York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 25th March 2026
Time: 9:00am – 12:30pm
Venue: Board Room, York Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
Public Agenda - Draft

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 25 February 2026** 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	Verbal	-	9:05
7.	**True North Report** To review the report.	Chief Executive	Report	18	9:15
8.	**Chair's Report** To receive the report.	Chair	Report	36	9:25

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	39	9:30
10.	**Quality Committee Report** To receive the March meeting summary report.	Chair of the Quality Committee	Verbal	-	9:45
11.	**Resources Committee Report** To receive the March meeting summary report.	Chair of the Resources Committee	Report	70	9:55
12.	**Group Audit Committee** To receive the March meeting summary report.	Chair of the Group Audit Committee	Report	75	10:05
13.	**Trust Priorities Report (TPR)** February 2026 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	78 82 128 149 160 168	10:15
Break 11:05					
14.	**CQC Compliance Update** To consider the report.	Chief Nurse	Report	188	11:15

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Maternity and Neonatal Report** To consider the report.	Chief Nurse - Executive Maternity Safety Champion	Report	193	11:25
16.	**Mortality Review – Learning From Deaths Report** To consider the report.	Medical Director	Report	204	11:35
17.	**Staff Survey Annual Report** To consider the report.	Director of Workforce & OD	Report	220	11:45
18.	**Equality Delivery System** To consider the report.	Director of Workforce & OD	Report	226	12:10
Governance					
19.	**Corporate Governance Update:** • Annual Committee Effectiveness Reviews • Committee Terms of Reference Amendments • Board of Directors' Work Plan • Modern Slavery Act Statement To consider the report.	Associate Director of Corporate Governance	Report	255	12:20
20.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	-
21.	**Time and Date of next meeting** The next meeting held in public will be on 29 April 2026 at 9.30am at Scarborough Hospital.				
22.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				

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

Minutes
Board of Directors Meeting (Public)
25 February 2026

Minutes of the Public Board of Directors meeting held on Wednesday 25 February 2026 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.20pm.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Ms Rukmal Abeysekera
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Ms Helen Grantham *(Via Teams)*
- Ms Jane Hazelgrave
- Mrs Jenny McAleese
- 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 and Executive Maternity & Neonatal Safety Champion
- Ms Claire Hansen, Chief Operating Officer
- Mr James Hawkins, Chief Digital and Information Officer
- Miss Polly McMeekin, Director of Workforce and Organisational Development

Corporate Directors
- Mr Chris Norman, Managing Director, YTHFM
- Mrs Lucy Brown, Director of Communications
- Mr Mike Taylor, Associate Director of Corporate Governance

In Attendance:
- Ms Donna Jack, Head of Nursing, Acute and Emergency Medicine (For Item 6)
- Ms Emily Douse, Patient Equality, Diversity and Inclusion Lead (For Item 6)
- Ms Sascha Wells-Munro, Director of Midwifery (For Item 15)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:
- Ms Linda Wild, Elected Governor – Public
- Mr Graham Lake, Elected Governor – Public
- Mr Nick Bosanquet, Elected Governor – Public
- Ms Carol Popplestone, Elected Governor – Staff
- Ms Jean Flanagan, Elected Governor – Public
- Dr Adnan Faraj, Elected Governor – Staff

- One member of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

2 Apologies for absence

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

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 28 January 2026

The Board approved the minutes of the meeting held on 28 January 2026 as an accurate record of the meeting.

5 Matters arising/Action Log

The Board reviewed the outstanding actions. The following updates were provided:

BoD Pub 47 *Investigate the apparent inconsistency in Infection Prevention and Control data between the Trust Priorities Report (TPR) and the National Oversight Framework*
Mrs Parkes had emailed an explanation to the Board. The action was closed.

BoD Pub 49 *Ensure that work on understanding referrals is presented to the Resources Committee*
Miss Smith advised that the trajectories associated with this work would be presented to the Resources Committee and to the Board in March.

BoD Pub 51 *Present to Resources Committee and then to the Board, a report on the shape of the curve for RTT numbers and the impact on forecasting.*
Ms Hansen advised that the Referral To Treatment numbers had been discussed by the Resources Committee and the information was also included in the TPR. The action was closed.

BoD Pub 53 *Add the metric recording the number of adults waiting more than 52 weeks for community services to the TPR.*
Mr Hawkins advised that the number of adults waiting more than 52 weeks for community services had been zero for a number of years, and it was agreed that this did not need to be added to the TPR. The action was closed.

BoD Pub 54 *Update the Board on the response from the ICB on the 24/25 unpaid Elective Recovery Fund (ERF) income.*
Mr Bertram reported that he written to the ICB, but no response had yet been received. He advised that the year-end financial position assumed that the 24/25 unpaid ERF would not be received.

BoD Pub 55 *Raise with the Chair of the ICB the proposal to replace the Local Maternity and Neonatal System*.

Mr Barkley had raised the matter with the Chair of the ICB who would look into it. The action was closed.

BoD Pub 57 *Identify separately the number of reports of sexual misconduct made through the reporting tool in the Reportable Issues log presented to the Private Board meetings.*
Miss McMeekin reported that the data was now included within the Reportable Issues paper. The action was closed.

BoD Pub 58 Update the Board on the timeline for the approval process for the updated Chaperone Policy
Miss McMeekin advised that the policy had been presented to the Executive Committee for information only, given the minor changes, and had now been published on Staff Room. The action was closed.

BoD Pub 60 *Update the wording regarding Single Tender Waivers in the Standing Financial Instructions as discussed and seek approval via Chair's action*
Mr Taylor reported that the action had been completed.

BoD Pub 61 *Undertake an investigation to inform a full reply to the questioner and update the Board at the next meeting.*
Dr Stone advised that that she had investigated the issue raised and would respond in writing to the questioner. The action was closed.

6 Patient's Story

Ms Jack and Ms Douse joined the meeting to provide a summary of the work which had been undertaken as a result of the feedback from neurodivergent patients on their experiences in the Trust's Emergency Departments (ED). Their experiences had been poor, not due to the quality of care, but to the environment which did not meet their needs. New software used for the Friends and Family Test enabled the collation of feedback in real time, and when triangulated with operational data, it was clear that some neurodivergent patients were leaving the department before being treated or were attending multiple times. In response, a video had been developed in collaboration with York St John University, with input from neurodivergent individuals and their representatives. The video was available on the Trust website and was being shared with new staff at induction and with current staff. Ms Douse and Ms Jack outlined some next steps: a steering group informed by stakeholders would seek funding to continue the work with York St John University.

Miss Smith asked if there was any practical support for neurodivergent patients attending ED who struggled with the environment. Ms Jack responded that patients who attended ED often had been provided with care plans, and boxes containing distraction aids were available in the department, but this type of support could be expanded.

Dr Reece asked if the team had linked up with any other centres or planned to share their work with other providers in the NHS. Ms Douse explained that the team was seeking funding to continue the work as a blueprint for delivering it on a larger scale.

Board members agreed that the work described by Ms Douse and Ms Jack was a very positive initiative and thanked them for attending the meeting.

7 True North Report

Miss Smith presented the report. She advised that the results of the national Staff Survey would be released in mid-March; the values recorded in the True North report were taken from the quarterly Staff Pulse survey which had a very low rate of engagement. She suggested that the use of the Staff Pulse survey to inform the True North report should be discussed by the Resources Committee.

Miss Smith reported that the sharp increase in the number of bed days lost to patients with No Criteria To Reside was due mainly to the impact of the closure of a local care home in December. The number had now reduced. A trial was being undertaken on transferring patients without the use of a Trusted Assessor Form, with a view to determining the risks and benefits.

Miss Smith recorded her thanks to colleagues working in Urgent and Emergency Care (UEC) for their unstinting efforts to maintain the safety and dignity of patients in the face of significant challenges. There had been a seasonal increase in the number of 12 hour waits in ED but, more positively, this had not been accompanied by an increase in the number of ambulances waiting outside ED. Miss Smith observed that a strong focus on reducing length of stay would be key to improvement in UEC. She also reported that the actions implemented to improve the Faster Diagnosis Standard (FDS) in cancer care were beginning to take effect which would be evidenced in the metrics for February.

Miss Smith noted that the trajectories for the reduction in the number of Category 2 pressure ulcers and the number of Trust onset MSSA bacteraemia continued to be relatively positive. With reference to the financial position, Miss Smith assured the Board that the monitoring of the delivery of the efficiency programme would be more rigorous in the next financial year.

Miss Smith referred to the email she had sent to the Board advising that the new Electronic Patient Record (EPR) programme would not be progressing at this time as planned. This was clearly a disappointment to all concerned. The Trust was still waiting for a response on the Continuous Improvement business case which had been submitted to NHS England. Finally, Miss Smith referred to the Productivity and Efficiency Group update and advised that consideration needed to be given as to how to present this information going forward.

In response to a question, Mrs Parkes confirmed that there was now a consistent process for managing MSSA cases.

8 Chair's Report

The Board received the report.

Mr Barkley advised that Mr Scanlon had tendered his resignation from the Board with effect from 28 February 2026. Mr Barkley updated the Board on the recruitment of Non-Executive Directors and indicated that there was a potential solution to secure the quoracy of the Quality Committee, following Mr Scanlon's resignation.

9 Chief Executive's Report

The Board received the report.

Miss Smith remarked that she had now been in post for three months, and despite the challenges, it had been a positive experience. She reported that a recent event with medical leaders to socialise the clinical strategy had been valuable and the Senior Leaders forum planned for 13 March would also be used to discuss the strategy. Miss Smith underlined the necessity of a cultural shift to an improvement mindset.

Miss Smith reminded the Board that this was Mrs Parkes' last Board meeting as she would be leaving the organisation on 18 March. Miss Smith paid tribute to Mrs Parkes' transformational leadership as Chief Nurse.

Board members were, as always, impressed by the Star Award nominations. There was a brief discussion on whether there was sufficient recognition of more senior clinical staff, such as consultants. Dr Stone assured the Board that they were generally well-represented in the nominations.

Mr Barkley referred to Section 5 of the report and asked if there would be any impact on the Trust. Mrs Parkes explained that Band 5 nurses could not now take charge of clinical areas; this would clearly have an impact which needed to be worked through. The work on reviewing the duties of Band 5 nurses to reflect their job description would be undertaken by the Regional Chief Nurse to ensure consistency across all providers.

10 Quality Committee Report

Dr Boyd highlighted the key escalations from the meeting of the Quality Committee held on 17 February 2026:

- the increase in 12 hour waits in ED and the potential impact on the quality of care; the Committee had noted the mitigations in place and had requested an assurance paper which would be presented in March;
- the Committee had discussed the new maternity heat map and agreed that there was a lack of clarity around the scoring; Ms Wells-Munro had raised this with NHS England;
- the Family Health Care Group had presented to the Committee: there had been a discussion on the reasons for the delays in completing After Action Reviews on pressure ulcers in the community; assurance had been provided that any learning was being identified at the first opportunity, with the backlog being around delays in the process;
- the Committee had received assurance on the clinical risks associated with the EPR;
- whilst the Trust was rated top regarding C.Difficile infections under the National Oversight Framework, this was a reflection of the improvement made and should not deflect from the task to reduce absolute rates of infection.

Mr Barkley queried the scores on the maternity heat map, specifically those which were below the regional average. Dr Boyd responded that the scoring had raised a number of questions. Mrs Parkes added that the heat map was new and would continue to be monitored and further information was being sought to fully understand the scoring methodology.

Mr Barkley questioned whether, in the light of the recently published Aubrey report, the Board should receive patient experience reports, for example, on maternity services and cancer tumour site services. Miss Smith suggested that the Quality Committee could review all the various patient experience reports, and recommend which were the most important for the Board to consider on a regular basis. Mrs Parkes observed that these

could be amalgamated with the complaints report which would provide a more balanced view. It was agreed that time for further discussion would be allocated as part of a Board Development Seminar.

Action: Mr Barkley/Mr Taylor

11 Resources Committee Report

Ms Grantham highlighted the key discussion points from the meeting of the Resources Committee on 17 February 2026:

- the Committee had undertaken focussed reviews on Elective Referral To Treatment (RTT) and on the Staff Survey actions from the 2024 survey and initial outcomes from the 2025 survey;
- the Committee had noted that both RTT and Cancer performance were off trajectory but robust plans for improvement were shared, which provided some assurance of better performance by year-end; a draft three year improvement plan would be presented in March;
- the Committee heard details of the revised financial plan for 2025/26, which had now been submitted to NHS England, and of the robust oversight of the Waste Reduction and Productivity (WRAP) plan for 2026/27; the Committee would monitor the delivery of the WRAP plan;
- the Committee had noted the high rate of staff sickness absence and would receive a paper at the next meeting describing actions to address this.

Dr Boyd questioned whether the Safer Nurse Staffing report should also be presented to the Quality Committee to be reviewed through a quality and safety lens. Mrs Parkes agreed that the report was appropriate for both Committees and she would give some consideration as to how it might be incorporated into the paper on the Nursing Quality Assurance Framework which was currently presented to the Quality Committee.

Action: Mrs Parkes

12 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hansen reported that the Trust was unlikely to meet the operational plan which had been agreed with the NHS regional team at the start of the financial year. In order to meet the performance targets set for 2026/27, there would need to be a wholesale revision of current practice which would be supported by the operational management re-structure in Care Groups, the Patient Administration Operational Toolkit and the resetting of the Medicine Care Group clinical leadership. With reference to the latter, Ms Hansen explained that the Associate Chief Operating Officer was focussed on elective care and Care Group finances, and the Deputy Chief Operating Officer was leading on improvements to Urgent and Emergency Care as part of concerted efforts to focus on ending the year as well as possible. The Trust had received extra funding from NHS England to increase the number of appointments for RTT patients until 31st March.

Ms Hansen advised that the Medicine Care Group director had been engaging with colleagues in the development of a new acute model of care, in collaboration with Surgery Care Group, which would change the way in which ED functioned, with the focus on Same Day Emergency Care and joint assessment of patients. This had been designed with the new EPR in mind but would now need to be re-considered in the light of the decision to defer implementation, as reported previously.

Ms Hansen advised that another Multi-Agency Discharge Event was taking place which would support a reduction in the number of patients with No Criteria To Reside. Ms Hansen noted that performance for the Cancer FDS remained off trajectory but there had been improvement in February, not least as the ICB had reached an agreement with GP practices to reinstate dermoscopy imaging. Ms Hansen expected to be able to maintain an improved position of 75% for the FDS and 67% of Cancer patients treated within 62 days of referral. There had been a re-design of pathways for challenged tumour site services which had supported an improvement in performance, alongside the Board's commitment to focus on cancer.

Ms Hansen reported that the RTT waiting list was above trajectory. There continued to be a substantial number of referrals, and the priority was to work with primary care colleagues on demand management. This was already in train, led by the ICB's Executive Director of Clinical and Professional. Ms Hansen noted that some 10,000 RTT clocks would need to be closed over the next 5 weeks to meet the year-end target; currently, the average was c3.5k a month so this would clearly be a very challenging task. Ms Hansen highlighted the management of outpatient appointments: almost a quarter were now delivered virtually, and the number of first appointments had increased. However, the number of follow-up appointments had also increased; Ms Hansen underlined the need to go much further with the use of Patient Initiated Follow Up (PIFU).

Ms Hansen reported that diagnostic performance had remained stable since December and she expressed some confidence that the percentage of patients waiting less than six weeks for a diagnostic procedure should be maintained at about 70% to the end of March. The percentage would be impacted by extra activity to reduce RTT and cancer waiting times.

Finally, Ms Hansen alerted the Board a national shortage of bone cement which would impact the supply for the next 8 to 10 weeks. As a result, 13 patients had had routine elective surgery cancelled. Other suppliers of bone cement had now been identified, and it was hoped that stocks would arrive by the end of the week. Ms Hansen confirmed that patients not needing bone cement had been substituted into theatre lists.

Ms Hazelgrave asked if the target for stopping clocks was a local one. Ms Hansen explained that the target had been agreed with NHS England. The extra funding received to increase the number of patient appointments was with an expectation to meet the year-end target, but Ms Hansen noted that the money had not been received until late January which had reduced the opportunity to put on additional activity. There had also been staffing issues which had not been foreseen and had hindered recovery in challenged specialties. NHS England and the regional team were aware of the issues.

Ms Hazelgrave asked for a comparative figures from month to month in the National Operational Framework rank oversight so that it was clear whether the Trust's position had improved or deteriorated.

Action: Ms Hansen

Ms Hazelgrave noted that the setting of locally agreed trajectories which were different to the original plan made oversight of performance difficult. Miss Smith responded that this had already been discussed and a clear approach to reporting performance in 2026/27 would be presented to the Board in March.

Action: Miss Smith

Mrs McAleese referred to the narrative on Acute Flow and the comment that more than half of audited cases of low acuity patients conveyed to ED in an ambulance were deemed to be clinically inappropriate for treatment in ED. Ms Hansen explained that she had asked the Collaboration of Acute Providers to work with the Yorkshire Ambulance Service on this issue as it affected other EDs in the ICB.

Mrs McAleese was of the view that the high sickness absence rate was beginning to impact on performance and that sickness absence had become too normalised. This was a challenge for organisation and should be a priority to address. Miss McMeekin noted that a paper would be presented to the Resources Committee which would describe measures to address sickness absence. She summarised that these were underpinned by a focus on being more reactive when a sickness absence first occurred and being more proactive in encouraging staff back to the workplace, supported by electronic rostering which allowed data to be pulled in real time. Other strategies included support for staff from psychological medicine, from the Wellbeing team and the Freedom To Speak Up process, coaching support for line managers and the use of final attendance reviews at an earlier stage.

Dr Reece asked if there had been any impact on staff from the cancellation of procedures due to the issue with bone cement. Ms Hansen commented that the team would no doubt have been affected. Directors discussed issuing a press release once the supply of bone cement had been definitely re-established.

Mr Barkley asked what the implication would be of not meeting the revised March 2026 target of 60% of RTT patients waiting less than 18 weeks for elective treatment. Ms Hansen responded that she had met with the regional team to work through the planned activity, as well as any other opportunities to increase activity. A further meeting was scheduled to discuss the implications of not meeting the target.

Action: Ms Hansen

In response to Mr Barkley's question, Miss Smith advised that the changes to the acute model of care would be presented to the Resources Committee and to the Board in March.

Mr Barkley questioned why the Trust's four hour performance in ED for patients who were not admitted was the worst in the region. Ms Hansen explained that a number of factors were responsible including overcrowding in the department, inefficient streaming at the Front Door, although this had improved, and the time to be seen by a doctor. A review was being undertaken of the medical workforce as part of the new acute model of care. This would place a senior decision maker at the front door.

Quality and Safety

Mrs Parkes advised that the Trust remained below trajectory for C.Difficile infections but over trajectory for E.Coli infections. Infection prevention and control strategies continued to focus on hand hygiene including a reduction in glove usage and visual aids on wards to remind staff of best practice.

Mrs Parkes reported that new principles around "corridor care", which had replaced the term "temporary escalation spaces", had been published by NHS England. Mrs Parkes assured the Board that patients in temporary escalation spaces on Trust sites were not cared for on corridors. As a result of the new guidance, a gap analysis had been completed and the Standard Operating Procedure updated. Mrs Parkes noted that the Board needed to be sighted on patients receiving corridor care which was also a core theme of complaints to the Trust, as it was clearly a poor experience for patients and

families. Mrs Parkes advised that Health Care Support Workers were undertaking regular walkarounds as part of care for patients not accommodated in bed spaces.

Mrs Parkes reported that Trust staff were collaborating with the ICB to reduce the number of pressure ulcers in the community as many of the patients were not under the Trust's care. The Trust would continue to support investigations.

Maternity

It was noted that the Maternity section of the TPR was to be reviewed, with some of the metrics transferred to the monthly report.

Workforce

Miss McMeekin reported that there had been an increase in the overall vacancy rate. The Executive Committee had approved more robust governance processes required by the double and triple lock implemented by the ICB and NHS England. There was a focus on consistency in the use of clinical bank staff. The Chief Nurse's team was also working to address the Health Care Support Worker increased vacancy rate.

In response to Ms Hazelgrave's question, Miss McMeekin advised that the total workforce number was reported in the TPR and was rigorously monitored. She noted that the metric did not include additional hours or overtime. Ms Hazelgrave asked that the Board be kept apprised of the workforce figures by staff group, including details of bank and agency staff and it was agreed that this would be regularly reviewed by the Resources Committee.

Action: Miss McMeekin

The Board congratulated the Occupational Health team on the award of its quality accreditation for a further 12 months.

Digital and Information Services

Mr Hawkins reminded the Board that the Digital team had been fully focussed on the implementation of the new EPR, which was not now proceeding, and would now need to take stock.

Mr Hawkins reported that the number of Priority 1 incidents had been low in January. The number of calls to the Service Desk had increased, as had the number of Subject Access Requests and Freedom of Information requests.

The Board recorded its thanks to Mr Hawkins for his leadership of the EPR programme and acknowledged the huge disappointment which the decision not to proceed had caused.

Finance

Mr Bertram referred to the extra information included in the Income and Expenditure table, which related to the Deficit Support Funding of £4.1m which had been withheld by NHS England. The Trust was £12.1m adrift of plan and a year-end deficit of £28.5m was forecast. This comprised an operational overspend of £16.5m, plus £13m in unpaid Elective Recovery Fund (ERF) income from 2024/25 and sparsity funding for Scarborough Hospital. Mr Bertram emphasised that this forecast position must be delivered and noted that the rate of deterioration from the plan was slowing.

Mr Bertram reported that the Cost Improvement Programme had delivered £33m as of Month 10 and he was confident that a further £2m would be delivered to meet the year-

end forecast. A weekly tracker for the programme was now in place and was rigorously monitored.

Mr Bertram reported that he was not anticipating any issues with cash this financial year. The cash position was supported by delays to the capital programme. Mr Bertram advised that the capital programme would be £4m under-delivered at year-end but the Trust would not lose funding. There had been significant issues in delivering a large capital programme, including a major contractor going into administration. Forward purchases were being made to ensure that the capital was used.

Mr Barkley asked about the hybrid theatre and MRI capital schemes which had been impacted by contractor issues. Mr Norman explained that complex discussions were currently underway and he would provide an update at the next meeting.

Action: Mr Norman

13 Quarter 3 Annual Reporting Plan Progress Report

The Board received the report.

Ms Hazelgrave asked about the Acute Medical Model referenced in a number of the actions. Miss Smith advised that an update would be brought to the Board at the next meeting.

Action: Ms Hansen

In response to a question, Mr Hawkins confirmed that the work on reviewing the DM01 logic in CPD would be transferable to Nervecentre.

14 CQC Compliance Update

The Board received the report.

Mrs Parkes advised that the draft report from the CQC inspection of Urgent and Emergency Care and Medical Care Services at Scarborough Hospital in October had now been received. Updates would be provided to the Board.

Mr Barkley referred to Section 3.3 of the report and asked if the Trust was using the new resource for triangulating feedback from patients on discharge. Mrs Parkes noted that any new resource would be considered for use through the relevant governance processes.

15 Maternity and Neonatal Report

Ms Wells-Munro presented the report which included the data for December. She highlighted:

- the month-on-month reduction in the use of agency midwives;
- the Maternity Service had submitted a critical safety alert generated by the Maternity Oversight Safety Signals (MOSS) in December and a second in January; these had been externally reviewed and accepted with no adjustments or additional actions;
- a Deputy Director of Midwifery had been successfully recruited;
- the key risk to the Service around water ingress at the Scarborough Maternity Unit was being well managed with excellent support from the Estates team;
- there had been a reduction in the Homebirth service in response to the Preventing Future Deaths report issued by the HRH Coroner; midwives attending home births

had been allocated compensatory rest; the service would be reviewed once more detailed guidance was received.

Mr Barkley raised some queries which Ms Wells-Munro would respond to in the Private Board meeting. She did assure the Board, however, that in relation to the sad cases of stillbirths and neonatal deaths in December, all the women had received the relevant information consistently throughout their pregnancies. Although there had been 18 clinical incidents graded as moderate or above in December, Ms Wells-Munro reported that there had been no Patient Safety Incident Investigations in December. There had been an increase in the number of Caesarean Sections which had impacted the rate of Post-Partum Haemorrhages over 1500mls. Ms Wells-Munro provided details of cases where women had been diverted to another maternity unit.

16 Complaints Report (half-yearly)

Mrs Parkes presented the report. She noted that the number of complaints received by the Trust from April to September 2025 had increased by 12% compared to the previous six months. The themes of complaints were centred on delays in ED and in outpatients, and on follow-up care. Complaints about inpatient care had reduced. Care Groups were using complaints to inform improvements and a Strategic Patient Experience Improvement Plan had been developed, the actions from which were beginning to impact on the number of complaints, particularly around inpatient care.

Mrs McAleese expressed disappointment that there were complaints to the Trust about staff attitude. Mrs Parkes advised that these were not centred on one particular area and were actively managed. Leaders were being supported to have appropriate conversations with staff about whom the complaint had been made.

Ms Charge noted that the prevalence of Artificial Intelligence might have impacted on the number of complaints, as it had become easier to formulate complaints. Miss Smith responded that complaints needed to be triangulated with other sources of feedback on patient experience. Dr Boyd added that patients might be more willing to complain about long waiting times. Mrs Parkes observed that this could be mitigated by better communication with patients.

17 Questions from the public received in advance of the meeting

There were no questions from members of the public.

As this was the last Board meeting for both Mrs McAleese and Mrs Parkes, Mr Barkley led a tribute to both on behalf of the Board.

18 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 25 March 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	Status
BoD Pub 49	28-Jan-26	5	Matters Arising/Action Log	Ensure that work on understanding referrals is presented to the Resources Committee	Chief Executive		Mar-26	On Track
BoD Pub 50	28-Jan-26	11	Resources Committee report	Produce a paper for discussion on reducing sickness absence for presentation to the Resources Committee	Director of Workforce & OD		Mar-26	On Track
BoD Pub 52	28-Jan-26	13	Trust Priorities Report	Bring a recommendation to the Board on a future strategy for Community Services	Chief Executive		TBC	On Track
BoD Pub 54	28-Jan-26	13	Trust Priorities Report	Update the Board on the response from the ICB on the 24/25 unpaid ERF income	Finance Director	Update 25.02.26: Mr Bertram reported that he written to the ICB, but no response had yet been received. He advised that the year-end financial position assumed that the 24/25 unpaid ERF would not be received.	Mar 26 from Feb 26	Delayed
BoD Pub 56	28-Jan-26	16	Mortality Review – Learning from Deaths Report	Include more details about the Hospital Standardised Mortality Ration (HSMR) in the next report, including why it is significantly different from the SHMI	Medical Director		Apr-26	On Track
BoD Pub 59	28-Jan-26	19	Q3 2025/26 Board Assurance Framework	Ensure that the scoring of BAF risks is discussed by Executive Directors	Chief Executive	Update 18.03.26: this will be discussed by Executive Directors and reported to Board in April 26	Apr-26	On Track
BoD Pub 62	25-Feb-26	10	Quality Committee report	Allocate time in a Board Development Seminar for further discussion on consideration of patient experience reports	Associate Director of Corporate Governance/Chair		Mar-26	On Track
BoD Pub 63	25-Feb-26	11	Resources Committee report	Consider how the Safer Nurse Staffing information might be incorporated into the Nursing Quality Assurance Framework paper for Quality Committee	Chief Nurse		Mar-26	On Track
BoD Pub 64	25-Feb-26	12	Trust Priorities Report	Add comparative figures from month to month in the National Operational Framework rank oversight in the TPR	Chief Operating Officer		Apr-26	On Track
BoD Pub 65	25-Feb-26	12	Trust Priorities Report	Present the new approach to reporting performance for 2026/27	Chief Executive		Mar-26	On Track
BoD Pub 66	25-Feb-26	12	Trust Priorities Report	Update the Board on the meeting with the regional team to discuss not meeting the target of 60% of RTT patients waiting less than 18 weeks for elective treatment	Chief Operating Officer		Mar-26	On Track
BoD Pub 67	25-Feb-26	12	Trust Priorities Report	Ensure that workforce figures by staff group, including details of bank and agency staff, are reported in the TPR, to be monitored by the Resources Committee	Director of Workforce & OD		Apr-26	On Track
BoD Pub 68	25-Feb-26	12	Trust Priorities Report	Provide an update on discussions to progress the hybrid theatre and VIU projects	Managing Director, YTHFM		Mar-26	On Track
BoD Pub 69	25-Feb-26	13	Quarter 3 Annual Reporting Plan Progress Report	Bring an update on the Acute Medical Model	Chief Operating Officer		Mar-26	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

March 2026

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’.

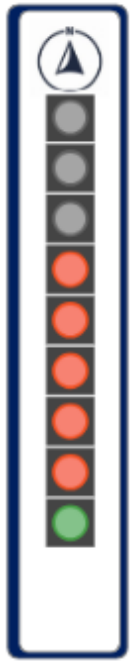
This is the single point of reference to measure our progress.

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)

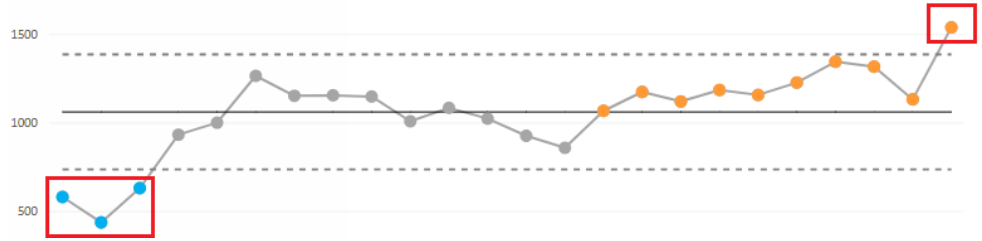
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

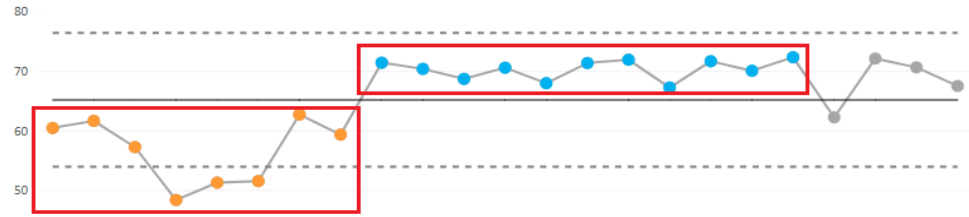
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

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

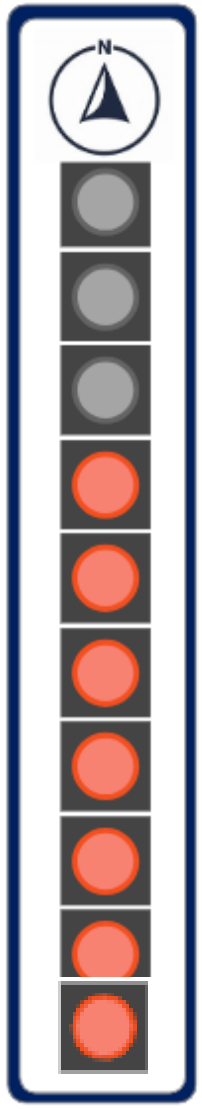


Shift: Counts the number of occasions there is a run of 7 consecutive points above OR below the mean.



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

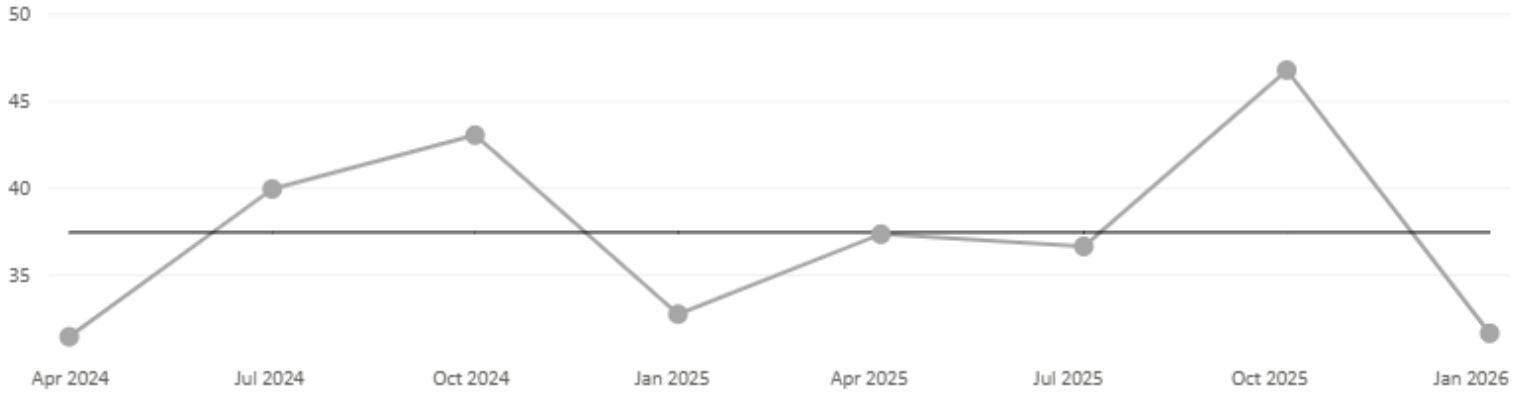
Staff Survey: Recommend Care

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

	Apr-24	Jul-24	Oct-24	Jan-25	Apr-25	Jul-25	Oct-25	Jan-26
Value	31.4%	39.9%	43%	32.7%	37.3%	36.6%	46.7%	31.6%
Trajectory								

Target Mar 2027
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 address unwanted behaviours
- Implement EDS22 and PSED recommendations
- Implement colleague engagement improvements
- Embed Quality Improvement
- Implement Speak Up gap analysis recommendations
- 2025 nationally benchmarked Staff Survey results update at Resources Committee in March
- Co-creating an updated Colleague Experience Improvement Plan for 26/27

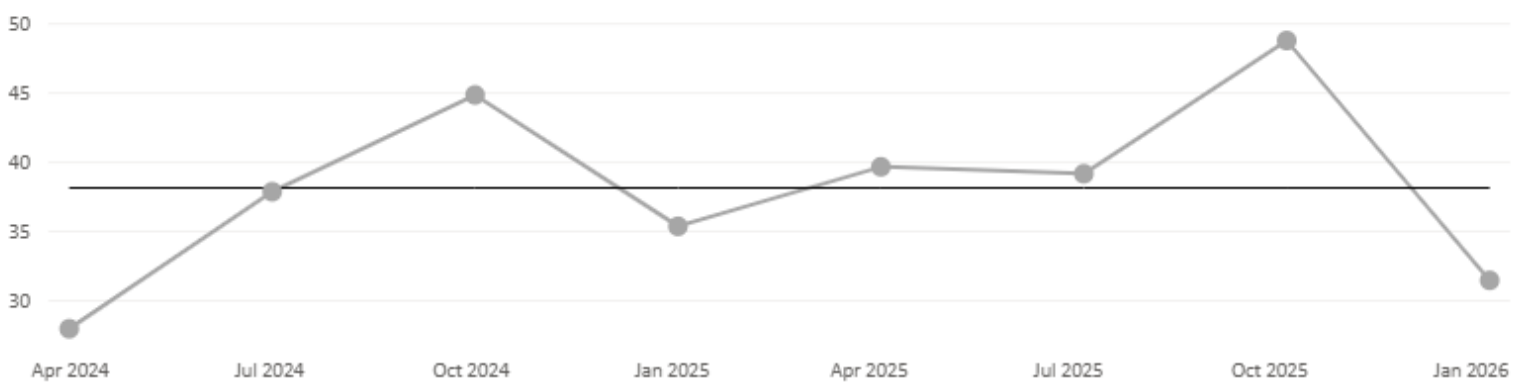
True North Report

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

	Apr-24	Jul-24	Oct-24	Jan-25	Apr-25	Jul-25	Oct-25	Jan-26
Value	27.9%	37.8%	44.8%	35.3%	39.6%	39.1%	48.7%	31.4%
Trajectory								

Target Mar 2027
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
- 2025 nationally benchmarked Staff Survey results update at Resources Committee in March
- Co-creating an updated Colleague Experience Improvement Plan for 26/27

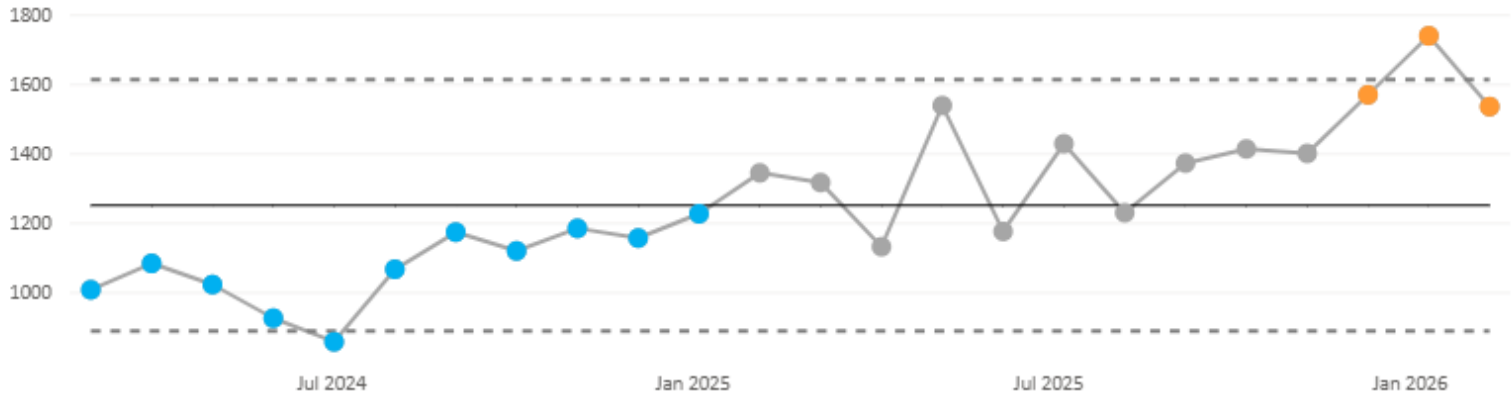
True North Report

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

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Value	1343	1315	1130	1537	1174	1427	1228	1371	1412	1399	1568	1738	1534
Trajectory													

Target Mar 2027

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?

- Carried out Multi-Agency Discharge Events in February at both main sites, with increased physical presence from system partners and increased escalation.
- Close working to ensure all partners proactively seek packages of care.
- Weekly Long length of stay meetings for Medicine, for medically fit and medically unfit patients (virtual meeting being replaced with face-to-face reviews)

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.

- Workforce challenges
- High acuity and volume of patients
- Funding challenges in the system / brokerage delays
- Low quality TAFs causing delays
- Availability of social worker allocation
- Care home assesment on wards causing delays
- Availability of nursing home placements in the area

What are we doing about them?

- Ongoing 2nd and 3rd line escalation (as appropriate) at Director level with support from across system.
- Discharge training sessions being co-delivered with LA
- Scarborough trailing paper version of Discharge Readiness Form (replacing TAF) given pause to Nervecentre go live
- A TAF-less transfer between Trust Inpatient Rehabs is being trialed on Ward 35, trial extended due to low numbers
- LLoS Review meetings are under review, exploring in person walk arounds, taking learning from Airedale visit and MaDE walkarounds.

True North Report

Objective Status — Up Is Good

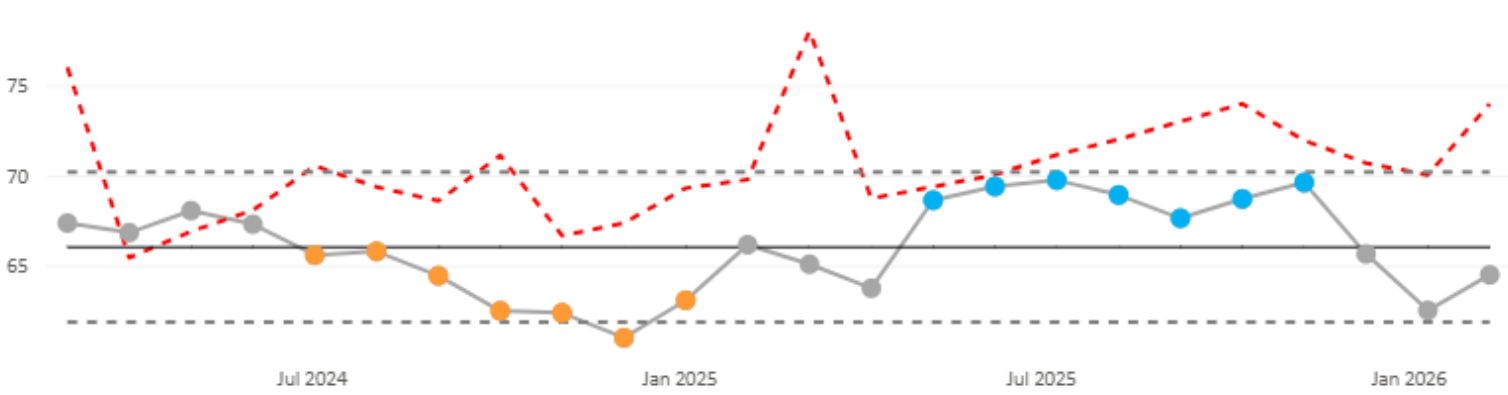
Urgent Emergency Care: Improve Emergency Care Standard (ECS)

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)?

1 found

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

Occurs

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

Does Not Occur

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Value	66.2%	65.1%	63.8%	68.6%	69.4%	69.7%	68.9%	67.6%	68.7%	69.6%	65.7%	62.5%	64.5%
Trajectory	69.8%	78%	68.7%	69.4%	70%	71.1%	72%	73%	74%	71.9%	70.7%	70%	74%

Target Mar 2027
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.

- Front door service redesign has been planned ready for implementation in March 2026.
- Ambulance handover protocols and other ED processes have been reviewed with support from Quality Improvement Team.
- Use of escalation tools and frameworks.

What are the current challenges?

- Year-on-year attendance increases to both main sites, and a continued increase in ambulance arrivals – indicating more patients with high acuity needs are attending.
- Workforce challenges at both EDs, including recruitment issues and poor staff morale.
- IPC outbreaks and need for isolation and side rooms.
- Financial constraints limiting options for testing new ways of working.

What are we doing about them?

- We are launching the first phase of the new acute model of care in March 2026. This will provide more robust specialty input in ED through a new Emergency Assessment Unit pathway at each site. It will also support the management of patients needing to spend more than four hours in ED, for example those requiring complex diagnostics, through a new off-clock pathway endorsed by NHS England. This is the Extended Emergency Medicine Ambulatory Care (EEMAC) pathway and we have followed national guidance in our plans.

True North Report

Objective Status ⊗ Down Is Good

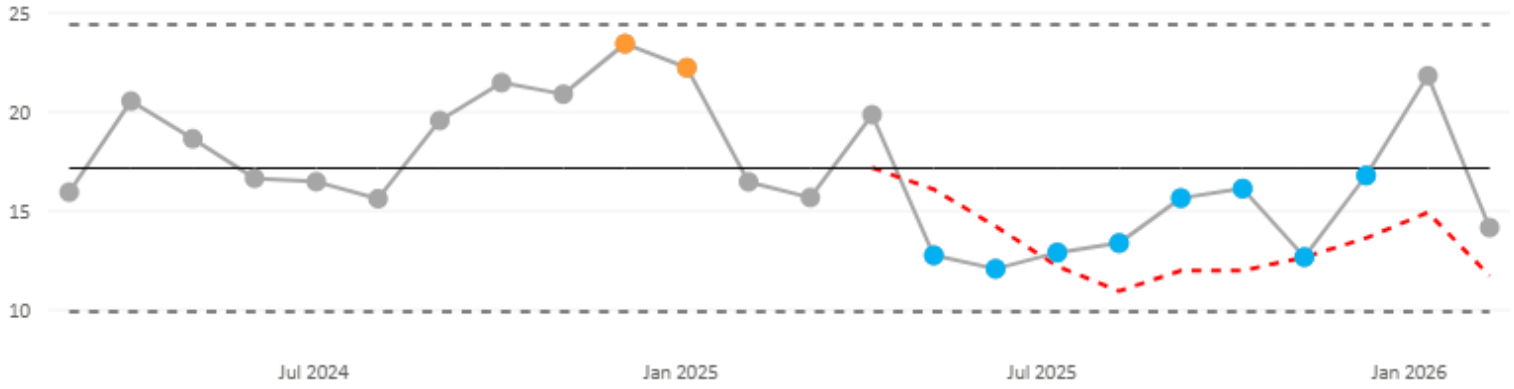
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Value	16.4%	15.6%	19.8%	12.7%	12%	12.9%	13.3%	15.6%	16.1%	12.6%	16.7%	21.8%	14.1%
Trajectory			17.1%	16%	14.2%	12.2%	10.9%	11.9%	11.9%	12.6%	13.6%	14.9%	11.7%

Target Mar 2027
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?

- Daily cross site operational meetings to escalate risk with more senior presence.
- Monitoring through fortnightly performance meetings and the monthly UEC Board.

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?

- Launching the first phase of the new acute model of care will support a reduction in patients spending over 12 hours in the Emergency Department, through a new Emergency Assessment Unit pathway which will be led by Acute Physicians with Geriatrician input.
- The launch of EAU will be supported by the implementation of the agreed Quality Standards which aim to expedite movement of patients from ED to the ward they require specialist care from.

True North Report

Objective Status | Up Is Good

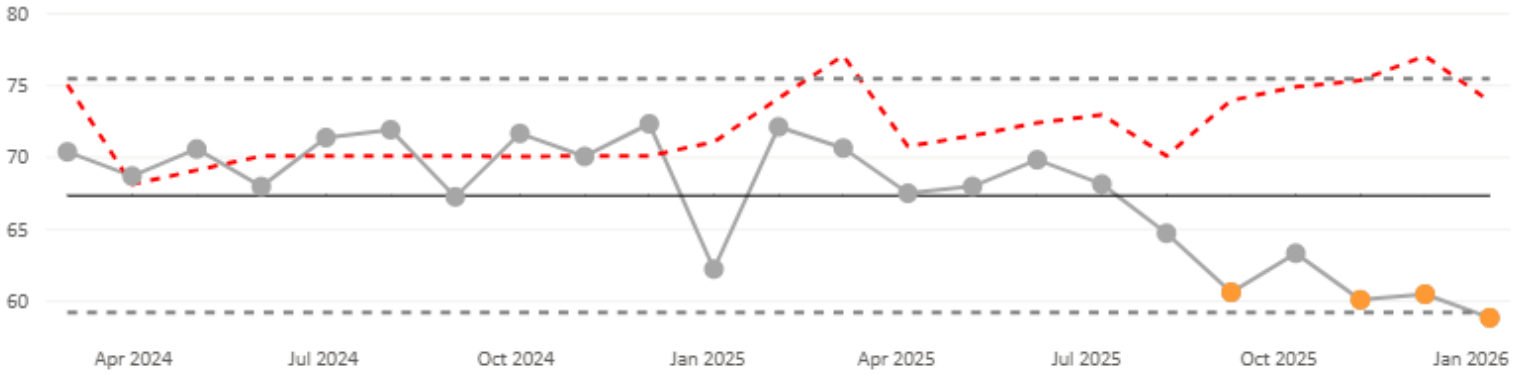
Elective: Cancer: Improve the Faster Diagnosis Standard

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)?

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

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Value	62.2%	72.1%	70.6%	67.4%	67.9%	69.8%	68.1%	64.7%	60.6%	63.3%	60%	60.4%	58.8%
Trajectory	71%	74%	77%	70.7%	71.4%	72.3%	72.9%	70%	73.9%	74.8%	75.3%	77%	73.8%

Target Mar 2027
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?

- Conversion of routine outpatient capacity to fast track commenced in December 2025 and ongoing through Q4.
- ICB implementation of dermoscopy local enhanced service (LES) commenced, 60% of referrals now received with image.
- NHSE funding submitted for 62-day performance improvement approved (£465k) and additional activity being delivered.
- Ongoing support around PTL management.
- Prioritisation of diagnostic capacity ongoing through Q4.

True North Report

Objective Status ⊗ Up Is Good

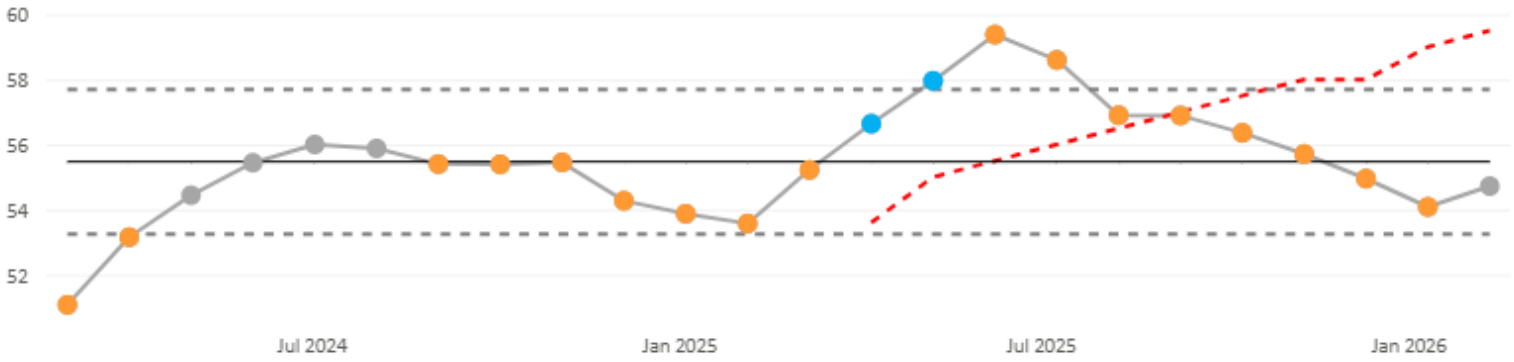
Elective: Improve RTT

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)?

5 found

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

Occurs

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

Occurs

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Value	53.6%	55.2%	56.6%	58%	59.4%	58.6%	56.9%	56.9%	56.4%	55.7%	55%	54.1%	54.7%
Trajectory			53.6%	55%	55.5%	56%	56.5%	57%	57.5%	58%	58%	59%	59.5%

Target Mar 2027
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
- Small amounts of mutual aid in place with Harrogate for T&O, Gynaecology and Endoscopy.
- Approved funding from NHSE for RTT activity sprints in Q4. 63% of Activity performed and planned.
- Undertaking an RTT priority clinics project in Q4 (2 weeks intensive RTT patients).
- Undertaking focused validation of cohorts of patients that could result in clock stops.
- Implementation of GIRFT Intensive Support Team recommendations following review on 4 February 2026.

True North Report

Objective Status — Down Is Good

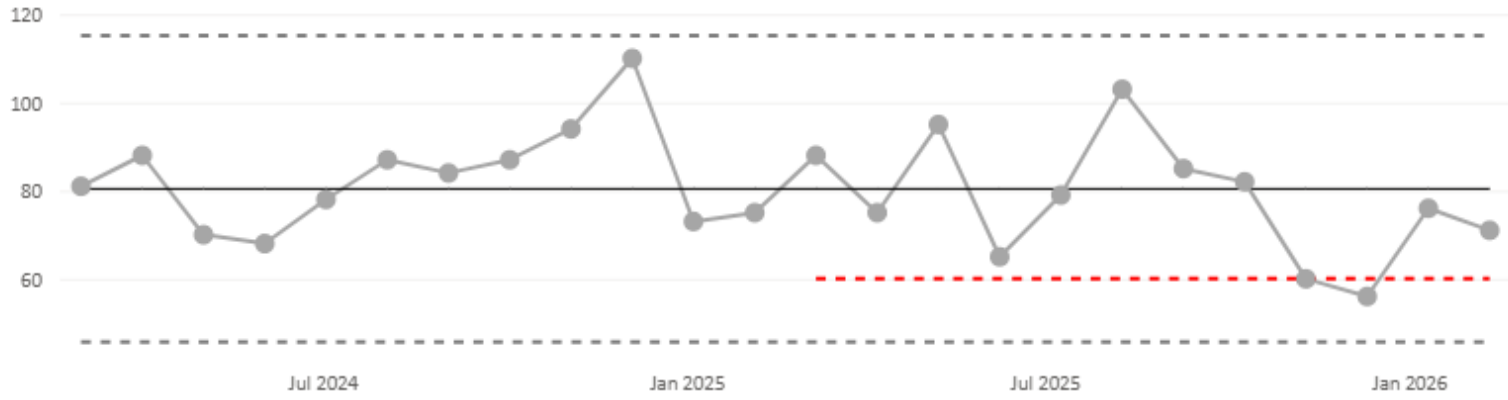
Q&S: Reduce Category 2 Pressure Ulcers

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

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Value	75	88	75	95	65	79	103	85	82	60	56	76	71
Trajectory		60	60	60	60	60	60	60	60	60	60	60	60

Target Mar 2027
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?

- Thematic reviews and monitored data, under the oversight of Heads of Nursing, ensure effective management and outcomes.
- Work continues to improve recognition and accurate categorisation of pressure ulcers, led by care groups with TVN support, focusing on hotspot areas.
- The introduction of photography via Nervecentre will be transformational, enabling the TVN to better support teams across the organisation in their assessments.
- Eliminated double counting and recording of a pressure ulcer has been achieved this month.

What are the current challenges?

- Ongoing issues with inaccurate validation and categorisation of Pressure ulcers within clinical areas.
- Appropriate Seating equipment to support patients.
- Our figures currently include pressure ulcers from local authority care/nursing homes, which has increased both workload and reported numbers.
- The pause in the launch of Nerve centre has meant we have not been able to launch ward level photography and new assessments/care plans
- Increased number of inpatients had no criteria to reside while patient acuity and frailty rose across the cohort.
- Increased sickness across the nursing workforce above the national average has impacted patients receiving timely care

What are we doing about them?

- Progress has been made on double counting; resolution is expected by the end of February due to focused work with community services.
- Work on appropriate seating continues with an initial sum of money secured for phased implementation of new chairs – procurement process in place
- Monthly data sets shared with ACNs and care groups to support targeted improvement work, managed through Professional Quality Standards Group.
- Training has commenced to support staff with the introduction of Nervecentre and its benefits for pressure ulcer management.
- Chief Nurse is in discussion with the ICB regarding appropriate reporting of community pressure damage

True North Report

Objective Status Down Is Good

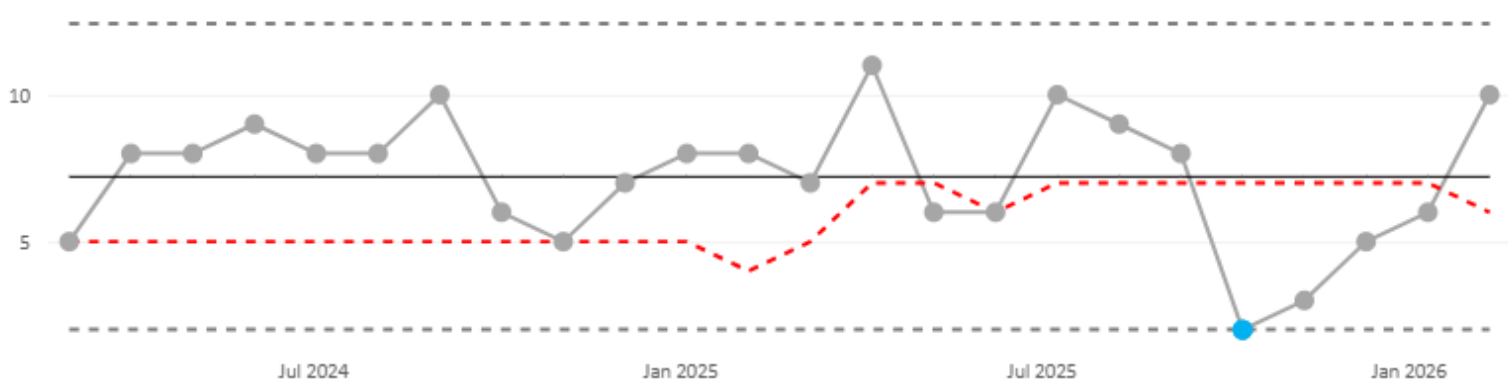
Q&S: Reduce the number of Trust Onset MSSA Bacteremia

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

	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Value	8	7	11	6	6	10	9	8	2	3	5	6	10
Trajectory	4	5	7	7	6	7	7	7	7	7	7	7	6

Target Mar 2027
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 – which we are on target to achieve with 75 cases to end of February 2026 and 5% reduction on 2025/26 would be 87 cases
- 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.
- VIP score compliance at 68% at end January 2026. Although this has increased from 57.6% since February 2025 further improvement is required.

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 has been developed with the Care Groups
- Line management, VIP scoring and ANTT education has been refreshed and re-launched.
- Additional review meetings for MSSA bacteraemia cases being set up for Surgery and CSCS care groups to ensure learning is identified and embedded into practice.

True North Report

Objective Status

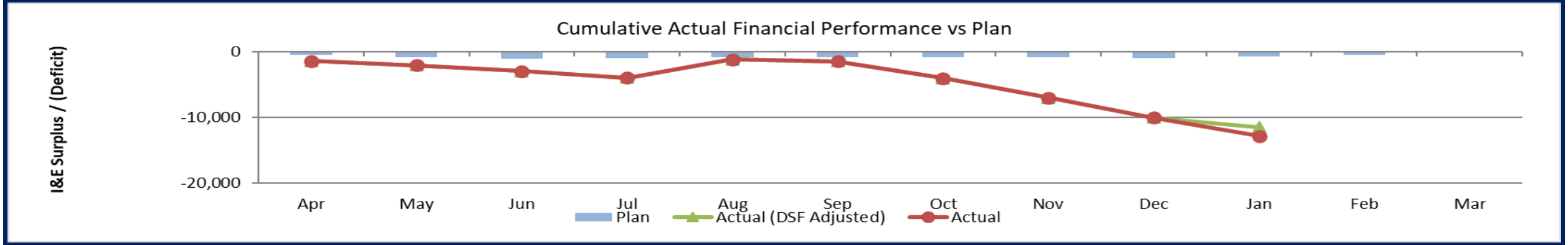
Finance: Achieve Financial Balance

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 - £28.5m Forecast Deficit (excl. DSF impact)		-1,386	-2,084	-2,936	-3,956	-1,151	-1,484	-4,047	-7,010	-10,049	-11,073	-13,683	-28,515

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.

Following a response from NHSE the £33m deficit submitted at Mth9 has been revised to £28.5m.

- **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:

- Business as usual controls: PRIM / FRM / EDG / Exec Comm / SFI / SoD.
- Increase oversight of efficiency programme.
- Recovery action plan in place.
- Engaged KPMG to provide a financial diagnostic, cost driver details, and structural pressures and they will also carry out a financial governance review, assessing the robustness of financial controls and cost-improvement governance including scheme identification.

What are the current challenges?

- The financial position is adrift of plan for M11 by £16.6m with an actual deficit of £17.1m against a planned deficit of £0.5m.
- 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 £28.5m deficit (Excl DSF)
- Delivery of the efficiency programme is a big driver of the deficit with a forecast £16m gap in delivery.
- Q4 DSF has not been secured which deteriorates the deficit position further to £32.6m at year-end.

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 £28.5m deficit is £5m The recovery plan is reviewed through EDG / Exec Comm – £3.1m delivered by end of Feb26
- 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).
- Work underway with KPMG

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 26 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
- Our configuration has been moved to the Nervecentre production environment, and testing continues to ensure everything is set up is as expected
- The teams are working through a list of outstanding issues, which are currently on track to be resolved prior to go-live
- User training continues, 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.

At time of writing, we are still awaiting a decision from NHS England on the consultancy business case that was submitted. In the meantime, we continue with the delivery of quality improvement training and where targeted, the Improvement Team are supporting priority areas with an improvement approach. This includes ongoing support of our Emergency Departments, the introduction of a 5S programme to keep our environments in a clean and ordered state as a baseline introduction to improvement approaches, and early work to support a targeted reduction in length of stay (at early planning stage with this improvement project).

We are still awaiting a decision from NHS England on approval of the consultancy business case. Disussions with NHS England are ongoing. The improvement team continue to deliver improvementn projects, deliver and support staff training and work colloaboratively with patners. The targeted improvement project to support a reduction in length of stay will start on the first five wards in April 2026.

3. Productivity and Efficiency Group Update

York and Scarborough Teaching Hospitals NHS Foundation Trust

Operational Productivity Workstreams

PIFU

PIFU 4.3% in February 2026. The Trust has maintained over 4% since April 2025.

PIFU as standard workstream continues with new pathways launched in gynaecology, ENT and audiology in 2025. Further opportunity in all areas as not delivered required improvement.

New to Follow up ratio's

New to Follow up ratio at Trust level is 2.17% in February 2026which is an improvement 0.43% 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. Further plans developed for 2026/27.

Service reviews

Service reviews have completed for:
Cardiology
Respiratory
Neurology
Paediatrics
ENT
Gynaecology

Action plans on standard template to deliver against opportunities being developed as part of 2026/27 delivery planning.

Clinic utilisation

Clinic utilisation has deteriorated slightly in February 2026 to 77.6%. An improvement from 73.2% in April 2025.

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.

2026/27 Planning

- Plans on a page being developed for key productivity projects focusing on outpatients, theatres and flow.
- Programme Management Office support identified to deliver a programme approach to the delivery of the projects including a programme plan and highlight reports.
- Monitoring to focus on increased activity / throughput to understand impact of enabling projects such as PIFU, utilisation etc.
- Focus is on delivery of productivity within 26/27 submitted plan and then further productivity opportunities to contribute to the WRAP
- Attended a webinar with University Hospital Southampton on productivity reporting and opportunity modelling and shared with BI&I to explore.

4. Efficiency Update

York and Scarborough Teaching Hospitals NHS Foundation Trust

2025/26 Cost Improvement Programme - January Position											
	Full Year CIP Target	January 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 Programm	55,290	48,426	35,452	12,975	37,273	18,018	38,838	16,453	38,493	345	0
	55,290	**48,426**	**35,452**	**12,975**	**37,273**	**18,018**	**38,838**	**16,453**	**38,493**	**345**	**0**

Efficiency Delivery

The Trust has set an efficiency target of £55.3m. So far, £37.3m has been achieved in full-year terms, but the year-to-date position is £12.9m behind plan, the current forecast year-end delivery is £38.8m, 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. Significant work continues in this area with £3.1m delivered at the end of February 2026.

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.

KPMG

The Trust have engaged KPMG through a joint procurement with Harrogate Foundation Trust to provide a financial diagnostic, reviewing income, expenditure, cost drivers, trends, and structural pressures and they will also carry out a financial governance review, assessing the robustness of financial controls and cost-improvement governance. KMPG will support the Group to validate current efficiency plans and support the early development of new, significant and additional plans on a page for service transformation and efficiency delivery.

Report to:	Board of Directors
Date of Meeting:	25 March 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 – March 2026

1. I have continued to visit various wards and services at Scarborough, Bridlington and York Hospitals. Until I visited the breast screening service, I had not realised that this Trust organises the breast screening service for the whole of North Yorkshire with the aim of screening 40,000 women each year. It is a very sophisticated operational responsibility. I also had a very informative visit to the neurology admin/secretarial support team and a long overdue introductory 121 with our Head of Legal Services. Through conversations with colleagues during these visits, I pick up valuable insight and issues which I share with the Chief Executive as appropriate.

2. As mentioned in my last report, I attended with our Chief Executive, Medical Director and Chief Operating Officer a summit on eliminating "Corridor Care" organised by NHS England. Trusts with a relatively high number of patients waiting more than 12 hours were invited to attend. Previously, the Board had agreed that one of our top three transformational priorities for 2026 is to reduce average length of stay by at least one day for non-elective patients admitted for one night or more. Achieving this ambition should virtually eliminate all long delays for admission and "corridor care". Our Medical Director is leading this crucially important programme of improvement.

3. I chaired the March meeting of the Council of Governors. Sadly, I had to announce that two Governors have had to stand down due to health reasons. Beth Dale, a York publicly elected Governor, has given outstanding service both as a Governor and a volunteer. Beth will continue to help us as a volunteer. Jill Quinn had only recently started as a Stakeholder Governor but then a health problem prevented her from continuing. I thanked both for their service and support.

4. From 1st April, Matthew Taylor (a York resident) who finishes in his role as Chief Executive of NHS Confederation/NHS Alliance at the end of March will join the Board as a Non-Executive Director succeeding Jenny McAleese. In addition, Ian Floyd (a Scarborough resident) will join the Board as an Associate Non-Executive Director. He retires from his position of Chief Executive of York City Council at the end of March. At the end of February, Noel Scanlon stepped down from his role as a Non-Executive Director. We will make arrangements in May to recruit a successor. I am delighted to advise that Dr Lorraine Boyd has agreed to serve the Trust for a further 6 months at the end of her current term which means that she will stay as a member of the Board and her various

roles until 31st December 2026. The Council of Governors have approved the extension of her term of office.

5. The day after the Board meeting, I will be chairing a meeting of our Organ Donation Committee, a role previously undertaken. We need to give consideration to a long term appointment of a Chair to this committee. The following day I will be chairing a meeting of our bi-monthly Digital sub-committee.

Martin Barkley
Trust Chair
15.03.2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 9

Report to:	Board of Directors
Date of Meeting:	25 March 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.
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☒ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
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Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The 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: Update on my first 100 days, update on financial and service delivery planning, eradicating corridor care, Staff Survey results, CQC report, EPR update, changes in the Executive Team and February's 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. My first 100 days: listening to colleagues and stakeholders

At the end of this month I will conclude my 'First 100 Days' engagement programme with colleagues and other stakeholders, where I have been spending time getting out and about to listen and learn, and to inform the priorities that should be my focus as Chief Executive going forward.

In addition to meeting and learning from the many colleagues who have written to me to share their thoughts, I have continued to engage through a range of routes including 'chat and brew' drop-ins, visiting departments and teams and meeting with individuals, and through our weekly live briefing and Q&A sessions. I have also held the second Senior Leadership Forum on 13 March and a Senior Medical Leadership forum on 24 February.

Both of these sessions, as well as my first Senior Leadership Forum in December, were opportunities to have open and honest discussions about where we are now, the Trust's strategy, and where we want to be in the coming years. We also discussed accountability and what that means in terms of leadership behaviours, in particular how we can truly live our values.

These sessions are really important as we move forward as I want ensure our medical leaders are well and truly integrated into our broader Senior Leadership community, as we require creativity and transformational leadership from the people closest to patient care, and thoughtful partnership across clinical and corporate teams, in order to improve.

My 100 day programme has been the start of a wider conversation, it is not the end, and I plan to continue and further strengthen these engagement principles throughout my time as Chief Executive. The themes and outputs will help us collectively build a shared direction and a clear, joined-up approach to improvement. In April I will be sharing the outcomes from my first few months, my insights and observations based on what I have heard, and to set out how I propose for us to move forward, collectively as a Trust, by focusing on a small number of absolutely key priorities.

One of my commitments is to create the right environment to engender a well-governed improvement mindset 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 I am confident our people have the right values, and the ideas for improvement, that will help up us move forward positively.

2. Update on financial and service delivery planning

On 18 March we submitted the full suite of NHS England planning returns including the detailed monthly financial projections and performance trajectories. These returns have not changed from those we discussed when we met as a Board last month other than reflecting more closely the most likely year end position and therefore starting position in April. As we are submitting a deficit plan, we anticipate there will be further regional and national review of the plan.

3. Eradicating corridor care

In my conversations with colleagues it is recognised, and frequently voiced by teams, that the care we deliver does not consistently achieve the standards we aspire to.

These pressures are real and the consequences are felt by both patients and colleagues, so it is important to acknowledge them openly and it remains essential that we do not allow care that falls short of our values to become normalised. Recognising the challenge is not the same as accepting it, and we must continue to uphold standards and consistently ask how we can deliver care more safely and effectively.

Martin Barkley, Chair, Karen Stone, Medical Director, Claire Hansen, Chief Operating Officer, and I recently attended a national Corridor Care Summit in London, aimed at supporting Trusts deemed to be facing the most significant challenges in this area to discuss and develop additional actions to support the eradication of corridor care.

At the summit we heard from Trusts who have been successful in either significantly reducing or eradicating corridor care, and what was clear from these examples and the conversations with others in the room is that in order to make improvements with this problem it should be owned and managed as an organisational risk, with trust boards routinely reviewing corridor care incidence and learning. Leadership visibility is important, with executives undertaking regular walkrounds to hear directly from patients waiting more than 12 hours and from the colleagues caring for them, and senior clinicians should be held to clear professional standards to lead timely organisational responses when corridor care is in use or at imminent risk.

I am firmly committed to eliminating corridor care within our Trust. We are developing our own actions and commitments to do this, and in my view, reducing length of stay remains the single most important action required to achieve this aim. This will require collective effort, and for all of us to fully lean in to our values, and I will be engaging colleagues across the organisation over the coming weeks and months to support this priority.

4. NHS National Staff Survey

The results of the 2025 NHS National Staff Survey have now been published. Our response rate increased to 55%, which is the highest and most representative response the Trust has seen in over 10 years.

The percentage of colleagues who would recommend the Trust as a place to work has gone from 44.81% last year to 48.72%, and the percentage of colleagues who would recommend the Trust as a place to receive care has gone from 43.09% last year to 46.74%.

Those two measures really matter because they go to the heart of how colleagues feel about the organisation - whether they would choose it as a place to work and whether they would trust it to care for the people they love.

Seeing those figures move in the right direction is genuinely encouraging, but it is important that we are realistic about how far we still have to go. It is concerning that around half of the colleagues who responded would not yet recommend the Trust as a place of care for the people who matter most to them. We need to really understand what's happening to create the conditions that mean colleagues cannot give the standard of care they want and tackle these issues.

In addition, fewer than half of those who responded would recommend our Trust as a place to work. Whilst it is positive that we have improved on this question (we have seen the second biggest improvement in the country), it really does highlight what a long way there still is to go, and I know that for some colleagues, their daily experience of working with us is far below what we would expect or should accept.

The survey gives us an opportunity to listen carefully to what colleagues are telling us about their experiences - where things are working well, but also where we need to do better. The most important thing now is how we respond to that feedback and the actions we take to improve both the care we provide and the experience of working here.

The free-text comments from the survey will also available later this month, and I will be reading every single one of them. Those comments are incredibly important because they tell us the stories behind the numbers, help us understand the experiences colleagues are having, and often contain the most practical ideas about what needs to change. If we are serious about improving colleague experience, we need to listen carefully to those voices and act on what we hear.

I am determined that we take a different approach in responding to this year's survey, truly engaging our teams in developing the plan and taking action on those priority areas that colleagues tell us will make the biggest difference.

5. Care Quality Commission (CQC) Report

We have now received the final report following the CQC's unannounced inspection at Scarborough Hospital last October. Inspectors spent three days on site and were looking at medical care services and urgent and emergency care pathways, with a view to re-rating both services.

We should have the opportunity to discuss the report when we meet as a Board as it will have been published, however at the time of writing it remains under embargo.

Following the inspection, which took place just before I joined the Trust, the CQC described colleagues as being passionate about providing excellent care, and talked about the strong multidisciplinary teamworking they witnessed wanting us to ensure we shared their thanks with all colleagues involved.

I would like to echo this feedback and to thank everyone for welcoming the inspectors into their work areas and being open with them about our services. The reception they were given is a positive reflection on our organisation, particularly as these visits can feel challenging in the moment.

We will have the opportunity to discuss the report more fully, and any subsequent action plans and responses, at future meetings.

6. Electronic Patient Record (EPR) update

As Board colleagues are aware we had to pause the go-live of our new EPR at the end of last month. At the time of writing we are yet to confirm a new go-live date, but we are working hard to revise the timeline and agree a new date to proceed.

I want to stress how incredibly proud I am of the Digital team and wider group of colleagues who have got us to this stage of readiness, but also to everyone who did their training - over 20,000 hours of it in total - and who contributed to pathway redesign. That effort will not be lost and provides an excellent foundation for us to move forward.

James Hawkins, Chief Digital and Information Officer and I recently participated in Cabinet Office, National Infrastructure and Service Transformation Authority (NISTA) Gate 5 review of the NHS England Frontline Digitisation Programme. We were invited to share our experiences of the Programme and share lessons learned.

7. Changes in the Executive Team

I want to update colleagues on some changes in the Executive Team. Firstly, Sarah Coltman-Lovell has joined the Trust as Director of Strategy until the end of May. I am absolutely committed to developing and then delivering a clinical strategy in our Trust, and Sarah will be supporting with that to help us set the direction for our future. Some of you will know Sarah from her time with the Trust and recall her experience in operational management, quality improvement and efficiency, and clinical strategy. Sarah has since had a successful career in commissioning and system leadership; most recently overseeing the health and care partnership in York and urgent and emergency care partnership across York and North Yorkshire.

Finally, as Dawn Parkes has now retired as Chief Nurse, Tara Filby, Deputy Chief Nurse will be holding the role of interim Chief Nurse until Joe Hague joins us on 4 May.

8. 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. February's nominations are in **Appendix 1**.

Date: 25 March 2026

NHS
York and Scarborough Teaching Hospitals
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STAR AWARD

February 2026

Poppy Sharp, Healthcare Support Worker **York** **Nominated by colleague**

Poppy was the only Healthcare Support Worker from Ward 32 on shift, so we helped. Poppy is mature and kind. She knows which patients need help and how to help them. Despite probably feeling overwhelmed, she does not show this. Poppy displays our Trust values of kindness, openness, and excellence. Well done, Poppy.

Nicola Whitehead, Clinical Educator **York** **Nominated by colleague**

Nikki is an amazing part of the Practice Education Team. She supports healthcare support workers out on the wards, especially those new to the Trust, and has been instrumental in setting up and delivering the Band 2 to 3 training. Nikki is well respected on the wards as well as in our team and can support our staff both clinically and pastorally. Nikki demonstrates out Trust values, especially kindness, and is a pleasure to work with.

Maple Ward **Scarborough** **Nominated by patient**

Maple Ward staff and the on-call surgery team saved my life. I was admitted with unbearable pain and declining health following a routine procedure on the previous Friday. From the moment I was admitted to ED, then SAU, I was treated with the best care. I was made to feel like I mattered in such gruelling times. It's thanks to the quick thinking and speedy service of the amazing staff both on Maple Ward and in the on-call surgical team that I was able to be treated and walk out the following day.

During a scary and concerning time, the Ward Sister on Maple Ward (with everything I forgot to record her name) was amazing. She was caring and attentive and made me feel calm in a fraught time. This is the same for the on-call surgical registrar and his team. Amazing teams and such assets to Scarborough Hospital. They truly need recognition.

Domestic Team **Malton** **Nominated by colleague**

The Malton Domestic Team are all proud of the site and genuinely strive to ensure their hospital is kept meticulously clean for patients, colleagues, and visitors alike, and in all weathers. Although they could sometimes be seen as 'just doing their job', the team always ensure their respective areas are maintained to a high standard.

They also ensure that each person they encounter on the corridors is greeted and welcomed to the hospital in a polite, personable, and friendly manner. They take time during their busy schedule to be helpful to anyone they meet who may have any anxieties when coming to the hospital for the first time and needing directions to a particular department. Keep up the good work, you all do a great job! Thank you.

Fatimah Aliyu, Consultant in Paediatrics **York** **Nominated by relative**

Dr Fatima was kind, patient, and thorough when I visited with my son, who had bumped his head. She was professional and reassuring and had a lovely bedside manner.

Helen Sweeting, Clinical Nurse Specialist | **York** | **Nominated by colleague**

I am nominating my colleague, Helen, for her outstanding hard work and support of both patients and the IBD team daily. She should be acknowledged for going above and beyond for an IBD patient with complex care needs, who requires continuity and time. Helen has been an essential part of their IBD journey, has made a huge difference, and continues to do so. Helen takes so much time to ensure patient-centred and holistic care, genuinely investing in what she does to ensure the best support and outcomes. Helen is a huge asset to the IBD team!

Zoe Murphy, Perioperative Specialist Nurse | **York** | **Nominated by patient**

I was on Ward 16 from August to September 2025 when I had a major operation. Zoe was amazing. She went above and beyond her job, from taking my pyjamas home to wash as I had run out and my family live three hours away to spending over an hour doing my hair and taking me for my first shower. She came every day to make sure I was OK and was there if I needed a chat. She did all this on top of caring for the other patients as well. I feel like I've made a friend for life. Zoe, Mr Chintapatla, Mr Chintapatla's team, and all staff on Ward 16 are amazing.

Milagros Ventura, Healthcare Assistant | **Bridlington** | **Nominated by colleague**

Mila is a team player who always works hard to ensure the best possible care for the patients on the ward. She always encompasses and exemplifies the Trust values and has a smile on her face. She ensures all patients are OK, with a caring and positive attitude, and always demonstrates professionalism in the work environment.

Shirley Ross, Midwife | **York** | **Nominated by colleague**

Shirley is supportive of her colleagues when they have been through difficult times, and her women appreciate her. One partner said, "This is the last time we will see Shirley, she has been amazing". Shirley has organised two Christmas nights out for all our colleagues to meet up, which is great for staff morale. Shirley is always willing to help and is a great team player.

Jay Varner, Senior EUC Engineer | **York** | **Nominated by colleague**

Jay always goes above and beyond. He is a fantastic asset to York Hospital.

Kieran McDonnell, Senior Platform Specialist | **York** | **Nominated by colleague**

We (SHYPS) went live with our new laboratory IT system in September. As with all systems, there were a few things that didn't work as they should. A key feature that wasn't working was the ability to generate BI reports and automatically schedule them to be generated and emailed to users. This is a useful feature, particularly for teams within Pathology (for example, to identify new cancer samples) or for teams that rely on Pathology information to support their work, such as infection prevention. With this not working, a member of the Pathology team was having to generate reports, save them and then email them out every day.

The root cause for the failure was difficult and complex to understand, something to do with firewall rules, IP addresses, SMTP servers, and a whole load of other acronyms I don't understand! We are therefore grateful to everyone in the digital team, but particularly Kieran, who has helped (along with our suppliers) identify the issues, correct them, test them, and, at 09:02 on Thursday 22 January, it finally worked!

We are now actively scheduling all our reports to automatically generate and email out to users. It will save us so much time, and we will be looking at how we can potentially use this feature to reduce some of the paper reporting we do. The pressure on the digital team is immense at the moment, so we want to recognise the continued support we continue to receive to help with issues stemming from the LIMS deployment. Thank you.

VIU Cardiac-Physiology Team | **York** | **Nominated by colleague**

I think the VIU cardio-physiology team deserve the recognition of a Star Award for the massive contribution they each make to the safe and effective running of interventional cardiac services within the Vascular Imaging Unit. They’re all capable, professional, diligent, approachable, and personable. They primarily work independently in the unit in what can be challenging circumstances, especially with unwell patients in a cardiac setting.

They often go above and beyond to ensure procedures go ahead, work hard to facilitate a good experience for the patient, and help enable other colleagues to provide good care and finish on time. I think they’re a brilliant team, a credit to their department and profession, and deserve to be acknowledged as such.

Joanne Shaw, Assistant Medical Secretary | **Scarborough** | **Nominated by colleague**

Urology has been behind and in a critical state for quite some time, and, in my opinion, Jo Shaw has been an absolute superstar in everything she has done. Jo has worked hard and tirelessly with me (and other members of the team) to assist in bringing the department to its current state.

Without her hard work and dedication (not to detract from everyone else's hard work), I'm sure my own workload would not be as it is today. She wholeheartedly deserves recognition for her part in our success. Well done, Jo, and thank you so much for all your hard work.

Diabetes and Endocrinology | **York** | **Nominated by colleague**

I have just completed my third week in this department as a new audio typist, and I cannot speak highly enough of how welcoming the team has been. Their helpfulness has made coming in so much easier. Everyone has been lovely and kind, with special thanks to the admin staff, Lucy Teale, Molly Smith, Emma Richards, Lisa Laverick, Karen Pawson, Rachel Laws, Mandy Alcock, and Anna Richards, of course, but everyone on the department has been welcoming, helpful, and nice, so I don't go away at night worrying about anything other than the traffic. I want to say thanks to them for taking me into their team with open arms.

Manish Mandal, Resident Doctor | **York** | **Nominated by patient**

Dr Manish has been a constant support during my most recent stay at York Hospital. He moved quickly when I suffered from excruciating pain due to a blocked nephrostomy to make decisions, asking for his registrar's advice, balancing benefits and risks while considering all options, constantly keeping a close eye on me when I was deteriorating, and helping move things forward.

A couple of days later, he again looked after me when I presented to ED with sepsis one night, quickly identifying the cause and acting on it so I could start the antibiotic treatment urgently. He treated me as a priority, he was honest, and we (my husband) trusted him entirely throughout this terrible time. I truly believe he made a significant difference to my recovery, and I want to thank him for all he did for us!

Chloe Jones, Clinical Lead Occupational Therapist | **York** | **Nominated by colleague**

I would like to nominate Chloe. I know she will just say, "I am just doing my job", but our team would not be the same without Chloe. I am not the only one to ask her to never leave our team because she is truly amazing. Whenever anyone needs advice, Chloe is there to ask whether it is about a patient or for a personal issue and make the time. I would truly say if I were a patient, I would want her as my OT. She encompassed every Trust value, and I don't say that lightly.

I have had a hard time personally lately, and her kindness and thoughts have made a difference to me when I needed it most. She is an inspiration, so thank you. I hope as an OT, I give my patients what Chloe has given to me, make them feel what Chloe has made me feel, that we do make a difference, and that we have a lasting impact, emotionally.

Andy Jones Ngonglaigha, Staff Nurse | **York** | **Nominated by colleague**

Andy is a great nurse and an asset to York. He always builds an excellent rapport with patients and comes in with lots of energy and a big smile. When he seeks support from resident doctors regarding patients, he clearly explains the patient and what he thinks would be a sensible plan, taking the initiative. He always helps with ward tasks, including cannulation or contacting colleagues to chase up patient tasks in other departments. Whenever Andy is on shift, the shift runs smoothly!

Adam Robinson, Healthcare Support Worker | **Scarborough** | **Nominated by colleague**

Adam is such a lovely, friendly, polite, considerate, and helpful person. He stays late after his shift time has finished and is still happy to help transfer patients across the hospital to help with the transition of patient flow. He always has a smile on his face, and nothing is ever too much for him. He always goes the extra mile to ensure patients are where they should be and are happy.

Goldi Rehan, Critical Care Outreach Sister | **Scarborough** | **Nominated by colleague**

I am nominating Goldi Rehan for a Star Award in recognition of her outstanding contribution as a Critical Care Outreach Sister. Goldi consistently goes above and beyond her role and has made a significant impact on both patient care and staff development. Goldi has demonstrated exceptional commitment to education by delivering high-quality tracheostomy care teaching to Beech Ward and ECU staff. She ensured staff completed their competencies within the required timeframe, providing clear guidance, reassurance, and ongoing support. Her teaching has greatly improved staff confidence and safety when caring for patients with tracheostomies.

In addition, Goldi has been instrumental in supporting ward staff with the discharge planning of complex patients with tracheostomies, ensuring safe, timely, and well-coordinated discharges. Her expertise and willingness to help have been invaluable. Goldi is consistently approachable, supportive, and professional. She always upholds Trust values and is an excellent role model to colleagues across departments. She is a strong advocate for patients, ensuring their needs and safety remain central to all decisions. Goldi is truly deserving of this award for her dedication, leadership, and positive influence on patient care and staff development.

Uzma Zafar, Resident Doctor | **York** | **Nominated by patient**

I was a patient on Ward 32 in January with a severe chest infection, and Dr Uzma Zafar looked after me with kindness and compassion. She went above and beyond when I was at my lowest, and her team displayed thorough professionalism throughout my stay. My husband and I would like to send our appreciation for her, her team’s, and everyone who works on Ward 32’s help and for looking after me. She is an amazing, kind, and considerate doctor.

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

Michael goes above and beyond in everything he does, and he never complains. He works on rapid response and in the laundry most of the time, so he does lots of different jobs throughout the day. He always wears a smile and is polite. He deserves recognition for the great work he does.

Lynn Spiers, Cleaning Operative | **York** | **Nominated by colleague**

Lynn is such a brilliant member of staff. She works mainly on the delivery ward, but she helps us as a department a great deal, and we call her to ask her to work off-site most weeks. She goes to Harrogate renal, Easingwold renal, St Monica's, Nelson’s Court, and White Cross Court, which are all different shift patterns to which she is contracted. For many weeks, she works every day off-site. She deserves some recognition for the great works she does.

Adebayo Akande, Specialty Registrar | **Scarborough** | **Nominated by colleagues**

Dr Bayo is one of the hardest-working doctors on our unit. He is always professional with a smile on his face, no matter how busy a day it is, is approachable, and has a great bedside manner. He is an asset to our unit, and he deserves recognition as he goes above and beyond for patients.

Freedom of Information Team | **York** | **Nominated by visitor**

The Trust's Freedom of Information team continue to be one of the best in the country that I've ever had the pleasure of interacting with. It's clear that your data infrastructure is set up in a way that allows for excellent reporting to be delivered quickly, but above and beyond that, the team deal with complex requests incredibly well.

In my case, I was trying to find some convoluted data, and the team were incredibly helpful in assisting me as a requester to understand how best to get the information I needed. They were patient with amendments to the request and still delivered responses earlier than statutory timeframes! This isn't the first time I've had cause to send a compliment regarding them, but the fact that they perform so consistently excellently is hugely impressive to me. This excellent performance is a testament to a Trust that genuinely values openness and invests in its datasets and data-sharing staff. Thank you very much!

Kirsty Bottomley, Sister | **York** | **Nominated by patient**

Due to autism and ADHD, I find any medical environment stressful to the point of leaving before an appointment or not accessing care at all. Kirsty listened to my needs, making sure I could access the service when needed and not have to come more times than needed. She also ensured I had an appointment with her that worked for me and where I was unlikely to have to wait. When she was held up once, she asked colleagues to bring me through, so I had something to do, and she was then ready.

Kirsty has gone out of her way to adjust things so that I can attend and receive medical care at my pace. This, in turn, has allowed me to attend work as this issue would potentially stop me if not treated with the sensitivity that Kirsty has shown.

Lloyd Ward	**Bridlington**	**Nominated by patient (1) and patient (2)**

Nomination 1

Lloyd Ward has fantastic staff who are friendly, reassuring, and helpful. They were compassionate and went above and beyond.

Nomination 2

The beautifully calm, warm, helpful, and inviting atmosphere of Anne and all staff on Lloyd Ward (nurses, surgery staff, anaesthetists, and surgeons) made my experience feel calm and safe. Everyone was smiling, helpful, and nurturing, and I felt they had good relationships with each other, too, which is lovely to see.

Michelle Lee, Administration Assistant	**York**	**Nominated by colleague**

Michelle is someone who regularly goes the extra mile for patients and visitors to our Trust - not only to our unit but the whole hospital. Her holistic, caring nature embodies the Trust values, and I regularly hear praise for her high level of care and attention towards the people visiting our department.

This dedication was recently highlighted when we came across a lost elderly couple as we were leaving the building to go home at the end of the day. They were looking for a specialist nurse but had no paperwork and had been incorrectly directed to our unit. Michelle offered to take them upstairs to see if their appointment was there, and then, when it wasn't, spent over half an hour with them, ensuring that she located the nurse they had their appointment with (no mean feat with no paperwork!), before escorting them through the hospital to the correct location.

This was all done with a smile and kindness, in her own time, and I only found out about it because I asked her the following day. As I said before, this is but one example of many. If you or your relative were vulnerable and under our care, Michelle would be someone you would be glad to meet on your journey.

Huda Mohamed, Consultant	**Scarborough**	**Nominated by colleague**

Dr Mohamad is an integral part of the Cherry Ward team. She is always polite and approachable, whether you are a colleague, patient, or family member. She never complains about anything, and nothing is ever too much for her to do. She always keeps patients' families as up to date as she possibly can and goes above and beyond for anyone she can help.

Breast Imaging Unit Administrators and Radiographers **York** **Nominated by colleague**

During a difficult time over the Christmas period, there were several medical emergencies within our Outpatients department. The staff response to these emergencies was amazing. Colleagues responded quickly, efficiently, and calmly, leading to a positive outcome for all the patients.

In one case, the patient deteriorated in our corridor, and, although they were not our patient, one of our colleagues noticed they were becoming unwell and gave a prompt response and immediate assistance. This highlighted how well the team incorporate Trust values in their daily work to support each other and improve patient experience and outcome.

Marilyn Rogers, Consultant Rheumatologist, and Rheumatology Specialist Nurses **York** **Nominated by patient**

I am 75 years old and have been cared for by Dr Rogers and the specialist rheumatology nurses for Polymyalgia Rheumatica for the last seven to eight years. Dr Rogers and the specialist nurses are always professional, knowledgeable, patient, kind, caring, and sympathetic. It is comforting to know that I can contact the nurses via phone when I have a painful flare up. The calls are always answered within 24 hours, and a plan is made to ease my pain and allow me to sleep again.

My appointments and phone calls are never rushed; everything is fully explained to me, and I am allowed plenty of time to ask questions or ask for clarification. I am grateful for the concern shown to me and their attention to “quality of life”. This is truly a remarkable service, and I feel they deserve recognition. Thank you, all.

Urgent Treatment Centre **Selby** **Nominated by patient**

On Wednesday 14 January, I went to Selby Hospital with a painful, inflamed cyst on my chest. I saw Lisa, who assessed me and was kind and empathetic. She asked if I would like to see the out-of-hours doctor and referred me to Dr Sher Afgan. He was kind and understanding, gave me a course of antibiotics, and suggested a line of treatment to make me feel better. He could not have been nicer. He told me to contact my doctor if the antibiotics had not cleared it up. The cyst grew redder and more painful, so on Monday, I contacted my GP, who gave me another prescription for the same antibiotics.

By the next Sunday, it was still getting bigger and more painful, so I rang 111 for advice and was told to go to Selby Hospital. I met Jayne Wood at reception, who was sympathetic and kind. I then saw Ellen, the triage nurse, who recognised me from earlier visits. She was concerned and consulted with Lisa, whom I had seen previously on 14 January. I showed her the photographs I had taken, which showed it worsening despite antibiotics. She thought it needed treating immediately on the surgical ward at York. She arranged for me to go straight there and have it excised and drained under local anaesthetic. I am grateful for her really doing all she could to help me become free of infection and pain. Sarah, the registrar, and Louis, her student, were sympathetic and said it needed to be done then. The service that these people offered was outstanding, and I am grateful for their kindness, empathy, and professionalism. It was outstanding service and should be rewarded.

Kent Ward **Bridlington** **Nominated by patient**

The overwhelming majority of staff I encountered within my surgical experience, including those in theatres, were amazing, making me feel safe and cared for at all times. The healthcare assistants should be particularly commended for what came across as genuine kindness, openness, and honesty and their excellent care. The only name I can remember is Sharon Pike, but she wasn't the only one. Both Sharon and her colleague who escorted me to x-ray were caring and communicated clearly about what was in my best interest, ensuring I knew exactly what was happening throughout their day shift. They supported and encouraged me to eat and drink post-surgery, and nothing was too much trouble. They supported staff nurses and ward doctors, who were equally kind and gave me confidence in their competence.

As a recently retired Clinical Lead/Ward Sister, I would have been proud to lead a team that treated patients so compassionately. I was aware of trying not to be the nightmare control freak ex-nurse patient, but even if I was, this team of staff were amazing at making me feel safe and truly looked after during this anxious time. They are all stars.

Matilda King, Healthcare Support Worker **York** **Nominated by colleague**

Matilda showed extraordinary bravery and compassion when faced with a life-threatening situation. Matilda noticed a patient quickly became unwell and acted quickly, pulling the emergency bell so the medical team could come and continue the medical treatment. Matilda acted without hesitation, resulting in a positive outcome. This achievement highlights her maturity at the age of 17 and her courage and commitment to the safety of others. Well done, Matilda.

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

I've worked with Denise and Dawn for several years in my role as a Healthcare Assistant on Ward 36. Given the acuity and needs of patients on Ward 36, both Dawn and Denise care for all patients in an exemplary way. They instinctively know how to communicate with people who have multiple care and mental health needs due to long-term substance and alcohol use. Their genuine kindness, realism, and encouragement ensure that a lot of patients achieve beyond their expected health rehab outcomes. They are not only HCAs, but they are also occupational therapists, physiotherapists, caterers, nurturers, and brilliant carers.

With these two on Ward 36, I genuinely feel that patient care reaches far beyond everyday standards, and I know others feel this way, too. I often hear people say they are the backbone of the ward. They are respected and cherished by all the patients on the ward and have nurtured therapeutic relationships with carers, families, and patients that go beyond their role. The Trust must and should recognise these two wonderful people.

Angela Hewitt, Senior Pharmacy Assistant **York** **Nominated by colleague**

In addition to her main role as a Senior Pharmacy Assistant, Angie is a bank Healthcare Assistant. She deserves a Star Award because she is hard-working and shows dedication to what she does. Nothing is too much trouble, and she shows care and compassion in what she does. With her kindness toward patients and colleagues, she consistently demonstrates excellence and goes above and beyond her role. She is always friendly and happy and adds a sparkle to the ward when you work with her. I feel bank staff don't get enough recognition for what they do, and Angie deserves to be nominated for a Star Award.

Emily Calvert, Staff Nurse **York** **Nominated by relative**

Emily, a Staff Nurse on Ward 34 at York Hospital, has truly astounded me with her clinical skill and professionalism. She has been part of the team caring for my father during his end-of-life care, and her contribution has been exceptional. Emily's observational skills are remarkable. She listens intently, notices even the most subtle clinical changes, and acts quickly to ensure my father receives the best possible care. Alongside her clinical expertise, she shows genuine compassion. She communicates openly and explains everything in a calm, reassuring, and empathetic way to both my father and me. She is consistently responsive whenever help is needed and carries out every action with diligence and care.

Emily is a real asset to York Hospital - a true ambassador for the Trust and the standard of care it provides. She has made an incredibly difficult time easier to bear, and her presence has been nothing short of extraordinary. The Trust should be immensely proud of her; she exemplifies everything that is good about the NHS, and especially about York Hospital.

Rebecca Lightfoot, Consultant **York** **Nominated by patient**

I recently had to visit York ED with a frightening health issue. I was reluctant due to previous traumatic and negative experiences. This time, my care was exemplary. Dr Lightfoot stood out to me for her brilliant interpersonal skills and outstanding level of care. She did not 'inform' me of anything; she involved me in it and asked for and valued my opinion. She listened, and she made a traumatic experience so much more palatable. I am grateful to everyone involved in my care that evening. All were examples of the NHS at its finest.

Debbie Ogden, Midwife **York** **Nominated by patient**

Debbie has been there for the birth of both my boys in 2022 and 2024. She is caring and provides the best advice when needed. She reassured me through both my births and even more so with my latest when we ended up in theatre. Thank you so much, Debbie.

Becky Williams, Deputy Sister **Scarborough** **Nominated by colleagues**

Beech ward would like to nominate Sister Becky for a Star Award. She embodies the true values of the Trust through her exceptional leadership, unwavering patient advocacy, and profound compassion that consistently go far beyond her formal duties. Becky is a foundational pillar of Beech Ward. A highly effective Sister, she leads with a direct and efficient approach, but beneath that professional, sometimes sharp, exterior lies a heartfelt dedication and a real 'softy' who cares deeply. This was powerfully demonstrated when she stepped up to cover for a colleague's bereavement absence, seamlessly managing the technical and clinical leadership of the additional responsibilities, proving herself to be a truly capable and reliable leader.

Her commitment to patients is absolute and knows no bounds. Becky regularly contacts the ward on her days off and after long, challenging shifts to check on patients' wellbeing and ensure safe discharges. This personal investment highlights her extraordinary dedication. Becky is a fearless advocate, speaking up for both colleagues and patients to address concerns and ensure the highest standards of care and safety.

A recent situation perfectly illustrates this: a patient with a challenging tracheostomy had been on the ward for over six weeks and was growing increasingly frustrated. Becky provided constant reassurance, but, more importantly, she took decisive action. Over two full days, she personally coordinated and chased multiple specialities and meticulously organised the patient's complex equipment. Her sole focus was ensuring they were comfortable, safe, and posed no danger to themself upon discharge. This was a masterclass in patient-centred leadership, tenacity, and compassion.

In summary, Becky is a 'true leader' in every sense. She combines sharp clinical acumen with profound kindness, advocates tirelessly, and takes personal responsibility for patient outcomes long after her shift ends. She is an immense asset to Beech Ward and Scarborough Hospital and deserves recognition. We strongly believe Becky is the most deserving recipient of a Star Award.

Pete Foster, Clinical Support Worker **Scarborough** **Nominated by colleague**

I was in a bad accident after finishing work, and Peter supported my head and kept me calm while waiting for the ambulance. I had just finished work when I was run over by a car, and Peter, who had also just finished work, saw the accident. He supported me, stopped me from panicking, and tried to get me up from the road. I'm grateful he was there for me, and I think he should be nominated for a Star Award.

Julie Bell, Healthcare Assistant **Scarborough** **Nominated by colleague**

I am writing to recognise my colleague, Julie, for her actions following an accident near Scarborough Hospital. When Julie left work at 8pm, she was one of the first people on the scene of an incident where a pedestrian was struck by a car. Along with other colleagues from the hospital, she was there to help the injured patient. Julie acted professionally in a stressful situation, and she reassured the patient until further help arrived. The incident was severe, and the patient received care in both Scarborough and Hull hospitals. Julie's quick actions, empathy, and commitment reflected the Trust values.

Megan Crookes, Sister **Scarborough** **Nominated by colleague**

I am writing to recognise my colleague, Meg, for her actions following an accident near Scarborough Hospital. When Meg left work at 8pm, she was one of the first people on the scene of an incident where a pedestrian was struck by a car. Along with other colleagues from the hospital, she was there to help the injured patient. Meg acted professionally in a stressful situation, and she reassured the patient until further help arrived. The incident was severe, and the patient received care in both Scarborough and Hull hospitals. Meg's quick actions, empathy, and commitment reflected the Trust values.

Sam Bugg, Respiratory Specialist Nurse **York** **Nominated by colleague**

Sam always comes to work with a smile. She is friendly and helpful to all patients and colleagues. She is more than happy to support colleagues with training and tricky situations. She is currently undertaking a non-medical prescriber course, and even though she is extremely tired from this, she remains helpful and friendly to all.

Urology Secretarial Team and Helen Hudson, Service Manager **York** **Nominated by colleague**

I'd like to nominate the Urology Secretarial Team and Helen Hudson, Urology Service Manager, for a Star Award to recognise just how much they've achieved during an incredibly tough period for the Urology department. The team had been severely understaffed for several years, which made it really challenging to keep patient letters going out on time. Despite this, they continued to show amazing resilience, positivity, and a genuine commitment to supporting both patients and clinical colleagues. Even under constant pressure, they kept going and stayed focused on doing the very best job they could.

Now that the team is fully established, and with Helen's supportive, hands-on leadership and close partnership with the secretaries, they've delivered a fantastic turnaround in the long-standing letter typing backlog, which has been a significant risk for a long time. What they've achieved shows what a fully staffed, highly motivated team can accomplish when they pull together. Their hard work, teamwork, and pride in what they do have taken the department from a difficult backlog to a place of real stability. This has made a huge difference to patient pathways, clinical flow, and the wider service.

Helen and the Urology Secretarial Team have genuinely gone above and beyond. They consistently show kindness, professionalism, and the values we want to see across our organisation. They absolutely deserve recognition.

Charlotte Simpson, Trainee Advanced Clinical Practitioner **York** **Nominated by colleague**

Charlotte has worked tirelessly to provide an exceptional service for a child requiring input from multiple specialities. Over several months, she coordinated a highly complex admission involving an MRI under general anaesthetic alongside ophthalmology, ENT, dental review, and blood tests. Bringing so many teams together at one time is no small feat, and Charlotte achieved this through outstanding communication, organisation, and her approachable, positive manner. Charlotte consistently goes above and beyond to make things happen.

Thanks to her determination and meticulous planning, the child and their family had the best possible experience during what could have been a challenging process. Patients and families are incredibly fortunate to have such a strong advocate, and Charlotte is a real credit to the team.

Paediatric Day Unit Team **York** **Nominated by colleague**

Rosie, Grace, Dannii, Lottie, Charlotte, and Chris have all worked exceptionally hard to keep the Paediatric Day Surgery service running while their usual day surgery area was repurposed to support winter pressures. Relocating a service to an alternative area is never easy, but the team approached this challenge with positivity, flexibility, and a real can-do attitude.

Despite the difficulties at times, they consistently pulled together to ensure that children, young people, and their families received the best possible experience. The Paediatric Day Unit Team are truly brilliant and a real credit to the wider paediatric team for the care they provide to their surgical children and young people.

Tracy Devine, Chief Audiologist, and Donna Rowan, Associate Audiologist **York** **Nominated by patient**

We have been visiting Tracy and Donna for about eight months or so, since our baby was only about five weeks old. He was diagnosed profoundly deaf in both ears, but Tracy and Donna have been with us every step of the way, have made us feel heard, and have helped us to navigate the diagnosis and journey to him getting cochlear implants.

They have been an absolute delight to visit every few weeks and have made us feel valued and worthy as parents. They have made us smile at each visit, for which we are eternally grateful. Getting such a heartbreaking diagnosis but having fabulous people taking care of you and your baby makes it so much easier.

Intensive Care Unit	**York**	**Nominated by relative (1) and relative (2)**

Nomination 1

The care and compassion of the ICU team when my sister passed away in January were outstanding. They made a difficult time in our lives peaceful and calm. Their sensitivity to my sister was wonderful to behold. We cannot praise them or thank them enough.

Nomination 2

Our dad was taken into ICU after collapsing at home. While he was on life support, the staff of the ICU, from the lady on reception to the nurses and doctors, were outstanding in their care towards him and towards us as a family. We were going through one of the worst times in our life and we were treated with such care and understanding. We were given time each day with the doctor who explained every step of his illness with patience and understanding.

Unfortunately, it was the worst outcome for us, as our dad did not survive. However, even on that day, while they removed the tubes and machines, our dad was treated with dignity and respect. While it was the worst day of our lives, the care from the entire team was something we will be forever grateful for.

Sarah Cuddy, Specialist Radiographer, and Ezinne Uzim, Specialist Radiographer	**York**	**Nominated by patient**

I attended for a CT scan. Unfortunately, I struggled with some personal difficulties during the procedure, such as difficulty inserting a cannula due to the state of my veins and a desperate need to use the toilet during the procedure. Sarah and Ezinne were incredibly sympathetic and patient and could not have done more to reassure me. I expressed concern about the time all this was taking, knowing they were working a long shift, but they told me not to worry.

I am sorry for the problems I caused them, and as I had to leave the scan room quickly, I did not have a chance to thank them. Please can you thank them for me for going above and beyond their jobs and ensure they are given recognition for this.

Sarah Bainbridge, Rapid Access Chest Pain Specialist Nurse **York** **Nominated by colleague**

Sarah goes beyond her job role, taking care of people in any way she can. We had a patient from a surgery clinic who had a vasovagal response, probably from pain during examination. The patient seemed to lose consciousness, and my colleagues shouted for help immediately.

Sarah heard the call for help, and she did not hesitate to check my colleagues and help the patient straight away (I was the only nurse in the department during that day). Eventually, the patient lost consciousness, and Sarah hurriedly put them on the floor just in case we needed to do chest compressions. She demonstrated her skills and knowledge and handled the situation smoothly, making my colleagues feel at ease even though the situation was shocking to everyone.

Though Sarah is busy doing her own clinic, she always mentions to the Outpatients Team that she is happy to help when needed. Sarah is kind to my colleagues and everyone around her. She is approachable, is always willing to help, and has excellent skills that she is happy to share with her colleagues. She is a good role model for every colleague in the hospital and a true star that always shines whenever she goes, saving lives with a smile.

On behalf of the Main Outpatients Team, I thank Sarah for all her efforts and help in the department. We are always happy to have Sarah in our department. Thank you so much.

Environment and Linen Team **York** **Nominated by colleague**

Despite a particularly challenging end to last week, the Environment (Waste) and Linen Team showed outstanding courage, resilience, and teamwork. Colleagues and management supported one another brilliantly, upholding our values throughout. I’m incredibly proud of how the team delivered their specialist duties, even in the toughest moments.

Rebecca Smith, Outpatient Services Administrator **York** **Nominated by colleague**

Bex has been amazing in helping organise a short-notice appointment for a deaf patient who wasn't able to travel and was having IT issues. Throughout the whole process, Bex has been calm, thoughtful, and solution-focused. She's gone the extra mile and hasn't minded when I've phoned her in a complete panic! Bex, thank you - you really are a star!

Charlotte Davitt, Staff Nurse **York** **Nominated by relative**

Charlotte was a ray of sunshine on some very dark days. My Nan had a stroke, and we were clueless as to what a stroke, past, present, and future, meant. Charlotte’s care, intelligence, real life advice, and all-round professionalism were what we needed as a close and worried family. She put our minds at ease and cared for Nan beyond words. She’s the reason Nan came home at the right time with the right care. A credit to the Trust. If Charlotte is a sign of the future of nursing, then long may it reign.

Gerry Robins, Consultant in Gastroenterology **York** **Nominated by colleagues**

We would like to nominate Dr Gerry Robins for a Star Award. The purpose of these awards is to recognise staff who genuinely live the Trust's values, making Dr Robins an unavoidable choice.

Dr Robins is exceptionally kind, endlessly approachable, and unfailingly respectful to everyone he works with. He makes time to speak to all colleagues, from fellow consultants to nursing staff, allied health professionals, porters, and cleaners, always treating people as equals and with genuine interest. His ability to connect with people across roles creates a working environment that is welcoming, inclusive, and human. He shares his considerable knowledge freely and without judgment, making learning feel safe rather than intimidating. He combines this with a sharp sense of humour, which not only makes him a pleasure to work with but also helps teams get through difficult and high-pressure situations with perspective and morale intact.

Dr Robins consistently goes above and beyond in supporting both medical and nursing teams. He is a strong advocate for patient and staff safety and is not afraid to challenge things when necessary, always to improve working conditions and maintain high standards of care. This commitment to doing the right thing - even when it is inconvenient - demonstrates real leadership and integrity. When we joined the team, Dr Robins made a particular effort to ensure we felt confident, supported, and genuinely part of the team. This was not performative or obligatory; it was thoughtful, consistent, and entirely in keeping with how he treats everyone he works with.

In summary, Dr Robins exemplifies kindness, openness, and excellence in his everyday actions. His impact on staff wellbeing, team culture, and patient care makes him thoroughly deserving of recognition. We are so very lucky to have Dr Robins, and we want to thank him for all he does!

Kevin Atkinson, Environment Team Member **York** **Nominated by colleague**

Kevin has been an exceptional asset to the Environment Team, consistently demonstrating dedication, initiative, and an unwavering commitment to excellence. He routinely goes above and beyond his duties, offering support to colleagues without hesitation and proactively identifying ways to improve service delivery.

Most notably, Kevin independently took on the task of counting and cancelling linen, resulting in a significant cost saving of approximately £21,000 over the last three months, with a projected annual saving of £84,000 for the Trust. His initiative, reliability, and positive influence make him truly deserving of recognition.

Kathryn Willmot, Medical Secretary **Scarborough** **Nominated by colleague**

Kath always puts the patient at the centre of all she does and empowers others to do the same. Recently, Kath went the extra mile and showed great compassion and understanding in supporting a colleague. The actions, kindness, and attention that Kath showed her colleague clearly demonstrate the Trust values of kindness, openness, and excellence.

Jane Wright, Ward Clerk **York** **Nominated by colleague**

I would like to nominate Jane for a Star Award in recognition of her exceptional dedication, professionalism, and the invaluable contribution she makes to our ward every single day. Jane is the right hand of the ward, the left hand, and sometimes the brain, too. She is one of the most valued and respected members of our team, and we say that not just because we rely on her for absolutely everything (although…we really do).

She communicates with patients and their relatives with compassion, clarity, and respect, ensuring they feel informed, valued, and supported. Her ability to maintain effective, calm, and empathic communication - even during challenging moments - makes a significant positive difference to the patient and family experience. Quite simply, the ward could not function without her. She is a credit to our team, and she is immensely deserving of this recognition.

Security Team **York** **Nominated by colleague**

During an intensely volatile incident within the NHS, the security officers, Kellan Harrison-Potts, Jordan Davis, Ikhtisham Ali, Adeyemi Benjamin, and Josh Allenby, were confronted with an extremely violent and rapidly escalating situation that posed an immediate threat to those nearby.

Under immense pressure and at significant personal risk, they remained remarkably calm and in complete control, placing the safety of patients, colleagues, and visitors above all else. With decisive action, clear communication, and exceptional restraint, they stepped directly into danger and successfully de-escalated the situation before anyone could be harmed.

Their willingness to put themselves in harm's way went far beyond the expectations of their role. The courage, dedication, and unwavering commitment they displayed embodied the core values and safety standards of the NHS, standing as a powerful and inspiring example of professionalism under extreme pressure.

Amarachi Chima, Staff Nurse **Scarborough** **Nominated by colleague**

Chima undertook training to become a Professional Nurse Advocate (PNA). She has embraced the role of PNA and has utilised her time effectively, providing one-to-one and group sessions. Colleagues have felt listened to and supported by Chima during some recent challenging times.

Chima has introduced an appreciation board, which encourages colleagues to nominate members of Cherry and Chestnut wards who have made a difference or gone that extra mile. This has impacted staff morale, and colleagues are feeling that their contributions are being recognised and acknowledged by members of their team.

I believe Chima has demonstrated the Trust values in performing this PNA role. She strives to give all colleagues the support and restorative supervision that she can offer in the time she has allocated. She is actively acting on themes brought up in the sessions and works with staff to consider changes at the ward level that may impact patient safety and quality of care.

Kelly-Ann Dobbin, Neonatal Clinical Educator | **York** | **Nominated by colleague**

Kelly has worked hard in preparation for SCBU moving to its temporary location during refurbishment. Kelly has undertaken training the nursing team to use the new equipment and SIMS in transporting a baby in the transport incubator. Kelly has worked flexibly, including weekends and nights, to ensure all colleagues have completed essential training. This was a huge task that needed to be completed in a short time frame. Well done, Kelly, you have done an amazing job.

Melanie Broadley, Healthcare Assistant | **White Cross Court** | **Nominated by colleague**

Mel has recently supported a patient who had no family, apart from her husband, who passed away in difficult circumstances while she was admitted to hospital. Mel has gone above and beyond to give this patient the time and space she has needed for someone to listen to her and support her while she is grieving. Mel also supported the patient down four flights of stairs, accompanied her to her husband's funeral, and got her back up the stairs afterwards to ensure she was safe. Mel always goes the extra mile for patients, and this is just one example of many.

Susan Birkitt, Specialist Practitioner District Nurse, Melanie Linley, Team Leader, and Temporary Staffing Service | **Community and York** | **Nominated by colleague**

Susan, Melanie, and the Temporary Staffing Service have gone above and beyond the Trust values of kindness, openness, and compassion. I have been unwell, and they have been outstanding in accommodating me. They deserve 100% of praise and promotions. The best knowledge, competency, and care I have seen in 26 years. Thank you.

Facilities Operatives | **Bridlington** | **Nominated by colleague**

The last two weeks have been stressful for all colleagues throughout the hospital, but especially for the facilities operatives. At short notice, they were put under more pressure than usual, due to other hospital colleagues having no access to the post room. This significantly increased their workload. All colleagues remained calm, courteous, and professional throughout, while the inconvenience was dealt with. Please can you let them know that they are appreciated. Thank you all for your continued hard work.

Alisha Hardaker, Healthcare Assistant | **York** | **Nominated by colleague**

Alisha maintains Trust values when working on the wards, and she demonstrates hard work, leadership, and that patient care is at the forefront of the care she provides. She maintains a good rapport across the surgery floor with all colleagues. Alisha is a pleasure to know and to work alongside. She listens and takes care in all that she does. This is to recognise that you are appreciated.

Jennifer Hughes, Occupational Therapist **Nelsons Court** **Nominated by colleague**

I am nominating Jenny in relation to the Trust value of excellence. Jenny undertakes a role in the Parkinson's clinic every Thursday Morning at Nelson's Court and is always passionate about providing a quality service for the service users. The Parkinson's MDT have been undertaking several projects for service improvement, and Jenny has been a key member of staff in this process.

More recently, Jenny has been nominated as a finalist for the Mali Jenkins Award at the Parkinson's Excellence Awards in March. Originally, there were 94 nominations, and Jenny has made it as one of the 21 finalists. The Mali Jenkins Award recognises services designed for individuals with Parkinson's Disease in mind. Mali Jenkins was a pioneer who founded Parkinson's UK. Jenny has worked closely with her colleague Maria Liversidge on this.

Anju Varghese, Specialist Radiographer **Scarborough** **Nominated by patient**

I attended Scarborough Hospital Radiology Department for a CT IAM scan with contrast. I have attended various hospitals on numerous occasions and am currently under the care of three departments. I'm claustrophobic and had hardly slept for three nights before the scan due to worrying about it. Anju was the amazing lady who did the scan.

When we first met, I explained my fears to her, and she showed me how the scan would be performed and explained everything to me in detail and in a calm and empathetic manner. I wear hearing aids in both ears, and she continued to make sure I had understood everything when I had to remove them for the scan. She even offered to stay with me until the last possible minute when she was needed to oversee the scan. Her bedside manner was the best I've ever encountered, and she made me feel at ease at every opportunity. So much so that I now have no fear at all if I ever need to have a CT IAM again.

I can't thank Anju enough, and I hope she realises what an amazing advocate she is for Scarborough Hospital and that she left me with a lasting impression thanks to her kindness and empathy.

Samantha Ritchie, Operational Service Manager	**York**	**Nominated by colleague (1) and colleague (2)**

Nomination 1

Samantha is always smiling and always cheerful. When she walks into a room, she brightens up the place. I work as a bank doctor, and whenever I am trying to get shifts booked, it's never a problem for her. She books them and puts them on Loop, and I know straight away. I sometimes feel she's an unrecognised hero, so that is why I have nominated her for a Star Award!

Nomination 2

I need to nominate Sam for her amazing attitude, for consistently doing her job well, for turning up every day and caring, for listening, for her resilience, for being super positive, sunny, and enthusiastic, and for going the extra mile to make life a bit easier for the rest of us. Sam is one of those people you can rely on to get things done, and, in an environment that is more stressful and pressured than ever before, that quality is worth everything. Sam earns the respect of others rather than demanding it, which facilitates a close working relationship between all team members. I believe there are many people, me included, who could learn a lot from Sam.

James Francis, Consultant Anaesthetist	**York**	**Nominated by colleague**

James is an invaluable member of the theatre department and makes a massive difference in not only his role as lead for theatres, but also every day within theatre lists as a consultant anaesthetist. He is kind, caring, and supportive of both his patients and all colleagues who work with him. He is approachable, goes above and beyond when someone comes to him with a problem, and always checks in afterwards to ensure everyone is happy and feels supported.

James is quick to respond when he is asked for help, putting staff at ease in even the trickiest and most challenging of situations. With the junior members of the department, he takes time to educate and support in any way he can. James stops to say hello to everyone, no matter where they are and is always smiling, even in the tougher times. He's a true ray of sunshine in the department!

Sandra Brown, Audio Typist, and Nikki Ferreira, Audio Typist	**York**	**Nominated by colleague**

Sandra and Nikki have reduced our letter typing backlog from that of many months to pretty much zero. A huge volume of dictation is generated every day by the urology specialist nurses and doctors from their clinic consultations. This dictation includes vital prescribing advice and key patient information which, in years gone by, patients have had to wait some time for.

Through their own initiative, Sandra and Nikki have now reached the point of typing and sending letters the same day as their dictation. This improvement means important information is relayed to the GP immediately, and our patients no longer have to wait to receive printed details of their management. Thank you so much for your dedication, commitment, and teamwork. Your work has had a massive impact on improving the care of all our patients. Thank you from the whole Urology department.

Marta Marmaj, Staff Nurse **York** **Nominated by colleague**

Marta is kind and caring, and in the last year, as well as other years, I've seen this amazing leader truly show leadership qualities and commitment, and live out the duty of care for patients, nurses, health care assistants, admin staff, and doctors in York Ophthalmology Outpatients and the Community Stadium Ophthalmology Retinal Treatment Clinic. The large service provision is often underestimated, as those who don't know much about ophthalmology don't know that it is a growing and busy service. Marta is required to be personable, caring, and approachable.

Over the years, Marta is often delegated more senior roles while managing her workload and providing hands-on patient care. She manages the cover of sickness, extra clinics, and constant changes in service provision to ensure patients receive their ophthalmology care. This leader has the great qualities to lead, is humble, and deserves a Star Award because she doesn't expect anyone to do anything that she isn't prepared to do herself. Marta often covers the overnight on-call out-of-hours service to cover sickness at short notice, ensuring patients can access emergency specialist eye care, covering the large population of patients coming from the coastal areas, the towns, and the cities we serve. No on-call role is left uncovered, so patients can access the emergency 24/7 specialist ophthalmology service at York Hospital.

Marta is a great leader. You are seen and appreciated. Thank you for your dedication to our patients and for your care of our team. Thank you for your wit and humour despite being under pressure in your busy and challenging role. You are great!

Mohamad Kajouj, Specialty Doctor **York** **Nominated by colleague**

I am nominating Mo for a Star award in recognition of his remarkable act of kindness. My father required emergency tracheostomy surgery while he was in Jamaica. He had travelled there last year to visit family after undergoing extensive cancer treatment in 2023. Unfortunately, his condition deteriorated rapidly over the Christmas period, resulting in the urgent need for surgery. The healthcare system in Jamaica is very different from that of the UK, and my father was not doing well. As a family, we decided that I would fly out to Jamaica to bring him back to the UK so he could continue his treatment here.

When Mo learned what had happened, he generously offered to meet me in Jamaica and escort my father and me back to the UK. I was deeply touched by his kindness, sacrificing his personal time and finances to support me and my family and me. His involvement made a meaningful difference to my father's quality of life, especially as he advised me on the medical equipment and supplies needed for my father's care, which I was able to take with me to Jamaica. This was a true and selfless act of compassion, and I feel honoured to have Mo as part of my team.

Although this nomination focuses on Mo's extraordinary kindness, I would also like to acknowledge the Head and Neck Outpatient Nurses, the ENT Consultants, and my entire team for their encouragement, advice, and support during this challenging time for my family. This experience was particularly frightening for me, as I sadly lost my mother to COVID in January 2021. She was admitted to a hospital in Jamaica and passed away four days later.

Liam Coxon, Clinical Support Worker **York** **Nominated by colleague**

Liam goes above and beyond, efficiently making patients feel comfortable and reassuring them when putting a cannula in or taking bloods.

Katie Hanrahan, Sister **Scarborough** **Nominated by colleague**

Katie has been excellent at helping me with a few circumstances. She has gone on and beyond with rearranging my shifts to accommodate my health. She has supported me and listened to my problems, advised me on health matters and personal matters, and supported me in meetings. She is a true inspiration, caring, considerate, and genuine. She always has time for me, and I feel she should be awarded a Star Award, as this is the best way to thank her.

Nicole Page, Community Midwife **York** **Nominated by colleague**

Nicole Page is a rotational midwife currently working in the community within the North East York Team. Nicole is consistently a pleasure to work alongside, and I have received overwhelmingly positive feedback from women who have experienced her care. She demonstrates genuine compassion and professionalism in every interaction, and her practice is always thorough, thoughtful, and woman-centred. Nothing is ever too much trouble for her; she approaches each situation with patience, kindness, and a calm, reassuring manner.

Nicole's support for colleagues is truly exceptional. She is generous with her time, always willing to assist, and contributes positively to team morale. Her collaborative approach and reliability make her a valued member of the team, and she will be greatly missed when she rotates back into the hospital setting. I recently worked with Nicole in a particularly challenging scenario, and she remained composed, professional, and supportive throughout. Her ability to maintain kindness and clarity under pressure was especially commendable.

I am nominating Nicole for a Star Award because she exemplifies the qualities of an outstanding midwife and colleague. This is made even more impressive by the fact that she is a Band 5 on her first rotation. Her dedication, professionalism, and natural aptitude for midwifery make her truly deserving of recognition.

Victoria Pattison, Healthcare Assistant **Scarborough** **Nominated by colleague**

Vicky is an absolute star who strives constantly to do her own job, while also offering support to colleagues when needed. She encourages and supports new starters, whether they be healthcare assistants or student nurses, imparting her knowledge, experience, and encouragement upon them. She never hesitates to support any member of the ward staff who needs it, in whatever way it is needed - a simple chat, a few words of encouragement and support, or just simply being the 'light that shines'. She is a true example of our Trust values and is worthy of recognition.

Diabetic Retinal Screening Admin Team **Community** **Nominated by colleague**

I am putting forward the team for this award as they have all worked hard in unforeseen circumstances. They have gone above and beyond and shown professionalism, strong teamwork, care, and support for each other and patients, while learning new skills along the way. How the team demonstrates the Trust values:

- Kindness: Treat everyone, patients and colleagues alike, with compassion, respect, and warmth
- Openness: Communicate clearly and work collaboratively within the existing structure
- Excellence: Deliver safe, efficient, and high-quality care while maintaining confidentiality

The team's professionalism, teamwork, and patient-centred approach make a real difference to both colleagues and patients.

Labour Ward **Scarborough** **Nominated by relative**

I would like to express my thanks to the Labour Ward staff at Scarborough following the birth of my granddaughter. The care my daughter received from everyone was outstanding, and the support given to her partner and me as birthing partners was so welcome. I would particularly like to thank the following people:

- Kim for the care, support and reassurance given to us when my daughter first arrived on the Labour Ward. I'd also like to thank her for the kindness she showed her during a visit to triage a few weeks earlier, which made such a huge difference to my daughter and her partner
- Leah, who supported us for the duration of her shift and stayed well after she was due to finish to deliver my granddaughter. A true professional who looked after us with care, kindness, empathy and humour
- Esther for her wonderful aftercare

Thank you all for the care shown to my daughter while she was delivering her daughter. You helped to make this experience special and memorable, and I am so grateful.

Committee Report

Report from:	Resources Committee
Date of meeting:	17 March 2026
Chair:	Helen Grantham

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

ALERT

- **Year-end operational performance**
  - As previously reported, the originally planned year-end trajectories relating to cancer, diagnostics and referral to treatment would not be met, however, it was anticipated that performance was on track to meet the revised trajectories for cancer and diagnostics (updated from 1 March 26). Whilst small improvements seen in RTT it remains behind the revised trajectory.
  - There was some significant improvement, particularly in diagnostics and cancer performance, diagnostics being key to meeting cancer and treatment targets – with referral to treatment performance remaining the most challenging area.
  - The Committee discussed the need for accurate planning and reporting to demonstrate progress and secure assurance.
- **Digital**
  - NHS England approval had not yet been received to progress with the launch of Nervecentre and it was unclear when this would be obtained. Implementation and associated benefits had been built into the 2026/27 plan and there would be an impact of the delay and additional costs which will need to be mitigated.
  - Digital robots, 'Esther' and 'Iris', had been introduced to support recruitment and assignment code creation (through Robotic Process Automation), aiming to reduce workload for line managers and improve efficiency.

ASSURE

- **Urgent and emergency care – focussed review**
  - A focussed review was provided to assure the Committee that a credible and deliverable recovery plan is in place for urgent and emergency care ahead of the start of the 2026/2027 planning year
  - Details of short and long-term actions were provided along with the challenges faced across the York and Scarborough sites (increased demand, bed availability, financial constraints, workforce challenges

and level of diagnostic requests) and risks and mitigations to achievement
  - The proposed plan has been developed by Trust colleagues working in the UEC (being shaped by NHSE preferred acute model of care)
  - Recent changes to the "front door" model of care had shown positive initial signs and, assuming this was sustained, Q1 ECS trajectories should be met
  - A more detailed plan was being developed (available in April 26) and the Committee requested that it receive additional information so it could
  - understand expected actions and impact on performance and monitor this over time. An update was provided on the governance processes and oversight of the plan.
  - Priority actions include close monitoring and refinement of the new acute model, preparation for further reconfiguration of the medical and surgical bed base, re-procurement of Urgent Treatment Centre services to strengthen performance and accountability, continued improvement in discharge processes (including Trusted Assessment Forms and length of stay reduction), and deeper collaboration with system partners to address demand and admission avoidance.
  - The strong improvement over recent months in ambulance handover was noted and this continued to be sustained. Discharge was also improving.
- **Embedding culture, leadership and behaviours**
  - A focussed review was provided on work to embed a positive and empowering culture within the Trust and to improve leadership and behaviours
  - The NHS Management and Leadership Framework would support in identifying and addressing development needs and would work alongside the Trusts own work as part of *Our Voice, Our Future,* which was co-created with our Change Makers. The importance of considering values in recruitment and development/appraisal conversations was discussed.
  - While there remained more to do, the recent colleague survey measures linked to this area had seem some improvement
  - upcoming activity was noted and the Committee requested further details of the plan including timelines, responsibility, expected outcomes and how success would be measured and could be monitored by the Committee
- **Staff Survey Results**
  - The Committee was updated on the nationally benchmarked 2025 Staff Survey results and proposals for improving colleague experience further.
  - The survey response rate significantly increased in 2025 meaning the results are more representative of the whole workforce, and the response rate is above the peer average for the first time since 2018.

- The scores by People Promise element/theme have all improved slightly and the importance of moving to positive improvement following several years of decline was discussed
- The team were realistic that there was more to do, with the Trust still below the peer group average in a number of key areas
- The key risks, opportunities and concerns were discussed – in particular how embedding a continuous improvement model could support progress
- More detailed plans were being produced to address issues highlighted – a focus on a small number of key areas to drive impact was planned – change makers, colleague networks and unions would be engaged to co-create the plans

- **Equality Delivery System**
  - A report was received providing a high-level overview of the Trust's performance against the NHS Equality Delivery System (EDS) 2022 for 2025/2026, which is an equality improvement tool comprising eleven outcomes spread across three Domains, which are:
    Domain 1 Commissioned or provided services
    Domain 2 Workforce health and well-being
    Domain 3 Inclusive leadership
  - The 2025/26 review has demonstrated improved accessibility, patient experience and feedback regarding workforce health and well-being; strengthened safety and governance; continued progress on inclusive leadership. The Trust has identified areas of improvement through internal and external engagement.
  - The Organisational Rating for 2025/2026 is 'Developing'.
- **2025/2026 Financial Plan**
  - An update was provided on performance against the revised 2025/26 financial plan as proposed to NHSE and in particular progress of the cost-improvement programme. The Finance Director was confident of delivery of the revised plan
  - A review of the capital plan was undertaken and it was expected that the year-end position would be in line with plan
- **2026/27 WRAP**
  - The Committee received an update on the WRAP progress for 2026/27.
  - Plans had been identified totalling £47.2m of the £54.6m target for the year
  - An explanation was provided of how projects to meet the improvement gap (£7.4m) would be identified
  - The approach to monitor performance on a month-by-month basis, with clear accountabilities, was shared and where performance was not in line with expectations clear plans to get back on track would be expected. Robust governance was being put in place and the Committee would be provided with relevant information so it could track performance on a month-by-month basis and seek assurance on mitigating action if performance was off track. The Committee

were shown the WRAP Tracker and how it was being populated, how it provided a single point of truth analysis and how the various reporting dashboards and actions were integrated. The methodology being used was being shared with other teams so that best practice could be implemented in operational areas
    - An update was provided on the work being undertaken by KPMG and their output to date. The Committee would be provided with a report when the work had concluded.
- The regular **Nursing Safer Staffing Report** was presented, and it was noted that the Trust continued to meet the national requirements for safer staffing reporting. There was an improving picture relating to workforce fragility, particularly with healthcare support worker vacancies, although fill rates had declined slightly with a slight increase in red flags. The picture was anticipated to improve as winter pressures subsided.
- Following a request at the February meeting, a paper was presented on the increase in **sickness levels** and the action being taken across the Trust to support colleagues who were experiencing sickness, as well as the wellbeing offering to support colleagues to remain well at work. Reduction in sickness absence is a key priority for the Trust. Variances across the Trust workforce were noted and discussed.
- **Sustainability Q4 Report** – A positive written report was received on sustainability – this area was well managed (with governance framework noted), there was some leading practice being undertaken by the Trust and good partnership working. The Trust also had some good success in bidding for funds to support the Trust's Green Plan. This was an area where the Trust had a legal obligation to meet targets by 2032. The Committee confirmed its support for the ongoing work.
- The Committee reviewed and approved its **annual report and effectiveness review** and terms of reference which would be presented to the Board. A discussion took place on the areas where there was some variation in the survey responses. It was planned to add a specific agenda item to ensure that the Committee reflected on the meeting – what went well and what could be improved.

ADVISE
- **Financial reporting** – as requested at the previous meeting, the Committee continued to engage with the Finance team on the best approach to reporting on financial performance and cost improvement so that the Committee could track performance monthly and understand corrective actions when performance was off track projects - **Committee papers** – feedback was provided on the content of papers and how these could be improved. Executive summaries were good in many, but not all, areas and engagement continued on ensuring plans presented to the Committee were clear on actions, impact, responsibilities, timelines, etc, which

would enable the Committee to monitor performance against plans as the 2026/27 year progressed.

- **YTHFM** – consideration of the YTHFM Business Assurance Report was delayed due to unavailability of colleagues. This was deferred to a future meeting
- **Work plan** – The 2026/27 work plan for the Committee was being worked up and would be available for discussion at the next meeting.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- No new risks identified
- See above for risks discussed

Committee Report

Report from:	Group Audit Committee
Date of meeting:	10/03/2026
Chair:	Jane Hazelgrave

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

ALERT

- Eleven internal audit reports have been issued to the Group since the last meeting. Four with significant assurance and seven with a limited assurance rating (see below).

ASSURE

External Audit

- An update was provided on the work plan for the 2025/26. Interim audit work commenced in March with no issues to report. There are no new accounting standards, and it is expected that the audit will be completed in line with the plan.
- In terms of the VFM assessment there is no change to the scope and methodology from last year.
- A materiality threshold has been set at £18.4m.

Internal Audit.

- **YTHFM.**

No recommendations were overdue; 31 recommendations have been completed.
Five reports have been issued since the last meeting. Two with significant assurance: Premises Assurance Model risk assessment and Business Continuity. Three with a limited assurance rating: Minor works, Cleaning standards and Management of stores.

- **Trust**

Eight recommendations were overdue.
Six reports issued to the Trust since the last meeting.
Two reports received significant assurance: Risk Management and Board Assurance Framework
Four reports were issued with a limited assurance rating: New Starters, Management of water, Manual handling risk assessment, Medical Agency.

- The IA plan for 2026/27 was approved for both the Trust and YTHFM with 8 less days than 2025/26 at 744 days.

- A thematic report was presented grouping the reason for all existing IA recommendations. There were 2 categories, the top 3 reasons were :Oversight and Accountability, Policies and Procedures and Compliance with Policy.

- A benchmarking report of Board Assurance Framework and Risk Management audits has taken place across all clients, and a report was presented setting out the key findings.

Fraud

An update was provided on work undertaken since the last meeting, 89% of planned days have been used.
Of the 60 recommendations suggested by the NHSCFA to help demonstrate that an organisation has effective processes and measures in place to combat the potential of being prosecuted under this offence continues to be worked on. There are currently 54 green ratings, six amber ratings and no red ratings.
A plan for next year was agreed. A reduction of 5 days (3%) to 160 days was approved.

Other items

- The Chief Nurse attended the meeting and provided assurance about the progress on actions attributable to her. There are no issues to escalate.

- A report on tender waivers was produced for YTHFM and the Trust. The period covered November 2025 to January 2026.

- A report was presented with regard to the Group Audit Committee Annual Report and Effectiveness review. Only 1 score out of 32 dipped below an average score of 3 which is a positive outcome. This will also be reported to the March Board of Directors.

ADVISE

Governance

A discussion took place about the terms of reference and the role and function of the committee with regard to the Trust overall system of assurance and risk management.

It was confirmed that work associated with the external Well Led review would help to inform how the system of risk management including the utilisation of the risk register and BAF was covered by committees and the Board in future.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
There are no new risks to escalate to the Board.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 13

TRUST PRIORITIES REPORT

March 2026

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NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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"):

- Workforce - Twelve month rolling turnover rate Trust (FTE).
- Workforce – Total Agency Whole Time Equivalent Filled.
- 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 - RTT – Total Waiting List.
- Operational Performance - RTT – Proportion of incomplete pathways 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.

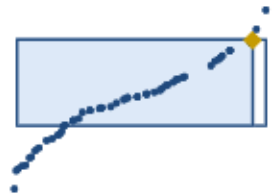
Information of the Trust's **National Operating Framework (NOF)** performance is included. The page provides the Trust's overall ranking and position nationally against each of the 22 metrics at the end of Q2. Q3 will be published as soon as possible after all official operating statistics for the quarter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

National Operational Framework
Rank Oversight

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

OPERATIONAL ACTIVITY AND PERFORMANCE

March 2026

Executive Owner: Claire Hansen

Summary Position

Performance across Urgent & Emergency Care, Cancer, RTT, Diagnostics, Outpatients, CYP and Community Services continues to face significant, system-wide pressure, driven by persistent diagnostic constraints and critical workforce gaps. These challenges are limiting the Trust's ability to stabilise patient flow and deliver recovery trajectories. Nevertheless, targeted mitigations are being deployed at pace, and several services are beginning to show early, measurable improvement.

ECS performance remains below trajectory, driven by high attendances, ambulance conveyances, and long stays. Flow is constrained by high bed occupancy and delayed discharge; however, MaDE events and strengthened escalation processes have delivered early improvements. New models of care (EEMAC and EAU) launch in March, these represent a different phase of the urgent care pathways, supporting patients after initial ED assessment and/or treatment, where further same-day care or senior decision-making is needed. This will have positive impacts on the front door ED assessment process including 4 hour and 12 hour metrics.

Cancer performance for FDS and 62-day standards remain off trajectory, the drivers include diagnostic delays, dermatology referral surges, FIT compliance issues, and pathway bottlenecks. Recovery actions active across colorectal, urology, gynaecology and skin, including expanded proformas, haematuria STT, GP engagement and super-Saturday clinics. High referral volumes and diagnostic limitations remain critical risks.

The RTT waiting list (TWL) reduced but remains behind trajectory, drivers include significant referral growth during the first half of the year and CPD logic changes. However, zero RTT65 week waits was delivered for the first time post. Trust delivering NHSE sprint-funded activity; validation, scheduling discipline and intensive specialty support programmes underway.

Outpatient productivity remains strong compared with peers, PIFU rates remain below plan and further work with team to accelerate improvements being identified, the Trust DNA rate improved to 4.4%.

Diagnostics DM01 performance improved to 77.5%, the highest since Feb 2020, though still below required standards. Long waits reducing, driven by insourcing, MRI GA lists, additional echo capacity, and backlog-focused clinics. Key risks include workforce shortages, equipment breakdowns, audiology capacity delays and continued prioritisation of cancer fast-track patients.

Executive Owner: Claire Hansen

Overall whilst targeted mitigations are underway, recovery remains fragile and the priority is to stabilise demand, implement key improvement projects and delivering the additional capacity approved through the Q4 sprint improvement funding for RTT and Cancer.

Key Risks (Cross-cutting)

- Rising UEC demand and ambulance conveyances.
- National workforce shortages (radiographers, echocardiographers, audiologists, SLT).
- Diagnostic capacity and equipment issues.
- High dermatology referral volumes and FIT non-compliance impacting Cancer.
- Community capacity limits affecting flow and discharge.
- Capital project and estate constraints (CDC build, RAAC, MRI/CT replacement).

Strategic Priorities (Q4 and Year-End)

1. Reduce 12 hour stays and improve patient flow through Multi Agency Discharge Events, discharge readiness reform and new models of care (EEMAC and EAU) launch in March, providing new next step pathways expected to improve 4- and 12-hour performance..
2. Increase Cancer and Diagnostics capacity via insourcing, imaging expansion, and FIT compliance improvement
3. Maintain RTT recovery momentum, delivering NHSE sprint-funded activity and focus on chronological scheduling
4. Support staff safety, morale and core clinical standards as winter pressures continue.
5. Stabilise community capacity and reduce therapy backlogs

For information, comparison against Model Hospital peer group where available is included in performance slides.

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.

Operational Activity and Performance
Chief Operating Officer Report

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Metric	February position vs plan	Key Mitigations – Next three months	Expected trajectory
Urgent & Emergency Care	ECS performance 64.5% vs 74% trajectory. Average Ambulance Handover ahead of trajectory. Long stays reduced; 12 hr waits 14.7% (behind 12.8% trajectory). Flow constrained by high occupancy, staffing and community capacity.	Multiple community partners are developing a joint action plan which aims to reduce conveyances of low acuity (CAT3 – CAT5) patients and reduce conveyances from Care Homes. New acute model of care to be launched in March 2026. Extended Emergency Medicine Ambulatory Care – EEMAC – will be the SDEC for ED. It is a pathway for patients identified at initial assessment as needing a longer period of investigation, observation or treatment but expected to be discharged from ED the same day. 100 day Sprint at Scarborough (Jan–Mar) including Super Discharge Team.	Improvement expected when EEMAC launched. Full recovery dependent on wider system demand management and community discharge capacity.
Cancer FDS/62 day	FDS 58.8% vs 73.8% trajectory; Trust ranked 115/119 nationally (Dec 25). 62-day 66.4% vs 70.4% trajectory. Trust ranked 106/119 nationally (Dec 25). Diagnostic performance, in particular endoscopy and imaging is impacting faster diagnosis performance due to delays in diagnostic pathways.	Frailty pathway expanded and new colorectal proforma launched by cancer alliance with ICB, alongside referral appropriateness and emphasis on FIT results accompanying. STT CT model in haematuria commenced implementation 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 56,641 (off plan). <18w: 54.7% vs 59.5% plan; Trust ranked 102/118. 52-week waiters improved to 1,253. GP Referral growth +1% YTD, CPD logic changes increased RTT clocks from Q1.	Validation sprint; WLIs & insourcing in key specialties. Intensive support programmes (Cardiology, Respiratory, Gastro). Pathway redesign (breathlessness, sleep, pipelle). RTT NHSE Sprints in progress for Q4.	Improvement expected Jan–Mar. Working to revised trajectories linked to NHSE Sprints.
Diagnostics	DM01 77.5%, 3.2% below plan, improvement from January. Impact from MRI workforce shortages, CT3 removal, mobile breakdowns, NOUS MSK backlog, audiology staffing gaps.	Extended endoscopy insourcing; ring fenced surveillance room. Additional capacity available in York and EC echo inpatient area to recover outpatient backlog in February. Continue insourcing/outsourcing and mobile solutions to address backlogs. CT - Higher Support Worker funding secured to establish post in York (already in place at Scarborough) by end of March 2026.	Improvement through Q4 but recruitment and equipment risks remain.
Outpatients	PIFU 4.2% vs 4.9% trajectory. RACP 14-day performance 83%, improving but below 99%. DNA rate reduced to 4.4%% (national average 5.6%). Digital letters live with pilot group.	"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. CYP EC improved to 87.5%	The introduction of the new model of care for adults should reduce congestion in departments which may lead to more timely assessment of children. This will be monitored closely at the point of go-live. 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 impacted by workforce shortages. Demand–capacity mismatch persists across therapy services.	SLT; Additional WTE mitigation included in 2026/27 plan. Tests underway around H@H in ED, SDEC and Selby.	Large strategic change required with low confidence for Q4.

Operational Activity and Performance

Acute Narrative

York and Scarborough Teaching Hospitals NHS Foundation Trust

Headlines:

- The February 2026 Emergency Care Standard (ECS) position was 64.5%, against the monthly planned improvement trajectory of 74%. **ECS performance is a True North metric.** In the latest available national data (January 2026) the Trust ranked 99th out of 118 providers and 11th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group.
- Average ambulance handover time in February 2026 was ahead of trajectory at 19 minutes 39 seconds against trajectory of 35 minutes 57 seconds.
- 14.1% of Type 1 patients spent over 12 hours in our Emergency Departments during February 2026, behind the monthly improvement trajectory of 11.7%. In the latest available national data (January 2026) the Trust ranked 108th out of 118 providers. **This is a True North Metric.**
- In February 2026 , the proportion of patients in our care who no longer meet the criteria to reside was 14.7% behind the internal trajectory of 12.8%.
- The average non-elective Length of Stay (LoS) acute for patients staying at least one night in hospital was 7.5 days during January 2026 (3,795 spells of care covering 28,425 bed days). Please note, this metric was modified from January 2026 onwards to correctly match the national guidance on how to calculate (all Trust sites which make up the spell have been included with maternity spells removed).
- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) was 86.4% (3,167 patients out of 3,667), behind the trajectory of 87.1% 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 4.1 days, ahead of the submitted trajectory (4.2 days).

Factors impacting performance:

- Signs of improvement in 4hr and 12hr performance could have been supported by the MaDE events that took place in February 2026. A full evaluation is underway.
- There are ongoing community health and social care constraints causing delays to discharges for patients requiring onward care.

Actions planned in March 2026:

- We are launching two new pathways at each Emergency Department in March 2026. These have been developed using new national guidance and we are anticipating an increase in ECS and 12 hour performance as soon as they launch. Daily and weekly monitoring will be in place to check for any unintended negative impact and a continuous improvement methodology approach will be taken.

- We care completing our 100-day Sprint with NHS England in March 2026; the focus is on decreasing length of stay on Oak Ward and early data suggests positive results.

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 - A&E Attendances - Types 2 & 3 - Declared Position * ED - Proportion of Ambulance handovers waiting > 45 mins
COMMON CAUSE / NATURAL VARIATION		* ED - Emergency Care Attendances - Declared Position * ED - A&E attendances - Type 1 - Declared Position	* ED - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - 12 hour trolley waits - Declared Position * ED - Emergency Care Standard (Trust level) - Declared Position * ED - Emergency Care Standard (Type 1 level) - Declared Position
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	2026-02	H		79.9%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2026-02			27.3%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-02		F	14.1%	11.7%	8.9%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2026-02			1456		
ED - 12 hour trolley waits - Declared Position	2026-02		F	406		0
ED - Emergency Care Attendances - Declared Position	2026-02		?	16508	14857	16377
ED - Emergency Care Standard (Trust level) - Declared Position	2026-02		F	64.5%	74%	78%
ED - A&E attendances - Type 1 - Declared Position	2026-02		?	10322	9978	10999
ED - Emergency Care Standard (Type 1 level) - Declared Position	2026-02		F	45.6%	63%	69.2%
ED - A&E Attendances - Types 2 & 3 - Declared Position	2026-02	L	F	6186	4879	5378
ED - Median Time to Initial Assessment (Minutes)	2026-02	L		4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-02			44.3%		

Summary MATRIX 2

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

MATRIX KEY

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

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

Acute Flow (2)
Scorecard

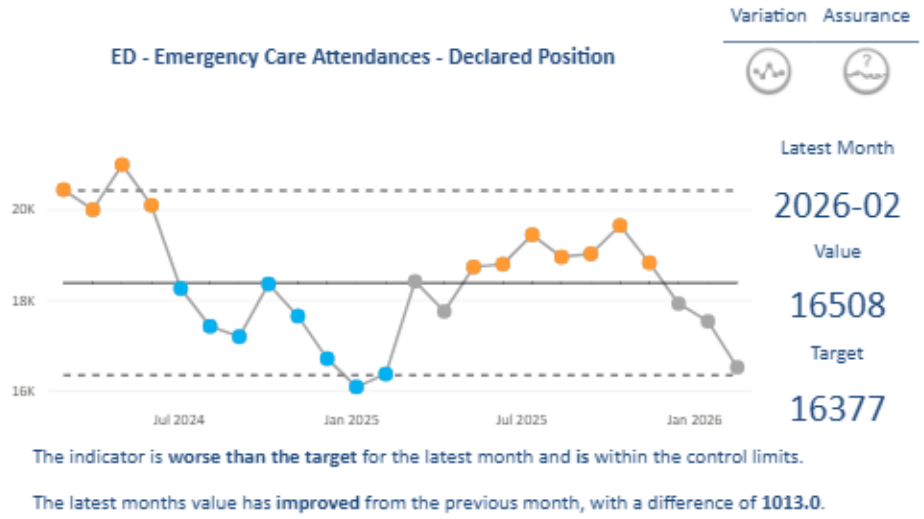
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-02			44.3%		
Number of SDEC attendances	2026-02			2469		
Proportion of SDEC attendances transferred from ED	2026-02			70.2%		
Proportion of SDEC attendances transferred from GP	2026-02			23.2%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2026-02	H		68.1%		
Proportion of SDEC admissions transferred to downstream acute wards	2026-02			14.9%		
Number of RAFA attendances (York Only)	2026-02			115		
Number of attendances at SAU (York & Scarborough)	2026-02	H		934		
ED - Proportion of Ambulance handovers within 15 mins	2026-02	H		39.9%		
ED - Proportion of Ambulance handovers waiting > 30 mins	2026-02	L		14.8%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2026-02	L	F	1.8%		0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2026-02	L	?	0%		0%
ED - Number of ambulance arrivals	2026-02			4476		
ED - Ambulance average handover time (number of minutes)	2026-02	L	?	20	35	29

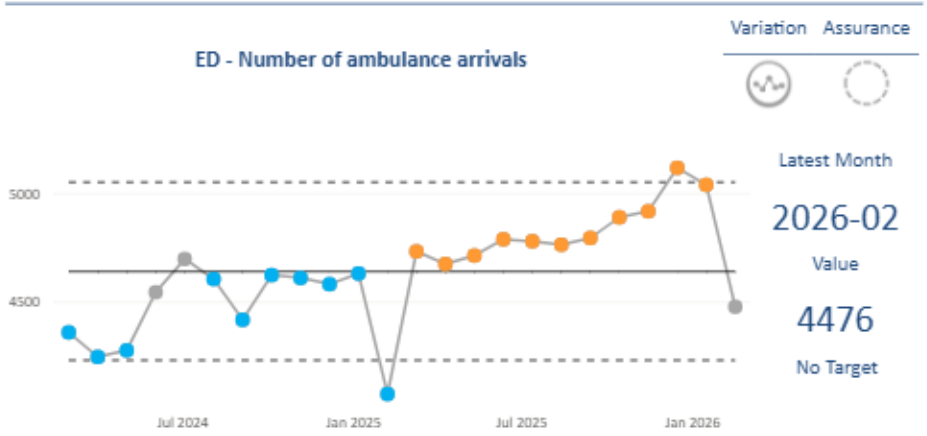
Executive Owner: Claire Hansen

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 **1013.0**.



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

The latest months value has **improved** from the previous month, with a difference of **562.0**.

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?

Multiple community partners are developing a joint action plan which aims to reduce conveyances of low acuity (CAT3 – CAT5) patients and reduce conveyances from Care Homes.

The Trust's lead for Health Inequalities is working with Primary Care Networks to explore crossover with the health inclusion agenda and high intensity users. Secondary care data on ED attendances and non elective admissions is being shared with GP practices as they start to identify their neighbourhood patient caseloads.

What is the expected impact?

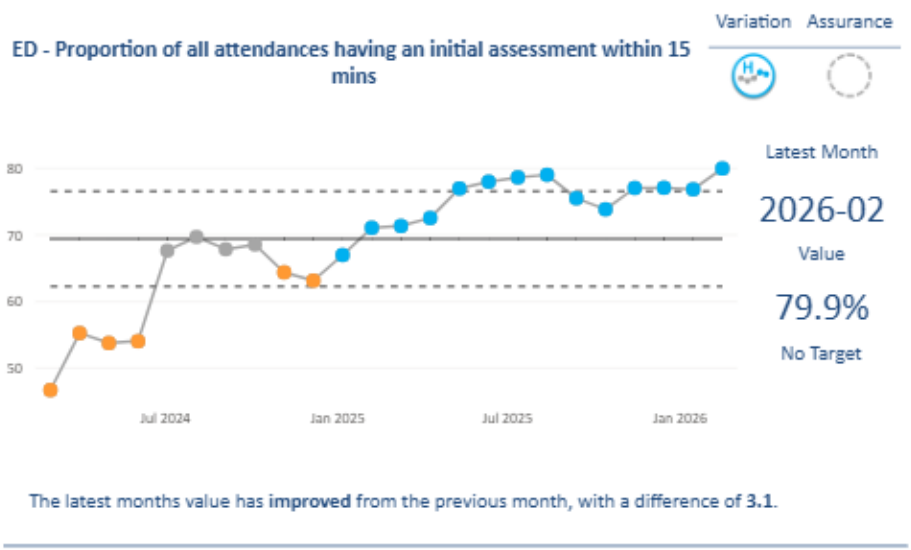
Increasing use of non-ED pathways may reduce or slow the increase of ambulance arrivals and attendances.

Potential risks to improvement?

Reducing conveyances and attendances depends on supporting patients and system partners, including YAS and care homes, to consistently access and use the most appropriate alternative care pathways.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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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 continues to hold improvements made in spring.

As both sites introduce a new acute model of care in March 2026, one of the key metrics that will be closely monitored is the time to initial assessment.

What is the expected impact?

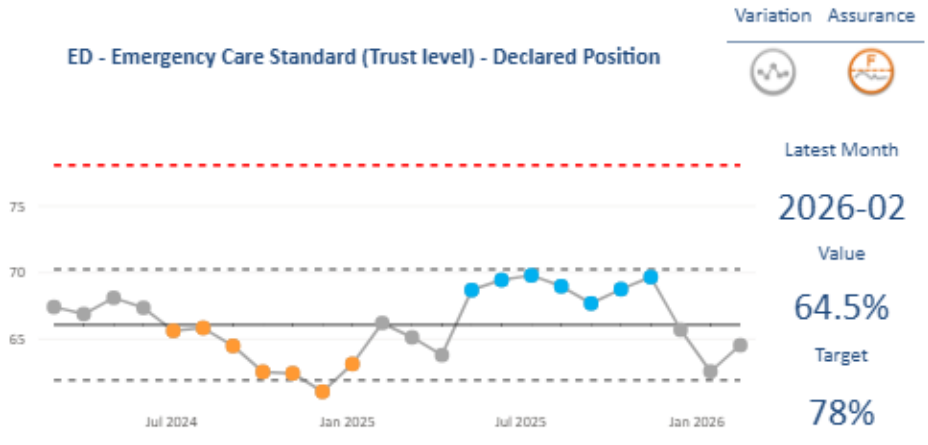
There may be a short period of disruption around the initial launch of the new model of care in March 2026 while teams working within our Emergency Departments adjust to new ways of working. This will be monitored through daily check-in calls and there will be additional senior staff in the department at the time.

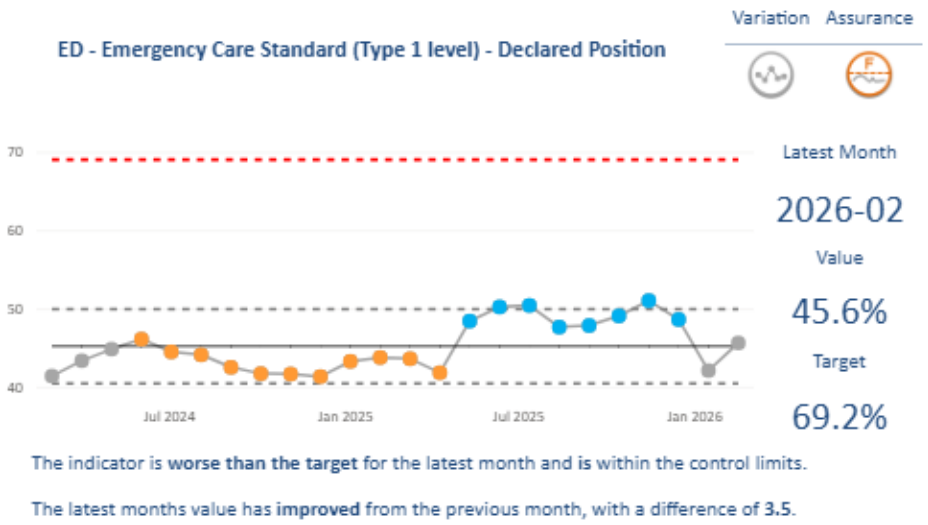
Potential risks to improvement?

- 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?

In March both sites are implementing the first phase of the new acute model of care, which affects pathways in the Emergency Departments.

Extended Emergency Medicine Ambulatory Care – EEMAC – will be the SDEC for ED. It is a pathway for patients identified at initial assessment as needing a longer period of investigation, observation or treatment but expected to be discharged from ED the same day. New national guidance supports the implementation of EEMAC as an off-clock area.

Emergency Assessment Unit (EAU) will be a pathway for patients needing further assessment to help determine whether an admission is required or not; and if so, to which specialty. It will be led by Acute Physicians with support and input from Elderly Medicine and Emergency Medicine. Many patients waiting for admission to the main bed base will do so under the care of the EAU team.

What is the expected impact?

We expect our ECS performance to increase, by at least 4%.

Potential risks to improvement?

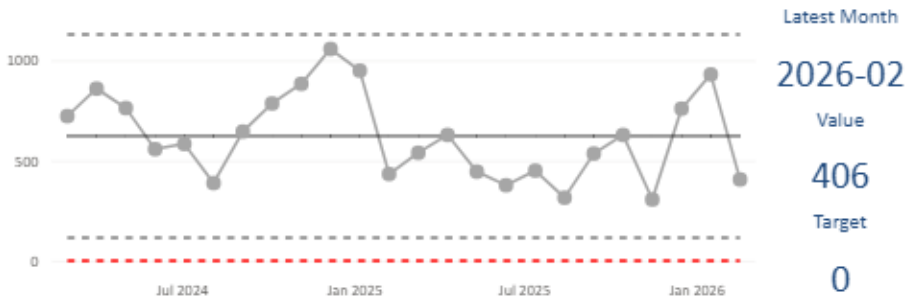
- High attendance levels likely to continue based on recent trends
- Continuation of an increase in ambulance arrivals
- High staff sickness levels – both in our Trust and community primary care
- Financial constraints could jeopardise the long-term workforce plan required to maximise the impact of the model.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

ED - 12 hour trolley waits - Declared Position



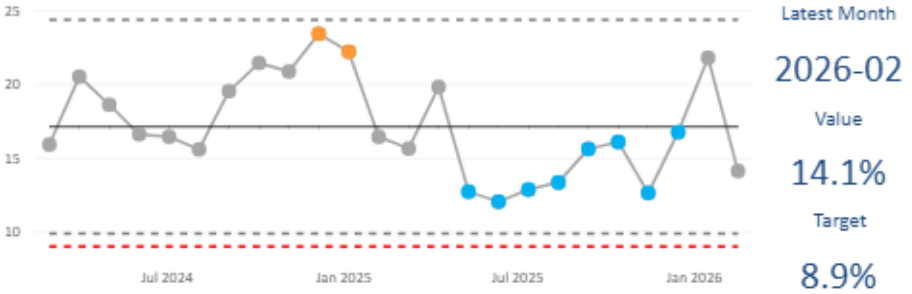
Latest Month
2026-02
Value
406
Target
0

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

The latest months value has **improved** from the previous month, with a difference of **524.0**.

Variation Assurance

ED - Total waiting 12+ hours - Proportion of all Type 1 attendances



Latest Month
2026-02
Value
14.1%
Target
8.9%

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

The latest months value has **improved** from the previous month, with a difference of **7.7**.

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?

The MaDE weeks at both sites in February supported improved flow out of both EDs and reduced the proportion of 12 hour waits.

Escalation processes at each site have been reviewed and the Quality Improvement team is supporting teams to update them in line with the new model of care implementation due mid-March 2026.

When the new model of care is implemented, medical patients awaiting admission to hospital will be managed in the Emergency Assessment Unit by Acute Physicians and will receive timely senior reviews.

What is the expected impact?

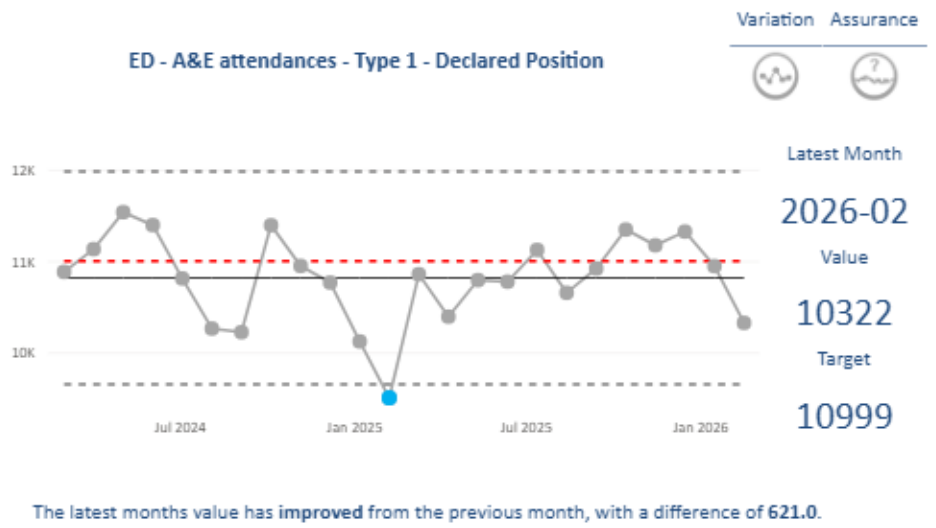
Both sites should see a significant reduction in 12hr breaches in March 2026.

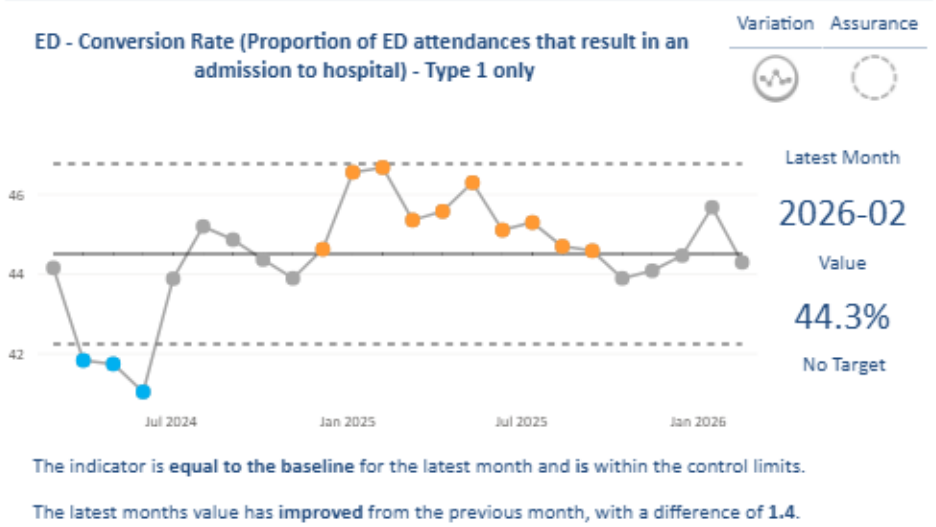
Potential risks to improvement?

Bed occupancy levels remain high and there is a risk that the level of required capacity on wards is higher than escalation spaces can support.
Community health and social care capacity remains challenged.
There is a risk that while the new model will reduce the number of patients waiting for 12 hours in our Emergency Departments, the wait will only transfer to the Emergency Assessment Unit which could quickly become full. To mitigate, all care groups and specialties must adhere to the Quality Standards.

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. Work is underway to increase appropriate use of SDEC, therefore increases may not be necessarily indicative of an issue.

What actions are planned?

The new model of care, being implemented in March 2026, will bring senior decision making closer to the front door and should support a reduction in the proportion of patients being admitted to the main bed base at both sites.

There will also be an additional senior medic overnight at Scarborough Hospital during March 2026 (non recurring). Again, this senior medic should be able to turn around some patients either to home or to an alternative pathway.

What is the expected impact?

A reduction in specialty admissions and increased use of SDEC including the new EEMAC pathway.

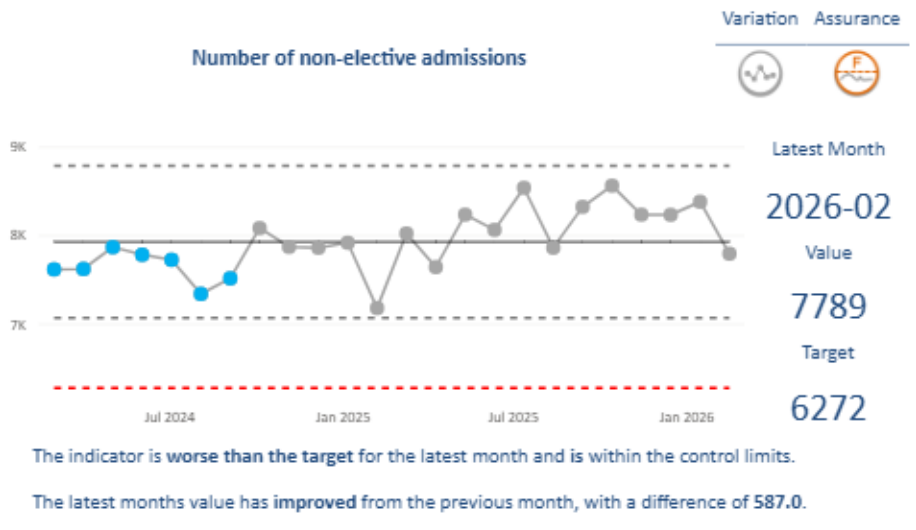
Potential risks to improvement?

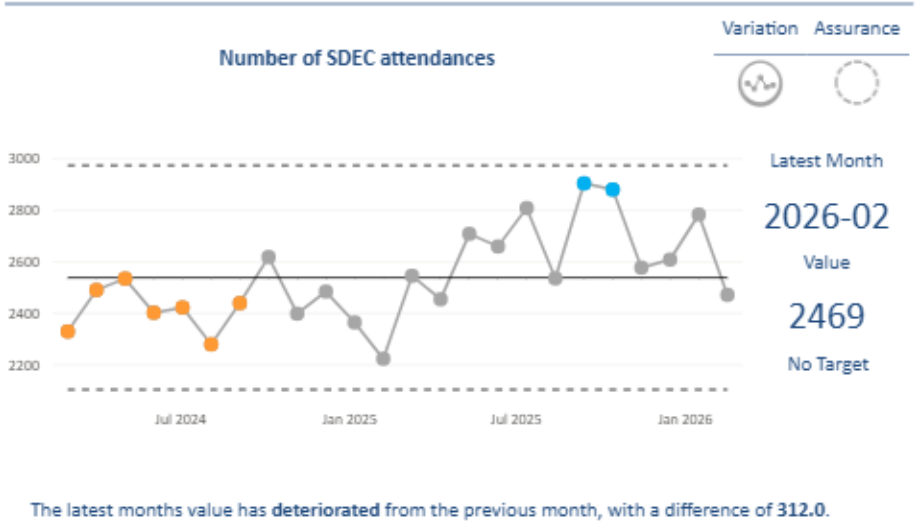
There is a risk that the volume of patients able to be turned around is lower than anticipated and has little impact on the total proportion of admissions.

There is an issue that the overnight doctor for Scarborough is temporary (to end March 2026). Medicine Care Group is progressing a request for additional recurring funds as outlined in the operational plan for 26/27 to address the overspend and capacity / demand gap.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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.

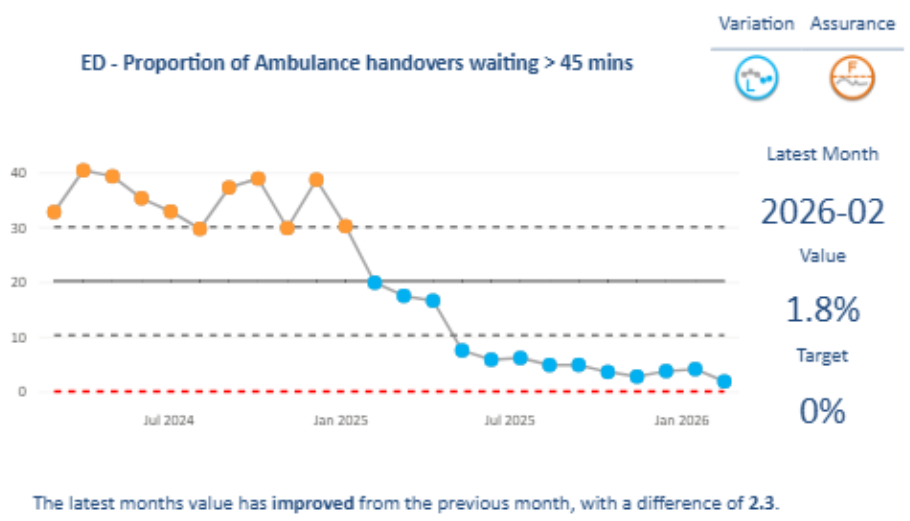
Note: The total admissions data includes admissions to all Same Day Emergency Care (SDEC) units. Work is underway to increase appropriate use of SDEC and reduce elective patients in SDEC, therefore changes in numbers are not indicative of quality.

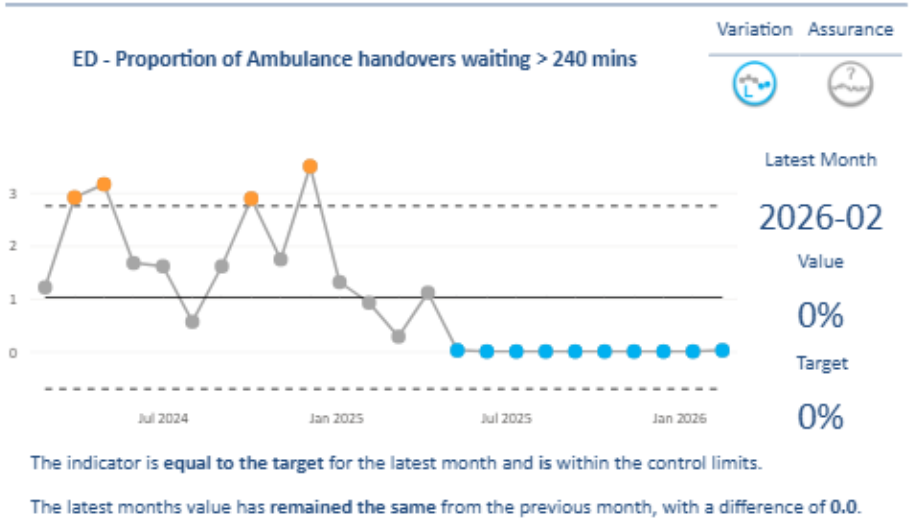
What actions are planned?

As per previous slide

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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?

The refreshed standard operating process for handovers at Scarborough has disseminated with the aim of more uniform practice across all shifts. Early indications are that this has been well received.

What is the expected impact?

We expect to sustain improvements in the timeliness of handovers and continue to work towards a lower average.

Potential risks to improvement?

- There is an ongoing issue that YAS timestamps cannot be amended even if both parties agree a recording was incorrect.
- Continually increasing number of ambulance attendances at both sites is causing congestion and risks delays to handover.
- There is a risk that implementing the new model causes temporary disruption to our Emergency Departments which could impact key performance indicators.

Acute Flow (3)
Scorecard

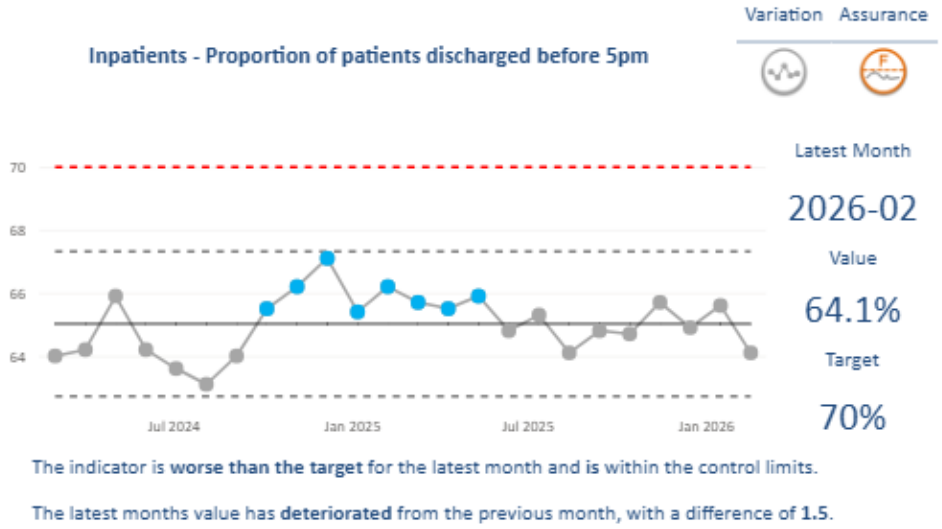
York and Scarborough Teaching Hospitals NHS Foundation Trust

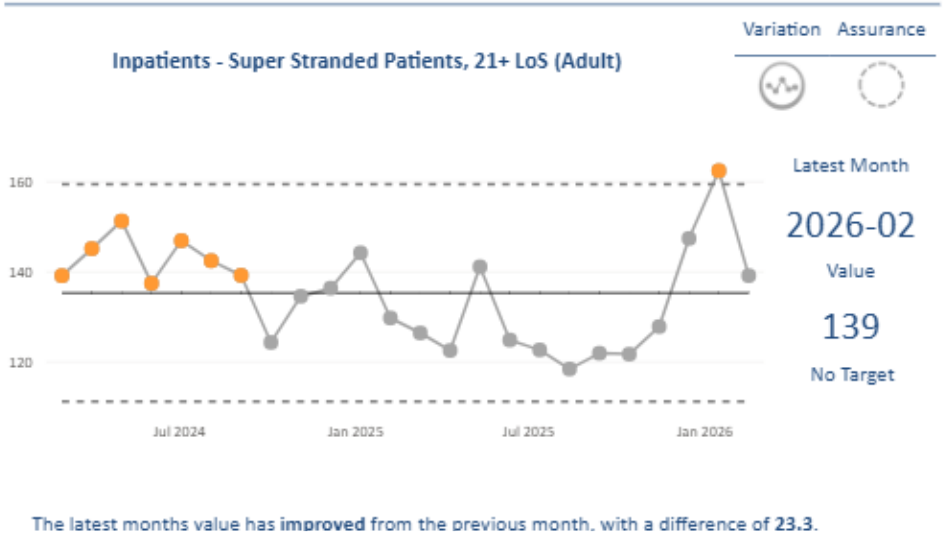
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2026-02		F	78.8%		90%
Patients with Senior Review completed at 23:59	2026-02			46.4%		
Inpatients - Proportion of patients discharged before 5pm	2026-02		F	64.1%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2026-02	H		1534		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2026-02	L	F	14.7%	12.8%	12.5%
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2026-02		?	4.1	4.2	3.9
Number of non-elective admissions	2026-02		F	7789	5777	6272
Number of zero day length of stay non-elective admitted patients	2026-02		?	2441	2268	2464
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2026-02			139		
Overnight general and acute beds open	2026-02		P	909	832	832
Of those overnight general and acute beds open, proportion occupied	2026-02		?	92.3%		92%
Community bed occupancy/availability	2026-02		?	94.4%		92%

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

Our 100-day Sprint project in conjunction with NHS England will conclude in March 2026. It focused on Super Discharge Team activities at Scarborough, with Oak ward a priority area and an aim of reducing length of stay through use of Super Discharge teams. Early data shows a positive trend.

The relaunch of York Discharge Lounge was delayed to the end of March. Significant targeted promotion of the service is planned, with distribution of information packs and stakeholder engagement meetings hoping to increase utilisation. The team will then produce a monthly pack with data and opportunities to improve early flow.

During the recent Multi-Agency Discharge Event (MaDE) the Medicine Care Group Director reviewed patients with a criteria to reside and a length of stay over 21 days. He found that almost all patients with a criteria to reside were appropriate to be in hospital. Following this review, a walk-around with the same purpose at York, and a visit to Airedale, the Long Length of Stay meetings are being reviewed again. The intention is to make these face-to-face rather than virtual in Q1.

What is the expected impact?

- Reduction in average length of stay on Oak Ward
- Increased use – and earlier use – of York Discharge Lounge

Potential risks to improvement?

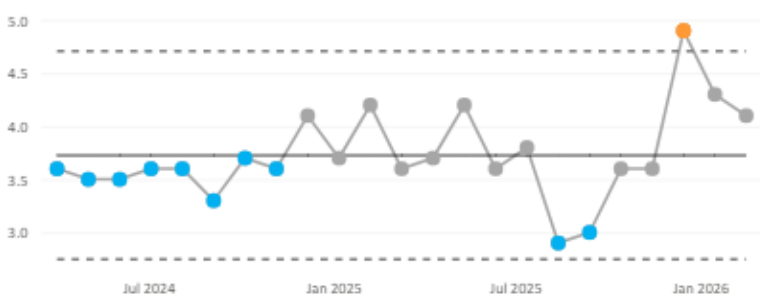
- More high acuity patients arriving to our hospitals, which could lead to longer lengths of stay.
- Limited community health and social care capacity to release patients no longer meeting the criteria to reside.

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



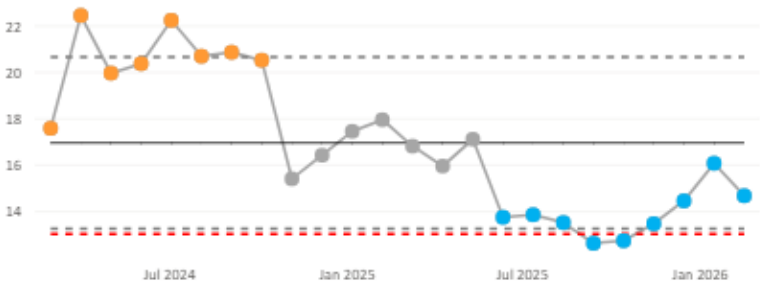
Latest Month: 2026-02
Value: 4.1
Target: 3.9

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

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

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

Variation Assurance



Latest Month: 2026-02
Value: 14.7%
Target: 12.5%

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

The latest months value has **improved** from the previous month, with a difference of **1.4**.

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?

The new partly automated Discharge Readiness Form (replacing Trusted Assessment Form -TAF) is delayed since it was directly linked to Nervecentre. Scarborough are continuing to trial a paper version during the interim.

A TAF-less transfer to Trust Inpatient Units has been trialed on Wards 35 for 7 weeks, the trial has been extended due to low numbers.

Discharge training has been delivered at Elderly Clinical Governance and Surgical Matrons and Ward Manager meeting. Further sessions to be delivered March/April as well as Learning Hub Module development.

Escalations continue through 2nd line and 3rd line (Director level) governance.

What is the expected impact?

Improved timeliness and quality of discharge

Potential risks to improvement?

- Sourcing complex packages of care remains a challenge which is escalated appropriately but not always possible to resolve.
- Social worker allocation is causing delays in the discharge process
- Care home assessments on wards causing delay to discharge

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 - Declared Position	* Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result
SPECIAL CAUSE CONCERN		* Cancer - 62 Day First Definitive Treatment Standard - Declared Position	* Cancer - Faster Diagnosis Standard - Declared Position

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 - Declared Position	2026-01	L	F	58.8%	73.8%	80.1%
Cancer - 62 Day First Definitive Treatment Standard - Declared Position	2026-01	L	?	66.4%	70.4%	75%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2026-02			175		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2026-02			7.7%		
Cancer 31 day wait from diagnosis to first treatment - Declared Position	2026-01		?	97.2%		96.1%
Total Cancer PTL size	2026-02	H		2353		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2026-02		F	74.6%	80.1%	80.2%

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

- The Cancer performance figures for January 2026 saw performance against the 28-day Faster Diagnosis standard (FDS) of 60.4%, failing to achieve the monthly improvement trajectory of 77.0%. In the latest available national data (December 2025) the Trust ranked 115th 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 January 2026 service standard was 62.8%, with the monthly trajectory of 70.4% not achieved. In the latest available national data (December 2025) the Trust ranked 106th out of 119 providers nationally and 10th 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 service standards and recovery actions, with a detailed cancer progress report taken to Resources Committee in February 2025. NHSE, ICB, Cancer Alliance and CAP have been sighted on Q4 recovery actions at tumour site level via Cancer and Diagnostic Tiering meetings.

Factors impacting performance:

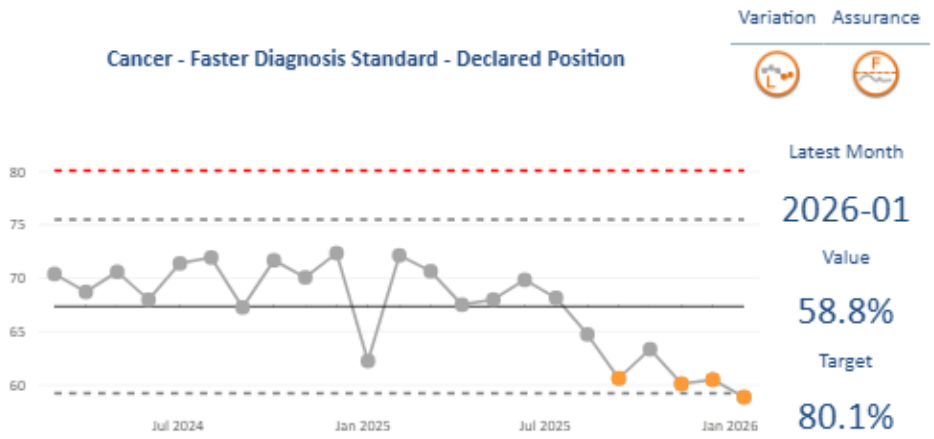
- The following cancer sites exceeded 80% FDS in January 2026: Breast & None Site Specific
- Gynaecology achieved above their internal trajectories.
- The following cancer sites exceeded 75% 62-day service standard in December 2025: Breast, Haematology & Skin
- Haematology, Skin & Urology achieved over internal trajectories.
- 31-day treatment standard was 97.2% overall, which achieved the national service standard of 96%.
- At the end of January, the proportion of patients waiting over 104+ days equates to 2.3% of the PTL size with 55 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, with Colorectal and Skin accounting for over 67% of this patient cohort.
- 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 was launched at end of December 2025 across Trust footprint to standardise referrals with enhanced place, ICB and cancer alliance comms to primary care. Process for rejecting referrals has been agreed and implemented and discussed in February 26 Colorectal Surgical Cancer Time Out session.
- 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 was implemented January 2026. Early data set shows 62% referrals are accompanied by image.

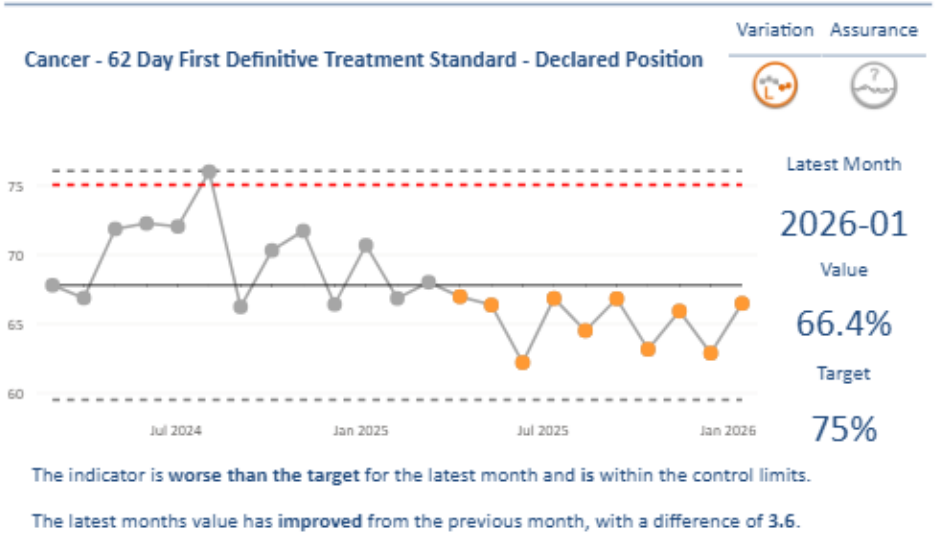
Actions:

- Please see following pages for details.

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 - Internal FDS trajectory of 70%. Frailty pathway expanded and new colorectal proforma launched by cancer alliance with ICB, alongside referral appropriateness and emphasis on FIT results accompanying. Weekend WLI's in endoscopy and FT clinic capacity with returning consultant. Colorectal cancer lead resignation, working through plans for recruitment of new lead.

Urology Plan- Internal FDS Trajectory of 56%. STT CT model in haematuria commenced implementation, however, capacity issues for consultant OPA and biopsies in January. WLI plans and insourcing to be worked through at pace.

Review of PSA pathway to understand opportunities for streamlining and efficiencies. Initial conversations taken place for scoping potential one stop prostate CDC models. Ongoing discussions for implementing standardised discharge post Likert score and scope and consult model for TP biopsy, with target start date of March 26, however workforce rota changes required alongside clinical governance review and support.

Gynaecology Plan - Internal FDS Trajectory of 53%. PMB pathway implementation on both sites, Pipelle commenced on York site in CDC,

Locum consultant on East Coast providing additional sessions to recover position, however lead clinician off for extended period. Arrangements made for consultant or CNS cover at MDT to present patients.

Skin – Internal FDS trajectory of 79%. 94% practices signed up with ICB LES, some require equipment (scopes) will be ordered within coming week. Accenda working on reporting functionality in Gateway to monitor compliance and asking for inclusion of prompt to GPs where requests are for skin lesion clinic types and do not include a dermatoscopic image.

Operational team undertaking super Saturday clinics in January and February to work through backlog of patients – there is an ongoing risk around team resilience and consultant availability, but two skin cancer consultants have been recruited.

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.

Potential risks to improvement?

- Disproportional impact of skin deterioration and Colorectal performance on trust position, with both significantly off trajectory.
- Volume of referrals significantly above planned activity, particularly primary care referrals
- Cancer performance dependent upon diagnostic capacity and recovery plans

Operational Activity and Performance

Referral to Treatment (RTT) Narrative

York and Scarborough Teaching Hospitals NHS Foundation Trust

Headlines:

- At the end of February 2026, the Trust had zero **Referral To Treatment (RTT) patients waiting over sixty-five weeks**.
- The Trust's **RTT Total Waiting list position** ended February 2026 behind the trajectory submitted to NHSE as part of the 2025/26 planning submission: 56,641 against the trajectory of 41,289.
- The Trust is behind the trajectory for the proportion of the **patients on an RTT waiting list under 18 weeks** at the end of February: 54.7% against 59.5%. In the latest available national data (December 2025) the Trust ranked 102nd worst out of 118 NHS providers and 8th worst out of 11 in our Model Hospital peer group. Revised March 2026 trajectory has been agreed with NHSE to deliver 60% of patients waiting less than 18 weeks for elective treatment. **This is a True North Metric.**
- The Trust is behind the **RTT52 week** trajectories submitted within the 2025/26 planning submission; 1,253 waiters and 2.2% of the total RTT Total Waiting list against the trajectories of 495 and 1.2%, respectively. In the latest available national data (December 2025) the Trust is ranked 79th worst out of 118 NHS providers and equal 5th 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 December 2025 there were 6,767,991 patients on the national TWL, of which 136,058 (2.2%) 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 59.5% against the end of February 2026 ambition to be above 66.2%. 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 contributed to the RTT TWL increase (up 8% in the first half of 2025/26), however Q4 to date has seen a reduction in GP referrals resulting in a YTD 1% rise (circa 1,100 referrals). Direct Cancer GP referrals (not including upgrades, incidental findings etc.) are up 11% YTD with ten of the eleven 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 February 2026 the Trust was ahead of the 2025/26 plan with a provisional performance of 102% against the funded ERF (excludes OP follow ups without procedure) plan.

Actions:

- Please see following pages for details.

Summary MATRIX

Referral to Treatment (RTT): *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* RTT - Waits over 78 weeks for incomplete pathways - Declared Position	* RTT - Waits over 65 weeks for Incomplete Pathways - Declared Position * RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Declared Position
COMMON CAUSE / NATURAL VARIATION			* RTT - Waits over 52 weeks for Incomplete Pathways - Declared Position * RTT - Proportion of incomplete pathways waiting less than 18 weeks - Declared Position * RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks
SPECIAL CAUSE CONCERN			* RTT - Total Waiting List - Declared Position

Referral to Treatment (RTT)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
RTT - Total Waiting List - Declared Position	2026-02	H	F	56641	41289	38992
RTT - Waits over 78 weeks for incomplete pathways - Declared Position	2026-02	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways - Declared Position	2026-02	L	F	0	0	0
RTT - Waits over 52 weeks for Incomplete Pathways - Declared Position	2026-02		F	1253	495	389
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Declared Position	2026-02		F	54.7%	59.5%	60.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2026-02	L		18.2		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Declared Position	2026-02	L	F	2.2%	1.2%	1%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-02		F	59.5%	66.2%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2026-02	H		2%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2026-02			12.3%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2026-02	H		68%		

KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

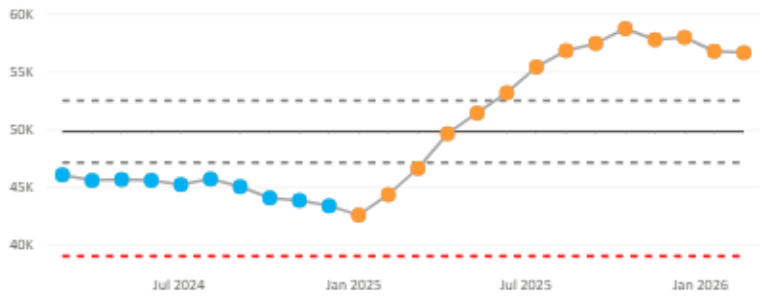
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

RTT - Total Waiting List - Declared Position

Variation Assurance



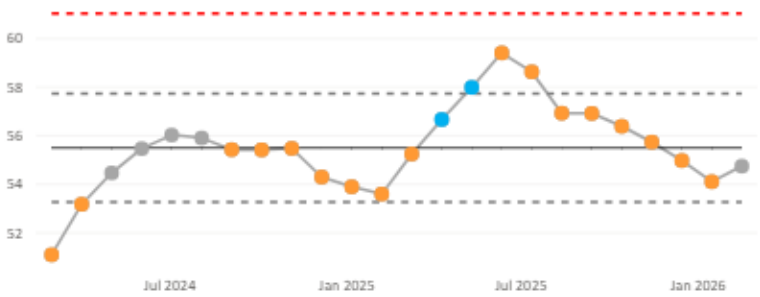
Latest Month
2026-02
Value
56641
Target
38992

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

The latest months value has **improved** from the previous month, with a difference of **130.0**.

RTT - Proportion of incomplete pathways waiting less than 18 weeks - Declared Position

Variation Assurance



Latest Month
2026-02
Value
54.7%
Target
60.5%

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

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

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 had sprint bids for 1st OP activity and 52-week FU and inpatient elective activity funding accepted by NHSE. 63% of the planned activity has been delivered or planned via WLIs & insourcing during Q4.
- Revised RTT trajectories accepted by NHSE for monitoring based on accepted bids.
- Intensive support programme for cardiology, respiratory and gastroenterology to commence February 2026 with corporate team supported by GIRFT/NHSE IST colleagues. Delayed from January due to operational pressures. Initial actions completed, focus on grip and control.
- RTT Priority clinics scheduled for gynaecology, ENT and Oral Surgery in March as part of an NHSE improvement project, impact to be assessed by end of March.
- Focused discussions to identify action to improve scheduling discipline and chronological booking ongoing with care groups and outpatient services.
- Two weeks of intensive validation of patient cohort between 30-40 week to reduce patients breaching 52 weeks in Q1.

What is the expected impact?

- Reduction in the TWL
- Reduction in the number of RTT52 week waiters if additional activity linked to NHSE funding bids delivered.
- 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 1%, circa 1,100 additional referrals).
- Ability to mobilise capacity funded through the NHSE sprints.
- Impact of delayed 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)

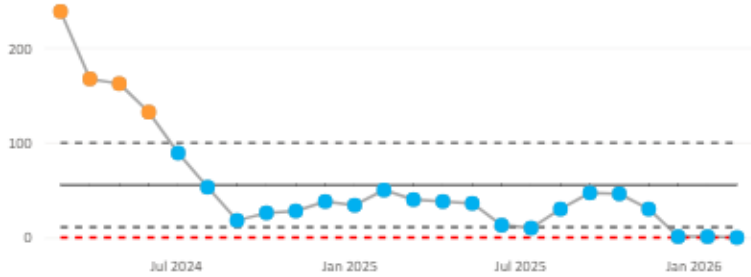
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

RTT - Waits over 65 weeks for Incomplete Pathways - Declared Position

Variation Assurance



Latest Month: 2026-02

Value: 0

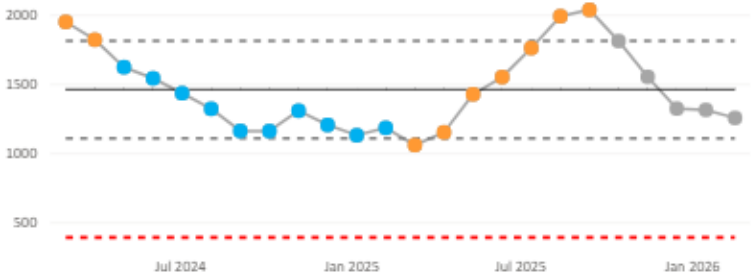
Target: 0

The indicator is **equal to the target** for the latest month and **is not** within the control limits.

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

RTT - Waits over 52 weeks for Incomplete Pathways - Declared Position

Variation Assurance



Latest Month: 2026-02

Value: 1253

Target: 389

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 **58.0**.

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 RTT52 week waits throughout March 2026 with weekly trajectory in place. Maintaining zero RTT65 week waits a priority.
- Trust had sprint bids for 1st OP activity and 52-week FU and inpatient elective activity funding accepted by NHSE. Capacity is being 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.
- Refresh of diagnostic escalation process to support delivery of 52weeks and move away from 65 weeks.

What is the expected impact?

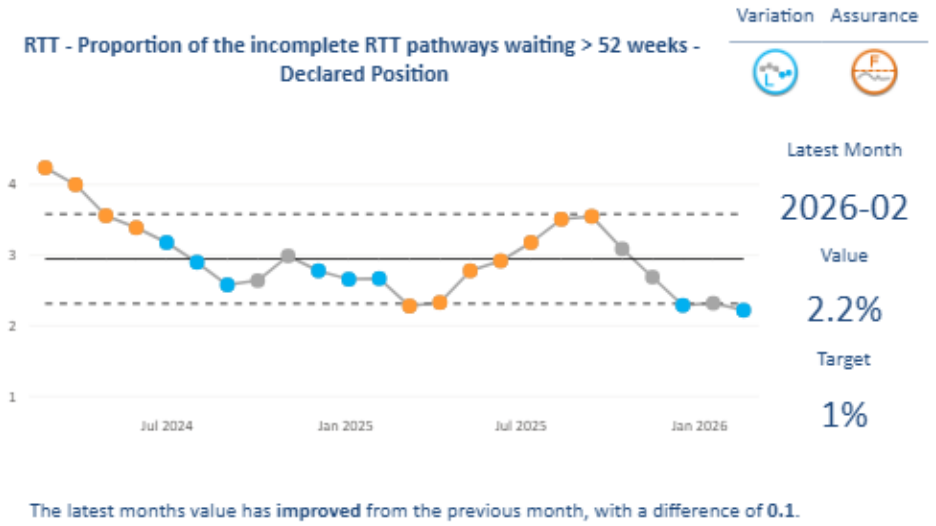
- Reduced RTT long waiters.
- ERF money targeted at specialties most in need.

Potential risks to improvement?

- Patient choice can lead to end of month breaches.
- Diagnostic performance.
- Capital programme delays (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 OPs 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 February 2026, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 4.9% 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 83% (January: 79.4%) which whilst a continued month on month improvement remains below the target of 99%.

Factors impacting performance:

- In the latest North East & Yorkshire Region 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) and DNA rate (lowest in NEY).

- The Trust's DNA rate was unchanged at 4.4% in February 2026, the lowest this financial year. The Trust has one of the lowest DNA rates in the country, the national average is 5.6% (NHSE).

- Digital letters for radiology went live on 17th of December 2025 and we are piloting this with a small group to refine the process before wider roll out in March. Clinical letters went live on 29th of January 2026 with a pilot group. Currently working through the process to refine the monitoring that all letters sent have been processed. Ongoing issues identified in the pilot that require resolution prior to wider roll out.

- 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		* 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*	* Outpatients - Proportion of appointments delivered virtually (S017a) * Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks) * Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU) * Trust waiting time for Rapid Access Chest Pain Clinic
COMMON CAUSE / NATURAL VARIATION	* Proportion of elective admissions which are day case	* Outpatients - DNA rates * Outpatients: 1st Attendances (Activity vs Plan) * Outpatients: Follow Up Attendances (Activity vs Plan) * Day Cases (based on Activity v Plan) * Electives (based on Activity v Plan)	
SPECIAL CAUSE CONCERN			

Outpatients & Elective Care
Scorecard

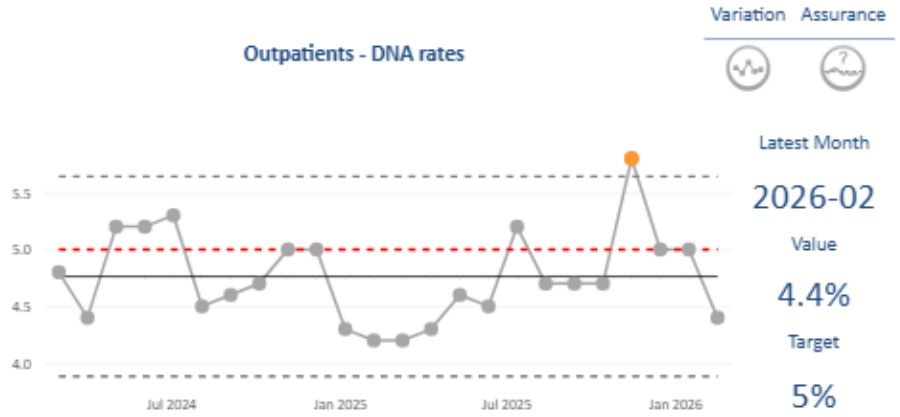
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2026-02	H	F	23.4%		25%
Outpatients - DNA rates	2026-02		?	4.4%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2026-02		?	21155	15960	17494
Outpatients: Follow Up Attendances (Activity vs Plan)	2026-02		?	43390	36684	38846
Outpatient procedures	2026-02			14673		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2026-02	L	F	25871		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2026-02	H	F	4.2%	4.9%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2026-02	H	F	83%		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*	2026-02	L	?	8		0
Day Cases (based on Activity v Plan)	2026-02		?	7545	7329	8144
Electives (based on Activity v Plan)	2026-02		?	680	676	816
Proportion of elective admissions which are day case	2026-02		P	91.7%		85%
Outpatients: All Referral Types	2026-02	H		24942		
Outpatients: Consultant to Consultant Referrals	2026-02			2312		
Outpatients: GP Referrals	2026-02			10480		

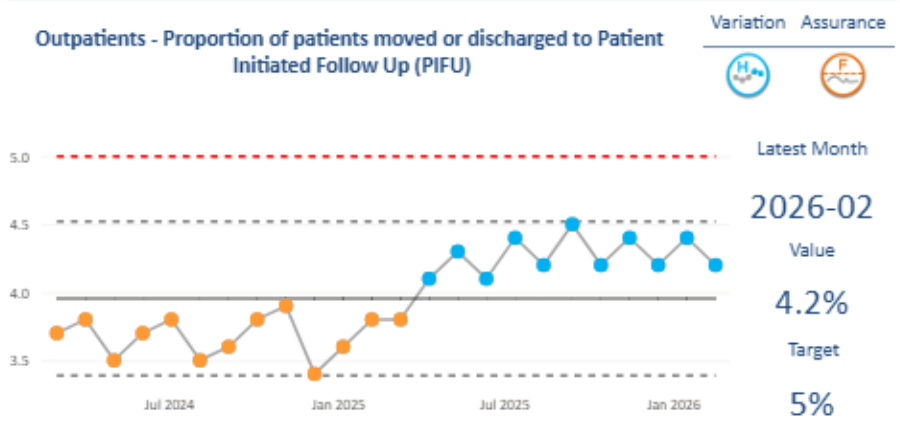
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

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



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

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

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

What actions are planned?

- 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. A shared learning event took place in February 2026. Internal project plan being refreshed for wider PIFU improvement project to delivery model hospital upper quartile performance.

- GIRFT clinic template standards audit completed, with opportunities in a couple of specialties identified. Gynaecology, ENT and Oral surgery have changed templates in January 2026 which will deliver increased 1st OP rates. Cardiology have planned template changes for February.

What is the expected impact?

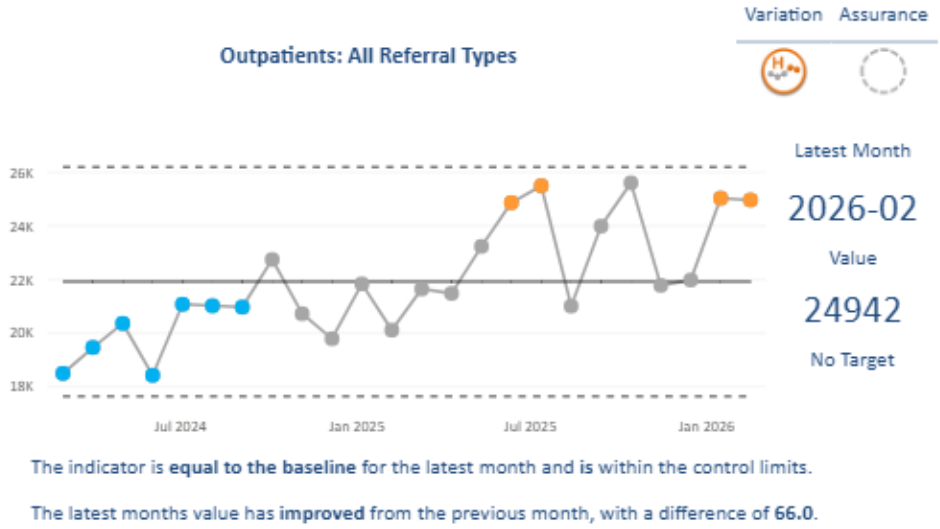
- **PIFU:** Y&S should see a continued improvement in PIFU. Y&S had one specialty in the lowest quartile of Trusts within the NE&Y region (Gynaecology), involvement in PIFU as standard has resulted in an improvement in this specialty (1.3% in April 2025 to 3.4% in December 2025, this was broadly maintained in January: 3.2%).

Potential risks to improvement?

- **PIFU** at Scarborough is significantly lower than York (February 2026: 1.9% at SGH/5.4% at York).

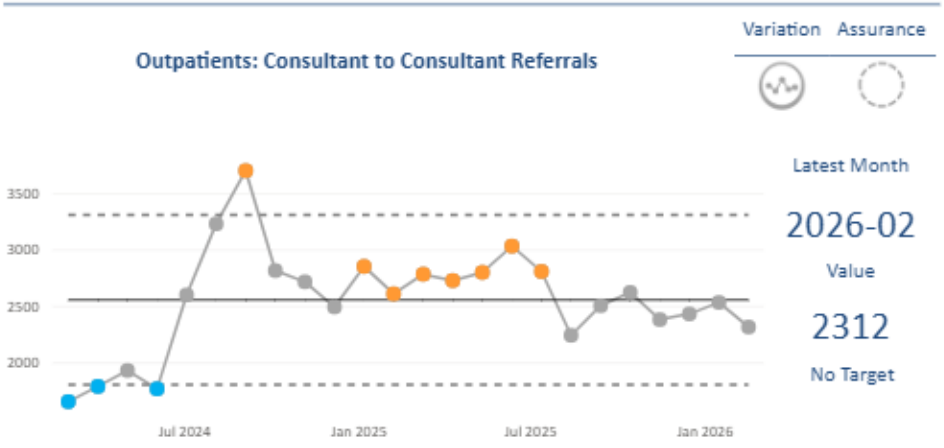
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **improved** from the previous month, with a difference of **66.0**.



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

The latest months value has **improved** from the previous month, with a difference of **218.0**.

Rationale: Number of outpatient referrals received from General Practice, Consultant to Consultant and from other sources.
SPC1: No internal target.
Rationale: Number of outpatient referrals generated internally from Consultant-to-Consultant referral..
SPC1: No internal target.

What actions are planned?

- Commenced with scoping project to reduce consultant to consultant referrals by 10% from April 2026.
- ICB undertaking review of GP referrals to identify outlying practices for further discussion and education.
- Review the REI, advice and guidance and NHSE single point of access roadmap to develop a joint approach with ICB around pre-referral triage to reduce overall demand. Initial Trust meeting scheduled in March 2026.

What is the expected impact?

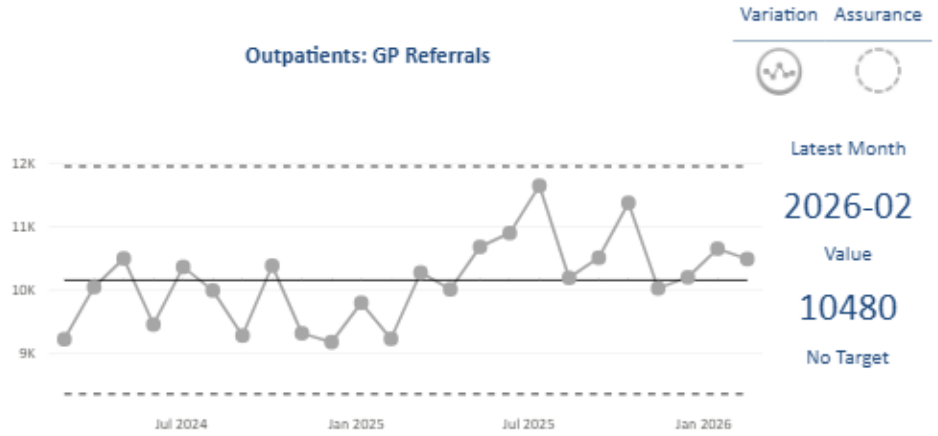
- Reduction in internal demand and reduction in open referrals**.**
- Reduction in GP demand
- Improved redirection of referral direct to test or to other services to reduce requirement for outpatient attendances.

Potential risks to improvement?

- Clinical engagement and compliance.
- Digital interface alignment between the Trust, ICB and NHSE guidance.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **improved** from the previous month, with a difference of **163.0**.

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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 February 2026 was 77.5%, an increase of almost 7% compared to 70.8% at the end of January. While this has the Trust 3.2% below planned trajectory for the month, it should be recognised that this the highest performance achieved by the Trust since February 2020.
- Total waiting list has increased slightly but 6+ and 13+ week breaches continue to see notable reduction.
- In the latest available national data (December 2025) the Trust ranked 80th worst out of 118 NHS providers and 8th worst out of 11 in our Model Hospital peer group.

Factors impacting performance:

- Endoscopy position continues to recover as additional clinics are utilised to tackle backlog of patients, including those who chose to delay until after the festive period which caused significant drop in performance in December and January.
- MRI insourcing has begun to deliver significant improvement using this additional capacity. Additional paediatric GA lists for MRI have been carried out which has reduced the backlog for this cohort by over 50%.
- Bank registrar has had positive impact on NOUS performance as significant volume of the soft tissue cohort has been cleared.
- Additional UDS lists in February led to improved performance as backlog began to be cleared.
- Additional resources and training underway (radiographers, sonographers, audiologists, echocardiographers).
- Community Diagnostic Centres (CDCs) performing well; Scarborough CDC due to be operational by end Q4 2025/26.
- Cystoscopy performance is being impacted by the prioritisation of the Haematuria pathway as the additional Friday list has been stood down to accommodate.
- Audiology has not yet been able to order the booths to provide additional capacity due to procurement delays. Revised go live is end of March 26.
- Outpatient echo at York reduced capacity for circa 10 days due to building works.
- Workforce shortages (radiographers, audiologists, echo techs, nurses).
- Equipment issues (MRI/CT breakdowns, delayed installations).
- Increased elective demand and prioritisation of cancer fast track is impacting routine waits and DM01 breaches. Further impact due to increased sprint activity is a risk to DM01 in Q4, this is currently being mitigated.
- Space constraints and ventilation issues in some sites.

Actions:

- We continue to explore additional UDS lists pending staffing.
- Additional capacity available in York and east coast echo inpatient area to recover outpatient backlog.
- Continue insourcing/outsourcing and mobile solutions to address backlogs in Q4.
- Accelerate recruitment and training pipelines for critical roles.
- Implement new equipment and expand CDC capacity.
- Prioritise Cancer / RTT long wait patients while balancing routine demand / surveillance.
- Ongoing capital investments and process improvements.

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

ASSURANCE

VARIATION	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT		* Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema * Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	* 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 - Urodynamics * Diagnostics - Proportion of patients waiting <6 weeks
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 - Echocardiography * Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy
SPECIAL CAUSE CONCERN			

DIAGNOSTICS – National Target: 95%

Scorecard

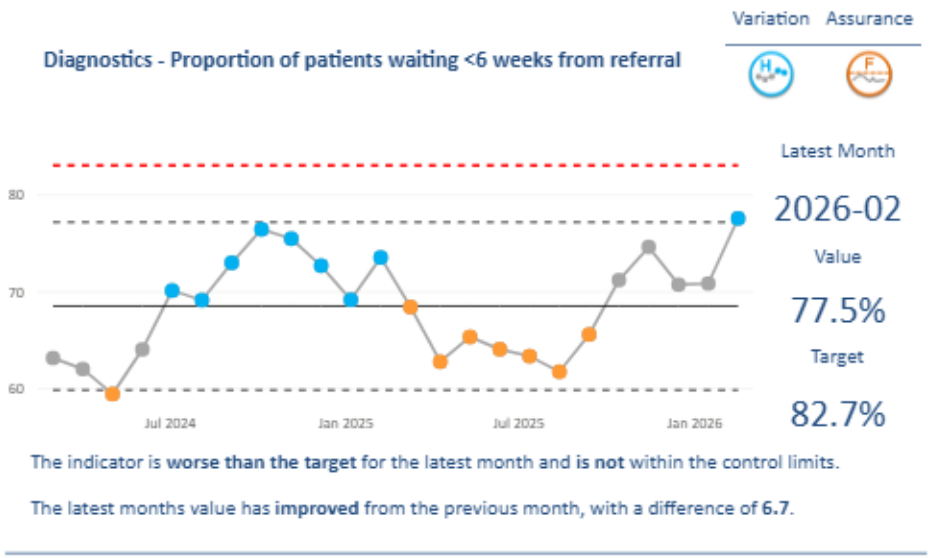
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-02	H	F	77.5%	80.8%	82.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2026-02	H	F	83.7%	89%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2026-02		?	70.8%	76%	78%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2026-02		?	75.9%	74%	75%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2026-02	H	?	86.7%	89.2%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2026-02	H	?	85.7%	66.9%	67.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2026-02	H	F	82.6%	92.6%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2026-02		F	50.1%	95.8%	95.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2026-02		?	94.8%	94.4%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2026-02		?	90.7%	94.6%	94.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2026-02	H	F	82.4%	93.3%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2026-02	H	F	88.9%	80.6%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2026-02		F	80.1%	76.4%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2026-02		?	75.4%	93.2%	94.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2026-02	H	F	90.3%	87.5%	90%

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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Rationale: Maximise diagnostic activity focused on patients of highest clinical priority.
Target: Increase the percentage of patients that receive a diagnostic test within 6 weeks to above 82.7% by end of March 2026.

What actions are planned?

Endoscopy: Validation of long waiters with regular meeting between ops manager and waiting list manager to ensure all DM01 rules are being correctly applied and patients booked appropriately. The Bridlington air handling unit requires replacement to address the temperature issues and has been approved on the capital programme for this year. This avoids lost capacity due to theatre closures. One room per day ringfenced for surveillance activity (40 procedures per week)

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 significantly. MRI radiographer insourcing started in October to mitigate capacity lost to vacancies at York. Recruitment has taken place so currently in process of onboarding and training. No additional capacity but retains core capacity. ERF funding approved for unstaffed scanner until January 2026, utilising staff that would have been at CDC. Delivers an additional 2,500 scans. CT - Higher Support Worker funding secured to establish post in York (already in place at Scarborough) by end of March 2026. NHSE deep dive planned for March 2026.

Physiological:

Echocardiography: Insourcing to support 7 day working, fixed term until end of financial year. With the scheme below will deliver an additional 1,040 ECHO scans.
Second insourced echocardiographer at the East Coast in place covering Mon – Fri 9-5. Additional echo tech offering an additional 40 scans per week which will help off set the impact of the additional outpatient activity.

Audiology: 4 x pop-up booths (two York, one Malton and one Brid) to deliver additional audiology capacity will be in place by end of March 2026. Contracts for current locum colleagues (all sites) have been extended until end of March 2026, York extended to end of September 2026.

What is the expected impact?

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

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 - Emergency Care Standard (Type 1 only)
COMMON CAUSE / NATURAL VARIATION		* Children & Young Persons: ED - Patients waiting over 12 hours in department	* 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

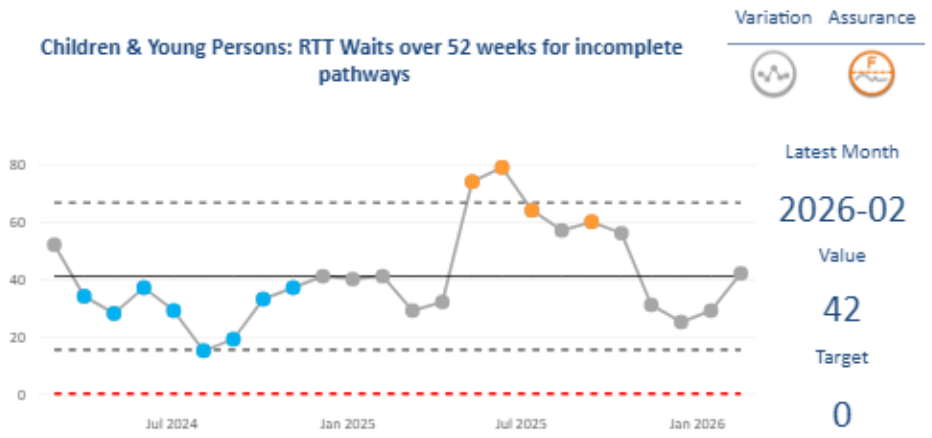
Executive Owner: Claire Hansen

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	2026-02			0		0
Children & Young Persons: ED - Emergency Care Standard (Type 1 only)	2026-02	H	F	87.5%		95%
Children & Young Persons: RTT - Total Waiting List	2026-02	H	F	4416	3395	3206
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2026-02	L	F	62.8%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2026-02		F	42	0	0

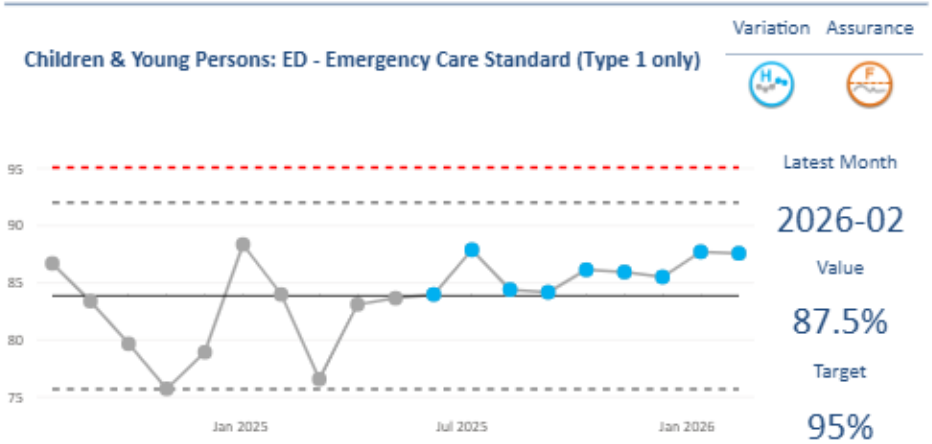
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi



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

The latest months value has **deteriorated** from the previous month, with a difference of **13.0**.



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 **0.2**.

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 (36 at the end of February 2026).
- ENT and Oral Surgery are planning to deliver zero RTT52 week waiters by the end of Q4 2025/26 (34 at the end of February 2026) .

SPC2:

- We have maintained improvement to paediatric ECS performance.
- The introduction of the new model of care for adults should reduce congestion in departments which may lead to more timely assessment of children. This will be monitored closely at the point of go-live.

What is the expected impact?

- Improved ECS and 'wait to be seen' for CYP patients.
- Delivery of zero paediatric RTT40 week waiters (except for Head and Neck) by end of March 2026.

Potential risks to improvement?

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

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			* Number of people on waiting lists for CYP services per system who are waiting over 52 weeks
COMMON CAUSE / NATURAL VARIATION		* Proportion of Virtual Ward beds occupied * 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

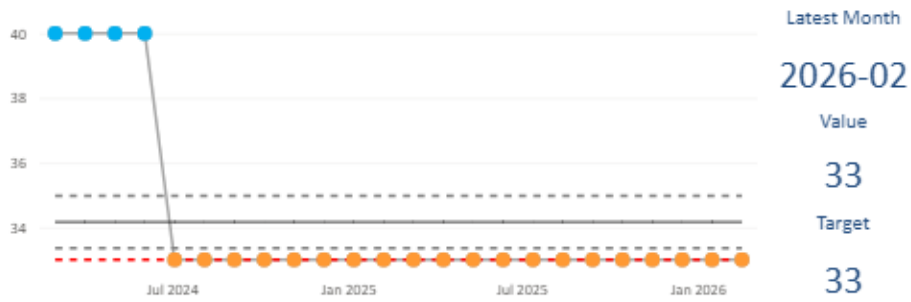
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of open Virtual Ward beds	2026-02	L	P	33	33	33
Proportion of Virtual Ward beds occupied	2026-02		?	78.8%	79%	79%
Community Response Team (CRT) Referrals	2026-02			554		
Total Urgent Community Response (UCR) referrals	2026-02		?	531	499	566
2-hour Urgent Community Response (UCR) care Referrals	2026-02	H		197		
2-hour Urgent Community Response (UCR) Compliancy %	2026-02			78.2%		
Number of Adults (18+ years) on community waiting lists per system	2026-02	L		720		
Number of CYP (0-17 years) on community waiting lists per system	2026-02	L		1594		
Number of District Nursing Contacts	2026-02			19271		
Number of Selby CRT Contacts	2026-02			2423		
Number of York CRT Contacts	2026-02			3187		
Referrals to District Nursing Team	2026-02			2127		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2026-02	L	F	586	54	0

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

Number of open Virtual Ward beds



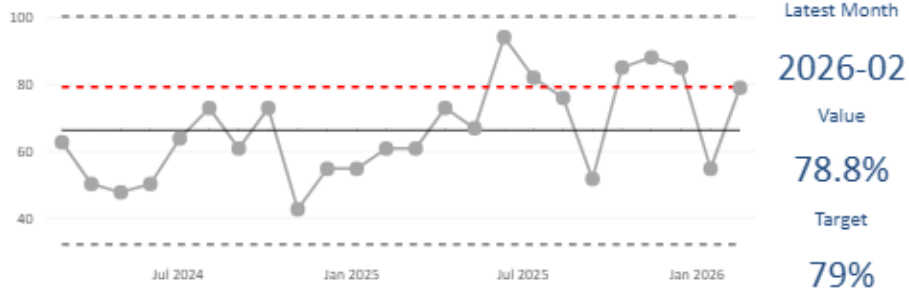
Latest Month
2026-02
Value
33
Target
33

The indicator is **equal to the target** for the latest month and **is not** within the control limits.

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

Variation Assurance

Proportion of Virtual Ward beds occupied



Latest Month
2026-02
Value
78.8%
Target
79%

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

The latest months value has **improved** from the previous month, with a difference of **24.2**.

Rationale: To monitor demand on Community virtual wards.
Target: SPC1: Trust is commissioned to deliver 33 virtual ward beds. **SPC2:** Aim to achieve 79% virtual ward bed occupancy as per activity plan.

Please note: Graphs show all 4 Virtual Wards. The Trusts virtual wards are made up of Frailty Virtual ward (12 beds) Heart Failure Virtual ward (10 beds) and Vascular and Cystic Fibrosis with 11 beds between them. FVW and HFVW are operationally managed by community services but delivered in partnership with acute colleagues

What actions are planned?

The York Hospital at Home service (previously known as Frailty VW) continues to routinely admit patients into its 12 beds with the vast majority being step-up instances from community. Pathway for direct step up IPUs tested in Selby and St Monicas – worked well. Aim to test this pathway for Nelsons court. Expansion of POCT planned for March 2026,

Following successful testing of a Selby H@H service, in combination with Selby UCR Trust grade medic, we continue to seek funding from the ICB for an additional senior nurse to implement a permanent 5 bedded Selby H@H model. Delivered in collaboration with Selby CRT. Clinical lead Rachel Davidson

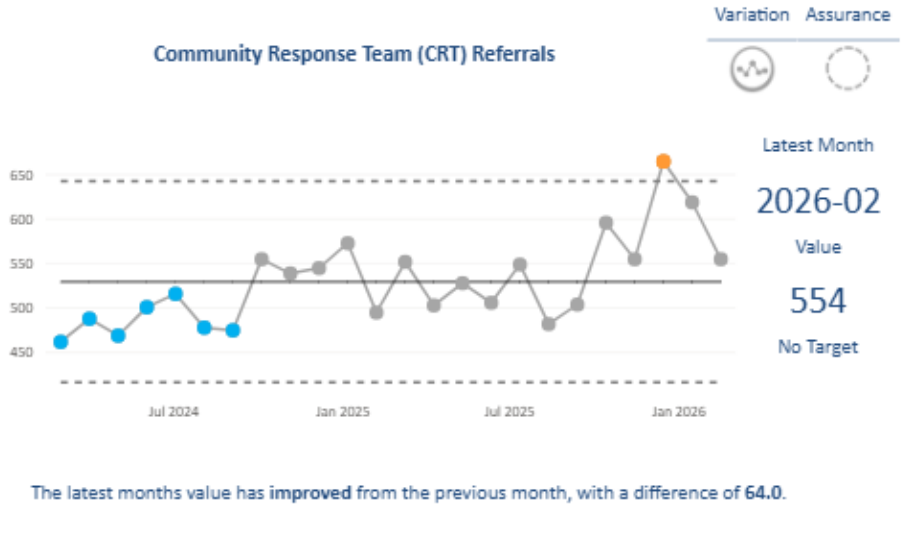
HFVW - Admission avoidance pathway for HF in place at York and working well. Service model expanded to now include early support discharge for HF patients Evaluation planned for March 2026. Pathways out of hospital are IV diuretic for ambulatory patients and partnership working for non-ambulatory frail older patients with H@H team

Potential risks to improvement?

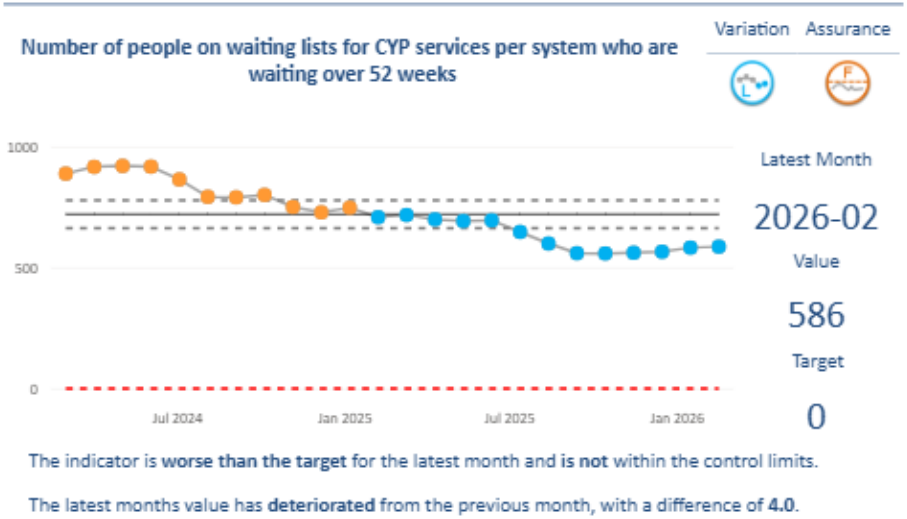
There remains no H@H service for SHAR or Selby
Funding for additional senior nurse to establish a 5 bedded Selby H@H service not confirmed

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi/Kim Hinton



The latest months value has **improved** from the previous month, with a difference of **64.0**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **4.0**.

Rationale: To monitor demand on Community services.
Target: SPC1: No target. **SPC2:** zero waiting over 52 weeks by end of March 2026 as per activity planning submission.

Please note: These two metrics should not be linked as they are different cohorts of patients.

What actions are planned?

SPC1: Referrals for UCR and home-based intermediate care at home remain high (with February appearing low due to the short month). .

Workforce challenges remain with high sickness actively managed. Over the winter period the team actively pulled in additional resource form Advanced Clinical Specialist, stepping down training and pulled on the wider community therapy team delaying routine appointments to help manage the flow out of hospital and prevent admissions.

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 mismatch. Additional WTE mitigation included in 2026/27 plan.

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.

A big increase in referral for Selby CRT since introduction of Trust Grade medic, with good partnership working with the local GPs.

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

March 2026

Executive Owner: Karen Stone and Dawn Parkes

Highlights: IPC

- Reduced rates of Clostridioides Difficile Infection (CDI) and Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteraemia, under agreed objectives; for CDI ranked 1/134 as per National Oversight Framework (NOF)
- E.coli Bacteraemia and Klebsiella Bacteraemia numbers reduced significantly in February.

Concerns / Risks :

- E.coli Bacteraemia - 32 cases **over** the year-to-date objective at the end of January 2026. Q2 National Oversight Framework metric rate 2.41 per 100,000 bed days, rank 47/134.

Next Steps:

- Focused work continues with improving hand hygiene and the Gloves Off Campaign, as agreed with the Care Group Senior Nursing Teams.
- Deliver improvement actions as per the Strategic IPC Improvement Plan, including development of an IPC skills matrix and review of training packages by March 2026.
- Clinical review of E.coli Bacteraemia and Klebsiella Bacteraemia cases to determine themes has commenced with support of Microbiology Registrars.
- Additional review meetings for MSSA bacteraemia cases being set up for Surgery and CSCS care groups to ensure learning is identified and embedded into practice.

Highlights: Pressure ulcers

- In February, there were 71 Category 2 pressure ulcers reported; improved position from 76 in January, against a monthly target of 60.
- Rate of pressure ulcers (all categories) is 3.9 per 1000 bed days, against a year end target of 4.0.

Concerns/Risks:

- During February, the organisation experienced increased sickness across the nursing workforce, above the national average, impacting on care delivery.
- An increased number of inpatients met no criteria to reside, while patient acuity and frailty rose across the cohort. These factors are known contributors to pressure ulcer development.
- The main hot spots identified were Elderly Ward Cherry (5 cases), Elderly Ward 28 (7 cases), and within the Community District Nurse caseloads (12 cases).

Next Steps:

- Lead Tissue Viability Nurse working with highest reporting areas to identify and support opportunities for improvement, including improving continence care to reduce incidence of moisture associated skin damage, and promoting mobility to reduce risk of deconditioning and improve pressure relief.
- Continued collaboration with community teams on accurate pressure ulcer categorisation and review of embedding skin assessment documentation within these settings.
- Liaison with ICB colleagues regarding appropriate reporting of pressure damage in a care home setting.
- Work on appropriate seating continues with an initial sum of money secured for phased implementation of new chairs – procurement process in place.

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)

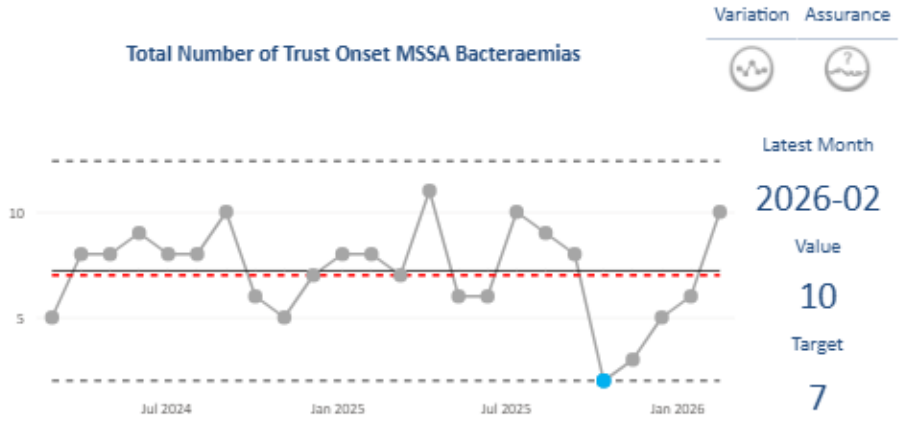
York and Scarborough Teaching Hospitals NHS Foundation Trust

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	2026-02			10	6	7
Total Number of Trust Onset MRSA Bacteraemias	2026-02			1		0
Total Number of Trust Onset C. difficile Infections	2026-02			7	12	12
Total Number of Trust Onset E. coli Bacteraemias	2026-02			5	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2026-02			1	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2026-02			1	1	2
Pressure Ulcers per thousand Bed Days	2026-02			3.9		4
Patient Falls per thousand Bed Days	2026-02			8.2		8.7
Medication incidents per thousand bed days	2026-02			5.7		5

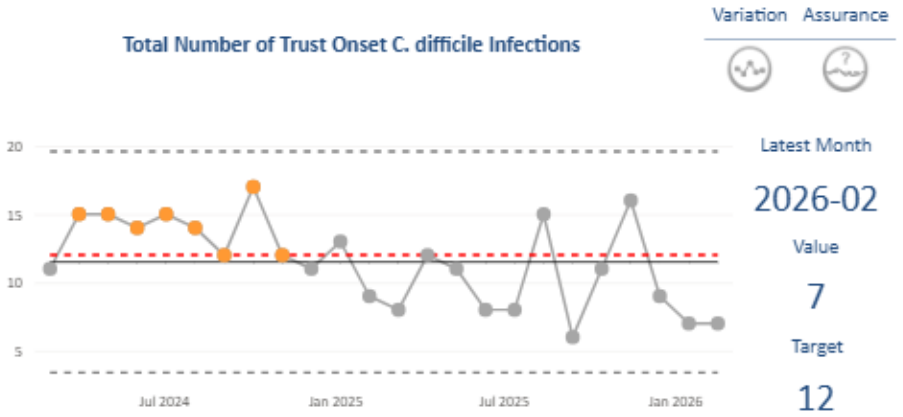
Executive Owner: Dawn Parkes

Operational Lead: Sue Peckitt



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

The latest months value has **deteriorated** from the previous month, with a difference of **4.0**.



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

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

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 7 cases up to the end of February 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 32 cases **over** the YTD objective at the end of February 2026. Q2 National Oversight Framework metric is 2.41 per 100,000 bed days, rank 47/134.
- Klebsiella bacteraemia - The Trust is 12 cases **over** the YTD objective at the end of February 2026
- Pseudomonas bacteraemia - The Trust is 17 cases **over** the YTD objective at the end of February 2026

Key assurances/brilliances:
- Clostridioides difficile - The Trust is 9 cases **under** the YTD objective at the end of February 2026. Q2 NOF metric 1, rank 1/134
- Methicillin-Sensitive Staphylococcus aureus bacteraemia – The Trust is equal to the YTD objective at the end of February 2026, however there was a rise in cases in February which is being reviewed.
- 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.
- The Internal Audit report of Infection Prevention and Control Governance has recorded Significant Assurance.

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 are 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 Q4 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 invasive devices.
- Focused work continues with improving hand hygiene and the Gloves Off Campaign, as agreed with the Care Group Senior Nursing Teams.
- Deliver improvement actions as per the Strategic IPC Improvement Plan, including development of an IPC skills matrix and review of training packages by March 2026.
- Clinical review of E.coli Bacteraemia and Klebsiella Bacteraemia cases to determine themes has commenced with support of Microbiology Registrars.
- Additional review meetings for MSSA bacteraemia cases being set up for Surgery and CSCS care groups to ensure learning is identified and embedded into practice.

Quality & Safety
Scorecard (2)

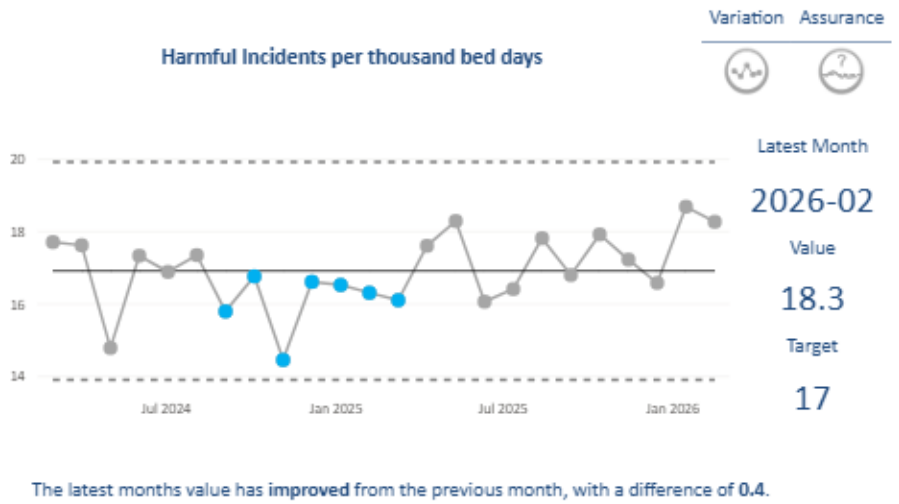
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-02			54.1		55
Harmful Incidents per thousand bed days	2026-02			18.3		17
Total Number of Never Events Reported	2026-02			1		0
In-Hospital Deaths	2026-02			177		
Quarterly SHMI	2025-09			90.7		100
Monthly SHMI	2025-08			77.3		100
Quarterly HSMR	2025-09			105.7		100
Monthly HSMR	2025-09			108.9		100
Trust Complaints	2026-02			141		
Antepartum Stillbirths	2026-01			2		
Intrapartum Stillbirths	2026-01			0		
Early neonatal deaths (0-7 days)	2026-01			2		
PPH > 1.5L as % of all women - York	2026-01			3.8%		
PPH > 1.5L as % of all women - Scarborough	2026-01			2%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2026-01			50%		

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.

Great-ix (39 submissions in February)

February Great-ix Highlights:

"…In the middle of a very stressful situation, she stepped in without hesitation and became an anchor for the team…"
"…Your flexibility and calm support made a real difference, and it didn't go unnoticed…"
"…Her composure, clarity and compassionate professionalism had a positive impact on both staff experience and patient care that day…"
"…The list ran smoothly and efficiently. All staff looked out for each other, there was time for teaching and supporting one another even when things were tricky…"
"…I really appreciate her genuine sympathy and, despite being obviously busy, she made me feel valued by taking the time to have a proper two-way conversation…"

Analysis of the Patient Safety Incident Data – Medication theme

Highlights

The Medication safety strategy 2026 to 2028 was produced with detailed workplans linked to the four strategic priorities:
1 Continue to improve medication incident reporting, investigation and learning, in line with PSIRF.
2 Develop a Medication Safety Culture, supporting all staff to improve medication safety.
3 Commission and support improvement projects linked to local and national priorities.
4 Respond in a timely fashion to newly identified medication safety concerns identified locally and nationally.
There have been 7 Medicine National Patient Safety Alerts over 2025/26, and these have all been reviewed and closed within the National deadline.

Concerns/risks

A defined process exists for managing all medication related incidents. Incidents are triaged and themed to support thorough investigation and potential thematic reviews, ensuring optimal learning opportunities are provided. In 25/26 we completed 2 internal thematic reviews into the management of Insulin and Opiates with the learning shared through the quality governance mechanisms.
Any incidents or potential risks arising from factors beyond the Trust's control are promptly reported to relevant external providers or regulatory bodies, ensuring transparency and compliance with established protocols.

Next steps

We have a program of regular monitoring of hypoglycaemic events, hypoglycaemia management, and instances of delayed insulin doses is conducted fortnightly. These reviews form part of collaborative initiatives aimed at enhancing the effectiveness and safety of insulin administration. Educational safety videos related to these have been developed and are available to support the learning needs of nurses and nursing associates.
Medication incident learning bulletins are now issued routinely to share key insights and promote continued improvement

Complaints

Factors impacting performance:

The SPC chart continues to show common cause variation in relation to the number of complaints received but has noted a decrease in month with 141 new complaints across the Trust received in the month of February 2026 (in contrast to 143 in January 2026).

56% of complaints were closed in 30 days (compared to 54% in January 2026) and 53% of complex complaints were closed in 45 days (compared to 44% in January 2026) showing an improvement in complaint response times, though there is progress is still needed to achieve 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.
- Whilst the Care Groups working diligently to both close the backlog of concerns and respond to complaints within agreed timeframes, there will be an outstanding backlog of concerns at the end of March 2026. As at the end of February 167 of 254 backlog concerns had been closed..

Key assurances

- The new member of the PALS team who is on secondment for a period of 4 months from late January 2026 has settled in well providing support to the team covering for the member of staff who is on long term sickness. This has enabled us to increase access to both in-person appointments and to the phone.
- The corporate patient experience team have supported Care Groups with a number of complex complaints to reduce the burden on Care Group leadership teams.

Next key improvement steps

- Care Groups to continue taking action to close the backlog of concerns.
- A rebuild of the complaints dashboard is underway to enable clearer accountability oversight linking identified actions with Care Group improvement plans.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

March 2026

Executive Owner: Dawn Parkes and Sascha Wells-Munro

Please note that Maternity Services provide a dedicated report to Trust Board against a range of quality and safety metrics. The metrics in this TPR are currently under review.

Highlights:
Special Care Baby Unit.
Concerns / Risks :
Special Care Baby Unit had a period of reaching full capacity in December 2025. This has now resolved and is managed through the business continuity plan in place to support that pathway of care.
Next Steps:.
Maternity and Neonatal services are working with the local Operational Delivery Network (ODN) to review the current service delivery pathway for SCBU in Scarborough.

Highlights:
Home birth service suspensions in Scarborough and the East Coast
Concerns/ Risks:
Due to significant shortfalls in the budgeted establishment because of maternity leave and LTS as well as no headroom applied to the service the ability to safely staff on-calls consistently for homebirth overnight has been increasingly harder to achieve. This has also been impacted by the HM Coroners Prevention of future deaths letter to NHS England and other key stakeholders around the commissioning and safety of homebirth service particularly related to midwives working hours. The service has undertaken a review and has temporarily implemented and on-call system that ensures midwives have reasonable compensatory rest to support safer care to women. Due to the afore mentioned staff shortages this safe practice has further impacted on the ability to provide the service overnight which has seen more suspensions due to maintaining safety for all women and staff.
Next Steps:
A full consultation for community Midwifery service across York and Scarbrough is planned following an increase in budgeted estabalishement in line with BR+ on the first of April and after publication of new guidance for homebirth service form NHS England and the Royal colleges of Midwives and Obstetrics and Gynaecology

Highlights:
Increase in Caesarean births at York
Concerns/Risks:
There has been a significant increase in the demand for maternity theatre time at York due to an increase in Caesarean births, particularly category 3 births. This is due to clinical guidance that means more women are being induced earlier in pregnancy for multiple reasons that then results in failed induction leading to the need for a caesarean birth

Next Steps:
A further review of demand V capacity is underway for planned caesarean births as well as the demand for acute activity that includes other clinical procedures as well as unplanned caesarean births.

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		* 1 to 1 care in Labour - Scarborough * 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	* 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

ASSURANCE

VARIATION

	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	2026-01			42.6%		57%	Target
Assisted Vaginal Births - Scarborough	2026-01			9.9%		12.4%	Target
C/S Births - Scarborough	2026-01			47.5%		44.5%	Baseline
Elective caesarean - Scarborough	2026-01			15.8%		16%	Baseline
Emergency caesarean - Scarborough	2026-01			30.7%		28.4%	Baseline
Induction of labour - Scarborough	2026-01			40.4%		44.9%	Baseline
HDU on L/W - Scarborough	2025-12			6		5	Target
BBA - Scarborough	2026-01			1		2	Target
HSIB cases - Scarborough	2025-11	L		0		0	Target
Neonatal Death - Scarborough	2026-01			1		0	Target
Antepartum Stillbirth - Scarborough	2026-01	L		0		0	Target
Intrapartum Stillbirths - Scarborough	2026-01		P	0		0	Target
Cold babies - Scarborough	2025-04			0		1	Target
Preterm birth rate <37 weeks - Scarborough	2026-01			5.9%		6%	Target
Preterm birth rate <34 weeks - Scarborough	2026-01			2%		1%	Target
Preterm birth rate <28 weeks - Scarborough	2026-01			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 * 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		* 3rd/4th Degree Tear - assisted birth - Scarborough	

Maternity Scarborough
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - Scarborough	2026-01			1%		0%	Target
Breastfeeding Initiation rate - Scarborough	2026-01			86.9%		75%	Target
Breastfeeding rate at discharge - Scarborough	2026-01			65.3%		65%	Target
Smoking at booking - Scarborough	2026-01			6.8%		6%	Target
Smoking at 36 weeks - Scarborough	2026-01			2.3%		6%	Target
Smoking at time of delivery - Scarborough	2026-01			6%		6%	Target
Carbon monoxide monitoring at booking - Scarborough	2026-01	H		94.2%		95%	Target
Carbon monoxide monitoring at 36 weeks - Scarborough	2026-01			86.5%		95%	Target
SI's - Scarborough	2025-10			0		0	Target
PPH > 1.5L as % of all women - Scarborough	2026-01			2%		2.4%	Baseline
Shoulder Dystocia - Scarborough	2026-01			0		2	Target
3rd/4th Degree Tear - normal births - Scarborough	2026-01			1%		0%	Target
3rd/4th Degree Tear - assisted birth - Scarborough	2026-01	H		1%		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	2026-01		P	103		169	Target
Bookings <10 weeks - Scarborough	2026-01		F	68%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - Scarborough	2026-01		?	4.9%		10%	Target
Births - Scarborough	2026-01		?	101		113	Target
No. of women delivered - Scarborough	2026-01		?	99		112	Target
Planned homebirths - Scarborough	2026-01		?	3%		2.1%	Target
Homebirth service suspended - Scarborough	2025-12		F	27		3	Target
Women affected by suspension - Scarborough	2025-12		?	0		0	Target
Community midwife called in to unit - Scarborough	2025-12		P	0		3	Target
Maternity Unit Closure - Scarborough	2025-12		?	1		0	Target
SCBU at capacity - Scarborough	2025-03	H	?	4		0.7	Baseline
SCBU at capacity of intensive care cots - Scarborough	2025-03	H	?	11		1.8	Baseline
SCBU no of babies affected - Scarborough	2025-03	H	?	1		0	Target
1 to 1 care in Labour - Scarborough	2026-01	H	?	100%		100%	Target
L/W Co-ordinator supernumerary % - Scarborough	2026-01	H	?	100%		100%	Target
Anaesthetic cover on L/W - Scarborough	2026-01	H	F	10		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 * Community midwife called in to unit - York * Anaesthetic cover on L/W - York	* Bookings - York * Births - York * No. of women delivered - York * Planned homebirths - York * 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			

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	2026-01			305		295	Target
Bookings <10 weeks - York	2026-01		F	71.2%		90%	Target
Bookings ≥13 weeks (exc transfers etc.) - York	2026-01		P	1%		10%	Target
Births - York	2026-01			211		245	Target
No. of women delivered - York	2026-01			208		242	Target
Planned homebirths - York	2026-01			0.7%		2.1%	Target
Homebirth service suspended - York	2025-12			13		3	Target
Women affected by suspension - York	2025-12			1		0	Target
Community midwife called in to unit - York	2025-12		P	0		3	Target
Maternity Unit Closure - York	2025-12			1		0	Target
SCBU at capacity - York	2025-06	L		0		0	Baseline
SCBU at capacity of intensive care cots - York	2025-06			28		10.8	Baseline
SCBU no of babies affected - York	2025-05			2		0	Target
1 to 1 care in Labour - York	2026-01			100%		100%	Target
L/W Co-ordinator supernumerary % - York	2026-01	H		100%		100%	Target
Anaesthetic cover on L/W - York	2026-01		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 * Elective caesarean - York * Induction of labour - York * HDU on L/W - York * BBA - York * HSIB cases - 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		* C/S Births - York * Emergency caesarean - 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	2026-01			44%		57%	Target
Assisted Vaginal Births - York	2026-01			10.9%		12.4%	Target
C/S Births - York	2026-01	H		44.7%		39.2%	Baseline
Elective caesarean - York	2026-01			18.2%		16.5%	Baseline
Emergency caesarean - York	2026-01	H		26.4%		22.6%	Baseline
Induction of labour - York	2026-01			38.9%		41.8%	Baseline
HDU on L/W - York	2025-12			5		5	Target
BBA - York	2026-01			0		2	Target
HSIB cases - York	2025-12			0		0	Target
Neonatal Death - York	2026-01			1		0	Target
Antepartum Stillbirth - York	2026-01			2		0	Target
Intrapartum Stillbirths - York	2026-01		P	0		0	Target
Cold babies - York	2025-08			0		1	Target
Preterm birth rate <37 weeks - York	2026-01			4.7%		6%	Target
Preterm birth rate <34 weeks - York	2026-01			1.4%		2%	Target
Preterm birth rate <28 weeks - York	2026-01			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 * Smoking at time of delivery - York	
COMMON CAUSE / NATURAL VARIATION		* Low birthweight rate at term (2.2kg) - York * Breastfeeding Initiation rate - York * Breastfeeding rate at discharge - York * Smoking at 36 weeks - York * Carbon monoxide monitoring at booking - York * PPH > 1.5L as % of all women - York * Shoulder Dystocia - York * 3rd/4th Degree Tear - normal births - York * Informal Complaints - York * Formal Complaints - York	* Carbon monoxide monitoring at 36 weeks - York
SPECIAL CAUSE CONCERN		* 3rd/4th Degree Tear - assisted birth - York	

Maternity York
Scorecard (3)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Low birthweight rate at term (2.2kg) - York	2026-01			0%		0%	Target
Breastfeeding Initiation rate - York	2026-01			90.4%		75%	Target
Breastfeeding rate at discharge - York	2026-01			75%		65%	Target
Smoking at booking - York	2026-01	L		3%		6%	Target
Smoking at 36 weeks - York	2026-01			3.1%		6%	Target
Smoking at time of delivery - York	2026-01	L		4.3%		6%	Target
Carbon monoxide monitoring at booking - York	2026-01			93.7%		95%	Target
Carbon monoxide monitoring at 36 weeks - York	2026-01		F	77.6%		95%	Target
SI's - York	2025-10			0		0	Target
PPH > 1.5L as % of all women - York	2026-01			3.8%		3.5%	Baseline
Shoulder Dystocia - York	2026-01			5		2	Target
3rd/4th Degree Tear - normal births - York	2026-01			1%		0%	Target
3rd/4th Degree Tear - assisted birth - York	2026-01	H		4.3%		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

March 2026

Workforce

Director of Workforce and Organisational Development Report

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Polly McMeekin

1. Highlights

- Workforce numbers (Whole Time Equivalent) at the end of January were broadly in line with plan, showing recovery from the seasonal slowdown seen in December.
- Use of temporary staffing (agency and bank) continue to track at a lower level than last year and largely in line with agreed reduction targets.
- Digital automation, Consultant appointments, and continued flow through nursing pipelines all feature as areas of progress in relation to recruitment activity in February.

2. Concerns

- Staff absence rates reduced in January after four months of increases but remain high when compared with recent years, continuing to place pressure on services.
- Staff Survey results show improvement across all key themes; however, overall scores remain below average in most areas, indicating that sustained improvement is still required.
- Some recruitment activity has been delayed, including the arrival of internationally recruited nurses, and vacancy controls are expected to slow some areas of recruitment in the short term.

3. Future

- Further reductions in temporary staffing are planned in the new financial year, alongside tighter approval controls to support affordability and workforce stability.
- A colleague experience improvement plan is being co-created following the 2025 Staff Survey and will be brought to the Board in the coming months.
- Staff wellbeing, training compliance, electronic rostering, and career development continue to be a focus, supporting retention, productivity and longer-term workforce sustainability.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	* 12 month rolling turnover rate Trust (FTE) * Total Agency Whole Time Equivalent Filled * Overall corporate induction compliance * A4C staff corporate induction compliance	* Overall vacancy rate	* Overall stat/mand training compliance * Appraisal Activity
COMMON CAUSE / NATURAL VARIATION		* Midwifery vacancy rate * Medical and dental vacancy rate * Registered Nursing vacancy rate * AHP vacancy rate * Total Bank Whole Time Equivalent Filled * A4C staff stat/mand training compliance * Medical & dental staff corporate induction compliance	* Medical & dental staff stat/mand training compliance
SPECIAL CAUSE CONCERN		* HCSW vacancy rate	* Monthly sickness absence * Annual absence rate

Workforce
Scorecard (1)

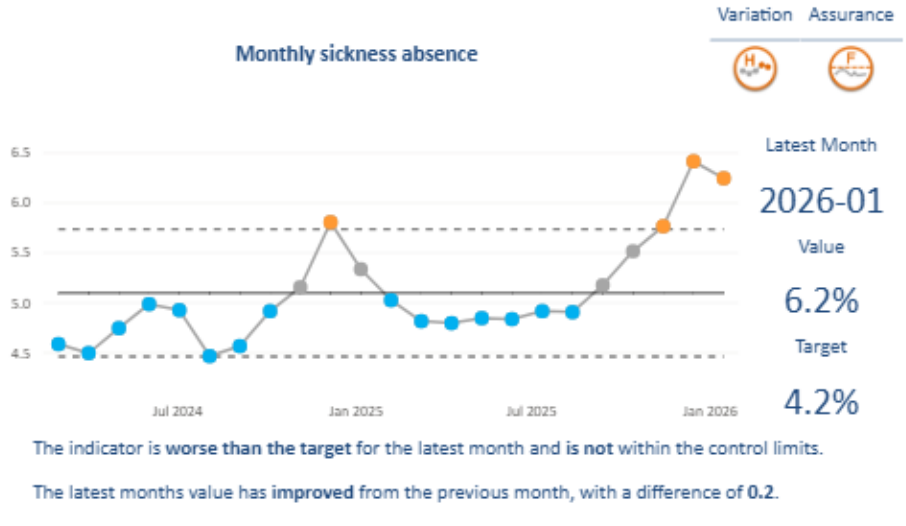
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

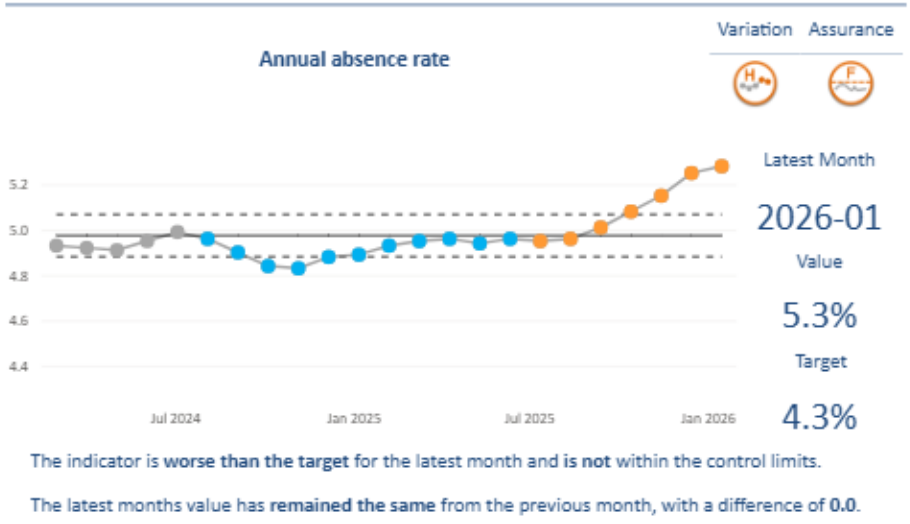
Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2026-01	H	F	6.2%	4.5%	4.2%
Annual absence rate	2026-01	H	F	5.3%		4.3%
AHP vacancy rate	2026-01		?	6.8%		8.5%
Total Agency Whole Time Equivalent Filled	2026-01	L	P	49.7		151
Total Bank Whole Time Equivalent Filled	2026-01		?	605.6		557
12 month rolling turnover rate Trust (FTE)	2026-02	L	P	7.5%		10%
Overall vacancy rate	2026-02	L	?	6.3%		6%
HCSW vacancy rate	2026-02	H	?	14%		5%
Midwifery vacancy rate	2026-02		?	-4.8%		0%
Medical and dental vacancy rate	2026-02		?	4%		6%
Registered Nursing vacancy rate	2026-02		?	5%		5%

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

Factors impacting performance and actions:

After four months of increases, absences appear to have reached their peak with a reduction in January; however, they remain at a high rate compared to recent years. The table below summarises the four main reasons for colleague absence in January and shows how these compare to December:

Reason	January 2026		December 2025	
	WTE lost	Proportion of all absences	WTE lost	Proportion of all absences
Anxiety, stress, depression	147 ↓	25%	158	26%
Cough, cold, flu	86 ↓	15%	100	16%
Musculoskeletal, back	62 ↑	11%	50	8%
Gastrointestinal	48 ↑	8%	44	7%

The Trust is continuing to make 'flu vaccination available to colleagues up until the end of March.

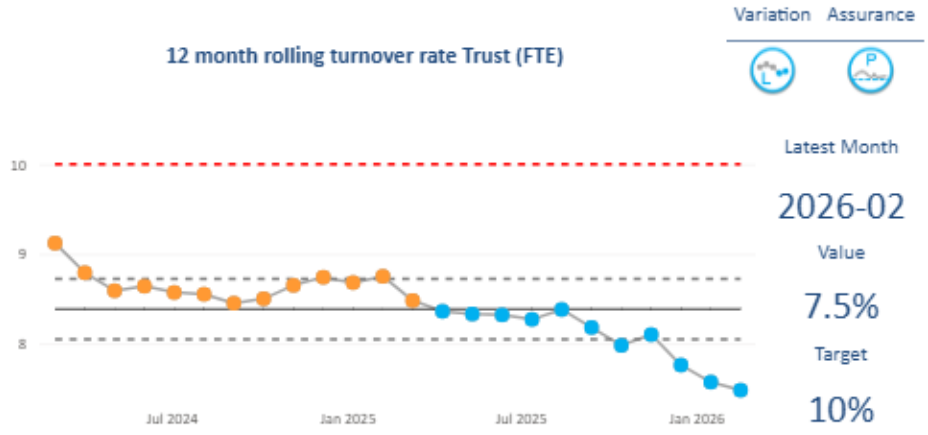
Work on a new wellbeing suite at Scarborough Hospital has been completed, and the space will officially open for use by colleagues shortly. Renovations are underway to provide a similar wellbeing space at York Hospital. Those works are expected to be completed in April and will ensure availability of dedicated facilities for rest and reflection at the Trust's three main hospitals. The development of these facilities has been made possible through funding provided by NHS Charities Together.

On 12 March, the 2025 Staff Survey results were published. Compared with 2024 the Trust's scores show improvements across all key elements and themes, but these remain below average in all areas except for flexible working. Qualitative information from the Survey is still awaited, but in the meantime the co-creation of a 26/27 Colleague Experience Improvement Plan has started and will be presented to the Board in due course.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

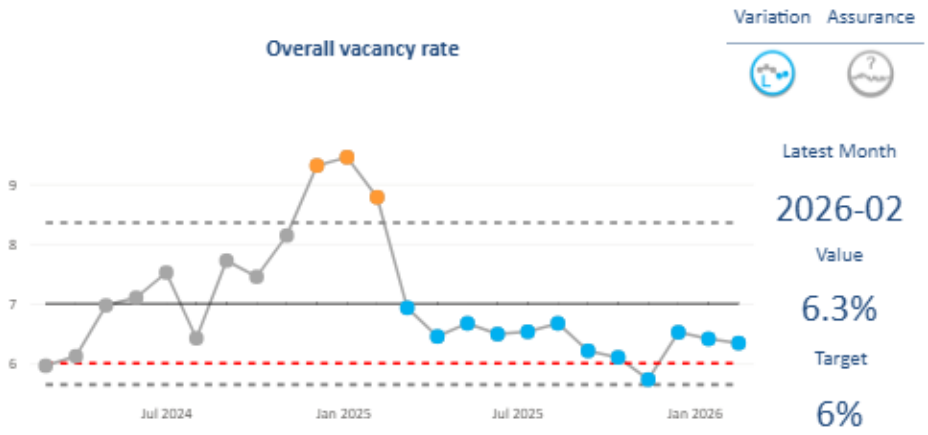
12 month rolling turnover rate Trust (FTE)



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 **0.1**.

Overall vacancy rate



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

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

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

Factors impacting performance and actions:

At the end of January, the Group recorded a total workforce position of 10,077 WTE. This position is broadly in keeping with the Trust's WTE plan (10,104 WTE at the end of January) and shows bounce-back from the December position when recruitment and temporary staffing activity slowed.

The combined bank and agency WTE position in January (656) was marginally lower than in November (660). Overall, at the end of January the Trust was tracking at a -46% reduction in Agency WTE (-62) and a -9% reduction in bank WTE (-55) compared with 2024-25, against targets of -40% (-54) and -10% (-65).

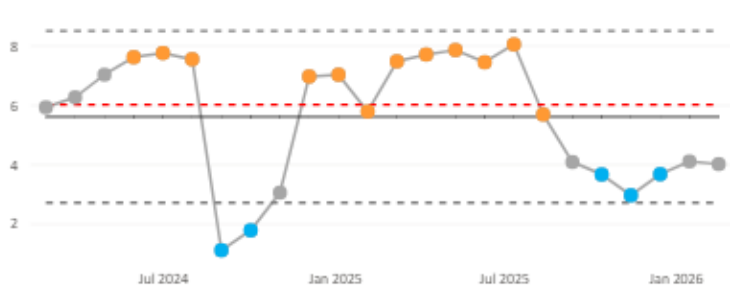
Although the current vacancy control 'triple-lock' system will slow down recruitment in the last month of the financial year, the Trust plans to maintain temporary staffing reductions, and then go further in the new financial year. The aim is for a -30% reduction in agency WTE and -10% in bank WTE by March 2027, and the elimination of agency utilisation by August 2029.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum

Variation Assurance

Medical and dental vacancy rate



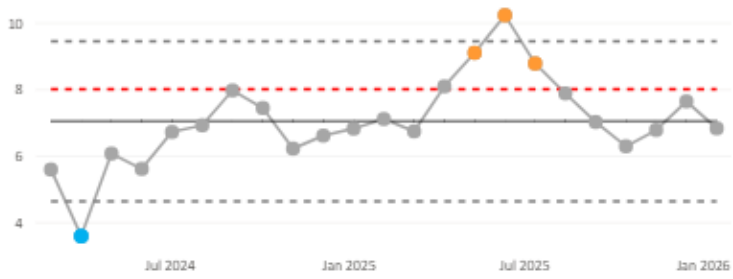
Latest Month
2026-02
Value
4%
Target
6%

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

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

Variation Assurance

AHP vacancy rate



Latest Month
2026-01
Value
6.8%
Target
8.5%

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

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

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

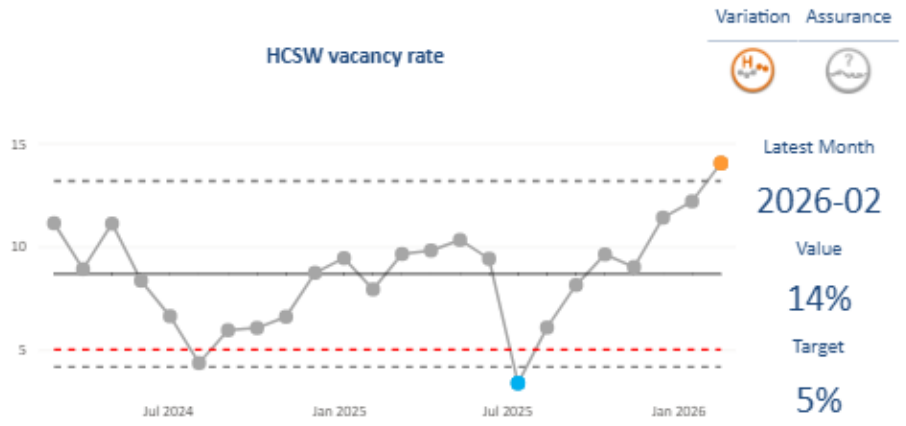
Factors impacting performance and actions:

The Trust has implemented two new Robotic Process Automation (RPA) tools, developed in partnership with a specialist technology provider and funded by NHS England. The first, IRIS (Intuitive Recruitment Information Solutions), is now live within recruitment processes and supports the longlisting of high-volume vacancies—particularly clinical and medical roles—by automating routine checks such as professional registration verification. The second RPA tool, Esther, streamlines the handling of recruitment-related requests by improving the quality of information capture for use in creation of job position records in the Electronic Staff Record. Together, these initiatives are intended to reduce administrative burden, release colleagues from low-value tasks, and improve the efficiency and timeliness of recruitment activity, with benefits to both operational teams and recruiting managers.

In February, the Trust welcomed 10 new medical colleagues, including five permanent Consultants within Occupational Health, Neurology, Histopathology, Trauma and Orthopaedics, and Anaesthetics. In addition, 19 offers of employment for medical posts were made, including four Consultant posts in the following specialties: Care of the Elderly, Ophthalmology (2) and Genito-Urinary Medicine (Sexual Health).

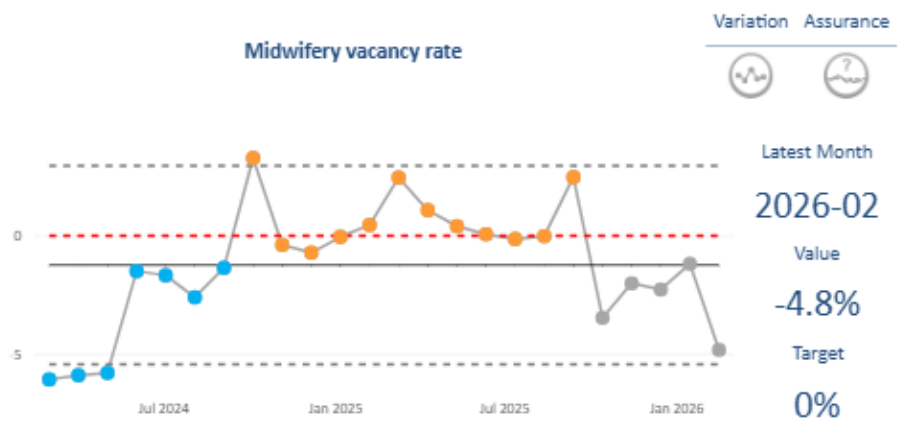
Executive Owner: Polly McMeekin

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 **1.8**.



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

The latest months value has **improved** from the previous month, with a difference of **3.6**.

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

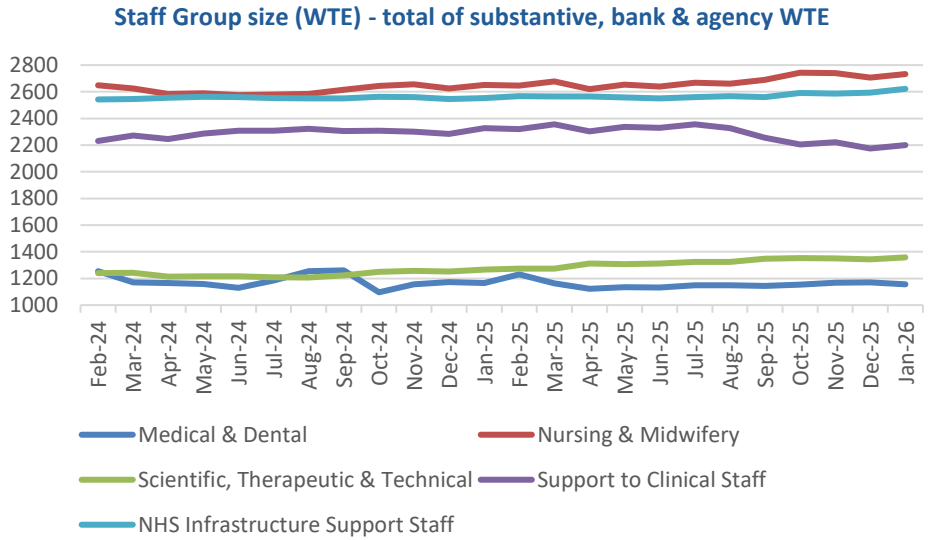
Factors impacting performance and actions:

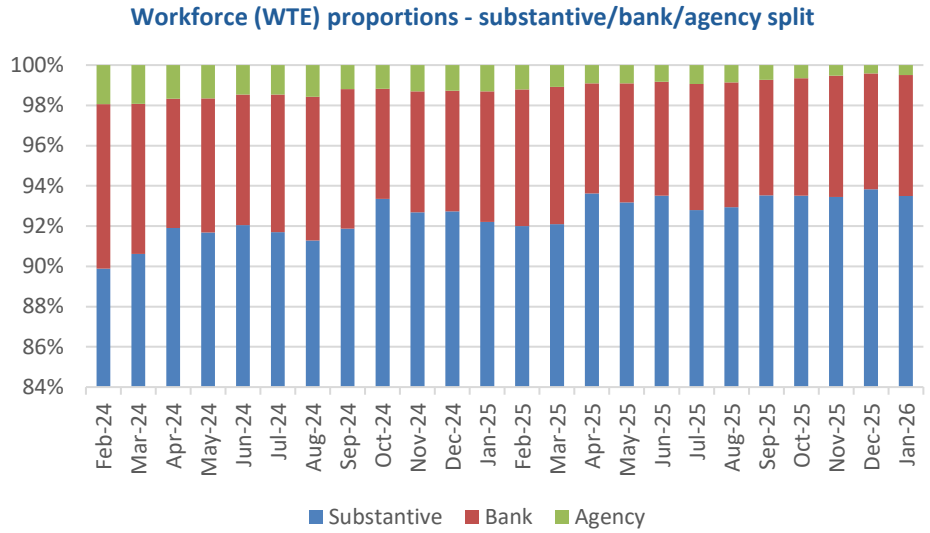
The HCSW recruitment pipeline includes 27 WTE HCSWs undertaking pre-employment checks, and 14 WTE who are booked onto the next Academy in March.

February saw the Nursing Associate headcount increase by 1 from 46 to 47, while the commencement of a new cohort with Coventry University Scarborough increased the number of Apprentice Nursing Associates by 10 to 57.

The final cohort of internationally recruited nurses from India were due to arrive in the Trust at the beginning of March; however, the situation in Iran has led to a re-arrangement. The organisation is now working to support their arrival at the end of the month instead.

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





Factors impacting performance and actions:

The Trust has updated its temporary staffing approval processes following the introduction of triple-lock approvals by the ICB and NHS England. The areas of focus are non-clinical bank and agency, and high-cost clinical agency use, where additional approval steps have been introduced to further scrutinise temporary staffing use.

Following approval of new medical bank rates and an updated escalation process in August, the number of escalated shifts has fallen significantly. 432 shifts had rates escalated in the week prior to the change. The number of rate escalations requested in February dropped slightly to an average of 64 shifts a week, down from an average of 67 shift requests in January.

Administrative bank activity decreased in February to 732 shifts compared to the 893 shifts worked in January. In February, the Trust approved a temporary staffing controls paper which include undertaking a full review of non-clinical bank shifts, and an increase to the level of authority required to request and approve non-clinical bank duties. The review is intended to support Care Groups to identify opportunities to reduce temporary staffing use.

The Group continues to make good progress with implementing eRostering, with over 93% of the workforce now on the system. For the remaining areas, administrative and clerical are at 86% with York Teaching Hospitals Facilities Management at 50%. Both are on track to be fully implemented by Summer 2026 as planned.

Workforce
Scorecard (2)

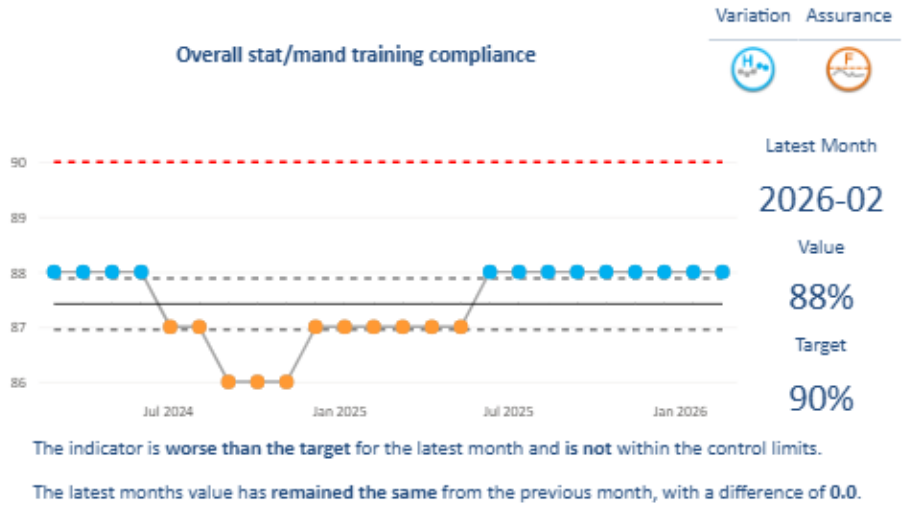
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

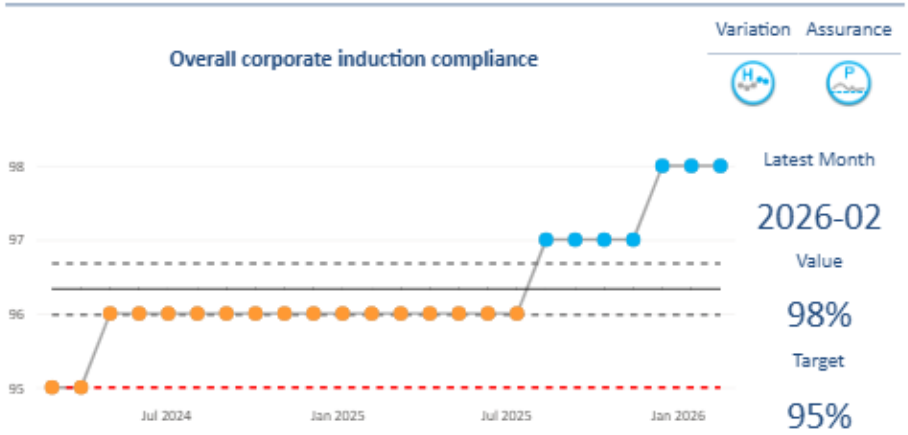
Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2026-02	H	F	88%		90%
Overall corporate induction compliance	2026-02	H	P	98%		95%
A4C staff stat/mand training compliance	2026-02		?	90%		90%
A4C staff corporate induction compliance	2026-02	H	P	98%		95%
Medical & dental staff stat/mand training compliance	2026-02		F	78%		90%
Medical & dental staff corporate induction compliance	2026-02		?	96%		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 February.

The Trust recently delivered a small multi-disciplinary Careers Conference, bringing together internal experts and partners to support colleague development, career progression and retention. The event combined practical workshops, a careers marketplace and interview preparation sessions. Early feedback has been positive, particularly in relation to the interactive sessions and the opportunity to engage directly with career pathways and development support within the Trust. There will now be consideration for scaling up the approach to develop talent, support internal progression and promote the Trust as an employer of choice.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

March 2026

Executive Owner: James Hawkins

Highlights

EPR implementation:

- A "go" decision for Tranche 1 go-live was recommended at the Trust Resilience Group on 19 February following successful completion of all Trust readiness criteria, and a submission was made to NHS England for approval. NHS England confirmed on Tuesday 24th February that they could not approve the go-live.
- The first Tranche includes observations, clinical documentation for inpatients, urgent & emergency care, electronic prescribing & medicine administration, bed management and read-only diagnostic results.
- The T1 build is complete, and the Nervecentre EPR is synchronised and working alongside our existing CPD EPR. Nervecentre is now considered a "live" production service in terms of change control processes, but end users do not yet have access.
- The Trust and Nervecentre have started to review the impact of the 'no go' decision from a milestone perspective and undertake replanning activities to determine potential new go live dates for all Tranches.

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 Copilot across the organisation with focus on efficiency and productivity opportunities.
- Supporting the launch of the new Sexual Health EPR system.

Concerns / Risks

- Uncertainty on EPR programme and impact on costs, benefits and overall schedule.
- 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.

Executive Owner: James Hawkins

Future / Next Steps

EPR implementation:

- Agree revised Tranche timelines with Nervecentre and seek NHS England agreement on revised T1 dates.
- Agree revised schedule for T2 and T3, based on T1 date with Nervecentre.
- Finalised approach to refresher training for T1, depending on revised schedule, and commence organisation wide refresher training.
- Revise and replan overall approach for T1, including scheduling additional clinical, operational and digital staff (including floorwalkers and digital champions.
- Work with Nervecentre to finalise the design for Tranche 2 (which contains full order comms).

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.
- Progress trials of AVT in outpatients.
- Develop governance model for greater alignment of departmental IT systems with Y&S digital.
- Support rollout of electronic ordering for image diagnostics in primary care.
- Support go-live of Scarborough Community Diagnostics Centre.

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

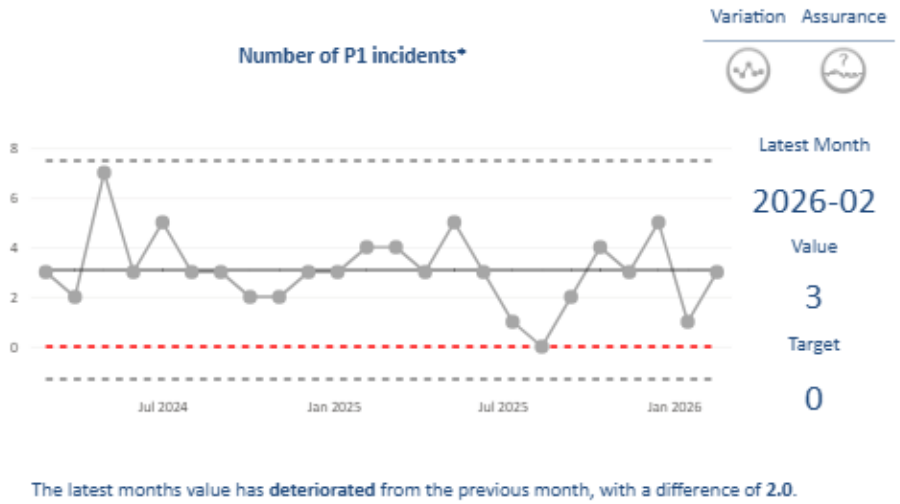
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents* * Percentage of FOIs and EIRs responded to within 20 working days (monthly)	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests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

Executive Owner: James Hawkins

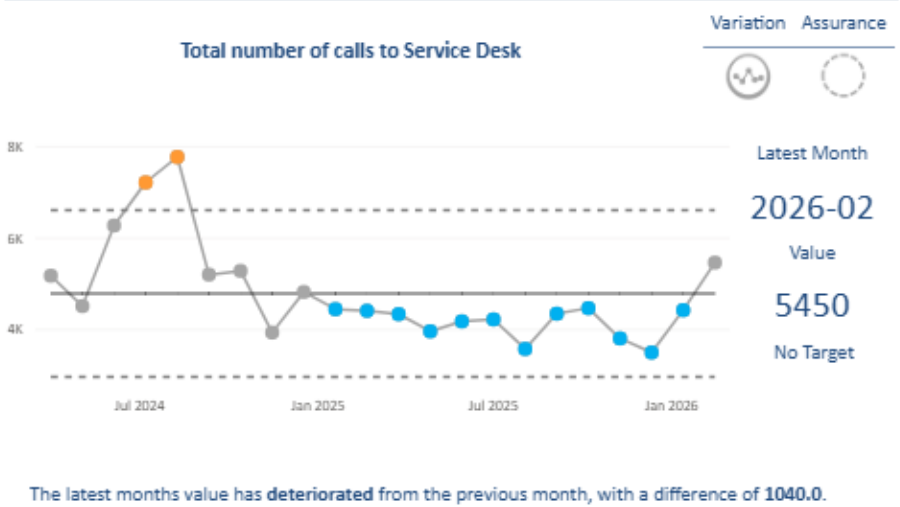
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2026-02		?	3		0
Total number of calls to Service Desk	2026-02			5450		
Total number of calls abandoned	2026-02	H		2997		
Number of information security incidents reported and investigated	2026-02			45		
Number of patient Subject Access Requests (SAR) received (monthly)	2026-02			338		
Number of patient Subject Access Requests (SAR) completed (monthly)	2026-02			229		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2026-02	L	?	81%		80%
Number of FOIs and EIRs received (monthly)	2026-02			64		
Number of FOIs and EIRs completed (monthly)	2026-02			61		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2026-02		?	95%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy



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



The latest months value has **deteriorated** from the previous month, with a difference of **1040.0**.

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

Target: 0 P1 Incidents

Factors impacting performance:

3x P1 incidents occurred in February.

1. 5/2 Issues relating to a Firewall change the previous week became evident and were impacting eReferral Service integration, and advanced tracing of NHS numbers.
2. 12/2 CPD printing of wristband and test request labels was affected by a problem with one of the print servers. Disruption lasted for approx. 30 minutes.
3. 18/2 A planned change to computers resulted in connections to network drives and some servers being blocked due to an error in the configuration. The disruption lasted for several hours for a number of computers before they were updated with new settings. It was not possible to detail how many had updated with the new settings before it was stopped and reverted.

Telephone support and abandoned calls increased during February due to the above incidents as well as the high focus on completing training for Nervecentre, combined with staffing challenges within the Service Desk team.

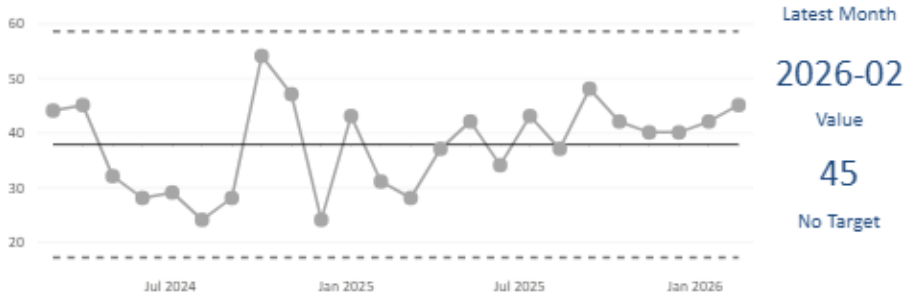
Recruitment is underway but has been prolonged due to ICB triple-lock and the need to offer opportunities to staff on the redeployment register.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2026-02
Value
45
No Target

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

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

Number of information security incidents reported and investigated

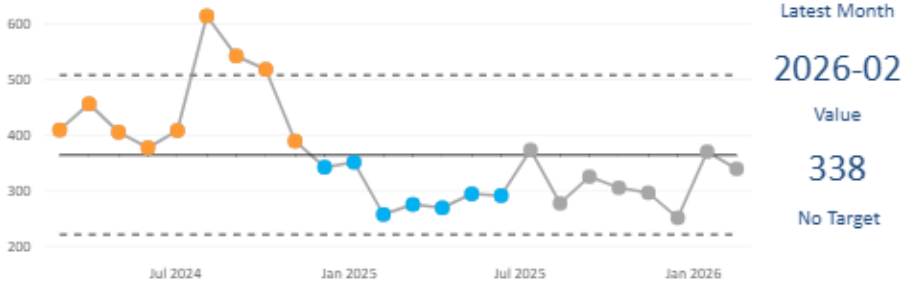
Factors impacting performance:

Information security incidents have slightly increased in February. We have seen a significant number of misfiles reported and email addresses used in error.

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
2026-02
Value
338
No Target

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

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

Number of Subject Access Requests (SAR) submitted by patients

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

Volumes received have increased dramatically, we have seen this trend with other types of information requests. The Trust is currently experiencing a backlog and response times have been impacted.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

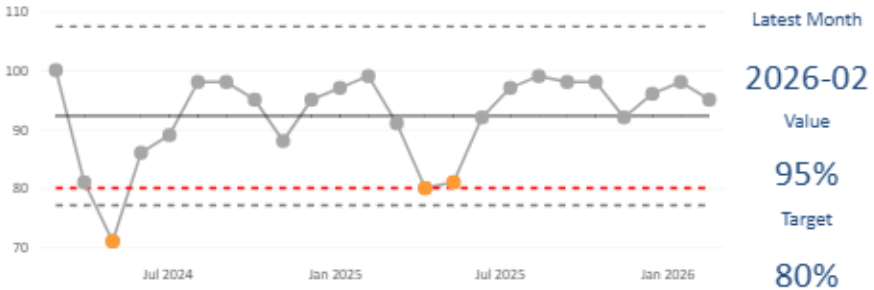
Number of FOIs and EIRs received (monthly)

Latest Month
2026-02
Value
64
No Target

The latest months value has **improved** from the previous month, with a difference of **9.0**.

Variation Assurance

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



Latest Month
2026-02
Value
95%
Target
80%

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

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

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

Factors impacting performance:.

Number of FOIs Received

The number of FoIs the Trust received has decreased.

Actions: N/A

Percentage of FOIs responded to within 20 working days

Requests being sent out on time has increased, and is above the target of 80%.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

FINANCE

March 2026

Executive Owner: Andrew Bertram

Highlights

Income and Expenditure Position

- Month 11 - The Trust are now monitoring financial performance against the £32.6m deficit forecast rather than the balanced plan. The expected position at M11 was a deficit of £16.4m and the actual position £16.6m, £162k adverse to the expected forecast position.
- Efficiency delivery is £12.9m behind plan (compared to £11.9m behind plan at Month 10)
- ERF income has been running ahead of our expected plan; this is now adjusted to £1.2m in line with the reducing trajectory to deliver within the capped value by the end of the financial year.
- The system has lost Q4 deficit support due to the ongoing deficits. This is a £2.8m loss to the Trust in January / February (£4.1m FYE).

Efficiency Programme

- Efficiency delivery has improved in Mth11, with £35.5m delivered to date against a plan of £48.4m. The full year impact of delivery is £37.3m (67.4% of the £55.3m target, and 4% of operational expenditure). Of the £37.3m FY delivery 27% (£10.1m) is recurrent and £73% (£27.1m) non-recurrent at this stage.
- Forecast delivery is £38.8m with £16.5m expected to remain undelivered at the end of the year.

Cash Position

February's cash balance was £39.3m, £3.9m above plan (£35.4m). The £33m I&E deficit, non receipt of sparsity income, and 24/25 ERF overtrade were offset by year-end PDC draw, working capital adjustments, and VAT reclaim timing.

The closing March cash balance now assumes a £24m timing gain from receipt of capital PDC funding drawn in line with NHSE deadlines where capital invoices are not anticipated to be due for payment until Q1.

Executive Owner: Andrew Bertram

Concerns / Risks

- The most significant risk to the financial position is the delivery of the efficiency programme and the recovery action plan. However, February has seen progression in both, with £3.1m recovery action plans delivered against the £5m forecast and efficiency delivery now progressing beyond the current forecast position of £35m. In February, the over delivery compensated for unexpected impacts re a reduction in Education & Training income (£1m) and additional costs of £0.4m through the procurement collaborative. It's vital therefore to continue with the momentum of recovery actions and CIP delivery to meet our expected forecast position.

- The delivery of recovery actions is vital to protect our cash position.

Future / Next Steps

The revised forecast deficit is £28.5m (excl. loss of Q4 DSF)

The Trust MUST meet this position or improve upon it. Ongoing delivery of the efficiency programme and recovery action plan is key to managing this.

Following submission of the Trust's Medium Term Financial Plan on 12 February, further review by the NHSE regional team led to a revised submission on 2 March. The updated plan included a Board-approved in-year improvement of £3m, reducing the projected 2026/27 deficit to £29.6m. Additionally, £5m was released to the ICB for revised high-cost drug growth; this does not change the Trust's deficit due to equal I&E entries but improves the system position by £5m.

Summary Dashboard and Income & Expenditure

Finance (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£12.1m	-£16.6m	↓	Deteriorating
CIP Delivery Variance to Plan (£55.3m target)	-£11.8m	-£13.0m	↓	Deteriorating
Variance to Agency Cap	£1.6m	£1.9m	↑	Improving
Month End Cash Position	£7.4m	£39.3m	↑	Improving
Capital Programme Variance to Plan	-£28m	-£27m	↑	Improving

	Plan	Plan YTD	Actual YTD	Variance	Forecast	FOT variance
	£000	£000	£000	£000	£000	£000
Clinical Income	796,098	729,756	738,573	8,817	788,378	-7,720
Other Income	97,815	89,667	91,977	2,309	103,701	5,886
Total Income	893,913	819,423	830,550	11,126	892,079	-1,834
Pay Expenditure	-592,655	-541,997	-553,340	-11,343	-601,955	-9,300
Drugs	-70,550	-65,184	-71,858	-6,675	-78,445	-7,895
Supplies & Services	-96,918	-88,892	-88,250	643	-95,065	1,853
Other Expenditure	-138,252	-119,807	-120,837	-1,030	-137,540	712
Outstanding CIP	18,018	12,975	0	-12,975	0	-18,018
Total Expenditure	-880,357	-802,905	-834,285	-31,380	-913,005	-32,648
Operating Surplus/(Deficit)	13,556	16,518	-3,736	-20,254	-20,926	-34,482
Other Finance Costs	-12,196	-11,180	-10,025	1,154	-10,367	1,829
Surplus/(Deficit)	1,360	5,339	-13,761	-19,100	-31,293	-32,653
NHSE Normalisation Adj	-1,360	-5,830	-3,333	2,497	-1,360	0
Adjusted Surplus/(Deficit)	0	-491	-17,094	-16,603	-32,653	-32,653
Remove DSF	-16,551	-15,172	-12,413	2,759	-12,413	4,138
NHSE DSF Adjusted Position	-16,551	-15,663	-29,507	-13,844	-45,066	-28,515

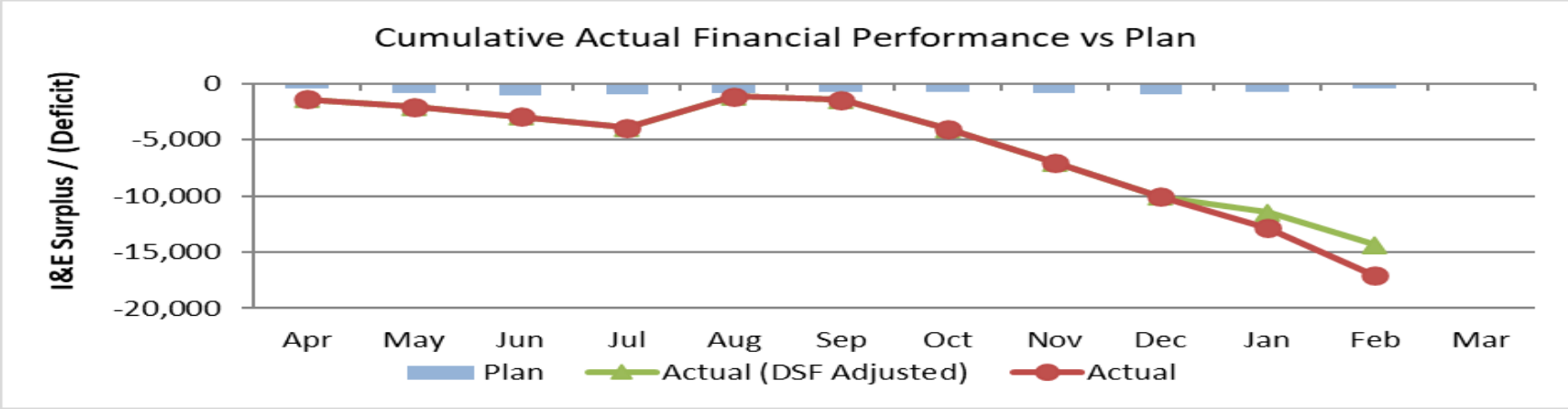
The I&E table confirms an actual adjusted deficit of £17.1m against a planned deficit of £0.5m, leaving the Trust with an adverse variance to plan of £16.6m. The Forecast outturn position is a deficit of £32.6m compared to the balanced plan. The variance from plan reduces to £28.5m following the adjustment to remove Deficit Support Funding (DSF).

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 adverse variance to plan of £28.5m 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 (2)

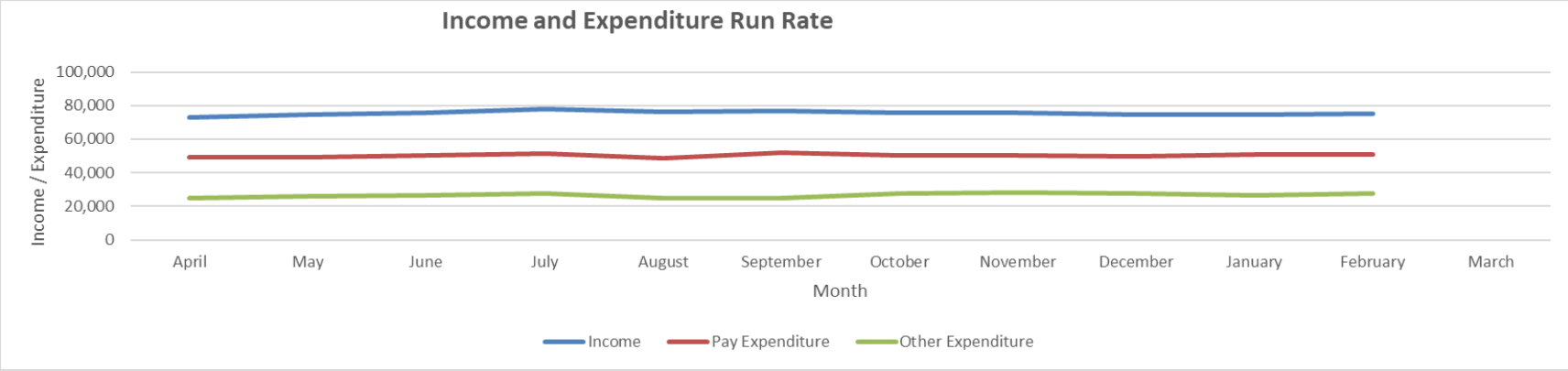
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable / (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	-£32.6m	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	£41.1m	ICB over trade linked to services which have been delegated from NHSE to ICBs to commission. The position also includes £1.2m linked to ERF activity ahead of plan. Although this income is covered by the block contract, £1.2m has been brought forward into the M11 position to recognise activity delivered to date. This action has been agreed by HNY ICB. The position also includes Industrial action funding £2.1m and an under-recovery of Deficit Support Funding for January and February £2.8m	Confirm contracting arrangements and ensure plans and actual income reporting align
Employee Expenses	-£11.3m	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	-£6.7m	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	-£12.9m	Year to date savings of £35.4m have been delivered compared to a plan of £48.4m.	Continued focus on delivery of the CIP overseen by the Efficiency Delivery Group. Financial Recovery Plan agreed with all areas. All action owners required to provide weekly progress update regarding delivery of outstanding CIP and recovery actions.
Other Costs	-£0.4m	Favourable variance on clinical supplies and services (£0.6m) offset by adverse variance on other non pay expenditure (£1.0m).	Identify drivers for increased costs and take corrective action as appropriate.



The income and expenditure plan profile shows an expected cumulative deficit throughout the year with a balanced position achieved in March 2026. The improvement in quarter 4 is due to an expected acceleration in delivery of the efficiency programme.

The actual I&E performance at the end of February 2026 is a deficit of £17.1m compared to a planned deficit of £0.5m. This represents an adverse variance to plan of £16.6m. The variance from plan reduces to £13.8m following the adjustment to remove Deficit Support Funding (DSF).



	April	May	June	July	August	September	October	November	December	January	February	March	YTD Average	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	72,779	74,484	75,671	77,777	76,308	76,960	75,846	75,876	74,851	74,864	75,133		75,542	-409
Pay Expenditure	49,260	49,340	50,028	51,273	48,784	51,884	50,282	50,548	49,895	51,005	51,041		50,230	-812
Other Expenditure	24,784	25,721	26,376	27,404	24,599	24,629	27,807	27,945	27,683	26,486	27,538		26,343	-1,195

The graph and table above show the monthly run rate for income, pay and other expenditure. Income in February was £75.1m, which was £0.4m lower than the average monthly income for April to January. This is mainly due to the Education Contract schedule received in February being lower than anticipated. Pay expenditure in February was £51.0m which was £0.81m higher than the average monthly pay expenditure for April to January. The increase was due arrears paid to maternity support staff and a reduction in the value of staff costs charged to capital schemes. Other expenditure was £27.5m in February, which was £1.1m higher than the average monthly expenditure for April to January. The increase was largely due to truing up charges from the purchasing consortium.

Forecast Outturn & Recovery Action Plans

Finance (5)

NHS
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..	£12m	Non-rec	
Recovery Action Plans		£5m	Rec	
Industrial Action Funding		£2m	Non-rec	
Q4 Spring Contribution		£0.3m	Non-rec	
Total Operational Position				**(£16.5m)**
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.	(£8m)	Non-rec	
Total Exceptional Items				**(£13m)**
Total Deficit Impact				**(£28.5m)**

Forecast Outturn

The forecast change protocol submitted to NHSE ahead of Month 9 accounts set out a most-likely deficit of £33m, based on continuation of the underlying monthly run-rate deficit. Key assumptions included:

- A £20m CIP delivery gap
- Medical and dental pay pressures
- Increased expenditure on high-cost devices and unbundled radiology

These pressures were partly offset by slippage in **non-medical staffing**, **SHYPs**, and **in-tariff drugs**, and assumed that **£10.4m sparsity funding** and **£4.6m ERF overtrade from 2024/25** would **not** be funded by HNY ICB.

The forecast was rejected by NHSE as being at an unacceptable level of deterioration for the final quarter of the year.

Following further discussion, the forecast was revised to reflect:

- Industrial Action Funding: **£2.1m,** Sparsity funding receipt from HNY ICB: **£2.0m,** Q4 spring contribution: **£0.3m,** HCSW pay arrears: **£0.5m**

The revised forecast deficit is £28.5m (excl. loss of Q4 DSF)

Recovery Action Plan

The forecast assumes delivery of **£5m of recovery actions**. The recovery plan remains a live programme overseen by the **Executive Delivery Group**, with progress and impact reviewed regularly and further measures introduced where required.

Scenario analysis has also been undertaken:

Best case: £17m deficit – assumes delivery of the likely case plus receipt in full of sparsity funding and ERF overtrade from 2024/25.

Worst case: £47m deficit – assumes recovery actions are not delivered and the monthly deficit run rate deteriorates further.

Forecast Outturn & Recovery Action Plans

Finance (6)

York and Scarborough Teaching Hospitals NHS Foundation Trust

	Actual April to December									Q4 Forecast		
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	January	February	March
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Revised position - £28.5m Forecast Deficit (excl. DSF Impact)	-1,386	-2,084	-2,936	-3,956	-1,151	-1,484	-4,047	-7,010	-10,049	-11,073	-13,683	-28,515
Revised position - £32.6m Forecast Deficit Including loss of DSF in Q4	-1,386	-2,084	-2,936	-3,956	-1,151	-1,484	-4,047	-7,010	-10,049	-12,452	-16,441	-32,652
Actual position - including loss of DSF in Q4	-1,386	-2,084	-2,936	-3,956	-1,151	-1,484	-4,047	-7,010	-10,049	-12,841	-16,603	
Variance to forecast - including loss of DSF in Q4	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-389	-162	

The table above identifies the actual income and expenditure position for the period April 2025 to December 2025 and identifies the forecast position declared to NHSE for quarter 4 of the financial year. The forecast position is shown both including and excluding lost deficit support funding for quarter 4. The position deteriorates significantly in March due to the full loss of sparsity funding, and the loss of 2024/205 ERF over-trade; both are profiled in full in March.

The forecast for February (including the lost DSF) was a deficit of £16.441m, the actual deficit at the end of February was £16.603m. This demonstrates that the Trust is on track to deliver to the forecast outturn position.

Care Group Forecast
Finance (7)

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	242,290	220,089	219,215	874	222,715	3,500	£1.95m underspend on CDC's due to delay at Scarborough, not expected to continue once all sites operational and £0.9m 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 £1.1m ahead of plan YTD.
Family Health Care Group	90,003	82,275	84,115	-1,840	82,617	-1,497	£654k relates to the premium cost of covering medical vacancies, £921k Community Nursing overspend, £746k Midwifery overspend, £541k Sexual Health underspend, £143k CGM overspend, £612k overachieved CIP.
Medicine	195,554	178,651	187,620	-8,969	179,521	-8,099	£3.7m relates to medical cost pressures in ED and Acute; £2.0m drugs overspend, primarily Gastro, Renal and Respiratory; £1.2m YTD pressure of the unachieved CIP target.
Surgery	168,258	153,137	158,538	-5,402	154,198	-4,340	£2.6m overspend in pay expenditure largely driven by Resident Doctor costs, with further non-pay overspends of £414k in drugs, £847k on consumables linked to increased non-elective activity, and £503k in other costs (removal expenses and premises). CIP overachieved YTD by £393k.
TOTAL	696,105	634,151	649,488	-15,337	639,051	-10,437	

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	242,290	239,278	0	239,278	3,012	Forecast includes £0.4m 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 £1.4m ahead of plan by year end.
Family Health Care Group	90,003	91,802	0	91,802	-1,799	£650k relates to the premium cost of covering medical vacancies, £985k Community Nursing overspend, £696k Midwifery overspend, £591k Sexual Health underspend, £238k CGM overspend, £172k CIP surplus.
Medicine	195,554	204,569	0	204,569	-9,015	£4.1m relates to medical staffing cost pressures, £2.2m drug overspend and £1.6m shortfall in CIP delivery
Surgery	168,258	172,689	0	172,689	-4,431	£2.9m relates to staffing cost pressures - mainly Resident Doctors. £451k drugs overspend, £924k CSS overspend (non-elective driven), and £469k other non-pay costs (removal expenses, premises costs). CIP delivery remains on track to deliver in full.
TOTAL	696,105	708,338	0	708,338	-12,234	

Recovery Action Plans
Finance (8)

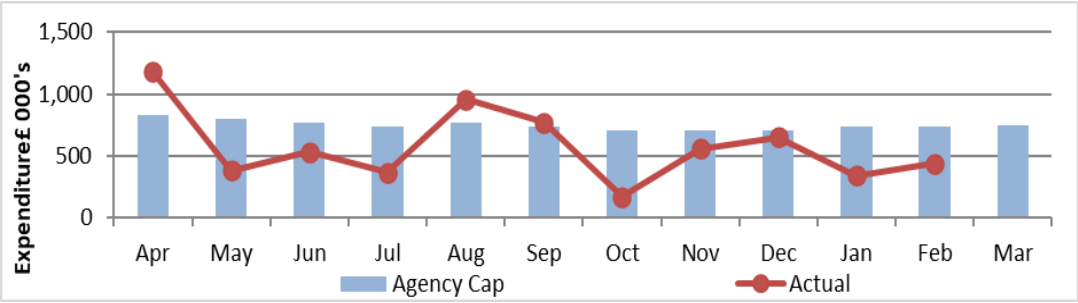
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

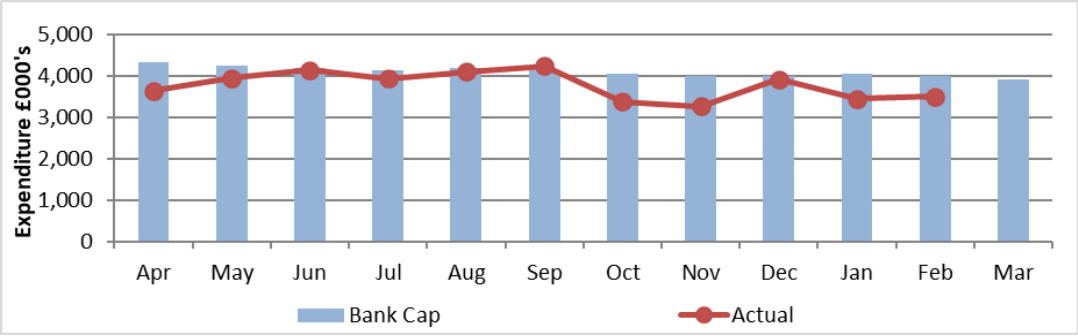
Care Group	Scheme Detail	Action Owner	Potential Value £000	Savings identified in January £000	Savings identified in February £000
Corporate Expenditure Cessation Programme	Consider price increases for all areas where the Trust can control what it charges - catering, parking, rentals, private patient work, etc	Chris Norman	220	26	26
Corporate Expenditure Cessation Programme	Discretionary Non Pay	Andrew Bertram	809	53	62
Corporate Expenditure Cessation Programme	Drug Savings	Stuart Parkes	400	0	395
Corporate Expenditure Cessation Programme	Energy reduction	Lucy Brown	0	0	0
Corporate Expenditure Cessation Programme	NCTR	Claire Hansen	400	0	0
Corporate Expenditure Cessation Programme	Overtime removal. Perform a monthly 'audit' of the top 10 highest overtime earners by central team.	ACOOs / CD	1,277	12	36
Corporate Expenditure Cessation Programme	Review ward stock to rationalise stock levels, requirements and create stock guardian wards for required but infrequently used items	Dawn Parkes	0	99	87
Corporate Expenditure Cessation Programme	Stop first class post	Andrew Bertram	300	0	0
Corporate Expenditure Cessation Programme	Target a 5% spend reduction for the next 5 months for all budget holders including waste reduction competitions	ACOOs / CD	91	0	0
Corporate Expenditure Cessation Programme	Vacancy Grip & Control (13 week firebreak / HNY IBC Double Lock)	ACOO / Directorate Leads	3	0	0
Corporate Expenditure Cessation Programme	Validation Sprint monies for 25/26	Claire Hansen	688	0	95
Corporate Expenditure Cessation Programme	Winter Schemes	Abolfazl Abdi	0	0	1,180
Corporate Expenditure Cessation Programme	EPR	James Hawkins	0	0	1,000
Corporate Expenditure Cessation Programme (cross cutting)	Nurse agency reduction. Including ensuring no off framework agency	Dawn Parkes	80	48	73
Corporate Expenditure Cessation/Reduction Programme	Study leave deferral until April (excluding apprenticeship study, role essential)	Andrew Bertram & Karen Stone	80	0	0
Corporate Expenditure Reduction Programme (cross cutting)	Reduce ward Enhanced Therapeutic Observational Care additional required workforce	Dawn Parkes	20	5	6
Corporate Expenditure Reduction Programme (cross cutting)	Reduction of nursing bank useage for short term cover to an 80% fill rate.	Dawn Parkes	51	28	21
CSCS	Insourced Reporting	Lisa Shelbourn	40	0	20
Medicine	Reduction in admin bank spend	Haaris Mian	11	0	0
Medicine	Reduction in medical agency spend	Haaris Mian	68	24	0
Medicine	Reduction in non-clinical non pay	Haaris Mian	38	25	33
Medicine	Reduction in premium rate spend following substantive consultant appointments	Haaris Mian	80	0	0
Medicine	Reduction in UTC & ED Spend	Haaris Mian	81	0	26
Surgery	Reduction in Medical Bank & Agency Spend	Liz Hill	248	69	58
Surgery	Reduction in overtime/bank spend (Admin)	Liz Hill	5	4	3
Surgery	Reduction in stock held for Clinical Supplies	Alison Pollard	75	19	13
Surgery	Ramsay Contract	Liz Hill	75	0	0
Total			5,139	411	3,134

The table above summarises the recovery schemes that have been agreed for implementation in quarter 4 and the actual run rate savings delivered in January and February 2026. The total planned savings for quarter 4 are £5,139k and actual savings of £411k have been delivered in January and £3,134k in February.

Agency, Bank and Workforce

Finance (9)





	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,656.84	2,562.15	94.69	138,832	141,537	-2,705
Scientific, Therapeutic and Technical	1,341.66	1,285.44	56.22	69,498	69,295	202
Support To Clinical Staff	1,965.65	1,507.97	457.68	59,264	54,652	4,612
Medical and Dental	1,130.40	1117.24	13.16	148,738	159,285	-10,548
Non-Medical - Non-Clinical	3,227.29	3,026.58	200.71	124,723	126,358	-1,635
Reserves				-1,071	0	-1,071
Other				2,013	2,212	-199
TOTAL	10,321.84	9,499.38	822.46	541,997	553,340	-11,343

Agency Controls

The Trust has an agency staffing spend reduction target of 40% based on 2024/25 outturn. The year-to-date expenditure on agency staff at the end of February 2026 is £6.3m, compared to a plan of £8.2m, representing a favourable variance of £1.9m.

Bank Controls

The Trust has a bank staffing spend reduction target of 10% based on 2024/25 outturn. The year-to date expenditure on bank staff at the end of February 2026 is £41.5m, compared to a plan of £45.2m, representing a favourable variance of £3.7m.

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 11 Phase (Av %)	Activity to Month 11 Actual	Variance - (Clawback Risk) M11
Humber and North Yorks	104.00%	£171,355,927	£156,636,395	£157,698,506	£1,062,112
West Yorkshire	103.00%	£1,570,160	£1,435,283	£1,782,974	£347,692
Cumbria and North East	115.00%	£223,602	£204,395	£258,745	£54,350
South Yorkshire	121.00%	£182,919	£167,207	£171,917	£4,711
Other ICBs - LVA / NCA	-				*£0*
All ICBs	***104.02%***	***£173,332,608***	***£158,443,279***	***£159,912,143***	***£1,468,864***
NHSE Specialist Commissioning	113.38%	£4,346,069	£3,972,740	£3,679,103	-£293,637
Other NHSE	104.13%	£305,100	£278,892	£318,092	£39,200
All Commissioners Total	**104.31%**	**£177,983,777**	**£162,694,910**	**£163,909,338**	**£1,214,428**

Please Note: Month 11 actuals include an estimated adjustment for tOphthalmology 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 ERF target levels without 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.

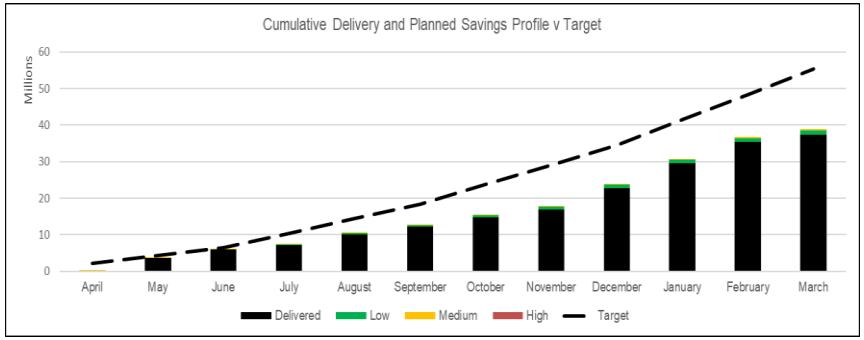
At Month 11, the ERF weighted activity is valued at £1.2m over the funded level of ERF activity across our commissioner contracts. The reported variance includes estimated adjustments for the removal of Ophthalmology OP attendances, where scans and tests, prior to the main eye procedure, have been recorded as a separate appointments. This correction is in line with updated guidance for 2025/26. We expect further adjustments to the SUS data to bring this back in line with ERF target value by the end of the financial year..

Cost Improvement Programme
Finance (11)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

In Year Efficiency Programme Position								
Full Year Delivery Progress			**YTD Delivery Progress**			**Forecast Position**		
	£000			£000			£000	
Trust Efficiency Target	55,290		YTD Target	48,426		Trust Efficiency Target	55,290	
Delivered Recurrently	10,181	18.4%	YTD Deliverey	35,452	73.2%	Delivered at Month 11	37,273	
Delivered Non Recurrently	27,092	49.0%	**YTD Variance**	**12,975**		Forecast Month 12 Delivery	1,565	
Total Delivery	37,273	67.4%						
Remaining to deliver	**18,018**					Forecast Total Delivery	38,838	70.2%
						Forecast Gap	**16,453**	

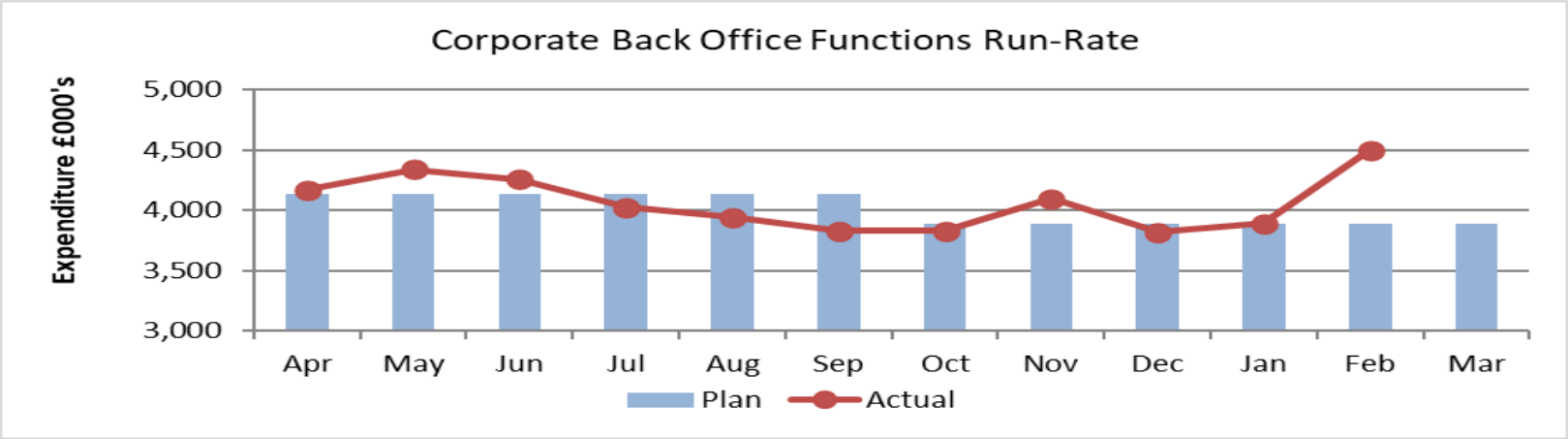
	Full Year CIP Target	February Position			Full Year Position		Planning Position		Planning Status		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Fully Developed	Plan in Progress	Opportunity
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Medicine	6,039	5,289	4,084	1,205	4,208	1,831	4,208	1,831	4,208	0	0
Surgery	4,524	3,963	4,355	-392	4,532	-7	5,381	-856	5,336	45	0
CSCS	7,044	6,169	7,330	-1,161	8,186	-1,142	8,363	-1,320	8,263	100	0
Family Health	2,306	2,019	2,370	-351	2,432	-127	2,478	-172	2,478	0	0
CEO	45	39	722	-683	772	-727	772	-727	772	0	0
Chief Nurses Team	893	782	897	-116	938	-45	938	-45	938	0	0
Finance	733	642	1,166	-525	1,234	-501	1,249	-516	1,249	0	0
Medical Governance	62	54	393	-339	394	-333	440	-378	440	0	0
Ops Management	382	347	948	-601	981	-599	983	-601	983	0	0
DIS	601	526	2,318	-1,792	2,501	-1,901	2,501	-1,901	2,501	0	0
Workforce & OD	763	668	1,562	-894	1,611	-848	1,611	-848	1,611	0	0
YTHFM LLP	1,962	1,718	3,308	-1,590	3,491	-1,529	3,764	-1,802	3,564	200	0
Central	29,939	26,210	5,998	20,212	5,992	23,947	6,150	23,789	6,150	0	0
Total	**55,290**	**48,426**	**35,452**	**12,975**	**37,273**	**18,018**	**38,838**	**16,453**	**38,493**	**345**	**0**



Significant in month delivery of £4.4m has contributed to a full year delivery of £37.3m. This has increased the YTD variance which is now £13m an increase of £1.1m.

Work continues with Care Groups and Directorates to deliver plans which are in place, and a further £1.6m has been forecast to be delivered in the final month. This would result in an under delivery of the Efficiency Programme of £16.5m.

A full exercise is underway to assess conversion of non-recurrent schemes to recurrent.



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 February is £4.50m. This is above the target monthly expenditure figure of £3.95m. The spike in expenditure in February is mainly due to truing up charges from the purchasing consortium (£0.43m).

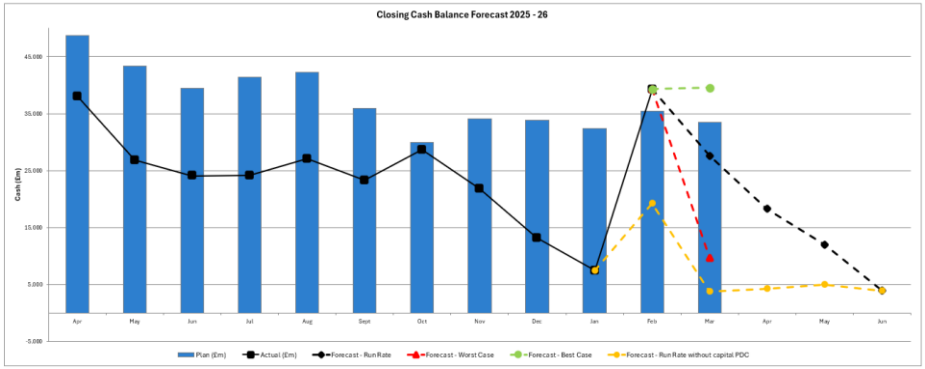
Current Cash Position and Better Payment Practice Code (BPPC)

Finance (13)

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	7,430	39,298	



Closing cash was £39.3m against a plan of £35.4m, which is £3.9m favourable. The significant contributing factors are:

- £19m – Adverse variance in I&E surplus / (deficit).
- £14m – Adverse variance due to non receipt of sparsity income and 24/25 ERF.
- £6m – Favourable variance from the remaining debtor and accrued income position.
- £20m – Favourable variance from capital PDC draw timings for year end.
- £7m – Favourable variance from timing of VAT reclaimed.
- £4m – Favourable variance in other working capital movement timings, including prepayments £2m.

The forecast contains 3 scenarios:

Run rate (black line) – Based on continuation of cash receipts & payment run rates in line with April to February levels and any known adjustments.

Best case (green line) – Based on the best-case scenario financial modelling.

Worst case (red line) – Based on the worst-case scenario financial modelling.

The closing March cash balance now assumes a £24m timing gain from receipt of capital PDC funding drawn in line with NHSE deadlines where capital invoices are not anticipated to be due for payment until Q1.

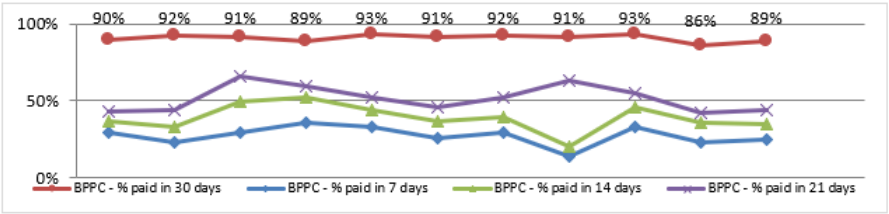
The orange line illustrates the run rate forecast adjusted for unspent PDC. It is assumed that all PDC funded scheme invoices will be paid by June.

This projection is heavily dependent on the 25/26 outturn position, highlighting the importance of the financial recovery actions to protect the cash position.

<u>Better Payment Practice Code</u>

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

The graph illustrates that in February the Group managed to pay 89% of its suppliers within 30 days. This is an increase from previous month where overdue catering invoices impacted on the performance in January.



Current and Forecast Capital Position

Finance (14)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Annual Plan £000s	FOT £000s	YTD Plan £000s	M10 Actual £000s	YTD Variance £000s
80,664	81,227	71,422	44,226	(27,196)

The M11 position is £27m adverse to plan.

This is mainly due to schemes running behind the plan profiles, including SGH RAAC £15m, SGH maternity roof replacement phase 1 £4m, York SCBU refurb £1.7m, the Electronic Patient Record scheme £3m, and backlog maintenance £1m. £4m 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 £81m 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.
- £15m – Additional national funded PDC schemes awarded in the year, including Net zero solar schemes £3m, Modernising histopathology & Labs £3.8m, Relocatable MRI £2m, Operational Capital (ESF & Op Cap) £3m & LIMS scheme £1.8m other PDC schemes at £2m.
- £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 decant of the services and completion of works.
- Hybrid Theatre and PACU schemes are facing contractor timeline pressures.

2025/26 Capital Position	Annual Plan £000s	FOT £000s	YTD Plan £000s	M10 Actual £000s	Variance to Plan £000s
PDC Funded Schemes	56,525	56,754	50,224	31,415	(18,809)
IFRS 16 Lease Funded Schemes	7,838	7,838	6,798	2,017	(4,781)
Depreciation Funded Schemes	16,626	16,635	14,400	10,794	(3,606)
Charitable & Grant Funded Schemes	7,213	7,213	6,445	4,134	(2,311)
Total Capital	**88,202**	**88,440**	**77,867**	**48,360**	**(29,507)**
Less Charitable & Grant Funded Schemes	(7,213)	(7,213)	(6,445)	(4,134)	2,311
Less Sale of Clarence Street	(325)	-	-	-	-
Total Capital (Net CDEL)	**80,664**	**81,227**	**71,422**	**44,226**	**(27,196)**

M10 Position

- ICB £54k overspend YTD, FOT £7.1m deficit relating entirely to non receipt of Q4 DSF funding.
- Providers £55.7m overspend YTD, FOT £93.3m deficit.
- The FOT deficit for the system would be a £73.5m deficit if DSF was received for Q4, (ICB Breakeven and Providers £73.5m deficit).
- Review and discussions are ongoing with NHSE on acute provider's forecast deficit position.

System Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD	Actual YTD	Variance YTD		Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£000	£000	£000	%	£000	£000	£000	%
Humber And North Yorkshire ICB	-	(54)	(54)	(0.0%)	-	(7,093)	(7,093)	(0.1%)
Harrogate And District NHS Foundation Trust	(1,706)	(18,948)	(17,242)	(5.4%)	-	(20,000)	(20,000)	(5.2%)
Hull University Teaching Hospitals NHS Trust	(3,079)	(22,870)	(19,791)	(2.4%)	-	(22,030)	(22,030)	(2.3%)
Humber Teaching NHS Foundation Trust	(424)	2,576	3,000	1.3%	-	3,000	3,000	1.1%
Northern Lincolnshire And Goole NHS Foundation Trust	(4,379)	(13,888)	(9,509)	(1.9%)	-	(14,534)	(14,534)	(2.4%)
York And Scarborough Teaching Hospitals NHS Foundation Trust	(747)	(12,839)	(12,092)	(1.7%)	-	(32,652)	(32,652)	(3.7%)
ICS Total	(10,335)	(66,023)	(55,688)	(1.4%)	-	(93,309)	(93,309)	(1.9%)

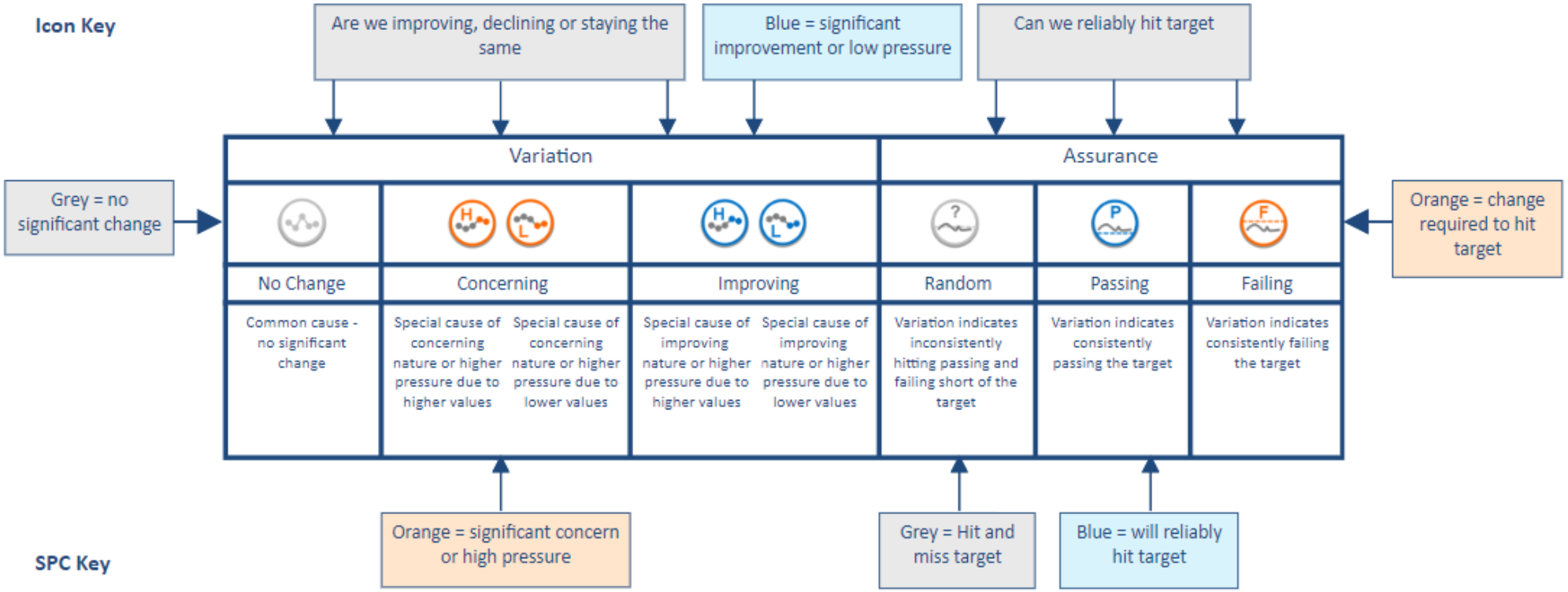
System Revenue excluding Deficit Support Funding

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD	Actual YTD	Variance YTD		Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£000	£000	£000	%	£000	£000	£000	%
Humber And North Yorkshire ICB	(23,587)	(20,826)	2,760	0.1%	(28,304)	(28,304)	-	0.0%
Harrogate And District NHS Foundation Trust	(6,116)	(23,358)	(17,242)	(391.0%)	(5,297)	(24,410)	(19,113)	(360.8%)
Hull University Teaching Hospitals NHS Trust	(14,929)	(33,545)	(18,616)	(157.1%)	(14,233)	(32,705)	(18,472)	(129.8%)
Humber Teaching NHS Foundation Trust	(424)	2,576	3,000	0.0%	-	3,000	3,000	0.0%
Northern Lincolnshire And Goole NHS Foundation Trust	(16,755)	(25,030)	(8,275)	(66.9%)	(14,856)	(25,676)	(10,820)	(72.8%)
York And Scarborough Teaching Hospitals NHS Foundation Trust	(14,540)	(25,253)	(10,714)	(77.7%)	(16,551)	(45,066)	(28,515)	(172.3%)
ICS Total	(76,350)	(125,436)	(49,086)	0.0%	(79,241)	(152,722)	(73,481)	2.3%

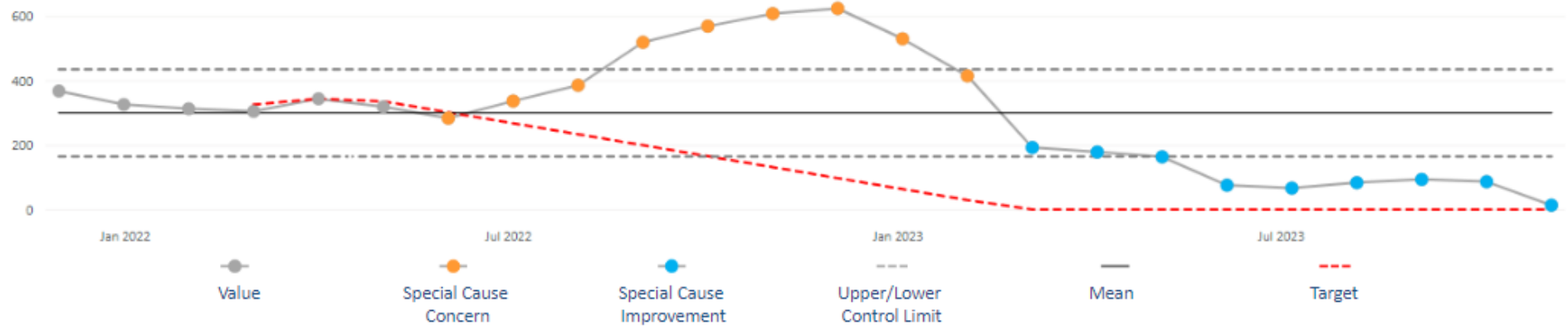
Keys

York and Scarborough Teaching Hospitals NHS Foundation Trust

Icon Key



SPC Key



The orange and blue points indicate either increasing or decreasing trends. The colour will update if 7 points appear either above or below the mean or if 2 out of 3 are near the upper or lower control limit. The target can be either static or moving.

Icon Descriptions

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 14

Report to:	Board of Directors
Date of Meeting:	25 March 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:

Recent CQC activity includes an IR(ME)R inspection of Nuclear Medicine at York Hospital, which identified no breaches and two areas for improvement, with an action plan due by 7 April 2026.

The draft report from the October 2025 inspection of Scarborough Hospital has undergone factual accuracy review, and quarterly updates continue following the July 2025 York inspection.

Ongoing engagement with the CQC continues through quarterly meetings, with non-inspection visits planned for April and October 2026.

At 4 March 2026, the Trust had 19 open CQC cases.

Recommendation:

- Note the current position regarding the recent CQC inspection activity.
- Note the current position of the open CQC cases

CQC Update

1. CQC Activity

1.1 York Hospital Ionising Radiation (Medical Exposure) Regulations (IRMER) Inspection : Nuclear Medicine

The CQC were onsite to inspect Nuclear Medicine at York Hospital on 28 January 2026 as part of their proactive Ionising Radiation (Medical Exposure) Regulations (IRMER) programme.

There were no breaches under IR(ME)R 17 which met the threshold for action.

Two areas for improvement were identified during the inspection. An action plan to address these recommendations must be submitted by 7 April 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 was received for factual accuracy review on 24 February 2026. The review was completed and a response was submitted on 3 March 2026.

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.

There were six breaches to regulation identified in the report. Updates on progress are made at the quarterly engagement meetings.

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 initially planned for February 2026. This has been delayed with the factual accuracy review, but will be completed in March 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 April visit will focus on Surgery.

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 4 March 2026, there are 19 open CQC cases. Of these:

- Six cases have had responses submitted, and we are awaiting feedback from the CQC.
- Seven 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 New guidance for inspectors on care in non-clinical spaces

The CQC have updated their guidance for inspectors assessing safety and quality of hospital care provided in a non-designated clinical space.

Across the NHS, patients are receiving 'corridor care' in spaces that were not designed, staffed or equipped for patient care, including waiting rooms, corridors, and other temporary care environments. This reflects the current lack of capacity to manage rising demand.

Delivering care in such spaces should not be regarded as acceptable and must not become normalised. However, in situations where physical capacity is unable to meet the demand for clinical space, hospital staff need to make risk-based decisions to decide the safest possible approach.

For more information click here**.**

3.2 An update to Right Support, Right Care, Right Culture

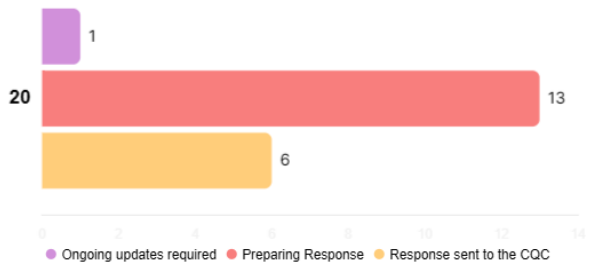
The CQC have revised their statutory guidance, Right Support, Right Care, Right Culture, which sets out their regulatory approach to services for autistic people and people with a learning disability. The revision clarifies how the CQC assess existing services that were developed prior to the guidance was published.

For more information click here.

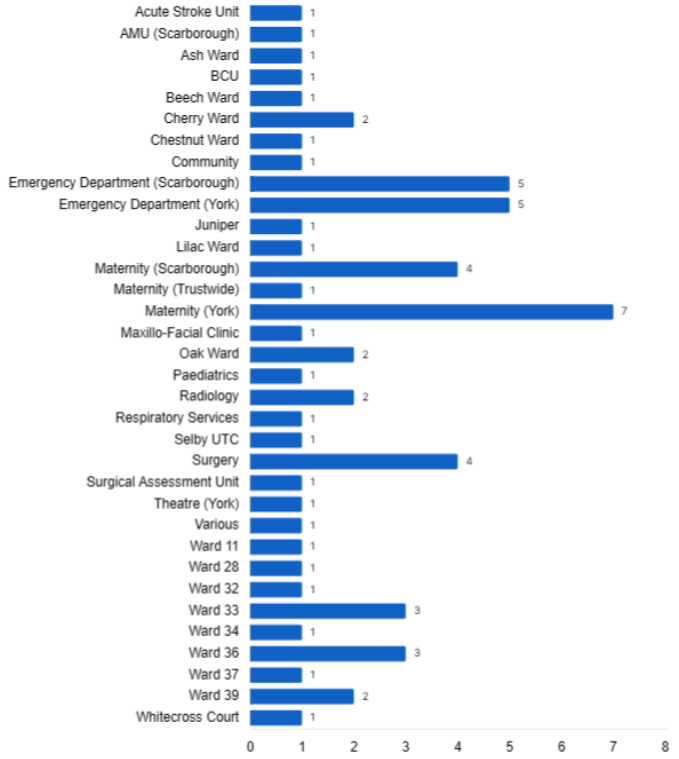
Date: 4 March 2026

Appendix A – CQC cases received over the last 12 months

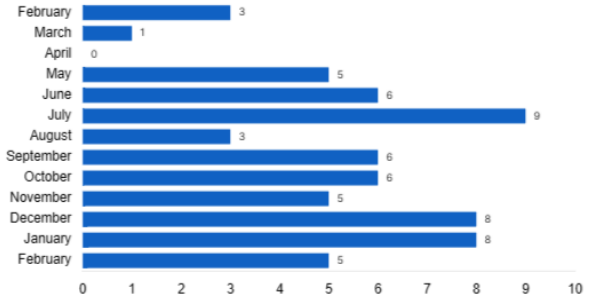
Number of Open CQC Enquiries / Cases



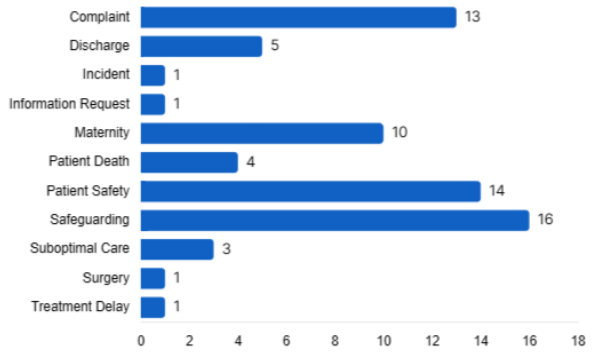
Number of CQC Enquiries by Ward / Dept



Number of Enquiries Received



Number of CQC Enquiries by Theme



York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Trust Board of Directors
Date of Meeting:	25 March 2026
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Dawn Parkes, Chief Nurse (Executive Maternity and Neonatal Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

☒ 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 month of January 2026.

Key Assurance

- The Trust perinatal mortality rate remains at 3.8 /1000 births, this is around average for similar Trusts and remains within 5% mortality rate when compared

with the group average. The stillbirth rate is 2.9% per 1000 births and the neonatal rate is 0.9 per 1000 births.
- The postpartum haemorrhage (PPH over 1500 mls) rate for January was 3.2 % (10 cases) based on the national data the trust is not an outlier for PPH rates.
- The maternity service submitted Maternity Incentive Scheme compliance by the required date of 3 March and is compliant with 7/10 safety actions and if mitigations are accepted by NHSR this will increase to 8/10.
- The newly appointed Deputy Director of Midwifery will commence in role on the 1 June 2026.
- Community Midwifery Services in Scarborough and the East Coast have now moved into a facility called the Street which will enable women to have greater access to antenatal and postnatal community care as well as antenatal education and infant feeding support.

Key Risks

- There is a risk that maternity services receive the funding requested from NHS Resolution in full to progress the implementation of Transitional care across the two sites and deliver on the two key elements within Saving Babies Lives Care Bundle.

Key Concerns

- The total roster vacancy is 21.54 WTE for midwives, which continues to impact on the ability to meet minimum safe staffing requirements for front line clinical areas and impacts on the wider quality, safety and improvement agenda for maternity services. However, there has been successful recruitment that will start to have a positive impact from the new year.
- WRAP target for maternity services has been identified as £1m. The risk to achieving this needs to be recognised with a direct impact on achieving minimum safe staffing levels following investment on the 1 April of £1.5m.

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 March 2026	1. **To note the assurance, risks and concerns as well as the progress in 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, to inform the Trust Board of key areas of improvement to enhance safe maternity care and identify any present or emerging safety concerns and actions required or taken to address them.

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 January 2026.

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 month of January 2026.

Perinatal Deaths

In January, sadly there was one stillbirth and one neonatal death. The service has reported all cases in line with national requirements.

Maternity and Newborn Safety Investigations (MNSI)

There were no cases in January that met criteria for referral to MNSI and one draft report was received which is being reviewed and an action plan is being developed to deliver the five safety recommendations that were made by MNSI.

Moderate Harm Incidents and above

There were 16 incidents graded moderate or above in January along with 4 red flags as per NICE guidance reported which were 2 occasions when the labour ward co-ordinator was not supernumerary and had to provide one to one clinical care to women, 1 delay of planned induction of labour by 2 hours and one delay greater than 24 hours for artificial rupture of membranes to progress the planned induction of labour

Maternity Unit diverts/ closures and suspension of services

The maternity services had to divert on two occasions between York and Scarborough sites. One divert from Scarborough to York due to an estates issue which was rapidly resolved, and one divert from York to Scarborough due to high acuity in the York unit. No women were affected through this period of formal divert due to high acuity and to ensure women received essential planned care safely.

Home birth services were suspended 27 times for Scarborough and the east coast and 22 times for York services due to inability to provide on call overnight. Two women's birth choices were affected, and they attended the unit for their birth.

NHS England have launched a national working group to develop standards for homebirth for maternity services to include women who request care at home with significant clinical risks.

Heath Inequalities, Data and Quality Improvement

The Maternal Care Bundle benchmarking will take place in April following the launch of the assessment tool. Leads and key stakeholders for each of the workstreams have been identified. Implementation of the care bundle is due by April 2027.

NHS England have published a health equalities dashboard; they will be using this data to feed into the Trust health inequalities agenda.

The current dashboard does not include the key metrics for maternity Core 20 plus 5, however the LMNS/ICB have developed a dashboard that does show these metrics and access to this will be provided to the service to provide greater and more valuable analysis of the health equality agenda for maternity and neonatal services. Maternity are engaging with the Trust health inequalities delivery group to provide assurance on the ongoing work in this area.

The Services are working with the City of York Council to support the implementation of the Best Start in Life and are supporting with the 1001 critical day foundation visit on 9th March 2026. The services have expressed an interest in working with North Yorkshire County Council as they commence this work, as well as working to ensure the approach is equal across York, Scarborough and the East Coast.

Maternity Incentive Scheme Year 7 and Year 8

The Maternity Service submitted Maternity Incentive Scheme compliance by the required date of 3 march and is compliant with 7/10 safety actions and, if mitigations are accepted by NHSR, this will increase to 8/10. This shows a significant improvement from last year's position. An action plan has been submitted with funding requested to progress the outstanding two safety actions, which are transitional care Safety Action 3 and Saving Babies Lives Care Bundle V3.2 Safety Action 6.

Overview of the MIS Year 8 Development
Year 8 represents a significant shift in how MIS functions. It responds directly to the findings of our MIS evaluation, national inquiries, system feedback, and Trust-level learning from previous years. The refreshed scheme focuses on:

- greater focus on outcomes, and the assurance of these, rather than processes;
- flexibility for local implementation, recognising that Trusts deliver safe care to meet the needs of their local population in diverse ways;
- a single, coherent set of six safety actions, replacing the previous ten, promoting greater join-up via themes and across professions;
- increased Trust flexibility while emphasising Board accountability; this represents a reduction in prescribed process, combined with a greater emphasis on demonstrating the outcomes and improvements that matter most for women, babies and staff.

A webinar is to be held on 23 April by NHS Resolution to launch the new safety actions. A wide range of the multi-disciplinary team will be in attendance.

Midwifery Workforce

	February 2026
Establishment budget (band 5&6)	147.59 WTE
Staff in post (band 5&6)	159 WTE (includes supernumerary B5)
Roster vacancy	21.54 WTE

This shows an over recruitment to current establishment, due to recruitment to cover maternity leave. Maternity leave for February is 6.67WTE at York and 2.61WTE at Scarborough (9.28WTE total).

Unregistered workforce (B3&4)

There is a vacancy rate of 7.73WTE at York, and -0.93WTE at Scarborough, totalling 6.8WTE vacancy. An additional 4.42WTE Band 3 and 4s will commence in employment in March across the service.

B3 Maternity Assistant posts are currently out to advert, interviewing for Labour Ward Coordinators is scheduled for the first week in March. Recruitment into several specialist and managerial roles has been successful and a Manager for Hawthorne and Community Equitable Health Midwife is going through pre-employment checks currently. Recruiting into the Workforce and Retention Lead post (fixed term to cover maternity leave) was unsuccessful and out to advert again currently.

Improvement and Transformation in January 2026

- the personalised care plans were launched on Monday 2 February 2026 and circulated to all existing and new pregnant women and birthing people;
- the bespoke service user survey to capture real time feedback from service users has been launched alongside the personalised care plans on 2 February 2026;
- the Maternity Services website review and ideas for improvement commenced in hot topics (rapid weekly QI group) during February 2026;
- CQC survey action plan began being developed with a number of actions already progressing within the improvement plan and a new action on pain relief options being proposed for delivery in 2026/27;
- the Perinatal Equity and Anti-Discrimination Programme was discussed at the Maternity and Neonatal Voices Partnership quarterly meeting to commence raising awareness of the programme;
- internal recruitment of Band 3 maternity support workers commenced in February 2026;
- meeting with temporary staffing held to propose improved process to support maternity service needs;
- opportunity of midwifery secondment from inpatient to community advertised to support community midwifery staffing gap;
- “Kindness is our Culture” maternity and neonatal event took place on Friday 6 February; the engagement day brought maternity and neonatal staff together to focus on “Kindness is our culture”, responding directly to themes of burnout and poor behaviours identified in the culture score survey;
- the PPH action plan was presented and approved at the PSI panel;

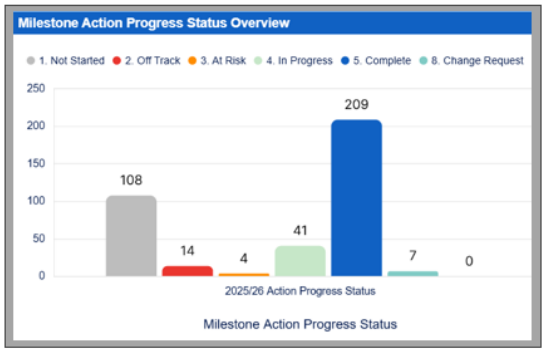
- a bench marking exercise was carried out to refresh how we align to the maternity and neonatal quality and patient safety framework;
- a review of the maternity and neonatal internal communications strategy has been completed;
- ODN cot capacity discussions took place to help inform future service delivery needs; 7 years of data has been sent to the ODN for review and decision pending;
- develop actions to support addressing the gaps following the capacity and demand model for outpatient obstetrics;
- 4-week trial of the G3 main entrance reception role carried out;
- business case for the redevelopment of the G3 entrance drafted;
- project brief outlining the immediate estates works at the Scarborough site was finalised;
- C-section patient information leaflet reviewed and co-produced with MNVP;
- MIS LMNS Assurance meeting held;
- MIS compliance position confirmed and declaration form submitted to Trust Board for sign-off.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

February 2026 Position

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

- **209 out of the 383 milestone actions have been completed to date** (16 actions completed in February 2026)
- **41 milestone actions are in progress**
- **14 milestone actions are off track as the delivery date has passed, and the action has not been completed**
  - 1 off track action is aligned to the care group restructures timeline
  - 6 off track action will be completed by 31/03/2026
  - 7 off track action will be completed by 30/04/2026
  - **4 milestone actions are marked as at risk**, which are due for delivery 01/07/2026. these relate to the implementation of the Saving Babies Lives in house tobacco dependency service due to improvement work stalling in February 2026.
- **7 milestone actions are under review and listed as a 'change request'.**
  - 6 of these milestone actions relate to strengthening the perinatal mental health service offer and actions around equity, information accessibility and discrimination which require review in line with the AMOS interim report which was published on Thursday 26th February 2026.
  - 1 milestone action requires breaking down into career progression planning for each profession and we be incorporated into the 2026/27 delivery plan.
- **108 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.

Risk title	Risk Description	Risk score
Risk of timeline delays impacting overall programme delivery	There is a risk that key programme actions may not be completed within planned timelines due to factors such as interdependencies with other services, delayed decision making, delayed governance processes, resource constraints, extended stakeholder reviews, or unforeseen operational pressures. These delays can cause slippage across key milestones,	12 *Impact: High* *Likelihood: Medium*

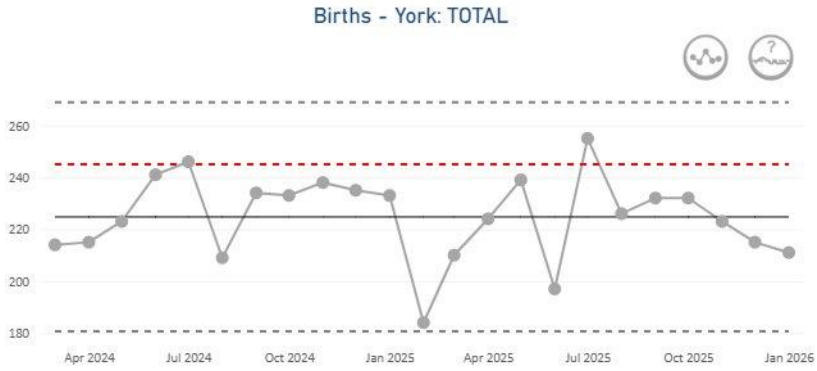
	affecting the ability to meet overall delivery timelines.	
Insufficient investment to support programme and project delivery	There is a risk that the Maternity & Neonatal Service will not receive the required financial investment, resource uplift, or capital funding needed to progress key improvement plan actions	16 *Impact: High* *Likelihood: High*
Expansion of programme scope	There is a risk that the programme's scope expands beyond what was originally agreed, due to informal requests, evolving expectations, national context or pressure from stakeholders to include additional work.	16 *Impact: High* *Likelihood: High*
Loss of key staff impacting programme delivery	There is a risk that key members of the programme leadership team (SRO's, Workstream leads, subject matter experts, programme team etc.) leave the organisation or move roles. Loss of key staff may lead to gaps in expertise, reduced institutional knowledge, delays in decision making, and decreased programme momentum.	12 *Impact: High* *Likelihood: Medium*
Insufficient resources, skills, tools and over-reliance on third parties	There is a risk that the programme will be unable to deliver key actions due to limited internal capacity, shortages of specialist skills, lack of access to required tools or systems, and a dependency on third parties (e.g. contractors, suppliers, business intelligence and partner organisations)	12 *Impact: High* *Likelihood: Medium*

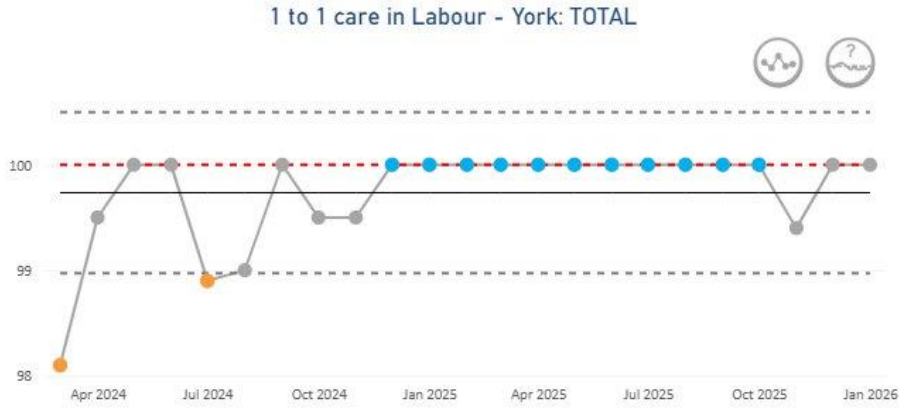
Recommendations to Trust Board

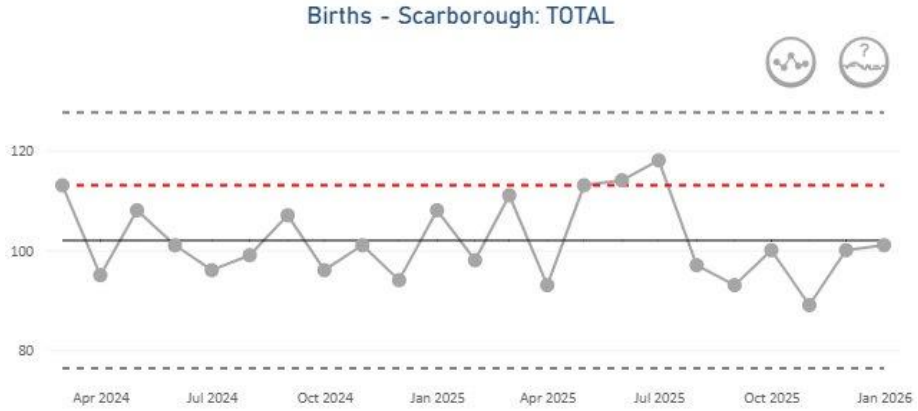
To note the contents of this report

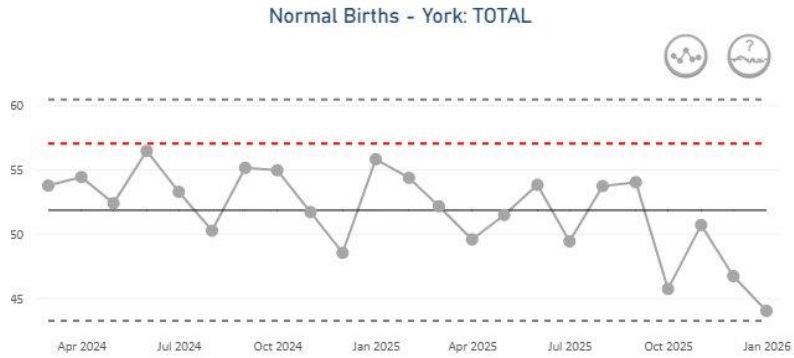
Date: 25 March 2026

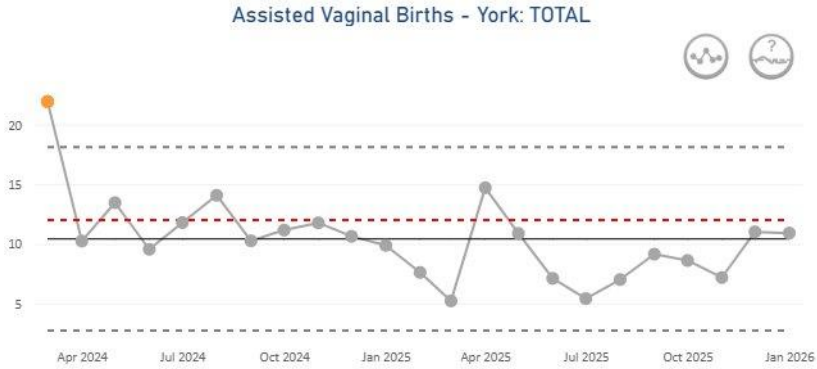
Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery January 2026

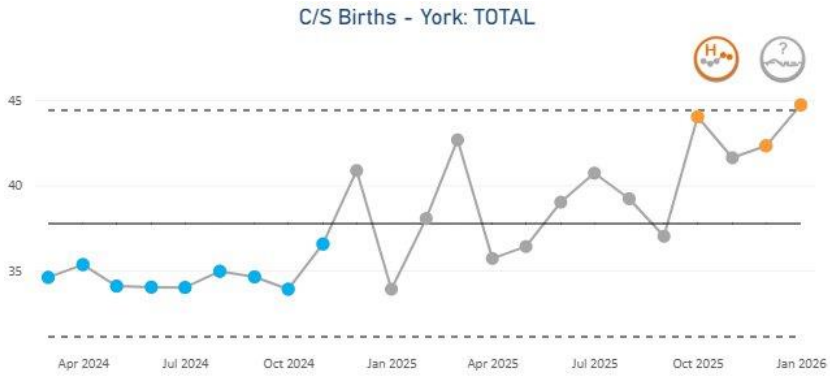


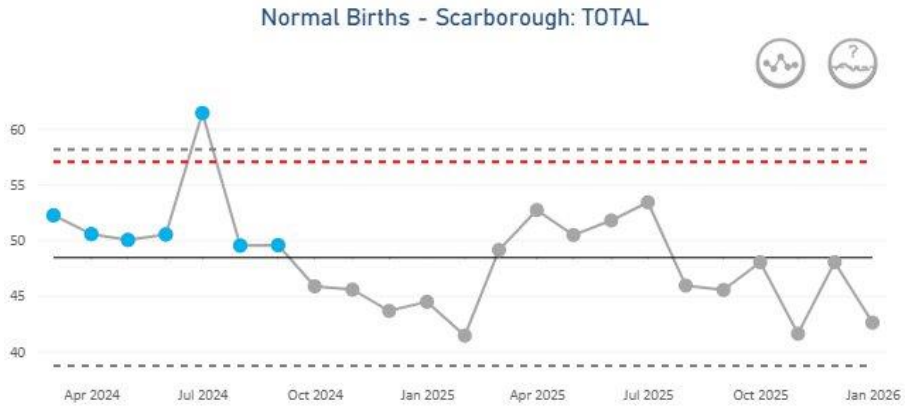


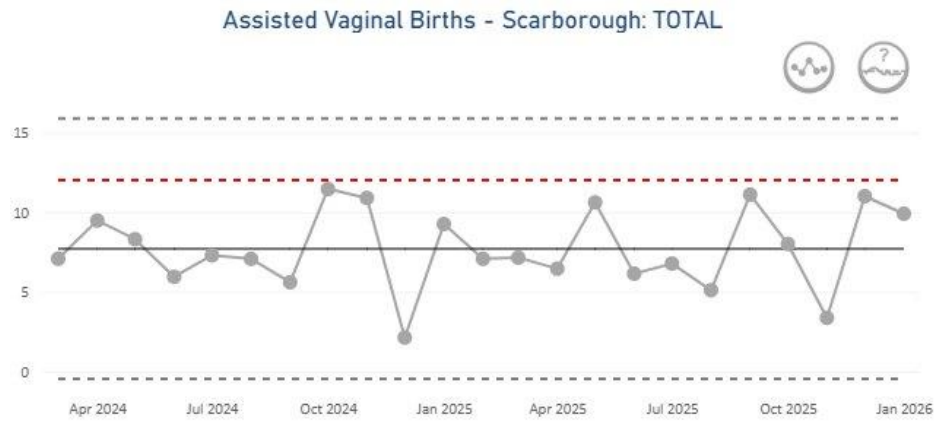


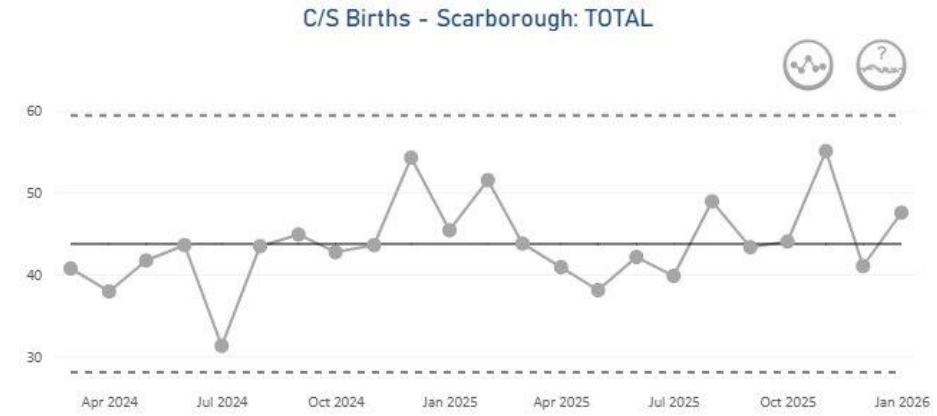

Normal Births - York: TOTAL
60
55
50
45
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

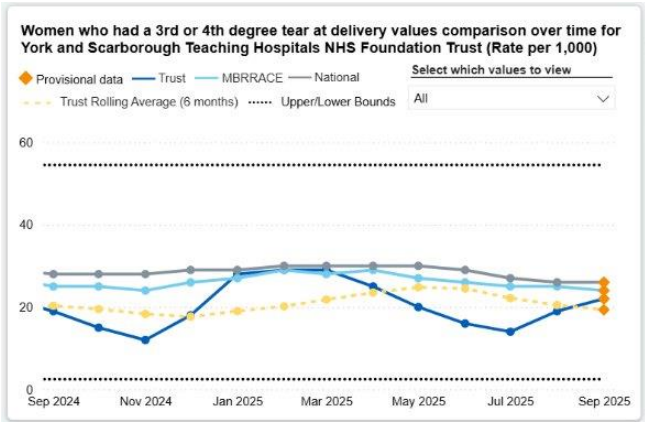

Assisted Vaginal Births - York: TOTAL
20
15
10
5
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

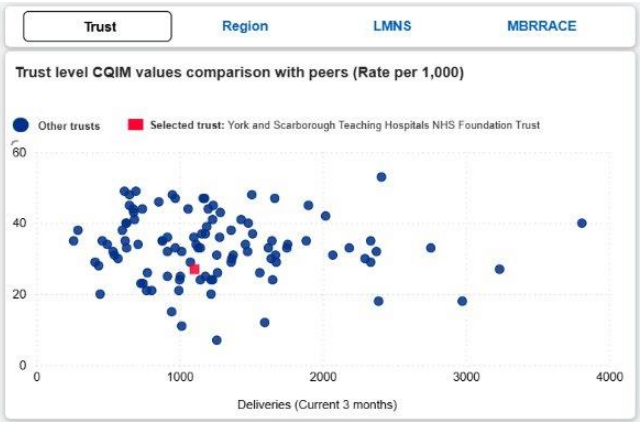

C/S Births - York: TOTAL
45
40
35
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026


Normal Births - Scarborough: TOTAL
60
55
50
45
40
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026


Assisted Vaginal Births - Scarborough: TOTAL
15
10
5
0
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026


C/S Births - Scarborough: TOTAL
60
50
40
30
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026


Women who had a 3rd or 4th degree tear at delivery values comparison over time for York and Scarborough Teaching Hospitals NHS Foundation Trust (Rate per 1,000)
Provisional data
Trust
MBRRACE
National
Trust Rolling Average (6 months)
Upper/Lower Bounds
Select which values to view
All
60
40
20
0
Sep 2024
Nov 2024
Jan 2025
Mar 2025
May 2025
Jul 2025
Sep 2025


Trust
Region
LMNS
MBRRACE
Trust level CQIM values comparison with peers (Rate per 1,000)
Other trusts
Selected trust: York and Scarborough Teaching Hospitals NHS Foundation Trust
60
40
20
0
0
1000
2000
3000
4000
Deliveries (Current 3 months)

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 16

Report to:	Board of Directors
Date of Meeting:	25 March 2026
Subject:	Quarter 3 Mortality and Learning from Deaths Report
Director Sponsor:	Karen Stone – Medical Director
Author:	Owen Bebb- Associate Medical Director for Patient Safety Alice Hunter- Patient Safety Specialist

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☐ Not Applicable

Summary of Report and Key Points to highlight:
This report encompasses the following areas:

- York and Scarborough Hospitals NHS Foundation Trust mortality rates:
  - Crude mortality
  - SHMI (Summary Hospital Mortality Index)
  - HSMR (Hospital Summary Mortality Indicator)
- Diagnostic groups most contributing to mortality rates
- Learning from deaths - data:

- Nationally mandated data
- Locally mandated data
- Quality account data

- Learning from deaths – themes, actions and escalations
  - Poor care was given to 4/15 SJCR's reviewed.
  - Moderate harm was given to 1/15 SJCR's reviewed.
  - Reintroduction of Medical Examiner representation
  - Improvement Group reporting schedule reintroduced
  - Maternity update in section 5.1 of the report

Metric	Result
Crude mortality	Crude mortality is 3.1s% (September 2024 to August 2025) (12 month rolling HES data)
SHMI - NHS England[1]	SHMI for 12months (September 24 to August 2025) is 90.9

[1] SHMI NHS England - Summary Hospital Mortality Indicator 12month rolling, NHSE SHMI dataset

Recommendation:
The Board of Directors is asked to note the report and receive the escalations.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation
Learning from Death Group	09/02/2026	
Patient Safety & Clinical Effectiveness Subcommittee	11/02/2026	
Quality Committee	24/03/2026	

Special note

The Trust no longer subscribes to the HED data system, as a result the information provided in this report will change and appear different, other data sources are currently being explored. The datasets are not as current. The data for October 24 to September 25 will not be published till 12th February 2026.

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 provider spells. The rolling 12month trend is now decreasing compared previous 12 month periods. The crude mortality rate (12-month rolling, September 24 to August 25) stands at 3.1%.

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.

There is now one risk-adjusted mortality rate model.

- NHS Digital-SHMI: uses HES data and is available 6 months in arrears.

The latest NHS-Digital Summary Hospital Mortality Index (SHMI) to August 2025 (covering September 24 to August 25) shows the SHMI was 90.96 The SHMI in comparison to other Trusts is displayed below (Figure 1). We continue to see a decrease in SHMI HES data previously 92.64 (August 24 to Jul 25). The numbers in this period were for expected deaths 3450 and observed deaths 3135. These are similar to previous values.

The SHMI across both sites continue to reduce York 0.88 (previously 0.90) has a lower SHMI than Scarborough 0.94 (previously 0.95). Figure 2 shows the position of both sites in a funnel plot format, Figure 3 as box plot.

Figure 1 SHMI (HES data) Funnel plots (in comparison with other Trusts)

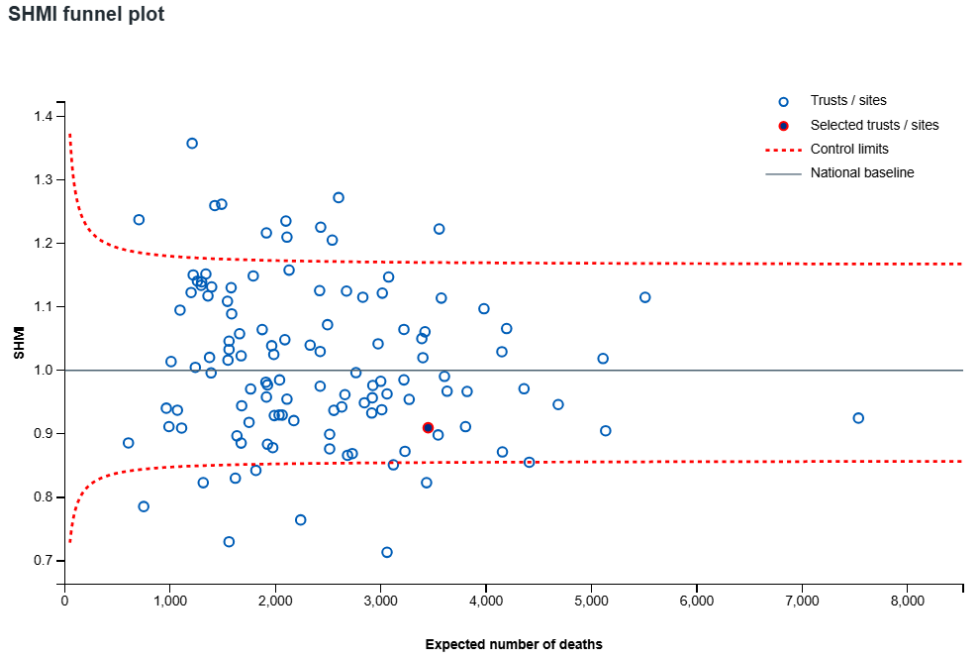


Figure 2 SHMI site comparison September 2024 to August 2025

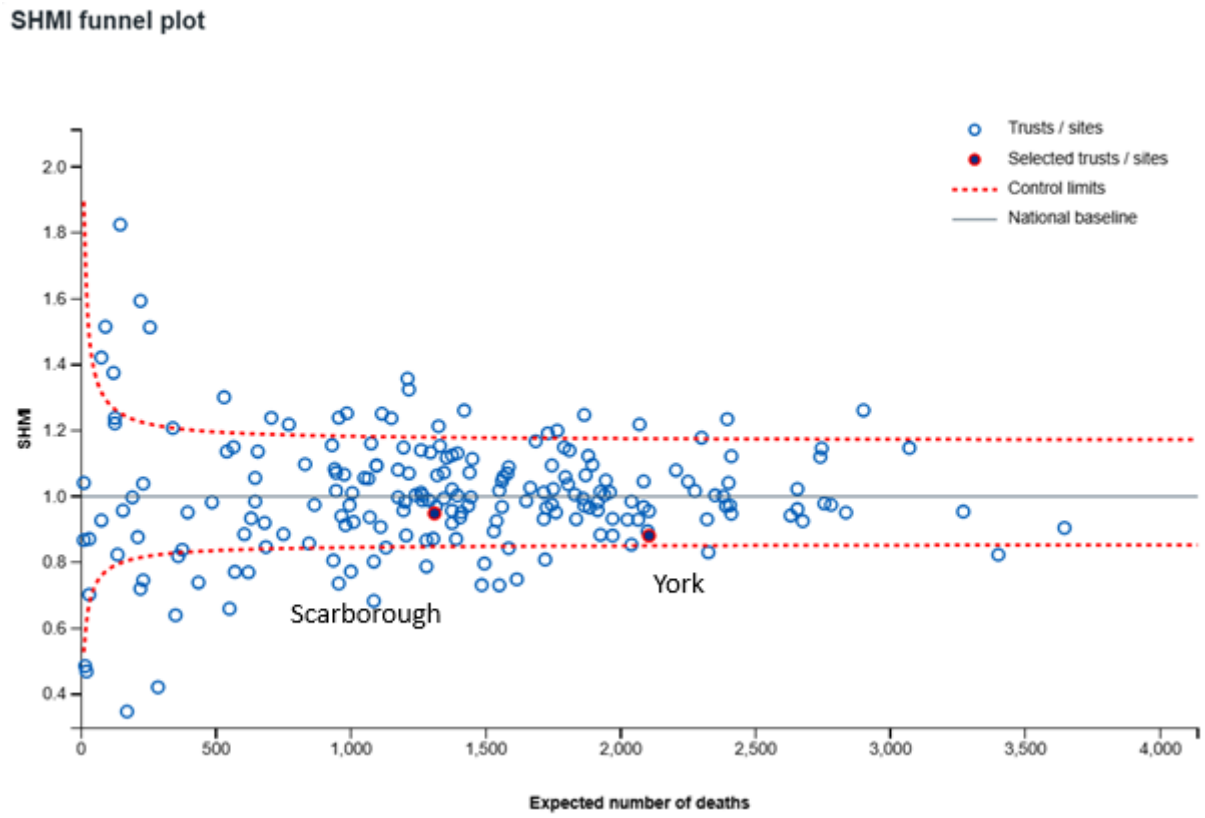
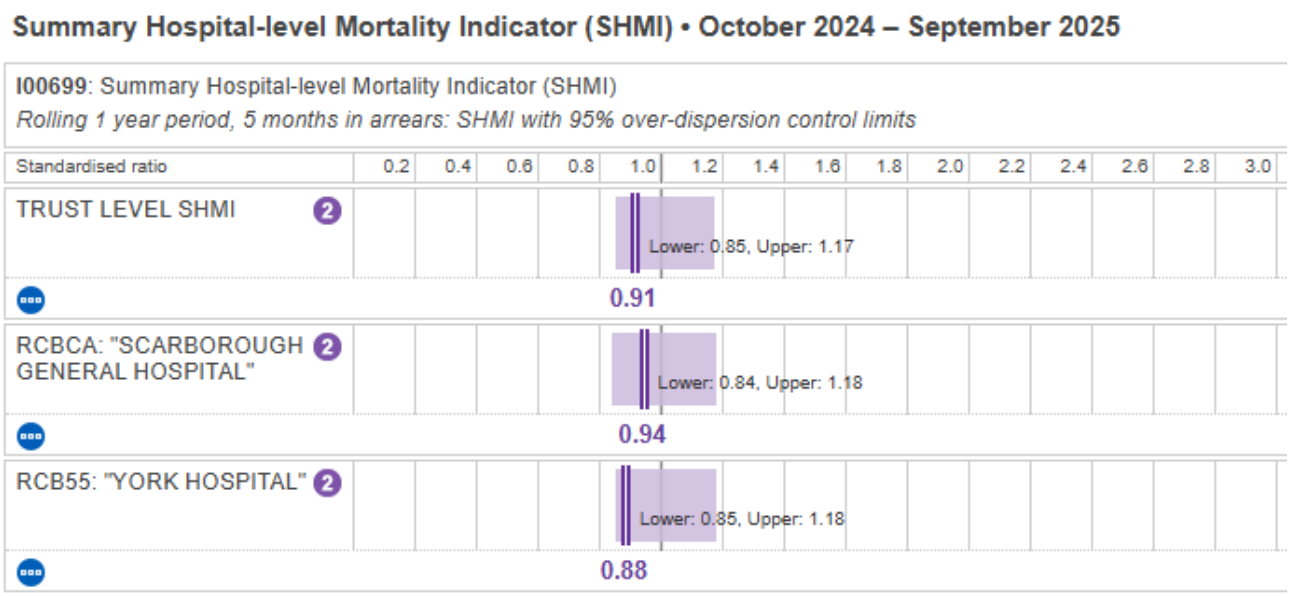


Figure 3 SHMI site comparison



1.3 Hospital Standardised Mortality Ratio (HSMR)

HSMR is not routinely reported as part of the HES data set available to the trust at present.

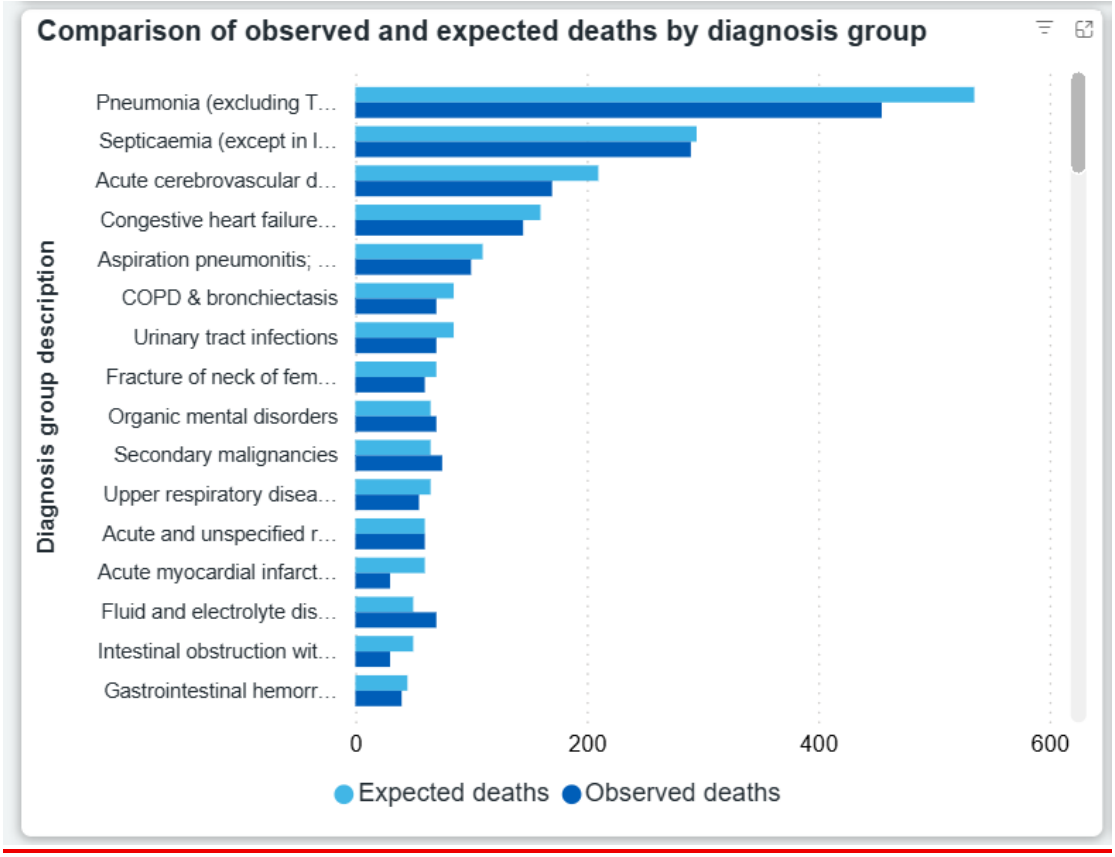
2. Diagnostic groups contributing to our mortality rates

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 4 below. At present there remain no diagnostic groups causing concern (all are at or below the expected level when adjusted for SHMI). There are more observed than expected deaths in secondary malignancies, organic mental disorders and fluid and electrolytes. Septicaemia which has been a key focus in the trust and we now see more expected deaths than observed deaths in this group.

Figure 4: SHMI associated with various diagnostic groups (from HES data) for September 24 to August 25 (Top 16)



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 was introduced in December 2023.

Table 1 – National data summary

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
	Quarter 4 (24/25)			**Quarter 1 (25/26)**			**Quarter 2 (25/26)**			**Quarter 3 (25/26)**		
Total in-patient deaths (inc ED, exc community)	257	211	253	196	187	178	168	141	171	185	166	197
No. SJCRs commissioned for case record review[1]	6	4	7	5	7	3	2	2	5	5	9	2
No. PSII commissioned of deceased patients	0	2	1	2	2	2	0	1	1	1	1	0
No. deaths likely due to problems in care	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).

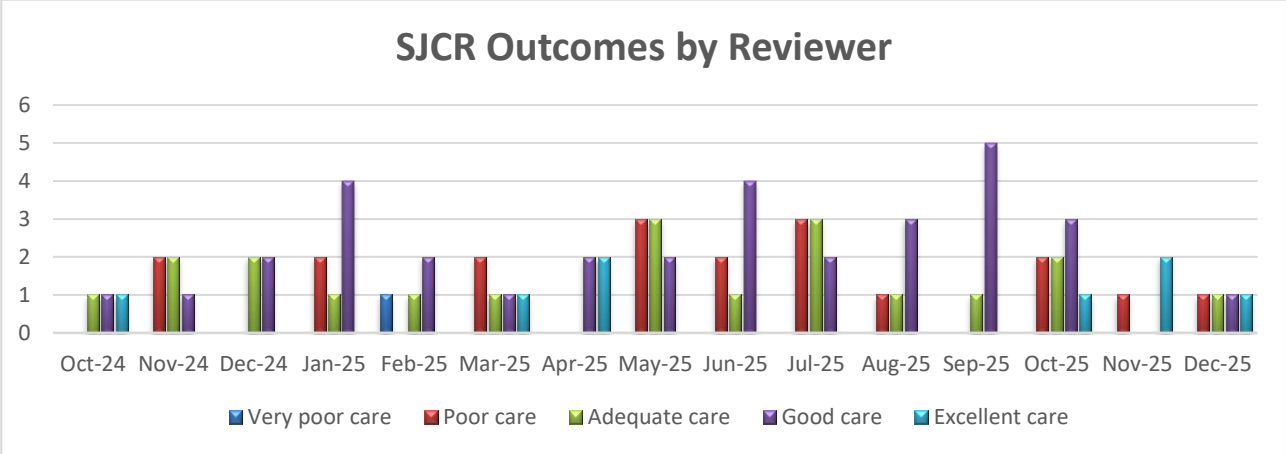
National guidance requires the publication of the number of deaths reviewed or investigated judged more likely than not to have been due to problems in care. Whilst avoidability of death is not measured at the Trust, a judgement of the overall standard of care, and the consideration of harm, forms part of the review process.

Figure 6 shows the outcomes of the SJCRs **completed and reviewed** during, Q4, 24/25 and Q1, Q2 and Q3, 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 Q3 15 SJCRs were reviewed (19 in Q2):

Figure 6 – SJCR outcomes assigned by the Reviewer (overall score)



The Reviewer found there to be:

- Good care in 4/15 cases.
- Excellent care in 4/15 cases
- Adequate care in 3/15 cases
- Poor care in 4/15 cases
- Very poor care in 0/15 cases

The Poor care cases were all discussed at Q&S prior to LFD to ensure they were not potential Patient Safety Incident Investigations (PSII's).

These were:

Oct '25

ID3628 -Low harm, theme Communication and documentation.

ID4004- No harm, theme clinical assessment.

Nov '25

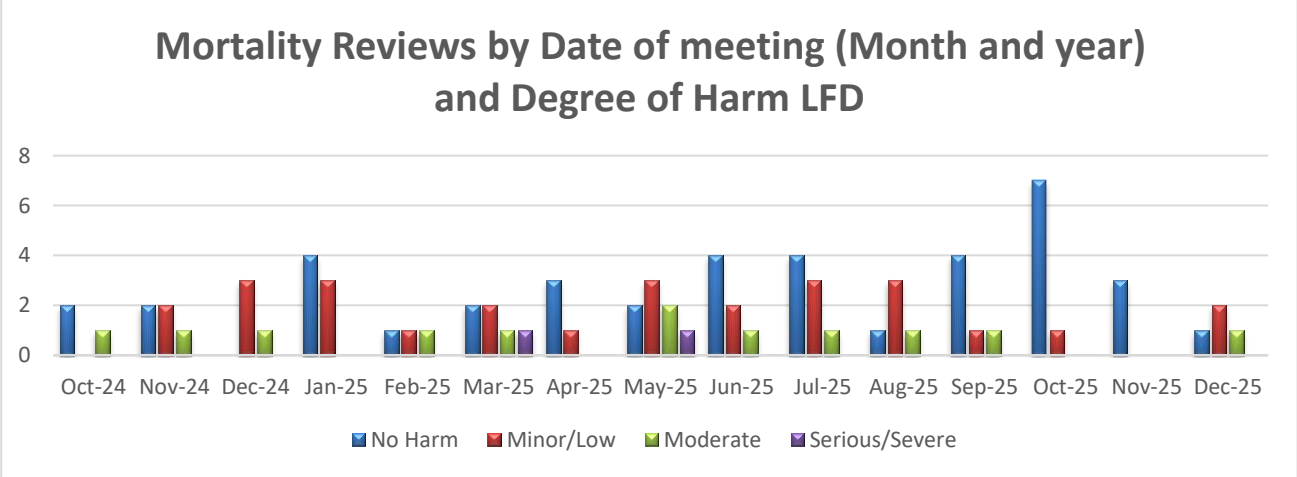
ID4173- No harm, theme MCA.

Dec '25

ID5075- No harm, theme of delayed diagnosis.

The LfD group will decide on the level of harm for the SJCRs presented. The degree of harm levels is 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 1 case, low in 3 of the cases and no harm in 11 cases.

Moderate harms

ID3460 – Adequate care, there was no ED assessment, Clerking was illegible, Admitted to general ward rather than cardiology.

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 (12/01/2026)

Overall no. of SJCRs open 34 (previously 40 as of 04/07/2025)

Figure 8 – Mortality Reviews by SJCR Status (date collected (12/01/2026)

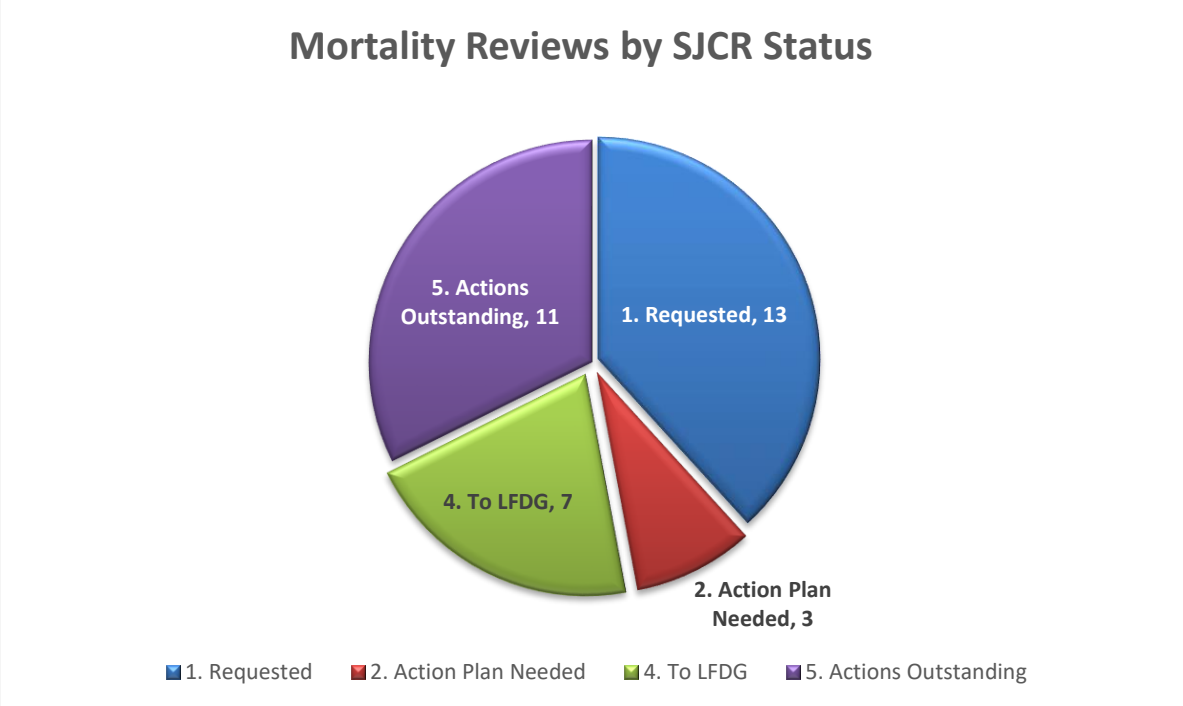


Table 2 - Status of open SJCRs

	Q4 (24/25)	Q1 (25/26)	Q2 (25/26)	Q3 (25/26)
Number under review	17	15	17	20
Awaiting action planning	3	5	5	3
Actions outstanding	1	8	12	11
More than 60 days overdue (exc. awaiting LfD Group & action implementation)	9	8	5	4

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 3 – 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	Q3 25/26	
27.1	Total number of in-hospital deaths	561	480	548	
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	ME:548	
		SJCRS: 15	SJCRS:9	SJCRS:16	
		PSII:6	PSII:2	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	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	SJCR:	
		PSII:5	PSII:0	PSII:3	
27.8	No. of deaths in item 27.7 judged more likely than not were due to problems in care.	0	0	0	

27.9	Revised no. of deaths stated in 27.3 of the previous reporting period, taking account of 27.8	0	0	0	

[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:

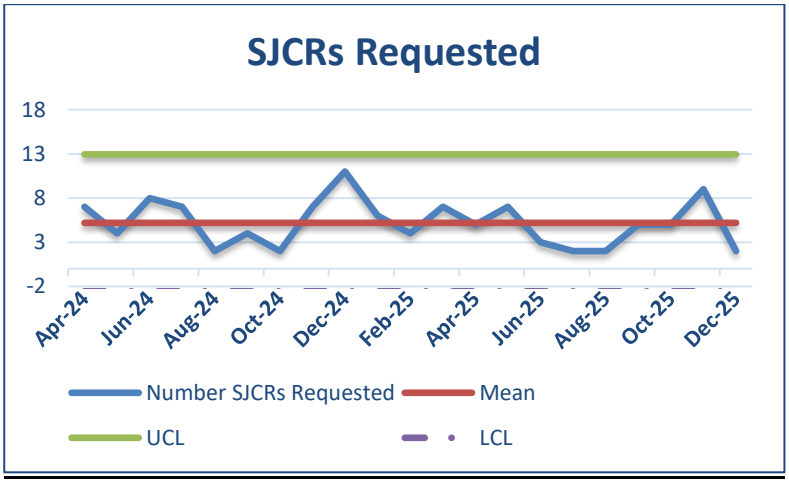
a. Children
b. Patients with Learning Disabilities / Autism
c. Women where death is directly related to pregnancy or childbirth
d. Stillbirths or perinatal deaths

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 4 – SJCRs Requested



During Q4 of 24/25, there were 17 requested SJCRs. The numbers for the following quarters were: 15 in Q1 25/26, 9 in Q2 25/26, and 16 in Q3 25/26.

Table 5 – Source of request for SJCR

*It should be noted that there can be more than one source, however, to avoid duplication only the original inputted source is considered.

SJCR Request Source	24/25 Q4			25/26 Q1			25/26 Q2			25/26 Q3		
	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Care Group	3	2	6	3	3	1	1	1	1	4	6	1
Learning Disabilities	0	0	0	1	2	2	0	0	2	1	3	1
Medical Examiner Review	2	1	0	0	0	0	1	0	1	0	0	0
NoK Concern/ Complaint	0	1	0	0	0	0	0	0	1	0	0	0
Elective Admission	0	0	1	1	1	0	0	0	0	0	0	0
Q & S	1	0	0	0	1	0	0	1	0	0	0	0
Initial Mortality Review	0	0	0	0	0	0	0	0	0	0	0	0

Table 5 presents the origins of SJCR requests for Q4 of 2024/25 and Q1 to Q3 of 2025/26. Most of these requests still come from Care Groups, with learning disabilities being the next most common source.

4.1 Themes from SJCRs considered by the LfD Group in Q3:

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 6.

Table 6 – Themes identified

Themes	24/25 Q4			25/26 Q1			25/26 Q2			25/26 Q3		
	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Capacity/Demand	1	1	0	0	0	0	0	0	2	1	1	0
Clinical Assessment	0	0	2	0	0	0	2	3	0	1	0	1
Communication/Documentation	2	1	1	2	4	2	1	0	1	3	1	0
Consent	0	0	0	0	0	1	0	0	3	0	1	0
Delayed Diagnosis /Treatment	0	0	0	0	0	0	1	2	0	1	0	1
Escalation	0	0	1	0	1	3	4	0	0	0	0	0
Guidance/Policies	0	0	0	0	0	0	1	0	0	0	0	0
No Themes Identified	3	0	2	2	1	2	2	1	0	1	1	1
Not listed (please specify)	0	1	2	0	1	1	0	0	0	1	1	1
Nutrition and Hydration	0	1	0	1	0	0	0	0	1	0	0	0
Pathways/Process	2	0	0	0	3	0	0	0	2	1	1	0
Patient Factors	0	0	0	0	0	0	1	0	0	0	0	0
Team Factors	1	0	0	0	0	0	0	0	0	0	0	0
Transfer Issue	0	0	0	0	0	1	0	0	0	0	1	0

The key themes identified from October, November, and December predominately revolved around communication/documentation.

5.0 Escalations & Learning

5.1 Maternity update Q3

There was a total of 16 perinatal deaths eligible to be notified to MBRRACE-UK from York and Scarborough Hospital and 15 of these cases were notified within seven working days, during the reporting period, 01/7/2025 to 31/12/2025. 1 was reported outside of the 7-day reporting requirement due to confusion nationally around the timing of classification of a stillbirth in terms of gestation and this has been escalated to the national team as a significant issue and risk and for further clarification on which guidance is to be followed. There were 3 antenatal stillbirths, 6 neonatal deaths, (two of which were from a twin pregnancy), 1 intrapartum stillbirth, 2 late fetal losses and 4 terminations of pregnancy which met criteria for reporting due to gestation. There are 3 perinatal deaths of babies who died at other Trusts however they received some care at York and Scarborough Hospital. These cases will have a joint PMRT review.
There are currently 9 open PMRT cases where reviews have been completed, and the reports require completion with other Maternity Units which date back to 2019. The Deputy Director of Midwifery has contacted the other Maternity Units with an aim to complete all reports.

5.2 Learning from deaths group overview

5.21 PSI Group escalations

The group was reminded the SJCRs rated poor and very poor are taken to the quality and safety meeting for further discussion around if they require to be a PSII. However, there could still be some rated adequate / good that may have been a serious incident before the introduction of PSIRF and these should be taken to PSI group for wider oversight.

Safeguarding reported no escalations.

5.22 Martha's rule update

The Critical care outreach lead attended to provide an update about Martha's rule, this is overtaking the call for concern campaign that was started within the trust in September 2022. The data is submitted to NHSE.

Phase one 2024- 25:

- Asking patients a 'patient wellness question' if they felt they were getting better or worse.
- Escalations from any staff.
- Escalation from patients / families.

Phase two 2025-26:

- Increase service to more area's paediatrics and maternity.
- Emergency department it was noted no other trust currently offer this and the team feel it might overwhelm the service.
- Offer the service to other inpatient areas such as Bridlington and community rehab units that do not have an outreach service.

Data over last 10 months:

- 5-9 calls a week.
- There have been few paediatric calls.
- Most of the calls are split between medical and surgery.
- 78% referrals from families.
- Most calls relate to analgesia, pain relief, cannula replacement, nutritional issues and the management of long-term conditions.

To date, there have been three paediatric referrals. It has been noted that the outreach team lacks training in paediatrics; therefore, they do not review these patients themselves but instead refer them directly to the consultant and advocate on behalf of the patient and their family.
Since September, a dedicated workforce within the outreach team has ensured the continuation of this service. The team now has a dedicated mobile phone to enhance responsiveness and can also accept text messages. Additionally, the Standard Operating Procedure (SOP) has been updated, and posters and leaflets have been distributed throughout the trust.

5.23 Nutrition & hydration update

The Nutrition and Hydration lead attended to discuss the nutrition and hydration report attached to the agenda. This has also been discussed at PSCE.

- NG /NJ policy approved and published on staff room.
- New pathway to be used by ward staff for guidance and checks for NG / NJ tubes.
- Good compliance with the nutrition and hydration E-learning.
- Process in place for new PSO's to attend the health care academy for one day training on nutrition and hydration.
- New catering dietitian appointed, new menus being rolled out.
- New standardised nutrition and hydration whiteboards rolled out across the wards.
- Mealtime observations survey ongoing this month.
- Review of the E-learning packages.

6. Service developments

Medical Examiner representation has been reinstated within the Learning from Deaths group. A quarterly report will be present at LFD and a summary included in the Q4 LFD report to track the organisation's timeframes regarding death certificate processing and the quality of information provided.

Additionally, from November 2025, the LFD administration team has worked to reintroduce quarterly updates from specialist groups, including the End-of-Life group, Nutrition and Hydration Group, and Deteriorating Patient Group.

Group	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Nutrition Steering Group			✓			✓			✓			✓
Deteriorating Patient Group		✓			✓			✓			✓	
End of life		✓		✓		✓		✓		✓		✓
ME update	✓			✓			✓			✓		
Family health update		✓			✓			✓			✓	
SJCR training	✓		✓		✓		✓		✓		✓	
Actions			✓		✓		✓		✓		✓	

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:	Board of Directors
Date of Meeting:	25 March 2026
Subject:	Nationally Benchmarked 2025 Staff Survey Results
Director Sponsor:	Polly McMeekin, Director of Workforce & Organisational Development
Author:	Vicki Mallows, HR Workforce Lead for Corporate Services

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

As part of the Trust's objective to create a great place for our people to work, learn and thrive we wish to see colleague experience match or exceed the best of our peer group Trusts, as benchmarked by the annual national staff survey results.

The purpose of this paper is to update the Board with the nationally benchmarked 2025 Staff Survey results and proposals for improving colleague experience further.

Key Assurances:

- The survey response rate significantly increased in 2025 meaning the results are more representative of the whole workforce, and the response rate is above the peer average for the first time since 2018.
- The scores by People Promise element/theme have all improved slightly (national benchmarking data is reported to two decimal points, and at this level 'We are safe & healthy' shows a tiny improvement, in other reporting it is classed as no change from 2024).
- We are above the peer group average for one area (We work flexibly).
- We are still below the peer group average for the other eight areas but have started to close the gap in all those areas. It is worth noting that as national benchmarking data is reported to two decimal points, it shows the gap closing in 2025 for 'We are a team', in other reporting it is classed as remaining the same as in 2024.
- Compared to the 2023 Staff Survey results which reflected colleague experience prior to the launch of the Our Voice Our Future change programme (December 2023) – we have improved in all areas. Again, it should be noted that when reporting to one decimal point, 'We are safe and healthy' is unchanged, but at the national benchmarking level of two decimal points there is a tiny improvement.

Key Risks:
Resource Constraints: Funding, space, and/or project management capacity have all impacted upon the ability to deliver some changes e.g. health and wellbeing factors such as improved shower and changing facilities have been an ongoing 'Fix the Basics' priority since 2020.

Key Opportunities:
Embedding a continuous improvement model will support and can underpin many of the cultural changes needed to make consistent and sustainable improvements.

Key Concerns:
Leadership & Management capability varies in quality across the organisation. Consistency is required to deliver sustained improvements to colleague experience.

Recommendation:
The Board is asked to review the findings and support the co-creation and delivery of the 26/27 Colleague Experience Improvement Plan in all areas of the Trust.

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

Meeting/Engagement	Date	Outcome/Recommendation
Initial results and update on 25/26 Colleague Experience Improvement Plan went to Resources Committee.	February 2026	Report back when received nationally benchmarked results.
Resources Committee	17 March 2026	

2025 NHS Staff Survey Results and Colleague Experience Improvement Plan

1. Introduction and Background

The Staff Survey was open between 3 October and 28 November. It measures how engaged staff are and provides insight into how colleague experiences can be improved. Evidence shows that more engaged staff result in better staff retention, patient experiences and outcomes. The results were embargoed until national publication on 12 March. Prior to that date they were shared internally for planning purposes.

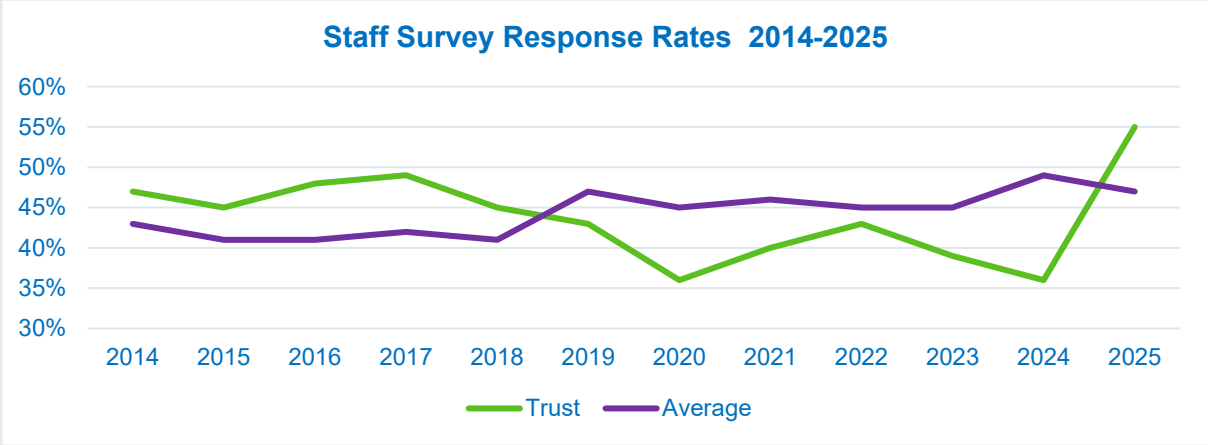
2. Considerations

We have now received our full results benchmarked against our national peer group of all Acute/Acute & Community Trusts in England.

Note - the Trust overall scores referenced in this paper includes the results from YTHFM, but bank-only workers are excluded as they are surveyed separately.

3. Where we are now – 2025 results

Our **response rate** improved significantly in 2025 to 55% (from 36%) and is above the peer group average (47%) for the first time since 2018:



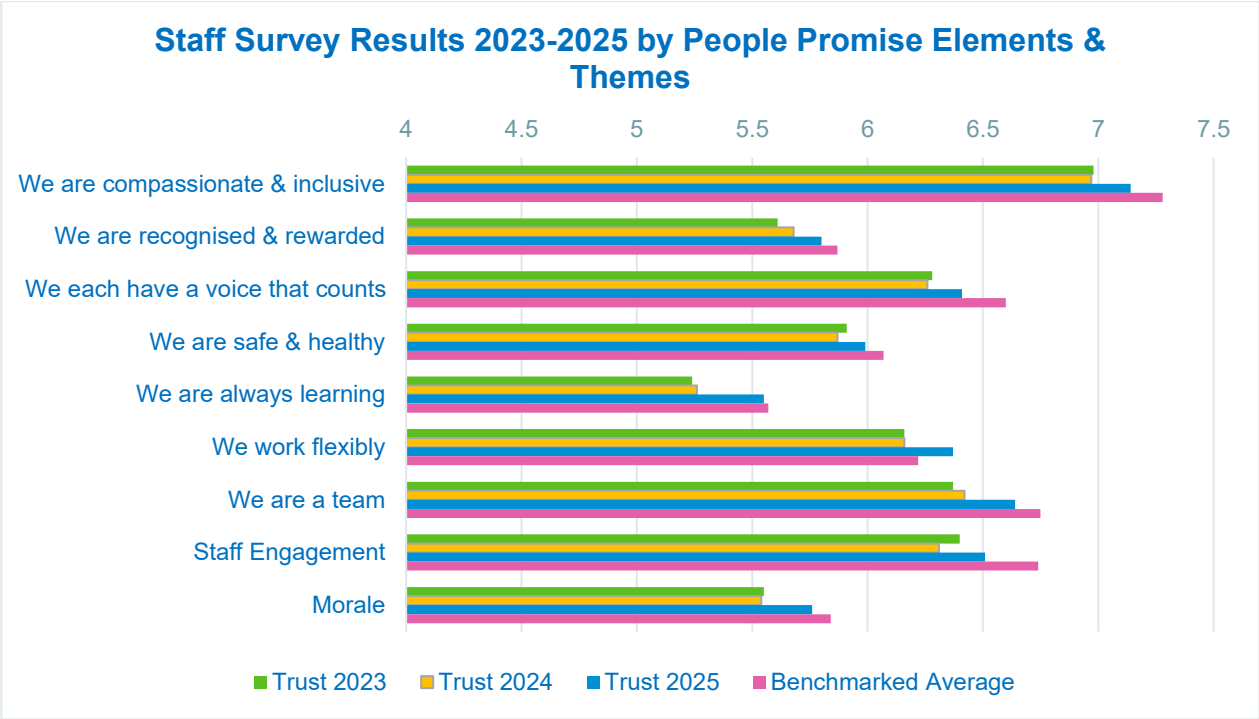
Incentives were used (£3.50 voucher for all completing the survey and entry into a prize-draw) to encourage greater participation and make the results more representative.

In terms of aspiring to excellence, the highest response rate amongst our peer group in 2025 was 74%.

Analysis by People Promise element

The national benchmarking data is reported at two decimal points (initial survey results were reported to one decimal point), on that basis we have **improved** in all areas by 0.12 – 0.29.
You may see other reports where data is rounded up, this would show improvements in all areas except for 'We are safe and healthy'. We have not deteriorated in any area.

Compared to our peer group average in 2025 we are **above average** in one area, 'We work flexibly' (by 0.15); in all other areas we remain **below average**.

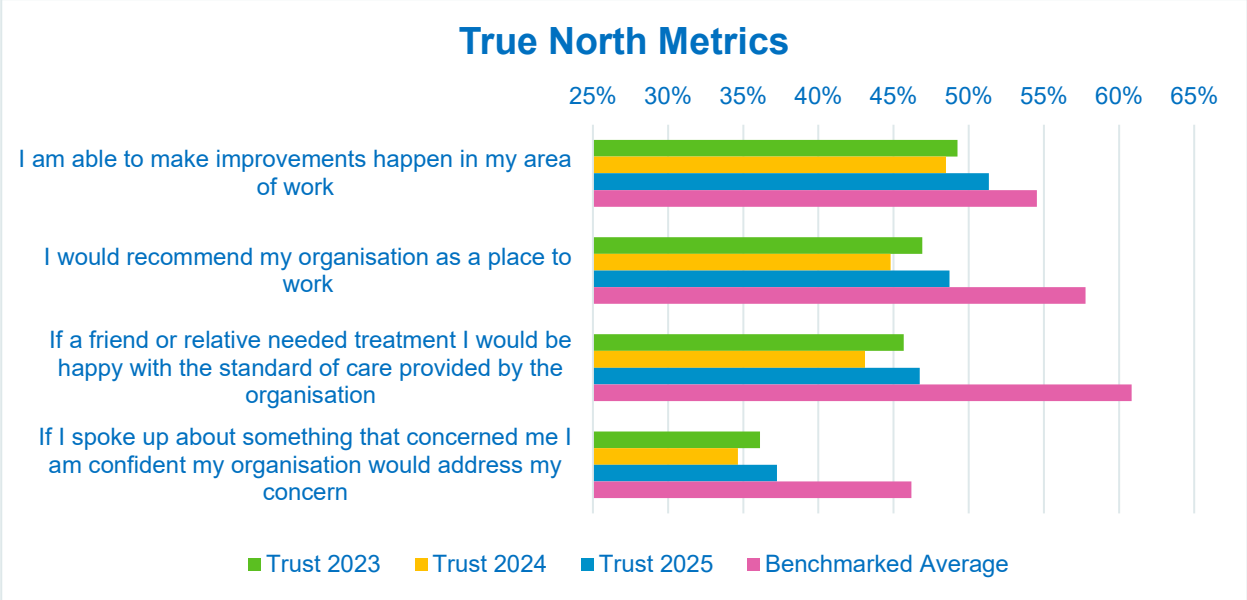


[score out of 10]

The gap between the Trust and the national average was smaller in 2025 in all areas compared to 2024, except for 'We work flexibly' where we have closed the gap completely and are now exceeding the average performance.

True North Metrics

The graph below shows the four survey questions that are included as metrics in the Trust's True North report. All have improved between 2024 and 2025 but remain below the peer group average.



Workforce Race Equality Standard & Workforce Disability Equality Standard

The questions relating to the WRES standard continue to show that staff from all other ethnic groups have a worse experience than their white colleagues, and worse than the peer average. It is positive to note however that bullying and harassment from other colleagues and discrimination from managers has decreased since 2024.

The questions relating to the WDES standard continue to show that staff with a disability / long term health condition have a worse experience than their colleagues; when compared to the peer average the Trust is better for some questions but worse for others. It is positive to see that bullying and harassment from managers has decreased, as has pressure from managers to attend work whilst unwell.

Questions not linked to a People Promise Element / Theme

In relation to questions about errors/near misses/incidents, the Trust performs worse than the peer average for the number of errors etc observed, feeling that staff involved will be treated fairly, and that the organisation takes action to ensure they are not repeated. On a positive note, there has been a 6% increase in the number of colleagues saying they are given feedback about changes made if they have reported something.

For the fourth year running the Trust is better overall than the peer average at making reasonable adjustments where required, although it should be noted that our performance has deteriorated by 2% since 2024.

Variations by Staff Group

Both response rates to the survey and results scores vary by staff group. The results have been shared with the professional leads (or deputies) for the largest groups (nursing, allied health professionals and medical) to consider what actions need to be taken.

Variations by Location

Again, response rates and results vary by location. In terms of results, colleagues based at Hull and Scarborough hospitals are reporting the poorest experience, with Bridlington and Selby hospitals next, Malton and York hospitals much better, and colleagues not based at any of our main delivery sites reporting the most positive overall experiences.

Whilst our teams are managed by their individual services (Care Groups etc) rather than each overall site being treated as one big team, it may be useful to note the variation as background context when senior leaders are visiting different locations.

4. Aspirations

As part of the Trust's objective to create a great place for our people to work, learn and thrive we wish to see colleague experience match or exceed the best of our peer group Trusts, as benchmarked by the annual national staff survey results. Acknowledging that culture change takes years rather than months, we have set interim targets to match and then exceed our peer group averages.

The 2025/26 Colleague Experience Improvement Plan included actions identified in response to the 2024 staff survey results, targets for improvement, and metrics to track progress. Performance against those metrics, as measured by the 2025 results for these metrics were shared at February's Resources Committee.

We will review the 25/26 Colleague Experience Improvement Plan, good practice case studies published from Trusts that have improved their staff engagement and experience scores, and the 2025 Staff Survey results to co-create an updated plan for 26/27 with input from:

- Change Makers

- Staff Networks
- Union Representatives
- Management Teams

Each Care Group, Corporate Directorate and YTHFM are required to update their own improvement plans and continue to involve team members in driving the changes that will make the biggest impact on them. Progress with plans will be monitored via PRIMs/EPAM.

All managers from the Board down to first-line supervisors, need to take responsibility for applying the improvements in their own teams if we are to see widespread and sustainable improvement.

5. Summary

Compared to our 2023 Staff Survey results which reflected colleague experience prior to the Our Voice Our Future change programme being launched in December 2023, we have improved in eight of the nine key areas (all nine when reporting data to two decimal places rather than rounding up). It is encouraging to see that we are making some progress, but we need to recognise that we are still below average in most areas and therefore colleague experience needs to remain a priority for us.

Annual staff survey and quarterly pulse survey results should be treated as progress reports to evidence whether ongoing plans to improve colleague and patient experiences, and patient quality and safety outcomes are working or not. They should be triangulated with other metrics (related both to the workforce and to patient experience and outcomes).

6. Next Steps

A requirement of the medium-term planning framework is that ‘every NHS Board will be expected to use the 2025 Staff Survey findings to commit to a full and detailed analysis of all free text comments generated through their staff survey. Identifying, as a minimum, 3 areas where the data shows the greatest staff dissatisfaction, generating a detailed analysis where those issues impact most within their organisation, and developing detailed action plans to resolve those issues within the year wherever possible.’

The Trust improvement plan will be updated as outlined previously. Resources Committee will receive another update in three months’ time, when we will have received the narrative comments from the survey (expected at the end of March), undertaken the analysis required by the planning framework, and co-created the new plan.

Date: 05 03 2026

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 18

Report to:	Board of Directors
Date of Meeting:	25 March 2026
Subject:	Equality Delivery System (EDS) 2022
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development and Tara Filby, Interim Chief Nurse
Author:	Virginia Golding, Head of Equality, Diversity and Inclusion (EDI)

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

Approve ☒ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This report provides a high-level overview of the Trust's performance against the NHS Equality Delivery System (EDS) 2022 for 2025/2026, which is an equality improvement tool. All NHS providers and commissioners are required to implement the EDS. It comprises eleven outcomes spread across three Domains, which are:

Domain 1 Commissioned or provided services
Domain 2 Workforce health and well-being
Domain 3 Inclusive leadership

Key Assurances

The 2025/26 review has demonstrated:

- Improved accessibility, patient experience and feedback regarding workforce health and well-being.
- Strengthened safety and governance.
- Continued progress on inclusive leadership.
- The Trust has identified areas of improvement through internal and external engagement.

Key Risks

- The 2025/26 review has identified risks in relation to: Workforce experience and retention challenges.
- Some variation in patient access, experience and outcomes.

Key Concerns

The 2025/26 review has identified concerns relating to:

- Under-utilisation of resources offered to staff.
- Slow progress in workforce culture improvements.
- Continued health inequalities in deprived communities.

The Organisational Rating for 2025/2026 is 'Developing'. Appendix 1-NHS England's standard reporting template documents progress with the 2024/2025 plans and the plans for 2026/2027.

Recommendations:

- Review and accept the EDS 2022 report.

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation
Resources Committee	17 March 2026	

Equality Delivery System (EDS) 2022

1. Introduction and Background

The Equality Delivery System (EDS) is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks, and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight. The EDS comprises eleven outcomes spread across three Domains, which are:

- Domain 1 Commissioned or provided services
- Domain 2 Workforce health and well-being
- Domain 3 Inclusive leadership

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives. All NHS providers and commissioners are required to implement the EDS.

Engagement

- Includes: colleagues, patients/service users, external partners, Staff Networks, Trade Union Representatives, and senior leaders.

Assessment

- Domains 1 and 2, assessed through engagement events.
- Domain 3, peer reviewed by Harrogate and District Foundation Trust.
- Stakeholder events included, Trade Union Representatives, the Staff Networks, senior leaders, colleagues, and patient/service users.

Domain Scoring and Rating

- Evidence is reviewed and scored by stakeholders.
- Domain ratings are ‘Underdeveloped,’ ‘Developing,’ ‘Achieving’ and ‘Excelling’.
- The score and rating for each Domain provides the Trust with its overall rating. (This fluctuates annually as the services chosen differ each year.)

Implementation of Improvement Plans

- Throughout 2024/2025 Improvement Plans continued to be implemented.
- Appendix 1-NHS England’s standard reporting template documents progress with the 2024/2025 plans and the plans for 2026/2027.

2. Current Position/Issues

Domain 1 – Commissioned or Provided Services

The requirement for Domain 1 is to choose three services that are provided for patients. Service number 1 should be a service where data indicates that it is doing well. Service number 2, where data indicates a service is not doing so well and service number 3 should be where its performance is unknown. The choice of service will change annually.

The four 'Domain Outcomes' assessed and ratings achieved are:

	2025/26 Rating		
Domain	**MSK (Service 1)**	**York ED (Service 2)**	**Scarborough Community Speech & Language Therapy (Service 3)**
1A: Patients (service users) have required levels of access to the service.	Achieving	Developing	Developing
1B: Individual patients (service users) health needs are met.	Achieving	Developing	Achieving
1C: When patients (service users) use the service, they are free from harm.	Achieving	Achieving	Excelling
1D: Patients (service users) report positive experiences of the service.	Achieving	Developing	Excelling

Domain 2 – Workforce health and well-being

The four ‘Domain Outcomes’ assessed and ratings achieved are:

Domain	2023 Rating	2024/25 Rating	2025/26 Rating
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions.	Developing	Achieving	Achieving
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.	Underdeveloped	Underdeveloped	Achieving
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.	Developing	Developing	Achieving
2D: Staff recommend the organisation as a place to work and receive treatment.	Underdeveloped	Underdeveloped	Underdeveloped

Domain 3 – Inclusive Leadership

The three ‘Domain Outcomes’ assessed and ratings achieved are:

Domain	2023 Rating	2024/25 Rating	2025/26 Rating
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.	Achieving	Achieving	Achieving
3B: Board/Committee papers (including minutes) identify	Achieving	Achieving	Achieving

equality and health inequalities related impacts and risks and how they will be mitigated and managed.			
3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.	Achieving	Achieving	Achieving

The Trust and HDFT agreed to conduct reviews to establish if both Trusts continued to remain within the 'Achieving' Category rather than 'Excelling', as implementation of the previous Improvement Plans were yet to be completed. The stakeholder group established that the Trust continued to hold this position.

For Domain 1, service leads have identified specific actions to support the delivery of improving the areas of development. These will be embedded into Care Group improvement plans. Each service will present the outcomes of the reviews at their Care Group Patient Experience Group meeting by 31 March 2026 so that improvements can be embedded into 2026/27 plans.

The improvement plans for Domains 2 and 3 focus on implementing actions to improve within each 'Domain Outcome'. It should be a realistic expectation to achieve the next level of activity on an annual basis, i.e. to move from 'Underdeveloped' to 'Developing'.

3. Summary

- Assessment outcomes identified strong performance in patient safety, leadership, and patient experience (in specific services).
- Areas for improvement include communication and engagement across staff groups for workforce experience, and access/experience in 'Developing'-rated services.
- The Trust has identified areas of improvement through internal and external engagement which includes accessibility and patient experience.
- The EDS Reporting Template detailing Domain Scores, Ratings and progress is at Appendix 1.
- The Organisational Rating is 'Developing.'

4. Next Steps

Domain 1:

- Review patient demographics reported through the new Family and Friend Test (FFT) platform to understand diversity of feedback and to gather insights into the disparity of patient experience.
- York Emergency Department seeks to recognise patients requiring additional assistance more effectively and connect them with appropriate services, either within or outside the organisation.
- Embed specific actions to support delivery into Care Group Improvement Plans.

Domain 2:

- Implement the colleague engagement improvement plan.
- Raise awareness of the support available to help manage health conditions, ensuring accessibility for all.
- Target monthly Health and Well-being initiatives to specific areas.
- Review and complete Due Regard Assessments (Equality and Health Impact Assessments).
- Partnership working with Union Representatives and the Staff Networks
- Continuation of cultural change work through Our Voice Our Future.
- Review and relaunch the Civility, Respect and Resolution Policy
- Delivery of management training and implementation of a continuous improvement programme.

Domain 3:

- Complete integration of the new Equality and Health Impact Assessment (EqHIA) process with the Trust's Quality Impact Assessment process and implement the new process for policies, functions, and events.
- Implementation of Well Led report actions.

The EDS outcome will be submitted to NHSE and be published on the Trust's website.

Date: February 2026

Classification: Official

Publication approval reference:

Appendix 1

NHS Equality Delivery System 2022

EDS Reporting Template 2025-2026

York and Scarborough Teaching Hospitals Foundation Trust

Version 1, 15 August 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation	York and Scarborough Teaching Hospitals NHS Foundation Trust	**Organisation Board Sponsor/Lead**	Director of Workforce and Organisational Development and Interim Chief Nurse
Name of Integrated Care System	Humber and North Yorkshire		

EDS Lead	Head of Equality, Diversity and Inclusion	**At what level has this been completed?**	
			***List organisations**
EDS engagement date(s)	D1, 3 September, 7 & 4 December 2025 D2, 10 December 2025 D3, 23 January 2026	**Individual organisation**	York and Scarborough Teaching Hospitals NHS Foundation Trust D1 & D2
		Partnership* (two or more organisations)	D3: Harrogate and District Teaching Hospitals D1: Patients, Healthwatch York, Healthwatch North Yorkshire, local VCSE sector.
		Integrated Care System-wide*	D1: Local VCSE health and wellbeing sector.

Date completed	January 2026	**Month and year published**	April 2026
Date authorised		**Revision date**	February 2027

Completed actions from previous year	
Action/activity	**Related equality objectives**
Domain 1 **Sexual Health and HIV Service:** • New patient record system, allowing patients to include their demographical information. • Friends and family tests now capture demographical information. • Launched a feedback initiative. • Service continues to incorporate patient voice in service design and delivery. • Employed a dedicated outreach worker. • Partnership and outreach working. • Hold incident reviews and collate staff feedback on needed changes. • The new website launched on 1 September 2025. • Secured executive support to launch HIV Confident within the organisation **Ophthalmology:** • Friends and family tests include standardised demographic questions allowing for analyses between experiences. • Promotion of transport options via the Trust's website. • Display public boards showing actions taken based on patient feedback. • Mandatory Oliver McGowan. • Information session on assistance animals. • Reasonable adjustment requests are recorded within the new patient records system. **Endoscopy:** • Friends and family tests include standardised demographic questions. • Information on patient transport options are promoted on the Trust website. • Staff have been made aware of the 'No Excuse for Abuse' campaign. The main aspects of the EDS framework are now included in the Terms of Reference for Care Group Patient Experience Groups, making EDS a part of everyday practice.	**Public Sector Equality Duty (PSED)** Ensure the Trust's systems can capture equality monitoring information in order to provide insight to improve access, experience and outcomes of our patients. Develop a plan that encompasses the overall Trust's Inequality Strategy to address and mitigate health disparities within the Trust's catchment area. Implement the plan through Task and Finish groups.

Domain 2 – Improvement Plan 2024-2025 – completed actions • Staff communication through a variety of sources. Wellbeing Booklet available on Staffroom and promoted through internal communications. • Line Manager Toolkit was developed and commenced roll out in 2024, with Line Manager Development training open to all managers across the Trust. • Ward visits are ongoing, with a 66% increase in the number of visits from 2024 to 2025. • No Excuse for Abuse campaign – Campaign ongoing and anonymous reporting tool launched in March 2025. • Sexual Misconduct Policy launched in March 2025, and training is available to all staff. • Implemented the Civility, Respect & Resolution Policy. • Implemented the Managing Violence and Aggression Policy. • Implemented the Conduct and Disciplinary Policy. • Violence Reduction Training launched on Learning Hub. • New Conduct and Disciplinary Policy launched in January 2025. • The continuation of Our Voice, Our Future, a 2-year continuous improvement programme.	Ensure all areas of EDI compliance are met and action plans are implemented to improve experience. NHSE EDI Improvement Plan. EDS 2022, Workforce Race and Disability Standards, Accessible Information Standard, Sexual Orientation Monitoring Standard, Gender Pay Gap. Develop a plan that encompasses the overall Trust Inequality Strategy to address and mitigate health disparities within the Trust's catchment area. Implement the plan through Task and Finish groups.
Domain 3 – Improvement Plan 2024-2025 – completed actions • Executive Director Staff Network Sponsors to use their position as a network sponsor to question and challenge reports and discussions at Committee and Board meetings. • Communications Team to create an annual communication timetable plan. • Upon analysis of the 2025 WRES and WDES data, track and report on the progress of the top three priority metrics. • Gender Pay Gap (GPG), continue to report on the year-on-year progress made. (Increase in GPG for 2025.) • Progress made in complying with the Accessible Information Standard reported through the Equality Objectives Annual Report and the assigned steering group. • Menopause support included in the Wellbeing report presented to the Executive Committee. • The Trust has menopause support built into the wellbeing offer, and this will continue to be highlighted, including being a focal point for one of the awareness weeks each year. • The Trust is an accredited menopause friendly employer, and there are training and guidance documents available to all staff. Under the new Employment Rights Bill, the Trust will also begin work on a Menopause Action Plan. This is voluntary from Spring 2026, and mandatory from Spring 2027.	Ensure all areas of EDI compliance are met and action plans are implemented to improve experience. NHSE EDI Improvement Plan, EDS (2022), Workforce Race and Disability Standards (WRES & WDES), Accessible Information Standard (AIS), Sexual Orientation Monitoring Standard and Gender Pay Gap (GPG).

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**York Emergency Department:** The Emergency Department addresses access barriers by providing appropriate personalised support, which covers equipment, the environment, communication and information. Actions have been highlighted to improve access for all, including those with protected characteristics and at risk of health inequalities.	**Developing 1**	York ED/ Matron
		Musculoskeletal Outpatients and community days: The MSK Outpatient Clinic offers multiple access routes: self-referral, GP/FCP, Occupational Health, internal and out-of-area referrals. Services are delivered across various sites. Community Appointment Days, partnerships with VCSEs, and locality-based rehabilitation enhance accessibility. Barriers addressed include geography, language, and social factors. The service is committed to EDI principles, developing accessible websites, easy-read materials, and responding to patient feedback to address access barriers.	**Achieving 2**	Associate Chief AHP
		Scarborough Community Children's Speech and Language Therapy: The service has transformed access by replacing paper referrals with a helpline triage system. Clinics are held in community settings. Telephone reminders and targeted support for areas of deprivation will improve attendance and inclusivity. Interpretation is provided, and access needs are recorded at first contact. The service actively identifies and addresses barriers, ensuring tailored support for disadvantaged groups and those with protected characteristics. Patient feedback is regularly sought and acted upon.	**Developing 1**	Children's Therapy Team Manager

	1B: Individual patients (service users) health needs are met	**York Emergency Department:** The department uses a variety of Reasonable Adjustment Alerts and personal care plans. Partnership working with Learning Disability and Autism Services, Mental Health, and Safeguarding teams ensures holistic support. There are ongoing efforts to personalise care for those at higher risk.	**Developing 1**	York ED/ Matron
		Musculoskeletal Outpatients and community days: The MSK team collaborates with internal and external partners to meet complex health needs. Initiatives include recruiting Community MSK Champions, trialling non-attendance SOPs, and re-establishing community appointment days. The service adopts a health coaching approach, personalising care and signposting to relevant services, with continuous feedback informing improvements.	**Achieving 2**	Associate Chief AHP
		Scarborough Speech and Language Therapy, Community Clinical leads have completed insights training and health inequalities analyses, informing a service review to restructure care around individual needs. The team partners with schools, nurseries, local councils, families, and the voluntary sector to reach seldom-heard groups. Care plans are personalised, and interventions are tailored to each child's interests and circumstances. Feedback highlights the team's responsiveness and adaptability, with staff providing advice for home and school settings. The service supports EHCPs and uses social prescribing, ensuring that those at higher risk due to protected characteristics receive care that works for them.	**Achieving 2**	Children's Therapy Team Manager

	1C: When patients (service users) use the service, they are free from harm	**York Emergency Department:** Policies and guidance cover trans and gender-diverse communities, accessible information, and reasonable adjustments. Incident reporting, safeguarding, and quality assurance are embedded. Compliance with training and safety initiatives is tracked monthly. The department encourages a culture of accountability and learning, supporting staff and patients to report incidents. Evidence of improvement includes increased reporting and targeted actions to address identified risks, ensuring safety for all, especially those with protected characteristics and health inequalities.	**Achieving 2**	York ED/ Matron
		Musculoskeletal Outpatients and community days: Robust governance structures ensure patient safety. Policies cover trans and gender diverse communities, accessible information, and safeguarding. Staff receive mandatory training and additional training. Clinical supervision is audited. The service promotes a culture of accountability, learning, and improvement.	**Achieving 2**	Associate Chief AHP
		Scarborough Children's Speech and Language Therapy, Community: Robust governance includes policies for trans and gender-diverse communities, accessible information, and reasonable adjustments. Incident reporting is encouraged. Safeguarding supervision is attended quarterly, and audits are conducted biannually to ensure high standards. Statutory and mandatory training compliance is at 93%. The service fosters a culture of improvement, supporting staff and patients to report incidents and near misses, and actively considers equality and health inequality themes in safety. Actions are taken promptly to address issues, ensuring a safe environment for all.	**Excelling 3**	Children's Therapy Team Manager

	1D: Patients (service users) report positive experiences of the service	**York Emergency Department:** Patient experience data is collected and analysed. Action plans are developed in response to feedback. The department engages with patients and carers to improve services. The new Friends and Family Test shows a difference in the felt experience between those with a self-reported disability, and those without. The department is looking to work with VCSE partners to improve signposting to support services. **Musculoskeletal Outpatients and community days:** Patient experience is measured through feedback from Community Appointment Days. The service actively engages with patients with protected characteristics, using feedback to inform action plans and improvements. Data-driven approaches ensure patient voices influence service delivery. **Scarborough Speech and Language Therapy, Community:** Positive feedback regarding inclusive, accessible sessions and tailored support. “You said, we did” boards in clinics demonstrate that feedback is reviewed and acted upon. The service collaborates with VCSE organisations to ensure all voices are heard, and data-driven action plans are developed in response to feedback. Patient experience data informs ongoing improvements and innovative interventions.	**Developing 1** **Achieving 2** **Excelling 3**	York ED/ Matron Associate Chief AHP Children's Therapy Team Manager
Domain 1: Commissioned or provided services overall rating			22	

Domain 1: Commissioned or provided services

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	**Obesity and Diabetes** • Free access to the Step into Health course. • National week-long awareness events run throughout the year at all Trust sites, several of which target obesity. • Know your numbers week for BMI, weight, waist measurements, BP etc. • Nutrition and Hydration week. • Be Active/On your feet Britain week the importance of activity for physical health/weight management. • On-site gyms at Scarborough and Bridlington Hospitals. • Discounted gym memberships. • Cycle to work scheme. • Physical activity grant. • Online course – Learning Curve Group (Understanding Nutrition and Health). • Free 30-minute virtual health checks. • Virtual workshops, including Eat Well and Weight Management. • Be Active. • Free access to a library of 20-30-minute activity.	**Achieving 2**	Head of Occupational Health and Wellbeing
		Asthma and COPD • The Occupational Health (OH) team check for occupational acquired asthma and perform lung function tests and complete Pre-Employment Health Questionnaires (PEHQ). • Advice provided during Management Referrals. • Tobacco Dependency Advisers support colleagues. • The OH team conduct Health Surveillance in areas where there are known respiratory sensitisers. • During Management Referrals, the OH team ask about individual health conditions, treatment etc, and advise their line manager about adjustments to role, to reduce the impact of their health condition in the workplace.		

		Mental health conditions • The Trust currently has 116 trained Mental Health First Aiders. • Time 2 Talk Week (mental health focussed). • Mental Health Awareness Week. • Menopause Week (strong focus on women's mental health) (October) – all Trust sites visited. • Men's Health Week (strong focus on men's mental health) (November) – all Trust sites visited. • Wellbeing apps promoted e.g. Headspace, Unmind, Stay Alive etc. • Menfulness (male mental health charity) promoted in the Trust. • Employee Assistance Programme (EAP), which now has an online platform, Ele, the digital wellbeing. platform, with thousands of video resources. • Staff Health and Wellbeing room openings - Bridlington Hospital July 2025, Scarborough Hospital December 2025 and York Hospital March 2026. • The Trust has a Staff Support Psychology Team. • The Staff Psychology Team also offer: ➢ 30-minute signposting and support sessions. ➢ Workshops and webinars e.g., sleep, burnout etc. ➢ Ward/department support and group sessions. ➢ Post Event Pathway. ➢ Schwartz Rounds.		
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	In the 2024 Staff Survey results the Trust was below average in comparison to other Acute and Acute and Community Trusts in relation to staff reporting negative experiences. • No Excuse for Abuse launched August 2024. • No Excuse for Abuse anonymous reporting tool available for colleagues. • Launch of new Civility, Respect and Resolution Policy. Refreshed December 2025 based on staff feedback. • Launch of Just and Learning Assessment to ensure a fair process for all, everyone is accountable for their own behaviours. Signed up to the Sexual Safety Charter, Sexual Misconduct Policy launched, training available to all staff members. Sexual misconduct working group established with union	**Achieving 2**	Head of Employee Relations

		• colleagues to review effectiveness of policy. • Anti-bullying, harassment and victimisation training available on Learning Hub. • Review of the Trust's exclusion policy and associated training. • Managing Violence and Aggression Policy launched. • Enhanced Conflict Management Training available for patient facing colleagues. • Partnership working with external agencies such as the Police and Crown Prosecution. • Single points of contact for York and Scarborough sites in North Yorkshire Police. • Area specific violence and aggression risk assessments are available. • Reduction in Violence and aggression incidents across the Trust.		
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	The Trust has a range of support available to staff: • Union Representatives. • Freedom to Speak up Guardian. • Fairness Champions. • Staff networks. • Chaplaincy. • Mental Health First Aiders. • Health and Wellbeing Booklet. • Psychological support. • Occupational Health and Wellbeing. • Due Regard Impact Assessments on all policies. • No Excuse for Abuse reporting form. Actions taken by the Trust in support: • Review and relaunch of the Civility, Respect and Resolution Policy working in collaboration with trade union colleagues. • Equality Impact Assessment completed through policy development. • Development of Just and Learning Assessment. • Policy review engagement with the Staff networks. • Relaunch of the Fairness Champions. • Continuation of Our Voice Our Future. • Union representatives as independent members on CRR panels. • Implementation of the Sexual Safety at Work Charter and launch of the Sexual Misconduct Policy. • No Excuse for Abuse Campaign. • Development of an Anti-Racism statement.	**Achieving 2**	Head of Occupational Health and Wellbeing and Head of Employee Relations

	2D: Staff recommend the organisation as a place to work and receive treatment	• Our Voice Our Future, a multi-year cultural change programme is running in the Trust. The Change Makers are taking forward actions based on staff feedback, for example the 'Kindness in Communication' campaign. • Promotion and collation of exit interview data which now includes protected characteristics. • Implementation of Line Management Development and Fundamentals training through 2024/25. • Revised categories at the 2025 Celebration of Achievement awards increased the number of nominations. • Wellbeing rooms being opened across the main Trust sites. • Careers conferences in 2025, professional leads developing career progression pathways. • Dedicated section on Staffroom for development opportunities, with links to free courses and information on funding. • An incentive offered with the 2025 staff survey to try and increase participation to amplify the employee voice. • Ongoing work to ensure colleagues rosters are published 6-12 weeks in advance. • Expanding the opportunities for self-rostering.	**Under-developed 0**	Head of Employee Relations
Domain 2: Workforce health and well-being overall rating			6	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	EDS Domain 3 Evidence 25-25  Evidence table 2025.docx	**Achieving 2**	Head of EDI and Director of Workforce and Organisational Development
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	As above	**Achieving 2**	Head of EDI and Director of Workforce and Organisational Development
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	As above	**Achieving 2**	Head of EDI and Director of Workforce and Organisational Development
Domain 3: Inclusive leadership overall rating			6	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s):	**Independent Evaluator(s)/Peer Reviewer(s):** Stakeholders from Harrogate and District Hospitals Foundation Trust

EDS Organisation Rating (overall rating):

*Score 20, rating Developing
*Calculated using the Trust's method

Organisation name(s): York and Scarborough Teaching Hospitals

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Head of Equality Diversity and Inclusion	2026
EDS Sponsor	**Authorisation date**
Director of Workforce and Organisational Development and Interim Chief Nurse	

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• Improve accessibility of services for those with sensory loss/differences. • Utilise technology to improve efficiencies and health outcomes. • To reduce DNA's. • To address health inequalities in accessing services.	**York Emergency Department, Responsible Officer, York ED/Matron:** • Re arrange seating within the waiting area to allow for colour contrasting, enabling people with vision loss to better navigate the waiting area. • Create dedicated quiet spaces with features like dimmable lighting for those who need them. **Musculoskeletal Outpatients and community days, Responsible Officer, Associate Chief AHP:** • Explore digital solutions to support MSK practice. **Scarborough Community Children's Speech and Language Therapy, Responsible Officer, Children's Therapy Team Manager:** • Explore the use of telephone reminders. across the services. • Complete the review of appointment letters, addressing health literacy barriers. • Further explore some of the reasons for DNAs. • Invest in tablet devices to increase access to communication programmes. • Increase awareness of SLT services across high deprivation areas, where referral rates are below what's expected.	December 2025 January 2027 June 2026 August 2026 June 2026 September 2026 October 2026 February 2026 ongoing

	1B: Individual patients (service users) health needs are met	• Improve how we identify and address complex needs to improve health outcomes. • Providing personalised support to improve health outcomes • Incorporating patient voice within service design/delivery	**York Emergency Department, Responsible Officer, York ED/Matron:** • Equip staff to ask the right questions to better identify and support complex needs. • Provide leaflets and VCSE info in waiting areas to signpost support services. **Musculoskeletal Outpatients and community days, Responsible Officer, Associate Chief AHP:** • Consider how MSK services can further empower individuals to take ownership of their own health and wellbeing • Monitor FFT following recent roll out of new provider	January 2026 - October 2026 October 2026 December 2026 Ongoing
	1C: When patients (service users) use the service, they are free from harm	• Improve how we identify and address complex needs to improve health outcomes • Providing personalised support to improve health outcomes. • Strengthen MSK practice via development and supervision.	**York Emergency Department, Responsible Officer, York ED/Matron:** • Collect wider health determinants to support with signposting and discharge. • Enhance electronic patient records to better capture and address these requirements. **Musculoskeletal Outpatients and community days, Responsible Officer, Associate Chief AHP:** • Continue to explore advanced practice opportunities for MSK physiotherapists. • Review how clinical supervision compliance is captured. **Scarborough Community Children's Speech and Language Therapy, Responsible Officer, Children's Therapy Team Manager:** All compliance areas met. Continue to monitor.	January 2027 April 2026 – January 2027 Ongoing April 2026 Ongoing

	1D: Patients (service users) report positive experiences of the service	• Incorporating patient voice within service design/delivery.	**York Emergency Department, Responsible Officer, York ED/Matron:** • Continue to review FFT feedback, looking at disparities between experiences. **Musculoskeletal Outpatients and community days, Responsible Officer, Associate Chief AHP:** • Review FFT following recent roll out of new provider. **Scarborough Community Children's Speech and Language Therapy, Responsible Officer, Children's Therapy Team Manager:** • Review FFT following recent roll out of new provider.	Ongoing Ongoing Ongoing

Domain	Outcome	Responsible Officer	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Head of Occupational Health and Wellbeing	• To continue to raise awareness of the current support and how it is accessed. • Utilise the monthly wellbeing roadshows to target specific. • Targeted health support.	Ongoing throughout 2026 December 2026 June 2026
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Head of Employee Relations	• Full review of the CRR policy. • Review of the Sexual Safety Charter Assurance Framework. • Delivery of management fundamentals training.	December 2026 April 2026 Quarterly, 2026
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Head of Occupational Health and Wellbeing and Head of Employee Relations	• Retrain outstanding Mental Health First aiders. • Continue to distribute Health and Wellbeing booklets. • Continue to raise the profile of the Staff Psychology and Occupational Health Services. • Due Regard Assessment on all policies. • Review and relaunch of the Civility, Respect and Resolution Policy.	Ongoing throughout 2026 Quarter 2 2026 Ongoing throughout 2026 2026/27 December 2026

	2D: Staff recommend the organisation as a place to work and receive treatment	Head of Employee Relations	• Continuation of OVOF. • Implementation of a continuous improvement programme.	July 2026 2026/27

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities		No action plan is required as the 2026 peer review was to assess if the Trust remained within the Achieving Activity category for D3 as there was one. There is one action left to implement demonstrate the Trust is working towards the Excelling Category.	
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Provide a sample of completed EqHIA for policies and projects which are signed off at the appropriate level where required.	Implement the draft new Equality and Health Impact Assessment process for the Trust. (Action on the 2024/25 Improvement Plan to move towards 'Excelling Activity). **Responsible Officer, Head of EDI**	June 2026
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Actions implemented.	Non-required. Assessment in 2026 was to determine if the Trust remained in the Achieving Activity category.	

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	25 March 2026
Subject:	Corporate Governance Update
Director Sponsor:	Martin Barkley, Trust Chair
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary

The Annual Report and Committee Effectiveness Reviews have been concluded and are presented for Board of Directors consideration:

- Group Audit Committee
- Resources Committee

The reviews for the Quality Committee and the Digital Sub-Committee are to be considered by those Committees this month to be reported to the April Board.

The terms of reference for the Resources Committee following its review have not been amended, the 2026/27 Board Work Plan and the 2026 Modern Slavery Statement are asked to be approved.
Recommendation The Board of Directors is asked to approve the Resources Committee Terms of Reference, the 2026/27 Board work plan and the 2026 Modern Slavery Statement.

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

Meeting/Engagement	Date	Outcome/Recommendation

Corporate Governance Update

1. Introduction and Background

Annual Committee Effectiveness reviews are an important process to reflect on the achievements of the Board of Directors Committees and where they could improve in the future. The Group Audit Committee and Resources Committee Annual Report and Effectiveness Review has now been concluded for the Board to consider.

The Resources Committee Terms of Reference, the 2026/27 Board work plan and the 2026 Modern Slavery Statement are also provided for Board approval.

2. Committee Annual Report and Effectiveness Review, and Terms of Reference

The 2025/26 Group Audit Committee and the Resources Committee Annual Reports and Effectiveness Reviews are presented at appendix 1 and 2 respectively for the Board to consider.

The Resources Committee terms of reference has had no suggested amendments and is presented at appendix 3 for approval. The Group Audit Committee terms of reference following the effectiveness review are currently under review.

The Annual Report and Committee Effectiveness Reviews for the Quality Committee and Digital Sub-Committee have been concluded and due to timing of those March meetings, will be reported to the April Board of Directors.

3. 2026/27 Board Work Plan

The Board Work Plan has been reviewed for the coming year and is presented at appendix 4 for Board approval.

4. Modern Slavery Statement

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act. The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking, and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36 million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Board of Directors and YTHFM LLP Management Group.

The aim of the statement is to encourage transparency within organisations. There are potential consequences for organisations who fail to produce a slavery and

human trafficking statement for a particular year. The statement has been prepared on a Group basis.

The Board is asked to approve the Modern Slavery Act Statement for publication on the Trust's website as presented at appendix 5.

Group Audit Committee Annual Report and Effectiveness Review 2025/26

1. Introduction

This report has been prepared to provide the Board of Directors with a summary of the work of the Group Audit Committee and its effectiveness during the period April 2025 – March 2026, and, in particular, how it has discharged its responsibilities as set out in its Terms of Reference.

The Board of Directors approved the terms of reference for the Committee in March 2025 with no subsequent amendments made since that time. This report also forms the annual report of the Committee over this period.

2. Governance

The membership of the Group Audit Committee is as follows:

- Non-Executive Director (Chair)
- 2 x Non-Executive Director

Attendees of the Committee are:

- Director of Finance
- Deputy Finance Director
- Associate Director of Corporate Governance
- Head of Internal Audit
- Internal Audit Manager
- External Audit Partner
- External Audit Manager, if required
- Counter Fraud Specialist
- YTHFM Representative
- Executive Directors (as and when required)

Table 1: Group Audit Committee Attendance

	May 2025	Jun 2025	Sep 2025	Jan 2026	Mar 2026	Total
Jane Hazelgrave (Chair)	✓	✓	✓	✓	✓	5/5
Stephen Holmberg	✓	N/a	N/a	N/a	-	1/1
Helen Grantham	✓	✓	Ap	✓	✓	4/5
Lorraine Boyd	N/a	✓	✓	✓	✓	4/4

Ap - Apologies, Deputy - Deputy provided, ✓ - in attendance

The Group Audit Committee met on 5 occasions during 2025/26 (including the Annual Report and Accounts Year-End meeting), and all meetings were quorate.

The Committee received secretarial and administrative support from the Chair and Chief Executive Office with minutes taken of all Group Audit Committee meetings.

3. Duties of the Committee

The Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance and which support the achievement of the Trust's objectives. At a high-level this involves:

- The Committee reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's and YTHFM's activities (both clinical and non-clinical) that supports the achievement of the Trust's or YTHFM's objectives.
- The Committee ensuring there is an effective Internal Audit function established that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive (Accounting Officer), the Board and YTHFM.
- The Committee reviewing and monitoring External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee reviews the work and findings of the External Auditors and considers the implications and management's responses to their work.

The Committee on reviewing financial reporting:

- Monitors the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.
- Ensures that the systems for financial reporting to the Board/YTHFM and the Council of Governors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.
- Reviews the Annual Report and financial statements before submission to the Board/YTHFM, focusing particularly on:
  - the wording in the Annual Governance Statement and other disclosures relevant to these Terms of Reference
  - changes in, and compliance with, accounting policies and practices and estimation techniques
  - unadjusted misstatements in the financial statements
  - significant judgements in preparation for the financial statements
  - significant adjustments resulting from the audit
  - letter of representation
  - explanations for significant variances
- Considers the Trust's/YTHFM's in-year financial position.
- Reviews the Trust's/YTHFM's annual financial plan.
- Approves changes to accounting policies and practice.

On other assurance duties:

- Reviews the findings of other significant assurance functions, both internal and external to the Trust, and considers the implications for the governance of the Trust/YTHFM.

- Reviews the Trust's/YTHFM's Standing Orders, Standing Financial Instructions and Schemes of Delegation.
- Receives details of waivers to standing orders approved by the Executive Director of Finance.
- Reviews the schedule of Losses and Compensations and approve write-offs as appropriate.
- Satisfies itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and reviews the annual fraud report and other fraud updates and any outcomes from the work.
- In accordance with 3.2 of the NHSCFA's Fraud Commissioners Standards, the Group Audit Committee has: 'stated its commitment to ensuring commissioners achieve these standards and therefore requires assistance that they are being met via NHSCFA's quality assurance programme.'
- Refers any suspicions of fraud, bribery or corruption to the NHSCFA.
- Requests and reviews reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control.
- Receives reports from any sub-groups of the Committee as appropriate.
- Requests specific reports from individual functions with the organisation (eg: Clinical Audit).
- Reviews the adequacy and security of the organisation's arrangements for its employees and contractors to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee ensures that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.
- Receives investment reports and agrees investment limits.
- Supports and advises the Council of Governors and any sub-Committee as requested.
- Escalates any areas of concern identified to the Board/YTHFM for further discussion and resolution.
- Submits a report of escalated items and minutes to the Board following each of its meetings (at least 5 times per year) and the Chair of the Committee draws to the attention of the Board any issues that require disclosure or require Executive action
- Prepares an Annual Report for presentation to the Board and the Council of Governors on its work in support of the Annual Governance Statement, specifically commenting on:
    - the fitness for purpose of the assurance framework
    - the completeness and embeddedness of risk management in the organisation
    - the integration of governance arrangements
    - the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
    - the robustness of the processes behind the quality accounts

The Annual Report also describes how the Committee has fulfilled its terms of reference and give details of significant issues that the Committee considered in relation to the financial statements and how they were addressed.

4. Delivery of the Work Programme

A work plan to deliver the duties of the Committee was drafted at the outset of the year and reports presented to the Committee by the Executives or subject matter experts responsible for each report.

Over the year Committee reporting has included:

- Internal Audit: Trust and YTHFM
  - Plan review and approval
  - Progress Reporting
  - Overdue recommendations reporting
- External Audit
  - Group Plan Approval
  - Progress Reporting
- Risk Management
  - Board Assurance Framework
  - Corporate Risk Register
  - Annual Review of the Risk Management Policy
- Governance Framework Review: Powers of Reservation and Scheme of Delegation, Standing Orders and Standing Financial Instructions, Trust Constitution
- Board Assurance Committee reporting
- Freedom to Speak Up processes reporting
- Counter Fraud Annual Plan and Progress Reporting
- Executive Director reporting of areas of concern, overdue internal audit actions and review of Board Assurance Framework risks
- Year-End review and recommendation:
  - Annual Accounts and Financial Statements
  - Annual Governance Statement
  - Head of Internal Audit Opinion
  - External Auditors completion report and letter of representation

Escalation reports have been provided to each Board of Directors meeting highlighting areas to alert, assure and advise alongside any risks discussed or new risks identified, at each Board meeting following the Audit Committee presented by the Audit Committee Chair. From the February 2026 meeting onwards private verbal escalations were provided at the Board of Directors as and when required.

5. Assessment of Effectiveness

A questionnaire was provided to each of the Audit Committee members and regular attendees based on the HFMA Audit Committee Handbook. A high-level summary is provided below:

Highest self-assessment scores

- The committee has made a conscious decision about the information it would like to receive.
- There is a formal appraisal of the committee's effectiveness each year.

- The committee has the right balance of experience, knowledge and skills to fulfil its role.
- The committee environment enables people to express their views, doubts and opinions.
- Members provide real and genuine challenge – they do not just seek clarification and/ or reassurance.
- Debate is allowed to flow, and conclusions reached without being cut short or stifled.

Lowest self-assessment scores

- The committee receives clear and timely reports from other Board committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.
- Other committees provide timely and clear information in support of the audit committee.
- At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, not so well and so on.

The Committee's terms of reference and work plan have subsequently been reviewed and are provided for the Committee to consider at its March meeting. Any agreed amendments will be reserved for Board approval at its March meeting.

Other discussions at the Committee of further improvements have included:

- The clarification of review of the effectiveness of risk management and assurance frameworks systems concerning the Board Assurance Framework, Corporate Risk Register and Freedom to Speak Up Reports
- The relationship of the Group Audit Committee and other Assurance Committees of the Board
- Executive attendance and the assurance provided over internal audit actions and the numbers of internal audit action overdue throughout the year.

6. Further comments

The Trust External Well-Led Developmental Review reviewed the Audit Committee and noted the following comments not picked up elsewhere in the above:

'Good practice would be for the Group Audit Committee to receive assurance from Quality Committee over the robustness of clincial audit as opposed to undertaking direct oversight itself. The point we are making here is that the standard Quality Committee effectiveness report does not provide explicit assurance over the robustness of clinical audit with Group Audit Committee requiring a separate commentary or the Quality Committee annual report to be more explicit in regard to its oversight over the system of internal control relating to quality/clinical governance. Committee annual reports tend to focus on the coverage, attendance and effectiveness of the Committee's operation not details of how it has met its duties and how it is assured.'

7. Assurance Statement

The Audit Committee continues to deliver its core functions as described in its terms of reference to a high standard. The Audit Committee ensures control processes and procedures are fit for purpose and continue to function effectively alongside the drive to improve wider organisational performance.

The Audit Committee has reflected throughout the year on its core function/purpose and how these fit with the Trusts overall system of governance and assurance. This has aligned with the 'well led' external review that has supported the board to reflect on its internal control systems to ensure that the role of the board and its committees are fit for purpose and support delivery of the Trusts overarching strategic objectives. I am encouraged by the debates that have taken place at audit committee throughout the year and have every confidence that the emerging new ways of working will support the Trust in a positive way.

This is my first year as chair of audit committee and I would like to take this opportunity to pay tribute to the finance, Internal and External Audit teams and the Chair and Chief Executive's Team support team for their hard work in relation to the preparation and audit of the Annual Accounts and the associated reports.

Jane Hazelgrave
Chair of Group Audit Committee
March 2026

Resources Committee Annual Report and Effectiveness Review 2025/26

1. Introduction

This report has been prepared to provide the Board of Directors with a summary of the work of the Resources Committee and its effectiveness during the period April 2025 – March 2026, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

The Board of Directors approved the revised terms of reference for the Committee in January 2025 and this also forms the annual report of the Committee over this period.

2. Governance

The membership of the Resources Committee is as follows:

- Non-Executive Director (Chair)
- 2 x Non-Executive Director (inc Associate Non-Executive Director)
- Director of Finance
- Chief Operating Officer
- Director of Workforce and Organisational Development
- YTHFM Representative
- Chief Nurse
- Medical Director
- Chief Digital Information Officer

Attendees of the Committee are:

- Chief of Allied Health Professionals

The Associate Director of Corporate Governance has a standing invitation to the Committee

Table 1: Resources Committee Attendance

	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
Jim Dillon (Chair until Jun)	✓	✓	✓	-	-	-	-	-	-	-	-	-	3/3
Helen Grantham (Chair from July)	✓	✓	✓	✓	✓	✓	✓	✓	✓	Ap	✓	✓	11/12
Jane Hazelgrave	✓	✓	✓	✓	✓	✓	✓	Ap	✓	✓	✓	✓	11/12
Jenny McAleese	-	-	-	✓	✓	✓	✓	✓	Ap	✓	✓	-	7/8
Richard Reece	-	-	-	✓	✓	✓	✓	✓	✓	Ap	✓	Ap	7/9
Rukmal Abeysekera	-	-	-	-	-	-	-	-	✓	✓	✓	✓	4/4

Andrew Bertram	✓	Dp	Dp	✓	✓	✓	Dp	Dp	✓	✓	✓	✓	12/12
Claire Hansen	✓	✓	✓	✓	✓	✓	✓	✓	Ap	✓	✓	✓	11/12
James Hawkins	✓	✓	✓	✓	✓	✓	Dp	✓	✓	✓	Ap	✓	11/12
Karen Stone	✓	✓	Dp	✓	✓	✓	✓	✓	✓	✓	Ap	✓	11/12
Polly McMeekin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12
Dawn Parkes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Dp	12/12
YTHFM Representative	✓	✓	Dp	✓	✓	✓	✓	✓	✓	Ap	Ap	Ap	9/12

Ap - Apologies, Deputy - Deputy provided counting towards quorum, ✓ - in attendance

The Resources Committee met on 12 occasions during 2025/26 and all meetings were quorate.

The Committee received secretarial and administrative support from the Chair and Chief Executive Office with minutes taken of all Resources Committee meetings. The Chair provided an escalated items log of those matters that the Committee considers should be drawn to the attention of the Board.

The Chair of the Resources Committee was also a member of the Group Audit Committee from May 2025.

3. Duties of the Committee

On behalf of the Trust Board, the Resources Committee will receive reports across Finance, Performance, People and YTHFM as follows:

Finance

- To consider the Trust's financial strategy, in relation to both revenue and capital.
- To consider the Trust's annual financial targets and performance against them.
- To review the annual budget, before submission to the Trust Board of Directors.
- To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets.
- To commission and receive the results of in-depth reviews of key financial issues affecting the Trust.
- To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and contractual safeguards.
- To oversee and receive assurance on the financial plans of significant programmes.
- To seek assurance on delivery of the Trusts efficiency programme.
- To review performance indicators relevant to the remit of the Committee.
- To monitor the risk register and other risk processes in relation to the above.

Performance

- To require regular operational performance reports from management which enable the Committee to consider the operational risks involved in the Trust's business and how they are controlled and monitored by management.

- To obtain assurance that the Trust delivers services which are consistently meeting nationally defined minimum standards and performance and key standards required by the Trust's regulator.
- To obtain where performance is below the standard required, robust recovery plans developed and implemented for nationally defined minimum standards and performance and key standards required by the Trust's regulator.

People:

- To consider organisational development and strategy relating to organisational development and workforce (including recruitment, retention and organisational culture).
- To provide assurance of management recommendations in relation to local pay and contractual arrangements in support of NHS service modernisation.
- To take an overview of the equality and diversity and inclusion policy and achievement of goals (WRES/WDES).
- To review key workforce performance indicators, including: sickness absence, vacancy data, bank/agency usage and expenditure, training, appraisal, staff turnover (stability) and achievement of key performance indicators.
- To provide assurance to the Trust board that HR initiatives in support of strategic workforce development are making appropriate progress against agreed measures.
- To gain regular assurance on the results of the Trust's Staff Surveys, the annual staff survey, the GMC survey and Staff Engagement, and to link this to the delivery and outputs required of associated People Strategies.
- To provide assurance to the Trust Board that the Trust is compliant with relevant HR legislation and best practice, for example nursing and medical revalidation regulations.
- To provide assurance employee relations issues are proportionate and timely.
- To gain regular assurance on the quality of medical and non-medical education and training within the organisation, including student satisfaction, the delivery of action plans to address any gaps identified through feedback, and feedback on quality of placements.
- To gain assurance that the Trust is meeting its regulatory requirements as an education provider (GMC/NMC) and education and training standards (HEE framework, HEI programme requirements)
- To consider statutory and mandatory training processes to ensure all staff remain compliant.
- To receive assurance in relation to erostering implementation against the national Levels of Attainment framework
- To receive the Trust's Workforce Plan
- To support the Trust's organisational development and work on leadership, staff engagement, staff culture and becoming a learning organisation, through review, action planning and assurance processes
- To assure that the statutory duty of revalidation for doctors and nurses is delivered effectively and for other professionals as this is mandated.
- To maintain an oversight of the Raising Concerns Policy (including the Freedom to Speak Up guardians) and the effectiveness of the policy.
- To review the associated risks from the Board Assurance Framework and Corporate Risk Register

- To receive quarterly updates to include performance
- To monitor the implementation of the YTHFM estates and facilities management strategy and plans
- To seek and provide assurance to the Board on the strategic performance of the YTHFM.
- To agree and monitor key performance indicators for the assessment of the YTHFMs performance through the receipt of the minutes of the YTHFM Executive Performance Assurance Meeting (EPAM)

4. Delivery of the Work Programme

A work plan to deliver the duties of the Committee was drafted at the outset of the year and reports presented to the Committee by the Executives or subject matter experts responsible for each report.

Over the year Committee reporting has included:

- Trust Priorities Report (TPR) reporting on:
  - Finance - Income and expenditure, efficiency programme update and cash and capital
  - Operational Performance - Performance to national standards and recovery plans
  - People Update – Workforce and Organisational Development update
- YTHFM Assurance Quarterly Reporting: Operational Performance, Estates and Facilities Management, Sustainability Reporting
- Nursing Workforce Reporting
- Medical Workforce Reporting
- Annual Reporting of Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Staff Survey Results, Freedom to Speak Up, Equality Delivery System (EDS) and Health and Wellbeing Reporting
- Risk Management Reporting

A new Committee Chair was appointed in July 2025 and as from September 2025 the Committee work plan and delivery of its duties changed to incorporate focussed reviews of key areas of delivery for the Trust across:

- Performance: Diagnostics, UEC, Elective, Cancer
- Finance: Cost Improvement Programmes
- Workforce: Staff Survey, Embedding Culture and Leadership Behaviours
- Estates and Facilities Management (YTHFM): 6 Facet Survey

5. Assessment of Effectiveness Self-Assessment by Committee Members

Highest self-assessment scores

- The committee have written terms of reference that clearly describe the purposes and duties of the Committee.
- Executive officers and attendees are well prepared in presenting reports.
- The outcomes of each meeting and any escalations are reported effectively to the Board.
- Committee papers are distributed in sufficient time for members to give them due consideration.

- Committee members contribute regularly to the matters discussed.
- The committee is aware of the key sources of assurance and who provides them.
- All executive officers and attendees that you would expect to attend present at meetings.
- The committee integrates with other Board committees in escalation, reviewing risk and assurance etc.

Lowest self-assessment scores

- The committee receives information that is accurate, complete and timely supporting the committee to gain assurances on the subject matter.
- Debate is allowed to flow, and conclusions reached without being cut short or stifled.
- At the end of each meeting the committee discuss the outcomes and reflect on decisions made, identifying successes and areas to develop.

The Committee's terms of reference and work plan will subsequently be reviewed by the Committee at its March meeting. Any amendments will be reserved for Board approval at its March meeting.

6. Assurance Statement

The Resources Committee covers finance, operations and people matters relating to the Trust and seeks assurance from the Executive that these areas are being well run and supports, questions and challenges as appropriate. It also provides an oversight of the performance of the YTHFM and the trust's Digital challenges through the Digital sub-committee.

I took over as chair of the Committee in the middle of 2025 and have worked with the executive and non-executive members of the Committee with the aim of ensuring that the Committee uses its time well and focusses on the right areas. The Committee has a work plan covering matters within its terms of reference and on which it needs to provide assurance to the Board. During the year, it has kept its work plan under regular review so that there is good time for consideration and debate on areas where the Trust is experiencing significant challenge. The Chair, Trust Secretary and Chief Operating Officer have also worked on ways to improve the information being presented to the Committee so that good assurance is provided.

A key focus during the year has been on operational challenges with focussed reviews being undertaken on diagnostics, cancer, referral to treatment and urgent and emergency care. Significant increases in demand, workforce pressures and equipment issues have all impacted performance and the ability of the Trust to ensure appropriate and timely care is provided to patients. The Committee has challenged, questioned and supported a number of initiatives to help address issues and a key focus of the Committee has been to ensure that clear and credible plans are in place to support sustained improvement and working towards meeting trajectories.

The Committee has also had a focus on people issues considering culture, leadership, diversity and inclusion and wellbeing initiatives as well as safe staffing

levels in nursing and monitoring and supporting initiatives around e-rostering, reducing the use of agency and bank workforce and using the Healthcare Academy to support recruitment and development of registered and non-registered colleagues.

In common with other Trusts and sectors within the NHS both regionally and nationally, the financial challenges have been particularly significant with the requirement to deliver efficiency targets and operational savings whilst ensuring patient care and safety remains the priority. The Committee has sought to provide the Board with assurance that the Trust takes responsibility to best strive towards the delivery of its financial targets without compromising the needs of patients, colleagues and the wider community. There has been ongoing dialogue with the Finance team on ensuring it has the right information to enable it to perform this role and to hold the Executive to account for delivery of plans.

Helen Gratham, Chair of the Resources Committee
March 2026

Appendix 3

Terms of Reference for: **Resources Committee**	NHS York and Scarborough Teaching Hospitals NHS Foundation Trust
Authors Name: Mike Taylor, Associate Director of Corporate Governance	
Contact Name: Mike Taylor, Associate Director of Corporate Governance	
Scope: Trust wide	**Trust Priorities: Trust Strategy 2025-2030: Towards Excellence**
Keywords: People, Finance, Performance, YTHFM	**Replaces: N/A**
To be read in conjunction with the following documents: **Trust Strategy and Priorities, Board Assurance Framework, Corporate Governance Manual**	

Unique Identifier: RC	**Review Date: March 2027**	
Issue Status: Final	**Issue No: v2.1**	**Issue Date: March 2025**
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Officer responsible for archive: Associate Director of Corporate Governance		

RESOURCES COMMITTEE

Terms of Reference

1	**Status**
1.1	The Board has resolved to establish a Committee of the Board to be known as the Resources Committee ("the Committee").
2	**Purpose of the Committee**
2.1	The purpose of the Resources Committee is to lead on behalf of the Board of Directors the acquisition and scrutiny of assurances to ensure: (i) The Trust delivers the six strategic objectives of the Trust Strategy 2025-2030: Towards Excellence (ii) The reviewing and seeking of assurance regarding the operational and strategic plans and activities for Finance, Performance and People aspects of the Trust. This will include areas such as York Teaching Hospitals Facilities Management (YTHFM) estates and facilities, and sustainability (iii) The meeting of regulatory requirements of CQC and NHS England
3	**Authority**
3.1	The Committee is authorised by the Board to investigate any activity within its terms of reference. Changes to the terms of reference can only be approved by the Board of Directors. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.
3.2	The Committee may invite any Director, Executive, external or internal auditor, or other person to attend any meeting(s) of the Committee as it may from time to time consider desirable to assist the Committee in the attainment of its role and duties.
3.3	The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experiences and expertise if it considers this necessary.
4	**Legal requirements of the committee**
4.1	There are no specific legal requirements attached to the functioning of the Committee. The Committee will however be made aware of any future legal requirements the Trust is expected to fulfil relating to its role and function.
5	**Role and duties**
5.1	The Resources Committee shall on behalf of the Board of Directors review assurances in delivery of the Trust Strategy 2025-2030: Towards Excellence and key enablers in the following areas as part of the Trust's longer-term strategy: (i) Workforce strategy

	(ii) Trust operational performance plans and processes; (iii) Financial performance, material variance and remedial plans; (iv) YTHFM and Sustainability strategies
5.2	To do this it will receive reports including the Trust Priorities Report (TPR) where applicable, across the following areas: • Finance • Performance • People • YTHFM
5.2.1	Finance • To consider the Trust's financial strategy, in relation to both revenue and capital. • To consider the Trust's annual financial targets and performance against them. • To review the annual budget, before submission to the Trust Board of Directors. • To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets. • To commission and receive the results of in-depth reviews of key financial issues affecting the Trust. • To maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources and contractual safeguards. • To oversee and receive assurance on the financial plans of significant programmes. • To seek assurance on delivery of the Trusts efficiency programme. • To review performance indicators relevant to the remit of the Committee. • To monitor the risk register and other risk processes in relation to the above.
5.2.2	Performance • To require regular operational performance reports from management which enable the Committee to consider the operational risks involved in the Trust's business and how they are controlled and monitored by management.

	• To obtain assurance that the Trust delivers services which are consistently meeting nationally defined minimum standards and performance and key standards required by the Trust's regulator. • To obtain where performance is below the standard required, robust recovery plans developed and implemented for nationally defined minimum standards and performance and key standards required by the Trust's regulator.
5.2.3	People: • To consider organisational development and strategy relating to organisational development and workforce (including recruitment, retention and organisational culture). • To provide assurance of management recommendations in relation to local pay and contractual arrangements in support of NHS service modernisation. • To take an overview of the equality and diversity and inclusion policy and achievement of goals (WRES/WDES). • To review key workforce performance indicators, including: sickness absence, vacancy data, bank/agency usage and expenditure, training, appraisal, staff turnover (stability) and achievement of key performance indicators. • To provide assurance to the Trust board that HR initiatives in support of strategic workforce development are making appropriate progress against agreed measures. • To gain regular assurance on the results of the Trust's Staff Surveys, the annual staff survey, the GMC survey and Staff Engagement, and to link this to the delivery and outputs required of associated People Strategies. • To provide assurance to the Trust Board that the Trust is compliant with relevant HR legislation and best practice, for example nursing and medical revalidation regulations. • To provide assurance employee relations issues are proportionate and timely. • To gain regular assurance on the quality of medical and non-medical education and training within the organisation, including student satisfaction, the delivery of action plans to address any gaps identified through feedback, and feedback on quality of placements. • To gain assurance that the Trust is meeting its regulatory requirements as an education provider (GMC/NMC) and education and training standards (HEE framework, HEI programme requirements) • To consider statutory and mandatory training processes to ensure all staff remain compliant.

	• To receive assurance in relation to erostering implementation against the national Levels of Attainment framework • To receive the Trust's Workforce Plan • To support the Trust's organisational development and work on leadership, staff engagement, staff culture and becoming a learning organisation, through review, action planning and assurance processes • To assure that the statutory duty of revalidation for doctors and nurses is delivered effectively and for other professionals as this is mandated. • To maintain an oversight of the Raising Concerns Policy (including the Freedom to Speak Up guardians) and the effectiveness of the policy. • To review the associated risks from the Board Assurance Framework and Corporate Risk Register
5.2.4	YTHFM • To receive quarterly updates to include performance • To monitor the implementation of the YTHFM estates and facilities management strategy and plans • To seek and provide assurance to the Board on the strategic performance of the YTHFM. • To agree and monitor key performance indicators for the assessment of the YTHFMs performance through the receipt of the minutes of the YTHFM Executive Performance Assurance Meeting (EPAM)
5.3	The Committee will work closely with the following in escalations and in sharing information via Chair's reports to: • Board of Directors (in informing of significant issues, underperformance, and deviation from plans to deliver the Trust Strategy 2025-2030: Towards Excellence • Quality Committee; • Digital Sub-Committee, and • Audit Committee
5.4	The Committee will support specifically the Audit Committee to review and oversee the effectiveness of the Trust's internal control framework in considering material issues communicated to it by the Audit Committee arising from the work of the Internal Audit function relating to matters which fall within the scope of the objective and responsibilities of the Committee. The Committee shall provide feedback on its review of such referred internal audit work, in particular as to any shortcomings perceived in the scope or adequacy of the work. Additionally, the Committee shall respond to any other matters of an internal audit nature that are referred to it by the Audit Committee as appropriate.

5.5	To examine any other matter referred to the Committee by the Board of Directors.
5.6	The Committee will escalate items to the Board of Directors following each meeting and will submit minutes to the Board of Directors for information.
6	**Membership**
6.1	The membership of the Committee shall be comprised of the following core members: • Three Non-Executive Directors – (one of whom will be the Chair of the Committee) • Director of Finance • Chief Operating Officer • Director of Workforce and Organisational Development • Managing Director of YTHFM • Chief Nurse • Medical Director • Chief Digital Information Officer The following Directors and officers will be attendees: • Chief of Allied Health Professionals Other attendees: • Any Director, the Chair or Chief Executive is able to attend at any time on an occasional basis subject to notifying the Chair in advance. • The Associate Director of Corporate Governance will have a standing invitation to the Committee. Representation from Humber and North Yorkshire Integrated Care Board will also have a standing invitation.
6.2	The duties of members and attendees shall be to:- • attend and contribute; • have read the papers and materials in advance and be ready to work with them; • actively participate in discussions pertaining to Committee business ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact Trust-wide; • disseminate the learning and actions form the meetings; • to attend at least 75% of meetings of the Committee per year.
7	**Quoracy**

7.1	The quorum of any meeting shall be a minimum of two Non-Executive Directors and two Executive Directors. The Chair of the meeting will ensure that a deputy is appointed to preside over a meeting when the Chair is unavailable or has a conflict of interest.
7.2	It is expected that all members will attend meetings of the Committee. An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.
7.3	If Executive Directors are unable to attend a meeting, they may nominate a deputy subject to consultation with the Committee Chair. Deputies will be counted for the purpose of the quorum.
7.4	The Chair may request attendance by relevant staff at any meeting.
8	**Frequency of meetings**
8.1	Meetings of the Resources Committee shall be held up to 12 times per year, scheduled to support the business cycle of the Trust and at such times as the Chair of the Committee shall identify, subject to agreement with the Chair of the Trust and the Chief Executive.
8.2	The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.
8.3	Meetings of the Committee shall be set at the start of the calendar year.
9	**Administrative support**
9.1	The Committee will be supported administratively by the Corporate Services Team, who will ensure: • Agreement of the agenda with the Committee Chair • Collation and distribution of papers at least 7 days before each meeting • Minutes are taken, actions followed up prior to the next meeting and records are maintained of matters arising and issues to be carried forward. • Support the Chair and members as required. • Executive members are supported in carrying out their duties in delivery of Committee roles and duties
9.2	Where members of the Committee are unable to attend a scheduled meeting, they should provide their apologies, in a timely manner, to the secretary of the group and provide a deputy.
10	**Monitoring Effectiveness and Compliance with Terms of Reference**
10.1	The Committee will carry out an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference, specifically commenting on

	relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.
11	**Review of Terms of Reference**
11.1	The terms of reference of the Committee shall be reviewed at least annually by the Committee and approved by the Board of Directors.

Author	**Associate Director of Corporate Governance**
Owner	**Associate Director of Corporate Governance**
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Appendix 4

York and Scarborough Teaching Hospitals NHS Foundation Trust

Board of Directors Public Meeting Work Plan 2026/27

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Governance Standing Items													
Apologies	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Declarations of Interest	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Approval of previous meeting's minutes	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Matters Arising	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chair's Report	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chief Executive's Report	Chief Exec	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
True North Report	Chief Exec	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Items													
Trust Priorities Report (TPR): - Performance - Quality & Safety - Workforce - Digital - Finance	Each Exec Director	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Maternity Reports (inc): - Maternity & Neonatal - Perinatal Quality Surveillance - Maternity Dashboard - Maternity self-assessment tool	Chief Nurse	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
CQC Compliance Update Report	Chief Nurse	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Summary Reports of Assurance Committees	Comm Chairs	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Quarterly Items													
Risk Management report - Board Assurance Framework	Asso Dir CG	✓			✓			✓			✓		
Mortality Review (Learning from Deaths) Report	Medical Director			✓			✓				✓		✓
Emergency Preparedness Resilience and Response (EPRR) Action Plan Update	Chief Operating Officer		✓				✓		✓			✓	
Annual Operating Plan Progress Report	Chief Exec		✓				✓		✓			✓	
FTSU Quarterly Report	FTSU Guardian	✓			✓			✓			✓		
Annual Items													
Infection, Prevention and Control Annual Report	Chief Nurse			✓									
Safeguarding Annual Report	Chief Nurse						✓						
Freedom to Speak Up Annual Report	FTSU Guardian							✓					
Complaints Report (half-yearly Jan)	Chief Nurse				✓						✓		
Responsible Officer Annual Report	Medical Director						✓						
Medical Education Report	Medical Director							✓					
Guardian of Safe Working Hours Annual Report	Medical Director		✓										
Midwifery, Maternity and Neonatal Nursing and Medical Staffing Report (Bi-annually)	Chief Nurse		✓								✓		
Midwifery Obstetric and Anaesthetic Report	Chief Nurse										✓		

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Maternity Safety Champion Report (Bi-annually)	Chief Nurse		✓								✓		
Maternity Incentive Scheme	Chief Nurse										✓		
Staff Survey Report	Dir Work & OD												✓
WRES & WDES inc Action Plan	Dir Work & OD	✓						✓					
Gender Pay Gap Report	Dir Work & OD										✓		
Public Sector Equality Duty (PSED) report	Dir Work & OD				✓								
Equality Delivery System	Dir Work & OD												✓
Health & Wellbeing Report	Dir Work & OD											✓	
Winter Plan	Chief Operating Officer						✓						
EPRR Annual Report	Chief Operating Officer								✓				
Governance Framework Review: - Constitution - Standing Orders - Scheme of Reservation and Delegation - Standing Financial Instructions	Asso Dir CG										✓		
Fit & Proper Persons Annual Report	Asso Dir CG		✓										
Modern Slavery Act Statement approval	Asso Dir CG												✓

Last updated 19 March 2026

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Assurance Committees Annual Reports approval (ToR as required)	Asso Dir CG												✓
Board Register of Interests	Asso Dir CG	✓											
Research and Innovation Strategy	Medical Director											✓	
Research and Innovation Annual Report	Medical Director		✓										
Premises Assurance Model (PAM)	YTHFM MD						✓						
Board Work Plan - Public													✓

Modern Slavery and Human Trafficking Act 2015
Annual Statement 2026

York and Scarborough Teaching Hospitals NHS Foundation Trust and York Teaching Hospital Facilities Management LLP (the Group) offers the following statement regarding its efforts to prevent slavery and human trafficking in its supply chain.

The Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

York and Scarborough Teaching Hospitals NHS Foundation Trust and York Teaching Hospital Facilities Management LLP provide a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles. The annual turnover is approximately £0.9bn. We manage 8 hospital sites, circa 880 beds (including day-case beds) and have a workforce in excess of 10,000 staff working across our hospitals and in the community.

The Group has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. There are robust recruitment policies and processes in place, including conducting eligibility to work in the UK checks for all directly employed staff and agencies on approved frameworks.

There are a range of equal opportunities controls in place to protect staff such as a Freedom to Speak Up Guardian, Fairness Champions and a Raising Concerns and Whistleblowing Policy.

The Group has in place a Standards of Business Conduct Policy which covers the way in which the organisation and staff behave.

The Procurement Department’s senior team are all Chartered Institute of Purchasing and Supply (CIPS) qualified and abide by the CIPS code of professional conduct. The intranet includes a link to an ethical procurement training module which is available to all members of staff. Competency assessments are currently being developed for all bands in the department some of which will include requirements around modern slavery.

The top 50% of suppliers nationally affirm their own compliance with the modern slavery and human trafficking act within their own organisation, sub-contracting arrangements and supply chain. The Group has written to its top suppliers requesting them to affirm their compliance with the legislation.

Modern Slavery is referenced in the Safeguarding Adults Policy and features as part of the safeguarding adults training following the changes in the Care Act. The Safeguarding Adults Staff intranet resource includes signposting to help and provide advice for patient’s affected by Modern Slavery. Modern Slavery is included on the Safeguarding work programme with plans to review processes over the next 12 months.

The Group has evaluated the principal risks related to slavery and human trafficking and identify them as:

- Reputational

- Lack of assurances from suppliers
- Lack of anti–slavery clauses in contracts
- Training staff to maintain the Group's position around anti-slavery and human trafficking.

Aim

The aim of this statement is to demonstrate the Group follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

…… ……

Martin Barkley
Chair

Clare Smith
Chief Executive

1 April 2026

…… ……..

Julie Charge
Chair (YTHFM LLP)

Chris Norman
Managing Director (YTHFM LLP)

1 April 2026