive. I am delighted and relieved that the process has led to a successful outcome with the appointment of Clare Smith who will start in that role on Monday 24th November. In the meantime, she will spend 5 to 6 days in the Trust to have introductory 121s with members of the Board and other senior colleagues and attending one or two meetings as part of her induction into the Trust. I want to thank members of the Council who ratified her appointment and Staff Governors in particular who were members of one of three Focus Groups.

2. I have welcomed Noel Scanlon to his first meeting of the Trust Board. Noel was appointed to the vacancy created by Steve Holmberg's term of office ending. I also welcomed Dr Richard Reece to his first Board meeting in his capacity as an Associate NED. I have received an excellent nomination from the Vice-Chancellor of University of York for consideration/approval by the Council of Governors.

3. I have been appointed as a member of the Scarborough Neighbourhood Board and a member of the Cohesion, Health & Wellbeing, and Safety & Security Thematic Group. To date I have attended one meeting of each. I am there to primarily represent the health and wellbeing sector and provide advice and suggestions accordingly.

4. I have received a letter from NHS England advising that the "league table" of the 134 acute Trusts will be published in early September. This based on about 20 performance metrics. We already know that we will be in segment 4. We believe the league table is apportioned into quartiles.

5. I have continued to visit a variety of wards, teams and services including spending one and a half days visiting 8 of our community teams. Our community services and discussions with "partner" organisations are of particular importance as the plans to implement Neighbourhood Health Teams start to be developed in accordance with the NHS 10 Year Plan.

6. In July and August, the Members Constituency meetings were held in York and Malton respectively for the York and Hambleton, Ryedale & East Riding constituencies. The East Coast Constituency meeting takes place the day after the Council of Governors meeting. I certainly believe that having learnt the lessons from last year we have had an effective approach re the venues, start time and scheduling the meetings in British Summer time when the evenings are lighter. I therefore recommend we have a similar schedule in 2026.

Martin Barkley
Trust Chair

Forvis Mazars – External audit 2024/25

York & Scarborough Teaching Hospitals NHS Foundation Trust

Presentation to Council of Governors

10 September 2025

Our responsibilities

Our responsibilities are defined by the Local Audit and Accountability Act 2014, and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO').

What our external audit covers

- **Financial statements**
  - We give an opinion on the Trust's financial statements
- **Value for Money arrangements**
  - We are required to be satisfied the Trust has proper arrangements in place to deliver value for money in its use of resources
- **Wider reporting responsibilities**
  - We have specific powers and responsibilities as set out in the NHS Act 2006

Who we report to

Meeting	Communication
Group Audit Committee	We attend all Group Audit Committee meetings We present our annual Audit Plan, and report progress against that plan during the audit We present our audit findings to the Group Audit Committee at the completion of the audit
Trust Board	The Audit Committee uses our work to provide assurance to the Board Occasionally, we may report directly to the Board, but have not needed to do that this year
Council of Governors	Annually we issue a summary to the Governors

The scope of our work

Opinion on the financial statements

We carry out our audit in accordance with the requirements of the NAO's Code of Audit Practice and International Standards on Auditing (ISAs).

The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error.

The output from our audit work is the Audit Report containing our audit opinion, this is published alongside the Trust's financial statements in its Annual Report.

Value for money arrangements

We are required to consider whether the Trust has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources. We consider arrangements and report against the following criteria:

- **Financial sustainability** - How the Trust plans and manages its resources to ensure it can continue to deliver its services
- **Governance** - How the Trust ensures it makes informed decisions and properly manages its risks
- **Improving economy, efficiency and effectiveness** - How the Trust uses information about its costs and performance to improve the way it delivers services

We report any significant weaknesses in arrangements and provide a commentary from our VFM work in our Auditor's Annual Report.

Wider reporting

The NHS Act 2006 provides auditors with specific powers where matters come to our attention that, in our judgement, require specific reporting action to be taken. We have the power to:

- issue a report in the public interest; and
- make a referral to the regulator.

We are also required to report if the Annual Governance Statement does not comply with relevant guidance or is inconsistent with our knowledge and understanding of the Trust.

The outcome of our work in 2024/25

Opinion on the financial statements

Work complete ✓	Unqualified audit opinion

- The external audit progressed well and we completed our audit in advance of the 30th June NHS deadline for submission of audited accounts.
- We issued our audit report on 24 June 2025 giving an unqualified opinion on the Trust and Group financial statements for the year ended 31 March 2025.
- The Trust produced good quality draft accounts and supported the audit process well, fully assisting us to complete the audit in advance of the NHS submission deadline.
- We identified and reported four non-material misstatements in the draft accounts. Three of the misstatements were identified from our sample testing of expenditure transactions. One misstatement related to the year-end valuation of the Trust's Electronic Patient Records system. Management accepted the misstatements but chose not to amend the draft accounts as the misstatements were immaterial cumulatively.

- We raised two recommendations to improve the control framework for financial accounting and reporting. Both were accepted by management with actions agreed to address the weaknesses. We followed up our prior year recommendations and reported that all three recommendations had been implemented during the year.
- We have a positive and professional relationship with the Trust leadership team, the finance team, and the Group Audit Committee. The Trust engage proactively with external audit and are focused on continuously improving the closedown process.
- Although we haven't met privately with Group Audit Committee during 2024/25, we have not identified any matters to raise privately with Non-Executives without management present, and we have had access to Non-Executives should we have the need.
- We will meet privately with the Group Audit Committee before each Committee meeting in 2025/26.

The outcome of our work in 2024/25

Work on the Trust's Value for Money arrangements

Work complete ✓

- We issued our Auditor's Annual Report on 24 June 2025 incorporating our commentary on the Trust's VFM arrangements.
- The work progressed well and we had the support and assistance of Trust management in completing the work.
- In the prior year we issued one recommendation relating to the Trust's Journey to Excellence programme. Our work this year confirmed the recommendation had been implemented and we reported the updated position in our Auditor's Annual Report, confirming the prior year weakness had been addressed.

The weakness reported in 2023/24 has been addressed

One new significant weakness reported in 2024/25

- We reported one new weakness and raised a recommendation relating to the Trust's arrangements to achieve financial sustainability.
- While the Trust achieved a small surplus in 2024/25 this was after receiving significant non-recurrent funding. In addition, the Trust had a very challenging efficiencies target for 2024/25, and although it delivered the highest level of efficiencies it has achieved, the achievement was significantly below the required target level.
- We will follow up this work in 2025/26 and will consider the further progress the Trust has made in its arrangements as the funding and cost position evolves through 2025/26.

Wider reporting

Work complete ✓

- We have not exercised our additional reporting powers during 2024/25.

No reporting required

- We reported no issues over the form and content of the Trust's Annual Governance Statement.

Contact

Forvis Mazars

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Report to:	Council of Governors
Date of Meeting:	10 September 2025
Subject:	Performance Report
Director Sponsor:	Martin Barkley, Chair
Author:	Martin Barkley, Chair

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

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

Trust Objectives

- ☒ Timely, responsive, accessible care
- ☐ Great place to work, learn and thrive
- ☐ Work together with partners
- ☐ Research, innovation and transformation
- ☒ Deliver healthcare today without compromising the health of future generations
- ☐ Effective governance and sound finance

Board Assurance Framework

- ☒ Quality Standards
- ☒ Workforce
- ☒ Safety Standards
- ☐ Financial
- ☒ Performance Targets
- ☐ DIS Service Standards
- ☐ Integrated Care System
- ☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction. This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

The Council of Governors is asked to note the current positions.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Performance Report key metrics

September 2025 Council of Governors meeting

Diagnostic 6week standard

York and Scarborough Teaching Hospitals NHS Foundation Trust

- In June achieved 64% against a standard of 83% compared to 63.7% in same month last year.
- 14 types of diagnostic work are in the statistics with levels of attainment ranging from 51% re Urodynamics, to 97% for neurophysiology. Urodynamics is a 21% improvement since my last report to CoG.

Acute Flow

York and Scarborough Teaching Hospitals NHS Foundation Trust

- Number of 12+ hour trolley waits in June was 377 compared to 628 in April and compared to 557 in same month last year.
- Proportion of ambulance handovers waiting more than 45 minutes which was 5.8% in June – an improvement of 11% since April and compares to in excess of 26.3% in same month last year – when the metric was 60minutes not 45 minutes.
- Proportion of patients seen and treated in ED waiting less than 4 hours was 69.4% in June was 6% better than April and compares to 67.3% for same month last year.
- Lost bed days for patients with no criteria to reside was 1174 compared to 942 in same month last year.

Cancer

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- Proportion of patients who had their first treatment within 62 days was 66.3% in May a reduction of 4% since March and compares to 71.8% for same month last year and a year end target of 75%. We are 102nd out of 145 providers.
- Cancer faster diagnosis standard was 67.9% in May, a reduction of 2.7% since March, and compares to 70.5% in same month last year and against a year end standard of 80.1%. We are 128th out of 137 providers.

Referral to Treatment (RTT)

York and Scarborough Teaching Hospitals NHS Foundation Trust

- Number of people waiting is 53,707, which is 7,000 more than trajectory. This is mainly due to transferring patients from the Non-RTT list to the RTT list following a data quality check. However there is recent evidence of an increasing number of GP referrals. The number people waiting in same month last year was 45,565
- 15 patients waiting more than 65 weeks, against a target of zero and compared to 132 for same month last year.
- 1,593 in June waiting more than 52 weeks, an increase of 250 since April and compares to 1,539 in same month last year, and a year end target of 389.
- The mean waiting time for incomplete pathways is 17.6 weeks, compared to 18.8 weeks for same month last year.

Children scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

- 81 children waiting over 52 weeks in June an increase of 49 since April and compares to 37 for the same month last year and against a target of zero.
- Proportion seen within 18 weeks in June was 64.8% compared to 84% for same month last year.
- On the non RTT list the number of children waiting more than 52 weeks in June is 695 compared to 2,052 for same month last year.

Workforce

York and Scarborough Teaching Hospitals NHS Foundation Trust

- In June staff sick leave rate was 4.8% compared to same in June last year with a year to date rate of 4.9%.
- Rolling 12 month staff turnover rate is 8.3% in June which compares to 8.5% in June last year, better than plan of 10%.
- Overall vacancy rate of 6.5% In June compared to 7.1% same month last year.
- 9.4% HCSW vacancy rate in adult in-patient wards in June compared to 7.6% same month last year.
- RN vacancy rate 6.6% in June compared to 6.1% same month last year.
- Midwifery recruitment: aim to get to Birth within two years subject to recruitment & retention with a backstop of 3 years
- Medical & Dental vacancies 7.4% in June compared to 7.6% same month last year.

Patient experience

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- The number of complaints received in June was 91 compared to 78 in June last year.

Finance

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- £3million adverse against our plan after 3 months.

Report to:	Council of Governors
Date of Meeting:	September 2025
Subject:	CQC Update
Director Sponsor:	Dawn Parkes, Chief Nurse Adele Coulthard, Director of Quality, Improvement and Patient Safety
Author:	Emma Shippey, Head of Compliance and Assurance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The CQC inspection report for York Hospital Urgent and Emergency Care and Medical Care services was published on 2 July 2025. The Trust was required to respond to the six identified breaches in regulation in the form of an improvement response. The improvement responses were submitted to the CQC on 22 July 2025 and approved on 1 August 2025

An application to remove the conditions on the Trust registration for maternity services is in progress and scheduled to be presented to the Maternity Assurance Group and the Executive Committee. CQC colleagues were invited to visit the new Urgent and Emergency Care Centre and Maternity Services at Scarborough Hospital in July 2025. The monthly engagement meetings between the Trust and the CQC continue.
Recommendation: For the Council of Governors to note the current position in relation to CQC inspection activity and ongoing engagement.

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

CQC Update

1. CQC Unannounced Inspection Activity

Inspectors from the CQC visited the York Hospital site on 14 and 15 January 2025. Two teams were onsite who undertook:

- An unannounced inspection of the Urgent and Emergency care pathway to review the rating received following the last inspection in 2022.
- An unannounced inspection of the Medical Care Services to again review the Trust rating. This was done as part of the new CQC Systems Pathway Pressures inspection process.

The CQC inspection report for York Hospital Urgent and Emergency Care and Medical Care services was published on 2 July 2025. The report can be accessed here.

The Trust was required to respond to the six identified breaches in regulation in the form of an improvement response. The two improvement responses (one for Urgent and Emergency Care and one for Medical Care) were approved at the Journey to Excellence meeting on 14 July 2025 and the Executive Committee on 16 July 2025. The improvement responses were submitted to the CQC on 22 July 2025.

The CQC approved the improvement responses on 1 August 2025.

The CQC have asked for quarterly updates on progress with actions to be provided, the first of which will be due by 31 October 2025. A standing agenda item will also be added to the monthly engagement meetings the next of which is 23 September 2025 (gap in August due to leave).

Alongside the six identified breaches in regulation which the Trust must respond to, Trustwide learning themes from the report are being identified are shared.

Maternity Services Section 31

The application to remove the conditions of registration on the Trust licence for maternity services is in progress. The application is due to be presented to the Maternity Assurance Group and the Trust Executive Committee.

Mental Health Needs in the Emergency Department Section 31

The Trust has introduced an electronic mental health risk assessment which is used in the York and Scarborough Hospital Emergency Departments. Quantitative data on its utilisation is available on the Signal Business Intelligence dashboard. Improvement actions in relation to the Trust pathway for the care of patients with mental health needs in our Emergency Departments are being overseen through the Trust Complex Need Assurance Group. The improvement actions have been shared with the CQC and updates on progress provided through the monthly engagement meetings.

2. Informal Scheduled Visits by the CQC

The CQC were invited to visit Scarborough Hospital site to tour the new Urgent and Emergency Care Centre (UECC) and Maternity Services on 8 July 2025. The enthusiasm displayed by staff from both services was praised, as was the progress made in aligning pathways across the York and Scarborough sites.

The improvements to the UECC environment were positively received, but the estate challenges within the older Scarborough Maternity Unit were also noted.

At the time of writing this report, there are no further visits planned.

3. CQC Engagement Meetings

Monthly engagement meetings are held between the Trust and the CQC. The agenda is varied and focusses on emerging issues or concerns. The Trust will also request items to be added onto the agenda. As an example, in August 2025, an update on the Pressure Related Skin Damage Thematic Review and the introduction of the Quality Governance Framework and the Ward Accreditation Scheme was provided.

4. Journey to Excellence Group

.

The next meeting of the Journey to Excellence Group is scheduled for 8 September 2025. The inaugural update on the improvement actions from the January 2025 inspection will be provided. This will inform the update provided at the monthly CQC engagement meeting on 23 September.

5. 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.

Between 1 August 2024 and 31 July 2025, the Trust has received 54 cases from the CQC. For each case, a learning response is drafted with supporting evidence provided if needed, for example ward audit results from Tendable. The Trust triangulates all CQC cases to patient safety incidents and complaint learning responses.

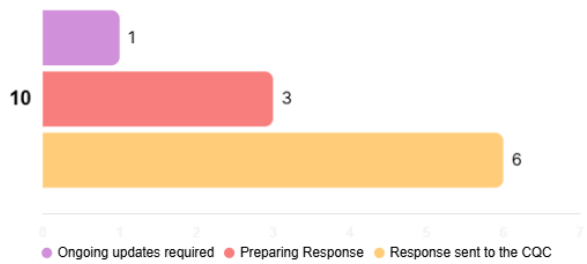
The CQC review the patient safety incidents reported in Datix by Trust staff through the Learning from Patient Safety Events (LFPSE) system. Included in the 54 cases referenced above are 25 trust reported patient safety incidents.

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

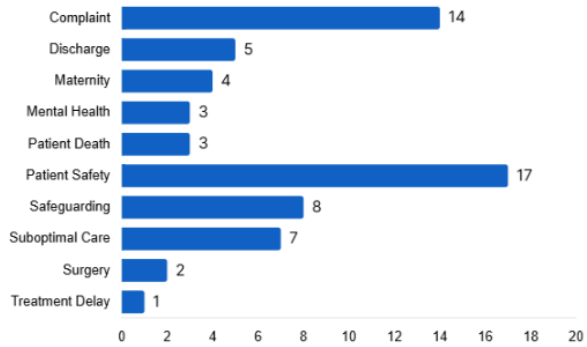
Date: 28 August 2025

Appendix A

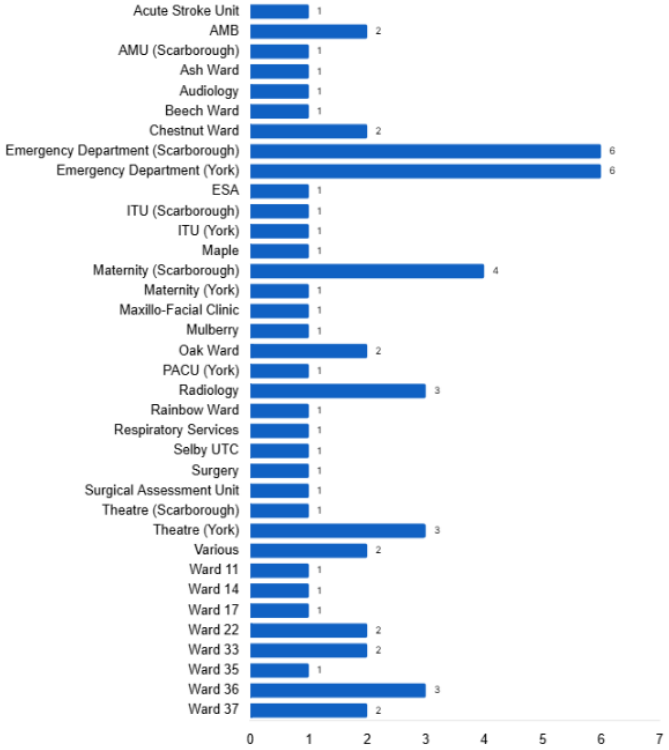
Number of Open CQC Enquiries / Cases



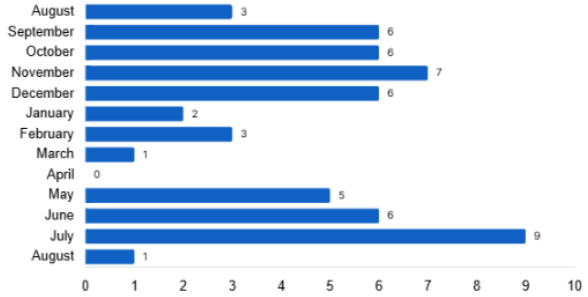
Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Number of Enquiries Received



Report to:	Council of Governors
Date of Meeting:	10 September 2025
Subject:	Infection Prevention and Control Annual Report (1st April 2024 to 31st March 2025)
Director Sponsor:	Dawn Parkes, Chief Nurse/Director Infection Prevention and Control
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Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:
This annual report for 2024-25 highlights the Trust performance against the national Healthcare Associated Infection (HCAI) objectives and the high-level actions that are being taken to reduce incidence of avoidable infection.

The Trust has exceeded the annual objectives for all nationally set Healthcare Associated Infections (HCAI's), apart from Klebsiella Bacteraemia.

The governance of Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS) has been strengthened by the introduction of Care Group IPC/AMS monthly meetings, which are becoming established and developing improvement action plans.

Recommendation:
The Council is asked to note the trust performance with regards to HCAIs and acknowledge the actions being taken to reduce the incidence of avoidable HCAI's.

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

Meeting/Engagement	Date	Outcome/Recommendation
Patient Safety and Clinical Effectiveness	11/06/2025	Approved
Infection Prevention Strategic Assurance Group	05/06/2025	Noted
Quality Committee	17/06/25	Noted

Infection Prevention and Control Annual Report 2024-25

1. Introduction and Background

The Health and Social Care Act 2008: code of practice on the prevention and control of infections (Department of Health 2015) stipulates the importance of the Director of Infection Prevention and Control (DIPC) reporting regularly to the Board of Directors. This includes an annual written report summarising key Infection Prevention and Control (IPC) issues and progress against agreed improvements.

This annual report for 2024-25 highlights the Trust performance against the national Healthcare Associated Infection (HCAI) objectives and the high-level actions that are being taken to reduce incidence of avoidable infection. HCAI annual objectives run 1st April to 31st March and focus on reducing CDI and gram-negative blood stream infections. There is a requirement for the Trust to deliver a 5% reduction from the 2023/24 output. The document detailing the HCAI objectives can be accessed via this link. Whilst *Staphylococcus aureus* bacteraemia is not detailed with the NHS Contract document, the Trust have continued to focus on their reduction and monitor them against a 5% reducing target.

This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving patient safety and the quality of patient experience as well as striving to reduce the risk of infections.

2. The Infection Prevention and Control Team (IPC Team)

The IPC team have provided a dynamic service over 2024/25. Operational pressures over winter due to high levels of respiratory viruses and Norovirus with associated bed/ward closes required the IPC team to adjust their service provision. They provided additional weekend cover from December 2024 to March 2025 to review closed beds and support the site team to undertake risk assessments and risk mitigation of patient placement.

The Head of IPC post has been vacant since January 2024. There have been 3 unsuccessful recruitment attempts and discussions are on-going with the Chief Nurse regarding further recruitment.

There are no other vacancies within the team.

2.1 Infection Prevention and Control Governance

The Infection Prevention Strategic Assurance Group (IPSAG) meets monthly and reports to the Patient Safety and Clinical Effectiveness Sub-Committee (PSCE); the DIPC and Deputy DIPC are members of the PSCE.

Monthly Care Group IPC and Antimicrobial Stewardship (AMS) groups were commenced in quarter 2 . These are a formal sub-group of the Care Groups Governance and Management Boards. The focus has been to develop and deliver Care Group specific HCAI/AMS improvement plans.

The NHS England IPC Board Assurance Framework (BAF) was refreshed in October 2024, and we expect a new version of this to be issued by NHS England in Q1 2025/26 which will be completed, and progress overseen by IPSAG.

3. Current Position/Issues

3.1 Clostridioides Difficile Infection (CDI) Performance:

The Trust attributed annual objective for 2024/25 was set by NHS England at 144 cases. This includes community-onset healthcare-associated (COHA) and healthcare-onset healthcare-associated (HOHA) cases in patients aged over 2 years. Definition of a COHA case is the specimen is taken in community or by day two following admission, but patient has been discharged from the Trust within previous 28 days. These cases are attributed to the ward that the patient was previously discharged from.

The Trust ended the year with 155 Trust attributed cases; COHA=58; HOHA=97. The objective was exceeded by 11 cases. It is worth noting that the attribution criteria changed this year to include virtual wards and counting admission date from the decision to admit date in the Emergency Department, if we excluded the cases that met the new criteria, we would have ended the year 5 cases above trajectory but 1 case less than 2023/24.

Of the 155 Trust attributed cases this year, 84 (54%) are attributed to the York Hospital, 56 (36%) are attributed to Scarborough and Bridlington Hospitals, and 15 (10%) are attributed to Community In-patient Units.

In 2023/24 Scarborough and Bridlington Hospitals accounted for 59% of the CDI cases and the reduction of incidence in 2024-25 can be directly related to the improvement work on Cherry and Chestnut wards which commenced in November 2023 and has been sustained throughout this reporting period as demonstrated in Table 1.

Table 1: Clostridioides difficile rates per 100,000 bed days and cases 2023/24 vs 2024/25

CDI Toxin positive	April -October 2023 Rates per 100,000 bed days			Total Number cases 2023/24	April -September 2024 Rates per 100,000 bed days			Total number of cases 2024/25
Ward	Bed Days	Cases	Rate		Bed Days	Cases	Rate	
Cherry	5471	9	164.50	19	3209	2	62.32 ↓	6 ↓
Chestnut	5231	9	172.05	12	3022	2	66.18 ↓	5 ↓

High operational pressures have placed an additional strain on both the workforce and isolation capacity across the Trust which has implications on patient placement, timely and effective environmental decontamination and fundamental infection prevention and control (IPC) practice. Limited side room capacity results in delayed isolation of patients with diarrhoea thereby increasing the risk of environmental contamination. Competing priorities for side rooms during winter is made worse due to respiratory viruses that also require isolation. The Transmission Based Precautions guidance was updated within this reporting period and is available to all the staff on the Trust intranet to aid with prioritisation of side rooms. As part of the Trust resizing work additional side room capacity has been identified to move back to patient availability and the enabling work is currently on-going.

Within Appendix1, Figure 1 demonstrates the monthly Trust attributed case against trajectory. Figure 2 shows the annual CDI rates per 100,000 bed days for the trust versus the average of other Trusts. Figure 3 provides a comparison of annual cumulative CDI cases from the four years 2021/22 to 2024/25 which highlights that the CDI case rate has

been relatively static over the last four years. Figure 4 shows the Cumulative Trust attributed Clostridioides difficile by area from April 2024 with Ward 36 having the most cases (12), predominately in Q3 and no cases since February 2025, followed by Lilac ward at 8 cases.

All Trust attributed cases require a Patient Safety Incident Response Framework (PSIRF) review. Of the 155 cases, 140 (90%) have received a PSIRF review. The main learning points identified are hand hygiene compliance, antimicrobial prescribing (suitability/course length) and timeliness of stool sampling. Improvement actions are being re-iterated with all the care groups via the IPC/ IPC/AMS meetings.

Actions taken within 2024/25 to reduce the incidence of CDI have included:

- The IPC team have continued to undertake fundamental practice audits which currently include CDI control measures compliance, hand hygiene compliance, commode, and bedpan cleanliness. Where areas do not meet the compliance standards, face to face education is provided and follow up audits conducted. There is a process embedded for escalations should timely improvements not occur which includes the review of data within the care group IPC/AMS monthly meetings. The audit data can be seen in Section 5, table 2, further improvement work will be delivered in 2025/26.
- Face to face training in ward areas is delivered whenever gaps in audit compliance are identified. Compliance is monitored via the care group IPC/AMS meetings with escalation to IPSAG.
- Additional education and support have been provided to ward 36 during Q3 & Q4 in response to the increased number of CDI cases. The ward responded well and there have been no further cases since February 2025.
- Additional education regarding sampling and CDI management has been provided to Lilac Ward, which has the second highest number of cases in the Trust (8 since April 2024). This is an admissions ward, so the recognition of symptoms and collection of a sample at the earliest opportunity is important to identify cases that started in the community. A revised stool sampling and isolation flowchart poster has been produced and circulated.
- Cherry and Chestnut Ward continue to be supported by the IPC team to maintain their CDI control.
- The Trust did not achieve the proactive Hydrogen Peroxide Vapour (HPV) decontamination programme within this year for all inpatient areas due to the lack of decant facilities across both main sites, however we have whenever possible deployed deep cleaning/HPV during ward moves during refurbishments or capital builds. The requests for reactive deployments of HPV or Ultra-Violet (UV) following cases of infection have been monitored throughout the year and when operational pressures have meant one of these options was not able to be deployed, a risk assessment is undertaken by the IPC team and Site co-ordinators and a suitable alternative manual decontamination undertaken. These are recorded by the Domestic Services Team and HPV or UV deployed as soon as the bedspace becomes available.
- Clear the clutter days have been held on both sites during October 2024 to support ward and department cleanliness.

Methicillin sensitive Staphylococcus aureus (MSSA) & Methicillin resistant Staphylococcus aureus (MRSA) Bacteraemia:

There were 5 Trust attributed MRSA bacteraemia for 2024/25 against a zero-tolerance objective, a deterioration from the annual position of 2023/24 of 4 cases. The wards with a case of MRSA bacteraemia attributed to them are highlighted in Appendix 1, Figure 5. All 5 cases were attributed to the Medicine care group and have undergone a multidisciplinary clinical team post infection review (PIR).The lessons and actions identified in each case are being enacted via the care group and where appropriate wider Trust actions are being supported by the IPC team. These lessons and improvement actions include:

- Access to suppression treatment which has been resolved following revision of IPC guidelines.
- Community management of MRSA which has been escalated to the ICB IPC team.
- Lack of skin checks
- Cannula documentation which is being addressed via improvements to the Trust wide Visual Infusion Phlebitis scoring and documentation on Nucleus.

There has been a total of 92 Trust attributed cases of MSSA bacteraemia for 2024/25 against an agreed internal target of 82 cases. Of the 92 cases; COHA =34; HOHA = 58 with 66 cases (72%) attributed to York Hospital, 24 cases (26%) attributed to Scarborough hospital and 2 cases (2%) being attributed to the community sites, which is similar to the previous year.

The 2024/25 incidence shows slight deterioration from the previous years where 87 Trust attributed cases were recorded. Appendix 1 Figure 6 demonstrates the monthly Trust attributed cases against trajectory and Figure 7 shows the annual MSSA bacteraemia rates per 100,000 bed days for the Trust versus the average of other Trusts. Figure 8 provides a comparison of annual cumulative CDI cases from the four years 2021/22 to 2024/25 which highlights that the MSSA bacteraemia rate has been increasing over the last four years despite efforts to reduce the bacteraemia rates.

Appendix 1, figure 9 shows the cumulative rate per ward area, with ward 36 and Haematology/Oncology having the highest number of cases, 6 each since April 2024. The cases associated with Haematology/Oncology have been investigated by the care group using a PSIRF approach and an MSSA improvement action plan has been implemented. The cases associated with ward 36 learning themes have been included within the quality improvement work that has been undertaken on this ward in Q3 & Q4.

Actions taken within 2024/25 to reduce the incidence of MRSA/MSSA bacteraemia have included:

- An Internal Audit report regarding cannula management was published in March 2024. The report identified 1 major and 6 moderate recommendations. An action plan was developed and approved by IPSAG. Evidence for closure of all recommendations were submitted to the Internal Audit team and the action plan was closed in October 2024. We continue to monitor compliance with the required improvements.
- Visual infusion phlebitis (VIP) scores are now included within nucleus with a requirement for twice daily documentation. Compliance is being driven to improve by the care groups IPC/AMS meeting.
- All cases are now recorded on Datix, and the care groups are leading the investigation of these with IPC support.
- A standard operating procedure has been drafted for MSSA case reviews and details the governance route for these cases and is due to be presented to the care groups and IPSAG for approval and implementation.

Gram Negative Bacteraemia (GNBSI)

Escherichia coli (E. coli) bacteraemia:

There has been a total of 196 Trust attributed cases of E.coli bacteraemia for 2024/25 against an objective of 170 cases. Of the 196 cases; COHA =115; HOHA = 81 with 121 cases (62%) attributed to York Hospital, 65 cases (33%) attributed to Scarborough hospital and 10 cases (5%) being attributed to the community sites.

The 2024/25 incidence shows deterioration from the previous years where 174 Trust attributed cases were recorded. Appendix 1 Figure 10 demonstrates the monthly Trust attributed cases against trajectory and Figure 11 shows the annual E.coli bacteraemia rates per 100,000 bed days for the Trust versus the average of other Trusts. Figure 12 provides a comparison of annual cumulative E.coli cases from the four years 2021/22 to 2024/25 which highlights that the E.coli bacteraemia rate has been increasing over the last four years.

Ward 35 at York Hospital and Maple ward at Scarborough has the highest cumulative number of cases with 9 attributed to each of them, as demonstrated in Appendix 1, Figure 13.

Klebsiella bacteraemia:
There has been a total of 46 Trust attributed cases in 2024/25 against an objective of 65. The Trust is 19 cases **under** the annual objective. Of the 46 cases; COHA =31; HOHA = 15 with 31 cases (67%) attributed to York Hospital, 12 cases (26%) attributed to Scarborough hospital and 3 cases (7%) being attributed to the community sites.

Appendix 1, Figure 14 provides a comparison of annual cumulative Klebsiella cases from the four years 2021/22 to 2024/25 which highlights that the Klebsiella bacteraemia rate is the lowest it has been in the last four years.

Ward 14 at York Hospital has the highest cumulative number of cases with 4 attributed to them, as demonstrated in Appendix 1, Figure 15

Pseudomonas bacteraemia:
There has been a total of 26 Trust attributed cases in 2024/24 against an objective of 16 cases. Of the 26 cases; 16=COHA; 10=HOHA with 17 cases (65%) attributed to York Hospital, 8 cases (31%) attributed to Scarborough hospital and 1 case (4%) being attributed to the community sites.

Appendix 1, Figure 16 provides a comparison of annual cumulative Pseudomonas bacteraemia cases from the four years 2021/22 to 2024/25 which highlights that the Pseudomonas bacteraemia rate is the higher than 2023/4 but lower than 2021/22 and 2022/23.

Ward 28 at York Hospital has the highest cumulative number of cases with 3 attributed to them, as demonstrated in Appendix 1 Figure 17.

Actions taken within 2024/25 to reduce the incidence of GNBSI bacteraemia have included:

- The Deputy DIPC attended an NHS England North East and Yorkshire regional workshop on the reduction of Klebsiella bacteremia on the 5th of March 2025. Key learning points will be included within improvement plans for 2025/26.
- Humber and North Yorkshire ICB will be hosting a workshop on reducing GNBSI in May 2025 and the Trust will be actively participating in this with representatives from each care group, corporate nursing team and the IPC team attending.
- Dr Mawer, IPC Doctor, has reviewed a selection of the Pseudomonas bacteraemia cases and has not identified linked cases or common themes.

4. IPC Training

The IPC team continue to deliver IPC training with face-to-face training in classroom settings and clinical areas in both a reactive manner to observed practice during ward and department visits and proactively, such as the response to the high levels of respiratory viruses over the winter and preparedness to respond to emerging infections. The IPC team has continued the intensified clinical education on back to basics, including planned educational sessions for all staff groups throughout the year.

The team have provided new Healthcare Assistant training within the academy at Holgate York and are now supporting the registered staff training. This is an excellent opportunity to deliver scenario based training and practical application of fundamentals of IPC.

The mandatory IPC training Trust compliance has remained static over the year and is recorded as core level 1 at 90% and core level 2 at 83% (against a target of 95%), see appendix 1, Figure 18. Care Groups are aware of compliance rates via the IPC dashboards and are being asked to drive improvement.

A focus on Aseptic Non-Touch Technique (ANTT) training continues as a key element on reducing bacteraemia rates. Compliance has remained static with the ANTT theory recorded at 88% whilst the practical compliance has risen slightly to 81%, as shown in Appendix 1, Figure 18. Care Groups are aware of compliance rates via the IPC dashboards and are being asked to drive improvement via the IPC/AMS meetings. The IPC team are collaborating with the Clinical educators to promote ANTT, invasive device management, including VIP scoring, “scrub the hub” and removal when no longer required.

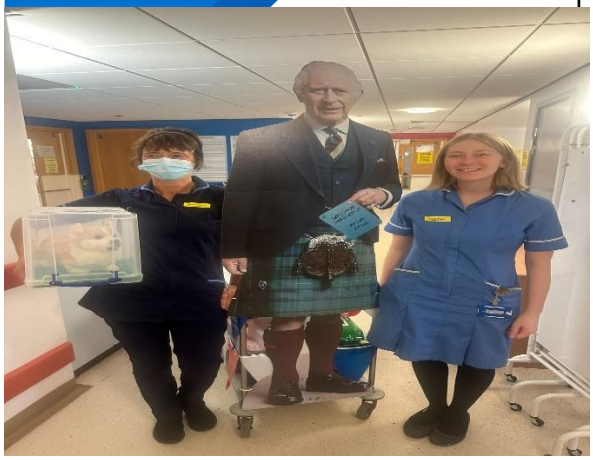
High Impact Actions

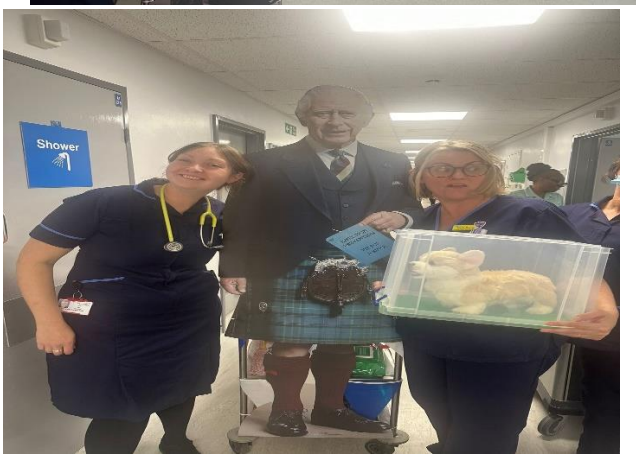
September and October 2024 have been the Chief Nurse Year of Quality months for IPC. The team have co-ordinated several events over the 2 months which have focused on the embedding of **high impact actions**:

1. Bare below the elbow and effective hand hygiene
2. Appropriate use of Personal Protective Equipment (PPE)

3. When to take stool samples
4. Decluttering the clinical areas, including linen management
5. Effective aseptic non-touch technique.

The team have used innovative approaches including ward walk rounds with visual aids, fun quizzes, conversation points, campaigns, awareness sessions, new information posters and prompt cards and de-clutter days.





Hand hygiene wordsearches were given to patients (who were able to participate) to raise their awareness of hand hygiene.

As part of the IPC months of quality 19 Healthcare Assistants have successfully undergone NHS England leadership in IPC education in this quarter. These staff are all IPC champions within the clinical areas and will be supporting the IPC team to drive improvements in practice.

Whilst the impact of this concentrated effort is slow, we have seen more engagement with the IPC team and positive feedback from clinical areas. Outcomes from available audit metrics are included in section 5, table 2.

5. IPC Audits

Audit information on Hand Hygiene, Symbiotix Cleaning Scores, bedpan and commode cleanliness and CDI practice compliance is available in the care group dashboards located via this link Care Group Dashboards. Key points of note are listed in table 2 which shows that compliance of 95% has not been reached for the CDI audit but there has been some improvement, hand hygiene compliance remains static, however improvements are being seen in commode and bedpan cleanliness compliance.

Hand hygiene audits were re-introduced onto Tendable in November 2024 but completion of these is not yet consistent, therefore the data included for information is the IPC team

compliance audits, reminders to complete weekly ward/department hand hygiene audits have been sent out to all areas.

Table 2 IPC Audit points of note – 95% or above is required for compliance, figures in brackets are 2023/24 % compliance

Audit	Medicine Care Group Average compliance	Surgery Care group Average compliance	Family Health Care Group Average compliance	CSCS Average compliance	Trust Average
CDI, Saving lives bundle	91% (87%)	86% (87%)	85% (91%)	94% (88%)	89% (86%)
Hand Hygiene **	89% (87%)	89% (87%)	90% (91%)	96% (83%)	91% (87%)
Commode cleanliness	90% (75%)	90% (72%)	98% (84%)	100% (83%)	95% (77%)
Bedpan cleanliness	98% (95%)	99% (95%)	98% (958%)	100% (100%)	99% (95%)

**Hand hygiene audits using IPC audit data not ward/department data.

6. Orthopaedic Surgical Site Infections (SSI)

The Trust continues to work on reducing the incidence of orthopaedic SSI in the past year. Appendix 2 details the Trust incidence versus the national incidence rate. The Trust is above the infection rate for total knee replacement in York but below the national infection rate for the other interventions and sites.

Post infection review meetings have been taking place within the Care Group with support from the IPC team; with lessons learnt being acted upon by the care group.

7. Outbreaks: Respiratory Virus Infection (RVI) and Norovirus

The RVI guideline, RVI screening guideline, the management plan for RVI in winter and RVI risk assessment and decision log were approved and published in December 2024. These documents detail patient screening and placement within the organisation, including the escalation to opening RVI cohort areas and de-escalation process, alongside a risk assessment and decision log to inform decisions regarding patient movement during operational pressures.

The Trust saw significant numbers of patients with RVI requiring admission to hospital this winter. The RVI incidence has followed the national pattern which has been higher than recent years and has caused significant operational pressures. This led to the activation of phase 3 of the RVI management plan in winter with ward 29 at York and Lilac ward at Scarborough being used as RVI cohort wards.

The Trust has also been affected by Norovirus throughout 2024/25 which has resulted in bay and ward closures across the Trust. Most significantly were the outbreaks over December 2024 and January 2025 which included 5 wards at York Hospital and 3 wards at Scarborough Hospital. The outbreaks were all managed within the Trust guidelines and wards/beds were cleaned and re-opened as soon as safe to do so.

8. Antimicrobial Stewardship (AMS)

The AMS team continues to work to optimise the use of antimicrobials at the Trust, to improve patient outcomes, safety and reduce risk of antimicrobial resistance (AMR). Section 8.1b summarises the Trust position regarding outcome measures of the Trust's AMS strategy (2024/25) and human health targets of the UK AMR National Action Plan (NAP) 2024-29. These measures are discussed in sections 8.1c-f. More granular data is available and reported via newly established lines of communication with the Care Groups (refer 8.1a for details).

8.1a Care Group IPC/AMS Meetings

The IPC/AMS Care Group (CG) meetings were launched in 2024 Q2. Each CG has a nominated AMS pharmacist, AMS pharmacy technician and microbiologist. The pharmacy team provide a monthly AMS dashboard bespoke for the CG and facilitate both discussion and actions under the expert guidance of the microbiologists. The dashboards include:

- Safety data: Datix reports relating to antimicrobials for the CG on a rolling 3-monthly basis.
- Guideline assurance: status of antimicrobial guidelines for which the CG is responsible.
- Quality data: AMS ward round data including specific for the CG, recommendation type and uptake by ward.
- NAP 2024-29 measures: comparison of watch and reserve antimicrobial use across CGs and top 10 for the CG, with quarterly trends reported over a rolling 12-month period.

The CG meetings provide more robust lines of communication between the CGs, IPSAG and AMS Team meetings (AST) with the aim of delivering measurable improvements in practice and patient outcomes.

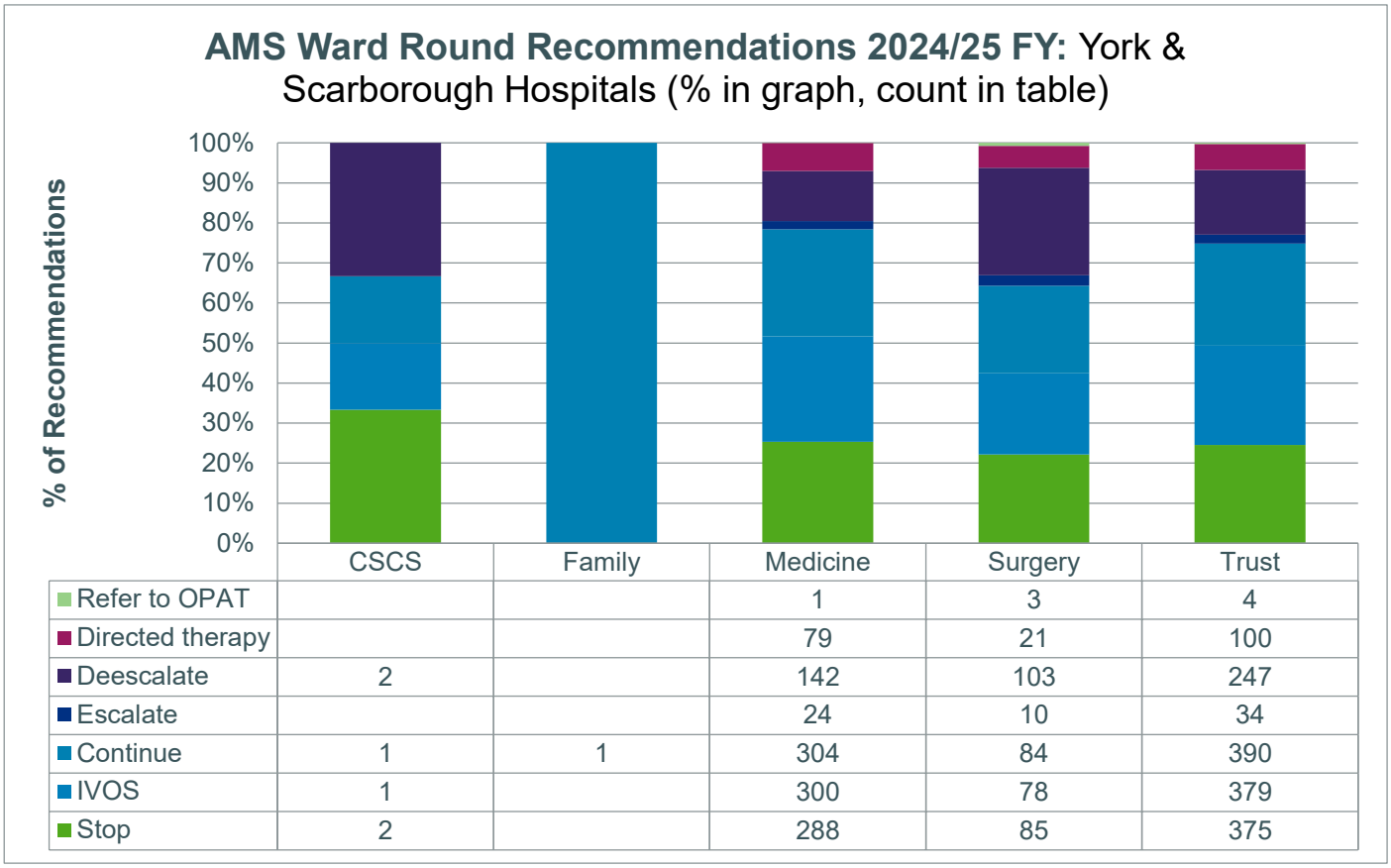
8.1b Trust Position 2024/25

Measure	Target	Y&H Region	Trust Baseline	Trust 2024/25	Medicine 2024/25	Surgery 2024/25	Family 2024/25	CSCS 2024/25
No. of AMS reviews 2024/25[1]	≥ 1202	No data	2023/24: 1202	1529 (↑)	1138	384	1	6
% of AMS reviews suggest IVOS[1,2]	< 15%	No data	26%	25% (↓)	26%	20%	<0.5%	17%
Uptake of AMS ward round recommendations < 24h	> 80%	No data	2023/24 Q3&4: 77%	80% (↑)	82%	74%	N/A	100%
% of antimicrobials are IV (DDDs)[3]	No data	22.2%	2023/24: 26.5%	24.5% (↓)	No data	No data	No data	No data
NAP 4a: Total antimicrobial consumption[3]	5% ↓ from 2019	6.9% growth	N/A	5.1% growth (↑)	No data	No data	No data	No data
NAP 4b: % of Abx are from Access category (DDDs)[3]	≥ 70%	55%	2023/24: 65%[4]	65% (-)	60%	70%	76%	66%
AMS Team meeting quoracy	100%	N/A	2023/24: 20%	14% (↓)	14%	43%	0%	0%

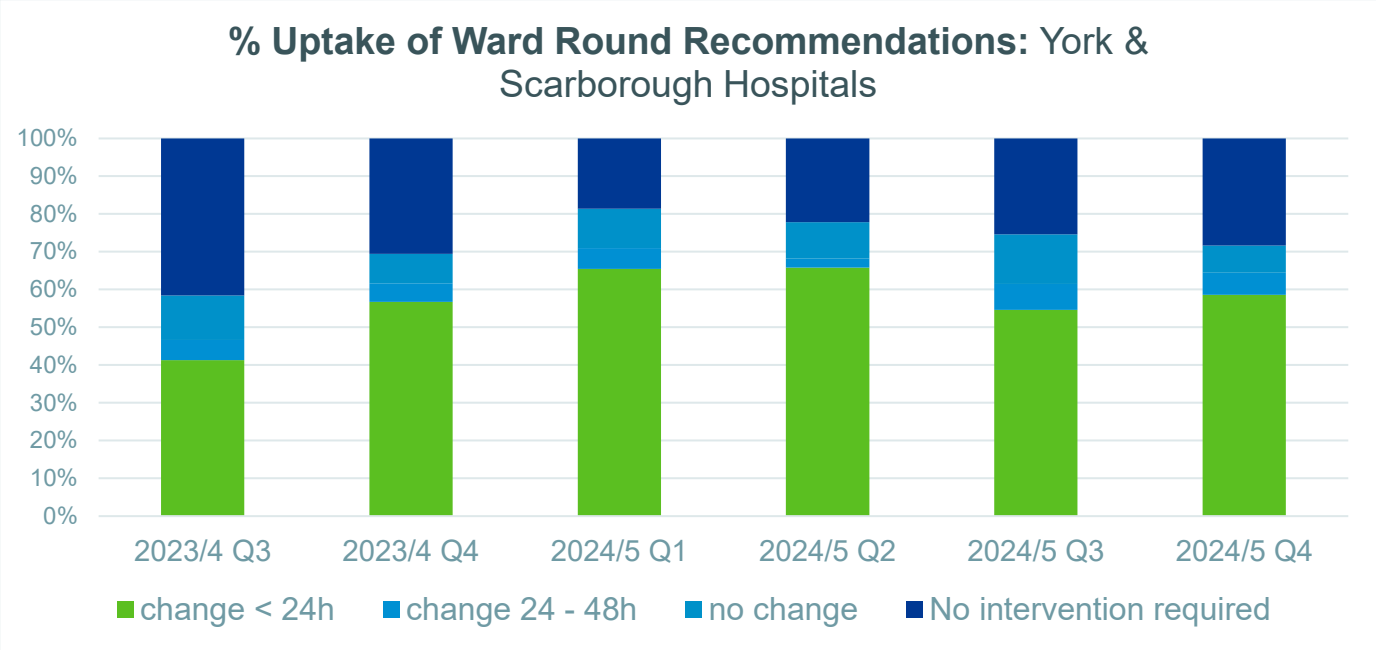
[1]Y&S AMS team data [2]IV to Oral Switch [3]Rxinfo data
[4]AWaRe categories were updated in 2025, baseline data relates to 2020 AWaRe categories, most significant change being cefalexin moving to access category.

8.1c Direct patient reviews (AMS ward rounds)

The AMS team conduct twice weekly ward rounds on both York and Scarborough sites, focusing on broad spectrum antimicrobials prescribed for greater than 48h. The number of reviews performed has continued to increase, though has plateaued due to competing factors on ward rounds and workforce capacity. The AMS team have adapted to support areas of variance, such as wards with high C. difficile rates, poor uptake of recommendations or a high proportion of reviews resulting in stop, IV to oral switch (IVOS) or de-escalate recommendations suggesting lack of appropriate review and rationalisation. The outcome of reviews is summarised below.

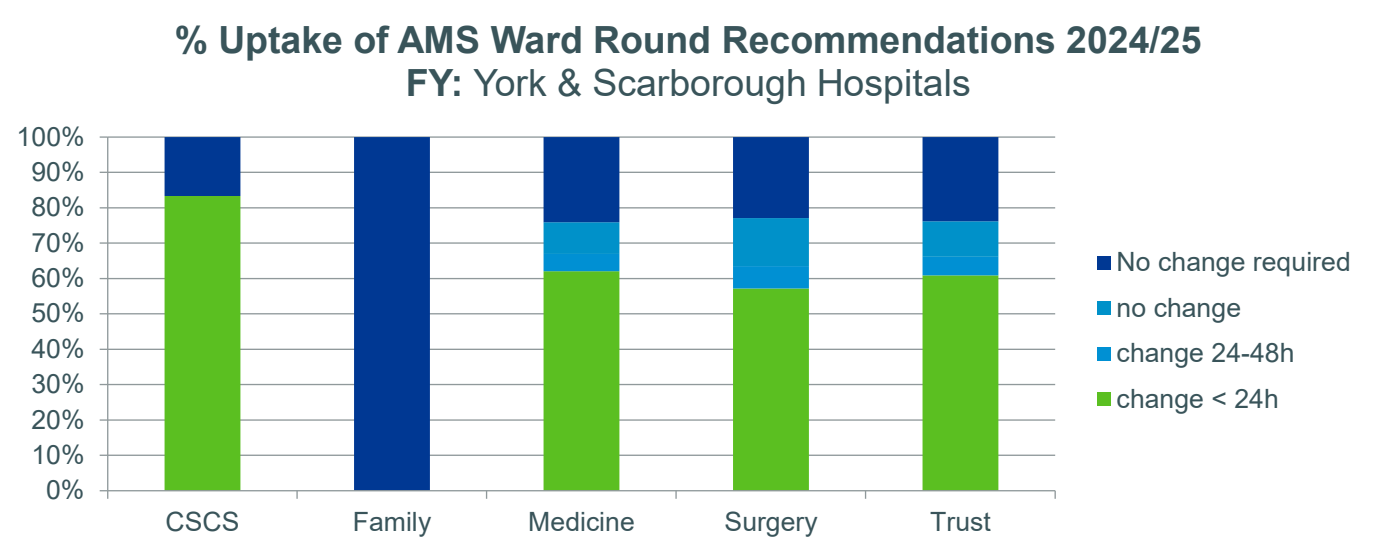


	CSCS	Family	Medicine	Surgery	Trust
Refer to OPAT			1	3	4
Directed therapy			79	21	100
Deescalate	2		142	103	247
Escalate			24	10	34
Continue	1	1	304	84	390
IVOS	1		300	78	379
Stop	2		288	85	375



Uptake of recommendations made within 24 hours increased over the first 3 quarters of the data collection period and has been sustained since, currently sitting at 80% across the Trust.

This improvement was supported by the IVOS work, increased focus on face-to-face communication, and ongoing ward pharmacist engagement. Over 2024/5 the proportion of reviews requiring intervention decreased, suggesting overall improvement of prescribing practice.

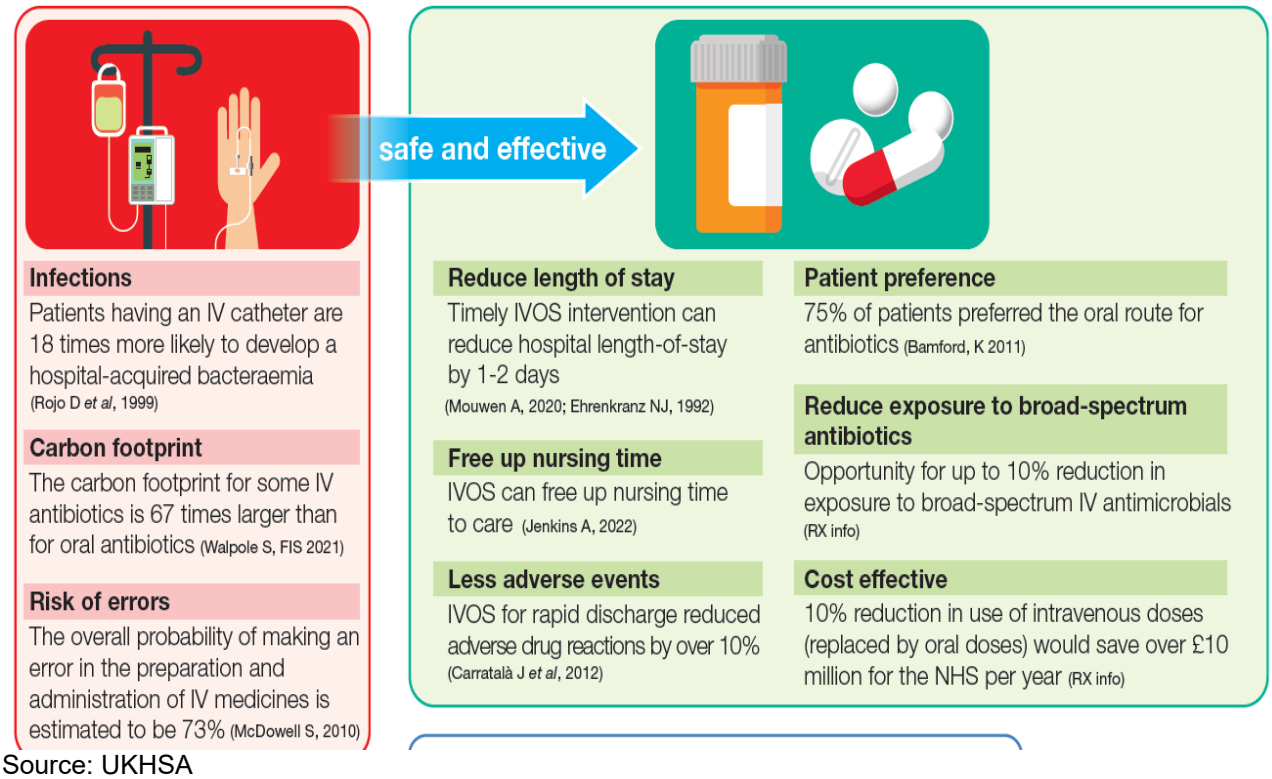


Subgroup analysis is performed, by CG, ward, and day of ward round. This is reviewed within AST and presented to the Care Groups for review. At the York site, uptake is less consistent on Fridays than Tuesdays, and as a Trust uptake is poorer across surgery. Stakeholder engagement work and further data collection is planned to better understand practice and support improvements.

8.1d IV to Oral Switch (IVOS) data

In 2023/24, the national IVOS target (< 40%) was achieved in all four quarters, with a reduction of patients on day 2 or more of IV treatment meeting criteria for oral switch from

33% to 17%. IVOS provides significant advantages to patient care, the Trust and staff capacity as illustrated below.

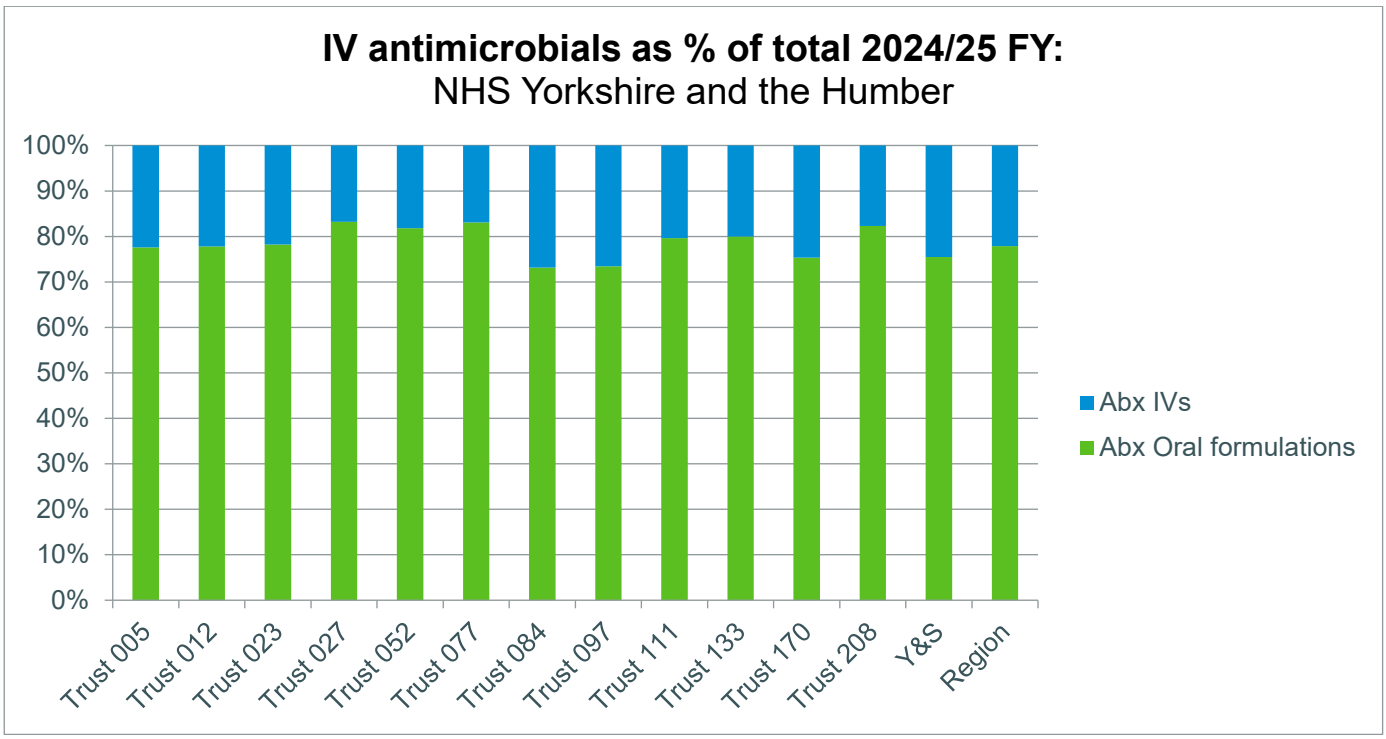


Source: UKHSA

Projected financial and nursing resource savings for the Trust based on 10% reduction in IV antimicrobials (source: Future.NHS.uk):

	Annual saving if IV antibiotics reduced by 10% (one dose from a 3.5 day course of 8-hourly dosing)	**Annual saving if IV antibiotic DDDs* reduced by 10% & were replaced by oral antibiotics**	**Total hours saved if IV DDDs reduced by 10% (40mins per DDD)**	**Value of total hours saved * mid-point AfC Band 6 (£18.19 per hour)**	**Total projected saving (New DDD cost + Nursing time)**
Typical 1000 bed hospital	£122,682	£111,909	11,035	£200,736	£311,245
Y&S Trust (est. 1128 beds)	**£194,185**	**£180,011**	**10,013**	**£182,145**	**£362,156**

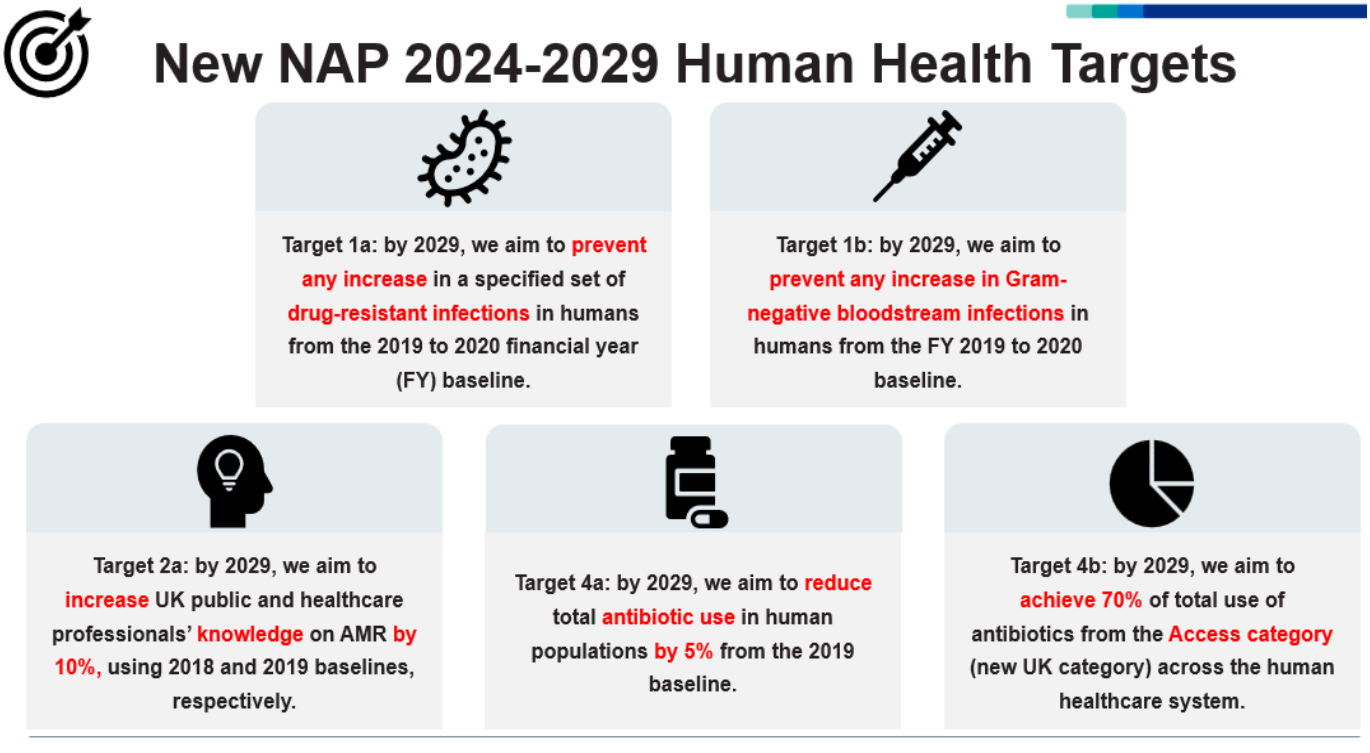
The IVOS CQUIN was no longer mandated in 2024/25, however there is an expectation that the Trust continues to collect this data, with the target reduced from < 40% to 15%. Quarterly data collection was previously undertaken almost entirely by the AMS pharmacy team. For further embedded and sustained improvements, it has been agreed that ongoing data collection be performed in collaboration with the CGs. This objective was not achieved in 2024/25.



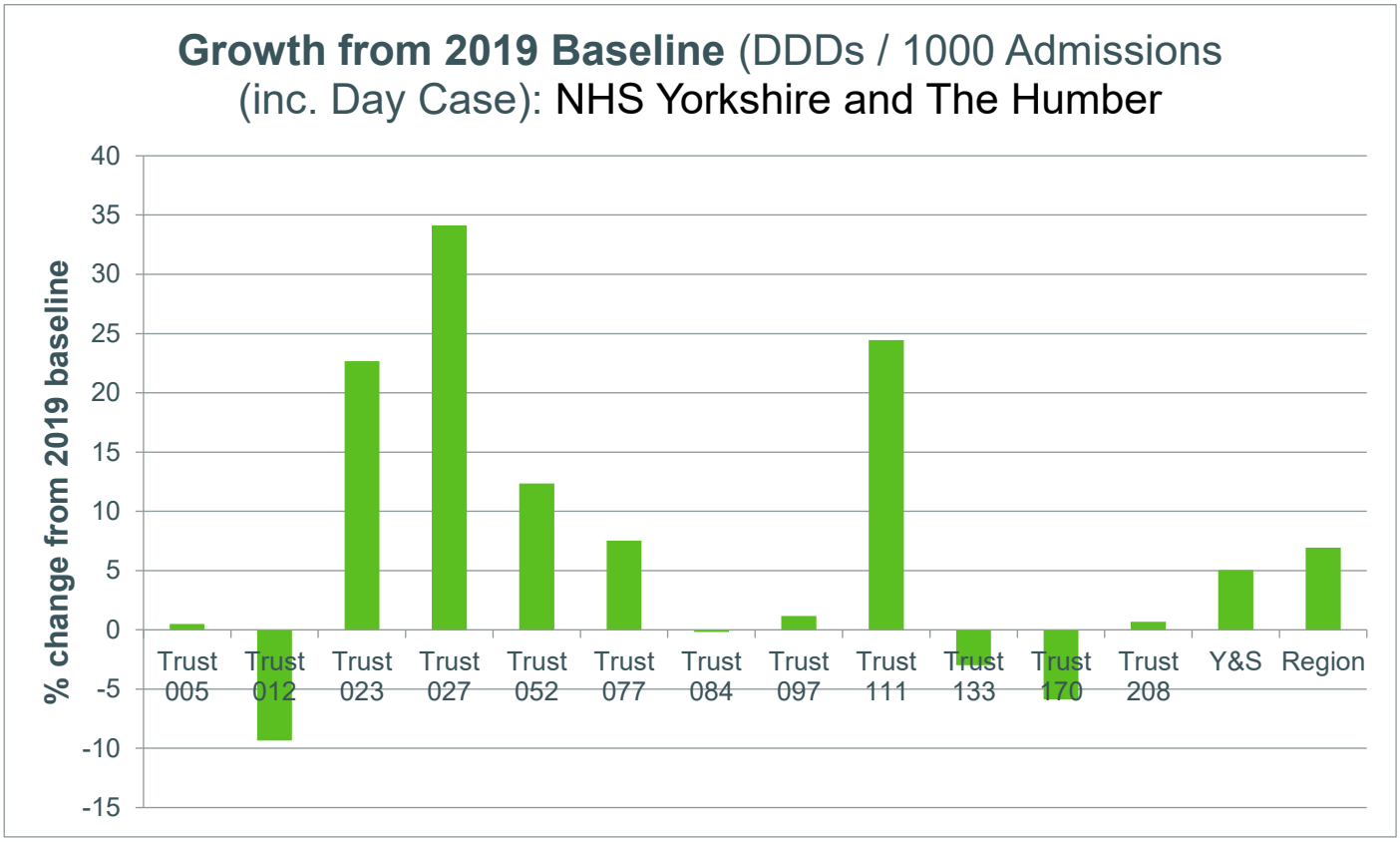
Whilst the Trust has had a modest improvement in % of antimicrobials being IV, it remains above regional average (24.5% vs 22.2% respectively). Further work is required in this space, including greater engagement with prescribers nursing staff, facilitated by the CG meetings. Initial meetings with the Nervecentre EPR team have identified opportunities to support review of patients on IV antimicrobials and the key stakeholders within AST continue to engage with the optimisation process to maximise potential.

8.1e UK 5-YEAR NATIONAL ACTION PLAN (NAP) 2024-2029

The UK Government released the new AMR 5 year national action plan, 'Confronting antimicrobial resistance 2024 to 2029', in May 2024. The human health targets are summarised below:



Target 4a: By 2029 reduce total antibiotic use in human populations by 5% from the 2019 baseline.



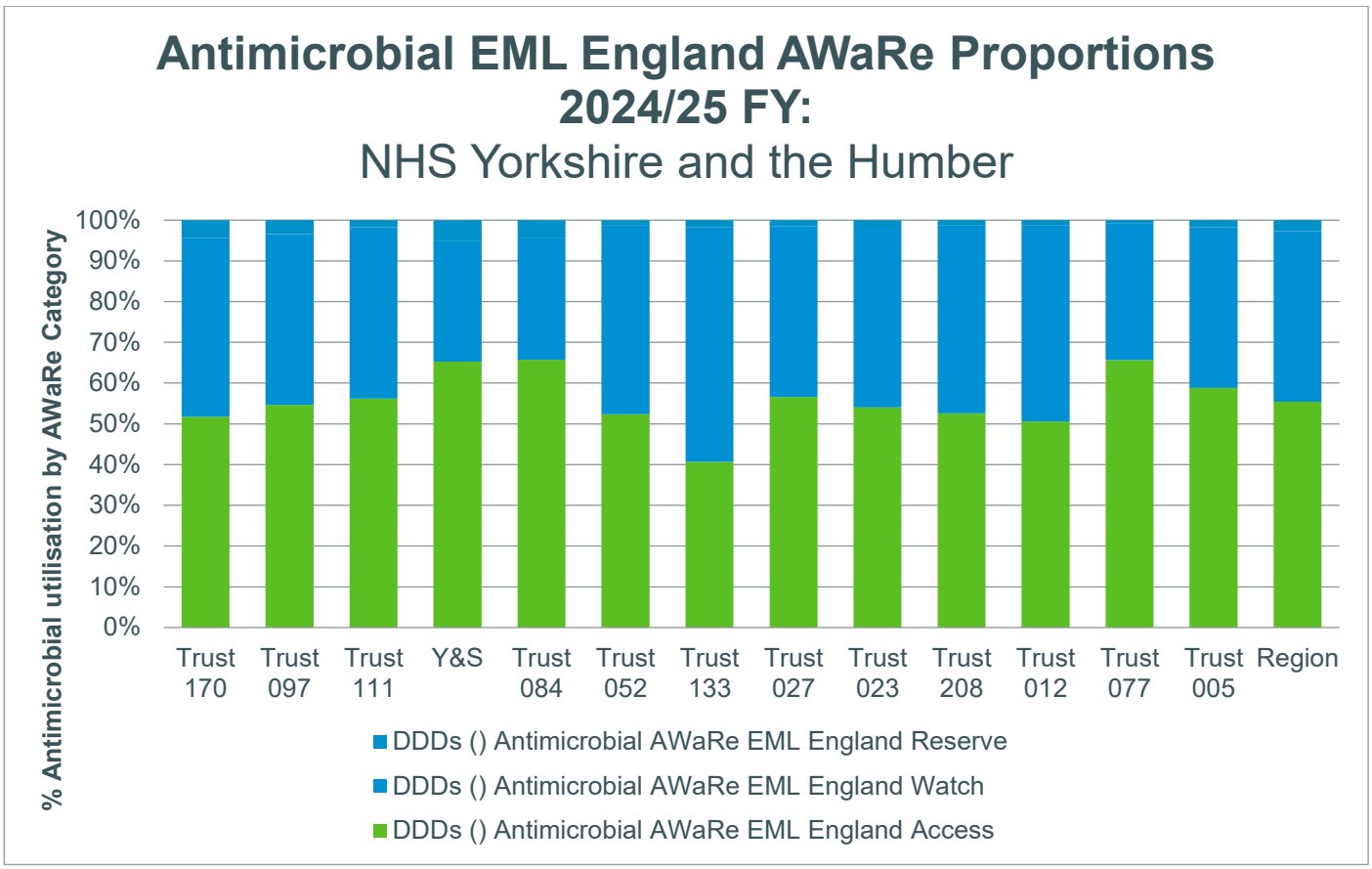
The Trust is not currently meeting Target 4a. Total consumption has increased by 5% rather than decreased. Improved, consistent and timely review of patients on antimicrobials would support a reduction in unnecessary antimicrobial use, for example when non-infective causes are identified.
The 'Antimicrobial Review Kit' (ARK) has demonstrated improvement in practice locally and nationally and the antimicrobial team remain committed to facilitate the relaunch of collaborative data collection incorporating ARK measures (CSCS delivered this in March 2025).
Further to this, the extended and emergency department antimicrobial guidelines are currently under review and look to incorporate shortened course lengths in line with NICE guideline updates release in the last 12 months.

Target 4b: by 2029 achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system.

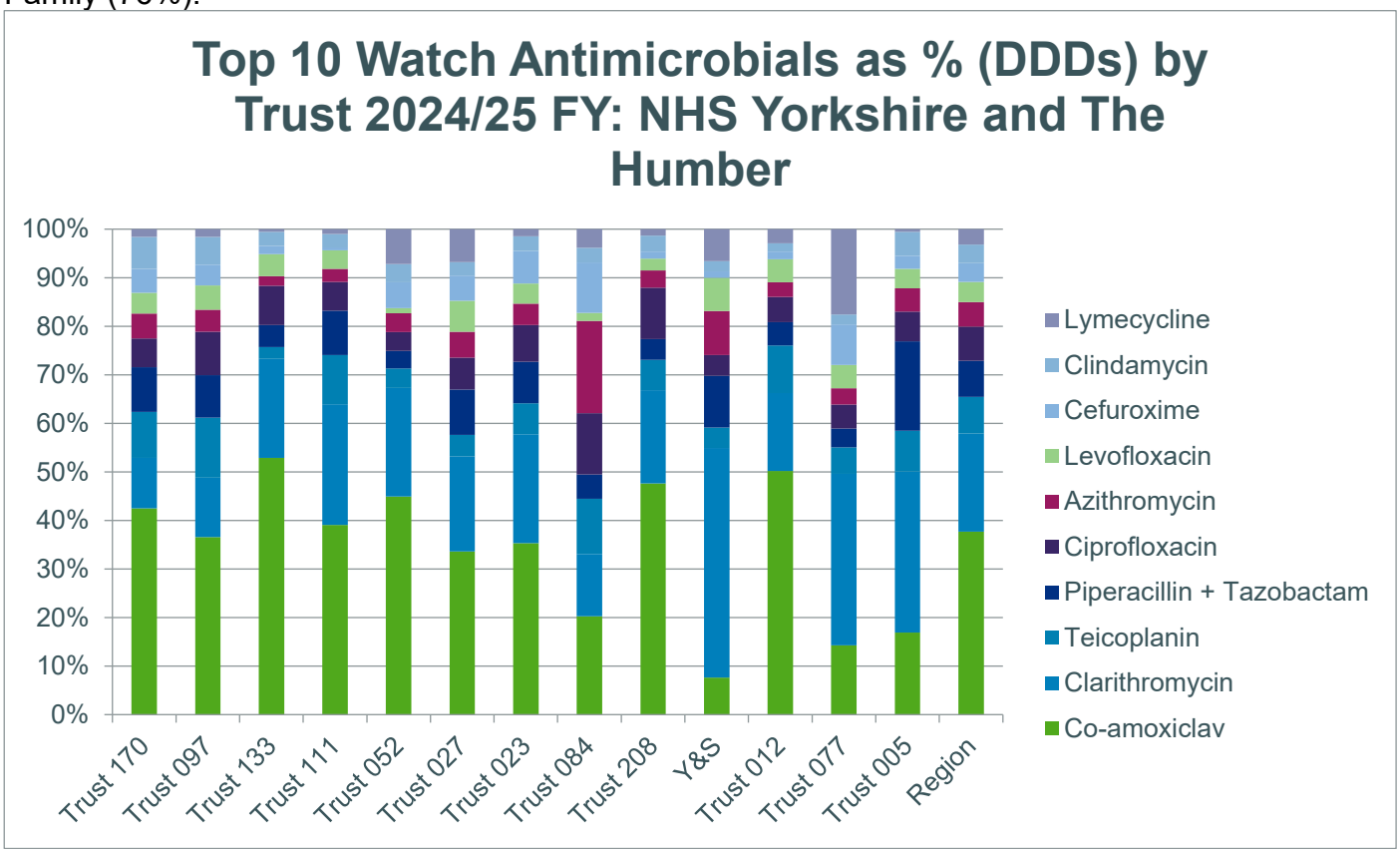
Antimicrobials are classified using the abbreviation **AW**a**R**e as follows:

1. **Access**: Antibiotics used to treat common and serious infections.
2. **Watch**: Antibiotics available at all times in the healthcare system.
3. **Reserve**: Antibiotics to be used sparingly or preserved and used only as a last resort.

The categories are defined by the WHO and adapted nationally. The UK AWaRe classification was updated in 2025 (i.e. new).



The Trust is not currently meeting target 4b. with 65% of antimicrobial utilisation being from the access category. The only Care Groups meeting this target are surgery (70%) and Family (76%).



The antimicrobial team present usage trends to the CG IPC/AMS meetings for scrutinisation, both as performance by Care Group and breakdown of the CG's top 10 watch and reserve antimicrobials by usage.
As a Trust use of clarithromycin continues to be the antimicrobial contributing highest to watch category %. The place in Trust guidelines for clarithromycin remains under review including course length, however this is done with the awareness of historical resistance to alternative antimicrobials.

8.1f Antimicrobial Team Quoracy
The AMS team meeting (AST) terms of reference have been reviewed, and whilst the CG meetings have provided an excellent means for CG engagement and improvement work, until they are fully established and delivering measurable improvement, it is felt that CG representation is still required in AST. This continues to be under review as the CG meetings mature, with the aim that AST maintains the overarching responsibility for the strategic focus and direction of the AMS program across the Trust.

8.1g Other improvement activities of note

AMS Pharmacy Technician-led Fluoroquinolone Patient Safety Initiative
In January 2024 the Medicines and Healthcare Products Regulatory Agency (MHRA) advised fluoroquinolones 'must now only be prescribed when other commonly recommended antibiotics are inappropriate'. Following this publication, the antimicrobial stewardship (AMS) team implemented a technician-led initiative designed support informed decision making and reduce risk of patient harm.
Over a 3-month data collection period (2024/25 Q3), the AMS technicians reviewed 200 patients, identifying co-morbidities of significant concern (history of neurological effect secondary to fluoroquinolone, seizures, aortic aneurisms, psychosis, and suicide ideation/attempt) in 13.5% of patients. Of these, retrospective follow-up found 42% of prescriptions were stopped or changed on the day of technician intervention and this rose to 50% within 48h hours, demonstrating the success of the initiative.

Vancomycin prescribing support and EPMA update.
Glycopeptides continue to be antimicrobials with a high number of medication incident reports, and prescribing remains complex due to having a narrow therapeutic index. The pharmacy antimicrobial team provided enhanced review of patients prescribed vancomycin during 2024/25 Q2 and identified improvement opportunities with the EPMA system. These have been implemented and the Trust guideline optimised to support safe and appropriate prescribing. Reaudit is due and will be reported via established pathways.

Outpatient prescribing review.
The pharmacy AMS team have initiated review of outpatient prescribing along with FP10 data, to understanding practice for non-admitted patients as part of the requirements of NG15. Areas of variance are discussed within AST and relevant information reviewed within CG meetings.

8.1h Plans for 2025/26
The key focus of the Trust AMS team is to continue with stakeholder engagement across the organisation, to embed the mantra that AMS is everybody's responsibility. The team with continue to work with the Care Groups to deliver this objective, including implementation of a robust program of quantitative and qualitative data collection performed in partnership with the Care Groups.

Review of the extended Trust guidelines and emergency department guidelines will support appropriateness of initial prescription, but a primary focus for the Trust is to improve the quality and timeliness of reviews of patients on antimicrobials.
The gap in the team of an AMS lead nurse has been identified, through both regional benchmarking and awareness of the lack of utilisation of such a critical group of healthcare professionals, with the aim of establishing the role to improve nursing education and engagement.
Lack of quoracy for AST has been primarily due to lack of CG representation. Gaps are to be taken to the CG meetings and review of the Terms of Reference will continue as the CG meetings become more established.
It is of note that the AMS pharmacy team has been running with a 25% pharmacist vacancy rate since September 2024, and 67% pharmacy technician vacancy rate since March 2025 which has impacted on development of key national objectives such as penicillin allergy de-labelling (PADL), optimisation of aminoglycoside assessment and genetic testing, collaborative (with care group nominated prescribers) qualitative data collection, and further enhancement of IV to oral switch (IVOS) initiatives. The vacancies have now been filled, and once on-boarding has been completed the aim is to progress with these initiatives.

9. Standards for Healthcare Cleanliness

Within 2024/25 the Trust and York Teaching Hospitals Facilities Management (YTHFM) have completed and implemented the revised Cleaning Standards Policy which reflects the National Standards for Healthcare Cleanliness, 2021 with agreed derogations. The cleanliness standards compliance for the environment, clinical equipment and estates elements continues to be reviewed within the Cleaning Standards Committee, IPSAG and YHTFM meetings.

An internal audit for cleaning was published in March 2023. An improvement plan was developed and overseen by IPSAG. The action plan was completed and evidence for closure submitted in October 2024. We continue to refine the cleaning efficacy audits and escalation responses.

10. Other IPC Activity

- The IPC are represented on the Water Safety Committee and provide input into the Water Safety Plan regarding Legionella and Pseudomonas water monitoring, improvement actions and remedial work as required.
- Several capital schemes have been progressing with IPC involvement this year including the Scarborough new build for Urgent and Emergency Care. The team are working closely with the Capital Projects team and Estates teams regarding development of a clear standard Operating Procedure for commissioning and sign off for new builds and refurbishments.
- IPC policies, Guidelines and Patient Information Leaflets have undergone review and have been updated to reflect the National IPC manual over 2024/25. There are 7 documents that will go out of date in Q1 2025/26 and there is a plan to have these completed and approved via IPSAG by the end of the quarter.
- The Trust Purchasing team have worked with the IPC team on a Trust wide soap and hand sanitiser replacement programme following the existing supplier going into administration. The installation commenced in October 2024.

11. Summary

The overall HCAI performance for the organisation requires improvement. The IPC team are committed to change their working practice and improve the delivery of the IPC service. The governance, ownership and accountability for IPC is now strengthening within the care groups and by introducing care group IPC meetings this will continue to improve. The monitoring metrics are currently being reviewed to increase the assurance that the IPC team can provide to the organisation.

12. Next Steps

- Stabilise the IPC Team
- Complete the 2025/26 IPC Board Assurance Framework.
- Develop and deliver a focussed improvement plan for at least a 5% reduction of avoidable MRSA/MSSA bacteraemia and GNBSI in 2025/26.
- Strengthen IPC Governance by working with Care Groups to develop and embed local IPC/AMS improvement plans.
- Deliver against the NHS England HCAI objectives.
- Refresh the HCAI PSIRF review process to make improvements for 2025/26 in relation to timeliness, ownership of improvement actions by the care groups and wider Trust feedback.

Appendix 1 HCAI performance data to end March 2025

Figure 1: Cumulative Trust attributed Clostridioides difficile against trajectory

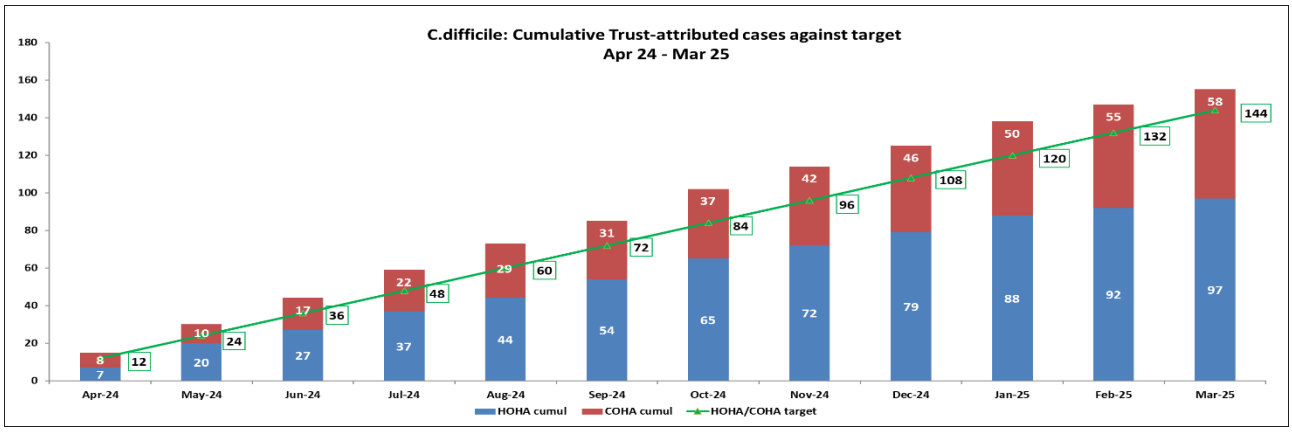


Figure 2: Clostridioides difficile national comparative rates per 100,000 bed days & day admissions monthly rate

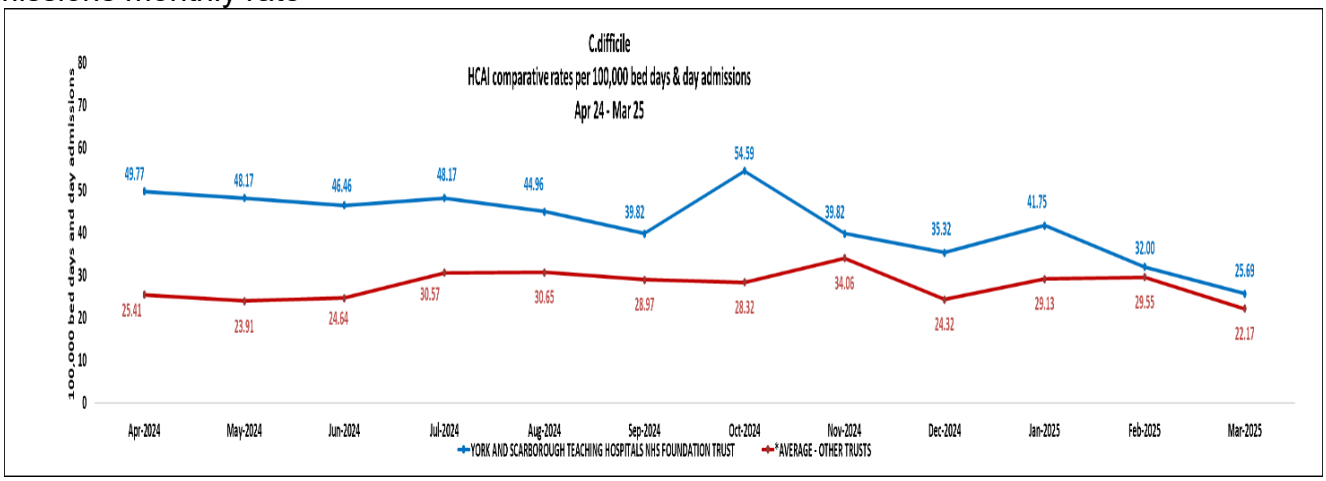


Figure 3: Cumulative Trust attributed Clostridioides difficile April 2021-March 2025

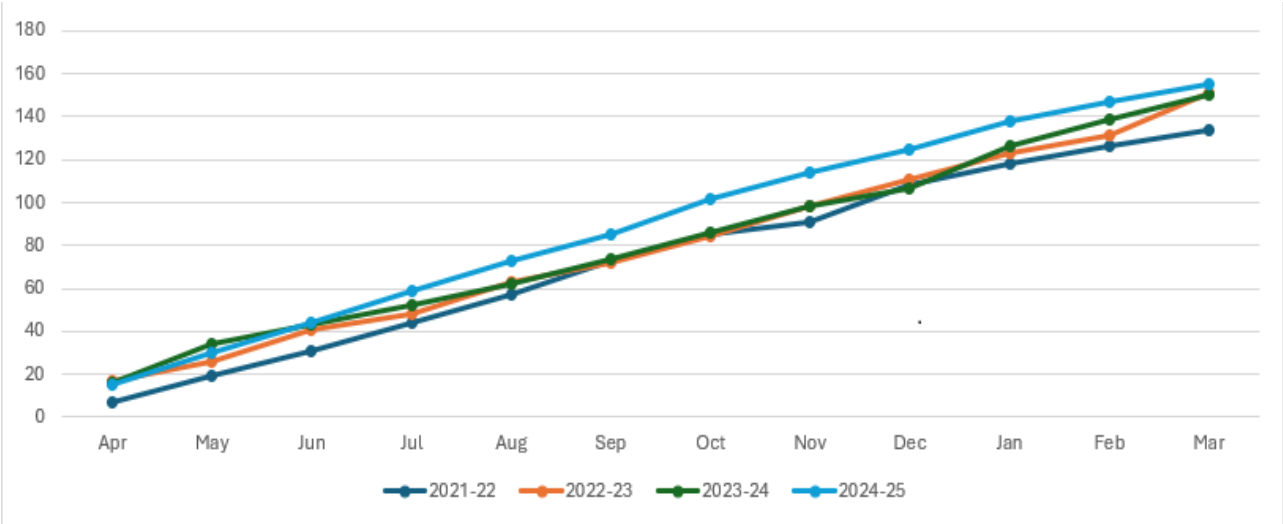


Figure 4: Cumulative Trust attributed Clostridioides difficile by area from April 2024

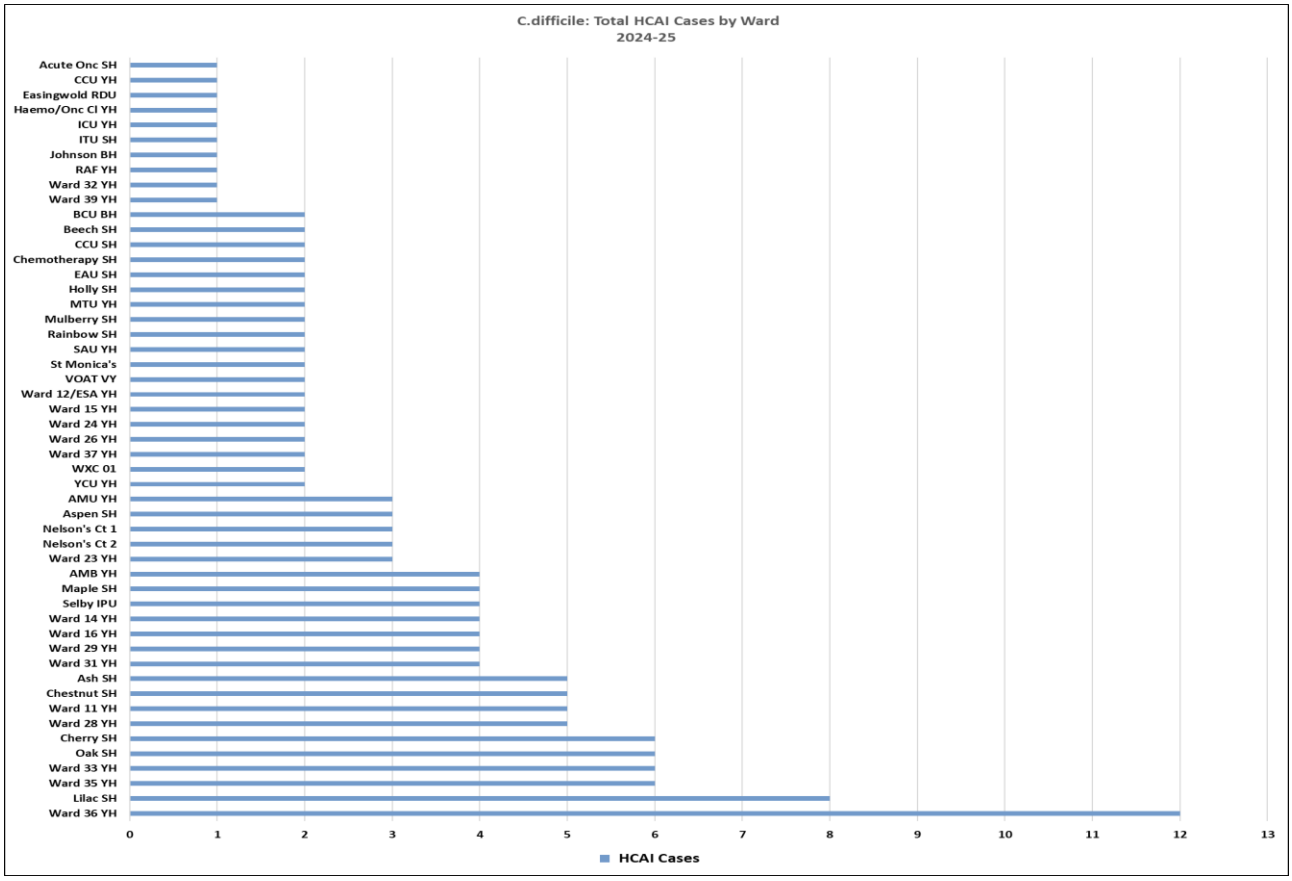


Figure 5: Cumulative Trust attributed MRSA by area from April 2024

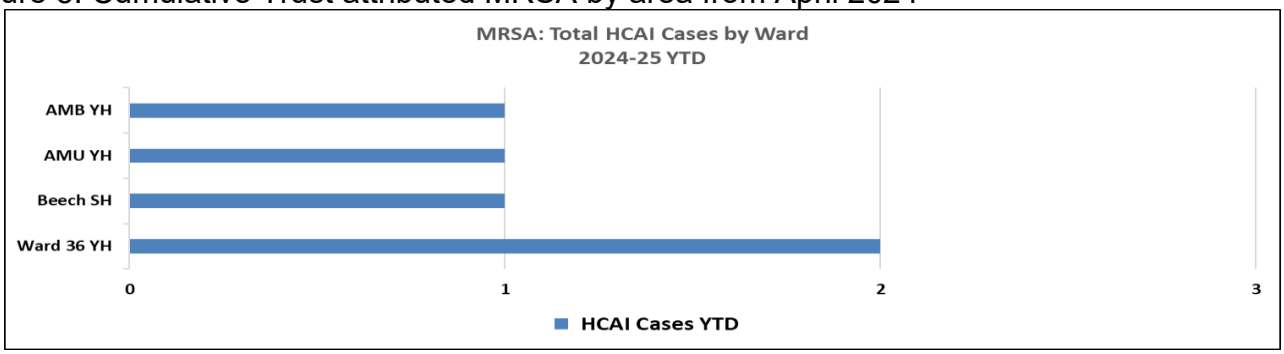


Figure 6: Cumulative Trust attributed MSSA Bacteremia against trajectory

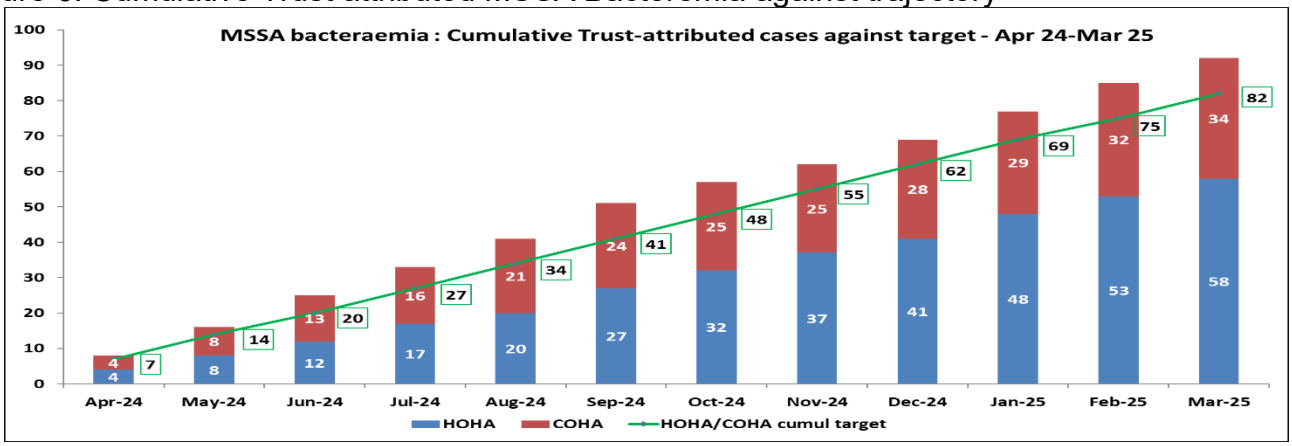


Figure 7: MSSA national comparative rates per 100,000 bed days & day admissions monthly rate

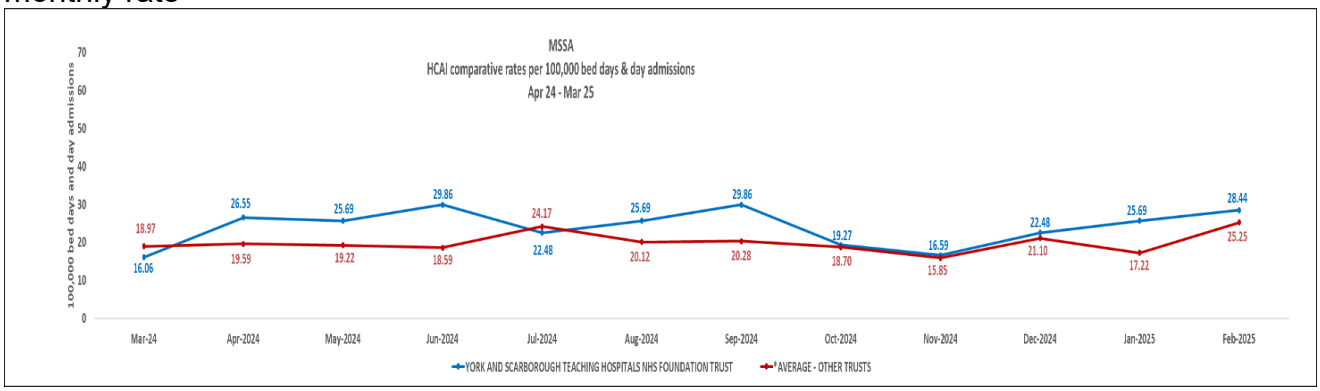


Figure 8 : Cumulative Trust attributed MSSA bacteremia April 2021-March 2025

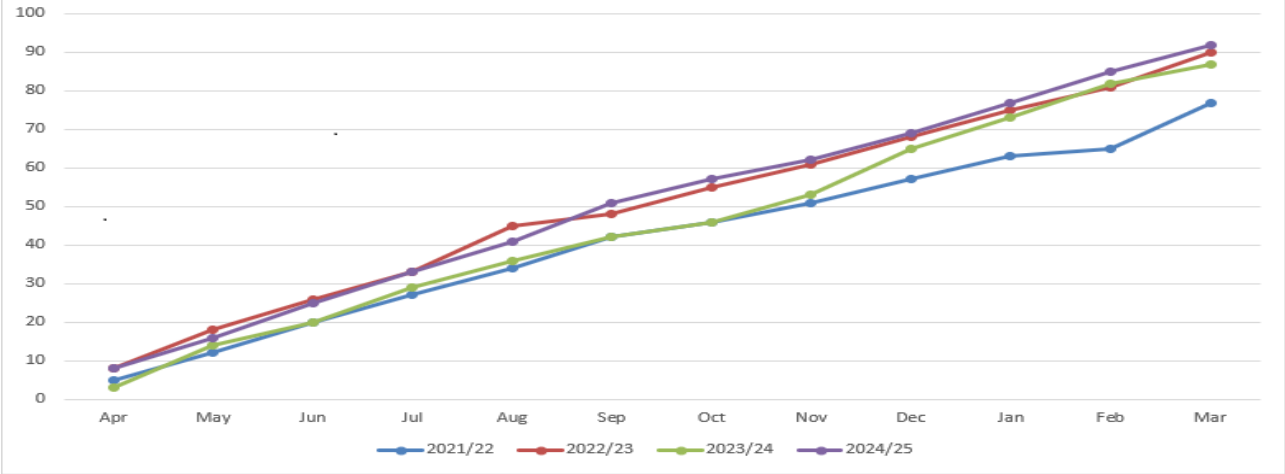


Figure 9: Cumulative Trust attributed MSSA Bacteremia cases by area from April 2024

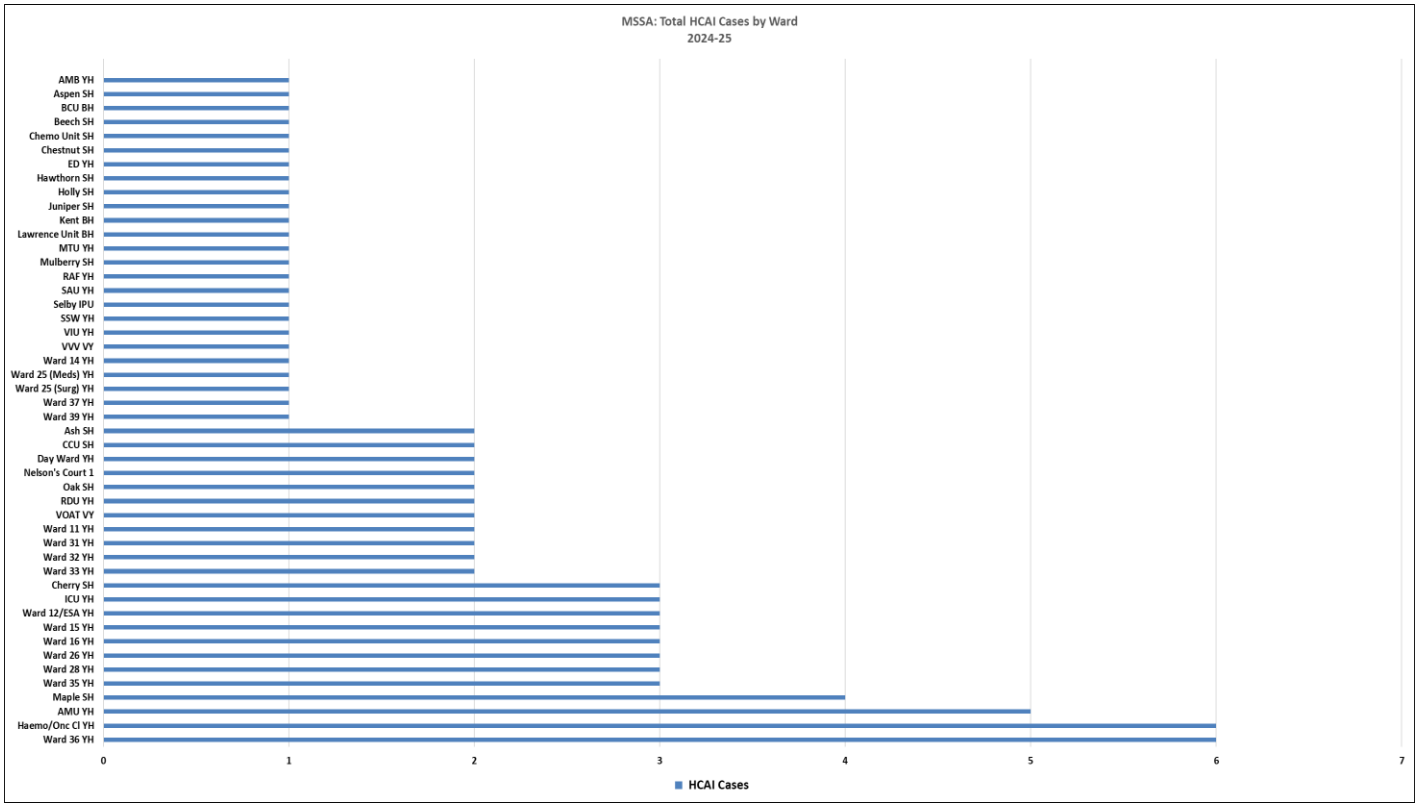


Figure 10: Cumulative Trust attributed E.coli Bacteremia against trajectory

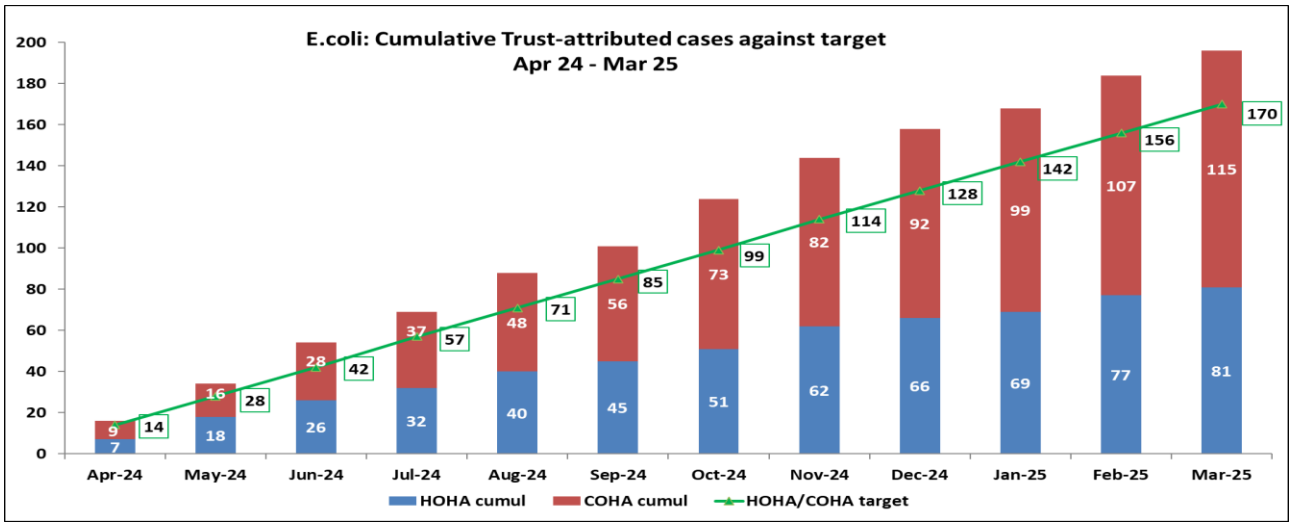


Figure 11: E. coli national comparative rates per 100,000 bed days & day admissions monthly rate

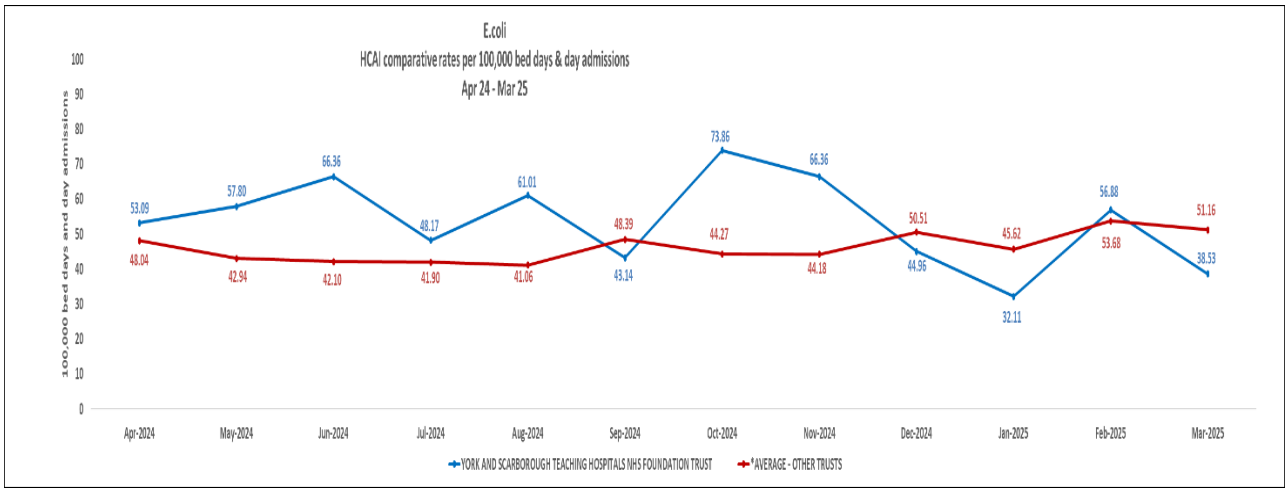


Figure 12: Cumulative Trust attributed E.coli April 2021-March 2025

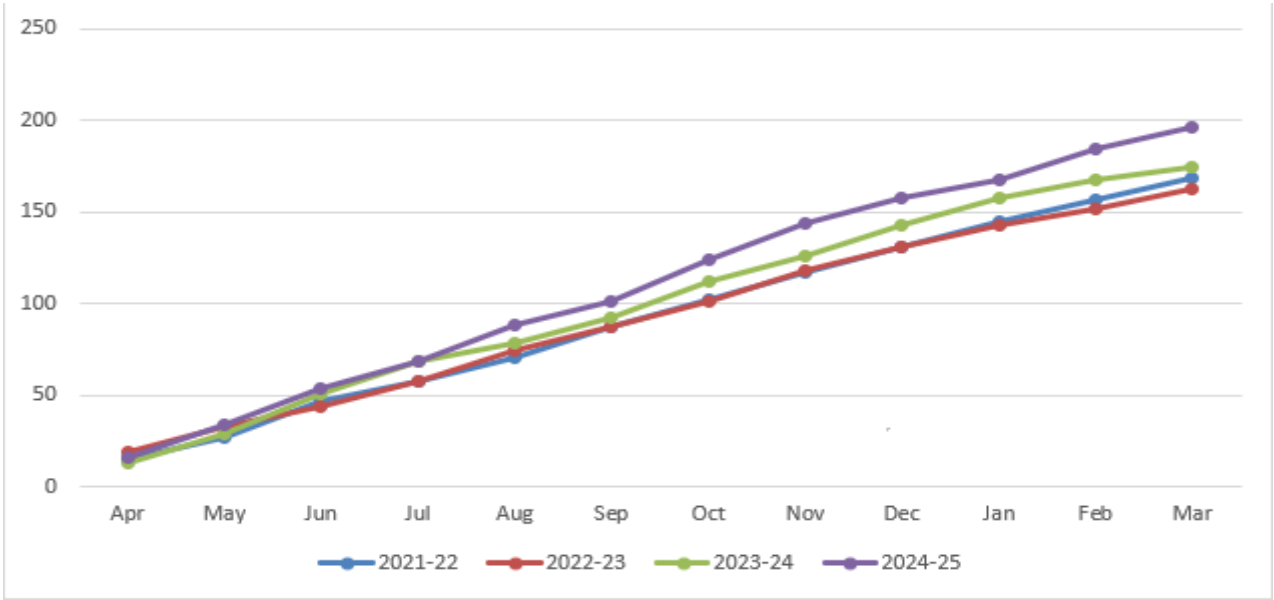


Figure 13: Cumulative Trust attributed E.coli Bacteremia cases by area from April

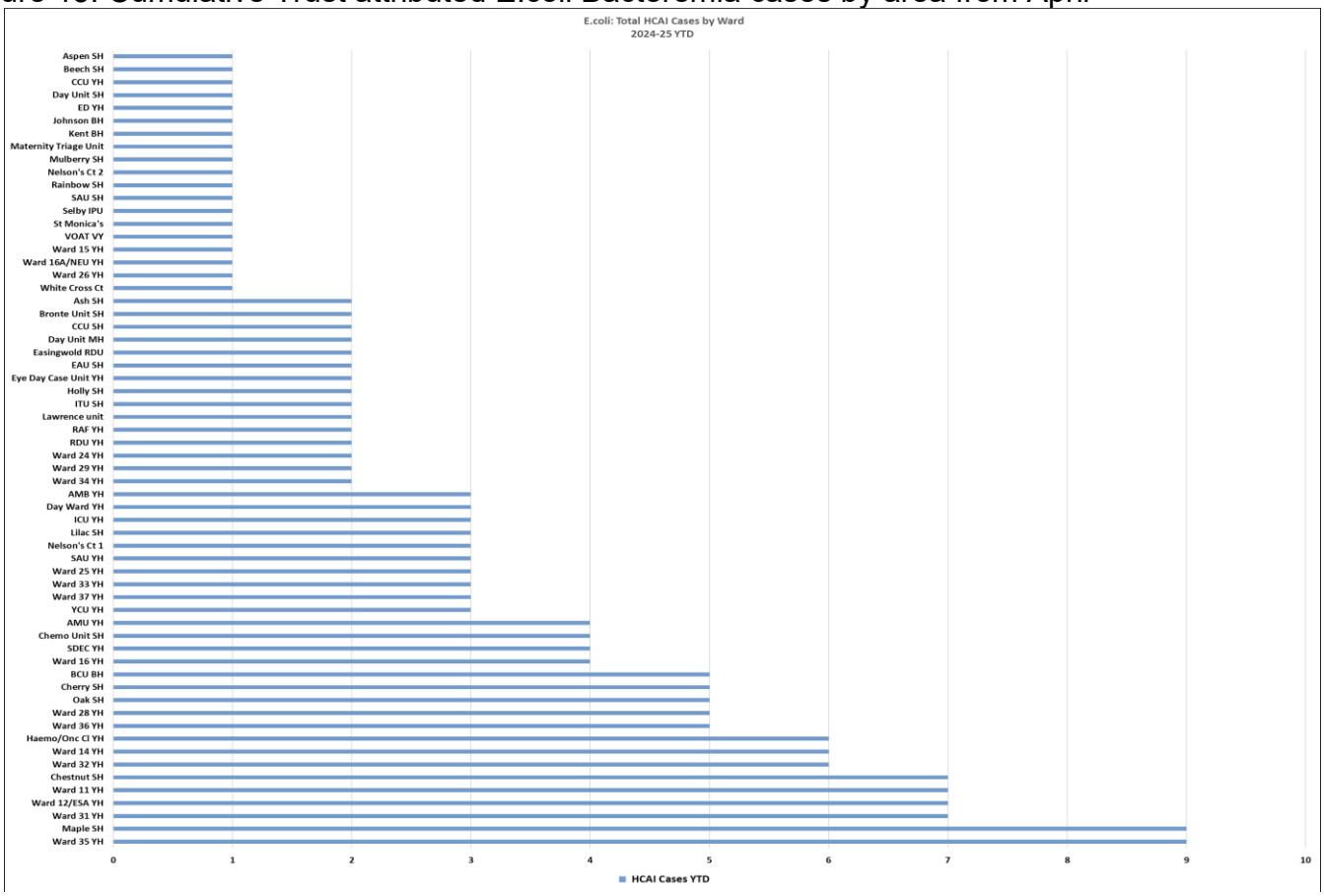


Figure 14: Cumulative Trust attributed Klebsiella bacteremia April 2021-March 2025

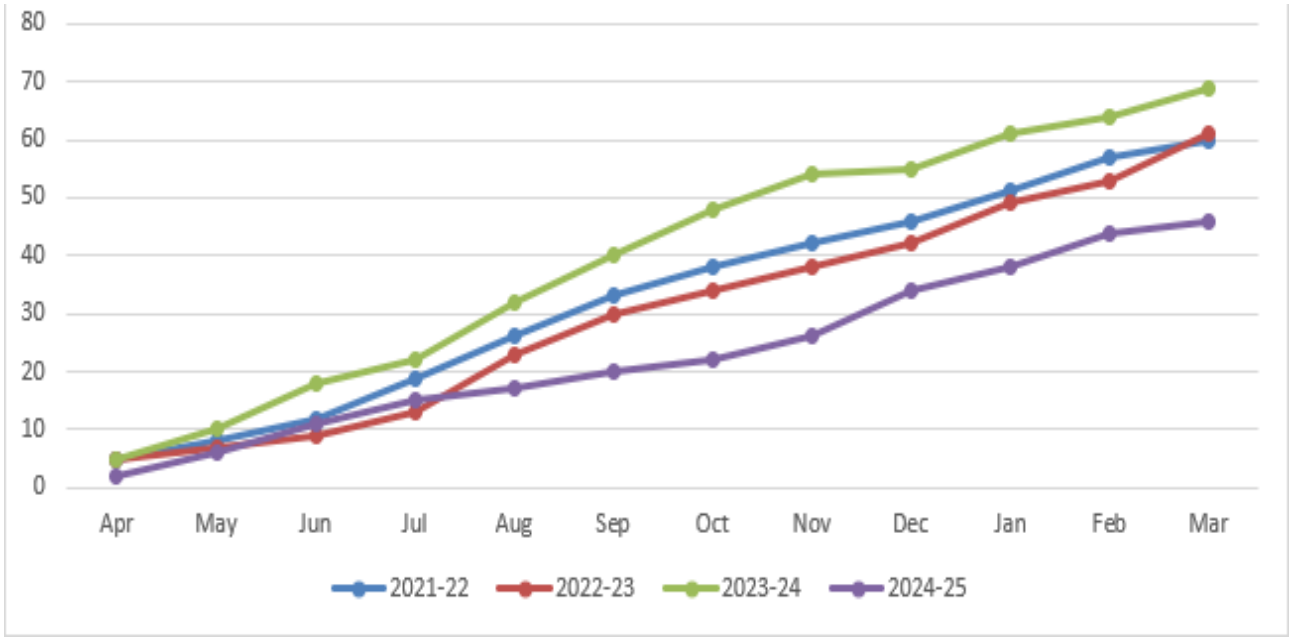


Figure 15: Cumulative Trust attributed Klebsiella Bacteremia cases by area from April

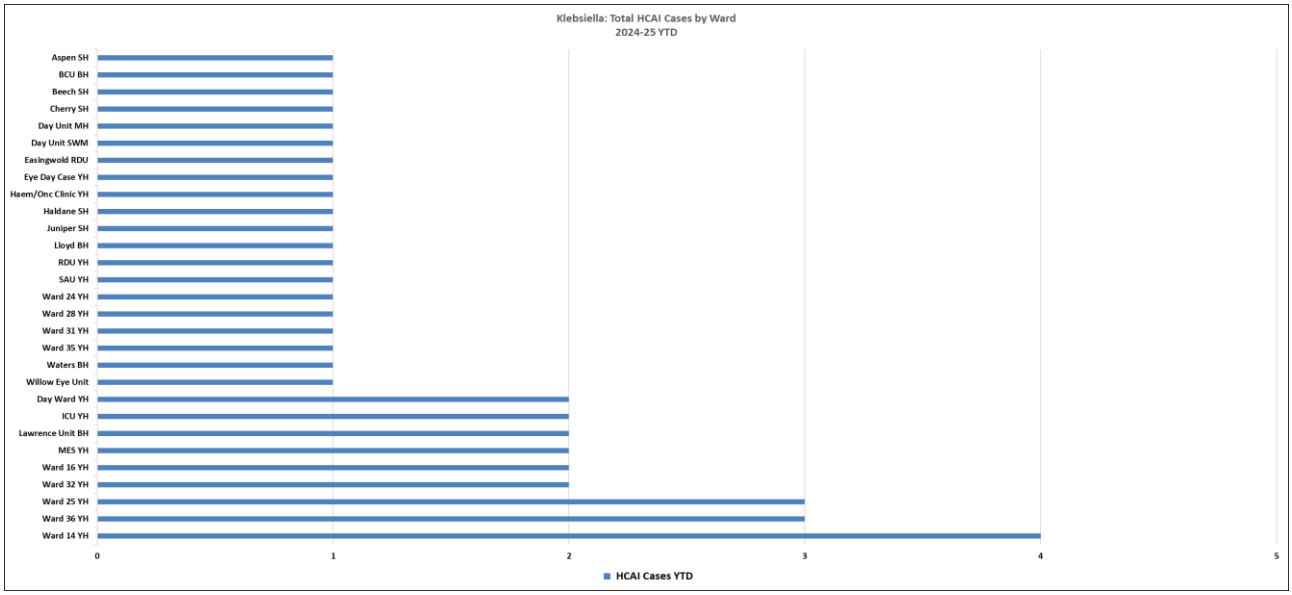


Figure 16: Cumulative Trust attributed Pseudomonas Bacteraemia April 2021-March 2025

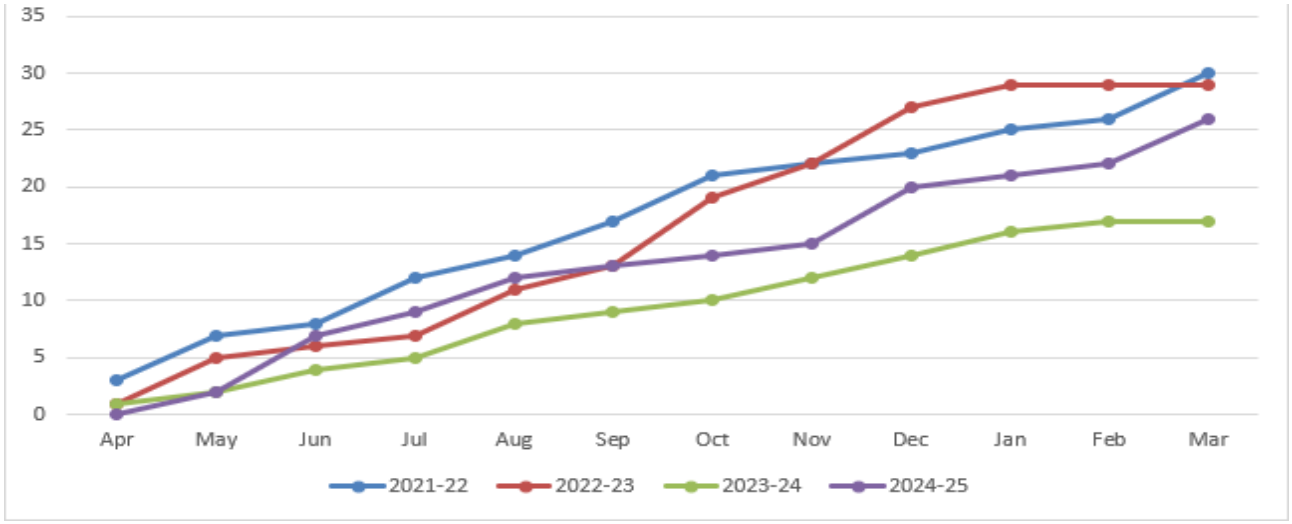


Figure 17: Cumulative Trust attributed Pseudomonas Bacteremia cases by area from April

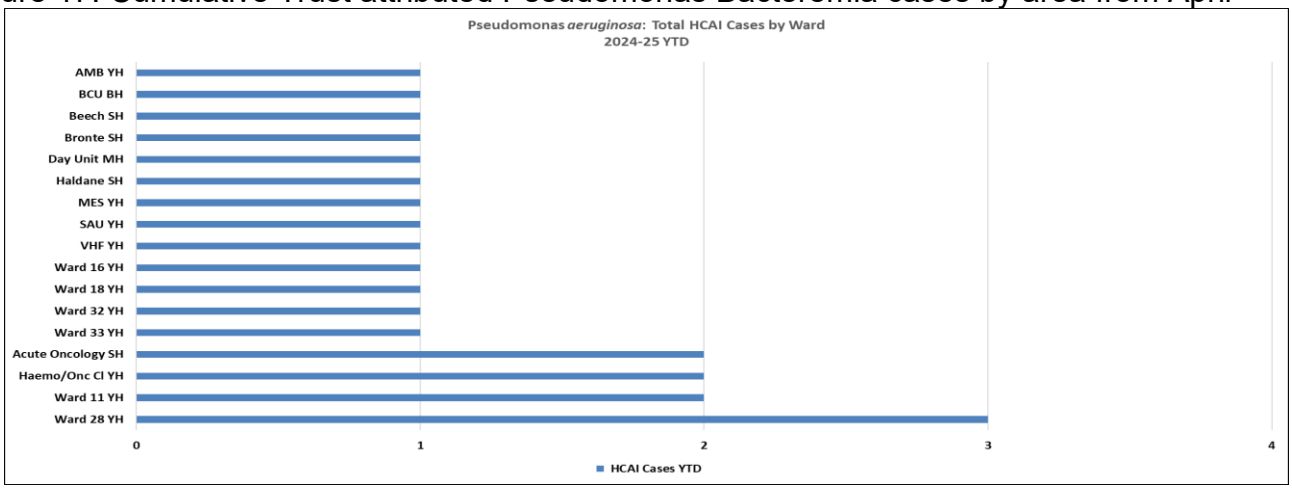
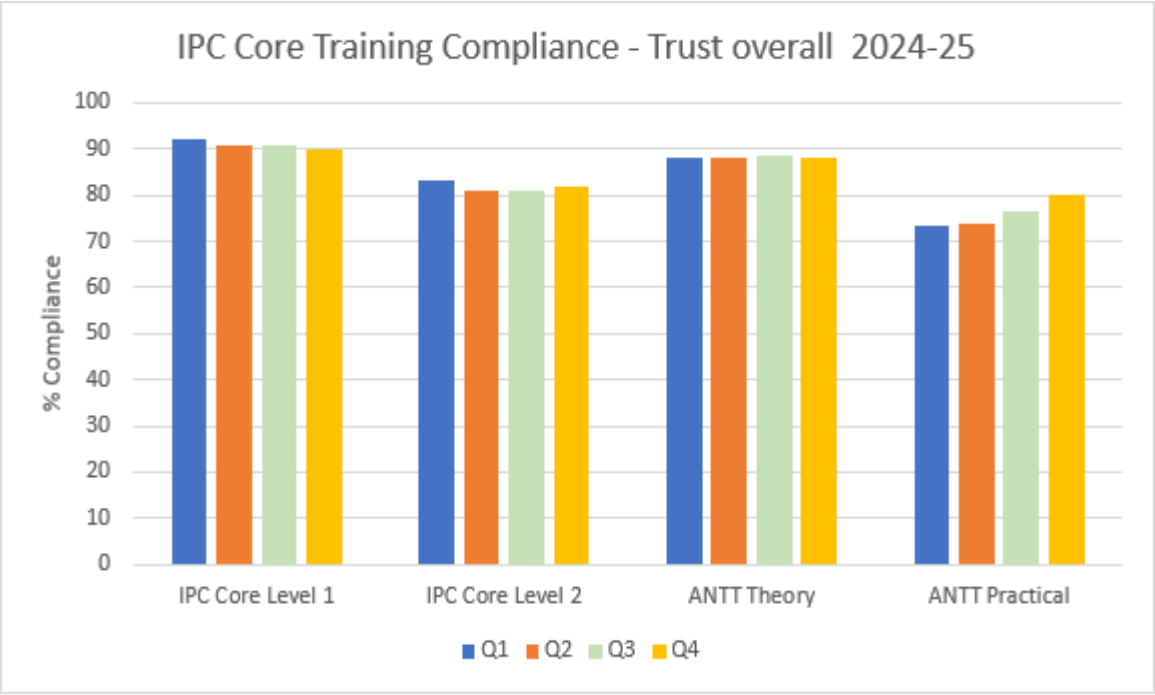


Figure 18: IPC Core training compliance 01st April 2024-31st March 2025



Appendix 2 Orthopaedic Surgical Site Infection

Orthopaedic surgical site infection surveillance report

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

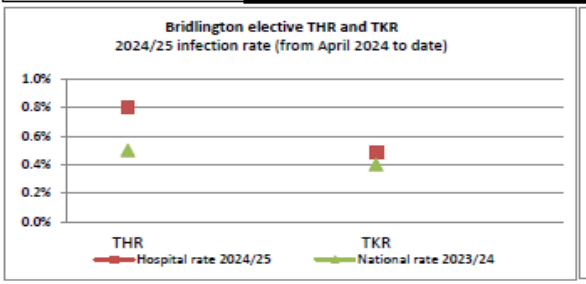
Report to the end of Mar-25

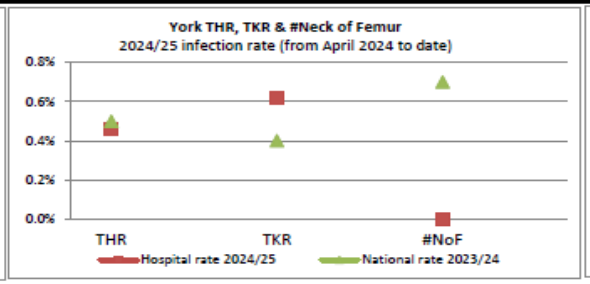
Actual number of infections - cases reported in month of inital surgery

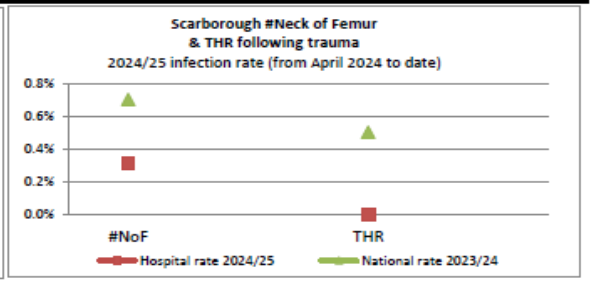
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Bridlington (Hips)	0	0	0	0	1	0	0	1	0	1	0	0	3
Number of operations	25	33	32	38	29	32	28	29	21	39	31	37	374
Bridlington (Knees)	0	0	0	1	0	0	0	0	0	1	0	0	2
Number of operations	23	39	27	45	33	27	35	33	30	36	34	46	408
York (Hips)	0	0	0	0	0	0	0	1	0	0	0	0	1
Number of operations	14	15	12	17	19	21	20	17	20	14	23	26	218
York (Knees)	0	0	0	1	0	0	0	0	0	0	0	0	1
Number of operations	10	14	16	12	9	9	16	16	14	12	14	20	162
York (#NoF)	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of operations	35	36	42	34	46	34	36	30	31	38	34	44	440
Scarborough (#NoF)	0	0	0	0	0	0	0	0	1	0	0	0	1
Number of operations	25	29	30	23	35	34	20	25	25	25	16	33	320
Scarborough (THR)	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of operations	4	7	6	2	3	3	5	6	6	5	4	4	55

Infection rate to date (number of infections/number of operations)

	Bridlington		York			Scarborough	
	THR	TKR	THR	TKR	#NoF	#NoF	THR
Hospital rate 2024/25	**0.80%**	**0.49%**	**0.46%**	**0.62%**	**0.00%**	**0.31%**	**0.00%**
Hospital rate **2023/24**	0.33%	0.30%	0.62%	1.22%	0.69%	0.00%	0.00%
Hospital rate **2022/23**	2.07%	1.06%	1.42%	0.00%	0.47%	0.00%	3.85%
Hospital rate **2021/22**	0.0%	0.9%	0.0%	0.0%	0.7%	1.03%	x
National rate 2023/24	0.5%	0.4%	0.5%	0.4%	0.7%	0.7%	0.5%







Infections may not be identified within the reporting month therefore data may change. New infections will be added when identified.
Post Infection Review may determine that a case does not fit the reporting criteria and will be removed from the figures

Report to:	Council of Governors
Date of Meeting:	10 September 2025
Subject:	Annual Complaints Report 2024/25
Director Sponsor:	Tara Filby, Director of Nursing and Deputy Chief Nurse
Author:	Justine Harle, Complaints and Concerns Lead

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

- The Trust is meeting its statutory obligations for complaints handling and addressing complaints in accordance with our local policy.
- 1221 complaints were received compared to 816 in 2023/24, an increase of 49.6%.
- The main subjects for complaints related to delays in treatment/procedure, attitude of medical and nursing staff, communication with patients and their relatives/carers and diagnosis delays.
- Performance has remained the same as 2023/24 and 49% of complaint responses were completed within timescales in 2024/25.

- Online training for investigators has been introduced this year as well as writing skills training. The training seeks to embed effective and engaged investigations, empathetic responses, and appropriate and effective learning within the Trust's handling of complaints.
- Priorities for 2025/26 include a focus on better learning from complaints and streamlining processes for greater efficiency.

Recommendation:

The Council is asked to note the contents of the report and continue to support the work being undertaken to improve patient and carer experience.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Patient Experience Sub Committee	11 June 2025	Approved and endorsed to be reviewed at the Quality Committee
Quality Committee	15 July 2025	Noted

Complaints Annual Report 2024/25

1. Introduction

In managing complaints, the Trust is required to adhere to The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16 – Receiving and acting on complaints.

This is the complaints annual report for the period 1 April 2024 to 31 March 2025. It includes details of numbers of complaints received during this period, performance in relation to responding to complaints, Parliamentary and Health Service Ombudsman (PHSO) investigations and examples of actions the Trust has taken in response to complaints.

The Trust welcomes all feedback from patients, their families and carers about their experience of our services and this information as invaluable in enabling us to learn and improve the experience for patients and carers as well as determining whether changes can be made to the services we provide.

2. The number of complaints which the responsible body received and the number of complaints which the responsible body decided were well-founded

2.1 New complaints

The data contained in this report has been obtained from Datix, our electronic risk management system. 1221 formal complaints were received during 2024/25 compared to 816 in 2023/24, an increase of 50%. This increase is in line with the national trend and equates to a weekly average of 23 complaints. Healthwatch England published their report 'A Pain to Complain: Why it's time to fix the NHS complaints process' in 2025 and highlighted that written complaints in the NHS reached a record high in 2024.

For context, in 2023/24 the Trust had 115,414 A&E attendances, 100,613 attendances in Urgent Care Centres on our sites, 779,908 outpatient attendances (also including telephone and video appointments), 160,808 inpatients (adults, including maternity), 9,921 inpatients (children), 121,700 operations or procedures as an inpatient and 3,916 babies delivered (data taken from the Trust 2025-2030 strategy).

Complaints generally correlate with services as expected (i.e. the higher volume areas receiving more complaints). Some complaints are complex and involve multiple care groups or agencies and require longer to investigate and in June 2024 the category of complex complaint was introduced, giving investigating officers 45 working days to conclude their investigation. These cases accounted for 97 of the overall complaints registered in 2024/25.

New Complaints 2024/25	Q1	Q2	Q3	Q4	Total
York Hospital	244	210	193	169	**816**
Scarborough Hospital	68	92	70	69	**299**
Bridlington Hospital	3	3	1	2	**9**
Total	**315**	**305**	**264**	**240**	**1124**

New Complaints by Care Group	Q1	Q2	Q3	Q4	Total
Medicine	137	127	123	102	**489**
Surgery	80	80	72	72	**304**
Cancer, Specialist & Clinical Support Services (CSCS)	39	46	25	25	**135**
Family Health	46	42	32	33	**153**
Corporate Services	13	10	12	8	**43**
Total	**315**	**305**	**264**	**240**	**1124**

New Complex Complaints 2024/25	Q1	Q2	Q3	Q4	Total
York Hospital	5	24	32	19	**80**
Scarborough Hospital	1	3	5	6	**15**
Bridlington Hospital	0	1	0	1	**2**
Total	**6**	**28**	**37**	**26**	**97**

New Complex Complaints by Care Group	Q1	Q2	Q3	Q4	Total
Medicine	3	17	17	11	**48**
Surgery	1	10	10	6	**27**
CSCS	1	1	7	1	**10**
Family Health	1	0	3	8	**12**
Total	**6**	**28**	**37**	**26**	**97**

2.2 Reopened Complaints

The Trust always seeks to apologise for failings in care and applies the duty of candour principles to the complaints process. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or, in their absence, the Chief Nurse or an Executive Director designated signatory.

In 2024/25, 1203 complaint investigations were concluded, of which 5% (63) were reopened at the request of the complainant and further investigations undertaken. These figures are a small reduction on 2023/24 (6%). Complainants are encouraged to contact the Trust if they have any further questions and almost half of complainants took the opportunity to raise additional questions. 13 of the reopened cases for Medicine (39%) related to Emergency Medicine. No other trends were identified.

Reopened complaints 2024/25	Total
CSCS	**3**
Family Health	**10**
Medicine	**33**
Surgery	**17**
Total	**63**

2.3 Outcome data

The Trust is required under the complaints legislation to record whether the issues were substantiated following investigation. Of the complaints closed this financial year, 1145 had an outcome code provided by the investigating officer at the time of this report. Of

those case, 20% were upheld, 44% were partially upheld and 36% were not upheld. These figures are comparable to previous years.

Outcomes 2024/25	Not upheld	Partially upheld	Upheld	Total
CSCS	36	54	45	**135**
Corporate Services	10	6	23	**39**
Family Health	46	75	30	**151**
Medicine	164	267	82	**513**
Surgery	150	106	51	**307**
Total	**406**	**508**	**231**	**1145**

2.4 Parliamentary and Health Service Ombudsman (PHSO)

Although the Trust makes every effort to resolve formal complaints locally, we understand that this is not always possible. Service users have the statutory right to refer their complaint to the PHSO for an independent review. In 2024/25 the PHSO undertook an initial inspection of eleven complaints and concluded no further action was required. Two PHSO full investigations were registered in 2024/25, and we are currently awaiting the outcome of these along with a case registered in 2022/23.

One case registered in 2021/22 was concluded this year and was partially upheld. It related to confusion that resulted in the patient being discharged from cardiology without being seen for necessary care (this was addressed at the time of the local investigation). This was due to an error in the Clinical Assessment Services and the Trust made some immediate changes to inform patients that they should not attend on the date in the letter, as it was a date for their referral to be triaged. We received several complaints about these “dummy appointments”, and we were able to explain to the patient the work that was underway to remove the need for these appointments to enable a referral into hospital services. The PHSO was satisfied that the Trust had made changes to address their findings.

3. The subject matter of complaints that the responsible body received

The top five themes in 2024/25 are listed in the table below. It should be noted that complainant’s comments are opinions and not always statements of fact and failings were not identified in 36% cases concluded in 2024/25. However, emerging trends or themes are monitored regularly as complaints are received, and any areas of concern are highlighted to the Care Group management teams. Deep dives are undertaken where indicated by the Triangulation of Concerns Forum (Joining the Dots). This group aggregates intelligence and uses this to guide a general overview, to determine specific actions e.g. visits to teams, promotional work, targeted interventions.

Complaint (inc Complex) Top Themes	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Delay or failure in treatment or procedure	23	38	28	21	110
Attitude of medical staff	17	13	16	22	68
Delay or failure to diagnose	9	19	16	16	60
Communication with Patient	16	16	8	14	54
Attitude of nursing staff/midwives	18	11	10	12	51
Total	**83**	**97**	**78**	**85**	**343**

NB: There are often multiple subjects within a single complaint, reflecting the complexity of many complaints.

3.1 Key Themes

As well as communication being the main issue for some complainants, it was often included in a complaint about something else. Some patients told us that they were not informed enough about their diagnosis or treatment options and that staff often lacked the time necessary to provide clear and comprehensive information, resulting in misunderstandings and dissatisfaction and patients feeling “left in the dark” about their treatment plans.

Many individuals are now accustomed to instant access to information and swift responses in their daily lives, leading to higher expectations when they come to hospital. When we fail to meet these expectations, patients are more likely to voice their dissatisfaction, contributing to the increase in complaints that we have seen over the last few years.

Some communication themed complaints related to a lack of communication about how patients should manage their condition and aftercare on discharge from hospital. Prolonged wait times for appointments, diagnoses, and treatment were a frequent source of frustration and complaints often related to the quality of care received, including issues with nutrition, hydration, and overall attention to patient needs.

Our administrative processes can sometimes be convoluted and inefficient. Delays in receiving important information, such as test results, appointments and treatment plans were all commonplace issues having an impact on our patients. These administrative bottlenecks led to frustration and a perception of poor communication, even when the patient acknowledged that clinical care itself was good. Difficulties getting through to wards and departments on the phone remains a theme in complaints as well as letters arriving after appointment dates.

Patients and their families have complained about rude, unprofessional, or indifferent staff members, who make them feel unwelcome, uncomfortable, or unsafe. They also perceive a lack of empathy, respect, or courtesy from the staff and often told us they didn’t feel listened to.

By addressing these issues thoughtfully and proactively, we can improve communication and enhance patient and carer experience and satisfaction. Improving communication is a key theme in Care Group and corporate patient experience improvement plans for 2025/26.

3.2 Communication: Accessible Information Standard

All NHS organisations are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Two formal complaints were received in 2024/25 relating to the Accessible Information Standard. One patient attended an audiology appointment and was not provided with suitable support or advice leaflets in a larger print. This complaint was upheld, and training provided to the member of staff.

In the second case the patient attended Scarborough Hospital for an MRI and no British Sign Language (BSL) interpreter was provided, despite assurance some years ago that he would have access to an interpreter for all his future appointments. His complaint was upheld and resulted in a full review and the team was briefed on how to access and use the translation and interpreting tablet to access the Trust's BSL service.

4. Any matters of general importance arising out of those complaints, or the way in which the complaints were handled.

The national regulations, together with guidance from the Parliamentary and Health Service Ombudsman, indicate that the Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed.' When a response is not possible within the agreed timescale, the investigating officer should inform the complainant of the reason for the delay and a new date is agreed by which the response will be sent.

On average 49% of closed cases met the Trust's response target.

2024/25	2023/24	2022/23	2021/22	2020/21	2019-2020	2018-19
49%	49%	55%	57%	57%	41%	36%

Overall performance in responding to complaints was 49%, the same as in 2023/24 and the focus for 2025/26 will be to improve the quality of our complaint process, investigations, and responses.

An effective complaints process requires a strong partnership between the Patient Advice and Liaison Service (PALS) and Care Group managers and clinicians. For the process to work well, an investigator needs to be allocated quickly by the Care Group leadership team. An investigator must also have the capacity to spend time, both on the investigation itself and on engaging with the complainant. Workforce issues do at times, impact on this process

Plans have been established to host a Rapid Process Improvement Week in June 2025, sponsored by the Chief Nurse, with representatives from PALS, Care Groups and corporate staff, supported by the Trust's Quality Improvement Team with the objective of identifying and implementing changes to improve the effectiveness and efficiency of our complaints processes and procedures.

5. Care Group Actions to improve performance

Medicine Group has extended the current weekly complaint meeting time to enable all investigating officers to attend for support and advice from the senior team. They have changed the way responses are submitted for approval to prevent delays and the senior team members who quality check complaints are working together to standardise advice given to the investigating officers.

Surgery Group has continued with weekly complaint meetings to try and improve response times and support investigating officers. This has helped in building the confidence of investigating officers to contact complainants early and try to resolve concerns informally.

The Deputy Director of Midwifery commenced in post in November 2024 and has implemented a weekly complaint meeting to ensure there is support and guidance for the team. A midwifery staffing gap has been identified of 44 WTE Clinical frontline Midwives following the midwifery workforce review and BirthRate+ findings in 2024. This poses a risk as there is no long-term solution. The short-term solution is to mitigate using bank, agency midwives and redeploy specialist midwives and managers. The redeploying of the midwifery management team and specialist midwives continues to hinder progress in the quality and safety portfolio.

6. Examples of actions that have been taken to improve services as a result of complaints

Communication is a strong theme across incidents, complaints, and concerns and Medicine Group is piloting a bedside handover on ward 33 and 36, which will be rolled out across the organisation. Evidence shows that this improves communication for patients, and reduces risks and incidents, as clinical teams are seeing patients straight away.

Ward 37 introduced a communication log very successfully to keep families up to date and the plan is to roll this out to all wards. Ward 37 has also undertaken a refurbishment of the relative's room with relevant resources in relation to patient pathways and discharges.

Ward 39 created infographics of the patient pathway and a ward/hospital information leaflet. They created a patient/relative space and ward information cards as well as a nutrition board. As a result of these changes, they saw a reduction in the number of complaints and an increase in patient satisfaction.

There has been a review of the streaming and triage process at the front door in response to concerns regarding delays and the Trust has taken part in Emergency Department improvement sprints with regional teams to reduce waiting times.

Surgery Group launched a pilot project for the wards, with a poster and contact details for a dedicated phone number for the matron team so there is always someone available Monday - Friday to speak with patients and their families if required. They have also engaged with IT services to move some of the ENT and Audiology telephone numbers to a queuing system to support patients being able to get through.

Complaints are now used in training modules as part of the maternity core competency framework. In addition, anonymised complaints have now been included in the Maternity unit level meetings to share learning with staff.

The Maternity Services have commenced using the action plan tab on Datix in February 2025 to ensure there is evidence of addressing from complaints going forward. This will support oversight of themes and improvements going forward. Patient feedback is also triangulated from the Maternity CQC survey annual results and a co-produced action plan has been developed by the Maternity and Neonatal Voice Partnerships (MVNP). The action plan was presented at the Patient Experience Subcommittee in February 2025. In addition, the Maternity Service undertakes a triangulation of complaints, incidents and claims on a bi-annual basis. The last report was presented at Quality Committee in February 2025.

The Maternity Services also has a Non-Executive Safety Champion who has oversight of maternity services with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. The MNVP chair is a core member of the Safety Champions meeting. In addition, there is a monthly MNVP meeting.

Over the last 18 months there have been many projects undertaken in Maternity to support themes identified from the NHS claims scorecard, NHS Resolutions thematical review, thematical review from Serious Incidents/ Patient Safety Incident Response Plan and feedback from the CQC women's experience survey, the Friends and Family Test (FFT) and complaints. Examples are Prevention and Management of the Postpartum haemorrhage action plan, documentation on BadgerNet, interpreting services and personalised care plans and consent.

In response to a complaint about the lack of appropriate facilities for an autistic child, paediatrics reviewed the use of flash cards to help ascertain if non-verbal children do feel sick or dizzy and trigger concerns post head injury. There is a plan to link in with the play team to discuss the possibility of the provision of dark glasses, headphones and fidget toys as a further option plan in addition to a quiet space or in the absence of one.

Patient Access has introduced an email address that patients can use as well as a telephone number as a direct result of an autistic person complaining about the lack of options for neurodivergent individuals. The patient was grateful that his concerns had been listened to and constructive changes made.

7. Looking Ahead: Quality Priorities 2024/25

- Streamlining the complaints processes for greater efficiency.
- Introducing the Action module for complaints on Datix across all care Groups so that we have a reportable way of capturing actions taken as a result of complaints and to better share learnings.
- Continue with support and training for investigating officers, including PHSO complaints training, letter writing skills training and customer service training
- Explore ways of garnering complainants feedback about the process of making a complaint.
- Care Groups to continue focus on improving response times.

8. Conclusion and request for the committee

Complaints are often viewed as negative and consume significant resource and time in addition to the emotional impact on both patients and staff. Our refreshed Trust strategy focusses on putting patients first and delivering safe and compassionate care every time. An important aspect of this is the way we respond to feedback from patients, carers and their families. People have the right to raise concerns about their experience and we should endeavour to respond in a timely way, ensuring we learn from feedback.

The committee is asked to note the contents of the report and continue to support the work being undertaken to improve patient experience.

Date: 4 June 2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

Report to:	Council of Governors
Date of Meeting:	10 September 2025
Subject:	Reports from Board Sub-Committees
Director Sponsor:	Martin Barkley, Chair
Author:	Tracy Astley, Governor & Membership Manager

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

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

Trust Objectives

- ☒ Timely, responsive, accessible care
- ☒ Great place to work, learn and thrive
- ☒ Work together with partners
- ☒ Research, innovation and transformation
- ☒ Deliver healthcare today without compromising the health of future generations
- ☒ Effective governance and sound finance

Board Assurance Framework

- ☒ Quality Standards
- ☒ Workforce
- ☒ Safety Standards
- ☒ Financial
- ☒ Performance Targets
- ☒ DIS Service Standards
- ☒ Integrated Care System
- ☒ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction. This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

This paper provides the escalation logs from each sub-Board committee. The Council of Governors is asked to note the report and the authors will respond to any questions or comments, as appropriate.

Quality Committee Reports

Date of meeting:	19th August 2025
Chair:	Lorraine Boyd

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

ALERT

* **Short notice withdrawal of ICB funding for patient transport services** from 10pm to 7pm both sites causing issues with flow through high acuity spaces as well as other areas of the hospitals. Discussions re timely resolution with ICB and YAS are ongoing.

* **Resident doctor deficit** for current bed base and activity has been flagged by multiple stakeholders. A supported review is underway and recommendations to be presented to the Executive Team.

* **FU delays of >2 years for cardiology partial bookings** and patients effectively lost to FU with resultant increasing clinical risk as time goes on. Issue being incorporated into cardiology service review. Recovery actions to be defined by mid Sept. Exec oversight and support is required with an update report to Quality Committee in October.

ASSURE

MEDICINE CARE GROUP (MCG)

* highlighted an increase in the number of falls in the last 2 months has been identified through current governance processes and a deep dive is underway to support understanding and required action. Progress will be monitored by the Falls Prevention Group and reported via the Clinical Effectiveness Subcommittee.
* an increase in controlled drug (CD) incidents has been identified in ED in the last 2months. A deep dive led jointly by pharmacy and nursing teams is underway, as well as immediate measures to reinforce CD policies. Progress will be monitored through ED & CG governance processes and escalated as necessary.
* patient experience data identifies a theme around pain assessments and control. A review to support understanding and improvement is underway and expected to be completed by end of October.

MATERNITY UPDATE

* PROMPT and foetal monitoring compliance has been achieved across all required professional groups following focussed improvement work and a rolling plan is in place to ensure improvements are sustained and maintained.
* there is a current assurance gap in Newborn Basic Life Support Training with a clear plan to address by September.
* Maternity Claims Scorecard was received, discussed and approved in line with MIS requirements. Assurance was provided to support the integration and triangulation of this information with that from other sources, shared throughout the year with Quality Committee, and to inform the ongoing development and delivery of the Maternity Single Improvement Plan.

* **AHP Strategy (Year 3) Delivery Annual Update** highlighted the extensive work undertaken to enhance the AHP profile across the organisation, delivery performance and triangulated quality and safety measures. The follow on strategy will be more integrated, encompassing nursing & midwifery as

well as AHPs and be informed by the anticipated new strategy to be launched by the NHSE Chief Nurse in October as well as the National AHP strategy.

* **Patient Safety & Clinical Effectiveness (PSCE) Group**
* have undertaken a deep dive into the longest overdue incidents and are supporting the Care Groups to improve oversight and governance.
* are undertaking a learning response audit to understand how PSIR framework is embedded and working for the Trust. Summaries of learning responses will be appended to future reports for added assurance.

ADVISE

* **SSNAP data** gives a rating of E for stroke care. Framework for assessment has changed, making direct comparisons difficult, nonetheless it is an area of concern. Work is ongoing around skill mixes and MDT members supporting therapy delivery**.**

* **MIS funding** of c£420k has been awarded to the Trust to support delivery of MIS year 7 safety actions. Audit Lead Midwife, PMRT & ATAIN Lead Midwife and PMA Lead roles will be developed in 2025/26.

* **Maternity Funding** has been identified to support 16.29 WTE midwives, closing the gap from Birthright plus recommendations to 30.31WTE. A plan to further close the gap by 2027/28, in response to the Trust Board funding commitment, and ensure new midwives are deployed safely and in line with priorities is in development and a draft will be shared with Quality Committee in September.

* **NHSE MSSP review and reset meeting** was positive. It was agreed the Trust would remain in the Improvement Phase of the programme and next review in 6 months.

* **Maternity CQC Section 31 Update** was received and approved on behalf of the Board.

* **Maternity and Neonatal Safety Champions Report** outlining the requirements and aligned activity was received and discussed in line with MIS requirements.

* **Q1 IPC update** presented a mixed picture with Clostridium Difficile (CD) and Pseudomonas infections matching improvement trajectories, but all other monitored Health Care Acquired Infections are above improvement trajectories. Learning outcomes, education initiatives and plans for improvement were shared.

* **Q1 Safeguarding Report** highlighted improving compliance with SAAF, meeting 69% of requirements. Mitigations and work in progress to close the assurance gap were presented and discussed.

* **Trust Cancer Strategy 2025 - 2030** was reviewed and fully endorsed as a document which is focussed and visionary and well aligned to the Trust values and the NHS 10 year plan.

* RISKS DISCUSSED AND NEW RISKS IDENTIFIED

* **Haemodialysis** is an ongoing risk for medicine care group in terms of capacity, infection control and estate challenges. A service review is underway and an estates options appraisal should be shared with Executive team by Sept 25.

* **High number of medical outliers** (frequently >50) impacting on specialty alignment & flow.

* **Cardiology service** is noted to be an area of increased clinical risk as a result of FU delays and rising RTT with a risk of breaching the 65w target for some patients. Detailed service review to understand gaps and support development and transformation of integrated service across both sites, with expected completion by mid September.

* **Medicine Care Group Risk Registers** have been reviewed and streamlined, resulting in greater confidence in visibility of the risks and issues and a feeling of better grip and control. In turn this is enabling the challenges to be effectively prioritised.

* **Safeguarding Level 3 training compliance** remains suboptimal without significant change from last report. As such it remains on the Trust Risk Register.

Date of meeting:	July 2025
Chair:	Lorraine Boyd

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

ALERT

Delays in Medical Review for Outlier Patients were highlighted by the Surgery Care Group as an ongoing issue, with negative impacts on patient experience, flow through the hospital and working relationships and communication. A collaborative, systematic approach will be required to fully understand and address this issue.

Surgical treatment delays following fractured neck of femur fall well short of the 'within 36 hours' national target (90%) and national average (60 %) at 47% and 55% in York & Scarborough respectively. Business Case for additional trauma lists is in development and, given the poor patient experience and risk of patient harms from prolonged delays, an urgency to addressing this issue was recommended.

Annual Complaints Report identifies a 49.6% rise in the number of complaints (1221) in 2024/25 compared with 2023/24. Delays in diagnosis and treatment, attitude of nursing and medical staff and poor communication with patients and carers were the outstanding themes.

NICHE report recommendation that Board level insight into caring for patients with health concerns needs further consideration and strengthening. In addition, significant gaps in assurance relating to training and support for our staff in the care of patients with mental health issues were discussed and will be addressed through the development of comprehensive improvement plans and strengthened collaboration with the mental health provider TEWV. Monitoring will be through Complex Needs Assurance Group reporting into Patient Safety & Clinical Effectiveness who will update and escalate to Quality Committee. Board and CQC will also be kept informed of progress.

ASSURE

3 annual reports and one quarterly report were received and discussed, and an assurance update was provided by Surgery Care Group.

Quality Account, outlining **a** review of the past year's activity, particularly in relation to the quality and safety of care provided, was presented and reviewed. Progress during the past year towards fulfilling our priority ambitions was outlined and challenges acknowledged. The evidence provided was well aligned to the work of the Quality Committee across the same period. Plans to continue to pursue the aims and ambitions for 2025/26 were outlined and will continue to be monitored through Quality Committee work programme.

Complaints Annual Report was received, discussed. The Trust meets its statutory obligations for complaints handling. Performance is unchanged from last year with 49% responded to within proscribed timescale in 2024/25. Evidence of improvement work to streamline processes and focus on better learning was shared. Care groups have increasingly taken ownership of this work, with support, as necessary. Examples of actions taken by the Care Groups to improve services as a result of complaints were provided. Goals to support further improvement in 2025/26 were identified.

Complex Needs Annual Report highlighted the significant progress throughout 2024/25, particularly the development of a clear supporting governance structure and sense of purpose. There remains a significant assurance gap in relation to caring for patients with mental health

needs and active plans are in place to address this. Quarterly update reports will come to Quality Committee.

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

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

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

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

ADVISE

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

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

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

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

PPH improvement work continues and progress has been made and sustained

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

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

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

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

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

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

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

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

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

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

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

Date of meeting:	June 2025
Chair:	Lorraine Boyd

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

ALERT

* **Sepsis Report Emergency Departments** highlighted a gap in assurance on our ability to deliver safe and effective care. There are delays in time to see a doctor and poor performance against the target to administer first antibiotics within an hour of suspected sepsis. There is variation within and between the sites. Audit of the sepsis pathways is ongoing and measures to sustain improvements are being undertaken. Triangulation with other influencing factors eg operational pressures, staffing constraints is taken into consideration. Undertaking the necessary audit to support improvement work on the Sepsis Pathway in in patient areas is proving particularly challenging and this is a significant assurance gap.

* **Maternity Safe Staffing updates** indicate that increased current vacancies, due to a combination of promotions, maternity leave and leavers, alongside the establishment gap identified by Birthrate plus assessment, are testing the resilience of the already challenging mitigations in place to support safe staffing, particularly on the York site. Discussions on a number of potential resource releasing solutions within Maternity, across the organisation and within the ICB are ongoing and may provide a partial relief if realised. This safe staffing risk is on the both the Trust and ICB Risk Registers. Allied to this, the short term solutions to the

immediate issues, using released resource, may result in an inability to secure the services of our newly qualified midwives in September, presenting a risk to future workforce planning.

* **Gynaecological Cancer performance has deteriorated and a significant cause for concern,** presenting an increased risk of patient harm. Plans for immediate improvements were shared and are expected to impact positively in the next few months. Changes in disease patterns and the longer term implications for demand upon the services are recognised. Collaborative work with primary care to optimise patient pathways is ongoing.

ASSURE

*** 1 quarterly and 3 annual assurance reports were received and discussed, as well as a number of update reports.**

*** Family Health Care Group provided an assurance update, highlighting their current risks and plans to mitigate and address.**

*** Maternity Quality & Safety Metrics Report was received and discussed.** A rise in number of open incidents was noted and a plan to reduce was in place, focussing on oldest incidents first and overseen by the Medical Director.

* **Learning from Deaths Quarterly Report received.** Gap in assurance was identified by LfD group, relating to perinatal and paediatric deaths, which are subject to bespoke processes within the Care Group. This data is now also centralised into the Datix Mortality module to facilitate discussions at LfD group.

* **Infection Prevention & Control Annual report** was received. Meeting IPC expectations has been a significant challenge over the past year and is recognised to require improvement. There has been and continues to be a strengthening of governance processes to underpin improvements and in particular a focus on Care Groups taking ownership and accountability for delivery of the agenda. Wards or departments flagging to be of particular concern through audit or other triangulated data are proactively supported in improvement by the IPC team and / or Anti Microbial Stewardship Team.

* **Safeguarding Annual Report**, providing an overview of the safeguarding work undertaken during the year and assurance that our practices in the Trust are compliant with national statutory and mandatory requirements, was received and approved. Gaps in compliance with Safeguarding Adults Assurance Framework in areas of Leadership & Governance and Workforce were noted with plans in place to address. The introduction of Domestic Abuse Practitioners has had a demonstrated significant positive impact on identification and referral of individuals at risk.

*** Palliative and End of Life Care Annual Report outlined the increase year on year of the number of patients requiring specialised services.** This trend is expected to continue. The work to improve delivery and optimise resources to meet this rising demand was shared along with a recognition of a need to support the education of all staff groups in Palliative & End of Life care on the basis that 'good EOL care is everyone's business'

ADVISE

* **Family Health Care Group** shared that the Paediatric Consultants in Scarborough had been recognised by HYMNS excellence award nomination and the innovation work Speech & Language Therapy Team to address paediatric long waits for their services featured on the Future NHS platform for wider sharing.

* **Community Therapy & Response Teams** are a key, but limited, resource that can impact positively on the flow into and out of the acute sites. Fully understanding and quantifying the impacts of the interventions would provide assurance that the resource is being used to best effect and highlight gaps to address. A report to that effect will come to the Committee in a couple of months

* **Maternity Incentive Scheme Year 7** compliance is an improving picture with clear plans in place to deliver and areas of particular challenge understood. Action plans have produced within NHSR timescales. Transitional care services and workforce planning (SAs 3,4 &5) represent the highest risk to achievement and are on the care group risk register. Progress will be monitored quarterly by Quality Committee.

* **Maternity Section 31** monthly submission was discussed and Board approval recommended

* **British Association of Paediatric Medicine (BAPM) standards** for safe neonatal nurse and medical staffing are currently not being fully met. Mitigations are in place to support patient safety and plans to reach compliance are in train. The issue is on the Trust Risk Register.

Resources Committee Reports

Date of meeting:	19 August 2025
Chair:	Helen Grantham

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

ALERT

- Cancer – not meeting trajectory for faster diagnosis standard (FDS) and 62 day waits for first treatment (latter continuing to show a deteriorating position)
  - FDS – 67.9% against a trajectory of 71.4% - ranked 128th out of 137 nationally
  - 62 day waits for first treatment – 62.2% against trajectory of 71.7% - ranked 98th out of 145 nationally (ranking a slight improvement on prior month)
  - Continued risk that year-end target will be missed
  - some positive areas, however, colorectal, gynaecological and urology continuing to be the particular areas of concern
  - impact of diagnostics – see below
  - July 2025 saw the highest referrals for urgent suspected cancer in trust history

- Diagnostics – deteriorating position
  - 63.3% against trajectory of 71.4% - ranked 131st out of 157 nationally
  - improvement expected in endoscopy following in-sourcing commencing september - could take up to 6 months to fully clear backlog
  - CT breakdowns continue to impact delivery
  - some areas of improvement however MRI, barium enema, audiology, sleep studies, colonoscopy, flexi sig, cystoscopy and gastroscopy all significantly behind planned trajectory
  - detailed written information was provided on 15 DM01 reportable diagnostic tests covering performance against planned trajectory, expected impact of planned improvement schemes, actions planned and associated risks by test – more committee time was needed to gain assurance on the different modalities and the plans to bring performance back on track - the RC Chair and COO to speak – the aim is that groups of modalities will come to the committee for discussion at meetings over the next few months
  - discussion ongoing with Harrogate Trust to understand if any support can be provided

- RTT – total waiting list (TWL) continues to increase due in part to ongoing review of all waiting lists and movement of some patients to RTT list, although ahead of the trajectory for RTT waiting list waiting under 18 weeks
  - 55,405 against trajectory of 45,129
  - 55 th highest out of 152 nationally for proportion of waiting over 52 weeks (a deteriorating position)
  - 102nd out of 152 nationally for waits under 18 weeks – maintaining position
  - Committee monitoring waiting lists review work
  - The planned roof repair work at Scarborough would further impact on elective activity and a plan would be provided to the committee of expected impact and planned mitigating action

- Rapid access chest pain metric significantly below target despite plans being in place to recover performance to 99% of RACP being seen within 14 days of referral – being monitored

Finance

- £3m adverse variance to plan – discussions on:
  - FY risk, cost improvement plan, colleague pay and medical rosters, sparsity and ERF payments and cash
  - NHSE approach to deficit funding and associated risk
  - A paper on the efficiency programme and potential for a committee deep dive in this area
  - Positive work to reduce agency spend

Tiering

- The committee discussed NHS tiering – which was expected to be published later in the year.

ASSURE
○ The good progress continues on Emergency Care Standard, 12-hour trolley waits and ambulance handover with work still to do ○ ECS 69.7% against the planned trajectory of 71.1% and a target year-end of 78% - this is the highest performance since August 2023, although the Trust is ranked 81 out of 121 providers nationally ○ Average Ambulance handover times continue to improve ahead of trajectory at approx 22 minutes 11 seconds v trajectory of 30 minutes 12 seconds, although the rate of improvement is slowing ○ 12.9% of type 1 admissions spent over 12 hours in ED (a slight increase on prior month) and slightly worse than monthly trajectory of 12.2% ○ Against a backdrop of type 2/3 attendances significantly above trajectory and type 1 slightly below ○ Good progress continues towards meeting the required core standards for emergency preparedness, resilience and response
ADVISE
- The Committee has agreed a new approach to committee agendas and papers - to enable good discussion on key risk areas/projects with a rotational focus on performance in finance, workforce, operations and YTHFM – the committee will review the approach in early 2026. - Introduction of Nervecentre will support the move to Emergency Care Data Set (ECDS) version 5 and will mean that Same Day Emergency Care patients will not be counted as admissions. - A presentation was given on the Integrated community model of care – next steps were noted and the committee and Board would be updated as the future approach and options for the trust become clearer - The further work on nursing and AHP priorities was noted - future work in the areas of workforce strategy, expanding local recruitment and apprenticeship priorities, strengthening exit interview processes, financial planning and modelling and monitoring fill rate to ensure patient safety
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
- On 1 September 2025, the new Scarborough, Hull, and York Pathology Service (SHYPS) Laboratory Information Management System (LIMS) goes live across the Scarborough, York and Hull Hospitals – while extensive planning and testing has been undertaken there is a risk that the implementation of the new system causes disruption and potential for operational and reputational risk. - Cancer faster diagnosis and diagnostics' performance – see above - Risks to delivery of financial plan

Date of meeting:	July 2025
Chair:	Helen Grantham

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

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

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

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

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

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

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

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

- Other unions conducting indicative ballots

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

- Cyber security – see below

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

ASSURE

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

ADVISE

- Positive progress shown on nursing and AHP priorities

- Positive progress on appraisal/revalidation for medical colleagues – more to do on mandatory training

- Process for agreeing medical agency spend noted – Director of Workforce & OD and Medical Director to approve

- Planning ongoing for organisational change – potential timing and budget impact noted

- Committee reviewing approach to agenda/papers to focus on exec delivery in key areas/risks

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Final risk report in current format – future reports will be in line with previous Board discussion

- The risk management report to include updates from Risk Sub-Committee– key items discussed/actions/timing etc

- Cyber security – action to address NHS benchmark – Digital Sub-Committee monitoring

- EPR – delivery of project and realising benefits – proposal for development session at Board - Cancer faster diagnosis and diagnostics performance – see above

Date of meeting:	June 2025
Chair:	Jim Dillon

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

ALERT
▪ April Emergency Care Standard was 68.6% against a target of 69.4%. The Trust is ranked 21st out of 22 providers in the North East and Yorkshire Region and 103rd out of 121 nationally. ▪ Cancer 28 day faster diagnosis was 67.3% against a trajectory of 70.5%. The trust is ranked 134 out of 140 nationally ▪ Maintaining operational performance over weekends a challenge due to staffing issues ▪ Proportion of patients discharged on their discharge ready date was 85.5% against a trajectory of 88.7% ▪ The number of patients with NCTR continues to cause concern with 17.1% against trajectory of 14.7%. ▪ Committee concerned that the continued deterioration of CT scanning equipment is significantly impacting diagnostics. This issue requires immediate addressing. ▪ Cancer diagnosis hindered by primary care not agreeing to pre screen patients in some area of the trust.
ASSURE
▪ Average Ambulance handover times continue to improve ahead of trajectory at 23 minutes and 24 seconds against a trajectory of 40 minutes and 32 seconds ▪ 12.7% of type 1 admissions spent over 12 hours in ED ahead of a 16% trajectory
ADVISE
▪ Discussion took place on the need to align workforce planning with operational planning, efficiency programmes and financial plans. ▪ Work ongoing on the validation of the outpatient tracking list ▪ A revised Colleague Experience Improvement Plan in response to the staff survey presented as a framework for the Trust to move forward. The Committee stressed the need to produce a related plan for staff consumption based on a “you said, we will do” format.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
No new significant risks identified

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 12

Report to:	Council of Governors
Date of Meeting:	10 September 2025
Subject:	Governors Activities Report
Director Sponsor:	Martin Barkley, Chair
Author:	Tracy Astley, Governor & Membership Manager

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

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

Trust Objectives

- ☐ Timely, responsive, accessible care
- ☐ Great place to work, learn and thrive
- ☒ Work together with partners
- ☐ Research, innovation and transformation
- ☐ Deliver healthcare today without compromising the health of future generations
- ☒ Effective governance and sound finance

Board Assurance Framework

- ☒ Quality Standards
- ☐ Workforce
- ☒ Safety Standards
- ☐ Financial
- ☐ Performance Targets
- ☐ DIS Service Standards
- ☐ Integrated Care System
- ☐ Sustainability

Equality, Diversity and Inclusion requirements

This report has been considered by the director sponsor, with a view to ensuring that any service provision and work practices tackle health inequalities and promote equality, diversity, inclusion and human rights with the highest possible standards of care and outcomes for patients and colleagues.

Sustainability

This report has been considered against the Trust Green Plan and reports on how this work will help to meet the Green Plan targets under one or more of the workstream areas that can be found in the Green Plan. If required a consultation will have taken place with the Trust's Head of Sustainability where comments and direction from this consultation will be noted in this report and how this work will meet that direction. This report also advises where it impacts on the broader aspects of sustainability - economic, environmental and social.

Recommendation:

This paper provides an overview of Governor Activities. Reports are provided on the following: Lead Governor, Membership Development Group, Constitution Review Group, and the Out of Hospital Care Group.

The Council of Governors is asked to note the report, and the authors will respond to any questions or comments, as appropriate.

Governors Activities Report

1. Lead Governor Report

I have summarised below some of the activities I have undertaken since my last report to the CoG (Council of Governors) meeting held on 11th June 2025.

Anti-racism Steering Group
The work of the Anti-racism Steering Group continues to progress. Two meetings were held since the last CoG meeting and the Y&STHNHSFT Anti-racism Statement was finalised.

Selby constituency meeting
The Selby constituency meeting was held on the evening of 11th June and chaired by Martin Barkley. Unfortunately, the member attendance (three attendees) did not improve irrespective of changing the venue and the timing for the event compared to the previous meeting.

York constituency meeting
The York Constituency meeting, chaired by Martin Barkley on the evening of 31st July was attended by 17 Trust members and the Governors Beth Dale, Ros Shaw, Mary Clark, Jason Rose and me. The meeting was also attended by Mike Taylor (Associate Director, Corporate Governance), Lucy Brown (Director of Communications) and Tara Filby (Deputy Chief Nurse). A very useful discussion on various matters were held.

Hambleton, Ryedale & East Yorkshire constituency meeting
A joint Hambleton, Ryedale & and East Yorkshire constituency meeting, chaired by Martin, was held on the evening of 14th August in Malton. The meeting was attended by 9 Trust members and joined by Lucy Brown and me. Once again, a very useful discussion was held.

CEO recruitment
I was very pleased to have been involved in the recruitment of a new CEO for the Y&STHNHSFT in August. Staff Governors were involved in a focus group that provided feedback to the interview panel that unanimously agreed to appoint Clare Smith as the Trust CEO to begin her appointment this autumn.

Forum meeting
The Council of Governor Forum meeting was held on 13th August, which I chaired and was attended by 9 governors and the Governor Manager, Tracy Astley. Issues were discussed and actions to address were taken forward.

Out of Hospital Care Group meeting
The Out of Hospital Care Group was re-launched with new membership and a new chair, the appointed Governor Elizabeth McPherson (CEO, Carers Plus). Lorraine Boyd (the Senior Independent Director at Y&STHNHSFT) represents the NED in this group. The group is seeking for governor representation from each of the constituencies as well as representation from the Executive Team. Terms of Reference were established. I would like to thank Elizabeth for taking up the chair role of this group in addition to her busy role at Carers Plus.

Constitutional Review Group and the Membership Development Group
We are actively looking for a Governor/s to chair for these 2 groups following Michael Reakes departure as a governor after 9 years. I would whole heartedly like to thank Michael for his immense input, focus and dedication over the last several years to put order, structure and outputs to these two groups.

Hambleton Governor
I would like to thank Catherine Thompson, who has also served as a governor for 9 years. Your knowledge and thought-provoking input to the discussions will be sorely missed.

One-to-one meetings with the Chair and SID
I hold monthly meetings with Martin Barkley and Lorraine Boyd, where Governor concerns, Trust progress and governance matters are discussed and actions agreed.

I would like to thank Martin and all the NEDs for their continued efforts to work with the CoG to improve patient care. I would also like to thank Tracy Astley for all her support over the last four months.

Rukmal Abeysekera
Lead Governor

2. Membership Development Group (20.08.25)

Governors on the Membership Engagement Group (MEG) review actions within the Membership Engagement Action Plan, which has three goals: 1) increase the size of the membership; 2) increase the diversity of the membership; and 3) improve engagement and communication with members.

The primary action to increase membership and diversity is to place membership postcards in a variety of community areas, and in all waiting areas of our hospital facilities. Governors and staff have been tasked:

- the Governor and Membership Manager periodically places the cards in the waiting areas at York hospital
- the Director of Communications regularly distributes the postcards with the Staff Matters magazine
- the Director of Communications also arranges advertising via digital social media such as Facebook.
- Membership banners will be located in prominent locations at York and Scarborough Hospitals.
- York Hospital Radio is also playing adverts for Trust Membership.

With respect to engagement, it is encouraging that there was a good turnout of members and the public at a face-to-face Constituency Meeting held at York on 31 July 2025. Similar meetings are scheduled in rotation for each constituency.

Data presented at the 20.08.25 MEG indicates that the actions taken are not having an effect to reduce the gradual long term decline in membership numbers. All the actions within in the plan need to be reviewed and actioned.

Governors on the MEG have developed a survey to seek inputs and priorities of our members and the public, and any responses will be reviewed at each meeting.

Michael Reakes
MDG Chair

3. Constitution Review Group (20.08.25 meeting postponed)

Governors on the Constitution Review Group (CRG) have the mandate to periodically review how many Public Governors are needed in each constituency and to review the constituency boundaries. The current version of the constitution defines constituency boundaries based on electoral wards areas, and the number of public governors for each constituency is based on the number of Trust Members living within those boundaries, regardless of whether they are likely to use the services of our Trust.

It has been agreed to research new Constituency boundaries based on readily available data (Middle Layer Super Output Areas or MSOA) which can define local areas and populations in which our Trust is the primary provider of acute hospital services. This work is being done by the Associate Director of Corporate Governance at the Trust and will take several months to compile. The advantage of the new approach is that the areas are well defined, and the associated populations that use our services are also better defined. It has been confirmed that the approach is acceptable to Civica, who manage the Governor elections.

Since this data is not yet ready, the 20.08.2025 meeting was postponed, and the upcoming Governor elections in September will be conducted using the old constituency boundaries. When ready, these proposals will be brought via the CRG to the Council of Governors, together with a review of possible changes to the Staff Governor representation.

Michael Reakes
CRG Chair

4. Out of Hospital Care Group (26.08.25)

This was our first meeting where we looked at the Terms of Reference and received a presentation from Shaun Macey, Assistant Director of Neighbourhoods York Place (NHS Humber & NY ICB). Outcomes from this meeting were:

a) **Change of name:** The group would like to change the name to better reflect its evolving focus on community and neighbourhood care. We would like the Council to discuss and ratify the new name (suggestions given at the meeting).

b) **Governor Recruitment and Engagement:** It was noted the current low engagement among governors and the need to recruit more proactive members, especially those involved with PPGs, to ensure the group reflects a broad range of community perspectives. We would like a representative from each constituency, if possible. If any governor is interested in joining then please contact Tracy for further information.

c) **Membership Expansion:** It was agreed that the membership be expanded to ensure broader representation and feedback from across the communities within the Trust footprint. The group will be looking to identify additional stakeholders and invite them to join the group.

Elizabeth McPherson
OHC Group Chair

Name	14.03.24 CoG	12.06.24 CoG	11.09.24 CoG	02.12.24 CoG	11.12.24 CoG	13.03.25 CoG	02.05.25 XCoG	11.06.25 CoG	06.08.25 XCoG	10.09.25 CoG	10.12.25 CoG	11.03.26 CoG
Martin Barkley (Chair)	√	√	√	√	√	√	√	√	√			
Rukmal Abeysekera (Public Governor – York)	√	√	√	√	√	√	√	√	√			
Cllr Jonathan Bibb Stakeholder Governor - East Riding CC			√	Ap	√	Ap	Ap					
Rebecca Bradley (Staff Governor - Community)	Ap	√	Ap	Ap	√	Ap	Ap	√	√			
John Brian (Public Governor - Ryedale & EY)	Ap	Ap	Ap									
Bernard Chalk (Public Governor - East Coast)								√	√			
Mary Clark (Public Governor - York)	√	√	Ap	Ap	√	√	Ap	√	√			
Cllr Liz Colling (Stakeholder Governor - NYC)	√	Ap	Ap	Ap	√	√	Ap	√	√			
Beth Dale (Public Governor - York)	√	√	√	√	Ap	√	√	Ap	√			
Abbi Denyer (Staff Governor - York)	√	√	√	Ap	√	√	Ap	√	√			
Adnan Faraj (Staff Governor - SGH & Brid)	Ap	√	√	Ap	Ap	√	Ap	√	√			
Paul Gibson (Public Governor - East Coast)				Ap	√	√	Ap	Ap	√			
James Hayward (Public Governor - East Coast)				Ap	Ap	√	√	√	√			

Name	14.03.24 CoG	12.06.24 CoG	11.09.24 CoG	02.12.24 CoG	11.12.24 CoG	13.03.25 CoG	02.05.25 XCoG	11.06.25 CoG	06.08.25 XCoG	10.09.25 CoG	10.12.25 CoG	11.03.26 CoG
Graham Healey (Staff Governor - SGH & Brid)				Ap	Ap	Ap	Ap	Ap	√			
Gary Kitching (Staff Governor - York)				√	√	Ap	√	√	√			
Graham Lake (Public Governor - Ryedale & EY)								Ap	√			
Wendy Loveday (Public Governor - Selby)	√	√	Ap	Ap	√	√	Ap	Ap	√			
Elaine McNichol Public Governor - East Coast)								√	√			
Elizabeth McPherson (Stakeholder Governor - Social Care)	√	√	Ap	√	√	√	Ap	√	√			
(Stakeholder Governor - Dementia Forward)	Ap	Ap	Ap	Ap	Ap	Ap	Ap	Ap	√			
Michael Reakes (Public Governor – York)	√	Ap	√	√	√	√	√	√	√			
Gerry Richardson (Stakeholder Governor – York University)	√	√	√	Ap	√	√	Ap	√	√			
Cllr Jason Rose (Stakeholder Governor - CYC)	√	√	√	Ap	√	√	Ap	√	√			
Ros Shaw (Public Governor - York				√	√	√	√	√	√			
Julie Southwell (Staff Governor - York)	√	√	√	√	√	√	√	√	√			
Catherine Thompson (Public Governor- Hambleton)	√	Ap	√	√	Ap	Ap	√	√	√			

Name	14.03.24 CoG	12.06.24 CoG	11.09.24 CoG	02.12.24 CoG	11.12.24 CoG	13.03.25 CoG	02.05.25 XCoG	11.06.25 CoG	06.08.25 XCoG	10.09.25 CoG	10.12.25 CoG	11.03.26 CoG
Franco Villani (Staff Governor - SGH & Brid)	√	√	√	√	√	√	Ap	√	√			
Linda Wild (Public Governor - East Coast of Yorkshire)	Ap	√	Ap	√	Ap	√	√	√	√			

ITEM 13.2

Name	14.03.24 CoG	12.06.24 CoG	11.09.24 CoG	11.12.24 CoG	13.03.25 CoG	11.06.25 CoG	10.09.25 CoG	10.12.25 CoG	11.03.26 CoG
Martin Barkley (Chair)	√	√	√	√	√	√			
Jenny McAleese	√	√	√	Ap	Ap	√			
Lynne Mellor	√	√	√	√					
Lorraine Boyd	Ap	√	√	√	Ap	√			
Jim Dillon	Ap	√	√	√	√	√			
Steven Holmberg	Ap	Ap	Ap	Ap	Ap	Ap			
Matt Morgan	Ap	Ap	Ap	Ap	Ap	Ap			
Julie Charge	Ap	√	√	√	Ap	√			
Helen Grantham	Ap	√	√	√	√	√			
Jane Hazelgrave						√			
Noel Scanlon						√			
Richard Reece									