York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 28th January 2026
Time: 9:00am – 12:30pm
Venue: Boardroom, 2nd Floor, York Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 26 November 2025** To be agreed as an accurate record.	Chair	Report	6	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	17	
6.	**Patient's Story** To consider.	Chief Nurse	Report	18	9:05
7.	**True North Report** To review the report.	Chief Executive	Report	31	9:25
8.	**Chair's Report** To receive the report.	Chair	Report	49	9:35

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	52	9:40
10.	**Quality Committee Report** To receive the January meeting summary report.	Chair of the Quality Committee	Report	98	10:00
11.	**Resources Committee Report** To receive the January meeting summary report.	Chair of the Resources Committee	Report	101	10:10
12.	**Group Audit Committee** To receive the January meeting summary report.	Chair of the Group Audit Committee	Report	104	10:20
13.	**Trust Priorities Report (TPR)** December 2025 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	 Chief Operating Officer Medical Director & Chief Nurse Director of Workforce & OD Chief Digital Information Officer Finance Director	Report	107 111 157 177 188 196	10:30
Break 11:20					
14.	**CQC Compliance Update** To consider the report.	Chief Nurse	Report	214	11:35

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Maternity Reporting** To consider: 15.1 Maternity and Neonatal Report 15.2 Maternity Safety Champion Report 15.3 Workforce: Midwifery, Neonatal, Nursing, Neonatal Medical and Obstetric, Anaesthetic reports 15.4 Maternity and Neonatal Voices Partnership (MNVP) Annual Report	Chief Nurse - Executive Maternity Safety Champion	 Report Report Report Report	 219 232 237 265	11:45
16.	**Mortality Review – Learning from Deaths Report** To consider the report.	Medical Director	Report	271	12:00
17.	**Update on actions to prevent Sexual Misconduct in the NHS – Trust Response** To consider the report.	Director of Workforce & OD	Report	288	12:10
Governance					
18.	**Emergency Preparedness, Resilience and Response (EPRR) Annual Self-Assessment** To approve the report.	Chief Operating Officer	Report	309	12:15
19.	**Q3 2025/26 Board Assurance Framework** To approve the Q3 2025/26 Board Assurance Framework.	Associate Director of Corporate Governance	Report	319	12:20

Item	Subject	Lead	Report/ Verbal	Page No	Time
20.	**Annual review of the Trust's and YTHFM Governance Framework** To approve the review of: 20.1 Review of the Trust Reservation of Powers and Scheme of Delegation, Standing Financial Instructions and Standing Orders 20.2 Review of the YTHFM Reservation of Powers and Scheme of Delegation, Standing Financial Instructions and Standing Orders	Associate Director of Corporate Governance	 Report Report	 338 344	12:25
21.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
22.	**Time and Date of next meeting** The next meeting held in public will be on 25 February 2026 at 9.30am at Scarborough Hospital.				
23.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
24.	**Close**				12:30

Minutes
Board of Directors Meeting (Public)
26 November 2025

Minutes of the Public Board of Directors meeting held on Wednesday 26 November 2025 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.30pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Ms Rukmal Abeysekera
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Ms Helen Grantham
- Mrs Jenny McAleese
- Mr Noel Scanlon
- Dr Richard Reece, Associate Non-Executive Director

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

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

In Attendance:
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 13)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Linda Wild, Public Elected and Lead Governor
- Ms Mary Clark, Public Elected Governor
- Mr Nick Bosanquet, Public Elected Governor
- Mr Graham Lake, Public Elected Governor
- Prof Gerry Richardson, Appointed Governor
- Cllr Tim Norman, Appointed Governor
- Ms Elena Clerici, Staff Elected Governor
- Two members of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting with a particular welcome to Ms Smith, attending her first meeting as the new Chief Executive, to Ms Abeysekera, joining her first meeting as a Non-Executive Director, and to new governors observing the meeting.

Mr Barkley recorded his thanks to Mr Bertram for his outstanding service as interim Chief Executive.

2 Apologies for absence

Apologies for absence were received from:
Ms Jane Hazelgrave, Non-Executive Director

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 22 October 2025

Ms Hansen proposed the following as an amendment to Item 5 *Matters Arising/Action Log,* with respect to BoD Pub Action 30:
Ms Hansen reported that the ICB had agreed to extend the service by two hours to midnight each weekday. This was not extended at a weekend, however. Ms Hansen advised that the reduction in transport options would impact on discharges, and inter site transfers, as well as increase pressure on the system, as community services were experiencing the same pressures. She would continue to escalate the issues to the ICB and agreed to prepare a briefing paper for Mr Barkley.

Subject to this amendment, the Board approved the minutes of the meeting held on 22 October 2025 as an accurate record of the meeting.

5 Matters arising/Action Log

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

BoD Pub 26 *Schedule a deep dive of Cancer performance for the Resources Committee*
The deep dive had taken place. The action was closed.

BoD Pub 32 *Provide a detailed timeline of the upgrade of the telephony system.*
Mr Hawkins had circulated the timeline. The action was closed.

BoD Pub 33 *Prepare a briefing paper for Mr Barkley on the impact of the reduction in the out of hours patient transport service.*
Mr Barkley had received the briefing paper. The action was closed.

BoD Pub 35 *Produce a summary paper for the Board on the approach to the EPR Tranche 1 go live date and to staff training.*
Mr Hawkins had circulated two papers to address the action, which as closed.

Ms Smith advised that the new Electronic Patient Record (EPR) programme would be a standing item on the Risk Sub-Committee agenda going forward. Mr Barkley confirmed

that a monthly EPR progress report would be on the Board agenda from January for at least 2026.

Action: Mr Hawkins & Mr Taylor

BoD Pub 36 *Add an item on the community model of care to the Private Board agenda for November.*
The item had been added, and the action was closed.

BoD Pub 37 *Include the metrics used by NHS England to determine the Trust's position under the National Oversight Framework in one section of the Trust Priorities Report (TPR).*
Mr Hawkins had circulated the metrics, and work was underway to include these in the TPR. A paper on the Trust's position in relation to the Framework had also been circulated. The due date was deferred to January.

BoD Pub 38 *Provide an analysis of the number of outpatient referrals which are not from GPs or consultant to consultant.*
Mr Hawkins had provided the analysis by email although the data only recorded referrals from consultants and GPs. Ms Hansen undertook to provide further details about the referrals to bring back to the Board. The due date was deferred to January.

BoD Pub 39 *Ask the Director of Midwifery to include information about the number of women affected by closures of Maternity Units in her reports to the Board.*
Mrs Parkes advised that the Director of Midwifery would provide a verbal update when she joined the meeting and the information would be included in her report going forward. The action was closed.

BoD Pub 40 *Provide further details of the adverse variance in debtors.*
Mr Bertram advised that the debts highlighted at the last meeting had now been cleared and the TPR showed a much improved position. The action was closed.

BoD Pub 41 *Consider which maternity metrics in the TPR could be removed from the report and add details of the number of women affected when a Maternity unit is temporarily closed.*
Mrs Parkes advised that the Director of Midwifery would add the key metrics to her monthly report, and these would be removed from the TPR. The action was closed.

BoD Pub 42 *Circulate information on how many SAS and Locally Employed doctors are HYMS graduates.*
Dr Stone provided details and advised that this would in future be added to the regular Medical Education report. The action was closed.

BoD Pub 43 *Work on the WRES action plan to be presented to the Board again at its meeting in November.*
The action plan was presented under Item 15. The action was closed.

6 True North Report

The Board received the report.

Miss McMeekin reported that completion rates of the national Staff Survey, which would close on 28 November, had thus far reached 53.7%, as compared to 36% for the equivalent date last year. Ms Smith noted that the higher completion rate would afford

leaders a broader understanding of staff members' views of the Trust. Directors agreed that the improved completion rate was positive.

Ms Smith acknowledged that neither the Emergency Care Standard (ECS) metric, nor the number of 12 hour waits in Emergency Departments (ED) were acceptable, but she was encouraged, in visiting ED, to hear staff members actively discussing the continuous flow model and keen to improve the ECS figure.

In relation to the Faster Diagnosis Standard (FDS) for Cancer. Ms Hansen reported that there had been agreement between the ICB and GPs to undertake dermoscopy services which would reduce the number of referrals and improve the FDS metric. However, there was a backlog of referrals to manage and no extra funding for resource. The improvement trajectory would be monitored by the Resources Committee.

Ms Hansen provided an update on the Referral To Treatment (RTT) waiting list. She cautioned that the year-end trajectory might not be met as the Trust had made the decision to focus on reducing waiting times for Cancer services. Weekly meetings with challenged specialties were being held.

A question was raised as to whether the reduction in the number of Category 2 pressure ulcers and Trust Onset MSSA Bacteraemia infections was sustainable. Mrs Parkes expressed confidence that the work with ward managers would underpin sustainable improvement in these areas.

Mr Barkley queried an action described in the report in relation to the number of bed days lost to patients with No Criteria To Reside, which was around discharge training for staff. Ms Hansen explained that the training had been rescheduled. There was some discussion on the application of the Choice on Discharge Policy: Mr Barkley was keen to see evidence that patients were moved in a timely way to more appropriate settings. Ms Hansen advised that more work was planned with ward managers and discharge teams to ensure that the policy was applied correctly and consistently. This would involve a change in culture.

Mr Barkley asked why the FDS metric had not improved when the Board had agreed to prioritise cancer referrals. Ms Hansen responded that the data was from September; October's data should evidence an improvement.

Mrs Parkes undertook to inform the Board of the planned date of submission of the Continuous Improvement Business Case to NHS England.

Action: Mrs Parkes

7 Chair's Report

The Board received the report.

Mr Barkley reported that the letter following the mid-year review of the Trust by NHS England had been received. The review included determining whether the Board had sufficiently strong ambition to achieve NHS constitutional standards and achieve financial balance. The letter confirmed that Mr Barkley and Mr Bertram had successfully communicated the Board's commitment to these obligations. NHS England colleagues had acknowledged the significant performance and financial challenges facing the Trust but were assured that the Board was clear on its priorities. The financial plan must be delivered. The letter also acknowledged the challenges of working within an ICB system

which was in flux, but wanted to see more evidence of partnership working. The Trust's progress against the actions would continue to be monitored and future support was conditional on progress being made.

Ms Hansen advised that NHS England representatives had discussed with the ICB issues previously noted around GP dermoscopy services and the reduction in the Patient Transport Service, which had been beneficial for the Trust. Mr Barkley added that NHS England had also been supportive of the decision to prioritise patients waiting for cancer services. Ms Smith added, however, that the trajectory for RTT still had to be met. Corporate Directors would allocate time to discuss the outcomes of the mid-year review.

8 Chief Executive's Report

The Board received the report, which was presented by Mr Bertram, this being his last report as Interim Chief Executive.

Mr Bertram recorded his congratulations to colleagues in Maternity Services following the removal of the Section 31 conditions on the Trust's registration for Maternity Services at York Hospital. He drew attention to the new 10 Point Plan to improve the working lives of resident doctors which Dr Stone would lead. This had been reviewed by the Resources Committee. The Committee requested that the Board include resident doctors in its programme of monthly visits to areas and services, and this was agreed.

Mr Bertram reported that all Chief Executives had been asked to consider their organisation's Anti-Racism Statement. The Trust's Statement had been revised and updated, following review by the Anti-Racism Steering Group, and Mr Bertram sought the Board's approval for the new version. A question was raised as to how staff working for the Trust could be clear that the organisation was anti-racist and how the actions would be evaluated and progress monitored. Mr Bertram referenced the No Excuse for Abuse campaign and explained that the success of the programme would be monitored via the Staff Survey which had specific questions relating to racism at work. These strategies would be supported by the NHS Workforce Race Equality Standard action plan. Miss McMeekin added that a new policy on managing violence and aggression had been published which needed to be fully communicated.

The Board of Directors approved the Anti-Racism Statement for publication on the Trust's website.

Mr Bertram reported that the planning guidance for 2026/27 had been published. The Trust would be submitting a 3-year revenue plan and a plan for performance. The guidance included details of a 4-year capital programme which would support the development of a multi-year capital programme. Mr Bertram noted that a number of elements in the guidance were new and needed to be worked through. The submission of the first draft of the plan for 2026/27 was due on 17 December with the final submission due in February. Mrs Parkes added that a robust Equality Impact Assessment (EQIA) process was now in place; directors were therefore sighted on the consequences of their decisions and the level of risk to patients and staff.

Mr Bertram also highlighted the financial control measures which must be implemented; the impact of these would be monitored through the Resources Committee and the Trust Priorities Report. Patient safety would be paramount.

The Board noted the publication of the Strategic Commissioning Framework and the ongoing recruitment process at the ICB for a substantive Chief Executive.

Directors were pleased to see the number of support workers nominated for Star Awards. Mrs Parkes was pleased to report that two Health Care Support Workers had been nominated for a national Chief Nurse award.

9 Quality Committee Report

Dr Boyd highlighted the key escalations from the meeting of the Quality Committee on 18 November 2025:

- the Trust had received a response from NHS Resources following a request for clarification of the Maternity Incentive Scheme (MIS) Safety Action 5 which related to safe midwifery staffing; the implications of this were being assessed;
- the Committee was pleased to note the removal of the Maternity Section 31; all information previously included in the Section 31 report was now incorporated in the other maternity papers presented to the Committee;
- the work resulting in the removal of the Section 31 notice and the ongoing improvement in Maternity services had been noted; the Maternity and Neonatal Voices Partnership (MNVP) had been central in the response to the CQC;
- the time taken for patients to access surgery for hip fractures remained a concern; a proposed increase in theatre capacity was going through the business planning process;
- water safety risks were being considered for escalation to the Corporate Risk Register, and the Committee had requested further assurance on this work;
- the Committee had discussed how best to monitor Board Assurance Framework risks, and it was agreed that it would focus on the three highest risks in future meetings.

Mr Barkley queried whether the Board should be concerned about safeguarding statutory compliance and quality of assurance. Mr Scanlon had noted gaps in the safeguarding report as there had been no reference to safeguarding activity which he would expect to see and thus it did not provide full assurance. The Head of Safeguarding had agreed to revise the report to include more information which would assure the Committee.

10 Resources Committee Report

Ms Grantham highlighted the key discussion points from the meeting of the Resources Committee on 18 November 2025:

- the Committee had undertaken a focussed review of diagnostic services; Ms Hansen had cautioned that the year-end trajectory would not be met due to MRI equipment and staffing capacity;
- a report had been received detailing actions to improve the performance of Cancer services; an EQIA had been undertaken for each of the proposed actions;
- a financial recovery plan was presented to the Committee; this required further work;
- in terms of assurance, the Committee had received the Safer Nursing Staffing report, and an update from York Teaching Hospitals Facilities Management (YTHFM); the six facet survey was due to be presented at the next meeting;
- there had been discussion on using innovation to drive improvement.

Ms Hansen observed that the performance of certain diagnostic services was a significant concern. As noted above, equipment and staffing were the key factors but the priority now

being given to cancer referrals would have an impact. She was confident that the team were reviewing every option to increase capacity.
Mr Scanlon reported that cancer diagnostic performance had also been discussed at Quality Committee, where Ms Hansen had provided assurance that employee relations issues in the MRI department were being addressed.

Ms Smith and Ms Hansen again drew the Board's attention to the clinical impact of the decision to prioritise cancer referrals. Ms Hansen emphasised that the impact of the actions agreed had been robustly assessed through the EQIA process.

11 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Mr Barkley expressed concerned at the increase in 12 hour trolley waits. Ms Hansen was confident that the figure would be much improved in November. A daily rhythm of meetings had been established which was facilitating patient flow from ED to the wards. The ward managers' new supervisory status was underpinning this. Ms Hansen added that senior leaders had engaged staff in the improvement plans which had been very impactful.

Ms Hansen reported that the response from teams in managing the impact of the resident doctors' period of industrial action had been remarkable. There had been minimal gaps in services and acute flow had improved due to the seniority of the decision making.

Mr Barkley drew attention to the positive metric for the 31-day treatment standard for cancer which was at 97.6% overall, achieving the national target of 96%.

There was some discussion on the Trust's approach to accepting lower gastrointestinal suspected cancer referrals without an accompanying faecal immunochemical test (FIT). Ms Hansen advised that this was under discussion with primary care.

Mr Barkley asked if Ms Hansen was confident that there would be no patients waiting over 65 weeks for treatment by year-end. Ms Hansen explained that patients were being tracked individually. Eleven patients waiting for cardiology services were most at risk of breaching the deadline and the delay arose from the wait for results of diagnostic procedures. She was, however, optimistic overall.

The Board noted the significant improvement in the number of patients accessing the Rapid Access Chest Pain Clinic within 14 days of referral and the significant improvement in CT diagnostic performance.

Ms Hansen was not confident that a target of zero children and young people waiting over 52 weeks for treatment would be met. She would include more information in the written commentary in the next TPR.

Action: Ms Hansen

Quality and Safety

Mr Barkley noted that the National Oversight Framework data which had been circulated before the meeting by Mr Hawkins demonstrated that the Trust's performance in infection prevention and control was deteriorating, whereas the TPR showed a more positive picture. Mrs Parkes would investigate this apparent inconsistency.

Action: Mrs Parkes

Mrs Parkes confirmed that there had been no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) for a few months as there had been a focus on improved cannula care, this having been the cause of a number of MRSA infections.

Mr Barkley drew attention to the high number of formal complaints received by the Trust. Mrs Parkes outlined the actions implemented to address the management of complaints which included a standard process across Care Groups and a zero tolerance of breaching deadlines for responses. Mrs Parkes expressed confidence that the position was improving and confirmed that robust leadership of the complaints process was now in place.

Maternity

There were no comments or questions on this section of the TPR.

Workforce

The Board noted that the substantive staff proportion of the total workforce had risen to over 93%, with a corresponding reduction in the use of bank and agency staff, which was positive.

Mrs McAleese drew attention to the sickness absence rate which was significantly above the target. This had also been discussed by the Resources Committee.

Miss McMeekin reported that the Trust had met the target for staff flu vaccinations set by NHS England and she confirmed that all clinical staff were now on eRoster which was very positive.

A question was raised about the changes to the national immigration policy. Miss McMeekin advised that these would impact on the Trust: international staff who could apply for leave to remain after 5 years were not doing so due to the cost and were therefore requesting that the Trust fund extensions to their time-limited visas which was an unbudgeted cost. Miss McMeekin flagged the need to create robust staff pipelines domestically and to invest more in apprenticeships. Plans for active international recruitment had been stepped down. Mrs Parkes confirmed that the Trust would support employees to be successful to meet the new English language requirements. It was noted that the NHS had benefited significantly from international staffing, so the government's direction of travel was disappointing.

In response to a question, Miss McMeekin confirmed that the Trust offered a Health and Wellbeing programme and funded an employee assistance programme which had received very good feedback. She explained that it could not be determined from figures on sickness absence whether stress or anxiety was work-related or not. The support in place for staff experiencing financial difficulties was outlined.

Mr Barkley was pleased to note the number of Nursing Associates who had graduated to Band 5 nursing roles. Mrs Parkes advised that the Nursing Associate vacancies were being filled to maintain the pipeline.

Digital and Information Services

In response to a query, Mr Hawkins confirmed that the experiences of other Trusts in implementing Nervecentre modules were being fully monitored to inform the Trust's own programme. In terms of the go-live of the Tranche 1 module scheduled for February 2026, Mr Hawkins advised that more non-functional testing was planned.

Mrs McAleese noted that Mr Hawkins had highlighted the need for investment in the transformational opportunities offered by the Nervecentre EPR to realise the full benefits. Mr Hawkins provided some examples but acknowledged that there was a risk that opportunities might be missed due to the need to focus on the current delivery of the programme.

Finance

Mr Barkley asked that a report be circulated showing the cumulative volume of activity as at Month 6 this year compared to the same period in 2024 (using the same categories as his team had used for the 6 year comparative position).

Action: Mr Hawkins

Mr Bertram reported that, at Month 7, the Trust was £3.2m adrift of plan which included £0.5m attributed to the resident doctors' industrial action in October. The main driver of the deficit was the delivery of the Cost Improvement Programme which was behind plan. Mr Bertram emphasised that there would be no more funding provided. Referring to the projections in the TPR, Mr Bertram forecast that, if there was no further efficiency delivery, the year-end deficit would be £26m. Actions to reduce the deficit were already underway which Mr Bertram outlined.

Mr Bertram referred to the delivery of the Cost Improvement Programme, particularly the lack of progress to implement low risk efficiency schemes as these would help to close the gap. He acknowledged that the efficiency target would not be met and advised that a list of financial recovery plans had been devised, which could reduce the year-end deficit to £5m if all were able to be actioned.

In addition to this likely deficit, risks to the financial position included the sparsity payment for Scarborough Hospital and last year's ERF overtrade, both of which were included in the budget but for which income had not yet been received. Discussions with the ICB continued to secure this income. Ms Hansen flagged the opportunity to evidence work undertaken by the Trust for the wider system in these discussions. Combined with the operational in-year deficit, these risks now posed an increasing likelihood of the Trust missing its financial plan.

Mr Bertram report that the cash position was close to plan but was masked by income set aside for large capital programmes which were behind schedule. He underlined that the cash position must be protected by the recovery actions.

It was noted that the worst case deficit could be significantly higher than £26m. Mr Bertram did not expect that the position would deteriorate further due to the mitigations being put in place.

12 Q2 Annual Operating Plan Progress Report

Ms Hansen presented the report. She advised that 70% of actions due in Quarter 1 and Quarter 2 within the Annual Operating Plan had been completed. Some actions had been carried forward, with delays due to staffing capacity, progress through governance structures or Business Cases, or actions being rolled out. She had no concerns about the delivery of the plan which had not already been raised.

13 CQC Compliance Update Report

Mrs Parkes presented the report. She highlighted again the removal of the Section 31 notice on Maternity Services at York Hospital and advised that the draft inspection report from the unannounced CQC inspection of Urgent and Emergency Care and Medical Care Services at Scarborough Hospital was imminent.

Mr Barkley referred to the numbers of open CQC enquiries/cases and asked if the Board should be concerned about any. Mrs Parkes responded that she had no concerns to raise.

14 Maternity and Neonatal Report

Ms Wells-Munro presented the report. She summarised the key risks:

- the CTG tocos and transducer cables currently used in the Trust were made from material that was prone to damage and cracking; attempts were being made to progress a resolution with the supplier;
- the rate of Post Partum Haemorrhage (PPH) over 1500mls had increased in September to 15 cases, eight of which were in the Scarborough Maternity Unit; a thematic review had been undertaken which had identified actions around risk assessments; a multi-disciplinary team approach had been adopted to effect further improvement.

Key concerns included the impact on the midwifery workforce and on mothers-to-be of the tragic case of a homebirth in Manchester and the implications of the coroner's issue of a Prevention of Future Deaths letter to multiple organisations across England. Ms Wells-Munro advised that women had a choice under the NHS constitution to give birth at home but there was no national guidance for homebirths. The Trust had already taken action on shift patterns to prevent midwives being on call when they had worked all day.

On a more positive note, Ms Wells-Munro highlighted the formal removal by the CQC of the Section 31 conditions on maternity services at York Hospital, and the go-live of the Badgernet system in the Neonatal Unit which had received very good feedback from staff. The Single Improvement Plan had been reviewed against the terms of reference of the national maternity review, and gaps around addressing racism and discrimination had been identified. A refreshed weekly briefing had been introduced, covering safety, news, actions and knowledge. This had been co-developed with frontline staff.

Mr Scanlon queried the reference to the increase in workload which would result from the introduction of a daily situation report for maternity and neonatal services by 11.30am seven days a week. Currently the report was required only on weekdays. Options for deploying staff to complete the report at weekends were being explored but more detail on the requirements was awaited from NHS England. Ms Hansen advised that an automated process was being considered so that the report would not be an added task for the clinical teams.

The Board congratulated Ms Wells-Munro on her leadership of improvements which had resulted in the removal of the Section 31 notice.

Mr Barkley asked about plans for the decant of Maternity Services at Scarborough Hospital during the roof project. Ms Wells-Munro explained that a number of options had been considered and reduced to two of which one was more viable. Mr Norman advised that the options paper would be presented to the Executive Committee on 3 December.

Mr Barkley questioned why the Trust's extended perinatal mortality rate was higher than its peers. Ms Wells-Munro explained that this was the result of the health inequalities and the service provision on the East Coast. A community engagement event had been arranged with the MNVP to help shape future service provision.

As requested by Mr Barkley under action BoD Pub 39, Ms Wells-Munro provided details of the number of unit closures in September, the number of suspensions to the home birth service and the number of women affected.

15 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Action Plans

Miss McMeekin presented the WRES and WDES action plans which had been strengthened as a result of discussion at the previous meeting. She highlighted the WRES action: *Implement a process for BME representation on recruitment panels at band 7, expanding to Band 8a and upwards in the future* and advised that the process would begin at Band 7 recruitment panels and more senior staff recruitment panels would be added gradually.

Mr Scanlon queried the focus on the victim, not sanctions for the perpetrator, in the actions to address bullying and harassment. Miss McMeekin clarified that actions to address individuals who bullied or harassed had been in previous action plans.

16 Annual Pay Gap Report

Miss McMeekin noted that the information was a snapshot of Trust staff as at 31 March 2025. There had been a slight deterioration but, if medical and dental staff pay was excluded, pay was broadly equitable across different cohorts. She drew attention to the action plan included in Appendix 2. Dr Stone observed that Clinical Excellence awards were impacting the gender pay gap as these were mostly held by male consultants. As these were no longer offered, the pay gap should reduce. Miss McMeekin reported that there was an ethnicity pay gap of 8.5% although this was not formally recognised by NHS England as it was in favour of ethnic minority staff.

17 Review of the Remuneration Committee Terms of Reference

The Board approved the Remuneration Committee's Terms of Reference.

18 Questions from the public received in advance of the meeting

There were no questions from members of the public.

19 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 28 January 2026 at 9.00am at York Hospital.

Action Ref.	Date of Meeting	Item Number Reference	Title (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / comments	Due Date	
BoD Pub 54 (24/25)	26-Feb-25	10	Trust Priorities Report	Explore options to provide more accurate ethnicity data for the Health Inequalities section of the TPR	Chief Operating Officer	Update 26.03.25: Ms Hansen and Mrs Parkes would progress work on the collection of ethnicity data and which metrics to report in the Health Inequalities section of the TPR, and refer to Mr Hawkins with any system changes as appropriate. Update 30.07.25: Mrs Parkes reported that a suite of health inequality metrics were being progressed by the Deputy Chief Operating Officer and the Chief of Allied Health Professionals, with clinical input. These would be presented to the Quality Committee and the Board in September. Update 22.10.25: Ms Hansen outlined the actions taking place to improve the progress in the collection of ethnicity data which involved working with the teams involved and changes to the patient database. She hoped to see an improvement by the end of the calendar year.	Jan 26 from Mar 25	Delayed
BoD Pub 34	22-Oct-25	5	Matters Arising/Action Log	Discuss with the Counter Fraud team which of the 60 recommendations to prioritise, in relation to the Failure to Prevent Fraud legislation, and report back to the Group Audit Committee.	Finance Director		Jan-26	On Track
BoD Pub 37	22-Oct-25	11	Trust Priorities Report	Include the metrics used by NHS England to determine the Trust's position under the National Oversight Framework in one section of the TPR.	Chief Digital & Information Officer/Chief Operating Officer	Update 26.11.25: Mr Hawkins had circulated the metrics, and work was underway to include these in the TPR. A paper on the Trust's position in relation to the Framework had also been circulated. The due date was deferred to January.	Jan 26 from Nov 25	Delayed
BoD Pub 38	22-Oct-25	11	Trust Priorities Report	Provide an analysis of the number of outpatient referrals which are not from GPs or consultant to consultant	Chief Digital & Information Officer	Update 26.11.25: Mr Hawkins had provided the analysis by email. Ms Hansen undertook to provide further details about the referrals to bring back to the Board. The due date was deferred to January.	Jan 26 from Nov 25	Delayed
BoD Pub 44	26-Nov-25	5	Matters Arising/Action Log	Ensure that an EPR progress report is on each Board agenda, beginning in 2026	Chief Digital & Information Officer/Associate Director of Corporate Governance		Jan-26	On Track
BoD Pub 45	26-Nov-25	6	True North Report	Inform the Board of the planned date of submission of the Continuous Improvement Business Case to NHS England.	Chief Nurse		Jan-26	On Track
BoD Pub 46	26-Nov-25	11	Trust Priorities Report	Include a narrative in the TPR on waiting times over 52 weeks for Children and Young People	Chief Operating Officer		Jan-26	On Track
BoD Pub 47	26-Nov-25	11	Trust Priorities Report	Investigate the apparent inconsistency in Infection Prevention and Control data between the TPR and the National Oversight Framework	Chief Nurse		Jan-26	On Track
BoD Pub 48	26-Nov-25	11	Trust Priorities Report	Circulate a report be showing the cumulative volume of activity as at month 6 this year compared to the same period in 2024 (using the same categories as were used for the 6 year comparative position).	Chief Digital & Information Officer		Jan-26	On Track

Providing excellent patient experience every time- why personalised care matters

28.1.26

Caroline Brown (AHP Leadership Fellow)

What are the reasons person centred care is important for all of us?

York and Scarborough Teaching Hospitals NHS Foundation Trust

Research has demonstrated better outcomes, better experiences and reduced health inequalities when patients are involved in personalised health care decisions

(Personalised Care Institute, 2025).

Is this what our patients want? Yes

- Being believed
- Being treated as an equal
- Being given a voice
- Actively listened to
- Treated with genuine care and trust

Trust's Mid Year Complaints Report 2025/26

York and Scarborough Teaching Hospitals NHS Foundation Trust

Top themes 2025-26	Q1	Q2	Total
Communication with patient	54	61	**115**
Delay/failure in treatment or procedure	46	53	**99**
Attitude of nursing staff/midwives	32	31	**63**
Communication with relatives/carers	25	20	**45**
Arranging/Undertaking Diagnostics	23	21	**44**
Total	**180**	**186**	**366**

Top themes Complex Complaints 2025-26	Q1	Q2	Total
Delay or failure in treatment or procedure	25	26	**51**
Communication with relatives/carers	26	22	**48**
Medication Issues	19	15	**34**
Pain Management	15	16	**31**
Food and Nutrition	14	15	**29**
Total	**99**	**94**	**193**

Are we already working in this way?

York and Scarborough Teaching Hospitals NHS Foundation Trust

Evidence would suggest – Not always

3/5 top themes from causes of complaints and 1/5 from complex complaints are communication related

This equates to 61% of complaints and 25% of complex complaints

What are we doing?

York and Scarborough Teaching Hospitals NHS Foundation Trust

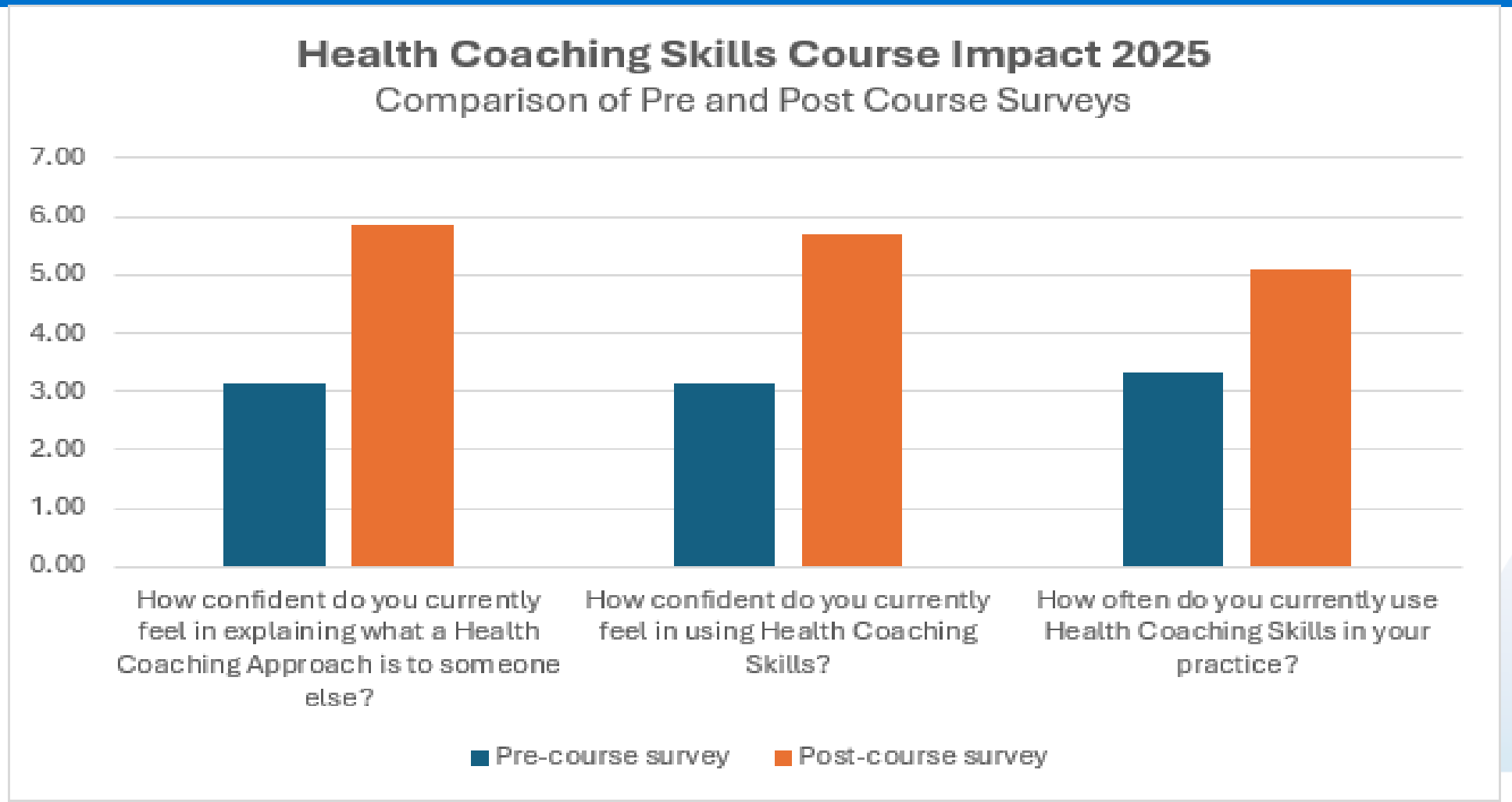
Supporting staff working with patients to have the knowledge, skills and confidence to communicate in a way that promotes person centred care

In 2021 a Health Coaching training package was created. 505 Allied Health Professionals, 108 Nurses and 77 Other Staff have attended training. 150 staff have attended bespoke training

In 2025 a project to support learning for all staff on 3 wards (Ward 29 in York, Ash ward in Scarborough and Water's ward in Bridlington) was initiated.

Does Health Coaching Training have an Impact?

York and Scarborough Teaching Hospitals NHS Foundation Trust



Qualitative feedback Summary 2025

York and Scarborough Teaching Hospitals NHS Foundation Trust

Overwhelmingly positive – highlighted significant impact on clinical practice, professional confidence and staff development

Improved communication skills, increased self-awareness and staff were keen to embed health coaching approaches

The course was also valuable beyond patient-facing roles: supporting leadership, team development and organisational culture

The most important question?

York and Scarborough Teaching Hospitals NHS Foundation Trust

What matters to you?

(Clinician as an enabler)

Patients on Water's Ward, Bridlington Hospital (Nov 25) Acute Setting

- 'Having something constructive to do'
- 'Getting this boot off'
- 'Being somewhere quiet for a few minutes'

Health Coaching Conversation Impactful examples

York and Scarborough Teaching Hospitals NHS Foundation Trust

Lady supported to restart her HIV treatment. Nurse asked ‘What does it feel like?’ Left silence. Patient said ‘I’m excited about getting a phonecall in the future to say my HIV is undetectable.’ Nurse felt this conversation was transformational in the patient’s journey

Patient unable to go home due to her oven not working. Occupational Therapist asked the patient if she had any solution ideas. Patient said she wanted a microwave she could use independently. Family sorted and reduced length of stay by likely 4 days.

Return to work interview. Staff member was upset. Manager used a health coaching approach to allow staff member to set their own goals of how they were going to remain at work. Significantly better experience for both staff members.

What does this way of working support?

York and Scarborough Teaching Hospitals NHS Foundation Trust

10-year NHS Health Plan : Sickness to Prevention

Trust Values: Kindness, Openness, Excellence

Trust Strategies: Quality of Care, Our People

What Next?

York and Scarborough Teaching Hospitals NHS Foundation Trust

Work together to embed a person centred care culture in our Trust

Find out ‘What Matters to You?’

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

True North – Introduction

York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

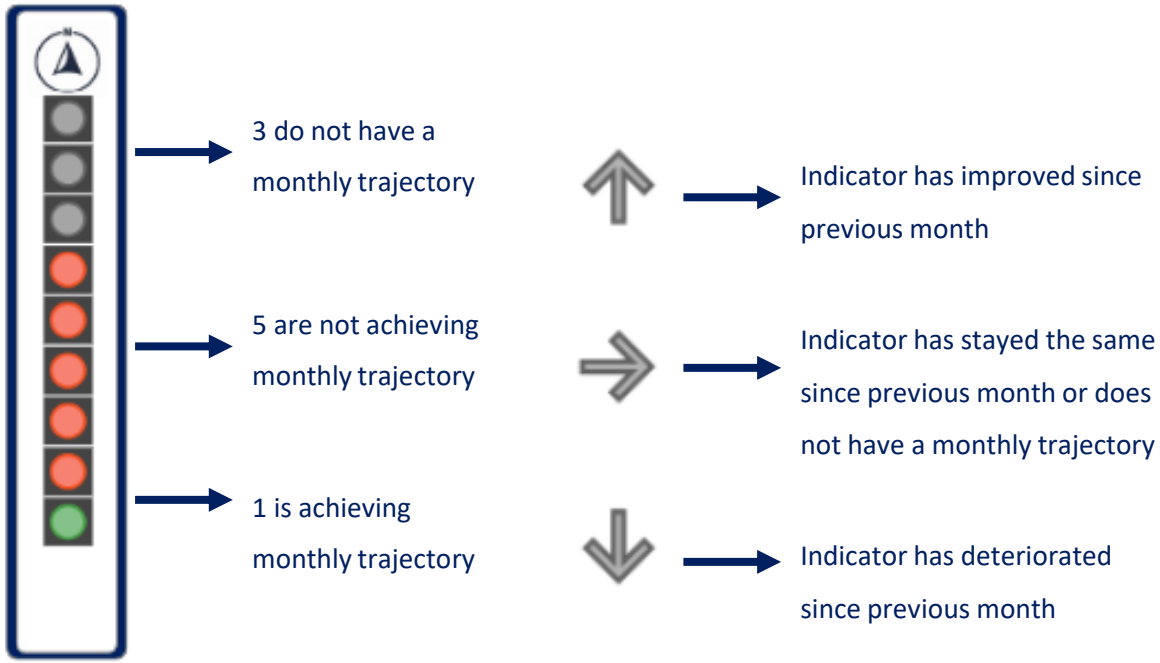
This is the single point of reference to measure our progress.

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

The True North Report is a monthly report on the Trust’s key transformational objectives measured by ten key metrics for 2025/26 that have been identified as YSTHFT critical priorities.

True North – User Guide

Understanding the Thermometer Reading (Examples Only):



3 do not have a monthly trajectory

5 are not achieving monthly trajectory

1 is achieving monthly trajectory

Indicator has improved since previous month

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

Indicator has deteriorated since previous month

Objective Status (top right of indicator page):

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

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

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

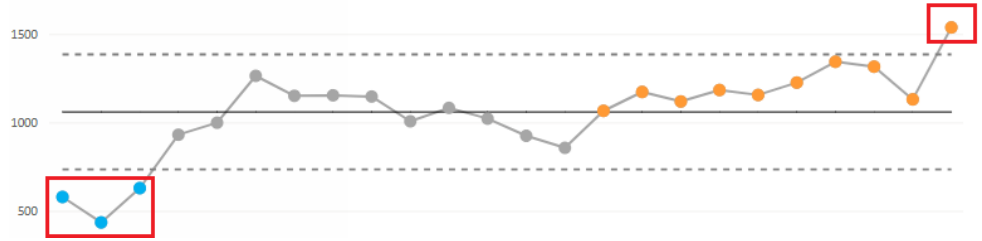
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

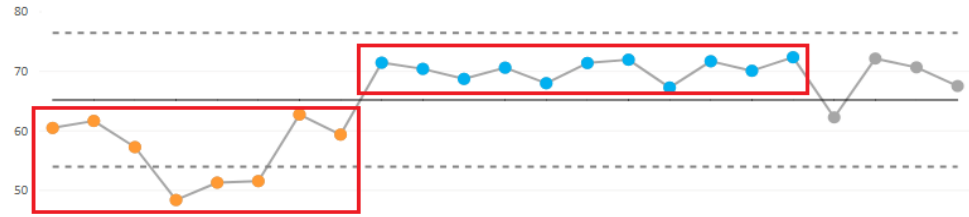
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

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

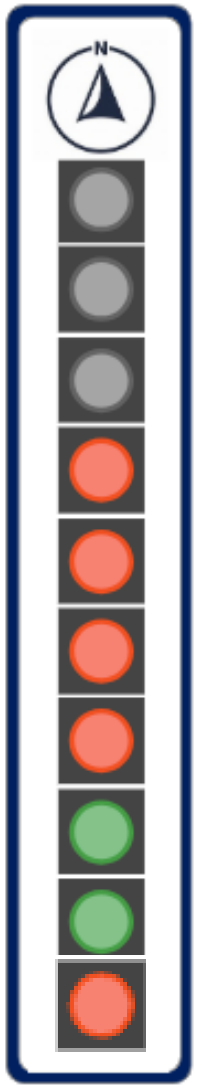


Shift: Counts the number of occasions there is a run of 7 consecutive points above OR below the mean.



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

True North Report



Performance Improvement Overview

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

Staff Survey: Recommend Care

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

Staff Survey: Recommend Work

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

Inpatient: Reduce Bed Days Lost to NCTR

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

Urgent Emergency Care: Improve Emergency Care Standard (ECS)

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

Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

Elective: Cancer: Improve the Faster Diagnosis Standard

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

Elective: Improve RTT

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

Q&S: Reduce Category 2 Pressure Ulcers

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

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

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

Finance: Achieve Financial Balance

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

True North Report

Objective Status No Trajectory

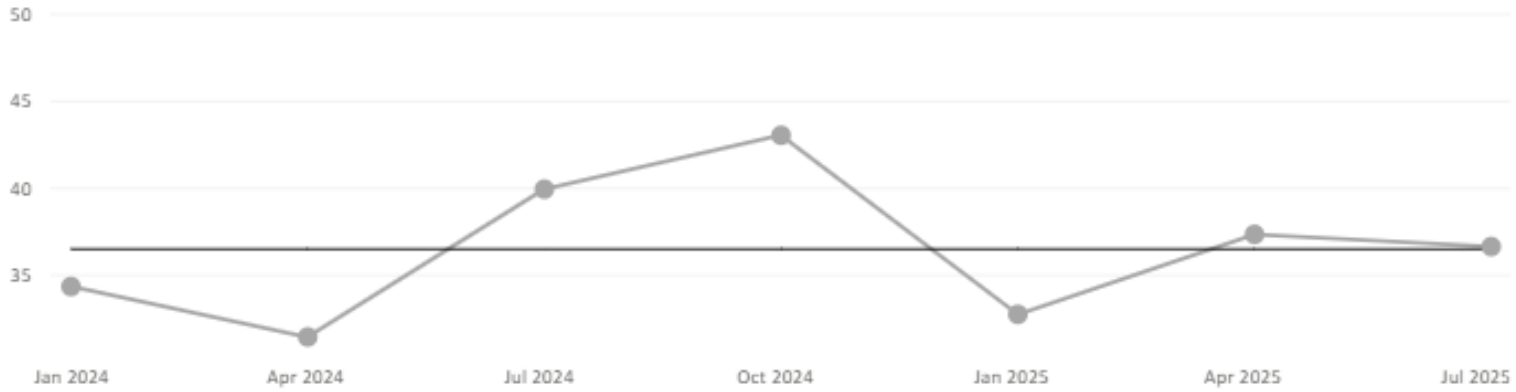
Staff Survey: Recommend Care

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

Lead Director: Dawn Parkes & Karen Stone

Operational Lead:

Committee: Resources



Is there special cause variation?

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

Not enough data points to produce Control Limits

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

Does Not Occur

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

Does Not Occur

	Jan-24	Apr-24	Jul-24	Oct-24	Jan-25	Apr-25	Jul-25
Value	34.3%	31.4%	39.9%	43%	32.7%	37.3%	36.6%
Trajectory							

Target Mar 2026
49%

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

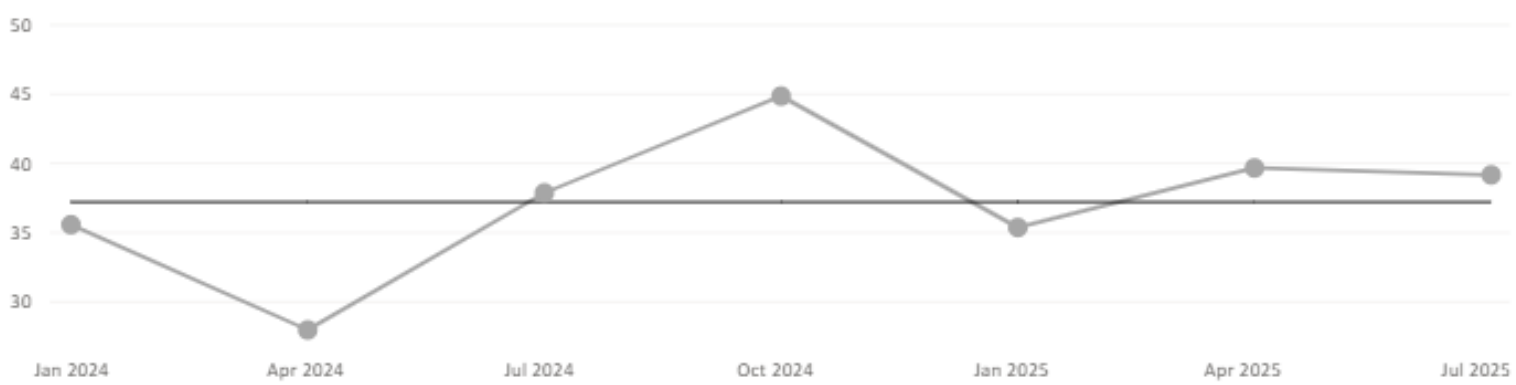
True North Report

Objective Status — No Trajectory

Staff Survey: Recommend Work

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

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



Is there special cause variation?

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

Not enough data points to produce Control Limits

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

Does Not Occur

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

Does Not Occur

	Jan-24	Apr-24	Jul-24	Oct-24	Jan-25	Apr-25	Jul-25
Value	35.5%	27.9%	37.8%	44.8%	35.3%	39.6%	39.1%
Trajectory							

Target Mar 2026
50%

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

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

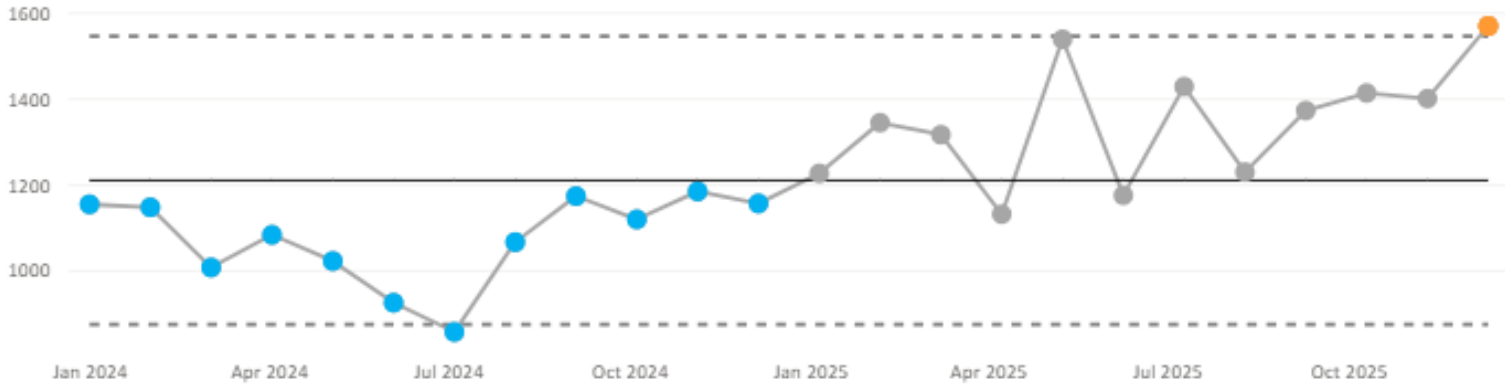
True North Report

Objective Status — No Trajectory

Inpatient: Reduce Bed Days Lost to NCTR

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

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



Is there special cause variation?

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

2 found

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

Occurs

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

Does Not Occur

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Target Mar 2026
Value	1155	1225	1343	1315	1130	1537	1174	1427	1228	1371	1412	1399	1568	
Trajectory														

What are the organisational risks?

- Patient deconditioning (loss of mobility and independence)
- Hospital acquired infections
- Poor flow through our hospitals resulting in mortality/morbidity risks
- Overcrowding
- Emergency readmissions due to pressure resulting in rushed discharge planning
- Increased financial pressure
- Moral distress to staff

How are we managing them?

- Escalation meetings with system partners, increasing awareness of delays and the impact.
- Close working to ensure all partners proactively seek packages of care.
- Long length of stay meetings for Medicine, for medically fit and medically unfit patients. This supports teams to keep patients medically fit while they wait.

What are the current challenges?

Note: This graph includes all adult (non-elective) bed days including non-acute, rehabilitation and community – some of these pathways are intended to support patients with NCTR.

- Post festive period backlog for the Las.
- Limited capacity for community health and social care.
- Workforce challenges, in particular therapists
- Funding challenges in the system
- High acuity and volume of patients

What are we doing about them?

- 2nd line escalation has been looking into 5 day plus backlog following the festive period.
- Further rigor through the 3rd line escalation and with support from across system.
- Multiple discharge training sessions.
- Senior therapy input in Discharge Command Centres to support increased quality of Trusted Assessment Forms. This may result in less complex packages of care being required, which would shorten delays.
- Weekly LLOS reviews

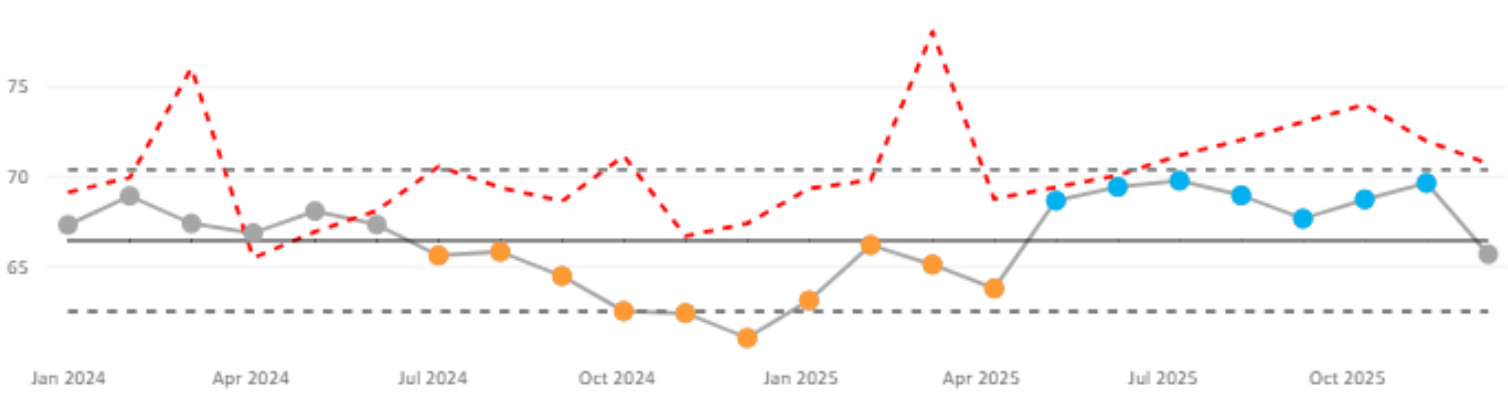
True North Report

Objective Status ⊗ Up Is Good

Urgent Emergency Care: Improve Emergency Care Standard (ECS)

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

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



Is there special cause variation?

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

2 found

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

Occurs

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

Does Not Occur

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Value	61%	63.1%	66.2%	65.1%	63.8%	68.6%	69.4%	69.7%	68.9%	67.6%	68.7%	69.6%	65.7%
Trajectory	67.4%	69.3%	69.8%	78%	68.7%	69.4%	70%	71.1%	72%	73%	74%	71.9%	70.7%

Target Mar 2026
78%

What are the organisational risks?

- Increased mortality and morbidity
- Delayed care for critical patients
- Staff burnout and retention problems
- Financial risk
- Regulatory risk
- Reputational risk
- Negative impact on national oversight framework segmentation

How are we managing them?

A fortnightly ECS performance meeting, chaired by the Chief Operating Officer, oversees performance.

Work includes:

- Maximising appropriate use of SDEC capacity
- Front door service redesign
- Ambulance handover protocols
- Improving ED processes
- Use of escalation tools and frameworks
- Effective discharge planning and processes

What are the current challenges?

- Attendances at both sites continue to be high, with a 10% increase to our main sites in December 2025 compared to December 2024.
- Workforce challenges at both EDs, including recruitment issues and poor staff morale.
- IPC outbreak and need for side rooms.
- Disruption caused by industrial action and the festive period
- Financial constraints limiting options for testing new ways of working.

What are we doing about them?

- "Fit to sit" test of change launching in January, whereby patients pended to a surgical bed or Acute Medical Unit at York who are ambulatory move directly to the relevant SDEC unit.
- Developing future workforce plan and new rosters for each ED, ready to implement in August 2026.
- Working with YAS to develop an action plan for more non-ED conveyance, following a recent audit of low acuity conveyances to Scarborough.

True North Report

Objective Status Down Is Good

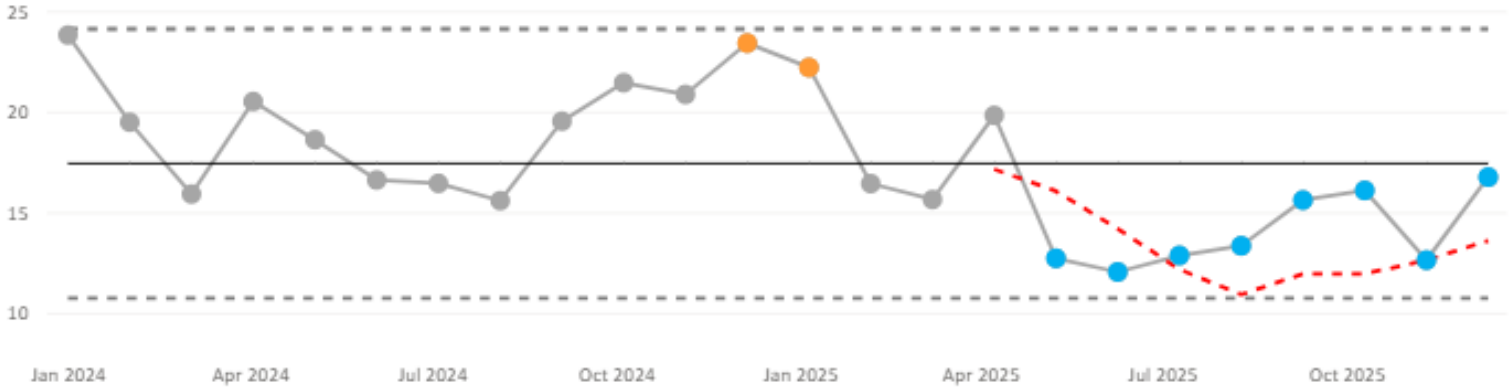
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

Lead Director: Claire Hansen

Operational Lead: Ab Abdi

Committee: Resources & Quality



Is there special cause variation?

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

0 found

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

Occurs

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

Does Not Occur

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Value	23.4%	22.2%	16.4%	15.6%	19.8%	12.7%	12%	12.9%	13.3%	15.6%	16.1%	12.6%	16.7%
Trajectory					17.1%	16%	14.2%	12.2%	10.9%	11.9%	11.9%	12.6%	13.6%

Target Mar 2026
8.9%

What are the organisational risks?

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

How are we managing them?

- In November 2025 we increased the use of Continuous Flow and TES policies which brought us back to our agreed trajectory. We continue with these actions, though winter pressures and high acuity have limited impact in December.
- Gradually introducing Quality Standards to ensure patients always move forward on their care journey; the "Fit to Sit" initiative outlined on slide 8 is one example of this.

What are the current challenges?

- High attendance levels.
- High number of patients with high acuity.
- High demand for side rooms.
- Workforce: capacity, skill mix, sickness rates.
- High sickness levels in community / primary care
- Winter infections and need for side rooms.
- Financial constraints mean limited options for testing new ways of working.

What are we doing about them?

- Matrons continuing morning ward presence to support early discharge of patients.
- Keeping Winter Ward 25 open through January in line with our winter plan.
- Daily IPC outbreak meeting(s) to optimise cohorting in the closed and lost capacity.
- Refining new workforce models in ED with a view to implementing in August 2026

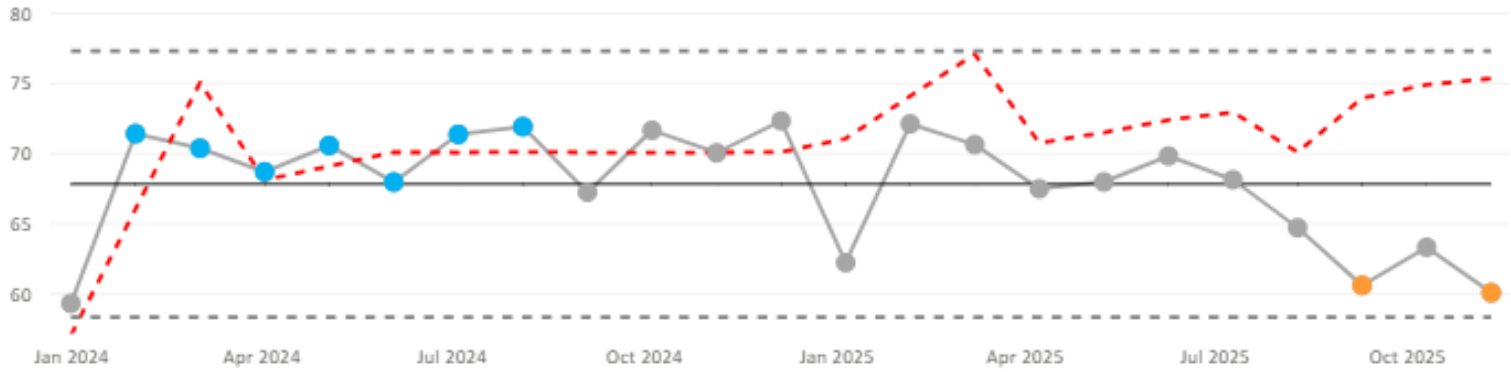
True North Report

Objective Status ⊗ Up Is Good

Elective: Cancer: Improve the Faster Diagnosis Standard

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

Lead Director: Claire Hansen
Operational Lead: Kim Hinton
Committee: Resources



Is there special cause variation?

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

0 found

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

Occurs

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

Does Not Occur

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Value	70%	72.3%	62.2%	72.1%	70.6%	67.4%	67.9%	69.8%	68.1%	64.7%	60.6%	63.3%	60%

Target Mar 2026
80.1%

What are the organisational risks?

- Delay in patient with cancer receiving treatment resulting in poorer outcomes
- Reduced patient experience for patients not being informed of cancer and non-cancer diagnosis
- Increased risk of emergency presentations
- Regulatory and reputational implications
- Potential financial implications
- Reduced organisational credibility
- Retention and recruitment issues
- Risk of negative impact on national oversight framework segmentation as not on planned improvement trajectory

How are we managing them?

- Weekly Trust cancer PTL meeting with a focus on patients breaching FDS with clear escalation routes. New PTL Tool launched in Sept 25.
- Monthly cancer delivery group to oversee focused pathway improvement plans for gynaecology, colorectal and urology
- Clinical harm reviews for patients who breach 104 days to identify level of harm and learning
- Weekly diagnostic improvement meeting with modalities.
- Use of transformation funding to support pathways and capacity

What are the current challenges?

- Urology, gynaecology and colorectal pathway delays
- Skin referrals not accompanied with picture impacting ability to triage patients effectively because of GP action, resulting in increasing demand and deteriorating performance
- Diagnostic delays in CT (4wks), MRI (4wks) and endoscopy (3-4wks)
- Increase in suspected cancer referrals month on month from May 2025

What are we doing about them?

- Urology Haematuria pathway implementation in January 2025.
- One stop staging CT pathway for colorectal commences in January 2025
- Conversion of routine outpatient capacity to fast track commenced in December 2025.
- Communication with GP's regarding strengthening adherence to NICE NG12 referral criteria supported by cancer alliance.
- ICB implementation of dermoscopy local enhanced service (LES) commenced
- NHSE funding submitted for 62 day performance improvement

True North Report

Objective Status ⊗ Up Is Good

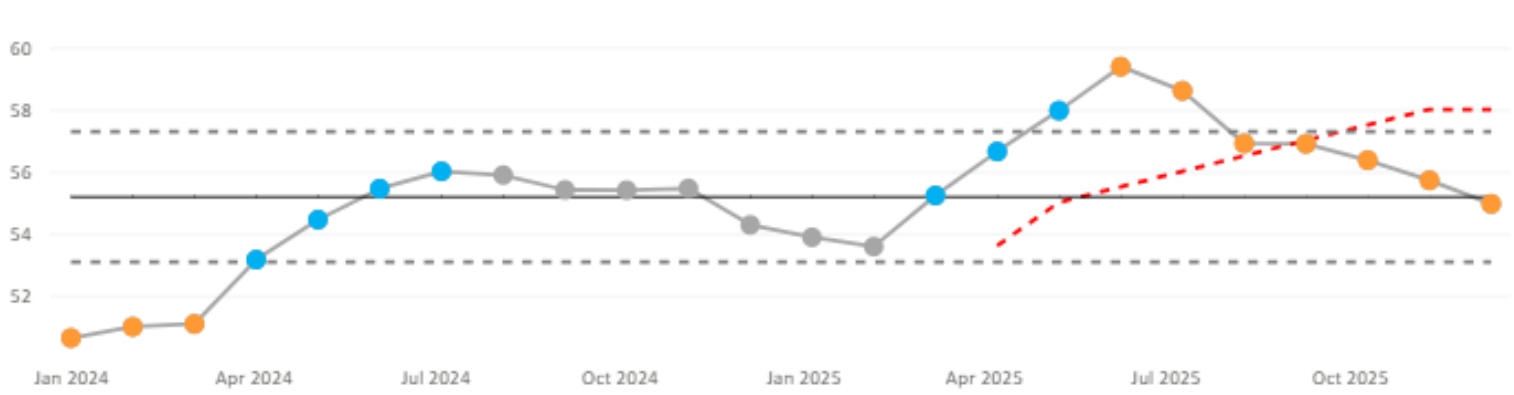
Elective: Improve RTT

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

Lead Director: Claire Hansen

Operational Lead: Kim Hinton

Committee: Resources



Is there special cause variation?

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

6 found

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

Occurs

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

Occurs

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Value	54.3%	53.9%	53.6%	55.2%	56.6%	58%	59.4%	58.6%	56.9%	56.9%	56.4%	55.7%	55%
Trajectory					53.6%	55%	55.5%	56%	56.5%	57%	57.5%	58%	58%

Target Mar 2026
60.5%

What are the organisational risks?

- Lengthening waits could lead to increase in clinical harm and litigation
- Impact on patient experience resulting in an increase in patient complaints
- Higher emergency care utilisation while waiting
- Reputational risk of not meeting improvement trajectories
- Risk of negative impact on national oversight framework segmentation as not on planned improvement trajectory

How are we managing them?

- Weekly elective recovery meetings with all specialities to review progress and use of Power BI tool to track all end of month breaches at patient level
- Individual speciality meetings for most challenged specialities
- Weekly diagnostic improvement meeting
- Risk stratified scheduling and pathway validation
- Staff training
- Use of elective recovery fund monies to support additional activity
- NHSE validation sprint delivered above baseline clock stops in Q1-Q3.

What are the current challenges?

- Validation of non RTT waiting lists resulting in an increase of patients with RTT clock
- Diagnostics delays across radiology, physiology and endoscopy
- Underlying demand and capacity mis match in specialties
- Increase in referrals seen in 25/26, 8% rise in GP referrals compared to 24/25.

What are we doing about them?

- NHSE RTT validation sprint continues for Q4 25/26
- Analysis ongoing on increase in referrals and discussion with ICB on demand management.
- Projects commencing in January 2025 with a focus on 1st outpatient wait and clinic utilization.
- Chief Operating Officer mutual aid discussions supported by commenced in December 2025.
- Submitted bids for NHSE sprints for RTT activity in Q4.
- Undertaking an RTT priority clinics project in Q4 (2 weeks intensive RTT patients).
- Undertaking a telephone validation pilot in January 26
- Intensive support project with cardiology and respiratory medicine supported by GIRFT colleagues

True North Report

Objective Status Down Is Good

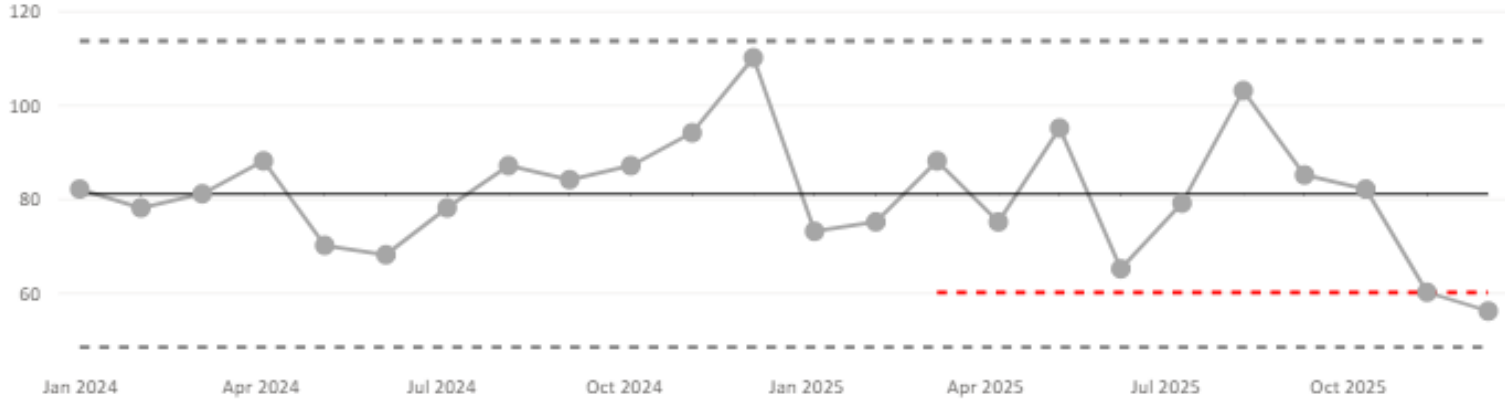
Q&S: Reduce Category 2 Pressure Ulcers

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

Lead Director: Dawn Parkes

Operational Lead: Emma Hawtin

Committee: Quality



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Value	110	73	75	88	75	95	65	79	103	85	82	60	56
Trajectory				60	60	60	60	60	60	60	60	60	60

Target Mar 2026
60

What are the organisational risks?

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

How are we managing them?

- Sharing of monthly data at HARM meeting with Hons and completion of thematic cluster reviews to ensure appropriate action and change
- Virtual education sessions have been delivered by the TVN team over the last three months to improve recognition and accurate categorization of pressure ulcers.

What are the current challenges?

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

What are we doing about them?

- A trust wide seating audit has been completed and shows the need in Trust wide investment to provide adequate seating
- Care group cluster reviews completed within care groups and SMART actions to be discussed at PSII
- Collaborative work with the DATIX team and insight and intelligence to identify opportunities for improving data quality
- Monthly data sets shared with care groups exploring and ensuring validation at ward level is commencing
- Development of an electronic ASSKIN bundle within the new EPR with integrated photography capabilities
- Updating the current referral process to strengthen and support the service

True North Report

Objective Status Down Is Good

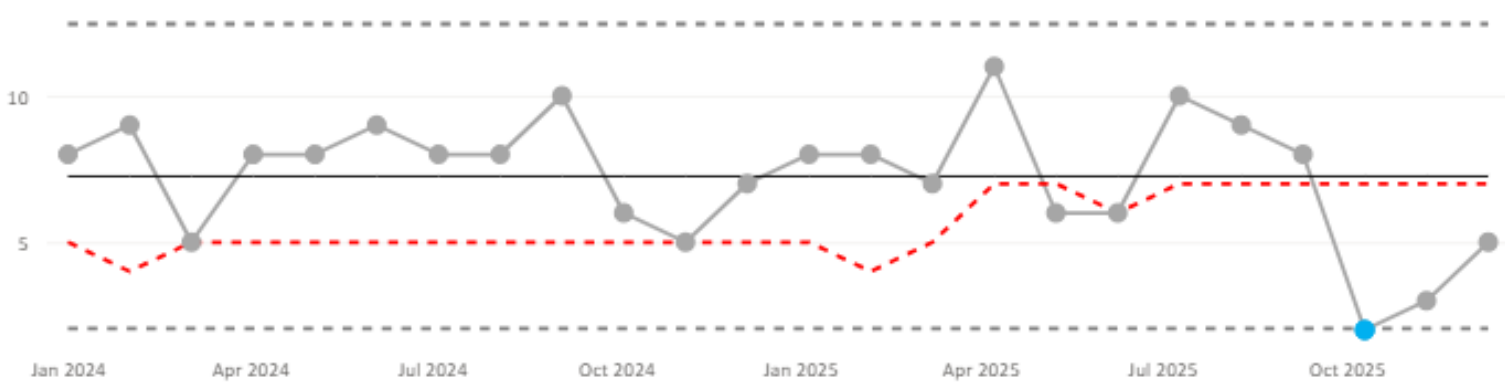
Q&S: Reduce the number of Trust Onset MSSA Bacteremia

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

Lead Director: Dawn Parkes

Operational Lead: Susan Peckitt

Committee: Quality



Is there special cause variation?

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

1 found

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

Does Not Occur

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

Does Not Occur

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Value	7	8	8	7	11	6	6	10	9	8	2	3	5
Trajectory	5	5	4	5	7	7	6	7	7	7	7	7	7

Target Mar 2026
7

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

- Care group reduction action plans in place and monitored via IPSAG.
- A Trust wide improvement plan has been developed and approved at IPSAG.
- A standardised Care Group Dashboard and PSIRF/AAR process is being developed with the Care Groups
- Line management, VIP scoring and ANTT education has been refreshed and re-launched
- A Trust wide peripheral cannula care audit being undertaken in December by BD
- ICB wide workshop for bacteraemia reduction is being arranged

True North Report

Objective Status

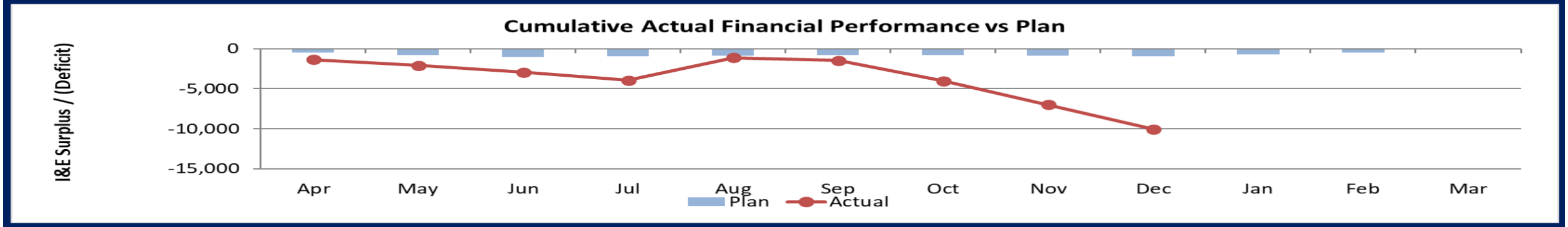
Finance: Achieve Financial Balance

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

Lead Director: Andrew Bertram

Operational Lead: Sarah Barrow

Committee: Resources



Indicator	Target £'000	Apr 25 £'000	May 25 £'000	Jun 25 £'000	Jul 25 £'000	Aug 25 £'000	Sep 25 £'000	Oct 25 £'000	Nov 25 £'000	Dec 25 £'000	Jan 26 £'000	Feb 26 £'000	Mar 26 £'000
Meet our obligation to deliver the financial plan for 25/26	0	-476	-820	-1,050	-962	-904	-807	-812	-900	-994	-747	-491	0
Revised position - £31m Forecast Deficit (excl. DSF impact)		-1,386	-2,084	-2,936	-3,956	-1,151	-1,484	-4,047	-7,010	-10,049	-13,145	-16,775	-31,306

What are the organisational risks?

- **Failure to Deliver Financial Balance** - The most critical financial risk is the Trust's potential failure to deliver financial balance in line with the 2025/26 annual plan –

The Trust has now submitted a forecast change protocol to confirm that we will not hit a balanced position at the end of March and will have a £33m deficit, subsequent to this the Trust has been notified of receipt of £2.1m Industrial Action Funding (IA) which reduces the deficit to £31m

- **Efficiency Programme Delivery Risks** – Failure to deliver the required reduction in costs to meet our financial plan

How are we managing them?

The following controls maintain in place to ensure the £33m deficit doesn't deteriorate:

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

What are the current challenges?

- The financial position is adrift of plan for M9 by £9m with an actual deficit of £10m against a planned deficit of £1m
- The Trust has submitted a forecast change to confirm we will not hit a balanced position by the end of the year but will have a £31m deficit (after IA funding)
- Delivery of the efficiency programme is a big driver of the deficit with a forecast £20m gap in delivery.
- Q4 DSF has not been secured which deteriorates the deficit position further to £35m
- The challenge now is to ensure the £31m deficit does not deteriorate any further

What are we doing about them?

- Financial Recovery Plan in place. This is a live process with clear owners and timescales for delivery. The current recovery plan within the £31m deficit is £5m The recovery plan is reviewed through EDG / Exec Comm
- Ongoing increased focus on efficiency delivery
- Expenditure control in process with all discretionary non pay orders with FD for approval and double lock system in place for non medical / non clinical vacancies and non pay (including insourcing)
- Line by line budget review;

1. EPR Update: Nervecentre Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- Currently, overall progress is in line with plan and go-live of the first Tranche is expected to commence on 27 Feb 2026.
- The first Tranche includes observations, clinical documentation for inpatients, urgent & emergency care, electronic prescribing & medicine administration, bed management and read-only diagnostic results.
- Good progress is being made configuring the Nervecentre product to our needs
- User acceptance testing continued and will complete in late January 2026
- User training is underway, utilising a combination of e-learning, specialist classroom training, and drop-in sessions
- Go-live planning continued, with a focus on transition, operational readiness, hyper-care support and business continuity plans
- The current plan includes a go-live of Tranche 2 on 30 Jun 2026 and Tranche 3 on 30 Oct 2026.

2. Continuous Improvement Update Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Following the completion of the readiness assessment, a business case has been produced to initiate the process to procure the support of a strategic partner to help the trust initiate its structured programme of work to systemically and systematically embed a continuous quality improvement method. This business case was discussed in detail at a trust Board Workshop on 5th October and approved at the formal Trust Board meeting on 22nd October.

This case is recommending a full support programme to be delivered over 3 years.

The next steps are to present this case to NHS England to seek their support and them to prepare the procurement documentation. The aim is to secure a start on site in April 2026.

Guidance has been received from NHS England as to the relevant governance documentation to be completed. This has been received and will be completed early December 2025.

07/01/26 - The case to secure regional approval for consultancy support was submitted to NHS England on 22nd December 2025. At time of writing, we are awaiting feedback.

3. Productivity and Efficiency Group Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Operational Productivity Workstreams

The Trust operational productivity group has identified 8 priority workstreams for 2025/26 to improve operational productivity. Updates and oversight is provided the Trust productivity group. Updates against 4 outpatient productivity workstreams.

PIFU	New to Follow up ratio's	Service reviews	Clinic utilisation
PIFU remained at 4.4% in December 2025. The Trust has maintained over 4% since April 2025. PIFU as standard workstream continues with new pathways launched in gynaecology, ENT and audiology in November 2025. PIFU report in SIGNAL updated and data sent to all teams to identify quick win opportunities in specialities to achieve 5%.	New to Follow up ratio at Trust level is 2.29% in December 2025 which is an improvement 0.3% improvement from 2.6 in April 2025. Review of templates against the GIRFT recommendations completed and clinics being changed in gynae, ENT and oral surgery.	Service reviews have completed for: Cardiology Respiratory Neurology Paediatrics ENT Gynaecology Action plans on standard template to deliver against opportunities being developed. Review for gastroenterology due to commence in January 26.	Clinic utilisation has deteriorated slightly in December to 74.2%. Elective recovery workshop focused on clinic utilisation and actions from workshop being consolidated into a programme of improvement. Ongoing clear down to clinic templates ongoing. No slot goes unfilled campaign to be launched in January 2026.

4. Efficiency Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

2025/26 Cost Improvement Programme - December Position											
	Full Year CIP Target	December Position			Full Year Position		Planning Position		Planning Status		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Fully Developed	Plan in Progress	Opportunity
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Total Programme	55,290	34,470	22,832	11,638	27,745	27,546	35,297	19,994	32,764	2,532	0

Efficiency Delivery

The Trust has set an efficiency target of £55.3m. So far, £27.7m has been achieved in full-year terms, but the year-to-date position is £11.7m behind plan, the current forecast year-end delivery is £35.3m, 4% of operational expenditure, which in any past or typical year would have represented strong delivery.

To address the gap in efficiency delivery, the recovery action plan is now in place, this is a live document reviewed regularly at EDG, the current value of the recovery plan is £5m. Each recovery action has a clear owner and timescale for delivery, of the £5m, £3m has been confirmed as implemented. Significant work continues in this area.

Governance

The Trust is following the recently introduced NHSE enhanced governance expectations for efficiency programs, to provide sound governance and a clear project plan for delivery of each of the efficiency schemes. As at the end of June, all governance requirements were met.

Efficiency Delivery Group

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	Chair's Report
Director Sponsor:	Martin Barkley, Chair
Author:	Martin Barkley, Chair

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Recommendation:
For the Board of Directors to note the report.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

No ☒ Yes ☐

Report History
Board of Directors only

Chair's Report to the Board – January 2026

1. I have continued to visit various wards and services including two District Nursing Teams as well as undertaking several 121s. Through conversations with colleagues during these visits, I pick up valuable insight and issues which I share with the Chief Executive as appropriate. I believe I have now visited every community team, community facility, and wards and departments in every hospital except York Hospital. My priority is to spend time visiting services and listening to colleagues at York Hospital that I have not yet been to, starting with the cancer centre in the next few days.

2. I chaired what I thought was an excellent meeting of the Council of Governors that took place in December. The new Governors and indeed many of our existing Governors asked really good penetrating questions leading to constructive discussion. A presentation from our Patient EDI lead officer on the work that she is leading regarding informal carers was very well received and again led to important debate. She will be invited to a future Council of Governors meeting this year to update the Council especially in view of their very high level of interest. Governors also received a detailed briefing about the huge change programme we are undertaking regarding the implementation of a new Electronic Patient Record digital system which reaches a crescendo in 2026 – the biggest change programme since York and Scarborough merged to form the current Trust in 2012.

3. I have been a member of three recruitment interview panels all of which had very positive outcomes: the recruitment of two Consultant Radiologists, a new Chief Nurse to succeed Dawn Parkes who retires at the end of March; and a new non-executive Director to succeed Jenny McAleese whose term of office ends at the end of February, and an associate non-executive Director.

4. I very much valued the Board development session we had earlier this month led by experts from NHS Providers on the role of the Board regarding the modernisation of processes using digital systems (including AI), and in our case particularly the implementation of a new Electronic Patient Record system which is imminent.

5. Recently our Chief Executive Clare Smith and Deputy Trust Chair Jenny McAleese met with officers of NHSE Regional Team. Also present was the Chair and a couple of Executive Directors of our ICB. The purpose of the meeting was to review and obtaining a deeper understanding of the Trust's plans for next year in detail and in

outline for a further two years on how the Trust will meet as a minimum the service access standards set by NHSE and the NHS Constitution within the available finances. From the discussions the Board previously had, it was recognised that the draft submitted needed more detailed work within the Trust and with the ICB over the next few weeks prior to submitting the final version of the plan to NHSE on 12th February. I have received very positive feedback about the way both Clare and Jenny conducted themselves in the meeting and the way they spoke about the scale of our challenges and the Board's determination to address those challenges.

6. I write this report two days before the really important all day meeting the Board has with many of our senior clinical leaders to further develop our plans for 2026/27 and in outline for a further two years. With the very severe operational and financial pressures the Trust has, it would be all too easy to forget our ambition "to provide an excellent patient experience every time" and to do so whilst ensuring all our work places enable our colleagues to thrive, have job satisfaction and enjoy coming to work. We must keep focussed on these two fundamentals, and to achieve these within the financial resources allocated to us as we do not have the right to spend money we do not have. Wednesday 21st January is thus going to be a very important day to work out how best we can develop and navigate a path forward to achieve our ambitions for our patients and workforce whilst being mindful of the Trust's financial obligations and our contribution to reduce health inequalities.

Martin Barkley
Trust Chair
19.01.2026

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 9

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	Chief Executive's Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Clare Smith, 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 Board of Directors in relation to the Trust's priorities. Topics covered this month include: Introduction and thank you, winter and operational pressures, update on financial and service delivery planning, Resident Doctors' industrial action, countdown to EPR go-live, JAG accreditation, new Chief Nurse appointed, ICB update, and star award nominations.

Recommendation:

For the Board of Directors to note the report.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

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

Chief Executive's Report

1. Introduction and thank you

As this is my first formal report to the Board I want to record my thanks for the welcome I have received from colleagues. The openness and genuine warmth I have been greeted with has made such a difference in helping me to find my feet.

I made a commitment to all colleagues that I will spend the majority of my first 100 days in the organisation getting out and about listening to our teams across the organisation, learning as much as I can about all of the services we provide and hearing how colleagues want to improve the care and experience of our patients.

I have been doing this in a whole variety of ways, including 'Chat and a Brew' drop-ins, weekly emails to colleagues where I talk about what I've been doing and what I've heard, and a 'live' half hour online Q&A session with my executive director colleagues, as well as visits to departments and team meetings and plenty of one-to-one discussions.

I also hosted my first Senior Leadership Forum on 18 December, and will be holding a similar session for medical leaders in February. The Senior Leadership Forum sessions will become important milestones in our improvement journey, where we will proactively shape the future of the organisation and agree the action we need to take as leaders to get to where we all want to be.

At the time of writing I am just under half way through this introductory period, but I can already see the enthusiasm and sense of pride our colleagues have for our services, and that they have a clear idea of what they want to do to make improvements for our patients, which is fantastic.

One of my commitments is to create the right environment to engender a well-governed improvement ethos across the organisation, so that colleagues feel able and supported to make the changes they want to see. What is so encouraging from the conversations I have had so far is that we absolutely have the people and values to do this.

The role of Chief Executive is a privilege, and not something I take lightly. I look forward to continuing to work with Board colleagues to collectively improve the experience and outcomes for the communities we serve.

2. Winter and operational pressures

As is perhaps to be expected in the health service we have started the new year faced with high demand on our acute services.

I have spent some time in the emergency departments in Scarborough and York and on some of our wards, watching our teams under significant pressure providing care and endeavouring to meet the demand in often difficult circumstances. I also know that our Urgent Treatment Centres have seen a rise in pressure, and I thank our colleagues in the community for their efforts to avoid patients being redirected to our emergency departments.

On top of that, the weather took a turn for the worse, bringing its own set of challenges, particularly on the East Coast.

I heard many examples of colleagues going above and beyond: people picking up and dropping off members of their teams to make sure shifts were covered, colleagues making plans to stay over so clinics could run across two days without the worry of getting stuck, and teams doing everything possible to keep services safe and running for patients.

We must thank all colleagues for their efforts during what is proving to be another difficult winter for the NHS.

3. Update on financial and service delivery planning

Colleagues across the organisation are engaged in a significant effort to finalise our medium-term operational, financial and workforce plans ahead of final submission on 12 February 2026, whilst at the same time working hard to meet this year's trajectories.

As we will discuss in more detail in other parts of this meeting's agenda, the landscape remains very challenging, particularly with regard to our finances. We have declared to NHS England that we will not achieve financial balance this year, and our most likely position is a £33m deficit.

What this means for the remainder of the year is that we must continue with - and accelerate - our recovery actions. It is essential that we deliver our revised year-end forecast position if we are to avoid interventions from our regulator.

Looking ahead, we are required to submit a three-year Medium Term Financial Plan, and I met with the Regional NHS England team and the ICB Chief Executive and Chair, along with our Deputy Chair Jenny McAleese, to talk through the work we have done so far.

To meet the plan, we will need a significant efficiency programme, and productivity, waste reduction and transformation will remain core themes in getting back to financial sustainability, however to achieve sustained improvement the two key things that we must put in place in 2026/27 are a Continuous Improvement Method and a Clinical Strategy so that we can build a clinically-led, sustainable Trust for the people we serve. Both of these were discussed with NHS England as fundamental elements of our recovery plan.

4. Resident Doctors' Industrial Action

Resident Doctors participated in a period of industrial action from 17 to 22 December as part of the ongoing national dispute over pay and conditions.

As with previous rounds of action, 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 us to sustain as many of our services as possible to avoid disruption and delay for patients. Non-clinical colleagues from all parts of the organisation also provided further support to reduce the impact as far as possible. Thank you for everyone's collective efforts and for continuing to prioritise patient care.

The BMA's legal mandate for strike action ran out on 7 January 2026, and a further ballot of their members is taking place which is due to end on 2 February.

5. Countdown to EPR go-live

When we meet as a Board we will be 29 days from go-live of the first phase of implementing Nervecentre, our new Electronic Patient Record (EPR).

Bridlington will be the first site to go live on 26 February followed by Scarborough on 27 February. York will go live on Friday 6 and Saturday 7 March.

Training is rolling out at pace, and we have a network of well over 500 digital champions who will be out and about in all corners of the organisation to support a smooth transition.

This is without doubt the largest transformation programme this organisation has seen, and we have reached this point as a result of an immense effort from key teams and individuals within the Trust who have shaped the system and helped to design and plan for the implementation that we are about to embark on.

However, everyone has a role to play in the coming weeks and through the later stages of rollout, and it is our collective responsibility to help make it a success.

6. JAG Accreditation

I am delighted to share that we have retained our Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation for Endoscopy across the Trust, following our annual review.

JAG accreditation is a UK-based quality standard for endoscopy services, and to retain accreditation we must undergo regular reassessment at each site where we provide an endoscopy service.

I know firsthand how much work goes into gaining and then maintaining accreditation, and I want to thank everyone for the effort and strong teamwork that went in to ensuring this important milestone was achieved.

7. New Chief Nurse appointed

I am really pleased to be able to share that we have appointed Joe Hague as Chief Nurse, following the upcoming retirement of Dawn Parkes our current Chief Nurse. Joe will join us on 5 May.

Joe is an experienced senior clinical and operational leader, currently serving as Deputy Chief Nurse at King's College Hospital NHS Foundation Trust and Clinical Care Professional Lead for Urgent and Emergency Care in South East London ICB (Bromley).

We are fortunate to have Dawn for a while longer, and I know she has no intention of taking her foot off the pedal during this time! There will be many opportunities to thank Dawn for everything she has done during her time with us, but I would just like to say a thank you to Dawn for her personal and professional support to me as I have moved into this role.

8. Integrated Care Board update

Teresa Fenech has been appointed Chief Executive of NHS Humber and North Yorkshire Integrated Care Board (ICB) and officially moved into the role on 1 January 2026, having held the role in an Acting capacity since March last year.

Teresa joined NHS Humber and North Yorkshire ICB at its inception in 2022, having held several Executive Director roles across NHS Trusts and NHS Foundation Trusts, spanning Nursing, Quality, Performance and Improvement portfolios as well as National roles with NHS England and NHS Improvement.

As colleagues will be aware the ICB is undergoing significant change as part of the wider transformation work that is impacting the whole of the NHS, and I would like to thank those colleagues in our ICB who are affected by this for all the work they have done in support of the Humber and North Yorkshire system.

9. Star Award nominations

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

Date: 28 January 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

December 2025

Mandy Jenkinson, Healthcare Assistant | **Scarborough** | **Nominated by colleague**

Mandy is a true credit to the Oak Ward night team, who are often overlooked despite night shifts being physically and mentally draining. Mandy takes everything in her stride, could not be more helpful if she possibly tried, and has adapted so well to the new strain and stresses caused by the banding differences. She is incredibly supportive and a joy to work with.

Janet Hall, Healthcare Assistant | **York** | **Nominated by colleague**

Healthcare Assistant Janet Hall has exemplified compassion, integrity, and excellence in caring for patients and supporting her colleagues in the Ophthalmic Theatres for many years. Her unwavering commitment to quality and care has had a positive impact on the lives of others. As she retires, I feel that her achievements and dedication to work should be recognised, not only her professionalism, but also her kindness. Over the years she has touched countless lives with gentle hands, a warm heart, and a steady presence. Her commitment to supporting patients and colleagues alike has made an enduring difference in the Eye Theatres team and she will be greatly missed.

Sally Langton, Project Support Officer | **York** | **Nominated by colleague**

Sally has been an invaluable member of the Humber and North Yorkshire Acute Collaborative team for the past two years, consistently demonstrating the Trust's values of kindness, openness, and excellence in all that she does. Often described as the glue that holds us together, Sally is always the first to offer a helping hand, never shying away from a challenge, and going out of her way to support her colleagues.

Sally’s recent handling of a particularly complex HR situation is a testament to her kindness, dedication and problem-solving abilities. She proactively sought advice and implemented thoughtful solutions that benefitted both the individuals involved and the wider team. Sally demonstrated empathy and compassion in her approach to the sensitive situation, gaining positive feedback from the staff involved.

Over the past year, she has also shown remarkable growth in her resilience to change, embracing new challenges with maturity and composure. She supports the delivery of improvement across the Humber and North Yorkshire system, being fundamental in the review and supply of data to both identify the opportunity and outcomes of projects. Sally is always keen to support the learning of others and has presented her insights regarding metrics and KPI to the wider Acute Collaborative, demonstrating her professionalism, enthusiasm, and confidence amongst senior colleagues.

Sally’s positive attitude, unwavering support, and commitment to excellence make her an outstanding asset to our team and a deserving nominee for this recognition.

Rebecca Muggeson, Healthcare Support Worker **Scarborough** **Nominated by patient**

There are many superlatives I could use to describe Becca, but I would be writing this for a long time if I were to use all of those that are appropriate. Needless to say, her professionalism and dedication, coupled with her personality, make her a major asset to the medical profession. Not only was she supportive and helpful, but she also went ‘over and above’ in her duties. I felt valued and respected during my two visits, one of which was cancelled before surgery. Becca took it upon herself to resolve a logistical problem that I had due to the cancellation of the surgery. I hope she receives the recognition that she deserves. Well done, Becca.

Beverley Shipley, Patient Services Assistant **York** **Nominated by patient**

Beverley is so much more than just somebody who provides meals. She calms and helps any patient in any way that she can. I was in hospital for 10 weeks, and whilst on Ward 36, I saw her use her time to take patients to the hospital shop, sit with patients who didn't have visitors, and be there for patients, like me, who are in a crisis, whether emotionally, physically, and mentally. I will forever remember her as my saving grace from Friday to Sunday. I believe she deserves valuing a lot more.

Edward Kenny, Associate Practitioner **Scarborough** **Nominated by colleagues**

Eddie truly embodied the Trust’s values of kindness, openness, and excellence when he stepped in at short notice to cover the ward, supporting the cardiology patients. From the moment he arrived, Eddie was a breath of fresh air. He immediately and politely introduced himself to the team and quickly integrated into the ward’s dynamics and established processes. His approachable manner and clear communication worked seamlessly with colleagues from all areas.

Eddie ensured patient confidentiality, keeping sensitive information secure, returning folders containing patient details promptly, and maintaining a tidy and organised workspace. He also adhered strictly to infection prevention measures, sanitising his hands after every patient interaction without fail. Eddie got straight to work assessing patients and formulating clear, thoughtful management plans. He took the time to discuss these plans with the Discharge Liaison Officer, enabling safe, timely discharges and improving patient flow.

Despite being called in at short notice, Eddie never complained and maintained an upbeat, solution-focused attitude throughout the day. Patients also provided feedback on his professional bedside manner. How Eddie demonstrates the Trust values:

- Kindness: Treated everyone, patients and colleagues alike, with compassion, respect, and warmth
- Openness: Communicated clearly and worked collaboratively within the existing ward structure
- Excellence: Delivered safe, efficient, and high-quality care while maintaining confidentiality and infection control standards

Eddies professionalism, teamwork and patient centred approached made a real difference to both colleagues and patients that day. We hope he comes back again!

Philippa Peters, Sister **Scarborough** **Nominated by colleagues**

Phillipa has led this team with great passion. After having a full and eventful week, she took the time to make sure her staff knew how great of a job they had done. She is always happy to get stuck in. She is approachable and willing to listen. She is a fantastic boss and needs to be shown that she a great leader and that we on Bronte Ward appreciate her.

Alison Harrison, Sister, Rebecca Muggeson, Healthcare Support Worker, and Beth Sheader, Staff Nurse **Scarborough** **Nominated by patient**

I attended Haldane Ward in September for surgery, but, unfortunately, it was cancelled. I returned in November and, when greeted on the ward, it felt like coming home. Alison Harrison's team, especially Alison herself, Becca Muggeson, and Beth Sheader, made me feel like an old friend when welcoming me to the ward.

Their treatment of me was exemplary. Nothing was too much trouble. They were attentive, professional, and supportive. Apart for the surgery element of my visit, I quite enjoyed my stay!

Alison Webb, and Julie Robson, Radiology Services Administrators **York** **Nominated by colleague**

On Friday evening, on the last call of the day (just before the clinic was due to finish), a client called up advising that she would be late to her appointment. After speaking to the client for a while, she advised that she was lost and had got the train from a far distance away to get to this appointment.

Alison stayed on the phone to the client, who was understandably lost and quite panicked, and figured out whilst looking at a map where the client was, with Julie guiding Alison on the best route to explain to the patient. The client was a good distance away from the hospital and Alison stayed on the phone guiding the client to where she needed to be. Once the client had got into the Bootham entrance, she became upset as she was lost again. Julie went straight away to go find the client who was going to miss her appointment as the clinic had nearly finished and brought her to her appointment.

Alison and Julie showed patience, kindness, and empathy towards the client and helped the client's experience massively.

Oak Ward **Scarborough** **Nominated by colleague**

I am nominating the whole team on Oak Ward for a Star Award because of their consistent kindness and openness to help. Every time I go to Oak Ward, no matter how busy they are, every member of staff is always willing to help me with a smile. I work on an Outpatient Unit, and sometimes we need to borrow equipment or need help with barrier cream, and Oak Ward is our closest place to seek help.

A big thank you to Martha, a Staff Nurse, and Jodie, a Housekeeper, for helping me this week. All staff members are friendly, kind, and helpful, and I think they should be thanked and know they are shining stars.

Jonathan Cole, Healthcare Support Worker **York** **Nominated by patient**

After my recent knee surgery, I was incredibly fortunate to be cared for by Jonathan. From start to finish, his kindness, professionalism, and genuine care made a difficult experience so much easier. In what was often quite a busy and chaotic atmosphere, Jonathan remained calm, reassuring, and completely focused on patient care.

Nothing was ever too much trouble for him. He supported me with every aspect of my recovery, from helping me manage pain and mobility, to assisting with the smallest of tasks that made a big difference to my comfort and dignity. He even went above and beyond to make sure I got safely to my car on discharge day, personally wheeling me down and helping me get in. That thoughtful gesture summed up the kind of person he is, someone who doesn't just do his job, but truly cares about the people he's helping. And, as a bonus, he makes an excellent cup of NHS coffee (a rare skill!), which is a small but much-appreciated act of kindness that brought a smile at just the right time.

Jonathan embodies what it means to go above and beyond. His compassion, patience, and positivity made a real difference to my recovery and overall experience at York Hospital. He is a credit to his team and a shining example of what great care looks like. In short, Jonathan didn't just care for me, he cared about me. I can't thank him enough, and I truly believe he deserves recognition with a Star Award.

Shoshanna Hayward, Associate Practitioner **York** **Nominated by colleague**

I would like to nominate Shanna for the work she has been doing in her department (VIU) to proactively and successfully take forward sustainable practices. This included an audit to identify and reduce the amount of waste she observed across her department, presenting her findings to her colleagues and implementing a system that has seen about £85,000 of savings realised.

By way of background, several months ago, Shanna approached me with her observations of the number of items being wasted, and seeking advice and support (which to be honest she needed very little of) due to overstocking of items etc. Since then, now as one of the Trust's green champions, she has gone out of her way to do an audit of the items that are and aren't using and put in measures to tackle this, ranging from pricing labels on shelves to highlight the cost of each item, through to team meetings to bring her colleagues onboard.

To date she has identified about £85,0000 worth of items that may not have been needed and have had to be disposed of due to being past their use by date. Using data like this and visuals to show X item cost £X, has had a significant impact on the staff across VIU in support of her work and thinking more sustainably. Shanna's enthusiasm has been fantastic, where she has been working in her own time as well to help bring about this change and the savings, both in terms of cost and waste. As a result, she is showing her department as a fantastic example of change and incorporating of sustainability that continues to bring further benefits and savings.

For me, Shanna has gone above and beyond to serve and support her department, which has been made possible by her supportive management team. For me, she is a shining example and deserving of a Star Award.

Nichelle Watkin, Sister **Scarborough** **Nominated by colleague**

I would like to nominate Nichelle for the work she has been doing in her department (Scarborough ICU) in proactively and successfully taking forward sustainable practices. Since the UECC opened, Nichelle has jumped on a passion to increase sustainability across the ICU and seizing on the opportunity of going into this fantastic new space (UECC) to leave old habits behind and adopt new ones. This included an audit to identify and reduce the amount of waste she observed across her department, and initiated campaigns including Gloves Off, Bin the Pinny (tackle single-use apron use), waste segregation, ordering, and reviewing a move away from liquid and intravenous forms of medication to oral.

Nichelle's work is proving exemplary with significant savings being realised, where she has been asked to take this forward across York ICU as well. Her work has also inspired other departments, following a successful presentation to clinicians. Supported by her fantastic teams, other clinical colleagues and senior management, Nichelle's passion, caring and supportive approach to incorporating sustainable practices across the ICU departments, has gone above and beyond.

As a Sister, in one of the most intensive departments, she could have easily let all this go and got on with the day job, but she hasn't, and, like a growing number of others, she is a shining example of the passion to deliver the best care and adopting sustainable practices. Her work will go on to inform other departments across the Trust to further consider how sustainability can be incorporated into their day-to-day work and meeting the Trust's Green Plan ambitions. As a result of her dedicated and positive drive and sheer determination, Nichelle is truly deserving of a star Award.

Alison Goodall, Staff Nurse **York** **Nominated by relative**

I would like to nominate Ali Goodall for a Star Award in recognition of exceptional care and compassion shown to my mother-in-law who was admitted to the ward after an outpatient appointment. My father-in-law accompanied her to the appointment and Ali went above and beyond to make sure they understood what was happening and were well looked after. Her kindness, patience, and genuine concern made such a difference. We are so grateful for the outstanding care Ali provided.

Katie Brice, Care Group Team Secretary **Scarborough** **Nominated by colleague**

I am nominating Katie for a Star Award in recognition of her exceptional dedication and compassion. She went above and beyond to support a new employee relocating from overseas, a young adult who had never left their home country. Despite numerous challenges, she worked outside the remit of her usual role, committed additional hours, and coordinated with multiple staff groups to ensure a smooth transition. Her efforts included overcoming logistical hurdles at significantly short notice and providing reassurance during a stressful process.

What truly sets her apart is her ability to see the individual as a person, not just another job applicant. She approached the situation with empathy and humanity, creating a welcoming environment that made a significant difference to the new employee's experience. Her actions exemplify the Trust values and demonstrate outstanding commitment to supporting colleagues and fostering inclusivity.

Niamh Thorpe, Healthcare Support Worker **York** **Nominated by relative**

Niamh has a great sense of humour that is much appreciated and understood by those in the bay around us. She is always kind to all and is open and honest about what she is doing. Today while helping a patient eat tea, she noticed the patient in the next bed who had taken himself to the toilet was about to fall (directly behind her). She got to him in time to tell him to sit down on the floor and held him, so, rather than falling, he was lowered gently and did not do any damage to himself.

She kept talking to him and kept him calm while arranging for a nurse to come help by giving clear instruction to food service colleague and getting another colleague to get a pillow for patient's head. Excellent care and communication with patient meant he was calm and was soon back in bed.

Ellen Womersley, Advanced Practitioner Ultrasound **York** **Nominated by patient**

I would like to nominate Ellie for a Star Award for her kindness and professionalism when I was under her care in the Early Pregnancy Unit. As a member of staff at the Trust, now on the other side of the care as a patient of Ellie, I feel she demonstrated the Trust values.

She was kind, calming, and offered lots of information about what she was doing and what she was looking at whilst caring for me. She put me at ease during such a worrying time and answered any of my questions with ease and care. Her knowledge and professionalism were so appreciated, and she even made time for me to be seen the same day, after a confusion of appointment times and days.

Her calming and positive attitude was welcomed, and I'd like her to be recognised for this. As a staff member myself, I understand the strains on colleagues, with factors such as time and emotional demands of the role, but Ellie she took the time to go beyond her role for me, which is so appreciated. Thank you, Ellie.

Peter Haswell, Pensions Specialist **York** **Nominated by colleague**

We recently had a deeply sad and complex case where a longstanding and highly valued colleague was unexpectedly facing end-of-life care. While the local team supporting them were phenomenal, the pensions process can be an absolute minefield. Peter approached this case with compassionate urgency, demonstrating our Trust values at their very best.

Despite everyone’s competing priorities, full inboxes, and heavy workloads, he ensured this colleague was able to leave a much-deserved financial legacy for their family, completed just in the nick of time thanks to Peter. Throughout every stage of the process, Peter communicated clearly, coordinated each element seamlessly, and provided expert advice to support the manager as they worked closely with the family on the colleague’s final wishes.

Although I played only a small part in this case, I know I am submitting this nomination not only on my own behalf, but also on behalf of the manager and, importantly, the family.

Gemma Messruther, Ophthalmic Imaging Technician, Vicky Connolly, Healthcare Assistant, Michelle Metcalfe, Senior Healthcare Assistant, and Abbie Johnson, Staff Nurse **Scarborough** **Nominated by colleague**

A patient came into a cardiology appointment and, while having their BP measured, a varicose vein in their ankle burst causing a major bleed. Healthcare Assistant (HCA) Vicky and HCA Michelle dealt very well with the initial issue by applying pressure and finding Staff Nurse Abbie to escalate.

Abbie attended and began treating the patient rapidly, by delegating to staff in the area. She asked for the Vicky and Michelle to elevate the patient's foot, and whilst Vicky applied pressure and held the patient's foot up, Michelle went to find a way to keep the foot elevated. Abbie shouted for someone to call for the Med Emergency Team, which is where Gemma Messruther stepped in. Gemma called and came to communicate this to Abbie. Abbie then delegated to Gemma for her to take the patient's blood sugars whilst she did observations on the patient. Pressure was applied whilst the foot was elevated by Vicky, and Michelle went to direct the Med Emergency team to their whereabouts. Gemma and Vicky kept the patient calm and spoke to them, even though they spoke very little English. They did this with the tone of their voice, using gestures, and comforting the patient by holding their hand.

Abbie did a great job of leading the team (including the med emergency team) when logistic issues arose around moving the patient and room for the striker bed. She provided problem solving answers and ensured that she was listened to. She showed great confidence and communication and leadership skills, and I would like to say thank you for her calm demeanour and keeping everyone at ease. She didn't panic and we felt confident in her skills and abilities which calmed us down.

The Staff Nurse, HCAs, and Imaging Technician worked incredibly together in an environment that is not designed for major traumas and emergencies, used their initiatives and worked as a well-oiled machine meaning the patient was seen and taken to the Emergency Department quickly.

Paediatric Autism MDT **York** **Nominated by colleague**

A multidisciplinary team of Paediatrics, SEND Transition, Anaesthetics, Paediatric Day Unit, Security, Special Dental, and Podiatry, came together and was co-ordinated by the Autism Liaison Team. They did this to ensure a patient received equitable access to the healthcare they needed with a hugely successful outcome. All involved were driven by the Trust values and went above and beyond to ensure all went smoothly on the day.

Andrew James Murray, GP ST1 **York** **Nominated by colleague**

James is a GP trainee currently on rotation to the paediatric department. He is an exceptional resident doctor, with a great work ethic and a professional and caring approach to every family and young person he sees. His communication skills are outstanding, and he is always kind and approachable.

James was recently involved with a difficult case involving a young person who was unwell with an eating disorder. His holistic approach, kindness, and compassion made a difference to their experience, and he offered some much-needed continuity by ensuring he was able to see them again at their next review. James will make for a truly excellent GP, though I have high hopes that we can encourage him towards a career in paediatrics, to which he is so clearly suited!

Grace Waddington and Meika Baldwin, HR Business Partners, Mel Taylor, HR Advisor, and Peter Haswell, Pensions Specialist **York** **Nominated by colleague**

I nominate Grace Waddington, Mel Taylor, Meika Baldwin in HR and Peter Haswell from Pensions for their outstanding support and guidance over the last few weeks. Both the teams are dedicated, compassionate, and thorough professionals in the face of challenging circumstances.

The team's commitment to help and support is truly commendable. Specifically, their ability to work collaboratively, provide guidance, and show sympathy and understanding has made a significant difference and have been key in achieving the best possible outcome. I am grateful to have worked alongside such a talented and dedicated team and strongly believe their efforts deserve recognition and appreciation.

Sarah Waugh, Cleaning and Catering Operative **Scarborough** **Nominated by colleague**

Sarah always goes above and beyond, and not just for the department and colleagues. Sarah takes pride in her work and the department is always spotlessly clean. She greets the staff with a friendly smile and cheery "hello". Anything we request she does straight away without issue. Sarah truly demonstrates the Trust values. Thank you, Sarah, from the Outpatient Team, we are all truly grateful and appreciate everything you do.

Leah Hoggan, Clinical Nurse Specialist **York** **Nominated by colleague**

Leah is part of the Dermatology Drug Monitoring Nurse Team, a team of four nursing staff and one co-coordinator. She is a valuable, loyal, and respected staff member, not only in her own team, but also across the whole of the Dermatology Department. The Dermatology Drug Monitoring Team share the caring of sick patients with debilitating and life changing skin conditions who take a lot of time and energy to care for.

This is all in a day's work for Leah and she takes the demanding role she has in her stride. She is always approachable and willing to help to find answers if she does not know them. She is a huge help to the secretarial team and consultants. She always goes that extra mile and always demonstrates the Trust values, no matter how busy she is. Well done, Leah. You absolutely deserve this Star Award, and you should wear your badge with pride.

Gillian Dawson, Neonatal Clinical Educator, and Philippa Satchwell, Specialty Registrar **York** **Nominated by colleague**

It is with great pleasure and admiration that we nominate Gillian Dawson and Philippa Satchwell for a Trust Star Award in recognition of their exemplary contribution to the implementation and management of the BadgerNet Neonatal Electronic Patient Record system within the Special Care Baby Unit (SCBU) departments.

Gill and Philippa undertook the complex task of configuring the BadgerNet Electronic Patient Record (EPR) system, ensuring it was tailored to meet our specific processes and clinical needs. Their attention to detail and commitment to clinical excellence were evident throughout the project, as they meticulously aligned the system with the department's workflow and requirements. Demonstrating outstanding leadership and dedication, they orchestrated comprehensive training sessions for all staff members across the department, including those from supporting specialities. This extensive training ensured that everyone, regardless of role, was fully equipped to utilise the new system effectively.

The project, especially for clinical-facing staff, presented significant challenges, yet Gill and Philippa delivered with remarkable precision and within the required timeframe. By successfully adopting BadgerNet, the SCBU has greatly improved its procedures by making digital processes a central part of service delivery. This achievement not only streamlines processes but also marks a pivotal first step in realising the Trust's digital strategy, advancing our commitment to innovation and excellence in patient care.

This nomination has been formally endorsed by Nicola Lockwood, Katie Mortimer, and Gary Adamson, who collectively recognise the extraordinary effort, professionalism, and impact of Gillian Dawson and Philippa Satchwell. We respectfully submit this citation for consideration, confident that Gill and Philippa's outstanding achievements merit the highest recognition from the Trust.

Andrew Manson, HR Support Team Manager | **York** | **Nominated by colleagues**

The Enable Network has spent a lot of time this year updating our merchandise and contact forums to being inclusive and accessible to all. Andy has been an integral part of making this happen. Between all our questions, worries, and all over guidance, we have been able to renew our pens, badges, and business cards to be distributed in the new year.

For the final step, our business cards, Andy was able to go from the request to the confirmation of the order within four hours! This was the last thing for the network to tick off this year and working with Andy has been a smooth and enjoyable process. It's clear that he cares about supporting staff and the networks. He gives excellent instructions and guidance on a process that can be quite confusing if you've never done it before.

Grace Roberts, Healthcare Support Worker | **York** | **Nominated by relative (1) and relative (2)**

Nomination 1

Grace has been caring towards my husband Grahame. He is a patient on Ward 39 with a broken hip, and he loves all the staff on here, but especially Grace. She is always patient with him, even when he got confused and tried to get up on his own. She looks after all the other men in Grahame's room with kindness and she always goes above and beyond for her patients. She is only 18, but she is mature on the ward.

Nomination 2

Grace has been wonderful with my mum, Jean, who was a patient on Ward 39 three separate times. She always takes the time to be patient and kind with her. She listens to my mum and chats with her when she is fed up.

Grace is a superstar! She is a lovely girl and is perfect for the care job (and would be perfect as a nurse). She has made a difference to my mum's experience in hospital.

Iaoouee Collins, Senior Healthcare Support Worker | **Scarborough** | **Nominated by relative**

Iaoouee has been an absolute brick from day one of my grandfather's admission. While he struggled with an infection, he was a challenging patient, and she handled him with grace and dignity. She has gone above and beyond to support me and my family while he continues his treatment and is simply a joy to speak to. She is an asset to the team and that extends to all the nurses and HCAs on Beech Ward, they have been wonderful.

Laura Moore, Business Manager **York** **Nominated by colleague**

I would like to nominate Laura for a Star Award in recognition of the outstanding support and commitment she demonstrates every day. Laura consistently goes above and beyond, making a tangible difference to both colleagues and the wider team. Her reliability and accessibility mean that help is always at hand, and her ability to simplify complex business processes and jargon has saves me significant time. This has allowed me to focus on other priority issues, which is invaluable in my role.

Laura embodies the Trust values of kindness, openness, and excellence through her behaviours and actions. She approaches every interaction with calmness and compassion, creating an environment where colleagues feel supported and understood. Her openness ensures clarity and transparency, while her dedication and hard work exemplify excellence in everything she does. Laura is approachable, kind, and always willing to do whatever it takes to help others succeed. Her efforts not only make a difference to individuals but also contribute positively to the overall effectiveness of our team. She truly deserves recognition for her exceptional contribution.

Kathleen Sanjongco, Staff Nurse **York** **Nominated by colleague**

Kit has been a great team member in Ophthalmic Theatre. She is an incredible, competent, and skilful scrub nurse. She has been active in training others. She is an unsung hero.

Charlotte Taylor, Play Specialist	**York**	**Nominated by relative (1) and colleague (2)**

Nomination 1

My 14-year-old autistic daughter needed an operation quite quickly. All the medical staff involved were so kind and patient and we are grateful for the care she received from everyone, and the kindness shown towards both of us. This nomination is for Charlotte from the Play Team because my daughter was anxious about having the operation and Charlotte was there to support her all day and always knew exactly what to do to help her feel calmer.

Charlotte also kindly supported me while my daughter was having her operation, and we found out that she'd even come in to help on what was meant to be her day off. This is the second time Charlotte has helped us (the first time was helping my daughter get through an MRI scan) and we can't thank her enough.

Nomination 2

Charlotte has done some outstanding work to support a child to manage anxiety related to attending hospital for investigations. This child had previously required general anaesthetic for MRI scan and was anxious about the need for a repeat scan. Charlotte arranged to meet with the child and family on several occasions before the date of admission to listen to her feelings about the tests and plan how they could be managed. She arranged for the child to visit the scanning room and see some of the staff involved beforehand.

On the day of admission, Charlotte accompanied the child and supported her to complete her MRI along with intravenous cannula and later in the admission an anaesthetic. All the complex investigations were completed in a single visit which was a great help to this child and family.

Hayley Hardcastle, Deputy Sister	**York**	**Nominated by colleague**

I was away in Scotland when I got a call from my daughter who was in ED with a pain in her ribs after a karting accident. I felt anxious that I was so far away and unable to help or be with my daughter. I called up the ward I work on, Ward 14, and asked if there was anyone able to help my daughter as she has already been waiting for an x-ray in ED for a long time.

Hayley kindly went out of her way to see my daughter and take her a hot cup of tea. She then reassured me that my daughter was OK and would be seen soon. This was such a lovely and kind thing to do, and I can't thank Hayley enough for making myself and my daughter feel better about the situation.

Louise Walmsley and Aimee Jones, Women's Unit Administrators | **Scarborough** | **Nominated by colleague**

Lou and Aimee have been invaluable with the support they have offered to effectively set up the new pessary management clinic on the Women's Unit at Scarborough Hospital. They have developed frameworks to support the clinic using their own initiative and worked hard to get the right patients into the clinic in a timely manner, often filling lists at short notice.

They have been a constant support to me whilst I develop both my clinic skills and knowledge of the unit and hospital. They offer a constant warm and friendly welcome to all patients on the unit, and I always see them being kind. Thank you, Lou and Aimee, I really appreciate your support.

Jeena Byju, Staff Nurse | **Scarborough** | **Nominated by colleague**

Jeena spent her time listening to our concerns when we felt nobody else was helping (in a separate department). She then went out her way to support us and help find a solution. Without Jeena and her hard work and efforts, we would have still been sat waiting hours later with no answers. Jeena was kind, caring, and supportive in a difficult time and made our experience 100% better.

Jitesh Jassal, Dental Core Trainee | **York** | **Nominated by colleagues**

Jitesh came to assess a patient on SAU who has a complex mental health history and is neurodiverse. They were being assessed for a self-harm wound infection and Jitesh listened and didn't judge. The patient (who can struggle to communicate verbally) was kept calm and was made to feel comfortable enough to respond to Jitesh.

Jitesh communicated with such a kind, sensitive, and understanding manner, building a trusting rapport. He explained and gained consent at each stage and clearly explained what was going to happen to put the patient at ease, as well as giving options to help with sensory hurdles such as taking antibiotic tablets. The patient has previously had negative experiences and has PTSD around hospital. Jitesh demonstrated such kindness, and excellent care was delivered to the patient. You were amazing, well done!

Sophie Longhorn, Outpatient Services Administrator | **York** | **Nominated by colleague**

Sophie took a call from an upset patient from Selby who was unable to get to York for an outpatient appointment. She didn't qualify for patient transport any longer and couldn't afford a taxi. The patient was so distraught she threatened to harm herself.

Sophie took it upon herself to call the local transport organisations to see if they could bring the patient to York. They were unable to, so Sophie rebooked the appointment for Selby and checked whether the patient would be able to get to that appointment in a week or so. She also called the GP to request a welfare check for the patient and called the patient again to check on her. Sophie went above and beyond her duties to ensure patient care and wellbeing and does this daily.

Nick Boyt, Directorate Pharmacist **York** **Nominated by colleague**

I would like to nominate Nick Boyt for a Star Award for his consistent dedication to facilitating safe and effective patient discharges. Nick ensures medications are prescribed on time, follows through on every admission, catches things that no one else sees, and always goes above and beyond to support the flow of care. He is an oracle of knowledge, continuously educating and guiding every level of the medical team with patience, clarity, and skill.

Nick embodies our Trust values in every aspect of his work. His professionalism is matched by his humour and wit, making each day brighter for the team. As a nurse in charge, I can confidently say that I would be lost without his support, when I hear his computer on wheels enter the ward, I know that that day will be a good day. He is fair, appropriately firm when needed, and is exactly the kind of senior staff member any Trust would be proud to have. His unwavering support and exceptional clinical knowledge never go unnoticed. Ward 16 is truly fortunate to have him, and it is always evident when he is not here. The day is undeniably better when Nick is on shift.

For his expertise, his leadership, and the positivity he brings to our ward, Nick is truly deserving of this award. I would say nearly every half an hour you will hear the words 'Let me call Nick' or 'Let's ask Nick', even with this knock-off Aldi Snickers, we owe Nick a lot and I want him to know we really appreciate him.

Jolly Mathew, Advanced Clinical Practitioner **York** **Nominated by relative**

My 91-year-old mother was readmitted to the Frailty Day Ward via ambulance four days after discharge from the same ward. The care and compassion received from Dr Jolly was faultless and led to a prompt diagnosis of a cardiac condition. She was assessed by a cardiologist within 30 minutes of arriving and transferred to cardiology for a pacemaker. Being able to bypass the Emergency Department and receive immediate care and attention was amazing and thanks to Dr Jolly. We cannot praise this admission system enough.

Samantha Armour, Community Staff Nurse **York** **Nominated by colleague**

Sam is coming to the end of her preceptorship year. As part of her role, she visited a lady with arterial leg ulcers for dressing change. This lady had a significant haemorrhage from the ulcer site as Sam was removing the dressings and she rapidly went into hypovolaemic shock, requiring Sam to commence cardiopulmonary resuscitation.

Sam managed the whole situation single-handedly as this lady lives alone. Sam had to call a neighbour for help, call the ambulance, and get the neighbour to apply pressure to the wound while Sam carried out CPR until the ambulance arrived. She then had to support the lady's son emotionally when he arrived and clean up the aftermath of the haemorrhage before leaving the premises. This lady was resuscitated and has now returned home following vascular surgery.

Robin Hughes, Consultant in Obstetrics and Gynaecology **York** **Nominated by patient (1) and patient (2)**

Nomination 1

Dr Hughes provided me such compassion and care during one of the most overwhelming times in my life. I was just under 36 weeks pregnant when I first met Dr Hughes at York Hospital (before this I was being seen by Leeds Hospital). Dr Hughes made me feel heard and cared for which I had not felt at all during my pregnancy. Dr Hughes listened to me, and we agreed together for my baby to be delivered at 36 weeks.

My pregnancy was an incredibly anxious time due to raised concerns and, even though I only had one appointment with Dr Hughes before I gave birth, he made me feel listened to and supported during my last few days before I gave birth. If it wasn't for Dr Hughes and his expertise, I don't know if my baby would be here. Dr Hughes also came to see me and baby on the Friday that I had him, which was lovely of him considering how busy he must be. It was so kind of him to check in.

Even though I felt unsupported during my early pregnancy, Dr Hughes made my experience towards the end of my pregnancy a lot better. I will forever feel indebted to him and the SCBU unit for all the support and care that was given to me and baby. Every family that receives care from Dr Hughes is lucky.

Nomination 2

Dr Hughes has been my consultant through both my successful pregnancies, helping me through to the birth of two healthy babies. Having suffered 15 years of infertility and loss and previously accessing private healthcare and IVF, I was an anxious patient. Dr Hughes always asked me my thoughts and wishes and worked with me to achieve successful, well-monitored pregnancies. My first birth he was called due to my emergency situation, right at the end of his night shift, taking him into overtime. But he was still calm, polite, and professional.

My second birth he was not on shift but when he came on for the night shift, he popped into Labour Ward to see us, check on us, and wish us well. This made us feel heard and remembered. Which was unexpected by us in such a busy department. He was always able to make us feel like we mattered at every appointment, even though he must see hundreds of patients a week! Sometimes he also had trainees with him at appointments and how he spoke to them and allowed them involvement was also humbling to see, hopefully they will have learnt his wonderful 'bedside manner' from him and will follow in his footsteps.

Colorectal Surgical Care Practitioners and GI Clinical Nurse Specialist Team	**York**	**Nominated by colleague**

The surgical care practitioners and GI CNS Team have demonstrated exceptional collaboration by successfully delivering a pilot project with no additional resources, making a genuine and measurable difference to cancer patient pathways. Through joint working and shared commitment, the practitioners and the team ensured patients were identified at triage and proactively contacted to direct them to the most appropriate clinic or diagnostic test within the suspected cancer pathway.

This approach has significantly improved patient experience and efficiency - 76% of patients contacted within the first two weeks were streamed directly to a diagnostic test, avoiding unnecessary clinic appointments. This means patients receive timely diagnostics and either a confirmed diagnosis or reassurance sooner, reducing anxiety and improving outcomes. The success of this pilot is centred in the teams' willingness to share clinical skills, knowledge, and expertise, while making the most of limited capacity.

Despite operating in a challenging environment, they deliver continuity of service and uphold high standards of care. This demonstrates NHS values of teamwork, innovation, and patient-centred care, and highlights what can be achieved through collaboration, even without additional resources. Thank you to both teams for their dedication and impact.

Estates Team	**Scarborough**	**Nominated by colleague**

We had bad snow in Scarborough, but the Estates Team did their best to keep it clear. I had got my car stuck and the team helped me to move it, with snow shovels and pushing. Their actions were appreciated.

Daniel Robinson, Administrative Assistant	**York**	**Nominated by colleague**

Dan is always helpful. Each month he assists the Healthcare Academy with a multitude of tasks, from issuing ID badges for new staff members to assisting with their parking permits and answering numerous questions along the way. He consistently does this with a kind and helpful attitude. Your kindness truly makes a difference, and I would like you to know how appreciated you are.

Janine Crotty, Cleaning and Catering Operative	**Selby**	**Nominated by colleague**

I just wanted to acknowledge this lovely lady who has been asked to hoover our large, shared community office today. She does it all with a smile on her face and a friendly word. She is obviously passionate about her job and making a difference. She has put time into maintaining her cleaning equipment so it is fit for purpose to do the best job she can for us. We have benefited from her attention to improving the office carpet appearance and our working environment. Everyone could do with a Janine, thank you so much. Hope we see you again soon.

Flu Vaccinators	**Trust-wide**	**Nominated by colleague**

This year we have had a coordinated flu campaign working closely with Occupational Health, Pharmacy, Communications Team, and all care groups to ensure everyone had an opportunity to have a flu vaccine. We have had great success in the amount of people who have had a vaccine this year. This has only been achieved by collaborative working and everyone going above and beyond their normal 'day job' to ensure this could happen. This includes the vaccinators themselves, the leads for the care groups, Occupational Health Team, and the Pharmacy Team who ensure the vaccines are always available to be administered.

Rhett Richardson, Staff Nurse	**Scarborough**	**Nominated by relative (1) and relative (2)**

Nomination 1

Our brother was taken to hospital, and after a lengthy wait in ED and a brief overnight stay on Lilac Ward, he was moved over to Beech Ward. Rhett was the nurse that would be looking after him that day. He took the family aside and explained in detail what would be happening.

Our bother has autism, so a stay in hospital was a huge thing for him, on top of the diagnosis. Rhett took the time to listen to our concerns as a family regarding medical history and our brother’s needs and worries. His communication was second to none. He spoke in detail and with care and compassion to explain what would be happening. He is a great asset to not only Beech Ward, but also to the Trust. Thank you also to Student Nurse Rachel, the Cardiac Consultant and his team, and the whole of the Beech Ward team. The care you give goes above and beyond.

Nomination 2

My brother Rhys was admitted to Beech Ward after spending time in Urgent Care with a suspected heart attack at only 30 years old. During an understandably worrying time for him and his family, we cannot praise the care afforded to Rhys by Rhett enough. The care and compassion shown not only to Rhys who is also diagnosed with ASD, but also us as family members is clearly top of Rhett’s agenda. Passion and care for his patients emitted from him. He took time to sit with us and explain thoroughly ensuring that we understood tests and test results and spoke to Rhys in a way that he understood. He is calming, reassuring, and a real asset to the NHS, particularly Beech Ward. We, as a family, believe he is highly deserving of an award and would love to see one go to an individual that deserves it.

Jason Angus, Healthcare Assistant, and Ama Agyepong, Staff Nurse | **York** | **Nominated by colleague**

My 6-year-old son had a serious fall from height, and it was a scary experience for him attending the hospital. Jason helped make my son feel at ease during his time in ED with his fun magic squeaker, his rainbow stamp (which he told my son that it could have biscuits from the nurses!), and his bubble machine which led to my 3-year-old daughter calling him bubble man! These were such a good distraction.

It was clearly a busy shift but the kindness and time he showed to the children helped them feel more comfortable and made such a difference for them. He could also see as parents we were worried, but he explained what would be happening, and gave us a heads up that a trauma call had been put out and that a lot of doctors were going to come into the room to help prepare us during a stressful time.

I would also like to say a massive thank you to Ama, the nurse who looked after my son when he first arrived and throughout his time there. She was also brilliant with him, explaining everything she was doing and telling him she would be checking how big his muscles were whilst doing his BP! These little things make a huge difference for a young child.

Please pass on so Ama, Jason and their managers to know what brilliant, caring team members they have. They are a perfect example of living the Trust values.

Bethanie Pattison, Senior Healthcare Assistant | **Scarborough** | **Nominated by relative**

Beth was able to access music therapy for my daughter who's a long-term patient on Rainbow Ward. Beth has taken note of things my daughter enjoys and went above and beyond to arrange music therapy from an outside agency for her.

Andrea Lawry, Healthcare Assistant | **York** | **Nominated by patient**

I had a pre-op assessment at the Ophthalmology Outpatients today and I have to say, Andrea was exceptional. From the moment I arrived, she put me completely at ease with her warmth and friendly chat. She was not only professional but genuinely kind and even walked me to the door when I left. She's an absolute credit to the hospital, and it was such a pleasure to spend time with her.

Gary Pentland, Healthcare Assistant | **York** | **Nominated by patient**

Gary made me feel comfortable and relaxed as I'm quite a nervous person. He talked me through everything, asked if I was OK, and kept on checking on me. Gary was the best Healthcare Assistant I have ever met; he made my experience a positive one.

Mattress Audit Team **York and Scarborough** **Nominated by colleague**

I am nominating the Equipment Library colleagues in both the York and Scarborough teams who completed the Trust-wide mattress audit with me over four days in November (Andy Mc, Andy M, Jenny, Darren, Ben I, and Ben R). The timeframe we had to achieve this audit across York, Scarborough, and Bridlington hospitals was limited. Snow and freezing temperatures presented additional challenges when auditing on the East Coast!

The team worked together to ensure minimal disruption to staff and patients in clinical areas whilst ensuring mattresses were repaired or replaced in a timely manner. The audit would not have been successful without the hard work and excellence of this team.

Sally Lawrence, GP ST1 **York** **Nominated by colleague**

During a busy blood clinic, Sally spent 45 minutes with a nervous child who was scared to have their bloods done. She calmed the child's nerves and was successful in taking the bloods. Sally is a great example of a doctor following the Trust values, showing kindness and excellence.

Rebecca Lawty, Maternity Support Worker **Scarborough** **Nominated by colleagues**

Becky has been an amazing team player this week on Maternity even when she has not felt herself and known that she has been the only Maternity Support Worker. Becky consistently demonstrates outstanding dedication in her role as a Maternity Support Worker. She reliably attends even the most challenging shifts, showing unwavering commitment, professionalism, and resilience. Her standard of care is exceptional, and her compassion makes a meaningful difference to both colleagues and the families she supports. She is a hardworking and highly valued team player who contributes positively to the ward environment every day.

Beyond her clinical duties, she also raises money for charity, reflecting her generosity and drive to support others both inside and outside the workplace. Becky is truly an asset to the team, and her efforts are deeply appreciated.

Henry Baker, Audio Typist **York** **Nominated by colleague**

Henry has worked above and beyond in his role. He has supported the team during some challenging times. Henry has helped to keep the team morale up by displaying such a positive outlook and supporting team members who were struggling.

Emergency Department **Scarborough** **Nominated by colleague**

I have been in post at Domestic Abuse Liaison Practitioner (DALP) for one year. This role was a new post, and with it has come a lot of new processes and learning for all colleagues within the hospital. When a patient attends ED, and there is a concern for domestic abuse, staff can directly refer to a DALP so we can see them first-hand. If it is out-of-hours, that patient should be asked, and any disclosures recorded and sent to the DALP so onward referrals can be screened and completed for safeguarding of them and any children.

Scarborough ED have taken all this information and new processes on board with enthusiasm, continually evidencing how the colleagues really care about people and recognising how important delivering a holistic approach is to vulnerable people who are subjected to domestic abuse. Staff have been attending training with eagerness and evidencing that they have found this valuable. In total, 263 referrals have been sent to me in 2025, the majority of these coming from Scarborough ED, with 34 for the month of November.

This month (November 2025), the quality of referrals has been outstanding. 34 patients have been recognised as victims of domestic abuse and either have been asked routine questions due to their presentation or colleagues have flagged alerts and asked patients if they are currently safe. Patients who were assessed as high risk of serious harm or homicide were referred, with excellent documentation meaning I could refer to high risk case reviews with meaningful information to maximise safety planning for external services. Children have been considered in all cases, so important considerations for child safeguarding could also be completed.

Nursing and medical staff in ED continually show they are treating people with real kindness and compassion, and want to make a difference, often keen to tell me about patients they are concerned about or asking me for updates for patients they cared for. I feel Scarborough ED deserve the Star Award this month because they have not only taken on new processes and guidance, but continually evidence that despite the pressures of ED, they care about helping people who can be in a vulnerable position, and this excellent work is going on to save lives outside of hospital.

Emily Douse, Patient Equality, Diversity and Inclusion Lead **York** **Nominated by colleague**

I was recently contacted by the ICB raising concerns that a patient needed urgent support to attend their appointment as they rely on British Sign Language (BSL) to access healthcare. I contacted Emily, who immediately acted. The patient had faced repeated barriers in arranging an interpreter, with multiple appointments cancelled due to a shortage of BSL provision. Recognising both the urgency of the upcoming appointment and the patient's frustrations, Emily took ownership of the situation. She liaised directly with the patient's advocate, escalated the issue with the service lead, and ensured that a face-to-face interpreter was secured.

What stands out is Emily's kindness and thoughtfulness throughout. She communicated with warmth and clarity, keeping the patient, advocate and ICB informed, and reassured them that their needs would be met. She demonstrated openness by collaborating across teams and navigating challenges to find a practical solution. Emily not only resolved an immediate access issue but also modelled patient-centred practice, ensuring that the patient could engage safely and effectively with their care. Her advocacy, persistence, and professional empathy had a tangible impact, exemplifying the Trust's values of kindness, openness, and excellence. Thank you, Emily, for going above and beyond to make a real difference for one our patients.

Sophie Keely, Matron, Anna Vale, Clinical Skills Support Midwife, Leila Fahel, Consultant in Obstetrics and Gynaecology, Hayley Robson-James, Safeguarding Lead Midwife, Sarah Harris, Midwife, and Charlotte Copson, Practice Development Midwife **York** **Nominated by colleague**

I would like to nominate Sophie, Sarah, Anna, Hayley, Charlotte, and Miss Fahel for a Star Award in recognition of their outstanding teamwork, professionalism, and commitment to patient-centred care.

Recently, the team were faced with an exceptionally complex and time-critical situation when a highly complicated patient was transferred from ED to Delivery Suite. Without hesitation, colleagues from both areas came together, communicating clearly, acting swiftly, and coordinating their efforts with exceptional effectiveness. Several team members stayed well beyond the end of their scheduled shifts to ensure the patient received safe, timely, and effective care, demonstrating remarkable dedication and compassion.

Their collaborative approach, calm under pressure and unwavering focus on the patient's wellbeing exemplify the highest standards of care. This team truly went above and beyond, and their actions reflect the very best of our values. I wholeheartedly believe they deserve recognition for their exemplary service and extraordinary teamwork.

Maternity Multidisciplinary Team **York** **Nominated by colleague**

I would like to nominate the Maternity Multidisciplinary Team for their outstanding collaboration and dedication in providing exceptional care to a complex and high-risk maternity patient and her babies. The team came together across specialties to ensure that care was delivered at the right time, in the right place, in the best way, and with the safest possible outcome.

Particularly, Dr Wright's coordination pulled the entire process together, ensuring communication and planning across all specialties. This coordination, combined with the contributions of the whole team, was critical in achieving a safe and positive outcome for the patient and her babies. This nomination recognises the MDT's commitment, professionalism, and ability to work together to achieve the best possible outcome for our patients. Their efforts truly embody the values of excellence, teamwork, and compassion in healthcare.

The team was made up of Emma Falconer, Obstetrics Staff grade, Blair Sorbie, Obstetrics Registrar, Peter Walsh, Anaesthetist, James Wright, Anaesthetist, Jess Dawson, ODP, Charlie Oldfield, ODP, Jess, ODP, Becki Davidson, ODP, Juliana, maternity theatre, Kharys Day, maternity theatre, Katie Coxon, maternity theatre, Prabina Rana, maternity theatre, Jen Broadhead, CCO, and Fran South, PACU.

Kate Izims, Staff Nurse **Scarborough** **Nominated by relative**

My daughter was brought to ED with breathing difficulties. Nurse Kate acted swiftly to provide oxygen and immediate review by the doctors. Although she was busy, she kept regular checks on her and contacted the doctors for checks when she was concerned. She also kept me at ease and reassured me along the way, when the doctors said we needed to transfer to York. Nurse Kate is a true angel and her care was outstanding.

Gemma Newell, Oncology Secretary **York** **Nominated by colleague**

We have been short-staffed for varying reasons and Gemma is proactive as a team member that she always goes above and beyond to help in every situation possible. She makes work under tough circumstances more bearable. It is a pleasure to witness her caring attitude with patients and if I was poorly, I would appreciate Gemma being in my corner.

Lisa Dalby, Senior Pharmacy Assistant **Scarborough** **Nominated by colleague**

Lisa had stayed past her finish time at work to support completing a discharge TTO for a patient going home, due to the delay in her leaving on time she missed her usual bus to get home. When Lisa boarded the next available bus, she noticed a member of the public getting on who was taking one of the Trust wheelchairs away with them. Lisa challenged the individual as to why they had the wheelchair and pointed out the signage on the back indicating it was not to leave the hospital. She faced abuse from the individual but calmly stood her ground and was able to persuade them to give the wheelchair back.

Lisa asked the bus driver to stop the bus, and she disembarked at the bottom of the ambulance hill and walked back up to return the wheelchair safely back onsite. Lisa then had to wait another half an hour for another bus to get her home. She has had a recent ankle injury so pushing the wheelchair back up the hill would have been much harder for her than others. Well done, Lisa.

Miroslawa Bakalarska, Domestic Assistant **York** **Nominated by colleague**

When I am on Critical Care undertaking my audits, especially in the ICU section where Miroslawa cleans, it is immaculate and always clean. When I approach Miroslawa and ask her if she could do something for me, no matter where on Critical Care, she will always do it without hesitation. She upholds the Trust values as she is kind and respectful of my guidance, and when she is asked to do something, she shows respect. I feel happy that when she is on the ward area as I know it is going to be cleaned to a high standard.

It is lovely to talk with Miroslawa and I cannot think of anything negative about her and her kind, thoughtful, helpful, respectful, and happy nature. She is genuinely lovely throughout and has a great work ethic. I feel she is an asset to the Trust and the Domestic Services team.

Christopher Brewer, Consultant in Obstetrics and Gynaecology **York** **Nominated by colleague**

I would like to nominate Chris for his help with achieving our Fast Track pathway targets and for his communication with patients who are receiving a cancer diagnosis. As well as the many patients he sees for cancer investigation, treatment, and follow-up, he often must cover for his colleagues in communicating difficult news and always does this efficiently, compassionately, and without complaint.

Christopher is a big help to the secretarial team when ensuring that result letters for the fast track PTL are completed to ensure we meet our targets. Last week, he had to action 20 results in one day for colleagues who were on leave/off sick to ensure we met our targets. Again, he did this efficiently and without complaint, and alongside his own busy workload. This is much appreciated by the secretarial team, and we feel he deserves a Star Award for this.

Theatres Team and Day Unit Team **York** **Nominated by colleague**

Both the York Theatre Team and the York Day Unit Team worked collaboratively to minimise patient cancellations and successfully facilitated alternative options for lists to proceed when six of the day unit theatres were out of action for several days. Amalgamating such a high level of activity within an already busy theatre schedule, while managing changes to patient pathways and expectations, was an incredible achievement.

The teams demonstrated outstanding professionalism, flexibility, and unwavering resilience in a challenging situation to deliver the best possible outcomes for our patients. Well done to everyone involved!

Jessica Smith, Specialist Radiographer **York** **Nominated by colleague**

Jess has recently completed her Breast Imaging Practice PgCert in record time, achieving outstanding results and passing with flying colours. Her commitment, professionalism, and ability to balance academic study alongside clinical responsibilities has been exceptional.

Throughout this period, she has continued to make a highly valued contribution to the breast imaging team, demonstrating strong clinical skills, initiative, and a supportive, positive presence within the department. Her achievement reflects both her dedication to personal development and her ongoing commitment to delivering high-quality patient care.

Rob Newton, Associate Director to Medical Director **York** **Nominated by colleague**

I would like to acknowledge Robert Newton, Associate Director to Medical Director, for the extraordinary support he has given to me during my training period. It is with great pleasure that I extend my sincere appreciation to Rob for his exceptional support and guidance during my one-year placement as a Medical Manager at York Hospital, which commenced on 7 November 2024.

I had the privilege of working closely with Rob, whose extensive experience and deep understanding of managerial operations within the Medical Directorate greatly enriched my learning journey. As my immediate supervisor, Rob played an instrumental role in facilitating my introduction to key personnel within the Trust and arranging meetings to support my learning objectives. Through his guidance, I was able to gain valuable insights into areas such as the Shared Care Policy Environment, Adult Community Care Services, SHYPS, and several key projects, including the Survey on GP Sample Transportation Services of York and Scarborough, the Access Audit of York Hospital, and the L2P Project related to consultants' job planning and appraisals.

Rob's professionalism, dedication, and collaborative spirit were evident throughout my placement. He welcomed my suggestions on various managerial initiatives and always approached our work with enthusiasm and openness. Beyond being a supportive supervisor, Rob has been a wonderful colleague and a trusted friend, generously sharing his extensive NHS experience and providing every possible opportunity for me to achieve my learning objectives.

I take this opportunity to convey my heartfelt gratitude to Rob for his time, commitment, and expertise, which have been pivotal to the success of my training period. I am confident that with his exemplary dedication and leadership qualities, Rob will continue to excel and reach even greater heights in his career. I highly value the companionship of Rob and wish him every success in all his future endeavours.

Chris Miles, Porter **Scarborough** **Nominated by colleague**

Chris consistently demonstrates an exceptional commitment to patient care and team support. He is known for his proactive attitude and his willingness to go above and beyond his assigned duties.

A standout example of this occurred during a particularly busy 8pm handover in the x-ray department. Despite not being the designated x-ray porter that evening, Chris recognised that the department was under significant pressure. Without being asked, he took the initiative to transport patients from their UEC cubicles to x-ray. This allowed the radiographers to focus fully on imaging, what would have taken several hours to clear by one radiographer imaging and pushing trollies was cleared significantly quicker with Chris's help.

What Chris sees as simply "keeping busy" made a profound difference to both staff workflow and patient waiting times. His actions reflect outstanding teamwork, compassion, and dedication to delivering high-quality patient care. Chris is a valued member of the team, and his consistent willingness to step in wherever needed makes him an asset to the Portering Team.

Sharon Barnes, AHP Senior Support Worker | **White Cross Court** | **Nominated by relative and patient**

Sharon came as part of the brilliant Hospital@Home team when, as my husband's wife and long-term carer, I found I couldn't cope. She was always bright and cheerful while helping a very private man with washing and changing in a way that didn't embarrass him. She gave me guidance on how to manage things and, once a stairlift was installed, Sharon encouraged Jan to use it with care, to come downstairs after a lengthy time of bedrest. 'Well done!" was her response to this progress, then ensuring that he got safely upstairs and into bed again. She telephoned to check how he was doing after a visit. After seeing me attempting to unpack and unroll a hybrid mattress, she just chuckled, said that she had done one like it before and helped me do it. My husband and I think that she is a star!

Sherrine Dobson, Medical Secretary, and Christine Sanderson, Outpatient Administrator | **York** | **Nominated by colleague**

Christine and Sherrine have worked tirelessly over the past few months while we have been short staffed. They have kept the outpatient arm of the department running smoothly as well as taking the time to help support colleagues with training in other departments. They live by the Trust values every day, striving for excellence in their work and showing kindness to our patients, some of whom are coming into the department to receive a life-changing diagnosis.

Andrew Chamberlain, Consultant | **York** | **Nominated by colleague**

The Trust has recently rolled out new blood gas analysers. As these went live, an issue with compatibility with the Trust's inpatient digital records on CPD, BadgerNet and Metavision became apparent. To get results to feed through to the new system, significant changes to the coding system in all the Trust's electronic patient records had to be instituted.

As the digital lead for ICU, Andy was quickly asked to support the changes required in Metavision, with a new manual entry system put in place within six hours followed by automation of the system over the following weeks. This meant changing personal plans and unplanned working out of hours which Andy took on board without complaint. As a result, ICU and Metavision was the first area to have fully automated complete results feed from the new system.

Angela Shroder, Senior Support Worker | **York** | **Nominated by colleague**

Angela is an exceptional member of the team within the Allergy Service. She is professional, supportive, and knowledgeable and does everything she can to make the hospital experience positive for children and families.

Angela recently supported a patient for a procedure in the allergy clinic, where the patient then became unwell after having an unrelated adverse event. Angela's response and support to the patient exemplified our Trust values beautifully, ensuring the patient got the care required quickly, maintaining their safety, and staying with them until recovered. Well done, Angela, for all you do within the Allergy Service.

Gemma Barnes, Consultant Paediatrician **York** **Nominated by colleague**

Dr Barnes has consistently gone above and beyond to support juniors and ward staff, especially during some of the busiest and most stressful periods. When the Assessment Unit is overwhelmed, she simply cracks on, seeing patients promptly, making clear plans without hesitation, and helping the whole team stay calm and focused. She is always positive and cheerful, bringing an energy that lifts staff morale even on the hardest days. Dr Barnes makes time for everyone, offering steady guidance during challenging shifts and checking in on staff wellbeing despite her own busy workload.

Her kindness shows in the way she listens, encourages learning, and makes every team member feel valued. She demonstrates openness by creating a safe space for questions and honest conversations, and she shares her expertise freely. Her commitment to excellence is evident in the high standard of care she models and the confidence she helps build within the team. Dr Barnes has made a tangible, lasting difference to staff morale and patient care, and the ward feels stronger and more supported because of her.

Emergency Department **York** **Nominated by relative**

On 4 December, my wife had an accident in York and was treated by the ED team. Despite being under considerable pressure, the diagnosis and treatment was first class. I would like to give my most heartfelt thanks to all the ED staff who diagnosed and them provided treatment to my wife. Although all staff we interacted with were extremely hard pressed, they delivered exceptional treatment. Thank you.

Abbie Chappell and Denize Antonsson, Midwives **Scarborough** **Nominated by patient**

Abbie, I would just like to start by saying you are an incredible human and thank you so much for bringing my baby boy into this world! You are an inspirational midwife and student midwife (at the time). Abbie qualified as a midwife when my little one was born, and as an apprentice nurse myself at a different hospital, I can confirm she is a role model of a student and was outstanding! Her care, courage, compassion, and knowledge were exceptional! What a gorgeous human being and an absolute asset to the Maternity Service in Scarborough Hospital.

I got sent to Scarborough to give birth, which was an hour and 45 minutes away from home and I was scared. I hate going to unknown places, especially with medical care, but I can say that due to Abbie and the rest of the Maternity Unit, I would have all my children there if I could! From being onto the ward to begin with to giving birth, the theatre staff and then the neonatal team, they were all incredible. Abbie went above and beyond during my the whole of my labour. She did everything professionally and was like an extra birthing partner. I wish I could have her as my midwife for any future babies. Future new mums are lucky to have her as their midwife.

I would also like to say Denize on the Postnatal Ward is also a treasure and an excellent midwife! She didn't just feel like a midwife, she also felt like a friend when I needed one the most. I instantly felt comfortable in her care after speaking to her for five minutes. She couldn't have helped me, my partner, or my little boy more if she tried. She is one in a million. Scarborough are blessed with some amazing midwives. Thank you every single one of you, and a special thanks to Abbie and Denize.

Karen Bentham, Nursing Associate **Scarborough** **Nominated by colleague**

It was a difficult shift when a patient had unexpectedly become very unwell and was suddenly deemed end-of-life. Karen was amazing and took the rest of my patients so that I could concentrate all my time on my patient and their family to ensure that I could give the best care possible. Karen made sure during all this that she kept checking if I needed anything and she also kept a close eye on if the patient and their family needed anything while I was preparing medication to keep my patient comfortable.

When the patient passed away Karen comforted the family and ensured that they had everything they needed and were aware of what would happen next. She was a great support to me and other members of the team by checking in on how we were feeling and encouraging us to debrief the situation which had happened suddenly. Karen is kind, caring, and an amazing nurse. The whole team and patients are lucky to have her.

Richard Taylor, Consultant in Oral Maxillofacial Surgery **York** **Nominated by patient**

Mr Richard Taylor always has time to explain procedures. I never feel rushed. His kind, gentle nature comes across in his smooth Scottish accent. He treats patients as people and not just as part of his work schedule. I have every trust in him for my upcoming operation. He deserves acknowledgment.

Jennifer Peate, Healthcare Assistant **Scarborough** **Nominated by colleague**

Jen is brilliant in the way she discharges her duties on the ward. She is kind and caring, gets along with everyone, maintains positive energy throughout the shift, manages time effectively, and supports team members. Jen makes the dream team.

Jangchuk Lhamo, Healthcare Assistant **Scarborough** **Nominated by colleague**

Jang is great at what she does. Patients receive best care, she answers the call light with smile, and she radiates positivity even under stressful and busy conditions. In line with the Trust values, Jang supports other team members with tasks.

Tasmin Putt, Physiotherapist **Selby** **Nominated by colleague**

Taz and I visited a patient together and I was impressed by how kind, considerate, and understanding Taz was. She put the patient at ease and demonstrated amazing knowledge of her subject without overwhelming the patient. I feel that the patient's experience was made much easier because of Taz.

Taz was also clear and concise, which meant the patient could understand easily what she was trying to achieve. Even the family commented on how lovely Taz had been and were grateful.

Andrew Proctor, Consultant in Oncology **York** **Nominated by patient**

I am truly grateful to have been treated in the past and currently to date, via this NHS Trust. The nomination is because while I feel like this about the whole unit and multi-disciplinary team, I feel it about this gentleman in particular. I feel he represents the ethos of the Trust values of kindness, openness and excellence in his behaviours and actions.

I am nominating Dr Proctor who is a truly remarkable man within his field of expertise. Working tirelessly and providing the necessary means to help people, woman like me with breast cancer, whatever the stages or reoccurrence. Including, and not forgetting, the vast amount of research that goes on and is required behind the scenes. He does this alongside his wonderful breast care nurses and team. I found his underpinning knowledge and passion reassuring. He listens to you and shows empathy and compassion. He went above and beyond when answering questions and more. A clever, intelligent, and kind man indeed. He is courteous, well mannered, respectful, and professional. He provides excellent and 110% service. Thank you.

Eleanor Oakes, Phoebe King, and Drew Tordoff, Midwives	**York**	**Nominated by patient**

I would like to formally nominate El, Phoebe, and Drew for their truly exceptional care and unwavering support throughout my pregnancy, labour, and birth. From the beginning of my maternity journey, El and Phoebe were my community midwives, and their kindness, professionalism, and dedication immediately stood out. They were consistently supportive, endlessly reassuring, and always available whenever I needed guidance or reassurance. No question ever felt too small, and no concern was ever dismissed. Their openness and compassion created an environment of trust where I felt genuinely listened to and cared for as an individual, not just a patient.

When I went into labour, their commitment went far beyond what could ever be expected. My labour lasted 14 hours and ultimately resulted in an emergency caesarean section, which was an extremely intense and emotional experience. El was on shift when I was first admitted to the Labour Ward and remained with me through the most difficult stages. Her calm presence, clear communication, and constant reassurance helped ground me throughout a frightening and exhausting time. Drew then took over and demonstrated extraordinary dedication and determination to ensure my safety and my baby's wellbeing. At one point, while I was leaning forward over a birthing ball, Drew was literally under the bed holding the monitoring equipment in place so that accurate readings could be maintained. This moment alone captures the level of commitment, selflessness, and excellence she demonstrated. It was far beyond what anyone would reasonably expect and made a significant difference to my care and clinical outcome.

Phoebe was also present for my emergency caesarean and continued to deliver the same outstanding level of care. After surgery, both Phoebe and El worked together seamlessly to support both me and my partner during recovery. They provided not only excellent clinical care, but also emotional reassurance at a time when we were vulnerable, overwhelmed, and exhausted. Their teamwork, compassion, and attentiveness never wavered.

What sets these midwives apart is not just their technical expertise, although that is clearly exceptional, it is their humanity, their kindness under pressure, their openness in communication, and their relentless pursuit of excellence in even the most challenging circumstances. They did not simply do their jobs, they went the extra mile at every stage, often in ways that will stay with me for the rest of my life. Because of El, Phoebe, and Drew, I felt safe, supported, and respected throughout one of the most significant experiences I will ever have. Their actions made a tangible and lasting difference to my outcome and to my family. I will always be profoundly grateful for their care, and I cannot think of a more deserving team to be recognised for living and breathing the Trust values every single day.

Denise Pooley, Healthcare Support Worker	**York**	**Nominated by patient**

Excellent personal care to everyone on the female short stay ward. She stayed on to help after her shift finished. She kept everyone informed and explained any difficulty occurring in the room.

Phill Fletcher, Electrical Services Technician AP | **York** | **Nominated by colleague**

When I was leaving home for work, my door handle came off, resulting in me being unable to lock my house securely, or get back inside. Rather than miss work and call an emergency locksmith, I still attended work, although with a lot of anxiety at the back of my mind. I went to the Estates department at York Hospital to see if they could loan any suitable tools (all my tools were inside my house).

Phill came to see me and listened to what the problem was. He took my door handle and went to find tools the correct size, adjusted the handle, offered advice, and loaned me the tools. Thankfully, I was able to enter using the tools supplied and get back in after my day at work. He enabled me to fix the handle back on and close and lock my house door. Big thanks for readily giving kindness and excellence and applying yourself to a non-work issue in support of an unknown York Hospital colleague.

Courage Ojei, Staff Nurse, and JoJo Generoso, Healthcare Assistant | **Scarborough** | **Nominated by relative**

Courage and Jojo worked tirelessly to meet the many differing needs of the patients on the bay my mum was on. They completed tasks that were outside of their own roles to get the patients' care needs met and prioritised them. I have never seen people work so hard and in such a dedicated manner as I saw this evening. And on a challenging ward and bay. They deserve to be recognised for their commitment and for how they allowed each patient to feel seen and heard. They work within the values of your Trust, and you should be exceptionally proud of them.

Jon-Paul Bouckley, Operating Department Orderly | **Scarborough** | **Nominated by colleagues**

During a Haldane Ward waiting list, JP went above and beyond to help facilitate the safe and timely transfer of patients to theatre, assisting nursing staff on the ward. We absolutely could not have run the waiting list as smoothly without him. He was an asset to the team.

Nicola Jones, Midwife, and Jasmine Rascol, Student Midwife | **York** | **Nominated by relative**

We would like to express our deepest gratitude to Jasmine and Nicola, the two incredible midwives who supported us during the birth of our child. They were brilliant from start to finish - attentive, caring, and completely dedicated. Jasmine, a third-year Student Midwife, showed remarkable skill and compassion, and it's clear she has a bright future ahead. Nicola's calm experience perfectly complemented her, and together they made us feel safe and supported throughout.

When my wife needed to go to theatre, they stayed by her side with unwavering kindness. They also took the time to support me as the father, ensuring I understood what was happening and felt reassured. They even stayed beyond their shift to make sure our new family was settled. Their dedication went above and beyond, and we are truly grateful for everything they did. We will never forget their compassion and professionalism on such an important day.

Melanie Hill, Heart Failure Administrator **York** **Nominated by colleague**

Thank you for considering Melanie Hill for a Star Award. Her outstanding contributions to the Trust through her leadership of the change makers' Communications & Engagement Pillar team have significantly advanced our goals.

Melanie has made an exceptional contribution to the Trust through her leadership of the Communications & Engagement Pillar within the Our Voice, Our Future programme. Her genuine passion for culture, communication, and staff experience has inspired others, fostering a sense of pride and motivation among colleagues. She consistently demonstrates kindness, openness, and excellence, which uplifts the team and reinforces our shared values. Melanie has energised the change makers within the Communications & Engagement pillar team, giving fellow volunteer change makers clarity, purpose, and confidence to contribute. Her calm assurance and clear vision for good communication inspire trust and admiration.

To keep the team connected and motivated, she set up a WhatsApp group that provides real-time updates, encourages questions, and sustains momentum between meetings, demonstrating her proactive leadership. Her leadership of the communications survey as part of the Communications & Engagement Pillar Group, which secured over 844 responses, demonstrated her ability to mobilise colleagues and create an open environment where staff feel safe to share honest feedback. She also works closely with the senior Board Communication Sponsor, ensuring that updates are timely, expectations are clear, and resources are secured to deliver activities effectively.

On 13 November, Melanie coordinated World Kindness Day as part of the Communications & Engagement pillar team work across hospital sites, designing posters that explain what kindness means in our workplace and why it matters to staff and patients, demonstrating her proactive leadership and commitment to staff wellbeing. Melanie consistently goes far beyond what is asked of her. Her dedication, creativity and values-driven leadership of the Communications & Engagement Pillar team make her a standout ambassador for the culture we are building.

This submission is supported by Lucy Brown, Director of Communications, Gail Dunning, Head of Organisational Development, Alex Kilbride, Programme Manager, and Mo Jogi, Senior OD Facilitator.

Ellie Pickin, Nursing Associate **Scarborough** **Nominated by colleagues**

We would like to recognise Ellie for her outstanding advocacy and compassionate care during a particularly challenging situation with a very unwell patient on our ward. Over several days, it became increasingly apparent that the patient was deteriorating, and, during our review, he showed clear signs of being near comfort rather than active treatment. Ellie had been persistently raising these concerns throughout the day, always with the patient's comfort and dignity at the forefront of her mind. She escalated appropriately and professionally when further input was required, involving senior clinicians and the Parkinson's specialist team, who confirmed that the patient was for comfort care.

Thanks to Ellie's commitment, the patient was able to have unnecessary interventions removed and spend his final moments as comfortable as possible. Her actions exemplify compassionate, patient-centred practice and made a meaningful difference to both the patient and his family. Well done, Ellie, for advocating for your patients and their families.

Rebecca Marr, Associate Audiology Practitioner **Scarborough** **Nominated by colleague**

Becky defines our Trust values and is a rising star. Becky started as a trainee apprentice and is currently progressing through the apprenticeship levy training as an associate audiologist. Becky puts the patient's experience at the heart of each appointment. Today, we have had staff sickness at Bridlington Hospital and Becky has stepped forward to cover these patients in addition to her own, starting earlier and finishing a little later. Becky knows how important it is to patients to have their hearing aids reviewed prior to Christmas, especially as many are elderly and will be on their own or visiting family, and if their hearing aids are not working, they will be isolated at family gatherings. Today, Becky is my hero.

Joanna Bowe, Healthcare Support Worker **York** **Nominated by colleague**

Joanna has created beautiful artwork in our quiet room for the patients to enjoy. We are proud and grateful.

Jaison Parackal, Healthcare Support Worker **York** **Nominated by colleague**

Jaison has worked hard to create beautiful artwork in the quiet room on Ward 36 for patients to enjoy. The detail is amazing. Thank you.

Vicky Davey, Deputy Manager **York** **Nominated by colleague**

Vicky has been dedicated to creating a space for patients to enjoy on Ward 36. She has helped with designing and organising. It will open this month. Thank you for your hard work.

Emma Clement, Head of Communications **York** **Nominated by colleagues**

We are nominating Emma Clement for a Star Award as a team because we want her to know how much we all truly appreciate her and to acknowledge the excellent and essential work she produces every day.

As Head of Communications, most of Emma's work takes place behind the scenes, yet it makes a real and tangible difference to colleagues, patients and the wider Trust. She manages a busy Communications Team while organising both internal and external communications, and does so with a level of kindness, openness and excellence that sets the standard for all of us. Emma uses her extensive communications knowledge and experience to ensure that the Trust's messages are clear, accurate and supportive. Whether she is crafting responses to media enquiries or developing communications plans for important clinical updates, she puts in significant time and care to make sure colleagues across all sites, partner organisations and the public receive the information they need. These tasks are rarely visible to others, but they are vital to keeping staff well-informed and helping services run smoothly, which ultimately benefits patients and visitors.

Emma is also responsible for organising the Long Service Awards and the Celebration of Achievement (CoA) Awards. These events are a major undertaking, and it is no exaggeration to say they take over her life in the weeks leading up to them. Much of the Trust will never know how much work goes into these events, but we see firsthand the countless hours she spends coordinating nominations, planning the programme, managing logistics, and keeping everything on track. Despite the challenges, she leads by example, keeping the team motivated with kind words, encouragement and constructive feedback. On the night of CoA, she runs the event with absolute precision, ensuring that every detail is taken care of so colleagues feel valued and celebrated. These events play an important role in recognising staff achievements and supporting morale and retention across the Trust, and they would not be the success they are without Emma.

As a manager, Emma balances supporting the team with encouraging us to push ourselves and develop new skills. Thanks to her leadership, a team of five consistently produces the work of ten. She gives us opportunities to learn, grows our confidence, and is always ready to stand by us, both professionally and personally. During difficult moments in our lives, Emma has been there with empathy, reassurance, and practical support, going out of her way to help us through it. Her kindness has made a profound difference to members of the team and her willingness to step in, offer help, and give her time demonstrates the very essence of going the extra mile.

The Trust relies heavily on effective internal and external communications, and it is thanks to Emma's dedication, professionalism, and values-led leadership that our team consistently produces the high-quality work required. She goes the extra mile time and time again, and her impact is felt across the organisation. Emma truly embodies kindness, openness, and excellence, and she is wholeheartedly deserving of a Star Award.

Sandi Halliday, Staff Nurse **York** **Nominated by colleague**

Sandi helped with the new quiet room makeover. Thank you for your hard work.

Mark Fox, General Manager **York** **Nominated by colleague**

On Monday, Mark supported the maternity staff when he was on-call. The staff had a difficult safeguarding case and called Mark for support. He responded immediately with kindness and compassion. He supported the staff to maintain a baby's safety and wellbeing, whilst also helping the staff navigate an emotionally challenging situation.

Mark always approaches calls in this way. He is level-headed, calm in a crisis, and makes colleagues feel truly supported with any queries they may have. He always takes a holistic and considerate approach to keep our families safe and feel cared for. Many staff have commented to me how they feel when Mark is on call as they always feel able to approach him for support and advice as he makes them feel valued. He is just a lovely person. Thank you, Mark.

Vascular Team, Ward 14, Ward 11, Pharmacy, and CT Scanning **York** **Nominated by patient**

It has been my first visit to hospital to stay overnight. The experience throughout has been amazingly positive for me. It's difficult for me to pick an individual as I feel like everyone involved went the extra mile. I would like to thank these professional, caring, and helpful teams.

Sascha Evans, Student Midwife **York** **Nominated by colleague**

Sascha was a student involved in an emergency during a massive maternal haemorrhage. During this emergency, she took notes, remained calm, and worked brilliantly with the team. She scribed for the emergency and her documentation was brilliant. Sascha then attended the After Action Review and participated in the investigation, giving her opinion of the situation and providing some great comments and insight.

It's difficult for anyone involved in any emergencies, but especially students, and she acted with courage, confidence, and professionalism throughout the emergency and the investigation.

Honey Dineen, Midwife **York** **Nominated by patient**

We first met Honey when I came to maternity triage due to reduced baby movements. As a result, I was sent for further scans and ultimately ended up being booked in for an induction. Both times I was looked after by Honey. We wanted to express our sincere gratitude for her care throughout my time in hospital.

I have never met somebody so sweet, caring, and reassuring. Honey went above and beyond to provide excellent care, ensuring everything was thoroughly explained to both me and my husband. Her care absolutely stood out to us. She even saw us through the window when we were going home with our baby and came over to say goodbye. We will never forget how Honey made us feel and wish her every success in her career. Well done, Honey, you should be proud of yourself!

Margot Cottam, Healthcare Assistant **Scarborough** **Nominated by patient**

Margot looked after us on the night shifts while we were in hospital after the birth of our first baby. Quietly and unassumingly she fundamentally changed the game in our breastfeeding journey on more than one occasion, allowing us to go home confident in our ability to feed and care for our son.

Margot showed compassion for my needs as a new mother, coming to perform observations on me when she could tell I was already awake caring for our baby, so as not to disturb my now precious sleep. She respected and maintained my dignity while caring for me during a time which could easily feel undignified and vulnerable. When I asked for help, or expressed concerns, she listened and understood what I needed. Instead of just responding to my request she often suggested alternative solutions that I hadn't considered and better met my needs.

Margot was reassuring and patient, spending time to instil confidence in me as a new mother. She helped me find alternative feeding positions that worked for me and baby and helped me to express and pump to ensure baby was fed and could settle when feeding was a challenge. This allowed us to create a feeding plan that worked for our family, and supported us to keep breastfeeding, which was so important to me. Margot was generous with her time, providing much needed emotional support over and above what was required from her in her clinical role. We are so grateful for her kind and compassionate care during our stay.

Anne Ward, Cleaning and Catering Operative **Selby** **Nominated by colleague**

Anne provided domestic services for the Community Response and Therapy Team offices at Selby Hospital. She greeted us with a lovely smile and hello each day and went the extra mile by ensuring the offices were hoovered daily and bins emptied regularly. The toilets were cleaned to a high standard and always replenished. Towards the end of her shift, she would come and ask us if there was anything we need doing, even if it was another hoover of the main walkways, it was never too much to ask!! Thank you, Anne, for everything you have done for us in the Community Response and Therapy Team office, we appreciate it and hope we see you again on our floor.

Leonis Taenas, Deputy Finance Manager **York** **Nominated by colleague**

I would like to nominate Leonis for a Star Award in recognition of her outstanding contribution as Deputy Finance Manager. Leonis consistently demonstrates exceptional clarity and conciseness during our monthly budget meetings, ensuring everyone is well-informed and able to make confident decisions. She regularly asks thoughtful, curious questions that help us explore the best possible use of our resources.

Leonis is always proactive in supporting us to maximise our budgets, offering clear explanations, practical options, and valuable insights that help us plan effectively. Her responsiveness is exceptional - she answers email queries quickly and thoroughly. Alongside her professional expertise, Leonis is friendly, fair, and approachable. Her positive attitude and willingness to help create a supportive environment for the whole team. For these reasons, I believe Leonis is truly deserving of this recognition.

Bethany Black, Preceptorship Midwife, and Stephanie Carroll, Workforce and Retention Lead Midwife | **York** | **Nominated by colleague**

Since Beth and Steph came into post, they have been a breath of fresh air. They are a delight to work with. Their passion for their roles comes across and they always demonstrate our Trust values. They are efficient in the way they work and are always on hand to help.

Facilities Supervisors | **Bridlington** | **Nominated by colleague**

The Bridlington facilities supervisors have demonstrated exceptional professionalism, resilience, and commitment, maintained high standards of performance, and overcome challenges during an extended period without an on-site management presence. Their proactive approach and strong communication, along with a willingness to support each other, have not only kept operations running smoothly but reflected the strength of the team. I am grateful for their dedication to the service, a true reflection of the core values.

Grace Hadfield, Specialist Physiotherapist, and Maria Liversidge, Parkinson's Disease Physiotherapist Clinical Lead | **York** | **Nominated by colleague**

I had a patient who was sadly trapped in his bed rails for three to four hours, resulting in a significant nerve injury. Due to the patient's Parkinson's disease, I was particularly worried about his function and potential risk of increased muscle tone in the affected, dominant hand. If the patient had not been seen quickly, this is an injury that could have impacted his function for the rest of his life.

I referred the patient for nerve conduction studies and the neurophysiologist was very quick and thorough. Their report was detailed and hopeful that the patient would improve with time and therapy. I also enquired as to whether the patient could be booked in for a joint assessment with the hand team and the Parkinson’s team for their combined specialist opinions. Maria was immediately responsive and incredibly helpful in arranging this. Maria and Grace spent around two hours assessing the patient and making him a bespoke 'outrigger' splint. The patient fed back to me that he was so impressed with their care and knowledge and both he and I are confident that their care has helped (and will continue to help) regain the function he so desperately needed to recover.

The patient is now able to feed himself with the affected hand and has been able to move back into his own home from respite care. I'd like to nominate both Grace and Maria on behalf of the patient and myself - I hope they both know the difference this has made.

Hannah Pacey and Justyna Gebczyk, Staff Nurses, and James Robertson, Specialty Doctor | **Scarborough** | **Nominated by colleague**

My mum and I were both at work at Scarborough Hospital when we received a call that my dad had been involved in an RTC. He had been knocked off his bike and had to come into ED Resus via an ambulance. Both being staff nurses, we thought of every possible worst-case scenario.

We cannot thank the team down in ED enough for the care my dad received by Nurse Justyna and Dr James on the late shift and then Nurse Hannah onto the night shift. You all put my dad at ease and constantly updated our family during his time in resus. We knew the department and the staff were busy, but that did not impact the care he received, and we cannot fault them in any way.

Being in the position of a patient's relative was unusual, trying our best not to get involved and to act as a relative and not healthcare professional. However, the staff nurses knew our background and were able to make the situation light-hearted and whilst maintaining professionalism which put us at ease and was appreciated by our family. Thank you all so much, you went above and beyond for him, and he is now making a speedy recovery!

Abbie Chappell, Midwife | **Scarborough** | **Nominated by patient**

Abbie looked after us on the night shifts while we were in hospital after the birth of our first baby. She was kind, supportive, and compassionate throughout my stay on Hawthorn Ward. She was open and honest about likely timelines for being discharged, enabling me to manage my expectations but also to feel fully supported after delivery. Abbie recognised when I was struggling emotionally and practically and offered help without me having to ask. She seemed to understand my concerns without me having to articulate them, which was especially helpful in my sleep-deprived state.

Most notably though, Abbie treated us as part of a family unit, going above and beyond to consider our needs as a whole and suggesting and offering help in a way that supported us together rather than just treating individual patients. This ultimately made a huge difference to our confidence when going home and we are so grateful for all that she did for us.

Helen Rogers, Patient Flow Coordinator | **York** | **Nominated by relative**

After my wife was delivered by ambulance to the busy Emergency Department, I had not had a proper meal for a long time by the time my wife was moved from the corridor. I am on a new diabetes medication that may cause hypos if I am not careful. Helen spotted that things were not quite right, and she provided me with a sandwich and crisps, which was utterly transformative for me. She is a real star performer. Perhaps the Epiphany star has arrived ahead of schedule this year.

Ash Ward **Scarborough** **Nominated by relative**

The team are supportive to both patients and families when going through the emotional time of spending several weeks in hospital. They were professional and nothing was too much for them, no matter how big or small. They would go over and beyond the extra mile and give reassurance The staff would come and say hello and ask if you were OK, even if they were not caring for your family member. They are a credit to the hospital.

Abigail Clarke, Staff Nurse **Scarborough** **Nominated by relative**

Abi provided outstanding physical and emotional care to my child throughout their stay. She consistently took the time to listen, offering calm reassurance in moments of worry and uncertainty, and always making us feel heard and supported. Her compassion, patience, and professionalism made an incredibly difficult time more manageable, and her presence brought genuine comfort to both my child and us. We truly would not have got through this experience without her.

Mike Glenwright, Cleaning Operative **York** **Nominated by colleague**

Two years ago this month, we had a harrowing resus case in York ED. After the patient left, I was left to clean the resus room, which, without exaggeration, looked like it had been ransacked. With packaging, equipment, and blood everywhere, I began sorting everything out when Mike turned up. He looked at the room, at my face, and gently started helping me start getting everything ready for the next patient. Working in silence, his calmness, evident understanding, and care shone through. To this day, I've not forgotten how his presence helped during a difficult shift.

Mike is exactly the example of the Trust value of kindness and how teamwork gets you through the difficult moments in the ED. He asked if there was anything else he could do to help, but he'd done more than enough. Looking back at that shift, it was him that made a very difficult situation just a tiny bit less bad.

This nomination is much delayed, I hope that he still works here, I took his name down when I saw him a month later but never got round to submitting this due to the circumstances of the shift. Even if he's left the Trust, I'd appreciate it if someone could reach out to him and tell him what a difference he's made.

Cindy Ewen, Staff Nurse **York** **Nominated by colleague**

On 5 October, Cindy came to our rescue in the ED. I had gone up to the colorectal surgical unit to get some equipment for stoma care, but Cindy, upon hearing about the pressures within our department, offered to come down and help. Bringing the necessary supplies with her, Cindy came down and cared for the patient herself; nothing being too much. Her offer to help, her manner with the patient, and her generosity in her teaching went above and beyond and reflected Trust values. Her temporary presence in our department made a tangible difference in the quality of care the patient received and helped during a difficult moment.

Committee Report

Report from:	Quality Committee
Date of meeting:	20th January 2026
Chair:	Lorraine Boyd

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

ALERT
* **Nerve Centre Go Live** was discussed and the need to acknowledge that a change of this magnitude will inevitably lead to safety risks, foreseen and unforeseen, during the implementation period. The Board needs to be assured that robust clinical processes are in place to predict and mitigate those risks as far as possible and in the case of unforeseen risks emerging after Go Live, safety risks are identified, assessed, prioritised and mitigated at the earliest opportunity.
ASSURE
* **CSCS Learning Responses** to recent PSIIs and Coroners Preventing Future Deaths were shared and discussed, including a PSII relating to SHYPS with action delivery being monitored via SHYPS governance meeting. * **Homebirth Service** has been reviewed in line with recent directive from them Senior Coroner and NHSE. Interim changes have been made which will improve safe working but will reduce availability of the service while work continues to support further understanding and delivery of new models. * **Maternity Claims Scorecard 2015- 2025** was reviewed and discussed in line with MIS requirements. Discussion focussed on top themes and recurring themes. Together with triangulation through other relevant data sources eg concerns & complaints, PSIIs, MNSIs (Maternal & Neonatal Safety Investigation), moderate harm and above incidents, opportunities for quality improvement and harm reduction are identified and used to continually refresh the Single Improvement Plan, ensuring it remains a live and relevant document. * **Prescribing Incidents Update** provided assurance and evidence to support the reduction of CRR 54 'Prescribing Practice' from 16 to 12. The risk remains on the Pharmacy and Corporate Risk Register. Both prescribing and medicine incidents are triaged and investigated, using PSRIF, by Care Groups Quality & Safety Committees and overseen monthly by the Medicines Safety Group, escalating to the Patient Safety Experience Group and reporting 6 monthly to Quality Committee for assurance. Strengthened governance has supported the risk reduction. Regular and reliable medical engagement could be better to support the Medication Safety Group and the timely completion of policy reviews. * **Nursing Quality Assurance Framework** continues to develop. The dashboard is being continually reviewed and improved, moving towards moving towards a multidisciplinary approach to support triangulated, evidence based oversight of standards of nursing care. All actions arising from recent the recent NAF Internal Audit have now been completed and closed. Professional and Quality Standards Group has been established with a focus on bedside handover, continence

assessment, urinary catheter care and nursing documentation. Ward accreditation continues to be rolled out across all sites, as well as focussed reviews of ward areas flagging concern.

* **Patient Experience Report Q2** outlined progress against key priorities articulated in the Patient Experience Action Plan, with notable improvements in awareness of Carer needs and both the involvement and support of Carers. The new digital FTT platform is being adopted across the Trust and showing encouraging uptake in completion rates and insights gained should improve further when integrated into the Nervecentre platform. Handling of concerns and complaints is an on ongoing challenge and focussed improvement work continues with high priority to support Trust Strategic Objective of excellent patient experience every time.

* **Trust Policies Update** was received and discussed. No concerns were raised

* **Clinical Effectiveness Report** was provided, including a narrative on the outlier notifications received, reports published with Trust level data and reports with national level data and recommendations, along with summary of Trust responses to these.

* **Urgent and Emergency Care Update** led to reflection on the format and focus of the UEC Board Update and to a discussion on how to move from performance focussed reporting to a more quality oriented report that would strengthen assurance relating to quality and safety of care in ED . The discussion broadened out to consider the same in temporary care spaces in other areas of the hospital, recognising the similarities and also the differences. There was recognition that, particularly in times of extreme pressure, a balance would have to be struck between safety and quality to support the 'least worst option'. It was agreed that a paper would be prepared, reviewing recommendations from national reports eg HSIB Investigation Report: Patient Care In Temporary Care Environments (January 2026) and local assessments to clarify current assurance sources and identify gaps and to help the Committee to understand trades offs, their context and impacts.

ADVISE

* **CSCS Care Group** attended and shared their new and ongoing risks & mitigations.

* **CSCS Learning Responses** to recent PSIIs and Coroners Preventing Future Deaths were shared and discussed, including a PSII relating to SHYPS with action delivery being monitored via SHYPS governance

* **Dermatosopy related delays** impacting on dermatology performance is an improving picture following an agreed Dermatoscopy Local Enhanced Service with good uptake by GPs and additional capacity through Consultant recruitment

* **CSCS MSSA rate** is above trajectory and therefore a focus of improvement, monitored through the Care Group IPC meeting

* **Endoscopy Service awarded JAG (Joint Advisory Group) accreditation** following annual review. The service met all required accreditation

* **CSCS Patient Experience improvements** shared included more patients being referred to the Out Patient Antimicrobial Treatment (OPAT) Service on the East Coast and the Mobile Chemotherapy Unit now operating 4 days a week. Both initiatives enable patients to access treatment closer to home.

* **Maternity and Neonatal Quality & Safety Update** outlined the progress towards delivery of the Single Improvement Plan, particularly noting the significant success of Scanning Compliance in line with SBL (Saving Babies Lives) V3.2. In 2023 10.3% were scanned within the recommended timeframe. This figure is now consistently above 80%. PPH remains an area of focus and improvement. Training compliance demonstrated significant, sustained improvement.

* **Maternity Safety Champions Annual Report** was received and discussed in line with MIS requirements.

* **Biannual Maternity, Obstetric, Anaesthetic and Neonatal Workforce Report** was presented and discussed. Non compliance with minimum safe staffing levels for midwifery, neonatal nursing and medical staffing was highlighted and mitigations shared as well an indication of plans to address in longer term. Consideration of strengthening the assurance presented in relation to obstetric and anaesthetic staffing and, to a lesser extent neonatal staffing, challenges was requested to provide greater clarity around current and future risks.

* **Internal Audit Reports** and how they are managed through the Committees to support assurance was discussed and it was agreed to review the quarterly IA Update to help understand the IA reports in context and gain assurance that, triangulated with other information sources, appropriate learning and actions are planned and undertaken. Further assurance will be developed to ensure the loop is closed and intended outcomes have been achieved.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

* **PR3- 'working effectively with Trust partners to contribute to effective patient care, good patient experience and system sustainability'** was subject to a focussed review leading to greater understanding of the risk, in particular the complexity of the system encompassing multiple local authorities and providers. Supporting this agenda requires significant Trust resource and there is currently a gap in assurance that this resource is effectively and efficiently deployed with ongoing work to fully understand. The restructure of the ICB adds to the complexity as responsibilities are redefined, providing both threats and opportunities which are yet to be fully understood but will have wide ranging impacts. This risk would benefit from greater Board visibility and oversight and a clear understanding of the links to our strategic priorities.

* **CSTS Medisight/CPD Dual Entry Risk** was discussed and assurance provided, with both current mitigations and plans for longer term solution under consideration.

CR54 Prescribing Practice was reviewed through discussion of the Prescribing Incidents paper.

Committee Report

Report from:	Resources Committee
Date of meeting:	20th January 2026
Chair:	Jane Hazelgrave

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

ALERT

Diagnostics:

- A focussed review was undertaken on diagnostics (supported by a detailed paper covering the different modalities, performance and plans). The Trust has achieved sustained improvement in diagnostic waiting times from September to November 2025 (74.6%), with a seasonal reduction in December (70.7%). This is better than the lowest month of August 61.7 % but below the Trusts internal planned trajectory (76.9%) for December and the year end internal target (82.7%).
- A revised year end trajectory has been produced at 75.6% with contributions to improved performance broken down into 6 main areas: MRI insourcing for an unstaffed scanner, NOUS bank registrar, Endoscopy in sourcing, Audiology booth and locum, UDS additional lists and long waiting validation.
- NHS England has invited the trust to participate in a deep dive, including imaging and endoscopy workshops. The team is conducting a gap analysis against the imaging recovery plan and auditing demand management, especially for non-obstetric ultrasound and MSK patients. Initiatives such as the 'right test, right place, right time' programme and senior decision sign-off for requests are being implemented to manage demand and reduce unnecessary diagnostics.

Workforce:

- Sickness Absence and Sickness absence remains high at 5.8%, with increases in stress, anxiety, depression, and respiratory illnesses. The impact of organisational change consultations on staff well-being was noted, and various support initiatives, including psychological services and financial advice, are in place.
- Vacancy Rates and Recruitment Controls: Vacancy rates have risen to 6.5%, partly due to the implementation of double and triple lock controls on recruitment.

Digital including cyber security. A paper setting out a number of digital priority areas was presented which included investment for compliance with the DSPT and cyber security. The committee noted the paper and discussed the importance of the investment.

Medical Staffing:

- Guardian of safer working hours: Exception reporting remains high, reflecting ongoing staffing pressures—particularly in Medicine—and an upward trend in breaches of the 13-hour shift limit, resulting in Guardian fines.

Acute

- The December 2025 Emergency Care Standard (ECS) position was 65.7%, against the monthly planned improvement trajectory of 70.7%. The Trusts ranked 74 out of 118 providers.
- Although attendances are higher than last year (up 10% on 2024) there was a drop off of total attendances in November and December. However the was a significant increase in

ambulance attendances indicating an increase in patient complexity resulting in long stays in ED with the 12 hour waits 16.7% versus a target of 13.6%
- Average ambulance handover time in December 2025 was ahead of trajectory at 22 minutes 02 seconds against trajectory of 42 minutes 05 seconds.
- 12+ hour trolley waits increased by 453 in the month to 759 which is the highest level for 11 months.

Finance
- Actual deficit of £10m against a planned deficit of £1m
- Efficiency delivery is £11.6m behind plan (compared to £12.1m behind plan at Month 8)
- ERF income has been running ahead of our expected plan; this is now adjusted to £3m in line with the reducing trajectory to deliver within the capped value.
- Q3 deficit support funding was confirmed at month 5 but continues to be at risk due to the deteriorating system position as of January 26, this is still awaiting a final decision. It has been confirmed that due to the system position Q4 deficit support will not be received.
- Efficiency Programme. At month 9 we have delivered year to date savings totaling £22.8m against a planned savings trajectory of £34.4m. We are currently falling £11.6m short of the year-to-date target requirement. The full year effect of the savings delivered to date is £27.7m.
- Cash Position. The cash balance at the end of December is £13.2m against a plan of £33.8m, which is £20.6m adverse. Of which £11.5m is due to the I&E deficit and £12.4m is due to non-receipt of sparsity income & 24/25 ERF overtrade.

Workforce
- Rising sickness absence is an area of concern driven by stress/anxiety/depression and seasonal illnesses

ASSURE

Diagnostics:
- The overall waiting list has fallen for 2 consecutive months to 13102 (14,908 in October)
- Significant progress has been made in in reducing long waits (13+ weeks) from 17.5% to 8.7%
- A number of modalities will achieve compliance of the 95% standard by March: DEXA and Peripheral Neurophysiology, and potentially Barium Enema if performance improvement continues at current pace. Endoscopy and Audiology are looking to end up around the 90% range Q4 efforts will leave a positive foundation for 2026/27 with validated waiting lists additional equipment funded (MRI, CT scanners) arriving in 2026, and an expanded workforce (new hires, trainees) coming on stream.
- The deep dive was facilitated with a detailed plan by modality setting out the issues, short and longer term actions to improve performance with timescales and risks. The committee welcomed the detailed analysis.

Workforce
- Good progress continues decreasing agency and bank usage
- Flu Vaccination**:** The trust exceeded the NHS England flu vaccination target, achieving 52%.

Medical and Dental Workforce Report Q3 (incorporating the Guardian of Safe Working Hours Quarterly Report).
- The committee were assured that where vacancies exist at speciality level that appropriate cover is sought through locums, bank and agency and that patient safety is not compromised through the desire to reduce medical bank and agency.
- Revalidation deferment rate for the past 12 months is 6.7%, compared to a national average for Acute Trusts of 18%; the appraisal rate is 94% which is the highest it has ever been reported; The ambition and expectation is that the Trust will be at above 90% job planning completion for 2026/27.

- Guardian of safe working hours: Early adoption of the national exception reporting reform from 5 January 2026 introduces centralised management, clear closure timelines, and financial penalties to improve accountability

Nursing:

- The adult and paediatric nurse staffing establishment reviews are complete for 2026/27. This review also included outpatients, endoscopy, and community nursing.
- A Temporary Staffing Approval Panel Group has been set up chaired by the Director of Nursing to improve controls associated with bank and agency usage.
- The safer nurse staffing dashboard provided assurance of fill rates by ward and described the governance and controls used to maintain safe staffing.

ADVISE

- A **workplan** for was presented setting out 10 key priority areas of focus. The recommended format of deep dives into the focussed areas was agreed with some minor amendments. It was recommended that this be reviewed alongside the well led review which may provide further recommended changes to the functioning of the committee.

- **Digital Investment**. The committee advised executive that the investment should be appropriately prioritised as part of the Trust overall planning process and that the risks should be sufficiently weighted.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- There are 2 risks to meeting the revised trajectory for **diagnostics**: the impact of additional NHSE funding to meet RTT times could further increase the demand for diagnostics and there is always a risk to further equipment breakdown.
- Risks to delivery of **financial plan** and the **cost improvement programme** – see ALERT above
- Risks of rising colleague sickness levels
- Risk to delivery of the financial plan.

Committee Report

Report from:	Group Audit Committee
Date of meeting:	13/01/2026
Chair:	Jane Hazelgrave

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

ALERT

- Six of nine reports issued to the Trust since the last meeting have been issued with a limited assurance rating (see below). Ten reports are still in draft, 7 of which have also limited assurance rating. This may impact on the 'Head of internal audit opinion' for 2025/26.

ASSURE

External Audit

- The delayed audit certificate for 2024/25 accounts has now been issued. This was a national issue for all external auditors as a result of delayed guidance from the NAO
- Audits have now been completed for the LLP (November) and the Trust charity (November) with no issues to report.
- Work on the 2025/26 external audit had begun, with the focus being on audit planning and on the Value For Money work. The Trust's forecast of financial sustainability by Year 3 in the recent plan submission should impact on the external auditors' opinion on Value For Money arrangements.

Internal Audit.

- **YTFM.**

No recommendations were overdue.
Two audit reports have been issued over the period. Planned preventative maintenance (significant) ; Residential accommodation (significant)

- **Trust**

No recommendations were overdue.

Nine audit report have been agreed with management since the last Audit Committee and a further 10 audit reports in draft.

Two reports received significant assurance: Patient Safety Incident Response Framework; Management of In-Patient Medicines.

Six reports were issued with a limited assurance rating: Safe Storage of Medicines; Elective Operational Toolkit/Non RTT; ED Mental Health Risk Assessments; Training Budgets Non-Medical Staff ; Outpatient and Inpatient Clinical Coding ; Management of Ventilation Assurance and Governance. One report had no rating and was advisory in nature.

Other items

A report on tender waivers was produced for YTHFM and the Trust. The period covered was January 2024 to November 2025. In future the re[ort will be prepared for every audit committee. The report described new internal arrangements to limit the requirement for future STA's.

The committee approved minor changes to the YTHFM and Trust Reservation of Powers and Scheme of Delegation, Standing Financial Instructions, Standing Orders and Trust Constitution.

Fraud

New anti-fraud legislation which came into effect in September 2025. The NHS Counter Fraud Authority (CFA) had issued 60 recommendations in relation to the legislation, of which the Trust had already addressed 51 with an expectation one would remain red and three recommendations would remain amber. These did not pose a significant risk to the Trust and it is expected that the NHS Counter Fraud Authority would accept this as an acceptable position

ADVISE

Governance

A report on the Trust BAF and risk register was presented to the committee. A discussion took place about the appropriateness of this agenda item. The role of audit committee is to gain assurance around the process/system of risk management and assurance, not to discuss individual risks. It was confirmed that the report from the recent external Well Led review would help to inform how risk was covered by committees and the Board in future.

Fraud.

Although it is acknowledged fraud training cannot be deemed mandatory for all staff the committee recommended that the annual training should be mandated for 'higher risk' groups of staff such as Finance, HR and procurement.

IA recommendations

The process for revising internal audit target dates was discussed at the meeting. The committee recommended that a formal standard process be agreed by executive directors to manage the process of date changes in a more systematic way.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
The 6 limited assurance reports set out a number of risks that management are working through and would be managed through the Trusts risk management system. A theme of lack of 'standard work' and cultural challenges were detected and discussed. The committee recommended that the report of safe storage of medicines be taken to Quality committee.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 13

TRUST PRIORITIES REPORT

January 2026

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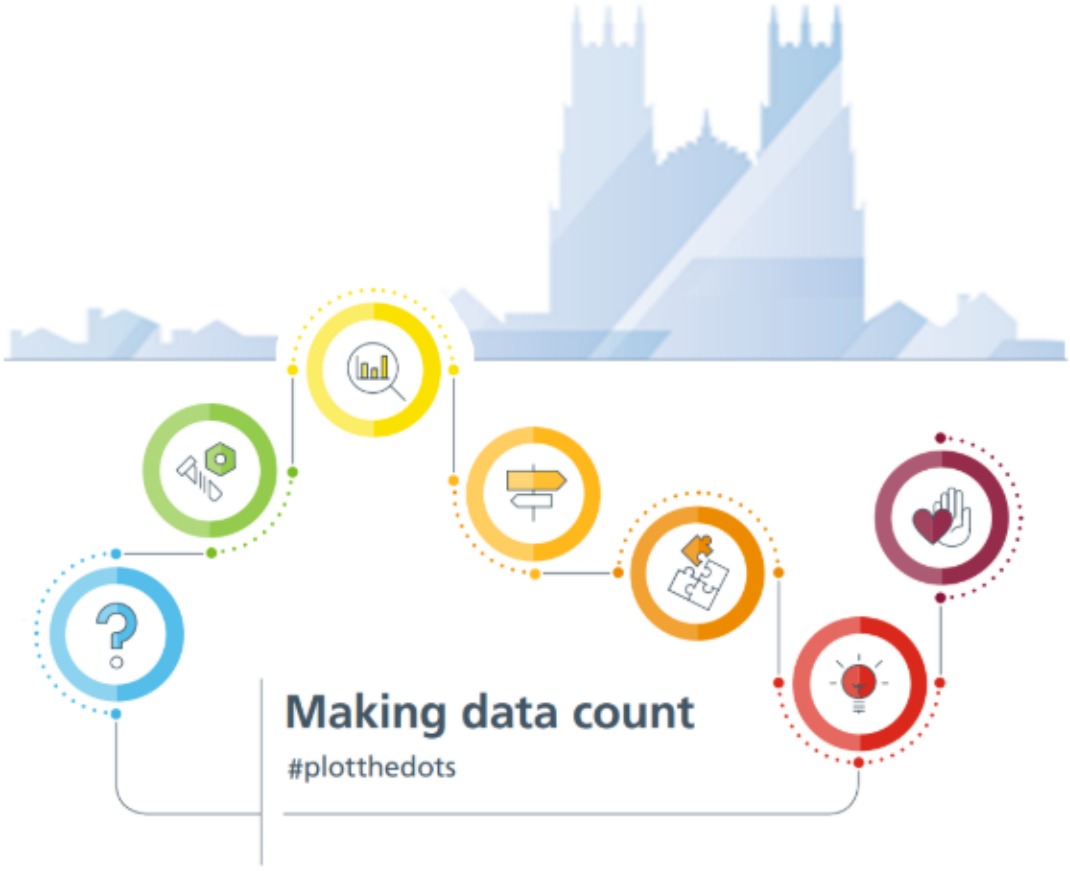

Executive Summary
Narrative

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

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

- Operational Performance – Proportion of elective admissions which are day case.
- Workforce - Twelve month rolling turnover rate Trust (FTE).
- Workforce - Overall Corporate Induction Compliance.
- Workforce - A4C Staff Corporate Induction Compliance.

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

- Operational Performance – Cancer – Faster Diagnosis Standard.
- Operational Performance – Cancer – Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result.
- Operational Performance – Outpatients – Follow-up Partial Booking (FUPB) Overdue (over 6 weeks).
- Operational Performance - RTT – Total Waiting List.
- Operational Performance - RTT – Proportion of incomplete pathways waiting under 18 weeks.
- Operational Performance - RTT – Proportion of patients waiting for their first appointment who are waiting under 18 weeks.
- Operational Performance – Children & Young Persons: RTT – Total Waiting List.
- Operational Performance - Children & Young Persons: RTT – Proportion of the incomplete RTT pathways waiting less than 18 weeks.
- Workforce – Annual absence rate.
- Workforce – Monthly sickness absence.

Information of the Trust's **National Operating Framework (NOF)** performance is included for the first time this month. The page provides the Trust's overall ranking and position nationally against each of the 22 metrics at the end of Q2. Q3 will be published as soon as possible after all official operating statistics for the quarter have been published.

National Operational Framework
Rank Oversight

NHS
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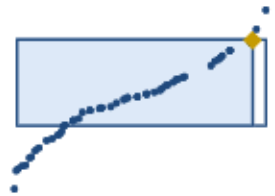
Metric Description	Latest Reporting Date	Previous Value	Latest Value	Difference	Rank
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Sep-25	3.15	3.53	0.38	108
Percentage of patients waiting over 52 weeks for community services	Sep-25	3.75	3.80	0.05	73
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q2 2025/26	3.78	3.81	0.03	110
Percentage of patients treated for cancer within 62 days of referral	Q2 2025/26	3.18	3.06	-0.12	80
Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q2 2025/26	3.20	3.21	0.01	92
Percentage of emergency department attendances spending over 12 hours in the department	Q2 2025/26	3.51	3.49	-0.02	99
Number of MRSA bacteraemia cases	Oct 24 - Sep 25	3.01	3.40	0.39	100
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Sep-25	2.75	3.38	0.63	104
Average number of days from discharge ready date to actual discharge date (including zero days)	Sep-25	1.74	1.68	-0.06	29
Summary Hospital-level Mortality Indicator	Jul 24 - Jun 25	2.00	2.00	0.00	
Proportion of E. coli bacteraemia	Oct 24 - Sep 25	2.54	2.41	-0.13	47
Urgent Community Response 2-hour performance	Q2 2025/26	2.95	2.85	-0.10	43
NHS Staff survey - raising concerns sub-score	2024	3.95	3.95	0.00	132
CQC inpatient survey satisfaction rate	2024	2.00	2.00	0.00	
Planned surplus/deficit	2025/26	3.00	3.00	0.00	76
Combined finance	Q2 2025/26	3.00	3.00	0.00	
Variance year-to-date to financial plan	Month 6 2025	3.00	2.00	-1.00	83
Sickness absence rate	Q1 2025/26	2.12	2.47	0.35	78
NHS staff survey engagement theme sub-score	2024	3.98	3.98	0.00	133
Implied productivity level	Q1 2025/26 vs Q1 2024/25	2.85	2.69	-0.16	76
Proportion of C. difficile infections	Oct 24 - Sep 25	1.00	1.00	0.00	1
Difference between planned and actual 18 week performance	Sep-25	1.00	2.06	1.06	68
Access to services domain score	Q2 2025/26	3.04	3.29	0.25	122
Patient safety domain score	Q2 2025/26	3.07	3.11	0.04	111
Finance and productivity domain score	Q2 2025/26	2.92	2.85	-0.07	96
People and workforce domain score	Q2 2025/26	3.05	3.22	0.17	119
Effectiveness and experience domain score	Q2 2025/26	2.17	2.13	-0.04	61

127 out of 134
Latest Rank



Latest Average Metric Score

Latest Average Segment Score

Latest Adjusted Segment Score

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OPERATIONAL ACTIVITY AND PERFORMANCE

January 2026

Executive Owner: Claire Hansen

The Trust continued to experience sustained operational pressure throughout December, with rising demand, workforce constraints and diagnostic limitations affecting performance across urgent care, cancer, RTT and diagnostics. Ambulance arrivals and attendances increased again, and although conversion rates remain stable, the continued rise in 12-hour stays is a significant concern and reinforces the need to accelerate discharge and improve patient flow.

There are areas of progress. Children's assessment times improved markedly, with a December average of 15 minutes and further gains expected in January. ED transfers to SDEC within 60 minutes continued to increase, demonstrating the impact of strengthening same-day pathways. Quality standards and the acute model of care will be finalised in January to support safety and staff morale.

Financial and workforce challenges continue to constrain service delivery. The closure of Scarborough's ED Ambulatory Care pathway has negatively impacted ECS performance, and limited specialty decision-maker availability restricts the ability to test improvement initiatives. Implementation of the "fit to sit" model, alongside completion of Ward 12 and strengthened SAU/SDEC pathways, will support flow once fully operational. Community bed occupancy remains above 90%, with improved consistency in processes across the system.

Cancer performance remains significantly off trajectory, driven by continued diagnostic delays and high referral volumes, particularly dermatology. Mitigations include additional endoscopy capacity and strengthened dermoscopy pathways. The frailty pathway trial in colorectal surgery continues to show strong impact, reducing unnecessary outpatient attendances.

RTT performance reflects both improvement and ongoing pressure. Targeted action reduced 65-week waiters from 30 to 1, but overall waiting list size increased due to sustained GP and cancer referral growth. Outpatient productivity indicators remain strong compared with peers, though PIFU uptake is slightly below trajectory.

Diagnostics performance deteriorated to 70.7%, affected by seasonal cancellations, equipment failures and workforce shortages. However, additional paediatric MRI GA lists have halved the longest waits for children, and overall diagnostic performance is expected to gradually improve through Q4. Community services remain under pressure, with virtual wards operating near capacity and therapy and SLT backlogs constrained by national workforce shortages.

Executive Owner: Claire Hansen

Overall, while targeted mitigations are underway and local improvements are visible, recovery remains fragile. Achieving year-end trajectories will depend on stabilising demand, improving diagnostic capacity and securing additional recovery funding. Continued system-wide coordination will be essential to maintain safe, effective care through winter.

Priorities:

1) Reduce 12 hour stays and improve flow
2) Strengthen Same Day and Ambulatory Pathways
3) Restore Cancer and Diagnostic Capacity
4) Maintain RTT Recovery momentum
5) Support staff safety, morale, and core clinical standards
6) Stabilise community capacity and reduce therapy backlogs

For information, comparison against Model Hospital peer group where available has been included.

The Trusts within this group are; ROYAL CORNWALL HOSPITALS NHS TRUST, MID YORKSHIRE TEACHING NHS TRUST, EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST, UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST, ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST, UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST , UNITED LINCOLNSHIRE TEACHING HOSPITALS NHS TRUST, NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUSTEAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST and UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST.

These Trusts are assessed by Model Hospital to be like ourselves in terms of size, casemix and geography.

Executive Owner: Claire Hansen

Metric	December position vs plan	Key Mitigations – Next three months	Expected trajectory
Urgent & Emergency Care	ECS performance 65.7% vs 70.7% trajectory. Attendances +10% YoY, ambulance arrivals increasing. Long stays rising; 12 hr waits 16.7% (behind 13.6% trajectory). Flow constrained by high occupancy, respiratory outbreaks, staffing and community capacity.	Fit to Sit expansion; additional ED flow coordination. 100 day Sprint at Scarborough (Jan–Mar) including Super Discharge Team. Multi Agency Discharge Event (Feb). Recruiting second Flow Coordinator for York ED. Paediatric rota and assessment-time improvements.	Fragile improvement expected Jan–Feb. Full recovery dependent on wider system demand management and community discharge capacity.
Cancer FDS/62 day	FDS 60% vs 75.3% trajectory; Trust ranked 114/118 nationally. 62 day 65.9% vs 72.3% trajectory. Performance heavily impacted by +35% dermatology referrals, diagnostic delays, and FIT non compliance.	Colorectal frailty/STT pathway; Urology STT CT model (Q4). Skin insourcing and mutual aid; primary care dermoscopy LES. Lower GI proforma rollout; enhanced GP comms. Endoscopy and imaging recovery actions via ERF.	Gradual improvement through Q4. March 2026 national targets remain high risk due to referral volume and diagnostics.
RTT TWL / %<18w/52w	TWL 57,971 (off plan). <18w: 54.9% vs 58% plan; Trust ranked 97/118. 52 week waiters improved to 1,329. GP Referral growth +5% YTD, CPD logic changes increasing RTT clocks.	Validation sprint; WLIs & insourcing in key specialties. Intensive support programmes (Cardiology, Respiratory, Gastro). Pathway redesign (breathlessness, sleep, pipelle). Managing 65 week risks through Jan escalation.	Improvement expected Jan–Mar. Return to trajectory uncertain without referral moderation & diagnostic recovery.
Diagnostics	DM01 70.7%, 6.2% below plan, deterioration from November. Impact from MRI workforce shortages, CT3 removal, mobile breakdowns, NOUS MSK backlog, audiology staffing gaps, and festive cancellations.	Extended endoscopy insourcing; ring fenced surveillance room. Additional MRI GA lists; radiographer insourcing; CT capacity via lung van. Recruitment to NOUS, respiratory physiology, audiology; pop up booths. NHSE deep dive planned Feb/March.	Improvement through Q4, but recruitment and equipment risks remain.
Outpatients	PIFU 4.2% vs 4.7% trajectory. RACP 14 day performance 78.7%, improving but below 99%. DNA rate reduced to 5.0% (national average 5.6%). Digital letters paused due to technical issue.	"PIFU as standard" rollout (Gynae, Cardiology, Gastro, ENT). Template redesign in multiple specialties to raise 1st OP capacity. ICB–GP demand management on high growth specialties.	Incremental improvement through Q4; largest opportunity in PIFU uplift. Transformative pathway design is required over the longer term.
Children and Young people	CYP RTT waits off trajectory, mainly ENT and Oral Surgery. Initial paediatric assessment times improved (15 mins in Dec; aiming 12 mins Jan).	Standalone paediatric rota for York to improve ECS & assessment. Weekly RTT review; ENT/OS working toward zero 52 week waits by Q4.	Improved ECS for CYP; zero RTT40 week waits by March 2026 (except H&N).
Community	Virtual wards near capacity; SLT backlogs worsened by workforce shortages. Demand–capacity mismatch persists across therapy services.	"Leap into Language" backlog reduction showed early positive results. Expansion of virtual ward & hospital at home models. Strategic resource rebalancing to enable project-based recovery. Escalation framework (2nd line/3rd line) for care transfers.	Large strategic change required with low confidence for Q4.

Headlines:

- The December 2025 Emergency Care Standard (ECS) position was 65.7%, against the monthly planned improvement trajectory of 70.7%. **ECS performance is a True North metric.** In the latest available national data (November 2025) the Trust ranked 74th out of 118 providers and 8th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group.
- Average ambulance handover time in December 2025 was ahead of trajectory at 22 minutes 02 seconds against trajectory of 42 minutes 05 seconds.
- 16.7% of Type 1 patients spent over 12 hours in our Emergency Departments during December 2025, behind the monthly improvement trajectory of 13.6%. . In the latest available national data (November 2025) the Trust ranked 75th out of 118 providers. **This is a True North Metric.**
- In December 2025, the proportion of patients in our care who no longer meet the criteria to reside was 14.4% behind the internal trajectory of 13.2%.
- The average non-elective Length of Stay (LoS) acute for patients staying at least one night in hospital was 6.5 days during December 2025 (3,943 spells of care covering 25,679 bed days). This was ahead of the trajectory to have an average LoS for this cohort of less than 6.8 days submitted as part of the 2025/26 annual planning process.
- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) was 87.1% (3,291 patients out of 3,779), narrowly behind the trajectory of 87.2% submitted as part of the 2025/26 annual planning process. The average delay (number of days after the DRD that a patient was subsequently discharged) was 4.9 days, exceeding the submitted trajectory (4.1 days). Challenges in community health and social care capacity continue, and escalation processes are being followed.

Factors impacting performance:

- Attendances continue to be high, with 10% more patients at each main site in December 2025 compared to 2024.
- Ambulance conveyances continue to increase month on month.
- IPC outbreaks and need for side rooms and isolation.
- Staff sickness levels in the Trust and in Community Primary Care

Actions planned in January 2026:

- Starting a test of change which will move Fit to Sit patients from ED to either Medical SDEC or SAU in York, when pended for a bed on AMU or in surgery.
- Launching our participation in a 100-day Sprint challenge with NHS Learning and Improvement Network. This will test Super Discharge Team implementation at Scarborough in January – March.
- Continuing discussions with several voluntary care sector organisations to seek support in areas of challenge.
- Planning a Multi-Agency Discharge Event (MaDE) to take place late February in advance of the change to Nervecentre

Summary MATRIX 1

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

MATRIX KEY

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

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

Acute Flow (1)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Proportion of all attendances having an initial assessment within 15 mins	2025-12	H		77%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2025-12	H		33.4%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2025-12	L	F	16.7%	13.6%	8.9%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2025-12	L		1895		
ED - 12 hour trolley waits	2025-12		F	759		0
ED - Emergency Care Attendances	2025-12		F	17910	16616	16377
ED - Emergency Care Standard (Trust level)	2025-12		F	65.7%	70.7%	78%
ED - A&E attendances - Type 1	2025-12		?	11321	11160	10999
ED - Emergency Care Standard (Type 1 level)	2025-12	H	F	48.6%	58%	69.2%
ED - A&E Attendances - Types 2 & 3	2025-12		F	6589	5456	5378
ED - Median Time to Initial Assessment (Minutes)	2025-12	L		4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-12			44.5%		

Summary MATRIX 2

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

MATRIX KEY

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

ASSURANCE

VARIATION

	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT		* Of those overnight general and acute beds open, proportion occupied	* Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside
COMMON CAUSE / NATURAL VARIATION	* Overnight general and acute beds open	* Number of zero day length of stay non-elective admitted patients * Community bed occupancy/availability	* Patients receiving clinical Post Take within 14 hours of admission * Inpatients - Proportion of patients discharged before 5pm * Number of non-elective admissions
SPECIAL CAUSE CONCERN		* Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	

Acute Flow (2)
Scorecard

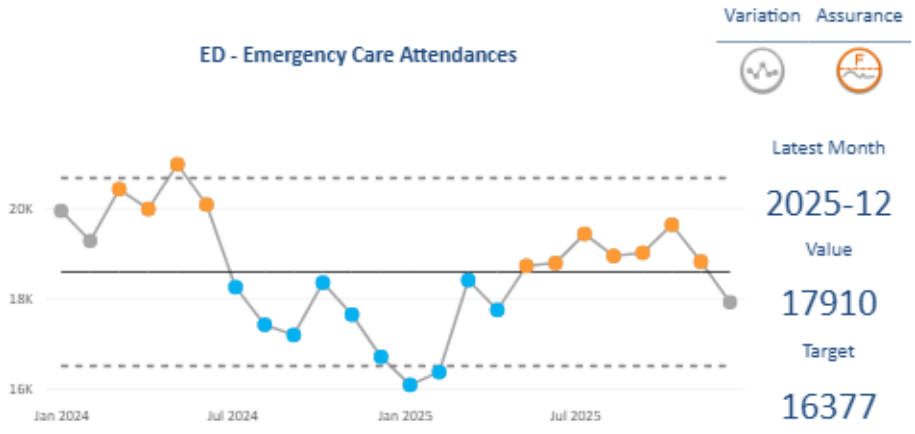
York and Scarborough Teaching Hospitals NHS Foundation Trust

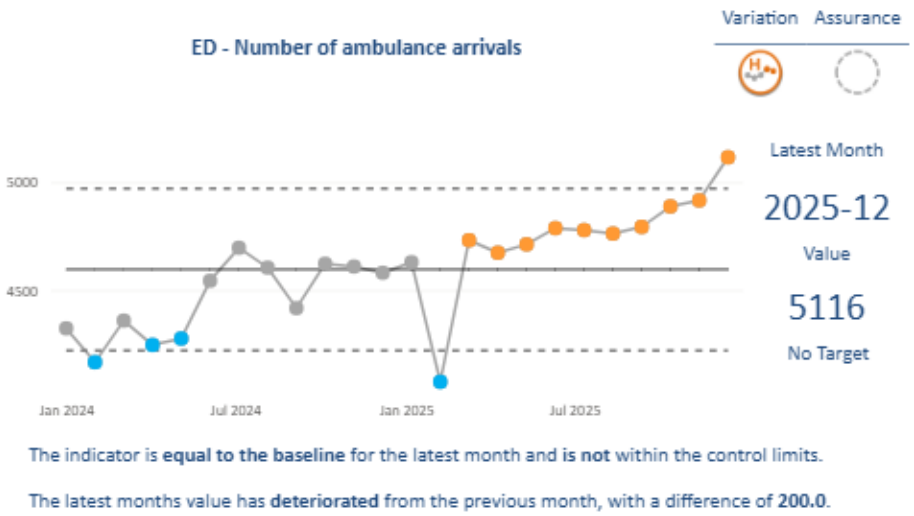
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2025-12			44.5%		
Number of SDEC attendances	2025-12	H		2606		
Proportion of SDEC attendances transferred from ED	2025-12			68.1%		
Proportion of SDEC attendances transferred from GP	2025-12			22.6%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2025-12	H		71.9%		
Proportion of SDEC admissions transferred to downstream acute wards	2025-12			15.4%		
Number of RAFA attendances (York Only)	2025-12			148		
Number of attendances at SAU (York & Scarborough)	2025-12	H		1041		
ED - Proportion of Ambulance handovers within 15 mins	2025-12	H		34.9%		
ED - Proportion of Ambulance handovers waiting > 30 mins	2025-12	L		21.3%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2025-12	L	F	3.7%		0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2025-12	L	?	0%		0%
ED - Number of ambulance arrivals	2025-12	H		5116		
ED - Ambulance average handover time (number of minutes)	2025-12	L	?	22	42	29

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





Rationale: SPC1: To monitor demand in A&E. **SPC2:** To monitor Ambulance demand in A&E.
Target: SPC1: Monthly activity plan as per chart. **SPC2:** No target

What actions are planned?

NHS England has completed an audit of low acuity (CAT3 – CAT5) patients conveyed to Scarborough ED by Yorkshire Ambulance Service (YAS). More than half of the audited cases were deemed to be clinically inappropriate for conveyance. Our Community Improvement Group (CIG) will support YAS to develop and implement actions to address identified issues.

Data about care homes with highest YAS call-out and conveyance rates has been shared, and a plan for working with these homes is being developed through CIG.

Individual high users continue to be supported with a system-wide case management approach. The Trust's lead for Health Inequalities is also working with Primary Care Networks to explore crossover with the health inclusion agenda.

What is the expected impact?

Increasing use of non-ED pathways may reduce or slow the increase of ambulance arrivals and attendances.

Potential risks to improvement?

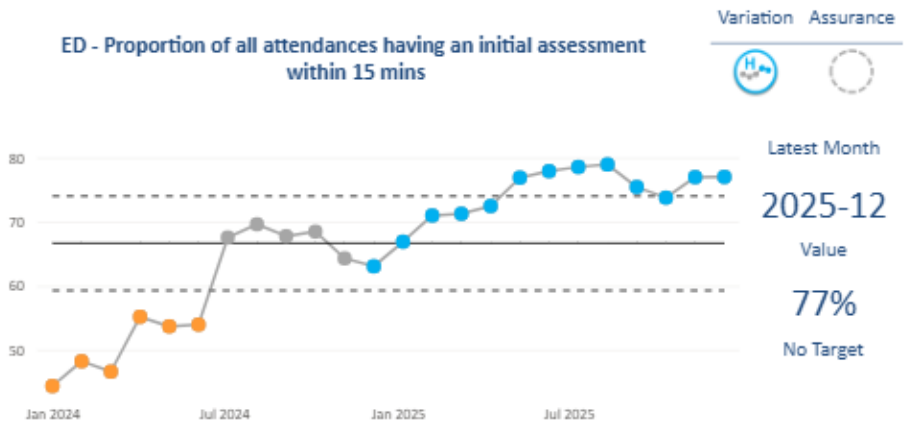
Direct pathway use will not be sufficient to mitigate the demand increase.

Increased acuity of arriving patients – despite total attendances decreasing, the number of Type 1 patients has not.

Continued increase in ambulance arrivals.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

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Rationale: : To monitor waiting times in A&E. Patients should be assessed promptly by within 15 minutes of arrival based on chief complaint or suspected diagnosis and acuity.
Target: No target

What actions are planned?

The proportion of patients having an initial assessment within 15 minutes is holding improvements made since spring.

Paediatric specific actions have been taken during December and will continue throughout the coming months.

What is the expected impact?

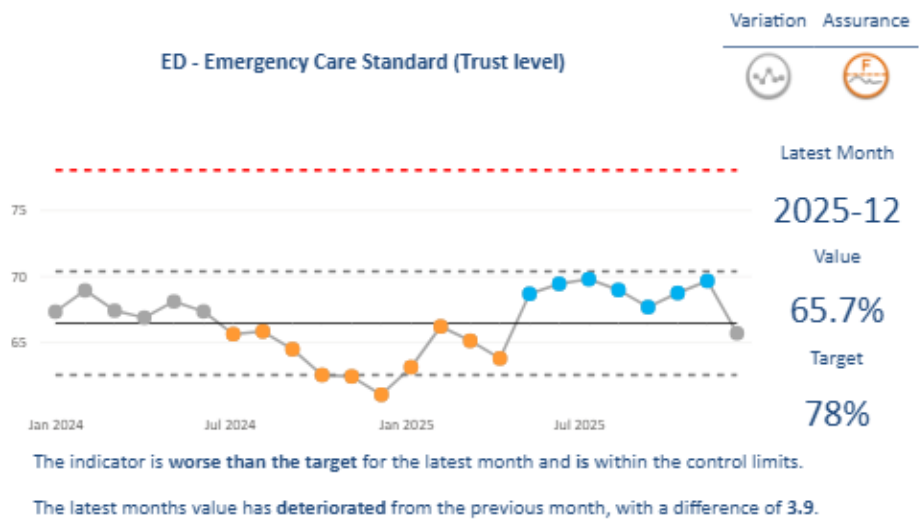
The average time to assessment for children improved to 15 minutes in December 2025 and is on track to reach 12 minutes in January 2025. This will support improvement in the Trust's overall time to initial assessment.

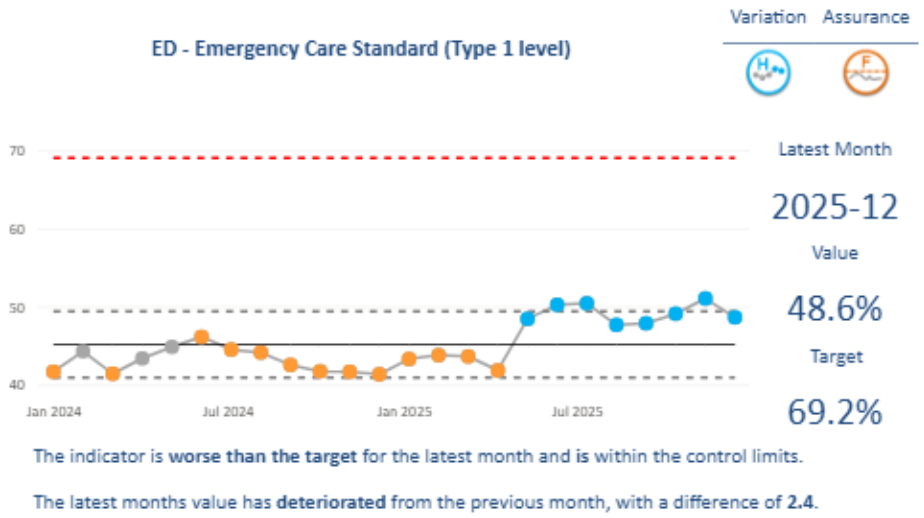
Potential risks to improvement?

- Continued high attendances
- Increasing ambulance arrivals
- Staff sickness levels

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





Rationale: To monitor waiting times in Emergency Departments and Urgent Treatment Centres. **Target: SPC1:** NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2026. **This is a True North Metric. SPC2:** Modelling showed that to achieve 78% as a Trust Type 1 performance needs to be at least 69%.

What actions are planned?

Interviews are taking place in January 2026 to recruit a second Flow Coordinator within York ED. This will increase consistency in daily operations, and support clinical teams by chasing progress of diagnostics, patient movement and more.

Specific actions to improve paediatric performance have been underway, including additional training and communications, and reviewing data to identify specialties with longest delays so that quality improvement work can be developed.

What is the expected impact?

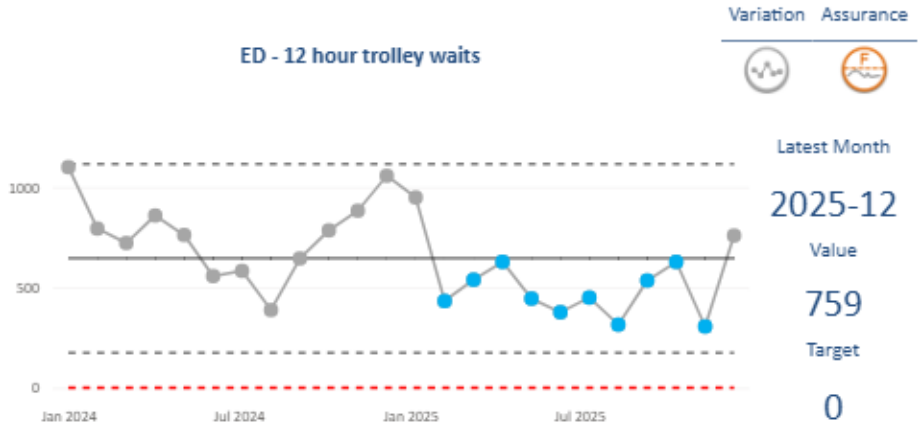
It is expected that meeting ECS targets will continue to be a challenge, but should remain above the same period last year.

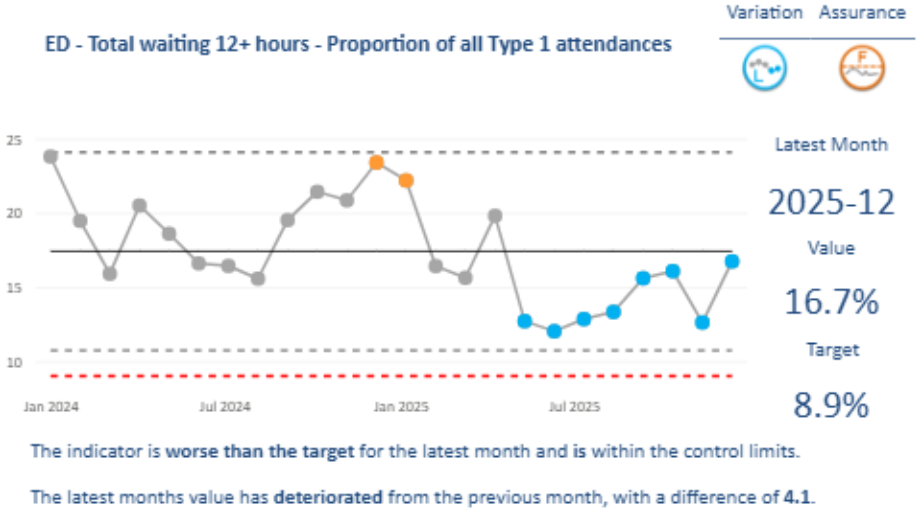
Potential risks to improvement?

- High attendance levels likely to resume in January after a decrease during the festive period
- Continuation of an increase in ambulance arrivals
- Staff sickness levels – both in our Trust and community primary care which will increase attendance
- Increased acuity
- Financial constraints have led to the Emergency Department Ambulatory Care pathway at Scarborough ceasing to operate
- Resources cannot support tests of change, for example having senior decision makers from specialties (Acute / Frailty) in the EDs.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

Actions taken in November to reduce 12 hour stays in ED were successful in bringing the Trust's overall position back to our agreed trajectory. Maintaining this in December was challenging due to the arrival of flu, high occupancy rates, and increased staff absences due to illness and weather affected travel.

Teams continue to implement the Continuous Flow and TES SOPs while using escalation process tools to support flow. Several nurses from the corporate nursing team are deployed daily to mitigate risks. The team is conducting risk assessments and feeding in to operational site meetings to maintain oversight and safety, despite the challenges.

What is the expected impact?

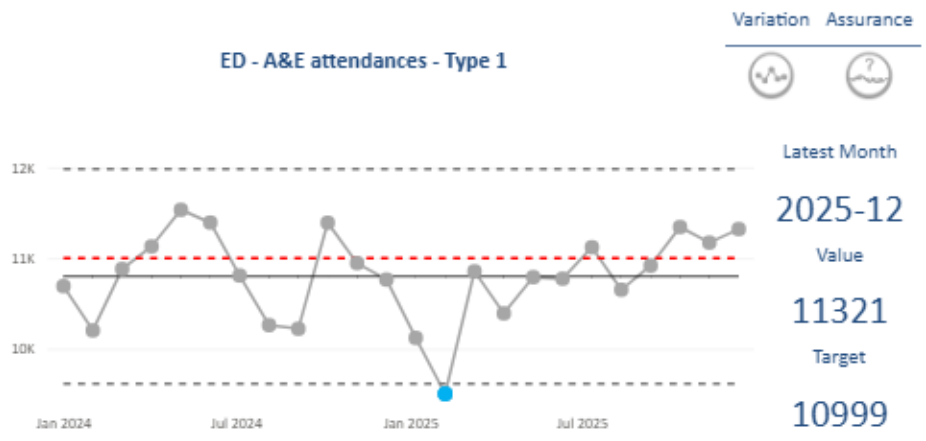
Meeting our trajectory for January will a high risk.

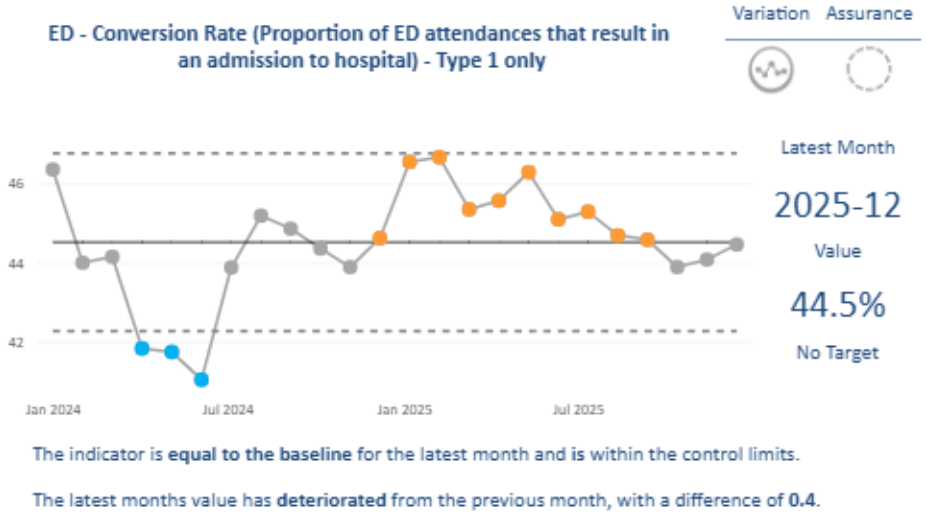
Potential risks to improvement?

The level of required capacity is higher than escalation spaces can support.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

Note: The admissions data includes admissions to all Same Day Emergency Care (SDEC) units. Our non-SDEC admission rate is ~30%. Work is underway to increase appropriate use of SDEC, therefore increases may not be necessarily indicative of an issue.

What actions are planned?

A "fit to sit" model is being implemented, whereby ambulatory patients pended to either a surgical ward bed or an AMU bed at York will be admitted to the Surgical Assessment Unit and Medical SDEC respectively. This will benefit patients who will be in an area supported by specialty staff and it will support ED staff due to a reduction in the number of patients waiting for a bed in ED.

What is the expected impact?

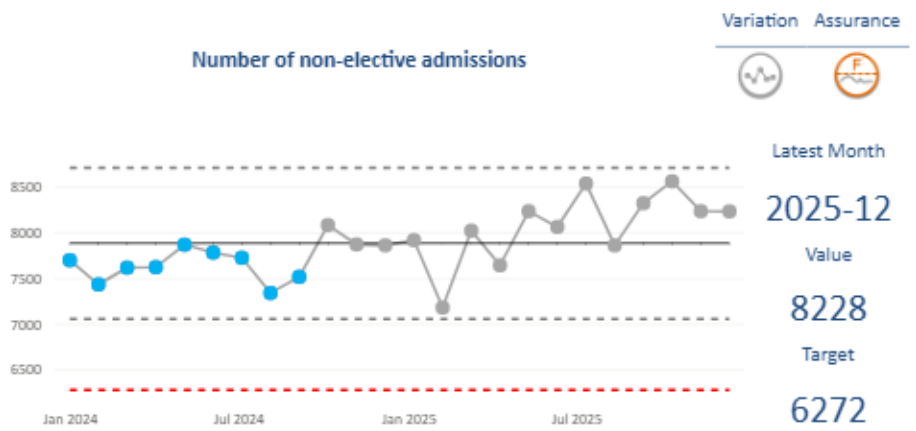
We expect the total number of fit to sit patients to be on average six per day however we do not capture data on whether patients are ambulatory at the point of transfer. The change will be closely monitored during implementation to review numbers and receive feedback from staff in each affected area.

Potential risks to improvement?

- There is a risk of further delaying this pathway due to the delayed expansion of SAU on Ward 12.
- There is a risk that the volume of patients is higher than anticipated and SAU or Medical SDEC are not able to support the volume of patients.
- There is a risk that the volume of patients is lower than anticipated and has little positive impact on the Emergency Department.

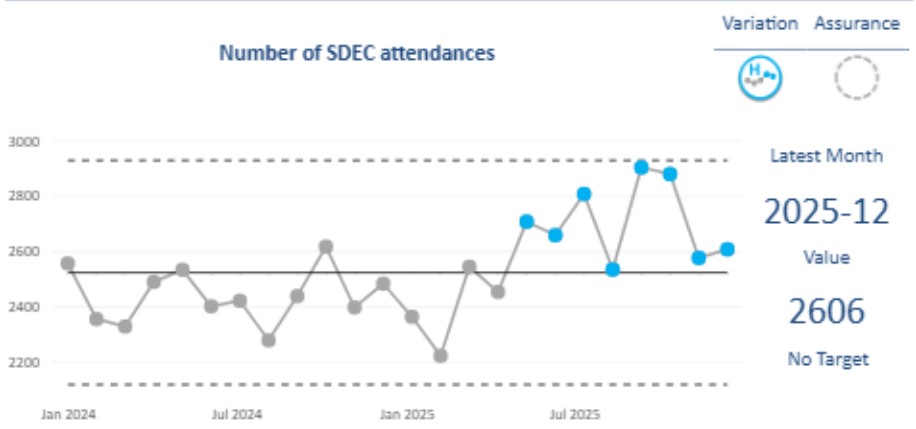
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

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



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

Rationale: SPC1: To monitor acute inpatient demand. **SPC2:** SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.
Target: SPC1: Monthly activity plan as per chart. **SPC2:** No target.

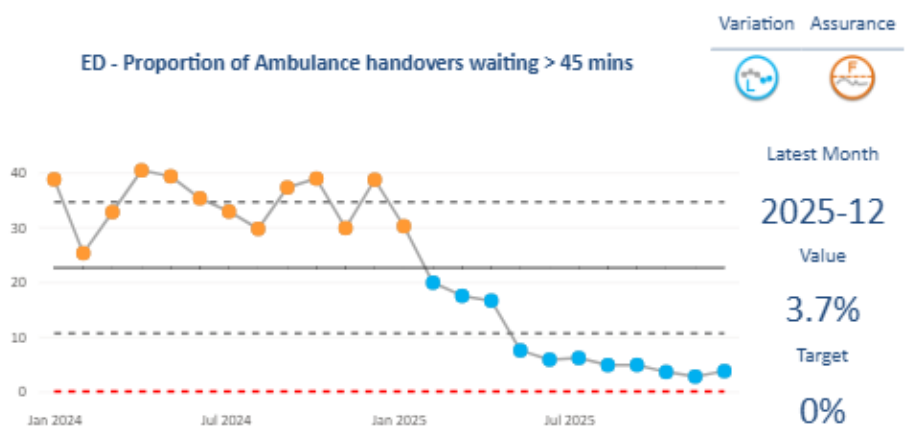
Note: The total admissions data includes admissions to all Same Day Emergency Care (SDEC) units. Work is underway to increase appropriate use of SDEC and reduce elective patients in SDEC, therefore changes in numbers are not indicative of quality.

What actions are planned?

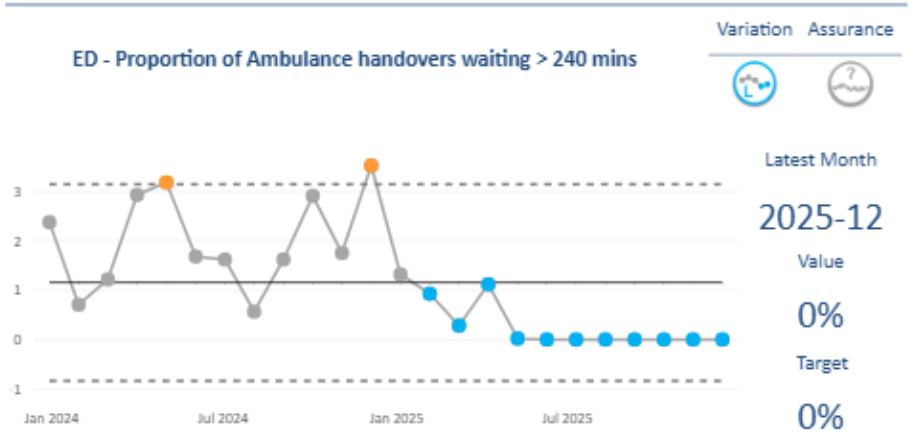
As per previous slide

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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



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

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

Rationale: Proportion of ambulances which experience a delay in transferring the patient over to the care of ED staff.
Target: SPC1: Patients arriving via an ambulance should be transferred over to the care of ED staff within 15 minutes of arrival. 0% should wait over 45 minutes from arrival to handover. **SPC2:** Patients arriving via an ambulance should be transferred over to the care of ED staff within 15 minutes of arrival. 0% should wait over 240 minutes from arrival to handover.

What actions are planned?

Continue to support YAS to safely hand patients over and return to the road as soon as possible. Staff are redirected to support handovers where required.

The Scarborough team is conducting a review of current protocols at the point of handover, to identify inconsistencies and then clearly define responsibilities. A standard operating process will be developed and disseminated, to ensure uniform practice across all shifts.

What is the expected impact?

Continued improvement in timeliness of handovers.

Potential risks to improvement?

- YAS timestamps cannot be amended even if both parties agree a recording was incorrect.
- Increasing number of ambulance attendances at both sites.

Acute Flow (3)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

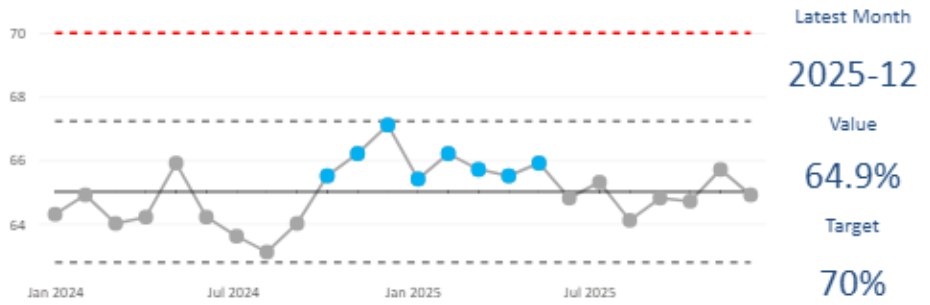
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2025-12		F	78.9%		90%
Patients with Senior Review completed at 23:59	2025-12			45.3%		
Inpatients - Proportion of patients discharged before 5pm	2025-12		F	64.9%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2025-12	H		1568		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2025-12	L	F	14.4%	13.2%	12.5%
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2025-12	H	?	4.9	4.1	3.9
Number of non-elective admissions	2025-12		F	8228	6660	6272
Number of zero day length of stay non-elective admitted patients	2025-12		?	2716	2618	2464
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2025-12			147		
Overnight general and acute beds open	2025-12		P	880	832	832
Of those overnight general and acute beds open, proportion occupied	2025-12	L	?	92.6%		92%
Community bed occupancy/availability	2025-12		?	92%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

Inpatients - Proportion of patients discharged before 5pm



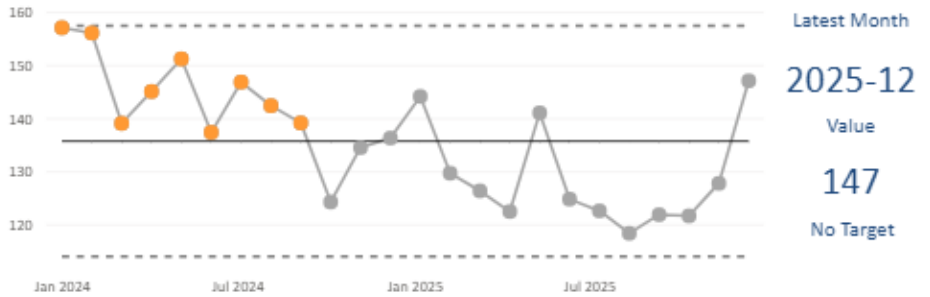
Latest Month
2025-12
Value
64.9%
Target
70%

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

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

Variation Assurance

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



Latest Month
2025-12
Value
147
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **19.3**.

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

What actions are planned?

A small multi-disciplinary team is leading a 100 day Sprint project in conjunction with NHS Learning and Improvement Network, from January – March 2026. The project will focus on Super Discharge Team activities at Scarborough, with Oak ward being a priority area. A launch event in January 2026 will give the opportunity to progress plans and link with other Trusts involved to share ideas and best practice.

Planning is underway for a Multi-Agency Discharge Event (MaDE) to take place late February in advance of the change to Nervecentre. The aim will be to reduce G&A bed occupancy and generate as much acute flow as possible.

What is the expected impact?

- Improved understanding (after the Sprint evaluation) of the impact of Super Discharge Teams which can then inform future strategic approach.
- Reducing bed occupancy to ~85% to generate flow prior to Nervecentre go live.

Potential risks to improvement?

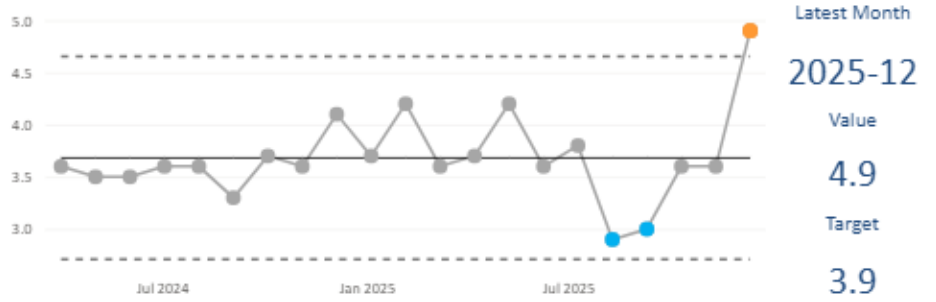
- More high acuity patients arriving to our hospitals, which could lead to longer lengths of stay.
- Limited community health and social care capacity to release patients no longer meeting the criteria to reside.
- Lack of funding to support additional clinical staff required to bring bed occupancy down ahead of the switch to Nervecentre.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

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

Variation Assurance

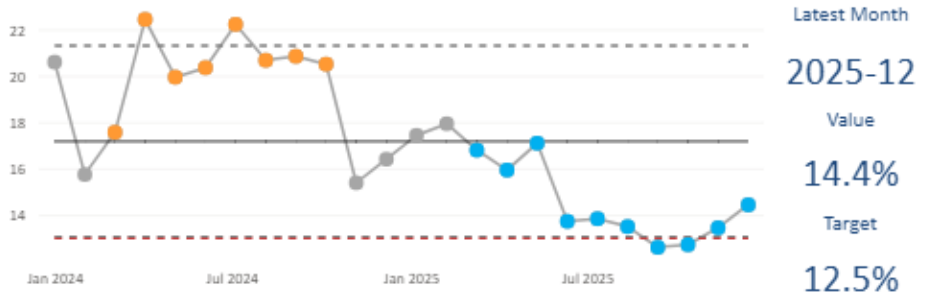


The indicator is **worse than the target** for the latest month and **is not** within the control limits.

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

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

Variation Assurance



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

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

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: SPC1: To reduce the average number of beds days between the time a patient is assessed and fit for discharge to when a patient returns to the place they call home to less than 3.9 days. **SPC2:** Internal aim to achieve less than 12.5% by March 2026.

What actions are planned?

There has been an impact in December due to the festive period and the backlog that the system partners to clear. We continue to constructively address with the system parters to support more discharges for patients no longer meeting the criteria to reside. On a daily basis escalations happen through 2nd line and 3rd line (Director level) governance.

Daily processes and escalations are taking place across medicine care group and site operations to support flow. Escalation huddles between Matrons and Ops Manager of the day continue and help manage escalations in a timely manner.

Golden rounds are now taking place at night in York, with patients being pended to the discharge lounge for the following morning; bed managers were finding it challenging to carry these out during daylight hours due to operational pressures.

Discussions are underway regarding a new pathway plan for complex neurology rehab patients, who are often delayed in our care (Ward 32, York) for long periods.

What is the expected impact?

Continue to sustain the improvements gained this year and reduce the proportion of patients who do not meet the criteria to reside.

Potential risks to improvement?

Sourcing complex packages of care remains a challenge which is escalated appropriately but not always possible to resolve.

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

- The Cancer performance figures for November 2025 saw performance against the 28-day Faster Diagnosis standard (FDS) of 60%, failing to achieve the monthly improvement trajectory of 75.3%. In the latest available national data (October 2025) the Trust ranked 114th out of 118 NHS providers nationally and 11th out of 11 against our Model Hospital peer group. **This is a True North Metric.**

- 62 Day waits for first treatment November 2025 performance was 65.9%, with the monthly trajectory of 72.3% not achieved. In the latest available national data (October 2025) the Trust ranked 93 out of 118 providers nationally and 9th out of 11 against our Model Hospital peer group. The HNY cancer alliance footprint remains one of the lowest performing in the country for 62 days.

- Executive and Resource Committee sighted on cancer performance and recovery actions.

Factors impacting performance:

- The continued deterioration in skin performance due to the cessation of dermoscopy in some GP practices resulting in a 35% increase in dermatology referrals requiring appointments. The ICB have made a funding offer to primary care, with 94% practices taking up the offer, but this will take some months to see benefits.
- The following cancer sites exceeded 80% FDS in November 2025: Breast & Non-Site Specific
    - Gynaecology achieved above their internal trajectories.
- The following cancer sites exceeded 75% 62-day performance in November 2025: Breast, Haematology, Head & Neck and Upper GI
    - Head & Neck and Upper GI above their internal trajectory.
- 31-day treatment standard was 94.4% overall, which didn't achieve the national target of 96%. This is expected to be recovered to back above national standard in December, with reduction of Colorectal surgical breaches being a contributing factor.
- At the end of November, the proportion of patients waiting over 104+ days equates to 2.3% of the PTL size with 58 patients. Colorectal, Skin and Urology are areas with the highest volume of patients past 62 days with/without a decision to treat but are yet to be treated or removed from the PTL.
- Diagnostic performance, in particular endoscopy and imaging is impacting faster diagnosis performance due to delays in diagnostic pathways.
- Referrals received with FIT has seen deteriorating performance. Sessions held with ICB and cancer alliance primary care leads around FIT compliance – list of practices shared with highest proportion of referrals received without FIT and cancer alliance creating plan of engagement. Lower GI referral proforma to be launched December 2025 across Trust footprint to standardise referrals with enhanced place, ICB and cancer alliance comms to primary care. Process for rejecting referrals being agreed.

Actions:

- Please see following pages for details.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Cancer 31 day wait from diagnosis to first treatment	
SPECIAL CAUSE CONCERN		* Cancer - 62 Day First Definitive Treatment Standard	* Cancer - Faster Diagnosis Standard * Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result

CANCER
Scorecard

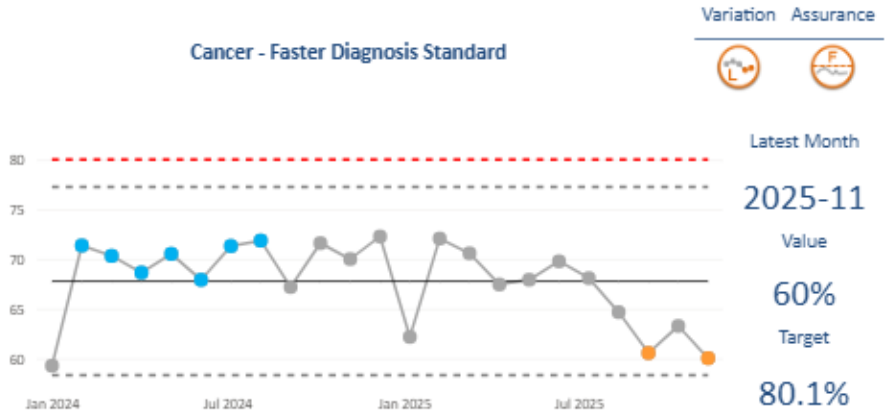
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

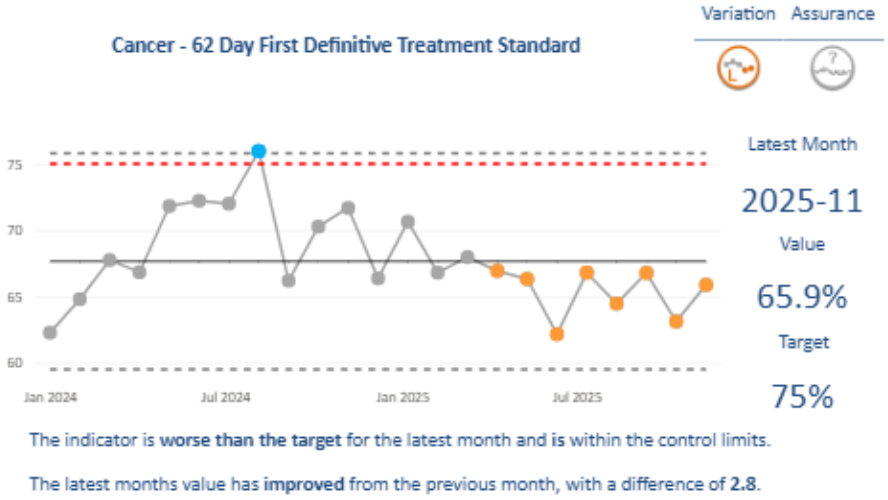
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard	2025-11	L	F	60%	75.3%	80.1%
Cancer - 62 Day First Definitive Treatment Standard	2025-11	L	?	65.9%	72.3%	75%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2025-12			236		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2025-12			9.1%		
Cancer 31 day wait from diagnosis to first treatment	2025-11		?	94.4%		96.1%
Total Cancer PTL size	2025-12	H		2579		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2025-12	L	F	70%	80.2%	80.2%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





Rationale: SPC1: Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. **This is a True North Metric. SPC2:** National focus for 2025/25 is to improve performance against the headline 62-day standard**.**
Target: SPC1: 80% by March 2026. **SPC2:** 75% by March 2026.

What actions are planned?

Colorectal Plan - Frailty pathway implemented and expanded to phone calls to patients with no performance status to try to stream more patients STT- 76% patients in first two weeks have been diverted from OPA to endoscopy. Constructive discussion with cancer alliance primary care lead around referral appropriateness and communications circulated. Lower GI proforma approved and awaiting roll out. Trust will provide supporting communications and ongoing discussions internally around Fit Negative patients with normal bloods and no other symptoms. Continued work with Rapid Diagnostic Centre (RDC) redirect pathway for colorectal patients who are suitable. Plans to recover colonoscopy capacity linked to endoscopy actions detailed in diagnostic recovery plan.

Urology Plan- STT CT model in haematuria pathway approved for Q4 implementation and working through final pre- implementation and communications. Recruitment of additional Surgical Care Practitioners completed started in role, commenced training in TP biopsies- required to complete SCP course in order to practice independently .

Review of PSA pathway to understand opportunities for streamlining and efficiencies- Urology time out approved implementing standardised discharge post Likert score and scope and consult model for TP biopsy, following implementation of STT haematuria,

Gynaecology Plan -Internal Trajectory of 52%. Locum consultant providing additional sessions on East Coast to recover position. PMB live, following GP education sessions & USS contracting changes to take place. Pipelle clinics in Community Diagnostic Centre live in Selby.

Skin - Internal trajectory of 78%. Funding to insource additional capacity implemented, time limited mutual aid with Harrogate enacted and ICB offer of funded dermoscopy image with referral in progress.

What is the expected impact?

Each cancer site has own trajectory for FDS and 62 day, to achieve month and year end position against national targets, the accumulative impact was presented at September Resources Committee.

Potential risks to improvement?

- Disproportional impact of skin deterioration on If Skin had achieved November 2024 position (73.0%), the Trust FDS position in November 2025 would be 67.5%.
- December seasonality affecting patient behaviours and bank holiday MDT moves
- Volume of referrals significantly above planned activity, particularly primary care referrals
- Cancer performance dependent upon diagnostic capacity and recovery plans
- Colorectal and Skin patient volumes have direct impact on trust cumulative FDS and 62 position and both sites significantly off trajectory.

Headlines:

- At the end of December 2025, the Trust had one **Referral To Treatment (RTT) patients waiting over sixty-five weeks**, a decrease on the thirty at the end of November 2025. The patient required a Cardiac MRI at Leeds Trust which occurred on the 2nd of January. The patient has been subsequently discharged.
- The Trust's **RTT Total Waiting list position** ended December 2025 behind the trajectory submitted to NHSE as part of the 2025/26 planning submission: 57,971 against the trajectory of 43,113, this was an increase of 200 on the end of November 2025 position (57,771).
- The Trust is behind the trajectory for the proportion of the **patients on an RTT waiting list under 18 weeks** at the end of December: 54.9% against 58.0%. In the latest available national data (October 2025) the Trust ranked 97th worst out of 118 NHS providers and 7th worst out of 11 in our Model Hospital peer group. By March 2026, the intention is that the percentage of patients waiting less than 18 weeks for elective treatment will be 65% nationally. **This is a True North Metric.**
- The Trust is behind the **RTT52 week** trajectories submitted within the 2025/26 planning submission; 1,329 waiters and 2.3% of the total RTT Total Waiting list against the trajectories of 560 and 1.3%, respectively. However, this was a reduction of 221 and 0.4% on the October 2025 position (1,550 and 2.7%). In the latest available national data (October 2025) the Trust is ranked 90th worst out of 118 NHS providers and 7th worst out of 11 in our Model Hospital peer group for the proportion of the TWL waiting over 52 weeks. Nationally at the end of October 2025 there were 6,865,854 patients on the national TWL, of which 165,909 (2.4%) were waiting over 52 weeks. By March 2026, the national ambition is that the percentage of patients waiting longer than 18 weeks for elective treatment will be less than 1% nationally.
- NHSE has introduced a new metric target for 2025/26 with the ambition set for the Trust to have over 67.1% of **patients waiting no longer than 18 weeks for a first appointment** by March 2026. The Trust is behind the trajectory submitted to NHSE as part of the 2025/26 planning submission with performance of 58.0% against the end of December 2025 ambition to be above 64.9%. There is currently no nationally available comparative data for this metric.

Factors impacting performance:

- RTT Total Waiting List metric impacted by an increase in referrals in Quarters 1 and 2 of 2025/26 and the update to CPD logic which has resulted in additional RTT clocks being opened since April 2025. The increase in referrals from primary care is now the main driver in the RTT TWL increase, YTD there has been an 5% rise (circa 7,00 referrals), if this trend continues for the rest of this financial year, the Trust will receive an additional ten thousand GP referrals compared to 2024/25. Direct Cancer GP referrals (not including upgrades, incidental findings etc.) are up 11% YTD with eight of the nine months in 2025/26 higher than the Trust has ever received during a month, this impacts the ability to see routine RTT patients.
- Delivery of the 2025/26 elective recovery plan; initial analysis shows that at the end of December 2025 the Trust was ahead of the 2025/26 plan with a provisional performance of 106% against the funded ERF (excludes OP follow ups without procedure) plan.
- The ethnicity recording project has commenced. Barrier to recording is additional 'other' categories on CPD, change to CPD went live on 5 December 2025.
- Reduction in clock stops in Dec 2025 due to decrease in activity and reduction in validation capacity due to annual leave and bank holidays.

Actions:

- Please see following pages for details.

Summary MATRIX

Referral to Treatment (RTT): *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			* RTT - Waits over 65 weeks for Incomplete Pathways * RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks
COMMON CAUSE / NATURAL VARIATION		* RTT - Waits over 78 weeks for incomplete pathways	* RTT - Waits over 52 weeks for Incomplete Pathways
SPECIAL CAUSE CONCERN			* RTT - Total Waiting List * RTT - Proportion of incomplete pathways waiting less than 18 weeks * RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks

Referral to Treatment (RTT)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
RTT - Total Waiting List	2025-12			57971	43113	38992
RTT - Waits over 78 weeks for incomplete pathways	2025-12			0		0
RTT - Waits over 65 weeks for Incomplete Pathways	2025-12			1	0	0
RTT - Waits over 52 weeks for Incomplete Pathways	2025-12			1321	560	389
RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-12			55%	58%	60.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2025-12			18.4		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks	2025-12			2.3%	1.3%	1%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2025-12			58%	64.3%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2025-12			1.9%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2025-12			12.1%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2025-12			67.7%		

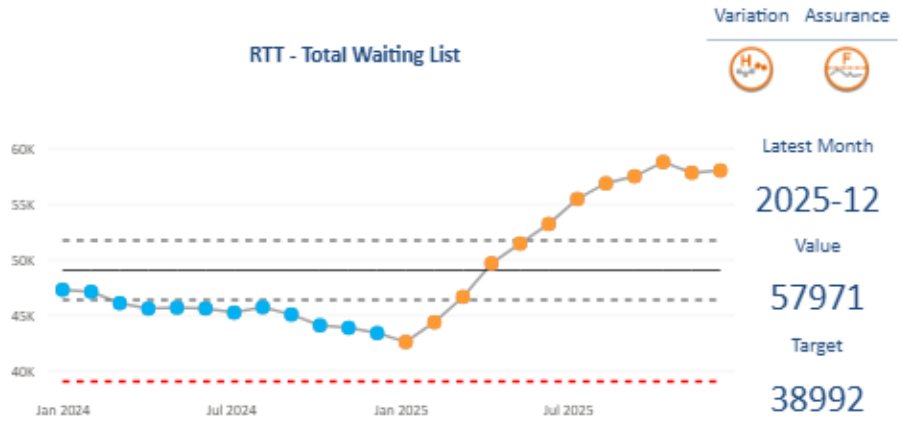
KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

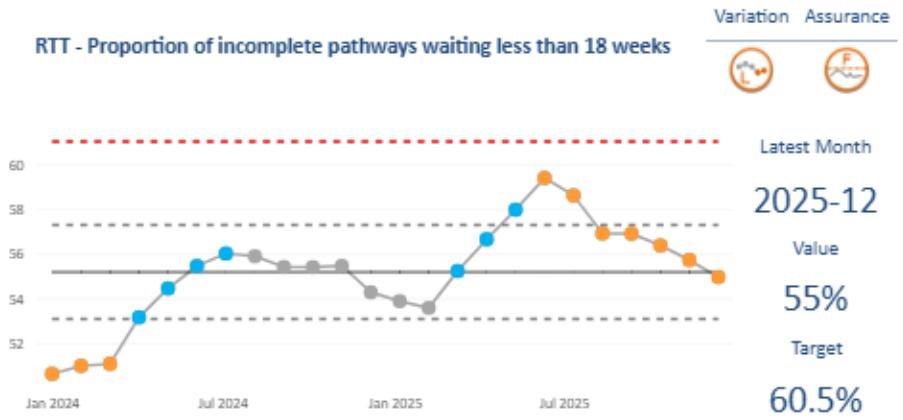
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **deteriorated** from the previous month, with a difference of **200.0**.



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

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

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

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

What actions are planned?

- Trust has submitted bids for 1st OP activity and 52-week FU and elective activity funding from NHSE. Responses awaited. Capacity to be delivered via WLIs & insourcing.
- Revised trajectories submitted for monitoring based on bids being accepted**.**
- Telephone validation pilot in January 2026 (ENT, Oral Surgery and Gynaecology).
- Insourcing and additional clinics in key specialties (Cardiology, Respiratory, ENT, Oral Surgery and Gynaecology).
- Intensive support programme for cardiology, respiratory and gastroenterology to commence January 2026 with corporate team supported by GIRFT/NHSE IST colleagues.
- Outpatient improvement workstreams, “find it, fill it” campaign in Q4, productivity benchmarking, RTT priority clinics underway.
- Pathway redesigns (breathlessness, sleep, pipelle, CY asthma) and super clinics being scoped.

What is the expected impact?

- Reduction in the TWL or offsetting impact of the ongoing increase in referrals.
- Reduction in the number of RTT52 week waiters back to plan if additional NHSE funding bids accepted.
- The Trust continues to do very well on missed appointments, pre referral triage and high level of Advice and Guidance in Further faster cohort 2 and above the national provider median.

Potential risks to improvement?

- Increase in GP referrals to date in 2025/26 compared to same period in 2024/25 (up 5%, circa 7,000 additional referrals). Discussions with ICB ongoing to identify causes of referral increases.
- Timeline for response from NHSE to additional funding submissions unclear and ability from that point to mobilise capacity.
- Impact of capital builds (CDC, Hybrid theatre, MRI, VIU, SGH Roof and RAAC), resulting in reduction in capacity and increasing waiting times.

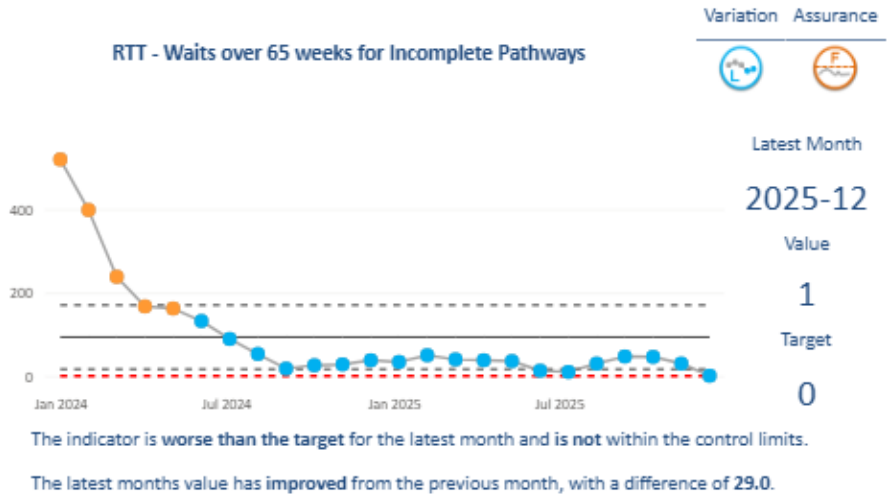
KPIs – Operational Activity and Performance

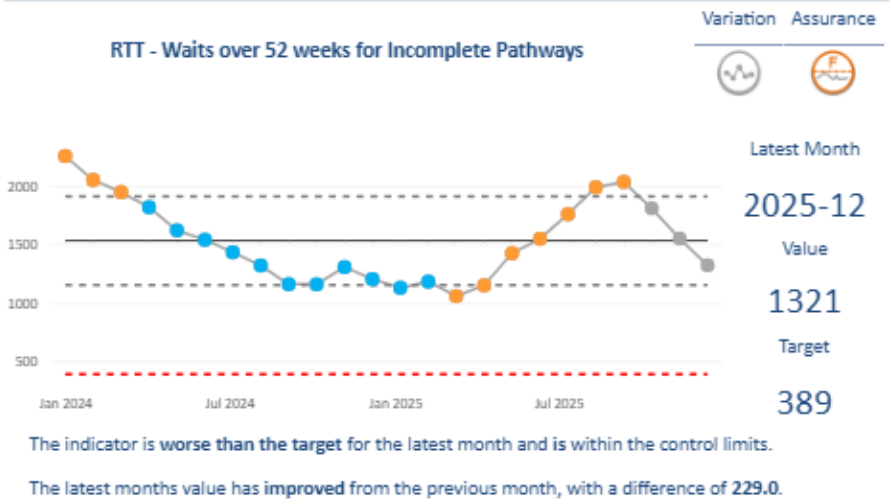
Referral to Treatment RTT (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.
Target: SPC2: National ambition to have 0 patients waiting more than 65 weeks **SPC2:** Aim to have less than 389 patients waiting more than 52 weeks by March 2026 as per activity plan.

What actions are planned?

- Weekly monitoring of RTT65 week waits throughout January 2026 with weekly trajectory in place to deliver zero.
- Trust has submitted bids for 1st OP activity and 52-week FU and elective activity funding from NHSE. Responses awaited. Capacity to be delivered via WLIs & insourcing.
- Discussion with NHSE focused on validation approach and support being identified to explore additional support.
- Weekly 'challenged' specialty meetings in place to support escalation and actions required.

What is the expected impact?

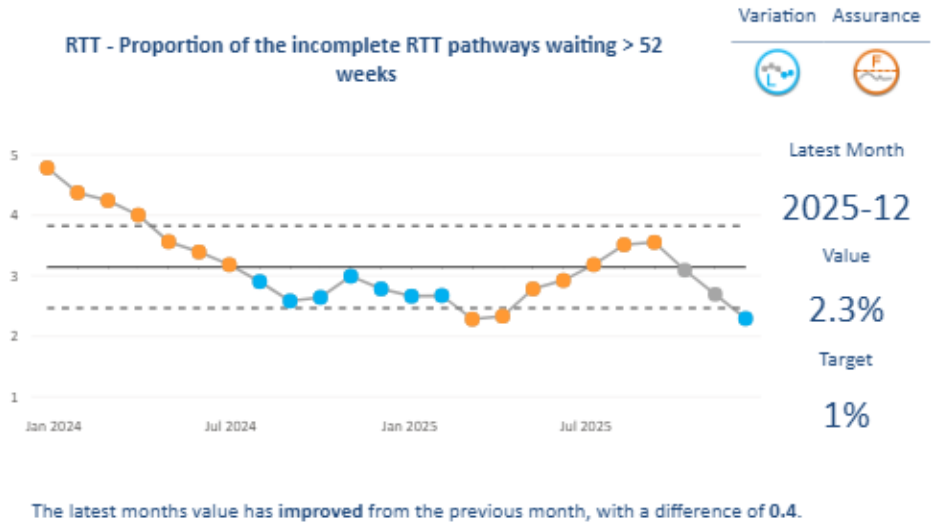
- Reduced RTT long waiters.
- ERF money targeted at specialties most in need.

Potential risks to improvement?

- Patient choice can lead to end of month breaches.
- Diagnostic performance.
- Capital programme (RAAC replacement, CT replacement, Roof replacement)) which could impact on Diagnostic and theatre capacity at Scarborough and York through construction phases.
- Impact of diagnostic delays and prioritisation of cancer resulting in increase in 52-week waiters
- Volume of 1st OP's on PTL, risk of breaches due to pathways of care resulting in longer waits and increase in 52 weeks

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

Please see previous page.

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

Headlines:

- For the month of December 2025, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 4.7% with performance of 4.2%. Y&S has three specialties in the upper quartile of Trusts within the NE&Y region (Clinical Haematology, Physiotherapy and Rheumatology).

- Rapid Access Chest Pain (RACP) seen within 14 days was at 78.7% (November: 72.1%) which whilst an improvement remains below the target of 99%.

Factors impacting performance:

- In the latest North East & Yorkshire provided Outpatient data the Trust is above the national provider median for Pre-Referral Specialist Advice Utilisation and Diversion Rate (highest quartile for dermatology, gynaecology, paediatrics and urology), DNA rate (lowest in NEY), proportion of appointments delivered remotely and PIFU rate (July and August 2025 data).

- The Trust's DNA rate was at 5.0% in December an improvement on the 5.6% seen in November 2025 despite the Resident Doctor strike. The Trust has seen rises in DNA rates in months that have had strikes as text message reminders were paused before the Resident Doctor strikes begin. The Trust has one of the lowest DNA rates in the country, the national average is 5.6% (NHSE).

- Roll out digital clinical letters went live in December 2025 but needed to be paused due to a technical issues that requires resolution. Impact assessment of resolution being completed.

- PAS readiness validation of non RTT waiting lists and embedding the operational toolkit, supported through EPR programme.

Actions:

- Please see following pages for details.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* Proportion of elective admissions which are day case		* Outpatients - Proportion of appointments delivered virtually (SO17a) * Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU) * Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)
COMMON CAUSE / NATURAL VARIATION		* Outpatients - DNA rates * Outpatients: 1st Attendances (Activity vs Plan) * Outpatients: Follow Up Attendances (Activity vs Plan) * All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days* * Day Cases (based on Activity v Plan) * Electives (based on Activity v Plan)	
SPECIAL CAUSE CONCERN			* Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)

Outpatients & Elective Care
Scorecard

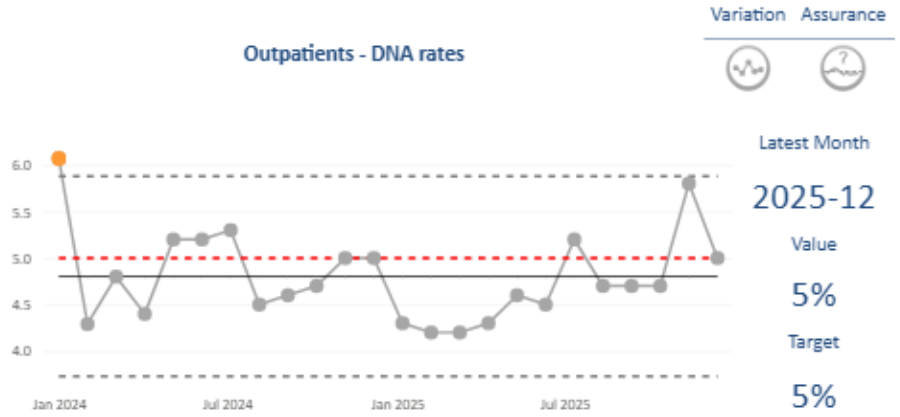
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

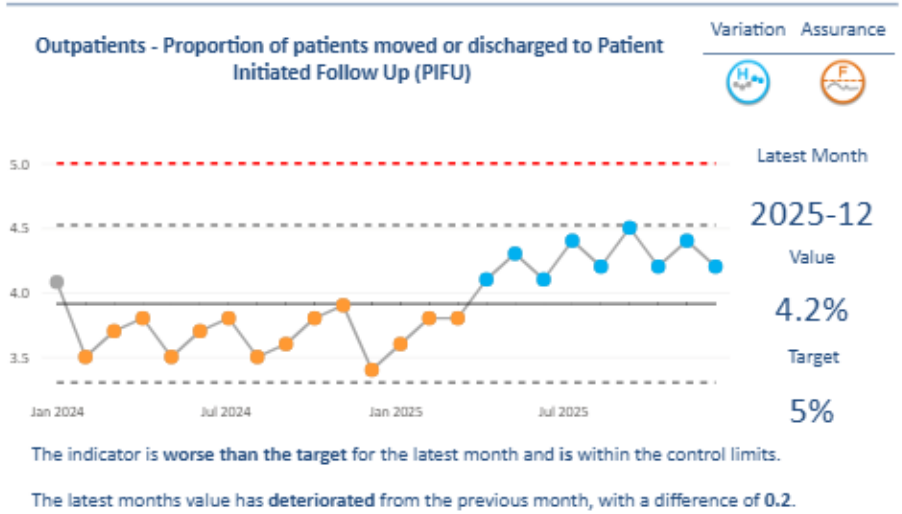
Executive Owner: Claire Hansen **Operational Lead:** Kim Hinton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2025-12	H	F	22.4%		25%
Outpatients - DNA rates	2025-12		?	5%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2025-12		?	19912	15453	17494
Outpatients: Follow Up Attendances (Activity vs Plan)	2025-12		?	42525	33325	38846
Outpatient procedures	2025-12			14597		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2025-12	H	F	27950		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2025-12	H	F	4.2%	4.7%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2025-12	H	F	78.3%		99%
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days*	2025-12		?	4		0
Day Cases (based on Activity v Plan)	2025-12		?	7543	7164	8144
Electives (based on Activity v Plan)	2025-12		?	677	685	816
Proportion of elective admissions which are day case	2025-12	H	P	91.8%		85%
Outpatients: All Referral Types	2025-12			21956		
Outpatients: Consultant to Consultant Referrals	2025-12			2428		
Outpatients: GP Referrals	2025-12			10192		

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton





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

What actions are planned?

- The Trust is one of 6 Trusts in the North East and Yorkshire region who have agreed to participate in the NHSE 'PIFU as standard' programme. The PIFU pathways the Trust are developing as part of this programme are Gynaecology, Cardiology, Gastroenterology and ENT.

- GIRFT clinic template standards audit completed, with opportunities in a couple of specialties identified. Gynaecology, ENT and Oral surgery changing templates in January 2026 which will deliver increased 1st OP rates.

- PIFU dashboard updates to include numbers. Information shared with care groups to identify specialties with opportunity to increase to 5% at pace.

What is the expected impact?

- **PIFU:** Y&S should see a continued improvement in PIFU through 2025/26. Y&S had one specialty in the lowest quartile of Trusts within the NE&Y region (Gynaecology), involvement in PIFU as standard has resulted in an improvement in this specialty (1.3% in April 2025 to 3.4% in December 2025).

Potential risks to improvement?

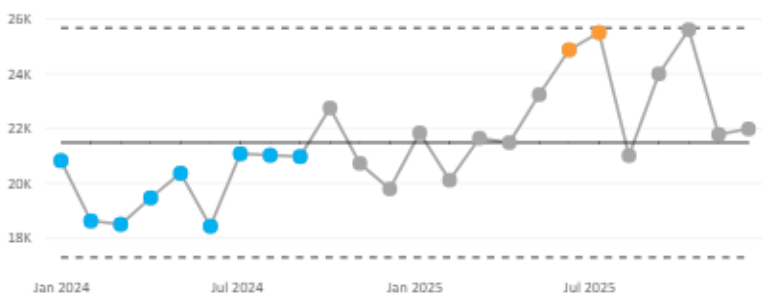
- **PIFU** at Scarborough is significantly lower than York (December 2025: 2.4% at SGH/5.0% at York).

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Outpatients: All Referral Types



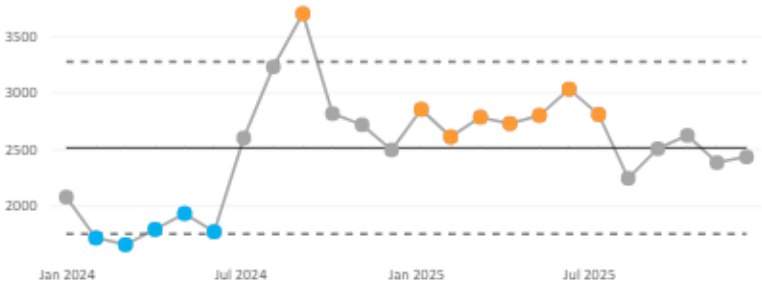
Latest Month
2025-12
Value
21956
No Target

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

The latest months value has **deteriorated** from the previous month, with a difference of **201.0**.

Variation Assurance

Outpatients: Consultant to Consultant Referrals



Latest Month
2025-12
Value
2428
No Target

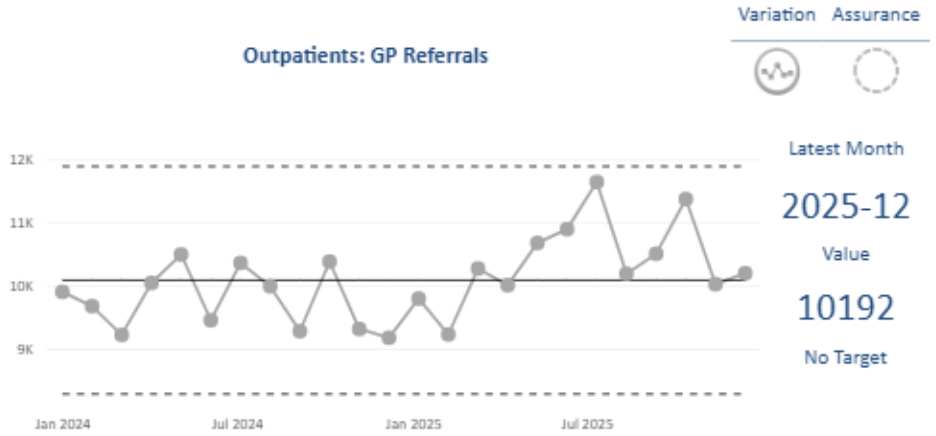
The indicator is **equal to the baseline** for the latest month and **is** within the control limits.

The latest months value has **deteriorated** from the previous month, with a difference of **50.0**.

Rationale: Number of outpatient referrals received from General Practice, Consultant to Consultant and from other sources.
SPC1: No internal target.
Rationale: Number of outpatient referrals generated internally from Consultant-to-Consultant referral..
SPC1: No internal target.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **deteriorated** from the previous month, with a difference of **174.0**.

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

Please see previous page

Operational Activity and Performance
Diagnostics Narrative

York and Scarborough Teaching Hospitals NHS Foundation Trust

Headlines:

- Trust DM01 performance at end December was 70.7%, which is 6.2% below planned trajectory for the month. This is a decline from November performance of 74.6%. While the total waiting list decreased in December, we saw a slight deterioration in the number of patients over 6 weeks and over 13 weeks. This follows seasonal trends due to a combination of reduced capacity during December due to the festive period combined with significant cancellations due to patient choice and sickness.
- In the latest available national data (October 2025) the Trust ranked 89th worst out of 118 NHS providers and 9th worst out of 11 in our Model Hospital peer group.

Factors impacting performance:

- Significant increase in elective demand for all radiology modalities to support RTT position. Significant increase also seen in MRI fast track referrals with the highest level of referrals in 2+ years received in December 2025.
- Vacancies in MRI at York continue to impact capacity though are being mitigated by use of insourcing. Ongoing equipment issues with intermittent breakdowns of mobiles.
- MRI Paeds GA scans account for a cohort of the longest waiters. Sought mutual aid from Leeds, Hull and Sheffield but no uptake.
- CT3 at York removed in October 2025 as part of the capital replacement scheme. Continued intermittent breakdowns impacting delivery of activity.
- NOUS performance continues to be driven by MSK backlog. 3 NOUS consultant vacancies are out to recruitment with interviews planned for March but lack of candidates nationally so it is challenging to recruit.
- Impact of increase in elective demand to support long wait RTT patients in ENT, Respiratory and Cardiology (impacts Audiology, Sleep studies & Echo).
- Audiology vacancies impact on capacity to accommodate increase in demand. Compounded by staff sickness and maternity leave this leads to challenges regarding skill mix and ability to deliver activity in challenged services such as tinnitus and paediatric audiology assessment. Lack of appropriate clinical space to deliver audiology activity due to increased demand for services which require specialist rooms e.g., soundproofing, observation room for Paediatrics. A locum audiologist appointed on the east coast has given back word and therefore we are working to recruit to support performance recovery
- Lack of CTCA capacity at the East Coast during 2025 has led to an increased volume of stress echo referrals as an alternative.
- Equipment failure in October and lack of clinical cover in November led to an accumulation of UDS backlog as multiple lists had to be cancelled. Staff issues led to reduced activity compared to expected capacity due to requirements for additional training and supervision. Additional lists required to clear backlog but staff appetite for WLIs is low due to other service pressures and clinic space is limited to deliver additional lists.
- Increase in elective demand for Endoscopy to support long wait RTT patients in Gastroenterology, Colorectal and UGI.
- Patient choice impacting all Endoscopy services in December and early January, in particular Colonoscopy. Many patients chose to delay to avoid requirement to bowel prep over the Christmas and New Year period. Significant sickness in admin teams in December and January has led to challenges in operational management and clinic booking.

Actions:

- Performance recovery actions expected to deliver continued improvement by the end of Q3 as actions continue to be embedded.
- Please see page below for detail.

Summary MATRIX

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

MATRIX KEY

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

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

DIAGNOSTICS – National Target: 95%

Scorecard

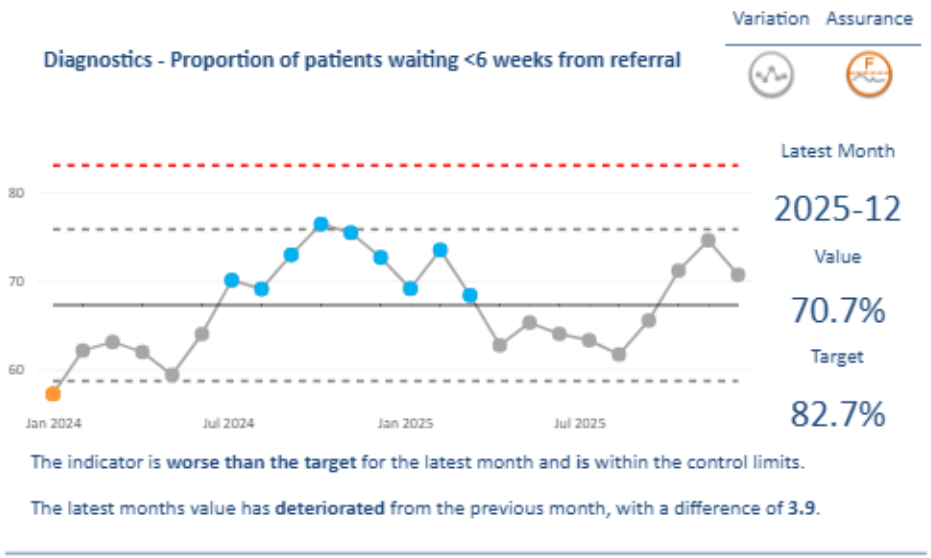
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Diagnostics - Proportion of patients waiting <6 weeks from referral	2025-12		F	70.7%	76.9%	82.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2025-12		F	67.8%	80%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2025-12		?	76.6%	72%	78%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2025-12		?	72.7%	71%	75%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2025-12	H	F	86.1%	88.3%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2025-12	H	?	86.9%	65%	67.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2025-12		F	57.7%	89.8%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2025-12	H	F	68.4%	95.8%	95.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2025-12		?	93.2%	94.1%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2025-12		?	76.9%	92.2%	94.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2025-12	H	F	43.3%	86.7%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2025-12		F	61.2%	80.6%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2025-12		F	64.6%	81%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2025-12		?	71.6%	90.5%	94.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2025-12		F	80.3%	85.9%	90%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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Rationale: Maximise diagnostic activity focused on patients of highest clinical priority.
Target: Increase the percentage of patients that receive a diagnostic test within 6 weeks to above 82.7% by end of March 2026.

What actions are planned?

Endoscopy: One room per day ringfenced for surveillance activity. Funding secured through ERF to extend insourcing contract with YMS until backlog is cleared. Nurse vacancies out to advert to recruit substantive staff and remove the need for insourcing. Work ongoing with recruitment to agree a long-term insourcing provider as a backstop for future issues. NHSE deep dive planned for Feb / March 2026.

Imaging: Additional paeds MRI GA lists have been added which has reduced the backlog for this cohort by circa half and has reduced longest wait to 25 weeks down from 52 weeks. MRI radiographer insourcing in place to mitigate vacancies at York while recruitment is ongoing. Radiographer training for contrast at both YSJ and Scarborough CDC planned for January which will improve throughput once completed. ERF funding approved for unstaffed scanner until January 2026, utilising staff that would have been at CDC. At end November we began using the lung health van at York to cover activity lost from CT3. Options being explored to clear MSK backlog. Bank registrar appointed and planned to be in post mid January 2026. Also reviewing CVs for locum but no suitable candidates yet. NHSE deep dive planned for Feb / March 2026.

Physiological:

Echocardiography: ERF approved for Scarborough full time echocardiographer via insourcing to support 7 day working in post on fixed term until end of financial year. Second insourced echocardiographer at the East Coast covering Mon – Fri 9-5 providing outpatient and inpatient capacity. Locum cardiologist to do extra stress echo lists at both York and Scarborough. This would support east coast patients by preventing the need to travel to York.

Sleep studies: 2 respiratory physiologist vacancies at the east coast have been recruited to, aiming for start this calendar year. B6 vacancy at York is in the process of being approved for recruitment.

Audiology: 4 x pop-up booths (two York, one Malton and one Brid) requested to deliver additional audiology capacity. Working to recruit locum to support performance recovery.

UDS: Deterioration in Urology UDS, seeking to understand issue and identify recovery actions.

What is the expected impact?

Increased capacity leading to increase in activity, reduction in backlogs and improvement to DM01 performance. While hitting original plan is unlikely for this financial year we anticipate continuing on an improving trajectory.

Potential risks to improvement?

Ongoing issues with equipment breakdown and recruitment challenges.

Summary MATRIX

Children & Young Persons: *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Children & Young Persons: ED - Patients waiting over 12 hours in department	* Children & Young Persons: ED - Emergency Care Standard (Type 1 only)
COMMON CAUSE / NATURAL VARIATION			* Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways
SPECIAL CAUSE CONCERN			* Children & Young Persons: RTT - Total Waiting List * Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

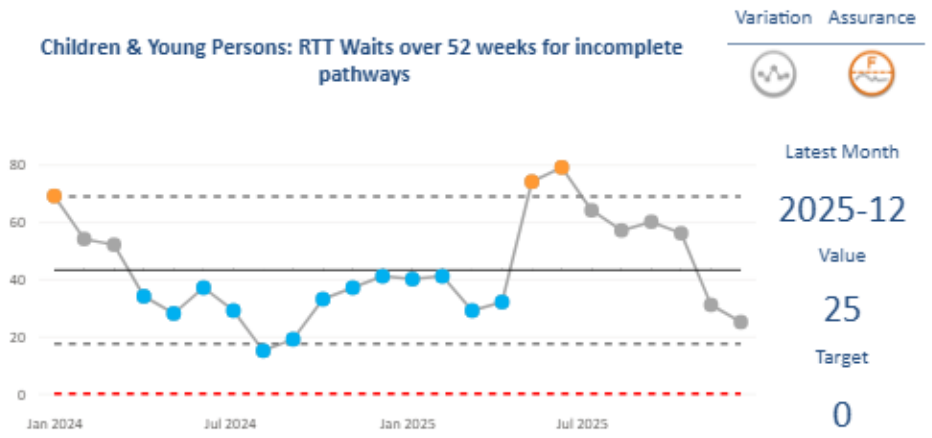
Executive Owner: Claire Hansen

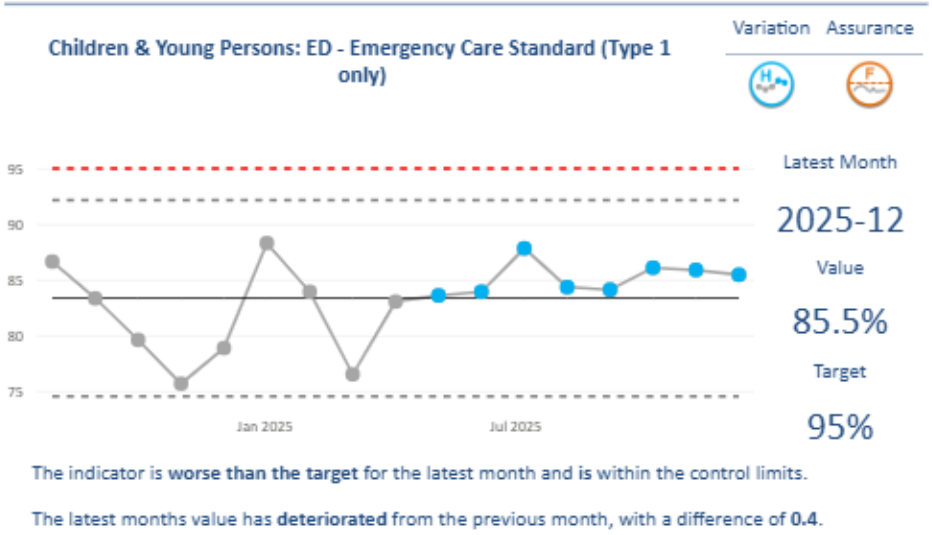
Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2025-12			2		0
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2025-12			85.5%		95%
Children & Young Persons: RTT - Total Waiting List	2025-12			4564	3545	3206
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2025-12			60.3%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2025-12			25	0	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi





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

Target: SPC1: Aim to have zero patients waiting more than 52 weeks by end of September 2025. **SPC2:** NHS Objective to improve A&E waiting times so that no less than 78% of patients are seen within 4 hours by March 2026.

What actions are planned?

SPC1:

- The Trust's internal weekly Elective Recovery Meeting monitors and challenges performance against the trajectory for RTT52 weeks wait for patients aged under eighteen. There is confidence amongst the Care Groups that they will deliver and maintain zero RTT40 week waits by the end of Q4 2025/26 except ENT and Oral Surgery (35 at the end of December 2025).
- ENT and Oral Surgery are planning to deliver zero RTT52 week waiters by the end of Q4 2025/26 (22 at the end of December 2025) .

SPC2:

- A standalone paediatric doctor rota at York is being developed, to support improvements in ECS and initial assessment times.

What is the expected impact?

- Improved ECS for CYP patients.
- Delivery of zero paediatric RTT40 week waiters (except for Head and Neck) by end of March 2026.
- Improved 'wait to be seen by a doctor' for children.
- More robust and consistent approach to the paediatric service.

Potential risks to improvement?

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

Summary MATRIX

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

MATRIX KEY

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

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

COMMUNITY
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of open Virtual Ward beds	2025-12	L	?	33	33	33
Proportion of Virtual Ward beds occupied	2025-12	H	?	84.9%	79%	79%
Community Response Team (CRT) Referrals	2025-12	H		664		
Total Urgent Community Response (UCR) referrals	2025-12		?	631	523	566
2-hour Urgent Community Response (UCR) care Referrals	2025-12	H		228		
2-hour Urgent Community Response (UCR) Compliancy %	2025-12	L		73.7%		
Number of Adults (18+ years) on community waiting lists per system	2025-12	L		572		
Number of CYP (0-17 years) on community waiting lists per system	2025-12	L		1573		
Number of District Nursing Contacts	2025-12			21435		
Number of Selby CRT Contacts	2025-12	L		2468		
Number of York CRT Contacts	2025-12	L		3562		
Referrals to District Nursing Team	2025-12			2070		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2025-12	L	F	565	224	0

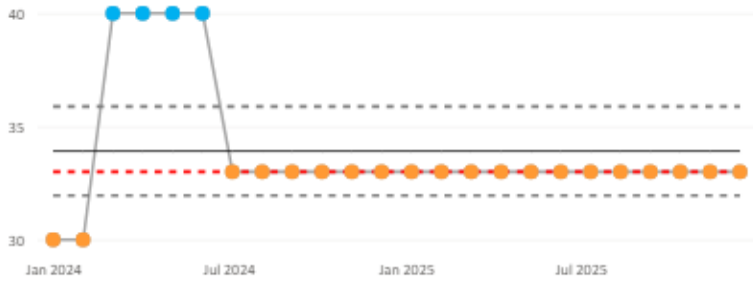
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Rationale: To monitor demand on Community virtual wards.
Target: SPC1: Trust is commissioned to deliver 33 virtual ward beds. **SPC2:** Aim to achieve 79% virtual ward bed occupancy as per activity plan.

Number of open Virtual Ward beds

Variation Assurance



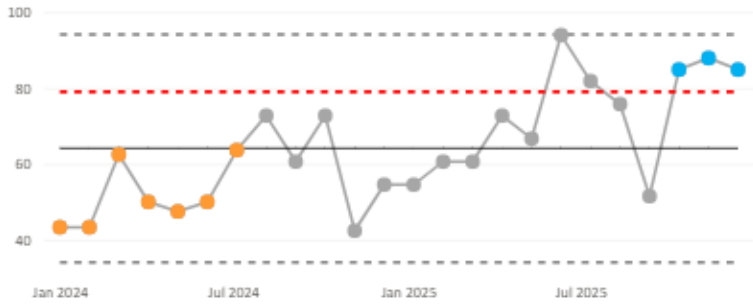
Latest Month
2025-12
Value
33
Target
33

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

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

Proportion of Virtual Ward beds occupied

Variation Assurance



Latest Month
2025-12
Value
84.9%
Target
79%

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

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

Virtual wards continue to support hospital capacity by providing alternative care for acutely unwell patients.

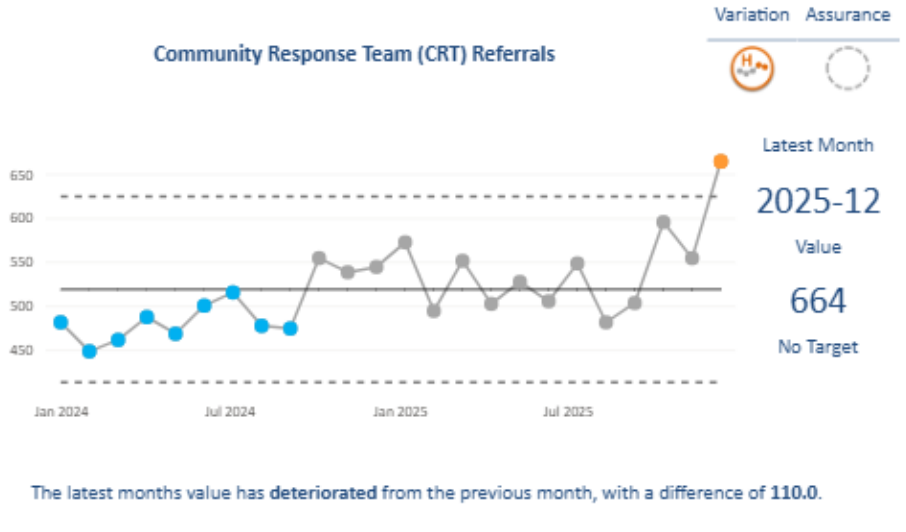
The Frailty Virtual Ward (Hospital at Home) needed to reduce capacity over the festive period due to the bank holidays and the fact that bank cover is not available to the service.

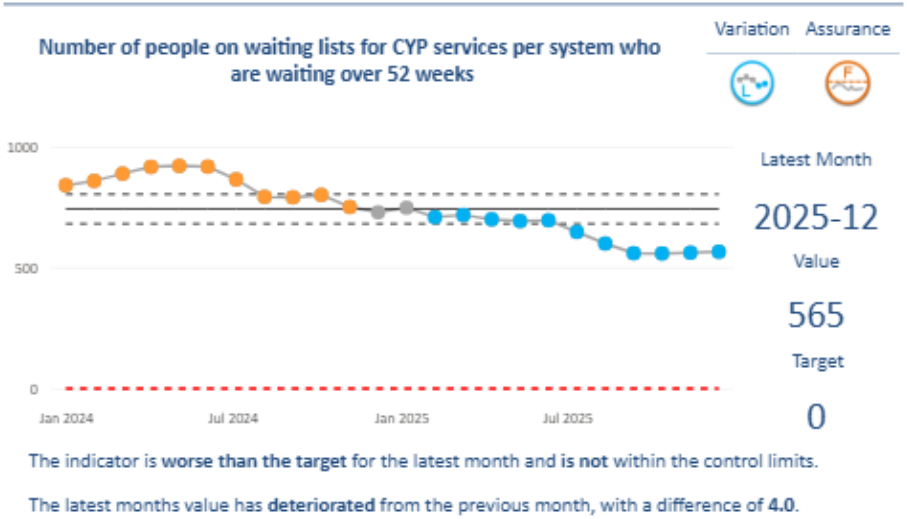
Despite challenges, the Hospital at Home team supported Community Response Team over this period. The teams pooled resources to support as many patients as possible.

The heart failure virtual ward had high levels of sickness and annual leave in December.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi/Kim Hinton





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

Please note: These two metrics should not be linked as they are different cohorts of patients.

What actions are planned?

SPC1: The Care Group is facing challenges regarding workforce. The team is looking into mutual aid form the acute team as well as any scope for efficiency. A weekly 2nd line escalation for the home care patients has been established to stand up as required that helps with transfer of care to the local authority and consequently release the CRT capacity.

SPC2: Speech and Language Therapy: the Trust is involved in regional and national work. A national toolkit is in development with the Trust involved in workshops to support. The 2025/26 plan was based on potential change in coding which has been scoped and not possible, so impact of actions are limited due to core demand and capacity mis match. Looking to address in 2026/27 planning.

What is the expected impact?

The service is exploring all options to reduce the long waiting patients. The Request for Help phone line and resources available through the Trust's website have been well received by patients and their families.

Potential risks to improvement?

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

QUALITY AND SAFETY

January 2026

Executive Owner: Karen Stone and Dawn Parkes

Highlights: IPC

- Positive progress has been achieved in month with reduced rates of Clostridioides Difficile Infection (CDI) and Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

Concerns / Risks :

- E.coli Bacteraemia - The Trust is 16 cases **over** the year-to-date objective at the end of Q3 2025/26. Q2 National Oversight Framework metric rate 2.41 per 100,000 bed days, rank 47/134
- Increased incidence of respiratory viruses, including flu, and outbreaks of norovirus, resulting in reduced bed availability and staff sickness

Next Steps:

- Focused work on improving hand hygiene and the Gloves Off Campaign, as agreed with the Care Group Senior Nursing Teams
- Focussing on the management and control of respiratory viruses and Norovirus over the coming month to support effective flow through our inpatient services and using risk assessments for effective patient placement.
- Continuous programme of improvement as set out in the Strategic IPC Improvement Plan.

Highlights: Mental Health

- A focus is being taken in January on improving our mental health clinical pathways across adult and child services.
- Inpatient assessment tool launched on Nucleus November 2025
- Complex needs team reviewed, and funding identified for a mental health professional

Concerns/Risks

- The ongoing daily review of detained patients has raised questions around the Section 17 pathway for both adults and children to ensure the Trust is aware of every patient transferred to us so that we can provide the most appropriate care.
- Use of the inpatient tool not yet embedded and will be replaced February 2026 with new tool on Nervecentre

Next Steps:

- There is a multiagency meeting, involving the Consultant Psychiatrists scheduled for 23 January 2026 to initiate this pathway review.
- Recruitment of mental health professional to be progressed Q4

Highlights: Pressure ulcers

- In December, performance remained within the expected trajectory, with 56 Category 2 pressure ulcers reported against a target trajectory of 60.

Concerns/Risks:

- The current risk profile continues to highlight issues relating to the accurate categorisation of Category 2 pressure ulcers, including authentication at ward and matron level, as well as insufficient access to appropriate seating across inpatient areas.

Next Steps:

- A funding plan has been submitted to the Trust's capital prioritisation process for inclusion in the 2026/27 budget in relation to seating. .

Summary MATRIX 1

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

MATRIX KEY

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

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

Quality & Safety
Scorecard (1)

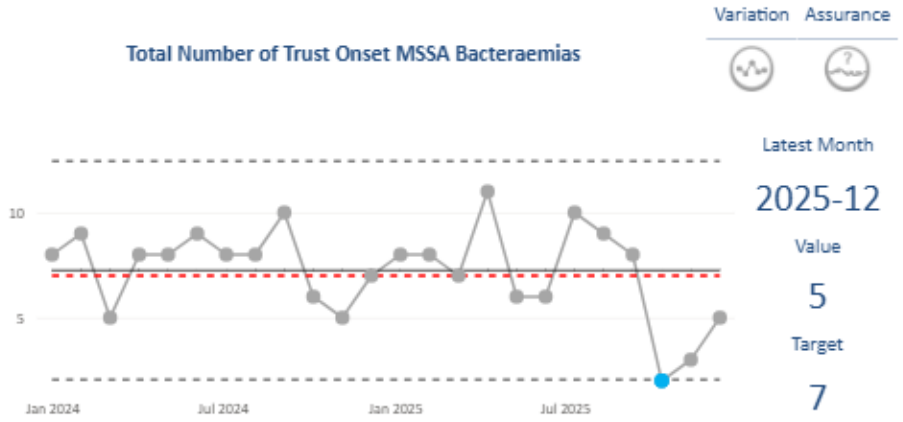
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

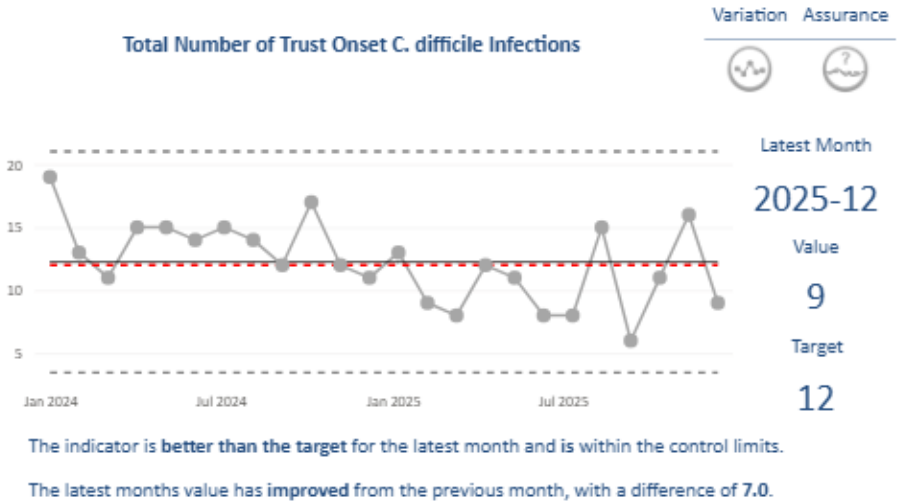
Executive Owner: Dawn Parkes **Operational Lead:** Sue Peckitt

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2025-12			5	7	7
Total Number of Trust Onset MRSA Bacteraemias	2025-12			1		0
Total Number of Trust Onset C. difficile Infections	2025-12			9	12	12
Total Number of Trust Onset E. coli Bacteraemias	2025-12			20	15	14
Total Number of Trust Onset Klebsiella Bacteraemias	2025-12			6	6	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2025-12			4	2	2
Pressure Ulcers per thousand Bed Days	2025-12			3.3		4
Patient Falls per thousand Bed Days	2025-12			8.3		8.7
Medication incidents per thousand bed days	2025-12			4.9		5

Executive Owner: Dawn Parkes

Operational Lead: Sue Peckitt





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

Target: National thresholds for 2025/26 have remained the same as the previous year except Klebsiella bacteraemia which has reduced by 25 cases. MSSA bacteraemia has an internal 5% reduction on the 2024/25 year-end position. **MSSA is a True North Metric.**

Key Risks:

- Methicillin-Resistant Staphylococcus aureus bacteraemia objective breached with 6 cases up to the end of Q3 for 2025/26 against a zero tolerance. Q2 National Oversight Framework metric 3.40 per 100,000 bed days, rank 100/134.
- E.coli bacteraemia - The Trust is 18 cases **over** the YTD objective at the end of Q3 for 2025/26. Q2 National Oversight Framework metric is 2.41 per 100,000 bed days, rank 47/134.
- Klebsiella bacteraemia - The Trust is 28 cases **over** the YTD objective at the end of Q3 2025/26
- Pseudomonas bacteraemia - The Trust is 15 cases **over** the YTD objective at the end of Q3 2025/26
- Rates of Respiratory Virus infection (RVI) continue at elevated rates: in December 2025, Scarborough had 194 RVI cases that were inpatients and 51 from ED that weren't admitted, York had 300 RVI cases that were inpatients and 72 from ED that weren't admitted; the York winter RVI ward is in use and full

Key assurances/brilliances:

- Clostridioides difficile - The Trust is 12 cases **under** the YTD objective at the end of Q3 2025/26. Q2 NOF metric 1, rank 1/134
- Methicillin-Sensitive Staphylococcus aureus bacteraemia – The Trust is 4 cases **under** the YTD objective at the end of Q3 2025/26.
- There is a robust Hospital Acquired Infection review process in place led by the Corporate IPC lead nurses and the Care Group senior team to identify key learning opportunities and key actions.
- The IPC Deputy Director of Infection Prevention & Control reports against the agreed strategic IPC improvement plan to the Infection Prevention Strategic Advisory Group and to Quality Committee.

Next Key Improvements:

- We have a clear standard around Visual Infusion Phlebitis Scores (VIPS) and will be supporting care groups to deliver against this. There is a clear plan for a Gloves Off and Hand Hygiene compliance campaign for all professional groups with a focus on sign posting and standardised expectations across ward and department environments. We will also be emphasising the use of hand gel at the entrance to all wards and departments.
- There is a priority improvement objective around the management of both urinary and venous catheters by end of Q2 in 2026/27. This is based around the findings of a local audit undertaken in Q3 with an agreed Care Group improvement objective of achieving 90% of all care delivery outcomes for catheters.

Quality & Safety
Scorecard (2)

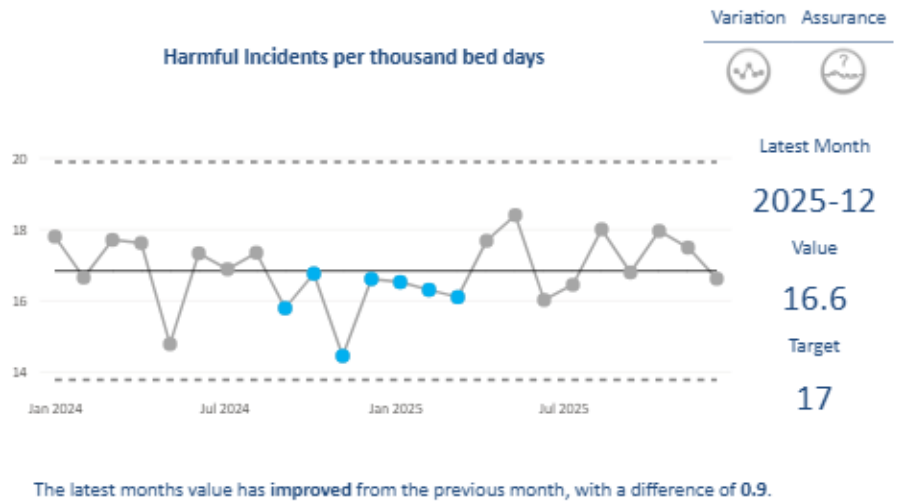
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Adele Coulthard/ Dawn Parkes **Operational Lead:** Dan Palmer/Alice Hunter/Tara Filby/Sacha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patient Safety Incidents per thousand Bed Days	2025-12			53.7		55
Harmful Incidents per thousand bed days	2025-12			16.6		17
Total Number of Never Events Reported	2025-12			0		0
In-Hospital Deaths	2025-12			191		
Quarterly SHMI	2025-06			92.2		100
Monthly SHMI	2025-08			77.3		100
Quarterly HSMR	2025-09			105.7		100
Monthly HSMR	2025-09			108.9		100
Trust Complaints	2025-12			126		
Antepartum Stillbirths	2025-11			0		
Intrapartum Stillbirths	2025-11			0		
Early neonatal deaths (0-7 days)	2025-11			1		
PPH > 1.5L as % of all women - York	2025-11			4.5%		
PPH > 1.5L as % of all women - Scarborough	2025-11			2.2%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2025-11			56.9%		

Executive Owner: Adele Coulthard/ Dawn Parkes/Karen Stone

Operational Lead: Dan Palmer/Alice Hunter/Vicky Mulvana- Tuohy



Rationale: The Trust is committed to learning from incidents and complaints and improving the patient experience

Target: No target identified as the reporting of incidents/complaints is an indicator of an open reporting culture

Factors impacting performance:

Harmful Incidents per 1000 bed days:

The SPC chart continues to show common cause variation in relation to the number of harmful incidents per 1000 bed days.

Analysis of the Patient Safety Incident Data Quarterly Publication

Between Q3 2024/25 and Q2 2025/26, incident reporting demonstrated notable improvement, with total incidents reported increasing from 3,723 to 4,138 (an 11.1% rise) and the rate of total incidents reported per 1,000 patient days rising from 48.6 to 55.8 (a 14.8% increase). These gains indicate stronger engagement with reporting systems and a more robust safety culture, supported by initiatives such as enhanced staff training and simplified reporting processes. Benchmarking against 21 acute trusts in the Northeast and Yorkshire region shows progress, with overall reporting rank improving from 14th to 11th and rate per 1,000 bed days from 19th to 17th. Continued focus on staff engagement, advanced analytics, and regular monitoring will be essential to sustain and build on this positive trajectory.

Most frequently reported incident types continue to be patient falls, notification of pressure ulcers on initial assessment both in community, in ED and inpatient wards, and violence towards staff. Improvement work programmes are in place associated with all three themes.

Factors impacting performance:

Complaints

The number of new complaints has **increased** with 126 new complaints received in the month of December 2025 (in contrast to 112 in November 2025, 134 in October 2025) but the SPC chart continues to show **normal variation** in relation to the number of complaints received.

50% of complaints were closed in 30 days and 30% of complex complaints were closed in 45 days versus the target of 90%.

Key risks and emerging risks

Continued high number of complaints and concerns, including issues that are not addressed in the moment e.g. at ward/service level.
Increased waiting times and deterioration in patient experience due to winter pressures and staff vacation over the holiday period.
Reduced access to PALS due to long term sickness absence and outstanding vacancy which has been further delayed due to current Trust wide staff consultation process leading to delayed responses.

Key assurances

There is a clear plan to address the backlog of +300 outstanding concerns which has been allocated to Care Groups for action.
Working toward the delivery of a zero-tolerance approach to not meeting the complaint and concerns timescales to be actioned by the end of March 2026.
Recruitment for 4-month secondment to the role of Concerns and Complaints Officer to support the PALS team staffing challenges to start end January 2026.

Next key improvement steps

Care Group taking action to close the backlog of concerns.
Exploring corporate support for the backlog concerns.
Implement a standardised terms of reference for weekly Care Group complaints meetings, incorporating PALS Officers , to ensure consistent processes and to strengthen assurance around complaints handling.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

January 2026

Summary MATRIX 1 of 3

Maternity Scarborough

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* L/W Co-ordinator supernumerary % - Scarborough	* Anaesthetic cover on L/W - Scarborough
COMMON CAUSE / NATURAL VARIATION	* Bookings - Scarborough * Community midwife called in to unit - Scarborough	* Bookings ≥13 weeks (exc transfers etc.) - Scarborough * Births - Scarborough * No. of women delivered - Scarborough * Planned homebirths - Scarborough * Women affected by suspension - Scarborough * Maternity Unit Closure - Scarborough * 1 to 1 care in Labour - Scarborough	* Bookings <10 weeks - Scarborough * Homebirth service suspended - Scarborough
SPECIAL CAUSE CONCERN		* SCBU at capacity - Scarborough * SCBU at capacity of intensive care cots - Scarborough * SCBU no of babies affected - Scarborough	

Summary MATRIX 2 of 3

Maternity Scarborough

MATRIX KEY

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

VARIATION

	ASSURANCE		
	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT		* HSIB cases - Scarborough * Antepartum Stillbirth - Scarborough	
COMMON CAUSE / NATURAL VARIATION	* Intrapartum Stillbirths - Scarborough	* Normal Births - Scarborough * Assisted Vaginal Births - Scarborough * C/S Births - Scarborough * Elective caesarean - Scarborough * Emergency caesarean - Scarborough * Induction of labour - Scarborough * HDU on L/W - Scarborough * BBA - Scarborough * Neonatal Death - Scarborough * Cold babies - Scarborough * Preterm birth rate <37 weeks - Scarborough * Preterm birth rate <34 weeks - Scarborough * Preterm birth rate <28 weeks - Scarborough	
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Normal Births - Scarborough	2025-11			41.6%		57%	Target
Assisted Vaginal Births - Scarborough	2025-11			3.4%		12.4%	Target
C/S Births - Scarborough	2025-11			55.1%		44.6%	Baseline
Elective caesarean - Scarborough	2025-11			21.3%		16.1%	Baseline
Emergency caesarean - Scarborough	2025-11			33.7%		28.4%	Baseline
Induction of labour - Scarborough	2025-11			43.8%		45.3%	Baseline
HDU on L/W - Scarborough	2025-11			3		5	Target
BBA - Scarborough	2025-11			0		2	Target
HSIB cases - Scarborough	2025-11			0		0	Target
Neonatal Death - Scarborough	2025-11			1		0	Target
Antepartum Stillbirth - Scarborough	2025-11			0		0	Target
Intrapartum Stillbirths - Scarborough	2025-11			0		0	Target
Cold babies - Scarborough	2025-04			0		1	Target
Preterm birth rate <37 weeks - Scarborough	2025-11			7.9%		6%	Target
Preterm birth rate <34 weeks - Scarborough	2025-11			1.1%		1%	Target
Preterm birth rate <28 weeks - Scarborough	2025-11			1.1%		0.5%	Target

Summary MATRIX 3 of 3

Maternity Scarborough

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Carbon monoxide monitoring at booking - Scarborough * 3rd/4th Degree Tear - assisted birth - Scarborough * Informal Complaints - Scarborough	
COMMON CAUSE / NATURAL VARIATION		* Low birthweight rate at term (2.2kg) - Scarborough * Breastfeeding Initiation rate - Scarborough * Breastfeeding rate at discharge - Scarborough * Smoking at booking - Scarborough * Smoking at 36 weeks - Scarborough * Smoking at time of delivery - Scarborough * Carbon monoxide monitoring at 36 weeks - Scarborough * PPH > 1.5L as % of all women - Scarborough * Shoulder Dystocia - Scarborough * 3rd/4th Degree Tear - normal births - Scarborough * Formal Complaints - Scarborough	
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - Scarborough	2025-11			1.1%		0%	Target
Breastfeeding Initiation rate - Scarborough	2025-11			76.4%		75%	Target
Breastfeeding rate at discharge - Scarborough	2025-11			62.4%		65%	Target
Smoking at booking - Scarborough	2025-11			12.5%		6%	Target
Smoking at 36 weeks - Scarborough	2025-11			2.3%		6%	Target
Smoking at time of delivery - Scarborough	2025-11			2.3%		6%	Target
Carbon monoxide monitoring at booking - Scarborough	2025-11	H		97.3%		95%	Target
Carbon monoxide monitoring at 36 weeks - Scarborough	2025-11			76.7%		95%	Target
SI's - Scarborough	2025-10			0		0	Target
PPH > 1.5L as % of all women - Scarborough	2025-11			2.2%		2%	Baseline
Shoulder Dystocia - Scarborough	2025-11			0		2	Target
3rd/4th Degree Tear - normal births - Scarborough	2025-11			1.1%		0%	Target
3rd/4th Degree Tear - assisted birth - Scarborough	2025-11	L		0%		0%	Target
Informal Complaints - Scarborough	2025-11	L		0		0	Target
Formal Complaints - Scarborough	2025-11			1		0	Target

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - Scarborough	2025-11		P	112		169	Target
Bookings <10 weeks - Scarborough	2025-11		F	74.1%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2025-11		?	4.7%		10%	Target
Births - Scarborough	2025-11		?	89		113	Target
No. of women delivered - Scarborough	2025-11		?	89		112	Target
Planned homebirths - Scarborough	2025-11		?	0%		2.1%	Target
Homebirth service suspended - Scarborough	2025-11		F	16		3	Target
Women affected by suspension - Scarborough	2025-11		?	0		0	Target
Community midwife called in to unit - Scarborough	2025-11		P	0		3	Target
Maternity Unit Closure - Scarborough	2025-11		?	0		0	Target
SCBU at capacity - Scarborough	2025-03	H	?	4		1.1	Baseline
SCBU at capacity of intensive care cots - Scarborough	2025-03	H	?	11		3.2	Baseline
SCBU no of babies affected - Scarborough	2025-03	H	?	1		0	Target
1 to 1 care in Labour - Scarborough	2025-11		?	100%		100%	Target
L/W Co-ordinator supernumerary % - Scarborough	2025-11	H	?	100%		100%	Target
Anaesthetic cover on L/W - Scarborough	2025-11	H	F	5		10	Target

Summary MATRIX 1 of 3

Maternity York

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* SCBU at capacity - York * L/W Co-ordinator supernumerary % - York	
COMMON CAUSE / NATURAL VARIATION	* Bookings ≥13 weeks (exc transfers etc.) - York * Anaesthetic cover on L/W - York	* Bookings - York * Births - York * No. of women delivered - York * Planned homebirths - York * Homebirth service suspended - York * Women affected by suspension - York * Maternity Unit Closure - York * SCBU at capacity of intensive care cots - York * SCBU no of babies affected - York * 1 to 1 care in Labour - York	* Bookings <10 weeks - York
SPECIAL CAUSE CONCERN	* Community midwife called in to unit - York		

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - York	2025-11			296		295	Target
Bookings <10 weeks - York	2025-11		F	80.1%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - York	2025-11		P	5.4%		10%	Target
Births - York	2025-11			223		245	Target
No. of women delivered - York	2025-11			221		242	Target
Planned homebirths - York	2025-11			0.9%		2.1%	Target
Homebirth service suspended - York	2025-11			18		3	Target
Women affected by suspension - York	2025-11			0		0	Target
Community midwife called in to unit - York	2025-11	H	P	1		3	Target
Maternity Unit Closure - York	2025-11			2		0	Target
SCBU at capacity - York	2025-06	L		0		0	Baseline
SCBU at capacity of intensive care cots - York	2025-06			28		14.8	Baseline
SCBU no of babies affected - York	2025-05			2		0	Target
1 to 1 care in Labour - York	2025-11			99.4%		100%	Target
L/W Co-ordinator supernumerary % - York	2025-11	H		100%		100%	Target
Anaesthetic cover on L/W - York	2025-11		P	10		10	Target

Summary MATRIX 2 of 3

Maternity York

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION	* Intrapartum Stillbirths - York	* Normal Births - York * Assisted Vaginal Births - York * C/S Births - York * Elective caesarean - York * Emergency caesarean - York * Induction of labour - York * BBA - York * Neonatal Death - York * Antepartum Stillbirth - York * Cold babies - York * Preterm birth rate <37 weeks - York * Preterm birth rate <34 weeks - York * Preterm birth rate <28 weeks - York	
SPECIAL CAUSE CONCERN		* HSIB cases - York	

Maternity York
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Normal Births - York	2025-11			50.7%		57%	Target
Assisted Vaginal Births - York	2025-11			7.2%		12.4%	Target
C/S Births - York	2025-11			41.6%		38.7%	Baseline
Elective caesarean - York	2025-11			17.2%		16%	Baseline
Emergency caesarean - York	2025-11			24.4%		22.6%	Baseline
Induction of labour - York	2025-11			47.5%		41.5%	Baseline
HDU on L/W - York	2025-11			9		5	Target
BBA - York	2025-11			2		2	Target
HSIB cases - York	2025-11	H		1		0	Target
Neonatal Death - York	2025-11			0		0	Target
Antepartum Stillbirth - York	2025-11			0		0	Target
Intrapartum Stillbirths - York	2025-11		P	0		0	Target
Cold babies - York	2025-08			0		1	Target
Preterm birth rate <37 weeks - York	2025-11			8.1%		6%	Target
Preterm birth rate <34 weeks - York	2025-11			2.7%		2%	Target
Preterm birth rate <28 weeks - York	2025-11			0%		0.5%	Target

Summary MATRIX 3 of 3

Maternity York

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Smoking at booking - York * Carbon monoxide monitoring at booking - York	
COMMON CAUSE / NATURAL VARIATION		* Low birthweight rate at term (2.2kg) - York * Breastfeeding Initiation rate - York * Breastfeeding rate at discharge - York * Smoking at 36 weeks - York * Smoking at time of delivery - York * PPH > 1.5L as % of all women - York * Shoulder Dystocia - York * 3rd/4th Degree Tear - normal births - York * 3rd/4th Degree Tear - assisted birth - York * Informal Complaints - York * Formal Complaints - York	* Carbon monoxide monitoring at 36 weeks - York
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - York	2025-11			0%		0%	Target
Breastfeeding Initiation rate - York	2025-11			88.2%		75%	Target
Breastfeeding rate at discharge - York	2025-11			72%		65%	Target
Smoking at booking - York	2025-11	L		2.7%		6%	Target
Smoking at 36 weeks - York	2025-11			2.7%		6%	Target
Smoking at time of delivery - York	2025-11			3.1%		6%	Target
Carbon monoxide monitoring at booking - York	2025-11	H		98.6%		95%	Target
Carbon monoxide monitoring at 36 weeks - York	2025-11		F	75.1%		95%	Target
SI's - York	2025-10			0		0	Target
PPH > 1.5L as % of all women - York	2025-11			4.5%		3.7%	Baseline
Shoulder Dystocia - York	2025-11			1		2	Target
3rd/4th Degree Tear - normal births - York	2025-11			0.5%		0%	Target
3rd/4th Degree Tear - assisted birth - York	2025-11			0.5%		0%	Target
Informal Complaints - York	2025-11			2		0	Target
Formal Complaints - York	2025-11			0		0	Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

January 2026

Workforce

Director of Workforce and Organisational Development Report

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Polly McMeekin

1. Highlights

- Flu vaccination uptake from frontline colleagues has continued to increase, reaching 52% against a 45% NHS England target.
- Agency WTE reduced for the fourth consecutive month and is now at its lowest level in eight years (53 WTE).
- Recruitment activity has continued during December, resulting in the appointment of new consultants, continued growth of the Nursing Associate pipeline, and strengthened HCSW recruitment through the 'SWAP' partnership with the Job Centre.

2. Concerns

- Sickness absence has risen sharply, reaching 5.8% in November, driven by seasonal illness despite the improved vaccination uptake.
- Industrial action impacted workforce capacity, with 30% of resident doctors participating in December and the potential for further strikes between February and August 2026.

3. Future

- Medium-Term Plan finalisation is underway, requiring significant reductions in agency (30% annually) and bank usage (10% annually) from 2026–2029.
- Global majority nurse cohorts arrive in January and March, with no further international recruitment planned beyond current commitments.
- National and local mandatory training reviews will reshape statutory/mandatory requirements in 2026–27, aiming to release workforce time and ensure training demonstrates measurable outcomes.

Summary MATRIX

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

MATRIX KEY

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

VARIATION

	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* 12 month rolling turnover rate Trust (FTE) * Overall corporate induction compliance * A4C staff corporate induction compliance	* Overall vacancy rate * Registered Nursing vacancy rate * Total Agency Whole Time Equivalent Filled * Total Bank Whole Time Equivalent Filled * Medical & dental staff corporate induction compliance	* Overall stat/mand training compliance * A4C staff stat/mand training compliance * Appraisal Activity
COMMON CAUSE / NATURAL VARIATION		* HCSW vacancy rate * Midwifery vacancy rate * Medical and dental vacancy rate * AHP vacancy rate	* Medical & dental staff stat/mand training compliance
SPECIAL CAUSE CONCERN			* Monthly sickness absence * Annual absence rate

Workforce
Scorecard (1)

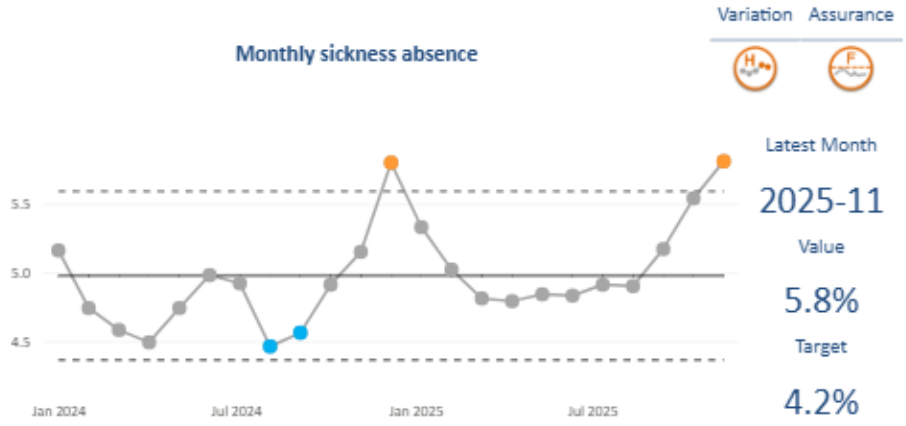
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2025-11	H	F	5.8%	4.2%	4.2%
Annual absence rate	2025-11	H	F	5.2%		4.3%
Total Agency Whole Time Equivalent Filled	2025-11	L	?	52.6		151
Total Bank Whole Time Equivalent Filled	2025-11	L	?	606.6		557
12 month rolling turnover rate Trust (FTE)	2025-12	L	P	7.7%		10%
Overall vacancy rate	2025-12	L	?	6.5%		6%
HCSW vacancy rate	2025-12		?	11.4%		5%
Midwifery vacancy rate	2025-12		?	-2.3%		0%
Medical and dental vacancy rate	2025-12		?	3.7%		6%
Registered Nursing vacancy rate	2025-12	L	?	4.2%		5%
AHP vacancy rate	2025-12		?	7.6%		8.5%

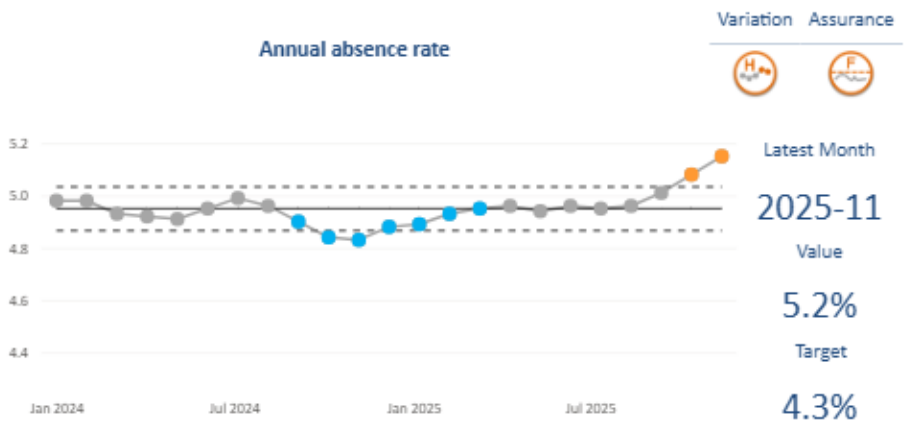
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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

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



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

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

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

Factors impacting performance and actions:

Sickness absence in the Trust has been on a steep climb since the summer and reached 5.8% in November (a 0.3% increase on the rate for the month of October). The table below summarises the four main reasons for colleague absence in November and shows how these compare with the position one month previously:

Reason	November 2025		October 2025	
	WTE lost	Proportion of all absences	WTE lost	Proportion of all absences
Anxiety, stress, depression	147 ↑	27%	139	26%
Cough, cold, flu	69 ↑	13%	53	10%
Musculoskeletal, back	69 →	13%	69	13%
Gastrointestinal	44 ↓	8%	45	9%

The increase in seasonal illness has come despite significant improvement in the level of take-up of the flu vaccination by frontline colleagues. At the start of January, the Trust had achieved a 52% vaccination rate against an organisational target of 45% set by NHS England. The Trust is continuing to offer the vaccine to colleagues until the end of March via appointment with the Occupational Health service.

The Trust is refreshing capability in sickness absence management through its new Management Fundamentals training programme. This two-day course equips line managers with the skills and confidence to manage colleagues in a supportive and effective way, including the appropriate use of employment processes. To date, 133 colleagues have completed one day of the programme, with a further 456 bookings for course dates in the first half of 2026.

Between 17 and 22 December, 30% of resident doctors in the Trust participated in national strike action. The action was taken in the context of a national ballot seeking a renewed six-month mandate for further industrial action on pay erosion and the resident doctor training and employment bottleneck. Subject to the outcome of that ballot, further strike action across England may take place between February and August 2026.

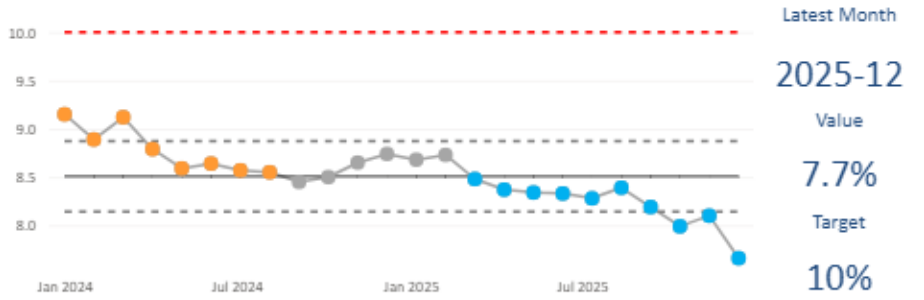
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

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

12 month rolling turnover rate Trust (FTE)

Variation Assurance

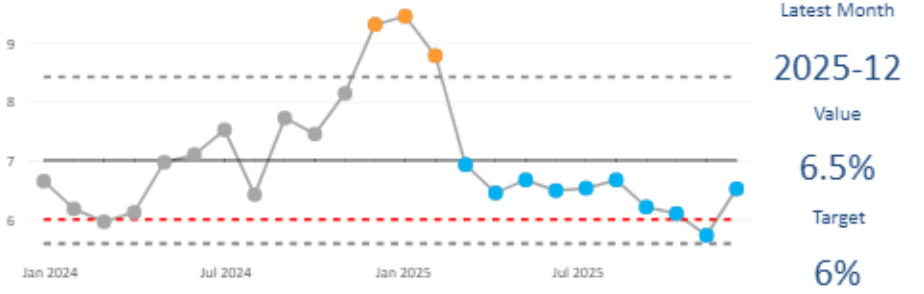


The indicator is **better than the target** for the latest month and **is not** within the control limits.

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

Overall vacancy rate

Variation Assurance



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

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

Factors impacting performance and actions:

Across NHS Trusts in England, colleague turnover has fallen consistently over the last two years and is now at its lowest level since before the pandemic. Within the Trust over the last 12-months, this metric has consistently tracked below 8.5% (NB. Turnover does not include where colleagues leave employment at the end of a fixed-term contract, including Resident Doctors on rotation).

At the end of November, the Group recorded a total workforce position of 10,076 WTE. This represents an increase of 22 WTE from October, and includes 21 WTE additional Bank usage (16 of which is attributed to the Resident Doctor's strikes).

The budgeted WTE establishment for November was 10,218 WTE. At staff group level, the total size of the medical and dental and registered nursing and midwifery groups exceeded establishment levels. In addition to the strikes, this has been influenced in part by higher than planned sickness levels.

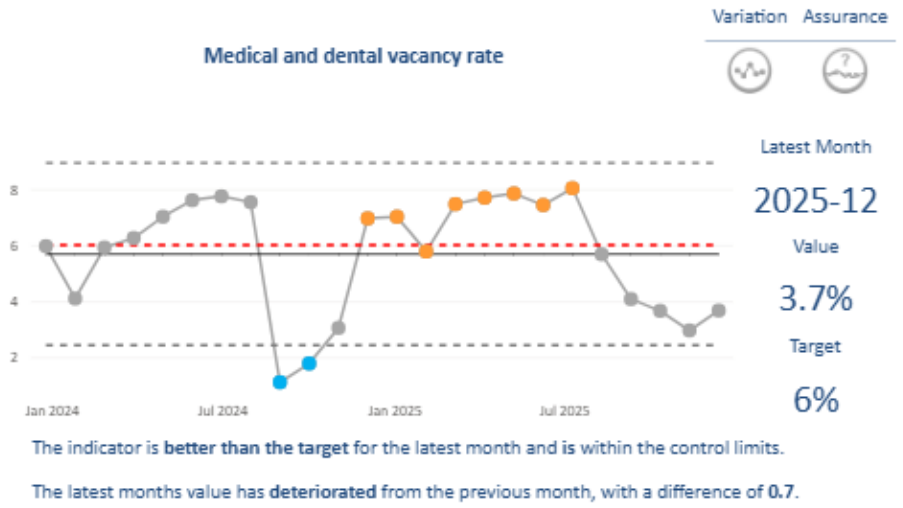
Despite these challenges, the Group continued to reduce agency WTE. This fell for a fourth successive month, to 53 WTE. This is the lowest agency WTE figure recorded in the eight years since collection of this information began.

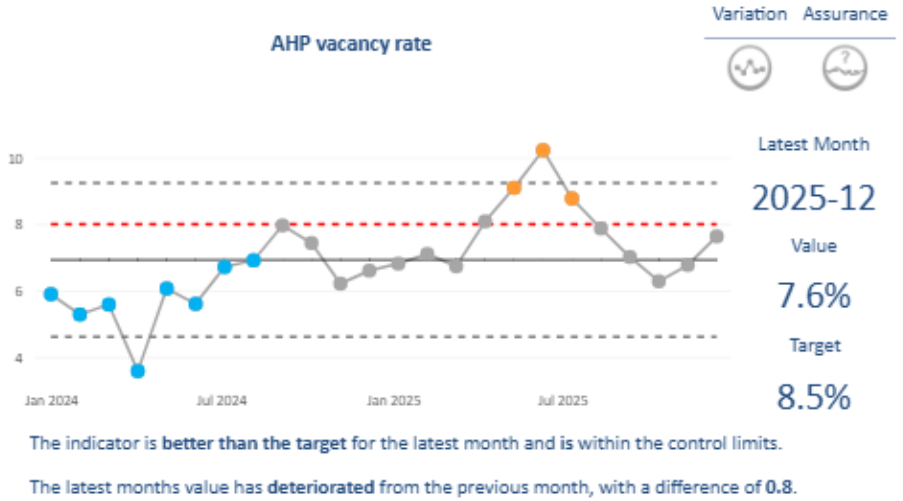
In the medium term (2026-2029), the Group is required to make year-on-year reductions of 30% in agency utilisation and 10% in bank utilisation. It is currently in the process of finalising its Medium-Term Plan for final review in February.

In the short term, the Group vacancy rate may increase following implementation of a vacancy control 'double-lock' system by Humber and North Yorkshire ICB. The mechanism requires ICB approval for recruitment to non-clinical vacancies, and forms part of the system's essential expenditure control measures during Q4 of the 2026-27 financial year.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

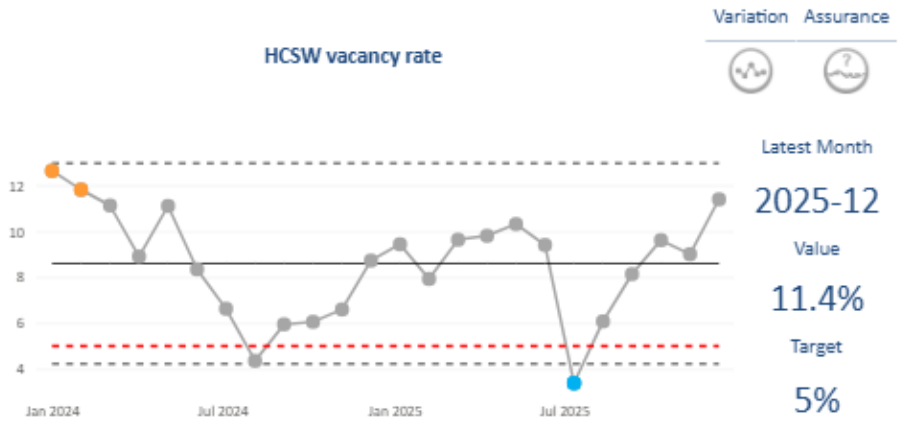
Factors impacting performance and actions:

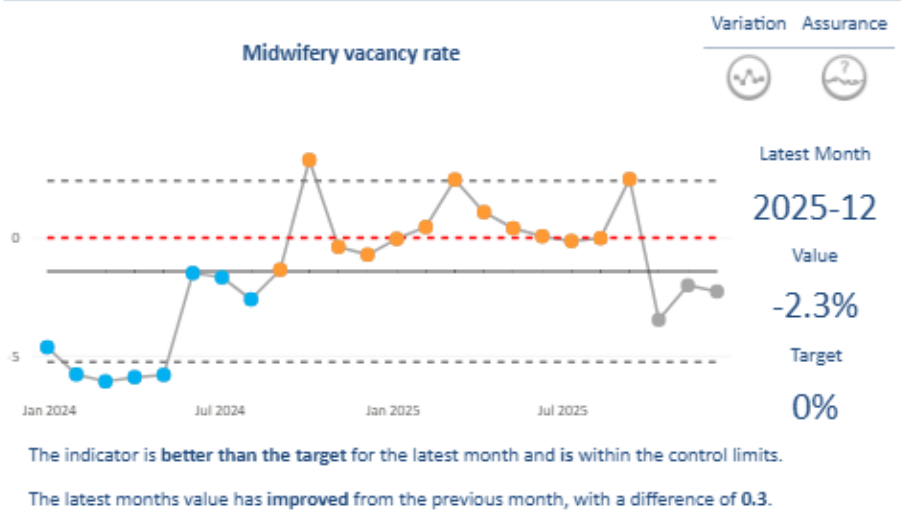
In December, the Trust welcomed eight new medical colleagues including two permanent Consultants working within Care of the Elderly and Gastroenterology. In addition, nine offers of employment for medical posts were made, including three permanent Consultant posts in Anaesthetics and Occupational Health.

The Trust ran a two-page print campaign in the Christmas edition of the British Medical Journal (BMJ) to seek interest in Consultant vacancies across specialties which are experiencing national supply shortages, including Maxillofacial Surgery. The article generated some interest in vacancies at the Trust but unfortunately not in the hard-to-fill roles. The Trust is working with the BMJ to explore ways to generate greater interest.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

Factors impacting performance and actions:

The HCSW recruitment pipeline includes 18 WTE HCSWs undertaking pre-employment checks, and 16 WTE who are booked onto the next Academy in January. Working in partnership with the Job Centre, the Trust has recruited a cohort of 13 people to a Sector-based Work Academy Programme (SWAP). The programme, which is running for a second time, provides a pathway directly into HCSW roles upon completion.

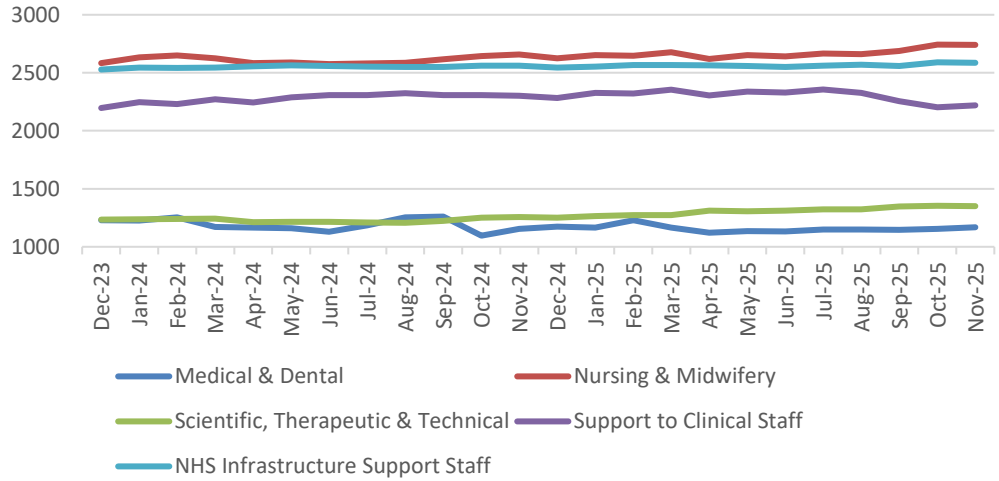
The current registered nursing vacancy rate is 4.2%. Some vacancies will be filled later this month by the arrival of a cohort of 10 global majority nurses from Kerala, India. A further cohort of eight global majority nurses are scheduled to arrive in March. The Trust has no further plans for global majority recruitment campaigns beyond these dates.

December saw the Nursing Associate headcount decrease by two from 47 to 45. There are a further 47 colleagues enrolled on the Level 5 Nursing Associate Apprenticeship course who are due to complete at different stages during the next 20-months. An additional 10 Apprentices are due to commence training with the Trust and Coventry University Scarborough by March 2026.

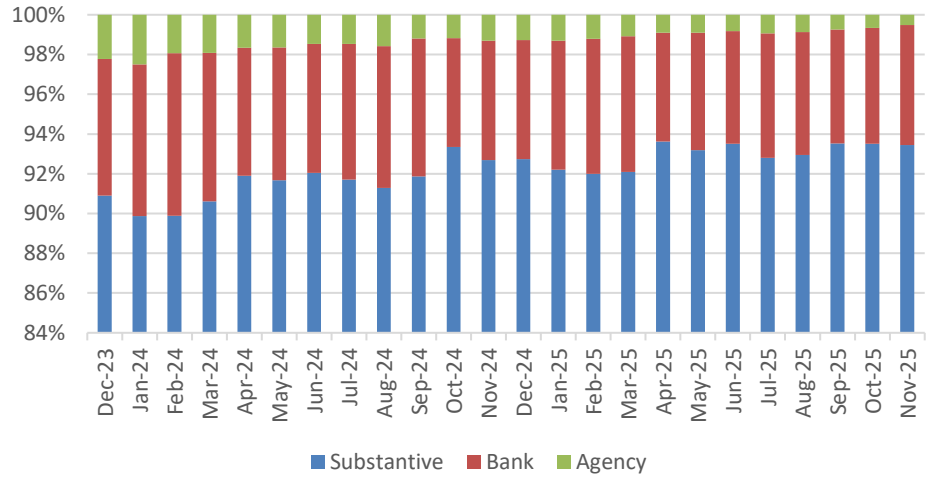
As part of its ongoing efforts to bolster the Maternity workforce, the Trust has recently recruited five new Band 5 Midwives, two Maternity Assistants and four Maternity Support Workers. Efforts to recruit to Band 6 Midwife roles were unsuccessful; but there will be a further campaign to seek new applications.

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

Staff Group size (WTE) - total of substantive, bank & agency WTE



Workforce (WTE) proportions - substantive/bank/agency split



Factors impacting performance and actions:

The Trust is reviewing its temporary staffing approval processes following the introduction of double-lock approvals via the ICB. The areas of focus are non-clinical bank and agency and high-cost clinical agency use, where additional approval steps are being introduced to further scrutinise temporary staffing use.

Following the introduction of new medical bank rates and an updated escalation approval process in August, the number of escalated shifts has fallen significantly. 432 shifts had rates escalated in the week prior to the change. In response to industrial Action in December, Care Groups were given permission to escalate bank rates locally. This resulted in 553 shift requests with escalated rates during the week of strikes. The average number of rate escalations requested in the non-strike weeks of December remained steady at an average of 78 shift requests, a slight increase from November's non-strike weeks (74 shifts).

Negotiations with agency workers and providers continue, focusing on long-term and high-cost usage. Positively, the Trust has ended its most high-cost medical agency booking for a long serving Consultant. Five Theatre Nurse bookings have been extended until the end of January, with on-going efforts to convert these to bank posts. One Biomedical Scientist block booking has also been ended. In addition, the Trust has successfully converted two high-cost medical bank posts to fixed-term contracts.

Administrative bank activity reduced in December to 808 shifts, compared to 905 in November. The time of year is likely to be a notable factor in the reduction, with staff opting to take leave over the Christmas period, however, the introduction of double-lock approvals for temporary staffing use is expected to support a reduction in administrative bank use. The Trust will continue to monitor activity closely, with monthly reports shared with Care Groups to support reduction opportunities and ensure appropriate approvals are in place.

Workforce
Scorecard (2)

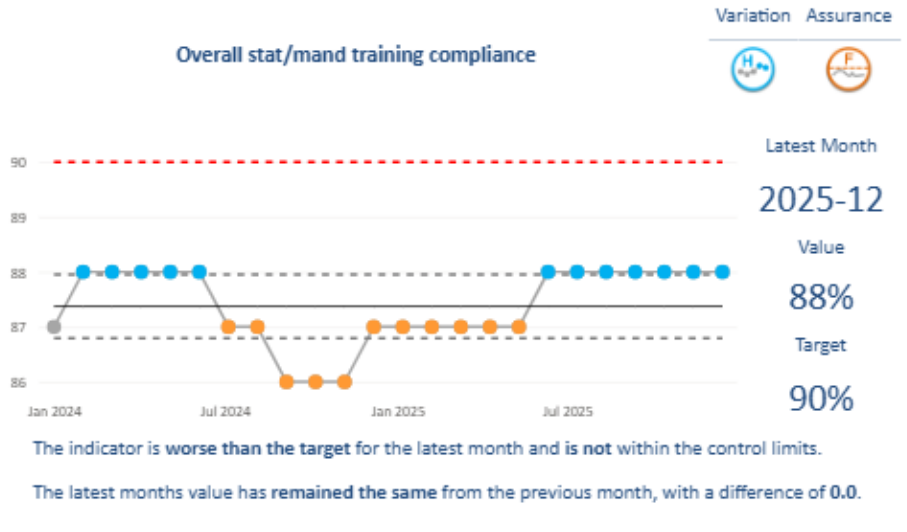
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

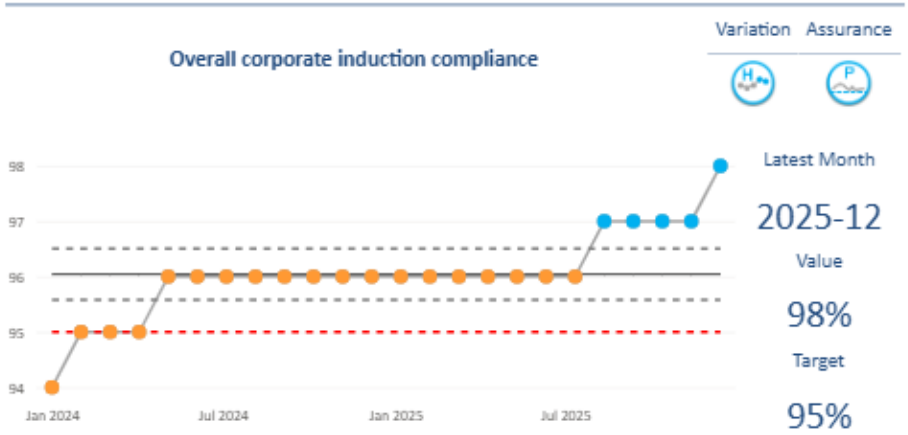
Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2025-12	H	F	88%		90%
Overall corporate induction compliance	2025-12	H	P	98%		95%
A4C staff stat/mand training compliance	2025-12	H	F	90%		90%
A4C staff corporate induction compliance	2025-12	H	P	98%		95%
Medical & dental staff stat/mand training compliance	2025-12		F	77%		90%
Medical & dental staff corporate induction compliance	2025-12	H	?	97%		95%
Appraisal Activity	2025-11	H	F	87.2%	81.8%	95%

Executive Owner: Polly McMeekin

Operational Lead: Will Thornton & Gail Dunning





Rationale: Trained workforce delivering consistently safe care
Target: Mandatory Training 90% and Corporate Induction 95%

Factors impacting performance and actions:

From April, the Group adopted a new target for statutory and mandatory training compliance. The 90% target strives for a 3% increase in the level of completions compared with our previous aim for 87% compliance. Mandatory training compliance has maintained at 88% in December.

The national mandatory training programme is currently under review and will be refreshed in 2026-27 as part of a commitment from NHS England to release up to 200,000 days of colleagues' time. In the Trust, this is being augmented through review of locally-mandated training requirements by a multi-professional group, adopting the same principles used by the national review. This requires that each training course can demonstrate impact with reference to tangible outcome measures rather than focusing on the proportion of colleagues who have completed it. The review of the 11 subjects, some of which include multiple levels of training linked to a role's duties, is due for completion by the end of the financial year.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

January 2026

Executive Owner: James Hawkins

Highlights

EPR implementation:

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

Wider Digital Portfolio delivery continues with key focus on:

- Multi-year programme of paper records scanning and storage consolidation continues.
- Supporting AI trials in both diagnostics and wider trials of Microsoft Co-pilot across the organisation with focus on efficiency opportunities.
- The Neonatal Badgernet implementation successfully went live.
- Microsoft Sharepoint adoption continues to build and AI knowledge base for the organisation.

Concerns / Risks

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

Executive Owner: James Hawkins

Future / Next Steps

EPR implementation:

- Complete software build for Tranche 1.
- Finalise Tranche 1 cutover planning and initiate Trust Resilience Group to focus on EPR Readiness activities.
- Develop detailed cutover plans, including transcribing plans, and how we will undertake the safe go-live of this first Tranche.
- Continue EPR Design and readiness work on Tranches 2 and 3.
- EPR Tranche 2 (which contains full order comms) is due to complete design by the end of December 2025.

Wider Digital Portfolio:

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

Summary MATRIX

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

MATRIX KEY

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

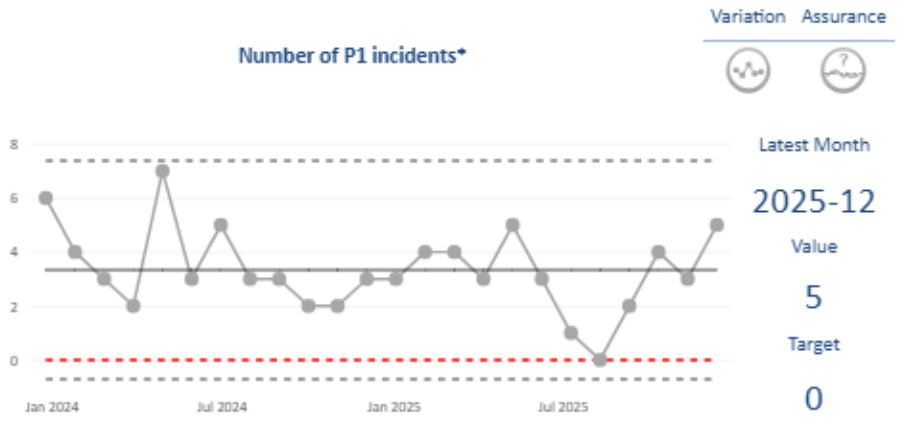
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents* * Percentage of FOIs and EIRs responded to within 20 working days (monthly)	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests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

Executive Owner: James Hawkins

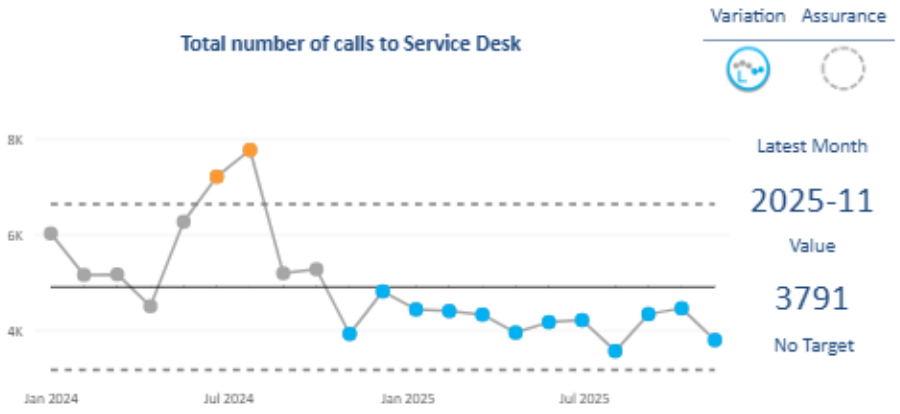
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2025-12			5		0
Total number of calls to Service Desk	2025-11			3791		
Total number of calls abandoned	2025-11			837		
Number of information security incidents reported and investigated	2025-12			40		
Number of patient Subject Access Requests (SAR) received (monthly)	2025-12			250		
Number of patient Subject Access Requests (SAR) completed (monthly)	2025-12			266		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2025-12			71%		80%
Number of FOIs and EIRs received (monthly)	2025-12			42		
Number of FOIs and EIRs completed (monthly)	2025-12			55		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2025-12			96%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy



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



The latest months value has **improved** from the previous month, with a difference of **662.0**.

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

Target: 0 P1 Incidents

Factors impacting performance:

5x P1 incidents occurred in December.

1. 1/12 Users unable to upload documents to CPD patient records. Database configuration issue – duration 2hr 30m
2. 9/12 WinPath (Lab system) fault. A network "loop" created during a planned change earlier that day, but not detected at the time. Duration – approx. 2 hours
3. 15/12 Northway clinic network fault. Old hardware failed and required replacement (work planned but not yet scheduled). Duration 1 day
4. 16/12 CMM (Pharmacy system) unavailable for users at Scarborough. Caused by an underlying misconfiguration of Network services. Duration – 1hr 20m
5. 23/12 CPD unavailable. Caused by unexpected event during planned maintenance on failed storage hardware. Duration 1hr 43m

Actions:

P1 Incident reviews have identified changes to improve Change Management processes, and include additional checks within planned work statements to avoid recurrence.
The underlying network issue affecting CMM at Scarborough has been resolved.
Follow-on work to complete the planned work that caused the CPD incident has been scheduled with additional steps to ensure it cannot recur.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated

Latest Month
2025-12
Value
40
No Target

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

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

Number of information security incidents reported and investigated

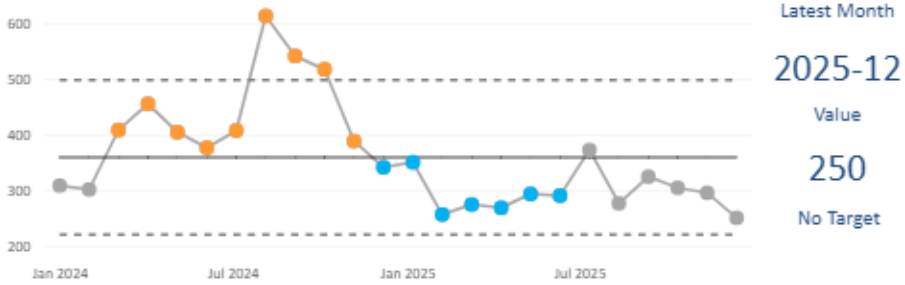
Factors impacting performance:

Information security incidents stayed steady throughout November and December.

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

Variation Assurance

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



Latest Month
2025-12
Value
250
No Target

The latest months value has **improved** from the previous month, with a difference of **45.0**.

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

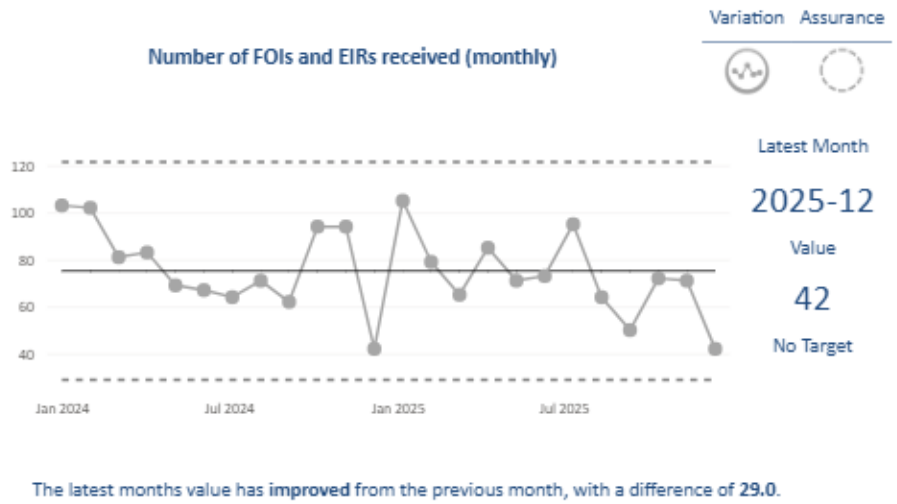
Number of Subject Access Requests (SAR) submitted by patients

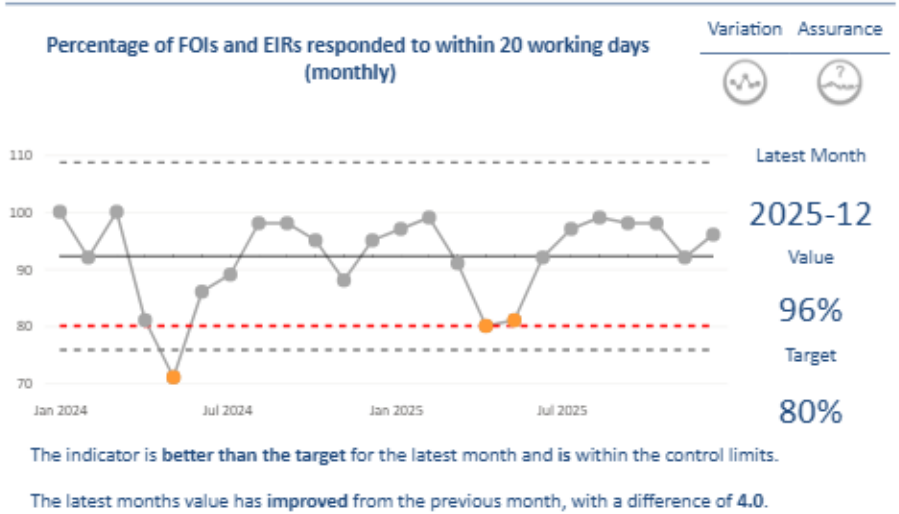
Factors impacting performance:
The reporting for SARs has changed to only include patient access requests. Previous reports have also included police requests, access to health records (deceased patients) and ad hoc external requests which are no longer included in this count.

Volumes received have remained similar this month and timeliness of responses has improved, which is achieving target.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley





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

Factors impacting performance:.

Number of FOIs Received

The number of FoIs the Trust received throughout December decreased, this reflects trends from 2024 and is likely due to the seasonal holidays.

Actions: N/A

Percentage of FOIs responded to within 20 working days

Requests being sent out on time has increased, and is above the target of 80%.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

January 2026

Executive Owner: Andrew Bertram

Highlights

Income and Expenditure Position

- Month 9 – Actual deficit of £10m against a planned deficit of £1m, so we are £9m adversely adrift of plan.
- £0.5m of the adverse variance is in relation to industrial action – at present, there is no national funding to cover this cost or for the loss of elective income (both of which have been covered in the past)
- Efficiency delivery is £11.6m behind plan (compared to £12.1m behind plan at Month 8)
- ERF income has been running ahead of our expected plan; this is now adjusted to £3m in line with the reducing trajectory to deliver within the capped value.
- Q3 deficit support funding was confirmed at month 5 but continues to be at risk due to the deteriorating system position as of January 26, this is still awaiting a final decision. It has been confirmed that due to the system position Q4 deficit support will not be received.

Efficiency Programme

- At month 9 we have delivered year to date savings totaling £22.8m against a planned savings trajectory of £34.4m. We are currently falling £11.6m short of the year-to-date target requirement. The full year effect of the savings delivered to date is £27.7m.

Cash Position

The cash balance at the end of December is £13.2m against a plan of £33.8m, which is £20.6m adverse. Of which £11.5m is due to the I&E deficit and £12.4m is due to non-receipt of sparsity income & 24/25 ERF overtrade.

The revised March forecast is benefiting from a £15m timing difference in drawing capital PDC funding before paying capital invoices next financial year. The timing benefit is expected to unwind during Q1 2026/27. Current forecasts suggest a cash support request may be required in Q1 2026/27; however, this is heavily dependent on both the financial & capital program outturn positions and will be monitored closely as we progress towards year end.

Executive Owner: Andrew Bertram

Concerns / Risks

- There remains a risk in relation to 24/25 elective activity and payment under PbR. Our reported income position for 24/25 included £5.1m of additional work done for which payment was reasonably expected. NHSE are indicating this is an ICB system issue to resolve and the initial formal response from the ICB is not to recognise this. The Trust has now formally written to the ICB for resolution.

- The current reported position assumes the sparsity payment of £10.3m (in full year terms) is met by the ICB. At present the ICB has only identified a partial source of funding but remains committed to working with the Trust on a solution. This is transparently recognised and agreed by all parties in our plan but securing funding remains a key concern area.

- The Trust has now submitted a forecast change protocol declaring an expected £33m deficit at the end of the year.

- The delivery of recovery actions over the remaining 3 months is vital to protect our cash position.

Future / Next Steps

Forecast

The Trust has submitted a forecast change protocol to NHSE to confirm that we do not expect to hit financial balance at the end of 2025/26. The most likely forecast is a £33m deficit, the expected operational deficit is £17m, significantly of note is the forecast gap in efficiency delivery of £20m, offset by recovery actions. Further to the operating deficit, the Trust have now taken into account the anticipated loss of the 24/25 ERF overtrade income, and non receipt of sparsity funding.

The Trust will have to at the very least meet this position or improve upon it. Ongoing delivery of the efficiency programme and recovery action plan is key to managing this.

Summary Dashboard and Income & Expenditure

Finance (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

- The Trust Submitted its Operational Financial Plan to NHSE on 30th April 2025. The plan presented a balanced income and expenditure (I&E) position as per the table opposite.
- The Trust's balanced position forms part of a wider HNY ICB balanced I&E plan.
- The Trust has a planned operational I&E surplus of £1.4m, but for the purposes of assessing financial performance NHSE remove certain technical adjustments to arrive at the underlying financial performance.
- It should be noted that the Trust's projected balanced position is after the planned delivery of a significant efficiency programme of £55.3m.
- The plan is designed to assist the Trust meet all the required performance targets in 2025/26
- The plan includes £16.5m of deficit support funding. This is not guaranteed and can be withdrawn if the Trust and ICB are not meeting their financial obligations.

OPERATIONAL FINANCIAL PLAN 2025/26
SUMMARY INCOME & EXPENDITURE POSITION

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

Summary Dashboard and Income & Expenditure

Finance (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£6.1m	-£9.1m	↓	Deteriorating
Corporate CIP Delivery Variance to Plan (£29.8m target)	-£15.5m	-£17.6m	↓	Deteriorating
Core CIP Delivery Variance to Plan (£25.5m Target)	£3.3m	£6.0m	↑	Improving
Variance to Agency Cap	£1.2m	£1.2m	-	Unchanged
Month End Cash Position	£21.9m	£13.1m	↓	Deteriorating
Capital Programme Variance to Plan	-£18.9m	-£19.7m	↓	Deteriorating

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	797,152	597,864	605,630	7,766
Other Income	95,815	71,879	74,883	3,003
Total Income	892,966	669,743	680,513	10,770
Pay Expenditure	-597,473	-445,111	-451,293	-6,182
Drugs	-70,558	-54,422	-59,426	-5,003
Supplies & Services	-97,691	-73,157	-71,874	1,283
Other Expenditure	-141,234	-95,764	-97,577	-1,813
Outstanding CIP	27,546	11,635	0	-11,635
Total Expenditure	-879,410	-656,820	-680,170	-23,350
Operating Surplus/(Deficit)	13,556	12,923	342	-12,581
Other Finance Costs	-12,196	-9,147	-8,030	1,117
Surplus/(Deficit)	1,360	3,776	-7,687	-11,463
NHSE Normalisation Adj	-1360	-4770	-2362	2408
Adjusted Surplus/(Deficit)	0	-994	-10,049	-9,055

The I&E table confirms an actual adjusted deficit of £10.0m against a planned deficit of £1.0m, leaving the Trust with an adverse variance to plan of £9.1m.

Deficit support funding (DSF), has been secured for Q1 & Q2. Q3 but continues to be at risk due to the deteriorating system position. As of January 26, this is still awaiting a final decision. It has been confirmed that due to the system position, Q4 deficit support will not be received. The Trust has submitted a forecast change protocol to confirm an expected deficit of £33m at the end of the year. Continued delivery of CIP and recovery action plans are vital to enable the Trust to meet this revised position.

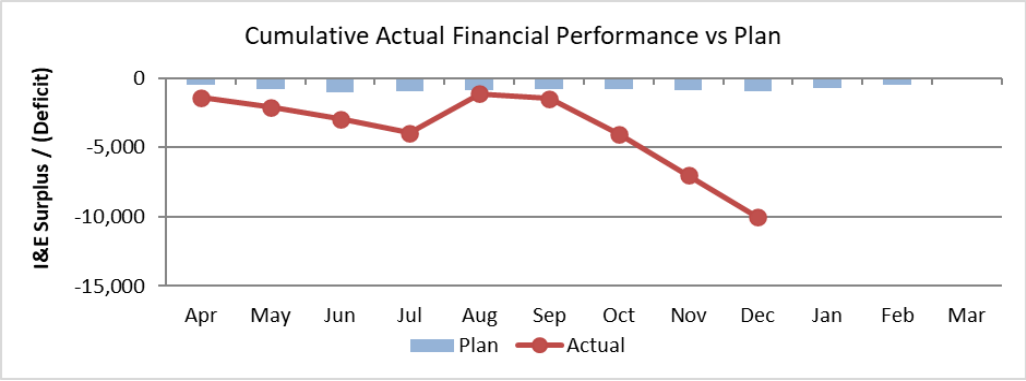
Key Subjective Variances: Trust
Finance (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable / (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	-£26.0m	NHSE under trade linked to services which have been delegated to ICBs to commission. There is a corresponding over trade on the ICB line below.	Confirm contracting arrangements and ensure plans and actual income reporting align.
ICB Income	£33.4m	ICB over trade linked to services which have been delegated from NHSE to ICBs to commission. The position also includes £3.0m linked to ERF activity ahead of plan. Although this income is covered by the block contract, £3.0m has been brought forward into the M9 position to recognise activity delivered to date. This action has been agreed by HNY ICB.	Confirm contracting arrangements and ensure plans and actual income reporting align
Employee Expenses	-£6.2m	Agency, bank and WLI spending is ahead of plan to cover medical vacancies.	To continue to control agency spending within the cap. Work being led by HR Team to apply NHSE agency best practice controls, continued recruitment programmes (including overseas recruitment). Vacancy control measures in place.
Drugs	-£5.0m	A risk share arrangement was agreed in the 2025/26 plan to reduce expenditure on drugs commissioned by ICBs that were previously contracted for on a pass-through basis. Savings have not been delivered at the required rate.	Identify opportunities to expedite reduction in cost growth including switching to biosimilar products. Work led by Chief Pharmacist to review cost effective use of first line treatment options.
CIP	-£11.6m	The Corporate Programme is £17.6m behind plan, the Core Programme is £6.0m ahead of plan.	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group. CIP Time Out session, lead by CEO, held in October 2025. Financial Recovery Plan agreed with all areas.
Other Costs	-£0.5m	Favourable variance on clinical supplies and services (£1.2m) offset by adverse variance on other non pay expenditure (£1.8m).	Identify drivers for increased costs and take corrective action as appropriate.

Cumulative Actual Financial Performance vs Plan & Forecast

Finance (4)



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

The actual I&E performance at the end of December 2025 is a deficit of £10.0m compared to a planned deficit of £1.0m. This represents an adverse variance to plan of £9.1m.

Forecast			
	Adjusted Surplus/(deficit)		
Scenario	Plan £'000	Forecast £'000	Variance £'000
Likely Case	0	-33,406	-33,406
Best Case	0	-16,595	-16,595
Worst Case	0	-48,938	-48,938

Forecast Scenarios

Likely Case

The most likely case assumes that the underlying monthly run rate deficit continues for the remainder of the financial year. This includes a material £20m gap against CIP Delivery. It also assumes that the £10.4m sparsity funding and £4.6m ERF overtrade from 2024/25 are not funded by HNY ICB. Additionally, it factors in the achievement of £5m in savings from the Financial Recovery plan

Note: Following notification of Industrial Action funding, the M9 submitted forecast will be amended from £33.4m to £31.3m

Best Case

The best case has the same assumptions as the likely case but in addition assumes that the sparsity funding and ERF overtrade from 2024/25 are received in full.

Worst Case

The worst case assumes that financial recovery mitigations identified in the likely case are not delivered and a further deterioration in monthly deficit run rate.

Care Group Forecast
Finance (5)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Year to Date 2025/26 Care Group Financial Position							
Care Group	Annual Adjusted Budget	YTD Budget	YTD Actual	YTD Variance	YTD Adjusted Budget	YTD Adjusted Variance	Key Drivers of YTD Adjusted Variance
	£000	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	241,502	180,045	179,626	419	182,264	2,638	£1.65m underspend on CDC's due to delay at Scarborough, not expected to continue once all sites operational and £0.5m underspend on Lung Health Check, spend will increase as activity increases throughout remainder of year, growing Cell Path demand also causing £0.4m outsourcing cost pressure, offset largely by vacancies and CIP £0.4m ahead of plan YTD.
Family Health Care Group	89,574	67,097	68,436	-1,339	67,391	-1,044	£551k relates to the premium cost of covering medical vacancies, £894k Community overspend, £534k Midwifery overspend, £566k Sexual Health underspend, £561k overachieved CIP.
Medicine	193,905	145,736	153,485	-7,749	145,900	-7,585	£3.3m relates to medical cost pressures in ED and Acute; £2.1m drugs overspend, primarily Gastro, Renal and Respiratory; £1.8m YTD pressure of the unachieved CIP target.
Surgery	166,435	124,740	129,679	-4,939	125,213	-4,466	£2.3m overspend driven by Resident Doctor costs, with further non-pay overspends of £379k in drugs, £496k on consumables linked to increased non-elective activity, and £366k in other costs (removal expenses and premises). CIP overachieved YTD by £338k.
TOTAL	691,416	517,619	531,227	-13,608	520,769	-10,458	

Full Year 2025/26 Care Group Forecast Financial Position						
Care Group	Annual Adjusted Budget	Forecast Prior to Mitigating Actions	Mitigating Actions	Forecast Post Mitigating Actions	Forecast Variance	Key Drivers of Forecast Variance
	£000	£000	£000	£000	£000	
Cancer Specialist & Clinical Support Services Group	241,502	240,173	0	240,173	1,329	Forecast includes £0.6m NHSE clawback expected regarding reduced Lung Health Check activity numbers (mitigations currently being put in place) expenditure for winter diagnostics and opening of all CDC sites by end of financial year. As well as Endoscopy, MRI and CT Insourcing to improve performance, to counter these cost pressures CIP delivery planned to be £1.3m ahead of plan by year end.
Family Health Care Group	89,507	91,892	0	91,892	-2,385	£886k relates to the premium cost of covering medical vacancies, £970k Community Nursing overspend, £769k Midwifery overspend, £120k Sexual Health underspend, £22k CIP surplus.
Medicine	193,905	204,476	-56	204,420	-10,514	£4.4m relates to medical staffing cost pressures, £2.8m drug overspend and £3.2m shortfall in CIP delivery
Surgery	166,435	172,119	0	172,119	-5,684	£4.5m relates to staffing cost pressures - mainly Resident Doctors. £506K drugs overspend, £581K CSS overspend (non-elective driven), and £439k other non-pay costs (removal expenses, premises costs). CIP delivery remains on track to deliver in full.
TOTAL	691,349	708,659	-56	708,603	-17,254	

Forecast Outturn & Recovery Action Plans

Finance (6)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Issue	Comment	Value	Rec/non-rec	Total
Shortfall in Efficiency Programme Delivery	Efficiency delivery expected to finish at 4% of operational budgets.	(£20m)	Rec	
Operational Pay Pressure (notably Medical Agency Costs)	Note: NHSE reported pay position includes element of unmet efficiency.	(£9m)	Non-rec	
Devices & Unbundled Radiology	Currently managed as block. Will move to pass through in line with national contract.	(£6m)	Non-rec	
Underspends	Misc compensatory items – non medical & dental staffing costs / slippage on SHYPS etc. / In tariff Drugs etc..	£13m	Non-rec	
Recovery Action Plans		£5m	Rec	
Total Operational Position				**(£17m)**
2024/25 ERF Non-payment Risk	Work done in 24/25 not paid for by ICB.	(£5m)	Non-rec	
2025/26 Sparsity Payment Risk	NHSE/ACRA calculated value for 2025/26. Included in plan with NHSE & ICB agreement. System challenge in resourcing.	(£11m)	Non-rec	
Total Exceptional Items				**(£16m)**
Total Deficit Impact				**(£33m)**

Forecast Outturn

The forecast change protocol submitted to NHSE aligns to the most likely scenario (£33m Deficit) which assumes the underlying monthly run rate deficit continues for the remainder of the financial year. This includes:

- A material £20m gap against CIP delivery
- Operational pay pressures for medical and dental staffing
- Increased costs associated with high-cost devices and unbundled radiology

These pressures are partially offset by slippage in non-medical and dental staffing costs, SHYPs, and in-tariff drugs.

The forecast also assumes that £10.4m sparsity funding and £4.6m ERF overtrade from 2024/25 are not funded by HNY ICB.

Recovery Action Plan

The forecast assumes delivery of £5m recovery actions. The recovery plan is a live document, reviewed regularly by the Executive Delivery Group. Actions are monitored for progress and effectiveness, with new measures introduced as required to address emerging risks or shortfalls.

Forecast Movement

The forecast change protocol requires that forecast positions exclude any loss of deficit support funding. For clarity:

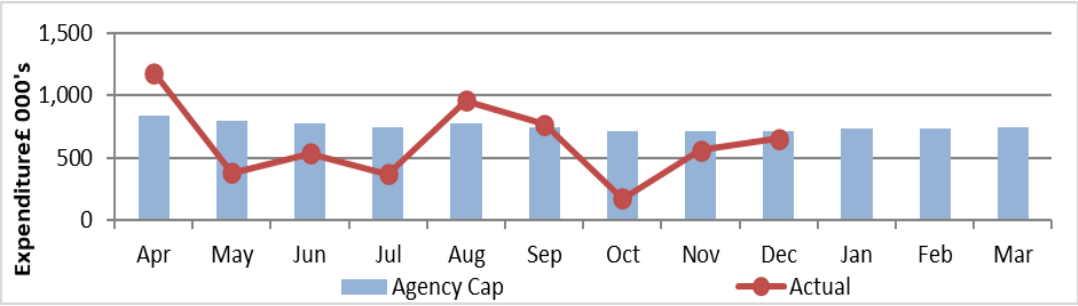
- The loss of Q4 Deficit Support Funding (DSF) of £4.1m deteriorates the forecast position from £33m to £37m.

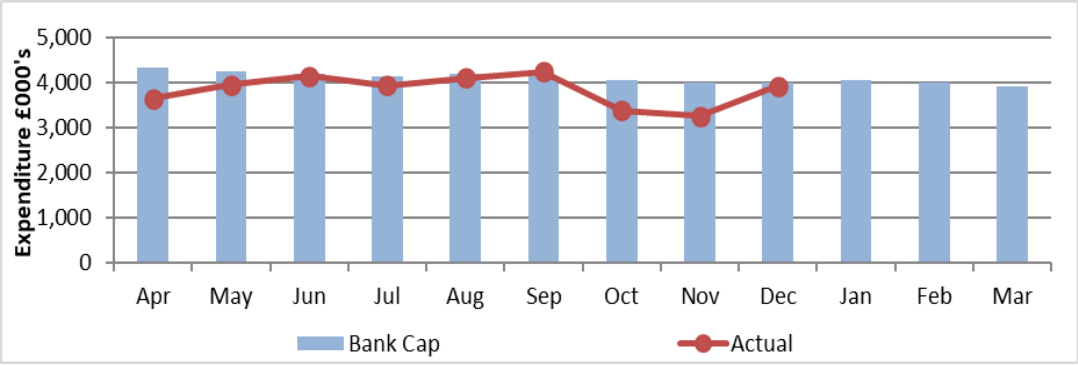
In addition, the Trust has recently been informed of receipt of £2.1m funding related to industrial action NHSEs expectation is that this allocation will improve forecast positions.

- Incorporating this funding improves the forecast to £31m (or £35m including DSF).

Note: The Month 9 accounts submission to NHSE includes £2.1m IA Funding

Agency, Bank and Workforce
Finance (7)





	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,645.29	2,557.59	87.70	114,307	115,616	-1,309
Scientific, Therapeutic and Technical	1,336.49	1,268.60	67.89	56,741	56,613	128
Support To Clinical Staff	1,937.47	1,468.93	468.54	47,163	44,293	2,870
Medical and Dental	1,124.00	1079.96	44.04	119,753	129,910	-10,156
Non-Medical - Non-Clinical	3,218.85	3,008.30	210.55	104,679	103,052	1,627
Reserves				819	0	819
Other				1,649	1,809	-160
TOTAL	10,262.10	9,383.38	878.72	445,111	451,293	-6,182

Agency Controls

The Trust has an agency staffing spend reduction target of 40% based on 2024/25 outturn. The expenditure on agency staff at the end of December is £5.563m compared to a plan of £6.775m, representing a favourable variance of £1.212m.

Bank Controls

The Trust has a bank staffing spend reduction target of 10% based on 2024/25 outturn. The expenditure on bank staff at the end of December is £34.550m compared to a plan of £37.207m, representing a favourable variance of £2.657m.

Workforce

This table presents a breakdown by staff group of the planned and actual workforce establishment in whole time equivalents (WTE) and spend for the year. The table illustrates that the key driver for the operational pay overspend position is premium rate spend against Medical and Dental staff.

Trust Performance Summary vs Commissioner ERF weighted Values in Contract.

Commissioner	25-26 Target % vs 19/20	Value ERF scope Indicative Weighted Values at 25/26 prices	ERF Month 09 Phase (Av %)	Activity to Month 09 Actual	Variance - (Clawback Risk) M09
Humber and North Yorks	104.00%	£171,355,927	£128,396,495	£131,793,422	£3,396,927
West Yorkshire	103.00%	£1,570,160	£1,176,516	£1,350,282	£173,766
Cumbria and North East	115.00%	£223,602	£167,544	£193,893	£26,348
South Yorkshire	121.00%	£182,919	£137,061	£123,696	-£13,365
Other ICBs - LVA / NCA	-				*£0*
All ICBs	***104.02%***	***£173,332,608***	***£129,877,617***	***£133,461,293***	***£3,583,676***
NHSE Specialist Commissioning	113.38%	£4,784,314	£3,584,872	£3,047,417	-£537,456
Other NHSE	104.13%	£305,100	£228,610	£262,513	£33,903
All Commissioners Total	**104.31%**	**£178,422,022**	**£133,691,100**	**£136,771,222**	**£3,080,123**

Please Note: Month 9 avtuals includes estimated adjustment for expected Ophthalmology data submision corrections in line with 2025/26 national guidance.

Elective Recovery Fund

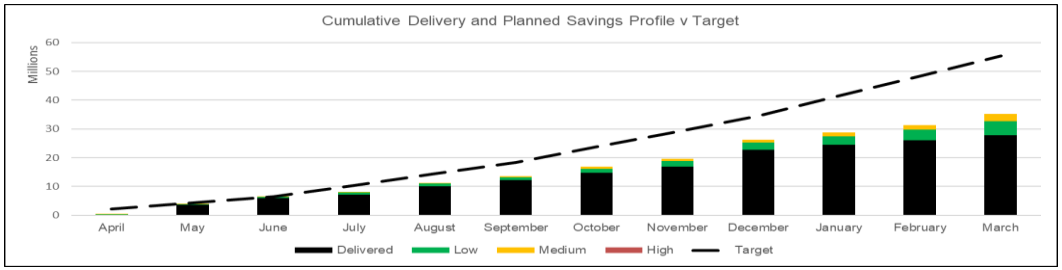
We continue to report on elective recovery performance on an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date before applying average tariff income to the activity.

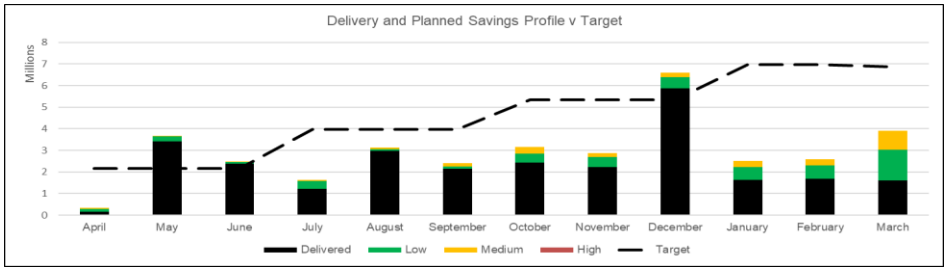
Given the financial limits on elective recovery funding in 2025/26, it is important to closely monitor the position to ensure that the weighted activity undertaken, where it incurs additional costs, does not exceed the planned levels without ICB commissioner authorisation. Additional system ERF funding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

At Month 9, the ERF weighted activity is valued at £3.1m over the funded level of ERF activity within our commissioner contracts. Most of this variance relates to outpatient ophthalmology attendances where additional scans and tests prior to the main eye procedure have been recorded as a separate appointments. Following updated guidance for 2025/26, these additional appointments will need to be removed from the SUS submissions, which will support financial delivery back in line with ERF target by the end of the financial year..

Cost Improvement Programme
Finance (9)

York and Scarborough Teaching Hospitals NHS Foundation Trust





	Full Year CIP Target	December Position			Full Year Position		Planning Position		Planning Status		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Fully Developed	Plan in Progress	Opportunity
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Corporate Programme	29,939	18,623	994	17,629	1,092	28,847	1,888	28,051	1,359	529	0
	29,939	**18,623**	**994**	**17,629**	**1,092**	**28,847**	**1,888**	**28,051**	**1,359**	**529**	**0**
Core Programme											
Medicine	6,039	3,765	1,972	1,793	2,352	3,686	3,362	2,677	2,573	789	0
Surgery	4,524	2,821	3,158	-337	3,716	808	5,324	-800	5,221	103	0
CSCS	7,044	4,391	4,847	-455	7,302	-258	8,557	-1,513	7,918	639	0
Family Health	2,306	1,437	1,998	-561	2,183	123	2,363	-57	2,360	3	0
CEO	45	28	450	-422	601	-556	601	-556	601	0	0
Chief Nurses Team	893	556	264	292	367	526	601	291	601	0	0
Finance	733	457	595	-138	798	-65	862	-129	862	0	0
Medical Governance	62	38	10	29	13	49	58	3	58	0	0
Ops Management	382	280	225	55	299	83	316	66	316	0	0
DIS	601	374	221	153	296	304	607	-7	337	270	0
Workforce & OD	763	476	842	-367	991	-228	991	-228	991	0	0
YTHFM LLP	1,962	1,223	2,322	-1,099	2,837	-875	3,165	-1,203	2,965	200	0
Central	0	0	4,932	-4,932	4,900	-4,900	6,602	-6,602	6,602	0	0
	25,351	**15,847**	**21,837**	**-5,990**	**26,653**	**-1,301**	**33,408**	**-8,057**	**31,405**	**2,004**	**0**
Total Programme	**55,290**	**34,470**	**22,832**	**11,638**	**27,745**	**27,546**	**35,297**	**19,994**	**32,764**	**2,532**	**0**

Efficiency Programme

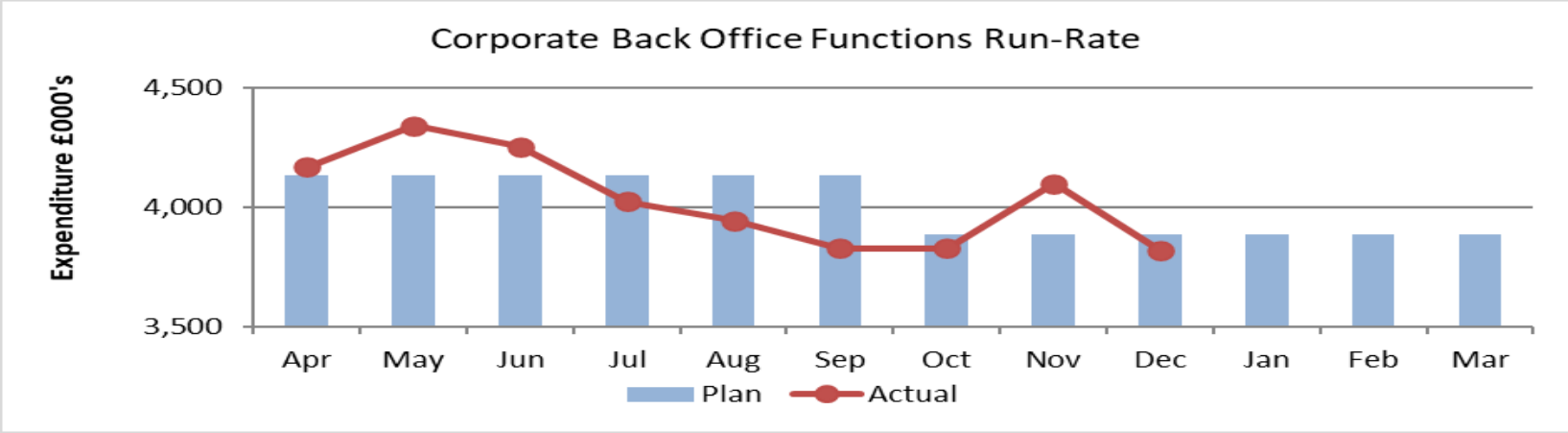
The total trust efficiency target is £55.3m; £27.7m has been achieved in full year terms and the year-to-date position is £11.6m behind plan. Identified plans total £35.3m, which matches the revised forecast year-end delivery of £35.3m (4% of operational expenditure). The gives a shortfall of £20m. The forecast delivery has been adjusted with key amendments as follows: reduced non-recurrent savings estimates (£8m), removal of agency reduction plans (£9.1m), and slippage in the implementation of the YTHFM model of delivery (£2.4m).

Corporate Efficiency Programme

The Corporate efficiency programme has a target of £29.9m and £1.1m has been delivered in full year terms. At the end of December, the year-to-date delivery is £17.6m behind plan. Identified plans total £1.9m, leaving a gap of £28.1m.

Core Efficiency Programme

The Core efficiency programme target is £25.4m and £26.7m has been delivered in full year terms. At the end of December, the year-to-date delivery is £6m over plan. There are identified plans totaling £33.4m which is £8.1m over the target.



The graph above demonstrates the Trust's progress towards achieving the target to reduce the growth in back-office function costs between 2018/19 and 2023/24, by 50%, effective from October 2025. The Trust's indicative full year target is a £5.4m cost reduction which the Trust has committed to deliver and schemes have been included in Corporate Directorate's CIP programmes phased between 2025/26 and 2026/27.

The return provided to NHSE on 31 May 2025 identified £2.4m of 'exceptions' that reduced the expected run rate savings in back-office functions to £3m. Run rate savings of £1.5m are expected to be delivered between October 2025 and March 2026 with the full £3m delivered in 2026/27.

The back-office function return is a detailed and complex analysis that is completed annually. NHSE have asked providers to calculate a proxy back-office cost each month and to demonstrate a downward trend in expenditure. The graph above demonstrates the calculated corporate back-office function monthly cost in April 2025 at £4.2m and the plan shows that this is expected to reduce by £250k per month from October (£1.5m by March 2026).

The calculated back-office costs for December is £3.8m. This is below the target monthly expenditure figure of £3.95m and meets the required run rate reduction.

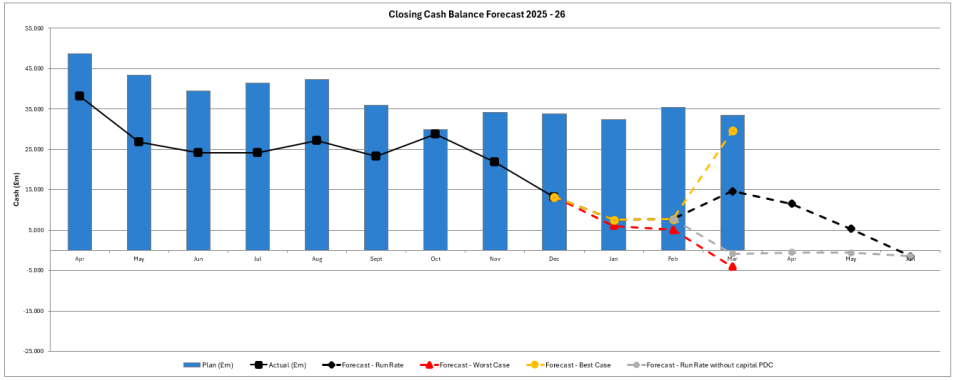
Current Cash Position and Better Payment Practice Code (BPPC)

Finance (11)

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Group's cash plan for 2025/26 is for the cash balance to reduce through the year resulting in a closing balance of £33.4m at the end of March 2026. The table below summarises the planned and actual month end cash balances.

Month 2	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	48,728	43,285	39,402	41,443	42,294	35,924	29,962	34,122	33,845	32,386	35,435	33,442
Actual	38,105	26,832	24,135	24,178	27,143	23,374	28,710	21,882	13,184			



Closing cash was £13.2m against a plan of £33.8m, which is £20.6m adverse. The variance from plan has increased from the M8 position. The significant factors contributing to the variance are:

- £11.5m – Adverse variance in I&E surplus / (deficit).
- £12.4m – Adverse variance due to non receipt of sparsity income and 24/25 ERF.
- £0.8m – Favourable cash impact of the capital program running behind plan.
- £2.5m – Favourable variance in other working capital movement timings.

The forecast contains 3 scenarios:

Run rate – Based on continuation of cash receipts & payment run rates in line with April to December levels and any known adjustments.

Best case – Based on the best-case scenario financial modelling.

Worst case – Based on the worst-case scenario financial modelling.

The scenarios are modelled to March. The graph extends the run rate forecast into Q1 to provide an indication of potential cash balances in the new financial year.

The closing March cash balance is heavily influenced by receipt of capital PDC funding drawn in line with NHSE deadlines where capital invoices are not anticipated to be due for payment until Q1. Currently there is £15m of funding in the March forecast for this timing issue, however this is reliant on the capital outturn position for project completion. Forecasts will be updated and monitored.

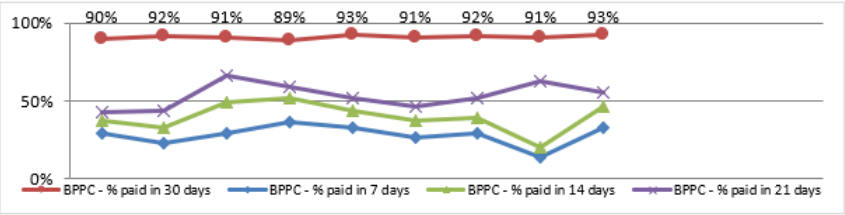
The grey line illustrates the run rate forecast adjusted for any unspent capital PDC each month. It is assumed that all capital PDC funded scheme invoices will be paid by June. This highlights potential pressure where cash support would be required.

This projection is heavily dependent on the outturn position for 25/26 and highlights the importance of the financial recovery actions to protect the cash position.

Better Payment Practice Code

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

The graph illustrates that in December the Group managed to pay 93% of its suppliers within 30 days.



Current and Forecast Capital Position

Finance (12)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Annual Plan £000s	FOT £000s	YTD Plan £000s	M9 Actual £000s	YTD Variance £000s
80,664	75,983	49,218	29,471	(19,747)

The M9 position is £19.7m adverse to plan.

This is mainly due to schemes running behind the plan profiles, including SGH RAAC £9m, SGH maternity roof replacement phase 1 £3m, York SCBU refurb £1.9m, the Electronic Patient Record scheme £1.9m, and backlog maintenance £1.1m. £3.1m is also due to IFRS 16 leasing behind plan, with a large value of leases currently in procurement.

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

The forecast outturn is now £76m due to the in-year changes below:

- £14m – Reduction due to Scarborough RAAC scheme reprofiled between financial years from £28m in the original plan to £14m for 25/26 expenditure.
- £9m – Additional national funded PDC schemes awarded in the year, including Net zero solar schemes of £3.3m, Modernising histopathology of £2m, Relocatable MRI of £2m & Critical Infrastructure Scheme of £1.4m.
- £0.3m – CDEL adjustment due to the sale of Clarence Street, which will not complete this FY.

Currently, the main risk schemes for delivery are:

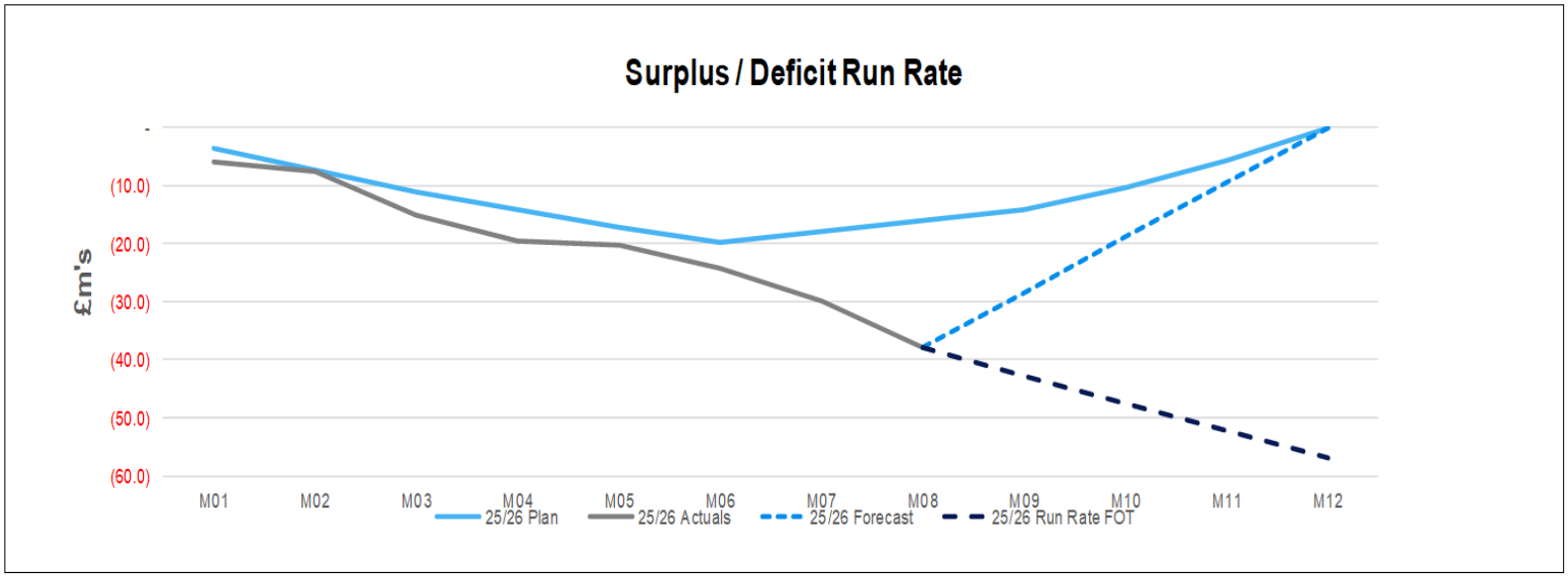
- SGH maternity roof & York SCBU schemes due to agreeing decant of the services and commencement of enabling works.
- Hybrid Theatre and PACU schemes are facing contractor timeline pressures.

2025/26 Capital Position	Annual Plan £000s	FOT £000s	YTD Plan £000s	M9 Actual £000s	Variance to Plan £000s
PDC Funded Schemes	56,525	51,519	34,161	18,561	(15,600)
IFRS 16 Lease Funded Schemes	7,838	7,838	4,718	1,558	(3,160)
Depreciation Funded Schemes	16,626	16,626	10,339	9,352	(987)
Charitable & Grant Funded Schemes	7,213	7,213	5,159	3,002	(2,157)
Total Capital	**88,202**	**83,196**	**54,377**	**32,473**	**(21,904)**
Less Charitable & Grant Funded Schemes	(7,213)	(7,213)	(5,159)	(3,002)	2,157
Less Sale of Clarence Street	(325)	-	-	-	-
Total Capital (Net CDEL)	**80,664**	**75,983**	**49,218**	**29,471**	**(19,747)**

M8 Position

- ICB £44k overspend YTD, FOT breakeven.
- Providers £22m overspend YTD, FOT breakeven.
- Straight line extrapolation of run rate is circa £57m deficit.
- YTD variance has deteriorated in providers by circa £10m mainly due to further slippage against efficiency schemes. Medical staffing and drugs and devices cost pressures continue.

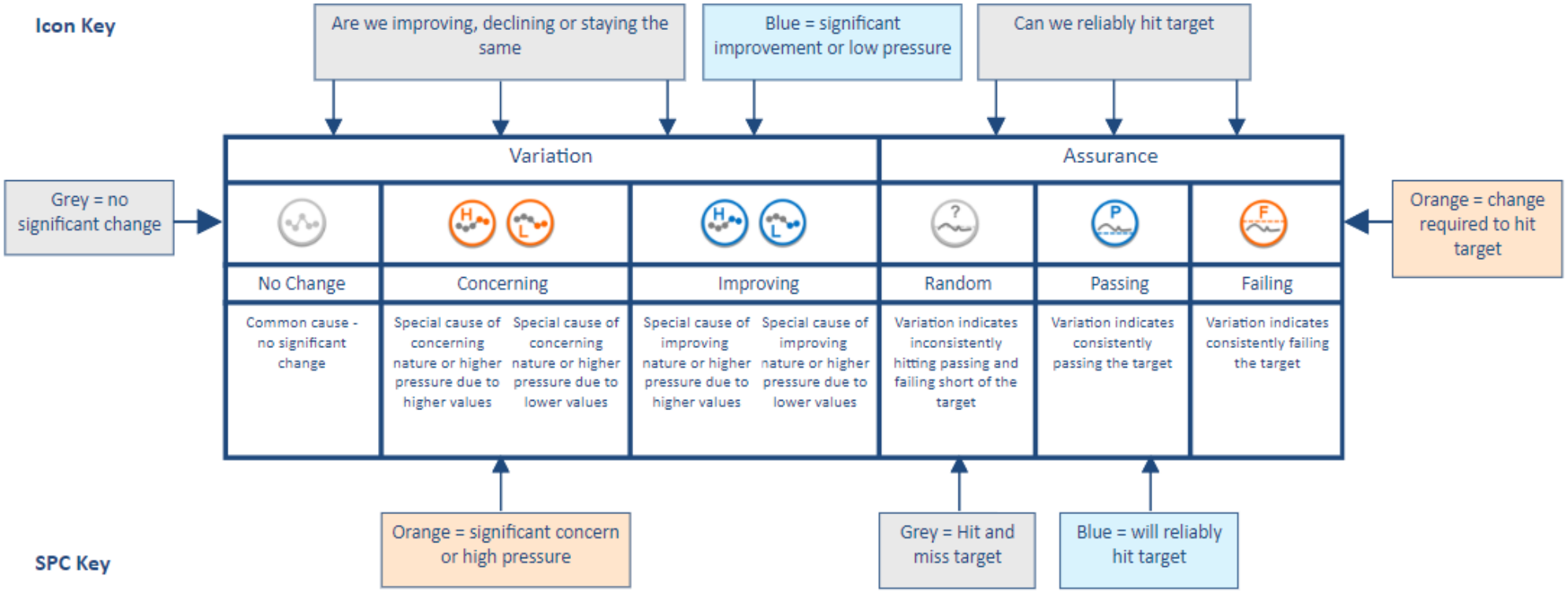
Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Variance Year Ending %
Humber And North Yorkshire ICB	-	(44)	(44)	(0.0%)	-	-	-	0.0%
Harrogate And District NHS Foundation Trust	(3,668)	(14,567)	(10,899)	(4.2%)	-	-	-	0.0%
Hull University Teaching Hospitals NHS Trust	(4,454)	(11,432)	(6,978)	(1.1%)	-	-	-	0.0%
Humber Teaching NHS Foundation Trust	(619)	2,382	3,001	1.7%	-	-	-	0.0%
Northern Lincolnshire And Goole NHS Foundation Trust	(6,412)	(7,356)	(944)	(0.2%)	-	-	-	0.0%
York And Scarborough Teaching Hospitals NHS Foundation Trust	(900)	(7,013)	(6,113)	(1.0%)	-	-	-	0.0%
ICS Total	(16,053)	(38,030)	(21,977)	(0.7%)	-	-	-	0.0%



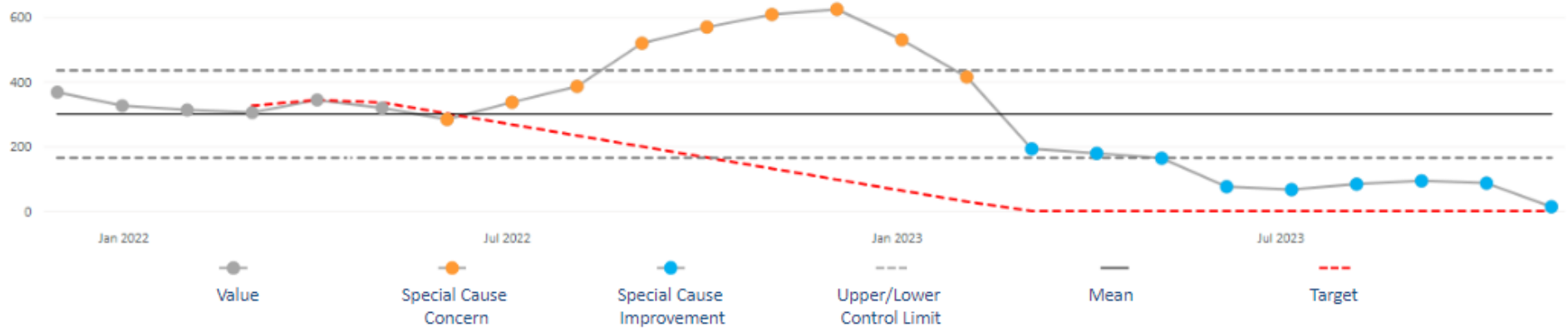
Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key



SPC Key



The orange and blue points indicate either increasing or decreasing trends. The colour will update if 7 points appear either above or below the mean or if 2 out of 3 are near the upper or lower control limit. The target can be either static or moving.

Icon Descriptions

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	Care Quality Commission (CQC) Update
Director Sponsor:	Dawn Parkes, Chief Nurse Adele Coulthard, Director of Quality, Improvement and Patient Safety
Author:	Emma Shippey, Head of Compliance and Assurance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

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

There was an unannounced CQC inspection of Urgent and Emergency Care and Medical Care Services at Scarborough Hospital between 7 and 9 October 2025. The draft report has yet to be received

As of 16 January 2026, there are 21 open CQC cases.
Recommendation: • Note the current position regarding the recent CQC inspection activity. • Note the current position of the open CQC cases
Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting) No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation
N/A		

CQC Update

1. CQC Activity

1.1 York Hospital Ionising Radiation (Medical Exposure) Regulations (IRMER) Inspection : Nuclear Medicine

The CQC will be onsite to inspect Nuclear Medicine at York Hospital on 28 January 2026 as part of their proactive Ionising Radiation (Medical Exposure) Regulations (IRMER) programme. This is scheduled to be a one day visit and two inspectors will be onsite.

Pre-inspection information was requested and this was submitted on time on 16 January 2026.

1.2 Scarborough Hospital Inspection (October 2025)

There was an unannounced CQC inspection of Urgent and Emergency Care and Medical Care Services at Scarborough Hospital between 7 and 9 October 2025. The draft report has yet to be received

1.3 York Inspection (January 2025)

In response to the CQC inspection report published on 2 July 2025, the CQC have asked for quarterly updates on progress with actions to be provided, the first of which was sent in November 2025.

Future updates will align to reporting through the Integrated Quality Improvement Group.

1.4 Section 31: Care and Assessment of Patients with Mental Health Needs in the Emergency Department

An application to remove the conditions is being drafted with approval through the Executive Committee planned for February 2026.

1.5 Ongoing CQC Engagement

Quarterly engagement meetings are scheduled with our CQC colleagues and a workplan for 2026 is being developed. The CQC have been invited to visit services (these not inspections) in April and October 2026. The services to be visited are being agreed.

2. CQC Cases / Enquiries

The CQC receive information from a variety of sources in relation to the quality of care provided at the Trust. This information can be related to known events, for example patient safety incidents (PSI's), formal complaints and Datix incidents, or unknown events, such as concerns submitted directly to the CQC from either patients, staff, members of the public, or other organisations. Following receipt of such information, the CQC share the concerns with the Trust for review, investigation, and response. The CQC monitor themes and trends of enquiries received, and these can inform inspection and other regulatory activity.

As of 16 January 2026, there are 21 open CQC cases. Of these:

- Five cases have had responses submitted, and we are awaiting feedback from the CQC.
- Ten cases are progressing, with either an approved complaint response or a Section 42 response to be submitted once finalised.
- Responses to the remaining six cases are being drafted.

The enquiry dashboard can be viewed in **Appendix A**.

3. CQC Updates

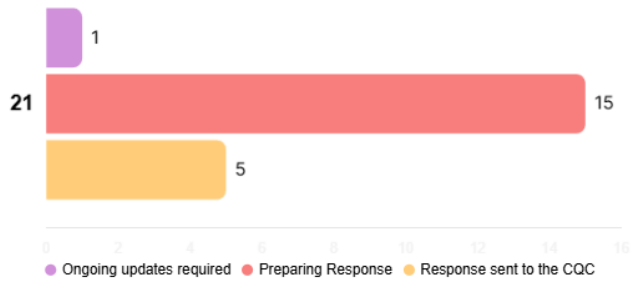
3.1 Progress during 2025

The CQC issued an update on their achievements during 2025 including a reduction in outstanding assessment reports, an increase in the number of completed assessments and further developing the assessment framework. Click here for more information.

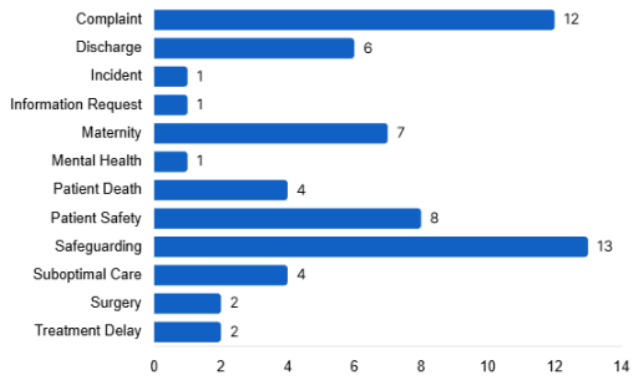
Date: 16 January 2026

Appendix A – CQC cases received over the last 12 months

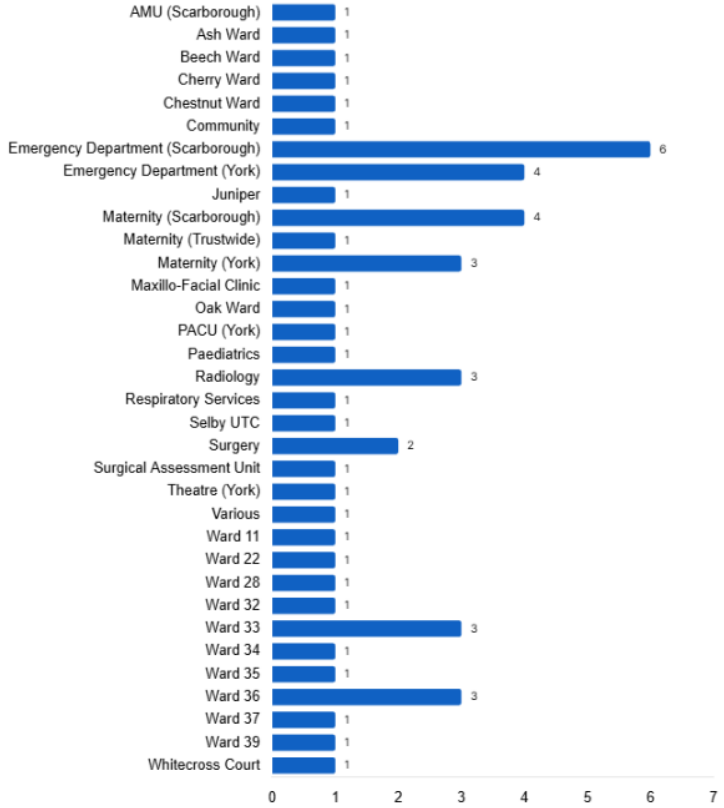
Number of Open CQC Enquiries / Cases



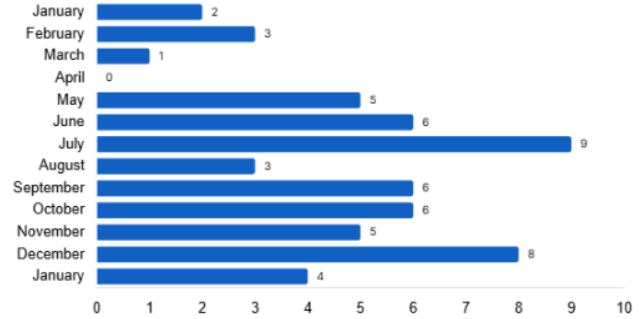
Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Number of Enquiries Received



Report to:	Trust Board of Directors
Date of Meeting:	28th January 2026
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Dawn Parkes Executive Chief Nurse (Executive Maternity and Neonatal Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midiwfery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

☒ 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)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team. The data shared is for the months of October and November.

Key Assurance

- The Trust perinatal mortality rate remains at 3.78/1000 births, this is around average for similar Trusts and remains within 5% mortality rate when compared with the group average.
- The Maternity Services continue to be on track for 6 out of 10 safety actions for Year 7 of the Maternity Incentive Scheme. We are now compliant with safety Action 4 that was previously reported as being at risk. For safety Action 1, a conversation has been had with NHS Resolution and mitigations will be submitted that is likely to see the safety action approved to be complaint. Which would see the trust position improve to 7/ 10 safety actions being fully compliant.
- The postpartum haemorrhage (PPH over 1500 mls) rate for October was 2.5% (8 cases) and in November was 3.8% (12 cases) based on the national data the trust is not an outlier for PPH rates however; a refreshed working group led by the lead Consultant Obstetrician for Governance is in place to review all previous actions taken to improve the position and align these actions across the trust and reflect recommendations by the MNSI report received by the trust in October relating to a cases in November 2024.
- Further recruitment for Midwives and Maternity support workers continues.

Key Risks

- There continues to be a risk that the estates structural issues at Scarborough's Maternity Unit may result in reduction of service provision if there is further significant water ingress over the coming winter months. A decision has now been made regarding the decant plan for the repair of the roof and clinical planning meetings will be commenced to ensure robust planning is in place when work commences. The start date will be March 26 with the first work being commenced in the Old Intensive care unit to move oak ward there.

- NHS England have launched a Maternal Care Bundle (MCB) with an implementation date end of March 2026. This is in response to the latest MBRRACE-UK data (2021 to 2023)

In the first version of the MCB, it establishes a baseline of best practice in 5 areas of care associated with higher rates of maternal mortality and morbidity. The 5 elements are:

- Element 1: Venous thromboembolism
- Element 2: Pre-hospital and acute care
- Element 3: Epilepsy in pregnancy
- Element 4: Maternal mental health
- Element 5: Obstetric haemorrhage

Key Concerns

- There is a concern related to the Maternity outcomes Safety Signal alerts following a level one safety alert being sent to the perinatal team in late December and that the system centrally is not working as it should. Alerts are being received third hand and therefore could cause a delay to the timely response required. This has been escalated to the regional and national teams.
- The Director of Midwifery continues to work with no Deputy Director of Midwifery or Deputy Head of Midwifery. The advert has now closed, and five potential candidates have been shortlisted for interview in early February.

Recommendation:

The Board is asked to receive the updates from the maternity and neonatal service.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting) No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

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

Meeting/Engagement	Date	Outcome/Recommendation
Quality Committee	17th November 2025	**1. To note the progress with recruitment of Midwifery staff versus the current roster Gap and the maternity and neonatal quality and safety metrics.** **2. To note the progress with the Maternity and neonatal single improvement plan (MNSIP)** **3. To note the ongoing risks for delivery of operational services and the MNSIP**

Introduction

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team.

The maternity and neonatal services continue to review and monitor improvements in key quality and safety metrics, and this paper provides the Trust Board with the performance metrics for the month of September 2025.

Annex 1 provides the current delivery position for the service against the core national safety metrics.

Perinatal Quality Surveillance Model

In line with the perinatal quality surveillance model, the service is required to report the information outlined in the data measures monthly to the Trust Board. Data is for the months of October and November 2025.

Perinatal Deaths

There was one stillbirth at 37 weeks gestation in October 2025 and one neonatal death at 23 weeks gestation in November 2025.

Maternity and Newborn Safety Investigations (MNSI)

Two reports were received, one in October 2025 which had key recommendations made in related to PPH. The report received in November 2025 had no safety recommendations or safety prompts made.

Patient Safety Incident Investigations (PSII)

There was no New PSII declared for the months of October or November 2025.

Moderate Harm Incidents and above

There were 23 moderate harm incidents reported over the months of October and November 2025, all were appropriately graded, and the increase is directly related in the increase in Post Partum Haemorrhage over 1500mls.

Maternity Unit diverts/ closures and suspension of services

In October and November 2025, the maternity units diverted three times in total. One divert occurred from Scarborough to York in October 2025 and 2 diverts to Scarborough form York in November 2025. No women were adversely affected, and this was to ensure ongoing safe care for all women and prevent delays in planned care, due to high acuity and staff sickness at short notice. Where any women are asked to attend another unit, their care is followed up by the Unit Manager in the postnatal period where appropriate to do so.

In October 2025 the homebirth service was suspended 23 times in Scarborough and 44 times in York, 2 women were affected meaning they had to attend the maternity unit for their birth.

Core Competency Training

Fetal monitoring training compliance remains above 90% for all staff groups. Training compliance for PROMPT has met the trajectory for 90% for all staff groups and has met the Maternity Incentive Scheme deadline of the 30th November. There is a plan in place to

support Obstetric and Anaesthetic staff groups to maintain >90% with training through the forthcoming year to continue to be monitored by the Consultant Leads for each speciality.

Service User Feedback

Women have described seeing multiple community midwives particularly in the postnatal period which has an impact on continuity of care and that they must repeat any concerns they have each time they are seen. Those women who have had the same midwife throughout describe the huge value that this brings them and leads to a better supportive relationship as well as consistency in information and advice. Other women have shared that the scheduling of antenatal appointments needs to be better streamlined to avoid them having multiple appointments on the same day in different sites. This is being addressed through the Antenatal Clinic improvement work, but will also link with community midwifery services to ensure they are streamlined in the provision for women.

Special Care Baby Unit Refurbishment on York Site

Work continues across the multi-disciplinary teams and neonatal and maternity services to plan safely for the decant of current services to their temporary space of Ward 12. Enabling works will be concluded by the 23rd of Jan with a deep clean to follow. It is anticipated the move to Ward 12 will occur by the end of January. The contractors are booked to commence work on the 2nd February.

Maternity Incentive Scheme

The service remains on track to achieve full compliance in 6/10 safety actions**.** For safety Action 1, a conversation has been had with NHS Resolution and mitigations will be submitted that is likely to see the safety action approved to be complaint. If this does occur this would see the trust position improve to 7/ 10 safety actions being fully compliant.

Midwifery Workforce

	November 2025
Establishment budget	150.39 WTE
Staff in post (band 5, band 6)	150.72 WTE (21.52WTEn 129.20WTE)
Maternity leave	9.20 WTE
Roster vacancy	8.87 WTE

October sickness and secondment totalled 11.18WTE. Sickness, maternity leave and supernumerary shifts in November created a roster vacancy of 22.67 WTE.
The second cohort of 7.5WTE Band 5s will commence their preceptorship in February (2.5WTE in Scarborough and 5WTE in York). A further 5 Band 5 midwives (5WTE) were appointed in December**,** 4WTE York and 1WTE Scarborough. Three of these will join the February cohort, one as soon as pre-employment check are complete.

Unregistered workforce (B3&4)
There is a vacancy rate of 11.99 WTE at York, and -0.13 WTE at Scarborough, totalling 11.86 WTE vacancy. 6 B3 Maternity Assistants and B4 Maternity Support Workers have been appointed (5.4WTE). 1.8WTE are allocated to the remaining 3.6WTE will work at York.

Improvement and Transformation in December

- The MDT has approved the rollout plan, implementation schedule, and communication strategy for the Personalised Care Plan.
- The personalised care plan order has been submitted to the print shop, and the Standard Operating Procedure has been prepared and shared with colleagues for feedback.
- Baby TV screens have been fitted at the Scarborough site on 3rd December 2025
- Maternity Services bespoke service user survey has been finalised and inputted into Microsoft forms ready for roll out in February 2026 alongside the personalised care plan
- Perinatal Pelvic Health Service admin role has commenced in post on 1st December enabling the service to fulfil the national service specification requirements
- Band 3 & 4 uplift process underway. The task lists for both bands have been approved at maternity directorate and circulated to Managers to display in clinical areas and to all midwives and MAs/MSWs.
- PMA roster commenced in December
- Shortlisting and interviews for newly qualified midwives and MSWs took place
- Options appraisal for Scarborough Neonatal outreach service developed. The current service is only provided in York and is therefore an inequitable service offer.
- 6-month post-implementation review of the PPH action plan took place. Assessment reviewed all completed actions to evidence if they are embedded and we are seeing sustained improvements
- Communications for NEWTT2 training e-learning programme to be drafted and shared with colleagues
- NEWTT2 guideline reviewed and approved at the guideline and audit group in December 2025
- Content for the communications progress of the culture score action plan communications to staff to feedback on progress made against the culture score action plan and agree the 5 methods of communication with staff
- Neonatal BadgerNet post implementation review document was co-produced with neonatal and digital staff including lessons learnt.
- Telephone triage review meeting held and reporting channels confirmed for moving monitoring into business as usual
- High-level capacity and demand model for outpatient obstetrics has been developed for SLT review
- Lone worker policy guideline and SOP drafted and circulated for comments
- Business case to purchase 5 CTG machines approved at executive committee
- Annual planning for 2026/27 equipment requests agreed with clinical and medical teams and submitted on 18th December
- A bid was submitted to NHS England to use external funding to support completion of estates work and purchase equipment by 31 March 2026. This bid was co-produced with Maternity, Neonatal and Estates.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

December 2025 position:

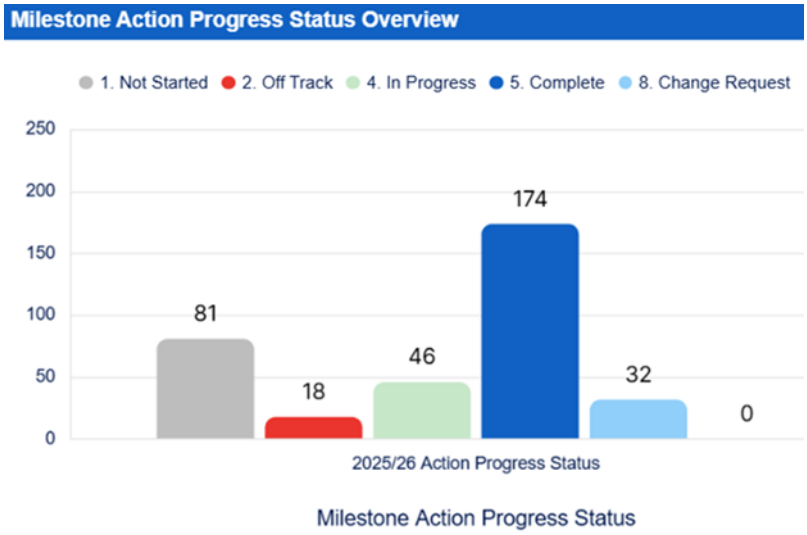
174 out of the 351 milestone actions have been completed to date (8 actions completed in December)
46 milestone actions are in progress
18 milestone actions are off track as the delivery date has passed, and the action has not been completed

1 milestone action's delivery is interdependent with a trust wide project timeline

17 milestone actions are off track but are due to deliver by 28th February 2026

32 out of 351 milestone actions have been identified for review and will require a change request submission through our programme governance, following the Maternity and Neonatal Single Improvement Plan Scrutiny Session held in October 2025. The overarching high-level action and ambition for these actions remains unchanged, the milestone actions require revision as they were established over two years ago after our initial engagement session and no longer reflect the current work underway to achieve the high-level action. The change requests for these actions will be submitted to the Maternity and Neonatal Single Improvement Plan Oversight Group in February for discussion and decision.

81 milestone actions are not scheduled to start yet



Key Risks to Delivery of the Single Improvement Plan

The risks to delivery of the MNSIP remain the same from last month's report.

1. A midwifery staffing gap has been identified following the midwifery workforce review and BirthRate+ findings in 2024. There is a risk that staff will not have capacity to continue to support developing and implementing the Maternity and Neonatal Single Improvement Plan. This will result in high-level and milestone actions going off track and will also result in non-compliance with national reporting requirements (MIS/SBLV3). 2025/26 prioritisation and delivery dates have been aligned to focus resource on delivery of the priority 1 actions. However, delivery dates were agreed as part of the speciality clinical strategy and annual planning process with the anticipation that investment would be received in April 2025/26 to support increasing the midwifery staffing establishment in line with BirthRate+ report (2024). At the July 2025 Public Trust Board, it was agreed to fund the midwifery staffing gap in a phased approach over the next three years with this year being year one. However, the likelihood of actions going off track remains high due to the timeline gap/lag in planned vs actual investment.
2. There is a risk that the additional workforce reviews underway will result in gaps being identified in the other staffing establishments (Obstetrics, Neonatal, Operational and Admin establishments). If additional workforce gaps are identified, it may result in non-compliance with national staffing standards such as BAPM. Workforce reviews and recommendations are being conducted in line with national best practice standards and initial findings will be shared with the Senior

Responsible Owners to escalate to the Trust Senior Leadership Team and agree appropriate action if applicable. A review of the frontline neonatal nursing workforce at York and Scarborough has identified a shortfall of £1,500,000 recurrently to align the services to national safe staffing requirements. Further reviews are scheduled. Obstetric reviews and operational reviews are scheduled to conclude in 2025/26, and findings will be presented to the Maternity Directorate.

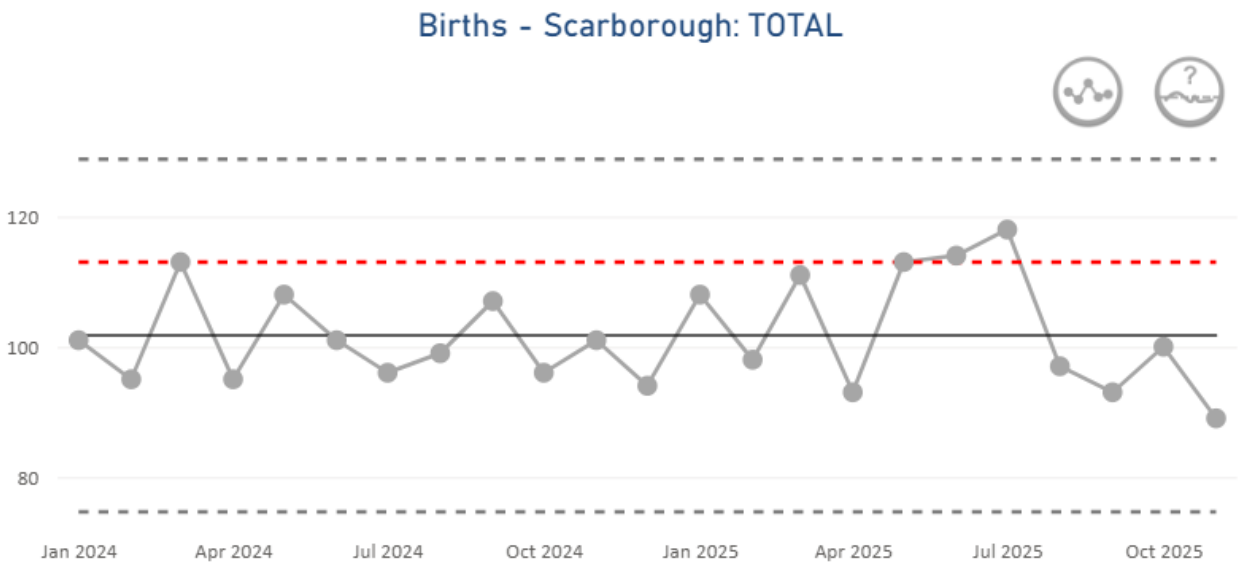
3. There is a risk that the Quality and Patient Safety Framework cannot be fully embedded due to gaps identified in the Maternity Quality and Safety Governance Team establishment. The staffing requirements to support full implementation are outlined within the Midwifery Business Case submitted to Board of Directors in 2024; The Maternity Incentive Scheme 2025/26 non-recurrent funding will be used to support creation of some critical roles in 2025/26 (Audit Midwife, Lead PMA and ATTAIN and PMRT Midwife) these will then be funded recurrently from 2026/27 onwards. Remaining roles to support embedding the quality and patient safety agenda will be recruited in 2026/27 onwards. The timescales to support the national Quality Agenda remains challenged and has an ongoing impact to patient safety.
4. There is a risk that the estates structural issues at Scarborough's Maternity Unit may result in delays to the overall progress of the Single Improvement Plan. To ensure standardisation across the service and reduce clinical variation, improvement changes must be applied to both sites. The process of where services will be provided during the repairs are still in development and not finalised though will involve staff and service users before any final decisions are made. It is anticipated there will be a reduction in ability to support continued delivery of the improvement plan should the service require decanting.
5. There is a risk the equipment requirements outlined in the 2025/26 Capital Prioritisation plan for maternity and neonates may not be progressed. Funding for equipment and minor works has been allocated to the Family Health Care Group. The General Manager and Transformation Lead Midwife are overseeing the completion of the required MERGs. Once equipment is in place, risk can be reduced.
6. The programme team have been assigned to take on the oversight and delivery of an additional programme of work within the organisation from May 2025. There is a risk that this may impact the programme team's ability to support maternity and neonatal teams to deliver the improvement action plans in line with the 2025/26 delivery dates. The programme team are monitoring the impact of the additional programme of work and will escalate any issues accordingly.

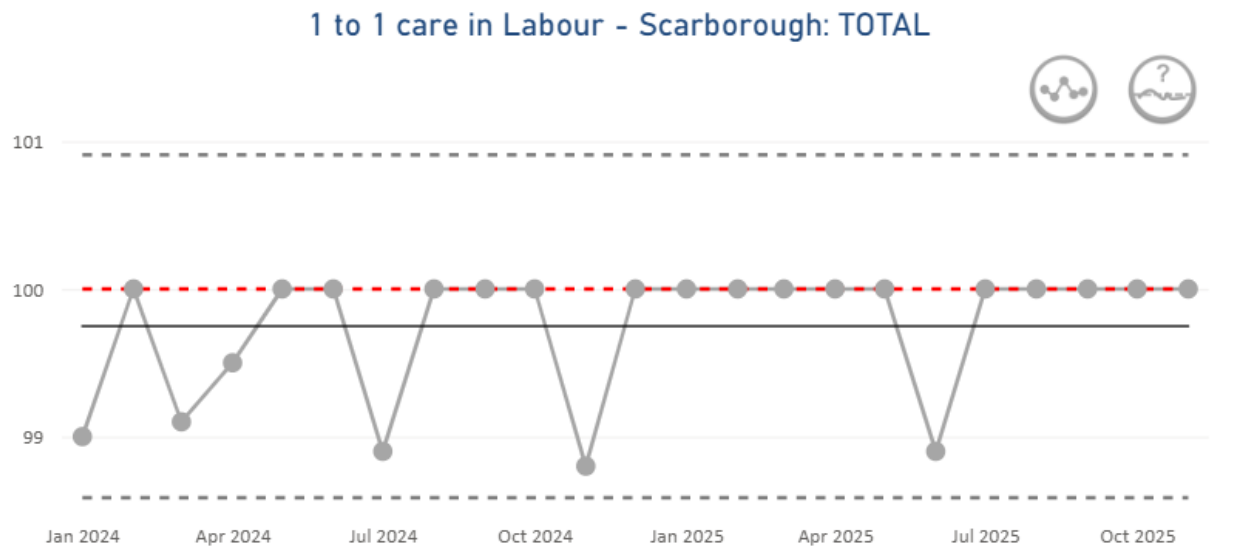
Recommendations to Trust Board

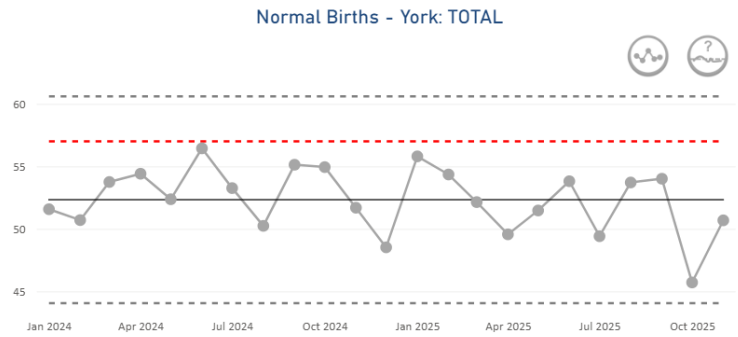
To note the contents of this report

Date: 28th January 2026

Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery October and November 2025






Normal Births - York: TOTAL
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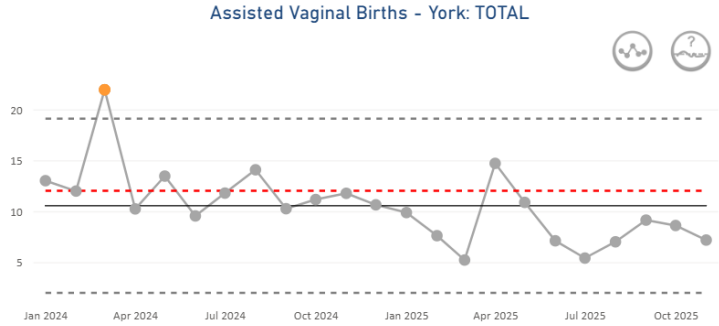
50
45
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025


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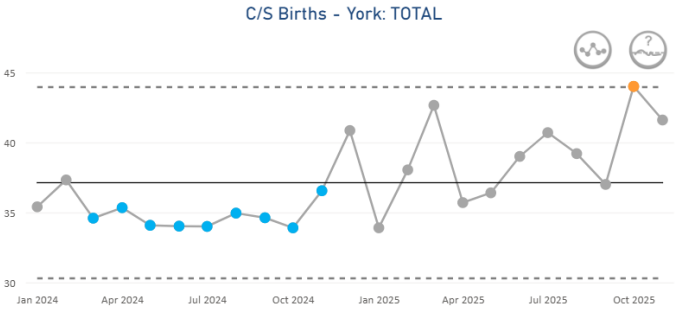
15
10
5
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025


C/S Births - York: TOTAL
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35
30
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
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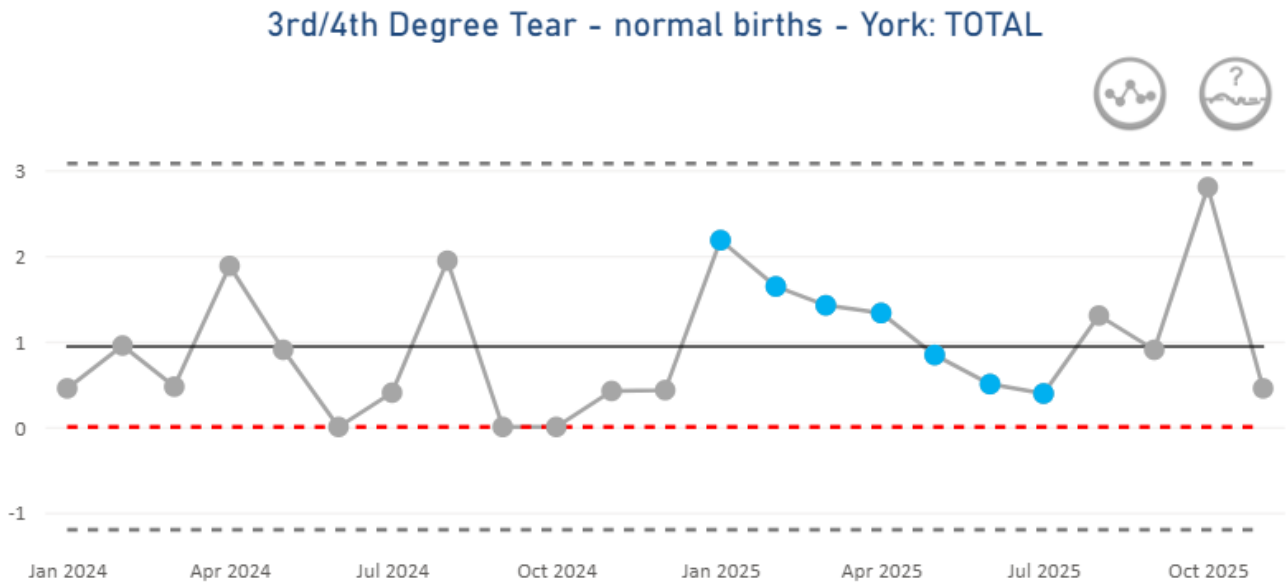
3rd/4th Degree Tear - normal births - York: TOTAL
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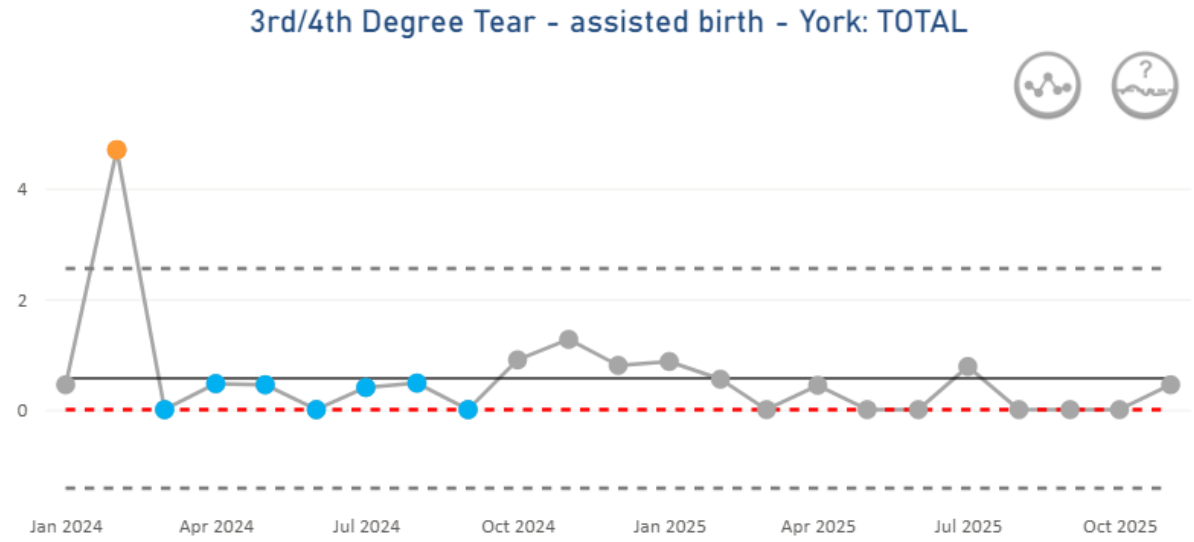
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025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Jan 2025
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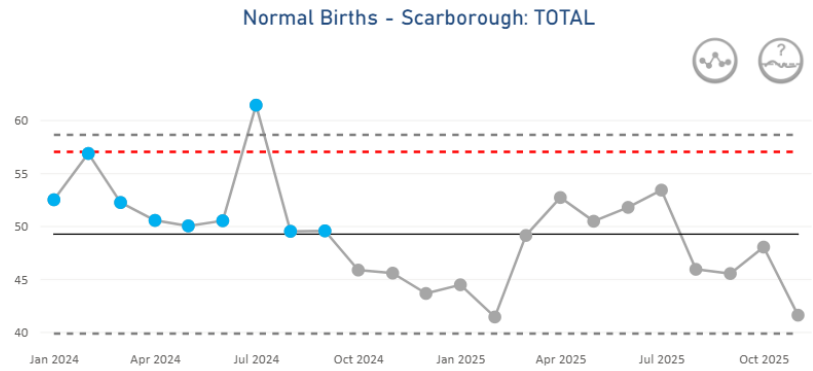
Normal Births - Scarborough: TOTAL
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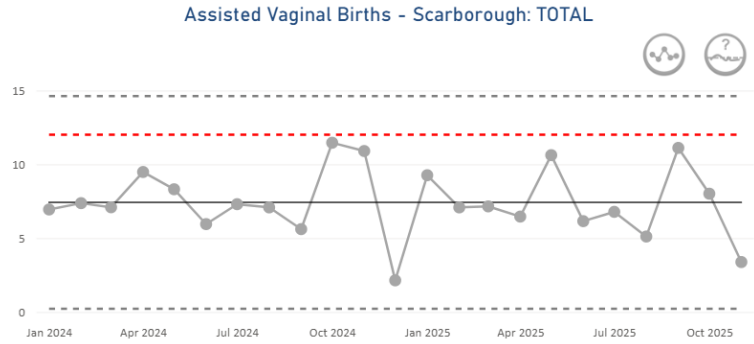
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025


Assisted Vaginal Births - Scarborough: TOTAL
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Jan 2024
Apr 2024
Jul 2024
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Jan 2025
Apr 2025
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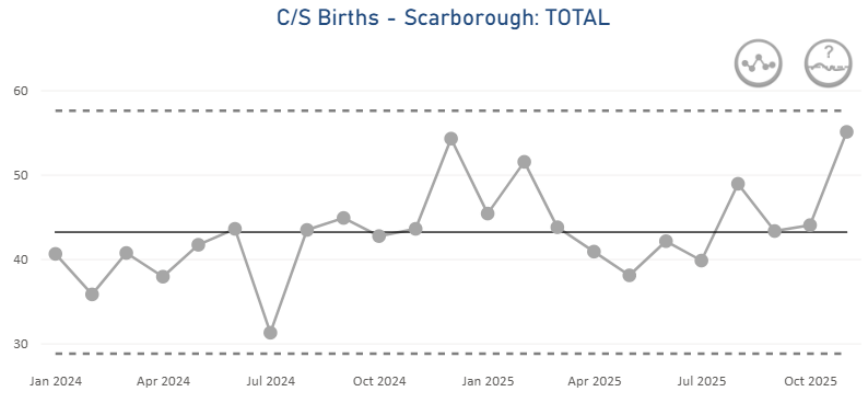
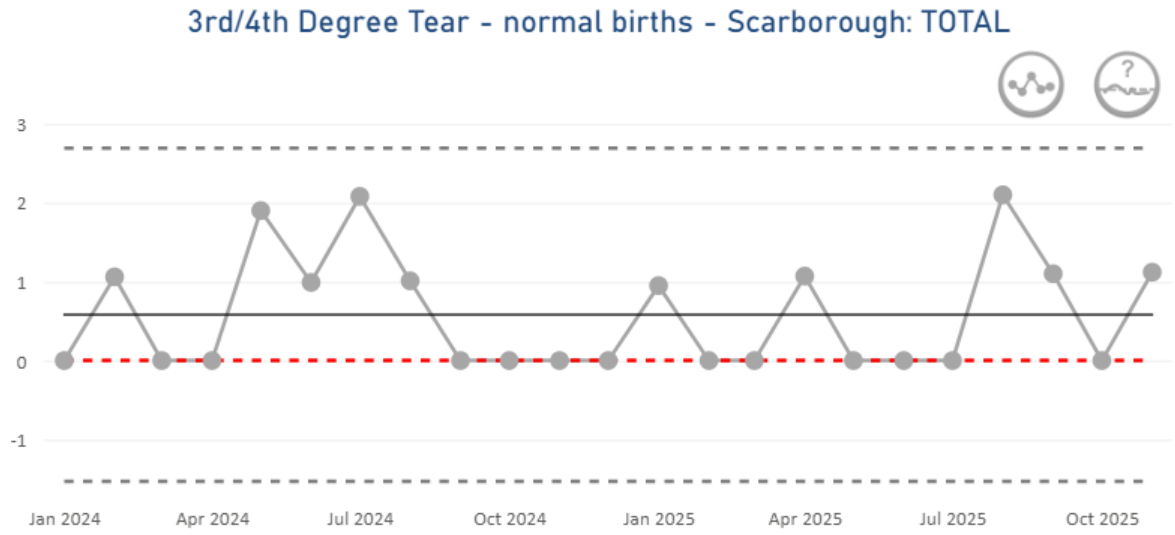
Oct 2025


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


3rd/4th Degree Tear - normal births - Scarborough: TOTAL
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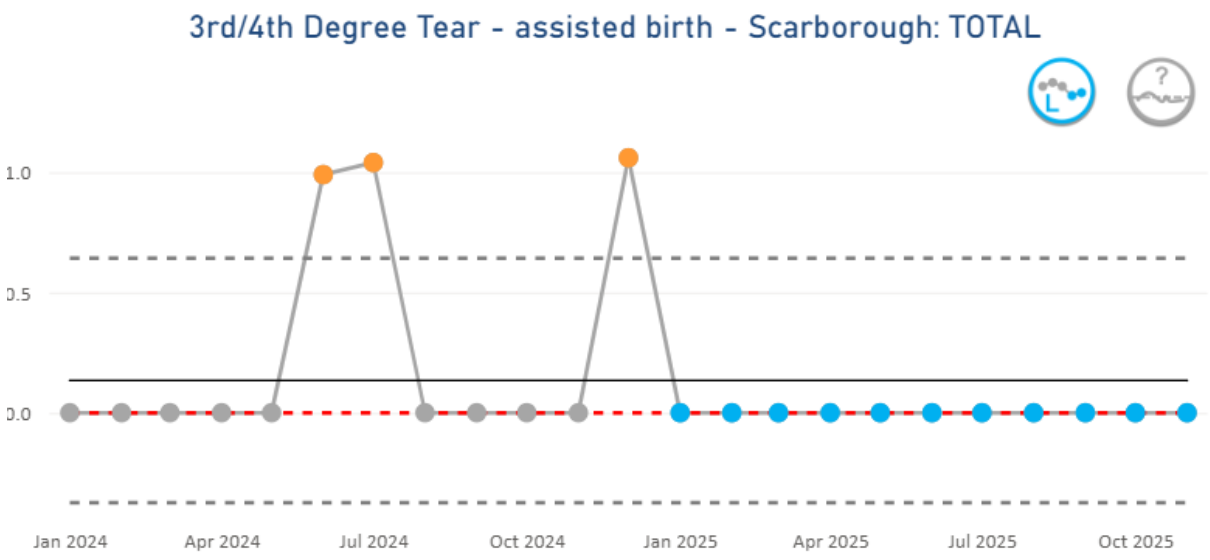
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025


3rd/4th Degree Tear - assisted birth - Scarborough: TOTAL
1.0
0.5
0.0
Jan 2024
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025

Item 15.2

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	Maternity Safety Champions Annual Report Summary
Director Sponsor:	Dawn Parkes, Chief Nurse & Executive Maternity & Neonatal Safety Champion Dr Lorraine Boyd, Non-Executive Maternity Safety Champion
Author:	Sascha Wells-Munro, Director of Midwifery and Strategic Clinical lead for Family Health, Maternity Safety Chamion

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:
The report provides the Trust Board with a summary oversight of the key actions taken and completed by the Maternity Safety Champions in response to safety concerns raised or identified across the year from April 2025. It also provides the key themes of concerns articulated by staff or improvements that have been made and the impact of these identified through the safety walkabouts on both sites.

Recommendation:

- The Trust Board is asked to receive and review the contents of this summary report.

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation
Quality Committee	20 January 2026	

Maternity Safety Champions Annual Summary Report

Background and Context

Safer Maternity and Neonatal Care (2016 and 2017) made the case for strong leaders at every level of the system, working across regional, organisational, or service boundaries to provide the professional cultures needed to deliver better care. Safer Maternity and Neonatal Care set out the need for a Board Level Maternity and Neonatal Safety Champion to ensure a board level focus on improving safety and outcomes as part of improving maternity and neonatal services as well as service level champions. They are jointly responsible for championing maternity and neonatal safety locally, making appropriate links with the Trust Board and Local Maternity & Neonatal System (LMNS). Strong cohesive relationships at the frontline between all those leading maternity and neonatal safety initiatives will enable insights from local intelligence coupled with recommendations from national reports to form the basis on which safety improvements are made locally, regionally and through our LMNS. The aim as outlined in the maternity and neonatal and neonatal three-year plan (NHSE 2023) is to make care safer, more personalised and more equitable. Safety Champions play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice. NHS England has developed the Maternity and Neonatal Champions toolkit to support staff in this role.

This section will outline the maternity and neonatal safety champions pathway within the maternity and neonatal quality and safety framework and their respective lead roles and responsibility, see Appendix 1.

Maternity and Neonatal Safety Champions Roles and Responsibility.
The role of the maternity and neonatal provider safety champions is to support the regional and national maternity and neonatal safety champions as local representatives for delivering safer outcomes for pregnant women and babies. They provide visible organisational leadership to the wider maternity and neonatal team working to deliver safe, personalised maternity and neonatal care. They develop strong partnerships, can promote the professional cultures needed to deliver better care and play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.

Current position

The Maternity and Neonatal Safety Champions meetings were formally established in February 2025 in line with the national framework set out by NHS England.
From 1 April to 31 December, there have been nine formal meetings and nine safety walkabouts on each acute maternity service site.

The Maternity and Neonatal safety champions are:

Safety concerns identified and actions taken

Over the last nine months, the safety champions have pursued eight safety concerns that could have impacted negatively for women and families but also staff. Where a safety concern was identified, clear action was identified and support provided to the service to make the changes and improvements required to address the issues efficiently and effectively.

Top three themes to the safety concerns were

- Reduction in workforce to support safe clinical care, due to high levels of long-term sickness and maternity leave across both sites
- Women not receiving pain relief when requested
- Delays to essential equipment being received following allocation of funds to purchase.

These three themes link with those identified in formal complaints, After Action Reviews and patient safety responses. The safety champions have supported the maternity and neonatal services to identify the required leaning and actions within the overarching maternity and neonatal single improvement plan, of which progress is reported to the group monthly.

Maternity safety walkabouts

Safety walkabouts are undertaken monthly on each site and are completed by the Executive and Non-Executive safety champions along with the Maternity and or Obstetric and neonatal champions where possible. The purpose is to meet with frontline clinical staff across all aspects of the service including community midwifery to understand from staff how they feel regarding safe maternity care, the opportunity for them to raise any safety concerns directly, to share how it feels to work in the organisation and if any improvements have been made since the last walkabout for them.

The top three themes for staff were

- Workforce and staffing issues both in the acute and community services
- Environmental issues on both sites
- Lack of space to provide community midwifery clinics as being removed by GP surgeries.

Staff were able to articulate the impact these issues had for women and families and how this prevented being able to consistently provide high quality safe maternity care as well as being demoralising for them as workforce, particularly in relation to the poor estate and environment of both sites, feeling embarrassed about how it looks to women particularly in relation to the roof issues at the Scarborough site. All issues have been escalated to the Quality Committee, and the safety champions have ensured that the Board are well sighted, and actions and improvements to address the issues are supported and agreed.

In the months from October, staff started to articulate that things were feeling better that there was a significant improvement from three years ago and that staff now feel supported particularly when there has been a significant clinical incident which would never have happened previously. They welcomed the news of the investment and look forward to supporting the newly qualified midwives along with the Professional midwifery advocates to support their transition from student to qualified midwife.

Next steps

Over the next year, the maternity safety champions will undertake a review of the Terms of Reference to ensure they reflect current priorities for the safety of maternity services to include the oversight and review of the Maternity Outcomes safety signal alerts in line with the national standard operating procedure. To have oversight of the Regional Heatmap Dashboard and identify any emerging safety concerns that with appropriate action can be addressed proactively. The group will continue to have oversight of all learning and themes from key reports and investigations to ensure they are implemented and that shared learning is disseminated to improve and support a positive safety culture across Maternity and Neonatal services.

Item 15.3

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	Bi-annual Maternity, Obstetric, Anaesthetic and Neonatal Workforce Report April – June 2025 Q1 July – September 2025 Q2
Director Sponsor:	Dawn Parkes, Chief Nurse & Executive Maternity and Neonatal Safety Champion
Author:	Sascha Wells-Munro – Director of Midwifery Gill Locking – Cross-site Outpatient Matron Stephanie Carrol – Cross-site Workforce and Retention Lead Midwife James Wright – Consultant Anaesthetist Medhat Ezzat – Cross-site Neonatal Lead Sunny Sandhu – Neonatal Consultant - York Katie Mortimer – Cross-site Neonatal Matron Gail Lindley – Neonatal Ward Manager - York Jen Robinson – Neonatal Ward Manager - Scarborough Georgina Rowe – Cross-site Project manager

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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☒ 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	Implications for Equality, Diversity and Inclusion (EDI) *(please document in report)*
☒ Effective Clinical Pathways ☒ Trust Culture ☒ Partnerships ☒ Transformative Services ☐ Sustainability Green Plan ☒ Financial Balance ☒ Effective Governance	☐ Yes ☒ No ☐ Not Applicable

Executive Summary:

This report provides a full review of all measures in place to delivery of safe Midwifery, Obstetrics, Obstetric Anaesthesia, Neonatal Medical and Nursing workforces using the national recognised workforce metrics.

The report provides a workforce position against national best practice requirements and standards identifying actions required to be fully compliant and mitigations in place to maintain safe services until compliance is achieved

Recommendation:

The Board is asked to note the contents of the report and formally record to the Board minutes non-compliance with minimum safe staffing levels for midwifery, neonatal nurse and medical staffing and agree to the actions required to meet full compliance.

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation
Quality Committee	20 January 2026	

Bi-annual Midwifery, Maternity and Neonatal Staffing Report
April – June 2025 Q1 and July – September 2025 Q2

1. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements (2016).

Organisational requirements for safe midwifery staffing for maternity settings (NICE, 2015) state midwifery establishments must develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Midwifery staffing data has previously been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics.

2. Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator (LWC), one to one care in labour and red flag incidents.

It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 7.

An action plan has been developed however it is recognised an increase in staff is necessary as per the Midwifery Workforce Business Case.

2.1 Safe staffing maternity indicators

Indicators are events that should be considered when reviewing the midwifery staffing establishment and should be agreed locally.

Outcome measures reported by women in maternity services (as suggested by CQC Maternity Services Survey)

- Adequacy of communication with the midwifery team.
- Adequacy of meeting the mother's needs during labour and birth.
- Adequacy of meeting the mother's needs for breastfeeding support.
- Adequacy of meeting the mother's postnatal needs (postnatal depression and post-traumatic stress disorder) and being seen during the postnatal period by the midwifery team.

Outcome measures

- Booking appointment within 13 weeks of pregnancy (or sooner): record whether booking appointments take place within 13 weeks of pregnancy (or sooner). If the appointment is after 13 weeks of pregnancy the reason should also be recorded, in accordance with NHS Digital's Maternity Services Data Set.
- Breastfeeding: local rates of breastfeeding initiation can be collected using NHS England's Maternity and Breastfeeding data return.

- Antenatal and postnatal admissions, and readmissions within 28 days: record antenatal and postnatal admission and readmission details including discharge date. Data can be collected from NHS Digital's Maternity Services Data Set.
- Incidence of genital tract trauma during the labour and delivery episode, including tears and episiotomy. Data can be collected from the NHS Digital's Maternity Services Data Set.
- Birth place of choice: record of birth setting on site code of intended place of delivery, planned versus actual. Data can be collected from the NHS Digital's Maternity Services Data Set.

Staff-reported measures (as indicated in NHS staff survey)

- Missed breaks: record the proportion of expected breaks that were unable to be taken by midwifery staff.
- Midwife overtime work: record the proportion of midwifery staff working extra hours (both paid and unpaid).
- Midwifery sickness: record the proportion of midwifery staff's unplanned absence.
- Staff morale: record the proportion of midwifery staff's job satisfaction.

Midwifery staff establishment measures

Data can be collected for some of the following indicators from the NHS England and Care Quality Commission joint guidance to NHS trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels and more detailed data collection advice since provided by NHS England.

- Planned, required and available midwifery staff for each shift: record the total midwife hours for each shift that were planned in advance, were deemed to be required on the day of the shift, and that were actually available.

3. Birthrate Plus Workforce Planning

A formal Birth Rate Plus assessment was completed in March 2024, which reviewed the acuity of women who use maternity services at York and Scarborough Teaching Hospitals Foundation Trust. The final report was received in June 2024 and highlighted a deficit in the funded establishment of 43.64 WTE midwives. Funding has been approved for this deficit and will be allocated in a phased approach over three years with year one being 2025/26 through to 2027/28 increasing clinical frontline establishments, headroom and creation of essential specialist roles.

3.1 Vacancy rates

3.11 Registered Workforce

Registered Workforce	Sum of WTE Budget	Sum of WTE Actual	Maternity Leave WTE	Sickness/Supernumerary WTE	NET	Birth rate plus recommended WTE	Variance WTE (Actual v BR+)
Registered Midwives	173.98	169.9	10.48	10.60	148.82	205.58	-56.76
Specialists	9.55	12.55	1.88	1.20	9.47		
Midwifery Management	21.1	18.2	1.8	0.8	15.6	32.89	-7.82
	204.63	200.65			173.89	238.47	-64.58

Table 1. Registered maternity workforce overview (Data source: Finance)There are 8.47 WTE newly qualified midwives who will join the Trust in February 2026.

This will not reduce the roster vacancy immediately due to the preceptorship programme which allows supernumerary time in each area before incorporation into the roster, anticipated in 12 months' time.

The establishment for Specialist midwives is spread across a range of band 6 and 7 midwives, 3 and 5 admin, clerical and support staff, and 7 and 8a senior managers. There is a roster vacancy for 0.4 WTE band 6 (perinatal mental health and clinical skills) and 0.4 WTE band 5 admin and clerical (governance and maternity leadership support – temporarily).

Senior Leadership team has experienced significant turnover in Q1 & Q2, resulting in commencement of 4 new matrons. Currently the Deputy Director of Midwifery remains vacant, the recruitment process has commenced with interviews planned for the 3rd and 4th of February 2026. The Deputy Head of Midwifery remains off on long term sickness, impacting the workload of the Leadership team, resulting in challenges in operational delivery of services the extensive maternity quality and safety agenda as well the timelines within the single improvement plan.

3.12 Unregistered Workforce

Unregistered Workforce	Sum of WTE Budget	Sum of WTE Actual	Variance (Budget v Actual)
York	**28.51**	**14.02**	**-14.49**
SGH	**17.59**	**15.10**	**-2.49**
	46.10	**29.12**	**-16.98**

Table 2. Unregistered midwifery workforce overview. (Data source: Finance)

In line with BR+ the registered to unregistered ratio should be 90% registered and 10% unregistered. With consideration of the large geographical distance and smaller size of Scarborough site of the service, the percentages, when recruited will be higher than the recommended BR+ ratios which will further support safety in the service.

Recruitment to the vacancy commenced in December. The impact of this vacancy is noted daily operationally, resulting in inconsistency of delivery of key services such as maternity triage. This is reflected in the ongoing sickness rates, the staff survey results and feedback from the culture survey engagement day feedback.

4. Sickness absence, Maternity Leave and Planned Versus Actual Midwifery Staffing Levels

Headroom remains 20%, with 0% headroom for all specialist midwifery teams and the Community midwifery team covering Scarborough and the East coast. There has been agreement from the trust board to increase the headroom across all maternity services to 24%, reflecting the national position and the increasing mandatory training requirements. This will be phased in as per appendix 1, with clinical teams increasing to 24% in April 2026, and specialist midwives in March 2027 due to the phased approach to financial investment into maternity workforce.

4.1 Sickness

Month	Sickness %	Registered	Unregistered	A&C
April	6.21%	3.82%	15.44%	7.85%

May	6.03%	4.29%	13.06%	7.15%
June	7.07%	5.70%	12.73%	8.17%
July	7.34%	6.96%	9.00%	7.82%
August	5.75%	5.14%	7.60%	6.87%
September	5.69%	5.21%	9.41%	4.77%
Total	6.35%	5.19%	11.21%	7.11%

Table 3. York and Scarborough Maternity workforce sickness and absence (Data Source: HR / Healthroster)

Data shows the top three reasons for sickness are Anxiety, Other – not elsewhere classified and Cold/ Flu. This remains consistent from findings in Q3 & Q4 and reflective of the wider trust. Engagement has commenced with the psychological wellbeing team alongside the proposed introduction of increased PMA presence on site for staff to access.

The trust target for sickness levels remains at 4.3%, with a view to adopt the proposed National reduction to 4.1% by 2035. To achieve this, regular workforce meetings will be established with the engagement of HR, finance, PMA and union where required. A workforce panel for review and agreement of flexible working requests has been established in Q2, providing staff with equity in decision making to support their work life balance, thus, reducing potential carers leave or sickness absence.

4.2 Maternity Leave

Site	Maternity	Registered	Unregistered
SGH	12.39%	5.42%	6.97%
YH	6.35%	6.35%	0.00%

Table 4. York and Scarborough Maternity Leave overview (Data Source: Healthroster)

Parenting leave remains high on Scarborough site particularly. Recruitment has been agreed to replace at 100% of working time. This is included in the vacancy rate with a rolling advert to capture any applications.

4.3 Bank and Agency

Bank and Agency Staffing Overview

Recruitment challenges persist, with ongoing vacancies, increased sickness rates, and a rise in maternity leave levels. The implementation of a comprehensive 12–18-month preceptorship programme further impacts workforce availability. As a result, the use of Bank and Agency staff continues across both sites to maintain safe staffing levels.
To address these staffing needs, unfilled shifts are promptly sent to both agency and bank staff, ensuring that staffing levels are optimised as early as possible.

Registered Unfilled Shifts

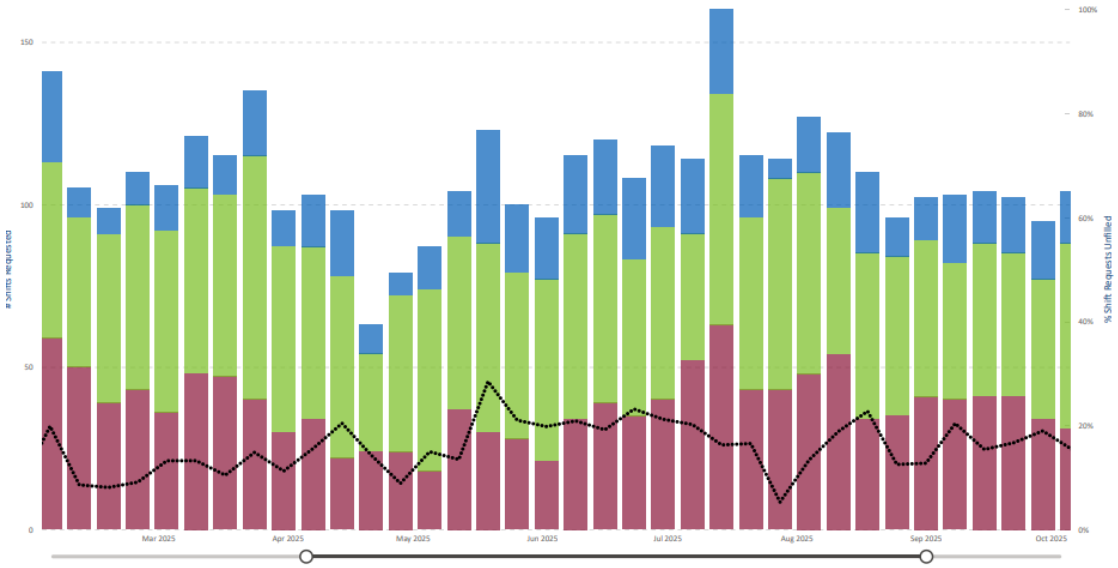


Table 5. York and Scarborough Registered Unfilled Shifts (Data Source: Power BI)

Open in Power BI

Filled/Unfilled (Bank/Agency) Filled - Agency Filled - Bank Unfilled % Shift Requests Unfilled

Non-Registered Unfilled Shifts

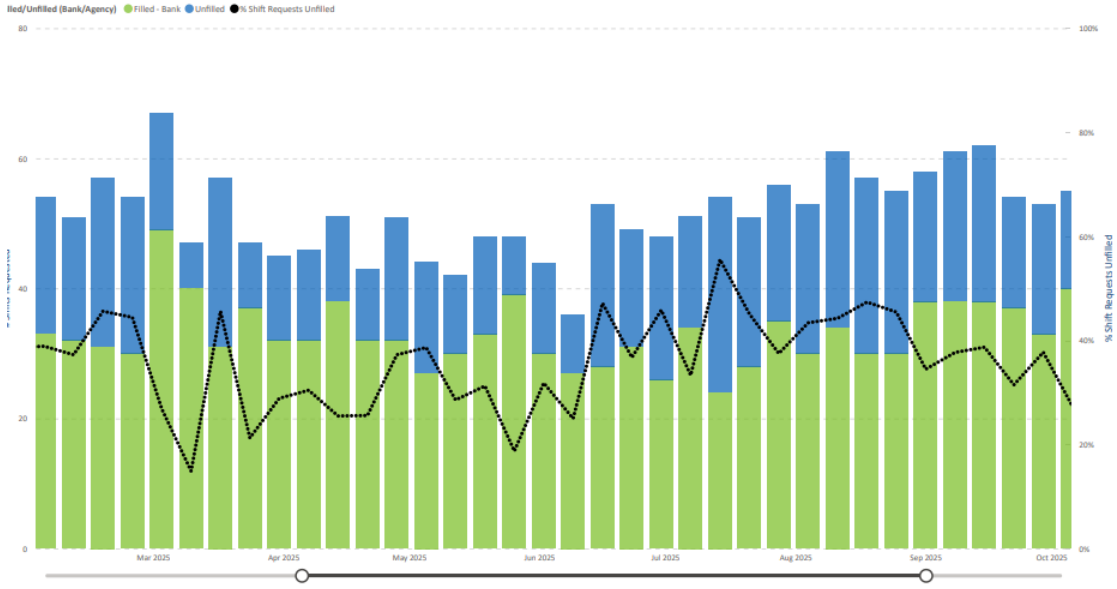


Table 6 York and Scarborough Non-Registered Unfilled Shifts (Data source: Power BI)

Open in Power BI

Filled/Unfilled (Bank/Agency) Filled - Agency Filled - Bank Unfilled % Shift Requests Unfilled

Data analysis indicates a consistently higher need for agency staff at Scarborough over the past 18 months. Induction packs are provided for new attendees, including orientation sessions; however, most agency midwives currently working in the department have worked with the service for over 18 months and are well integrated into the team. At York, there is a greater reliance on bank staff, with shifts covered by midwives already employed within the department. The department reviews the skills mix daily and redeploys staff as needed each shift to maintain safety.

Regular monthly "check and challenge" meetings are in place to assess rostering metrics. Since September, a monthly oversight group, including key stakeholders, has convened to review key performance indicators (KPIs), identify areas for quality improvement in rostering compliance, address payroll discrepancies, and prioritise safe staffing. Although broader improvements are underway across the trust, this project specifically aims to enhance roster management, workforce oversight, and ultimately, staff retention.
Daily safety huddles are firmly established, promoting early recognition of service pressures and facilitating cross-site discussions. These meetings help support patient flow and alleviate pressure at one site when challenges arise. During these huddles, an OPEL score is determined, and escalation policy actions are followed in response to service or staffing issues. The escalation policy has been reviewed and is set to be relaunched in December 2025.

Band 7 managers continue their role as the manager of the day at both sites. According to the phasing paper, recruitment for flow midwives is proposed to begin in March 2026, further enhancing daily safety monitoring across both maternity units.

5. Birth to Midwife Ratio

The birth-to-midwife ratio is calculated monthly using the Birth Rate Plus methodology in conjunction with the actual delivery rate. This metric has now been incorporated into the maternity dashboard, enabling ongoing monitoring alongside clinical data. The accompanying table presents the real-time monthly birth-to-midwife ratio.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Births	**315**	**350**	**311**	**376**	**320**	**324**
Clinical RM	125.65	124.84	121.64	119.58	123.17	121.33
Clinical Specialists	15.1	15.1	15.1	15.1	15.1	15.1
Substantive total	**140.75**	**139.94**	**136.74**	**134.68**	**138.27**	**136.43**
Bank / Agency	25.79	16.36	8.99	24.52	24.28	26.09
Including Bank / Agency	**166.54**	**156.3**	**145.73**	**159.2**	**162.55**	**162.52**

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Birth: Midwife Ratio Substantive	1:27	1:30	1:27	1:33	1:28	1:29
Birth: Midwife Ratio	1:23	1:27	1:25	1:28	1:24	1:24

Substantive& Bank / Agency						

Table 7. York and Scarborough Birth to Midwife ratio overview

This ratio includes WTE employed by the trust in a clinical role, with the exclusion of labour ward coordinators to enable supernumerary status. Sickness and supernumerary WTE have been removed to give an accurate reflection of the Birth: Midwife ratio.

6. Specialist Midwives

Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. The current percentage for York and Scarborough is calculated to be 6.25% of non-clinical specialist midwives with a total of 13.78% employed in clinical and non-clinical specialist midwifery roles to support the workforce and progression of all specialist services.

7. Birth Rate Plus Live Acuity Tool

The Birth Rate Plus Live Acuity Tool is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four-hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and is supported by the escalation policy when required.

For data interpretability, compliance of the acuity tool on BR+ must be completed 85% of the time. Compliance at York site is 78.8%, with Scarborough at 85.6%. Compliance and importance of the tool will be included in the training schedule for all Labour ward coordinators with the launch of the reviewed Escalation Policy in December /January 2026.

8. Supernumerary Labour Ward Co-ordinator

The presence of a supernumerary labour ward co-ordinator is recognised as a fundamental aspect of safe maternity care. This role is filled by an experienced midwife who provides

advice, support, and guidance to clinical staff while effectively managing activity and workload across the labour ward.

Compliance with having a Supernumerary Labour Ward Co-ordinator in place at the beginning of each shift was 100% for both Q1 and Q2. The BR+ system offers a comprehensive overview of shift developments, enabling accurate documentation of any periods where the co-ordinator is unable to maintain supernumerary status.

The table below details monthly compliance, specifically highlighting instances when the co-ordinator was not supernumerary. With the recent approval of additional funding to fully implement the recommendations of BR+, it is expected that these occurrences will decrease, ensuring the co-ordinator can consistently remain supernumerary during times of high acuity.

Site 1: York

York	Number of episodes non-supernumerary status per month (number of shifts)	Number of shifts per month	Compliance
April 25	0	60	100%
May 25	0	62	100%
June 25	0	60	100%
July 25	1	62	98.4%
August 25	1	62	98.4%
September 25	0	60	100%

Table 8. York Labour ward coordinator supernumerary compliance (Data source: BR+ Acuity)
*NB. Data to be interpreted cautiously as the BirthRate+ Acuity tool is validated at data entry of 85%. For Q1 – Q2, data entry compliance was 78.78% at York.

Site 2: Scarborough

Scarborough	Number of episodes non-supernumerary status per month (number of shifts)	Number of shifts per month	Compliance
April 25	1	60	98.3%
May 25	2	62	96.8%
June 25	3	60	95.2%
July 25	1	62	98.4%
August 25	0	62	100%
September 25	4	60	93.6%

Table 9. Scarborough labour ward coordinator supernumerary compliance (Data Source: BR+ Acuity)
*NB. Data to be interpreted cautiously as the BirthRate+ Acuity tool is validated at data entry of 85%. For Q – Q2, data entry compliance was 85.61% at SGH.

9. One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

Month	% one to one care provided	Comments
April 25	100%	
May 25	100%	
June 25	98.9%	1 x precipitate delivery on ward (SGH)
July 25	100%	
August 25	100%	
September 25	100%	

Table 10. York and Scarborough One to One care in established labour (Data Source: Datix)

10. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following tables demonstrate red flag events on each site:

Site 1: York Q1 and Q2

	Red Flag Incidents York Q3 And Q4 2024/25	April 25	May 25	June 25	July 25	Aug 25	Sept 25
1	Delayed or cancelled time critical activity	2	0	0	2	3	0
2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	4	3	7	0	0
3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	1	1	0	2	0	2

4	Delay in providing pain relief Delay of more than 30 minutes	1	1	0	1	0	2
5	Delay between presentation and triage Delay of 30 minutes or more	10	20	7	9	4	26
6	Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0
7	Delay between admission for induction and beginning of process Delay of 2 hours or more	0	0	0	0	0	0
8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0
9	Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0	0	0	0	0
10	Coordinator not able to maintain supernumerary/supervisory status	0	0	0	1	1	0
Subtotal:		15	26	10	22	8	30

Table 11. Red Flag Incidents York (Data Source: Datix & BR+ Acuity Tool)

Site 2: Scarborough Q1 & Q2

	Red Flag Incidents Scarborough Q3 and Q4 2024/25	April 25	May 25	June 25	July 25	August 25	Sept 25
1	Delayed or cancelled time critical activity	1	1	1	1	0	0
2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0	0	0	1	0
3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0	0	0	0	0
4	Delay in providing pain relief Delay of more than 30 minutes	0	0	0	0	0	0
5	Delay between presentation and triage Delay of 30 minutes or more	0	1	0	1	0	0
6	Full clinical examination not carried out when presenting in labour	1	2	2	0	0	0

7	Delay between admission for induction and beginning of process Delay of 2 hours or more	0	2	2	0	1	0
8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	0	0	0
9	Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	1	0	0	0	0
10	Coordinator not able to maintain supernumerary/supervisory status	1	2	3	2	0	4
Subtotal:		3	9	8	4	2	4

Table 12. Red Flag Incidents Scarborough (Data Source: Datix & BR+ Acuity Tool)

During Q1 and Q2 the red flag data reflected delays in induction of labour admissions and coordinator supernumerary status. Ongoing work is taking place to support accurate data entry. Local red flag data is collected and reviewed on a monthly basis.

There are differences noted between the number of red flags reported via birth rate plus and datix. This is because some of the reported incidents occur in other clinical areas e.g. triage delays/IOL delays, and are therefore not captured in the LW coordinator birth rate plus submission

11. Obstetric staffing

The rotas and skill mix on both sites for obstetric staffing on the labour ward are in line with RCOG guidelines for entrustability and include the use of occasional locum staff where necessary to ensure rotas do not have gaps.
The contracted obstetric staffing for both sites is summarised below:
York Scarborough Grade WTE Headcount WTE Headcount Consultant

	York		Scarborough	
Grade	WTE	Headcount	WTE	Headcount
Consultant	17.9	18	8.7	9
Resident Doctor – Tier 2	10.7	13	8.8	9
Resident Doctor – Tier 1	9.6	10	6.8	7

Table 13. Cross-site Obstetric staffing

Non-resident consultants will come on to site if there are gaps which cannot be mitigated with locum staff with time compensated for them if they do the following day for rest. The on-boarding of locum medical staff is overseen by the Trust medical staffing team and is supported by a defined SOP which ensures all qualifications and competency is reviewed.

Any short-term locum doctors in Obstetrics and Gynaecology are currently working in our unit or have worked in the trust within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP). Therefore, an audit was not required as all are compliant with RCOG guidelines.

Ordinarily, long-term locums employed on the middle grade rota have evidence of clinical competencies and are assigned a Consultant for Clinical and Educational Supervision. After a period of supernumerary induction role, they are supervised directly on site by resident consultants in the daytime, before progression to indirect supervision out of hours. However, during the reporting period there were no long-term locums employed within the Trust.

There is daily monitoring of consultant compliance with consultant attendance on labour and the twice daily clinical ward rounds. The attendance rates are reviewed, audited and monitored through the Consultant meeting with escalation where needed from the Clinical Director and with oversight from the Maternity Senior Leadership Team weekly to support any action plans as required to prevent further non-attendance. This oversight has been shared through both the QPAS monthly report and the Quality and Regulatory Assurance Framework workforce report with the Board champions.

In accordance with the Maternity Incentive Scheme Trusts should ensure they are compliant with a consultant attendance, in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations. The audit undertaken from January to current date 2025 demonstrates full compliance, which is reported in the Perinatal Quality Surveillance Model Tool.

The Trust follows the RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours. The rotas allow for a non-clinical day following an on-call shift for the majority of consultants. The daily handovers have the operational administration team in attendance to support any changes to the rota that, may be required to support the provision of compensatory rest at short notice.

12. Anaesthetic staffing

At York, a Duty Anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising Anaesthetic Consultant at all times. Where the Duty Anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1

Appendix 1. is an example of a typical month for York Anaesthetic staffing rota.

Anaesthetic staffing establishment at York and Scarborough

	York	SGH
General Anaesthetists	34	6
Obstetric Anaesthetists	13	4
SAS	12	4
TG	5	9

Trainees	24	6

Table 14. Anaesthetic staffing establishment at York and Scarborough as of November 2025.

All York consultants are dual site, whereas Scarborough are just there. The Obstetric Anaesthetists also come within the total general counts but I have just pulled them out as thought important. The trainee count is only involving those that may have to cover Labour Ward on call.

13. Neonatal medical staffing

Comparison of Neonatal Medical Staffing vs BAPM Standards
This document summarises the latest comparison between York & Scarborough's neonatal medical staffing and the most recent BAPM workforce standards (2025).

BAPM Requirements for Local Neonatal Units (LNUs)

- Minimum 8 WTE Tier 1 and 8 WTE Tier 2 resident doctors.
- Dedicated Tier 1 practitioner 24/7.
- Tier 2 practitioner with intermediate airway skills for day & evenings; immediate availability overnight
- Minimum 7 WTE Tier 3 consultants.

Current Trust Position (York)

Tier 1: Non-compliant
8 WTE (meets number requirement).
Dedicated 09:00–17:00 only - No dedicated overnight or weekend Tier 1

Tier 2: Non-compliant
9 WTE
Does not meet recommendations in view of requirement for intermediate airways skills

Tier 3: Compliant
8 WTE consultants.
Non-resident but available within 30 minutes.

Action plan to achieve full compliance:

1. Recruit a minimum of 2x additional WTE Tier 1 doctors.
2. Develop a business case
3. Ensure dedicated Tier 1 cover overnight and at weekends by adjusting rota to provide 24/7 neonatal-only Tier 1 coverage.
4. Early identification of the gaps in the next 6 months rota to be covered by locums to allow time to recruit to these vacant posts till they are permanently filled
5. Rota master will be reporting to the management every week if the rota has been compliant with the BAPM recommendation and if was not will be escalated as a safety risk
6. Any staff shortages will be datixed
7. Need to review tier 2 rota to determine if additional numbers required and also agree training plan for ongoing assessment of airway skills

Current Trust Position Scarborough

SCARBOROUGH WORKFORCE – TIERS 1, 2 & 3 – STANDARD							
	DAY SHIFT		EVENING SHIFT		NIGHT SHIFT		
TIER	**Recommended**	**Current Practice**	**Recommended**	**Current Practice**	**Recommended**	**Current Practice**	**COMPLIANT?**
1 minimum 8 WTE on rota	At Least one dedicated Tier 1 with basic airway capability	8 WTE on the rota cover the SCU during the day (week days from 9am - 5pm) and experienced QIS nurses carry the resuscitation bleep for immediate response	At least one immediately available tier 1 The sharing of the tier 1 should not reduce quality of care delivery and safety to the neonatal unit	Tier 1 covers both sites Paediatrics/ neonates and experienced QIS nurses carry the resuscitation bleep for immediate response	At least one immediately available tier 1 The sharing of the tier 1 should not reduce quality of care delivery and safety to the neonatal unit	Tier 1 covers both sites Paediatrics/ neonates and experienced QIS nurses carry the resuscitation bleep for immediate response	YES
2 minimum 8 WTE on rota	8.30am - 1.00pm at least one dedicated Tier 1 with standard airway capability 1pm – 5pm At least one immediately	8 WTE and one immediately available with standard airway capabilities					YES

	available tier 2 The sharing of the tier 2 should not reduce quality of care delivery and safety to the neonatal unit						

	DAY SHIFT		EVENING SHIFT		NIGHT SHIFT		
TIER	**Recommended**	**Current Practice**	**Recommended**	**Current Practice**	**Recommended**	**Current Practice**	**COMPLIANT?**
3 minimum 7 WTE on rota, 1:7 on call including weekends	Mon-Fri 8.30am – 5pm Sat/Sun 8.30am – 1pm (onsite hours) At least one immediately available with intermediate airway capability	10 tier 3 doctors (consultants) on the rota and a consultant is onsite from 9am – 9pm and when on call from home is available within 30 minutes			On call from home and available within 30 minutes		YES

Summary for Scarborough Workforce:

- Tier 1 compliant
- Tier 2 compliant
- Tier 3 compliant

14. Neonatal nursing staffing

Neonatal services in York and Scarborough are non-compliant with minimum safe staffing levels as outlined by BAPM. A full review of the front-line neonatal nurse staffing establishment has been conducted and a business case has been developed that addresses the identified front line nursing staffing gaps. It is anticipated the business case will be presented to Trust Board for consideration in Q1 2026.

Cross-site front-line neonatal workforce position

York
4 Nurses (1 of whom is QIS) + 1 support worker for 2 HDU/ICU cots and 13 SCBU cots.
BAPM compliance = 1 Supernumary shift coordinator, 5 Nurses (2 of whom are QIS) + 1 support worker. For 2 HDU/ICU cots and 9 SCBU cots.
QIS Compliance currently 62% (BAPM requirement 70%)
Current headroom 20% on each post, BAPM compliance is 25%

Scarborough
2 Nurses (1 of whom is QIS) + 1 support worker for 8 SCBU cots.
BAPM compliance = 3 Nurses (2 QIS) + 1 support worker. This allows for attendance at neonatal emergencies off the unit, whilst maintaining safe staffing on the unit.
QIS compliance 82% (BAPM requirement 70%)
Current headroom 20% on each post, BAPM compliance is 25%

BAPM_Service_Quality_Standards_FINAL.pdf

It is noted that both units do not meet the BAPM safe standards for staffing. A business case has been developed to address the short fall in frontline Neonatal staffing numbers and skill mix across both SCBU, LNU and TC services at York and Scarborough. This paper is currently going through governance processes before being shared with the ODN and LMNS.

Recommended BAPM safe staffing ratio:

- ICU cots must be staffed 1:1 Ratio QIS qualified
- HDU cots must be staffed 1:2 Ratio QIS qualified
- SCBU/TC cots must be staffed 1:4 Ratio (overseen by QIS qualified)

Sickness metrics

	Q1	Q2
York	6.58%	8.45%
SGH	8.9%	10.3%

Table 15. Neonatal Nurse sickness rates cross-site Quarter 1 and Quarter 2 2025/2026

The local Sickness and Absence policy target for sickness rate for Neonatal Nurse staffing is 3.1%. There is a monthly Check and Challenge roster review meeting attended by the Neonatal Senior Leadership Team whereby an in-depth review of historical rosters takes place to provide oversight and assurance on both previous and future roster compliance.
During Q1 and Q2 the sickness rate was above the Trusts local target due to insufficient headroom and insufficient investment into the staffing establishment cross-site. Currently

the headroom for neonatal nurses cross-site is 20% opposed to the BAPM requirement of 25%.
Following a of review sickness levels in Q1 and Q2 at York, findings showed an increase in sickness due to 2x substantive staff members being on long-term sick.

A review of Scarborough's sickness levels showed the main themes being long-term sickness, pregnancy and surgical related illnesses.

Training compliance

	York Q1 & Q2	SGH Q1 & Q2
NLS	83%	73%
NBLS/PROMT	93%	69%
BFI	93%	57%

Table 16. Neonatal Nurse training compliance cross-site Quarter 1 and Quarter 2 2025/2026

Compliance for external NLS is set via BAPM (2022) “All nurses attending deliveries and/or involved in direct clinical care of the neonate should have undertaken a Newborn Life Support course appropriate to their role as recommended by the Resuscitation Council UK (22) and receive regular training updates.” All nurses who attend deliveries at York are compliant with this. Scarborough is not compliant, NLS places are limited throughout the region, and a national shortage of courses has been recognised it is also difficult to release staff from Scarborough due to limited staff numbers.
Compliance with NBLS via MIS year 7 is 90%, Scarborough staff have been rostered to attend but have been pulled to work clinically due to sickness and shortfall.
BFI is included within annual statuary mandatory training. Compliance is not 100% in York due to one member of staff being on long term sick and one member of staff pulled to cover clinically. Scarborough have also been unable to release staff to attend due to staffing sickness and shortages.

Number of times the unit has closed due to staffing

	Q1	Q2
York	0	2
SGH	0	0

Table 17. Cross-site Neonatal unit closures during Quarter 1 and Quarter 2 2025/2026

In York Q2 the unit closed to the ODN but not to York Maternity.
In Scarborough, the figures don't show a true reflection as staff are frequently taken from York to keep Scarborough open, reflecting a staffing gap in Scarborough.

Refused admissions due to capacity

	Q1	Q2
York	2	5
SGH	5	7

Table 18. Cross-site refused admissions instances Quarter 1 and Quarter 2 2025/2026

Refused admission was due to increase in High Flow/Intensive Care babies.

Refused admissions due to staffing levels

York and Scarborough SCBU do not close to internal admissions due to staffing compliance, but may be closed to the ODN on a reduced cot capacity for a temporary period of time. Staffing in Scarborough is supported from York SCBU to maintain 2 RN on each shift

The cross site Neonatal workforce relies heavily on bank staff which are predominately staff with substantive contracts on the units, breaching work time directives.

York Q1

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 37.94, of which 26.56 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	30.42	23.80	28.01	2.41	-4.21
Total reg nurses	21.82	17.40	24.74	-2.92	-7.34
Total QIS	13.71	12.40	17.32	-3.61	-4.92
Total non-QIS	8.11	5.00	7.42	0.69	-2.42
Total non-reg	8.60	6.40	3.27	5.33	3.13
Reg nurses as % nursing staff	71.7%	73.1%	88.3%		
QIS as % reg nurses	62.8%	71.3%	70.0%		

York Q2

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 37.94, of which 26.56 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	31.29	25.61	28.01	3.28	-2.40
Total reg nurses	21.82	18.66	24.74	-2.92	-6.08
Total QIS	13.91	14.06	17.32	-3.41	-3.26
Total non-QIS	7.91	4.60	7.42	0.49	-2.82
Total non-reg	9.47	6.95	3.27	6.20	3.68
Reg nurses as % nursing staff	69.7%	72.9%	88.3%		
QIS as % reg nurses	63.7%	75.3%	70.0%		

SGH Q1

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 18.21, of which 12.75 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	15.76	14.76	12.58	3.18	2.18
Total reg nurses	11.82	10.82	12.14	-0.32	-1.32
Total QIS	9.60	8.60	8.50	1.10	0.10
Total non-QIS	2.22	2.22	3.64	-1.42	-1.42
Total non-reg	3.94	3.94	1.62	2.32	2.32
Reg nurses as % nursing staff	75.0%	73.3%	96.5%		
QIS as % reg nurses	81.2%	79.5%	70.0%		

SGH Q2

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 18.21, of which 12.75 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	15.37	14.37	12.58	2.79	1.79
Total reg nurses	11.82	10.82	12.14	-0.32	-1.32
Total QIS	9.60	8.60	8.50	1.10	0.10
Total non-QIS	2.22	2.22	3.64	-1.42	-1.42
Total non-reg	3.55	3.55	1.62	1.93	1.93
Reg nurses as % nursing staff	76.9%	75.3%	96.5%		
QIS as % reg nurses	81.2%	79.5%	70.0%		

Plan for QIS 2026

No members of staff in York are undertaking QIS in 2026. 1 Band 5 Neonatal Nurse in Scarborough will commence their QIS training in September 2026. There is currently no funding to renumerate any neonatal nurse who have completed QIS to move from Band 5 to Band 6. We are currently an outliner for this and there is ambition to address this through the funding requirements outlined in the neonatal and transitional care workforce business case.

15. Recommendations

The Board is asked to note the contents of the report and formally record to the Trust Board minutes non-compliance with BAPM minimum safe staffing levels for both neonatal nurse staffing and neonatal medical staffing and agree to the actions outlined in the action plans.

Date: **14/01/2025**

Appendix

Appendix 1. Scarborough annuaisation master consultant specialist timetable 24/11/2025

Scarborough Consultant / Specialist Timetable - 24 November 2025

LJH	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	SPA	SPA	SPA	Admin	off	off	SPA	GOPD (FT)	MDT	SPA		
2	Brid FT	SPA	SPA	Admin	off	off	MT	GOPD (FT)	MDT	SPA		
3	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
4	Brid FT	SPA	SPA	Admin	off	off	MT	GOPD (FT)	MDT	SPA		
5	Brid FT	SPA	SPA	Admin	off	off	SPA	GOPD (FT)	MDT	SPA		
6	Elec C/S	SPA	SPA	Admin	off	off	MT	GOPD (FT)	MDT	SPA		
7	Brid FT	SPA	SPA	Admin	off	off	SPA	GOPD (FT)	MDT	SPA		
8	SPA	SPA	SPA	Admin	off	off	MT	GOPD (FT)	MDT	SPA		

OA	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	Clin Lead	Colp Lead	Clin Lead	GOPD	COLP (BH)	COLP (BH)	off	off	MT	SPA		
2	Clin Lead	Colp Lead	SPA	SPA	Admin	COLP	off	off	SPA	SPA		
3	Clin Lead	Colp Lead	Colp Lead	GOPD	Admin	COLP	SPA	SPA	MT	SPA		
4	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
5	Clin Lead	Colp Lead	SPA	GOPD	Admin	COLP	SPA	SPA	MT	SPA		
6	Clin Lead	Colp Lead	SPA	SPA	Admin	COLP	SPA	SPA	Admin	SPA		
7	Clin Lead	Colp Lead	SPA	GOPD	Admin	COLP	off	off	MT	SPA		
8	Clin Lead	Colp Lead	SPA	Admin	Elec C/S	COLP	off	off	Elec C/S	SPA	NROC	NROC

JF	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	YH HW	HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW		
2	UG MDT	UG Clinic	off	off	off	SPA	UG Lead	SPA	MT (SH)	SPA		
3	off	Admin	off	off	MT (YH)	DT (YH)	Admin	GOPD (MH)	UG Lead	SPA		NROC (YH)
4	off	off	off	off	off	off	GOPD (MH)	UG Clinic	MT (SH)	SPA		
5	SPA	MT (SH)	off	off	off	off	Admin	GOPD (MH)	UG Lead	SPA		
6	off	Admin	off	off	off	SPA	Admin	GOPD (MH)	MT (SH)	SPA		
7	UG MDT	UG Clinic	off	off	MT (YH)	DT (YH)	Admin	GOPD (MH)	UG Lead	SPA		
8	off	Admin	off	off	off	off	GOPD (MH)	UG Clinic	MT (SH)	SPA	NROC (YH)	

CJ	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	GOPD	off	RTT Support	HYMS	MT	HYST	off	off	Admin	SPA		
2	SHADOW	HYST	Admin	CTG Lead	HYMS	off	off	off	ANC	SPA		
3	GOPD	off	Admin	HYMS	MT	Elec C/S	off	off	ANC	SPA		
4	HYMS	HYST	Admin	EPAU Lead	off	off	off	off	SHADOW	SPA		
5	HYST	RTT Support	Admin	HYMS	MT	HYST	off	off	ANC	SPA		
6	HYST	off	Admin	RTT Support	SHADOW	Elec C/S	off	off	HYMS	SPA		
7	HYMS	off	GOPD	CTG Lead	MT	HYST	off	off	ANC	SPA		
8	SHADOW	HYST	Admin	EPAU Lead	HYMS	RTT Support	off	off	ANC	SPA		

NA	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	Elec C/S	SPA	HYMS	HYST (FT)	off	off	GOPD	Admin	LWL	SPA		
2	Admin	MT	HYMS	HYST (FT)	off	off	SPA	ANC	LWL	SPA		
3	Elec C/S	MT	HYMS	HYST (FT)	off	off	GOPD	Admin	LWL	SPA	NROC	NROC
4	Admin	SPA	HYMS	HYST (FT)	off	off	SPA	ANC	LWL	SPA		
5	Elec C/S	SPA	HYMS	HYST (FT)	off	off	GOPD	Admin	LWL	SPA		
6	Admin	MT	HYMS	HYST (FT)	off	off	SPA	ANC	LWL	SPA		
7	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
8	Admin	MT	HYMS	HYST (FT)	off	off	SPA	ANC	LWL	SPA		

AJB	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	off	HYST	SPA	Admin	ANC	SPA	off	off	Preterm	SPA		
2	Elec C/S	off	GOPD	Admin	MT	SPA	off	MT	Brid ANC	SPA		
3	off	HYST	SPA	Admin	Preterm	GOPD	off	off	off	off		
4	off	off	GOPD	Admin	ANC	SPA	off	MT	Brid ANC	off	NROC	NROC
5	Preterm	HYST	SPA	Admin	ANC	SPA	off	off	off	off		
6	off	off	GOPD	Admin	Preterm	GOPD	off	MT	Brid ANC	SPA		
7	Elec C/S	HYST	SPA	Admin	ANC	SPA	off	off	Admin	SPA		
8	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		

OO	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	GSWH	GSWH	GOPD	Admin	GSWH	SPA	off	MT	Elec C/S	SPA	NROC	NROC
2	SPA	SPA	Admin	Diab ANC	GSWH	GSWH	Colp	SPA	CT	SPA		
3	off	off	GOPD	Admin	GSWH	CT	off	MT	SPA	SPA		
4	GSWH	GSWH	Admin	Diab ANC	MT	SPA	Colp	SPA	Elec C/S	COLP MDT		
5	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
6	GSWH	GSWH	Admin	Diab ANC	GSWH	CT	Colp	SPA	SPA	SPA		
7	off	off	GOPD	Admin	GSWH	GSWH	Colp	SPA	CT	SPA		
8	GSWH	GSWH	Admin	Diab ANC	GSWH	HYST	Colp	SPA	off	COLP MDT		

Scarborough Consultant / Specialist Timetable - 24 November 2025

1	SPA	Badgernet	SGH ANC	SGH JANC	off	off	SPA	MH GOPD	Admin	SPA									
2	Diab Lead	Badgernet	SGH ANC	SGH ANC	off	off	SPA	MH GOPD	SPA	Admin	NROC (SH)	NROC (SH)							
3	SPA	Badgernet	SGH ANC	SGH JANC	off	off	SGH MT	SPA	Badgernet	Admin									
4	Diab Lead	Badgernet	SGH ANC	SGH ANC	off	off	SPA	MH GOPD	YH C/S	Admin									
5	SPA	Badgernet	SGH ANC	SGH JANC	off	off	SGH MT	SPA	Admin	SPA									
6	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW									
7	Diab Lead	Badgernet	SGH ANC	SGH JANC	off	off	SGH MT	SGH MT	Admin	SPA									
8	Diab Lead	Badgernet	SGH ANC	SGH ANC	off	off	SPA	MH GOPD	YH C/S	Admin									

GCB	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	ANC (SH)	MT	off	off	GOPD	SPA	ANC (MH)	off	Fert (YH)	SPA		
2	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW		
3	Admin	off	off	off	GOPD	HYST	ANC (MH)	off	Fert (YH)	SPA		
4	Elec C/S	MT	off	off	GOPD	HYST	Admin	off	SPA	MT		
5	Admin	off	off	off	GOPD	SPA	ANC (MH)	off	Fert (YH)	SPA		
6	Admin	off	off	off	Elec C/S	HYST	Admin	off	SPA	MT	NROC (SH)	NROC (SH)
7	ANC (SH)	MT	off	off	GOPD	SPA	ANC (MH)	off	Fert (YH)	SPA		
8	Admin	off	off	off	GOPD	SPA	Admin	off	SPA	SPA		

LRW	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	DT (YH)	ANC (YH)	off	off	ELCS (SH)	SPA	CT	Colp (YH)	GOPD (YH)	SPA		
2	SPA	ANC (YH)	off	off	ELCS (SH)	SPA	CT	GOPD (YH)	SPA	SPA		
3	SPA	ANC (YH)	off	off	Admin	SPA	MT (YH)	GOPD (YH)	Colp (YH)	SPA		
4	SPA	ANC (YH)	off	off	Admin	Colp (YH)	CT	GOPD (YH)	SPA	Colp (YH)		
5	GOPD (YH)	ANC (YH)	off	off	Admin	Colp (YH)	CT	GOPD (YH)	SPA	SPA		
6	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW		
7	DT (YH)	ANC (YH)	off	off	ELCS (SH)	Admin	MT (YH)	Admin	CT	SPA		Res (YH)
8	off	Night	off	Night	off	Night	off	Night	off	off		

APY	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
2	off	off	SPA	Colp	Admin	off	GOPD	ANC	Elec C/S	MT		
3	off	off	HYST	Colp	off	off	GOPD	ANC	SPA	SPA		
4	off	off	SPA	Colp	Admin	Brid DT	Admin	ANC	SPA	SPA		
5	off	off	off	Colp	off	off	GOPD	ANC	SPA	SPA		
6	off	off	HYST	Colp	Admin	Brid DT	Admin	ANC	Elec C/S	SPA		
7	off	off	off	off	off	off	GOPD	SPA	SPA	SPA	NROC	NROC
8	off	off	off	Admin	SPA	Brid DT	GOPD	ANC	SPA	MT		

TM (lo	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	off	off	Admin	BDH Colp	Hyst	Colp	Hyst	Colp	off	off		
2	off	off	BDH Colp	Admin	Hyst	Hyst	Hyst	Colp	off	off		
3	off	off	BDH Colp	Admin	Hyst	Admin	Hyst	Colp	off	off		
4	off	off	BDH Colp	Admin	Hyst	Colp	Hyst	Colp	off	off		
5	off	off	BDH Colp	Admin	Hyst	Admin	Hyst	Colp	off	off		
6	off	off	BDH Colp	Admin	Hyst	Admin	Hyst	Colp	off	off		
7	off	off	BDH Colp	Admin	Hyst	Admin	Hyst	Colp	off	off		
8	off	off	BDH Colp	Admin	Hyst	Admin	Hyst	Colp	off	off		

Appendix 2. York annuaisation master consultant specialist timetable 29/09/2025

York Consultant Specialist Timetable - 29 September 2025

		Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
OAA	1	Digital L	Digital L	off	off	GOPD	GOPD	UDS	SPA	Admin	SPA	NROC	
	2	Digital L	GOPD	off	off	GOPD	GOPD	UDS	Digital L	Admin	SPA		
	3	Digital L	MT	off	off	GOPD	Digital L	UDS	GOPD	Admin	SPA		
	4	DT	MT	off	off	GOPD (FT)	SPA	UDS	Digital L	Admin	SPA		
	5	Digital L	MT	off	off	GOPD	DT	UDS	Digital L	Admin	SPA		
	6	Digital L	GOPD	off	off	GOPD	DT	UDS	GOPD	Admin	SPA		
	7	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
	8	Digital L	MT	off	off	GOPD	Digital L	UDS	SPA	Admin	SPA		NROC
NMD	1	off	CD	off	off	CD	CD	MT	GOPD	CD	SPA		
	2	off	CD	off	off	Hyst	Admin	MT	SPA	CD	SPA		
	3	off	CD	off	off	CD	CD	Hyst		CD	SPA		
	4	off	CD	off	off	CD	CD	MT	GOPD	UDS	SPA	NROC	
	5	HW	HW	HW	HW	HW	HW	CD	Admin	CD	SPA		
	6	off	CD	off	off	Hyst	Admin	MT	Admin	CD	SPA		
	7	off	CD	off	off	CD	CD	Hyst	GOPD	CD	SPA		NROC
	8	off	CD	off	off	CD	CD	MT	SPA	UDS	SPA		
CLO	1	Mat Trans	Admin	off	off	ANC	SPA	Mat Trans	Hyst	Mat Trans	SPA		
	2	Mat Trans	GOPD	off	off	ANC	SPA	off	off	MT	SPA		NROC
	3	Mat Trans	Admin	off	off	Vulval	Mat Trans	Mat Trans	Admin	MT	SPA		
	4	Mat Trans	Admin	off	off	ANC	SPA	Mat Trans	Hyst	Mat Trans	SPA		
	5	Mat Trans	GOPD	off	off	ANC	SPA	HW	HW	HW	HW	NROC	
	6	Mat Trans	GOPD	off	off	ANC	SPA	off	off	MT	SPA		
	7	Mat Trans	Admin	off	off	ANC	Mat Trans	off	off	Hyst	SPA		
	8	Mat Trans	Admin	off	off	ANC	SPA	off	off	Mat Trans	SPA		
FZS	1	Gyn Lead	Admin	MT	MT	off	off	SPA	Admin	Hyst	SPA	HYST	
	2	Gyn Lead	GOPD	Endo Lead	Hyst	off	off	SPA	GOPD	off	SPA		
	3	Hyst	Admin	MT	MT	off	off	Admin	MT *	SPA	SPA		
	4	Gyn Lead	GOPD	Endo Lead	Hyst	off	off	Endo Lead	GOPD	off	SPA		
	5	Gyn Lead	Admin	Flex DCC	MT	SPA	Admin	Admin	Flex DCC	Flex DCC	SPA	HYST	
	6	Gyn Lead	GOPD	Admin	Admin	off	off	SPA	GOPD	off	SPA		
	7	Hyst	Gyn Lead	MT	MT	off	off	SPA	MT *	SPA	SPA		
	8	Gyn Lead	GOPD	Endo Lead	Gyn Lead	off	off	SPA	GOPD	off	SPA		
LAF	1	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
	2	off	off	ANC	MML	LMNS	LMNS	ANC	Admin	Elec CS	SPA		
	3	SPA	SPA	ANC	RL	SPA	DT	ANC	Admin	SPA	SPA	NROC	
	4	off	off	ANC	MML	LMNS	LMNS	ANC	Admin	SPA	SPA		NROC
	5	off	off	ANC	RL	off	off	ANC	Admin	Hyst	SPA		
	6	off	off	ANC	MML	LMNS	LMNS	ANC	Admin	Elec CS	SPA		
	7	off	off	ANC	RL	SPA	DT	ANC	Admin	SPA	SPA		
	8	off	off	ANC	MML	LMNS	LMNS	ANC	RL	Hyst	SPA		
CJB	1	Colp	MT	off	GOPD (FT)	off	off	SPA	Admin	off	SPA		NROC
	2	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
	3	Colp	CA Lead	off	GOPD (FT)	off	off	SPA	Admin	off	SPA		
	4	LGT	SPA	off	CA Lead	off	off	GOPD	Admin	MT	SPA		
	5	CA Lead	Colp	MT	GOPD (FT)	off	off	SPA	Admin	MT	SPA		
	6	Colp	MT	off	SPA	off	off	GOPD	Admin	off	SPA	NROC	
	7	Admin	MT	off	GOPD (FT)	off	off	SPA	Admin	off	SPA		
	8	LGT	SPA	off	CA Lead	off	off	GOPD	Admin	MT	SPA		
SSG	1	off	GOPD	off	ANC	off	GOPD	Minor Ops	SPA	SPA	SPA		
	2	off	GOPD (5)	Admin	ANC	off	off	Admin	MT	SPA	EPAU SCAN	NROC	
	3	DT	GOPD	Hyst	ANC	off	Minor Ops	Admin	Hyst	SPA	SPA		
	4	off	GOPD (5)	Admin	ANC	off	off	Admin	MT	SPA	SPA		
	5	off	SPA	SPA	ANC	off	off	Admin	ANR	SPA	SPA		NROC
	6	off	GOPD (5)	SPA	ANC	off	off	SPA	ANR	Hyst	EPAU SCAN		
	7	off	GOPD	Hyst	ANC	off	off	Admin	Minor Ops	MT	SPA		
	8	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
JYT	1	off	off	off	off	USS	Admin	FM Lead	ANC	USS	SPA		
	2	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		

York Consultant Specialist Timetable - 29 September 2025

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
3	Elec C/S	SPA	off	off	USS	Admin	FM Lead	ANC	USS	SPA		
4	off	off	off	off	USS	Admin	SPA	ANC	USS	SPA		
5	Rainbow	SPA	off	off	USS	Admin	MT*	ANC	USS	SPA		
6	off	off	off	off	off	off	SPA	ANC	USS	SPA		NROC
7	Rainbow	SPA	off	off	USS	Admin	FM Lead	Admin	USS	SPA	NROC	
8	Elec C/S	SPA	off	off	USS	Admin	FM Lead	ANC	MT*	SPA		

KKM

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	off	off	off	off	Elec C/S	Admin	SPA	HYMS	ANC	SPA		Res
2	off	off	off	off	Elec C/S	Admin	SPA	ANC	ANC	SPA		
3	off	Night	off	Night	off	Night	off	Night	off	off		
4	Elec C/S	SPA	off	off	SPA	DT	Admin	HYMS	ANC	SPA		
5	DT	Admin	off	off	Elec C/S	SPA	off	off	ANC	SPA		
6	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
7	Elec C/S	SPA	off	off	SPA	SPA	SPA	ANC	ANC	SPA		
8	off	off	Elec C/S	HYMS	Elec C/S	SPA	Admin	HYMS	ANC	SPA		

SKR

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	ANC (S)	ANC (S)	SPA	CT	CT	Admin	off	off	MT	EPAU Scan		
2	off	Night	off	Night	off	Night	off	Night	off	off		
3	ANC (S)	GOPD (S)	SPA	Admin	CT	SPA	off	off	Admin	SPA		
4	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
5	ANC (S)	ANC (S)	SPA	SPA	MT	CT	off	off	SPA	EPAU Scan	Res	
6	ANC (S)	GOPD (S)	SPA	CT	CT	SPA	off	off	Admin	SPA		
7	ANC (S)	ANC (S)	SPA	off	MT	CT	off	off	Admin	SPA		
8	ANC (S)	GOPD (S)	SPA	off	CT	DT	off	off	Admin	SPA		

HAE

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	ANC	Admin	off	off	MT	off	Admin	MT	SPA	SPA		
2	ANC	SPA	off	off	PMRT/DCC	Min Op	GOPD	Admin	UDS	SPA		
3	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
4	ANC	SPA	off	off	Min Ops	GOPD	off	off	TBC	TBC		
5	ANC	SPA	off	off	Min Ops	off	GOPD	Admin	SPA	SPA	NROC (SH)	NROC (SH)
6	off	off	off	off	PMRT/DCC	GOPD	SPA	Admin	UDS	SPA		
7	ANC	SPA	off	off	Vulval	PMRT/DCC	GOPD	Admin	SPA	SPA		
8	ANC	SPA	off	off	PMRT/DCC	GOPD	TBC	TBC	TBC	TBC		

RCH

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	Rainbow	HYMS	ANC	USS	Admin	DT	off	off	SPA	SPA	Res	
2	off	off	ANC	USS	Admin	DT	off	off	SPA	SPA		
3	Rainbow	HYMS	ANC	USS	Admin	USS	off	off	SPA	SPA		
4	off	off	ANC	USS	Admin	USS	off	off	HYMS	SPA		
5	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
6	SPA	SPA	ANC	USS	Admin	USS	off	off	HYMS	SPA		
7	off	Night	off	Night	off	Night	off	Night	off	off		
8	MM	off	ANC	USS	Admin	USS	off	off	SPA	SPA		

MSB

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	off	Night	off	Night	off	Night	off	Night	off	off		
2	DT	Admin	off	off	Min Ops	ANC	off	off	SPA	SPA		
3	Admin	SPA	off	off	Hyst	ANC	SPA	GOPD	GOPD	SPA		
4	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
5	Admin	SPA	off	off	Hyst	ANC	SPA	MT	GOPD	SPA		
6	Admin	SPA	off	off	Min Ops	ANC	off	off	SPA	SPA		
7	Admin	SPA	off	off	Hyst	ANC	Admin	Hyst	GOPD	SPA	Res	
8	Admin	SPA	off	off	Min Ops	ANC	SPA	MT	SPA	DT		

JEJ

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	off	off	USS	Admin	SPA	SPA	D ANC	SPA	Admin	SPA		
2	off	off	USS	Admin	MT	GOPD	D ANC	LWL	SPA	SPA		
3	off	off	USS	Admin	MT	SPA	D ANC	LWL	SPA	SPA	Res	
4	off	off	USS	Admin	SPA	GOPD	D ANC	LWL	SPA	DT		
5	off	Night	off	Night	off	Night	off	Night	off	off		
6	off	off	USS	Admin	MT	GOPD	D ANC	LWL	SPA	SPA		
7	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		
8	off	off	USS	Admin	SPA	GOPD	D ANC	LWL	off	SPA		

CJW

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	CG	CG	Admin	off	off	off	CG	GOPD	off	SPA		
2	CG	MT	GOPD (FT)	Admin	off	off	CG	Hyst	off	SPA		
3	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		

York Consultant Specialist Timetable - 29 September 2025

4	off	Night	off	Night	off	Night	off	Night	off	off					
5	CG	GOPD	GOPD (FT)	off	off	off	MT	CG	off	SPA					Res
6	DT	Hyst	Hyst	Admin	off	off	CG	MT	off	SPA					
7	CG	GOPD	Admin	Hyst	off	off	CG	GOPD	off	DT					
8	DT	GOPD	Admin	CG	off	off	CG	SPA	off	SPA					

JF

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	YH HW	HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW		
2	UG MDT	UG Clinic	off	off	off	SPA	UG Lead	SPA	MT (SGH)	SPA		
3	off	Admin	off	off	off	off	Admin	GOPD (MH)	UG Lead	DT (YH)		NROC (YH)
4	off	off	off	off	MT (YH)	SPA	GOPD (MH)	UG Clinic	MT (SGH)	SPA		
5	SPA	MT (SGH)	off	off	off	off	Admin	GOPD (MH)	UG Lead	DT (YH)		
6	off	Admin	off	off	off	SPA	Admin	GOPD (MH)	MT (SGH)	SPA		
7	UG MDT	UG Clinic	off	off	off	off	Admin	GOPD (MH)	UG Lead	SPA		
8	off	Admin	off	off	MT (YH)	SPA	GOPD (MH)	UG Clinic	MT (SGH)	SPA	NROC (YH)	

NMS

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	SPA	Badgernet	SGH ANC	SGH JANC	off	off	SPA	MH GOPD	Admin	SPA		
2	Diab Lead	Badgernet	SGH ANC	SGH ANC	off	off	SPA	MH GOPD	SPA	Admin	NROC (SH)	NROC (SH)
3	SPA	Badgernet	SGH ANC	SGH JANC	off	off	SGH MT	SPA	Badgernet	Admin		
4	Diab Lead	Badgernet	SGH ANC	SGH ANC	off	off	SPA	MH GOPD	YH C/S	Admin		
5	SPA	Badgernet	SGH ANC	SGH JANC	off	off	SGH MT	SPA	Admin	SPA		
6	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW	YH HW		
7	Diab Lead	Badgernet	SGH ANC	SGH JANC	off	off	SGH MT	SGH MT	Admin	SPA		
8	Diab Lead	Badgernet	SGH ANC	SGH ANC	off	off	SPA	MH GOPD	YH C/S	Admin		

CMH

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	off	off	GOPD	HYMS	Admin	Hyst	Admin	SPA	ANC	DT		
2	off	off	Ed Lead	HYMS	SPA	Ed Lead	off	off	Hyst	SPA		
3	off	off	GOPD	HYMS	Admin	Hyst	Admin	MT	ANC	SPA		Res
4	off	off	SPA	HYMS	off	off	Ed Lead	SPA	Hyst	SPA		
5	off	off	GOPD	HYMS	Admin	Hyst	Admin	SPA	ANC	SPA		
6	off	Night	off	Night	off	Night	off	Night	off	off		
7	off	off	GOPD	HYMS	Admin	Hyst	SPA	MT	Elec C/S	SPA		
8	HW	HW	HW	HW	HW	HW	HW	HW	HW	HW		

LRW

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	DT (YH)	ANC (YH)	off	off	ELCS (SH)	Colp (BH)	off	Admin	GOPD	SPA		
2	SPA	ANC (YH)	off	off	ELCS (SH)	Colp (SH)	off	GOPD	SPA	SPA		
3	SPA	ANC (YH)	off	off	Admin	Colp (SH)	MT	GOPD	SPA	SPA		
4	SPA	ANC (YH)	off	off	Admin	off	off	GOPD	SPA	SPA		
5	GOPD (YH)	ANC (YH)	off	off	Admin	Colp (SH)	off	GOPD	SPA	SPA		
6	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW		
7	DT (YH)	ANC (YH)	off	off	ELCS (SH)	Colp (SH)	MT	Admin	ELCS (SH)	SPA		Res (YH)
8	off	Night	off	Night	off	Night	off	Night	off	off		

GCB

	Mon AM	Mon PM	Tues AM	Tues PM	Wed AM	Wed PM	Thurs AM	Thurs PM	Fri AM	Fri PM	Sat	Sun
1	ANC (SH)	MT	off	off	GOPD	SPA	ANC (MH)	off	Fert (YH)	SPA		
2	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW	SGH HW		
3	Admin	off	off	off	GOPD	HYST	ANC (MH)	off	Fert (YH)	SPA		
4	Elec C/S	MT	off	off	GOPD	HYST	Admin	off	SPA	MT		
5	Admin	off	off	off	GOPD	SPA	ANC (MH)	off	Fert (YH)	SPA		
6	Admin	off	off	off	Elec C/S	HYST	Admin	off	SPA	MT	NROC (SH)	NROC (SH)
7	ANC (SH)	MT	off	off	GOPD	SPA	ANC (MH)	off	Fert (YH)	SPA		
8	Admin	off	off	off	GOPD	SPA	Admin	off	SPA	SPA		

Appendix 3. York Anaesthetic staffing rota October 2025 demonstrating 100% obstetric 24/7 compliance

YORK ANAESTHETIC ON-CALL ROTA WEEK COMMENCING 6TH OCTOBER 2025

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
On Call		6th	7th	8th	9th	10th	11th	12th
ICU Consultant	08:00 - 18:00	KELLY	KELLY	KELLY	KELLY	HOWLEY	HOWLEY	HOWLEY
Acute Consultant	08:00 - 13:00	DILLEY	TAYLOR	HARVEY	STANNARD	STANNARD	MURGATROYD	KNOCK
Acute Consultant	13:00 - 18:00	DILLEY	TAYLOR	HARVEY	STANNARD	STANNARD	MURGATROYD	KNOCK
Overnight Consultant Acutes - Obs		FRANCIS	K TARRY	STONE	FITZMAURICE	STONE	DILLEY	MURGATROYD
Overnight Consultant - ICU		D TARRY	ANTILL	BERRIDGE	FERGUSON	REDMAN	FERGUSON	REDMAN
Obstetrics								
Consultant	08:00 -18:00	OLD	ROBINS	WALSH	VIPOND	TSANIDIS	MURGATROYD	KNOCK
Junior	08:00 -18:00	Poole	Poole	Poole	Poole	Mahmoud	Mahmoud	Mahmooud
Residents - day		**NB: ICU o/c Bleep 660, Obs o/c Bleep 600**						
SAS		**Feziula**	**Barsey**	**Prince**				
ICU	08:00 - 18:00	Akbar, Aslam	Aslam	Omer	Omer, Aslam, Wright	Batista, Samaliarachchi		
ICU	18:00 - 21:00	Akbar, Aslam	Aslam	Brooke, Aslam	Wright, Aslam	Batista, Samaliarachchi		
SR LD	08:00 - 21:00						Batista	Batista
LD Team	08:00 - 21:00							
LD Team	08:00 - 21:01						Samaliarachchi	Samaliarachchi
Acutes	08:00 - 18:00	John	Powell	Mahmood	Shelton	Onuwe		
Obs	18:00 - 21:00	Poole	Poole	Poole	Poole	Mahmoud		
Obs Bleep	08:00 - 21:00						Mahmoud	Mahmooud
Residents - night		**NB: ICU o/c Bleep 660, Obs o/c Bleep 600**						
SR	20:00 - 08:00	Ward	Ward	Ribeiro	Ribeiro	Eardley	Eardley	Eardley
Night Team	20:00 - 08:00	Batista	Batista	Chapman	Chapman	Suleiman	Suleiman	Suleiman
Night Team	20:00 - 08:01	Pinock, Samaliarachchi	Pinock, Samaliarachchi			Akbar	Wilkinson	Wilkinson
Obs Bleep	20:00 - 08:00	Ribeiro	Ribeiro	Pinnock	Pinnock	O'Rourke	O'Rourke	O'Rourke

YORK ANAESTHETIC ON-CALL ROTA WEEK COMMENCING

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
On Call		13th	14th	15th	16th	17th	18th	19th
ICU Consultant	08:00 - 18:00	CHAMBERLAI	CHAMBERLAIN	CHAMBERLAIN	CHAMBERLAIN	HOWLEY	RAMAN	RAMAN
Acute Consultant	08:00 - 13:00	JOLLIFFE	D TARRY	HARVEY	KNOCK	STONE	MURGATROYD	MURGATROYD
Acute Consultant	13:00 - 18:00	JOLLIFFE	D TARRY	HARVEY	KNOCK	STONE	MURGATROYD	MURGATROYD
Overnight Consultant Acutes - Obs		WALSH	TSANIDIS	WISE (KNOCK)	POLLARD	FITMAURICE	DAVIES	FRANCIS
Overnight Consultant - ICU		YATES	BERRIDGE	RAMAN	PRETORIUS	RAMAN	KELLY	HOWLEY
Obstetrics								
Consultant	08:00 -18:00	GILBERT	ROBINS	WRIGHT	TSANIDIS	WALSH	MURGATROYD	MURGATROYD
Junior	08:00 -18:00	Ward	Ward	O'Rourke	Lauder	Ribeiro	Ribeiro	Ribeiro
Residents - day		**NB: ICU o/c Bleep 660, Obs o/c Bleep 600**						
SAS								
ICU	08:00 - 18:00					Ireson		
ICU	18:00 - 21:00	Chapman, Ribeiro	Chapman, Powell	O'Rorke, Samaliarachchi	O'Rorke, Samaliarachchi	Ireson		
SR LD	08:00 - 21:00						Brooke	Brooke
LD Team	08:00 - 21:00					Suleiman	Ireson, Suleiman	Ireson, Suleiman
LD Team	08:00 - 21:01							
Acutes	08:00 - 18:00	Chiang	Khanvelkar	John	John	Powell		
Obs	18:00 - 21:00	Ward	Ward	Ebeid	Barsey	Ribeiro		
Obs Bleep	08:00 - 21:00						Ribeiro	Ribeiro
Residents - night		**NB: ICU o/c Bleep 660, Obs o/c Bleep 600**						
SR	20:00 - 08:00	Wright		Batista	Batista	Poole	Ebeid	Ebeid
Night Team	20:00 - 08:00		Brooke	Dunn-Roberts	Dunn-Roberts	Pinnock, Mina	Poole	Poole
Night Team	20:00 - 08:01	Ireson	Ireson, Wright			Aslam	Aslam	Aslam
Obs Bleep	20:00 - 08:00	Brooke	Dunn-Roberts	Onuwe	Onuwe		Pinnock	Pinnock

YORK ANAESTHETIC ON-CALL ROTA WEEK COMMENCING 20TH OCTOBER 2025

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
On Call		20th	21st	22nd	23rd	24th	25th	26th
ICU Consultant	08:00 - 18:00	ANTILL	ANTILL	ANTILL	ANTILL	RAMAN	PRETORIUS	RAMAN
Acute Consultant	08:00 - 13:00	WALKINGTON	CHEUNG	WALSH	CHIRVASUTA	WISE	HORNE	DHANDAPANI'
Acute Consultant	13:00 - 18:00	WALKINGTON	CHEUNG	McENROE	CHIRVASUTA	WISE	HORNE	DHANDAPANI'
Overnight Consultant Acutes - Obs		SOAR	WILLIAMS	WALSH	TAYLOR	DHANDAPANI	TSANIDIS	HORNE
Overnight Consultant - ICU		BERRIDGE	CARTER	URWIN	PRETORIUS	ANTILL	WASAWO	ANTILL
Obstetrics								
Consultant	08:00 -18:00	CURRAN	ROBINS	WISE	TSANIDIS	WALSH	HORNE	DHANDAPANI'
Junior	08:00 -18:00	Chiang	Mahmoud	Mahmood	Khanvelkar	Onuwe	Onuwe	Onuwe
Residents - day		**NB: ICU o/c Bleep 660, Obs o/c Bleep 600**						
SAS		**Feizula**	**Barsey**	**Prince**	**Bolton**			
ICU	08:00 - 18:00	Wright	Batista	Omer	Omer	Pinnock, Akbar		
ICU	18:00 - 21:00	Wright	Wright, Batista, Mahmood	Janardhana	Janardhana	Pinnock, Akbar		
SR LD	08:00 - 21:00						Savage	Savage
LD Team	08:00 - 21:00						Pinnock	Pinnock
LD Team	08:00 - 21:01						Akbar	Akbar
Acutes	08:00 - 18:00	Batista	Khanvelkar	Mahmoud	Powell	Savage		
Obs	18:00 - 21:00	Mahmood	Mahmoud	Mahmood	Mahmoud	Onuwe		
Obs Bleep	08:00 - 21:00						Onuwe	Onuwe
Residents - night		**NB: ICU o/c Bleep 660, Obs o/c Bleep 600**						
SR	20:00 - 08:00	Savage	Savage	Brooke	Ebeid	Ireson	Ireson	Ireson
Night Team	20:00 - 08:00	Eardley	Eardley	Eardley	Mina	Chapman	Chapman	Chapman
Night Team	20:00 - 08:01	Nel	Nel					
Obs Bleep	20:00 - 08:00	Onuwe	Onuwe	Ebeid	Brooke	Ribeiro	Ribeiro	Ribeiro

YORK ANAESTHETIC ON-CALL ROTA WEEK COMMENCING 27TH OCTOBER 2025

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
On Call		27th	28th	29th	30th	31st	1st	2nd
ICU Consultant	08:00 - 18:00	REDMAN	REDMAN	REDMAN	REDMAN	ANTILL	ANTILL	REDMAN
Acute Consultant	08:00 - 13:00	JOLLIFFE	HENDERSON	WISE	STANNARD	TSANIDIS	JOLLIFFE	CHIRVASUTA
Acute Consultant	13:00 - 18:00	JOLLIFFE	HEDNERSON	WISE	STANNARD	TSANIDIS	JOLLIFFE	CHIRVASUTA
Overnight Consultant Acutes - Obs		PHIN	MURGATROYD	CHEUNG	SMALES	CHIVASUTA	KNOCK	FRANCIS
Overnight Consultant - ICU		D TARRY	HOWLEY	RAMAN	URWIN	FERGUSON	PRETORIUS	ANTILL
Obstetrics								
Consultant	08:00 -18:00	GILBERT	WISE	Cowton	ROBINS	OLD	JOLLIFFE	CHIRVASUTA
Junior	08:00 -18:00	O'Rourke	Powell	Ireson	Chapman	Hayat	Chiang	Ebeid
Residents - day		**NB: ICU o/c Bleep 660, Obs o/c Bleep 600**						
SAS		**Feizula**	**Barsey**	**Prince**	**Bolton**			
ICU	08:00 - 18:00	Omer, Wright	Omer, Wright, Eardley	Akbar	Ireson, Akbar, Batista	Omer		
ICU	18:00 - 21:00	Ebeid, Eardley, Wright	Eardley, Wright	Ireson, Akbar,	Akbar, Batista	Khanvelkar		
SR LD	08:00 - 21:00						Ebeid	Chiang
LD Team	08:00 - 21:00						Hayat	Hayat
LD Team	08:00 - 21:01							
Acutes	08:00 - 18:00	Powell	O'Rourke	Poole	Dunn Roberts	Chiang		
Obs	18:00 - 21:00	O'Rourke	O'Rourke	Ireson	Ireson	Hayat		
Obs Bleep	08:00 - 21:00						Chiang	Ebeid
Residents - night		**NB: ICU o/c Bleep 660, Obs o/c Bleep 600**						
SR	20:00 - 08:00	Chaing	Chiang	Savage	Savage	Wright	Wright	Wright
Night Team	20:00 - 08:00	Mahmood	Mahmood	Mahmoud	Mahmoud	Samaliarachch	Samaliarachch	Omer
Night Team	20:00 - 08:01	Zaman	Zaman	Zaman	Zaman		Shelton	Samaliarachchio
Obs Bleep	20:00 - 08:00	Khanvelkar	Mahmoud	Mahmood	Mahmood	Janardhana	Janrardhana	Shelton

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	Maternity and Neonatal Voices Partnership (MNVP) Annual Report
Director Sponsor:	Sascha Wells-Munro OBE, Director of Midiwfery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)
Author:	Helen McConnell (Lead for York and Scarborough Maternity and Neonatal Voices Partnership - MNVP)

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)

☐ Yes

☐ No

☐ Not Applicable

Executive Summary

The purpose of the report is to inform the Trust Board of the work undertaken over the last year by the MNVP, in partnership with York and Scarborough maternity and neonatal services.

Key Assurances

- Increased Engagement: Social media presence and visibility improved; MNVP posters and information boards installed at York and Scarborough sites; neonatal and bereavement leaflets created to support service users in sharing challenging/sensitive feedback.

- Diversity & Inclusion: Active outreach to minority ethnic communities, teenage pregnancy groups, and marginalized populations; easy-read resources developed.
- Service User Voice Embedded: Listening events held across the patch geographically including York, Scarborough and Malton. Increase in number of invitations to attend existing parent groups
- Safety & Communication: Progress on communication strategy and leaflet accessibility; personalised care plans co-produced and ready for launch.
- Bereavement Support: Bespoke bereavement leaflet included in parent packs; mapping review completed; consultation on bereavement survey completed, joint working with bereavement team established with plans for joint listening events in 2026.
- Neonatal Collaboration: Neonatal engagement lead embedded; bespoke neonatal leaflet created; SCBU refurb discussions include MNVP input.
- Operational Planning: Quarterly meetings delivered; structural gaps escalated; risk register updated.

Key Risks

- Resource Constraints: Antenatal education programme and partner golden hour project delayed due to capacity and funding limitations.
- Homebirth Service Reliability: Service remains inconsistent.
- Translation & Accessibility: Ongoing gaps in language support and digital accessibility for marginalized groups.
- Feeding Support: Capacity issues identified
- Sustainability: ICB re-structure poses risk to continuation of MNVP

Key Concerns

- Variation in Antenatal Education Quality: Mixed feedback across geographic areas; cancellations and delays reported.
- Communication Gaps: Inconsistent documentation and trauma flags in BadgerNotes
- Operational Pressures: Heavy reliance on volunteers and limited admin support for MNVP impacting delivery of workplan actions.

Recommendation:
Review and accept the report from the Maternity and Neonatal Partnerships.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Quality Committee	16 December 2025	

Introduction:

The York & Scarborough MNVP workplan for 2024 - 25 focuses on embedding service user voices across maternity and neonatal services. Co-produced with the Trust, the MNVP workplan plan aligns with the trusts High-Level Action Plan and CQC maternity survey priorities. Seven key themes have driven the work over 2025: engagement, safety, choice, bereavement, neonatal voice, perinatal mental health, and operational sustainability.

Improvement and Transformation:

There have been several key successes in our work over 2025, where the MNVP have worked effectively with the trust to drive positive change and build on established good practice to continue to improve the experience of those using YSTHFT maternity and neonatal services.
This year we have:

- Increased our visibility through social media, hospital boards, and community events. Listening events and focus groups have expanded participation and seen our volunteer group expand by 150%. The more engagement we have with our service, the more we can build a picture of what the population of York, Scarborough and the surrounding area want their maternity and neonatal services to look and feel like.
- Built relationships with marginalised groups, working closely with NYCC teenage pregnancy taskforce, Refugee Action York, PRIDE, and Askham Grange Prison to ensure we are hearing a wide range of experiences from service users, to inform inclusive and meaningful change for all.
- Co-produced easy-read materials, demonstrating our commitment to equity.
- Streamlined the BadgerNotes timeline with an MDT team, to address 'notification overload' which resulted in unread information leaflets on BadgerNotes.
- Co-produced personalised care plans to meet both national guidelines and local needs and wants for care.
- Co-produced a maternity survey to increase the breadth and depth of feedback captured when women and birthing people are discharged from maternity care.
- Attended all meetings outlined in the MNVP national guidance, contributing to guidelines, PILS, PMRT, safety champions, assurance and directorate.
- Conducted 15 steps events at both sites, compiling reports with recommended actions which have been reviewed by the trust and are embedded within the single improvement plan.
- Celebrated international day of the midwife, giving service users the opportunity to nominate a midwife for providing wonderful care and sharing the feedback with staff.

(see appendix A for our 'you said, together we did' sections from MNVP quarterly meeting presentations)

Impact of work:

The work undertaken by the MNVP has significantly strengthened the voice of service users within maternity and neonatal services, leading to tangible improvements in experience and satisfaction. Through targeted listening events, bespoke surveys, and co-production of resources, service users have reported feeling more informed and included in decision-

making. For example, feedback gathered during focus groups has directly influenced updates to induction of labour information, partner access guidelines, and neonatal communication practices.

The introduction of easy-read materials, translated resources, and QR code access has reduced barriers for families from diverse backgrounds, while improvements in SCBU communication and accommodation have addressed previous concerns about separation and lack of support. Service users have noted greater responsiveness to their needs, such as the provision of meal vouchers for parents staying with babies in neonatal care and the development of personalised care plans that incorporate trauma-sensitive communication.

Formal complaint data is outside of the remit of the MNVP and therefore not included in this report, however anecdotal feedback and engagement metrics indicate a positive shift in trust and confidence in local maternity services. The MNVP's collaborative approach has ensured that issues raised—such as pain relief delays, feeding support gaps, and partner access—are now actively addressed through joint action plans with the Trust. These changes demonstrate a clear trajectory towards improved safety, inclusivity, and overall experience for families across York and Scarborough.

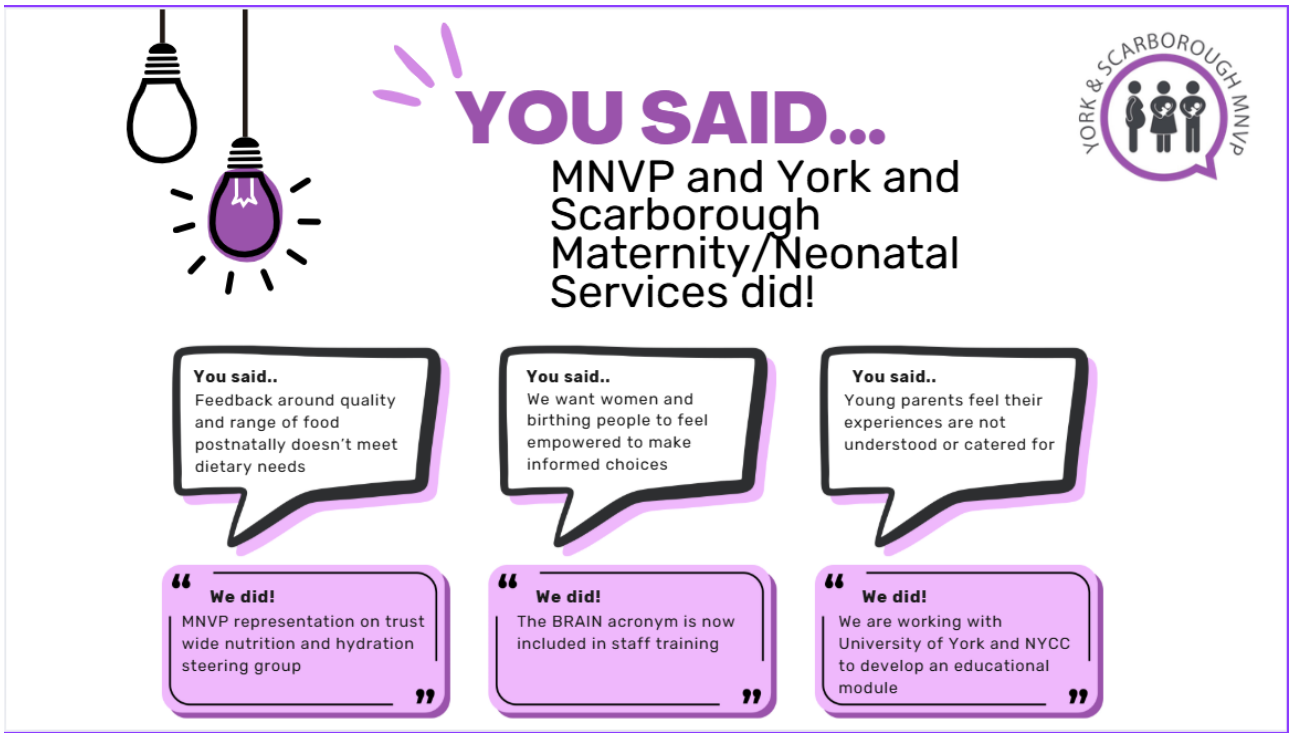
Collaboration:

The York & Scarborough MNVP is a fully embedded partner within local maternity and neonatal services, demonstrating best practice in co-production and service user engagement. The MNVP lead now serves as co-lead for Workstream One of the single improvement plan, ensuring that service user voices are not only heard but actively shape strategic priorities and operational improvements.

This embedded approach has strengthened collaboration across multiple levels. MNVP works hand-in-hand with the Trust on initiatives such as communication strategy development, antenatal education planning, and feeding support reviews, while also contributing to regional LMNS wide projects. The partnership extends beyond healthcare, engaging with community organisations, public health teams, and voluntary groups to address complex needs and reduce health inequalities.

Embedding MNVP within governance structures is widely recognised as best practice because it creates a continuous feedback loop between service users and providers. This model ensures that real-world experiences inform policy, leading to safer, more inclusive, and responsive maternity care. By integrating the MNVP into decision-making forums and quality improvement processes, the Trust benefits from early identification of issues, co-designed solutions, and increased confidence among families that their voices matter. Ultimately, this collaborative framework drives service improvements that enhance outcomes and experiences for all who use maternity and neonatal services.

Appendix 1


YOU SAID...
MNVP and York and Scarborough Maternity/Neonatal Services did!
YORK & SCARBOROUGH MNVp
You said..
Feedback around quality and range of food postnatally doesn't meet dietary needs
We did!
MNVP representation on trust wide nutrition and hydration steering group
You said..
We want women and birthing people to feel empowered to make informed choices
We did!
The BRAIN acronym is now included in staff training
You said..
Young parents feel their experiences are not understood or catered for
We did!
We are working with University of York and NYCC to develop an educational module


YOU SAID...
MNVP and York and Scarborough Maternity Services did!
YORK & SCARBOROUGH MNVp
You said..
The healthy start free vitamin information not always accessible
We did!
Links to who is eligible & how to access added to booking email to ensure widespread availability of information
You said..
There is not enough support around birthing outside of guidance
We did!
Process map & focus group build guideline to support safe personalised care
You said..
There is too many notification on badger notes
We did!
Conducted full timeline review in order to streamline push notifications

YOU SAID...

MNVP and York and Scarborough Maternity Services did!

You said..
The posters for visitors specify grandparents and that didn't always meet families needs.

We did!
Posters now state clearly that you can have 4 nominated visitors of your choice - York.

You said..
There is not enough representation from diverse voices

We did!
We are working with community midwifery teams & independent engagement to increase this

You said..
Limited patient information shared on badger notes

We did!
We completed a mapping exercise to streamline & organise patient information sent out via badger - ongoing

YOU SAID...

MNVP and York and Scarborough Maternity Services did!

You said..
The debrief is inconsistent and not always available, some not aware of it

We did!
Together with Humber & NY LMNS and Y&S maternity services to deliver a consistent debrief service

You said..
More partner access is needed

We did!
Partner project started, to look at more access for partners considering safety, estate & service user feedback

You said..
The bereavement wording needed adjustment on the birth stats post

We did!
We worked with a service user & the bereavement team to adjust the wording

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	Quarter 2 Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Owen Bebb- Associate Medical Director for Patient Safety Alice Hunter- Patient Safety Specialist

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

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

☐ Yes

☐ No

☐ Not Applicable

Summary of Report and Key Points to highlight:
This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
  - HSMR (Hospital Summary Mortality Indicator)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:

- Nationally mandated data
- Locally mandated data
- Quality account data

- Learning from deaths – themes, actions and escalations
  - Poor care was given to 4/19 SJCR's reviewed.
  - Moderate harm was given to 3/19 SJCR's reviewed.
  - Number of SJCR training attendees has declined
  - One case met the threshold for referral to the Maternity and Newborn Safety Investigations (MNSI) as am intrapartum stillbirth at over 37 weeks gestation.

Metric	Result
Crude mortality	Crude mortality is 2.37% (June 2024 to May 2025) (12 month rolling HES data)
SHMI – HES HED1	SHMI for 12 months (August 2024 to Julyl 2025) is 92.64
SHMI - NHS England2	
	SHMI for 12months (Mar 2024 to February 2025) is 92.84
HSMR3	

[1] SHMI HES HED - Summary Hospital Mortality Indicator 12month rolling, Hospital Episode Statistics and published by Healthcare Evaluation Data for UK Health Data Benchmarking
[2] SHMI NHS England - Summary Hospital Mortality Indicator 12month rolling, NHSE SHMI dataset
[3] HSMR – Hospital Standardised Mortality Ratio

Recommendation:
The Board is asked to note the report and receive the escalations.

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

Meeting/Engagement	Date	Outcome/Recommendation
Learning from Death Group	10/11/2025	
Patient Safety & Clinical Effectiveness Subcommittee	12/11/2025	
Quality Committee	16/12/2025	

1. Y&SH NHS FT mortality rates

The references in section 6 provide details about the methodologies for measuring mortality and their context.

1.1 Crude Mortality - unadjusted

Crude Mortality rate is the percentage of patients that have died. The crude rate includes all deaths up to 30 days post discharge. The crude mortality rate is the sum of the in-hospital deaths and the out-of-hospital deaths against all discharges. For quarter 2 in July it was 1.74% and for August 1.4%. The crude mortality (12-month rolling, September 24 to August 25) is 2.25% (National is 2.18%). The rolling 12month trend has returned to decreasing compared previous. Its likely we will see an increase with the winter months.

The crude mortality of all non-elective admissions (12-month rolling, September 24 to August 25) stands at 4.16%. The general trend month by month is that the crude mortality is falling.

Benchmarking of crude mortality against other Trusts is not recommended due to significant operational variations between Trusts. Instead, Trusts should monitor local trends comparing data from the same month or quarter each year. This takes account of seasonal variation seen locally and nationally. For our trust we see an increase in the winter months but overall there is a downward trend in crude mortality rates.

1.2 Summary Hospital-level Mortality Indicator - adjusted mortality

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust, including those receiving palliative care, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the Trust. It covers patients who died either while in hospital or within 30 days of discharge.

A standard approach is taken to ‘adjust’ the figures so that the England average is always reported as ‘100’. Values below 100 represent a better outcome, i.e. lower mortality, and vice versa.

Further information regarding the methodology can be found in the references towards the end of the report.

Two risk-adjusted mortality rates are presented:

- NHS Digital-SHMI: uses HES data and is available 6 months in arrears.
- HED HES-SHMI: This is provided by Healthcare Evaluation Data for UK Health Data Benchmarking (HED). It uses Trust hospital episode statistics (HES) to generate the outcomes. Data is available 3 months in arrears.

The latest NHS-Digital Summary Hospital Mortality Index (SHMI) to May 2025 (covering July 24 to May 25) shows the SHMI was 92.19 The SHMI in comparison to other Trusts is displayed below (Figure 1). Compared to July 24 we have seen a decrease in the SHMI from 95.99 to 92.19 in May 25.

The SHMI HES data reports the SHMI (12 month rolling, August 24 to Jul 25) at 92.64 this is continuing to reduce, (Expected deaths 3340, observed deaths 3094) (Figure 2). For in-

hospital deaths the numbers were as follows; observed 2113, expected 2316. For out of hospital deaths observed deaths were 991, expected deaths 1024. These all fall 'within expected range' as defined by HED.

Figure 3 shows the SHMI trend by month over the last 12 months. Overall the SHMI continues to improve. Figure 4 shows the rolling 12 month NHS SHMI for the individual sites (July 24 to June 25), York (0.90) has a lower SHMI than Scarborough (0.95). When compared to the previous reported period there has been a 0.03 reduction at Scarbrough whilst York has remained static.

Figure 1 SHMI benchmarked against all other Trusts (our Trust highlighted blue)

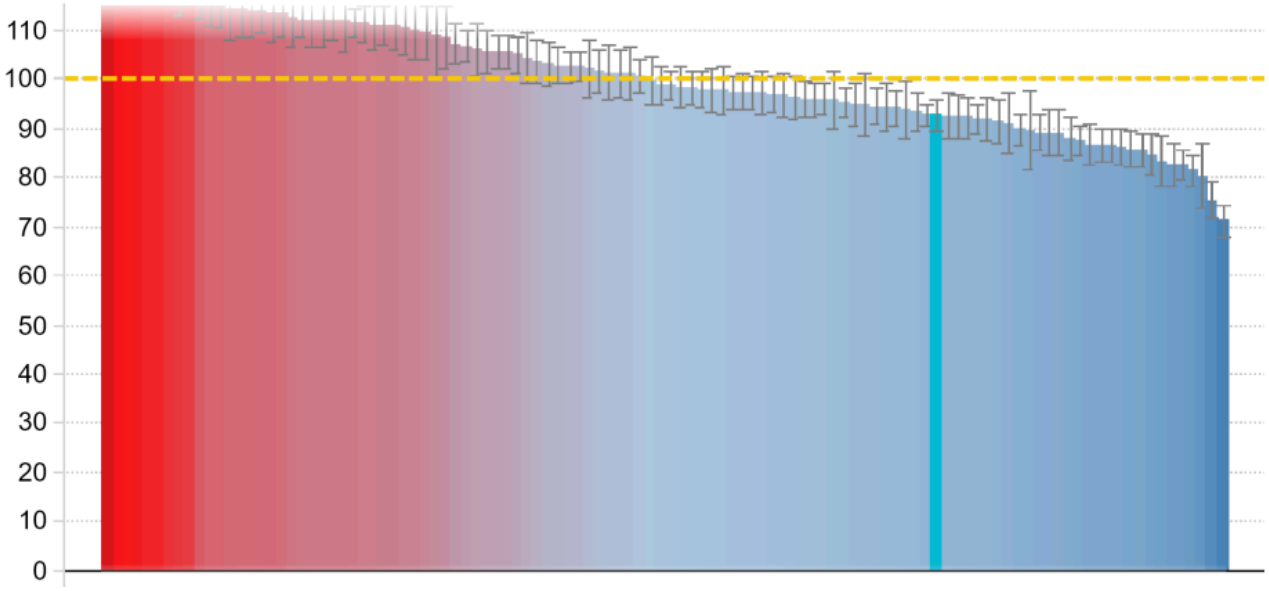


Figure 2 SHMI (HES/HED data) Funnel plots (in comparison with other Trusts)

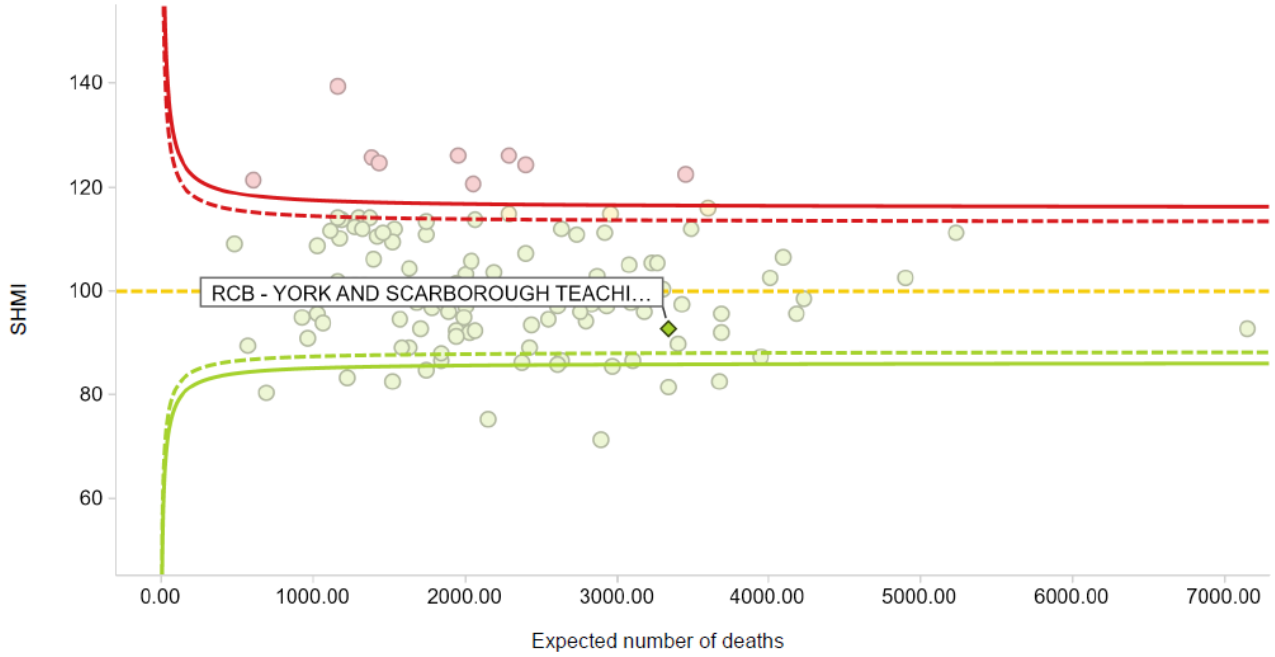
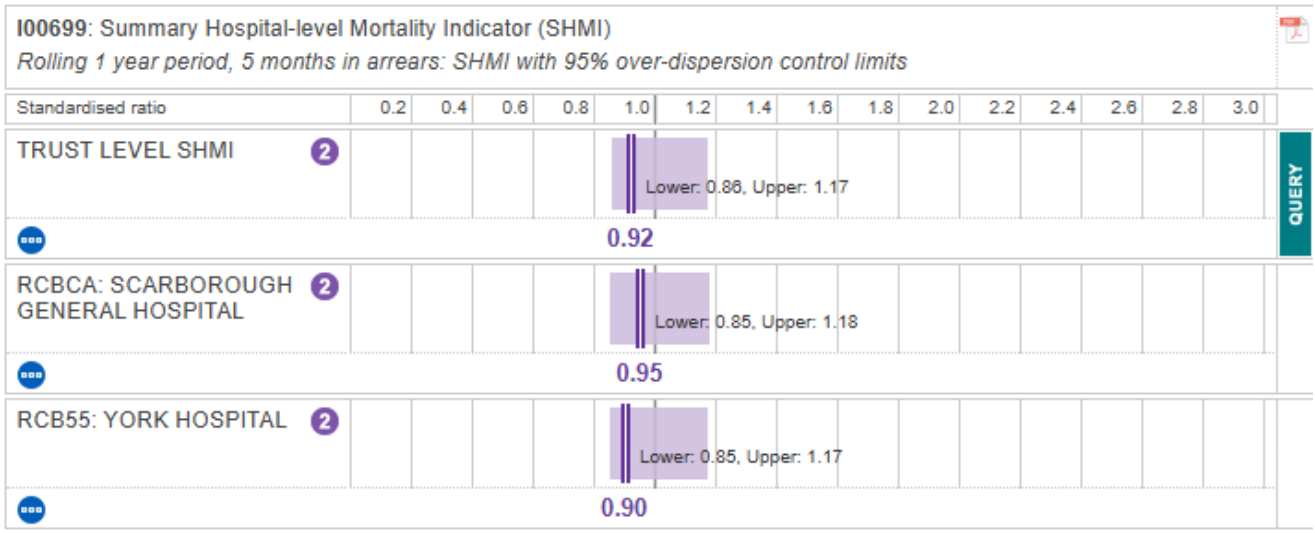


Figure 3: Time series data for SHMI (HES-HED data, to February 25) showing trend over time

Figure 4 SHMI site comparison July 2024 to June 2025



1.3 Hospital Standardised Mortality Ratio (HSMR)

The HSMR measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics e.g., demographics. It does not include as many diagnostic groups as the SHMI (only about 85% of total patient numbers) and this may affect applicability of the measure.

The most recent HSMR covers the period to October 2025 (covering September 24 to August 25) and is reported as follows:

Crude mortality rate 2.63%. (Observed deaths 1670, expected deaths 1577)

HSMR: 105.91 the previous report values was 108.36

The HSMR remains higher than would be expected and it is unclear at present as to what might be contributing to this. We are continuing to look at the hospital mortality coding to understand potential influences on this rate, and to understand the variability of the reported rate over time. The rolling 12-month HSMR continues to trend downwards.

Figure 5 shows our position in relation to other trusts, Figure 6 shows we remain outside expected limits however have moved closer to the upper limit. Figure 7 shows the HSMR on a month by month basis. The overall trajectory is down, there was a marked decrease in December the reason for this is unclear, as is the reason for the spike in June.

Figure 5. HSMR (to May 2025) – in comparison with other Trusts – Y&S Trust :light blue bar

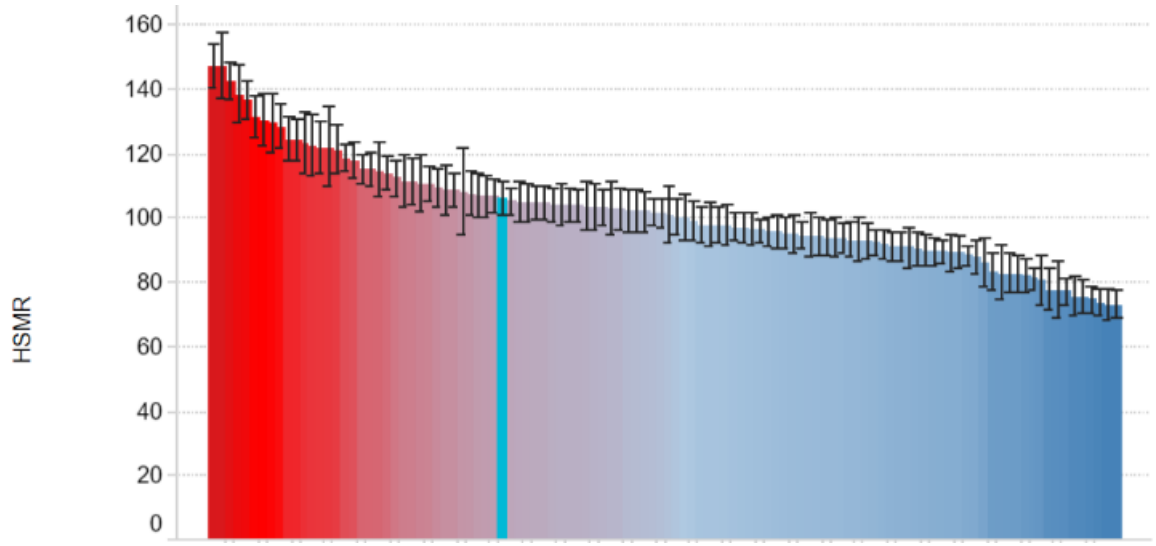


Figure 6 HSMR Funnel Plot (to August 2025)

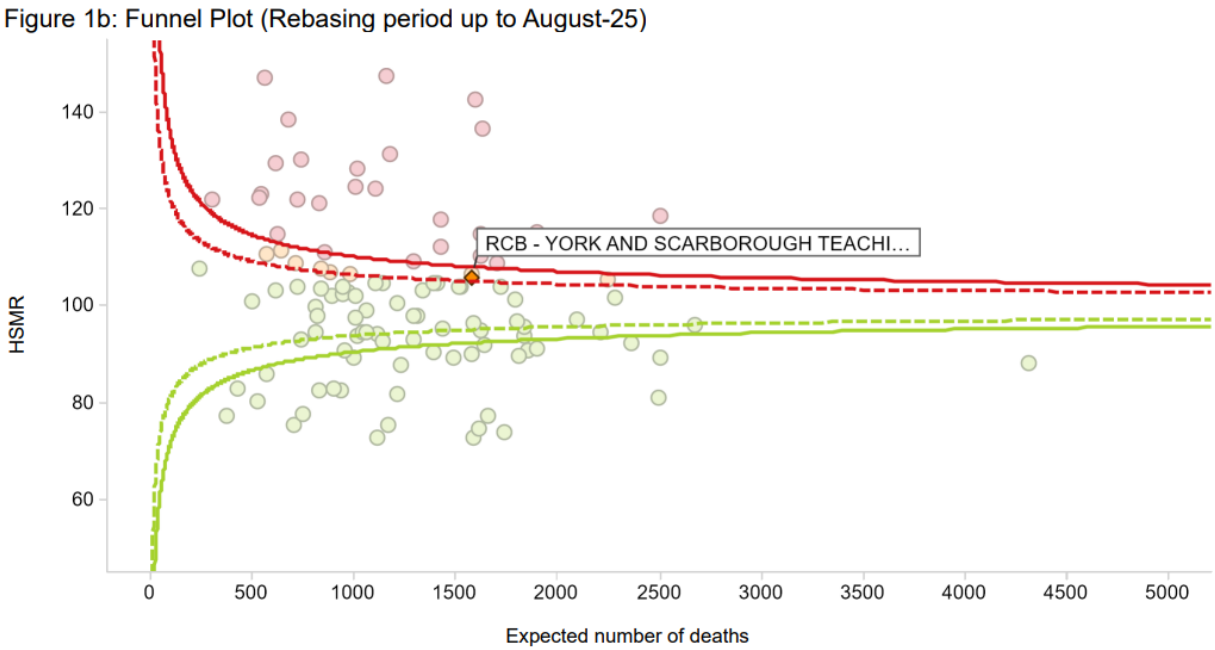
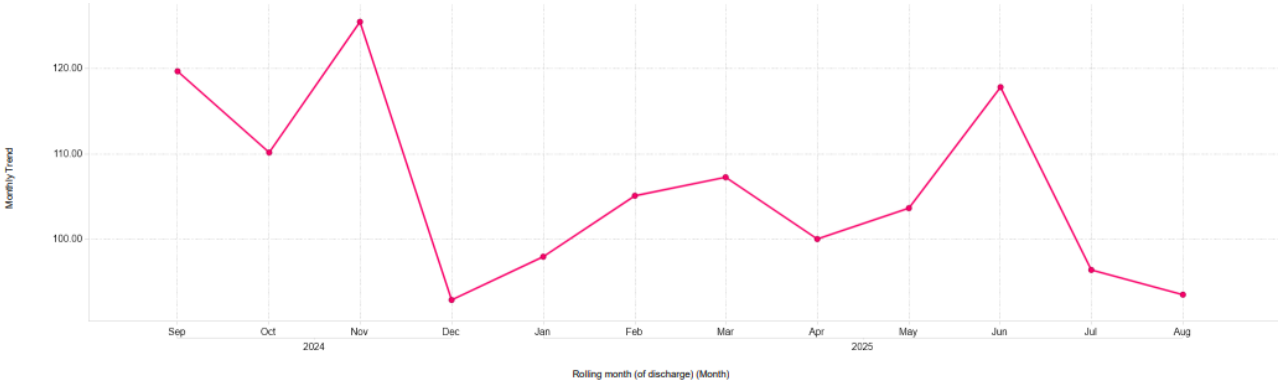


Figure 7 HSMR Time series data



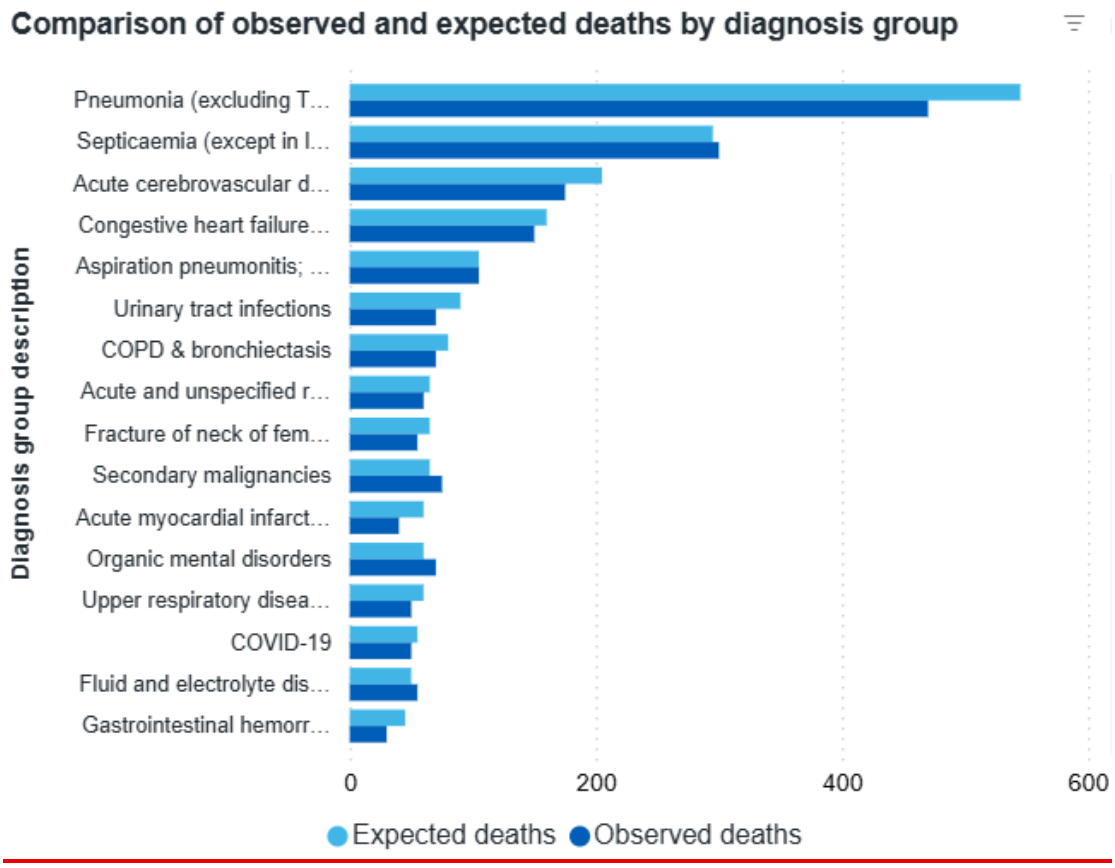
2. Diagnostic groups contributing to our mortality rates

There are 144 diagnostic groups that contribute to the NHS-Digital SHMI aggregate to give each Trust an overall SHMI value.

The way in which coding is applied to patients that die in the Trust can significantly affect mortality statistics. The “depth of coding” (coding of co-morbidities as well as primary diagnosis) is important as it allows for more accurate calculation of the expected number of deaths that should be seen during a specific time period. Coding of the primary diagnosis will also affect mortality statistics in particular diagnostic groups. We continue to work with the coding team to understand how better to managing this reporting and we are using the learning provided from Trust mortality reviews via the Learning from Deaths process to triangulate our current mortality outliers and ascertain if any further investigation is required.

The most recent breakdown of differential SHMI for common diagnostic groups is displayed in Figure 8 below. At present there remain no diagnostic groups causing concern, however this data does triangulate with other patient safety work that we are undertaking. There are more observed than expected deaths in septicaemia, secondary malignancies, organic mental disorders and fluid and electrolytes. Septicaemia is obviously a key focus in the trust and recent audits suggest we will hopefully see an improvement in this group in the near future.

Figure 8: SHMI associated with various diagnostic groups (from HES data) for June 24 to May 25



3. Learning from Deaths

The national Learning from Deaths (LfD) Framework, 2017 sets expectations for Trusts to conduct reviews of the care and treatment of patients who died in their care, acting on the findings and reporting outcomes. The requirement to publish outcomes from LfD within Quality Accounts was mandated at the same time.

This section provides data and outcomes in line with the requirements of the:

- National Guidance on Learning from Deaths (National Quality Board, 2017)
- Trust's Learning from Deaths Policy
- Department of Health and Social Care NHS (Quality Accounts) Amendment Regulations 2017

Whilst the report focuses on quarter 3 data, some information is provided for quarter 1 and 2 for comparison.

3.1 Nationally mandated data and information

The data provided in the table below is mandated by the national LfD framework. A narrative on learning and actions is provided in section 4.

When reading the table, SJCRs are Structured Judgement Case-note Reviews; PSII are Patient Safety Incident Investigation. It should be noted that that PSIIs replaced SIs when the new PSIRF

Table 1 – National data summary

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep
	Quarter 3 (24/25)			Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)		
Total in-patient deaths (inc ED, exc community)	195	216	200	257	211	253	196	187	178	168	141	171
No. SJCRs commissioned for case record review[1]	2	7	11	6	4	7	5	7	3	2	2	5
No. PSII commissioned of deceased patients	2	0	0	0	2	1	2	2	2	0	1	1
No. deaths likely due to problems in care	See tables below		See tables below		See tables below		See tables below		See tables below		See tables below	

1 The SJCRs are those requested in month (adjusted to account for reassignments; and including deaths from 24/25).

National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst

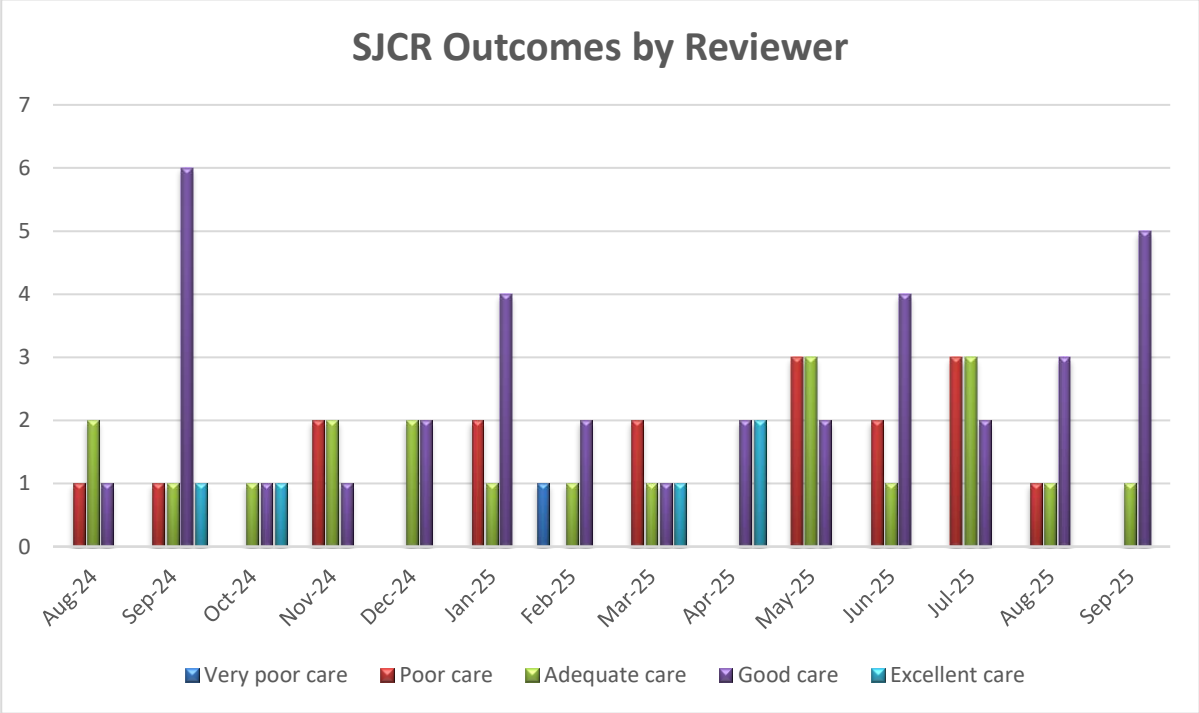
avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Figure 6 shows the outcomes of the SJCRs **completed and reviewed** during Q3, Q4 in 24/25 and Q1and Q2 in 25/26:

- Figure 6 - the 'overall score' provides the rating from the Reviewer based on their assessment of care during the last admission.
- Figure 7 - the 'degree of harm' agreed by the Learning from Death Group having considered the findings from the Reviewer, its context and consideration of any additional information**.**

During Q2 19 SJCRs were reviewed (19 in Q1):

Figure 6 – SJCR outcomes assigned by the Reviewer (overall score)

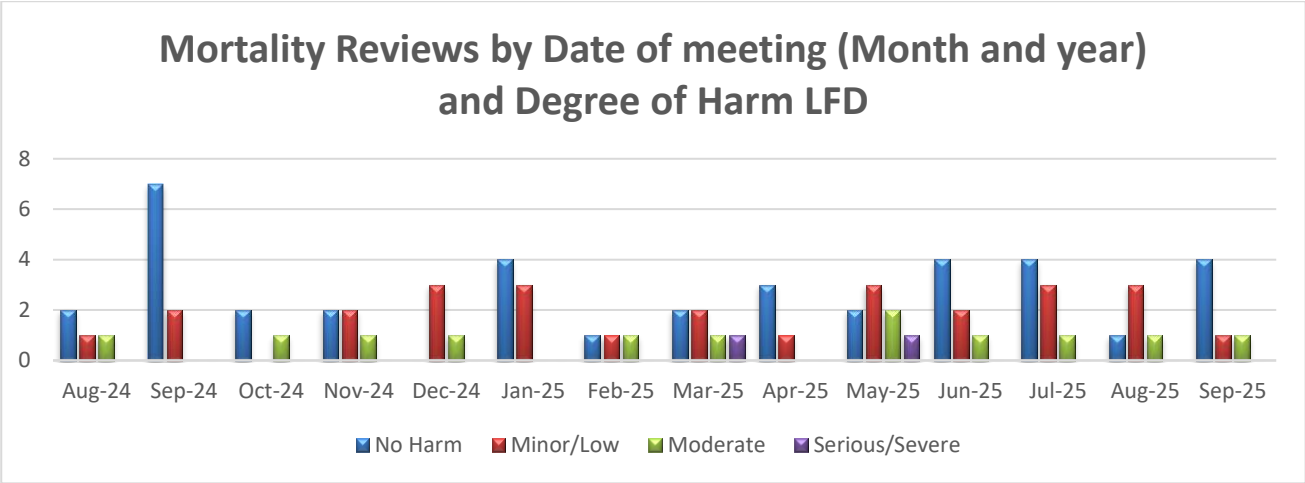


The Reviewer found there to be:

- Good care in 10/19 cases.
- Excellent care in 0/19 cases
- Adequate care in 5/19 cases
- Poor care in 4/19 cases
- Very poor care in 0/19 cases

The LfD group will decide on the level of harm for the SJCRs presented. The degree of harm levels are No harm, Minor, Moderate, Severe and Death.

Figure 7 – SJCR outcomes following review by LfD Group (degree of harm)



The Learning from Death Group agreed harm leading to death in 0 cases, severe in 0 cases, moderate harm in 3 cases, low in 7 of the cases and no harm in 9 cases.

Moderate harms

3544- Patient with multiple ward moves; discharge delays, oxygen provision, and outlier status discussed. Care rated adequate; moderate harm identified.

4470- Case downgraded to poor care due to missed fracture, delayed diagnosis, inadequate pain relief and moderate harm; further discussion planned.

3959- Care rating changed from very poor to poor; moderate harm identified; escalation and assessment failures highlighted; actions referred for review.

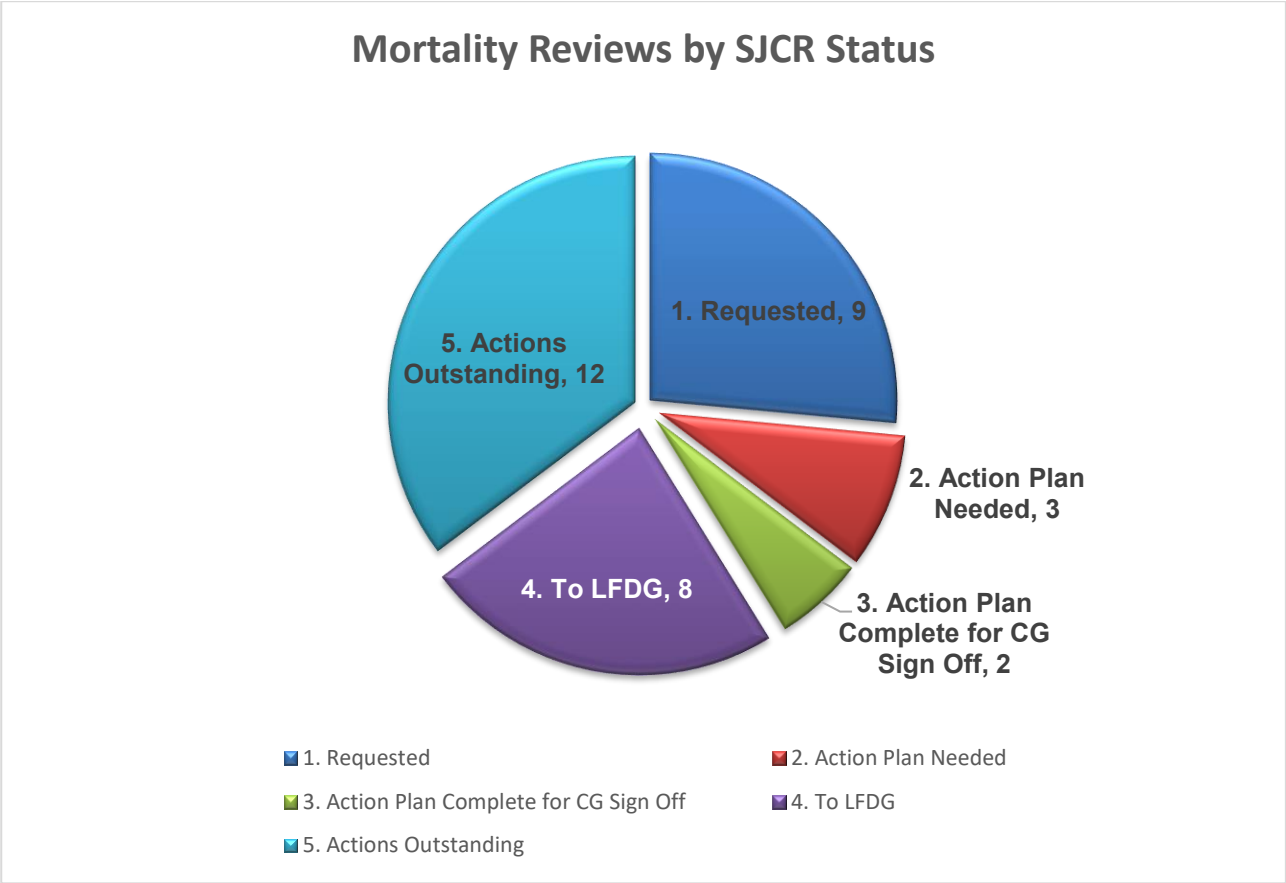
3.2 Locally mandated data

Trust policy requires that the national data is supplemented with locally mandated data to provide a richer picture of performance now Medical Examiners review all deaths; and the timely completion of structured judgement case-note reviews.

Data on progress of investigations at point of reporting (30/09/2025)

Overall no. of SJCRs open 34 (previously 40 as of 04/07/2025)

Figure 8 – Status of open SJCRs (date collected (30/09/2025)



	Q3 (24/25)	Q4 (24/25)	Q1 (25/26)	Q2 (25/26)
Number under review	24	17	15	17
Awaiting action planning	4	3	5	5
Actions outstanding	3	1	8	12
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	12	9	8	5

There is a positive decrease in the number of SJCR's more than 60 days overdue, this has been evident since the increase in the number of trained SJCR investigators.

3.3 Quality account data

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The data relates to regulation 27.

Table 2 – Quality Account Data

The data shown for sections 27.1-27.3 relate to the deaths that occurred in 2025/26. (please note that the numbering of these relate to the numbering dictated by the Quality Account Report which is why they differ from the rest of the report.

The data shown for sections 27.7-27.9 relate to the deaths that occurred in 2024/25 but were investigated during 2025/26 and hence not reported in the 2024/25 Quality Account.

	Requirement	Q1 25/26	Q2 25/26		
27.1	Total number of in-hospital deaths	561	480		
27.2	No. of deaths resulting in a case record review or PSII investigation (requested reviews of patients who died in 24/25 or 25/26)	ME:561	ME:480		
		SJCRS: 15	SJCRS:9		
		PSII:6	PSII:2		
27.3	No. of deaths more likely than not were due to problems in care[1] (completed investigations of patients who died in 24/25)	0	0		
27.7	No. of death reviews completed in year that were related to deaths in the previous reporting period [2] but not previously reported	SJCR: 6	SJCR: 6		
		PSII:5	PSII:0		
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	0	0		
27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	0	0		

[1] This is where the degree of harm after investigation / SJCR is agreed as death based on the opinion of the members of the SI Group and Learning from Deaths Group
[2] Reviews completed in 2025/26 after the 2024/25 Quality Account was published

4. Learning from Deaths - themes and actions

There are certain categories of deaths where a full review is automatically expected:

a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth
d. Stillbirths or perinatal deaths

Local PSII investigations, where death has occurred, are considered by the LfD Group to identify themes that are also common to SJCRs.

The national LfD Framework requires SJCRs to be undertaken when the following criteria are met:

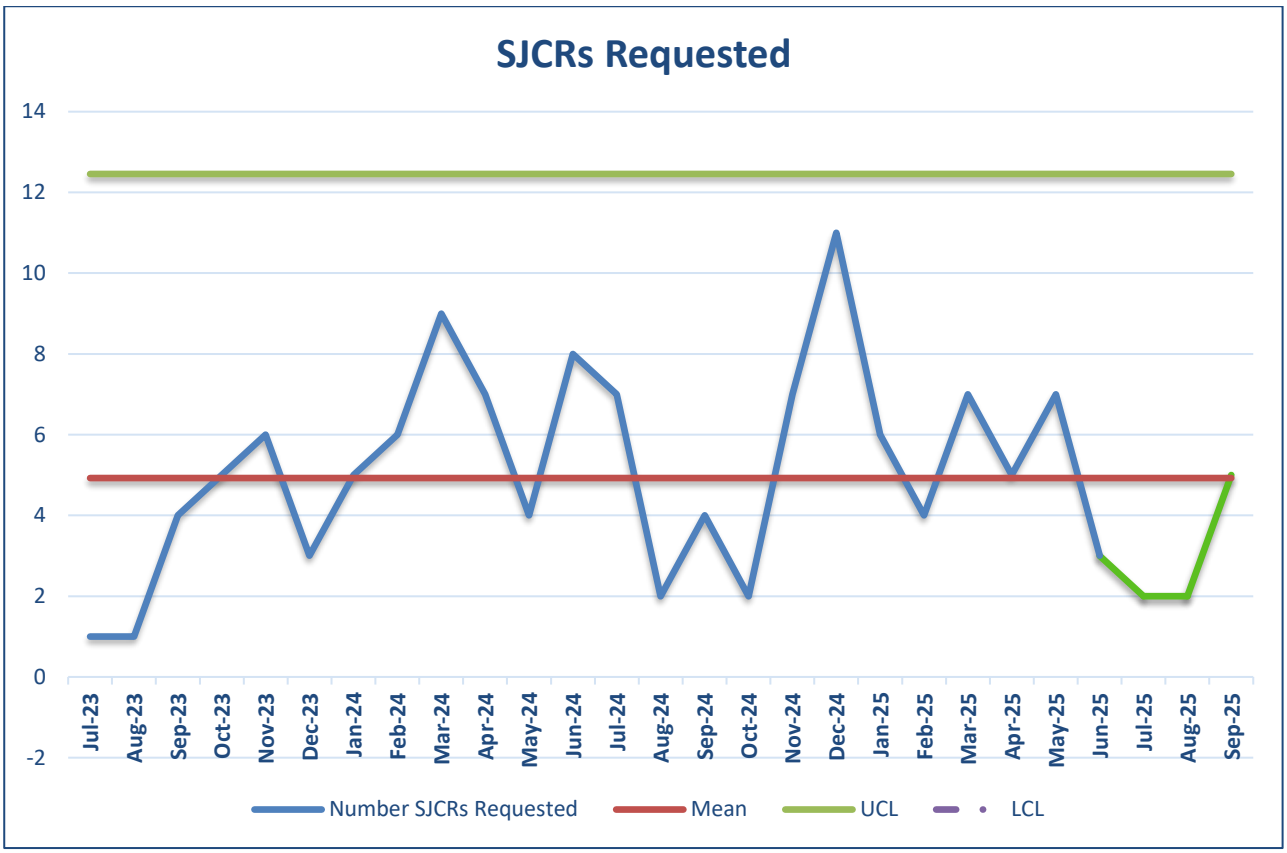
- Where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- Where a patient had a learning disability or severe mental illness.
- Where an 'alarm' has been raised e.g. via an elevated mortality alert, audit or regulator concerns.
- Where people are not expected to die, e.g. elective procedures.
- Where learning will inform the provider's existing or planned improvement work.
- A further random sample of other deaths so that providers can take an overview of where learning and improvement is needed most overall.

Table 3 below shows the source of SJCR requests for 2024/25 Q3 and Q4 and 2025/26 Q1, Q2; it should be noted that there can be more than one source, however, to avoid duplication only the original inputted source is considered.

Table 3 – Source of request for SJCR

There were 9 requested SJCR's in Q2, 15 were requested in Q1 25/26. 20 in Q3 and 16 in Q4 24/25.

SJCR Request Source	Oct -24	Nov -24	Dec -24	Jan -25	Feb -25	Mar -25	Apr -25	May -25	Jun -25	Jul -25	Aug -25	Sep -25
Care Group	1	3	8	3	2	6	3	3	1	1	1	1
Learning Disabilities	1	1	1	0	0	0	1	2	2	0	0	2
Medical Examiner Review	0	3	2	2	1	0	0	0	0	1	0	1
NoK Concern/ Complaint	0	0	0	0	1	0	0	0	0	0	0	1
Elective Admission	0	0	0	0	0	1	1	1	0	0	0	0
Q & S	0	0	0	1	0	0	0	1	0	0	1	0
Initial Mortality Review	0	0	0	0	0	0	0	0	0	0	0	0



4.1 Themes from SJCRs considered by the LfD Group in Q2:

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work.

The introduction of DCIQ and the mortality module has meant that themes and trends identification has had to be updated. During the creation of the mortality module, it was decided that themes would be based on the same ones as the other modules in DCIQ to allow cross comparison and triangulation of data when required.

The themes are identified within the Learning from Deaths meeting. These themes identified are shown in Table 4.

Table 4 – Themes identified

	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
Communication/ Documentation	1	0	3	2	1	1	2	4	2	1	0	1
No Themes Identified	0	2	0	3	0	2	2	1	2	2	1	0
Escalation	0	0	0	0	0	1	0	1	3	4	0	0
Not listed (please specify)	2	0	1	0	1	2	0	1	1	0	0	0
Pathways/Process	0	0	1	2	0	0	0	3	0	0	0	2
Clinical Assessment	0	0	0	0	0	2	0	0	0	2	3	0
Consent	0	0	0	0	0	0	0	0	1	0	0	3
Capacity/Demand	0	0	0	1	1	0	0	0	0	0	0	2
Nutrition and Hydration	0	0	1	0	1	0	1	0	0	0	0	1
Delayed Diagnosis /Treatment	0	0	0	0	0	0	0	0	0	1	2	0
Transfer Issues	0	0	0	0	0	0	0	0	1	0	0	1
Guidance/Policies	0	0	0	0	0	0	0	0	0	1	0	0

Patient Factors	0	0	0	0	0	0	0	0	0	1	0	0
Team Factors	0	0	0	1	0	0	0	0	0	0	0	0

The key themes identified from July, August, and September revolved around escalation, communication, and clinical assessment.

5.0 Escalations & Learning

5.1 Maternity update Q2

There have been a total of four eligible losses reported to MBRRACE-UK via the PMRT in Quarter 2.

One case met the threshold for referral to the Maternity and Newborn Safety Investigations (MNSI) as am intrapartum stillbirth at over 37 weeks gestation.

5.2 Learning from deaths group overview

Jul 2025

Key themes included escalation, communication and clinical assessment.
Training

- 18 new SJCR reviewer completed the training.
- Further sessions planned.
- Introductory session on new consultant programme.
- 47 active SJCR trained reviewers.

SJCR 4016 & 2017 were downgraded to poor care and referred to Q&S, however both low harm.

There has been a national domestic homicide project.

- 98 out of 262 deaths were felt to be suspected suicide following domestic abuse.
- Recommendations related to training for staff.
- There are domestic violence liaison practitioners now in post, one based at York, one based at Scarborough.
- They have had 230 referrals.
- They are going onto wards delivering bitesize training.

Aug 2025

Family Health provided an update and will be attending Quarterly. There were no escalations reported, indicating that no critical incidents or urgent issues arose during this meeting. Under Any Other Business (AOB), it was reiterated that no escalations were identified, confirming a stable situation.

Sep 2025

LeDeR SJCR position is improving

SJCR actions were discussed per Care Group and LFD continues to have oversight of actions and those that are overdue.

No Escalations or AOB .

6. Service developments
6.1 Training

JE attended to provide an update on SJCR training.

- 59 people now SJCR trained.
- 45 doctors and 14 nurses.
- 10 training sessions since March, usually run 2 a month one on each site.

JE raised that the sessions usually have around 3-4 attendees, and it was asked if it would be more beneficial to have less sessions to try and increase attendees per session. OB reported that the medical director would like all consultants to be SJCR trained. It was agreed to continue for 6 months as one session a month at alternate sites.

Requirement for an increase in SJCR training attendees.

7. References

1. Crude Mortality rate is the percentage of patients that died. The crude percentage includes all deaths up to 30 days post discharge. The crude mortality percentage is the sum of the in-hospital deaths and the out-of-hospital deaths.
2. NHS-Digital SHMI: SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England. The methodology is transparent, reproducible and sensitivity analysis of SHMI model had been carried out independently. The indicator is produced and published monthly by NHS Digital. University Hospitals Birmingham (UHB) is actively involved in developing and constructing SHMI as a member of Technical Working Group. In comparison to Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster, there are a few of key advantages advocating the use of SHMI -
    a. SHMI methodology is completely open and transparent. It is reproducible by third parties and less confusion has been caused within NHS hospitals compared to HSMR.
    b. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital, whereas the HSMR only includes 80% of in hospital deaths.
    c. SHMI does not account for palliative care (published as a contextual indicator instead) in the model due to coding issues. It could largely reduce the chance of gaming by coding more palliative care to reduce mortality ratio.
    d. Death is only counted once in SHMI to the last discharging acute provider. HSMR will attribute one death to all the providers within a chain of spells which are linked together due to hospital transfer (i.e., superspell if existing).

However, due to the limitations of administrative datasets (lack of clinical information in SUS/HES), SHMI-type indicators **cannot** be used to quantify hospital care quality directly and count the number of avoidable deaths.

HED's SHMI (NHSD) Module is built on the *SHMI Dataset* which is created by NHS Digital on a monthly basis. The dataset only includes necessary data fields for the purpose of validating SHMI model.

3. HES-SHMI: The HED team replicate the SHMI methodology by using our subscribed Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset from NHS Digital.

HED SHMI (HES-based) module is designed to provide a national, regional and bespoke peer benchmarking of overall SHMI and contextual indicators (released by NHS Digital) within all NHS acute hospitals in a more timely and detailed manner. The module will be refreshed every month after we receive monthly subscribed HES and HES-ONS datasets.

SHMI (NHSD) vs. SHMI (HES-based)

1. SHMI (NHSD) is built on the data with the same time period as that for the monthly official SHMI release (by NHS Digital); The SHMI (HED-based) module is refreshed on a monthly basis using the latest data available to the HED team through subscriptions to HES and ONS extracts. Therefore, monthly SHMI scores after the modelling data period are provisional and will be updated after the next SHMI model rebasing period.
2. SHMI (HED - based) utilises the same model built for monthly SHMI to make predictions on new data. It enables the trust to see a timely update of (provisional) SHMI figures prior to national monthly release. It also enables the trust to 'drill down' to patient level detail to facilitate local audit.
3. There is a slight difference in the data used to build SHMI (NHSD) and SHMI (HES - based). Since SHMI (HES - based) allows access to patient level detail it is not permitted to include data relating to patients who have chosen to 'opt-out'. These patients are those who have exercised their right for their personal data to only be used for purposes related to their own healthcare. Nationally this usually equates to approximately 2% of patients. HED believes that the benefit of being able to view patient level details outweighs the disadvantage of a slight mismatch with public SHMI figures. If an exact match to NHSD SHMI figures is required, then the SHMI (NHSD) module should be used.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Trust Board
Date of Meeting:	28 January 2026
Subject:	Actions to Prevent Sexual Misconduct in the NHS
Director Sponsor:	Polly McMeekin, Director of Workforce & Organisational Development
Author:	Jenny Flinton, Head of Employee Relations & Engagement

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This paper outlines the additional actions required by the Trust to prevent sexual misconduct, following an NHS England audit into sexual safety across the NHS. The Trust has already taken significant steps, including adopting the Sexual Safety Charter in 2024, implementing a Sexual Misconduct Policy in March 2025, and implementing an anonymous reporting tool for concerns about sexual misconduct.

Recommendation:
The Board is asked to review these new actions to ensure effective prevention and safeguarding of colleagues.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation

Actions to Prevent Sexual Misconduct in the NHS

1. Introduction and Background

Duncan Burton, Chief Nursing Officer for England, Dr Claire Fuller, National Medical Director NHS England and Professor Meghana Pandit, National Medical Director NHS England wrote to Trust Boards in light of media reports into historic sexual assault allegations at Royal Stoke University Hospital and Russells Hall Hospital (Appendix 1).

Their aim was to seek assurance following a recent NHS England audit around the adoption of the sexual misconduct policy framework for all organisations delivering NHS care.

The Trust adopted the Sexual Safety Charter in 2024 and implemented a Sexual Misconduct Policy on 1st March 2025. We are also within the 76% of Trusts and ICBs who have put in place an anonymous reporting tool, should individuals wish to raise concerns anonymously.

2. Considerations

In addition to the assurance sought by NHS England Trust Board should also note additional changes regarding sexual misconduct due to come into force under the Employment Rights Act 2025.

Effective April 2026 allegations that sexual harassment has, or is likely to occur, that are in the public interest will qualify as a protected disclosure. Individuals making these allegations will therefore receive whistleblowing protections against dismissal or detriment.

Responsibilities increase from October 2026 as employers will have to take 'all reasonable steps' to prevent sexual harassment in the workplace, this is increased from the current requirement for 'reasonable steps'. In addition employers will become liable for third party harassment of their workers.

3. Current Position

The recent audit by NHS England showed that further focus and consistency is needed in some parts of the NHS therefore additional actions have been set out for Trust's.

3.1. New Actions

Investigation Training
When the national training on sexual misconduct investigations is released we will nominate two people professionals to take part. This will be 'train the trainer' training, the learning will be shared with other investigators within the Trust.

Specialist Investigators
The Trust does not currently have specialist investigators for sexual misconduct investigations; however, this will be addressed once the above training is completed. Training sessions can be run with a select number of experienced investigators. It is worth noting that this is a risk for the Trust as colleagues are asked to pick up investigations alongside their substantive role, balancing operational pressures.

Chaperoning
The Trust's Chaperone policy has been reviewed against Annex 1A – Example list of core responsibilities of the chaperone in PRN02280_ii_Improving Chaperoning Practice in the NHS - Key Principles and Guidance pdf. Whilst the majority of roles and behaviors were already reflected, several material gaps were identified. These have now been addressed and strengthened to ensure alignment with NHS England's key principles, with updates made to Sections 4.3, 4.8, 4.4.1, and 6. Additionally, Section 4.4.5 on Virtual Consultations has been incorporated into the Trust's policy.

Although there is currently no mandatory training, the policy clearly states:
'There is no formal training associated with this policy. All managers should ensure that their staff are aware of this policy and the requirement for them to adhere to it. Managers are responsible for arranging appropriate training for staff as required. E-lfh have an e-learn chaperones and consent training.' The revised policy, which incorporates NHS England's guidance and the suggested strengthening of documentation requirements, is currently progressing through the internal approval process.

Review Groups
It is recommended that all organisations should consider adopting review groups, supported by appropriate safeguarding advice, to ensure sexual misconduct reports are correctly and robustly considered and investigated where appropriate. The Trust currently does this on a case-by-case basis with reviews taking place with the line manager, senior manager or professional lead, safeguarding and HR to ensure safety, consistency and the sharing for appropriate information.

Clarification on investigations involving resident doctors
It is recommended when allegations of inappropriate sexual behaviour are made against a Resident Doctor, there should be an initial discussion between the employer and the Postgraduate Dean, as the doctor's responsible officer, to agree next steps. The Trust currently has fortnightly Maintaining High Professional Standards Meetings with the Medical Director's Office and Human Resources, any cases regarding Resident Doctors are proactively discussed with the Deanery for support.

Referrals to the Disclosure and Barring Service (DBS)
The Trust acknowledges its legal responsibilities to make referrals to the Disclosure and Barring Service if the conditions for referrals are met. The HR team have been briefed on this requirement to ensure that Hearing Managers are appropriately advised, and appropriate actions are taken following a panel hearing. Recent cases are being reviewed to ensure appropriate referrals are made.

Sharing information where there is an active police investigation
During active police investigations the HR team regularly obtain updates from the police to understand whether internal processes can go ahead.

3.2. Trust Actions

The Trust has already established a sexual safety working group which comprises Union Representatives, the Freedom to Speak Up Guardian, Occupational Health and Wellbeing, Human Resources and Safeguarding colleagues. This group is working through the Sexual Safety Charter Assurance Framework regarding the implementation of the Sexual Safety Charter within the Group.

The latest NHS England assurance audit has also been completed on behalf of the organisation.

4. Summary

Following the release of the above actions the Trust has some further steps to take to safeguard colleagues within the workplace and will participate in investigation training once it becomes available. The Chaperoning Policy will be released once ratified and further advice has been provided to the HR team to support managers in making appropriate referrals to the Disclosure and Barring Service.

The latest NHS England assurance audit has been completed and proactive work is taking place with the establishment of the sexual safety working group.

5. Next Steps

The Board is asked to review these new actions to ensure effective prevention and safeguarding of colleagues.

Date: 19 January 2025

To:

- NHS trusts and foundation trusts:
  - chief executive officers
  - chief people officers
- integrated care boards:
  - chief executive officers
  - chief people officers

Cc:

- NHS England regions

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

5 December 2025

Dear colleagues,

An update on actions to prevent sexual misconduct in the NHS

We write today in light of media reporting of historic allegations of sexual assaults against young and vulnerable patients at Royal Stoke University Hospital and Russells Hall Hospital.

With legal proceedings ongoing, NHS England – alongside the trusts and ICBs involved – is continuing to fully support Staffordshire Police in its investigation into these alleged offences.

We ask all employers of NHS staff to take extra care in supporting staff or patients that may have been impacted by these events. In particular, if staff raise concerns about their own time at the affected organisations, employers should direct them to the contact details for each trust.

If a member of staff needs to report criminal allegations, they should be directed to the dedicated police portal. Any additional allegations that employers receive must take account of statutory safeguarding thresholds and related guidance. More generally, please check in with your teams and make sure you offer wellbeing support to anyone that needs help.

The results from our recent audit of adoption of the sexual misconduct policy framework show progress. Every trust and ICB now has a policy in place or is in the process of adopting

one, and 76 per cent have implemented anonymous reporting for staff who wish to speak up about sexual misconduct in the workplace.

However, the audit also highlights that further focus and consistency are needed in some parts of the NHS.

Actions for trusts; for all organisations delivering NHS care; and for primary care providers and their ICBs are set out below.

New actions for trusts

- **Investigation training**: Every chief people officer will be invited to put forward 2 people professionals to take part in national training on sexual misconduct investigations. This will follow a 'train-the-trainer' model, with the expectation that participants will share their learning with other investigators in their trusts. Training has been commissioned by NHS England for all trusts, and we are developing a national training specification that organisations will be able to use to commission their own local training. Training will cover core safeguarding awareness and the relevant referral processes. Training will begin in March 2026 and we will share sign-up details nearer the time.

- **Specialist investigators**: Organisations should ensure that investigators of sexual misconduct allegations have specialist training, as set out in the national sexual misconduct policy framework. Where trust policies require investigations to be carried out by doctors or dentists, the trust should ensure that this investigator has received specialist training in sexual misconduct. We are therefore asking trusts to build a pool of medical/dental investigators who are specially trained in sexual misconduct investigations. Responsible officers should also be trained in how to handle sexual misconduct cases. The national investigation training will support you in this objective.

New actions for all organisations delivering NHS care

- **Chaperoning**: Providers are required to review their chaperoning policies to ensure that the principles in annex A are adequately reflected. Where policies do not reflect these principles, please update them.

- **Review groups**: When concerns arise about an individual's practice, it is important to consider whether the actions could have a sexual dimension, even if this is not

immediately obvious from the allegation. All NHS organisations should strongly consider adopting review groups, supported by appropriate safeguarding advice, to ensure sexual misconduct reports are correctly and robustly considered and investigated where appropriate. Any necessary police involvement will also be considered by these review groups.

- **Clarification on investigations involving resident doctors:** When allegations of inappropriate sexual behaviour are made against a resident doctor, there should be an initial discussion between the employer and the Postgraduate Dean, as the doctor's responsible officer, to agree next steps. A review group may also be helpful in identifying the most appropriate course of action. If Maintaining High Professional Standards (MHPS) in the NHS is followed, it recommends initial consideration of whether there is a training aspect to the allegations. Where there is a clear sexual element to an allegation, this is very likely to require conduct processes, following consideration of safeguarding and any needing police involvement.

- **Referrals to the Disclosure and Barring Service (DBS):** NHS organisations that employ or engage individuals in regulated activity with children or adults have a legal duty to make barring referrals to DBS. If someone is removed from work or specific clinical duties due to concerns about conduct that has harmed a child or adult, or put them at risk of harm, then a barring referral should be made. Failure of organisations to fulfil this duty could result in police action. The Making barring referrals to DBS guidance explains the legal requirement to refer. Organisations can contact their DBS regional outreach advisor for more information and additional advice on referrals is also available in the Safeguarding Accountability and Assurance Framework.

- **Sharing information where there is an active police investigation:** Where there is police involvement in a case, employers are required to engage with their police liaison to understand which elements of the misconduct investigation can continue while the police investigation is underway.

- In August, we said we would return to trusts and ICBs in the autumn to check progress against the Sexual Safety Charter assurance framework and against the actions outlined in the August letter. We are now requiring trusts and ICBs to complete a new sexual misconduct audit by **Monday 2 February.**

New actions for primary care providers (working with their ICBs)

In our August letter, we indicated that we would follow up with actions for primary care providers on tackling sexual misconduct. All employers, including those providing primary care services, have a legal duty to take reasonable steps to prevent sexual harassment in the workplace. All primary care providers also have important regulatory duties around safeguarding and the reporting of incidents (for example, CQC regulation 13 and professional regulators standards). Primary care has specific sexual safety challenges, including the isolation that staff experience, and the one-on-one nature of many consultations. It is vital that patients can feel safe in the NHS, no matter what the setting.

Today, we are asking primary care providers to sign up to the 10 principles in the Sexual Safety Charter. These principles set the aspiration for the whole of the NHS and will ensure all providers have the same level of ambition.

However, we realise that some primary care providers will need help to fully implement the Sexual Safety Charter. ICBs should reach out to all their providers to offer support in helping primary care to fulfil the charter's ambitions. We expect all primary care providers delivering NHS services to:

- sign up to the principles of the Sexual Safety Charter
- complete the new Sexual Safety Charter self-assurance checklist (annex B), which we are publishing today. This can help providers to consider gaps in their current processes. Documenting the self-assessment can be useful in evidencing compliance with the legal duty for all employers to take reasonable steps to prevent sexual harassment (see the Worker Protection Act 2023) and could be used as part of evidence of compliance in future regulatory inspections
- ensure that you know where to access a sexual misconduct policy should you need one. NHS England will share a streamlined version of its national sexual misconduct policy framework – specifically tailored for primary care – by the end of January 2026
- ask members of staff to complete the national e-learning module on sexual safety awareness
- review chaperoning policies in line with the new principles published today

- ensure reporting to NHS England, and, where applicable, to the Care Quality Commission (CQC), the professional regulator, and the police, is embedded in sexual misconduct incident management

It is our expectation that you will all join us in our national commitment to protect staff and patients. All providers also have statutory safeguarding responsibilities and regulatory responsibilities on sexual safety.

To help providers, ICBs should support primary care as follows.

- By Monday 2 February 2026**:** Contact all primary care providers to offer support in completing the self-assurance checklist**.** Primary care providers should then confirm to the ICB that they have signed up to the charter and completed the self-assurance checklist.

- By Tuesday 31 March 2026, NHS England will carry out an initial review with ICBs to check how many providers have confirmed completion.

We will be in contact with ICB domestic abuse and sexual violence (DASV) leads to coordinate each ICB's response to these asks. Further resources will be made available for primary care over the coming months, including additional training by the end of 2025/26, posters to publicly display commitment to sexual safety, and webinars for ICB DASV leads in January to help with completion of the self-assurance framework.

Further assessment of progress

We are grateful for the response to our first audit and organisations' commitment to improved processes around sexual misconduct. However, the NHS must continue to demonstrate its commitment to ensuring the sexual safety of both staff and patients.

Any form of discrimination, violence and aggression towards colleagues with a protected characteristic is unacceptable. We also strongly advise focused action in these areas, as set out in our letter of 17 October 2025 on racism.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Dr Claire Fuller
National Medical Director
NHS England

Professor Meghana Pandit
National Medical Director
NHS England

NHS England

Improving chaperoning practice in the NHS: key principles and guidance

Publication reference: PRN02280_ii

1. Context

NHS organisations should use this guidance to support their review and improvement of local chaperoning practices.

Engagement with stakeholders and local chaperone policy owners has demonstrated that organisations need a set of principles to guide their co-ordinated approach to the use of chaperones during consultations, examinations and procedures across healthcare settings, one that ensures patient safety, dignity and staff protection.

2. Scope

Organisations should determine their own chaperone policies, to allow for flexibility in how chaperoning requirements are delivered based on specific needs, practices and settings. This should include consideration of any specialist services provided, specific patient cohort requirements and clinical settings (including primary care, maternity, virtual services and other settings where appropriate).

However, all local policies should be underpinned by a shared set of principles to ensure a level of commonality in our offer to patients and service users. The principles below provide a framework for organisations to develop and refine their local chaperoning policy and practice. They support more consistent implementation through providing clarity on:

- the purpose, terminology and role of chaperoning
- communication on the offer of a chaperone
- escalation process
- records management and information requirements
- training and competency frameworks
- alignment to legislative, regulatory guidance and local policies

3. Principles

3.1 Organisational requirements

As recommended by the Ayling report (2004), all NHS organisations are required to have a chaperone policy, with a regular policy review process in place.

All members of staff should be aware of the policy and it should be made readily available to ensure it is applied effectively.

Policies should also be made available and advertised to patients, the public and service users. This should include availability online and in easy-read formats.

Policies should align with wider safeguarding policies and practice.

3.2 Primary role and responsibility for chaperoning

An NHS chaperone is an appropriately trained member of staff who is present during an examination or treatment of a patient. The primary role of the chaperone is to assist the clinician undertaking the procedure in supporting the patient and to act as the patient's advocate, being sensitive to their needs and respecting and maintaining their privacy and dignity.

Local policies should clearly set out who can act as a chaperone and have as a minimum requirement that anyone undertaking the role has received appropriate training.

Organisations may wish to consider prioritising the use of clinical staff to undertake chaperoning duties where this is possible. Staff may undertake the role of chaperone as part of their wider clinical or support duties, in line with their training and the requirements of the service.

In instances where clinical supervision is in place, the clinical supervisor may wish to consider whether they can also act in a chaperoning capacity to make the patient more comfortable and to minimise disruption. However, in making this decision they should ensure that this does not impact on their ability to discharge either function effectively.

3.3 Provision of chaperones

It should be considered best practice to offer a chaperone to patients when undertaking examinations. The offer of a chaperone should be clear to the patient before any consultation, ideally at the time of booking the appointment in line with Care Quality Commission guidance. The offer should be reinforced at the time of the examination.

Staff must demonstrate cultural sensitivity and respect each patient's individual values regarding privacy, dignity and intimacy. When offering or providing a chaperone, staff should consider the patient's preferences in relation to choice of chaperone, which might include considerations relating to sex, religious beliefs or other personal circumstances.

Staff should also identify where patients may have additional needs, such as communication difficulties or learning disabilities, and make reasonable adjustments to ensure they understand the offer and feel supported. This may include using accessible information, involving carers or advocates, or allowing extra time for discussion.

The purpose of the examination and the role of the chaperone must be communicated using culturally appropriate and respectful language.

Intimate examinations

In all cases of intimate examinations, a chaperone should be offered and consent taken. The patient retains the right to decline.

It is acceptable for a healthcare professional to perform an intimate examination without a chaperone if the situation is life-threatening or time-critical.

The General Medical Council (2024) definition of an intimate examination is agreed as a guiding principle: “Examinations of the breast, genitalia and rectum but could also include any examination where it is necessary to touch, examine intimate parts of the patient’s body digitally, or even be close to the patient.”

Presence of family members or carers

The presence of a family member, parent or carer does not replace the need for a chaperone. A chaperone is for the organisation to provide, under their organisational chaperoning policy, on request of the patient or their family or carer. However, the patient may wish to decline the offer of a chaperone if they feel that their family member or carer is able to provide the support they need.

Any intimate examination on children and young people under 18 years should be carried out in the presence of a formal chaperone. A parent, carer or someone known and trusted by the child may also be present during the examination or procedure to provide reassurance. Parents or guardians must receive an appropriate explanation of the procedure to provide informed consent when the young person is unable to do so themselves.

Primary and community care and lone working

The provision of chaperoning in primary and community care will have unique challenges including the one-on-one nature of many consultations, less observed team-working and patients being visited by lone clinicians.

Though it is important that patients and service users are provided with the offer of chaperones in these settings, the need for adaptability in how this is fulfilled must be recognised. This may include a greater need for the use of the wider non-clinical

workforce as chaperones. Where this is the case, those acting as chaperones would still require appropriate training and support to act in this role effectively.

Practices should display information about the chaperone policy in waiting areas, consultation rooms and on practice websites to ensure patients are aware of their rights.

Healthcare professionals working alone, especially during intimate examinations or in isolated settings like a patient's home, face increased risk of their actions being misinterpreted. To mitigate this, they should offer a chaperone in advance of the appointment where possible. Where this is not possible, they should ensure clear communication and thorough documentation explaining why the examination proceeded without a chaperone present and that this was agreed with the patient.

Virtual consultation and appointments

Chaperoning policies should be applied to video, telephone and online consultations. Where these consultations take place, local policies should explain how to protect patients when images are needed to support clinical decision-making.

Consent and reasonable adjustments for vulnerable patients

If the patient cannot make an informed decision, the healthcare professional must use their clinical judgement and be able to justify their course of action. Organisations have a duty to ensure that reasonable adjustments are made for vulnerable patients as per their duty under the Equality Act.

Availability

If a patient requests a chaperone and one is not immediately available – whether due to patient preference or resource limitations – they must be offered the option to reschedule the appointment within a reasonable timeframe, taking into account the urgency of their clinical needs.

If postponing the examination would pose a risk due to the severity of the condition, this must be explained to the patient and recorded in their clinical notes. The decision to proceed or defer should be made collaboratively between the patient and the healthcare professional.

Patient declines a chaperone

Patients have the right to decline a chaperone for any reason, including personal, cultural or privacy concerns, the presence of a family member or carer, or because they do not feel it is necessary. Staff must respect this decision while ensuring the patient's safety and dignity.

If a clinician believes that proceeding without a chaperone would compromise professional standards or patient safety, they should risk assess and the examination should be postponed until an appropriate chaperone is available. The rationale for deferral must be clearly documented in the patient's record.

When a chaperone is declined, staff should consider appropriate safeguards, such as:

- documenting the discussion and decision
- maintaining clear and respectful communication throughout
- ensuring the examination takes place in a private and appropriate setting

3.4 Training and competency frameworks

Only individuals who have received appropriate training in the role and are deemed competent to be a chaperone may act as chaperones. It is suggested that awareness of local chaperoning policies should be incorporated into local staff training and embedded within staff induction programmes.

Where not already in place, chaperones must undergo a Disclosure and Barring Service (DBS) check. This should be at least a standard DBS check, but eligibility should be assessed individually based on the specific context of the ask.

Organisations must maintain an auditable record of staff who have completed chaperone training.

Training should be local and responsive to local settings and systems. Chaperoning training resources should consider:

- the role and purpose of chaperoning, aligned with national principles
- the responsibilities of a chaperone, including understanding the purpose of the examination or procedure
- the definition of an intimate examination and how it may vary based on patient perception
- why chaperones need to be present, taking into account privacy and dignity (for example, chaperones should be able to observe the examination and respond to patient needs and therefore will need to be inside any screened-off area)
- the rights of the patient
- records management procedures related to chaperoning including all documentation and recording processes
- the policy and mechanisms for raising concerns, including escalation routes
- relevant safeguarding policies and national guidance

Training should also cover the expectations of chaperones, which are:

- be sensitive and respect the patient's dignity and confidentiality
- reassure the patient if they show signs of distress or discomfort
- be familiar with the procedures involved in a routine intimate examination
- stay for the whole examination and be able to see what the examining clinician is doing, if practical
- be prepared and supported to raise concerns if they are concerned about any behaviours or actions they observe

Supporting chaperones

In all cases where a chaperone is used, the chaperone should be provided with sufficient information on the reason for the examination and background to the patient to allow them to provide sufficient support. In cases of intimate examinations, they should be provided with a clear rationale for this being required.

Local chaperone policies should consider how the organisation supports chaperones to:

- ensure that the patient understands why they are in attendance and has consented to this
- act as a witness as to the continuing consent of the procedure
- ensure time is provided for chaperones and patients to ask questions
- confirm the clinician has clearly communicated the role of the chaperone where the presence of one has been agreed
- promote awareness of chaperoning policies to staff and patients

3.5 Escalation and raising concerns

All organisations should have clear routes in place for raising concerns via line management or local operational escalation processes. More formal escalation processes such as Freedom To Speak Up (FTSU) policies and mechanisms should be followed as required. Within these, all staff should feel safe and empowered to raise concerns, supported by a culture and leadership that create psychological safety for everyone.

In this context, local chaperoning policies should consider:

- how concerns can be raised both during the examination and subsequently
- highlighting the duty of care to raise concerns about unsafe practices, in line with wider NHS policies
- how chaperones encourage patients to ask questions and seek clarification and be alert to signs of distress
- supporting chaperones to act as the patient's advocate when required

- processes for identifying and raising concerns about any unusual or unacceptable behaviour
- how chaperones support families to raise concerns, by providing clear signposting to standard organisational policies for the complaints process

3.6 Records management

Chaperoning policies should ensure that there are appropriate record management processes in place to record the offer and use of chaperones, and that minimum information requirements are met, including:

- explanation of the need for the examination or procedure clearly documented by the professional undertaking the examination. This should include confirmation of the patient's capacity and best interest
- confirmation that an active offer of a chaperone was made
- document the patient's decision regarding the examination and the offer of a chaperone in the clinical record. Recognise that patients have the right to decline a chaperone or refuse a specific individual offered as a chaperone, and record the outcome if either is the case
- any decision to proceed, postpone or cancel the examination or procedure, along with any alternative arrangements made, including the name and title of alternative chaperones
- any incidents or complaints related to the examination, procedure or use of chaperones, recorded in accordance with local policies and procedures
- ensure robust governance structures are in place to identify risks and unusual activity, and provide clear escalation procedures
- where possible, use a structured clinical electronic note to standardise record keeping, enable traceability and support effective auditing. To be complete the record should include:
    - date and time of examination or procedure
    - examination or procedure
    - indication – why the examination is required
    - consent to the procedure and a chaperone including details of the discussion between the practitioner and the patient regarding the offer of a chaperone and the name and title of the chaperone offered
    - name and role of chaperone and any additional persons present
    - if no chaperone present, explain why this was declined
- where possible the chaperone should confirm their presence within the record to allow for identification and audit
- the recording of chaperoning should be sufficient to support an auditable process where required, including the monitoring of trends and exemptions

3.7 Alignment to legislative, regulatory guidance and local policies

It is not within the role of a chaperone to provide a ‘second opinion’ or challenge clinical decision-making by the primary clinician. However, in line with clinical professional standards and broader NHS guidance on raising concerns (for example, FTSU), staff should be empowered to raise concerns where appropriate.

Chaperoning policies must align with national guidance to improve care quality and safety, privacy and dignity. This includes reflecting lone working policies, safeguarding, Mental Capacity Act, sexual safety in healthcare, clinical challenge and ‘second opinion’ including Martha’s Rule.

The procedures requiring chaperoning and all intimate examinations must follow good clinical practice including a full assurance that the procedure or examination is conducted appropriately, respecting patients’ choices and preferences through clear communication and informed consent.

Clinicians adhere to professional standards that describe good practice and set out the principles, values and standards of care and professional behaviour expected from all registered healthcare professionals. They should consider guidance from their professional regulatory bodies and Royal Colleges.

Policies must be accessible to staff, patients, the public and service users, ensuring inclusivity for everyone by providing alternative formats for those who are visually impaired, have learning difficulties or face language barriers, for example.

Executive accountability

The chaperoning policy should clearly identify the executive lead responsible for ensuring its implementation and assuring quality and safety governance. This includes ensuring staff are trained and competent to act as chaperones and that record keeping procedures are clear and well-implemented. Structures should be in place to identify risks and unusual activity, and provide clear escalation procedures.

Oversight of chaperone policies should be embedded within broader clinical governance structures, including the clear provision of auditing and monitoring compliance. This should include actively seeking feedback from patients and staff and triangulating data to learn and improve.

All policies should have a review date and scheduled basis for ongoing review, with responsibility assigned. This ensures alignment with evolving national guidance and local service needs.

Annex A – Example list of core responsibilities of the chaperone

This annex lists the core roles and responsibilities of a chaperone. The list is not exhaustive and organisations may wish to amend or add to it to reflect local service configuration or specialist requirements.

- Receive appropriate and necessary training.
- Be sensitive to the patient's needs, respecting and maintaining their privacy and dignity.
- Provide emotional comfort and reassurance.
- Be courteous and professional at all times.
- Encourage patients to ask questions and seek clarification.
- Be alert to signs of patient distress – both verbal and non-verbal.
- Understand the clinical context and be able to appropriately observe the examination or procedure.
- Act as the patient’s advocate when required.
- Identify and raise concerns about any unusual or unacceptable behaviour by the healthcare practitioner.
- Assist with undressing or dressing if requested by the patient.
- Help the patient understand what is being communicated to them.
- While chaperones may support clinicians, this is not their primary role.
- Chaperones are not required to be registered clinicians. It is outside their remit to challenge the clinical decision to perform an examination or procedure. However, they have a duty of care to raise concerns about unsafe practices, in line with wider NHS policies.
- The formal chaperone should document their presence in the clinical record, noting the date, time and nature of the examination or procedure.

Report to:	Board of Directors
Date of Meeting:	28th January 2026
Subject:	Emergency Planning Resilience and Response (EPRR) – Annual Self Assessment
Director Sponsor:	Accountable Emergency Officer – Claire Hansen
Author:	Head of EPRR – Richard Chadwick

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The Board of Directors are asked to:

- Note that following a self-assessment process against the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) Standards, the Trust has rated itself as "Partially" compliant. The Trust is "fully" compliant in 51 of the 62 applicable standards (82%). This is an improvement from last year's compliance rating of 56%.

- Note that the increased time spent on incident response and winter operational pressures by the Emergency Preparedness, Resilience and Response Team results in challenges to completing all core business.
- Note that the scale and scope of maintaining plans is a challenge that will endure through 2026. Testing and training completed plans also remains challenging as operational tempo and financial constraints are preventing the release of staff for events.

The Accountable Emergency Officer (AEO) has signed the Certificate of Compliance that can be found at Appendix 1. If the report is endorsed a amended version of the certificate (removing the "pending submission to the Board/governing body") will be resigned and submitted to the Integrated Care Board.

Recommendation:

To approve the report and assurance rating of "Partial" compliance with the NHS England EPRR Core Standards for the period 2024 – 2025.

Report History

Meeting/Engagement	Date	Outcome/Recommendation
Executive Committee	03 December 2025	Approved
Resources Committee	16 December 2025	Approved

EMERGENCY, PREPAREDNESS, RESILIENCE AND RESPONSE CORE STANDARDS – ANNUAL SELF ASSESSMENT

1. Introduction and Background

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHSE funded care must show that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

NHS England gain assurance of compliance through a provider conducted annual self-assessment against the core standards that is then confirmed through a check and challenge process conducted by the Integrated Care Board EPRR Team. The Local Health Resilience Partnership, chaired by the ICB Accountable Emergency Officer, then endorse all the provider gradings prior to submission to NHS England.

There are 62 core standards to be achieved split into 10 domains of governance, duty to risk assess, duty to maintain plans, command and control, training and exercising, response, warning and informing, cooperation, business continuity and HAZMAT/ Chemical Biological Radiological and Nuclear (CBRN). Overall gradings are achieved for full compliance against the standards as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

The governance and assurance timetable to finalise the Trust submission is as follows:

Date	Action
Aug – Sep 25	Trust Emergency Preparedness, Resilience and Response Team complete self-assessment.
24 Sep 25	Integrated Care Board Acute Providers conduct peer review
26 Sep 25	Self-assessment endorsed by Emergency Planning Steering Group as a draft submission for the Integrated Care Board
30 Sep 25	Trust submit draft to Integrated Care Board
14 Nov 25	Integrated Care Board and Trust Accountable Emergency Officers confirm Trust submission
20 Nov 25	Local Healthcare Resilience Partnership confirm all Trust submissions in Integrated Care Board
03 Dec 25	Emergency Preparedness, Resilience and Response Core Standards Report to Executive Committee
16 Dec 25	Emergency Preparedness, Resilience and Response Core Standards Report to Resources Committee

2. Core Standard Self-Assessment Observations

In 2024 the Trust was assessed as "Non-Compliant" against the 62 core standards with 35 graded as fully compliant (56%). This year the Trust has improved to "Partially Compliant" against the 62 core standards with 51 graded as fully compliant (82%). This improvement is in line with the timeline reported to the Board of Directors on 29th September 2023 where a return to SUBSTANTIAL compliance from NON-COMPLIANT would take approximately 24 months; SUBSTANTIAL compliance is likely to be achieved early next year.

A breakdown of compliance by domain is as follows:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	1	3	0
Cooperation	4	3	1	0
Business Continuity	10	9	1	0
Hazmat/CBRN	12	8	4	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	51	11	0

To better understand the progress made in each domain, observations and comments are as follows:

2.1 Governance

The governance domain has 5 x fully and 1 x partially compliant standards.

The EPRR Resource standard (Standard 5) requires confirmation that there is sufficient resource for the Trust to discharge it's EPRR duties. This standard has been declared as partially compliant to acknowledge that the scale and scope of the portfolio remains challenging for a team of 2 staff. The increased time spent on incident response and winter operational pressures is impinging on core business being completed in a timely manner. The action plan for 2025 contains actions to further review these shortfalls.

2.2 Duty to Risk Assess

All standards in the duty to risk assess domain are fully compliant. This is expected to endure for the next 12 months and therefore holds no risks.

2.3 Duty to Maintain Plans

The duty to maintain plans domain has 10 x fully and 1 x partially compliant standards.

The non-compliant standard is the Countermeasures Plan (Standard 14) which outlines the arrangements for administration, reception and distribution of prophylaxis and mass vaccination. The plan is now in draft and external consultation will be complete by early 2026. The plan will be ready for publication in Q2 of 2026 and stakeholder training will follow.

2.4 Command and Control

All standards in the command and control domain are fully compliant. This is expected to endure for the next 12 months and therefore holds no risks.

2.5 Training and Exercising

All standards in the training and exercising domain are fully compliant however testing and training contingency plans remains challenging as operational tempo and financial constraints prevent the release of staff in large numbers for events. The Emergency Preparedness, Resilience and Response Team will continue to work with Care Groups to try and release staff, to utilise less staff heavy training events such as table tops and to make more use of internet based learning.

2.6 Response

All standards in the response domain are fully compliant. This is expected to endure for the next 12 months and therefore holds no risks.

2.7 Warning and Informing

The warning and informing domain has 1 x fully and 3 x partially compliant standards.

The 3 partially compliant standards are warning and informing (Standard 33), incident communications plan (Standard 34) and media strategy in an incident (Standard 36). A draft Incident Communications Plan has been produced and has been reviewed by the Communications Team. A final meeting between Emergency Preparedness, Resilience and Response Team and the Communications Team is programmed to finalise the draft after which the draft will be circulated internally and externally for comment. The finalised plan is expected to be with the Executive Committee in early 2026.

2.8 Cooperation

The cooperation domain has 3 x fully compliant and 1 x partially compliant standards.

The partially compliant standard is Local Health Resilience Partnership engagement (Standard 37). The mandated Trust attendance at the quarterly Local Health Resilience Partnership meetings was narrowly missed due to operational pressures and annual leave.

2.9 Business Continuity

The business continuity domain has 9 x fully and 1 x partially compliant.

The partially compliant standard is the assurance of commissioned providers business continuity plans (Standard 53). This standard has been progressed since last year and engagement with the procurement team has identified a way forward however the number of commissioned providers required to provide assurance of BC plans is significant. Further progress will be made in 2026 however this standard may remain at this grading for at least a further 12 months with the number of historical contracts that will require assurance.

2.10 Hazardous Material (HAZMAT) and Chemical, Biological, Radioactive and Nuclear (CBRN)

The hazardous material and chemical, biological, radioactive, and nuclear domain has 8 x fully and 4 x partially compliant.

The 4 partially compliant standards are decontamination capability availability 24/7 (Standard 59), waste disposal arrangements (Standard 62), HAZMAT / CBRN training resource (Standard 63), and exercising (Standard 66).

This year an audit was conducted on a full 1 month of rosters at both York and Scarborough Teaching Hospitals NHS Foundation Trust Scarborough sites. The audit concluded that there were sufficient trained HAZMAT/CBRN trained staff on each site to staff the decontamination capability 24/7. The audit also recommended that the HAZMAT/CBRN staff competency be added to Health Roster to ensure that all rosters to ensure line managers have a clear and immediately available record of the competencies that are on duty when responding to incidents. The CBRN Chief Instructor is currently working on how to get that competency added to Health Roster.

A waste disposal contract has been placed after the self-assessment was conducted and Standard 62 is now compliant.

HAZMAT/CBRN training and exercising continues to be a challenge when trying to release staff. There are LIVEXs planned for both sites in 2026 and training on the new CBRN tentage will continue throughout 2026. This domain remains the most complex in terms of compliance and the work of the CBRN Chief Instructor has been pivotal to the good standing the Trust enjoys with the Integrated Care Board and Yorkshire Ambulance Service in terms of this competency.

3. Action Plan

The actions to address the partially compliant standards is included in the action plan at Appendix 2. In addition, the plan includes actions to sustain fully compliant standards and some actions that have been carried over from the 2024/2025 action plan that still require attention.

Progress reporting will be conducted throughout 2026 by the Head of Emergency Preparedness, Resilience and Response to the Resource Committee on behalf of the Accountable Emergency Officer.

4. Conclusion

Significant progress has been made over the last 12 months increasing the number of standards that are fully compliant. Progress over 2026 will be possible however the rate

this will be achieved will be dependent on the time available to the small Emergency Preparedness, Resilience and Response team to engage with core business.

Appendices:

1. EPRR Core Standards Assurance – Statement of Compliance.
2. EPRR Core Standards Assurance – Action Plan 2025-2026.

Date: 28th January 2026

Appendix 1 – EPRR Core Standards Assurance – Statement of Compliance

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-26

STATEMENT OF COMPLIANCE

York and Scarborough Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool V2.

Where areas require further action, York and Scarborough Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

I confirm that the above level of compliance with the core standards has been agreed by the organisation's Accountable Emergency Officer (AEO) pending submission to the Board/governing body.

Signed by the organisation's Accountable Emergency Officer:

Date signed: 28 November 2025

Date of Board/Governing Body meeting: 28 Jan 26	Date to be presented at public Board: 28 Jan 26	Date published in Annual Report: In board report 2026

Appendix 2 – EPRR Core Standards Assurance – Action Plan 2025/26

Ref	Domain	Standard name	Standard Detail	ICB Final Grading 2024	ICB Final Grading 2025	Trust Action 2025	Trust Action 2026	Actionee	Target Date	Assessed Grade 2027	Remarks / Updates
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	A	A	2 - Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	1 - Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	RC	Q2 - 26	A	2 - (08/04/25) - RC to speak to KH and see how this can be taken forward in light of Trust challenges and the political NHSE landscape.
14	Duty to Maintain Plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	R	A	8 - Capture specific Countermeasures Training in the central training log. (R) 9 - Write a new policy to consider mass vaccination and issue of prophylaxis. (A)	2 - Capture specific Countermeasures Training in the central training log. (R) 3 - Write a new policy to consider mass vaccination and issue of prophylaxis. (A)	CR RC	Q4- 25 Q2 - 26	G	1 (19/11/25) - Draft plan to be circulated internally and externally to achieve final draft. To Executive Committee in early 2026.
15	Duty to Maintain Plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	G	G	10 - Publish the Mass Casualty Plan. (A)	4 - Publish the Mass Casualty Plan. (A)	RC	Q1 - 26	G	10 (08/04/25) - Draft sent to PD for review to determine way forward. 4 (19/11/25) - Speciality 1 to 1 meetings completed by Dec 25 and initial draft circulated to stakeholders in Jan 26. Publication of main plan by Apr 26.
33	Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	A	17 - Determine 24/7 Comms capability and include in Incident Comms Plan (A)	5 - Determine 24/7 Comms capability and include in Incident Comms Plan (A)	RC	Q4 - 26	G	17 (08/04/25) - Included in draft with Comms Team. 17 - (05/06/25) - Chaser sent to LB. 5 - (19/11/25) - RC to meet Comms Team to finalise draft.
34	Warning and Informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	A	A	18 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercises to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (G) 19 - Write Incident Comms Plan (A)	6 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercises to practice comms action cards. 7 - Write Incident Comms Plan (A)	Comms Team RC	Q4 - 25 Q4 - 25	G	18 (08/04/25) - RC to include a comms slide in induction training, familirisation training and C2 training. 19 (08/04/25) - With Comms team for comment. 19 - (05/06/25) - Chaser sent to LB. 6 & 7 - (19/11/25) - RC to meet Comms Team to finalise draft.
36	Warning and Informing	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	A	A	20 - Write Incident Comms Plan (A)	8 - Write Incident Comms Plan (A)	RC	Q4 - 25	G	20 - (05/06/25) - Chaser sent to LB. 8 - (19/11/25) - RC to meet Comms Team to finalise draft.
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	A	A		9 - Engage with Exec PAs to ensure availability of AEO	RC	Q4 - 25	A	
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	A	G	23 - Review BRONZE BIAs to confirm compliance with NHS BC Toolkit. (G) 24 - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R) 25 - Develop BIAs for all Trust services in accordance with the NHS BC Toolkit and the review BRONZE BIAs. (G) 26 - Seperate project required to develop BIAs. (G)	10 - Develop a Trust BIA in accordance with the NHS BC Toolkit. (R)	CR	Q4 - 26	G	
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	A	G	27 - Review the BRONZE BCPs to confirm compliance with NHS BC toolkit. (A) 28 - Develop BCPs in accordance with the NHS BC toolkit and the BIAs for all services in the Trust. (A) 29 - Seperate project required to develop BCPs. (R)	11 - Seperate project required to develop BCPs. (R)	CR	Q4 - 26	G	
53	Business Continuity	Assurance of Commissioned Providers / Suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	33 - Review required of process and included in Trust BC Plan. (A)	12- Review required of process and included in Trust BC Plan. (A)	CR	Q3 - 26	A	33 (14/07/25) - Meeting programmed with IW and review post that meeting. 12 (19/11/25) - Number of contracts significant. Will capture new contracts going forward and work through historial contracts at best effort.
59	Hazmat/CBRN	Decontamination Capability Availability 24/7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	A	A	40 - Design an automated system for annotating who is CBRN trained when a incident occurs. (A) 41 - Amend CBRN Plan to include guidance provided in CBRN Audit (G)	13 - Design an automated system for annotating who is CBRN trained when a incident occurs. (A)	EC-S	Q3 - 26	G	40 (08/04/25) - Manual process in place whilst automation is explored. 13 (19/11/25) - EC-S to get comptency added to Health Roster.

Ref	Domain	Standard name	Standard Detail	ICB Final Grading 2024	ICB Final Grading 2025	Trust Action 2025	Trust Action 2026	Actionee	Target Date	Assessed Grade 2027	Remarks / Updates
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	G	G	45 - Ensure a preventative maintenance contract is in place for the tent and associated ancillaries. (A)	14 - Ensure a preventative maintenance contract is in place for the tent and associated ancillaries. (A)	EC-S	Q3 - 26	G	45 (08/04/25) - EC-S to chase. 14 (19/11/25) - EC-S to include in MS Teams site and provide evidence to YAS.
62	Hazmat/CBRN	Waste Disposal Arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	G	A	46 - Ensure CBRN Plan contains relevant waste and water legislation. (G)	15 - Ensure CBRN Plan contains relevant waste and water legislation. (G)	EC-S	Q3 - 25	G	46 (08/04/25) - RC to meet with EC-S & KB and include in plan. 46 (31/07/25) - Waste disposal retainer contract required 15 (17/11/25) - Control set and included in plan
63	Hazmat/CBRN	Hazmat/CBRN Training Resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	A	47 - CI CBRN to comply with guidance provided in CBRN audit.	16 - CI CBRN to comply with guidance provided in CBRN audit.	EC-S	Q3 - 26	G	16 (19/11/25) - EC-S to action and report to RC quarterly.
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	A	50 - Complete actions as per CBRN Audit guidance. (R)	17 - Complete actions as per CBRN Audit guidance. (R)	EC-S	Q3 - 25	A	17 (19/11/25) - LIVEXs planned for both sites in Jun 26.

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	2025/26 Q3 Board Assurance Framework
Director Sponsor:	Clare Smith, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides the 2025/26 Q3 Board Assurance Framework

All risk ratings are unchanged from Q2 of 2025/26. All amendments to all risks are provided in red text with identified gaps in blue text.

Three risks remain out of the Trust's risk appetite identified by the Board of Directors:

- PR1 - Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.

- PR3 - Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.
- PR6a - Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030

Recommendation:

The Board of Directors is asked to approve the 2025/26 Q3 Board Assurance Framework.

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

Meeting/Engagement	Date	Outcome/Recommendation
Executive Director Updates	January 2026	Risks reviewed and updated

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Q3 – 2025/26 Board Assurance Framework (BAF)

Q3 - 2025/26 Board Assurance Framework Dashboard

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Rank/Move	High Level Risk Description	Risk Assessment (Catastrophic / Major / Moderate / Minor / None)	Risk Rating	Actions	Owner	Oversight
1 ⇨	PR6a – Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-30.	C → T	25	0 0 3	Director of Finance	Resources Committee
2= ⇨	PR1 – Inability to provide consistently effective clinical pathways leading to poor outcomes, experience and possible harm.	I → C	12	0 0 0	Chief Nurse	Quality & Resources Committees
2= ⇨	PR2 – Inability to nurture a Trust culture that facilitates good staff engagement and development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.	I → C → T	12	0 0 2	Director of Workforce and OD	Resources Committee
2= ⇨	PR5 – Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.	I → C → T	12	0 0 4	Director of Finance	Resources Committee
2= ⇨	PR3 – Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.	I → C → T	12	0 0 4	Chief Operating Officer	Quality & Resources Committees
3 ⇨	PR6b – Failure to demonstrate effective governance to achieve the Trust's strategy.	I → C → T	9	0 0 2	Chief Executive	All Committees
4 ⇨	PR4 – Trust service, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.	I → C	6	0 0 1	Medical Director	Quality Committee

Key

- N — New Risk
- ⇧ Increase in Rank
- ⇩ Decrease in Rank
- ⇨ No movement in Rank
- I — Inherent Risk - The measure of risk before controls are considered
- C — Current Risk - The measure of risk after controls are considered
- T — Target Risk - The measure of risk once actions have been completed
- Reliance on controls (——▶)
- Planned mitigations (- - - -▶)
- 1 Action on track
- 1 Action delayed by 1-2mths
- 1 Action delayed by 3mths+

Risk Appetite

Low - 6
Moderate - 9
High - 12
Significant -15+

Summary of Risks by objective

Strategic Objective: Quality of Care – To provide timely, responsive, safe accessible, effective care at all times

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR1	Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.	Chief Nurse	Quality & Resources Committees	5	5	25	4	3	12	6 LOW	OUT	4	3	12	⟺

Strategic Objective: Our People – To create a great place for our people to work, learn and thrive

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR2	Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.	Director of Workforce & OD	Resources Committee	4	4	16	4	3	12	12 HIGH	IN	3	3	9	⟺

Strategic Objective: Our Partnerships – To work together with partners to improve the health and wellbeing of the communities we serve

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR3	Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.	Chief Operating Officer	Quality & Resources Committees	4	4	16	4	3	12	6 LOW	OUT	3	2	6	⟺

Strategic Objective: Research, Innovation and Transformation – Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR4	Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.	Medical Director	Quality Committee	3	3	9	3	2	6	6 LOW	IN	3	2	6	⟺

Summary of Risks by objective

Strategic Objective: Sustainability – To use the resources to deliver healthcare today without compromising the health of future generations

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR5	Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.	Director of Finance	Resources Committee	4	4	16	4	3	12	12 HIGH	IN	4	2	8	⟺

Strategic Objective: Governance and Finance – To be well led with effective governance and sound finance

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6 a	Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030	Director of Finance	Resources Committee	5	5	25	5	5	25	12 HIGH	OUT	4	4	16	⟺

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6 b	Failure to demonstrate effective governance to achieve the Trust's strategy.	Chief Executive	All Committees	5	4	20	3	3	9	12 HIGH	IN	2	3	6	⟺

Ref PR1 Board Assurance Framework (BAF)

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients in urgent care pathways
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Performance Improvement Review Meetings (PRIM) monthly for all Care Groups	PRIM letter outcomes and next steps reported to Executive Committee from Oct24 (Care Group escalation reports previously)	Infection Prevention Strategic Assurance Group (IPSAG)	- IPSAG monthly reporting - Apr 24-current, TPR reporting to Quality Committee and Board, including performance metrics associated with National Oversight Framework	Sustainable services reviews – internal and with the Collaboration of Acute Providers (CAP)	Internal sustainable services report and CAP reporting through CAP Committee in Common
Quality Committee, Patient Safety and Clinical Effectiveness, Patient Experience Sub-Committees, Resources Committee	- Apr 24-current, Quality and Safety reporting to sub-committees - Apr 24-current, escalation reports to Quality Committee - Apr 24-current, Quality Committee delivery of assurance work programme - Apr 24-current, Board escalations	Programme Management Office schedule of programmes	Specific programmes including: - Urgent and Emergency Care, Electronic Patient Record - Maternity - Culture and Leadership	Humber and North Yorkshire System oversight for diagnostics, cancer, urgent care, finance, workforce and place-based meetings	Collaboration meetings across Executive Portfolios: Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce and OD, Finance Director papers
Care Group Board sub-group oversees IPC, escalations made to IPSAG and Assurance Committees	Monthly reporting papers of IPC, Patient Experience and Patient Safety and Clinical Effectiveness Care Groups have each established an IPC/AMS group to oversee local improvement work re: infection prevention and anti-microbial stewardship	Integrated Quality Improvement Group (IQIG) NHSE oversight	Monthly reporting of Trust Improvement Dashboard, CQC Update, Maternity, risks -Revised measures of assurance agreed by IQIG linked to the original assurance metrics from 2023/24. Updated workplan to support the metrics now in place for IQIG.	Continuous flow (CF) and escalation model 3x Op sit rep, proactive management of discharges, proactive communications management with staff and patients, psychological support for staff	- Executive Committee reporting, Board escalations of outcomes and concerns, 3x daily operational sit rep. on-call arrangements in place, proactive management of discharges, oversight through Discharge improvement group - Datix field enabled to identify patient safety incidents linked to CF activity. - Corridor care SOP revised
Operations meeting oversight: Elective Recovery Board, Unscheduled Care Board, Maternity Assurance Group	- Monthly reporting papers of Elective and Unscheduled Care Boards - Apr 2024-current, Executive Committee - Tiering meetings with NHSE for performance	Corporate Quality Oversight: - Maternity Assurance Group (MAG) single improvement plan - Children's Board - Patient Quality Standards Group (PQSG) in place.	- Monthly reporting papers MAG - Single Improvement Plan progress report - PQSG established for oversight of fundamentals of patient care	*Gap – EPRR Core Standards limited compliance* *Gap – Clinical Estates Strategy*	EPR July 2024 Resources Committee and Board reporting EPRR Commander training in delivery Draft clinical estates strategy in place

Ref PR1 Board Assurance Framework (BAF) - continued

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients in urgent care pathways
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Trust performance report	- Monitored at Quality Committee and associated sub committees	Regulation and Assurance visits.	Regulation and Assurance group in place HTA, HNY Trauma network, LMNS, H&S, stroke peer review, CQC	Gaps in Technical Infrastructure and Cyber Security: Limited monitoring of IG policy adherence, lack of access management policy (currently being reviewed), specialist Board cyber security training, wide variety of policies requiring review and update inc cyber protocols, services and endpoint devices require investment, central 3rd party proc register	
Cyber Security Control Framework to safeguard the confidentiality, integrity, and availability of our systems and data and aligned with NHS policies, the Data Security Protection Toolkit aligned to the NCSC Cyber Assessment Framework	- Digital Sub Committee - Submission of DSPT on a yearly basis - Annual SIRO board report - GAPS: DSPT submission highlighted that the organisation was not meeting standards with 16 out of 47 areas below NHS England's minimum standard.	Quality Assurance Framework	Internal Audit review with significant assurance Operational performance managed via the Performance Review Improvement Meetings (PRIM) - Quality Assurance Framework reviewed and updated with pilot of ward accreditation commenced September 2025 including fundamentals of care - revised QAF approved October 25	Complex Needs Assurance Group established Complex Needs Assurance Improvement Plan in place in response to the Niche report	Group meets bi-monthly – Chaired by the Chief Nurse Quarterly progress updates to Patient Experience Subcommittee and Quality Committee for assurance

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Actions Implemented – Target Risk Score Achieved			

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	3	12

Next Review
Q4 | Apr 2026

Ref PR2 Board Assurance Framework (BAF)

Ref: PR2	Strategic Objective: To create a great place for our people to work, learn and thrive	**PRINCIPAL RISK 2:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

Consequences – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Our Voice Our Future Programme	- Discovery and Design phase – discovery and design phase complete. Delivery phase underway. - Q2-Q3 Board Seminar Development reports	Revised vacancy control process – implementation of up to 13-week firebreak and Double Lock in place New medical bank rates from Aug 25	- Vacancy reports (July 25 onwards) - EDG papers – (April 25 onwards) - TPR workforce reporting April 2025 – Dec 2025	Revised communications approach	- Back to the floor initiative - Senior Leadership blogs - Staff Briefs
Delivery of Internal Leadership Programmes in line with Leadership Framework	- Care Group Leadership Development Programme Cohorts phases 1-3 delivered - List of programmes and training programmes on Learning Hub	Implementation of People Strategy Freedom to Speak Up Reporting	TPR workforce reporting April 2025-Dec 25 EDS 2022; WRES, WDES & Pay Gap reports FTSU Board report September 2025	Formal workforce engagement	- JNCC and LNC meeting minutes - Staff Networks ToR - Anti-Racism Group
Line Management Toolkit and Training	Toolkit rollout to all Line Managers and training implementation records. Phase 2 – 'Line Manager Fundamentals' training delivered from Autumn 25	Senior Leadership Engagement Gap – engagement with all levels of leadership	- Quarterly Senior Leaders Forum - Senior Clinical Leadership monthly meeting	Wellbeing delivery	- Occupational Health and Wellbeing Annual Report to Resources Committee - Staff Psychologist Therapy - TPR (flu vaccination data (Oct25-Jan 26) - Reportable Issues paper (July 25 – Jan 26)
- Oversight of establishments and establishment reviews, job planning and medical deep dives - TPR reporting of nursing academy: retention of HCSW and apprenticeships levy	- TPR reporting Apr 2025-Dec 2025 - Nursing workforce Resources Committee reporting Apr 2025-Dec 2025 - Quarterly Medical Workforce Report – Resources Committee July 25 – Jan 2026	*Gap – Financial resources to recruit at the staffing establishments required*	- Annual financial planning Board sign-off April 2025 - Staffing business cases - Rostering data - - Nursing workforce establishment review approved, and funding released to support the 3 main priorities agreed	QI Readiness Assessment position when undertaken	

Ref PR2 Board Assurance Framework (BAF) - continued

Ref: PR2	Strategic Objective: To create a great place for our people to work, learn and thrive	**PRINCIPAL RISK 4:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

Consequences – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
- Our Voice Our Future – Delivery Phase implementation of actions	- Our Voice Our Future - Delivery phase currently underway	Chief Executive	2026
- Staff Survey Improvement Plan and People Promise Programme	- Colleague Engagement Improvement Plans – June 2025.	Polly McMeekin	2026

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	3	9

Next Review
Q4 - Apr 2026

Ref PR3 Board Assurance Framework (BAF)

Ref: PR3	Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve	**PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

Consequences – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. positive)	ii) Controls	ii) Assurances (inc. positive)	iii) Controls	iii) Assurances (inc. positive)
Strategic Alignment: Mechanisms in place to ensure alignment of priorities between partners. - Joint Committee in Common - Joint Operational planning meetings with Alliances, ICB and Place Colleagues throughout planning process. - Alignment of Cancer alliance objectives into Y&S Cancer Strategy - Recruitment of Head of Strategy to support partnership working	Shared system performance metrics managed with the ICB and tiering meeting with regional colleagues. ICB performance oversight arrangements. CAP meetings: Elective and UEC – joint leadership arrangements Trust strategy shared with Stakeholders (dec 2024) *Cancer Strategy Workshop – Feb 2025* *Gap: Joint strategic planning sessions with place & partners (not a gap for cancer as this is done collaboratively)*	Training and Development: Increasing the understanding of key Trust leaders in system working and partnership opportunities.	*Gap: Opportunity for leadership development in system collaboration.*	Resources: Senior management representation at core ICB and Place-based forums and alliances. Employment of Head of Strategy as key lead for partnership development	Attendance records at partnership meetings. Recruitment of Head of Strategy to support partnership working. Funding into NHS Benchmarking
Communications: Joint committees or forums for collaboration and conflict resolution.	- Trust CEO Committee in Common with other Trust Providers. - Harrogate Board to Board - York Health & Care Collaborative & Joint Delivery Board. - CAP Alliance Representation & clinical leads - Multiple Boards in place where Trust is represented: CAP/ UEC and Place and SOAG. - ICB Board Quarterly meeting minutes - York Health & Care Collaborative & Joint Delivery Board meeting minutes - CAP Quarterly meeting minutes *Gap: Audit of effectiveness of forums for delivering quality partnership working ?*	Data that support partnership working - North Yorkshire Overarching Multi Agency Information Sharing Protocol (MAIS) - Humber sharing charter - Specific sharing agreement with TEWV for them to access our systems as required - Information sharing as part of the Collaborative of Acute Providers Information	MAIS: this is managed by NYCC and is reviewed annually (partners include YAS, NY Police, CYC, Harrogate and District NHS Foundation Trust) *Humber sharing charter: T*his is managed by North East Lincolnshire Council and is reviewed annually (partners include HUTH, East Riding council, Humberside Police) TEWV and other agreements managed in line with SLAs CAP: Sharing is managed through the joint working arrangement	- System working to deliver EPR convergence and supporting initiatives around Population Health Management - Partnership working on the Yorkshire and Humber Care Record	- EPR Programme Management - Yorkshire and Humber Care Record Programme Management

Ref PR3 Board Assurance Framework (BAF) - continued

Ref: PR3	Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve	**PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

Consequences – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Conduct joint strategic planning sessions to align objectives and priorities across key partners (at place most likely).	Cancer Strategic review with partners complete, workshop held for Cancer Strategy 25-30. Collaborative Acute Providers (CAP) 25/26 work programme - awaiting Executive Planning Meetings – throughout the national planning round	Beth Eastwood / Jenny Piper CEO / COO and CFO	**Cancer Strategy:** Cancer Board – 14th May Exec Com – Early June Board June CAP - TBC Sept-Mar 2025
Audit of effectiveness of forums for delivering quality partnership working. Using partnership maturity matrix across providers / place and alliances	Audit of partnership meetings initiated across care groups and directorates Maturity matrix for assessing partnership working developed. Audit completed. There are over 220 partnership meetings listed, over 60 of these are Executive level. It is not possible, nor appropriate to conduct a maturity matrix on all identified partnership meeting. To this end the list will be shared with the executive team for prioritisation. Application on maturity matrix across partnerships and stakeholders *Establishment of Strategy and Partnership Sub- Committee – Dec 2025*	Tilly Poole	Q1 - Initiated Q1 – Matrix completed and being tested Q2-4 – identify priority groups and apply matrix Q3 – subcommittee complete – will support above in conjunction with Head of Governance
Governance arrangements to demonstrate delivery of primary care collaboration	New Place-based meeting established Q1 2025 - Integrated Primary Health Care Collaborative 2025/26	To be established on receipt of ToR – first meeting 23/04/25	Q1
Governance arrangements to demonstrate effectiveness of shared data for decision making	Supporting work of the emerging linked dataset with HNY Geomapping exercise initiated by CAP Data-led Planning Approach approved at Exec Com – speciality level data packs complete and shared with specialties in face-to-face meetings throughout September to support planning and clinical service strategy. Next step will be to update following feedback and to collate Trust wide insights – November 2025 Clinical service strategy framework developed in draft form, workshops with care groups planned	Tilly Poole Lynette Smith Tilly Poole Tilly Poole Tilly Poole	Q2-4 Q2&3 Completed Completed Q2 - CSCS and FH complete.

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6
Next Review		
Apr 2026		

Ref PR4 Board Assurance Framework (BAF)

Ref: PR4	Strategic Objective: Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow	**PRINCIPAL RISK 4:** *Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.*	Risk Score: 6

Causes – What must happen for the risk to occur?
- Failure to transform services sufficiently to within the current resource limits
- Capacity for the EPR programme delivery is not sufficient
- Lack of standard implementation of QI methodology
- Insufficient funds to allow running of services, allowing headroom to affect transformation, plan for the long term and change at pace

Consequences – If the risk occurs, what is its impact?
- The EPR programme is not sufficient to realise its full potential
- QI benefits not consistently delivered to transform services

Executive Risk Owner: Medical Director | **Assurance Committee:** Quality Committee | **Date Added to BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
3	3	9	3	2	6	LOW (1-6)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	6	6	6	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. positive)	ii) Controls	ii) Assurances (inc. positive)	iii) Controls	iii) Assurances (inc. positive)
Rollout of Quality Improvement Methodology (QSIR)	- Regular cohorts of QI training - QSIR tools available Trust wide - Governance Half-Days include improvement - Governance outputs reported through Care Group Governance - Readiness Assessment commissioned and completed to support the development of the next phase of our QI journey. - Business Case produced to support the appointment of a Strategic Partner to support our CQI journey. Business Case and Consultancy Application submitted to NHS England on 23rd December 2025	Implementation of the Nervecentre EPR Programme	- Business case approval - EPR Executive Steering Group ~~Programme Board~~ - Digital Sub-Committee - YSTHFT and HDFT Joint Programme Board ~~HNY EPR Board (ICB joint working)~~ - Project team appointments - Training plan - TRG established for Nervecentre readiness assessment - NHS England Gateway Review 4/4.5.	Building of commercial research team	- Establishment of commercial research team 13% of our research portfolio as commercial business - Collaboration agreements with Contract Research Organisations (CROs) underway
				Research and Innovation, People, Digital and Quality Strategies	- Approved at February-May 2025 Board of Directors Action plan reviewed quarterly and currently on track
Data for improvement	- Availability of data on Signal - Improvements to Trust Priorities Report True North Report developed and added to the reporting schedule. - Tendable data is being used to support measurement for improvement.	Joint working with partners across ICB for system-wide transformation	- Cancer Board, Cancer Strategy Workshop Feb 2025 - Elective Recovery Board, CAP meetings: Elective joint leadership arrangements - Community Improvement Group	Continuation and expansion of Research Delivery	- Partnerships with universities ongoing - Research leads and time assigned for Principal Investigators. Research monies are flowing to care groups but this is not being allocated to PAs
Transformation programmes with programme governance and infrastructure	- Programmes established including: - *Maternity Assurance Group* - *Community Diagnostic Centres* - *Urgent Care Improvement Programme* - *Urgency and Emergency Care Centre*	Annual Planning and Strategy Development	- Annual planning process to develop change and transformation priorities and initiatives in specialties - Joint meetings with ICB and Place during planning round to manage risks and ensure alignment of policy requirements. - Strategy and Partnership Subcommittee to Executive Committee now established.	Growth of coastal research capacity to create research and implement findings related to inequalities	- Establishment of Scarborough Coastal Health and Care Research Healthcare Collaborative (SHARC) - Partnerships with VCSE organisations

Ref PR4 Board Assurance Framework (BAF)

Ref: PR4	Strategic Objective: Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow	**PRINCIPAL RISK 4:** *Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.*	**Risk Score: 6**

Causes – What must happen for the risk to occur?
- Failure to transform services sufficiently to within the current resource limits
- Capacity for the EPR programme delivery is not sufficient
- Lack of standard implementation of QI methodology
- Insufficient funds to allow running of services, allowing headroom to affect transformation, plan for the long term and change at pace

Consequences – If the risk occurs, what is its impact?
- The EPR programme is not sufficient to realise its full potential
- QI benefits not consistently delivered to transform services

Executive Risk Owner: Medical Director | **Assurance Committee:** Quality Committee | **Date Added to BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
3	3	9	3	2	6	LOW (1-6)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	6	6	6	N/A
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
NHS Impact Actions and establishment of continuous improvement culture	Readiness Assessment commissioned from KPMG for the establishment of our management system to deliver our strategic priorities.	Adele Coulthard	Complete
Resource and focus on innovation	Delivery of Research and Innovation Strategy Action Plan	Lydia Harris/Adele Coulthard	April 2026

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6
Next Review		
Q4 - Apr 2026		

Ref PR5 Board Assurance Framework (BAF)

Ref: PR5	Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations	**PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

Consequences – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
External grant and match funding opportunities to help improve capital and infrastructure to better sustainable and energy saving standards	- NHSE and ICB informing of grant opportunities, horizon scanning, for example:- o PSDS o NEEF o Other opportunities including through our local/regional partnerships	Sustainable Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan).	- Senior Lead owner of each Green Plan workstream and theme - Monthly 1-2-1 with the Finance Director in his role as the Executive Sustainability lead *Gap – These workstreams are in place with identified leads but a minority still need to develop further.* The travel plan is to set forward a number of initiatives to promote sustainable travel across the Trust and improve efficiencies & logistics in terms of staff and operational travel. The work is supported by the Trust Travel & Transport group. *Gap – Staff Travel Plan does not control patient travel, which impacts on our 2045 carbon target, where there is a reliance on clinical changes to increase community care and treatment of patients. Other initiatives underway; continuation of the bus travel offers, secure cycle parking and increasing of EVCPs.*	Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group Monthly 1-2-1 with the Finance Director in his role as the Executive Sustainability lead	- Resources and Executive Committee Reporting every quarter - YTHFM Management Group reporting every quarter *Gap – Head of Sustainability has had to continue to chase workstream leads including supporting the draft of these sections in the revised Green Plan. A further series of 1-2-1's with workstream leads who are still yet to provide their draft is underway and proving successful so far.*
Sustainability Team delivering the green plan and staff travel plan agendas across the Trust	- Green Plan requiring redrafting to better align with new NHSE Green Plan guidance, ICB Green Plan and regional climate change strategies. - Green Champions network established but will be commencing a review shortly to co-design it into is next reiteration. - Staff Travel Plan agreed and published, January 2025 - Developing new external partnerships private & public sectors organisations to support our and their sustainability efforts, following external funding sources and support	Head of Sustainability oversight and lead, Finance Director steer and Sustainability Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan).		Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group. Regular meetings with the Finance Director to update, provide assurances and receive steers from.	
Sustainable Design Guide & NHSE building standards implementation	- BREEAM standards embedded in the Capital Team - Scarborough UEC delivery - Capital Projects' sustainability design guidance is in place. The Head of Capital Projects retains accountability for the broader sustainability improvements via the capital projects they are instructed to deliver, inline with NHS Net Zero Building Standards	Green Plan, Sustainability Development Group & newly established Capital and Estates workstream	*The guidance is now embedded within Capital and supported by a new officer who is experienced in sustainability. Gap – The newly formed workstream for Capital and Estates has only met twice but they are aware of a number of items they need to look at including embedding NHSE net zero building standards.*	Ongoing staff communications through the Heads of Capital and Estates to push the embedding of sustainability across their departments.	- Trust Communication on green plan interventions - Capital and Estates teams meetings and communications from the Head of Service with support from the Head of Sustainability.

Ref PR5 Board Assurance Framework (BAF) - continued

Ref: PR5	Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations	**PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

Consequences – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	N/A
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Staff Travel Plan Implementation	A new partnership has been developed between the Trust, both York universities and City of York Council to discuss and implement actions to help improve public and active travel links for our staff and customers, including bus access and car sharing. Bus operators to continue with staff bus discount offer with benefits to patients/visitors to travel sustainably. Funding from North Yorkshire and East Riding Councils and York Hospitals Charity to support new secure cycle parking facilities for York and Bridlington and a bus stop and shelter at Selby. The staff travel survey is underway, and due to close at the end of October, where several hundreds responses have been submitted already. Once complete this will help inform further work of the staff travel plan.	Daniel Braidley/Graham Titchener	Review April 2026
Review of YTHFM Capital Projects' Sustainability Design Guide against the NHSE Net Zero building Standard & chair of newly established Capital & Estates workstream.	Head of Capital projects has an officer who is qualified in sustainability, is ensuring sustainability guidance is incorporated all Capital Projects where possible. The new Green Plan workstream is now up and running, aligning responsibilities between Capital and Estates teams, chaired by the Head of Capital, with the two heads of service leading and ensure better embedding of sustainability policies, especially NHSE Net Zero Building Standards Externally funded sustainability projects worked into the Trust capital programme to ensure better alignment and prioritisation of project officer capacity to deliver these projects.	Andrew Bennett	Review April 2026
Sustainability Quarterly Assurance Reports and workstream establishment.	Workstreams are in place but not all being fully effective yet, however following a series of 1-2-1 meetings with all workstream leads, the main 'ask' to develop their update workstream sections for the Green Plan is underway however the Head of Sustainability still has concerns of the progress of some of these, that are due to a combination of work pressures, lack of staff or new staff coming into post. Other work is progressing through the Sustainability team but, while improved, there is still more that needs to be done by these workstreams. Ensuring better data is available to track progress against the newly update 1379t/CO2 saving per annum the Trust needs to make to achieve net zero targets. This is an increase of 1079t/CO2 due to the CHP engine breaking earlier this year. Once the data is more assured, we are aiming to provide a simple dashboard for all staff to show where we are on our CO2 journey.	Graham Titchener	Review April 2026
Trust Green Plan redrafted to better align with new NHSE Green Plan guidance, ICB Green Plan and regional climate change strategies and to include more KPIs/SMART outcomes.	Currently our annual Co2e target is 1350 tonnes per annum. This is an increase from the previous 1200t/Co2e per annuum due to the CHP going down in January 2024. Sustainability team continues to work with communications on a weekly basis to promote this and the Co2e journey .	Graham Titchener	April 2026

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	2	8

Next Review
Q1 - Apr 2026

Ref PR6a Board Assurance Framework (BAF)

Ref: PR6a	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6a:** Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030.	Risk Score: 25

Causes – What must happen for the risk to occur?

- Failure to achieve the annual financial plan through inadequate income allocations, poor income recovery, lack of expenditure control, non-delivery of the efficiency programme and unaffordable investment decisions.
- Cashflow difficulties
- Inadequate capital funding to meet all infrastructure backlog repair priorities and new investment requirements

Consequences – If the risk occurs, what is its impact?

- Trust entering SOF4 arrangements and special measures scrutiny
- Not achieving the Trust's part of the ICB overall financial balance (system failure consequence)
- Loss of Deficit Support Funding
- Externally imposed financial recovery plan
- Reputation impact on the Trust
- Site infrastructure failure
- Loss of autonomy and control
- Potential reduction in service quality and safety

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	5	5	25	OPEN (10-12)	OUTSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	25	25	25	N/A
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Annual business planning process including Board plan sign-off, triangulation with ICB and ICS and ultimate NHSE approval.	- Business plan, Board progress updates - ICB plan working groups - Internal Audit Reports 2025-26	Expenditure control - business case process *Gap – Unplanned expenditure commitments outside of process*	- Business Case manual and register - Internal audit report - SFI Business Case approval hierarchy	Overspend monitoring against approved scheme sums	- Scheme sum variation process - Scheme expenditure CPEG reports
Monitoring and reporting of I&E plan	- TPR Board and Committee reporting 2025-26 - PFR monthly NHSE. TPR Resources & Board - Care Group PRIMs and FRMs	Efficiency delivery – managed by Corporate Efficiency Team *Gap – insufficient planning to secure in year delivery*	- TPR Board, Committee and EDG reporting 2025-26 - PFR monthly to NHSE - Care Group PRIMs and FRMs	Management of national PDC schemes to required timelines (year-end cut-off deadlines)	- CPEG reporting 2025-26 - ICS/NHSE ad hoc reports
Income control - income contract variation process *Gap – unplanned income reduction*	- Income adjustment form register - TPR Board and Committee reporting	Cash flow monitoring. Cash working group. Monthly debtors and creditors review.	- Monthly debtor and creditor dashboard - Trend data and forecast data in TPR - Better Payment Practice in TPR	Backlog maintenance prioritisation *Gap – lack of understanding of full backlog requirements*	- Capital Investment needs schedules - Prioritisation scoring process - EC and Board sign off April 2025
Expenditure control - scheme of delegation, standing financial instructions, segregation of duties.	- SFIs Board approved - Written prime budget holders' approval - System enforcements and no PO no Pay	Capital planning process – preparation and sign off programme	- Capital Investment needs schedules - Prioritisation scoring process - EC and Board sign off April 2025	Identification of sparsity income stream (£10.3m)	- Formal agreement with ICB to include sparsity income & work on funding - Task & finish group to manage
Expenditure control - staff leaver process and Vacancy Control *Gaps – payroll untimely informed of leavers*	- Salary overpayment recovery policy - Staff Reports, REACH reporting	Routine monitoring and reporting against capital programme	- TPR Board and Committee reporting 2025-26 - CPEG reporting - ICS/NHSE ad hoc reports	Risk share agreed with the ICB for high-cost drug cost pressure	- £6m ICB funding agreed - Area prescribing committee work - ICB strategic commissioner role

Ref PR6a Board Assurance Framework (BAF) - continued

Ref: PR6a	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6a:** Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030.	**Risk Score: 25**

Causes – What must happen for the risk to occur?

- Failure to achieve the annual financial plan through inadequate income allocations, poor income recovery, lack of expenditure control, non-delivery of the efficiency programme and unaffordable investment decisions.
- Cashflow difficulties
- Inadequate capital funding to meet all infrastructure backlog repair priorities and new investment requirements

Consequences – If the risk occurs, what is its impact?

- Trust entering SOF4 arrangements and special measures scrutiny
- Not achieving the Trust's part of the ICB overall financial balance (system failure consequence)
- Loss of Deficit Support Funding
- Externally imposed financial recovery plan
- Reputation impact on the Trust
- Site infrastructure failure
- Loss of autonomy and control
- Potential reduction in service quality and safety

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	5	5	25	OPEN (10-12)	OUTSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	25	25	25	N/A
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Unplanned income or spend change – CG and Corp Dir reminders	As part of the 25/26 budget sign off process a specific reminder will be issued requiring signature.	Andrew Bertram	Complete
Payroll improvement project to tackle under & over payments - Deloitte	Improvement plan prepared. Delivery underway. HR Director chaired working group in place.	Andrew Bertram	Deloitte work complete. Action plan delivery group in place.
Insufficient efficiency programme – Productivity group / CIP Timeout to accelerate delivery in H2; Recovery action plans. Formal Financial Recovery plan prepared and managed through EDG.	ICS-wide System Engine Room governance programme. System leaders' group to manage pace & cover. Fully planned efficiency programme for 25/26 but need to manage high risk schemes and slippage. £5m of recovery actions identified and in train. Work to progress further actions continues – SROs identified, key milestones tracked, formal reporting lines created.	Andrew Bertram	Ongoing for 25/26 plans
6 Facet Survey to be completed to identify full backlog maintenance reqs.	Funding agreed. Survey work completed. Currently being quality checked prior to publishing	A Bertram/Penny Gilyard	Complete. Now being reviewed for 2026/27 capital programme
Formal notification provided to NHSE of likelihood of non-delivery of plan	NHSE advised in December. Formal notification issued to NHSE 8 January in line with national protocol.	Andrew Bertram	Complete

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	4	16

Next Review

Q4 - Apr 2026

Ref PR6b Board Assurance Framework (BAF)

Ref: PR6 b	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6b:** *Failure to demonstrate effective governance to achieve the Trust's Strategy.*	**Risk Score: 9**

Causes – What must happen for the risk to occur?
- Failure to achieve a satisfactory CQC well-led rating
- Inadequate escalation governance processes
- Trust Leadership and staff not held to account effectively
- Poorly structured and defined governance forums from 'Ward to Board'
- Unclear accountabilities and responsibilities of Trust leadership and Staff
- Insufficient grip on the governance of data

Consequences – If the risk occurs, what is its impact?
- Regulatory well-led scrutiny on the Trust leadership, staff and governance processes
- Trust resources not used effectively and efficiently in achieving the Trust's strategy
- Quality of patient care and experience is not at the level achieved
- Decision-making not consistent with achieving Trust goals
- Risks and issues not managed effecting patient care
- Poor staff morale

Executive Risk Owner: Chief Executive | **Assurance Committee:** All Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	4	20	3	3	9	OPEN (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	9	9	9	N/A
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances (inc Positive)	ii) Controls	ii) Assurances (inc Positive)	iii) Controls	iii) Assurances (inc Positive)
Monthly Trust Board of Directors reporting to Standing Orders, Reservation of Powers and Scheme of Delegation	- Approved Standing Orders and work programme (Jan 2025) papers, minutes and action logs - 2024/25 Committee effectiveness reviews and amendments to terms of reference	Patient Experience and Clinical Effectiveness Sub-Committees	- Approved terms of reference and work programmes (Jan 2025) - All Committee reporting papers, minutes, action logs Apr 2024-Jan 2026	Role job descriptions and annual appraisal processes	- 88% staff appraisals concluded for 2024
Trust constitution and governance framework: Scheme of Reservation and Delegation and Standing Financial Instructions	- Trust constitution and governance framework approved by Board of Directors Jan 2025, delivered through all Committees - January 2026 review reported to Board	Performance Review and Improvement Meetings (PRIM) with Care Groups	- Monthly letters of meeting outcomes and actions to Care Groups for action - Escalation reporting to Executive Committee for lessons learnt	Line Management Development Programme	- Trust line management training programme
- Monthly Quality and Resources Committees - Twice monthly Executive Committee in delivery of Trust Strategy - Quarterly Audit Committee	- Committees' terms of reference and work programmes (approved January 2025) - All Committee reporting papers, minutes and action logs Apr 2024-Jan 2026	Committee escalation processes and flow of information across governance forums	- Quality, Resources, and Audit Committee escalation reports to Board of Directors - Care Group reporting escalations to Executive Committee April 2024-Jan 2026	Business Intelligence data reporting processes	- Signal 'real-time' reporting - Trust Priorities Report (TPR) monthly reporting to Board, Quality, Resources and Executive Committees Apr 2024-Jan 2026
- Risk Management Strategy and Policy and Datix system - DSPT submission and cyber security management	- Board Approved January 2025 - BAF, Corporate Risk, Care Group and speciality risk registers Apr 2024-Jan 2026 - SIRO board report Sept 2025	Care Group governance forums (quality, performance, finance, workforce, risk)	*Gap - Approved consistent terms of reference and work programmes across all Care Groups* - Care Group reporting papers, minutes, action logs Apr 2024-Jan 2026	CQC 'Journey To Excellence' programme and relationship management meetings	- Journey to Excellence bi-monthly meeting Apr 2024-Jan 2026 - Journey to Excellence action plan outcomes evidence submitted to CQC Apr 2024-Jan 25

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Consistent Care Group governance terms of reference for Quality, Performance, Finance and Risk forums	Accountability framework drafted for future Trust wide dissemination. Training underway for specialities. Risk and Assurance Workshops conducted with Care Group leadership teams	Mike Taylor	March 2026
Well-led external assessment next steps to implement	External well-led assessment concluded and final report received. Well-Led Action Plan to be drafted.	Mike Taylor	January 2026
Review of Committee self-assessments evaluations	Self-assessment evaluation process underway, February Committee and March Board reporting.	Mike Taylor	March 2026

Target Risk (After Actions Implemented)		
I	L	Rating I x L
2	3	6

Next Review
Q4 - Apr 2026

Report to:	Board of Directors
Date of Meeting:	28 January 2026
Subject:	Review of the Trust Reservation of Powers and Scheme of Delegation, Standing Financial Instructions and Standing Orders
Director Sponsor:	Clare Smith, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides the results of the review of the Trust's Governance Framework summarised as follows:

Trust Reservation of Powers and Scheme of Delegation

- Reference to Code of Governance for NHS Provider Trusts
- Amendment for Chief Executive or Finance Director authority delegated through Executive Committee for business cases
- Scope of delegations changed to Quotations, Tendering and Contracts
- Bank and agency staff change of delegated authority to 2nd on-call out of hours

- Inclusion of authority to purchase IT hardware and software to the Head of IT Infrastructure

Standing Financial Instructions

- Amends to the formal tendering procedures may be waived by officers for whom powers have been delegated by the Chief Executive through the Scheme of Delegation where the estimated cost is not to exceed £75k.
- Specific reference to NHS England - Managing Conflicts of Interest in the NHS documentation.
- Inclusion of a procurement decision tree

Standing Orders

- Reference to all relevant legislation including the Health and Social Care Act 2008 and the Health and Care Act 2025 throughout the document.

Recommendation:

The Board of Directors is asked to approve the changes to the Trust Reservation of Powers and Scheme of Delegation, Standing Financial Instructions and Standing Orders.

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

Meeting/Engagement	Date	Outcome/Recommendation
Group Audit Committee	13 January 2026	Recommended for approval

Y&STHFT Reservation of Powers and Scheme of Delegation, Standing Financial Instructions and Standing Orders

1. Reservation of Powers and Scheme of Delegation

The Trust's reservation of powers and scheme of delegation have been revised as follows (additions in bold):

Area	Section and Amendment
Page 3 - Introduction	The **Code of Governance for NHS Provider Trusts** ~~NHS Foundation Trust Code of Governance~~
Page 3 - Scope	The Code of Governance **for NHS Provider Trusts**
Page 4 - Scope	The following statement included: **Depending on the Group's financial position, NHSE and HNY ICB may implement a financial protocol that overrides Scheme of Delegation authorities in relation to non-clinical non pay expenditure and non-clinical recruitment to vacant posts and this will be communicated to all budget holders at the time.**
Page 9 - Summary of Delegated Authorities	Capital and Investment Business Cases Delegated Matter Delegated authority from **Executive Committee** ~~Capital Programme Executive Group~~ £5k - £50k Authority delegated to Chief Executive or Finance Director through **Executive Committee** ~~Capital Programme Executive Group~~ £50k - £500k All Business Cases revenue investment (planned increases in expenditure or income from existing approved levels) Delegated Matter **(Any expenditure over £139k must publish a tender notice (UK4) on the Central Digital Platform / Find a Tender, which is what makes the opportunity public for suppliers. Further advice should be sought from Procurement)** ~~Any expenditure over £25k must be advertised under procurement rules. Further advice should be sought from procurement.~~ Authority delegated to Chief Executive or Finance Director through **Executive Committee** ~~Capital Programme Executive Group~~
Page 14 - Quotations,	Delegated Matter Quotations

Tendering and Contracts Page 15 - Quotations, Tendering and Contracts	Authority delegated to Director of Procurement Scope of delegation **£139k** ~~£213k~~ Delegated Matter Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders) Authority delegated to Director of Procurement Scope of delegation **£139k** ~~£213k~~ Delegated Matter Accepting contracts and signing relevant documentation Authority delegated to Director of Procurement Scope of delegation Up to the published UK procurement threshold **(£139,688)** ~~£214,904~~
Page 23 – Personnel and Pay	Delegated Matter Booking of bank and agency staff Authority delegated to **Any escalated rates requires the Exec level approval or approval of 2nd on-call Out of Hours.** ~~CG Director up to +49% of capped value with an absolute limit of £99.99; anything over 50% or £100 needs the Exec Rate Escalation Group~~
Page 24 – **IT Hardware and Software**	Delegated Matter **Authority to Purchase** Authority delegated to **Head of IT Infrastructure** Scope of Delegation **All** Details/Reference **Shadow IT Policy**

2. Standing Financial Instructions

Area	**Section and Amendment**

Page 31 - Tendering Quotation and Contract Procedure	9.5.2 **Formal tendering procedures may be waived by officers for whom powers have been delegated by the Chief Executive through the Scheme of Delegation where one or more of the following applies:** **(a) The estimated expenditure or income under the arrangement must not, and must not reasonably be expected to exceed £75,000 including VAT (this local threshold will be reviewed annually).** • **For this and statutory thresholds under the Procurement Act 2023, the contract value is the maximum amount the authority could expect to pay or receive over the full contract term, including all options, extensions, related income and any goods, services or works provided by the authority, inclusive of VAT, and is not based on annual or budgeted costs.** • **Furthermore, you must not estimate, structure or divide contracts with the intention of avoiding the Act or its thresholds. Where requirements could reasonably be supplied under a single contract, the value of each related contract must be treated as including the value of all such contracts for valuation and threshold purposes.** ~~(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £75,000 (this figure is reviewed annually).~~ • ~~*It is a breach of the UK Public Contracts Regulations to spilt contracts to avoid the thresholds. The value used should be the overall contract value for the life of the equipment or service (including VAT) not annual costs;*~~
Page 48 – Acceptance of Gifts by Staff	This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff **and in the NHS England - Managing Conflicts of Interest in the NHS.**
Page 52 – Procurement Act 2023 Route to Market	Insertion of amended matrix
Page 53 – Decision Tree	Insertion of flow chart

3. Standing Orders

The Standing Orders amendments include minor changes to reference all relevant legislation including the Health and Social Care Act 2008 and the Health and Care Act 2025 throughout the document.

All documentation is provided on the Board of Directors Teams Channel for reference.

4. Recommendation

The Board of Directors is asked to approve the changes to the Trust Reservation of Powers and Scheme of Delegation, Standing Financial Instructions and Standing Orders.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	28th January 2026
Subject:	YTHFM Revision of the Reservation of Powers and Scheme of Delegations and Standing Financial Instructions
Director Sponsor:	Penny Gilyard, Director of Resources Chris Norman, Managing Director
Author:	Penny Gilyard, Director of Resources Jackie Carter, Governance Manager

Status of the Report (please click on the appropriate box)
Approve ☒ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

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

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

Implications for Equality, Diversity and Inclusion (EDI) *(please document in report)*
- ☐ Yes
- ☐ No
- ☒ Not Applicable

Executive Summary:
The purpose of the report is to present to Board of Directors, YTHFM's Reservation of Powers and Scheme of Delegation and Standing Financial Instructions which have been reviewed in line with governance arrangements.

YTHFM reviews the corporate governance documents on an annual basis for recommendation for approval by Management Group and endorsement by Audit Committee.

The documents are a Reserved Matter and require final approval by Board of Directors.

Recommendation:
Board of Directors is asked to approve the documents.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)
No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Management Group	January 2026	Approved
Group Audit Committee	13th January 2026	Assurance

Revision of the Reservation of Powers and Scheme of Delegations and Standing Financial Instructions

1. Introduction and Background

1.1 YTHFM reviews the corporate governance documents on an annual basis for recommendation for approval by Management Group. There are no material updates to the SoDs and SFIs documentation.

2. Considerations

2.1. Reservation of powers and Scheme of Delegations

2.1.2 The following changes are made to the YTHFM's reservation of powers and scheme of delegations. (Updates in **bold**).

Area	Section and amendment
Scope:	2.6 Statement added - **Depending on the Group's financial position, NHSE and HNY ICB may implement a financial protocol that overrides Scheme of Delegation authorities in relation to non clinical non pay expenditure and non clinical recruitment to vacant posts and this will be communicated to all budget holders at the time.**
Capital investment and Business Cases: Backlog Maintenance Element of the capital programme	Authority delegated to: CPEG removed. **Executive Committee** added.
Condemning, disposal and security – YTHFM equipment: Stock Management	Responsibility of YTHFM Stores **Estates & Medical Engineering.**

2.2. Standing Financial Instructions (SFIs)

2.2.1 YTHFM's SFIs have been revised as follows (Updates in bold).

Area	Section and amendment
9.4. Building and engineering transactions	9.4.1 – **Procure 22 removed.**
9.5.2. Waivers of formal tendering	9.5.2 – The following 2 paragraphs have been added - **For this and statutory thresholds under the Procurement Act 2023, the contract value is the maximum amount the authority could expect to pay or receive over the full contract term, including all options, extensions, related income and any goods, services or works provided by the authority, inclusive of VAT, and is not based on annual or budgeted costs.**

	Furthermore, you must not estimate, structure or divide contracts with the intention of avoiding the Act or its thresholds. Where requirements could reasonably be supplied under a single contract, the value of each related contract must be treated as including the value of all such contracts for valuation and threshold purposes.
11. Stores and receipt of goods.	11.2 – **overall responsibility for the control of stores shall be delegated to the Deputy Director of Logistics & Supply Chain added.** **Head of Procurement removed.**
Appendix 1	Appendix 1 - **Thresholds apply for 2 years from 1.1.26.** **Procurement Act 23 "route to market" choice matrix added.** **Existing choice matrix removed.**

3. Recommendation

3.1 Board of Directors is asked to approve the documents.

Date: 19th January 2026