York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 29th April 2026
Time: 9:30am – 12:30pm
Venue: PGME Discussion Room, Scarborough Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:30
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 25 March 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	20	
6.	**Colleague's Story** To consider.	Deputy Director of Workforce	Verbal	-	9:35
7.	**True North Report** To review the report.	Chief Executive	Report	21	9:45
8.	**Chair's Report** To review the report	Chair	Verbal	-	9:55

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	39	10:00
10.	**Quality Committee Report** To receive the April meeting summary report.	Chair of the Quality Committee	Report	68	10:15
11.	**Resources Committee Report** To receive the April meeting summary report.	Chair of the Resources Committee	Verbal	-	10:25
12.	**Trust Priorities Report (TPR)** March 2026 Trust Priorities Report Performance Summary: • Operational Activity and Performance • Quality & Safety • Workforce • Digital and Information Services • Finance	 Chief Operating Officer Medical Director & Interim Chief Nurse Deputy Director of Workforce Chief Digital Information Officer Finance Director	Report	71 76 122 137 148 156	10:35
13.	**Q4 Annual Reporting Plan Progress Report** To consider the report.	Chief Executive	Report	175	11:15
Break 11:25					
14.	**CQC Compliance Update** To consider the report.	Interim Chief Nurse	Report	197	11:35

Item	Subject	Lead	Report/ Verbal	Page No	Time
15.	**Maternity and Neonatal Report** To consider the report.	Interim Chief Nurse - Executive Maternity Safety Champion	Report	206	11:40
16.	**Freedom to Speak Up Quarterly Report** To consider the report.	FTSU Guardian	Report	216	11:55
17.	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)** To consider the reports.	Deputy Director of Workforce	Report	225	12:05
Governance					
18.	**2025/26 Q4 Board Assurance Framework** To consider the report.	Associate Director of Corporate Governance	Report	232	12:15
19.	**Corporate Governance Update** • Quality Committee Annual Report and Effectiveness Review • Group Audit and Quality Committees Terms of Reference	Associate Director of Corporate Governance	Report	252	12:20
20.	**Fire Safety Policy and Strategy** To approve the Policy	Interim Chief Nurse	Report	276	12:20
21.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	12:30
22.	**Time and Date of next meeting** The next meeting held in public will be on 27 May 2026 at 9.00am at York Hospital.				

Item	Subject	Lead	Report/ Verbal	Page No	Time
23.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
24.	**Close**				12:30

Minutes
Board of Directors Meeting (Public)
25 March 2026

Minutes of the Public Board of Directors meeting held on Wednesday 25 March 2026 in the Trust Headquarters Boardroom, York Hospital. The meeting commenced at 9.00am and concluded at 11.50am.

Members present:

Non-executive Directors
- Mr Martin Barkley (Chair)
- Ms Rukmal Abeysekera
- Dr Lorraine Boyd (Maternity Safety Champion)
- Ms Julie Charge
- Ms Helen Grantham
- Ms Jane Hazelgrave
- Dr Richard Reece, Associate Non-Executive Director *(Via Teams)*

Executive Directors
- Miss Clare Smith, Chief Executive
- Mr Andrew Bertram, Finance Director and Deputy Chief Executive
- Dr Karen Stone, Medical Director
- Ms Tara Filby, Interim Chief Nurse
- Ms Claire Hansen, Chief Operating Officer
- Mr James Hawkins, Chief Digital and Information Officer
- Miss Polly McMeekin, Director of Workforce and Organisational Development

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

In Attendance:
- Mr Joe Hague, Chief Nurse Designate *(Via Teams)*
- Ms Alison Chorlton, Nurse Consultant, York and North Yorkshire Sexual Health and HIV Services (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
- Three members of the public

1 Welcome and Introductions

Mr Barkley welcomed everyone to the meeting.

2 Apologies for absence

There were no apologies for absence.

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 25 February 2026

The Board approved the minutes of the meeting held on 25 February 2026 as an accurate record of the meeting.

5 Matters arising/Action Log

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

BoD Pub 49 *Ensure that work on understanding referrals is presented to the Resources Committee.*
Miss Smith advised that a report would be presented to the Resources Committee and the Board in April. The due date was deferred.

BoD Pub 50 *Produce a paper for discussion on reducing sickness absence for presentation to the Resources Committee*.
The paper had been presented to the Resources Committee at its meeting on 17 March. The action was closed.

BoD Pub 54 *Update the Board on the response from the ICB on the 24/25 unpaid ERF income.*
Mr Bertram reported that a reply had been received from the ICB which rejected the claim for the unpaid ERF income, following discussion with the regional team. Mr Bertram advised that, whilst the income was not included in the forecast for 2026/27, there was one final avenue to explore in terms of securing payment. The action was closed.

BoD Pub 63 *Consider how the Safer Nurse Staffing information might be incorporated into the Nursing Quality Assurance Framework paper for Quality Committee*
Ms Filby advised that the Quality Assurance Framework paper for Quarter 4 would be amended to incorporate the relevant information. The action was closed.

BoD Pub 65 *Present the new approach to reporting performance for 2026/27.*
Miss Smith advised that the approach would be presented to the Board as part of the operational planning process. The due date was deferred.

BoD Pub 66 *Update the Board on the meeting with the regional team to discuss the unmet target of 60% of RTT patients waiting less than 18 weeks for elective treatment.*
Ms Hansen reported that she had met with the regional team on 13 March to discuss projected performance targets. There had been no repercussions from this meeting, but Ms Hansen was of the view that there would be consequences arising from the Trust's

position under the National Oversight Framework. However, the performance metrics were showing evidence of improvement in Quarter 4 in most areas other than Referral To Treatment (RTT). The action was closed.

BoD Pub 68 *Provide an update on discussions to progress the hybrid theatre and VIU projects.*
Mr Norman advised that an options appraisal was being worked through and a paper would be presented to the Board in April.

Action: Mr Norman

BoD Pub 69 *Bring an update on the Acute Medical Model.*
This would be covered under Item 13 *Trust Priorities Report.* The action was closed.

6 Patient's Story

Ms Chorlton joined the meeting and shared slides illustrating the aims and successes of the cervical screening service. Ms Chorlton also shared several brief patient stories associated with the service. Questions and comments were invited.

Miss Smith highlighted that the service was a good example of the move to neighbourhood care which would be particularly effective in reaching vulnerable populations. Ms Chorlton was asked if there were any examples of learning which could be applied to other services. She observed that the specific targeting of populations could be replicated in some services.

Ms Chorlton was thanked for her informative presentation and she left the meeting.

7 True North Report

Miss Smith advised that she would bring a recommendation for the True North metrics for 2026/27 to the next meeting.

Action: Miss Smith

Miss Smith reported that, whilst there had been some improvement in the national Staff Survey outcomes for the Trust in terms of staff recommending it as a place to receive care, there was clearly much further to go. This work would be supported by the development of a clinical strategy and the elimination of corridor care. Miss Smith was pleased to report that the Continuous Quality Improvement Business Case submitted to NHS England by the Trust had been approved which was hugely significant. In terms of recommending the Trust as a place to work, Miss Smith observed that, from her meetings with colleagues across the organisation, it was clear that Trust values and behaviours were not being consistently demonstrated.

Miss Smith advised that efforts continued to reduce the number of bed days lost to patients with no criteria to reside. A pilot of a process to transfer patients without a Trusted Assessor Form would be extended to more wards and further escalations were being explored in terms of long stay patients. A new Acute Model of Care was now in place which was providing benefits for both patients and staff in Emergency Departments (ED) and would underpin an improvement in the Emergency Care Standard (ECS) and in the reduction of 12 hour waits in ED. The aim was to eradicate corridor care and 12 hour waits.

Miss Smith reminded the Board that metrics relating to the performance of the Cancer service were a month behind other performance metrics and improvements should be evidenced in next month's report.

Ms Filby highlighted the targeted work to address the number of Category 2 pressure ulcers and Trust onset MSSA infections. Overall, good progress was being made.

Finally, Miss Smith noted that the Trust awaited confirmation from the NHS England regional team that the implementation of the new Electronic Patient Record (EPR) could proceed in the next few months. As outlined previously, the Business Case for the implementation of Continuous Quality Improvement methodology, which would link to productivity and efficiency work, had been approved and a procurement exercise could now be initiated.

8 Chair's Report

The Board received the report.

Mr Barkley advised that he had, in fact, chaired the meeting of the Digital Sub-Committee on 20 March 2026.

9 Chief Executive's Report

The Board received the report.

Miss Smith observed that, as she reached the end of her first 100 days in post, she had reflected on discussions with a range of colleagues on how it felt to work and to deliver care in the Trust. She would be sharing these reflections with the Board in April and the priorities arising from them would be incorporated into the operational plan.

Miss Smith cautioned that the implementation of the Continuous Quality Improvement programme would be a significant addition to Executive Directors' workload. She reported that the Annual Plan for 2026/27 had been re-submitted and she expected further discussions with the regional and national team around the forecast deficit position.

Miss Smith reported that she and Mr Barkley, Dr Stone, and Ms Hansen had attended an NHS England conference on eradicating corridor care; this had been very valuable and helped to inform the Executive team's commitment to this aim.

Miss Smith also highlighted some evidence of improvement in the results of the national Staff Survey and in the CQC report from the unannounced inspection of Scarborough Hospital. She reported that Tara Filby had been appointed as Interim Chief Nurse, following Dawn Parkes' retirement and until Joe Hague began in post as new Chief Nurse, and that Sarah Coltman-Lovell had joined the Trust as Director of Strategy until the end of May.

Board members had enjoyed, as always, reading the Star Award nominations. Dr Reece asked how patients were made aware of the opportunity to nominate staff. Mrs Brown responded that promotional material should be displayed on all sites, and the website also provided relevant information.

10 Quality Committee Report

Dr Boyd highlighted the key discussion points from the meeting of the Quality Committee on 24 March 2026:

- Surgery Care Group had provided an update, highlighting pressures on responding to complaints within the set timescales and on operating times for patients with a fractured neck of femur; the Committee would continue to monitor both;
- there was continued uncertainty around the future of the Maternity and Neonatal Voices Partnership;
- the Committee received assurances around Maternity Services, and from workstream including complex needs, mortality and learning from deaths, and sepsis;
- the Committee received a comprehensive update on internal audit actions relating to quality and safety.

Dr Boyd reported that, following the Board discussion at the last meeting on the maternity regional heatmap, Ms Wells-Munro had explained the information used for the reported metrics. Dr Boyd assured the Board that directors were already well-sighted on all this information.

11 Resources Committee Report

Ms Grantham outlined the key discussion points from the meeting of the Resources Committee on 17 March 2026. Operational performance was generally below forecast trajectories but there was evidence of improvement. The Committee had undertaken a focussed review of Urgent and Emergency Care and of culture, leadership and behaviours. The significantly increased response rate to the national Staff Survey was welcomed and it was agreed that the survey was now much more representative. The deterioration in scores had been halted which would at least provide a foundation for future improvement. The Staff Survey improvement plan would focus on a fewer number of priorities for greater impact.

Ms Grantham advised that the Committee would receive a monthly update on progress against the Waste Reduction and Productivity (WRAP) programme, alongside the usual financial report. Ms Abeysekera highlighted the WRAP tracking document which had been shared with the Committee as evidence of oversight and accountability.

Miss McMeekin was asked to arrange a demonstration of the Robotic Process Automation tools, Esther and IRIS, for Mr Barkley.

Action: Miss McMeekin

Mr Barkley asked who would be leading on the re-procurement of Urgent Treatment Centre services and what was the timeline. Ms Hansen responded this would be led by the Medicine Care Group and should be concluded in Quarter 3.

It was noted that the Equality Delivery System report was presented to the Resources Committee and the Board as part of the requirement for all NHS providers to implement the Equality Delivery System.

Mr Barkley asked when the revised Sickness Absence Policy would be implemented. Miss McMeekin advised that this was still under negotiation with trade union representatives but was being prioritised.

12 Group Audit Committee Report

Ms Hazelgrave highlighted the key points from the meeting of the Group Audit Committee on 10 March 2026:

- 11 internal audit reports had been issued since the last meeting of the Committee: four with significant assurance and seven with limited assurance; as the internal audit programme was risk based, it was expected that a number of areas would return reports with limited assurance, with the priority being to address the recommendations;
- external audit colleagues had begun work on this year's report; a materiality threshold had been set at £18.4m;
- the Committee had received internal audit progress reports for both the Trust and YTHFM and had approved internal audit plans for 2026/27 for both parts of the Group, this being eight fewer days than for 2025/26;
- a report from the Counter Fraud team was presented, and would be going forward at each meeting;
- the Chief Nurse had attended the meeting to report on her recommendations from Internal Audits undertaken in 2025/26; it was agreed by the Committee that this should be the focus of Executive attendance at the meeting;
- the Committee had reviewed its terms of reference and discussed its annual report which was positive overall;
- there were no new risks to escalate.

Mr Barkley referred to the eight overdue recommendations from the Trust's internal audit reports. Ms Hazelgrave responded that the Committee had been assured that these would be addressed by Executive Directors. Mr Taylor added that audit recommendations were reviewed at Risk Sub-Committee and Corporate Directors' meetings. Ms Hazelgrave noted that the Committee received full internal audit reports which would improve transparency.

13 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hansen reported that the new Acute Model of Care, which was in line with national guidance, had been implemented at pace at both York Hospital and Scarborough Hospital EDs. The model of care included two new areas: Extended Emergency Medicine Ambulatory Care (EEMAC) and the Emergency Assessment Unit (EAU). Ms Hansen recorded her appreciation for the support received by frontline ED staff from the Digital team during the period of implementation. Ms Hansen reported that the Acute Model of Care had resulted in an improvement in ECS performance in March of around 10% and a reduction in 12 hour waits of around 5%. The environment in the EDs for both staff and patients was calmer as a result of these changes, with patients waiting for specialty input now cared for in a different area. Ms Hansen reported that there had been no 12 hour wait breaches at York Hospital on the previous Sunday and it was agreed that this was extremely positive. Ms Hansen advised that the implementation of the Acute Model of Care was more challenging at Scarborough due to the medical staffing establishment which was being reviewed to support future changes.

Ms Hansen reported that work to reduce Length of Stay continued, which was part of a wider programme to address patient flow through the hospitals. Mr Hawkins advised that a first analysis of the data showed that the new EAU had avoided about 90 admissions in the first week on the York site.

Ms Hazelgrave questioned what the enabler had been for this significant change. Ms Hansen explained that the new model of care had been linked to the go-live of the new EPR and the Digital team had worked out of hours to make the appropriate changes to the current patient database. The changes had also been driven and well led by Dr Smith and Mr Stanley, Care Group directors for Medicine and Surgery respectively.

Ms Hansen advised that cancer performance metrics were gradually improving despite the challenging context. Work on pathways and additional funding received from the Cancer Alliance had supported this improvement. In terms of Referral To Treatment, funded sprints had continued throughout March: an additional 6,000 outpatient appointments had been created, based on the £1m of funding received. As the funding had been received after the start of Quarter 4, the agreed target would not be met. There had been a slight increase in the total waiting list due to the rise in referrals.

Ms Hansen reported that the Trust's diagnostic performance had improved by almost 7% at the end of February 2026, which was the best performance since February 2020. Whilst the end of year trajectory would be missed, the direction of travel was positive and long waits continued to be reduced. Ms Hansen advised that there had been some indication that sprint funding would be continued in April.

In response to a question, Ms Hansen advised that the Scarborough Community Diagnostic Centre was due to open this week for staff training, with operations being brought on-line throughout April.

Mr Barkley asked about the investment in capacity to address the long waiting times for paediatric speech and language therapy. Mr Bertram responded that the investment could not be made, and therefore recruitment could not begin, until the financial plan had been approved by NHS England. Ms Hansen advised that discussions had been taking place with system partners to ensure that children on the waiting list for speech and language therapy were on the right pathway. Mr Barkley emphasised the importance of treating children without delay.

Mr Barkley referred to the bullet point on page 86 of the report which read *"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)".* He questioned how data governance was overseen. Mr Hawkins advised that the national reporting of data was overseen by him, under the delegated authority of the Chief Executive. He would clarify if there had been a previous error in reporting non-elective length of stay or whether the national guidance had changed.

Action: Mr Hawkins

Mr Barkley highlighted the increase in referrals. Miss Smith reminded the Board that a paper would be presented to the Resources Committee on the reasons for, and the impact of, the increase.

The Board acknowledged the improvement in the metrics for diagnostics, particularly the reduction in the number of patients waiting more than six weeks for Audiology, MRI and Colonoscopy procedures.

Mr Barkley noted however the disappointing metric for the 2-hour Urgent Community Response compliance and requested that an improvement plan be brought to the Board in April.

Action: Ms Hansen

Quality and Safety

Ms Filby reported that the progress to reduce C.Difficile infections had been sustained and the Trust's position as first out of 134 Trusts under the National Oversight Framework for improvement in this metric had been recognised nationally, as Ms Filby had been asked to share the Trust's improvement journey with the Regional Directors of Nursing. Ms Filby also reported that there had been reductions in February of cases of E.Coli and Klebsiella Bacteraemia. She referenced the current improvement actions in the report and advised that governance around Infection Prevention and Control (IPC) had strengthened. An internal audit report on IPC governance had recorded significant assurance.

Ms Filby advised that in terms of pressure ulcers, the monthly target had been missed in February. Data was being used to drive focussed areas for improvement which were monitored closely. As reported at the last meeting, discussions had begun with system partners to initiate improvement work across other providers, particularly in how pressure damage which had developed in a care home setting was reported.

Maternity

There were no question or comments on this section.

Workforce

Miss McMeekin reported that the Health Care Support Worker (HCSW) vacancy rate stood at 14% with the majority of vacancies being in the Medicine Care Group. This position was being managed closely. Miss McMeekin noted that some HCSWs had moved onto nursing apprenticeships which was positive. A number of new HCSWs were currently undergoing recruitment checks or being trained through the Health Care Academy. Miss McMeekin assured the Board that no agency staff were being used to cover the vacancies.

Miss McMeekin also reported that the Scarborough Hospital staff wellbeing room had been completed and the one at York Hospital was due for completion next week.

The Board was pleased to note the use of apprenticeships to retain HCSWs within the organisation and to provide a stepping stone for their development.

Digital and Information Services

Mr Hawkins advised that the overall impact of the delay to the implementation of the new EPR was being mitigated whilst further communication was awaited from NHS England. He reported that the Trust had purchased licences to extend the trials of Ambient Voice Technology. The Service was also progressing the electronic ordering of radiology in primary care. The Digital Sub-Committee had met on 20 March when the pressures on the IT Service Desk in the lead up to the planned implementation of the EPR had been discussed. The team was reviewing the lessons learnt.

Finance

Mr Bertram reported that at Month 11, the Trust was on target to meet the revised year-end trajectory, which was a deficit of £32.6m. Good progress had been made against the financial recovery programme and it was expected that the £5m target for recovery actions would be delivered. The overtrade against the Elective Recovery Fund was being

corrected to ensure that it was in balance at year-end and that there was no exposure to risk.

In terms of the Cost Improvement Programme, Mr Bertram advised that £37m had been delivered in full year terms and the total was expected to reach £39m by year-end, although he cautioned that the majority of savings were non-recurrent. Care Groups and Corporate areas had been asked to review their savings line by line to identify more which could be recurrent.

Mr Bertram reported that £44m of the capital programme had been spent at Month 11. The procurement team was making every effort to ensure that the significant amount of remaining capital was spent by year-end.

In response to a question, Mr Bertram advised that KPMG were due to finish their work by the beginning of May. A report would be presented to the Board.

Action: Mr Bertram

Dr Reece highlighted the amount which could be saved by stopping the use of first class post. Mr Bertram commented that the organisation was a significant user of postal services but there was now much greater awareness of the spend, and the need to use first class post had been challenged which had led to a substantial reduction. Mr Hawkins advised that the Trust had the capability to move to digital communication, but patients needed to be voluntary users of the Patients Know Best system which was a challenge.

14 CQC Compliance Update

Ms Filby reported that a recent IR(ME)R inspection of Nuclear Medicine at York Hospital had identified no breaches and two areas for improvement, with an action plan due by 7 April 2026.

Ms Filby advised that the CQC report from the October 2025 inspection of Scarborough Hospital had been published on 20 March and described improvements in Medical Services and further improvements to make in Urgent and Emergency Care. A Trust response to the recommendations was due by 10 April 2026. Trust representatives continued to meet regularly with the CQC, and some non-inspection visits were planned for later in the year.

The Board recorded its congratulations to the Medicine Care Group for the positive report on Medical Services and the improvements in Urgent and Emergency Care.

15 Maternity and Neonatal Report

Ms Wells-Munro presented the report and highlighted the key assurances set out in the executive summary, in particular that the Trust's perinatal mortality rate remained at 3.8 per 1000 births, this metric being taken from the 2023 MBRRACE report. Ms Wells-Munro noted that the most recent report had now been received and the mortality rate had reduced. She would bring a full summary of the MBRRACE report to the next meeting.

In terms of the rate of Post-Partum Haemorrhage over 1500mls, the rate for January 2026 was 3.2%. A review of all the actions currently in place was being undertaken to identify any further improvements, although Ms Wells-Munro cautioned that this was in the national context of increased inductions of labour and a significantly increased rate of Caesarean sections.

Ms Wells-Munro confirmed that the Maternity Incentive Scheme submission had been made to NHS England by the deadline. The Trust had declared compliance with seven of the ten safety actions, and this might increase to eight if the mitigations for Safety Action 1 were agreed by NHS England. The number of safety actions had been reduced to six in Year 8 of the Maternity Incentive Scheme; Ms Wells-Munro would provide more information about these in her May report.

Ms Wells-Munro reported that a Deputy Director of Midwifery had been appointed and would begin in post on 1 June and that Community Midwifery Services in Scarborough and the East Coast were about to move into a facility called the Street which would enable women to have greater access to antenatal and postnatal community care as well as antenatal education and infant feeding support

Ms Wells-Munro flagged the key risks and concerns to the Service which included the risk that maternity services may not receive the funding requested from NHS Resolution in full to progress the implementation of transitional care across York and Scarborough and to deliver the two key elements within Saving Babies Lives Care Bundle. The WRAP target of £1m was also a concern.

Finally, Ms Wells-Munro highlighted the assurance visit from the Local Maternity and Neonatal System, noting that the feedback received was positive and all actions had been completed.

A question was raised about the impact of a reduction in the number of births at both York and Scarborough. Ms Wells-Munro explained that, whilst the national birth rate had reduced, the complexity of cases and length of stay of both mothers and babies had increased.

Mr Barkley asked why there were gaps on the rota given the increase in the number of midwives overall. Ms Wells-Munro explained that the gaps were due to maternity leave, sickness absence and new Band 5s midwives being supernumerary.

Ms Wells-Munro was thanked for her report and she left the meeting.

16 Mortality Review – Learning from Deaths Report

Dr Stone presented the paper, noting that it had been reviewed by the Quality Committee. She advised that the report did not contain Hospital Standardised Mortality Ratio (HSMR) data as this was no longer received. Dr Stone referred to the Summary Hospital-level Mortality Indicator (SHMI) funnel plots and highlighted that the Trust was in a good position in comparison to its peers. Dr Stone also referenced the comparison of observed versus expected deaths by diagnosis group, and the reduction in deaths from sepsis and pneumonia. There were no areas causing concern.

Dr Stone advised that she had requested that the Learning from Deaths team undertake some triangulation of the data from sepsis treatment by completing a Structured Judgement Case-note Review on deaths from sepsis.

Mr Barkly asked what the impact for the Trust was of not subscribing to the Healthcare Evaluation Data (HED) system. Dr Stone would ask the Associate Medical Director for Patient Safety to attend a Quality Committee meeting to speak to the next Learning from Deaths paper and to outline the reasons for not subscribing to the HED system.

Action: Dr Stone

Mr Barkley suggested that it would be valuable to include crude mortality trends within the paper.

Action: Dr Stone

17 Staff Survey Annual Report

Miss McMeekin presented the paper. She highlighted the response rate to the 2025 survey which had increased by 19% to 55%. The results showed an improvement in all People Promise themes but the Trust was only above the benchmark group as regards "we work flexibly", although gaps had been closed in other response areas. Miss McMeekin noted that the results demonstrated that the experience of Black and Minority Ethnic colleagues and those with a disability was less positive but there were fewer reported incidences of bullying and harassment from colleagues and managers. Incidences of sexual harassment from other members of staff had reduced, but not those from patients. Colleagues not based at any of the Trust's main delivery sites reported the most positive experience.

Miss McMeekin advised that a new improvement plan was being developed which would consolidate focus on two or three key areas. The team developing the plan would engage with groups such as the Change Makers, trade unions and other staff networks as usual and would also attempt to engage beyond, to staff who were not part of these networks. The improvement plan would be presented to the Resources Committee and to the Board for approval.

Action: Miss McMeekin

Miss Smith noted that colleague experience was key to the organisation achieving its ambitions. She recorded her thanks to Miss McMeekin and Mr Bertram for their efforts to increase the response rate to the survey, to the extent that the results could now be judged as representative. Miss McMeekin confirmed that the response rate had increased in all areas. She also confirmed that results had already been communicated to all areas and local improvement plans were already being developed.

Mr Barkley emphasised that the most important metrics for the Board were the percentage of staff recommending the Trust as a place to work and as a place to receive care, and there was still a significant gap to the benchmarked average. It was in this context that the agreement for funding for the implementation of a Continuous Improvement methodology was so important.

18 Equality Delivery System

Miss McMeekin presented the paper and reminded the Board that reporting had begun in 2022. The Equality Delivery System (EDS) was split into three domains: Domain 1 changed each year and Domains 2 and 3 were consistent. Domain 3 was peer assessed by Harrogate and District Foundation Trust. The only areas not showing improvement were those flagged by Mr Barkley as the most important metrics for the Board. However, this was based on the 2024 survey and so should show improvement next year. Miss McMeekin referenced the action plan included in the paper.

Miss McMeekin advised that the Board's view on the effectiveness of the EDS process in delivering positive change had been fed back to NHS England.

19 Corporate Governance Update

Annual Committee Effectiveness Reviews

The Board received the Group Audit Committee annual effectiveness review.

Ms Hazelgrave advised that the Committee had reviewed its agenda over the year, with a view to focusing more on its core purpose. She highlighted the year on year reduction in overdue internal audit actions.

The Board received the Resources Committee annual effectiveness review.

Ms Grantham advised that the Committee had reallocated time to focus on key priorities. It was agreed that this had worked well.

Committee Terms of Reference Amendments

Subject to the addition of an Associate Non-Executive Director to the quorum of the Committee, the Board of Directors approved the Resources Committee Terms of Reference.

Board of Directors' Work Plan

The following amendments were agreed to the Board of Directors' public meeting workplan:

- a report on patient experience and complaints to be received on a quarterly basis, beginning in April;
- a quarterly update on progress against the Staff Survey plan to be received, having first been reviewed by the Resources Committee.

With these amendments, the Board of Directors' public meeting workplan was approved.

Modern Slavery Act Statement

The Board of Directors approved the Modern Slavery Act Statement.

20 Questions from the public received in advance of the meeting

Questions had been received from the public in advance of the meeting. Mr Barkley read out the questions and the responses as follows:

Funding Disputes and Patient Safety (Inter-Agency Failure)
What is the Trust's policy when a high-risk patient requires 1-to-1 'Enhanced Care' but a funding dispute arises between the Hospital and Social Services? Specifically, does the Board find it acceptable for life-critical 1-to-1 support to be withdrawn solely because of a 'payment wrangle,' and what is the Board's 'Safety First' protocol to ensure care continues while financial disputes are resolved in the background?

The Trust's policy is explicit: care is provided solely on the basis of clinical need and is never withdrawn because of funding disputes. Enhanced care is delivered following an individual assessment of need and is supported by both an electronic patient care system and established policy.

The Mental Capacity Act (MCA) provides the legal framework within which we operate to keep patients safe, ensuring that all decisions are made using the least restrictive options available.

What is the Trust's formal policy regarding 'Clinical Escalation' when a high-risk neurodivergent patient repeatedly refuses vital sign monitoring? Specifically, does the Board find it acceptable for a junior staff member to fail to escalate this refusal to a senior clinician or a 'Patient Safety Lead' for more than four hours, and what audit is being done to ensure this lack of escalation is not a common practice on general wards?

The Trust's Deteriorating Adult Patients Monitoring and Escalation Policy sets out the organisation's responsibility to ensure that all patients are assessed and managed appropriately, reducing the risk of clinical deterioration and potential cardiac arrest. Registered Nurses are required to escalate concerns in line with the deteriorating patient escalation pathways.

As a minimum standard, all adult patients must have their observations recorded at least every 12 hours unless an alternative frequency is clinically indicated. Observation frequency should increase in response to clinical concern or in accordance with the escalation pathways. It would be expected that a junior member of staff seeks advice from a more senior nurse or medical colleague if, in their clinical judgement, a patient's refusal poses a risk to their safety—particularly in the case of a high-risk neurodivergent patient. Assurance regarding compliance is provided to the Patient Safety and Clinical Effectiveness Subcommittee through the Deteriorating Patient Group, supported by regular audit activity and established safety-governance structures. Any significant concerns are escalated to the relevant Board subcommittees.

Training Compliance (The 10% Gap) - In light of the Oliver McGowan Mandatory Training requirements, how is the Board addressing the current 10% compliance rate for Tier 2 training among frontline staff at York Hospital?

We have offered an online general-awareness resource since June 2023, with current compliance at 86.2%. In addition, Tier 2 face-to-face training was introduced in April 2025. The Trust's completion target for this training is 62% by 31 January 2028. To support improved compliance, we are expanding our workforce to increase the availability of training opportunities.

We now have a suite of qualified training facilitators within the Trust, including two Lead Trainers who can train additional trainers and co-trainers in-house. This increases our overall training capacity and reduces delays. We also have 16 affiliated expert co-trainers, 13 of whom are now experienced and confident in delivering training, enabling us to increase delegate numbers and enhance capacity further.

What 'Immediate Risk Mitigation' is in place for autistic patients currently on wards where the vast majority of staff have not received this legally mandated training?

The Trust demonstrates compliance with the Equality Act 2010, the NHS Learning Disability & Autism Improvement Standards, the National Autism Strategy, and associated statutory guidance through a comprehensive blend of operational mitigations and robust governance oversight.

A suite of identification and support systems—including Electronic Patient Record (EPR) alerts, Hospital Passports, and the Autism Spectrum Condition (ASC) register—ensures

that reasonable adjustments are consistently recognised, recorded, and acted upon. This is supported by specialist input from the Autism Liaison Team and clear escalation processes that activate when adjustments are not delivered.

Governance arrangements, including monitoring of mandatory training compliance, autism-specific Datix surveillance, rapid learning briefings, LeDeR reporting, and routine submissions for the Improvement Standards, provide assurance regarding quality, safety, and continuous improvement.

Mitigations in place:

- Autism Liaison Team established to provide oversight, specialist advice, and training.
- EPR alerts identifying patients' reasonable adjustment needs, linked directly to Hospital Passports.
- One-click access to Hospital Passports within the EPR.
- ASC register (with patient consent) enabling real-time notifications of admissions so that reasonable adjustment provision can be monitored.

Current governance actions:

- Monitoring of autism-related training compliance.
- Datix flagging of all autism-related incidents.
- Rapid learning briefings shared with ward teams.
- Escalation processes initiated where reasonable adjustments are not met.
- LeDeR reporting undertaken as required.
- Routine submission of evidence for the Learning Disability & Autism Improvement Standards.

Medication Security & Environmental Risk - Following recent incidents involving unauthorised access to restricted medication, has the Board commissioned an independent 'Environmental Safety Audit' of all treatment rooms and drug storage areas on general wards to ensure they meet modern security standards for vulnerable patients.

Safe medicine storage is audited on a weekly basis. Where themes or concerns emerge from these audits, security measures related to medication storage are communicated through our Staffing Briefing systems. All new builds and refurbishments are required to meet security specifications and standards for drug trolleys and cupboards. Where these specifications are not yet met, risk assessments are completed and mitigation measures are put in place until full compliance is achieved.

21 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 29 April 2026 at 9.30am at Scarborough Hospital.

Action Ref.	Date of Meeting	Item Number Reference	Title (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / comments	Due Date	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	Update 26.03.26: Miss Smith advised that a report would be presented to the Resources Committee and the Board in April. The due date was deferred.	Apr 26 from Mar 26	Delayed
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 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	Delayed
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	Update 25.03.26: Miss Smith advised that the approach would be presented to the Board as part of the operational planning process. The due date was deferred.	Apr 26 from Mar 26	Delayed
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	Update 25.03.26: Mr Norman advised that an options appraisal was being worked through and a paper would be presented to the Board in April.	Apr 26 from Mar 26	Delayed
BoD Pub 70	25-Mar-26	7	True North Report	Bring a recommendation for the True North metrics for 2026/27 to the next meeting.	Chief Executive		Apr-26	On Track
BoD Pub 71	25-Mar-26	11	Resources Committee report	Arrange a demonstration of the Robotic Process Automation tools, Esther and IRIS, for Mr Barkley	Director of Workforce & OD		Apr-26	On Track
BoD Pub 72	25-Mar-26	13	Trust Priorities Report	Clarify if there has been a previous error in reporting non-elective length of stay or whether the national guidance has changed.	Chief Digital & Information Officer		Apr-26	On Track
BoD Pub 73	25-Mar-26	13	Trust Priorities Report	Present an improvement plan for 2-hour Urgent Community Response compliance	Chief Operating Officer		Apr-26	On Track
BoD Pub 74	25-Mar-26	13	Trust Priorities Report	Present a report on the work undertaken by KPMG and its outcomes	Finance Director		May-26	On Track
BoD Pub 75	25-Mar-26	16	Mortality Review – Learning from Deaths Report	Ask the Associate Medical Director for Patient Safety to attend a Quality Committee meeting to speak to the next Learning from Deaths paper and to outline the reasons for not subscribing to the HED system	Medical Director		Apr-26	On Track
BoD Pub 76	25-Mar-26	16	Mortality Review – Learning from Deaths Report	Consider including crude mortality trends within the Learning from Deaths report	Medical Director		Jun-26	On Track
BoD Pub 77	25-Mar-26	17	Staff Survey Annual report	Present the Staff Survey improvement plan to the Resources Committee and to the Board for approval	Director of Workforce & OD		May-26	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

April 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’.

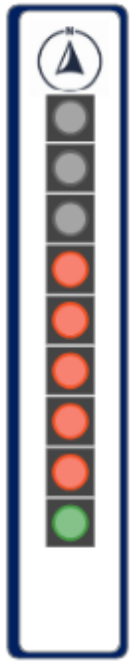
This is the single point of reference to measure our progress.

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)

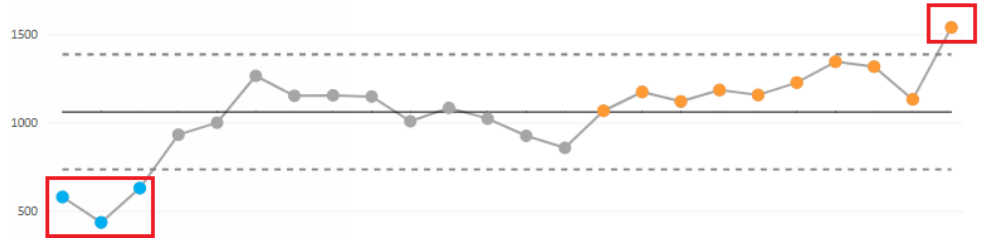
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

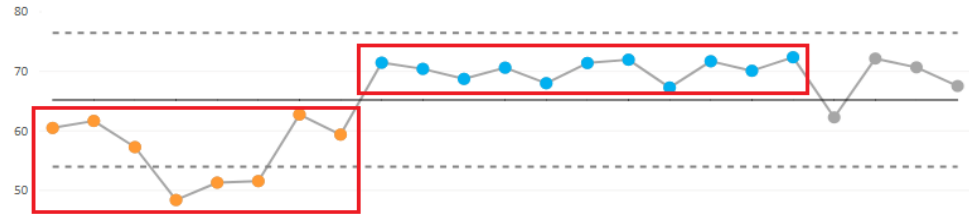
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

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

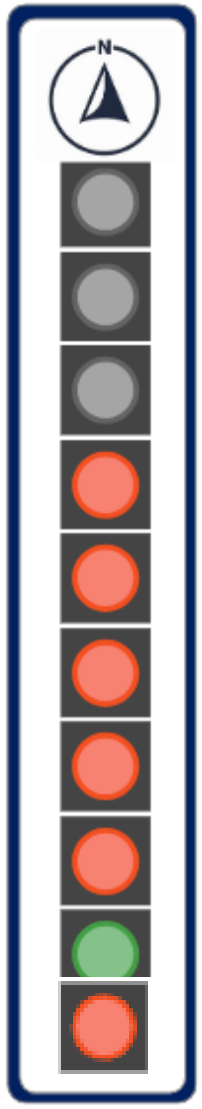


Shift: Counts the number of occasions there is a run of 7 consecutive points above OR below the mean.



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

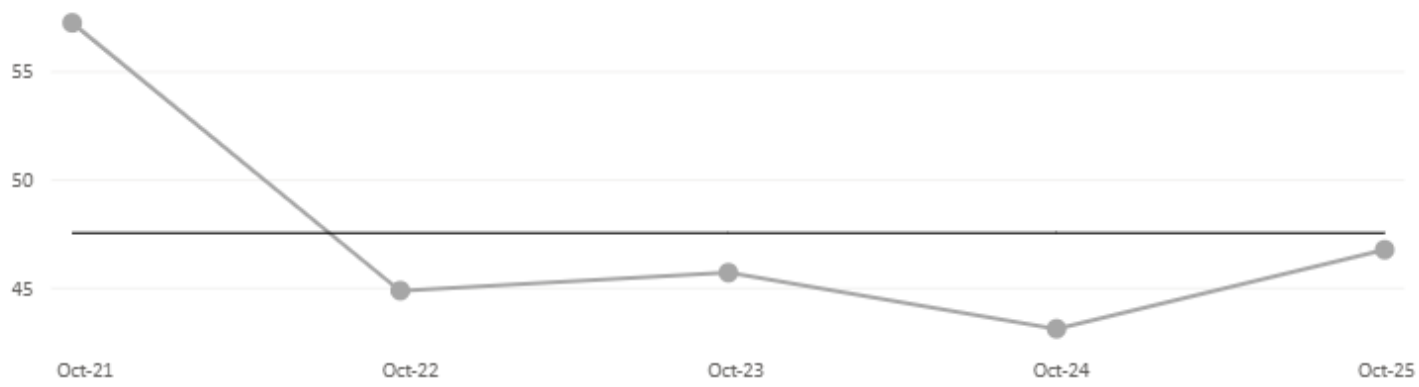
Staff Survey: Recommend Care

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

	Oct-21	Oct-22	Oct-23	Oct-24	Oct-25	Target Oct 2026
Value	57.2%	44.9%	45.7%	43.1%	46.7%	49%
Trajectory						

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

- Strengthen management and leadership capability
- Recruit to values and 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

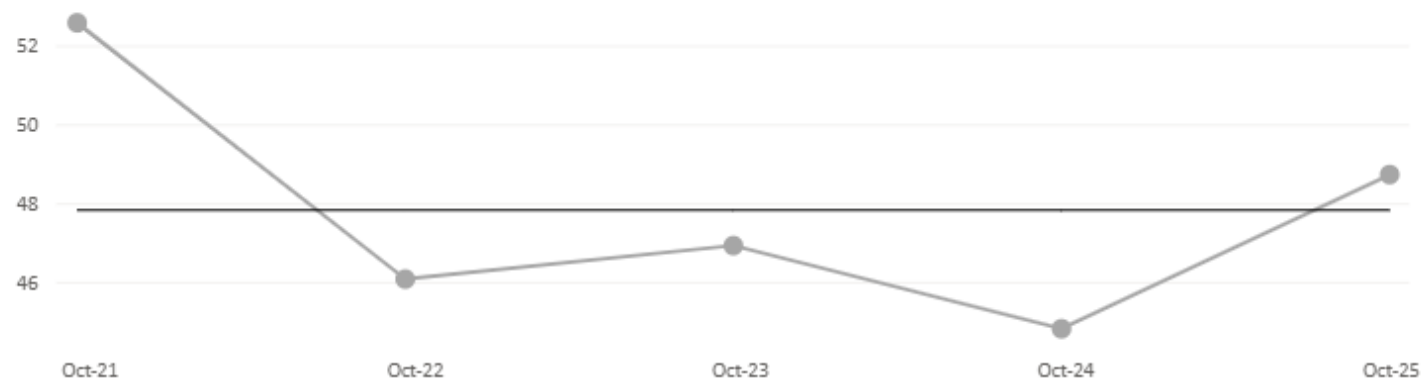
True North Report

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

	Oct-21	Oct-22	Oct-23	Oct-24	Oct-25	Target Mar 2027
Value	52.6%	46.1%	46.9%	44.8%	48.7%	50%
Trajectory						

What are the organisational risks?

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

How are we managing them?

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

What are the current challenges?

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

What are we doing about them?

- Strengthen management and leadership capability
- Recruit to values and proactively address unwanted behaviours
- Implement EDS22 and PSED recommendations
- Implement colleague engagement improvements
- Embed Quality Improvement
- Implement Speak Up gap analysis recommendations
- 2025 nationally benchmarked Staff Survey results update at Resources Committee in March
- Co-creating an updated Colleague Experience Improvement Plan for 26/27

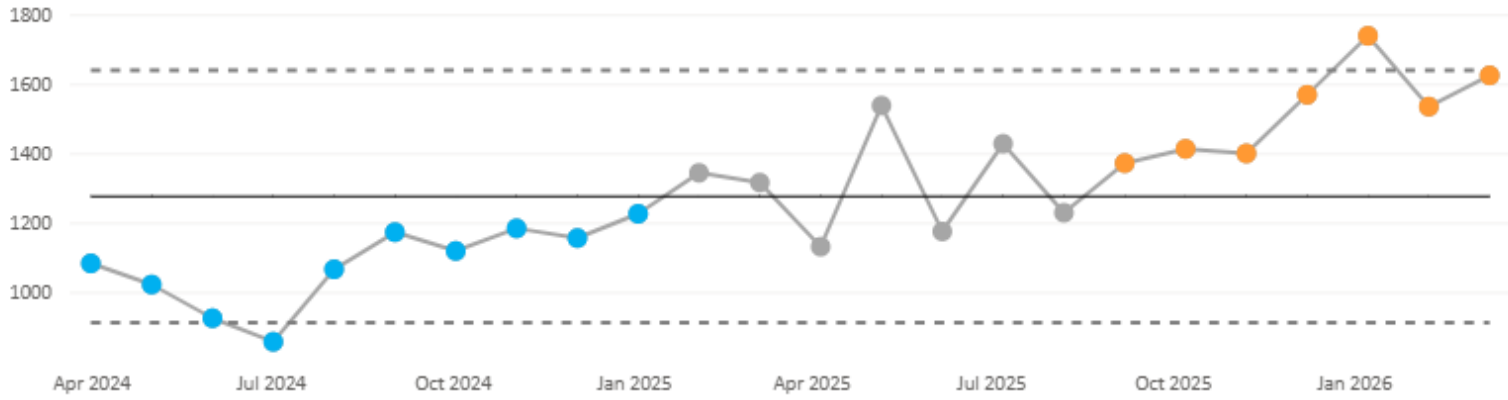
True North Report

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target Mar 2027
Value	1315	1130	1537	1174	1427	1228	1371	1412	1399	1568	1738	1534	1624	
Trajectory														

What are the organisational risks?

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

How are we managing them?

- 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?

- To improve quality of the Trusted Assessor Form (TAF), Describe not Prescribe and Discharge training is being refined to support better information on the TAF, including night needs/defensible recording and what constitutes 1:1. Training is being developed on Learning Hub where compliance will be monitored.
- Discharge Readiness Form to go live 07/05 with Nervecentre which will support automation of required fields.

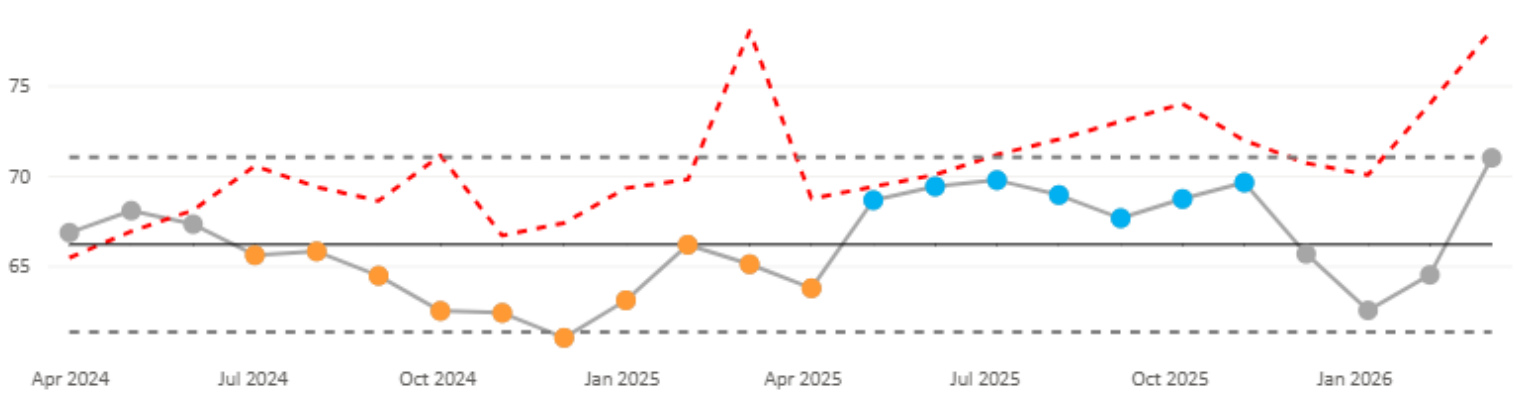
True North Report

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target Mar 2027
Value	65.1%	63.8%	68.6%	69.4%	69.7%	68.9%	67.6%	68.7%	69.6%	65.7%	62.5%	64.5%	71%	78%
Trajectory	78%	68.7%	69.4%	70%	71.1%	72%	73%	74%	71.9%	70.7%	70%	74%	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?

- In March, both acute sites implemented the first phase of the new acute model of care, which affects pathways in the Emergency Departments.
- We launched two new pathways at each Emergency Department in March 2026. These were developed using new national guidance and we have seen significant improvements in ECS 4-hour performance levels.
- The team are working to ensure the second middle grade doctor overnight at Scarborough hospital ED is in place recurrently.

True North Report

Objective Status ⊗ Down Is Good

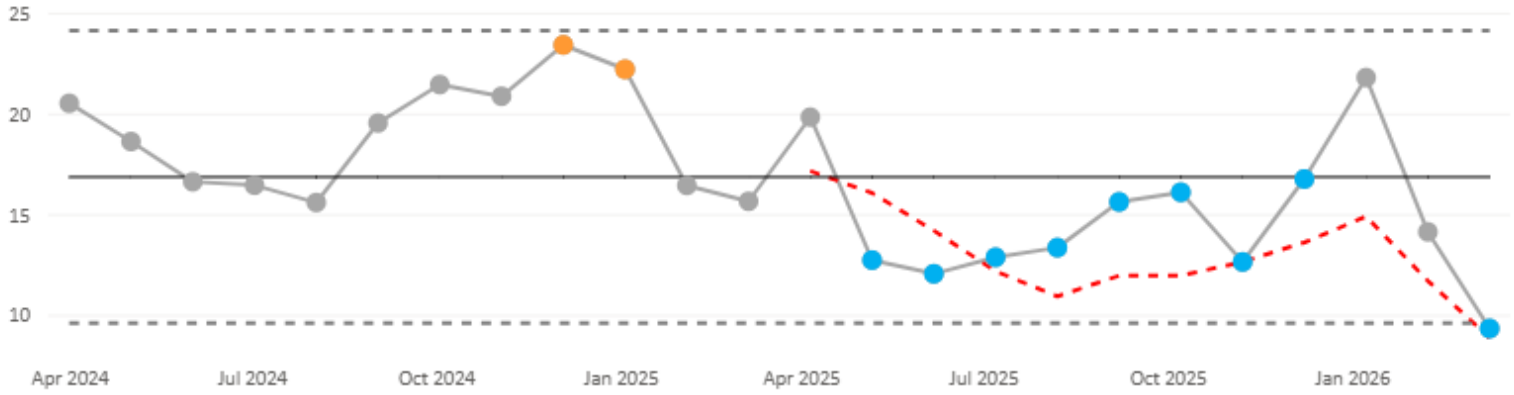
Urgent Emergency Care: Reduce 12 Hour Waits in ED

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)?

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target Mar 2027
Value	15.6%	19.8%	12.7%	12%	12.9%	13.3%	15.6%	16.1%	12.6%	16.7%	21.8%	14.1%	9.3%	8.9%
Trajectory		17.1%	16%	14.2%	12.2%	10.9%	11.9%	11.9%	12.6%	13.6%	14.9%	11.7%	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?

- 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.
- Both sites should see further reduction in 12hr breaches in April 2026, as the EAUs embed and are refined. This is an important step in managing our flow and working towards eradicating corridor care.

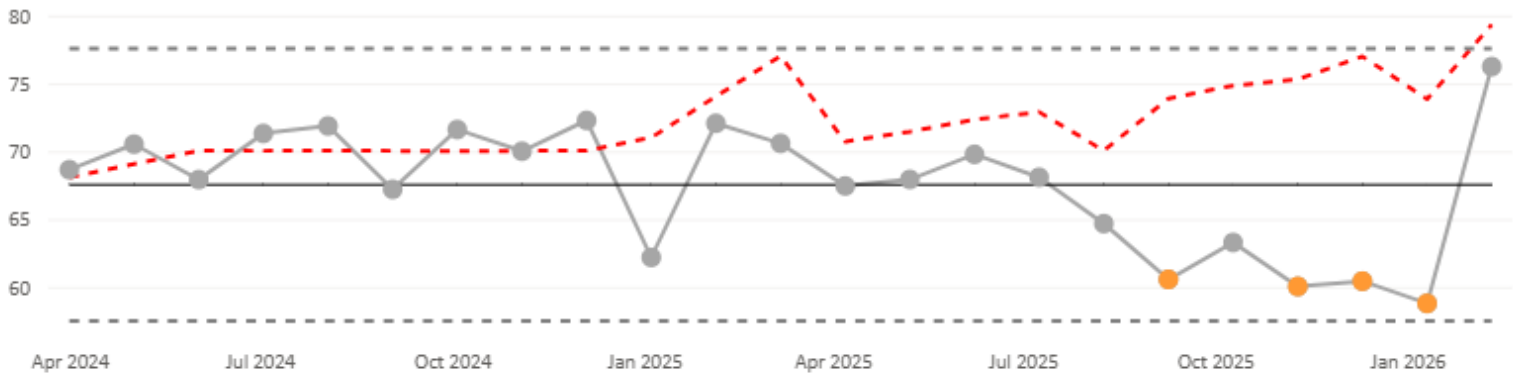
True North Report

Objective Status — Up Is Good

Elective: Cancer: Improve the Faster Diagnosis Standard

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

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



Is there special cause variation?

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

0 found

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

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	Target Mar 2027
Value	72.1%	70.6%	67.4%	67.9%	69.8%	68.1%	64.7%	60.6%	63.3%	60%	60.4%	58.8%	76.2%	80.1%
Trajectory	74%	77%	70.7%	71.4%	72.3%	72.9%	70%	73.9%	74.8%	75.3%	77%	73.8%	79.3%	

What are the organisational risks?

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

How are we managing them?

- Weekly Trust cancer PTL meeting with a focus on patients breaching FDS with clear escalation routes. Monthly cancer delivery group to oversee focused pathway improvement plans for gynaecology, colorectal and urology
- Clinical harm reviews for patients who breach 104 days to identify level of harm and learning
- Weekly diagnostic improvement meeting with modalities.
- Cancer actions outlined in the 26/27 service delivery plan

What are the current challenges?

- Urology, gynaecology and colorectal pathway delays.
- Full coverage of skin referrals not yet 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?

- Continued prioritisation of cancer activity in Q1 25/26.
- ICB implementation of dermoscopy local enhanced service (LES) commenced, 60% of referrals now received with image.
- Delivery of cancer system development funding scheme (£900k)
- Ongoing support around PTL management with additional weekly meeting to review thematic issues by tumour site.

True North Report

Objective Status ⊗ Up Is Good

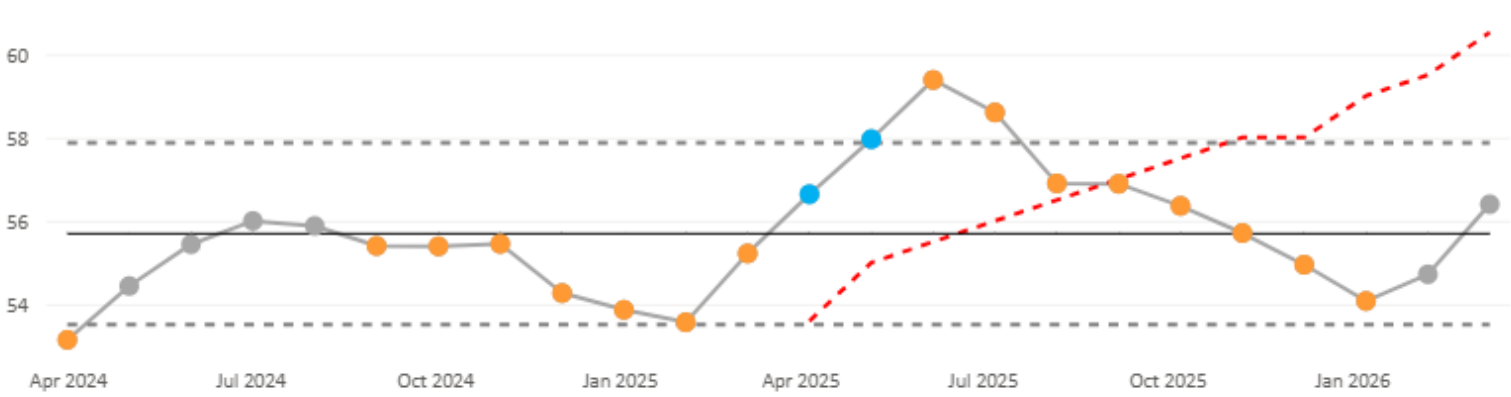
Elective: Improve RTT

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)?

4 found

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

Occurs

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

Occurs

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target Mar 2027
Value	55.2%	56.6%	58%	59.4%	58.6%	56.9%	56.9%	56.4%	55.7%	55%	54.1%	54.7%	56.4%	60.5%
Trajectory		53.6%	55%	55.5%	56%	56.5%	57%	57.5%	58%	58%	59%	59.5%	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 activity related investment monies to support high risk specialities.

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.
- Workforce vulnerabilities impact delivery of activity in plan.
- Delays in delivery of capital programme, impacting delivery of activity in plan.

What are we doing about them?

- Evaluation of RTT priority clinics project in Q4 (2 weeks intensive RTT patients) to understand potential to repeat.
- Undertaking focused validation of cohorts of patients that could result in clock stops.
- Implementation of GIRFT Intensive Support Team recommendations.
- Implementation of fortnightly performance and activity meeting with each care group to identify corrective actions.
- Development of service delivery plan with all actions monitored through monthly delivery boards.

True North Report

Objective Status ⊗ Down Is Good

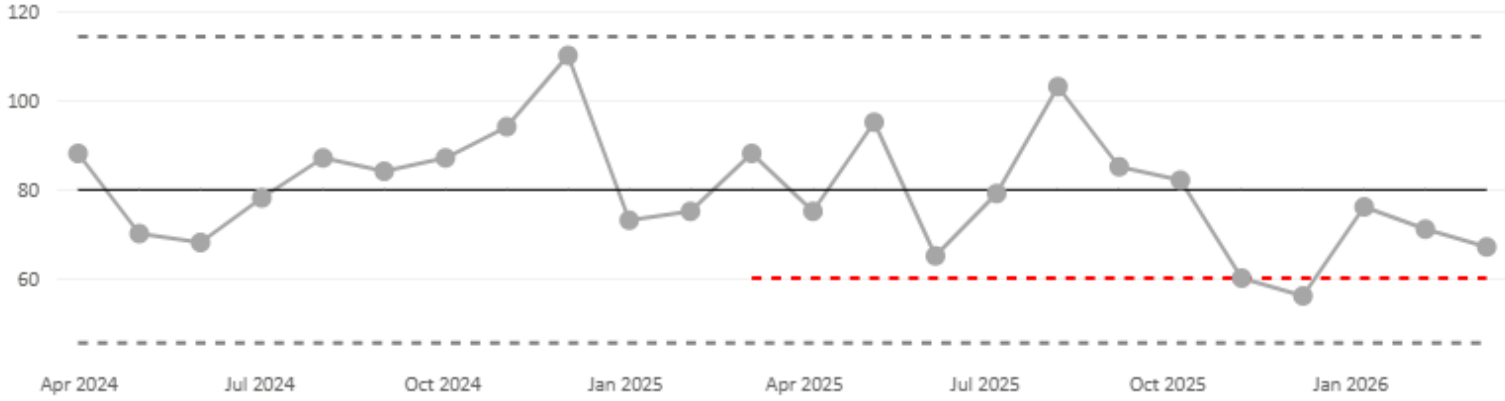
Q&S: Reduce Category 2 Pressure Ulcers

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

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target Mar 2027
Value	88	75	95	65	79	103	85	82	60	56	76	71	67	60
Trajectory	60	60	60	60	60	60	60	60	60	60	60	60	60	

What are the organisational risks?

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

How are we managing them?

- 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
- The main hotspots identified this month were Elderly Chestnut ward (5) respiratory ward 34 (5) 35 (7) DN team (11)
- The rate of mattress failure due to cell twisting has increased, impacting equipment reliability and requiring targeted corrective action.

What are we doing about them?

- Interim Chief Nurse is in discussion with the ICB regarding appropriate reporting of community pressure damage.
- Funding application submitted to charitable funds to support the purchase of high-risk bedside chairs.
- Agreement established with mattress supplier to install retro fits to all mattresses across Q1 and Q2.
- Presentation delivered at the PALF forum to senior Allied Health Professionals, focusing on seating, positioning, and patient experience in relation to pressure ulcer development.
- Chairs with inbuilt pressure redistribution, initially procured for winter wards, have been redistributed to medical and elderly care wards based on identified risk.

True North Report

Objective Status Down Is Good

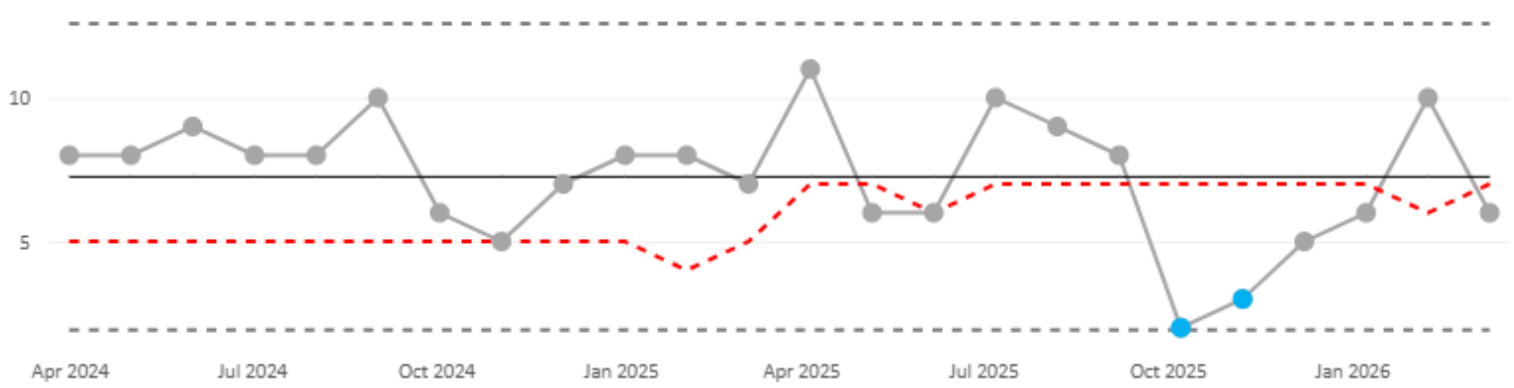
Q&S: Reduce the number of Trust Onset MSSA Bacteremia

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

Lead Director: Dawn Parkes

Operational Lead: Susan Peckitt

Committee: Quality



Is there special cause variation?

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

0 found

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

Does Not Occur

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

Does Not Occur

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Target Mar 2027
Value	7	11	6	6	10	9	8	2	3	5	6	10	6	7
Trajectory	5	7	7	6	7	7	7	7	7	7	7	6	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 we are now moving towards a standardised 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 – **we have exceeded this, achieving a 12% reduction with 81 cases recorded to the end of March 2026.**
- 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 have been held for Surgery and CSCS care groups to ensure learning is identified and embedded into practice.

True North Report

Objective Status

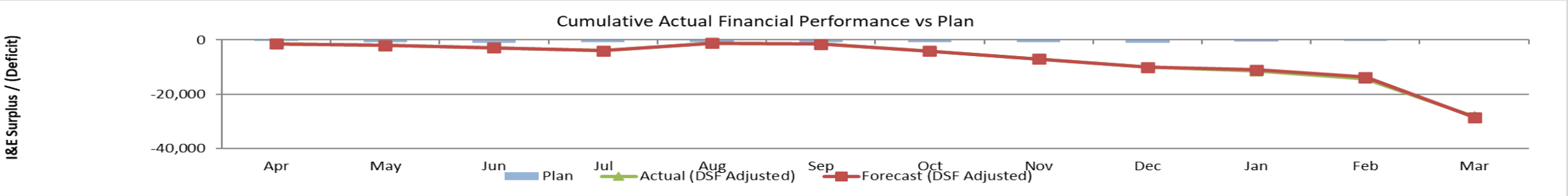
Finance: Achieve Financial Balance

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
Actual Position		-1,386	-2,084	-2,936	-3,956	-1,151	-1,484	-4,047	-7,010	-10,049	-11,462	-13,845	-28,156

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 Trust 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 loss of DSF)
- The Trust delivered its forecast outturn at Month 12, with a £28.1m (Excl loss of DSF), this was £360k better than forecast.
- Efficiency delivery improved in the final month of the year, with £40.5m delivered against the target of £55.3m (73.2% of the total target and 4.4% of operating expenditure).

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 – £4.2m delivered by end of Mar26.
- 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

- NHS England did not approve our February go live. Go live for the first Tranche has been rescheduled to start on 07 May, completing on 21 May
- The first Tranche includes observations, clinical documentation for inpatients, urgent & emergency care, electronic prescribing & medicine administration, bed management and read-only diagnostic results
- The build is complete, and the Nervecentre production environment is considered a “live” environment in terms of change control processes
- “Consolidation modules” have been added to training materials, to ensure that staff that completed their training for the original dates are still able to use the system confidently
- Go-live planning continued, with a focus on transition, operational readiness, hyper-care support and business continuity plans
- The EPR Trust Resilience Group (TRG) has been re-mobilised to plan and complete assurance activities for the new dates.

2. Continuous Improvement Update Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- Following the completion of the readiness assessment, a business case was produced to appoint a Strategic Partner to support us in embedding a Quality Management System and a continuous quality improvement method across the trust. The business case was approved at the formal Trust Board meeting on 22nd October. This progressed to a case made to NHS England for support with a consultancy application to proceed to tender. This was approved on 23rd March 2026, and the tender process was initiated on 30th March 2026.
- The approval from NHS England was subject to conditions, concerning the reporting requirements regularity of reporting requirements to them to monitor progress, detail of the specific improvements against our targets and an expectation of delivering minimum savings as outlined in the initial case. These details have been included in the tender specification for prospective strategic partners to be aware of.
- We have received several early expressions of interest in the tender and have prepared a timeline to secure a successful appointment with a start on site by the end of June 2026.
- 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.

3. Productivity and Efficiency Group Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

PIFU was 4.6% in March 2026 against a plan of 5%. Highest rate in 2025/26.

PIFU workstream continues in 26/27 with a target if 6.6%. Working with the NHSE regional team to identify Trust with high PIFU and discharge at first appointment rate for audiology.

New to Follow up ratio at Trust level is 2.16, which is the lowest month in 2025/26.

Template reviews ongoing and first and follow up activity v plan is monitored fortnightly to identify specialities higher than planned follow up's to agree early corrective action.

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

Action should be reflected in the service delivery plan.
Endocrinology planned for review in April 2026.

Clinic utilisation has deteriorated slightly to 77.2% which remains an overall improvement in 2025926 from 73.2%.
14 specialties have utilisation under the Trust average so will be focus of targeted programme support to deliver improvements.

The delivery of the 26/27 activity plan is reliant on the delivery of improved productivity across UEC, flow, outpatients and theatres. Several key workstreams have been identified with PMO support to develop and support monitoring of schemes.

- PIFU
- Outpatient utilisation (in session and room)
- Theatre utilisation and daycase rates
- Service review – GIRFT / model Hospital
- One stop clinics
- Single Point of Access
- Reduction in LoS

Plans on a page have been developed for schemes and are being presented to the productivity group.

Care group actions are also included and monitored through the service delivery plan. there are 123 actions included in the plan linked with delivering improved productivity.

4. Efficiency Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

2025/26 Cost Improvement Programme - March Position											
	Full Year CIP Target	March Position			Full Year Position		Planning Position		Planning Status		
		Target	Delivery	Variance	Delivery	Variance	Total Plans	Planning Gap	Fully Developed	Plan in Progress	Opportunity
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Total Programme	55,290	55,290	40,498	14,793	40,498	14,793	41,639	13,651	41,396	109	0

Efficiency Delivery

Efficiency delivery improved in the final month of the year, with £40.5m delivered against the target of £55.3m (73.2% of the total target and 4.4% of operating expenditure). Of the £40.5m FY delivery 25% (£10.2m) is recurrent and 75% (£30.3m) is non-recurrent. One of the WRAP programmes for 2026/27 is to review non-recurrent delivered schemes with a view to securing recurrent delivery where possible.

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.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	29 April 2026
Subject:	Chief Executive's Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Clare Smith, Chief Executive

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides an update from the Chief Executive to the Board of Directors in relation to the Trust's priorities. Topics covered this month include: Listening to colleagues and stakeholders, update on financial and service delivery planning, CQC updates, Electronic Patient Record (EPR) update, resident doctors' industrial action, changes in the executive team, awards success and March'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. Listening to colleagues and stakeholders

As I reported last month, I completed my initial 'First 100 Days' engagement programme at the end of March, however I have continued to take every opportunity to get out and about and meet colleagues, patients, and people from the communities we serve, and to listen to them and understand their perspectives on our organisation. This is something I am committed to continuing throughout my time as Chief Executive, as it is something I believe is of fundamental importance to the role.

I have continued to hold my 'chat and brew' drop-in sessions across our sites, including York, Scarborough, Bridlington, Selby and Malton since the last Board meeting. I am grateful to colleagues who come to these sessions to say either hello or to talk through an issue, but I am conscious that colleagues in clinical areas can find it difficult to leave their workplace, which is another reason I shall continue to get out and about. I have also trialled a virtual session, following a suggestion from a colleague who mainly works remotely.

We are getting into a good rhythm with York and Scarborough Live, our weekly online briefing and Q&A session open to all colleagues, and have held one every week (other than when it fell on Christmas Day!) since I joined the Trust. On the rare occasion I have been unable to join due to other commitments, Deputy Chief Executive and Finance Director Andrew Bertram has stepped in to ensure we can consistently continue to provide the opportunity each week for colleagues to ask questions and hear updates from the executive team. The number of colleagues joining the sessions is steadily going up, and feedback has been positive from those that take part.

I have continued to visit wards and departments and meet with teams and individuals, and I can't help but be impressed by the pride and enthusiasm I hear and see from colleagues when talking about their services.

This is also the case in abundance when I visit colleagues who have won a star award. I have presented quite a few of these across the Trust in the last month including a collective award for the SHYPS team, where I visited the teams on all three of our sites where our laboratory colleagues are based (Scarborough, York, and Hull Royal Infirmary).

As we see in the nominations we receive each month as an appendix to my report, there is no shortage of fantastic examples of colleagues and patients wanting to recognise others for living our values, which is hugely motivating to see.

I have also had a number of conversations with colleagues about equity of care for patients on the East Coast. I am really committed, via the development of the clinical strategy, to ensure that we have a clearly communicated plan that is worked up together, which describes how we are going to address some of these inequalities. What is reassuring to me is that there is a desire to do that in our teams where it is clinically appropriate, safe, and sustainable. We are one Trust needing different solutions for our population.

On this theme I have also met with members of local patient campaign and advocacy groups including the 'Save Scarborough Hospital' group and the Bridlington Health Forum, as well as continuing to meet with local MPs.

These have been really constructive meetings, and I am grateful for their openness when discussing concerns. These meetings further confirm the necessity of having a clearly communicated clinical strategy that considers population need, whilst also recognising the need to deliver safe and sustainable services. I look forward to continuing to develop this in collaboration with our communities as well as our colleagues.

2. Update on financial and service delivery planning

Along with all parties within the Humber and North Yorkshire system we still do not have an accepted and signed off financial plan for 2026/27 with NHS England.

The Board will remember that our plan was submitted with a £55m Waste Reduction and Productivity (WRAP) programme and a resulting financial deficit of £29m. We subsequently held an extraordinary Board meeting where we discussed the NHS England ask of the system for a £30m-£50m improvement on what was a total £130m deficit for the ICB. Our agreed share of this £30m improvement was £7m, taking our WRAP programme effectively to £62m and reducing our deficit to £22m for the new financial year.

This position is not yet accepted by NHS England and the plan has not been formally signed off. However, we have been asked to plan on this basis in order to set our operational budgets. We have also been advised that we will be joining the Regional NHS England Challenged Provider Programme that will assess whether we could go further on our cost reduction programme.

Details of the programme are awaited but discussions with NHS England have described a programme that will complement the work we commissioned from KPMG, link with our planned continuous quality improvement programme, and support the Trust get to the best possible financial position. We expect further details of the programme to be announced next month.

3. Care Quality Commission (CQC) Updates

Medicine and urgent and emergency care pathways (Scarborough Hospital)

The final report following the CQC's unannounced inspection at Scarborough Hospital last October has now been published. Inspectors spent three days on site and were looking at medical care services and urgent and emergency care pathways.

There is positive feedback in the report, in particular, the CQC has recognised the improvements in medical care.

Across both areas, inspectors saw colleagues often treating patients and those close to them with warmth, respect and compassion. They also noted the time taken to explain care and involve people in decisions, with a clear focus on what matters most to each individual.

Medical care services have improved to an overall rating of *'Good'*, reflecting real progress in safety, effectiveness and leadership, alongside strong multidisciplinary working.

At the same time, urgent and emergency care services have been rated *'Requires Improvement'* overall. The report highlights areas of good practice, including teamwork and a positive learning culture, but it is also clear about the ongoing pressures in urgent

and emergency care, particularly around safety and access. These are challenges we recognise, and they remain a priority for us to address.

The overall rating for Scarborough Hospital remains *'Requires Improvement'.*
It's important to say that this inspection took place nearly six months ago. Since then, teams have continued to work hard to address the issues raised and build on the progress already made.

We know that there is much more for us to do. The task now is to accelerate and sustain that progress we have made and make sure it is consistently felt by every patient, every time.

Maternity services

Earlier this month the CQC carried out an unannounced assessment of our maternity services at York and Scarborough. This was a follow-up to the 2023 inspection, which rated services as inadequate. The inspection team spent two days in York and two days in Scarborough.

Thank you to everyone involved for the warm welcome you gave the inspectors. They noted how passionate and proud teams are of their services, and the clear focus on improvement, describing it as a "pleasure to return" to inspect the service.

We received some high-level verbal feedback at the end of the visit. They found no significant areas of concern, although they did flag a small number of issues which we looked into immediate and addressed.

It is really encouraging to hear the areas of strength identified by the inspection team. These included our strong multidisciplinary team working and strengthened governance arrangements. Inspectors also highlighted high levels of staff engagement to support change, effective partnership working, and the compassionate care being delivered to patients, alongside respectful relationships between colleagues. In addition, they recognised the breadth of specialist midwifery roles, good continuity of care models, and a robust preceptorship programme supporting newly qualified colleagues.

The CQC has confirmed that two separate inspection reports will be issued for maternity services in York and Scarborough, and at the time of writing we do not know when we can expect to receive these, however I will keep the Board updated as soon as we know more.

4. Electronic Patient Record (EPR) update

It is fantastic to be able to report that following further engagement and assurance, we are proceeding towards a go-live for our Electronic Patient Record (EPR). The plan is to start in Bridlington on 7 May, Scarborough on 9 and 10 May and York the weekend after.

This means we have returned to a familiar and structured rhythm as we prepare the organisation for go-live; following the same approach, governance and disciplines that we applied previously.

This includes re-mobilising our go-live readiness and assurance processes including re-establishing the EPR Trust Resilience Group, refreshing training and competency checks where required, reconfirming operational readiness, command and control, and support arrangements, and finalising floorwalking and on-the-ground support plans.

We have a strong, experienced team that has already demonstrated it can deliver, therefore the period up to and including the roll-out is focussed on ensuring we are in the strongest position possible for a safe and successful go-live. I hope to be able to report next month that this is indeed the case.

5. Resident doctors' industrial action

Thank you to everyone involved in planning for the resident doctors' industrial action that took place from 7 to 13 April, particularly given the additional challenge of a double bank holiday weekend.

A significant amount of detailed work sits behind this from rota planning and service prioritisation, to coordinating teams, managing capacity and making sure every part of the organisation is prepared.

As always, we respect colleagues' right to take industrial action, whilst maintaining our focus on careful planning and safe care for our patients.

A the time of writing no further dates for resident doctor action have been announced, however the BMA has announced it will be holding simultaneous ballots of consultants and specialist, associate specialist, and specialty (SAS) doctors from 11 May until 6 July, which, depending on the outcome, may result in broader action involving wider groups of medical colleagues.

6. Changes in the Executive Team

Polly McMeekin, Director of Workforce and Organisational Development, has left the Trust to join Leeds Teaching Hospitals NHS Trust.

Polly joined York and Scarborough in 2015 as Deputy Director of Workforce before being appointed Director of Workforce and Organisational Development in 2019. During that time, she has made a significant contribution to the Trust, including through some of the most challenging periods we have faced - not least the pandemic, when she also took on the role of HR Director for the Yorkshire Nightingale Hospital.

On a personal note, I want to thank Polly for the support she has given me as I've settled into my role – She will be missed as part of the team.

I'm sure you will join me in wishing Polly all the very best for her next challenge, and in thanking her for her leadership and commitment during her time with us.

Lydia Larcum, Deputy Director of Workforce, will be stepping into the role on an interim basis, and we will begin recruiting for a substantive replacement for Polly as soon as possible.

7. Awards success

I want to end my report this month with some positive news about the fantastic work happening across our teams.

Our Glaucoma Team has been recognised as a winner in the Glaucoma UK Excellence in Glaucoma Care Awards 2026. These national awards celebrate individuals and teams who make a real difference to patients' lives, and this is a wonderful achievement. The team was nominated by Professor Pouya Alaghband, who highlighted the team's commitment to patient care, safety, and adaptability. Over the past year, they've delivered significant improvements to services - a great reflection of our continued focus on putting patients at the heart of what we do.

I am also really pleased to share that the Scarborough Lab Team has been shortlisted for the Institute of Biomedical Science 'Team of the Year' award, recognising the innovative, multi-disciplinary services they are providing.

Finally, our Care of the Elderly Parkinson's Multi-Disciplinary Clinic Team was highly commended for the Mali Jenkins Award at this year's Parkinson's UK Excellence Network Awards. This award recognises services that truly put people with Parkinson's at the centre of their care, and the team was praised for delivering consistent, personalised support that builds trust and helps patients stay engaged with their care.

On the same evening, Dr David Heseltine, retired Consultant in Elderly Medicine, was recognised as a finalist in the Lifetime Achievement Award category - a fitting recognition of his contribution over many years.

These are just a handful of examples of the amazing work that is taking place every day in our Trust, and it is so important that we recognise these efforts, particularly when it feels especially challenged.

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. March's nominations are in **Appendix 1**.

Date: 29 April 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

March 2026

Isabella Hawley, Theatre Practitioner **York** **Nominated by patient**

A calm and professional nurse, Isabella treated patients and colleagues with respect. She ensured I understood the process and was kind and caring. She treated me as an individual, and I was impressed with her nursing skills.

Gail Lindley, Neonatal Manager **York** **Nominated by colleague**

Gail is an exceptional ward manager and consistently embodies the Trust values of kindness, openness, and excellence, making a profound difference to patients, visitors, and colleagues. Her support for her team is evident in her willingness to go above and beyond, often stepping in to cover clinical duties when staffing is short and even volunteering her weekends to ensure the ward runs smoothly. This dedication ensures that patient care remains uncompromised and that her team feels valued and supported, even in challenging times.

Beyond her day-to-day clinical contributions, Gail has been a driving force in improving our physical environment. Her determination led to successfully securing funding and overseeing a significant ward refurbishment. This refurbishment will not only create a better, more comfortable unit for our patients but also demonstrate her commitment to excellence and her vision for a continuously improving ward. She has played a vital role in facilitating a smooth transition for us by contributing to coordinating the temporary ward arrangement while we await our new refurbishment. Her dedication and leadership ensured that the transfer process was smooth, minimising any disruption to our normal routine. Throughout this period, Gail has also ensured the highest standards of care were still met by ensuring parents and their babies continue to receive the best possible care and support.

Gail is always friendly and approachable and is consistently looking out for her team, fostering an environment where everyone feels heard and respected. She is a truly fair manager, always taking everyone's opinions into account, creating a collaborative and open atmosphere. Her dedication to her staff and her commitment to excellence in every aspect of her role truly distinguish Gail as an exceptional ward manager. Thank you for all you do!

Philippa Strachan, Ward Sister, Darren Strachan, Staff Nurse, and Karen Cooper, Senior Work-Based Learning Facilitator | **York** | **Nominated by colleague**

Darren, Philippa, and Karen were enjoying an evening out at a local band gig. Another audience member collapsed and was put into the recovery position by members of the public who thought they were having a seizure. Darren and Philippa rushed to see if they could help and, realising the person had gone into cardiac arrest, they took charge and commenced CPR. They located a community defibrillator, which they used successfully, managing to regain a pulse while they continued CPR.

Meanwhile, Karen cleared the area of the public, found screens to maintain privacy, and dealt with upset family members. Paramedics arrived on the scene, and the air ambulance was deployed to Leeds. The patient is now doing well and has reached out to Darren and Phillipa to thank them. It was recognised at the scene that the patient had survived thanks to their quick thinking and action. All three of them worked supremely well as a team in a critical situation. I think their actions and behaviour exemplify the Trust values, and I am proud of the actions they took, which saved a life.

Junaid Khan, Associate Specialist | **Scarborough** | **Nominated by patient**

I would like to nominate Dr Khan for a Star Award in recognition of the outstanding care and support he gave me during my recent gastroscopy. I was extremely nervous before the procedure, and I felt anxious about what was going to happen. However, from the moment I met Dr Khan, he made me feel completely reassured and safe. He took the time to explain everything clearly, answered all my questions patiently, and made sure I fully understood what to expect.

Dr Khan spoke to me with kindness and calmness, which immediately put me at ease. He made me feel involved in my own care rather than just being told what would happen. Throughout the whole experience, I felt genuinely looked after and confident that I was in the best possible hands. His team also reflected his professionalism and compassion, which made the entire process much more comfortable than I had imagined.

Because of Dr Khan’s reassurance, empathy, and excellent communication, what I had feared would be a stressful experience turned into one where I felt supported and cared for at every step. I am incredibly grateful for the way he treated me and believe he truly deserves recognition for the difference he makes to his patients.

Alexie Neville, Senior Occupational Therapist, and Emma Myers, Junior Physiotherapist | **Scarborough** | **Nominated by colleague**

With extremely high levels of staff sickness and unfilled vacancies, Emma and Alexie have worked without fault in maintaining a therapy service across elderly care.

Ward 15 **York** **Nominated by colleague**

I have picked up quite a few bank shifts on Ward 15. All colleagues on the ward, from the cleaners and management to the healthcare assistants and nurses, have always made me feel so welcome and appreciated whilst working there.

Despite Ward 15 being such a busy ward, I have learnt quite a lot from this ward, and the nursing team are always eager to help me learn more. For example, on one of my first bank shifts, there was a patient with an Aspen collar, which is something I had only seen once. I didn't know much about them, and I was shown all the steps of Aspen collar care. The ward staff always go above and beyond for their patients. Ward 15 is privileged to have such a supportive, friendly, and helpful team.

Kate Izims, Staff Nurse **York** **Nominated by patient**

I was admitted to the ED. Nurse Kate promptly took me for consultation and arranged immediate X-rays and blood tests. Nurse Kate was exceptionally kind, professional, and compassionate. I could not have received better care. Please pass on huge thanks.

Richard Parker, Head of Financial Management **York** **Nominated by colleague**

I'd like to nominate Richard for his fantastic support with my Freedom of Information (FOI) work. Even though he has an incredibly busy job in Finance, he always manages to find the time to help, and he's always patient, friendly, and reliable.

We get a huge number of FOI requests about finance, and interest from the public and commercial companies can be intense. Despite this, Richard consistently provides clear and accurate information that helps me meet deadlines and keep everything running smoothly.

People like Richard often work quietly in the background and don't always get the recognition they deserve, especially when the spotlight is usually on frontline teams (who all do an amazing job and deserve recognition). But without colleagues like him keeping things moving behind the scenes, the Trust simply couldn't function. Richard's support genuinely makes my job easier, and I'm grateful for everything he does.

Cheryl Moss, Receptionist **York** **Nominated by colleague**

Cheryl is like the Mum of the unit. She is so kind and knowledgeable and is always at hand to offer help and support to both her colleagues and the patients that she meets. She goes out of her way to provide a warm smile and is approachable, even when she is snowed under with work.

I would love her to know how much she means to us all and what high regard we hold her in. Thank you, Cheryl, for being such a precious part of the team. It wouldn't be the same without you, and we are so lucky to have you.

Alison Frost, Waiting List Co-ordinator **York** **Nominated by patient**

Alison has been amazing. She has not only always tried her best to find the correct information to update me on my wait but also followed up on queries I've had. She is cheerful and friendly. She never once made me feel judged for calling nonstop.

Heidi Fry, Deputy Sister **Scarborough** **Nominated by relative**

My elderly Mum, who has Alzheimer's, was brought into the ED in the early hours of Friday with a broken hip. The whole team were amazing; however, Heidi was outstanding, not only looking after my Mum, but also looking after my husband and me, keeping us informed every step of the way. The whole traumatic experience was made so much better by such a lovely, personable, and professional person.

Medical Illustration **York** **Nominated by colleague**

I would like to nominate Angela Keenan and Robyn Sotheran from Medical Illustration for their exceptional kindness, patience, and responsiveness in supporting the creation of our recent poster. My colleague Jenny Hughes and I required their support with this over a short deadline. The content that we originally presented to them needed much editing and rethinking. Their guidance came with kindness and understanding, ensuring a supportive working relationship.

Being part-time workers, they both approached this collaboratively to offer me and Jenny seamless support. Throughout the process, they ensured that they delivered to our brief and responded promptly to feedback. Their professionalism made the entire experience smooth. Even when multiple revisions were needed, they handled each request with patience.

Their efforts not only resulted in a creatively designed final product but were also pivotal in the poster making the finals for the Parkinson's Excellence Awards 2026. Robyn and Angela are an amazing example of what it means to be kind, patient, and collaborative. This deserves to be recognised and celebrated in the Star Awards!

Sheena King, Medical Secretary **York** **Nominated by patient**

Sheena has demonstrated every one of the Trust's values and so much more throughout my care. During a long and challenging period of recovery, she has been an unwavering source of support, reassurance, and strength. Whenever I have felt worried or overwhelmed, Sheena has responded with compassion, patience, and genuine understanding. She has an extraordinary ability to make me feel heard and valued, and never once have I felt like a burden on her time, even though I know how busy she must be. Her calm, reassuring manner has made an immeasurable difference to me.

Sheena consistently goes above and beyond her role. She proactively contacts other hospital departments on my behalf and coordinates appointments seamlessly, tasks that many might expect me, as the patient, to manage. Her willingness to take on this responsibility has lifted a huge weight from my shoulders during an already difficult time. She is exceptionally kind, caring, efficient, and professional. More than that, she embodies the very best of what the NHS represents. Sheena is not only a credit to her Trust, but to the NHS. I cannot thank her enough for the care and dedication she brings to her work. She is truly deserving of this award.

Lotty Barks, Radiographer **Scarborough** **Nominated by colleague**

A young adult patient with autism and significant social communication difficulties attended Radiology for a routine MRI, supported by their relatives and a member of the Learning Disability Team. From arrival, the patient was overwhelmed by the hospital environment and became increasingly distressed while waiting. They were unable to keep still, struggled to communicate, and it appeared highly unlikely the scan would proceed. Given that an MRI requires lying completely still for 20 minutes in a confined, noisy space, the situation presented a real challenge.

Despite it being an exceptionally busy day within MRI, Lotty demonstrated remarkable kindness and professionalism by taking the time to truly listen and understand the patient's individual needs. She engaged openly with the family and the Learning Disability Team colleague, valuing their insight and working collaboratively to identify what would help the patient feel safe. Rather than focusing on time pressures or operational demands, she prioritised the person in front of her. Through skilled verbal and non-verbal communication, reassurance, and a flexible approach, Lotty built trust quickly. Even after several false starts, she remained composed and encouraging, adapting her approach without frustration or judgment. She created an environment where the patient felt safe, respected, and in control.

Because of her persistence and compassion, the patient successfully completed the full diagnostic scan. High-quality images were obtained, preventing delays in treatment and avoiding the need for rebooking or potential sedation. Most notably, the patient left the department smiling and laughing with family and staff - a complete transformation from their initial distress.

Lotty demonstrated kindness through genuine empathy and patience, openness through collaboration and adaptability, and excellence through her determination to achieve both an outstanding clinical outcome and a positive patient experience. Without her, this scan would almost certainly not have gone ahead. Her actions made a measurable clinical difference and had a lasting positive impact on the patient's hospital experience. She is truly deserving of recognition.

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

I am writing to recognise my colleague Penny for her kindness and compassion with a patient in the ED. The patient was on a coach trip holiday miles away from home and was staying in Bridlington. Unfortunately, during her holiday, she had a nasty fall and broke her hip. She had come on the holiday alone. Penny showed empathy, kindness, and compassion by offering to call the hotel the patient was staying at and organise to collect the lady's belongings and bring them back to the hospital for her the following day, as the patient had no friends or family close by.

I can only imagine the patient was feeling scared and lonely. Penny went above and beyond by doing this, as the patient had nothing but her bag, coat, and shoes. She was worried about how she would charge her phone or how she would take her medications. Penny put the patient at ease, and she was very appreciative of Penny’s actions.

York North Locality Adult Community Nursing **Community** **Nominated by relative**

My wife was diagnosed with breast cancer six months ago. Sadly, she lost her fight today, but the entire North Community Nursing Team did everything in their power, every single day and night to help her, comfort her, tend to her, and make her comfortable. They also did the same for me every single day and night. They always went above and beyond the call of duty to do everything they could for her, and even though her fight ended today, her family, her friends, and I will forever be eternally grateful to them all and everything they did. They all deserve recognition.

Paediatric Outpatient Administration Team **York** **Nominated by colleague**

We would like to nominate the York Paediatric Outpatient Administration Team for a Star Award in recognition of their exceptional dedication, teamwork, and unwavering commitment to improving patient care. The team have worked tirelessly to ensure paediatric outpatient appointment slots are filled, often at extremely short notice. They have made hundreds of phone calls and sent hundreds of text messages, going above and beyond their usual responsibilities to make sure children are seen as quickly as possible. With current pressures on paediatric waiting times, their response has been outstanding. They have collaborated brilliantly across sites and worked closely with management to prioritise the longest waiting patients and bring them forward appropriately.

Following discussions with management, the teams embraced the challenge with professionalism and determination, taking ownership of the ask and fully understanding the importance of reducing wait times. Through their hard work, strong communication, and teamwork, they have played a pivotal role in succeeding in our aim to have no patients waiting over 40 weeks by the end of March.

Their efforts have made a real and meaningful difference to patient experience and service performance, and they consistently demonstrate the very best of our organisational values. For these reasons, we strongly recommend the York Paediatric Outpatient Administration Team for a Star Award.

Paediatric Outpatient Administration Team | **Scarborough** | **Nominated by colleague**

We would like to nominate the Scarborough Paediatric Outpatient Administration Teams for a Star Award in recognition of their exceptional dedication, teamwork, and unwavering commitment to improving patient care.

The team have worked tirelessly to ensure paediatric outpatient appointment slots are filled, often at extremely short notice. They have made hundreds of phone calls and sent hundreds of text messages, going above and beyond their usual responsibilities to make sure children are seen as quickly as possible. With current pressures on paediatric waiting times, their response has been outstanding. They have collaborated brilliantly across sites and worked closely with management to prioritise the longest waiting patients and bring them forward appropriately.

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Their efforts have made a real and meaningful difference to patient experience and service performance, and they consistently demonstrate the very best of our organisational values. For these reasons, we strongly recommend the Scarborough Paediatric Outpatient Administration Team for a Star Award.

Rebecca Debaughn, Staff Nurse | **Scarborough** | **Nominated by colleague**

Rebecca stayed calm and carried on when left in charge of the ward under difficult circumstances. As a newly qualified staff nurse, she is always approachable to colleagues, caring, and positive. If you didn't know, you would think she was an experienced nurse with strong leadership abilities.

Stefanie Greenwood, Freedom to Speak Up Guardian | **York** | **Nominated by colleague**

Stef is so supportive and easy to approach. She is compassionate and has such passion for her work supporting others. She wears her heart on her sleeve. She does this with dignity and respect and lives by the Trust values.

I have recently had the pleasure of meeting Stef and being helped by her. I felt listened to with empathy, with understanding, and without judgment. I think she deserves more than this Star Award, but this is a start. So, a huge thank you, Stef, and keep up the good work; you are an asset to the Trust.

Simon Murray, PACS Support Officer	**York**	**Nominated by patient**

I would like to say a sincere thank you to Simon Murray. Simon was extremely helpful, supportive, and professional when I contacted him on two separate occasions regarding results that had not gone through to our GP (these scans and X-ray results were from different hospitals, too). This was a stressful time for us, and Simon took the request and provided the reports to the GP, ensuring they were sent through promptly to enable continuity of care.

Without him chasing the reports, the reports would not be with the GP, and we could not receive some of the clarification on issues. His clear communication, efficiency, and kindness made a real difference and helped ease our worries. We are grateful for his support and excellent service.

Tracey Dixon, Clinical Coordinator, Mawusi Dei-Tutu, Radiographer, Monika Krupczak, Clinical Imaging Assistant, Kaitlin Wright, Radiology Services Administrator, and Anthony Taylor, Radiology Services Administrator	**Scarborough**	**Nominated by colleague (on behalf of a patient)**

We recently received some lovely feedback from a patient who wished to recognise the team within our Radiology Department. The patient shared their appreciation for the way the department is run and the professionalism, kindness, and care shown throughout their visit. They specifically mentioned Tracey, Mawusi, Monica, Kaitlin, and Anthony, highlighting the positive interactions they witnessed with other patients, as well as the support they personally received. The patient described the team as a credit to Scarborough Hospital and wanted to extend their sincere thanks for the compassion and professionalism shown by everyone involved in their care.

James Smith, Security Officer	**Scarborough**	**Nominated by colleague**

On Monday night, Security received a call from the ED regarding an elderly patient who was being discharged. The patient was in a panic as she could not remember where exactly she had parked her car. James went to speak with her and helped her to locate her car, which was parked off-site. James carried her bag and, with patience and compassion, found her car parked on a side street near the hospital, ensuring the patient got to her car safely on a cold, wet, and dark night. James went above and beyond his role and what is expected of him, taking time to help someone in need. The patient came back the next day and delivered a card of thanks to him, which reads:

“To James Diolch, yn fawr (thank you very much). You were wonderful last night, taking me to my car. Without your directions, I would have got totally lost, and you did it with no coat in the rain. You are brilliant. Cariad (Love), [patient’s name]”

Neezla Wilcox, Deputy Service Manager | **York** | **Nominated by colleague**

Neezla had been amazing and has gone above and beyond to help me following a traumatic life event, which led to a period of absence. On my return, she has always been willing to lend an ear and has treated me with so much kindness and compassion when I needed it most. She is an exceptional rota coordinator - always there when you need her and willing to go above and beyond to offer help and find solutions.

Physiotherapists and Occupational Therapists | **Nelsons Court** | **Nominated by colleague**

The team, a few of whom are new, made my life so much easier when I returned to work after a few months recovering from an operation. They helped me so much with patients and equipment, giving me advice on what not to do to keep myself well and on the road to recovery. They didn't have to help, but they went out of their way to help with washes and personal care when I was the only healthcare on shift. I cannot thank them enough for their kindness. Marta, Val, Jo, Mirren, Jeanette, and anyone I have missed.

Herma Magno, Associate Practitioner | **Scarborough** | **Nominated by colleague**

Herma is polite and willing to assist patients and colleagues. She can delegate tasks and advocate for her patients. She is always willing and able to support a struggling colleague. She is wonderful and always willing to deliver optimal care.

Debbie Manton, Assistant Medical Secretary | **York** | **Nominated by relative**

My partner has struggled with pain in his leg and has struggled to get his GP to take it seriously. We had to battle to get a referral. He has additional mental health issues that make dealing with adversity challenging. After he was referred and given an appointment, this was then rescheduled, and we were given a much later appointment date. I emailed the admissions team to make them aware of the impact the date changes were having on my partner's mental health and to ask if there was any possibility of any last-minute cancellations.

Debbie took it upon herself to check for cancellations regularly, including over the Christmas period, and kept us in mind, going well beyond what we expected. Thanks to her kindness and persistence, my partner was offered a much earlier appointment, and he is now scheduled for treatment today - far sooner than we had hoped.

This has made a huge difference to his pain levels and our overall stress during what has been a very difficult time. Her proactive approach, compassion, and willingness to go the extra mile did not go unnoticed. It genuinely meant a great deal to us, and we're incredibly grateful.

Imran Ahmad, Consultant in Cardiology | **Scarborough** | **Nominated by colleague**

I called a patient to book an echocardiogram, as Dr Ahmad had requested. On speaking to the 81-year-old lady, she expressed her feelings about her recent Cardiology appointment. She said what a 'breath of fresh air' Dr Ahmad was. She explained how he took his time to explain everything to her and the plan that he is going to put in place. She said she has never met a doctor who explained everything so well and that she could understand. She left the appointment feeling well-informed and confident that her care was in good hands.

Laura Simpson, Specialty Registrar | **Scarborough** | **Nominated by patient**

I met Dr Simpson in SDEC when she came to review me for queried cauda equina, which I was very anxious about. She immediately made sure I had the appropriate pain relief due to being in so much pain. She talked me through the next steps and ordered an urgent MRI for me, which she then reviewed immediately afterwards. Luckily, I had a slipped disc, not cauda equina, and she thoroughly talked me through what this meant, allowed me to ask all my questions, and gave me informative answers.

Dr Simpson knew I had been sitting for hours, which was causing so much pain, and wanted to make sure I got home as soon as possible, which was exactly what I wanted. She helped me explain what had happened to my family, who attended with me, and I felt so supported by her. She gave me great safety netting advice for going home. I also saw her interactions with other patients and colleagues, and she really was a doctor who cares about her patients. She could tell how much pain I was in and how anxious I was, and she put me at ease. I'm so grateful to her for the care I received.

I would also like to thank Tonia, a Nurse Associate on SDEC, who was really kind and supportive when performing my bladder scans and assisting me on the unit, and a doctor called Joshua, who was kind to me during my initial assessment in ED. Thank you all so much. This was my first time attending the new Scarborough ED department, and I would recommend it highly.

Karen Hind, Practice Development Admin Manager, and Laura Robertshaw, Directorate Secretary | **York** | **Nominated by colleague**

Karen and Laura are always kind and forthcoming with help and support, even if it isn't something they would normally deal with. They never say, "It's not my job". Instead, they always say, "Yes, I can help you with that", or "Leave it with me, and I'll see what I can do". I always feel comfortable going into their office to ask for yet another favour because they are always smiling and welcoming.

I could not get all the jobs on my list done in the time that I have if it wasn't for these two helping me - ordering things, sending forms, filling in forms, contacting the design team on my behalf, helping with admin, finding out information on my behalf, providing me with supplies - the list goes on. I can't thank them enough.

Cancer Clinical Nurse Specialists Teams **Scarborough** **Nominated by colleague**

Referrals to the cancer tumour sites have never been so high, and the teams (cross-site and clinical and non-clinical) have adapted to provide a high-quality patient experience. Over the last three years, they have led on improving the results of the National Cancer Patient Experience Survey. Patients, both in the diagnostic phase and beyond, recognise their role in modelling the Trust values.

It can be difficult to provide this level of care, where, in the media and beyond, cancer treatment times and nationally reported data don't show their input and drive for the patients. This national and local picture of achievement is often negative, but the teams rise above this and provide an excellent service to often anxious and upset patients and carers. I am proud to be their lead cancer nurse.

Julie Stephenson, AHP Senior Support Worker **Selby** **Nominated by colleague**

I was working on Selby Hospital's IPU, completing breakfast and lunches with no patient service officer. Julie helped me with the breakfasts and supported me with going around to the patients to complete their menus. Julie was helpful and supportive throughout the day, and nothing was too much trouble for her.

Ward 29 **York** **Nominated by relative**

I am nominating the whole team on Ward 29 for their kindness, compassion, and going above and beyond when caring for my Nan in the final days of her life. Nothing was too much for them, and they also provided so much kindness and care to us as a family. The overall care provided was outstanding, and as a family, we cannot thank them enough. Their support made such a difficult time easier to deal with, and their approaches and understanding were amazing. They should be proud of themselves as a team.

Willow Eye Unit **Scarborough** **Nominated by patient**

While I was having eye surgery, the whole team were efficient and caring. They made me feel relaxed and well cared for while ensuring everyone had their needs met. I felt listened to, and all my questions were listened to without feeling rushed. Mary held my hand throughout the whole operation. I cannot explain how this made me feel - thank you! They were super-duper! It's exactly how you would want treatment to be: streamlined, excellent, and top-notch! Girl power at its best.

Oncology and Haematology Outpatient Unit | **York** | **Nominated by colleague**

Two weeks ago, our team successfully managed a sudden medical emergency when a patient became critically unwell. A patient attended the chemotherapy unit alone for their pre-assessment; however, they experienced a sudden onset of chest pain and collapsed in the reception. The team quickly assessed the situation, followed the emergency protocols, and commenced the resuscitation measures.

Clear communication, effective delegation, and calm teamwork ensured that each intervention was delivered promptly and efficiently. Chest compression was started straight away when there were no signs of life until the medical emergency team arrived and took over. The patient was successfully resuscitated and stabilised, demonstrating the team's competence, preparedness, and collaborative approach in high-pressure situations. The patient was transferred to the ED and then to the CCU for monitoring and management.

Oliver Prince, Specialty Doctor and Medical Appraisal Lead | **York** | **Nominated by colleague**

Oliver consistently goes above and beyond his role as Appraisal Lead, undertaking a high volume of appraisals and making an important contribution to the Trust meeting its requirements. His commitment, support, and willingness to go the extra mile are genuinely appreciated by his appraisees and by the Medical Director’s team.

Julie Gallagher, Ward Sister | **Scarborough** | **Nominated by patient**

I was in a road traffic accident (run over by a car on a footpath) and was blue-lighted to Scarborough ED. The Resuscitation Sister, Julie, kept me calm while checking my wounds and treating me with respect and compassion. She rang my family members, calmly informing them of my accident, then stayed with my family and me until I was blue-lighted to Hull Trauma Unit. Julie is a fantastic nurse and Sister, and I want to show my appreciation for her by nominating her for a Star Award. In my opinion, she truly deserves one.

Haldane Ward | **Scarborough** | **Nominated by patient**

The ladies on the Haldane Ward were fantastic during my day surgery at Scarborough Hospital, as well as the receptionist, who was lovely and chatty and wished me luck! Although they were busy, they always took the time to check and double-check if I was OK. No ask was too big for them, especially Sherry and Beth. They are an absolute credit to the Trust. I hope they are there for many years to come to care and support the patients at the hospital and to grace the patients with their fantastic attitude and person-centred care.

Victoria Beckitt, Team Leader **York** **Nominated by colleague**

I would like to nominate my manager for the Star Award in recognition of her outstanding leadership and the positive impact she has on our team every day. She consistently demonstrates fairness, professionalism, and a genuine commitment to supporting the people she works with.

One of her greatest strengths is how approachable she is. She creates an environment where team members feel comfortable asking questions, sharing concerns, or seeking guidance. Her knowledge and experience are evident in the way she handles challenges and ensures that tasks are carried out correctly and to a high standard. She has a remarkable ability to guide colleagues with patience and understanding. Rather than overwhelming people, she eases them into new responsibilities, making sure they feel supported and confident in their roles. This approach not only helps individuals grow professionally but also strengthens the overall performance of the team.

What truly sets her apart is the way she looks after everyone. She takes the time to understand each person's situation and shows genuine consideration for their personal circumstances. Her support and empathy make a real difference in maintaining a positive and respectful workplace. She also ensures that things get done efficiently and properly, maintaining high standards while still being supportive and encouraging. Because of her leadership, the team feels motivated, valued, and confident in the work we do.

For these reasons, I believe she truly deserves recognition through the Star Award. Her dedication, fairness, and supportive leadership make her an exceptional manager and a role model for our team.

Blair Sorbie, Specialty Registrar **York** **Nominated by relative**

Dr Sorbie was fantastic! My wife and I had our first baby earlier this week, and he was delivered by Dr Sorbie. My wife was nervous about having a C-section, but he and the theatre staff were patient and kept us both in the loop throughout. He came to check on us later that day and popped by the following day (when he wasn't even on shift) to check up on my wife. He offered time for us to ask questions and was a credit to the profession. Thank you from me, Grace, and baby Asa!

Kim Robinson, Staff Nurse **Scarborough** **Nominated by colleague**

As a newly qualified nurse, I had unfortunately witnessed my first ever cardiac arrest. Kim was the nurse in charge on that shift. She was kind, considerate, and calm in a very stressful situation. She spoke clearly and calmly towards other colleagues and me about what needed to be done. I was thankful for how quick to act she was and how she made sure colleagues were OK after the event.

Philip Hodgson, Deputy Sister **York** **Nominated by patient**

Phil is always on the go, and he never stops. He goes beyond the extra mile and always brings a smile when you are down. I would like to say a big thanks to Phil.

Jenny Rajan, Emergency Nurse Practitioner **York** **Nominated by patient**

I would like to nominate Jenny Rajan. She was kind and supportive when she treated me. She kept checking if I was comfortable and asked if I needed water or anything, which I appreciated. She also handled my injury professionally and made me feel reassured during the treatment.

It was my first time going to a hospital since I arrived in York, so I was a bit nervous, but she made the experience much easier for me. Her kindness and professionalism really stood out to me.

Sienna Lewis, Cleaning and Catering Operative **Scarborough** **Nominated by colleague**

Sienna is always on her feet and finding stuff to do. She can always be found doing her job. She has been pulled to multiple wards, and colleagues always say amazing things about her. For example, she is always asking if there are more things to do or if there is something to do, even if it is not within her job description.

Even after an upsetting audit, she just got on with the work without even caring about what her jobs were, getting most of the audit list rectified. She is eager to learn new things and does not get upset by being corrected but learns from it. Her ward has always pulled the management to take a moment to appreciate her work.

Medical Engineering Team **York** **Nominated by colleague**

I would like to nominate Ben Ives, Niall Mullins, Andrea Pasquale, Jenny Bolton, Dan Brown, Ed Hewitt, Rich Long, Katie Ward, Janine Esteves, and Darren Carmichael for their excellent teamwork and commitment during the recent replacement of 146 hospital beds across the Trust.

The team volunteered to complete this work on a Saturday, outside of their normal hours, ensuring the project could take place at a time that minimised the effect on patient care or ward activity. Although the project required clear planning, excellently coordinated by Darren, it was the combined effort of the whole team that made the day run so smoothly. Everyone played their part, working efficiently, communicating well, and supporting each other throughout. The scale of the task was significant, yet the team completed the entire replacement programme with no issues and with a calm, organised approach.

Our partner company commented on how well the day had been managed and how impressed they were with the team's professionalism and the speed and ease with which the work was completed. This reflects the positive attitude and cooperation shown by everyone involved.

The successful completion of this project has already made a meaningful difference to the comfort and experience of patients across the hospital. It also demonstrated the value of a team that works well together and is willing to go the extra mile when needed. For these reasons, I believe the whole team deserves recognition for their contribution and the way they approached this important piece of work.

Martha Rye Lees, Student Midwife **Scarborough** **Nominated by colleague**

Martha recently started her placement with the Community Midwives Team, and she has been a breath of fresh air! She is proactive, independent, and knowledgeable and connects well with the service users. She is an excellent team member, and we will be sad to see her leave, but we look forward to working with her again as a qualified midwife. Well done, Martha.

Emily Burkill, Staff Nurse **York** **Nominated by patient**

As an inpatient, I travelled to St James Hospital, Leeds, in an ambulance for the first of my radiotherapy sessions. Emily came with me as my nurse escort. I was receiving irrigation through my three-way catheter, and we were both concerned about the potential length of time away from York Hospital, as, although the ambulance crew were happy to take the irrigation equipment on board, for some reason, which did not occur. Emily therefore had with her the necessary items to enable a washout to be carried out if she judged one necessary to avoid a build-up of clots.

On arrival at Leeds, while I was having my radiotherapy, she immediately pursued the arrangements for our return to York and discovered that no return journey had been booked. She initially managed to get one booked, but with a potential 4-hour delay. Following further discussion, she then managed to get this reduced to a 2-hour delay. However, even with this reduction, we both remained concerned over the potentially significant delay in restarting my irrigation.

Using her knowledge of St James (where she had done her training), Emily managed to obtain all the required equipment elements and set up a temporary irrigation system while we were waiting for the return ambulance, aiming to minimise the period without treatment and reduce the risk of clots developing. When the ambulance crew arrived, they were happy to take the equipment with them, so the irrigation was able to continue until we got back to York and could reconnect to the ward system.

Throughout, Emily showed great initiative and determination in ensuring that I suffered the minimum time possible without my irrigation treatment and reducing the risk of severe clots developing. She had my care and safety at the front of her mind throughout. She was a real star and deserves to be awarded one for her actions that day.

Jeny Jacob, Healthcare Support Worker, Anjaly Reji, Staff Nurse, Margaret Dawe, Healthcare Support Worker, Emma Loates, Healthcare Support Worker, Bernice Tandoh, Staff Nurse, Francisca Kusi, Staff Nurse, Steph Hodgson, Healthcare Support Worker, Alan Porter, Healthcare Support Worker, Malcolm Ashton, Healthcare Support Worker, and Charlotte Mapplebeck, Patient Services Assistant | **Scarborough** | **Nominated by patient**

I write this letter to recommend the above people for letters of commendation and a silver star. Many thanks for your care and attention, courtesy, patience, and kindness. As always, Malcolm is ever the gentleman, patient, kind and I have complete confidence in him and his abilities.

Stella-Maris Adeosun, Staff Nurse | **Scarborough** | **Nominated by colleague**

Stella was a champion in heading the shift; she was polite and kind to both colleagues and patients. Stella was patient in teaching colleagues and was open to answering any question without making it look like a burden. Stella was the support structure that knew everything and anything about the patients' care and appropriately escalated when necessary.

Vicky Reader, Operational Service Manager | **York** | **Nominated by colleague**

Whilst the team was understaffed, Vicky went above and beyond to make sure that the GI service, specifically the service managers, consultants, and secretaries, felt supported throughout the period. Vicky helped with several operational issues and provided mentoring, advice, and wellbeing support to the team. Vicky showed resilience and dedication and took the additional work in her stride while managing her own busy workload.

Georgina Cherry, Specialist Nurse **York** **Nominated by colleague**

I would like to express my sincere gratitude for Georgina's excellent support and coordination of DJW's care during her time at York Hospital. Her commitment to ensuring the people we support can access healthcare in a person-centred way is truly outstanding.

The reasonable adjustments Georgina put in place, and the way she educated the professionals involved, could not have been an easy task. However, she ensured that everyone understood what was expected of them and how to care for D using her preferred method of communication. This was incredible work.

DJW and her family have also asked me to pass on their heartfelt thanks for her tireless effort and care for their loved one. I look forward to working with Georgina, as always, in the future. Her level of understanding and her genuine passion for her work enable the people we support to achieve the best possible clinical outcomes. She is appreciated by us all.

David Wrigglesworth, Radiographer **York** **Nominated by colleague**

In X-ray, we were short on imaging support workers. I had rung round to VIU to see if they had any spare support workers that could come and assist, as we had a high volume of inpatients this day, a lot of which were post-op hips that, with x-ray, had a higher chance of being discharged.

When I rang VIU, David said they had no support workers, but he was available to come and assist for the morning. He came and cracked on with trolley patients, this considerable affected our list. It demonstrated our Trust values of:

- Kindness - coming to help his colleagues within Radiology and supporting the patients.
- Excellence - working to his best all around.
- Openness - being honest that he was available to come and assist, even though it is not his job.

David had a large impact on our patient list this day and allowed acute flow to continue.

Specialist Vascular Imaging Unit **Scarborough** **Nominated by colleague**

During yesterday's session, the team faced an unexpectedly heavy workload and managed around 11 patients, significantly more than anticipated. As a result, the session ran well beyond the planned finish time.

Despite this, the team remained committed to ensuring that all patients received safe and timely care. Everyone worked collaboratively and stayed late to complete the list, maintaining professionalism and focus throughout. Their willingness to go above and beyond ensured that the session was completed safely and that patients did not experience transfers, cancellations, or delays.

Sandra Hudson, Orthodontic Therapist | **York** | **Nominated by colleague**

Sandra has gone above and beyond for the Orthodontic department in the wake of recent sickness, short-notice clinic cancellations, and staffing shortages. She has been working hard to get patients seen so they are not left waiting and getting them put in as extras to her clinics. She has been seeing her patients as well as helping see other clinicians' patients, as well as seeing multiple emergency appointments a week. She well and truly is holding down the fort during this challenging time, and we would be lost without her.

Hayley Temple, Neonatal Digital Nurse | **Scarborough** | **Nominated by colleague**

Hayley's role as the Neonatal Digital Nurse in Scarborough has been vital in the rollout of the BadgerNet system. Hayley has been passionate, patient, hardworking, and pivotal in the training and smooth rollout of BadgerNet. Hayley's professional, approachable, and knowledgeable support has been essential to all team members. We have been lucky to have her in this role.

Ashleigh Forbes, Staff Nurse | **Community** | **Nominated by colleague**

Community nurses visited a patient on Monday, and the patient said they were marvellous. The hospital did not provide the patient with everything they needed, so nurses visited the local surgery for a prescription and went to Boots to collect it. The patient wanted to thank Ashleigh and the nurse who visited with her for their sheer good nature. They never grumbled or made any adverse comments. The patient says they are a credit to the community nursing service.

Jane Crewe, Principal Pharmacist | **York** | **Nominated by colleague**

I would like to formally acknowledge and celebrate the outstanding leadership demonstrated by Jane in delivering the new anticipatory prescription and syringe driver chart across our Trust and partner organisations.

Jane collaborated closely with both the specialist palliative care team and me as part of a comprehensive review of an overdue chart. She took the lead on implementing significant changes and edits to what was a complex document, coordinated its approval and printing, and managed a challenging cross-site rollout with remarkable composure and clarity, even when faced with logistical hurdles such as early requests from multiple areas and competing system priorities. Jane also worked with EPMA colleagues to ensure prescribing practices remained safe and aligned, to produce clear and accessible communications summarising key changes, and to provide steadfast support to colleagues across acute, community, primary care, and hospice settings.

Her meticulous operational planning, clinical expertise, and unwavering commitment to safe practice have ensured a seamless transition to the new chart and have strengthened end-of-life care throughout our system. The revised chart introduces significant changes expected to generate cost savings for the Trust, and it has been submitted as a cost improvement project under palliative medicine.

Joel Sharples, Occupational Therapist | **Selby** | **Nominated by colleague**

Joel is just about to come to the end of his first rotation in the Trust with us at Selby Inpatient Unit as a qualified Occupational Therapist. From his first day, he has fit into the team seamlessly. Joel is a calm and collected presence on the ward and will be much missed by all the team. Absolutely deserving of a Star Award for embodying the Trust values, always striving to support patients, and being proactive in himself and the ward. A highlight during his time here has been when he led music groups by singing and playing guitar for patients, which they have loved.

Vibhuty Arya, Trainee Sonographer, and Nicola Walker, Sonographer | **Scarborough** | **Nominated by patient**

Vibhu and Nicola did my dating scan. It took a long time for my baby to change position, which they needed the baby to do so they could take measurements, but they were patient and highly professional while doing this. I appreciate them.

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

Helena was friendly and welcoming today. I always say York Hospital have the best 'vampires', and Helena is yet another example of this amazing team. A wonderful mix of professionalism and personality.

Ailsa Atkinson, Specialist Nurse - Hysteroscopy | **York** | **Nominated by colleague**

Ailsa is a Nurse Practitioner in Hysteroscopy. She had been looking into ways to aid women who were anxious about attending hysteroscopy clinics. She saw research from other units using stress balls during the procedure and the positive effect this could have on patients undergoing hysteroscopy. Ailsa purchased several wipeable stress balls with her own funds to be available in all hysteroscopy and colposcopy clinics in the York and Scarborough women's units.

While we have only been using these for a short time, the amount of positive feedback we've received has been staggering. It has helped many women with their fear and anxiety in these clinics. Such a simple tool has made such a big difference. Ailsa is always professional, engaged, and striving to improve all aspects of hysteroscopy. She is a credit to our service.

Ward 35 | **York** | **Nominated by relative**

My mum has been on Ward 35 for around five weeks, and the care she has received is gold standard! Whoever leads that team needs an award, as do all the staff. Every one of them is outstanding, generous, sweet, kind, professional, and sincere. Sammyjo, Rita, Holly, and others, I'm sorry, their names have slipped my mind. A lovely nurse (who had the same as my mum) was also outstanding. Every one of them, from nurses, healthcare staff, the team who serve the food, and the cleaners, was considerate and caring. They all deserve recognition for their outstanding care to their patients and their families.

Joanne Slimene, Healthcare Support Worker **York** **Nominated by patient**

Jo was working on Ward 11 following my thyroid surgery. I had been struggling with anxiety following my surgery and being admitted. I'd had some issues with my drain leaking, nausea from seeing the drain contents, and low blood pressure. Jo went above and beyond, checking on my drain, providing a drain bottle cover, and getting IV fluids authorised. I will be forever grateful to Jo for advocating for me in a time of great need and vulnerability. She deserves this recognition.

Ward 26 **York** **Nominated by patient**

I had two stays on Ward 26 following thyroid surgery, once immediately following surgery and a second for wound infection. The entire team worked well together, and nothing was too much trouble. I was treated with compassion, respect, and kindness. I appreciated my time on the ward and felt in the best possible care. Thank you, Ward 26, for all your care and dedication. You are an amazing team of doctors, nurses, healthcare professionals, cleaners, and staff who bring tea and biscuits. You made a stressful time much more bearable. Thank you, all.

Tamaya Hudson, Patient Services Assistant **York** **Nominated by patient**

Tamayha went above and beyond when helping a patient who was feeling sad after his wife was unable to visit because of illness. She sat with him, played some of his favourite music, and comforted him until he was more cheerful. The patient asked us to nominate Tamayha.

Poppy Ryan, Housekeeper **Scarborough** **Nominated by colleague**

Poppy is always helpful and proactive on Juniper Ward. She is incredibly patient-centred and recently did a tour of the hospital trying to source a lumbar puncture pack for a patient who needed it. She keeps Juniper Ward well-stocked and organised as an excellent housekeeper. She also kindly supports Scarborough Doctors' Mess by delivering milk. Above all, she is a friendly and positive person, and it is a pleasure to work with her. Thank you!

Maxillofacial Surgery Team **York** **Nominated by colleague**

I work in Maternity and run a tongue tie clinic twice a month. I had my first frenotomy that bled heavily a couple of weeks ago. As I work alone and tend to have someone only to assist initially for the procedure, it was daunting to be faced with this emergency. I escalated to another midwife, and we followed the procedures to stop the bleeding, but it did not stop. We attended the Maxillofacial department to consider the following step within the management of a bleeding frenotomy, which is diathermy.

The team at Max Fax were incredible. I am afraid I do not know their names, but there was a female nurse who had only recently joined the team who greeted us and got a lovely Head and Neck surgeon to see us straight away. He was incredibly kind and calm and reassured everyone, claiming that we made his day as he got to cuddle a baby for a little while. The team put the parents and me at ease straight away. Luckily, the bleeding stopped without requiring cauterisation. It was wonderful to see such a cohesive team welcome us with open arms and support a different team within the hospital without judgment. Everyone was amazing, and I can't express my gratitude enough.

Fae Masterson, Staff Nurse **York** **Nominated by patient**

I would like to nominate Fae for the exceptional care she gave me while I was on the ward. She is caring and knows the job well. I cannot speak highly enough of her, and she is amazing.

Haematology Laboratories **Scarborough and York** **Nominated by colleagues**

We would like to nominate the Haematology teams at York and Scarborough hospitals for the exceptional dedication and teamwork they displayed. On Monday 9 March, the department experienced significant issues with the analysers, which could not be resolved in a timely manner. Despite these challenges, the team stepped up immediately and went above and beyond to ensure continuity of patient care.

Colleagues worked tirelessly to organise and send samples to the Haematology Laboratory at Scarborough, demonstrating outstanding problem-solving and collaboration under pressure. The team at Scarborough processed the additional workload alongside their own, ensuring that urgent testing needs were met without delay. Several members of the York team extended their shifts, while others from both the York and Scarborough teams came in at very short notice to provide additional support. Their commitment, flexibility, and teamwork that night were exemplary.

The professionalism and dedication shown by the Haematology teams at both York and Scarborough hospitals ensured that vital work continued seamlessly despite the circumstances. Their actions truly reflect the values of the Trust, and they are highly deserving of this recognition.

Item 10

Committee Report

Report from:	Quality Committee
Date of meeting:	21 April 2026
Chair:	Dr Lorraine Boyd (Chair)

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

ALERT
Sustained emergency care pressure, including the continued use of corridor and temporary escalation spaces, presents an ongoing risk to patient dignity, experience and the reliability of quality controls. Complaints handling capacity and timeliness remain inconsistent, creating a gap in assurance relating to responsiveness, learning and patient trust.
ASSURE
The Quality Overview within Emergency Departments Report provided strong assurance that patient safety and quality of care within Emergency Departments at York and Scarborough are being actively managed despite sustained operational pressure. Core safety standards are maintained; harm prevention standards are effective and patients with long waits are identified and monitored. Targeted audit identified no evidence of harm attributable to delay. It was noted however that the reliability of quality and safety assurance mechanisms deteriorates under extreme pressure, reducing the strength of assurance. **Maternity and Neonatal services** remain broadly in line with national benchmarks, including stillborn and neonatal mortality rates. Strong multidisciplinary governance, training compliance and case review processes are in place. It was noted, however, that workforce pressures, particularly midwifery vacancies, continue to constrain resilience and the pace of improvement delivery. **Nursing and AHP Quality Assurance Framework** continues to evolve to provide data driven triangulated assurance across the Trust. Governance arrangements are robust and there is evidence of improvements. However, assurance is weakened by persistent fundamental care issues and inconsistent data capture. **Q3 and Q4 Patient Experience** reports demonstrated reasonable assurance that controls, actions and improvements are in place and are progressing. Significant improvement in Friends and Family Test engagement, now well above national benchmarks, indicate an embedded process providing reliable, real-time feedback. Triangulation with other data sources give good assurance that the Trust has strong mechanisms to hear the patient voice and identify themes and trends. However, complaints handling remains a significant cause for concern with poor

and inconsistent performance evidenced, resulting in a gap in assurances that handling capacity and timeliness is under sustained control.

Clinical Effectiveness Report provided assurance that the Trust remains compliant with mandated national clinical audit requirements and has effective governance in place to manage participation, data quality and outlier reports. Identified outlier reports are understood, actively managed and appropriately overseen. Processes for sharing national audit findings and NICE guidance are established. While some actions remain under external review, no immediate gaps in assurance were identified.

ADVISE

Medicine Care Group provided assurance on current and emerging risks, mitigating actions and progress. Improvements as a result of flow initiatives, speciality recovery actions and governance oversight were noted. Ongoing risks relating to emergency demand, RTT fragility and rehabilitation capacity were acknowledged.
The **Corridor Care briefing** reaffirmed the Trust position, recognising that corridor care is unacceptable and must not be normalised. It should only occur in exceptional circumstances for the shortest possible time following a robust risk assessment process. SOPs and governance processes have been strengthened, and work continues to align with national expectations, but assurance gaps remain, which are being addressed. A more comprehensive report will be provided for discussion and assurance next month.
Learning from Deaths confirmed the rationale for adoption of SHMI, replacing routine use of HSMR, in line with national best practice.
Pressure Ulcer Performance Data (a True North Metric) was discussed and noted to remain above trajectories. A focused update report was requested.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

PR1 – Quality and Safety in Emergency Care is exposed to increased clinical risk at times of extreme pressure, with narrow safety margins and reduced reliability of assurance mechanisms
PR1 – Complaints handling capacity and compliance is challenged and risks compromising patient safety and trust, as well as potential regulatory and reputational risk.
PR1 - communication failures remain a top theme of complaints, risking patient harm and poor experience
PR3 – system level risks compromising patient flow continue to impact on ED and throughout the hospitals, resulting in increased clinical risk and fragile quality and safety assurance.
PR4 –'Services, pathways and support functions are not designed and improved in a sufficiently transformative way across the Trust for the benefit of patients' was

subject to a focused review and no obvious gaps in control and assurance were identified.
PR4 - multiple quality improvements (eg deteriorating patient, consistent documentation, MCA visibility) are reliant on Nervecentre delivery, representing a potential emerging risk.
CRR 866 relating to hospital acquired bacteraemias has been added to the CRR and will continue to be monitored through the quarterly IPC report to the Committee.
CRR 728 'deteriorating patient and Paediatric ED' risk was discussed and improvements to staffing model and triage processes with regular reporting through Patient Safety and Clinical Effectiveness Group has reduced this risk which will be reviewed in the Risk Committee

ASSURANCE GAINED

The Committee is assured that patient safety remains a priority, risks are appropriately escalated and governance arrangements remain effective, albeit increasingly constrained by system pressure.

Overall Position

Services reviewed remain safe, but assurance is increasingly constrained by cumulative operational, workforce, estate and digital pressures.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 12

TRUST PRIORITIES REPORT

April 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 – Number of Non-Elective Admissions.
- Operational Performance - RTT – Total Waiting List.
- Operational Performance – Children & Young Persons: RTT – Total Waiting List.
- Workforce – Annual absence rate.
- Workforce – Monthly sickness absence.

A True North metric page is included in this month's report.

Information of the Trust's **National Operating Framework (NOF)** performance is included. The first page provides the Trust's overall ranking and position nationally against each of the 22 metrics at the end of Q3. Q4 will be published as soon as possible after all official operating statistics for the quarter have been published in line with national reporting deadlines.

True North (TRUN)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

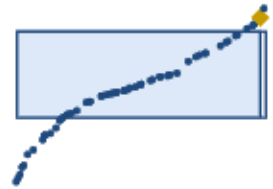
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Inpatients - Lost bed days for patients with no criteria to reside	2026-03			1624		
ED - Emergency Care Standard (Trust level) - Declared Position	2026-03			71%	78%	78%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-03			9.3%	8.9%	8.9%
Cancer - Faster Diagnosis Standard - Declared Position	2026-02			76.2%	79.3%	80.1%
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Declared Position	2026-03			56.4%	60.5%	60.5%
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Declared Position	2026-03			2%	1%	1%
Total Number of Trust Onset MSSA Bacteraemias	2026-03			6	7	7
Inpatient Acquired Pressure Ulcers - Category 2	2026-03			67	60	60

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 patients waiting over 52 weeks for elective treatment	Dec-25	3.53	3.12	-0.41	89
Percentage of patients waiting over 52 weeks for community services	Dec-25	3.80	3.79	-0.01	72
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q3 2025/26	3.81	3.92	0.11	115
Percentage of patients treated for cancer within 62 days of referral	Q3 2025/26	3.06	3.38	0.32	94
Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q3 2025/26	3.21	3.18	-0.03	86
Percentage of emergency department attendances spending over 12 hours in the department	Q3 2025/26	3.49	2.87	-0.62	77
Number of MRSA bacteraemia cases (12 months)	Jan 25 - Dec 25	3.40	3.60	0.20	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Dec-25	3.38	3.61	0.23	114
Average number of days from discharge ready date to actual discharge date (including zero days)	Dec-25	1.68	1.98	0.30	42
Summary Hospital-level Mortality Indicator	Oct 24 - Sep 25	2.00	2.00	0.00	
Proportion of E. coli bacteraemia	Jan 25 - Dec 25	2.41	2.26	-0.15	
Urgent Community Response 2-hour performance	Q3 2025/26	2.85	4.00	1.15	48
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	Q3 2025/26	3.00	4.00	1.00	
Variance year-to-date to financial plan	Month 9 2025	2.00	4.00	2.00	90
Sickness absence rate	Q2 2025/26	2.47	2.16	-0.31	65
NHS staff survey engagement theme sub-score	2024	3.98	3.98	0.00	133
Implied productivity level	Q2 2025/26 vs Q2 2024/25	2.69	2.85	0.16	83
Proportion of C. difficile infections	Jan 25 - Dec 25	1.00	1.00	0.00	
Difference between planned and actual 18 week performance	Dec-25	2.06	3.17	1.11	93
Access to services domain score	Q3 2025/26	3.29	3.38	0.09	122
Patient safety domain score	Q3 2025/26	3.11	3.12	0.01	118
Finance and productivity domain score	Q3 2025/26	2.85	3.42	0.57	112
People and workforce domain score	Q3 2025/26	3.22	3.07	-0.15	111
Effectiveness and experience domain score	Q3 2025/26	2.13	2.49	0.36	102

131 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

April 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 however a significant improvement has been seen in ECS since the implementation of the new models of care (EEMAC and EAU) were launched 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 has had a positive impact on the front door ED assessment process including ECS and 12-hour in department metrics with April 2026 performance up to and including the 13th of April provisionally at 79.5% and 5.1%, respectively.

Cancer performance for FDS and 62-day standards remain off trajectory however February 2026 performance for FDS was the highest that the Trust has ever achieved. The drivers include diagnostic delays, dermatology referral surges, FIT compliance issues, and pathway bottlenecks. Recovery actions continue across colorectal, urology, gynaecology and skin, including expanded proformas, haematuria STT and GP engagement. High referral volumes and diagnostic limitations remain critical risks.

The RTT waiting list (TWL) reduced but remained behind trajectory, drivers include significant GP referral growth during the year and CPD logic changes. However, zero RTT65 week waits was maintained.

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 remained at 4.4%.

Diagnostics DM01 performance was 77%, 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 activity and performance trajectories submitted as part of the 2026/27 annual plan submission.

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.
- 5% rise in GP referrals year on year.
- Community capacity limits affecting flow and discharge.
- Capital project and estate constraints (CDC build, RAAC, MRI/CT replacement).

Strategic Priorities (Q1)

1. Reduce 12 hour stays and improve ECS and patient flow through new models of care (EEMAC and EAU) launched in March, providing new next step pathways expected to improve 4- and 12-hour performance.
2. Increase Cancer and Diagnostics capacity via imaging expansion and FIT compliance improvement.
3. Maintain RTT recovery momentum, delivering activity plans and performance trajectories.
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 TRUST, EAST 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	Latest position vs plan	Key Mitigations – Next three months	Expected trajectory
Urgent & Emergency Care	ECS performance 71% vs year end 78% trajectory. Average Ambulance Handover ahead of trajectory. Long stays reduced; 12 hr waits 9.3% (behind year end 8.9% trajectory). We launched two new pathways at each Emergency Department in March 2026. These were developed using new national guidance and we have seen significant improvements in ECS and 12-hour performance levels. Flow constrained by community and social care capacity.	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. In March, both acute sites implemented the first phase of the new acute model of care, which affects pathways in the Emergency Departments. Extended Emergency Medicine Ambulatory Care (EEMAC) is the SDEC for ED. Emergency Assessment Unit (EAU) is for patients needing further assessment to determine whether an admission is required.	Full recovery dependent on wider system demand management and community discharge capacity.
Cancer FDS/62 day	February FDS 76.2% vs 79.3% monthly trajectory; this FDS position is the highest the Trust has achieved since the standard was introduced. February 62-day 70.7% vs 73% monthly trajectory. Diagnostic performance, in particular endoscopy and imaging is impacting faster diagnosis performance due to delays in diagnostic pathways.	Implemented returning referrals with no FIT to primary care. STT CT model in haematuria commenced implementation Lower GI proforma rollout; enhanced GP comms.	Gradual improvement through 2026/27. However national targets remain high risk due to referral volume and diagnostics.
RTT TWL / %<18w/52w	TWL 55,589 behind year end trajectory of 38,952 <18w: 56.4% vs 60.5% year end trajectory; Trust ranked 107/118. 52-week waiters improved to 1,088 (Provisional position) v year end trajectory of 389. GP Referral growth +5% at end of 2025/26 Vs 2024/25, CPD logic changes increased RTT clocks from Q1.	Fortnightly meetings in place from start of April 2026 with Care Groups to review activity and performance delivery at specialty level, proactive identification of issues to allow material mitigations to be made in month. Scope of weekly meeting to be expanded by end of April 2026 to monitor full pathway metrics rather than focus on longest waiters. Maintaining zero RTT65 week waits remains a priority.	Improvement expected in RTT under 18 week, TWL and RTT52 week waits.
Diagnostics	DM01 77%, 5.7% below year end trajectory of 82.7%, improvement from January. Impact from MRI workforce shortages, CT3 removal, mobile breakdowns, NOUS MSK backlog, audiology staffing gaps.	Endoscopy: Nurse vacancies out to advert to recruit substantive staff and remove the need for insourcing. Imaging: NOUS bank registrar has cleared the soft tissue backlog and will now begin to focus on injections. CT3 replacement awaited, delayed until circa Autumn 2026. MRI4 installation awaited, delayed until at least Q2 2026/27. In discussion with independent sector to take long wait DEXA patients unable to be completed on Trust equipment due to field safety notice.	Improvement through Q4 but recruitment and equipment risks remain.
Outpatients	PIFU 4.5% vs 5% year end trajectory. RACP 14-day performance 78%, below 99% target. DNA rate remained at 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 2026/27; largest opportunity in PIFU uplift. Transformative pathway design is required over the longer term.
Children and Young people	CYP RTT waits 567 off year end trajectory of zero, mainly ENT and Oral Surgery. CYP ECS 86,9%	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 ASAP.	Improved ECS for CYP; zero RTT40 week waits (except H&N).
Community	SLT backlogs impacted by workforce shortages. Mitigation in plan for 2026/27 are funded. 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 confidence for 2026/27 if WTE mitigation can be recruited to.

Headlines:

- The March 2026 Emergency Care Standard (ECS) position was 71%, against the monthly planned improvement trajectory of 78%. **ECS performance is a True North metric.** In the latest available national data (February 2026) the Trust ranked 94th out of 118 providers and 10th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group.
- Average ambulance handover time in March 2026 was ahead of trajectory at 19 minutes 46 seconds against trajectory of 29 minutes 42 seconds.
- 9.3% of Type 1 patients spent over 12 hours in our Emergency Departments during March 2026, behind the monthly improvement trajectory of 8.9%. This was however a 5% improvement on the February 2026 performance In the latest available national data (February 2026) the Trust ranked 62nd 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 14.6% behind the internal trajectory of 12.5%.
- The average non-elective Length of Stay (LoS) acute for patients staying at least one night in hospital was 6.9 days during March 2026 (4,227 spells of care covering 29,327 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) during March 2026 was 88.1% (3,637 patients out of 4,128), ahead of the trajectory of 87.4% 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 4.5 days, behind the submitted trajectory (3.9 days).

Factors impacting performance:

- We launched two new pathways at each Emergency Department in March 2026. These were developed using new national guidance and we have seen significant improvements in ECS and 12-hour performance levels. Daily monitoring has taken place, which is now being changed to a weekly continuous improvement meeting to hear ideas from teams about how to further refine the model.
- There are ongoing community health and social care constraints causing delays to discharges for patients requiring onward care.

Actions planned in April 2026:

- An after-action review is being completed, to consider how the new pathways were launched and how future changes could be communicated with increased involvement with staff.

Summary MATRIX 1

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

MATRIX KEY

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

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

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	2026-03			83.1%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2026-03			30%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-03			9.3%	8.9%	8.9%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2026-03			1170		
ED - 12 hour trolley waits - Declared Position	2026-03			237		0
ED - Emergency Care Attendances - Declared Position	2026-03			19818	16377	16377
ED - Emergency Care Standard (Trust level) - Declared Position	2026-03			71%	78%	78%
ED - A&E attendances - Type 1 - Declared Position	2026-03			12231	10999	10999
ED - Emergency Care Standard (Type 1 level) - Declared Position	2026-03			56.7%	69.2%	69.2%
ED - A&E Attendances - Types 2 & 3 - Declared Position	2026-03			7587	5378	5378
ED - Median Time to Initial Assessment (Minutes)	2026-03			4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-03			43.3%		

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

Acute Flow (2)
Scorecard

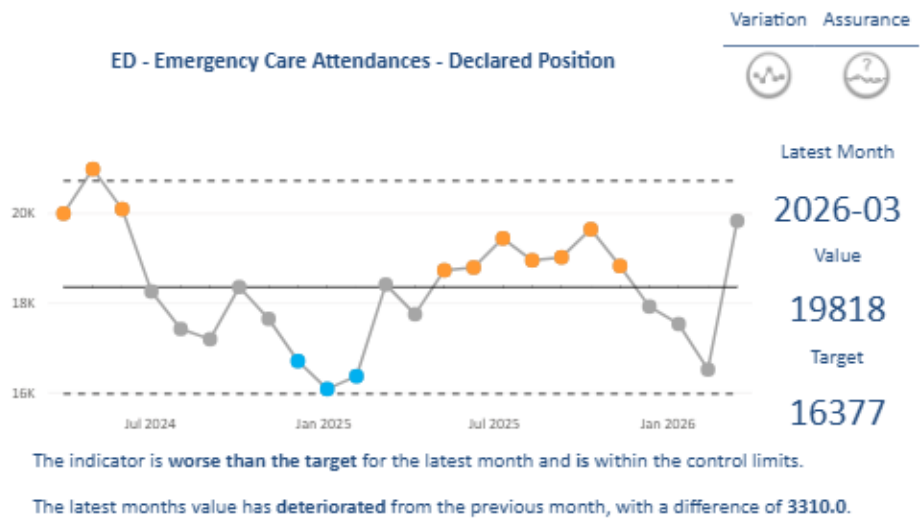
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

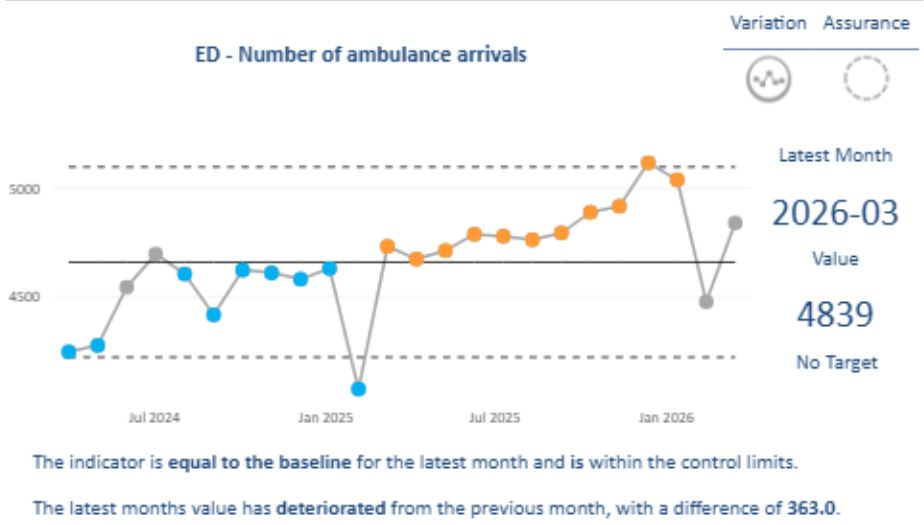
Executive Owner: Claire Hansen **Operational Lead:** Abolfazl Abdi

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	2026-03			43.3%		
Number of SDEC attendances	2026-03	H		3639		
Proportion of SDEC attendances transferred from ED	2026-03	H		74.7%		
Proportion of SDEC attendances transferred from GP	2026-03	L		19.1%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2026-03	H		68.5%		
Proportion of SDEC admissions transferred to downstream acute wards	2026-03	H		30.6%		
Number of RAFA attendances (York Only)	2026-03			141		
Number of attendances at SAU (York & Scarborough)	2026-03	H		1111		
ED - Proportion of Ambulance handovers within 15 mins	2026-03	H		38.9%		
ED - Proportion of Ambulance handovers over 15 mins	2026-03	L		61.1%		
ED - Proportion of Ambulance handovers waiting > 30 mins	2026-03	L		14.5%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2026-03	L	F	2.3%		0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2026-03	L	?	0%		0%
ED - Number of ambulance arrivals	2026-03			4839		
ED - Ambulance average handover time (number of minutes)	2026-03	L	?	20	29	29

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

What actions are planned?

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?

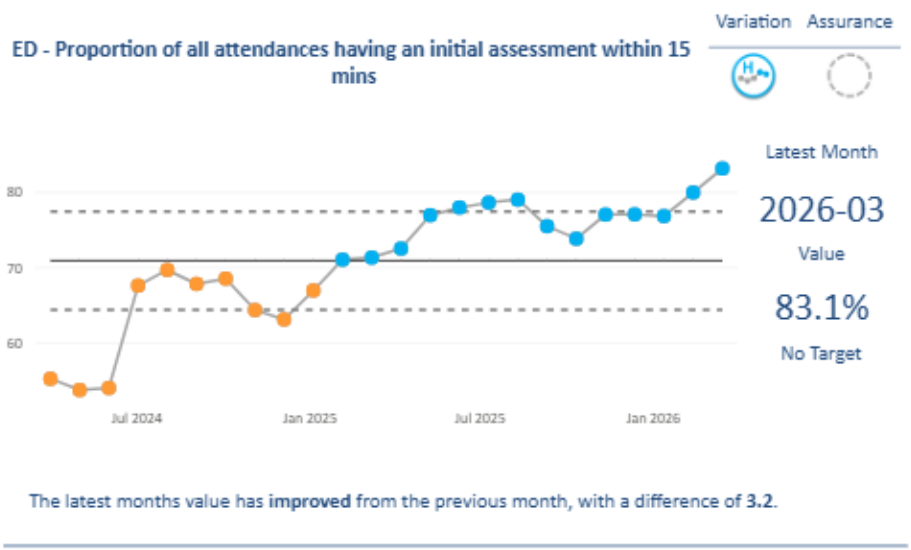
Increasing use of non-ED pathways may reduce or slow the increase of ambulance arrivals and attendances.

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?

Further improvements have been made to increase the proportion of patients having an initial assessment within 15 minutes. This could in part be due to the introduction of two new pathways introduced in our Emergency Departments in March 2026, and the additional focus on timeliness of processes at each point in patient pathways. There were also additional senior staff within the departments at the time of the launch.

Close monitoring of the new pathways continues to take place, and further refinement and improvements will emerge.

What is the expected impact?

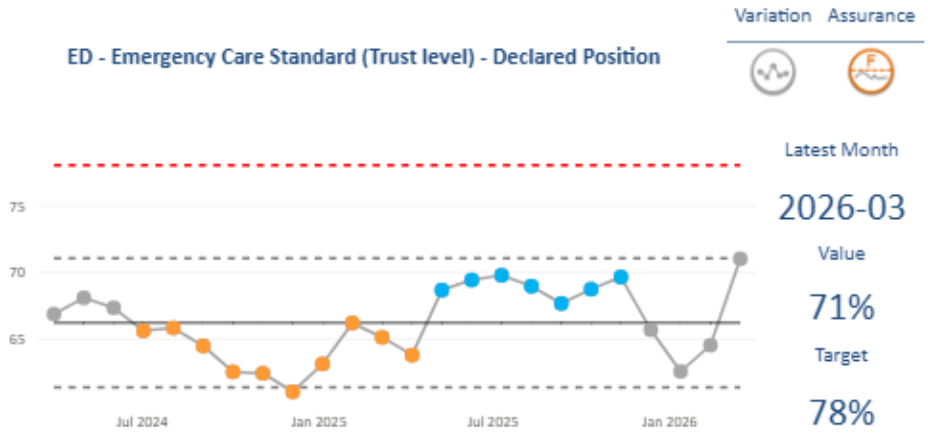
It is expected that multiple key metrics relating to our Emergency Departments hold improvements seen in March and potentially continue to improve as staff become more confident with the new ways of working and suggest further improvements.

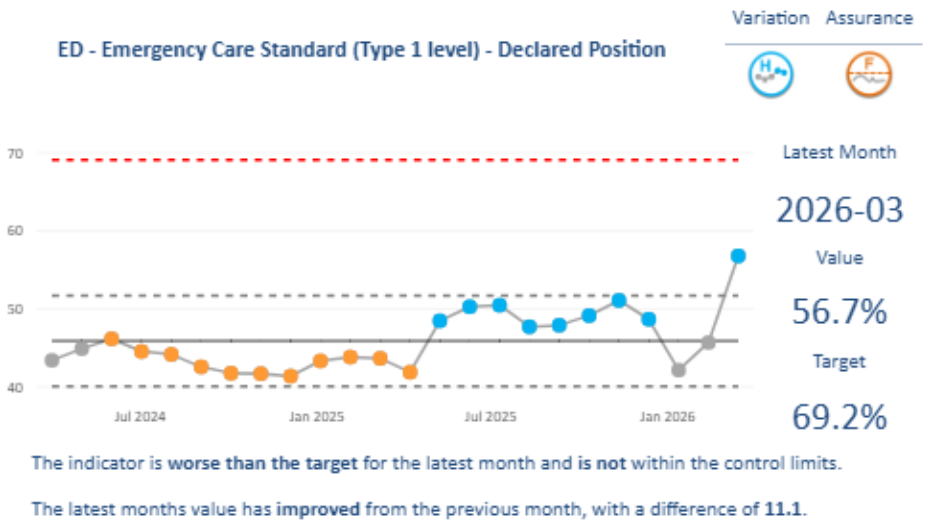
Potential risks to improvement?

- Risk of a small decline when additional attention and support reduces
- 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 acute sites implemented the first phase of the new acute model of care, which affects pathways in the Emergency Departments.

Extended Emergency Medicine Ambulatory Care (EEMAC) is the SDEC for ED. Emergency Assessment Unit (EAU) is for patients needing further assessment to determine whether an admission is required.

Daily calls took place to arrange implementation and monitor the launch; these are now weekly continuous improvement calls, open to all involved staff. They aim to give staff opportunities to feedback about how the change feels for them, and ideas for further refinement of the pathways. An after-action review is also taking place with support from the QI team, which aims to learn lessons about how we communicate changes and involve staff in them.

What is the expected impact?

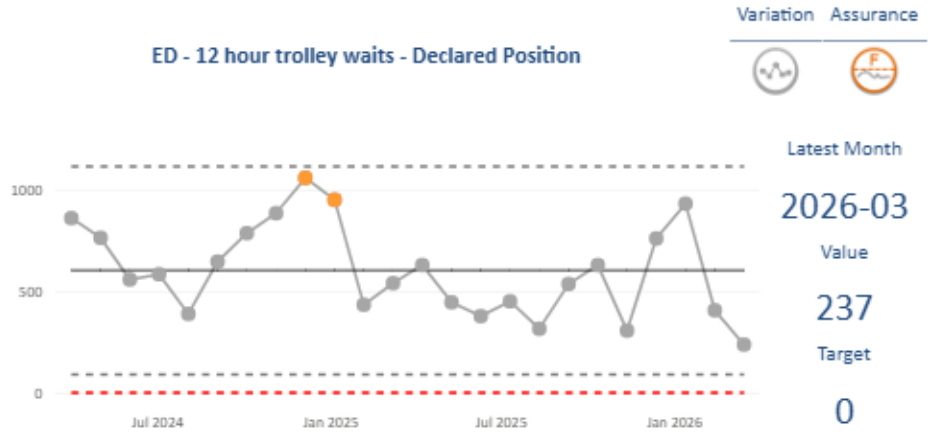
ECS performance was increased by approximately 7% in March. We expect performance to increase by circa 3% in April.

Potential risks to improvement?

- High attendance levels likely to continue based on recent trends
- Continuation of an increase in ambulance arrivals
- Financial constraints jeopardise the long-term workforce plan required to maximise the impact of the model.

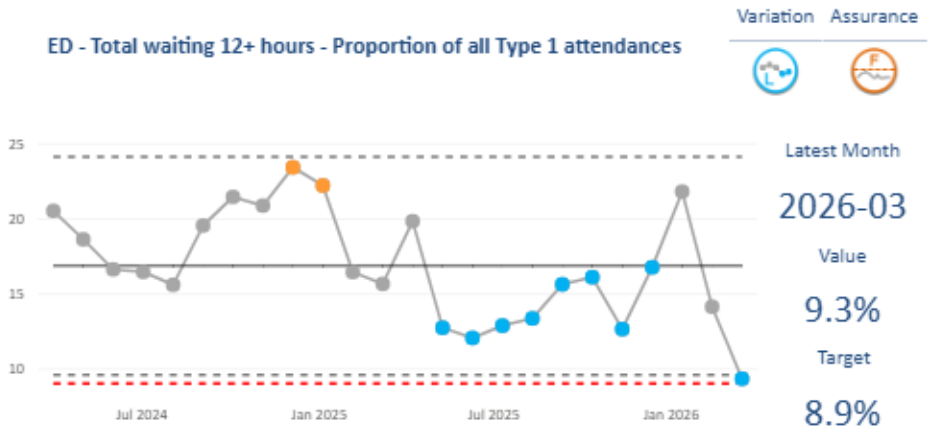
Executive Owner: Claire Hansen

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 **169.0**.



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

The latest months value has **improved** from the previous month, with a difference of **4.8**.

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 Emergency Assessment Unit (EAU) at each site has supported a reduction in patients spending over 12 hours in the Emergency Department (ED), particularly at the York site though Scarborough has seen improvement too. Medical patients awaiting admission are being managed in the Emergency Assessment Unit by Acute Physicians and receiving timely senior reviews.

What is the expected impact?

Both sites should see further reduction in 12hr breaches in April 2026, as the EAUs embed and are refined. This is an important step in managing our flow and working towards eradicating corridor care.

Potential risks to improvement?

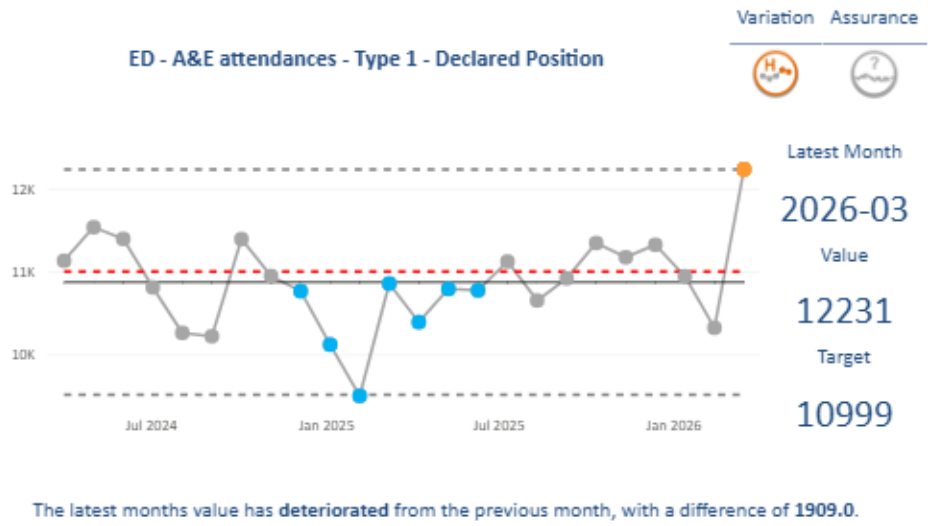
Bed occupancy levels remain high, and the capacity required on wards could be higher than escalation spaces can support.

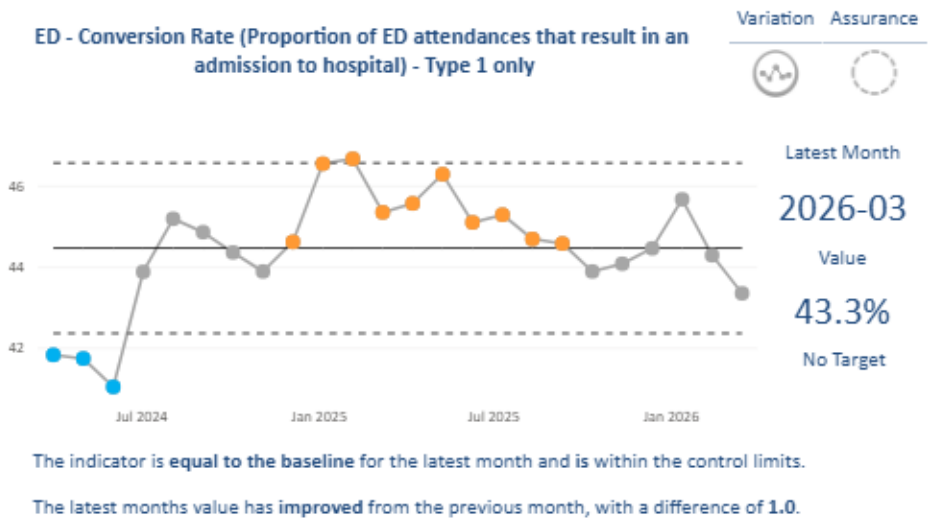
Community health and social care capacity remains challenged.

While the new model reduces patients waiting 12 hours in ED, some patients could be waiting for the same time in EAU which could quickly become full. To mitigate this, the situation is closely monitored on site calls and barriers to moving patients are being escalated and removed where possible.

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 and EAU. 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 has brought senior decision making closer to the front door and will support a reduction in the proportion of patients being admitted to the main bed base at both sites.

The team is working to ensure the second overnight middle grade doctor in the Scarborough ED is recurrently in place.

What is the expected impact?

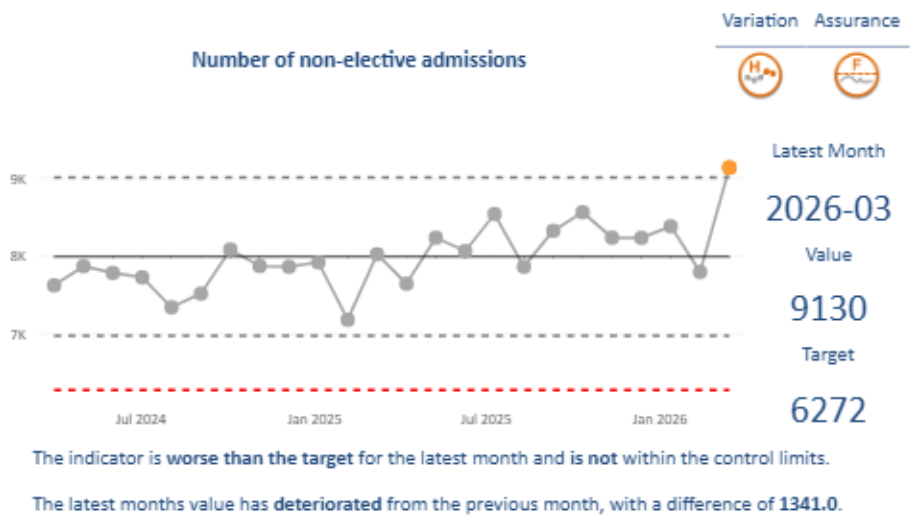
A reduction in direct specialty admissions but an increase in the use of SDEC admissions linked to the new EAU pathway.

Potential risks to improvement?

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.

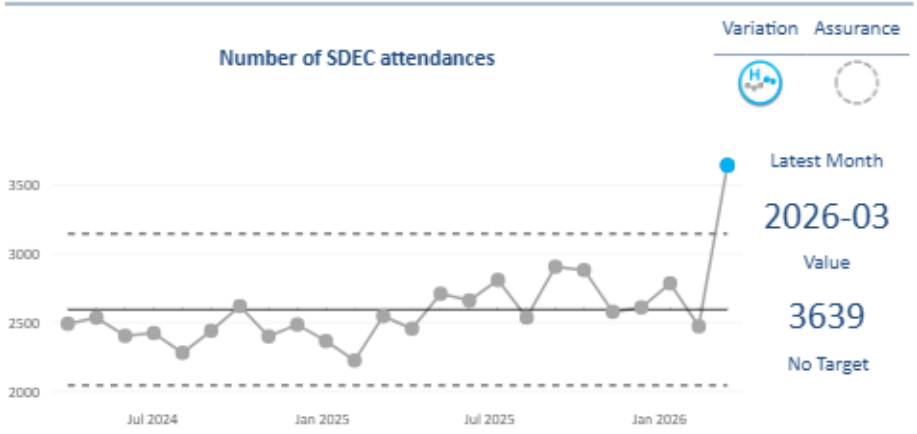
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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 **1341.0**.



The latest months value has **improved** from the previous month, with a difference of **1170.0**.

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

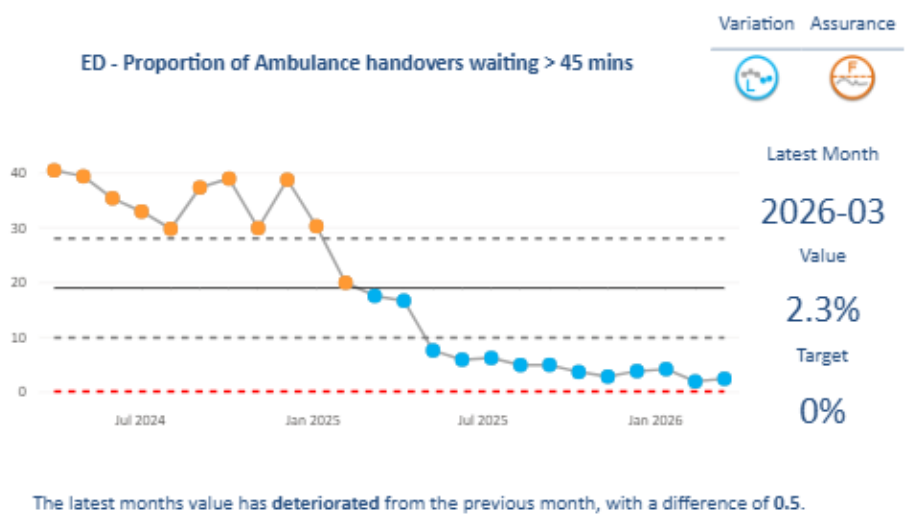
Note: The total admissions data includes admissions to all Same Day Emergency Care (SDEC) units. Work is underway to increase appropriate use of SDEC and reduce elective patients in SDEC, therefore changes in numbers may not be indicative of an issue.

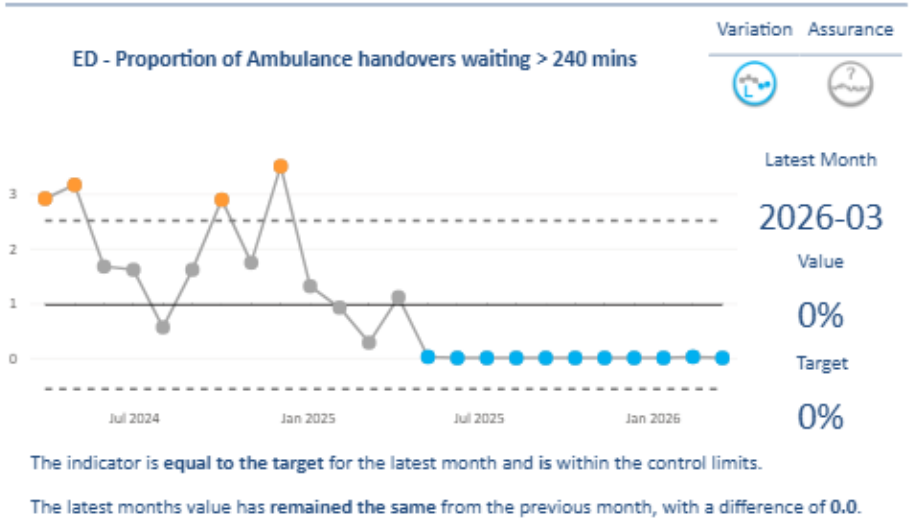
What actions are planned?

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?

EEMAC and EAU's function is designed to support overcrowding and moving patients to the right place with minimal delay. This should in turn support our ambulance handover improvements.

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?

Continually increasing number of ambulance attendances at both sites is causing congestion and risks delays to handover.

Acute Flow (3)
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Patients receiving clinical Post Take within 14 hours of admission	2026-03		F	79%		90%
Patients with Senior Review completed at 23:59	2026-03			46.4%		
Inpatients - Proportion of patients discharged before 5pm	2026-03		F	64.8%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2026-03	H		1624		
Inpatients - Proportion of intermediate care beds occupied by people with no criteria to reside	2026-03			26.6%		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2026-03	L	F	14.6%	12.5%	12.5%
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2026-03		?	4.5	3.9	3.9
Number of non-elective admissions	2026-03	H	F	9130	6272	6272
Number of zero day length of stay non-elective admitted patients	2026-03	H	?	3107	2464	2464
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2026-03			121		
Overnight general and acute beds open	2026-03		P	872	832	832
Of those overnight general and acute beds open, proportion occupied	2026-03		?	91.5%		92%
Community bed occupancy/availability	2026-03		?	88.4%		92%

KPIs – Operational Activity and Performance

Acute Flow (8)

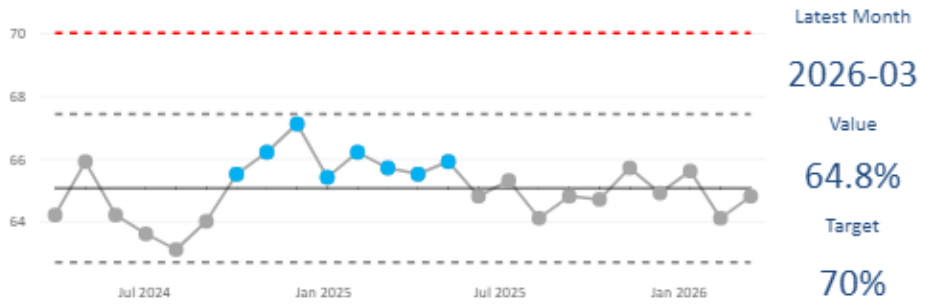
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

Inpatients - Proportion of patients discharged before 5pm



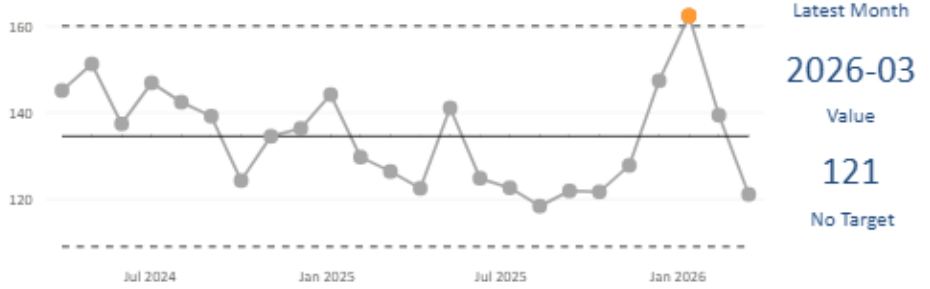
Latest Month
2026-03
Value
64.8%
Target
70%

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

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

Variation Assurance

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



Latest Month
2026-03
Value
121
No Target

The latest months value has **improved** from the previous month, with a difference of **18.3**.

Rationale: Understand flow in the acute bed base.

Target: SPC1: Internal target of 70%. **SPC2:** No target

What actions are planned?

- To improve quality of the Trusted Assessor Form (TAF), Describe not Prescribe and Discharge training is being refined to support better information on the TAF, including night needs/defensible recording and what constitutes 1:1. Training is being developed on Learning Hub where compliance will be monitored
- Discharge Readiness Form to go live 07/05 with Nervecentre which will support automation of required fields
- Ward staff, local authority, therapists, discharge hub staff reviewed complex patient complaint as a discharge learning event, potential to continue this practice going forward.

What is the expected impact?

- Improvement in the stranded percentage of occupancy.
- Improvement in the super stranded percentage pf occupancy.

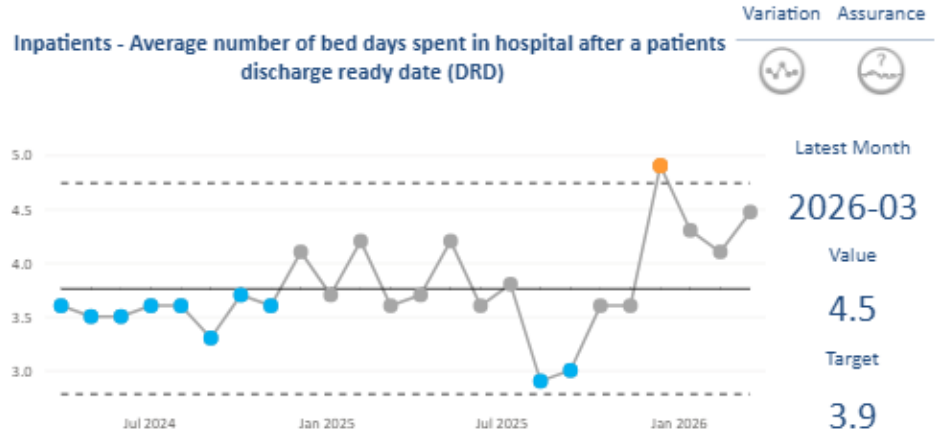
Potential risks to improvement?

- 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

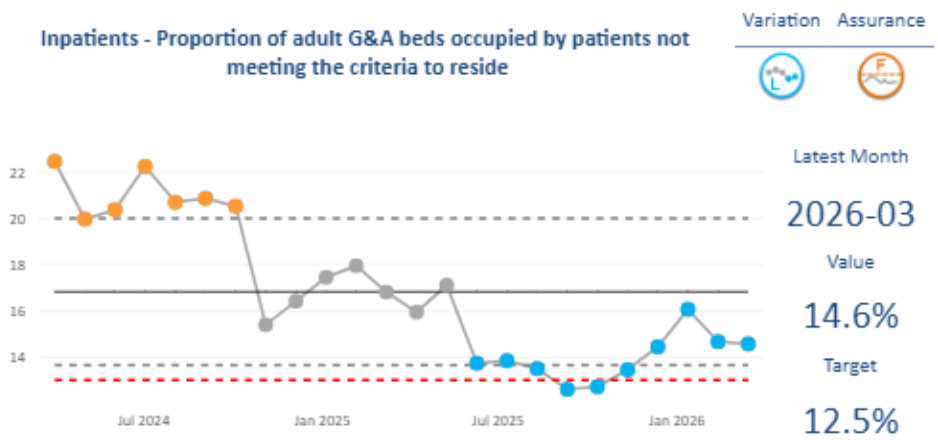
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)



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

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

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



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

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

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?

- Discharge Readiness Form to go live 7th of May with Nervecentre which will support automation of required fields
- A TAF-less transfer to Trust Inpatient Units has been trialed on Wards 35 for 7 weeks, the team is planning to extend the trial into Ward 39.
- 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 governance daily (weekdays).

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 - 62 Day First Definitive Treatment Standard - Declared Position * Cancer 31 day wait from diagnosis to first treatment - Declared Position	* Cancer - Faster Diagnosis Standard - Declared Position * Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result
SPECIAL CAUSE CONCERN			

CANCER
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Cancer - Faster Diagnosis Standard - Declared Position	2026-02		F	76.2%	79.3%	80.1%
Cancer - 62 Day First Definitive Treatment Standard - Declared Position	2026-02		?	70.7%	73%	75%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2026-03			142		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2026-03			6.2%		
Cancer 31 day wait from diagnosis to first treatment - Declared Position	2026-02		?	98%		96.1%
Total Cancer PTL size	2026-03			2180		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2026-03		F	75.3%	80.2%	80.2%

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

- The Cancer performance figures for February 2026 saw performance against the 28-day Faster Diagnosis standard (FDS) of 76.2% (up almost 16% from the January position of 60.4%), failing to achieve the monthly improvement trajectory of 79.3%. In the latest available national data (January 2026) the Trust ranked 111th out of 119 NHS providers nationally and 11th out of 11 against our Model Hospital peer group. **This is a True North Metric.** This does not reflect the February position and that this FDS position is the highest the Trust has achieved since the standard was introduced.

- 62 Day waits for first treatment service standard in February 2026 was 70.7% (up circa 8% from the January position of 62.8%), with the monthly trajectory of 73% not achieved. In the latest available national data (January 2026) the Trust ranked 73rd out of 119 providers nationally and 5th out of 11 against our Model Hospital peer group. This 62 day position is the highest the Trust has achieved in 12 months.

- Executive and Resource Committee sighted on cancer service standards and recovery actions, with a detailed cancer progress report taken to Resources Committee in February 2026. NHSE, ICB, Cancer Alliance and CAP have been sighted on Q4 recovery actions at tumour site level via Cancer and Diagnostic Tiering meetings. Provisional March data outlines that the service improvements achieved in February 2026 have continued to improve in March 2026.

Factors impacting performance:

- The following cancer sites exceeded 80% FDS in February 2026: Breast & None Site Specific. Gynaecology achieved above their internal trajectories.
- The following cancer sites exceeded 75% 62-day service standard in February 2026: Breast, Haematology & Skin. Haematology, Skin & Urology achieved over internal trajectories.
- 31-day treatment standard was 98% overall, which achieved the national service standard of 96%.
- At the end of February, the proportion of patients waiting over 104+ days equates to 2.3% of the PTL size with 50 patients, this position is fairly static between 2% and 2.6% over the last 6 months. 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 62% of this patient cohort, an improvement on January position where this accounted for 69% 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. The cancer alliance have been tasked with leading ongoing system work, including the appointment of a new Lower GI system clinical lead. Data has been provided to the alliance GP lead for targeted sessions with practices and additional prompts have been added to Gateway referral form. Process for rejecting referrals where NICE guidance states should be provided has been agreed, discussed in February 26 Colorectal Surgical Cancer Time Out session and implemented.
- 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, however this doesn't determine the quality of the image received.

Actions:

- Please see following pages for details.

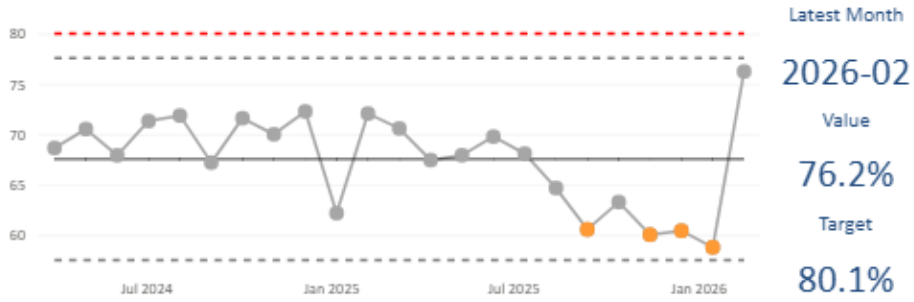
Executive Owner: Claire Hansen

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.

Variation Assurance

Cancer - Faster Diagnosis Standard - Declared Position

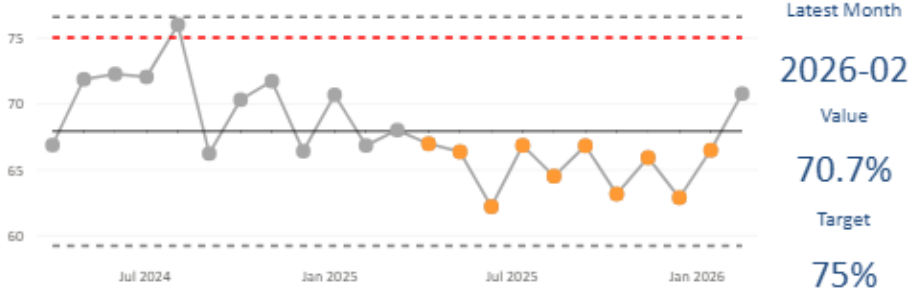


The indicator is **worse than the target** for the latest month and is within the control limits.

The latest months value has **improved** from the previous month, with a difference of **17.4**.

Variation Assurance

Cancer - 62 Day First Definitive Treatment Standard - Declared Position



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 **4.3**.

What actions are planned?

Colorectal Plan

Internal trajectory of 62%. Additional fast track clinics provided by senior consultant, leading to highest ever FDS achieved for tumour site (61.3%). Colorectal cancer lead resignation, working through plans for recruitment of new lead, associate medical director for cancer providing support. Implemented returning referrals with no FIT to primary care.

Urology Plan

Internal Trajectory of 57%. Highest ever FDS achieved at 66.3%, with 80.5% patients seen within 2 weeks. STT CT model in haematuria commenced implementation. WLI plans and insourcing to provide capacity in February- March for additional consultant.
Ongoing discussions for implementing standardised discharge post Likert score and scope and consult model for TP biopsy, with target start date of April 26 (delayed from March), however workforce rota changes required alongside clinical governance review and support.

Gynaecology Plan

Internal 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 trajectory of 75%. 94% practices signed up with ICB LES, some require equipment (scopes) will be ordered by end of April. 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.
There is an ongoing risk around team resilience and consultant availability, but two skin cancer consultants have been recruited.
Scoping for community models pre-LES expiry in December 2026.

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

Headlines (Provisional performance):

- **Please note: RTT figures for March 2026 are provisional, following a decision by NHSE national RTT performance will not be finalised until the 28th of April.**
- At the end of March 2026, the Trust had zero **Referral To Treatment (RTT) patients waiting over sixty-five weeks**.
- The Trust's **RTT Total Waiting list position** ended March 2026 behind the trajectory submitted to NHSE as part of the 2025/26 planning submission: 55,589 against the trajectory of 38,992.
- The Trust was behind the trajectory for the proportion of the **patients on an RTT waiting list under 18 weeks** at the end of March: 56.4% against 60.5%. In the latest available national data (January 2026) the Trust ranked 107th worst out of 118 NHS providers and equal 8th worst out of 11 in our Model Hospital peer group. **This is a True North Metric.**
- The Trust is behind the **RTT52 week** trajectories submitted within the 2025/26 planning submission; 1,088 waiters and 2.0% of the total RTT Total Waiting list against the trajectories of 389 and 1%, respectively. In the latest available national data (January 2026) the Trust is ranked 88th worst out of 118 NHS providers and equal 7th worst out of 11 in our Model Hospital peer group for the proportion of the TWL waiting over 52 weeks. Nationally at the end of January 2026 there were 6,722,905 patients on the national TWL, of which 130,997 (2%) were waiting over 52 weeks. By March 2026, the national ambition was 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 was behind the trajectory submitted to NHSE as part of the 2025/26 planning submission with performance of 61.2% against the end of March 2026 ambition to be above 67.1%. 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 during 2025/26 and the update to CPD logic which resulted in additional RTT clocks being opened since April 2025. The increase in referrals from primary care contributed to the RTT TWL increase (up 5% in 2025/26 compared to 2024/25). Direct Cancer GP referrals (not including upgrades, incidental findings etc.) are up 11% YTD with eleven of the twelve 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 March 2026 the Trust was ahead of the 2025/26 plan with a provisional performance of 104% against the funded (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 - Waits over 52 weeks for Incomplete Pathways - Declared Position * RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Declared Position
COMMON CAUSE / NATURAL VARIATION			* 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	2026-03	H	F	55589	38992	38992
RTT - Waits over 78 weeks for incomplete pathways - Declared Position	2026-03	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways - Declared Position	2026-03	L	F	0	0	0
RTT - Waits over 52 weeks for Incomplete Pathways - Declared Position	2026-03	L	F	1088	389	389
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Declared Position	2026-03		F	56.4%	60.5%	60.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2026-03			17.7		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Declared Position	2026-03	L	F	2%	1%	1%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-03		F	61%	67.1%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2026-03	H		2%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2026-03			12.4%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2026-03	H		68.4%		

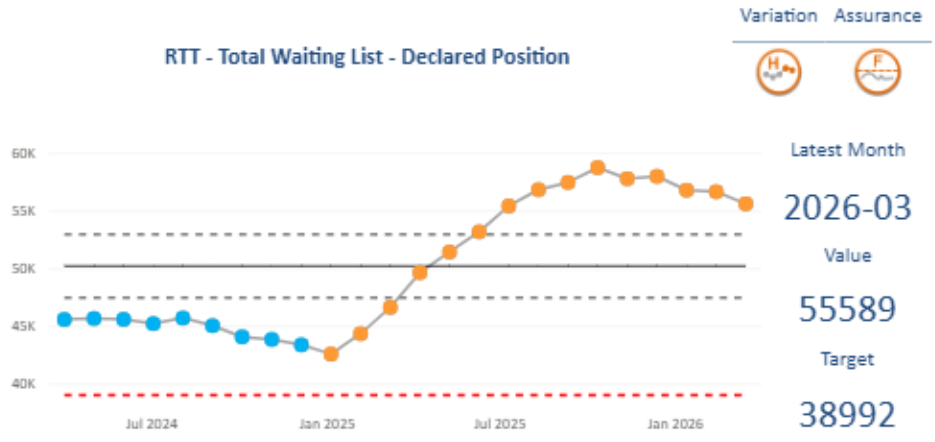
KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

York and Scarborough Teaching Hospitals NHS Foundation Trust

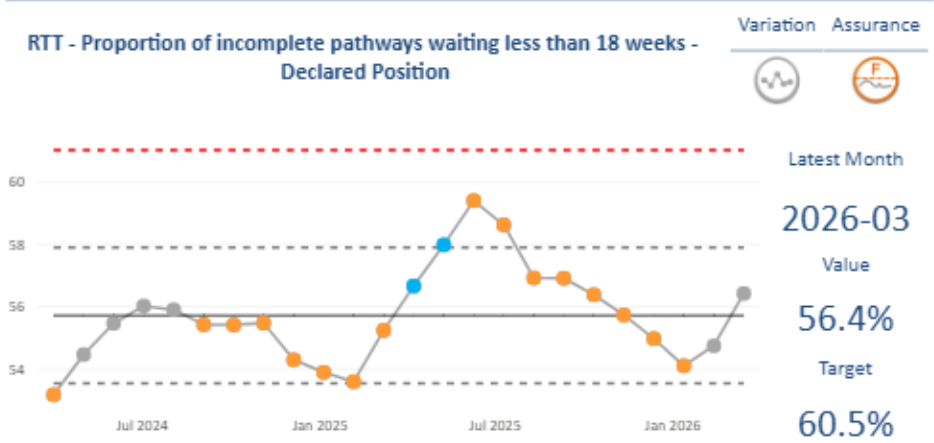
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **improved** from the previous month, with a difference of **1052.0**.



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 **1.7**.

Rationale: SPC1: To measure the size of the Referral to Treatment (RTT) incomplete pathways waiting list. **SPC2:** To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.

Target: SPC1: Aim to have less than 38,992 patients waiting by March 2026 as per activity plan. **SPC2:** National constitutional target of 92% of patients should be waiting less than 18 weeks. Target for March 2026 is to be above 60.5%. **This is a True North Metric.**

What actions are planned?

- Fortnightly meetings in place from start of April 2026 with Care Groups to review activity and performance delivery at specialty level, proactive identification of issues to allow material mitigations to be made in month.
- Intensive support programme for cardiology, respiratory and gastroenterology commenced in 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.
- Focused regular BAU discussions to identify action to improve scheduling discipline and chronological booking ongoing with care groups and outpatient services.
- 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 waits.
- 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 in 2025/26 compared to 2024/25 (up 5%, circa 7k additional referrals). 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)

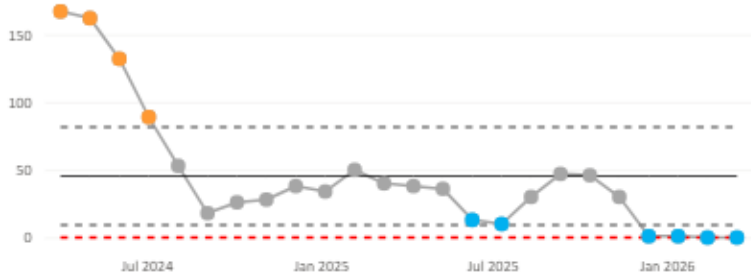
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

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

Variation Assurance



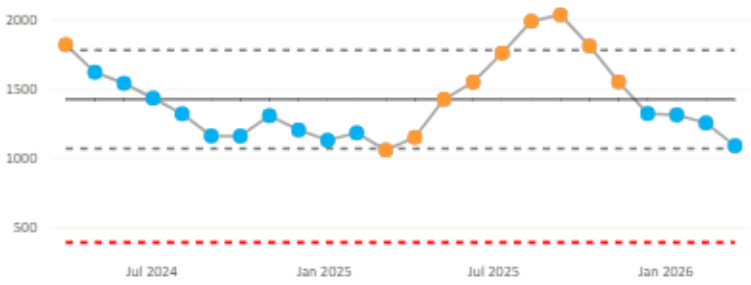
Latest Month
2026-03
Value
0
Target
0

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

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

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

Variation Assurance



Latest Month
2026-03
Value
1088
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 **165.0**.

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 the month with weekly trajectory in place. Scope of weekly meeting to be expanded by end of April 2026 to monitor full pathway metrics rather than focus on longest waiters. Maintaining zero RTT65 week waits remains a priority.
- Discussion with NHSE focused on validation approach and opportunities to be explored for clinical validation.
- Fortnightly meetings with Care Groups to review in month performance against activity and performance targets.
- Refreshed diagnostic escalation process in place to support delivery of 52weeks and move away from 65 weeks.

What is the expected impact?

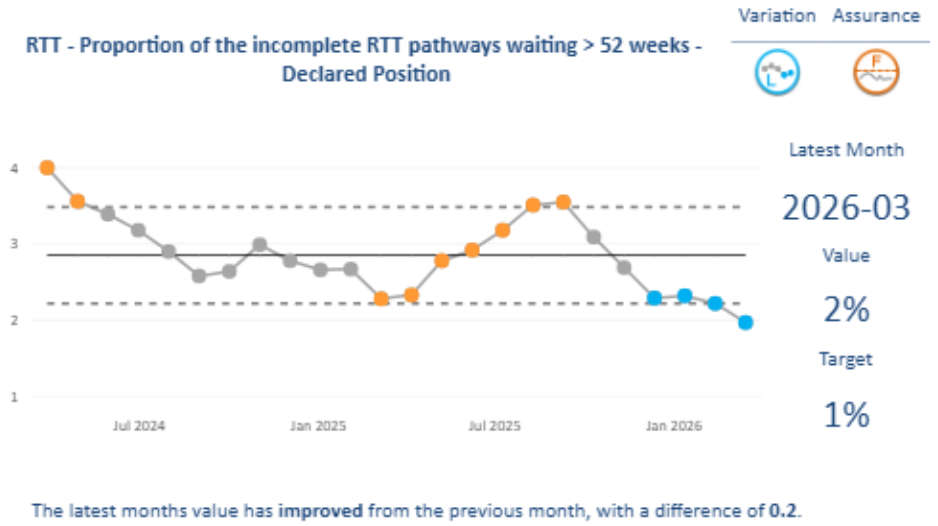
- Reduced RTT long waiters.
- ERF money targeted at specialties most in need.

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 will 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 March 2026, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 5% with performance of 4.5%. Y&S has three specialties in the upper quartile of Trusts within the NE&Y region (Clinical Haematology, Physiotherapy and Rheumatology).

- Rapid Access Chest Pain (RACP) seen within 14 days was at 78% (February: 83%) 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). Further internal opportunities identified to delivery productivity in plan.

- The Trust's DNA rate was unchanged at 4.4% in March 2026, the joint 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.

Actions:

- Please see following pages for details.

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Outpatients: 1st Attendances (Activity vs Plan)	* Outpatients - Proportion of appointments delivered virtually (S017a) * Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU) * Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)
COMMON CAUSE / NATURAL VARIATION	* Proportion of elective admissions which are day case	* Outpatients - DNA rates * Outpatients: Follow Up Attendances (Activity vs Plan) * All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days* * Day Cases (based on Activity v Plan) * Electives (based on Activity v Plan)	* Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)
SPECIAL CAUSE CONCERN			

Outpatients & Elective Care
Scorecard

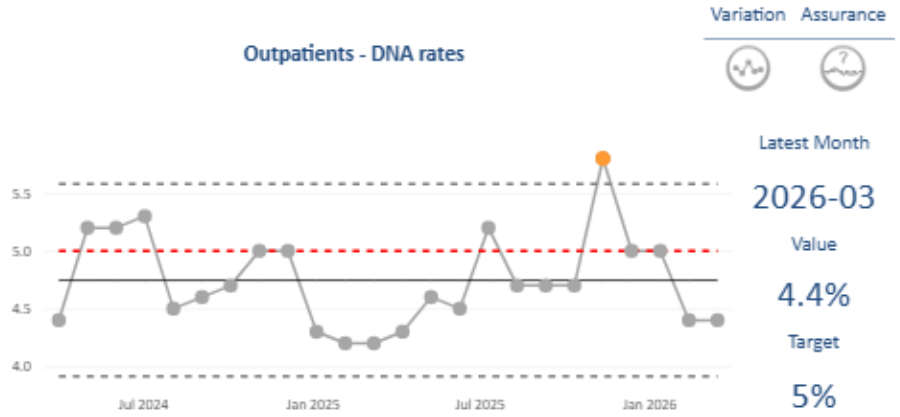
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Outpatients - Proportion of appointments delivered virtually (S017a)	2026-03	H	F	23.3%		25%
Outpatients - DNA rates	2026-03		?	4.4%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2026-03	H	?	23443	17494	17494
Outpatients: Follow Up Attendances (Activity vs Plan)	2026-03		?	47046	38846	38846
Outpatient procedures	2026-03			16422		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2026-03		F	26964		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2026-03	H	F	4.5%	5%	5%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2026-03	H	F	78%		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*	2026-03		?	11		0
Day Cases (based on Activity v Plan)	2026-03		?	8421	8144	8144
Electives (based on Activity v Plan)	2026-03		?	746	816	816
Proportion of elective admissions which are day case	2026-03		P	91.9%		85%
Outpatients: All Referral Types	2026-03			26571		
Outpatients: Consultant to Consultant Referrals	2026-03			2727		
Outpatients: GP Referrals	2026-03			11186		

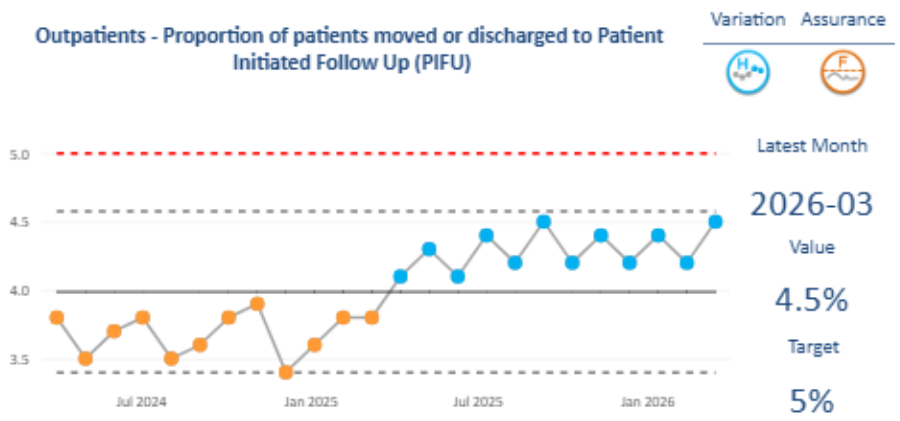
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

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



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

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

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

What actions are planned?

- PIFU is a key project in the productivity improvement programme in 2026/27. A PIFU rate of 6.6% by March 2027 was included in the submitted plan. Specialties identified for rapid improvement work using the GIRFT pathways for implementation. These are Cardiology, Dermatology, ENT, Gynaecology, Neurology, Respiratory medicine, Trauma and orthopaedics)

- GIRFT clinic template standards audit completed, with opportunities in a couple of specialties identified. Specialties have amended templates to reflect improvements, with further actions identified. Service reviews will continue in Q1 with endocrinology planned next.

What is the expected impact?

- PIFU improvement to 6.6% (March 2027).

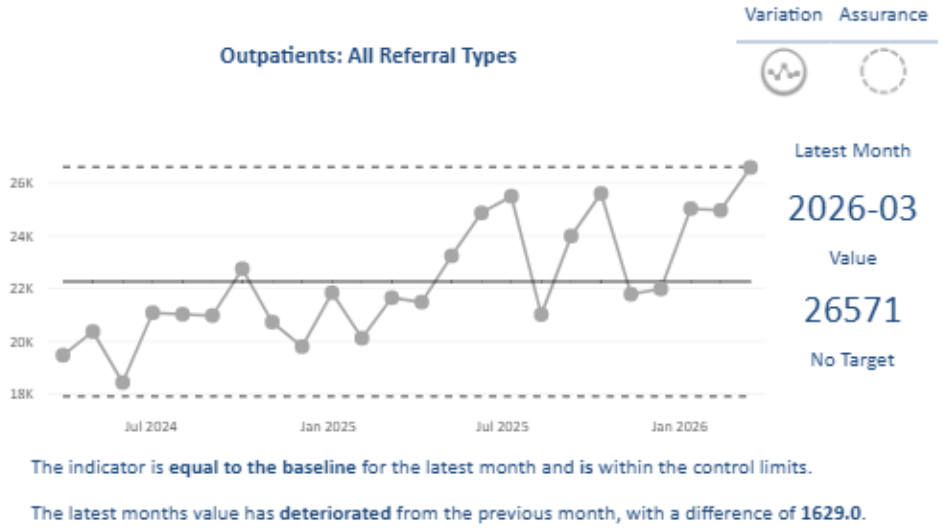
- Delivery of 1st Outpatient plan and reduction in new to follow up ratios.

Potential risks to improvement?

- **PIFU** at Scarborough is significantly lower than York (March 2026: 1.9% at SGH/5.4% at York). This difference is influenced by MSK catt service at York. The service at York are highest users of PIFU (25% which is circa 800 patients a month which is almost a third of all the patients added to PIFU at York). This service does not exist at Scarborough. AHP service overall at York appear to have higher PIFU proportions at York as well as ENT and Dermatology

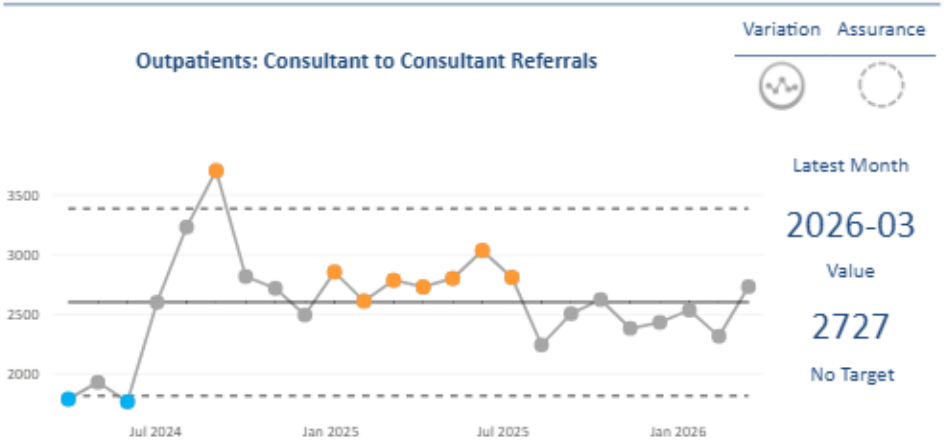
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **deteriorated** from the previous month, with a difference of **1629.0**.



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

The latest months value has **deteriorated** from the previous month, with a difference of **415.0**.

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 (compared to 2025/26).
- ICB undertaking review of GP referrals to identify outlying practices for further discussion and education.
- Single point of access/advice and guidance proposal to be presented at Executive Committee in May. Plan required to deliver in 10 specialties by October 2026 in line with NHSE roadmap. The Trust currently has 4 specialties with single point of access via gateway (REI); Clinical Haematology, Dermatology, Rheumatology and Neurology.

What is the expected impact?

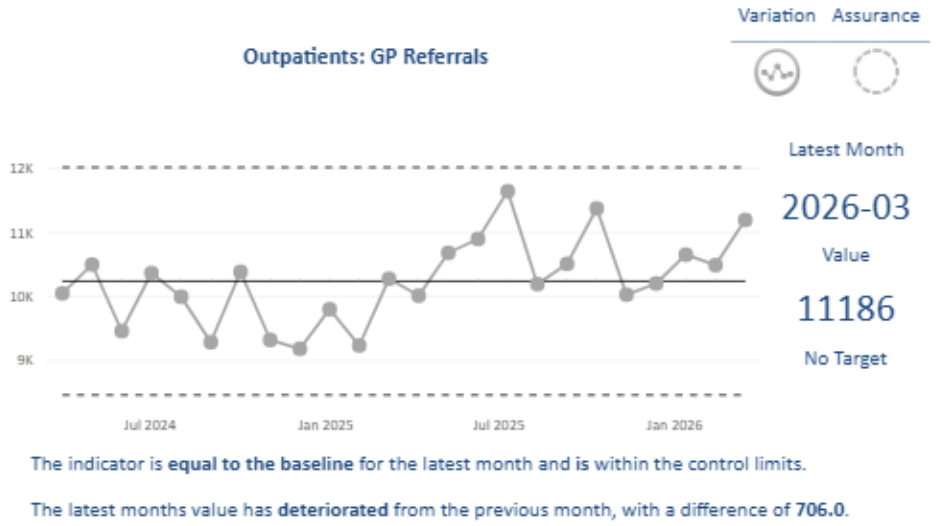
- Reduction in internal demand and reduction in open referrals**.**
- Reduction in GP demand.
- Improved redirection of referral direct to test or to other services to reduce requirement for outpatient attendances.

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 **deteriorated** from the previous month, with a difference of **706.0**.

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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 March 2026 was 77% against the planned trajectory of 82.7%.
- There is continued improvement in the number of patients over 13 weeks, but a slight increase to patients over 6 weeks as well as total waiting list. This is in line with expectations due to additional ERF activity in Q4 leading to a high rate of conversion to diagnostics, and the prioritisation of cancer waits which will fall into 0-5 weeks.
- In the latest available national data (January 2026) the Trust ranked 82nd worst out of 118 NHS providers and 8th worst out of 11 in our Model Hospital peer group.

Factors impacting performance:

- Significant increase in elective demand across multiple modalities following additional activity in Q4 to support RTT and Cancer position.
- Further delay in opening of Scarborough CDC.
- Delay in installation dates for new equipment in both MRI and CT. Ongoing intermittent equipment breakdown impacts on ability to deliver planned activity.
- Workforce challenges in multiple modalities due to staff shortages caused by vacancies, sickness, and maternity leave. Recruitment is challenging in many areas, particularly imaging and physiological modalities, due to a national shortage of trained staff.
- National field safety notice for DEXA scans remains in place meaning there is a cohort of patients with implantable devices who cannot currently be scanned on our equipment. In discussion with independent sector to take these patients.
- Delays in procurement of additional Audiology booths to allow extra clinical space to deliver activity. These have now been delivered and we are working towards implementation by end April 2026.
- 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 early Q4.
- Two full time Endoscopy admin vacancies combined with ongoing recovery following significant staff sickness in early Q4 has led to challenges in operational management and clinic booking, OT and bank offered out to support but limited uptake.
- MRI insourcing has delivered significant improvement using this additional capacity. Additional paediatric GA lists for MRI have been carried out which has substantially reduced the backlog for this cohort.
- Bank registrar in NOUS has cleared all of the soft tissue backlog which has had positive impact on NOUS performance. Now looking to focus this resource on injections.
- Workforce and clinical space constraints have impacted ability to deliver echo lists.
- Sleep studies has been challenged due to a large number of broken apnoea links, currently being assessed for repair or replacement.
- Cystoscopy performance has been impacted in recent months by the prioritisation of the Haematuria pathway as the additional Friday Malton list has been stood down to accommodate. This is in the process of being reinstated so it is hoped that we will see a positive impact in Cystoscopy performance by end Q1 2026/27.
- Additional UDS lists in February led to improved performance as backlog began to be cleared although this has deteriorated again slightly in March. We continue to scope further additional lists however there is limited staff uptake.
- Additional recruitment and training underway which will have long term impact once staff are fully qualified (radiographers, sonographers, audiologists, echocardiographers).

Summary MATRIX

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound * 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 - Urodynamics * Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy * Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy
COMMON CAUSE / NATURAL VARIATION		* Diagnostics - Proportion of patients waiting <6 weeks from referral - CT * Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema * 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 - Audiology * Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography * Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy
SPECIAL CAUSE CONCERN			

DIAGNOSTICS – National Target: 95%

Scorecard

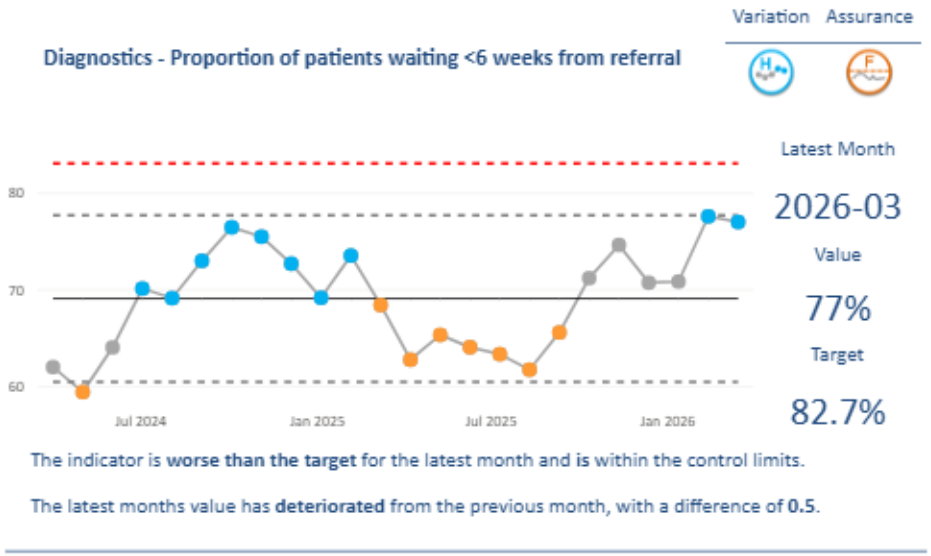
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Diagnostics - Proportion of patients waiting <6 weeks from referral	2026-03	H	F	77%	82.7%	82.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2026-03	H	F	89%	90%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2026-03		?	59.9%	78%	78%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2026-03	H	?	85.5%	75%	75%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2026-03		?	84.9%	90.1%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2026-03	H	?	76.5%	67.9%	67.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2026-03		F	66%	94.7%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2026-03		F	57.6%	95.8%	95.8%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2026-03		?	99.4%	95.2%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2026-03		?	81.4%	94.6%	94.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2026-03	H	F	72.3%	95.3%	95.3%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2026-03	H	F	90.5%	90%	90%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2026-03	H	F	85.3%	95.1%	95.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2026-03		?	70.5%	94.5%	94.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2026-03		F	86%	90%	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 to ensure all DM01 rules are being correctly applied and patients booked appropriately has been cascaded down to admin team as part of business as usual. Nurse vacancies out to advert to recruit substantive staff and remove the need for insourcing. 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 paediatric MRI GA lists have substantially reduced the backlog for this cohort and reduced longest wait significantly. MRI radiographer insourcing continues to mitigate capacity lost to vacancies at York. NOUS bank registrar has cleared the soft tissue backlog and will now begin to focus on injections. CT3 replacement awaited, delayed until circa Autumn 2026. MRI4 installation awaited, delayed until at least Q2 2026/27. In discussion with independent sector to take long wait DEXA patients unable to be completed on Trust equipment due to field safety notice.

Physiological:

Echocardiography: Two substantive staff returning to work in Q1 which will help to sustain capacity following the end of ERF funded insourcing. Validation of long waiters to identify any forward planned patients who should reflect as not yet due.

Audiology: 4 x pop-up booths (two York, one Malton and one Brid) to deliver additional audiology capacity planned to be in place by end of April 2026. Contracts for current locum colleagues at 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 (Ages 0-16)
COMMON CAUSE / NATURAL VARIATION		* Children & Young Persons: ED - Patients waiting over 12 hours in department	* Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks * Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways
SPECIAL CAUSE CONCERN			* Children & Young Persons: RTT - Total Waiting List

Children & Young Persons
Scorecard

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi (Acute)/Kim Hinton (Elective)

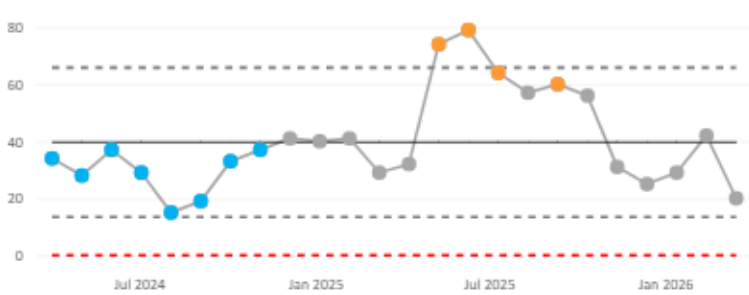
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2026-03			0		0
Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Ages 0-16)	2026-03			86.9%		95%
Children & Young Persons: ED Attendances - Type 1 only (Ages 0-16)	2026-03			1921		
Children & Young Persons: RTT - Total Waiting List	2026-03			4211	3206	3206
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2026-03			64.2%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2026-03			20	0	0

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton/Abolfazl Abdi

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

Variation Assurance



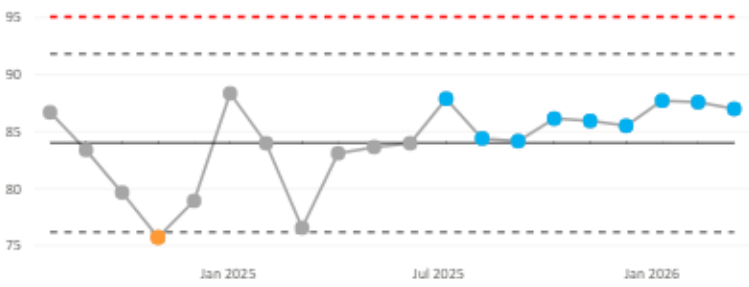
Latest Month
2026-03
Value
20
Target
0

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 **22.0**.

Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Ages 0-16)

Variation Assurance



Latest Month
2026-03
Value
86.9%
Target
95%

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

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

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. Zero RTT40 week waits by the end of Q4 2025/26 except ENT and Oral Surgery was not delivered, Care Groups have refocused on delivering by the end of Q1.

- ENT and Oral Surgery are planning to deliver zero RTT52 week waiters by the end of May 2026.

SPC2:

- Latest performance data continues to show 4-hour performance for CYP. April 2026, month to date performance is 93.03%.

- 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 from 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).

Potential risks to improvement?

- Impact of treating potential 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

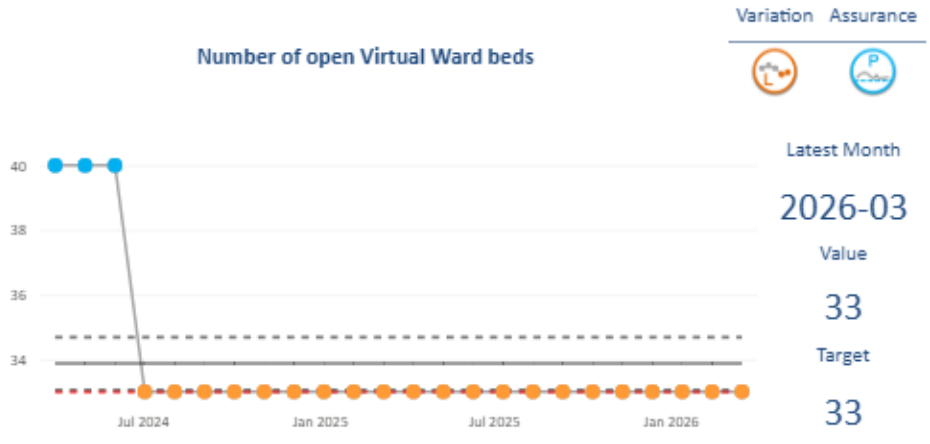
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-03			33	33	33
Proportion of Virtual Ward beds occupied	2026-03			57.6%	79%	79%
Community Response Team (CRT) Referrals	2026-03			580		
Total Urgent Community Response (UCR) referrals	2026-03			541	566	566
2-hour Urgent Community Response (UCR) care Referrals	2026-03			216		
2-hour Urgent Community Response (UCR) Compliancy %	2026-03			72%		
Number of Adults (18+ years) on community waiting lists per system	2026-03			692		
Number of CYP (0-17 years) on community waiting lists per system	2026-03			1590		
Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less as a proportion of the entire waiting list	2026-03			59%		
Percentage of people on waiting lists for Adult Community Services per system who are waiting 18 weeks or less as proportion of entire Adult waiting list	2026-03			100%		
Percentage of people on waiting lists for Children's Community Services per system who are waiting 18 weeks or less as proportion of entire Children's waiting list	2026-03			41%		
Number of District Nursing Contacts	2026-03			22278		
Number of Selby CRT Contacts	2026-03			2509		
Number of York CRT Contacts	2026-03			3108		
Referrals to District Nursing Team	2026-03			2185		
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2026-03			567	0	0

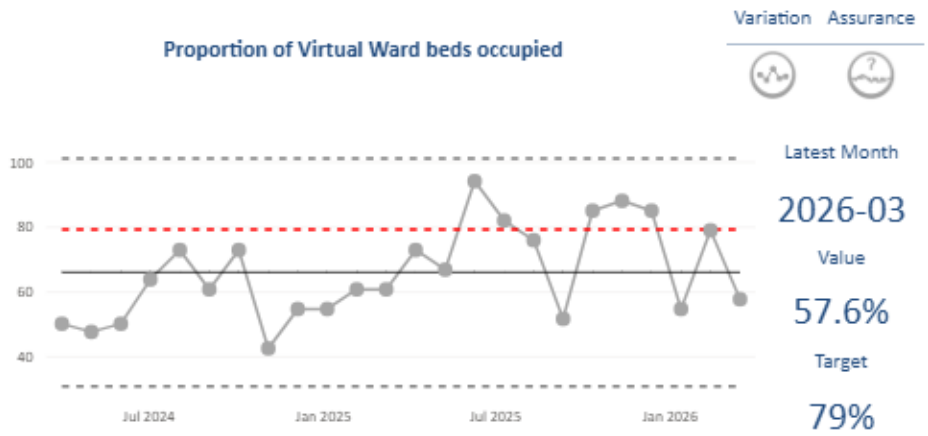
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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**.



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 **21.2**.

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?

Frailty VW – 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 and worked well. Aim to test this pathway for Nelsons court. Skills mix work for workforce underway due to a resident doctor rotations.

Selby H@H service, in combination with Selby UCR Trust grade medic, successfully tested but not sustainable with one resident doctor. No additional funding from ICB made available for band 7 nurse so due to current financial position, Selby H@H test is now paused. Selby IUCR continues with Selby CRT.

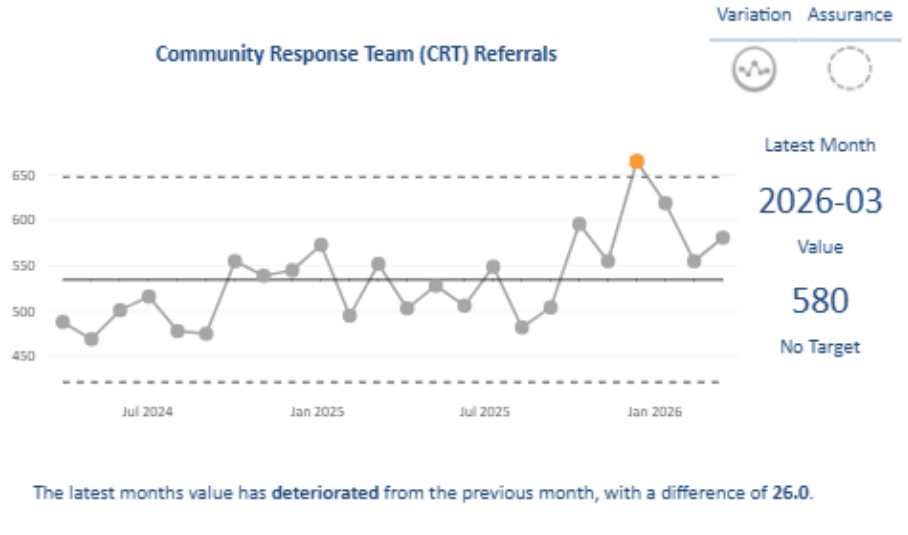
Heart Failure Virtual Ward (HFVW) – Admission avoidance pathway for HF in place at York and working well. Service model expanded to now include early support discharge for HF patients Evaluation planned for March 2026. Pathways out of hospital are IV diuretic for ambulatory patients and partnership working for non-ambulatory frail older patients with H@H team. This service remains non-compliant with VW operating framework due to lack of daily routine consultant cover and no weekend working other than shared care for some patients with the H@H service. This risk is mitigated through an admission criteria which is consistent with the current operational service. Access to a consultant is available on an ad hoc basis.

Potential risks to improvement?

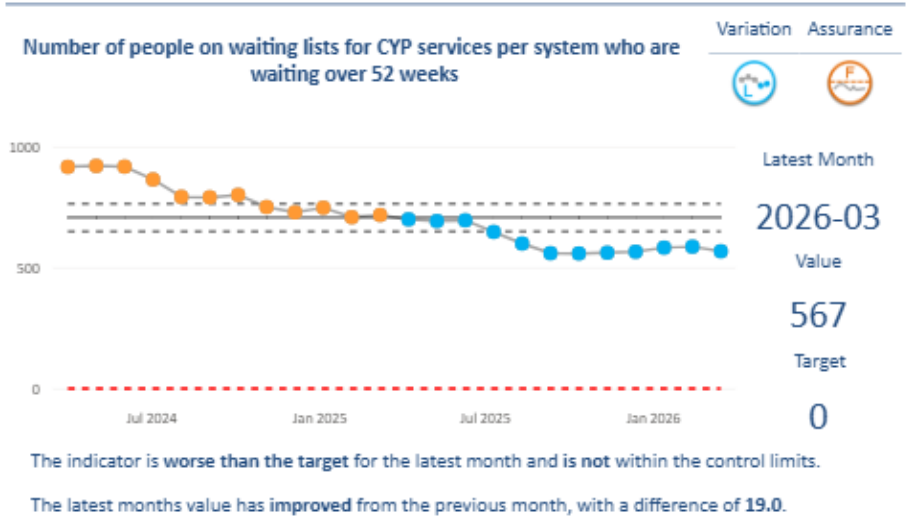
- There remains no H@H service for SHAR or Selby.
- Funding for additional senior nurse to establish a 5 bedded Selby H@H service not available.
- Missed opportunity to improve the Heart Failure Virtual Ward Service and associated compliance without further investment as noted in the GIRFT review in 2025.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi/Kim Hinton



The latest months value has **deteriorated** from the previous month, with a difference of **26.0**.



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

The latest months value has **improved** from the previous month, with a difference of **19.0**.

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. Workforce challenges remain with high sickness actively managed. Data reporting issues have been identified with the UCR 70% target, work has been undertaken to understand the difference and reporting has now been adjusted. Additional validation work has been undertaken for March and data quality themes have been identified and action underway to improve.

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

April 2026

Executive Owner: Karen Stone and Tara Filby

Highlights: IPC

- Clostridioides difficile - Despite a month of increased cases the Trust is 15 cases **under** the annual objective and 26 cases **less** than the previous year. Q3 National Oversight Framework metric 1, rank 1/134.
- Methicillin-Sensitive Staphylococcus aureus bacteraemia – The Trust is 1 case **below** the annual objective and 11 cases **less** than the previous year. Therefore, the internal target of a 5% reduction in cases has been met, achieving a 12% reduction on the 2024/25 year end output.
- IPC training packages have been reviewed for delivery in 2026/27

Concerns / Risks :

- Methicillin-Resistant Staphylococcus aureus bacteraemia annual objective breached with 7 cases to the end of March 2025 against a zero tolerance. Q3 National Oversight Framework metric 3.60 per 100,000 bed days, a deteriorated position since Q2. This is 2 cases **more** than the previous year.
- E.coli bacteraemia - The Trust is 13 cases **over** the annual objective. Q3 National Oversight Framework metric is 2.36 per 100,000 bed days, a slight improvement on the Q2 position. The Trust finished the year with 13 cases **less** than the previous year.
- Klebsiella bacteraemia - The Trust is 29 cases **over** the annual objective and 26 **more** cases than the previous year
- Pseudomonas bacteraemia - The Trust is 16 cases **over** the annual objective and 6 cases **more** than the previous year.

Next Steps:

- Clinical review of E.coli Bacteraemia and Klebsiella Bacteraemia cases to determine themes has commenced with support of Microbiology Registrars.
- The IPC improvement plan is being refreshed for 2026/27 in recognition of the further stretch improvements required.
- The IPC Hierarchy of Control Audits for all in-patient wards is commencing in April 2026

Highlights: Pressure ulcers

- In March, 67 Category 2 pressure ulcers were reported, representing an improvement from the previous month's total of 71. However, performance remained above the monthly target of 60.
- Monthly rate of pressure ulcers (all categories) is 4.2 per 1000 bed days, against a year end target of 4.0.

Concerns/Risks:

- The main hotspots identified this month were Elderly Chestnut ward (5 cases) respiratory ward 34 (5 cases) Elderly ward 35 (7 cases) District Nurse Team (11 cases)
- The rate of mattress failure due to cell twisting has increased, impacting equipment reliability and requiring targeted corrective action.

Next Steps:

- Funding application submitted to charitable funds to support the purchase of high-risk bedside chairs.
- Agreement established with mattress supplier to install retro fits to all mattresses across Q1 and Q2.
- Chairs with inbuilt pressure redistribution, initially procured for winter wards, have been redistributed to medical and elderly care wards based on identified risk.
- Presentation delivered at the leadership forum to senior Allied Health Professionals, focusing on seating, positioning, and patient experience in relation to pressure ulcer development.

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)

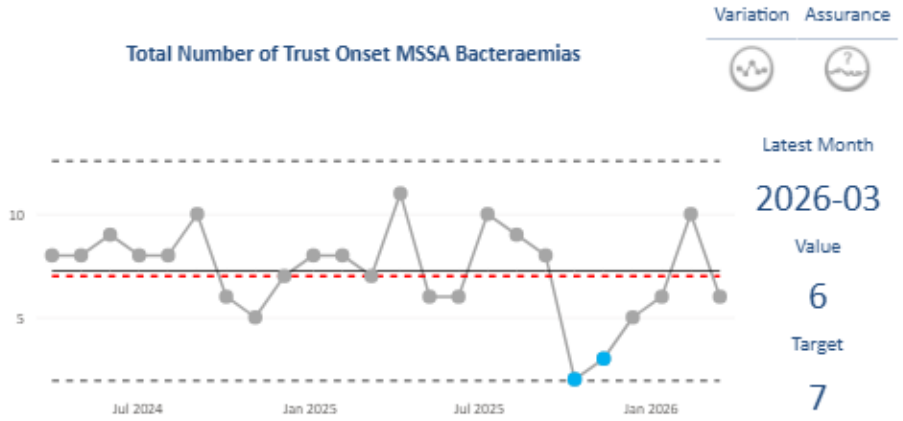
York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Tara Filby **Operational Lead:** Sue Peckitt

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Total Number of Trust Onset MSSA Bacteraemias	2026-03			6	7	7
Total Number of Trust Onset MRSA Bacteraemias	2026-03			0		0
Total Number of Trust Onset C. difficile Infections	2026-03			18	12	12
Total Number of Trust Onset E. coli Bacteraemias	2026-03			17	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2026-03			6	6	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2026-03			2	2	2
Pressure Ulcers per thousand Bed Days	2026-03			4.2		4
Patient Falls per thousand Bed Days	2026-03			8.7		8.7
Medication incidents per thousand bed days	2026-03			4.5		6

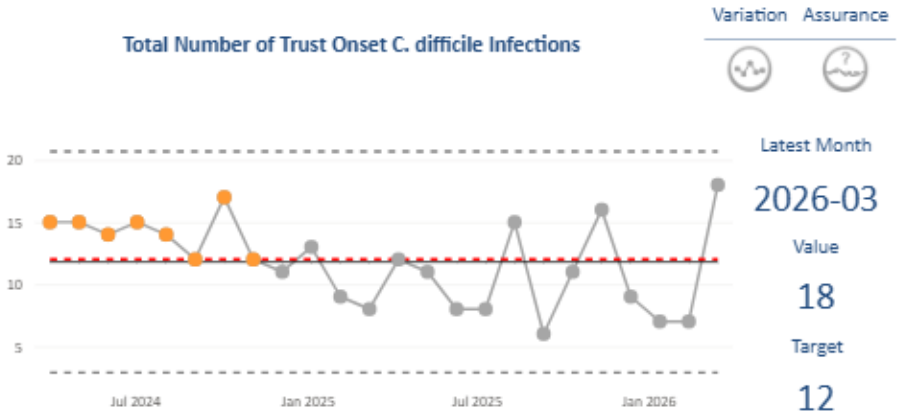
Executive Owner: Tara Filby

Operational Lead: Sue Peckitt



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 **4.0**.



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 **11.0**.

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 annual objective breached with 7 cases to the end of March 2025 against a zero tolerance. Q3 National Oversight Framework metric 3.60 per 100,000 bed days, a deteriorated position since Q2. This is 2 cases **more** than the previous year.
- E.coli bacteraemia - The Trust is 13 cases **over** the annual objective. Q3 National Oversight Framework metric is 2.36 per 100,000 bed days, a slight improvement on the Q2 position. The Trust finished the year with 13 cases **less** than the previous year.
- Klebsiella bacteraemia - The Trust is 29 cases **over** the annual objective and 26 **more** cases than the previous year
- Pseudomonas bacteraemia - The Trust is 16 cases **over** the annual objective and 6 cases **more** than the previous year.

Key assurances/brilliances

- Clostridioides difficile - Despite a month of increased cases the Trust is 15 cases **under** the annual objective and 26 cases **less** than the previous year. Q3 National Oversight Framework metric 1, rank 1/134.
- Methicillin-Sensitive Staphylococcus aureus bacteraemia – The Trust is 1 case **below** the annual objective and 11 cases **less** than the previous year. Therefore, the internal target of a 5% reduction in cases has been met, achieving a 12% reduction on the 2024/25 year end output.
- 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.
- Additional review meetings for MSSA bacteraemia cases have been held for Surgery and CSCS care groups to ensure learning is identified and embedded into practice.
- 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.
- IPC training packages have been reviewed for delivery in 2026/27

Next Key Improvements:

- The priority improvement objective around the management of both urinary and venous catheters is continuing into Q1 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.
- Clinical review of E.coli Bacteraemia and Klebsiella Bacteraemia cases to determine themes has commenced with support of Microbiology Registrars.
- The IPC improvement plan is being refreshed for 2026/27 in recognition of the further stretch improvements required.
- The IPC Hierarchy of Control Audits for all in-patient wards is commencing in April 2026

Quality & Safety
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Adele Coulthard/ Tara Filby **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	2026-03			53.9		56
Harmful Incidents per thousand bed days	2026-03			17.8		17
Total Number of Never Events Reported	2026-03			0		0
In-Hospital Deaths	2026-03			166		
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	2026-03			135		
Antepartum Stillbirths	2026-02			0		
Intrapartum Stillbirths	2026-02			0		
Early neonatal deaths (0-7 days)	2026-02			1		
PPH > 1.5L as % of all women - York	2026-02			3.1%		
PPH > 1.5L as % of all women - Scarborough	2026-02			4.6%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2026-02			71.4%		

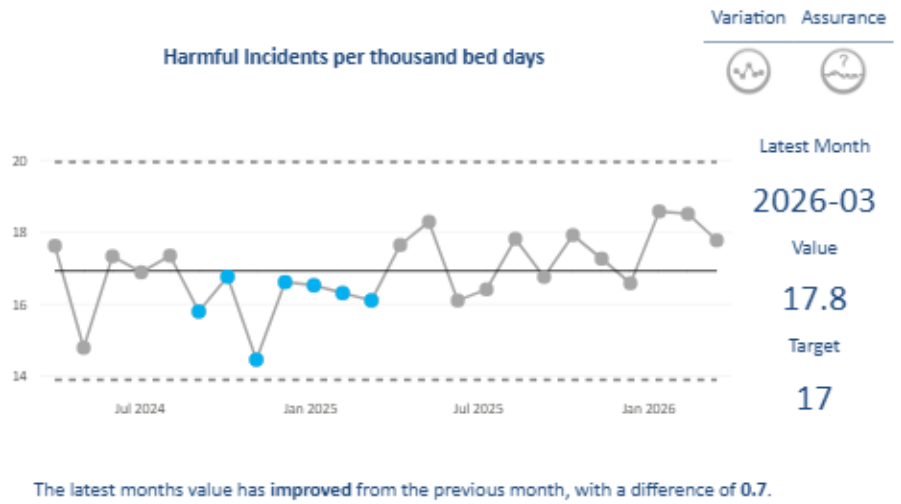
KPIs – Quality & Safety

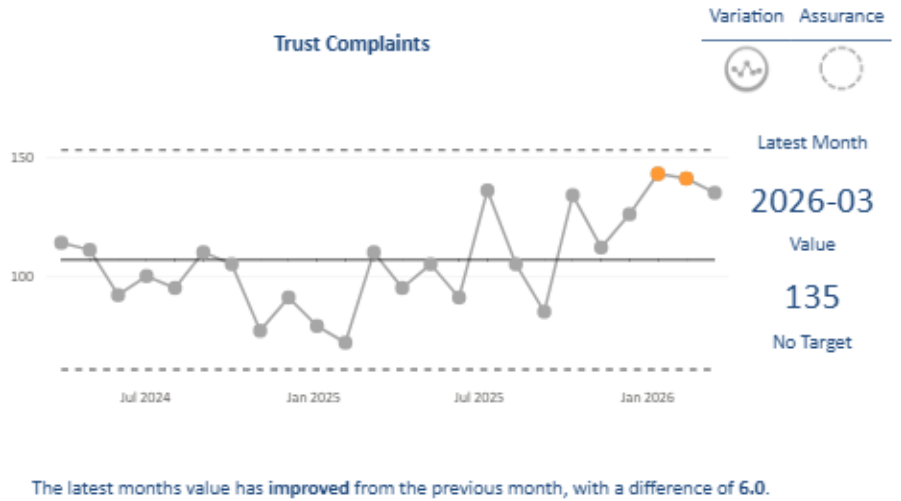
Q&S (2)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Executive Owner: Adele Coulthard/ Tara Filby /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 (51 submissions in March)

March Great-ix Highlights:

- *"Her clear communication and timely suggestions helped the team work cohesively and efficiently, ensuring we delivered the highest standard of care to the neonate"*
- *"She has been approachable and steady, creating a sense of stability during a time of increased demands.*
- *"X is always obliging and helpful when called, deals calmly and competently with patients and gives excellent advice and feedback to patients and staff"*
- *"Her professionalism, dedication and compassionate approach are outstanding"*
- *"Her ability to notice deterioration is fantastic, her adherence to the appropriate obs frequencies is great, her documentation is stellar, and her timely delivery of treatment cannot be faulted"*

Incident Reporting Rates - LFPSE

Recent figures published by LFPSE show that incident reporting at the Trust has shown steady and sustained improvement across the last five quarters. Total incident numbers have risen from 3,723 in Q3 24/25 to 4,424 in Q3 25/26, reflecting a stronger culture of transparency and learning. Importantly, the reporting rate per 1,000 bed days has increased consistently each quarter from 48.6 to 58.2 demonstrating that the rise is not due to changes in activity but genuine improvement in reporting behaviour. This upward trend highlights growing staff engagement with Datix and continued progress in strengthening patient safety reporting across the Trust.

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 135 new complaints across the Trust received in the month of March 2026 (in contrast to 141 in February 2026).

65% of complaints were closed in 30 days (compared to 56% in February 2026) and 50% of complex complaints were closed in 45 days (compared to 53% in February 2026) showing an improvement in complaint response times, though there is progress is still needed to achieve the target of 90% by the end of April 2026.

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.
- Care Groups are closing the backlog of concerns, however there will be an outstanding backlog of concerns at the end of March 2026. As at the end of February 191 of 254 backlog concerns had been closed.

Key assurances

- The member of staff from the PALS team who was on long term sickness is leaving the Trust following the Final Absence Review meeting - the vacancy will be advertised in April enabling th team to return to a full complement of staff.
- To support Medicine Care Group in achieving compliance with outstanding complaints, the Complaints and Concerns Lead will provide temporary support one day a week from mid-April.
- The corporate patient experience team continue to support Care Groups with a number of complex complaints to reduce the burden on Care Group leadership teams.
- A meeting will be held with all Investigating Officers led by the Chief AHP to reconfirm their responsibilities, remind them of the need to complete their complaints training and the zero-tolerance approach for complaint responses which will be effective from 1 May 2026.

Next key improvement steps

- Care Groups to continue taking action to close the backlog of concerns and work towards achieving compliance with complaint response deadlines by 30 April 2026.
- 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

April 2026

Executive Owner: Karen Stone 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
Maternity Scarborough

MATRIX KEY
- HIGH IMPROVEMENT
- IMPROVEMENT
- NEUTRAL
- CONCERN
- HIGH CONCERN

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT		* No. of women delivered - Scarborough * L/W Co-ordinator supernumerary % - Scarborough * Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	
COMMON CAUSE / NATURAL VARIATION	* Bookings - Scarborough	* Births - Scarborough * Induction of labour - Scarborough * Elective caesarean - Scarborough * Emergency caesarean - Scarborough * BBA - Scarborough * Neonatal Death - Scarborough * Breastfeeding Initiation rate - Scarborough	* Homebirth service suspended - Scarborough
SPECIAL CAUSE CONCERN			

Maternity Scarborough
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - Scarborough	2026-02		P	100		169	Target
No. of women delivered - Scarborough	2026-02	L	?	87		112	Target
Births - Scarborough	2026-02		?	90		113	Target
Induction of labour - Scarborough	2026-02		?	41.4%		44.2%	Baseline
Elective caesarean - Scarborough	2026-02		?	21.8%		16%	Baseline
Emergency caesarean - Scarborough	2026-02		?	32.2%		28.5%	Baseline
BBA - Scarborough	2026-02		?	1		2	Target
Total number of Stillbirths - Scarborough	2026-02			0			No Target
Neonatal Death - Scarborough	2026-02		?	0		0	Target
Number of maternity diverts/unit closures - Scarborough	2026-02			3			No Target
Homebirth service suspended - Scarborough	2026-02		F	26		3	Target
SCBU at capacity - Scarborough	2025-03			4		0.3	Baseline
% of 3rd and 4th degree tears - Scarborough	2026-01			2.2%			No Target
L/W Co-ordinator supernumerary % - Scarborough	2026-02	H	?	100%		100%	Target
Breastfeeding Initiation rate - Scarborough	2026-02		?	87.4%		75%	Target

Maternity Scarborough
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	2025-11			0		0	Target
% of women seen within 15 minutes in triage - Scarborough	2026-02			93.3%			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - Scarborough	2026-02			4			No Target
Number of babies born with an Apgar of 7 at 5 mins - Scarborough	2026-02			2			No Target
Number of midwifery red flags - Scarborough	2026-02			1			No Target

Summary MATRIX

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 - York * No. of women delivered - York * Births - York * Induction of labour - York * Elective caesarean - York * Emergency caesarean - York * BBA - York * Neonatal Death - York * Homebirth service suspended - York * Breastfeeding Initiation rate - York * Number of Maternity and Newborn Safety Investigations (MNSI) referrals - York	
SPECIAL CAUSE CONCERN			

Maternity York
Scorecard (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Bookings - York	2026-02			260		295	Target
No. of women delivered - York	2026-02			207		242	Target
Births - York	2026-02			210		245	Target
Induction of labour - York	2026-02			33.8%		41.5%	Baseline
Elective caesarean - York	2026-02			18.4%		16.8%	Baseline
Emergency caesarean - York	2026-02			17.9%		23.1%	Baseline
BBA - York	2026-02			1		2	Target
Total number of Stillbirths - York	2026-02			0			No Target
Neonatal Death - York	2026-02			1		0	Target
Number of maternity diverts/unit closures - York	2026-02			0			No Target
Homebirth service suspended - York	2026-02			25		3	Target
SCBU at capacity - York	2025-06	L		0		0	Baseline
% of 3rd and 4th degree tears - York	2026-02			1.9%			No Target
L/W Co-ordinator supernumerary % - York	2026-02	H		100%		100%	Target
Breastfeeding Initiation rate - York	2026-02			79.5%		75%	Target

Maternity York
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone **Operational Lead:** Sascha Wells-Munro

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target/Baseline	Target/Baseline
Number of Maternity and Newborn Safety Investigations (MNSI) referrals - York	2025-12			0		0	Target
% of women seen within 15 minutes in triage - York	2026-02			91.6%			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - York	2026-02			1			No Target
Number of babies born with an Apgar of 7 at 5 mins - York	2026-02			3			No Target
Number of maternal deaths - York	2026-02			0			No Target
Number of midwifery red flags - York	2026-02			1			No Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

April 2026

Executive Owner: Polly McMeekin

1. Highlights

- Sickness absence continued to reduce following the December peak, with a marked fall in winter-related illness, although overall absence remains higher than the national position.
- Use of temporary staffing reduced further, with bank and agency usage falling in line with lower sickness absence and exceeding agreed reduction targets.

2. Concerns

- Despite improvement, sickness absence remains high compared with national benchmarks, continuing to place pressure on services.
- Administrative bank activity increased in March, particularly within Medicine, Surgery and digital services, despite strengthened temporary staffing controls.
- Vacancy pressures persist in some support roles, requiring continued local oversight to ensure recruitment progress is sustained.

3. Future

- Maintain strengthened temporary staffing approval arrangements and continue negotiations with providers to reduce rates and manage high-cost staffing risks.
- Deliver the higher mandatory training compliance target, alongside changes to locally-mandated training that enable staff time to be reinvested into service delivery.
- Respond to forthcoming national guidance on statutory training requirements and continue to develop workforce supply routes that support recruitment and retention over the coming year.

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

Workforce
Scorecard (1)

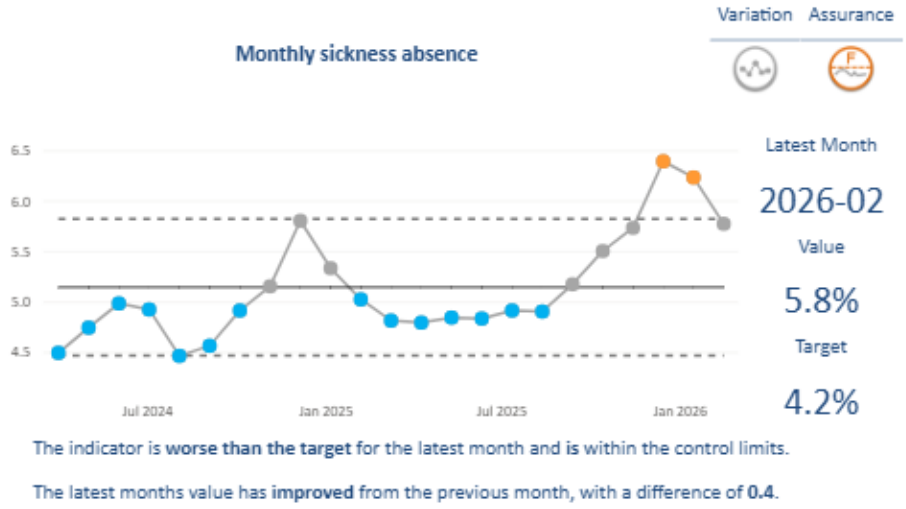
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

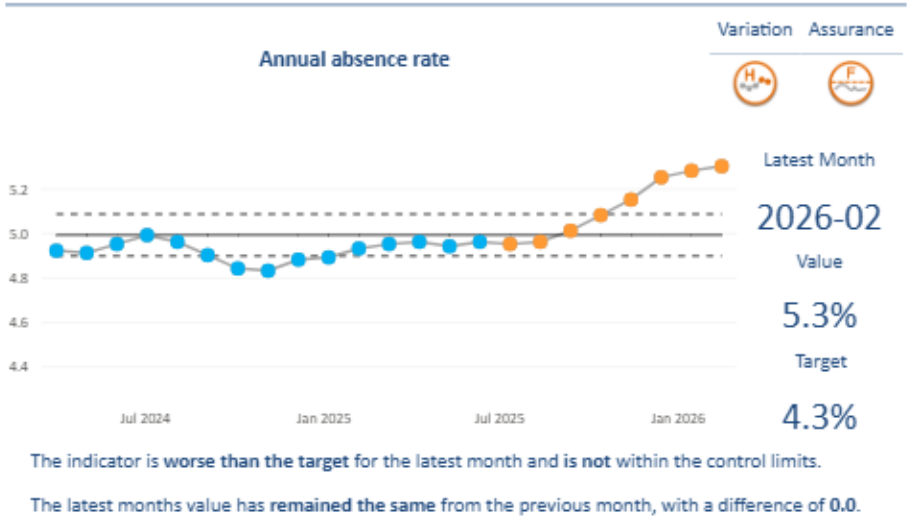
Executive Owner: Polly McMeekin **Operational Lead:** Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2026-02		F	5.8%	4.5%	4.2%
Annual absence rate	2026-02	H	F	5.3%		4.3%
Total Agency Whole Time Equivalent Filled	2026-02	L	P	45.3		151
Total Bank Whole Time Equivalent Filled	2026-02		?	565.3		557
12 month rolling turnover rate Trust (FTE)	2026-03	L	P	7.5%		10%
Overall vacancy rate	2026-03	L	?	6.3%		6%
HCSW vacancy rate	2026-03	H	?	14.2%		5%
Midwifery vacancy rate	2026-03	L	?	-4.6%		0%
Medical and dental vacancy rate	2026-03	L	?	3.8%		6%
Registered Nursing vacancy rate	2026-03	L	?	5%		5%
AHP vacancy rate	2026-03		?	6.1%		8.5%

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

Factors impacting performance and actions:

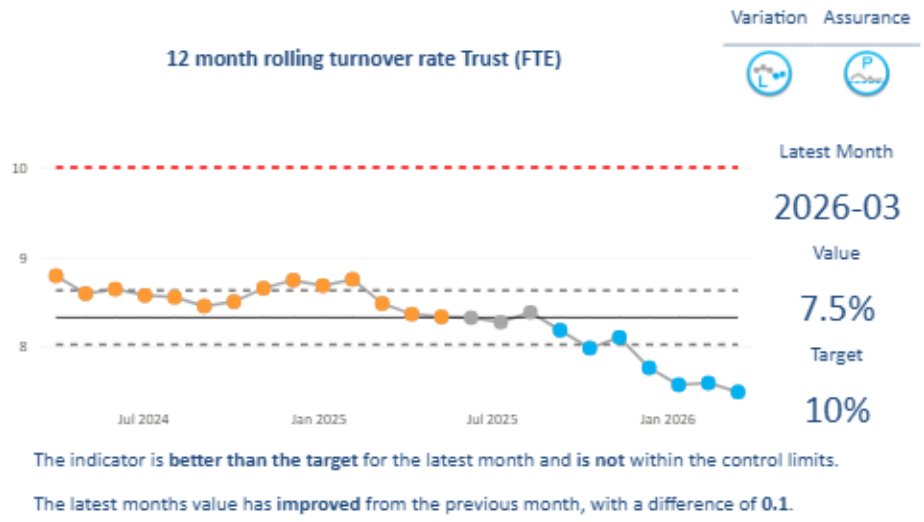
February saw a sustained decrease in sickness absence following the December peak, although the absence rate remained high. Benchmarking shows the Group's December absence rate (6.4%) ranked 36/51 when compared with other NHS organisations in the 'Acute – Teaching' benchmark group (source: NHS Digital). The national NHS absence rate for December was 5.9% (the most recent publication provides rates up to December 2025).

A summary of the main reasons for absence in February are shown in comparison with January. The most notable reduction was in absences attributes to coughs, colds and 'flu, consistent with patterns of national respiratory virus circulation in England.

Reason	February 2026		January 2026	
	WTE lost	Proportion of all absences	WTE lost	Proportion of all absences
Anxiety, stress, depression	137 ↓	25%	147	25%
Cough, cold, flu	65 ↓	12%	86	15%
Musculoskeletal, back	57 ↓	11%	62	11%
Gastrointestinal	41 ↓	8%	48	8%

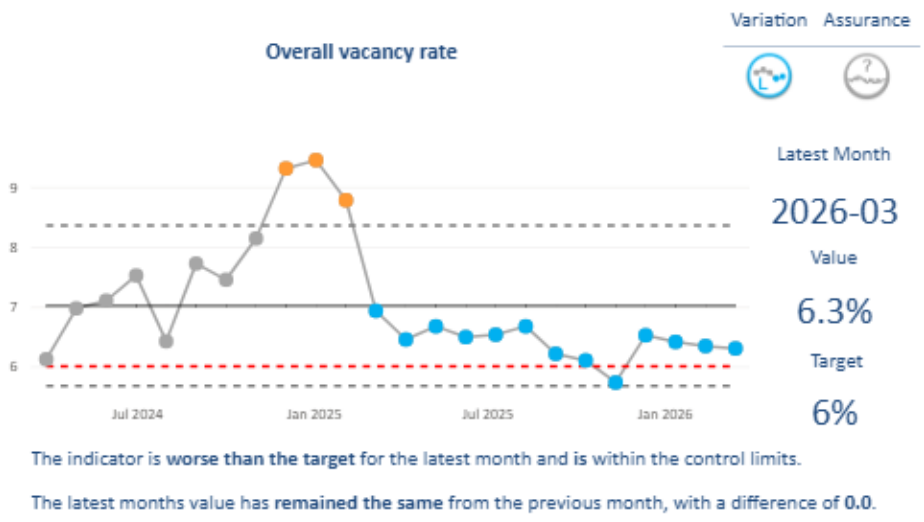
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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

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



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

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

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

Factors impacting performance and actions:

At the end of February, the Group recorded a total workforce position of 10,049 WTE. This position was less than the Trust's WTE forecast (10,079) due to reduced usage of temporary staffing (Bank and Agency).

The combined bank and agency WTE position in February (611) was lower than in January (655) and was broadly consistent with the reduction in sickness absence between months. Overall, at the end of February the Trust was tracking at a -48% reduction in Agency WTE (-65) and a -9% reduction in bank WTE (-57) compared with 2024-25 (against targets of -40% (-54) and -10% (-65)).

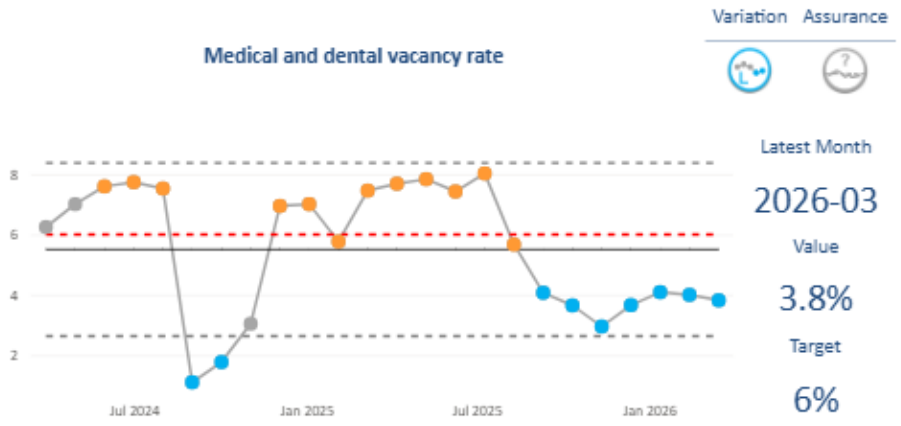
The number of substantive colleagues in post grew by 171 WTE between the end of the 2024-25 financial year and February 2026:

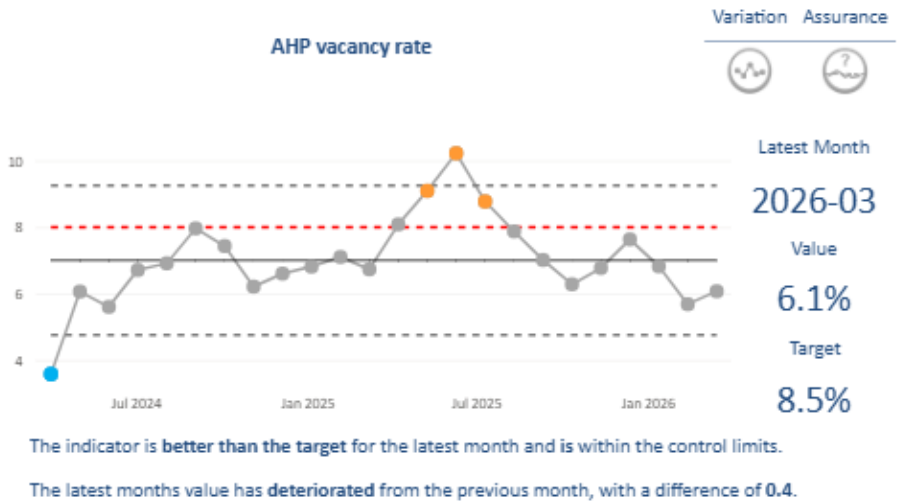
Staff group	Substantive WTE change since Mar-25	% increase in group WTE
Medical & Dental	67	7%
Nursing & Midwifery Registered	113	5%
Registered/Qualified Scientific, Therapeutic & Technical	86	7%
Support to Clinical*	-152	-7%
NHS Infrastructure Support*	85	3%

*includes a small number of coding changes moving roles to NHS Infrastructure.

Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum





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

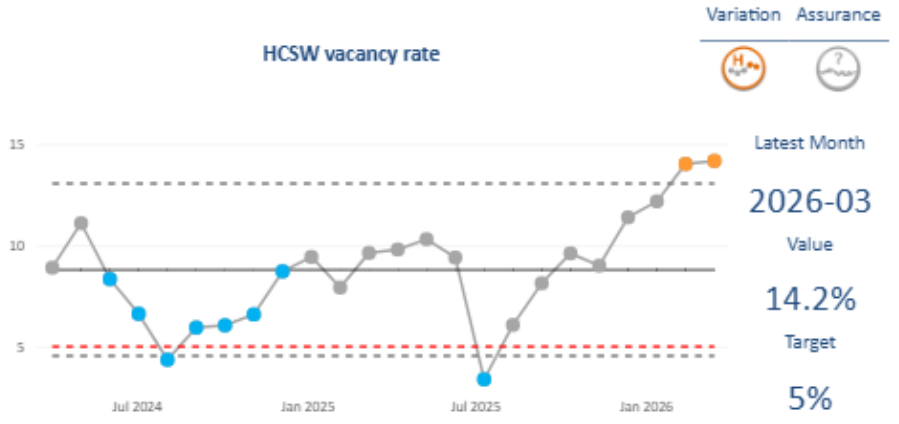
Factors impacting performance and actions:

In March, the Trust welcomed six new medical colleagues, including two permanent Consultants within Anaesthetics and General Surgery. In addition, six offers of employment for medical Trust Grade posts were made within General Medicine, Emergency Medicine and Anaesthetics.

Nationally, resident doctors undertook a period of industrial action from 7th – 13th April. Local participation in industrial action amongst the Trust's resident doctors varied each day, with the level of staff taking action recorded between 44% at its lowest and 57% at its highest, with an average of 50% recorded over the duration. Data shows the days with the highest percentage of staff taking action were recorded over the weekend (55% Saturday and 57% Sunday), but it is important to note that weekend cover is lower than weekday cover, meaning fewer doctors participated in action at this time (61/60 staff at the weekend versus an average of 174 a day during the week). During industrial action, the Trust was able to maintain generally good levels of rota coverage to support service continuity.

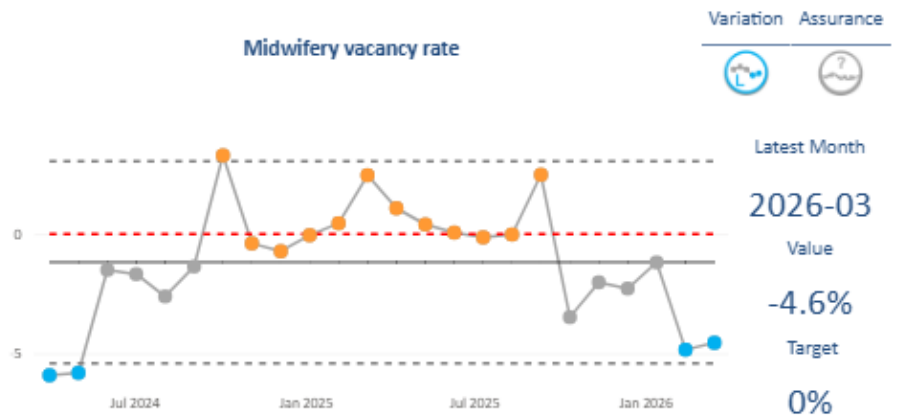
Executive Owner: Polly McMeekin

Operational Lead: Lydia Larcum



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

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



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 **0.2**.

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 17 WTE HCSWs undertaking pre-employment checks, and 21 WTE who are booked onto the next Academy. In response to the increasing vacancy rate, an internal program has been set-up to support and monitor recruitment to HCSW roles in the Medicine Care Group.

March saw the Nursing Associate headcount increase by 3 from 47 to 50 (this number does not include Student Nursing Associates).

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

Group WTE broken down by staff group and month:

Please note that the WTE count for each staff group includes substantive, bank and agency colleagues.

Staff Group	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Medical & Dental	1164	1121	1134	1133	1150	1149	1145	1155	1167	1169	1156	1157
Nursing & Midwifery	2677	2620	2653	2640	2667	2660	2689	2743	2741	2706	2732	2734
Scientific, Therapeutic & Technical	1274	1312	1307	1313	1324	1323	1347	1354	1351	1344	1358	1356
Support to Clinical Staff*	2355	2304	2337	2330	2356	2328	2254	2204	2220	2175	2199	2164
NHS Infrastructure Support Staff*	2565	2564	2559	2550	2560	2568	2559	2590	2586	2594	2622	2638
Total	10035	9920	9989	9967	10057	10027	9995	10045	10066	9988	10067	10049

*includes a small number of coding changes moving roles from the Support group to NHS Infrastructure.

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 March reduced again to an average of 56 shifts a week, down from 64 shift requests a week in February.

The Trust continues to negotiate with agency providers to reduce rates. Recent developments include a reduction of midwife rates by at least £1.50 per hour, bringing all midwifery agency providers in line on rates, and a reduction of £1.00 per hour on Theatre rates. Whilst reductions may appear small, overtime the cumulative reduction supports notable savings for the Trust and moves the organisation closer to the agency price caps for these specialised roles.

Administrative bank activity saw a significant increase in March with 866 shifts recorded compared to 732 shifts worked in February, despite the Trust introducing additional temporary staffing controls during this time. Areas with notable increase include Medicine, Surgery and Y&S Digital.

Workforce
Scorecard (2)

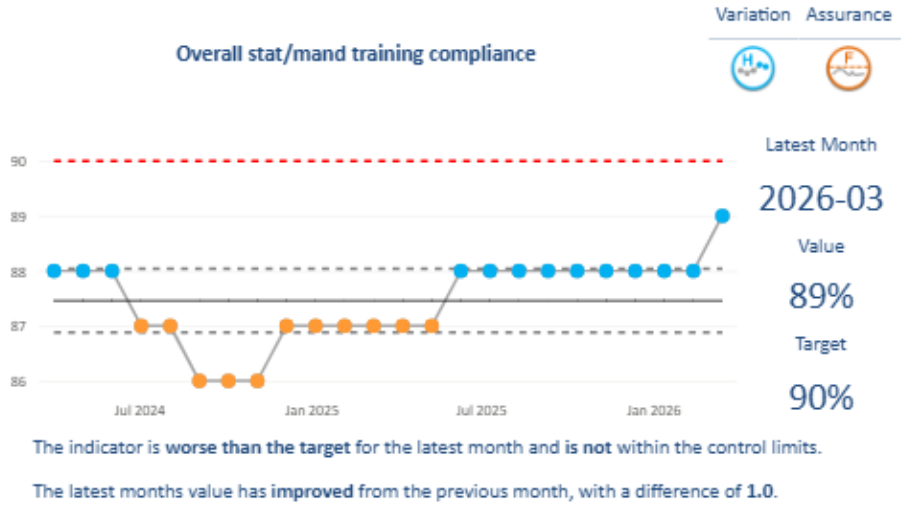
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

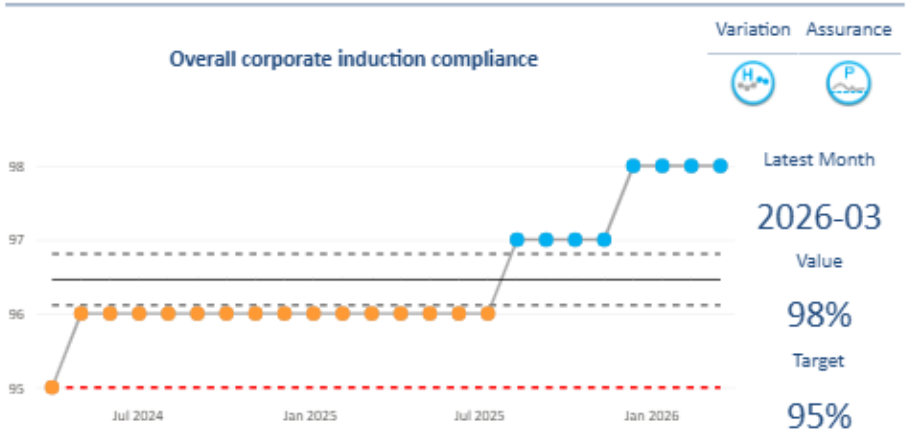
Executive Owner: Polly McMeekin **Operational Lead:** Will Thornton/ Lydia Larcum

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2026-03	H	F	89%		90%
Overall corporate induction compliance	2026-03	H	P	98%		95%
A4C staff stat/mand training compliance	2026-03		?	90%		90%
A4C staff corporate induction compliance	2026-03	H	P	98%		95%
Medical & dental staff stat/mand training compliance	2026-03	H	F	78%		90%
Medical & dental staff corporate induction compliance	2026-03	H	?	97%		95%
Appraisal Activity	2025-11	H	F	87.2%	81.8%	95%
I would recommend my organisation as a place to work	2026-03			48.7%		50%
If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation	2026-03			46.7%		49%
If I spoke up about something that concerned me I am confident my organisation would address my concern	2026-03			37.3%		40%
I am able to make improvements happen in my area of work	2026-03			51.4%		53%

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 increased to 89% in March.

Following a review of locally-mandated training in the Trust, colleagues will no longer be required to repeat the training at intervals of 3-5 years. The review by a multi-professional group determined there was little to no evidence of the 'repeat' approach having a positive impact on quality and safety outcomes. Therefore, in future such training will only be required to be completed once, with competence being reinforced through practice. Over five years, this change will allow up to 21,000 hours of colleagues' time to be reinvested.

A review of nationally-mandated training, which includes statutory requirements, is due to be published this Spring.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

April 2026

Executive Owner: James Hawkins

Highlights

EPR implementation:

- Revised go-live dates of the 7-10 May and 14-16 May for Scarborough and York have been agreed respectively. The Trust Resilience Group will follow the same process to access readiness criteria, and a submission was made to NHS England for final approval for 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 are working through the impact of the revised go-live dates on Tranche 2 and Tranche 3.

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 outpatients, alongside widespread trial 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 2 and 3 timelines with Nervecentre.
- Finalise hyper-care support plans for T1, including scheduling additional clinical, operational and digital staff (including floorwalkers and digital champions.

Wider Digital Portfolio:

- Overall cyber security posture: Track progress against independent Data Security and Protection Toolkit audit actions.
- 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

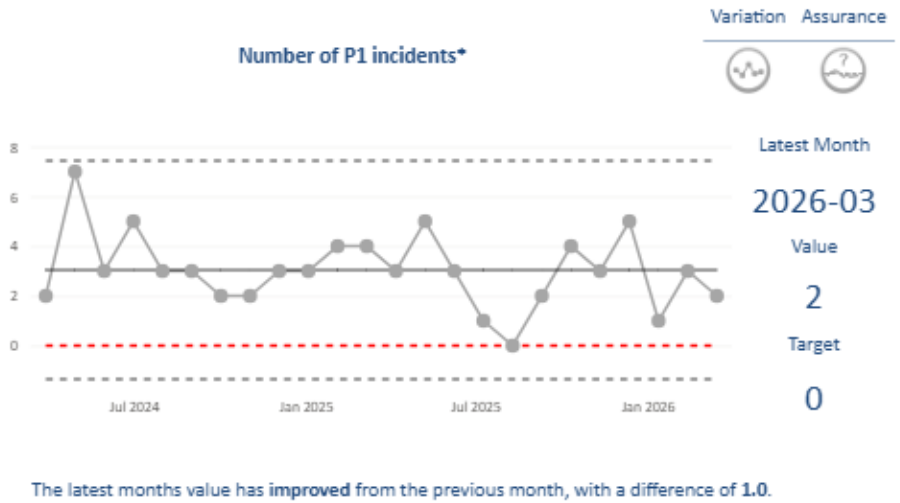
VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Number of P1 incidents* * Percentage of FOIs and EIRs responded to within 20 working days (monthly)	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests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

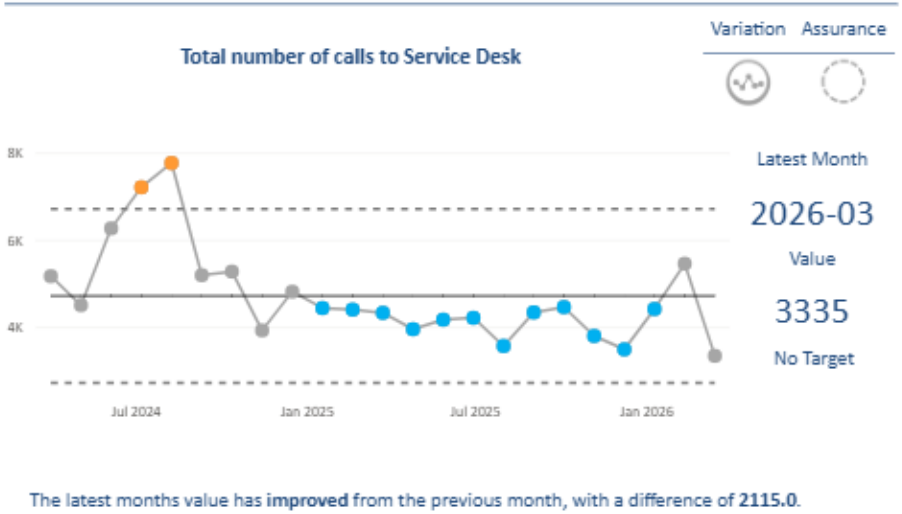
Executive Owner: James Hawkins

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2026-03			2		0
Total number of calls to Service Desk	2026-03			3335		
Total number of calls abandoned	2026-03			991		
Number of information security incidents reported and investigated	2026-03			36		
Number of patient Subject Access Requests (SAR) received (monthly)	2026-03			358		
Number of patient Subject Access Requests (SAR) completed (monthly)	2026-03			300		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2026-03			76%		80%
Number of FOIs and EIRs received (monthly)	2026-03			66		
Number of FOIs and EIRs completed (monthly)	2026-03			64		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2026-03			97%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy





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

Target: 0 P1 Incidents

Factors impacting performance:

2x P1 incidents occurred in March.

1. 16/3 damage by a contractor to external connections between York and Scarborough affected multiple services at Scarborough Hospital, including internal telephone calls between sites, along with some IT systems.
    - An investigation has found that whilst we do have separate redundant connections, designed to avoid this issue, they have a shared section of external ducting for part of the route, and when this was damaged it caused the loss of service.
    - Our Telecoms provider has now re-routed to ensure full separation and work to resolve related internal issues is in hand.

2. 20/3 Our "All Staff" e-mail distribution list was unavailable for several days following migration from NHSmail to NHS Connect. This affected communications such as Chief Executive Weekly bulletin, Patient Safety Bulletin, and the Y&S Live event communications.

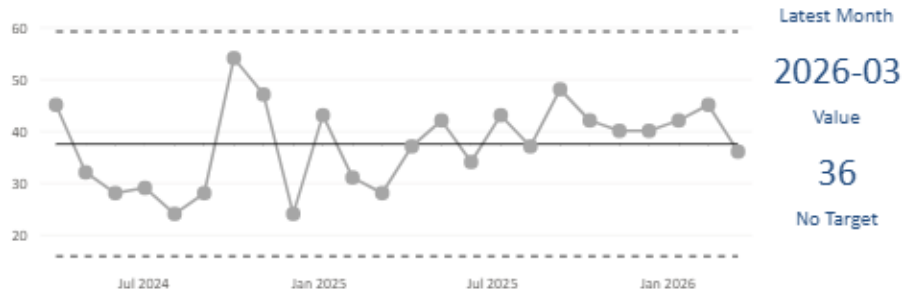
Telephone demand peaked in February as a result of preparations for Nervecentre and high impact P1 issues.
Activity during March returned to lower levels and is expected to rise during April and May in line with the new go live dates for Nervecentre.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2026-03
Value
36
No Target

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

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

Number of information security incidents reported and investigated

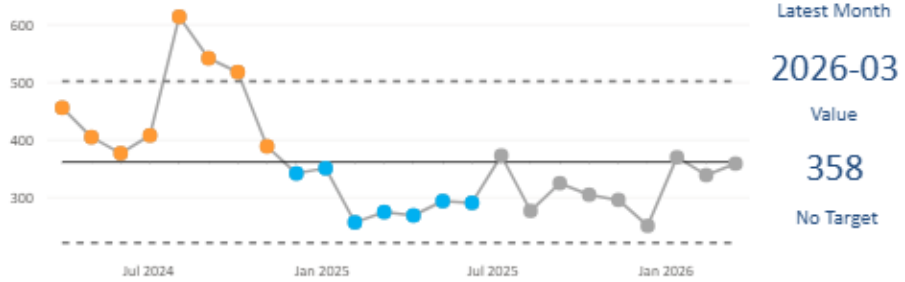
Factors impacting performance:

Information security incidents have decreased in March. We have seen a number of blood forms be sent home with the wrong patient.

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
2026-03
Value
358
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **20.0**.

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.

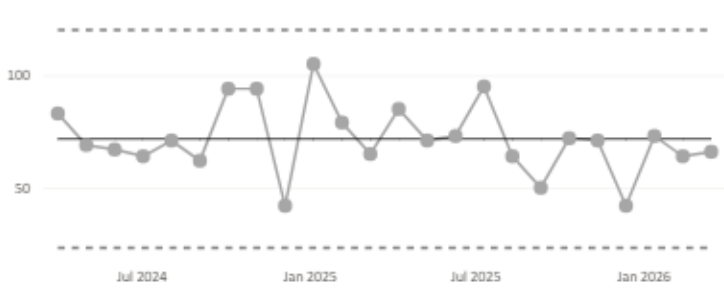
Volumes received have increased dramatically, we have seen this trend with other types of information requests. The Trust is currently experiencing a backlog and response times have been impacted. This is being communicated to requesters.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Number of FOIs and EIRs received (monthly)

Variation Assurance

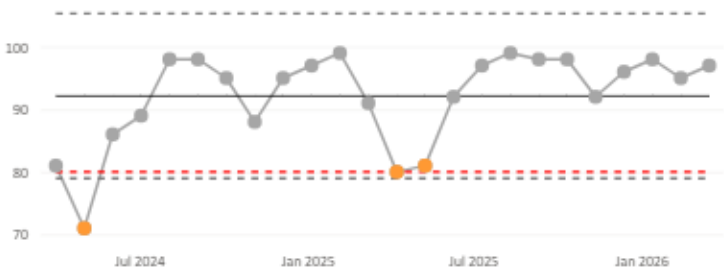


Latest Month
2026-03
Value
66
No Target

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

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

Variation Assurance



Latest Month
2026-03
Value
97%
Target
80%

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 **2.0**.

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 increased slightly.

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

April 2026

Executive Owner: Andrew Bertram

Highlights

Income and Expenditure Position

	Annual Plan	Actual	Variance	Agreed FOT	Agreed FOT Var	Actual Var to FOT
	£000's	£000's	£000's	£000's	£000's	£000's
SURPLUS/(DEFICIT)	1,360	-33,135	-34,495	-31,293	-32,653	-1,842
NHSE Surplus/(deficit)	0	-32,293	-32,293	-32,653	-32,653	360
NHSE Final Adjusted Position (excl DSF)	-16,551	-44,706	-28,155	-45,066	-28,515	360

The Trust delivered its forecast outturn at Month 12, with a £32.2m deficit following the loss of Q4 Deficit Support Funding, this was £360k better than forecast.

Efficiency Programme

Efficiency delivery improved in the final month of the year, with £40.5m delivered against the target of £55.3m (73.2% of the total target and 4.4% of operating expenditure). Of the £40.5m FY delivery 25% (£10.2m) is recurrent and 75% (£30.3m) is non-recurrent. One of the WRAP programmes for 2026/27 is to review non-recurrent delivered schemes with a view to securing recurrent delivery where possible.

Cash Position

March's cash balance stood at £27.3m, falling £6.1m short of the planned £33.4m. This shortfall was primarily driven by a £34.5m adverse variance in the income and expenditure plan, partially offset by favorable variances: £22m from capital creditors, largely due to year-end capital PDC draw timings and delayed invoice payments, and £6.5m from working capital movement timings, mainly related to lower-than-expected debtor and accrued income positions.

The requirement for cash support isn't currently anticipated for Q1 2026/27, but this is reliant on continued financial management within the organisation to live within the 2026/27 financial plan.

Executive Owner: Andrew Bertram

Future / Next Steps - 2026/27 Plan Update

York & Scarborough position

For 2026/27, the HNY system has confirmed to national colleagues a collective commitment to improve system financial plans by c.£30m. Within this, York & Scarborough Teaching Hospitals NHS Foundation Trust has committed to a £7m improvement, resulting in a proposed deficit of £22.7m. This level is currently described by NHSE as the maximum acceptable position for the Trust; however, the overall system deficit has not yet reached a level that allows plans to be approved. As a result, York & Scarborough has been placed in the regionally led Challenged Provider Programme, which will include a structured programme of activity and may involve additional support to drive further plan improvement.

Summary Dashboard and Income & Expenditure

Finance (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Key Indicator	Previous Month (YTD)	Current Month (YTD)	Trend	
I&E Variance to Plan	-£16.6m	-£32.3	↓	Deteriorating
CIP Delivery Variance to Plan (£55.3m target)	-£13.0m	-£14.8m	↓	Deteriorating
Variance to Agency Cap	£1.9m	£2.5m	↑	Improving
Month End Cash Position	£39.3m	£27.3m	↓	Deteriorating
Capital Programme Variance to Plan	-£27m	£0.1m	↑	Improving

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	796,754	796,754	836,648	39,894
Other Income	98,195	98,195	90,920	-7,275
Total Income	894,949	894,949	927,568	32,619
Pay Expenditure	-591,256	-591,256	-637,367	-46,111
Drugs	-70,550	-70,550	-78,060	-7,510
Supplies & Services	-97,567	-97,567	-97,352	215
Other Expenditure	-136,813	-136,813	-137,739	-926
Outstanding CIP	14,793	14,793	0	-14,793
Total Expenditure	-881,393	-881,393	-950,518	-69,125
Operating Surplus/(Deficit)	13,556	13,556	-22,950	-36,506
Other Finance Costs	-12,196	-12,196	-10,184	2,012
Surplus/(Deficit)	1,360	1,360	-33,135	-34,495
NHSE Normalisation Adj	-1,360	-1,360	842	2,202
Adjusted Surplus/(Deficit)	0	0	-32,293	-32,293
Remove DSF	-16,551	-16,551	-12,413	4,138
NHSE DSF Adjusted Position	-16,551	-16,551	-44,706	-28,155

The I&E table confirms an actual adjusted deficit of £32.3m against a planned balanced position, leaving the Trust with an adverse variance to plan of £32.3m. The variance from plan reduces to £28.2m following the adjustment to remove Deficit Support Funding (DSF). This position is £0.36m better than the forecast outturn variance agreed with NHSE

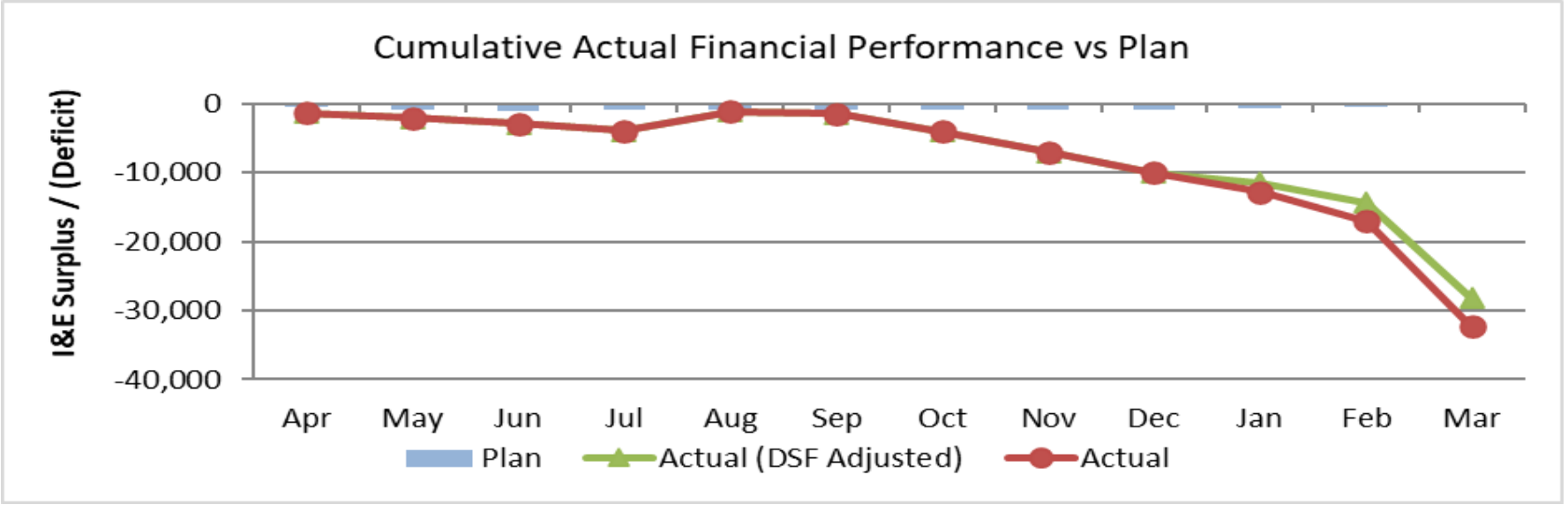
Key Subjective Variances: Trust
Finance (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Variance	Favourable / (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	£0.6m	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. The under trade has been offset by income paid by NHSE (£32.5m) to fund increased employers pension contributions that are excluded from baseline funding. The costs of the pension contributions paid in March are shown in the Employee Expenses line below.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27.
ICB Income	£39.4m	ICB over trade linked to services which have been delegated from NHSE to ICBs to commission. The position also includes Industrial action funding of £2.1m and an under-recovery of Deficit Support Funding in quarter 4 of £4.2m	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27
Employee Expenses	-£46.1m	Agency, bank and WLI spending is ahead of plan to cover medical vacancies. In addition, the position includes £32.5m of expenditure for the increased employers pension contributions paid in March.	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 and Devices	-£7.5m	A risk share arrangement was agreed in the 2025/26 plan to reduce expenditure on drugs and devices commissioned by ICBs that were previously contracted for on a pass-through basis. Savings have been delivered for high-cost drugs that have reduced this pressure, but growth and pressure has been evident with high-cost devices.	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. Move to pass-through in the 2026/27 contract,
CIP	-£14.8m	Savings of £40.5m have been delivered compared to a plan of £55.3m.	Continued focus on delivery of the WRAP overseen through the Finance Improvement Boards.
Other Costs	-£0.7m	Favourable variance on clinical supplies and services (£0.2m) offset by adverse variance on other non pay expenditure (£0.9m).	Identify drivers for increased costs and take corrective action as appropriate.

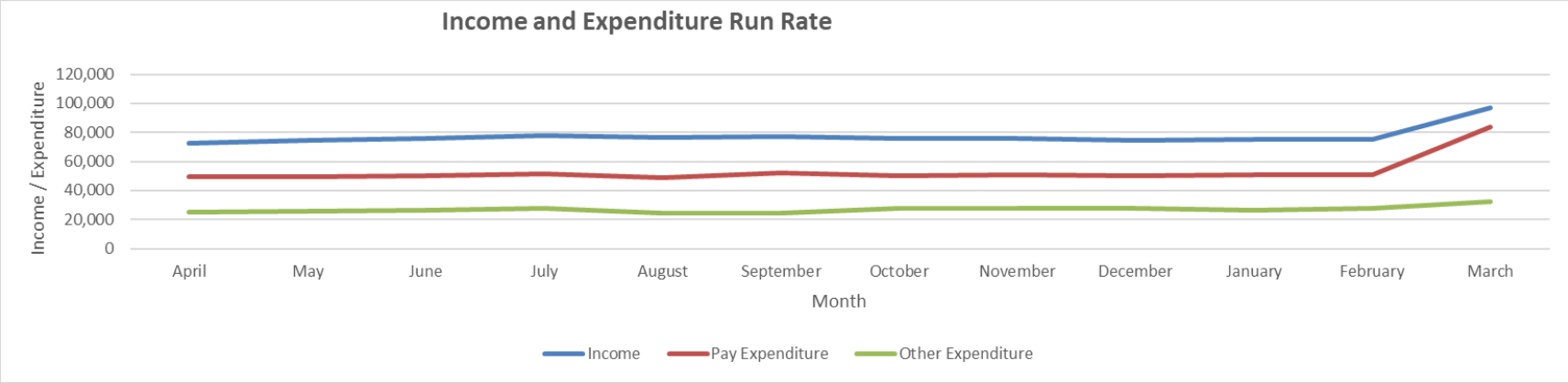
Cumulative Actual Financial Performance vs Plan

Finance (3)



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 March 2026 is a deficit of £32.3m compared to the balanced plan. The variance from plan reduces to £28.2m following the adjustment to remove Deficit Support Funding (DSF). This is £0.36m better than the forecast position proposed to NHSE.



	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	97,019	75,505	21,514
Pay Expenditure	49,260	49,340	50,028	51,273	48,784	51,884	50,282	50,548	49,895	51,005	51,041	84,026	50,304	33,723
Other Expenditure	24,784	25,721	26,376	27,404	24,599	24,629	27,807	27,945	27,683	26,486	27,538	32,365	26,452	5,913

The graph and table above show the monthly run rate for income, pay and other expenditure. Income and Pay Expenditure are both artificially inflated due to £32.5m of increased pension contribution income and spend incurred in March. Underlying income in March was £64.5m, which was £10.9m lower than the average monthly income for April to February. This is mainly due accruals for sparsity income and ERF overtrade in 2024/25 being removed from the position in March. Underlying Pay expenditure in March was £51.5m which was £1.2m higher than the average monthly pay expenditure for April to February. The increase was due to costs linked to delivery of activity in Q4. Other expenditure was £32.4m in March, which was £5.9m higher than the average monthly expenditure for April to February. The increase was largely due to technical impairment charges.

Forecast Outturn & Recovery Action Plans

Finance (5)

NHS
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	-32,293
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	359

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 March (including the lost DSF) was a deficit of £32.652m, the actual deficit at the end of March was £32.293m. The actual outturn was £0.359m better than forecast.

Care Group Outturn
Finance (6)

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	242,128	239,643	238,277	1,366	242,128	3,851	£1.95m underspend on CDC's due to delay at Scarborough, not expected to continue once all sites operational and £1m underspend on Lung Health Check, growing Cell Path demand causing £1.3m outsourcing cost pressure, offset largely by vacancies and CIP £2.3m over delivery.
Family Health Care Group	89,881	89,629	91,885	-2,256	89,881	-2,004	£621k relates to the premium cost of covering medical vacancies, £1.042m Community Nursing overspend, £825k Midwifery overspend, £740k Sexual Health underspend, £235k CGM overspend, £244k overachieved CIP.
Medicine	195,848	195,094	206,529	-11,435	195,848	-10,681	£4.2m relates to medical cost pressures in ED and Acute; £2.8m drugs overspend, primarily Gastro, Renal and Respiratory; £1.6m YTD pressure of the unachieved CIP target.
Surgery	168,200	166,878	172,264	-5,385	168,200	-4,064	£2m overspend in pay expenditure largely driven by Resident Doctor costs, with further non-pay overspends of £326k in drugs, £1,040k on consumables linked to increased non-elective activity, and £503k in other costs (removal expenses and premises). CIP overachieved by £134k.
TOTAL	696,058	691,245	708,955	-17,710	696,058	-12,897	

Recovery Action Plans
Finance (7)

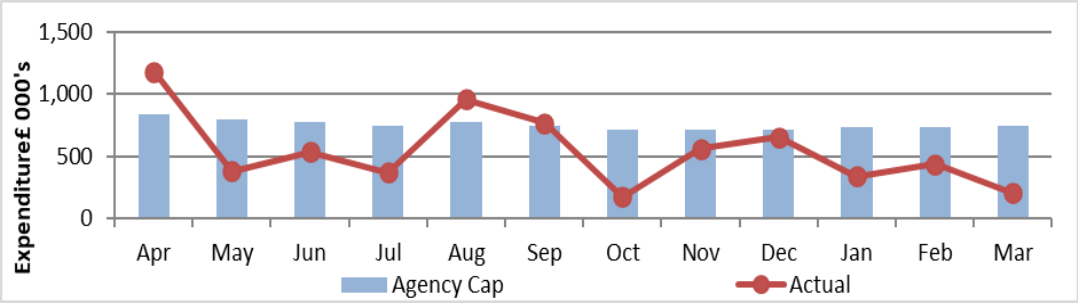
York and Scarborough Teaching Hospitals NHS Foundation Trust

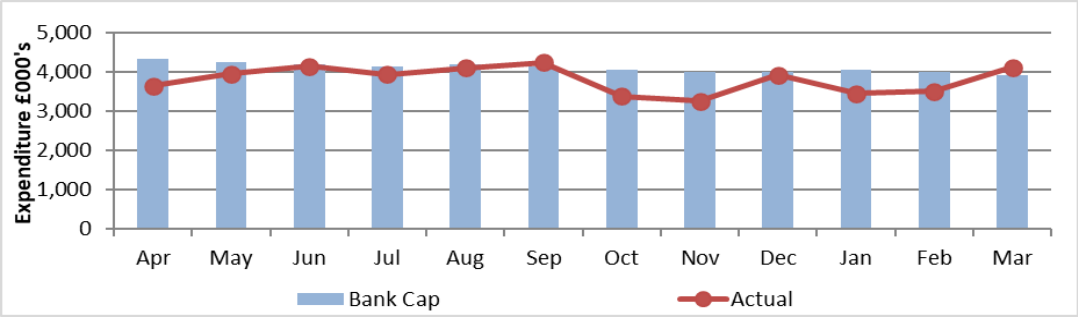
Scheme Detail	Action Owner	Potential Value £000	Savings identified in January £000	Savings identified in February £000	Savings identified in March £000	Total
Consider price increases for all areas where the Trust can control what it charges - catering, parking, rentals, private patient work, etc	Chris Norman	220	26	26	154	**206**
Discretionary Non Pay	Andrew Bertram	809	53	62	93	**207**
Drug Savings	Stuart Parkes	400	0	395	0	**395**
Energy reduction	Lucy Brown	0	0	0	0	**0**
NCTR	Claire Hansen	400	0	0	0	**0**
Overtime removal. Perform a monthly 'audit' of the top 10 highest overtime earners by central team.	ACOOs / CD	1,277	12	36	100	**148**
Review ward stock to rationalise stock levels, requirements and create stock guardian wards for required but infrequently used items	Dawn Parkes	0	99	87	30	**216**
Stop first class post	Andrew Bertram	300	0	0	83	**83**
Target a 5% spend reduction for the next 5 months for all budget holders including waste reduction competitions	ACOOs / CD	91	0	0	0	**0**
Vacancy Grip & Control (13 week firebreak / HNY IBC Double Lock)	ACOO / Directorate Leads	3	0	0	0	**0**
Validation Sprint monies for 25/26	Claire Hansen	688	0	95	143	**238**
Winter Schemes	Abolfazl Abdi	0	0	1,180	0	**1,180**
EPR	James Hawkins	0	0	1,000	0	**1,000**
Nurse agency reduction. Including ensuring no off framework agency	Dawn Parkes	80	48	73	36	**157**
Study leave deferral until April (excluding apprenticeship study, role essential)	Andrew Bertram & Karen Stone	80	0	0	0	**0**
Reduce ward Enhanced Therapeutic Observational Care additional required workforce	Dawn Parkes	20	5	6	9	**20**
Reduction of nursing bank useage for short term cover to an 80% fill rate.	Dawn Parkes	51	28	21	35	**84**
Insourced Reporting	Lisa Shelbourn	40	0	20	20	**40**
Reduction in admin bank spend	Haaris Mian	11	0	0	0	**0**
Reduction in medical agency spend	Haaris Mian	68	24	0	0	**24**
Reduction in non-clinical non pay	Haaris Mian	38	25	33	0	**58**
Reduction in premium rate spend following substantive consultant appointments	Haaris Mian	80	0	0	0	**0**
Reduction in UTC & ED Spend	Haaris Mian	81	0	26	0	**26**
Reduction in Medical Bank & Agency Spend	Liz Hill	248	69	58	0	**127**
Reduction in overtime/bank spend (Admin)	Liz Hill	5	4	3	0	**7**
Reduction in stock held for Clinical Supplies	Alison Pollard	75	19	13	0	**32**
Ramsay Contract	Liz Hill	75	0	0	0	**0**
		5,139	**411**	**3,134**	**703**	**4,247**

The table above summarises the recovery schemes that have been agreed for implementation in quarter 4 and the actual run rate savings delivered. The total planned savings for quarter 4 are £5,139k and actual savings of £4,247k have been delivered.

Agency, Bank and Workforce

Finance (8)





	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,638.80	2,566.02	72.78	151,425	154,755	-3,330
Scientific, Therapeutic and Technical	1,340.86	1,283.85	57.01	75,557	75,681	-124
Support To Clinical Staff	1,945.39	1,492.58	452.81	64,870	59,333	5,537
Medical and Dental	1,130.60	1094.77	35.83	162,111	173,313	-11,202
Non-Medical - Non-Clinical	3,241.58	3,042.56	199.02	134,992	137,259	-2,267
Reserves				105	0	105
Other				2,195	37,025	-34,830
TOTAL	10,297.23	9,479.78	817.45	591,256	637,367	-46,111

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 March 2026 is £6.5m, compared to a plan of £9.0, representing a favourable variance of £2.5m.

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 March 2026 is £45.6m, compared to a plan of £49.2m, representing a favourable variance of £3.6m.

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. The variance on the other line is due to the increased pension contribution payment made in March.

Elective Recovery Fund

Finance (9)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Trust Performance Summary vs Commissioner ERF weighted Values in Contract.

Commissioner	25-26 Target % vs 19/20	Value ERF scope Indicative Weighted Values at 25/26 prices	ERF Month 12 Phase (Av %)	Activity to Month 12 Actual	Variance - (Clawback Risk) M12
Humber and North Yorks	104.00%	£171,355,927	£171,355,927	£171,625,400	£269,473
West Yorkshire	103.00%	£1,570,160	£1,570,160	£1,776,730	£206,570
Cumbria and North East	115.00%	£223,602	£223,602	£276,563	£52,960
South Yorkshire	121.00%	£182,919	£182,919	£173,215	-£9,704
Other ICBs - LVA / NCA	-				*£0*
All ICBs	***104.02%***	***£173,332,608***	***£173,332,608***	***£173,851,908***	***£519,299***
NHSE Specialist Commissioning	113.38%	£4,346,069	£4,346,069	£4,149,886	-£196,182
Other NHSE	104.13%	£305,100	£305,100	£341,413	£36,314
All Commissioners Total	**104.31%**	**£177,983,777**	**£177,983,777**	**£178,343,207**	**£359,430**

Please Note: Month 10 actuals on this sheet include an estimated adjustment for the expected Ophthalmology data submision corrections in line with 2025/26 national guidance.

Elective Recovery Fund

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

Given the financial limits on elective recovery funding in 2025/26, it is important to closely monitor the position to ensure that the weighted activity undertaken, where it incurs additional costs, does not exceed the planned ERF target levels without Commissioner authorisation.

At Month 12, the ERF weighted activity is provisionally valued at £359k over the funded level of ERF activity across all our main commissioner contracts. The reported variance now includes the actual adjustments for the removal of Ophthalmology OP attendances, where scans and tests, prior to the main eye procedure, were recorded as a separate appointments. This correction is in line with updated guidance for 2025/26.

HNY ICB have confirmed funding to the Trust up to the value of the ERF planned allocation of £171.3m. For other commissioners we are expecting ERF payment to be reconciled based on actual ERF positions at the year end.

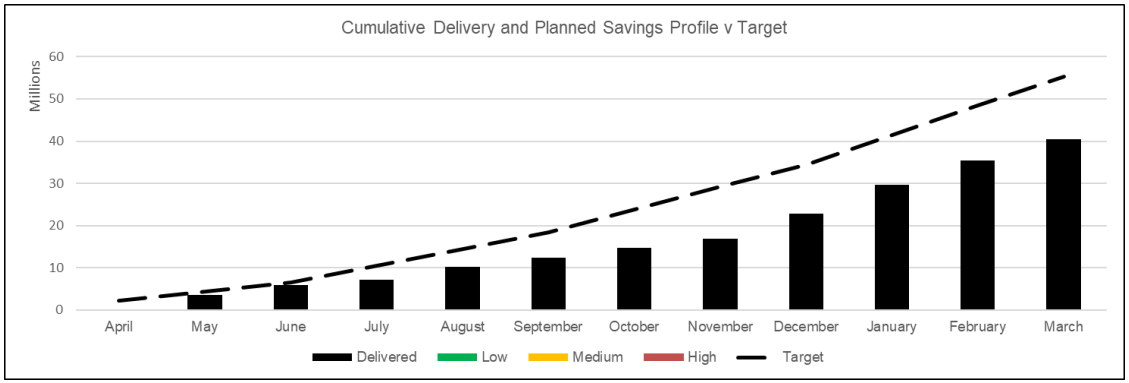
Cost Improvement Programme
Finance (10)

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	55,290		Trust Efficiency Target	55,290	
Delivered Recurrently	10,234	18.5%	YTD Deliverey	40,498	73.2%	Delivered at Month 11	37,273	
Delivered Non Recurrently	30,263	54.7%	**YTD Variance**	**14,793**		Delivery in Month 12	3,225	
Total Delivery	40,498	73.2%				Total Delivery	40,498	73.2%
Remaining to deliver	**14,793**					**Forecast Gap**	**14,793**	

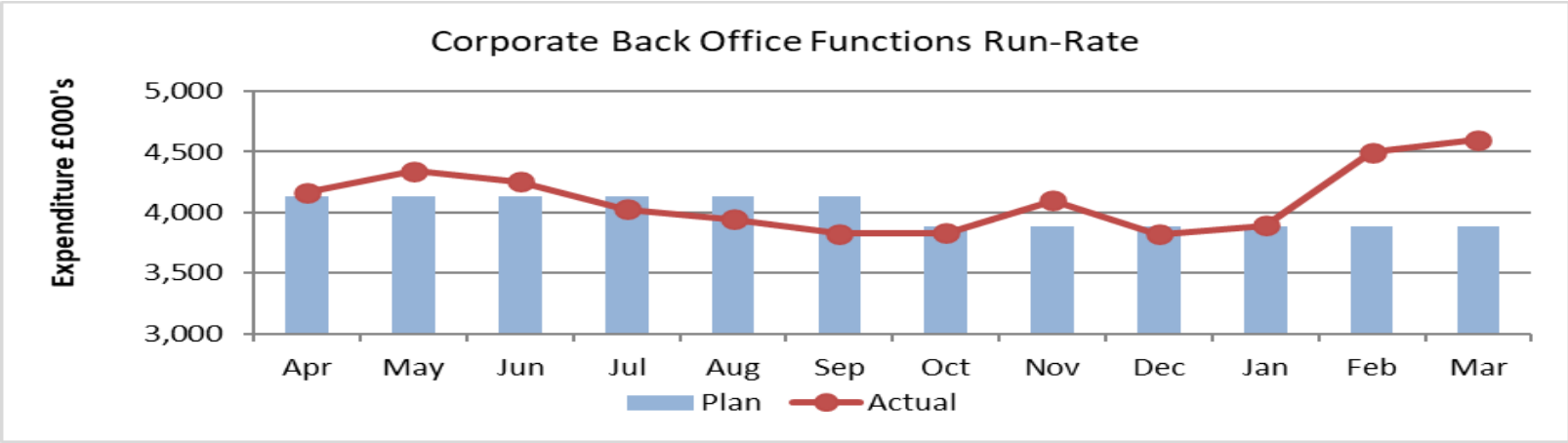
2025/26 Cost Improvement Programme - March Position

	Full Year CIP Target	March Position		
		Target	Delivery	Variance
	£000	£000	£000	£000
Medicine	6,039	6,039	4,399	1,639
Surgery	4,524	4,524	4,658	-134
CSCS	7,044	7,044	9,252	-2,209
Family Health	2,306	2,306	2,549	-244
CEO	45	45	772	-727
Chief Nurses Team	893	893	1,107	-214
Finance	733	733	1,544	-811
Medical Governance	62	62	396	-334
Ops Management	382	382	1,362	-980
DIS	601	601	2,501	-1,901
Workforce & OD	763	763	1,719	-956
YTHFM LLP	1,962	1,962	4,246	-2,284
Central	29,939	29,939	5,992	23,947
Total	**55,290**	**55,290**	**40,498**	**14,793**



In month delivery of £3.2m has contributed to a full year delivery of £40.5m. This has increased the YTD variance which is now £14.8m an increase of £1.8m. Delivery in the final month was £1.7m higher than forecast at month 11.

A full exercise is underway to assess conversion of non-recurrent schemes to recurrent ready for the new financial year.



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 graph above demonstrates that the Trust has met the required reduction in back-office function expenditure between October 2025 and January 2026. The spike in expenditure in February and March is due to truing up charges from the purchasing consortium and IT depreciation and amortisation being higher than expected.

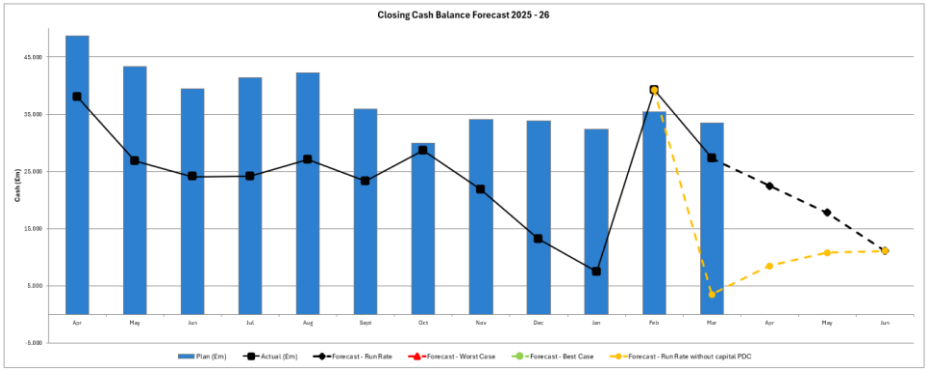
Current Cash Position and Better Payment Practice Code (BPPC)

Finance (12)

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Group's cash plan for 2025/26 is for the cash balance to reduce through the year resulting in a closing balance of £33.4m at the end of March 2026. The table below summarises the planned and actual month end cash balances.

Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	48,728	43,285	39,402	41,443	42,294	35,924	29,962	34,122	33,845	32,386	35,435	33,442
Actual	38,105	26,832	24,135	24,178	27,143	23,374	28,710	21,882	13,184	7,430	39,298	27,288



Closing cash was £27.3m against a plan of £33.4m, which is £6.1m adverse.

The significant contributing factors are:

- £34.5 – Adverse variance in I&E surplus / (deficit).
- £22m – Favourable variance from capital creditors. A significant element of which is linked to capital PDC draw timings for year end and invoices due to payment in Q1.
- £6.5m – Favourable variance in working capital movement timings, predominately debtor and accrued income position below plan.

The closing balance of £27.3m, is in line with the run rate FOT cash position highlighted in previous TPR reports.

The run rate forecast (black line), is based on continuation of cash receipts & payment run rates in line with FY 25-26 levels and any known adjustments.

The closing March cash balance includes 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.

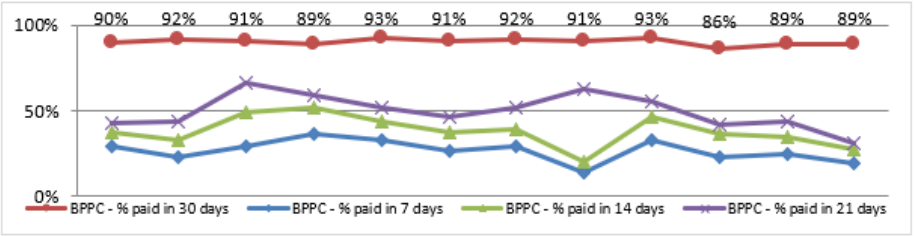
The orange line illustrates the run rate forecast adjusted for unspent PDC. It is assumed that all PDC funded scheme invoices will be paid by June.

The forecast suggest that no cash support will be required in Q1 but this is heavily reliant on continued financial management in the organisation to protect cash.

<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 March the Group managed to pay 89% of its suppliers within 30 days, in line with the previous month.



Current and Forecast Capital Position

Finance (13)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Annual Plan £000s	FOT £000s	YTD Plan £000s	M12 Actual £000s	YTD Variance £000s
80,664	81,218	80,664	81,343	125

The Month 12 capital position was slightly over by £125k forecast outturn. However, several large projects planned for completion in 2025/26 will now be completed in 2026/27, which will impact the 2026/27 capital position. These include CT3, PACU/HT and backlog schemes.

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.

As a reminder, the FOT position included the following schemes

- Scarborough RAAC scheme of £14m
- £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.

The focus is now on FY2026/27 projects, ensuring these are delivered within the CDEL limit.

2025/26 Capital Position	Annual Plan £000s	FOT £000s	YTD Plan £000s	M12 Actual £000s	Variance to FOT £000s
PDC Funded Schemes	56,525	56,754	56,525	56,754	-
IFRS 16 Lease Funded Schemes	7,838	5,532	7,838	5,532	-
Depreciation Funded Schemes	16,626	18,941	16,626	19,066	125
Charitable & Grant Funded Schemes	7,213	6,021	7,213	6,021	-
Total Capital	**88,202**	**87,248**	**88,202**	**87,373**	**125**
Less Charitable & Grant Funded Schemes	(7,213)	(6,021)	(7,213)	(6,021)	-
Less Sale of Clarence Street	(325)	-	(325)	-	-
Less PPE / Lease Disposals	-	(9)	-	(9)	-
Total Capital (Net CDEL)	**80,664**	**81,218**	**80,664**	**81,343**	**125**

System Summary – Month 11

Finance (14)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

M11 Position

- ICB £66k overspend YTD, FOT £7.1m deficit relating entirely to non receipt of Q4 DSF funding.
- Providers £71.9m overspend YTD, FOT £86.2m 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).
- NHSE are liaising directly with individual organisations with respect to forecast deficit positions.

System Revenue

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Variance Year Ending %
Humber And North Yorkshire ICB	-	(66)	(66)	(0.0%)	-	(7,094)	(7,094)	(0.1%)
Harrogate And District NHS Foundation Trust	(725)	(22,630)	(21,905)	(6.2%)	-	(20,000)	(20,000)	(5.2%)
Hull University Teaching Hospitals NHS Trust	(1,868)	(26,919)	(25,051)	(2.8%)	-	(22,030)	(22,030)	(2.3%)
Humber Teaching NHS Foundation Trust	(231)	2,769	3,000	1.2%	-	3,000	3,000	1.1%
Northern Lincolnshire And Goole NHS Foundation Trust	(2,294)	(13,600)	(11,306)	(2.0%)	-	(14,534)	(14,534)	(2.3%)
York And Scarborough Teaching Hospitals NHS Foundation Trust	(491)	(17,094)	(16,603)	(2.1%)	-	(32,652)	(32,652)	(3.7%)
ICS Total	(5,609)	(77,540)	(71,931)	(1.6%)	-	(93,310)	(93,310)	(1.9%)

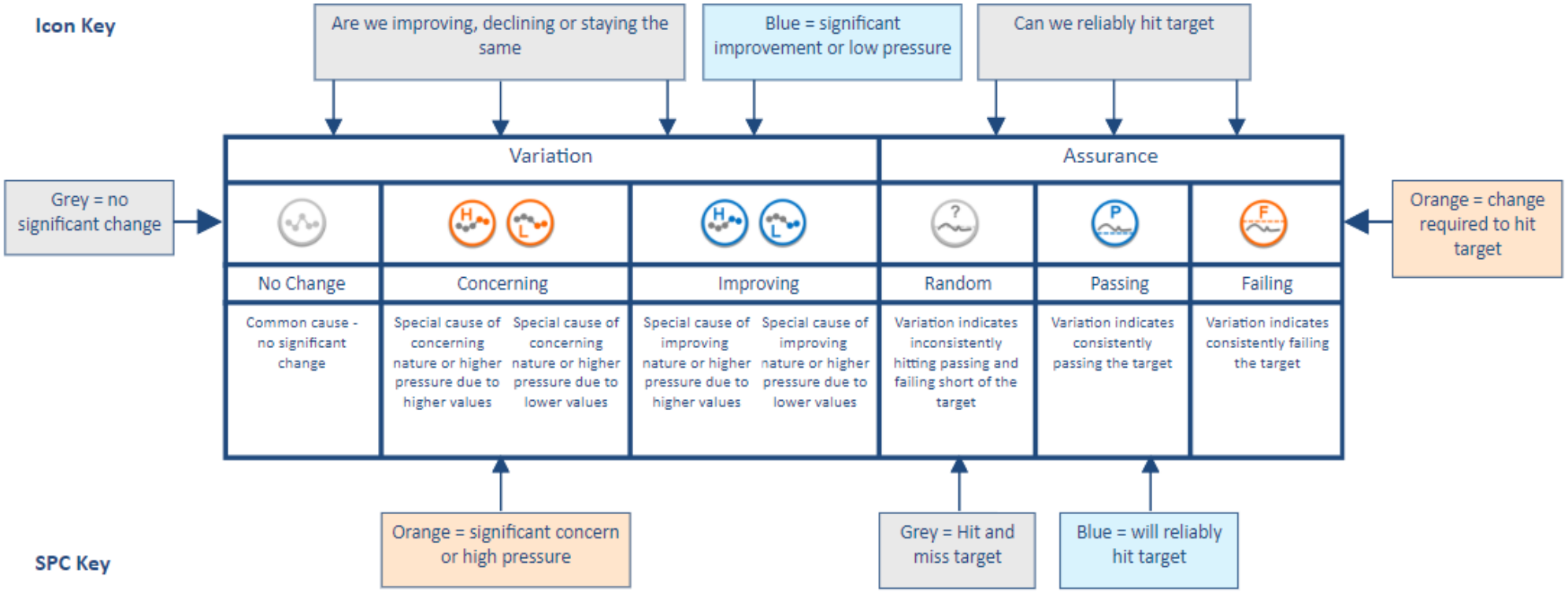
System Revenue excluding Deficit Support Funding

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year £000	Forecast Year £000	Variance Year Ending £000	Variance Year Ending %
Humber And North Yorkshire ICB	(25,945)	(21,275)	4,670	0.1%	(28,304)	(28,304)	1	0.0%
Harrogate And District NHS Foundation Trust	(5,576)	(26,603)	(21,027)	(433.5%)	(5,297)	(23,973)	(18,676)	(352.6%)
Hull University Teaching Hospitals NHS Trust	(14,903)	(37,594)	(22,691)	(174.1%)	(14,233)	(32,705)	(18,472)	(129.8%)
Humber Teaching NHS Foundation Trust	(231)	2,769	3,000	0.0%	-	3,000	3,000	0.0%
Northern Lincolnshire And Goole NHS Foundation Trust	(15,908)	(24,742)	(8,834)	(64.9%)	(14,856)	(25,676)	(10,820)	(72.8%)
York And Scarborough Teaching Hospitals NHS Foundation Trust	(15,663)	(29,508)	(13,845)	(91.3%)	(16,551)	(45,066)	(28,515)	(172.3%)
ICS Total	(78,226)	(136,953)	(58,727)	0.0%	(79,241)	(152,723)	(73,482)	2.3%

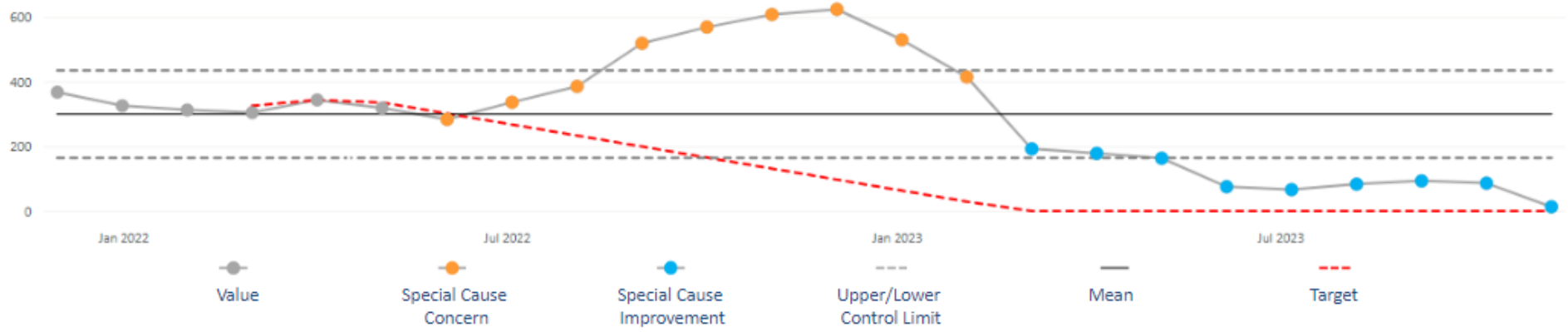
Keys

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 13

Report to:	Trust Board
Date of Meeting:	29th April 2026
Subject:	Annual Operating Plan Quarter 4 Update
Director Sponsor:	Clare Smith, Chief Executive
Author:	Tilly Poole, Head of Strategy and Planning

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The purpose of this paper is to inform the Board of the progress in relation to the 2025/26 Annual Operating Plan actions. The Board are asked to note the update.

The Annual Operating plan for 25/26 consists of 272 actions in total. These included operational actions to address 25/26 priorities.

At the start of April 2026, teams were asked to provide an update on the status of any action highlighted for completion in quarter 4 of which there are 65 actions – including the actions moved from previous quarters to Q4:

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- 26 actions (40%) were completed in full.
- 24 actions (37%) were not completed
- 11 actions (17%) remain ongoing or are partially completed
- 4 actions (6%) were closed – superseded or no longer required

The majority of incomplete actions reflect a small number of cross-cutting dependencies rather than a widespread failure to progress individual actions. Delays to the Nervecentre go-live and to major capital programmes (notably CDC and MRI/diagnostics) account for a significant proportion of actions where work has substantially progressed but completion is dependent on these wider milestones. Other delays relate to governance sequencing and capacity, which are being actively addressed, alongside a small number of actions that have been appropriately paused or reframed in response to changes in local or national direction.

The appendix includes the extract from the Annual Operating Plan for **all Q1-Q4** actions that remain incomplete or completed in part alongside accompanying narrative.

Next Steps

- Revise approach to annual operating plan development for 26/27 to complement Integrated Delivery Plan 2026-2031.

Recommendation:
Trust Board members are asked to note the content of the report.

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

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation

Improvement in the number of patients with No Criteria to Reside (NCTR)

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative if incomplete	Revised Delivery Quarter	Update provided by (add name)
Establish role and requirement of Super Discharge Teams	Q1	Ab Abdi	Claire Hansen	Close	Propose to close; no need to formalise but they are enacted when necessary and possible. Taking part in NHS England SPRINT project January - March 2026 which is enacting super discharge team principles.	n/a - no longer taking forward	Ab Abdi
Identify and improve delays in discharges in pathway 2 and 3	Q4	Sara Kelly	Ab Abdi	In part	A new Health Assessment Form (TAF), to be called the Discharge Readiness Form, will be partially automated, and will go live as part of Nervecentre go live. A TAF-less transfer between acute wards and Inpatient Rehabs has been trialled with ward 35 and ward 39. Targeted work with Wards to encourage completion of night diaries has taken place. Escalations continue to happen through 2nd line and 3rd line (Director level as appropriate) governance to ensure delays have been escalated and addressed. The outcomes of 1st and 2nd line meetings (and 3rd line when required) are communicated to the	N/A	Amy Gains

					relevant teams regularly during the course of the day / week. Reviews have taken place and feedback has been used to inform the process. A process map has been developed to help consistencies across sites. Band 7 Flow Therapist proposal is being presented to the Intermediate Care Board in April 2026 to support the York Discharge Command Centre processes and ensure quality TAFs and patients are on the correct pathway. Recent appointment of Band 5 Integrated Discharge Nurse at Scarborough DCC to support the interface between acute trust and care home providers. Action is ongoing and requires updating since it describes an output rather than an action. This will form part of a length of stay improvement plan in 26/27. The Discharge Improvement Group (DIG) and the trust UEC board monitor progress.		
Support Local Authority partners to establish Discharge to Assess model	Q4	Ab Abdi	Ab Abdi	In part	New 'Discharge Readiness Form' assessment template has been finalised and agreed across the system and it is ready to be used in time for Nervecentre implementation. The capacity and	Close	

					demand modelling is being worked on by the ICB and looking into some data quality issues. The progress is monitored through DIG and the UEC Board. Propose this is closed and new action in 2026/27 plan.		
Complete Capacity and Demand for D2A	Q3	ICB colleagues are leading	Ab Abdi	In part	The capacity and demand data was due to be presented at the D2A meeting on 25th February 2026 however it was incomplete due to issues with the ICB getting the data required.	Close	
Expand Discharge Command Centre Physical Spaces to allow space for system partners	Q1	Sara Kelly	Ab Abdi	In part	Delays due to staff consultations and consequent appeal. The appeal has been finalised in March 2026, however the delay has an impact on the available capital allocation in 2026/27.	Q1 2026/27	Amy Gains

Improvement in FDS and 61 Day Cancer Standards

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
2. Move of Colorectal MDT	Q4	Beth Eastwood/ Liz Hill	Claire Hansen	No	Surgical team unable to amend job plans at this time to change the of day of current MDT. Ongoing work around improving ability to preparation for MDT and streamlining of MDT, including advertising dedicated colorectal MDT lead	Q2 26/27	Beth Eastwood

1. Refresh of York RAPID Pathway	Q2	Beth Eastwood/ Harris Mian	Claire Hansen	No	New lung cancer consultant started at York end of Q2. Chest CT hot reporting capacity to be reviewed to support clinic activity. Capacity currently unable to be supported in radiology on Wednesday due to job plans, awaiting planning round outcome for Q1 26/27 feasibility.	Q1 26/27	Beth Eastwood

Improvement in the Emergency Care Standard

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Integrated Urgent Care Services (IUCS) development	Q3	Haaris Mian	Claire Hansen	Closed	Superseded by Acute Med Model and national guidance around a separate area for long stay ED patients. Paper to go through Care Group Board and Executive Committee in Q4.	Closed	Ab Abdi
Review workforce plan for ED and put forward business case for change: Present business case	Q2	Haaris Mian	Claire Hansen	No	Competing priorities and capacity challenges resulted in a delay to finalising the business case, this is now drafted for presentation to Care Group Boards in Q1	Q1 - Q2 2026/27	Catherine Rhodes
If approved, recruitment activity	Q3	Ally Crossley, Amjad Sami	Claire Hansen	No	If approved, recruitment and onboarding will be completed during 2026/27 financial year.	Q2 - Q3 2026/27	Catherine Rhodes
Maximise Acute Assessment usage: Extend opening hours of Frailty SDEC (York)	Q1	Sally Irwin	Claire Hansen	No	Action was superseded by EAU achieving many of the benefits of this action. Further work to assess impact of	To be monitored through UEC board	Ab Abdi

					EAU on frailty during early adoption.		
Support the ICB with their work on Regular Attenders / High Intensity Users	Q4	Andrew Phillips	Claire Hansen	No	Action requires reviewing as work is linked the Neighbourhood development work. Work is also underway with Primary Care Networks due to the link with inclusion health; a case management approach is being planned through PCNs.	Propose to close this action and re-write new actions for future plan.	Catherine Rhodes

Improvement in Referral to Treatment Time

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative if incomplete	Revised Delivery Quarter	Update provided by
Vascular Imaging Unit Capital Build 3. Operational go live	Q3	Karen Priestman	Claire Hansen	No	Original delay to March 2026. Further delays have been incurred due to equipment installing issues. Programme being developed with operational go live in 26/27.	Q4	Kim Hinton

Improvement in DM01

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Delivery of Scarborough CDC 1. Delivery of Capital Build	Q1	Karen Priestman (PM Jamie Baxter)	Claire Hansen / Chris Norman	No	Further delay to CDC completion date due to infrastructure challenges. New date for operational go live is in Q1 26/27	Q1 26/27	Kim Hinton
Delivery of Scarborough CDC 2. Operational Go Live	Q1	Karen Priestman (PM Jamie Baxter)	Claire Hansen / Chris Norman	No	Further delay to CDC completion date due to infrastructure challenges. New date for operational go live is in Q1 26/27	Q1 26/27	Kim Hinton
Delivery of Scarborough CDC 3. Development of pathways	Q1	Karen Priestman (PM Jamie Baxter)	Claire Hansen / Chris Norman	No	Delay to CDC completion date due to capital build and infrastructure challenges. New date for operational gio live is in Q1 26/27. However pathway development commenced development.	Q1 26/27	Kim Hinton

Delivery of MRI 3 at York 1. Capital Build	Q3	Karen Priestman (PM Jamie Baxter)	Claire Hansen / Chris Norman	No	The decision was taken to include the MRI3 facility in the scope of the Hybrid Theatre Project at YH, which was being constructed by a contractor called Merit. In Q3 2025-26 Merit went into administration and we are currently working with lawyers to manage the legal aspects of the administration process. As we continue to work with the administrators, we are also evaluating the procurement options for completing the project. Unfortunately, as a result of the administration, the project is in delay and is likely to increase in cost. Consequently, it is difficult to forecast with complete certainty the likely completion date for the construction project or the operational go-live date. We have, though, committed to presenting options for completing the project and a recommendation to the Trust by the end of March 2026.	Q4 2026-27 TBC	Andrew Bennett

Delivery of MRI 3 at York 3. Operational Go Live	Q3	Karen Priestman (PM Jamie Baxter)	Claire Hansen / Chris Norman	No	As above	Q4 2026-27 TBC	Andrew Bennett
Demand Management - Radiology 1. CT as diagnostics for internal requests	Q3	Lisa Shelbourn Marcus Nicholls	Claire Hansen	No	Paper to go to EC - re CT and MR internal requests. To be included as part of medicine's new Charter.	Q4	Lisa Shelbourn
Demand Management - Radiology 2. Acute OOH demand	Q4	Lisa Shelbourn Marcus Nicholls	Claire Hansen	No	Clinical discussions not progressed sufficiently to agree changes to pathways and requesting OOH.	Q1 26/27	
Demand Management - Radiology 3. GP MRI requests	Q4	Lisa Shelbourn Marcus Nicholls	Claire Hansen	No	Cauda equina - trial commenced - data being collected for evaluation.	Q1 26/27	

Improve 10 Day Turnaround plan for Histopathology 2. Additional office accommodation identified for York histopathologists. R+R package for remaining Hull vacancies tbc.	Q4	Dave Oglesby	Claire Hansen	No	The identified office accommodation at York for the consultants will be vacated from 10th April. Following this, modifications to the units will be made ready for the consultants to move into. Anticipated moves in Q1 26/27 but are subject to completion of the building modifications. No timeline provided for these at present. The refurbishment of the laboratory space will start once the medical consultants have moved. External design team have been commissioned to look at this work.	Q1 2026	D Oglesby
Improve 10 Day Turnaround plan for Histopathology 3. Roll out of digital pathology	Q4	Andrew Jackson	Claire Hansen	No	Delays with implementing digital package - Installation and testing of systems underway in April, go live in Q1 26/27 subject to system testing with external partners.	Q1 2026	D Oglesby
Improve 10 Day Turnaround plan for Histopathology 4. Histopathology recruitment	Q4	Dave Oglesby	Claire Hansen	No	Recruited 3 to Hull (1.5 remaining). Vacant posts have been advertised on NHS Jobs, holding an interview slot in June.	Q1 2026	D Oglesby
Review the DM01 logic in CPD 1. Task and finish group established	Q1	Sheena White	James Hawkins	No	This is no longer relevant as needs to be reviewed by modality. The actions will be completed by modality. Audiology has commenced and all speciality on track to be completed in Q2	no longer required	Kim Hinton

Review the DM01 logic in CPD 2. Systematic review of all CPD logic	Q2	Sheena White	James Hawkins	In Part	We have progressed through all four stages one modality at a time. Completed services include all imaging and endoscopy modalities (including cystoscopy) and UDS. Audiology is currently in UAT and targeted for launch in Q3. This has taken longer than expected due to complex data issues, delaying timelines for echocardiography, sleep studies, and peripheral neurophysiology, now planned for Q4. Earlier-reviewed modalities require updates to reflect CPD changes, with reviews underway alongside the audiology work. Once all modalities are complete, we will conduct a final review to identify any remaining issues. Delay to logic review for Echo and Sleep studies.	Q1 26/27	Sheena White
Review the DM01 logic in CPD 3. Identify any changes and impact	Q2	Sheena White	James Hawkins	In Part		Q1 26/27	
Review the DM01 logic in CPD 4. Present proposal for approval	Q2	Sheena White	James Hawkins	In Part		Q1 26/27	
Review the DM01 logic in CPD 5. Implement any CPD changes	Q2	Sheena White	James Hawkins	In Part		Q1 26/27	
Develop draft dashboard for imaging 4. Expand to include all diagnostics	Q2	Karen Priestman / BI&I	James Hawkins	No	Dashboards for imaging and endoscopy now completed. Dashboard for physiological diagnostics not yet developed yes.	Q1 2627	Kim Hinton
Replacement of CT3 4. Capital build	Q4	Karen Priestman / Andrew Bennett	Claire Hansen / Chris Norman	No	The CT3 Project is on site at YH and will be completed in Q2 2627. the scope of work increased due to additional backlog maintenance work that was not identifiable until the area was made available to the project team.	Q2 2627	Andrew Bennett

Implement Radiology text reminders	Q4	Lisa Shelbourn/Amber Lee	James Hawkins	No	Implementation of radiology text reminders is now scheduled for completion in May, later than the originally planned end-March date. This delay has arisen due to an unexpected coding amendment on a separate but interdependent project.	Q1 2627	Amber Lee

Reduction in CAT2 Pressure Ulcers

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Develop and implement standardised digital care plans and assessments within 6 months.	Q3	Emma Hawtin	James Hawkins	Partly	They are built and will launch in Q4 on Nervecentre final viewing has commenced in Q4 this has been built awaiting the launch of Nervecentre at the end of Feb 26 Launch did not proceed new date for May therefore 2026	Q1 26/27	Emma Hawtin
Ensure 100% of relevant clinical teams are trained on the new EPR and photography processes.	Q3	EPR implementation team & Helen Williams	James Hawkins	No	Training and view of the digital forms were not available in Q3 focus work for Q4 A trust priority is to ensure all staff are trained for nerve centre (80% by go live Feb/March 2026)	Q1 26/27	Emma Hawtin
Reduce referral processing times by 10% through the use of clinical images for faster triaging.	Q4	Emma Hawtin	James Hawkins	No	Was dependent on Nervecentre being introduced this was postponed new date working towards is May 2026	Q2 26/247	Emma Hawtin
Improve accuracy of wound and pressure	Q4	Emma Hawtin	James Hawkins	No	Tied to the implementation of the EPR nerve centre	Q2 26/247	Emma Hawtin

ulcer assessments by 60% as validated through audits.							
Development of a long-term plan to ensure a cost approved plan going forward	Q2	Helen Williams	Dawn Parkes	Partly	Chair audit has been completed, and a report/paper has been prepared for submission to the Executive Team, as a business case will be required. The Chief Nurse has agreed with the proposal for moving forward. The lack of appropriate seating has been recognised on the chief nurse risk register. the costing has been submitted to the Trust planning for finance for the next financial year. a further exploration with charitable Funds has also commenced. Seating was not included in any trust wide replacement plan. Work is underway to secure capital funding from the next financial Year. 10/02/26 Chair audit completed which identified significant investment needed to replace seating. Lack of recurrent investment was identified as a barrier. Partial investment has been identified in Q4 through the capital programme and charitable funds to progress a partial seating replacement programme. This will now progress towards implementation with high-risk wards/departments being prioritised. March 2026 37K has been secured from charitable funds to procure 91	Q1 26/27	Emma Hawtin

					high level seats however currently no funding is available in the capital funding for next year although it will remain a priority and if any funding becomes available it will be allocated to this project - a further piece of work now is to commence to prioritise and re-distribute stock to high risk areas as identified.		

Reduction in MSSA Infections

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Review the guideline for cleaning and decontamination of the environment	Q2	Jo Dea	Dawn Parkes	No	26/03/2026 Cleaning Policy was not approved at March's Infection Prevention Strategic Assurance Group (IPSAG) and to be re-presented at IPSAG on 15/04/2026 10/02/26 Policy for cleaning standards revised. Delays have occurred due to number of comments received and recent amendment of national guidelines for National Cleaning Standards. Revised policy scheduled for approval via Infection Prevention Strategic Assurance Group (IPSAG) and Executive Committee in March 202610/02/2026 final revisions being made. Policy will then need to go through IPSAG and Executive Committee in March 2026. Delays have occurred due to number of	Q1 26/27	Sue Peckitt

					comments and recent amendment of national guidelines		
Implement the guideline for cleaning and decontamination of the environment	Q3	Jo Dea	Dawn Parkes	No	26/03/2026 Cleaning Policy was not approved at March's Infection Prevention Strategic Assurance Group (IPSAG) and to be re-presented at IPSAG on 15/04/2026 10/02/26 Policy for cleaning standards revised. Delays have occurred due to number of comments received and recent amendment of national guidelines for National Cleaning Standards. Revised policy scheduled for approval via Infection Prevention Strategic Assurance Group (IPSAG) and Executive Committee in March 2026	Q1 26/27	Sue Peckitt
Antimicrobial Stewardship Drive improvement with IV to oral switch (IVOS) of antibiotics	Q3	TBC	Dawn Parkes	In progress	26/03/2026 Remains an agenda item on Antimicrobial Stewardship meeting. Improved attendance from care groups noted. IVOS as a workstream continues which will be further supported when Nerve Centre goes live. IVOS data collection on all Care Group IPC/AMS meeting agendas, residents nominated in surgery, data collected in CSCS, medicine and Family to identify medical representative from the care groups. Data presented at Trust AMS Group and being shared and discussed at Care Group IPC/AMS meetings	Q2 2026/27	Sue Peckitt

Antimicrobial Stewardship Refresh and promote standardisation of the MSSA/MRSA skin decolonisation guidance	Q2	TBC	Dawn Parkes	No	26/03/2026 Surgical team reviewing decolonisation guidance. Specialist medicine reviewing guidelines and developing options appraisal. To be discussed at IPSAG in April 2026. Work has commenced and is being reviewed as part of the Trust IPC improvement plan agreed at IPSAG in October 2025	Q1 26/27	Sue Peckitt

Improvement in the % of staff who would recommend the Trust as a place to work

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Building establishment control in the system	Q4	Amy Messenger	Polly McMeekin	No	(Updated 01/04) Preparatory work commenced to support building establishment control in ESR, this included cleansing data and naming conventions for nursing roles. The work paused due to challenges getting the level of budgetary information needed and is now being reviewed as a whole alongside manager self service as part of the preparation for the new workforce solution (ESR II), as the organisation will need to prioritise resource to be in a state of readiness to implement the new system. This work is being overseen by the Payroll and Workforce Improvement Programme, and a paper will be written in Q1 to describe the Trusts planned approach.	Propose to close. Project is under the review of Payroll and Workforce Improvement Programme.	Amy Messenger

Increase utilisation of the applicant dashboard to collect personal information	Q4	Amy Messenger	Polly McMeekin	No	(Updated 01/04) Interdependent with the action below re updating of HR/Payroll forms this work is on hold. Initial meetings were held to reduce the information required on HR1 forms by using the applicant dashboard instead. This was paused while development of a customer service portal/desk was developed for Payroll that would integrate the HR forms. Increased utilisation of the applicant dashboard will progress alongside this work.	Anticipated Q3-Q4 26/27 (resource dependent). Project is under the review of Payroll and Workforce Improvement Programme.	Amy Messenger
Develop new processes to improve the collection and flow of data e.g. HR/Payroll forms	Q4	Amy Messenger	Polly McMeekin	No	(Updated 01/04) Work commenced to deliver this action but was put on hold after a new development was planned by Payroll to introduce a customer service portal/desk which would integrate new forms to improve the flow of data. This project is part of the Payroll and Workforce Improvement Programme, with an interdependency on Finance resource. It has been delayed due to the prioritisation of other payroll projects e.g. weekly to monthly pay and annual leave averaging. Now these projects are coming to a conclusion, the intention is to refocus on the delivery of the customer service portal/desk.	Anticipated Q3-Q4 26/27 (resource dependent). Project is under the review of Payroll and Workforce Improvement Programme.	Amy Messenger

Green Plan Support Tool

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Sustainable Models of Care workstream development	Q1	Caroline Dunn	Dawn Parkes	No	10/02/26 Draft workstream suggestions in place and incorporated into Green Plan for the Trust - awaiting sign off. 01/04/2026- Awaiting sign off. Lack of robust project oversight identified as an issue. New action owner identified to commence 1 April 2026	Q1 26-27	Tara Filby
To review and update the Sustainable Models of Care section of the Green Plan with KPI and outcomes about when each identified project/item.	Q3	Caroline Dunn	Dawn Parkes	No	10/02/26 Delayed due to operational pressures. Project leads to be identified in Q4 to agree specific streams of work and relevant KPIs wider than nursing - to report progress to the Sustainable Development Group in March 2026. 01/04/2026 workstreams updated in March, e.g. wound dressings, ward stock procurement. Meeting took place week commencing 23rd March with Rob Newton and Stuart Parkes. Further meeting scheduled. New overall action owner identified to commence 1 April 2026	Q1 26-27	Tara Filby
Sustainable Models of Care workstream to ensure it contributes and delivers against the 15% improvement target and 5.7% in CO2 reduction of 2025/26	Q3	Caroline Dunn	Dawn Parkes	No	10/02/26 A cost-wise group has been established in Q3 meeting bi-weekly to streamline procurement of stock items. Furthermore, service costs have been challenged and scrutinised and changes made, e.g. continence product standardisation, taxi usage, patient transport, that will contribute to the sustainability agenda. 01/04/2026 Meetings continue fortnightly	Q1 26-27	Caroline Dunn

Sustainable Models of Care workstream to deliver against the main current Green Plan target to: Increase the percentage of virtual outpatient consultations (video and telephone)	Q3	Caroline Dunn	Dawn Parkes	No	10/02/26 This item will be reviewed with ACOOs/ACNs to agree the sustainability schemes for 2026-27.1/4/26 Meeting took place week commencing 23rd March with Rob Newton and Stuart Parkes. Further meeting scheduled. Scheme has lacked robust project oversight due to capacity constraints. New overall action owner identified to commence 1 April 2026.	Q1 26-27	Caroline Dunn

Reduction in Carbon Footprint (tCO2e)

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Reduction in carbon emissions from building energy usage to be -927tCO2e in order to meet overall reduction of 1,350tCO2e	Q4	Tunde Oyeledun / Daniel Emmott	Chris Norman	Ongoing	On track at the end of Q3 25/26. The year end position will be confirmed following collection of Q4 data in Q1 of 26/27.	Emission data released in Q1 26/27	Andrew Smith/Graham Titchener
Reduction in carbon emissions from anaesthetic gases and inhaler usage to be -150tCO2e in order to meet overall reduction of 1,350tCO2e	Q4	Sam Jackson	Stuart Parkes	Ongoing	Increased nitrous oxide usage in 2025/26 means we won't see a CO2e reduction this year. However, we plan to decommission the nitrous oxide manifolds in the next few months which will see a big drop in emissions next year.	Emission data released in Q1 26/27	Andrew Smith/Graham Titchener
Reduction in carbon emissions from Trust vehicle fleet, grey fleet and business travel to be -98tCO2e in order to meet	Q4	Dan Braidley/Kevin Richardson	Chris Norman	Ongoing	2025-26 tCO2e data won't be available until the end of May 2026, so unable to give an accurate progress report until then.	Emission data released in Q1 26/27	Andrew Smith/Graham Titchener

overall reduction of 1,350tCO2e							
Reduction in carbon emissions from waste streams and water usage to be -25tCO2e in order to meet overall reduction of 1,350tCO2e	Q4	Jo Dea/Hugh Stelmach	Chris Norman	Ongoing	2025/26 waste streams data will not be available until May 2026, but 2024/25 saw a massive reduction of 44tCO2e	Q4	Hugh Stelmach

Achieving Financial Balance

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
All CIP opportunities to have NHSE 4 tests applied in line with NHSE Closedown letter	Q1	Sarah Barrow	Andrew Bertram	No	125 out of 155 schemes (81%) have PiD created with 4 tests applied.	Q4	Sarah Barrow
50% CIP plans in progress to have Project Initiation Documentation (PID) initiated in line with NHSE Closedown letter	Q1	Sarah Barrow	Andrew Bertram	No	23 out of 48 schemes (48%) have PiDs completed to Plan in Progress status. EDG ask to complete EQIAs for outstanding schemes in January.	Q4	Sarah Barrow
100% CIP plans in progress to have Project Initiation Documentation (PID) initiated in line with NHSE Closedown letter	Q2	Sarah Barrow	Andrew Bertram	No	23 out of 48 schemes (48%) have PiDs completed to Plan in Progress status. EDG ask to complete EQIAs for outstanding schemes in January.	Q4	Sarah Barrow
All CIP fully developed plans to have completed PID in line with NHSE Closedown letter	Q2	Sarah Barrow	Andrew Bertram	No	102 out of 107 schemes have fully completed PiDS (95%)	Q4	Sarah Barrow

62% of total target to be delivered by end of Q3	Q3	Sarah Barrow	Andrew Bertram	No	50.2% (£27.7m of £55.3m target) has been delivered at Q3	Q4	Sarah Barrow
100% of total target to be delivered by end of Q4	Q4	Sarah Barrow	Andrew Bertram	No	73.2% (£40.5m of £553m target) as been delivered at the end of Q4	N/A	Sarah Barrow

At year end, the Trust successfully delivered 73.2% of its efficiency target, which equates to 4% of operational expenditure. However, only £10m of the £40m total (25%) was achieved on a recurrent basis, which contributes to the target set for 2026/27. Given the significant WRAP target set for 2026/27, the Trust acknowledges the need for enhanced governance arrangements. In response, Finance Improvement Boards have been introduced to oversee delivery, ensuring robust controls and accountability throughout the year.

To achieve future objectives, the Trust will prioritise waste reduction, productivity improvements and transformative initiatives, supported by strengthened governance processes.

The Trust continue to work with KPMG, through the joint procurement with Harrogate & District Foundation Trust to provide a financial diagnostic, reviewing income, expenditure, cost drivers, trends, and structural pressures and the financial governance review which will assess the robustness of financial controls and WRAP governance. KMPG are supporting the Trust in validating current WRAP plans.

Staff Survey: I am confident that my organisation would address my concerns

Actions	Completion Quarter	Action Owner	Responsible / Accountable Person	Complete Yes/No	Update narrative	Revised Delivery Quarter	Update provided by (add name)
Implement FTSU Board Gap Analysis Recommendations	Q4	Stef Greenwood	Polly McMeekin	In Part	A number of recommendations have been implemented such as the Sexual Safety Charter an anonymous reporting - others are ongoing.	Q2 26/27	Polly McMeekin

Report to:	Board of Directors
Date of Meeting:	29 April 2026
Subject:	Care Quality Commission (CQC) Update
Director Sponsor:	Tara Filby, Interim 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:

On Tuesday 14 April, the Care Quality Commission (CQC) notified the Trust of an unannounced onsite inspection of Maternity Services. The CQC inspection team were onsite at York Hospital on the 14 and 15 April and Scarborough Hospital on the 16 and 17 April.

The CQC completed an IRMER inspection of Nuclear Medicine at York Hospital in January 2026, identifying no breaches but raising two recommendations, with the Trust aiming to submit its action plan on 27 March 2026.

Following the unannounced October 2025 inspection at Scarborough Hospital, the CQC published its report in March 2026, requiring the Trust to address six regulatory breaches by 10 April 2026.

Quarterly updates continue to be provided to the CQC on actions arising from the York Hospital inspection published in July 2025, which also identified six breaches. Ongoing engagement includes preparation to remove Section 31 conditions relating to mental health care in the Emergency Department and scheduled CQC visits, including a Surgery inspection at York Hospital on 21 April 2026.

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 and Scarborough Hospital Inspection of Maternity Services

On Tuesday 14 April, the Care Quality Commission (CQC) notified the Trust of an unannounced onsite inspection of Maternity Services. The CQC inspection team were onsite at York Hospital on the 14 and 15 April and Scarborough Hospital on the 16 and 17 April. The inspection was a planned re-assessment following the 2023 inspection, where services were rated inadequate.

A letter confirming the verbal feedback provided at the end of the on-site inspection was received on 21 April 2026. This is included as **Appendix A** in this report.

1.2 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 but two recommendations were made. An action plan to address these recommendations must be submitted by 7 April 2026. At the time of writing the paper, the action plan had been approved and was being submitted on 27 March 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. **Click here to view**

The final report was published on 20 March 2026. The Trust must respond to six breaches by 10 April 2026 which are:

Urgent and Emergency Care

- **Regulation 10** The service was in breach of legal regulation in relation to dignity and respect as staff were not able to consistently maintain patient privacy and dignity due to the pressures on the department
- **Regulation 11** The service was in breach of legal regulation in relation to consent as staff did not review the recording of consent within local audits.
- **Regulation 12** The service was in breach of legal regulation in relation to safe care and treatment as it did they did not consistently make sure staff received effective support, supervision and development, did not always assess or manage the risk of infection, did not assess the risks to people's health and safety and did not always consistently monitor people's care and treatment to continuously improve it.

Medical Care

- **Regulation 12** The service was in breach of legal regulation in relation to Safe care and treatment as it did not ensure that staff have the qualifications, competence, skills and experience to keep people safe.
- **Regulation 17** The service was in breach of legal regulation in relation to good governance as staff did not assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service.
- **Regulation 16** The service was in breach of legal regulations in relation to receiving and acting on complaints as staff did not have an effective and accessible system, for identifying, receiving handling and responding to complaints from people using the service.

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 April 2026.

1.5 Ongoing CQC Engagement

Quarterly engagement meetings are scheduled with our CQC colleagues and a workplan for 2026 has been developed. The CQC will be on-site at York Hospital for a visit to Surgery on 21 April 2026

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 27 March 2026, there are 21 open CQC cases. Of these:

- Eight 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 B**.

3. CQC Updates

3.1 Sector-based approach to regulation

At the end of last year, the CQC consulted on proposals to improve the approach to assessing and rating health and social care providers. They are now moving forward with plans for a sector-based approach to regulation. An initial four draft sector-specific assessment frameworks have been developed for:

- adult social care
- mental health care
- primary care and community services
- hospitals (secondary and specialist care)

Click here for more information

3.2 CQC publishes research on good practice for dementia care

The CQC published a research report on good practice in health and social care services when caring for people living with a type of dementia.

The report shows the findings of a review of good practice published by UK and worldwide universities and organisations in health and social care in supporting people with dementia. The information has been shared with the Trust Safeguarding and Complex Needs Team.

Click here for more information.

Date: 27 March 2026

Appendix A – Maternity Services Feedback

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Sent by Email

Our reference: AP20892 and AP20902

Clare Smith
Chief Executive
York and Scarborough Teaching Hospitals NHS
Foundation Trust
Wigginton Road
York
YO31 8HE

20 April 2026

CQC Reference Number: AP20892 and AP20902

Dear Clare

Re: CQC inspection of Maternity at The York Hospital and Scarborough Hospital

Provider ID: RCB

Following your feedback meeting with Gillian and Rachel on 17 April 2026, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Tara, Sasha, Adele and Emma at the feedback meeting.

This letter does not replace the draft report we will send to you but simply confirms what we fed-back on 17 April 2026 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

The feedback to you was:

Areas for improvement across both sites

- Continued concerns for recovering post operative patients and staffing provisions for this
- The current gap in leadership, while the deputy posts remain unfilled, and the significant resilience shown by Sasha and her team during this period
- Low compliance with latest CTG audit 27%

York

- We found COSHH stored unsafely in unlocked areas accessible to patients and their visitors
- We found out-of-date consumables across various areas
- In some rooms we noted the cleaning records showed gaps

Scarborough

- Continued issues with estates footprint with regards to storage of equipment and breast milk

Positive findings across both sites

- Good multidisciplinary working
- All areas we visited were clean and equipment checks were completed
- Good care record keeping with evidence of individualised care
- Good governance and assurance
- Staff were actively encouraged and engaged to support change
- Good partnership working with external stakeholders
- Care and kindness between staff and patients, and between staff
- Use of specialist midwifery roles
- Continuity of care for patients
- Good preceptorship programme for newly qualified Band 5s

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to David Purdue at NHS England.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Rachel Beynon and Gillian Appleby

CQC inspectors

c.c. NHS England england.cqcreportsney@nhs.net

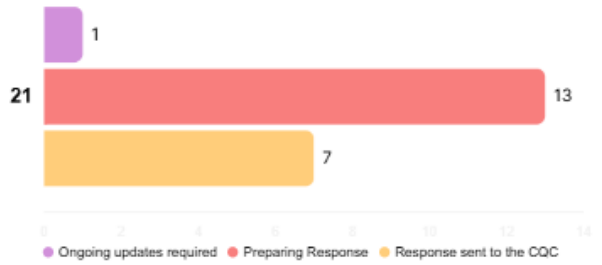
David Purdue david.purdue@nhs.net

Appendix B – CQC cases received over the last 12 months

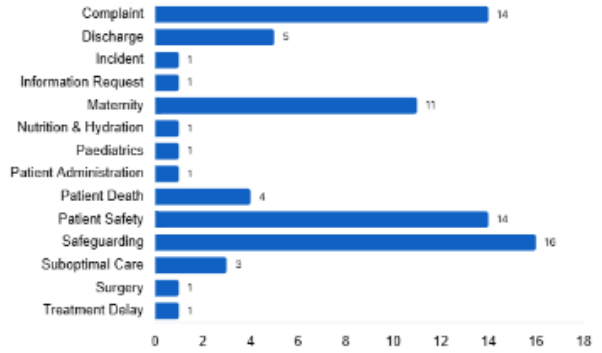
CQC Enquiries over the last 12 months

York and Scarborough Teaching Hospitals NHS Foundation Trust

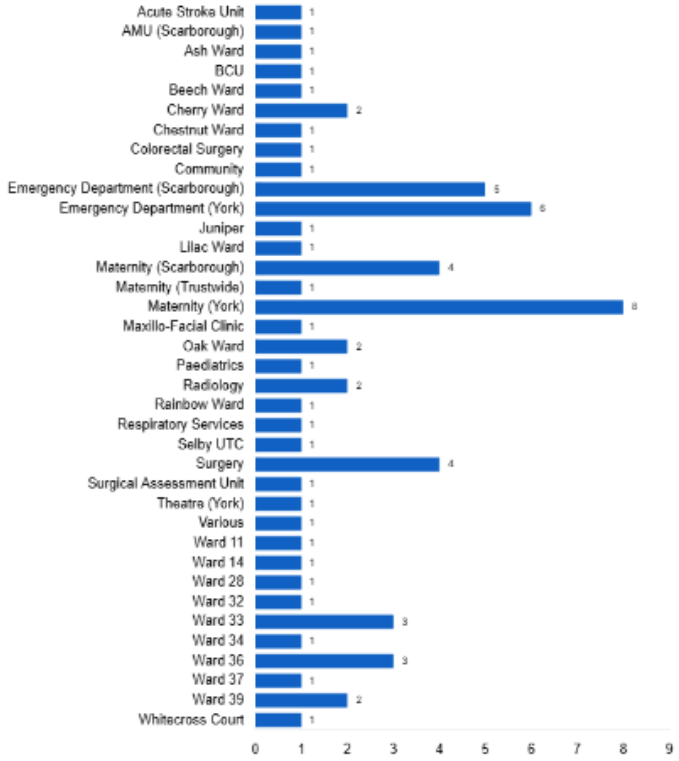
Number of Open CQC Enquiries / Cases



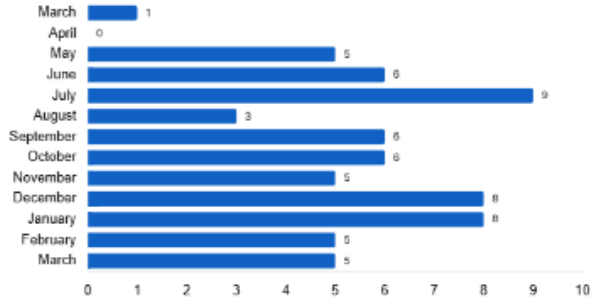
Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Number of Enquiries Received



Report to:	Trust Board of Directors
Date of Meeting:	29 April 2026
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Tara Filby, Interim 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.
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Board Assurance Framework

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

Implications for Equality, Diversity and Inclusion (EDI)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The purpose of the report is to inform the Trust Board 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 February 2026 for performance metrics and March 2026 for workforce, unit diverts and homebirth service provision.

Key Assurance

- The Trust perinatal mortality rate remains at 3.95 /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 2.84% per 1000 births and the neonatal rate is 1.1 per 1000 births which is average for similar Trusts.
- The postpartum haemorrhage (PPH over 1500 mls) rate for February was 4 % (12 cases) based on the national data the trust is not an outlier for PPH rates.
- Year 7 MIS compliance submitted with 7/10 safety actions. Key MDT personnel identified to attend MIS Year 8 Launch event in April 26.
- The newly appointed Deputy Director of Midwifery will commence in role on the 1 June 2026.

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 30.43 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.
- There is a concern associated with the reallocation of the Maternity and Neonatal Programme Manager to support another organisational programme. This would present significant challenges to the delivery of the Maternity and Neonatal Single Improvement Programme, including loss of specialist expertise, reduced strategic oversight, diminished programme capacity, and delays in decision-making, ultimately impacting programme momentum and delivery. The Director of Midwifery and the Programme Manager for the Maternity and Neonatal Improvement Programme have jointly produced a paper outlining these risks and their potential impact. This has been shared with the Chief Operating Officer and Chief Executive for consideration.

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

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 February 2026, and data for March 2026 for workforce, unit diverts and homebirth service provision.

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 (PQSM), the Service is required to report the information outlined in the data measures monthly to the Trust Board. The PQSM data for February 2026 is provided in a separate paper.

Perinatal Deaths

There were no stillbirths and one neonatal death at 23+0 weeks at York and Scarborough in February 2026.

Maternity and Newborn Safety Investigations (MNSI)

There were no incidents that met the criteria for reporting to the Maternity and Newborn Safety Investigation (MNSI) programme during February 2026. One final report was received (MI-045956) under the criteria of potential brain injury. The report identified five safety recommendations, an improvement plan has been developed and presented to the Trust PSI Group.

Moderate Harm Incidents and above

There were 15 incidents graded moderate or above in February 2026 along with three red flags as per NICE guidance reported which were one delay in induction of labour for more than 24 hours, a delay in assessment in maternity triage unit and one delay in caesarean section. The red flag incidents have been reviewed by the ward managers for the areas for immediate learning.

Maternity Unit diverts/ closures and suspension of services

In March, the maternity services had to divert on two occasions between York and Scarborough sites. Both diverts were from Scarborough to York due high acuity in the Scarborough unit, to ensure women received essential planned care safely. No women were affected through this period of formal divert.

In March there were 0 days where a 24 hour homebirth service could be provided on the East Cost, and 6 days where a 24 hour homebirth service was provided across York and Selby. Homebirth services were suspended 22 times for Scarborough and the East Coast and 17 times for York services due to inability to provide on call overnight. Providing continuity of antenatal care and staffing sickness/vacancy rates continue to be the challenge to provide 24hour homebirth service.

Community midwives completed 3 homebirths in York and Selby during March, with 1 homebirth on the East Coast not supported due to staffing. A further 3 homebirths were supported by independent midwives who had been engaged to provide service (1 East Coast and 2 York). There were no BBAs or freebirths in March, across the service. The

Director of Midwifery is in conversation with the legal team for a legal stance on "Threatened Freebirthing" and implications for homebirth service provision.

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 and May 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.

Midwifery Workforce

	March 2026
Establishment budget (band 5&6)	157.75 WTE
Staff in post (band 5&6)	164.09 WTE (includes supernumerary B5)
Roster vacancy	30.43 WTE

This shows an over recruitment to current establishment, due to recruitment to cover maternity leave and career breaks, totalling 10.44WTE- 6.11 WTE at York and 4.33 WTE at Scarborough.

Unregistered workforce (B3&4)

There is a vacancy rate of 8.30WTE at York, and -0.54WTE at Scarborough, totalling 7.76WTE vacancy. An additional 4.42WTE Band 3 and 4s commenced in employment in March across the service, reducing the vacancy position. This will be reflected in the April data.

Internal recruitment of HCSWs resulted in appointment of 3.32WTE B3 Maternity Assistants (1.52WTE Scarborough and 1.8WTE York). 1.6WTE Labour coordinator for York, were appointed in the March recruitment. The newly appointed Manager for Hawthorne Ward (Scarborough) and Community Equitable Health Midwife commenced in post in April. Recruitment to the Workforce and Retention Lead post (fixed term to cover maternity leave) was successful at interview, awaiting confirmation of acceptance.

Improvement and Transformation in March 2026

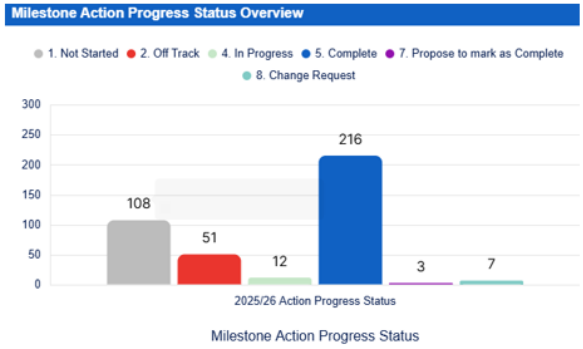
- The Maternity services website refresh proposal was drafted and has been shared at Maternity Directorate;
- CQC survey action plan is being developed with a number of actions already progressing within the improvement plan. In response to the CQC Maternity Services survey, actions have been developed and incorporated in response to pain relief options and timeliness of pain relief on maternity wards
- The Maternity and Neonatal Voices Partnership launched a Homebirth survey with service users
- A Quality Improvement project to facilitate partners to provide support outside of visiting hours is to commence via the Hot Topics forum;
- The baseline of the bereavement service against National Bereavement Care Pathway was completed;
- Maternity and neonatal escalation plan internal training with for labour ward coordinators and first on call managers was completed. The escalation plan launched on the 1st April;
- Rebanding for maternity non-registered workforce B3 to B4 aligned to the trust general nursing approach is complete;
- The national MEWS test cloud went live on badgernet;
- A summary of the "kindness is our culture" event was circulated to staff. An "accept / don't accept" behavioural charter and simple pathway to navigate and support staff will be developed based on the information gained at the engagement day;
- Induction of Labour guideline audit findings being presented in May 2026.
- Decision on neonatal unit cot capacity to be agreed with the ODN to inform finalisation of the neonatal nursing business case (delivery of action dependant on ODN)
- Successful 4-week trial of the G3 main entrance reception role carried out, second trial planned for May 26.
- The co -produced Caesarean birth patient information leaflet has been reviewed and uploaded onto the Intranet and website;

The Maternity and Neonatal Single Improvement Plan (MNSIP)

March 2026 Position

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

- **216 out of the 397 milestone actions have been completed to date** (6 actions completed in March 2026)
- **11 milestone actions are in progress**
- **51 milestone actions are off track as the delivery date has passed, and the action has not been completed**
  - 3 of which will be completed by 30/04/2026
  - 3 of which require evidence before being marked as complete
  - 45 off track milestone actions have been rescheduled for delivery in 2026/27
- **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.
  - 1 milestone action requires breaking down into career progression planning for each profession and is incorporated into the 2026/27 delivery plan.
- **108 milestone actions are not scheduled to start yet**



Milestone Action Progress Status

Key Risks to Delivery of the Single Improvement Plan

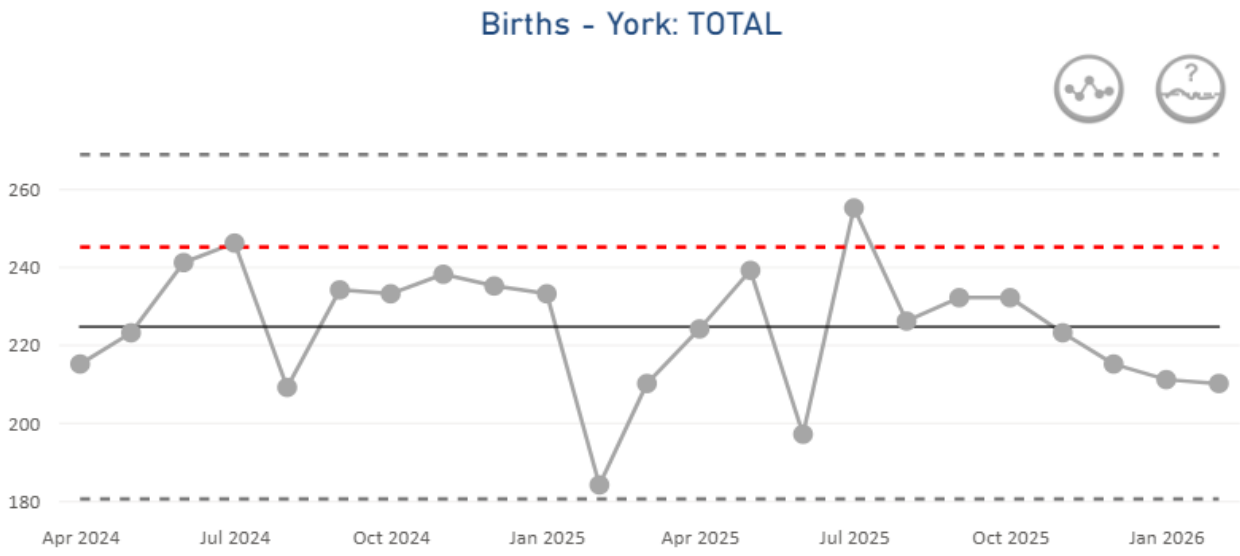
The risks to delivery of the MNSIP have been reviewed and scores updated

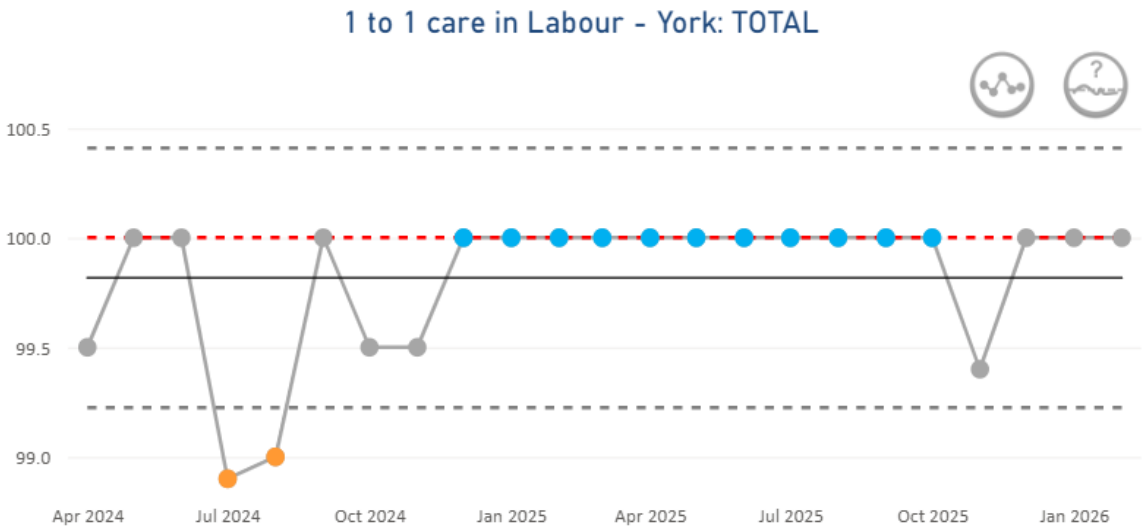
Risk title	Risk Description	Risk score
Risk of timeline delays impacting overall programme delivery	There is a risk that key programme actions may not be completed within planned timelines due to factors such as interdependencies with other services, delayed decision making, delayed governance processes, resource constraints, extended stakeholder reviews, or unforeseen operational pressures. These delays can cause slippage across key milestones, affecting the ability to meet overall delivery timelines.	12 *Impact: High* *Likelihood: Medium*
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, MNVP etc.) may: leave the organisation, move roles, be reallocated to support alternative programmes of work or may not have an identified recurrent funding source. Loss of key staff may lead to gaps in expertise, reduced institutional knowledge, delays in decision making and reduced programme level strategic oversight which will decreased programme momentum..	16 *Impact: High* *Likelihood: High*
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)	16 *Impact: High* *Likelihood: High*

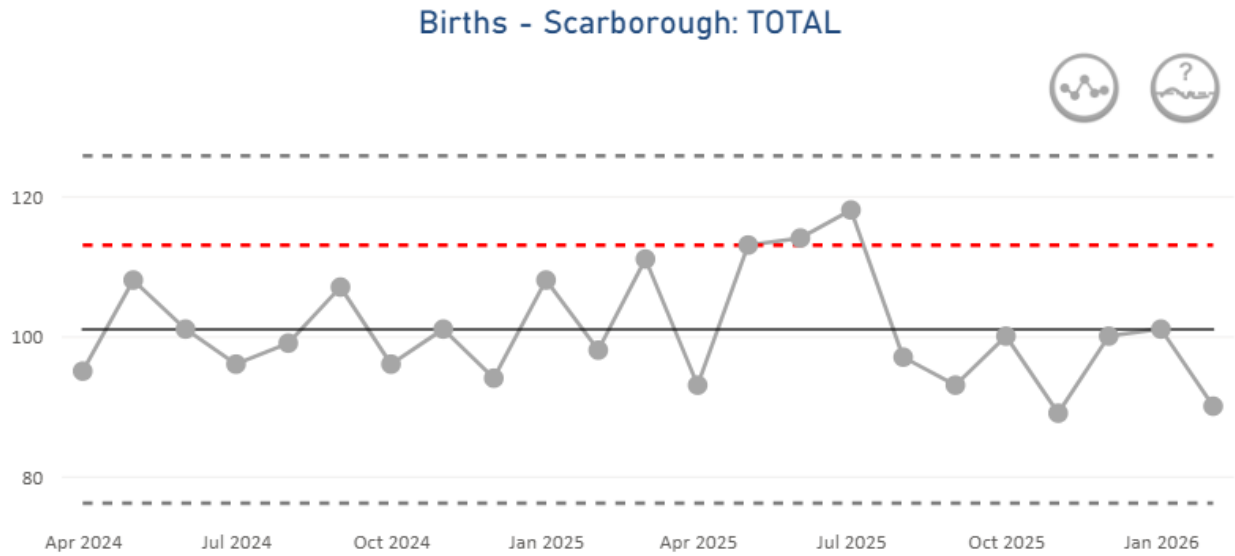
Recommendations to Trust Board
To note the contents of this report

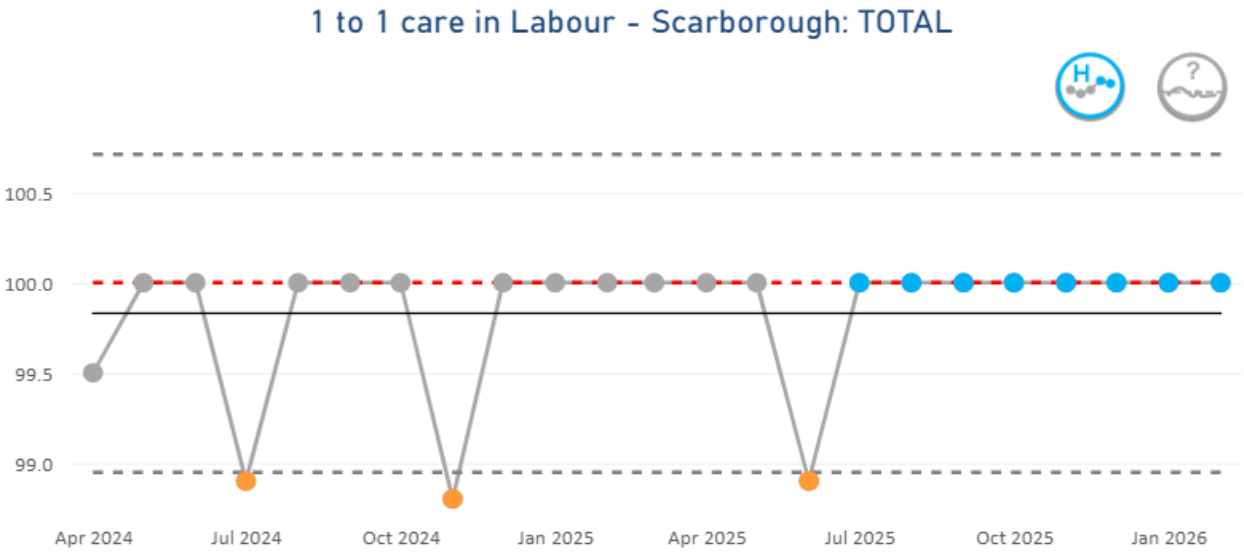
Date: April 2026

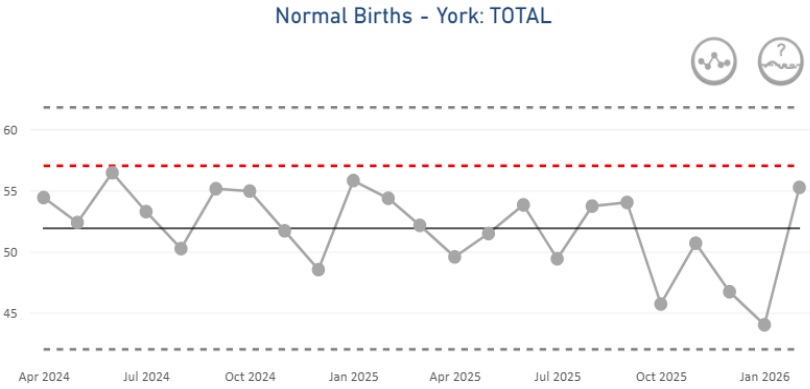
Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery February 2026

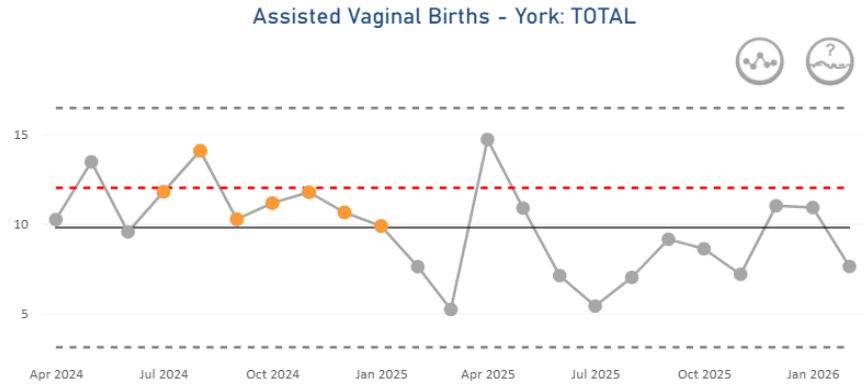


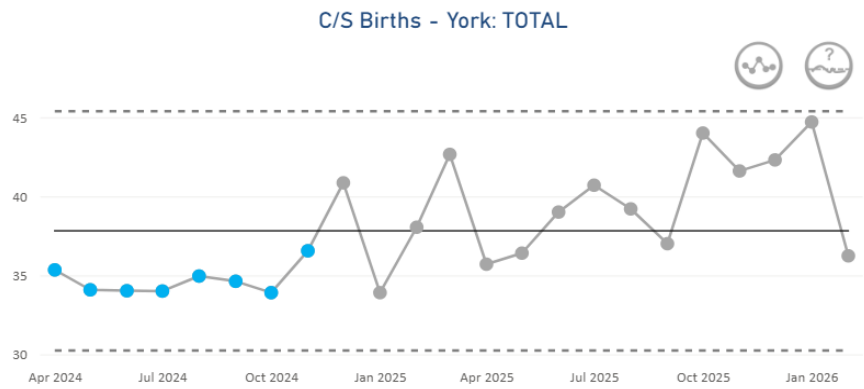


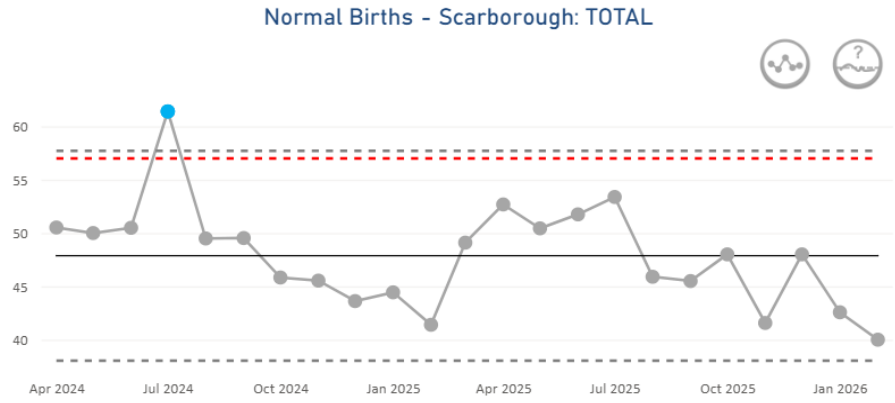


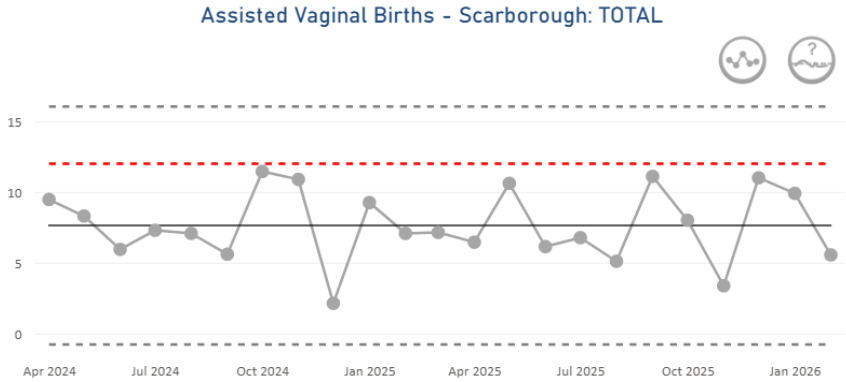

1 to 1 care in Labour - Scarborough: TOTAL
100.5
100.0
99.5
99.0
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

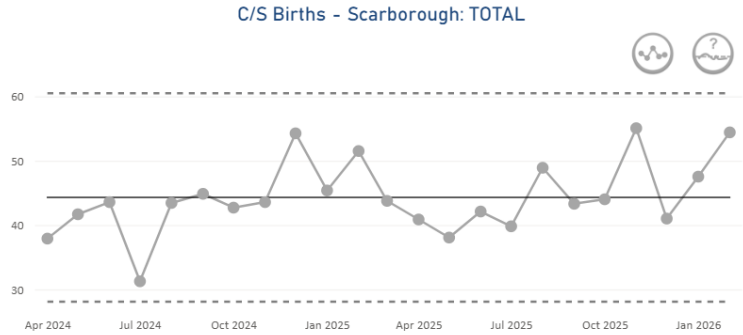

Normal Births - York: TOTAL
60
55
50
45
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

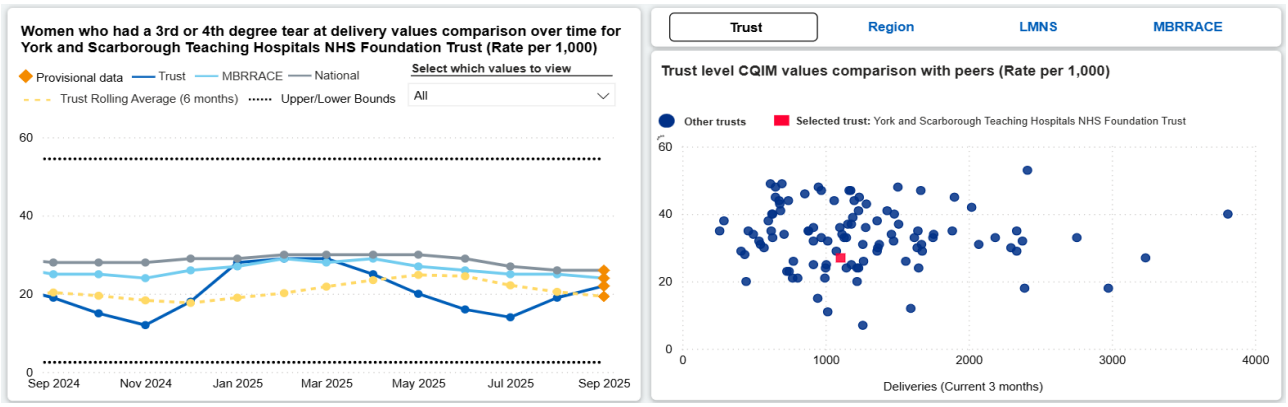

Assisted Vaginal Births - York: TOTAL
15
10
5
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026


C/S Births - York: TOTAL
45
40
35
30
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)

Report to:	Board of Directors
Date of Meeting:	Wednesday 29 April 2026
Subject:	Freedom to Speak Up
Director Sponsor:	Clare Smith, Chief Executive
Author:	Stefanie Greenwood, Freedom to Speak Up Guardian

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

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

This report provides the Board with an update on Freedom to Speak Up activity during Quarter 4 2025/26, highlighting a significant increase in concerns, particularly relating to psychological safety, behaviours, workforce wellbeing and patient safety, and outlines the impact of actions taken in response. Based on the data, trends and actions described, the report provides assurance that Freedom to Speak Up continues to operate as an effective early-warning system supporting patient safety, organisational learning and staff confidence to speak up.

Recommendation:

The Board is asked to:

1. Note the continued increase in Freedom to Speak Up activity and associated demand, particularly in relation to psychological safety, behaviours and workforce wellbeing.
2. Take assurance from the actions described in this report relating to escalation, feedback, leadership engagement and organisational learning, recognising Freedom to Speak Up as an effective early-warning system for patient safety and culture.
3. Acknowledge the implications of increased demand on capacity and timeliness of response, and support continued focus on visible learning, feedback and leadership role-modelling to maintain staff confidence to speak up.

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

No ☒ Yes ☐

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

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

Meeting/Engagement	Date	Outcome/Recommendation

Freedom to Speak Up

1. Introduction and Background

The Freedom to Speak Up Guardian provides a vital, independent, confidential route for staff to raise concerns where they may feel unable to do so through local management structures. This enables earlier identification and escalation of patient safety risks, workforce, behavioural and, including issues that may otherwise remain hidden due to fear of detriment or retaliation. Without this role, there is a heightened risk that patient safety risks and unsafe behaviours, poor culture go unreported until harm occurs, limiting the Trust's ability to act preventatively and undermining Board assurance.

2. Current Position/Issues

2.1 The future of Freedom to Speak Up April 2026

NHS England's recent publication *The future of Freedom to Speak Up* (April 2026) confirms that Trusts now carry greater responsibility for embedding effective Freedom to Speak Up arrangements and demonstrating that they work in practice. National support will remain, but impact, learning and assurance sit clearly at provider level. These changes reinforce existing expectations of effective local Freedom to Speak Up arrangements, rather than introducing a fundamentally new role for Trust Guardians.

2.2 Number of concerns raised via FTSU

Since the Guardian's appointment in 2020, the volume of FTSU cases has increased year on year, rising from 104 cases in 2020/21 to 330 cases in 2025/26. This represents a 73.7% increase compared to 2024/25 and a sustained upward trajectory over time. Quarter 4 (January–March 2026) recorded 101 concerns, a 60% increase compared with Quarter 4 of the previous year, demonstrating continued reliance on the FTSU route as a mechanism for escalation and support.

See Appendices for chart illustrating FTSU concerns raised monthly April 2024-March 2026

2.3 Themes of FTSU concerns Q4 2025/26

During Q4 2025/26, the Freedom to Speak Up Guardian received 101 concerns from workers across the organisation. 75.2% of FTSU cases related to worker safety/ wellbeing and psychological safety. This indicates a significant level of stress, with many individuals seeking psychologically safe support.

Concerns about bullying, harassment, and inappropriate behaviours made up 52.5%, highlighting ongoing challenges around interpersonal conduct and the need for continued focus on respectful workplace behaviours. Concerns escalated because:

- Informal routes did not resolve matters.
- Staff felt not listened to, dismissed, or discouraged.
- Managers named as barriers to speaking up in multiple cases.

For these cases, the FTSU Guardian supports in escalation to an appropriate person, signposts individuals to the Trust's Civility, Respect and Resolution Policy, HR, the anonymous reporting tool (where appropriate) and ensures wellbeing support.

Over one-third (34.7%) of concerns relate directly to patient risk or quality, reinforcing that FTSU remains a core early-warning system for safety, not just a cultural support function.

Health and Safety concerns represented 5% of concerns. The FTSU Guardian supports with escalation and ensures adequate oversight.

Overall, the data reflects a workforce that is actively using the FTSU route to raise a broad range of issues, with psychological safety, fear of retaliation and detriment, and behavioural concerns emerging as the most prominent themes.

See Appendices for charts illustrating Q4 FTSU data:

- ***Themes of FTSU cases.***
- ***Number of sexual misconduct cases raised via FTSU***
- ***Professional Groups speaking up via FTSU.***
- ***FTSU cases by Care Group/ Directorate.***
- ***FTSU cases by Trust site.***

2.4 Sexual misconduct concerns raised through FTSU

Sexual misconduct-related FTSU concerns have increased overall year-on-year, doubling from 6 cases in 2024/25 to 12 cases in 2025/26, with a peak in Q2 25/26. While the latter half of 2025/26 shows a reduction (2 in Q3 2025/26 and 1 in Q4 2025/26), the overall pattern indicates that sexual misconduct remains a live issue and that staff are using FTSU as a route to raise sensitive concerns.

This reinforces the importance of proactive prevention, clear reporting routes, and robust protections against detriment/retaliation, particularly as legal protections and employer duties in this area have strengthened.

2.5 Q3/Q4 2025/2026 comparison

Quarter 4 (101 cases) saw a marked increase in Freedom to Speak Up activity compared to Quarter 3 (68 cases), representing a 48.5% quarter-on-quarter increase and indicating significantly increased demand for the service in the final quarter of the year.

The Quarter 4 theme profile indicates that the increased demand is strongly associated with worker safety/psychological safety and behaviours/culture-related concerns, alongside ongoing patient safety/quality themes.

The increase from Q3 to Q4 has implications for capacity to respond, provide timely feedback, and ensure organisational learning is visible, particularly where concerns relate to psychological safety and behaviours.

Key risks

- Sustained increase in demand impacting timeliness of response and feedback
- Psychological safety and behavioural concerns remaining concentrated in some areas
- Risk of staff disengagement or escalation if feedback loops weaken

3. Impact and value of FTSU

3.1 Why Freedom to Speak Up matters

- Provides a safe, independent route for staff to raise concerns they cannot raise through line management
- Enables early identification of patient safety, quality, and workforce risks
- Supports psychological safety, staff confidence and retention
- Prevents escalation to formal complaints, litigation, regulators and public inquiries
- Provides the Board with critical intelligence on culture, leadership behaviours and system risks
- Meets legal and regulatory expectations, including PIDA and CQC “Well-Led” requirements

Feedback from concerns raised through the FTSU process this quarter has resulted in appropriate escalation of concerns to senior leadership to ensure patient safety risk is mitigated, local leadership actions to address concerns, clarification of working practices, and earlier resolution of workforce issues before escalation to formal grievance. Where appropriate, individuals have received feedback to ensure the feedback loop is closed.

3.2 Sexual Safety Group

The FTSU Guardian is a member of the Trust’s Sexual Safety Working Group, supporting objectives to ensure staff feel safe to speak up, are listened to with compassion, and are supported through clear, inclusive processes. Where sexual safety concerns have been raised, the Guardian has provided confidential drop-in sessions for staff and supported targeted improvement work, including within two Care Groups, working with senior leaders to develop actions to improve behaviours, sexual safety and the wider working environment.

3.3 Triangulation and partnership working

The FTSU Guardian works in partnership with the Patient Safety and Quality assurance teams and is a core member of the “Joining the Dots” group, to ensure triangulation of concerns, adequate action and timely support.

The FTSU Guardian attends JNCC and the Employment Policy Group to ensure that any learning from FTSU cases contributes to Trust wide learning and policy amendments.

3.4 Who are we not hearing from?

Part of the FTSU Guardian role is to consider who the Trust is not hearing from in relation to raising concerns. An impact assessment concluded that the number of bank workers raising concerns via FTSU is low therefore to mitigate the risk, revised communication is now readily available to that cohort of staff.

4. Considerations

4.1 Preventing sexual misconduct in the NHS

From 6 April 2026, disclosures relating to sexual harassment are explicitly included as a protected disclosure under the Public Interest Disclosure Act (PIDA). This clarification does not alter the role of the Freedom to Speak Up Guardian, who continues to support all colleagues to raise concerns, including sexual harassment, regardless of whether they meet the legal threshold of whistleblowing. This means employees who raise such concerns are legally protected from detriment or retaliation.

For NHS Trusts, this places increased responsibility on employers to provide safe, trusted and effective reporting routes, ensure timely and proportionate responses, and demonstrate a preventative approach.

From a Freedom to Speak Up perspective, this further elevates the importance of the FTSU Guardian role in supporting early disclosure, safeguarding staff, and providing assurance that sexual misconduct concerns are handled in line with legal, regulatory and cultural expectations.

From a governance perspective, this reinforces the importance of maintaining a healthy speaking up culture, where issues are raised early and addressed locally rather than escalated to the point where statutory whistleblowing protections become necessary

5. Summary

- Freedom to Speak Up activity continues to increase, with Quarter 4 showing a significant rise in concerns, particularly relating to psychological safety, behaviours and workforce culture.

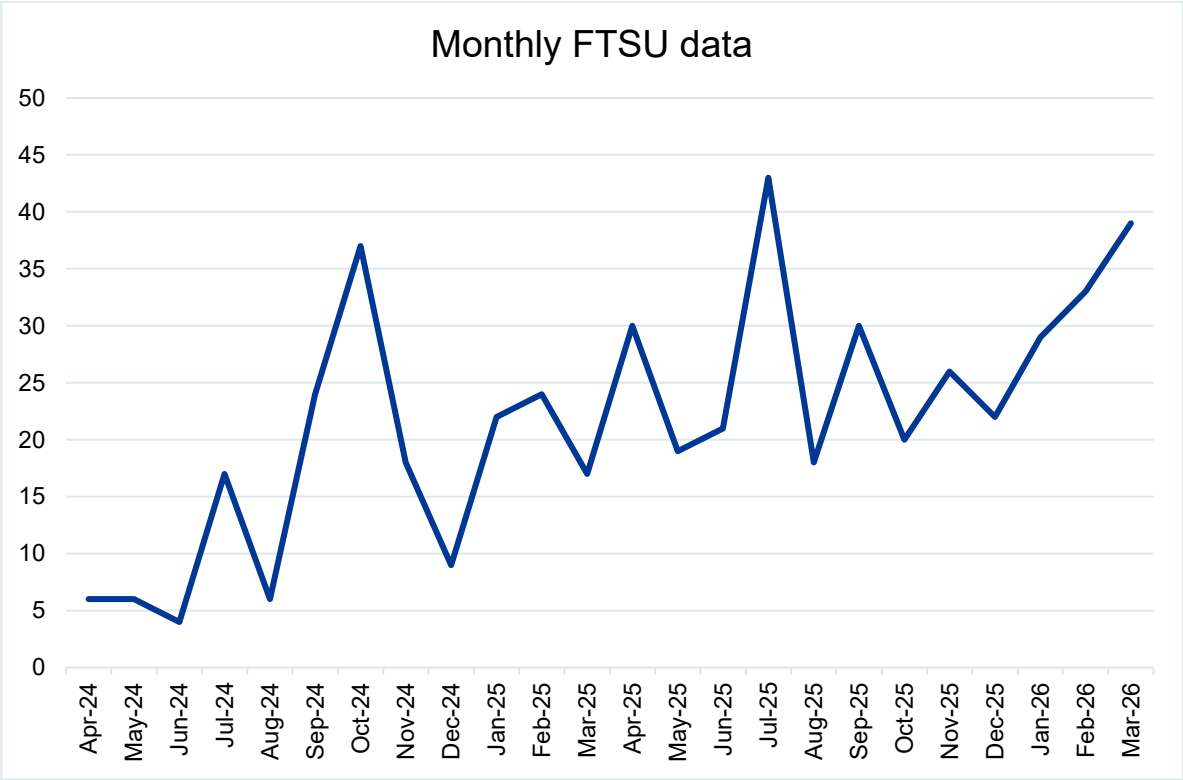
- NHS England's April 2026 update on the future of Freedom to Speak Up reinforces local accountability for demonstrating the impact of speaking up and embedding effective feedback and learning.

- The FTSU role continues to provide assurance to the Board through early identification of cultural and safety risks, targeted support to staff, and contribution to organisational learning.

- Strengthening feedback loops and visible learning from all speak up routes remain critical to staff confidence to speak up supporting a safe, healthy, open and learning culture.

Date: 21 04 2026

Appendices


Monthly FTSU data
50
45
40
35
30
25
20
15
10
5
0
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
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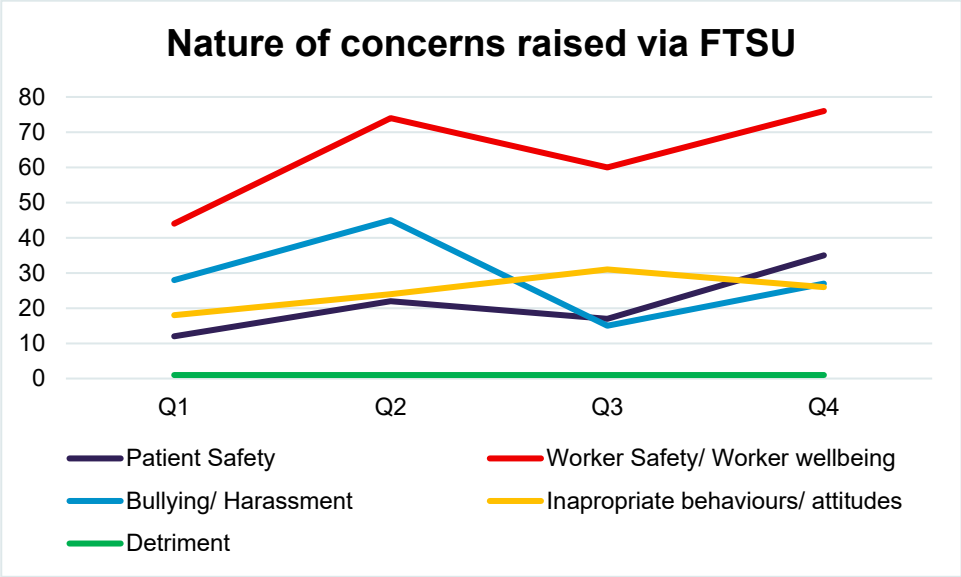
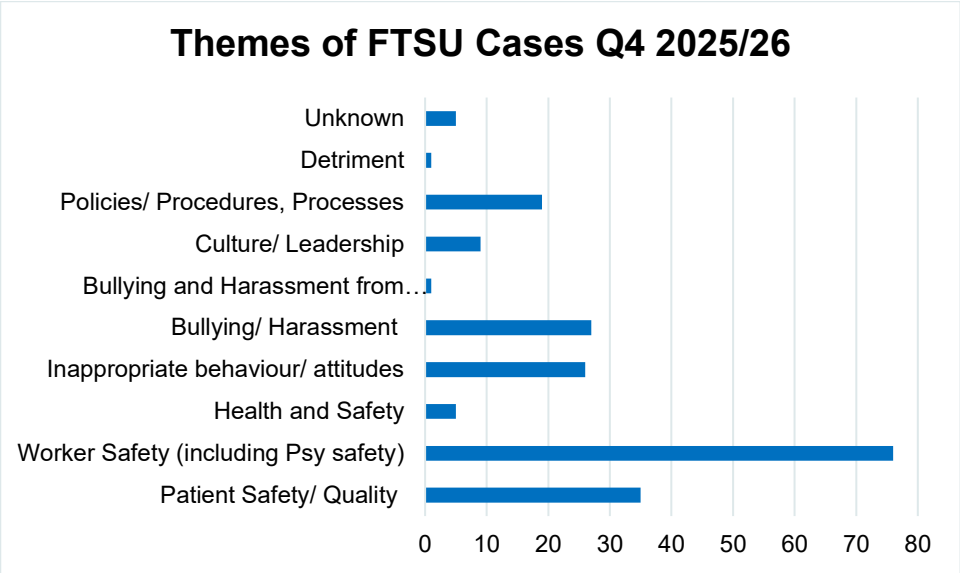
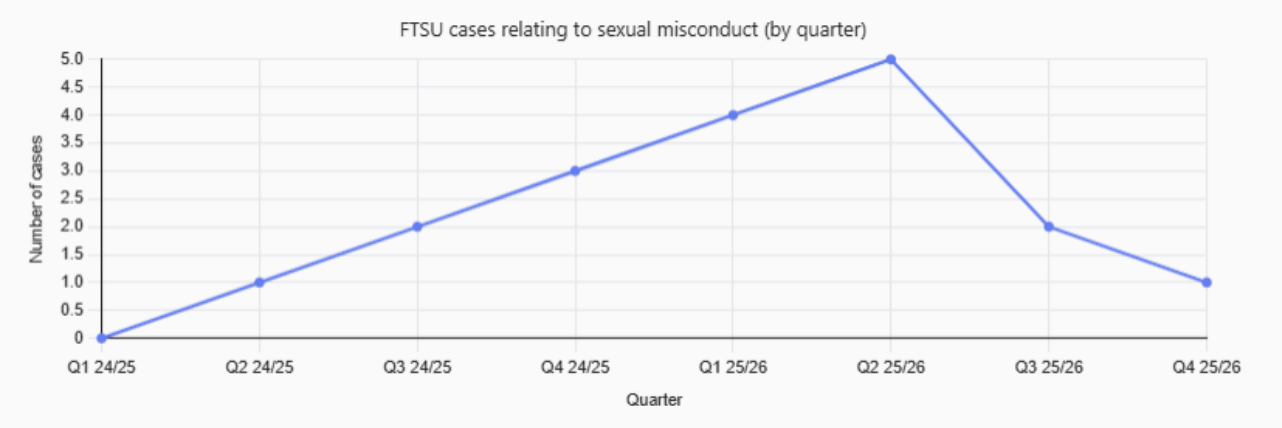
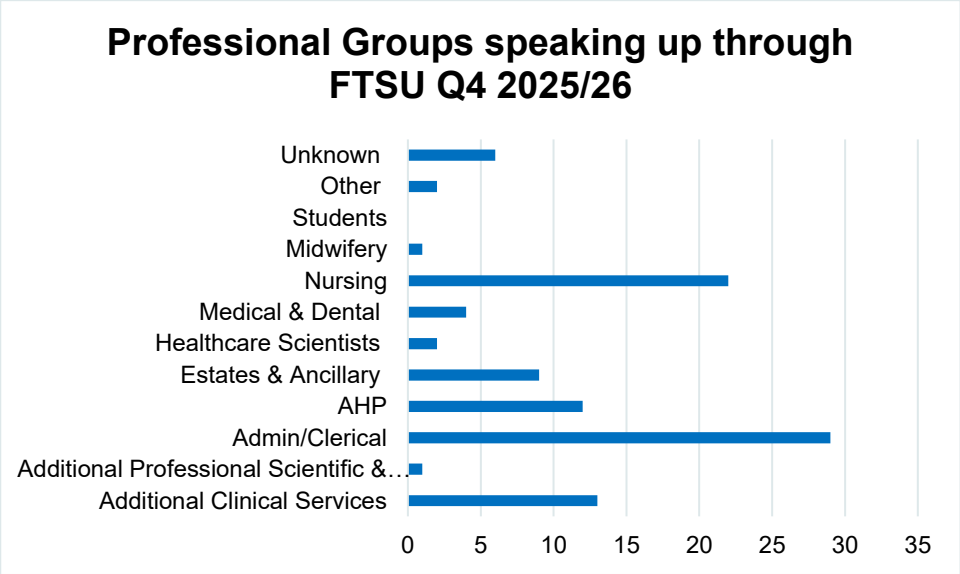
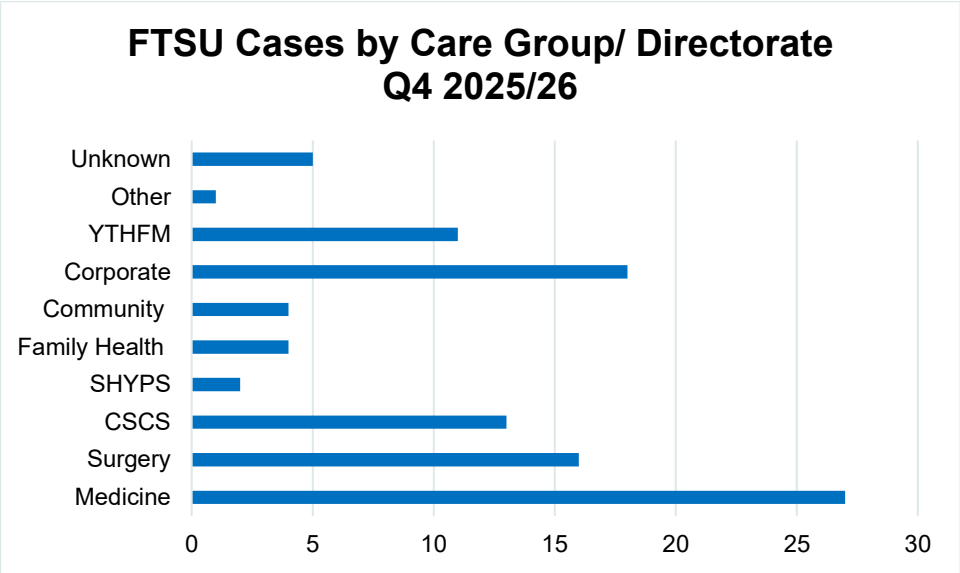
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26

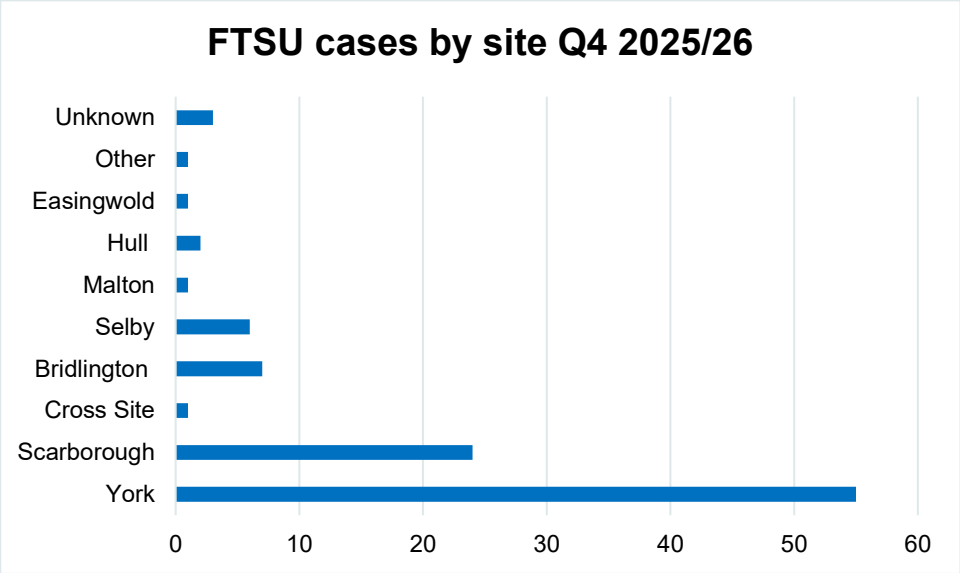

Nature of concerns raised via FTSU
80
70
60
50
40
30
20
10
0
Q1
Q2
Q3
Q4
Patient Safety
Worker Safety/ Worker wellbeing
Bullying/ Harassment
Inapropriate behaviours/ attitudes
Detriment


Themes of FTSU Cases Q4 2025/26
Unknown
Detriment
Policies/ Procedures, Processes
Culture/ Leadership
Bullying and Harassment from…
Bullying/ Harassment
Inappropriate behaviour/ attitudes
Health and Safety
Worker Safety (including Psy safety)
Patient Safety/ Quality
0
10
20
30
40
50
60
70
80


FTSU cases relating to sexual misconduct (by quarter)
Number of cases
5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0
Q1 24/25
Q2 24/25
Q3 24/25
Q4 24/25
Q1 25/26
Q2 25/26
Q3 25/26
Q4 25/26
Quarter


Professional Groups speaking up through FTSU Q4 2025/26
Unknown
Other
Students
Midwifery
Nursing
Medical & Dental
Healthcare Scientists
Estates & Ancillary
AHP
Admin/Clerical
Additional Professional Scientific &…
Additional Clinical Services
0
5
10
15
20
25
30
35


FTSU Cases by Care Group/ Directorate
Q4 2025/26
Unknown
Other
YTHFM
Corporate
Community
Family Health
SHYPS
CSCS
Surgery
Medicine
0
5
10
15
20
25
30


FTSU cases by site Q4 2025/26
Unknown
Other
Easingwold
Hull
Malton
Selby
Bridlington
Cross Site
Scarborough
York
0
10
20
30
40
50
60

Item 17

Report to:	Board of Directors
Date of Meeting:	29 April 2026
Subject:	Workforce Race and Disability Equality Standards Action Plans 2025-2027 - update
Director Sponsor:	Lydia Larcum, Deputy Director of Workforce
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 an update on the progress made with the 2025-2027 action plans, which were approved in November 2025, prior to further engagement in Q2 2026. The updated action plans will be shared with the Resources Committee and the Trust's Board of Directors in October 2026 after the 2026 data analysis has been completed and colleague engagement has been undertaken.

A RAG rating was used to keep track of progress, Green: Complete, Amber: Begun but not complete, Red: Not yet begun and Blue: a new action.

Across the WRES and WDES:

Key Assurances

- Anonymous reporting tool is being consistently promoted across both WDES & WRES actions.
- Management Fundamentals training is progressing well with high attendance. 151 delegates completed Day 1 and 142 completed Day 2 (WRES).
- Managing Violence & Aggression policy awareness is being promoted in internal bulletins.
- The initial review of the Civility & Respect policy has been undertaken.
- Staff Network engagement is embedded (Race Equality Network (REN) and Enable Network) and actions linked to lived experience are underway.
- Some development opportunities and mentoring programmes (including Reverse Mentoring) are being prepared.

Key Risks

- There are actions intended to address bullying and inequality that have yet to begin.
- Timescales will need to be adhered to, to reduce the high impact on workforce inequalities. Otherwise, they are at risk of slippage.
- Delays might directly impact staff experience scores.

Key Concerns

- Limited time remains to reverse deteriorating trends before the next reporting cycle.
- Some actions require cross-organisational behaviour change, which takes longer than the time available.

Appendix 1 – WRES, 2025-2027 Action Plan
Appendix 2 – WDES, 2025-2027 Action Plan

Recommendation:

Continued implementation of the 2025-2027 WRES/WDES Action Plans.

Report History

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

Meeting/Engagement	Date	Outcome/Recommendation
Resources Committee	28 April 2026	

Workforce Race Equality Standard Action Plan 2025-2027

APPENDIX 1

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Objective	Analysis	WRES Action	Executive Director Lead	Operational Lead	Commence Date	High Impact Actions*	Comments	RAG Rating
Metric 2 Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts								
Improve the relative likelihood of being appointed from shortlisting from 2.5, to a ratio of 1.	There is a trend of year on year deterioration from 2.33 likelihood in 2024 to 2.54 in 2025.	Breakdown metric data to identify areas where colleague are less likely to be appointed from shortlisting to identify areas of opportunity for improvement. Work with recruiting managers to review shortlisting and interview practice, promoting best practice and explore ways to increase diversity of recruitment panels across the organisation. **(amended from last action plan)**	Director of Workforce and Organisational Development	Deputy Head of Resourcing	Q3 2025-2026	2	Reviewed data to identify areas of focus, further analysis required to identify areas to target. Will then present case for diverse panels. Continuing work in Q4 25/26 & Q1 26/27.	
		Implement a process for BME representation on recruitment panels at band 7, expanding to band 8a and upwards in the future.	Director of Workforce and Organisational Development	Deputy Head of Resourcing	Q1 2026-2027	2	Reviewed data to identify areas of focus, further analysis required to identify areas to target. Will then present case for diverse panels. Continuing work in Q4 25/26 & Q1 26/27.	
Metric 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months								
Reduce colleagues experiencing harassment, bullying or abuse from patients, relatives and the public to be better than the benchmark average of 28.27%.	The percentage of colleagues receiving unwanted behaviour has increased from 29.4% in 2024 to 30.98% in 2025.	Support system partners with their equivalent campaigns by sharing our internal No Excuse for Abuse Campaign.	Director of Communications	Communications Team	Q3 2025-2026	6		
		Raise awareness of the Managing Violence and Aggression policy including Exclusion section.	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	6	MVA is promoted through Staff Bulletin and Staff Room. Further promotion is required.	
		Engage with internal stakeholders re colleagues uptake onto enhanced conflict management training.	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	6		
		Review Statutory and Mandatory training Conflict Resolution Training against enhanced conflict management model to ensure receive the essential training they need in this field.	Chief Nurse Director of Patient Safety	Darren Miller	Q4 2025-2026	6	Training is being reviewed by National Working Group. Y&S representation inc. April 2027 roll out expected.	
Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months								
Reduce the percentage of people experiencing, harassment, bullying or abuse to better than the benchmark average of 24.78%.	2025 has seen less than 1% decrease in unwanted behaviour since 2024. The current percentage is 29.75%, which is above the benchmark average of 24.78%.	Proactive and timely communication about the Trust values and support available when there is societal unrest and riots.	Director of Communications	Communications Team	Q3 2025-2026	6		
		Management fundamentals training to be delivered to line managers via HR Business partners.	Director of Workforce and Organisational Development	Operational HR Team	Q3 2025-2026	6	27/02/26: Training ongoing with dates planned throughout 2026. 151 delegates have attended Day 1 and 142 delegates have attended Day 2 to date.	
Metric 7 Percentage believing that the Trust provides equal opportunities for career progression or promotion								
Demonstrate equal opportunities for all through promoting career opportunities and promotion. To exceed the benchmark average of 49.70%.	The percentage of colleagues that believe the Trust is an equal opportunity employer has continued to deteriorate year on year. 2025, 40.56% 2024, 42.26% 2023, 43.25%	Develop a Staff Network development book to promote to members about career progression opportunities from NHS Elect, OD courses and Learning Hub.	Director of Workforce and Organisational Development	Race Equality Network	Q4 2025-2026	2	18/02/2026: REN engaging with Global Majority Nurse regarding progress.	
		Feature BME colleagues (along with other colleagues with protected characteristics) in the new EDI section of Staff Matters, raising awareness promoting good practice and role models, shadowing, acting up, what's it like being in a senior role.	Director of Communications	Communications Team	Q3 2025-2026	2		

		Explore career pathways through BAPIO as a means to increase opportunities for BME colleagues.	Director of Workforce and Organisational Development	Lead for Workforce Planning and Development and Head of Resourcing	Q4 2025-2026	2	The Trust previously engaged BAPIO through its Global Health Group to explore career pathways. December 25 - an update advised decision taken to close the programme and focus instead on supporting and learning from our International Medical Graduates working within the Trust. In line with this, IMG guidelines have been implemented, an IMG Handbook is available (with practical suggestions to make the first few weeks easier), two day induction programme for IMG's to attend. By supporting and retaining our IMGs, it presents an opportunity to develop the career pathways and increase opportunities for BME colleagues. Associate Director, Medical Directorate to engage with BAPIO.	
		Provide support to colleagues wishing to further their career within the Trust with information about, and access to, appropriate learning and development opportunities to better prepare individuals for their next steps. Building relationships with the Race Equality Network, targeting marketing through this link.	Director of Workforce and Organisational Development	OD Team	Q3 2025-2026	2	Regular attendance & input at Race Equality Network by a Snr OD Practitioner, further access to Reverse Mentoring is being offered through this link.	
Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months and Metric 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleague								
		Workforce Leads to work with those responsible for local Staff Survey Action plans in triangulating data from Freedom to Speak Up and Anonymous Reporting Tool reporting HBA and discrimination to target interventions at a local level, e.g. awareness training and support.	Director of Workforce and Organisational Development	Workforce Leads Care Group Quad HR Business partners Freedom to Speak Up Guardian	Q4 2025-2026	6	27/2/26: Staff Survey results have been shared with CGs who are in early stages of drafting their action plans.	
Metric 8. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleague.								
Reduce the percentage of people experiencing, discrimination to be better than the benchmark average of 15.72%.	There has been an increase from 22.08% in 2024 to 22.57% 2025.	Staff Survey action plans to include standing action on reducing discrimination in the workplace.	Director of Workforce and Organisational Development	Workforce Leads Care Group Quad	Q4 2025-2026	6	As above.	
		Blogs/videos/story telling about the impact of discrimination on colleagues and patient care.	Director of Workforce and Organisational Development	EDI Team	Q4 2025-2026	6	Engaging with REN to capture experiences.	
		Promote best practice in the line manager training, which is aligned with the NHS Management & Leadership Framework & Curriculum (launch November 2025).	Director of Workforce and Organisational Development	OD Team Operational HR	Q3 2025-2026	6	The OD Team are in the process of aligning the Line Manager Development Programme & all of their leadership offerings to the NHS Leadership & Management Standards.	
		Continue promotion of the anonymous reporting tool through the No Excuse For Abuse Campaign, to increase awareness of the tool and appropriate reporting of incidents.	Director of Communications	Communications Team	Q3 2025-2026	6	27/02/26: Ongoing promotion of the anonymous reporting tool throughout the year. Most recently in Communications bulletin 27/02/26.	
		Civility and Respect policy to be reviewed and republished.	Director of Workforce and Organisational Development	Operational HR Team	Q3 2025-2026	6	27/2/26: Initial review completed with Union RepresentativeGroup and taken to JNCC.	
		EDI is a feature of, and best practices embedded into, all Trust internal management and leadership programmes and aligned with the NHS Management & Leadership Framework & Curriculum (launch November 2025).	Director of Workforce and Organisational Development	OD team	Q3 2025-2026	6	The OD Team are reviewing all of their leadership & management offerings to ensure that ED&I is embedded and that these offerings align with the new NHS Leadership & Management standards.	
Metric 9 BME Board members – Percentage difference between the organisation's Board voting membership and its overall workforce								
Increase the number of ethnically diverse Board members to be more reflective of the organisation.	The % difference in 2025 is -18%. (There are no BME Board members).	Applications for Non-Executive Director appointments encouraged from a visibly diverse background. (Carried forward from last action plan).	Associate Director of Corporate Governance	Associate Director of Corporate Governance	Q3 2025-2026	2		
All Metrics								

To improve the employment experiences of our BME colleagues. (A Trust Equality Objective)	The majority of the metrics show a deterioration in the workplace experiences and career progression of BME colleagues.	Implement the Race and Health Observatory's 7 Anti-Racism Principles as a strategic framework: 1. Demonstrate leadership by naming racism 2.Understand and acknowledge 3. Meaningfully involve racially minoritised individuals and communities 4. Collect and publish data 5. Identify racial bias 6. Apply a race critical lens 7. Evaluate and reflect	Chief Executive	Anti-Racism Steering Group	Q3 2025-2026	1-6	The Board have appointed a BME Board member as a NED commencing at the Trust on 1 November 2025. Applications for future NED positions will be encouraged from a visibly diverse background, as has occurred in previous role recruitments with NED role descriptions stating candidates from Black Asian Minority Ethnic backgrounds are encouraged. Further specific steps will be reviewed at the time of future NED recruitment.	
		Update the Trust's Anti-Racism Statement to cover Anti-Semitism.	Director of Communications	Anti-Racism Steering Group	Q3 2025-2026	6		
*** The WRES Action Plan is cross referenced with the NHS EDI Improvement Plan's 6 High Impact Actions:**								
1, Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	3, Develop and implement an improvement plan to eliminate pay gaps	5, Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.						
2, Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	4, Develop and implement an improvement plan to address health inequalities within the workforce.	6, Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.						

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

Workforce Disability Equality Standard Action Plan 2025-2027

APPENDIX 2

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

York and Scarborough Teaching Hospitals NHS Foundation Trust

Objective	Analysis	WDES Action	Executive Lead	Operational Lead	Commence Date	High Impact Actions*	Comment	RAG Rating
Metric 1 Staff in AfC pay bands or medical and dental subgroups and very senior managers (Including Executive Board members) compared with the % of staff in the overall workforce								
Encourage colleagues to update their equality monitoring information to help determine who is in the workforce. Continue to increase declaration rates above the regional average of 5.9%.	The number of disabled colleagues in the Trust has increased from 4.86% in 2024 to 5.08% in 2025. Representation across the Trust is equitable, this action is to reduce the % of those 'not stated', which is 11.45%.	The Enable Staff Network will implement actions to encourage members and colleagues within the Trust to share their equality monitoring information.	Executive Sponsor of Enable Staff Network	Enable Staff Network	Q4 2025-2026		The network has been supporting and encouraging the promotion of colleague equality monitoring information. Members are encouraged to report and the Network is seeking to spread the word amongst members about the benefits of reporting. The Exec Sponsor has previously used their Exec Blog to encourage staff to update their ESR profile. Network members have undertaken data reviews to try to understand the depth of the data we do have as well as some of the barriers to reporting.	
Metric 3 Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure								
Ensure there is equity in the application of the Capability Procedure. Reduce to a likelihood of 1.	The likelihood has increased since 2024 and now shows inequality. 1.13 in 2024 to 2.05 in 2025.	Roll out Management Fundamentals training for all line managers. (**Training offer will be ongoing.**)	Director of Workforce and Organisational Development	Head of Employee Relations	Q3 2025-2026			
		Review number of colleagues who receive support through the Performance Improvement Policy to establish whether there is a higher number of colleagues with a disability. If a higher number is established review processes for consistency and equity.	Director of Workforce and Organisational Development	Head of Employee Relations	Q4 2025-2026		27/02/26: 9 colleagues supported through Performance Improvement Policy from January 2025 to February 2026. 1 has declared a disability and 8 have not.	
Metric 4a Percentage of staff experiencing harassment, bullying or abuse from patient/service users, their relatives or other members of the public in the last 12 months								
Reduce the percentage of colleagues experiencing harassment, bullying and abuse (HRA) from patients, relatives and the public by 3%.	HBA has deteriorated for 2025, 27.93% up from 25.13% in 2024.	Support system partners with their equivalent campaigns by sharing our internal No Excuse for Abuse Campaign.	Director of Communications	Communications Team	Q3 2025-2026	6		
		Raise awareness of the Managing Violence and Aggression policy including the Exclusion section.	Chief Nurse Director of Communications	Darren Miller Communications Team	Q4 2025-2026	6	MVA is promoted through Staff Bulletin and Staff Room. Further promotion is required.	
		Cross reference information captured through the Staff Survey with information on Datix to determine the level of reporting.	Chief Nurse Director of Patient Safety	Darren Miller Patient Safety Team	Q4 2025-2026	6	Pulling trends from Datix, promoting localised training. Monthly H&S report to include analysis.	
Metric 4b Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months								
Reduce the percentage of colleagues experiencing Harassment, Bullying and Abuse from managers to be better than the benchmark average (currently 15.10%.)	This has deteriorated from 15.40% in 2024 to 16.28% in 2025.	Workforce Leads to work with those responsible for local Staff Survey Action plans in triangulating data from Freedom to Speak Up and Anonymous Reporting Tool reporting HBA and discrimination. To then target interventions at a local level, e.g. awareness training and support.	Director of Workforce and Organisational Development	Workforce Leads Care Group Director Associate Chief Operating Officers Head of Employee Relations Freedom to Speak Up Guardian	Q2 2026-2027	6		
Metric 4d Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months								

Increase the percentage of disabled colleagues and colleagues reporting Harassment, Bullying and Abuse to better than the benchmark average (currently 51.82%)	There has been a deterioration since 2024, 54.99% to 48.90% in 2025.	Continue promotion of the anonymous reporting tool through the No Excuse For Abuse Campaign, to increase awareness of the tool and appropriate reporting of incidents.	Director of Communications	Head of Employee Relations Communications Team	Q3 2025-2026	6	27/02/26: Ongoing promotion of the anonymous reporting tool throughout the year. Most recently in Communications bulletin 27/02/26.	
		Civility and Respect policy to be reviewed.	Director of Workforce and Organisational Development	Head of Employee Relations Communications Team	Q4 2025-2026	6	27/02/26: Initial review completed with Union Representation Group and taken to JNCC.	
Metric 5 Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion								
Promote disabled colleagues as role models within the organisation to inspire other colleagues.	This metric continues to see a year on year deterioration. In 2024 it was 50.15% compared to 2025, 48.10%.	Feature Disabled colleagues (along with other colleagues with protected characteristics) in the new EDI section of Staff Matters, raising awareness promoting good practice and role models, shadowing, acting up, what's it like being in a senior role.	Director of Communications	Communications Team	Q3 2025-2026	2		
		Promote development opportunities to support career progression.	Director of Workforce and Organisational Development	OD Team	Q3 2025-2026	2	Links are being made with the Enable network to better promote development opportunities and support career development. Preparation of mentors & mentees is about to commence to support the latest cohort of Reverse Mentoring.	
*** The WRES Action Plan is cross referenced with the NHS EDI Improvement Plan's 6 High Impact Actions:**								
1, Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	3, Develop and implement an improvement plan to eliminate pay gaps	5, Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.						
2, Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	4, Develop and implement an improvement plan to address health inequalities within the workforce.	6, Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.						

Author: Head of Equality, Diversity and Inclusion
Senior Responsible Officer: Director of Workforce and Organisation Development
Publish and Submission Date: 30th November 2025
Note: BME staff were engaged with via a staff network meeting. These actions are designed to address the Workforce Race Equality Standard.
Where an action has been given a Green RAG rating to indicate complete, the action, where necessary, will be continuously implemented.

Report to:	Board of Directors
Date of Meeting:	29 April 2026
Subject:	2025/26 Q4 Board Assurance Framework
Director Sponsor:	Clare Smith, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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

Approve ☒ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The report provides the 2025/26 Q4 Board Assurance Framework

The following risk has been amended from a current risk score of 12 (impact 4, likelihood 3) to 16 (impact 4, likelihood 4) during the quarter:

- PR1 - Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.

All amendments to all risks are provided in red text with identified gaps in blue text.

Three risks remain out of the Trust's risk appetite identified by the Board of Directors:

- PR1 - Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.
- PR3 - Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.
- PR6a - Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030

Recommendation:

The Board of Directors is asked to approve the 2025/26 Q4 Board Assurance Framework.

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

Meeting/Engagement	Date	Outcome/Recommendation
Executive Director Updates	April 2026	Risks reviewed and updated

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Q4 – 2025/26 Board Assurance Framework (BAF)

Q4 - 2025/26 Board Assurance Framework Dashboard

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Rank/Move	High Level Risk Description	Risk Assessment (Catastrophic / Major / Moderate / Minor / None)	Risk Rating	Actions	Owner	Oversight
1 ⇨	PR6a – Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-30.	C → T	25	0 0 4	Director of Finance	Resources Committee
2= ⇨	PR1 – Inability to provide consistently effective clinical pathways leading to poor outcomes, experience and possible harm.	I → C → T	16	0 0 4	Interim Chief Nurse	Quality & Resources Committees
2= ⇨	PR2 – Inability to nurture a Trust culture that facilitates good staff engagement and development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.	I → C → T	12	0 0 2	Director of Workforce and OD	Resources Committee
2= ⇨	PR5 – Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.	I → C → T	12	0 0 4	Director of Finance	Resources Committee
2= ⇨	PR3 – Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.	I → C → T	12	0 0 4	Chief Operating Officer	Quality & Resources Committees
3 ⇨	PR6b – Failure to demonstrate effective governance to achieve the Trust's strategy.	I → C → T	9	0 0 2	Chief Executive	All Committees
4 ⇨	PR4 – Trust service, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.	I → C	6	0 0 2	Medical Director	Quality Committee

Key

- N — New Risk
- ⇧ Increase in Rank
- ⇩ Decrease in Rank
- ⇨ No movement in Rank
- I — Inherent Risk - The measure of risk before controls are considered
- C — Current Risk - The measure of risk after controls are considered
- T — Target Risk - The measure of risk once actions have been completed
- Reliance on controls →
- Planned mitigations - - - - →
- 1 Action on track
- 1 Action delayed by 1-2mths
- 1 Action delayed by 3mths+

Risk Appetite

Low - 6
Moderate - 9
High - 12
Significant -15+

Summary of Risks by objective

Strategic Objective: Quality of Care – To provide timely, responsive, safe accessible, effective care at all times

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR1	Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.	Interim Chief Nurse	Quality & Resources Committees	5	5	25	4	4	16	6 LOW	OUT	4	3	12	↑

Strategic Objective: Our People – To create a great place for our people to work, learn and thrive

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR2	Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.	Director of Workforce & OD	Resources Committee	4	4	16	4	3	12	12 HIGH	IN	3	3	9	↔

Strategic Objective: Our Partnerships – To work together with partners to improve the health and wellbeing of the communities we serve

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR3	Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.	Chief Operating Officer	Quality & Resources Committees	4	4	16	4	3	12	6 LOW	OUT	3	2	6	↔

Strategic Objective: Research, Innovation and Transformation – Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR4	Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.	Medical Director	Quality Committee	3	3	9	3	2	6	6 LOW	IN	3	2	6	↔

Summary of Risks by objective

Strategic Objective: Sustainability – To use the resources to deliver healthcare today without compromising the health of future generations

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR5	Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.	Director of Finance	Resources Committee	4	4	16	4	3	12	12 HIGH	IN	4	2	8	⟺

Strategic Objective: Governance and Finance – To be well led with effective governance and sound finance

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6 a	Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030	Director of Finance	Resources Committee	5	5	25	5	5	25	12 HIGH	OUT	4	4	16	⟺

REF	Principal Risk	Risk Owner	Assurance Committee	Initial Risk Rating (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Target Risk (After Actions)			Movement from Last Quarter
				I	L	Rating I x L	I	L	Rating I x L			I	L	Rating I x L	
PR6 b	Failure to demonstrate effective governance to achieve the Trust's strategy.	Chief Executive	All Committees	5	4	20	3	3	9	12 HIGH	IN	2	3	6	⟺

Ref PR1 Board Assurance Framework (BAF)

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	**Risk Score: 16**

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems, cyber attack including data integrity
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	4	16	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	16
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Performance Improvement Review Meetings (PRIM) monthly for all Care Groups	- PRIM letter outcomes and next steps reported to Executive Committee from Oct24 (Care Group escalation reports previously) - Review of PRIMS to include quality reporting	Infection Prevention Strategic Assurance Group (IPSAG)	- IPSAG monthly reporting - Apr 24-current, TPR reporting to Quality Committee and Board, including performance metrics associated with National Oversight Framework	Sustainable services reviews – internal and with the Collaboration of Acute Providers (CAP)	Internal sustainable services report and CAP reporting through CAP Committee in Common
Quality Committee, Patient Safety and Clinical Effectiveness, Patient Experience Sub-Committees, Resources Committee	- Apr 24-current, Quality and Safety reporting to sub-committees - Apr 24-current, escalation reports to Quality Committee - Apr 24-current, Quality Committee delivery of assurance work programme - Apr 24-current, Board escalations	Programme Management Office schedule of programmes	Specific programmes including: - Urgent and Emergency Care, Electronic Patient Record - Maternity - Culture and Leadership	Humber and North Yorkshire System oversight for diagnostics, cancer, urgent care, finance, workforce and place-based meetings	Collaboration meetings across Executive Portfolios: Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce and OD, Finance Director papers
Care Group Board sub-group oversees IPC, escalations made to IPSAG and Assurance Committees	Monthly reporting papers of IPC, Patient Experience and Patient Safety and Clinical Effectiveness Care Groups have each established an IPC/AMS group to oversee local improvement work re: infection prevention and anti-microbial stewardship	Integrated Quality Improvement Group (IQIG) NHSE oversight	- Monthly reporting of Trust Improvement - Dashboard, CQC Update, Maternity, risks - Revised measures of assurance agreed by IQIG linked to the original assurance metrics from 2023/24. Updated workplan to support the metrics now in place for IQIG.	Continuous flow (CF) and escalation model 3x Op sit rep, proactive management of discharges, proactive communications management with staff and patients, psychological support for staff	- Executive Committee reporting, Board escalations of outcomes and concerns, 3x daily operational sit rep. on-call arrangements in place, proactive management of discharges, oversight through Discharge improvement group - Datix field enabled to identify patient safety incidents linked to CF activity. - Corridor care SOP revised
Operations meeting oversight: Elective Recovery Board, Unscheduled Care Board, Maternity Assurance Group	- Monthly reporting papers of Elective and Unscheduled Care Boards - Apr 2024-current, Executive Committee - Tiering meetings with NHSE - Integrated Quality Improvement Group	Corporate Quality Oversight: - Maternity Assurance Group (MAG) single improvement plan - Children's Board - Patient Quality Standards Group (PQSG) in place.	- Monthly reporting papers MAG - Single Improvement Plan progress report - PQSG established for oversight of fundamentals of patient care	*Gap – EPRR Core Standards limited compliance* *Gap – Clinical & Clinical Estates Strategy*	EPR July 2024 Resources Committee and Board reporting EPRR Commander training in delivery Draft clinical estates strategy in place Director of Strategy in post

Ref PR1 Board Assurance Framework (BAF) - continued

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	Risk Score: 16

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems, cyber attack including data integrity
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	4	16	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	16
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Trust performance report	- Monitored at Quality Committee and associated sub committees	Regulation and Assurance visits.	Regulation and Assurance group in place HTA, HNY Trauma network, LMNS, H&S, stroke peer review, CQC	- NHS Digital Secure Boundary Service is leveraged to enhance perimeter security and monitor threats. - End-user devices cyber security, with continuous monitoring maintained - Regular/timely patching conducted in accordance with best practice standards to address vulnerabilities. - Vetting process for contract personnel is implemented, ensuring IT credentials are issued only to authorised users in alignment with the J/M/L process. - Penetration testing schedule is in place for the Trust's IT infrastructure.	- Schedules and records of controls being applied across the Trust
Cyber Security Control Framework to safeguard the confidentiality, integrity, and availability of our systems and data and aligned with NHS policies, the Data Security Protection Toolkit aligned to the NCSC Cyber Assessment Framework	- Digital Sub Committee - Submission of DSPT on a yearly basis - Annual SIRO board report - GAPS: DSPT submission highlighted that the organisation was not meeting standards with 16 out of 47 areas below NHS England's minimum standard.	Quality Assurance Framework	- Internal Audit review with significant assurance - Operational performance managed via the Performance Review Improvement Meetings (PRIM) - Quality Assurance Framework reviewed and updated with pilot of ward accreditation commenced September 2025 including fundamentals of care - Revised QAF approved October 25	Complex Needs Assurance Group established Complex Needs Assurance Improvement Plan in place in response to the Niche report	Group meets bi-monthly – Chaired by the Chief Nurse Quarterly progress updates to Patient Experience Subcommittee and Quality Committee for assurance

Ref PR1 Board Assurance Framework (BAF) - continued

Ref: PR1	Strategic Objective: To provide timely, responsive, safe, accessible effective care at all times	**PRINCIPAL RISK 1:** *Inability to provide consistently effective clinical pathways leading to poor patient outcomes, experience and possible harm.*	Risk Score: 16

Causes – What must happen for the risk to occur?
- Failure of fragile clinical services
- Lack of beds available at the time patients need to be admitted
- Poor staff health and wellbeing
- Poor patient experience in Emergency Departments
- Normalisation of poor patient experience
- Failure of IT systems, cyber attack including data integrity
- Unacceptable fundamentals of care and IPC
- Management of digital threat
- Capability and demand of discharge pathways

Consequences – If the risk occurs, what is its impact?
- Failure to respond to deteriorating patients
- Harm to patients
- Regulatory attention
- Poor staff experience, health and wellbeing

Executive Risk Owner: Chief Nurse | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	4	4	16	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	16
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Quality Corporate Governance structures including PRIM reporting to be reviewed	Review of governance meetings across the Trust currently underway	Interim Chief Nurse and Director of Quality, Improvement and Patient Safety	Q1 – June 2026
Focus on eradication of corridor care across the Trust	In progress and work underway with a corridor care plan	Interim Chief Nurse and Director of Quality, Improvement and Patient Safety	Q1 – June 2026 Review
Delivery of a Clinical Strategy	Working Group established and scope being defined	Interim Chief Nurse and Director of Quality, Improvement and Patient Safety	Q1 – June 2026 Review
Ward Accreditation Pilot	Roll out being conducted	Interim Chief Nurse and Director of Quality, Improvement and Patient Safety	Q4 - 2026/27

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	3	12

Next Review
Q1 - July 2026

Ref PR2 Board Assurance Framework (BAF)

Ref: PR2	Strategic Objective: To create a great place for our people to work, learn and thrive	**PRINCIPAL RISK 2:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

Consequences – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	12
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Our Voice Our Future Programme	- Discovery and Design phase – discovery and design phase complete. Delivery phase to concluded by July 26. - Q3-Q4 Board Seminar Development reports - Staff Survey report (Mar 26)	Revised vacancy control process – implementation of up to 13-week firebreak and Double Lock in place New medical bank rates from Aug 25 WRAP Programme	- EDG papers – (April 25 – Mar 26) - FIB Papers (Mar 26 – onwards) - TPR workforce reporting Sept 25 – Mar 26)	Revised communications approach	- Back to the floor initiative - Senior Leadership blogs - Staff Briefs - Y&S Live
Delivery of Internal Leadership Programmes in line with Leadership Framework	- Care Group Leadership Development Programme Cohorts phases 1-3 delivered - List of programmes and training programmes on Learning Hub	Implementation of People Strategy Freedom to Speak Up Reporting	- TPR workforce reporting April 25 – Mar 26) - EDS 2022; WRES, WDES & Pay Gap reports - FTSU Board report September 2025	Formal workforce engagement	- JNCC and LNC meeting minutes - Staff Networks ToR - Anti-Racism Group
Line Management Toolkit and Training	Toolkit rollout to all Line Managers and training implementation records. Phase 2 – 'Line Manager Fundamentals' training delivered from Autumn 25	Senior Leadership Engagement Gap – engagement with all levels of leadership	- Quarterly Senior Leaders Forum - Senior Clinical Leadership monthly meeting	Wellbeing delivery	- Occupational Health and Wellbeing Annual Report to Resources Committee - Staff Psychologist Therapy - TPR (flu vaccination data (Oct25-Jan 26) - Reportable Issues paper (Sept 25- Mar 26)
- Oversight of establishments and establishment reviews, job planning and medical deep dives - TPR reporting of nursing academy: retention of HCSW and apprenticeships levy	- TPR reporting Sept 25 – Mar 26 - Nursing workforce Resources Committee reporting June 25 – Mar 26 - Quarterly Medical Workforce Report – Resources Committee July 25 – Mar 2026	*Gap – Financial resources to recruit at the staffing establishments required*	- Annual financial planning Board sign-off Staffing business cases - Rostering data (LoA reports) - Temp staffing data (TPR Sept 25-Mar 26) - - Nursing workforce establishment review approved, and funding released to support the 3 main priorities agreed	QI Readiness Assessment position when undertaken	

Ref PR2 Board Assurance Framework (BAF) - continued

Ref: PR2	Strategic Objective: To create a great place for our people to work, learn and thrive	**PRINCIPAL RISK 4:** *Inability to nurture a Trust culture that facilitates good staff engagement and staff development leading to poor staff morale, recruitment and retention issues and ultimately poor patient outcomes.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure of leadership to oversee a shift in culture and mindset
- Inappropriate clinical workforce model
- Reduction in applications for training courses
- Lack of resources to grow our own staff

Consequences – If the risk occurs, what is its impact?
- Long term staffing shortages
- Poor organisation culture
- Poor staff morale
- Reduced patient outcomes

Executive Risk Owner: Director of Workforce and OD | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	12
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
- Our Voice Our Future – Delivery Phase implementation of actions	- Our Voice Our Future - Delivery phase underway	Chief Executive	During 2026
- Staff Survey Improvement Plan and People Promise Programme	- Colleague Engagement Improvement Plans – May 2026	Director of Workforce & OD	During 2026

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	3	9

Next Review
Q1 - July 2026

Ref PR3 Board Assurance Framework (BAF)

Ref: PR3	Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve	**PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

Consequences – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	12
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. positive)	ii) Controls	ii) Assurances (inc. positive)	iii) Controls	iii) Assurances (inc. positive)
Strategic Alignment: Mechanisms in place to ensure alignment of priorities between partners. - Joint Committee in Common - Joint Operational planning meetings with Alliances, ICB and Place Colleagues throughout planning process. - Alignment of Cancer alliance objectives into Y&S Cancer Strategy - Recruitment of Head of Strategy to support partnership working	Shared system performance metrics managed with the ICB and tiering meeting with regional colleagues. ICB performance oversight arrangements. CAP meetings: Elective and UEC – joint leadership arrangements Trust strategy shared with Stakeholders (dec 2024) *Cancer Strategy Workshop – Feb 2025* *Gap: Joint strategic planning sessions with place & partners (not a gap for cancer as this is done collaboratively)*	Training and Development: Increasing the understanding of key Trust leaders in system working and partnership opportunities.	*Gap: Opportunity for leadership development in system collaboration.*	Resources: Senior management representation at core ICB and Place-based forums and alliances. Employment of Head of Strategy as key lead for partnership development	Attendance records at partnership meetings. Recruitment of Head of Strategy to support partnership working. Funding into NHS Benchmarking
Communications: Joint committees or forums for collaboration and conflict resolution.	- Trust CEO Committee in Common with other Trust Providers. - Harrogate Board to Board - York Health & Care Collaborative & Joint Delivery Board. - CAP Alliance Representation & clinical leads - Multiple Boards in place where Trust is represented: CAP/ UEC and Place and SOAG. - ICB Board Quarterly meeting minutes - York Health & Care Collaborative & Joint Delivery Board meeting minutes - CAP Quarterly meeting minutes *Gap: Audit of effectiveness of forums for delivering quality partnership working ?*	Data that support partnership working - North Yorkshire Overarching Multi Agency Information Sharing Protocol (MAIS) - Humber sharing charter - Specific sharing agreement with TEWV for them to access our systems as required - Information sharing as part of the Collaborative of Acute Providers Information	MAIS: this is managed by NYCC and is reviewed annually (partners include YAS, NY Police, CYC, Harrogate and District NHS Foundation Trust) *Humber sharing charter: T*his is managed by North East Lincolnshire Council and is reviewed annually (partners include HUTH, East Riding council, Humberside Police) TEWV and other agreements managed in line with SLAs CAP: Sharing is managed through the joint working arrangement	- System working to deliver EPR convergence and supporting initiatives around Population Health Management - Partnership working on the Yorkshire and Humber Care Record	- EPR Programme Management - Yorkshire and Humber Care Record Programme Management

Ref PR3 Board Assurance Framework (BAF) - continued

Ref: PR3	Strategic Objective: To work together with partners to improve the health and wellbeing of the communities we serve	**PRINCIPAL RISK 3:** *Working ineffectively with the Trust's partners to contribute to effective patient care, good patient experience and system sustainability.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?

- Ineffective communication mechanisms between the Trust and its partners
- Insufficient resources to support collaboration (e.g. funding, staffing, or time constraints)
- System data not being used to drive change
- Primary Care's inability to provide effective services at the sufficient volumes
- Third parties not delivering services that prevents the Trust achieving its objectives
- Resistance to change from internal staff or partners.
- Policy or regulatory constraints hinder partnership activities
- Lack of shared objectives or misaligned priorities between partner organisations

Consequences – If the risk occurs, what is its impact?

- Reduced quality of care due to fragmentation of services.
- Delays in treatment or services, leading to poorer outcomes.
- Confusion among patients due to lack of coordinated communication
- Missed opportunities for innovation or service improvement.
- The most effective patient outcomes not achieved
- Loss of continuity in patient care
- Lower levels of patient satisfaction.
- Inefficient use of resources leading to increased costs
- Loss of public trust and credibility in the health system
- Inability to manage demand growth and overreliance on Trust services
- Strained relationships between the Trust and partners, reducing collaboration opportunities.

Executive Risk Owner: Chief Operating Officer | **Assurance Committee:** Quality & Resources Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	LOW (1-6)	OUT OF APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	12
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Conduct joint strategic planning sessions to align objectives and priorities across key partners (at place most likely).	Cancer Strategic review with partners complete, workshop held for Cancer Strategy 25-30. Collaborative Acute Providers (CAP) 25/26 work programme - awaiting Executive Planning Meetings – throughout the national planning round Planning reflection work initiated includes consideration of year-round commissioner and partner collaboration	Head of Cancer / Lead Consultants CEO / COO and CFO Head of Strategy & Planning	**Cancer Strategy:** Cancer Board – 14th May Exec Com – Early June Board June CAP - TBC Sept-Mar 2025 Q1 2026/27
Audit of effectiveness of forums for delivering quality partnership working. Using partnership maturity matrix across providers / place and alliances	Audit of partnership meetings initiated across care groups and directorates Maturity matrix for assessing partnership working developed. Audit completed. There are over 220 partnership meetings listed, over 60 of these are Executive level. It is not possible, nor appropriate to conduct a maturity matrix on all identified partnership meeting. To this end the list will be shared with the executive team for prioritisation. Application on maturity matrix across partnerships and stakeholders *Establishment of Strategy and Partnership Sub- Committee – Dec 2025* *Stakeholder mapping exercise with Communications team – action from Well-led Action Plan*	Tilly Poole completed Director of Communications and Head of Strategy & Planning	Q1 - Initiated Q1 – Matrix completed and being tested Q2-4 – identify priority groups and apply matrix Q3 – subcommittee complete – will support above in conjunction with Head of Governance Q1 26/27
Governance arrangements to demonstrate delivery of primary care collaboration	New Place-based meeting established Q1 2025 - Integrated Primary Health Care Collaborative 2025/26 Clinical Service Strategy in development will develop Strategic Operational Manual including partnership working		Q1 May 2026
Governance arrangements to demonstrate effectiveness of shared data for decision making	Supporting work of the emerging linked dataset with HNY Geomapping exercise initiated by CAP Data-led Planning Approach approved at Exec Com – speciality level data packs complete and shared with specialties in face-to-face meetings throughout September to support planning and clinical service strategy. Next step will be to update following feedback and to collate Trust wide insights – November 2025 Clinical service strategy framework developed in draft form, workshops with care groups planned Director of Strategy – in post – emerging clinical strategy – who we are and what we stand for	Head of Strategy & Planning CAP Lead Head of Strategy & Planning Head of Strategy & Planning Head of Strategy & Planning Director of Strategy	Q2-4 Q2&3 Completed Completed Q2 - CSCS, FH complete. May 2026

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6

Next Review
Q2 – July 2026

Ref PR4 Board Assurance Framework (BAF)

Ref: PR4	Strategic Objective: Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow	**PRINCIPAL RISK 4:** *Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.*	Risk Score: 6

Causes – What must happen for the risk to occur?
- Failure to transform services sufficiently to within the current resource limits
- Capacity for the EPR programme delivery is not sufficient
- Lack of standard implementation of QI methodology
- Insufficient funds to allow running of services, allowing headroom to affect transformation, plan for the long term and change at pace

Consequences – If the risk occurs, what is its impact?
- The EPR programme is not sufficient to realise its full potential
- QI benefits not consistently delivered to transform services

Executive Risk Owner: Medical Director | **Assurance Committee:** Quality Committee | **Date Added to BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
3	3	9	3	2	6	LOW (1-6)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	6	6	6	6
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

i) Controls	i) Assurances (inc. positive)	ii) Controls	ii) Assurances (inc. positive)	iii) Controls	iii) Assurances (inc. positive)
Rollout of Quality Improvement Methodology (QSIR)	- Regular cohorts of QI training - QSIR tools available Trust wide - Governance Half-Days include improvement - Governance outputs reported through Care Group Governance - Readiness Assessment commissioned and completed to support the development of the next phase of our QI journey. - Business Case produced to support the appointment of a Strategic Partner to support our CQI journey. Business Case and Consultancy Application submitted to NHS England on 23rd December 2025 and approved 23rd March 2026 further to be open to tender.	Implementation of the Nervecentre EPR Programme	- Business case approval and go-live implementation plan - EPR Executive Steering Group - Digital Sub-Committee - YSTHFT and HDFT Joint Programme Board - Project team appointments - Training plan - TRG established for Nervecentre readiness assessment - NHS England Gateway Review 4/4.5.	Building of commercial research team	- Establishment of commercial research team 13% of our research portfolio as commercial business - Collaboration agreements with Contract Research Organisations (CROs) underway
				Research and Innovation, People, Digital and Quality Strategies	- Approved at February-May 2025 Board of Directors Action plan reviewed quarterly and currently on track
Data for improvement	- Availability of data on Signal - Improvements to Trust Priorities Report True North Report developed and added to the reporting schedule. - Tendable data is being used to support measurement for improvement. - CQI model out to tender	Joint working with partners across ICB for system-wide transformation	- Cancer Board, Cancer Strategy Workshop Feb 2025 - Elective Recovery Board, CAP meetings: Elective joint leadership arrangements - Community Improvement Group	Continuation and expansion of Research Delivery through the Research and Innovation Group	- Partnerships with universities ongoing - Research leads and time assigned for Principal Investigators. Research monies are flowing to care groups but this is not being allocated to PAs - Well-led review focus on R&I
Transformation programmes with programme governance and infrastructure	- Programmes established including: - *Maternity Assurance Group* - *Community Diagnostic Centres* - *Urgent Care Improvement Programme* - *Urgency and Emergency Care Centre*	Annual Planning and Strategy Development	- Annual planning process to develop change and transformation priorities and initiatives in specialties - Joint meetings with ICB and Place during planning round to manage risks and ensure alignment of policy requirements. - Strategy and Partnership Subcommittee to Executive Committee now established.	Growth of coastal research capacity to create research and implement findings related to inequalities	- Establishment of Scarborough Coastal Health and Care Research Healthcare Collaborative (SHARC) - Partnerships with VCSE organisations

Ref PR4 Board Assurance Framework (BAF) - continued

Ref: PR4	Strategic Objective: Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow	**PRINCIPAL RISK 4:** *Trust services, pathways and support functions are not designed, and improved in a sufficiently transformative way across the Trust for the benefit of patients.*	Risk Score: 6

Causes – What must happen for the risk to occur?
- Failure to transform services sufficiently to within the current resource limits
- Capacity for the EPR programme delivery is not sufficient
- Lack of standard implementation of QI methodology
- Insufficient funds to allow running of services, allowing headroom to affect transformation, plan for the long term and change at pace

Consequences – If the risk occurs, what is its impact?
- The EPR programme is not sufficient to realise its full potential
- QI benefits not consistently delivered to transform services

Executive Risk Owner: Medical Director | **Assurance Committee:** Quality Committee | **Date Added to BAF:** April 2024

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
3	3	9	3	2	6	LOW (1-6)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	6	6	6	6
Risk Appetite	LOW (1-6)	LOW (1-6)	LOW (1-6)	LOW (1-6)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
NHS Impact Actions and establishment of continuous improvement culture	- Readiness Assessment complete - Business Case approved - Consultancy application approved - Procurement process underway from 30 March with anticipated start date of June 2026	Director of Quality, Improvement and Patient Safety	Q2 September 2026 review
Resource and focus on innovation	Delivery of Research and Innovation Strategy Action Plan	Head of Research and Innovation	Q1 June 2026 review

Target Risk (After Actions Implemented)		
I	L	Rating I x L
3	2	6
Next Review		
Q1 - July 2026		

Ref PR5 Board Assurance Framework (BAF)

Ref: PR5	Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations	**PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

Consequences – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	12
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
External grant and match funding opportunities to help improve capital and infrastructure to better sustainable and energy saving standards, but with little to no capital we are solely reliant on winning external funding.	- NHSE and ICB informing of grant opportunities, horizon scanning, for example:- ○ GB Energy/NHSE ○ Other opportunities including through our local/regional partnerships	Sustainable Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan).	- Senior Lead owner of each Green Plan workstream and theme - Monthly 1-2-1 with the Finance Director in his role as the Executive Sustainability lead - *Workstreams are in place with identified leads. Gap - the Sustainable Models of Care workstream.* - The travel plan is to set forward a number of initiatives to promote sustainable travel across the Trust and improve efficiencies & logistics in terms of staff and operational travel. The work is supported by the Trust Travel & Transport group. - *Gap – Staff Travel Plan does not control patient travel, which impacts on our 2045 carbon target, where there is a reliance on clinical changes to increase community care and treatment of patients.* - *Other initiatives underway; continuation of the bus travel offers, secure cycle parking and increasing of EVCPs.*	Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group, regular 1-2-1's with the Finance Director in his role as the Executive Sustainability lead	- Resources and Executive Committee Reporting every quarter - YTHFM Management Group reporting every quarter - *Gap – All elements for the Green Plan are not in place and once established further reporting via the Executive Sustainability lead to the Board of Directors.*
Sustainability Team delivering the green plan and staff travel plan agendas across the Trust	- Green Plan requiring redrafting to better align with new NHSE Green Plan guidance, ICB Green Plan and regional climate change strategies. - Green Champions network established and have agreed that 6-monthly Teams meetings will be put in place with occasionally information emails to share examples and offer support to the members. - Staff Travel Plan actions are being taken forward with a focus on external funding to enhance our cycle parking, work on the staff subsidy bus offer being agreed for the next 3 months and the expansion of a Trust led major employers network across York with a focus on staff travel and transport.	Head of Sustainability oversight and lead, Finance Director steer and Sustainability Development Group as the lead meeting to support delivery of the Green Plan targets, aims and outcomes across the Trust, delivered through each workstream (as seen in the Green Plan).		Sustainability Quarterly Assurance reports to Resources Committee, Executive Committee and YTHFM Management Group. Regular meetings with the Finance Director to update, provide assurances and receive steers from.	
Sustainable Design Guide & NHSE building standards implementation	- BREEAM standards embedded in the Capital Team - Capital Projects' sustainability design guidance is in place. The Head of Capital Projects retains accountability for the broader sustainability improvements via the capital projects they are instructed to deliver, inline with NHS Net Zero Building Standards	Green Plan, Sustainability Development Group & newly established Capital and Estates workstream	*The guidance is now embedded within Capital and supported by a new officer who is experienced in sustainability. Gap – The newly formed workstream for Capital and Estates has only met a few times but are aware of items they need to look at including embedding NHSE net zero building standards.*	Ongoing staff communications through the Head of Capital and Estates Op Managers to push the embedding of sustainability across their departments.	- Trust Communication on green plan interventions - Capital and Estates teams meetings and communications from the Head of Service with support from the Head of Sustainability.

Ref PR5 Board Assurance Framework (BAF) - continued

Ref: PR5	Strategic Objective: To use resources to deliver healthcare today without compromising the health of future generations	**PRINCIPAL RISK 5:** *Failure to maintain and transform services to deliver the Trust's green plan and sustainability agenda.*	**Risk Score: 12**

Causes – What must happen for the risk to occur?
- Failure to transform sufficiently within the current resource limits
- Availability of resources compromising the ability to deliver sustainably
- Scarcity of specialist local services leading to more patient visits to main site and thereby challenging sustainability targets

Consequences – If the risk occurs, what is its impact?
- Trust's green plan targets not achieved
- Loss of reputation and regulator attention
- Contribution to recruitment issues in securing new talent to join the Trust

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
4	4	16	4	3	12	HIGH (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	12	12	12	12
Risk Appetite	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)	HIGH (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Staff Travel Plan Implementation	A new partnership has been developed between the Trust, both York universities and City of York Council to discuss and implement actions to help improve public and active travel links for our staff and customers, including bus access and car sharing. Bus operators to continue with staff bus discount offer with benefits to patients/visitors to travel sustainably. A view is being taken to expand this to other major employers in the city. Funding from North Yorkshire and East Riding Councils and York Hospitals Charity to support new secure cycle parking facilities for York and Bridlington has been complete with new North Yorks MCA funding to enhance York cycle parking with shelters is forthcoming.	Travel and Partnerships Manager/Head of Sustainability	Review June 2026
Review of YTHFM Capital Projects' Sustainability Design Guide against the NHSE Net Zero building Standard & chair of newly established Capital & Estates workstream.	The new Green Plan workstream is now up and running, aligning responsibilities between Capital and Estates teams, chaired by the Head of Capital, with the two heads of service leading and ensure better embedding of sustainability policies, especially NHSE Net Zero Building Standards Externally funded sustainability projects worked into the Trust capital programme to ensure better alignment and prioritisation of project officer capacity to deliver these projects.	Andrew Bennett	Review June 2026
Sustainability Quarterly Assurance Reports and workstream establishment.	Workstreams are in place but not all being fully effective yet, however following a series of 1-2-1 meetings with all workstream leads, the main 'ask' to develop their update workstream sections for the Green Plan has been successful with new work by the nursing lead to expand the leadership of the sustainable models of care workstream to cover Pharmacy and Clinical. The Head of Sustainability still has concerns of the progress of some of these, but appreciate a combination of work pressures, lack of staff or new staff coming into posts are key factors. Other work is progressing through the Sustainability team but, while improved, there is still more that needs to be done by these workstreams. Ensuring better data is available to track progress against the newly update 1379t/CO2 saving per annum the Trust needs to make to achieve net zero targets. This is an increase of 1079t/CO2 due to the CHP engine breaking earlier last year. The data is more assured now so the team are working with Trust Communications to find the best way to communicate this to staff about our Net Zero journey.	Head of Sustainability	Review June 2026
Trust Green Plan redrafted to better align with new NHSE Green Plan guidance, ICB Green Plan and regional climate change strategies and to include more KPIs/SMART outcomes.	Currently our annual Co2e target is 1350 tonnes per annum. This is an increase from the previous 1200t/Co2e per annuum due to the CHP going down in January 2024. The Sustainability team continues to work with communications on a weekly basis to promote this and the Co2e journey, and delivery several capital schemes and projects, including a £3.2m solar PV programme, decommissioning of piped medical gases and a whole host of other initiatives to support Trust sustainability aims.	Head of Sustainability	Review June 2026

Target Risk (After Actions Implemented)		
I	L	Rating I x L
4	2	8

Next Review
01 July 2026

Ref PR6a Board Assurance Framework (BAF)

Ref: PR6a	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6a:** Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030.	Risk Score: 25

Causes – What must happen for the risk to occur?

- Failure to achieve the annual financial plan through inadequate income allocations, poor income recovery, lack of expenditure control, non-delivery of the efficiency programme and unaffordable investment decisions.
- Cashflow difficulties
- Inadequate capital funding to meet all infrastructure backlog repair priorities and new investment requirements

Consequences – If the risk occurs, what is its impact?

- Trust entering SOF4 arrangements and special measures scrutiny
- Not achieving the Trust's part of the ICB overall financial balance (system failure consequence)
- Loss of Deficit Support Funding
- Externally imposed financial recovery plan
- Reputation impact on the Trust
- Site infrastructure failure
- Loss of autonomy and control
- Potential reduction in service quality and safety

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	5	5	25	OPEN (10-12)	OUTSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	25	25	25	25
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances (inc. Positive)	ii) Controls	ii) Assurances (inc. Positive)	iii) Controls	iii) Assurances (inc. Positive)
Annual business planning process including Board plan sign-off, triangulation with ICB and ICS and ultimate NHSE approval.	- Business plan, Board progress updates - ICB plan working groups - Internal Audit Reports 2025-26	Expenditure control - business case process *Gap – Unplanned expenditure commitments outside of process*	- Business Case manual and register - Internal audit report - SFI Business Case approval hierarchy	- Budget sign-off process and reminders issued - Overspend monitoring against approved scheme sums	- Scheme sum variation process - Scheme expenditure CPEG reports
Monitoring and reporting of I&E plan	- TPR Board and Committee reporting 2025-26 - PFR monthly NHSE. TPR Resources & Board - Care Group PRIMs and FRMs	Efficiency delivery – managed by Corporate Efficiency Team *Gap – insufficient planning to secure in year delivery*	- TPR Board, Committee and EDG reporting 2025-26 - PFR monthly to NHSE - Care Group PRIMs and FRMs	Management of national PDC schemes to required timelines (year-end cut-off deadlines)	- CPEG reporting 2025-26 - ICS/NHSE ad hoc reports
Income control - income contract variation process *Gap – unplanned income reduction*	- Income adjustment form register - TPR Board and Committee reporting	Cash flow monitoring. Cash working group. Monthly debtors and creditors review.	- Monthly debtor and creditor dashboard - Trend data and forecast data in TPR - Better Payment Practice in TPR	Backlog maintenance prioritisation *Gap – lack of understanding of full backlog requirements*	- Capital Investment needs schedules - Prioritisation scoring process - EC and Board sign off April 2025
Expenditure control - scheme of delegation, standing financial instructions, segregation of duties.	- SFIs Board approved - Written prime budget holders' approval - System enforcements and no PO no Pay	Capital planning process – preparation and sign off programme	- Capital Investment needs schedules - Prioritisation scoring process - EC and Board sign off April 2025	Identification of sparsity income stream (£10.3m)	- Formal agreement with ICB to include sparsity income & work on funding - Task & finish group to manage
Expenditure control - staff leaver process and Vacancy Control *Gaps – payroll untimely informed of leavers*	- Salary overpayment recovery policy - Improvement plan being delivered following Deloitte review - Staff Reports, REACH reporting	Routine monitoring and reporting against capital programme	- TPR Board and Committee reporting 2025-26 - CPEG reporting - ICS/NHSE ad hoc reports	Risk share agreed with the ICB for high-cost drug cost pressure	- £6m ICB funding agreed - Area prescribing committee work - ICB strategic commissioner role

Ref PR6a Board Assurance Framework (BAF) - continued

Ref: PR6a	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6a:** Failure to deliver financial balance to deliver the 2025/26 annual plan of the Trust's Strategy 2025-2030.	**Risk Score: 25**

Causes – What must happen for the risk to occur?

- Failure to achieve the annual financial plan through inadequate income allocations, poor income recovery, lack of expenditure control, non-delivery of the efficiency programme and unaffordable investment decisions.
- Cashflow difficulties
- Inadequate capital funding to meet all infrastructure backlog repair priorities and new investment requirements

Consequences – If the risk occurs, what is its impact?

- Trust entering SOF4 arrangements and special measures scrutiny
- Not achieving the Trust's part of the ICB overall financial balance (system failure consequence)
- Loss of Deficit Support Funding
- Externally imposed financial recovery plan
- Reputation impact on the Trust
- Site infrastructure failure
- Loss of autonomy and control
- Potential reduction in service quality and safety

Executive Risk Owner: Director of Finance | **Assurance Committee:** Resources Committee | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	5	25	5	5	25	OPEN (10-12)	OUTSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	25	25	25	25
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Insufficient efficiency programme – Productivity group / CIP Timeout to accelerate delivery in H2; Recovery action plans. Formal Financial Recovery plan prepared and managed through EDG.	ICS-wide System Engine Room governance programme. System leaders' group to manage pace & cover. Fully planned efficiency programme for 26/27 but need to manage high risk schemes and slippage. Work to progress further actions continues – SROs identified, key milestones tracked, formal reporting lines created.	Director of Finance	Ongoing for 26/27 plans
6 Facet Survey to be completed to identify full backlog maintenance reqs.	Funding agreed. Survey work completed. Currently being quality checked prior to publishing	Director of Finance and YTHFM Managing Director	Now being reviewed for 2026/27 capital programme and beyond
KPMG efficiency governance and opportunity review	Commission underway	Director of Finance	May 2026
Participation in NHSE Challenged Provider Programme	Awaiting details from NHSE	Director of Finance	May 2026

Target Risk (After Actions Implemented)

I	L	Rating I x L
4	4	16

Next Review

Q1 - July 2026

Ref PR6b Board Assurance Framework (BAF)

Ref: PR6b	Strategic Objective: To be well led with effective governance and sound finance	**PRINCIPAL RISK 6b:** *Failure to demonstrate effective governance to achieve the Trust's Strategy.*	**Risk Score: 9**

Causes – What must happen for the risk to occur?
- Failure to achieve a satisfactory CQC well-led rating
- Inadequate escalation governance processes
- Trust Leadership and staff not held to account effectively
- Poorly structured and defined governance forums from 'Ward to Board'
- Unclear accountabilities and responsibilities of Trust leadership and Staff
- Insufficient grip on the governance of data

Consequences – If the risk occurs, what is its impact?
- Regulatory well-led scrutiny on the Trust leadership, staff and governance processes
- Trust resources not used effectively and efficiently in achieving the Trust's strategy
- Quality of patient care and experience is not at the level achieved
- Decision-making not consistent with achieving Trust goals
- Risks and issues not managed effecting patient care
- Poor staff morale

Executive Risk Owner: Chief Executive | **Assurance Committee:** All Committees | **Date Added to BAF:** January 2025

Inherent Risk (Before Mitigation)			Current Risk (After Mitigation)			Risk Appetite	Status: In or Out of Appetite
I	L	Rating I x L	I	L	Rating I x L		
5	4	20	3	3	9	OPEN (10-12)	INSIDE APPETITE

Risk Analysis	Q1 (2025/26)	Q2 (2025/26)	Q3 (2025/26)	Q4 (2025/26)
Current Risk Rating	9	9	9	9
Risk Appetite	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)	OPEN (10-12)

i) Controls	i) Assurances (inc Positive)	ii) Controls	ii) Assurances (inc Positive)	iii) Controls	iii) Assurances (inc Positive)
Monthly Trust Board of Directors reporting to Standing Orders, Reservation of Powers and Scheme of Delegation	- Approved Standing Orders and work programme (Jan 2025) papers, minutes and action logs - 2024/25 Committee effectiveness reviews and amendments to terms of reference	Patient Experience and Clinical Effectiveness Sub-Committees	- Approved terms of reference and work programmes (Jan 2025) - All Committee reporting papers, minutes, action logs Apr 2024-Mar 2026	Role job descriptions and annual appraisal processes	- Staff appraisals process for 2026
Trust constitution and governance framework: Scheme of Reservation and Delegation and Standing Financial Instructions	- Trust constitution and governance framework approved by Board of Directors Jan 2025, delivered through all Committees - January 2026 amendments Board approved	Performance Review and Improvement Meetings (PRIM) with Care Groups	- Monthly letters of meeting outcomes and actions to Care Groups for action - Escalation reporting to Executive Committee for lessons learnt	Line Management Development Programme	- Trust line management training programme
- Monthly Quality and Resources Committees - Twice monthly Executive Committee in delivery of Trust Strategy - Quarterly Audit Committee	- Committees' terms of reference and work programmes (Mar 2026) - All Committee reporting papers, minutes and action logs Apr 2024-Mar 2026	Committee escalation processes and flow of information across governance forums	- Quality, Resources, and Audit Committee escalation reports to Board of Directors - Care Group reporting escalations to Executive Committee April 2024-Mar2026	Business Intelligence data reporting processes	- Signal 'real-time' reporting - Trust Priorities Report (TPR) monthly reporting to Board, Quality, Resources and Executive Committees Apr 2024-Mar 2026
- Risk Management Strategy and Policy and Datix system - DSPT submission and cyber security management	- Board Approved January 2025 - BAF, Corporate Risk, Care Group and speciality risk registers Apr 2024-Mar 2026 - SIRO board report Sept 2025	Care Group governance forums (quality, performance, finance, workforce, risk)	*Gap - Approved consistent terms of reference and work programmes across all Care Groups* - Care Group reporting papers, minutes, action logs Apr 2024-Mar 2026	Delivery of Well-Led Action Plans throughout 2026/27 *Gap – Evidence of well-led action plan with implementation throughout 2026/27*	- Progress quarterly reportable to the Board of Directors

Mitigating Actions To Address Gaps What actions will further mitigate the risk and its identified rating?	Progress Update What is the current progress to date in achieving the action identified?	Action Owner Who is the action owner?	Target Date When does the action take effect?
Consistent Care Group governance terms of reference for Quality, Performance, Finance and Risk forums	Accountability framework drafted for future Trust wide dissemination. Training underway for specialities. Risk and Assurance Workshops conducted with Care Group leadership teams	Associate Director of Corporate Governance	Review June 2026
Well-led external assessment next steps to implement	External well-led assessment concluded and final report received. Well-Led Action Plan drafted, implementation underway and quarterly reporting to the Board of Directors.	Associate Director of Corporate Governance	Review June 2026 - Implementation throughout 2026/27

Target Risk (After Actions Implemented)		
I	L	Rating I x L
2	3	6
Next Review		
Q1 Jul 2026		

Report to:	Board of Directors
Date of Meeting:	29 April 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 2025/26 Annual Report and Committee Effectiveness Review for the Quality Committee has been completed for Board of Directors review.

The terms of reference for the Quality Committee and the Group Audit Committee are provided for Board of Directors review and approval.

Recommendation

The Board of Directors is asked to approve the Quality and Group Audit Committees terms of reference.

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
Audit Committee	10 March 2026	Recommended for approval
Quality Committee	24 March 2026	Recommended for approval

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 Quality Committee Annual Report and Effectiveness Review has now been concluded for the Board to consider.

The Quality and Group Audit Committees Terms of Reference are also provided for Board approval.

2. Committee Annual Report and Effectiveness Review

The 2025/26 Quality Committee Annual Report and Effectiveness Review is presented at appendix 1 for the Board to consider.

The areas of development identified in the review are to be focussed for areas of improvement during 2025/26.

3. Quality and Group Audit Committees Terms of Reference

The Quality Committee terms of reference reviewed by the Committee at its March meeting has had one amendment provided to include Associate Non-Executive Directors as part of the Committee's membership presented at appendix 2.

The Group Audit Committee terms of reference has been reviewed following the Annual Report and Effectiveness Review with changes including clarification on the wording of the purpose of the Committee, its role regarding the Board Assurance Framework and clinical audit assurance obtained through the Quality Committee.

This is presented at appendix 3.

Quality 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 Quality 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 2024 and this also forms the annual report of the Committee over this period.

2. Governance

The membership of the Quality Committee is as follows:

- Non-Executive Director (Chair)
- 2 x Non-Executive Director
- Medical Director
- Chief Nurse
- Chief Operating Officer

Attendees of the Committee are:

- Deputy Medical Director
- Associate Medical Director
- Deputy Chief Nurse
- Director of Quality, Improvement and Patient Safety
- Chief Clinical Information Officer
- Chief Pharmacist
- Chief of Allied Health Professionals
- Deputy Director of Infrastructure
- Senior quadrumvirate representation from each Care Group

Attendees (as and when required)
Senior representation from each Care Group when presenting divisional reports (For Care Groups of Medicine, Surgery, Family Health, Cancer, Specialist and Clinical Support Services this will be the Care Group Director, Associate Chief Operating Officer and Associate Chief Nurse or Associate Chief Allied Health Professional.)

The Associate Director of Corporate Governance has a standing invitation to the Committee.

Table 1: Quality Committee Attendance

	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
Stephen Holmberg	✓	✓	-	-	-	-	-	-	-	-	-	-	2/2
Lorraine Boyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12
Jenny McAleese	Ap	✓	✓	✓	✓	✓	✓	Ap	Ap	✓	✓	-	8/11
Noel Scanlon	-	-	Ap	✓	✓	Ap	✓	✓	✓	Ap	✓	-	6/9
Richard Reece	-	-	-	-	-	-	-	-	-	-	✓	✓	2/2
Rukmal Abeysekera	-	-	-	-	-	-	-	-	-	-	-	✓	1/1
Karen Stone (inc deputies)	✓	✓	Dp	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/11
Dawn Parkes (inc deputies)	Dp	✓	Dp	Dp	Dp	✓	✓	Dp	Dp	✓	Dp	-	11/11
Claire Hansen (inc deputies)	✓	Dp	✓	Dp	✓	✓	✓	✓	✓	✓	✓	✓	12/12
Tara Filby	-	-	-	-	-	-	-	-	-	-		✓	1/1

Ap - Apologies, Dp - Deputy provided counting towards quorum, ✓ - in attendance

The Quality Committee met on 12 occasions so far 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 Quality 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 at each meeting.

The Chair of the Quality Committee is also a member of the Group Audit Committee.

3. Duties of the Committee

On behalf of the Trust Board, the Quality Committee will:

- Oversee the writing and revision of the Quality Strategy.
- Review the Quality Strategy Dashboard and use information from several sources to inform the Committee of how well the Trust is performing and the quality-of-care patients receive.
- Monitor delivery and seek assurance that the Trust's Quality Strategy is being fully implemented.
- Seek assurance from the Patient Experience Sub-Committee regarding patient feedback including information obtained via complaints, contacts with the PALS service and Friends and Family Test returns. Identify areas for improvement based on this information.

- Consider and review the Trust's compliance with the statutory Duty of Candour, and to be satisfied that the Trust is being open, honest, and effectively engaging and supporting patients and their relatives who have been involved in a notifiable patient safety incident.
- Obtain assurance of the Trust's maintenance of compliance with the Care Quality Commission registration through assurance of the systems of control, with particular emphasis on the Fundamental Standards of Care, quality and safety including assurance on external assessment systems, professional bodies and regulatory bodies' requirements with subsequent action plans.
- Seek assurance from the Patient Safety and Clinical Effectiveness Sub-Committee regarding serious incidents including identification of themes and trends and actions taken to ensure learning has taken place.
- Seek assurance that the production of an annual clinical audit plan has been overseen by the Patient Safety and Clinical Effectiveness Sub-Committee including participation in national audit reports, and that the implementation of the plan has been kept under review at quarterly intervals.
- Receive and oversee the production of the Trust's Quality Account for presentation to the Trust Board.
- Seek assurance that the Patient Safety and Clinical Effectiveness Sub-Committee has ensured that agreed best practice, as defined in the national clinical audit framework, is reviewed and delivered where relevant in the context of the Trust's services. This will include, for example, NICE clinical guidelines and NHS frameworks as well as the guidance that emerges from national confidential enquiries, high level enquiries and other nationally agreed guidance.
- Receive a bi-monthly exception report from each of the care groups and escalate issues and risks as appropriate to the Trust Board.
- Implement the Learning from Deaths Policy and embed reporting arrangements.
- Receive a monthly Chair's report from the Patient Experience Sub-Committee and escalate issues and risks highlighted as appropriate.
- Receive a monthly Chair's report from the Patient Safety and Clinical Effectiveness Sub-Committee and escalate issues and risks highlighted as appropriate.
- Oversee care group governance and reporting arrangements.
- Undertake a quarterly review of the Board Assurance Framework and ownership of specific principal risks on behalf of the Board.

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:

- Care Group Deep Dive assurance presentations from each Care Groups leadership: Medicine, Surgery, Cancer, Specialist and Clinical Support Services (CSCS) and Family Health.
- Sub-Committee escalation reporting from:
  - Patient Experience Sub-Committee
  - Patient Safety and Clinical Effectiveness Sub-Committee

- Maternity and Neonatal Reports including the Maternity Section 31 submission
- CCQ Compliance Update Reporting
- Safeguarding and Complex Needs Reporting
- Overall Quality Strategy progress
- Nurse Staffing Reporting (in conjunction with the Resources Committee)
- Complaints and Staffing Reporting
- Infection Prevention and Control Reporting
- Patient Experience Reporting
- Risk Management Reporting

5. Assessment of Effectiveness

The membership of the Committee was asked to conclude a self-assessment of the committee's effectiveness with the following identified.

Highest self-assessment scores

- The Committee have written terms of reference that clearly describe the purposes and duties of the Committee.
- The Committee has devised a comprehensive year-round plan to address all necessary matters.
- Committee papers are distributed in sufficient time for members to give them due consideration.
- The Committee has the right balance of experience, knowledge and skills to fulfil its role.
- Debate is allowed to flow, and conclusions reached without being cut short or stifled.
- The outcomes of each meeting and any escalations are reported effectively to the Board.

Lowest self-assessment scores

- The Committee has set itself a series of objectives for the year.
- The quality of Committee papers received allows Committee members to perform their roles effectively.
- At the end of each meeting the Committee discuss the outcomes and reflect on decisions made, identifying successes and areas to develop.
- The Board of Directors challenges and understands the reporting from this Committee.

The lowest self-assessment average scores will be reviewed by the Associate Director of Corporate Governance and the Committee Chair to address any development opportunities for the Committee.

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 Quality Committee has met each month throughout the year and has effectively fulfilled the brief outlined in the Terms of Reference, through the delivery of the agreed work plan, to gain assurance of the Quality and Safety of Trust services and the Patient Experience as they engage with those services.

There has been a focus to improve Ward to Board assurance through regular attendance by Care Group Senior Leaders, sharing their issues, successes and risks. Patient Safety & Clinical Effectiveness and Patient Experience Subcommittees, also attended by the Care Groups, meet monthly and report up key issues. These have been evolving interactions and over time the Quality & Safety assurances have become clearer and stronger, providing an improving level of confidence in the governance structures that support the work of the Quality Committee.

The year has been one of transition from a focus on response to CQC inspection outcomes through Journey to Excellence, to one of sustained business as usual audit activity, learning responses and associated quality improvement. The Nursing Assurance Framework has been developed to support this shift and continued to evolve and strengthen data-based assurance, enabling triangulation of information sources.

The NICHE Report highlighted gaps in governance and assurance relating to Complex Needs, Mental Health and Safeguarding, which have been addressed through greater clarity and understanding of the issues and regulatory requirements. Improved, more focused reporting at both Committee and Board level have resulted and further confidence in assurances provided is anticipated.

Maternity oversight has remained a priority in line with national expectations. Hospital Acquired Infections and Pressure Ulcers are True North quality metrics and a regular focus of discussion and scrutiny. Sepsis data, Mortality data, Learning from Deaths reporting and scrutiny of internal and external clinical audit programmes provide assurance on the quality and outcomes of clinical activity.

As Chair of the Quality Committee I would like to thank my Non Executive and Executive colleagues who have supported me through the year, the Care Group Senior Leaders and other attendees who have brought the business of the meeting to life, the Business Intelligence Team who are vital to our mission of data driven scrutiny and curiosity, the Trust Secretary and last but not least the Corporate Governance Officer who so diligently supports and records the meetings.

Lorraine Boyd, Chair of the Quality Committee
March 2026

Terms of Reference for: **Quality 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	
Trust Priorities: Quality, patient experience, safety and clinical effectiveness	**Scope:** Trust wide
Keywords: Quality, Safety, Patient Experience, Clinical Effectiveness	**Replaces:** N/A
To be read in conjunction with the following documents: Trust Strategy and Priorities, Board Assurance Framework, Corporate Governance Manual, Care Group Quality Governance Arrangements	

Unique Identifier: QC	**Review Date: March 2027**	
Issue Status: Final	**Issue No: v2.1**	**Issue Date:** March 2026
To be Authorised by: Quality Committee and Board of Directors	**Authorisation Date:** Quality Committee: March 2026 Trust Board: April 2026	
Document for Public Display: Yes		
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Archive:	**Date added to Archive:**	
Officer responsible for archive: Associate Director of Corporate Governance		

QUALITY COMMITTEE

Terms of Reference

1. Status	
1.1	The Board has resolved to establish a Committee of the Board to be known as the Quality Committee ("the Committee").
1.2	The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.
2. Purpose of the Committee	
2.1	The purpose of the Quality Committee is to gain assurance, on behalf of the Board of Directors, that there are systems, processes and controls in place to deliver and monitor the achievement of consistently high-quality care to meet the Trusts legal and regulatory obligations.
2.2	The Committee will gain assurance that any shortcomings in the quality and safety of care against agreed standards are being identified and addressed in a systematic and effective manner.
2.3	The Committee will ensure that any risks to delivery of quality standards are escalated to the Trust Board and appropriate mitigations and remedial actions are implemented.
2.4	The Committee ensures that the Trust Board receives regular and reliable assurance on the quality of clinical services including safety, effectiveness and patient experience.
2.5	The Committee fosters the development of a learning organisation ensuring that feedback from patients and carers is heard, that there is learning from concerns, complaints, compliments, risks and incidents and acts to improve care.
2.6	The Committee ensures that there is appropriate planning in place around current and future statutory and mandatory quality and patient safety standards, and that best practice is identified, delivered and shared.
2.7	The Committee will review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function.

3. Authority	
3.1	The Committee is a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference.
3.2	The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, external and internal auditor and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required.
3.3	The Committee is authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever independent professional/legal advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).
3.4	The Committee shall have the power to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board.
3.5	In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Trust Board of Directors.
3.6	The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups must be approved by the Trust Board of Directors and reviewed on an annual basis.
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	On behalf of the Trust Board, the Quality Committee will: • Oversee the writing and revision of the Quality Strategy. • Review the Quality Strategy Dashboard and use information from several sources to inform the Committee of how well the Trust is performing and the quality-of-care patients receive. • Monitor delivery and seek assurance that the Trust's Quality Strategy is being fully implemented. • Seek assurance from the Patient Experience Sub-Committee regarding patient feedback including information obtained via complaints, contacts with the PALS service and Friends and Family Test returns.

	Identify areas for improvement based on this information. • Consider and review the Trust's compliance with the statutory Duty of Candour, and to be satisfied that the Trust is being open, honest, and effectively engaging and supporting patients and their relatives who have been involved in a notifiable patient safety incident. • Obtain assurance of the Trust's maintenance of compliance with the Care Quality Commission registration through assurance of the systems of control, with particular emphasis on the Fundamental Standards of Care, quality and safety including assurance on external assessment systems, professional bodies and regulatory bodies' requirements with subsequent action plans. • Seek assurance from the Patient Safety and Clinical Effectiveness Sub-Committee regarding serious incidents including identification of themes and trends and actions taken to ensure learning has taken place. • Seek assurance that the production of an annual clinical audit plan has been overseen by the Patient Safety and Clinical Effectiveness Sub-Committee including participation in national audit reports, and that the implementation of the plan has been kept under review at quarterly intervals. • Receive and oversee the production of the Trust's Quality Account for presentation to the Trust Board. • Seek assurance that the Patient Safety and Clinical Effectiveness Sub-Committee has ensured that agreed best practice, as defined in the national clinical audit framework, is reviewed and delivered where relevant in the context of the Trust's services. This will include, for example, NICE clinical guidelines and NHS frameworks as well as the guidance that emerges from national confidential enquiries, high level enquiries and other nationally agreed guidance. • Receive on a rolling basis a deep dive from each of the care groups escalating issues, actions, risks and mitigations reported as appropriate to the Trust Board. • Implement the Learning from Deaths Policy and embed reporting arrangements. • Receive a monthly Chair's report from the Patient Experience Sub-Committee and escalate issues and risks highlighted as appropriate. • Receive a monthly Chair's report from the Patient Safety and Clinical Effectiveness Sub-Committee and escalate issues and risks highlighted as appropriate. • Oversee care group governance and reporting arrangements. • Undertake a quarterly review of the Board Assurance Framework and ownership of specific principal risks on behalf of the Board.

5.2	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)
5.3	The Committee will support 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, 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.
5.4	To examine any other matter referred to the Committee by the Board of Directors.
5.5	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	**Full Members** Three Non-Executive Directors, one of which is the Chair. Associate NEDs can contribute to the membership but must not act as chair. Medical Director Chief Nurse Chief Operating Officer **Attendees** Deputy Medical Director – Quality Associate Medical Director – Quality Director Nursing & Deputy Chief Nurse Director of Quality, Improvement and Patient Safety Chief Clinical Information Officer Chief Pharmacist Chief of Allied Health Professionals YTHFM Representative Senior quadrumvirate representation from each Care Group **Attendees (as and when required)** Senior representation from each Care Group when presenting divisional reports (For Care Groups of Medicine, Surgery, Family Health, Cancer, Specialist and Clinical Support Services this will be the Care Group Director, Associate Chief Operating Officer and Associate Chief Nurse or Associate Chief Allied Health Professional.) **Other/Supplementary Attendees**

	The Associate Director of Corporate Governance will have a standing invitation to the Committee. Representation from Humber and North Yorkshire Integrated Care Board and a patient representative 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 from the meetings
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 each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year in the annual report of the Committee to the Board. A named deputy must be identified for members of the Committee and must attend when a member is unable to be present. A named deputy will count towards quorum. Senior representatives from each Care Group are expected to attend when presenting but do not count towards quorum.
7.3	The Chair may request attendance by relevant staff at any meeting.
8. Changes to the Terms of Reference	
8.1	Changes to the Terms of Reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.
9. Establishment of sub-groups	
9.1	The Quality Committee may establish sub-groups and/or sub-committees made up wholly or partly of members of the Quality Committee to support its work. The terms of reference of such sub-groups and sub-committees will be approved by the Quality Committee and reviewed at least annually. The Committee may delegate work to the sub-group and/or sub-committee in accordance with the agreed terms of reference. The Chair of each sub-committee will be expected to provide a Chair's report to the Quality Committee after each meeting. The Chair of each sub-group will be expected to provide a report to the Committee either bi- monthly, quarterly or annually dependent on their function.

	Sub-Committees in place: Patient Safety and Clinical Effectiveness Sub-Committee Patient Experience Sub-Committee Maternity Assurance Sub-Committee (time limited)
10. Frequency of meetings	
10.1	Meetings of the 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. Meetings will be expected to last no more than three hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of the Committee may be called by any member of the Committee, with the consent of the Chair.
11. Administrative support	
11.1	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 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
12. Reporting to the Trust Board	
12.1	The Chair of the Quality Committee will provide a 'Chair's Report' monthly to the Trust Board outlining key actions taken with regard to quality and safety issues, key risks identified, and key levels of assurances given.
13. Status of the Meeting	
13.1	All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee.
14. Monitoring Effectiveness and Compliance with Terms of Reference	
14.1	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 against its forward-looking work programme and

	complying with its terms of reference, specifically commenting on relevant aspects of the Board Assurance Framework and relevant regulatory frameworks.
15. Review of Terms of Reference	
15.1	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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Electronic file path:	**MS Teams Quality Committee channel**
Circulation:	**Quality Committee members and attendees**

Terms of Reference for: **Group Audit 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: All Objectives**
Keywords: Internal/External Audit, Risk, Governance, Counter Fraud, Control, Assurance	**Replaces: V1.0**
To be read in conjunction with the following documents: **Internal Audit and External Audit Plans, Board Assurance Framework, Corporate Governance Manual**	

Unique Identifier: GAC	**Review Date: March 2027**	
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To be Authorised by: Board of Directors	**Authorisation Date: 29 March 2026**	
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Terms of Reference

1	**Status**
1.1	The Group Audit Committee ('The Committee') is a formal committee of the Board of Directors ('The Board'). The Committee is a Non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.
1.2	The business of the Committee meetings shall be formally recorded. The formal minutes shall be distributed to the committee members for any immediate comments. Escalation reports shall be provided to the Trust Board at its next meeting proceeding the reported Group Audit Committee. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or require Executive action. Where urgent risks or control failures are identified between meetings, the Chair may escalate directly to the Chair of the Board and/or the Chief Executive (Accounting Officer) in accordance with Standing Orders.
2	**Purpose of the Committee**
2.1	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 the corporate level, this will include a Risk Management System and assurance over the design and operation of relevant performance management arrangements, underpinned by an Assurance Framework and Corporate Risk Register.
2.2	The Committee's focus is on the adequacy and effectiveness of assurance and controls; it does not substitute for executive management of performance, quality or operational delivery. The Committee also has a pivotal role to play in reviewing disclosure statements that flow from the organisation's assurance processes. The Committee also reviews the governance and assurance processes in place around the York Teaching Hospital Facilities Management Limited Liability Partnership (YTHFM).
3	**Authority**
3.1	The Committee is authorised by the Board and YTHFM to investigate any activity within its Terms of Reference and to take appropriate action.
3.2	The Committee is authorised to seek any information it requires from any employee of the Trust or YTHFM and all employees are directed to co-operate with any request made by the Committee.
3.3	The Committee is authorised by the Board and YTHFM to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers it necessary.
3.4	The Committee is authorised by the Board and YTHFM to establish and develop working groups as required by the activities of the Committee and the business needs of the Trust.
4	**Legal requirements of the committee**
4.1	The Committee will seek assurance that robust arrangements are in place to identify, review and respond to relevant legal and regulatory requirements affecting governance, risk management, internal control, audit and financial reporting. Key documents include, but are not limited to: • NHS Audit Committee Handbook 2024 • NHSE Code of Governance for NHS Provider Trusts 2023

	The Committee should have due regard to the Trust's and YTHFM's obligations under legislation relating to equality.
5	**Role and duties**
5.1	Governance, Risk Management and Internal Control The Committee shall review 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. In particular, the Committee will review the adequacy and effectiveness of: • All risk and control related disclosure statements, in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances prior to submission to the Board or YTHFM. • The underlying assurance processes that indicate the degree of achievement of the Trust's or YTHFM's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications. • The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHSCFA. The Board retains ownership of the Board Assurance Framework; the Committee will provide independent assurance through its review of the systems of internal control including advice on its structure, evidence base, and the robustness of the assurances presented to the extent they are covered through the committees workplan. In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources of assurance. It will also seek reports and assurance from Directors and Managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the use of an effective Assurance Framework to guide its work and the audit and assurance functions that report to it. The Committee will have effective relations with other key Committees so that it understands processes and linkages. However, these other Committees must not usurp the Committee's role. The Committee will avoid unnecessary duplication by focusing on the adequacy of assurance and controls, and by receiving assurance from other committees (e.g., Quality and Resources) where appropriate.
5.2	Internal Audit The Committee shall ensure 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. This will be achieved by:

	• Considering the provision of the Internal Audit service and the costs involved. The Committee should review the performance of the Internal Audit service on an annual basis. • Reviewing and approving the annual Internal Audit Plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework. • Considering the major findings of Internal Audit work (and management responses) and ensuring co-ordination between the Internal and External Auditors to optimise the use of audit resources. • Reviewing the Annual Report of Internal Audit. • Receiving the Head of Internal Audit Statement on the effectiveness of Internal Controls. • Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust. • Discussing problems and reservations arising from Internal Auditor's work and any matters Internal Audit wishes to discuss (in the absence of Executive Directors and other management where necessary). • Monitoring the effectiveness of the Internal Audit and carrying out an annual review.
5.3	External Audit The Committee shall review and monitor External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by: • Considering the appointment and performance of the External Auditors, as far as the rules governing the appointment permit (and make recommendations to the Board/YTHFM when appropriate). • Providing support to the Council of Governors in order that they can appoint External Auditors when necessary. • Reviewing all External Audit reports including the report to those charged with governance (before its submission to the Board/YTHFM) and any work undertaken outside the Annual Audit Plan, together with the appropriateness of management responses, including agreement of the Annual Audit Plan. • Discussing the nature and scope of the External Audit Plan with the External Auditor prior to commencement of the audit and agreeing the extent of reliance to be placed on Internal Audit. Where the timing of the Committee meetings makes this impractical, work may proceed with the approval of the Executive Director of Finance which will be subject to later consideration for approval by the Committee at its next meeting. • Discussing with External Auditors their evaluation of audit risks and assessment of the Trust/YTHFM and how the Audit Plan addresses these risks together with the impact on the audit fee. • Discussing issues and reservations arising from External Audit's work and any matters External Audit wish to discuss (in the absence of Executive Directors, Internal Audit and other management where necessary). • Keeping the performance of External Audit under regular review and raising any concerns with them in the first place. Any serious concerns should be drawn to the attention of the Council of Governors.

	• Ensuring that there is in place a clear policy for the engagement of External Auditors to supply non-audit services.
5.4	Financial Reporting The Committee will: • Monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance. • Ensure 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. • Review 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 • Seek assurance that appropriate financial governance, internal controls and reporting processes are in place; detailed in-year financial performance and planning are considered in the appropriate forum(s) as determined by the Board's committee structure. • Approve changes to accounting policies and practice.
5.5	Other Assurance Duties The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust/YTHFM. These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g., accreditation bodies, etc). The Committee shall review the work of the other Committees and work groups, whose work can provide relevant assurance to the Group Audit Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established and will satisfy itself on the assurance that can be gained from the clinical audit function. Assurance regarding clinical audit will normally be obtained through the Quality Committee and its reporting, unless otherwise agreed by the Board. The Committee shall review the effectiveness of the arrangements in place forallowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.
5.6	Other Duties

	The Committee will: • Review the Trust's/YTHFM's Standing Orders, Standing Financial Instructions and Schemes of Delegation. • Receive details of waivers to standing orders approved by the Executive Director of Finance. • Review the schedule of Losses and Compensations and approve write-offs as appropriate. • Satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and review 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.' • Refer any suspicions of fraud, bribery or corruption to the NHSCFA. • Request and review reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control. • Receive reports from any sub-groups of the Committee as appropriate. • Request specific reports from individual functions with the organisation (e.g. Clinical Audit), where required for assurance purposes. • Review 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 shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action. • Receive investment reports and agree investment limits. • Seek assurance that appropriate investment governance arrangements (including limits and delegations) are in place and are operating effectively in line with the Scheme of Delegation; decisions on investments remain with the Board or relevant committee as per delegated authority. • Support and advise the Council of Governors and any sub-Committee as requested. • Escalate any areas of concern identified to the Board/YTHFM for further discussion and resolution. • Submit 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 will draw to the attention of the Board any issues that require disclosure or require Executive action. • Prepare 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 will also describe 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.
6	**Membership**
6.1	The membership of the Committee shall comprise three Non-Executive Directors (NEDs). One of the members shall be appointed as Chair of the Committee by the Trust Board.
6.2	The Committee shall be appointed by the Board from amongst its independent Non-executive Directors and shall consist of not less than three members one of whom will have a financial qualification or relevant background in finance. The Chair of the Trust shall not be a member of the Committee.
6.3	Only members of the Committee have the right to attend committee meetings and have a single vote for any decisions to be taken by the Committee.
6.4	The following, or their nominated deputies, shall be expected to normally be in attendance at meetings: • Executive Director of Finance • Associate Director of Governance/Trust Secretary • Deputy Finance Director • Head of Internal Audit • Manager of Internal Audit • Audit Director for the External Auditor • Counter Fraud Specialist (attendance – minimum of 2 Committees a year) • YTHFM Managing Director (for the YTHFM section only) • Executive Directors will be invited to attend as required Attendance will be agenda-driven. The Chair may request any attendee to withdraw for specific items to support independence, confidentiality, or the candour of discussion (including private sessions with Internal and/or External Audit).
6.5	In addition, other senior specialist officers may attend from time to time to provide specialist advice and support.
6.6	The Chief Executive (Accounting Officer) will be invited to attend annually to discuss with the Committee the process for assurance that supports the Annual Governance Statement and should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.
7	**Quoracy**
7.1	The Committee will be quorate with not fewer than 2 members attending. 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 (if required).
7.2	Members should normally attend all meetings, and it is expected that members will attend a minimum of 75% of meetings held per annum.
7.3	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 Committee. Substitution by a deputy for Committee members is not permitted. If ongoing absence affects effective functioning, the Chair will raise with the Chair of the Board for consideration of membership changes in line with Board appointment processes.
8	**Frequency of meetings**

8.1	The Committee will meet as a minimum 5 times per year (including the year-end meeting and time out) and all supporting papers will be circulated 7 days in advance of the meeting.
8.2	The Chair of the Committee has the right to convene additional meetings should the need arise and/or in the event of a request being received from at least 2 members of the Committee.
9	**Administrative support**
9.1	The Committee will be supported administratively by the Chair and Chief Executive's Office, whose duties will include: Agreement of the agendas with the Chair and attendees; Advising the Committee on pertinent issues/areas of interest/policy developments; Formally recording the minutes of the Committee; Ensuring that action points are taken forward between meetings; Ensuring that Committee members receive the development and training they need; and, Other duties as required.
9.2	Minutes of the meetings and action log will be circulated to all members as soon as reasonably practical. Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of the report and key issues.
9.3	At least once a year the Committee should meet privately with the External and Internal Auditors. The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee.
9.4	Copies of all agendas and supplementary papers will be retained by the Chair and Chief Executive's Office in accordance with the Trust's requirements for the retention of documents.
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. The effectiveness review will, as a minimum, consider: member skills/experience and development needs; appropriateness and timeliness of information received; quality of challenge and independence; delivery against the work programme; and how the Committee has influenced the Board's assurance and internal control environment.
11	**Review of Terms of Reference**
11.1	The Terms of Reference of the Committee (including membership) shall be reviewed annually or in light of changes in practice or legislation and approved by the Trust Board.

Author	**Associate Director of Corporate Governance**
Owner	**Associate Director of Corporate Governance**
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Item 20

Report to:	Board of Directors
Date of Meeting:	29 April 2026
Subject:	Fire Safety Policy and Strategy
Director Sponsor:	Tara Filby, Interim Chief Nurse
Author:	Andy Hamer, Fire Safety Manager

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

Approve ☒ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:

The Fire Safety Policy and Strategy is a new policy, ensuring continued compliance with fire safety.
All the actions from the Executive Committee meeting on 17 December 2025 have been completed.

Recommendation:

The Board of Directors are asked to approve the Policy in accordance with governance procedures.
Once approved, the Policy will be published and communicated across the Trust.

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

Meeting/Engagement	Date	Outcome/Recommendation
Fire Safety Group	11 November 2024	Approved
Health and Safety Committee	30 July 2024	Approved
Executive Committee	15 April 2026	Approved

Reference:

Fire Safety Policy & Strategy

Version:
1.0

Summary	This strategy sets out the Trust management policy and strategy by setting out the strategic requirements for the operational management of fire safety in the Trust.	
Document	Fire Policy pages 1 - 8 Fire Strategy pages 8 - 25	
Target audience	This Strategy and Policy affects anyone who is treated, visits or comes onto or into any of our Trust sites for recreational or work purposes.	
Date issued	March 2025	
Approved & Ratified by	Health and Safety Committee Fire Safety Group	**Date of meeting:** **30 July 2024** **11 November 2024**
Next review date	March 2028	
Author	Andrew Hamer – Fire Safety Manager / LSMS	
Executive Director	Dawn Parkes – Chief Nurse	

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust Intranet is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Version Control

Change Record

Date	Author	Version	Page	Reason for Change
July 2024	A Hamer N Elliott	V1.0		Replaces previous Trust fire safety policy
Dec 2024	C Weatherill	V1.0	Page 6 Page 7 Page 8 Page 15 Page 15 Page 18	Add in 4.7 AP(F) Add in 4.8 CP(F) & 4.10 FIR Manager Add in 4.14 Fire Safety Group Link to the Building Management System – Fire 5.31 York Teaching Hospital Limited Liability Partnership – Estates will ensure all components of the Trust fire safety is maintained and managed including but not limited to ensuring relevant fire safety equipment is identified and labelled via CAFM/MiCad. 5.55 Add - Any Hot Works will require a Trust Hot Works Permit to be obtained and issued by the Trust estates department. Re-reference numbers in section 5.
Feb 2025	A Hamer	V1.0		Add 3 SOPs in the Appendices
March 2026	A Hamer	V1.0	Page 12	Evacuation Responsibility

Reviewers/contributors

Name	Position	Version Reviewed & Date
Andrew Hamer	Fire Safety Manager / LSMS	17/06/2024
Norman Elliott	Deputy Head Safety	22/07/2024
C Weatherill	Head of Safety & Security	24/12/2024

A Hamer	Fire Safety Manager / LSMS	26/03/2025

Contents

1. Introduction

York and Scarborough Teaching Hospitals NHS Foundation Trust is committed to its statutory requirements and obligations to comply with the Regulatory Reform (Fire Safety) Order 2005, and NHS Health Technical Memorandum 'Firecode' documentation. This strategy applies to all premises occupied by the Trust, and includes, where required compliant building fire safety measures when carrying out of structural improvements, ensuring fire detection is kept up to date and carrying out all scheduled maintenance of fire related equipment. The Trust will routinely ensure this document is reviewed and amended in line with legislation change, as well as changes to the buildings it covers.

This policy and strategy are made under York Teaching Hospital Group (YTHG)) Health & Safety Polices and outlines the steps to be taken to ensure compliance with fire safety requirements in NHS Trusts.

The Trust will ensure it continues to be committed to training of its staff in relation to fire safety, ensuring that there is a safe environment and culture in which patients can be treated safely, ensuring their well-being as well as that of staff and any other persons visiting of premises.

2. Scope

This document applies to all employees of York and Scarborough Hospital Trust Group (including contractors, volunteers, agency workers and students), and to all members of the public and patients whilst they are on any of our sites.

The aim of this document is to:

- Explain the organisational structure and how fire safety will be managed.
- Explain the specific duties within the Trust and detail the roles and responsibilities of those personal.
- Identify the procedures within the Trust that all staff are expected to follow, in the event of a fire.
- Identify fire precautions and measures to be complied with in relation to fire safety and to meeting regulatory requirements.
- Determine the Trusts strategy in relation to fire safety, including building infrastructure, fixture, fittings, maintenance, and testing regimes.

3. Statutory Requirements

The statutory and NHS best practice guidance for fire safety are as follows:

- The Regulatory Reform (Fire Safety) Order 2005
- Fire Safety Act 2021
- The Fire Safety (England) Regulations 2022
- Section 156 Building Safety Act 2022

- The Health and Safety at Work Act 1974
- The Management of Health and Safety at Work Regulations 1999
- The Workplace Regulations 1992
- The Furniture and Furnishings (Fire) (Safety) Regulations 1988
- NHS 'Fire code' Health Technical Memorandums (HTM's) 05-01, 05-02, 05-03 and associated documents
- The Building Regulations 2010 – Approved Document 'B' for Fire Safety
- Fire safety risk assessment guidance – Healthcare Premises

4. Duties and Responsibilities

Follows are the specific duties and responsibilities of personnel employed by the Trust Group regarding fire safety.

4.1 Chief Executive

The Chief Executive is the responsible person for the Trust, as defined in the Fire Safety Order 2005, meaning they are ultimately accountable and responsible. The responsibility for the strategic and operational oversight of Fire Safety is delegated through the corporate structure to the Director overseeing Fire Safety for the Trust, which is the Chief Nurse.

4.2 Chief Nurse

The Chief Nurse holds Fire Safety in their portfolio, as part of the wider Health, Safety, Security and Fire function. The Chief Nurse is responsible for Fire Safety at Board level. The responsibility for the strategic and operational oversight of Fire safety is delegated through the corporate structure to the Fire Safety Manager for the Trust.

4.3 Fire Safety Manager

The Fire Safety Manager is the Head of Fire Safety for the Trust and responsible for the implementation of this strategy and policy.

The Fire Safety Manager is to ensure compliance with all fire related legislation and ensure the correct implementation of the Trust fire strategy is managed. They should have an awareness of building fire safety design and ensure that fire safety risks are identified and managed. Other responsibilities include:

- Ensuring departments and areas are aware of their responsibilities in relation to fire safety matters.
- Ensure fire risk assessments are completed for all areas, ensuring significant risks are immediately escalated as appropriate.
- Ensure that all fire incidents are reported correctly, including any subsequent investigations, to ensure that monitoring and mitigations are in place.
- Report on fire safety and report externally when required to on fire safety compliance.

4.4 Associate Chief Operating Officer and Senior Managers

Associate chief operating officers and senior managers are responsible for to ensure staff are appropriately trained in fire safety for the activities in their charge, to promote a high degree of fire safety awareness amongst all their personnel. They have an overview to ensure that the biennial mandatory training is up to date.

4.5 Managing Director of the YTHFM LLP

The Managing Director in YTHFM has the responsibility for ensuring building, infrastructure, services and maintenance is undertaken on a regular basis for those elements, services and equipment which have a direct impact of fire safety.

Being responsible for ensuring the management of the operational estates team by maintaining staff fire safety training, competence and ensure all physical infrastructure, structural elements of fire protection equipment is maintained in accordance fire safety requirements, specifically including, but not limited to Regulatory Reform (Fire Safety) Order 2005, applicable statute, Healthcare Technical Memorandums (HTM's 05-01, 02 & 03) and applicable guidance.

4.6 Appointed Persons Fire (AP(F))

YTHFM is to ensure those who work on or maintain fire safety systems, infrastructure or equipment can demonstrate a sound knowledge of specific the aspects of fire safety in the works they carryout. Having the relevant and adequate technical knowledge and training commensurate.

The Fire Safety Manager will appoint in writing the AP(F) for each YTHFM operational areas / regions.

The AP(F) in conjunction with the fire safety manager is responsible for the written appointment of internal competent staff for working on fire safety systems or equipment.

4.7 Competent Person Fire CP(F)

YTHFM will ensure any installers and maintainers of fire safety equipment that are commissioned by YTHG, are able to demonstrate a sound knowledge and specific skills in the specialist service being provided.

This Will include the installation and/or maintenance of all aspects of related fire safety equipment/services.[1]

[1] *As a minimum as specified to in HTM 05-01 competent person's fire.*

4.8 Fire Response Team

The main hospital sites have a prescribed site response team who are trained to respond to fire alarm activations. The response team will attend fire alarm activations to assess the potential course of a fire alarm activation, dependant on the risk and outcome of this assessment take the appropriate action to address the situation.

For all Fire alarm activation, as Datix is completed by the estate's member of the fire response team in attendance, these Datix will be logged to the Fire Safety Manager and Fire Safety Officer / Advisor to investigate and close the Datix.

4.9 Fire Incident Response Manager

Is the most senior person in charge of an area or site at the time of any fire incident, this person will assume the role of fire incident response manager, taking control, liaising with the fire response team to determine the correct course of action including the commencement of evacuation if appropriate.

The fire incident response manager will remain in charge until the fire response team attend, an appointed senior manager fire, fire brigade commander attends the incident to take control.

4.10 Fire Safety Officers / Advisors

The Fire safety Officers / Advisors will ensure all procedures and plans are disseminated to relevant department managers, ensuring that lifesaving fire risk assessments, area evacuation plans, are in place and current. Assisting operational teams in development of General Emergency Evacuation Plan and Personal Emergency Evacuation Plans, deliver specific fire safety training, information packages which are shared with relevant staff.

Providing expert fire safety advice to all staff within the Trust Group on matters of Fire safety in accordance with the Fire Safety Order, HTM's and the Building Regulations. Providing expert advice and support as requested to the Trust Group on building fire safety matters.

4.11 Ward and Department Managers

All ward and department managers have overall responsibility for their areas regarding health and safety, which includes fire safety, and are responsible for ensuring:

- There is an appropriate response to fire alarms within the area, where all staff know and understand their responsibilities in case of a fire incident and where evacuation may be required.
- Staff understand what the risks are within their place of work regarding fire,

and know where firefighting equipment is, where the alarm points, fire exits, escape routes and evacuation equipment are located.

- Staff do not interfere with physical fire protection arrangements in place e.g. the unsafe acts wedging of fire doors, or the blocking of fire exits etc.
- Department have staff, who have the knowledge to support for the ward / department manager to help make sure that fire safety measures are complied with.

4.12 All Staff

Every member of staff should understand their duties in relation to fire safety, and comply with fire regulations and procedures, and they:

- Understand and follow the correct actions in the event of a fire, how they raise the alarm effectively and how to follow the evacuation strategy'.
- Attend all mandatory fire safety training available to them.
- Where there are concerns around fire safety procedures and processes not being followed, then appropriate escalation should be undertaken, to direct line management.

4.13 Fire Safety Group

The Fire Safety Group is responsible for monitoring and review of all aspects of fire safety matters. The fire safety group will be chaired by fire safety manager.

The fire safety reports to the Trust Health and Safety Committee for reporting of fire safety matters to the Board.

York and Scarborough Teaching Hospitals Group Fire Strategy

5.0 Trust Fire Alarm systems

5.01 Healthcare and clinical sites

Fire alarm systems for all Trust sites that are designated healthcare premises will be designed and commissioned to meet BS 5839 Part 1. This will include additional considerations for healthcare premises detailed in HTM 05-2 and HTM 05-03: Part B (Detection and Alarm Systems) L1 systems unless specific risk assessments indicate otherwise.

5.02 Administrative and non-clinical sites

Fire alarm systems for premises that are 100% non-clinical will be designed and commissioned to meet the relevant standards detailed within Approved Document B. Where existing buildings cannot easily meet the requirements of Approved

Document B, the guidance provided in the relevant HM Government guides for fire safety will be taken into account.

5.1 Fire Evacuation

5.1.1 Fire Evacuation procedure overview

The Trusts evacuation strategy for each premises, area or department will be based on the dependency of patients. This will take into account the clinical needs of patients to minimise harm from avoidable movement. Guidance for the appropriate evacuation strategy will be taken from HTM 05-02.

For all Trust clinical areas and main hospital sites with non-ambulatory patients, the Trust utilises the standard NHS evacuation strategy of progressive horizontal evacuation (PHE)[2]. This is a strategy of immediate and simultaneous evacuation where possible. Where clinical considerations are not required, the Trust will adopt the simplest and most time-effective means for evacuation, direct to final safety or to a place of relative safety with final safety if required by a fire situation.

The Trust PHE strategy is founded on three elements, these are:

- Active fire protection systems of automatic fire detection, warning systems and specified fire suppression systems, for early warning, response and to maximise the time available for escape to relative and final safety.
- Patient-access areas designed to allow for progressive horizontal evacuation to places of relative and final safety.
- Areas to which patients have access are not located where evacuation would necessitate travelling up a stairway to a final exit.

Below are the specific procedures required for effective PHE to occur.

5.1.2 Ward evacuation procedures

Ward evacuation procedures rely on PHE to be achieved safely, and to keep movement of patients to the minimum required to keep patients safe. The Ward manager, Nurse in Charge, or other most senior person who is immediately available, will assume responsibility for initiating the evacuation of a ward.

While evacuation should not be started until necessary, there should be no delay in preparing to evacuate as soon as it becomes apparent that patient safety is at risk.

The procedure is to move patients at greatest risk as a priority. This will normally be patients who are closest to any fire but will need to account patient dependency of

[2] "HTM 05-02 - The principle of progressive horizontal evacuation is that of moving occupants from an area affected by fire through a fire-resisting barrier to an adjoining area on the same level, designed to protect the occupants from the immediate dangers of fire and smoke (a refuge)."

care and, or lack of mobility. This will require specific patient risk assessment and, in some cases, may require patients with greater clinical dependency to be moved first.

Evacuation should always be away from the fire and towards an area of relative safety in an adjacent sub-compartment, or compartment. The direction of evacuation should take into account the possible need for further, progressive horizontal evacuation.

Ultimately, PHE should move towards areas where patient care can continue, patient safety and comfort is maintained and if necessary, allow for evacuation to a place of absolute final safety and ongoing care. This may require vertical evacuation via a stair or fire or independently supplied lift.

5.1.3 Vertical evacuation from clinical areas

Vertical evacuation from clinical area should not be necessary, where all other procedures work as planned and as expected. This evacuation strategy does account for the possible failure of one or more control measures to protect patient safety. This means in most cases PHE will ultimately move towards some means of vertical evacuation if this becomes necessary. This means staff are to plan and be prepared to be able to move patients to the next level(s), if necessary and always away from the fire by use of moving equipment (evac chairs, ski-pads etc) and aids or fire or independently supplied lifts.

5.1.4 Use of lifts for vertical evacuation

Unless specifically designed to be used in the event of a fire, (HTM 05-03: Part E) lifts should not be considered as safe to use for vertical evacuation in most circumstances, Trust fire lifts are specifically identified.

Regardless of the design of the lift, these may be used when the conditions described in HTM 05-02 are met in full. Specifically, in accordance with HTM 05-02 (3.51) lifts may be used for vertical evacuation when the following are satisfied:

- The lifts should be in a separate fire compartment from the fire and there is no risk of power failure.
- The lift should be separated by distance from the fire-affected part of the building.
- An assessment to support the use of non-escape lifts in an evacuation is undertaken.
- Assessment should consider guidance in BD 2466 – '*Guidance on emergency use of lifts or escalators and fire and rescue service operation'.*
- Competent staff are involved in the assessment.

Lifts are not to be used in a fire unless the above are met.

5.1.5 Isolation of medical gas supplies on wards

The decision to isolate medical gas supplies will need to consider the immediate risk to patients, who may be dependent on oxygen or other medical gases. This needs to be balanced against the increased risk of explosion, or rapid development of a fire with elevated oxygen levels.

The isolation of oxygen or other medical gases, is a joint decision between key stakeholders and clinical teams, will need to be made, in line with the national guidance for joint emergency services interoperability principles the JESIP joint decision-making model which provides the framework for this type of joint, dynamic decision making. Any decision must be evident as being in the best interest of the patient.

5.1.6 Fire evacuation control

The control for a fire evacuation will initially fall to the fire response team and local manager who will be the Fire Incident Manager[3]. The fire incident manager for clinical ward areas this will be the nurse in charge, or their immediate deputy. It is their responsibility to oversee fire evacuation in conjunction with clinical & non-clinical teams and the fire service when in attendance. On arrival of the fire service, the fire service incident commander will take lead following JESIP.

For non-clinical areas, the local manager or most senior person available on site, in conjunction with the trust fire response team[4], will be responsible for overseeing fire evacuation for the areas for which they run their support services. On arrival of the fire service, the fire service incident commander will take lead.

The fire incident manager is required to carry out the following actions:

- Take control of the incident.
- Direct the local response.
- Ensure that the fire alarm system has been activated and that staff in the area are aware of the incident.
- Initiate the local fire emergency action plan.
- Determine whether an evacuation is appropriate.
- Liaise with the fire response team and the response team leader.
- Liaise with site operational managers and emergency planning lead (as practicable).

Following the initial response, for sites with a fire response, the fire response team leader, in agreement with the fire incident manager may take lead on the incident management and liaise with the fire services on their arrival.

[3] HTM 05-01, 7.32

[4] Trust has in place fire response teams are on the Trust main hospital sites, on other sites the local manager or senior person will be responsible for overseeing site evacuation.

The fire response team leader will be a senior manager and is required to:

- Respond to confirmed fire events.
- Take responsibility for direction of the Fire Response Team.
- Liaise with the Fire Incident Manager.
- Liaise with the attending fire and rescue service.
- Inform Trust emergency planning lead to instigate the internal major incident plan (if required).

Inpatients units have a responsible member of staff available 24/7 (usually the Bed Manager where available), on the main Trust Hospital sites in hours, there are also local security, porters and estates staff, as well as the ward Sister / Charge Nurse (manager or their deputy) to support the fire incident manager.

There are three main stages of evacuation:

Stage 1 – Progressive horizontal evacuation from the area where the fire originates to an adjoining sub-compartment or compartment.
Stage 2 – horizontal evacuation from the entire compartment where the fire originates to an adjoining compartment on the same floor. Subsequent additional horizontal evacuation to adjacent compartments may be undertaken (thereby putting additional fire resistance between the building occupants and the threat) prior to undertaking vertical evacuation; and Stage 3 – evacuation to a specific location on site not adjacent to the fire, to a safe shelter area outside the building or to another healthcare location.
If Stage 3 is implemented this is likely to take place once staff and patients are in a safe location achieved in Stage 1 and / or Stage 2 and will take time to coordinate. The coordination of Stage 3 is a Trust responsibility as per the Trust Evacuation Plan and will be coordinated by the Head of EPRR.

5.1.7 Designated fire assembly areas

Where appropriate and possible, evacuated staff, patients and visitors should evacuate to designated fire assembly areas. Designated areas have been selected to ensure safety and consider as far is reasonably practicable:

- The potential location/proximity of fire and areas being evacuated or affected by the fire.
- Available routes to the designated assembly areas.
- Environmental factors (weather, wind direction etc.).
- Location of assembly points as not to impede or hamper arrival of fire crews and space required for fire service operations.
- Safety considerations from moving vehicles etc.

5.1.8 Evacuation of patients and visitors with disabilities

The use of progressive horizontal evacuation (PHE) will support the evacuation of non-ambulant patients and visitors and those with limited mobility and disabilities.

Where PHE is unable to effectively account for the needs of patients, staff or visitors with specific needs, then a personal emergency evacuation plan (PEEP) will need to be provided.

5.1.9 Evacuation procedures for offices and non-clinical areas

All staff are aware of the local fire alarm procedures and the meaning of different sounding alarm types (intermittent and continuous alarms).

In the event of an intermittent alarm, a nominated person/person, will investigate the cause of the alarm and if considered appropriate in a fire event, ensure a full alarm is activated and initiate an evacuation.

Where an office area receives a continuous fire alarm sounding, the area will be evacuated immediately and simultaneously. Only where an intermittent alarm, is sounding, should staff in office areas delay evacuation until further information, or warnings are received.

Standalone non-clinical sites default to full alarm for all parts of the building, requiring immediate and simultaneous evacuation on the sounding of the fire alarm.

5.2 Fire Alarm Response Actions

5.2.1 Fire alarm activation actions

The Trust has a standard approach to fire alarm activations. The actions required in response to a fire alarm activation will depend on the following circumstances:

- Is the alarm a full, continuous alarm; or an intermittent warning alarm.
- Is the alarm sounding in a clinical area; or non-clinical area that is occupied by staff only.
- Has a fire been confirmed; or is the cause of the alarm under investigation.

The main hospital sites fire alarm system is connected to an Alarm Receiving Centre (ARC) which is a 24/7 monitoring station, on activation an automatic call will be sent to the local fire service to summon attendance on site.

5.2.2 Action on hearing an intermittent alarm

In the event of an intermittent alarm, the responsible person for the area must arrange for an investigation of the alarm sounding. While it is not necessary to immediately evacuate the area(s) where an intermittent alarm is sounding, it is necessary to carry out some or all of the following actions:

- Find out the cause of the alarm.
- Consider preparations for evacuation, if it becomes necessary.
- While essential work should continue as normal, complex tasks should not be

started.
- Consider assisting areas that are in full alarm and may need additional support.
- Consider the possibility of adjacent areas evacuating into your area, or via your area.

5.2.3 Action on hearing a continuous alarm

In the event of an continuous alarm, the responsible person for the area must arrange for an investigation of the alarm sounding. For clinical areas, it is not necessary to immediately evacuate, unless a fire is confirmed. However, all staff should be preparing for evacuation and cease routine activities.

For non-clinical areas, all staff and visitors will evacuate where the local fire strategy is immediate and simultaneous.

5.2.4 Actions to be taken in the event of a confirmed fire

Where a fire is confirmed, all non-essential staff and visitors will evacuate immediately. The responsible person must make sure the following actions are initiated, ether directly, or through appropriate delegation:

- Confirm with switchboard the fire service has been summoned, or call (9)999, to confirm an actual fire.
- Confirm location of the fire and what is on fire, where possible and if safe to do so.
- Initiate Progressive Horizontal Evacuation of patient areas.
- Evacuate all non-essential staff and visitor, unless required to support evacuation.
- Tackle the fire where only safe to do so, and you feel confident with using extinguishers[5].

5.2.5 Action of person discovering a fire

Any person who discovers a fire must first raise the alarm. This is best achieved by operating (pressing firmly) on a manual call point. Note that most call points have a Perspex cover, which must be lifted up, prior to operating the fire alarm.

Make a (9)999 call to the fire service, or makes sure someone else does this, to confirm an actual fire, the location, and details. This is to assist the Fire Brigade in deciding on numbers and type of fire tenders to avoid subsequent delay.

Only if it is safe to do and the person feels confident with using the appropriate extinguisher, should anyone try to tackle a small fire[6]. A small fire is considered to

[5] *There is no obligation to tackle fires, priority is to raise the alarm and summon assistance.*

[6] *There is no obligation to tackle fires, priority is to raise the alarm and summon assistance.*

be any fire that is no bigger than a wastepaper bin, and does not include dangerous items, such as aerosol cannisters or gas cylinders (any type).

5.2.6 Silence and reset of fire alarms

Silencing and resetting a fire alarm are two separate actions. Silencing a fire alarm will only stop sounders from operating. Resetting the fire alarm will clear the alarm and put the system back into normal standby mode. The decision to silence an alarm, prior to confirming if an alarm is an actual fire, must consider the risk that people may re-enter building / area before it is safe to do so.

A fire alarm will only be silenced when a false alarm is confirmed, to avoid continuing sound that is causing unnecessary stress or anxiety to patients or visitors. The fire alarm should never be silenced simply because it is annoying.

The decision to reset the fire alarm can only be taken when it is fully confirmed that the alarm is a false alarm, and further assistance (from other departments and, or the fire service) are not required. A member of the Estates team will be required to reset the alarm, this decision will need agreement with the person responsible for the area/incident manager. On larger sites, the bed manager will also be involved in the decision to reset a fire alarm.

5.2.7 Stand down procedure

Where a false alarm has been confirmed, the fire service should be stood down as quickly as possible, to prevent unnecessary attendance. The procedure to stand down the fire service includes the following:

- A nominated person contacting the fire service, using the 999 service or via switchboard.
- This may be direct contact by the responsible person, or via a nominated person, such as switchboard or reception staff
- The call to the fire service must confirm the following:
    - The call is confirmed as a false alarm
    - If requested details of the fire alarm (i.e. burnt toast etc)
    - That a responsible person is prepared to take responsibility for standing down the fire service.

5.3 Maintenance Standards of Fire Safety Equipment

5.3.1 Maintenance of Fire Safety Equipment

York and Scarborough Teaching Hospitals has agreements in place with our partner organisation York Teaching Hospital Limited Liability Partnership, who are responsible for all elements of the Estate under its control and the maintenance of

buildings, infrastructure, capital equipment, and revenue equipment.

The maintenance, upkeep, repair, replacement (of life cycled items only), or renewal of any part or the whole of the Trust estate in accordance with the service standards[7].

A list of what the Estates Department will maintain (but not limited to) are as follows:

- Fire Detection and Alarm Systems.
- Aspirating Systems.
- Fire Doors, closing devices, vision panels, hinges and strips and seals.
- Fire Extinguishers / Blankets.
- Fire Dampers.
- Fire Compartment Stopping.
- Dry Risers.
- Evac Chairs.
- Link to the Building Management System – Fire.

Inspection and maintenance of fire safety equipment is agreed as detailed in the master services agreement and specific services specifications and are detailed in the estates planned preventative maintenance management system (MICAD).

5.3.2 Fire safety standards – buildings and infrastructure

The Trust will ensure fire safety standards, that meet with requirements of Fire Code HTM 05-02 & 05-03 and other relevant standards available from UK government or recognised bodies (NAHFO, IFE, FPA) will as practicable be used where required.

On behalf of the Trust, York Teaching Hospital Limited Liability Partnership are to ensure all new buildings and design and built to and that the current trust estate and buildings are compliant to fire code. As part of this agreement provide information and relevant records, documentation including (but not limited to) fire compartmentalisation and sub-compartmentalisation, building fire safety design, provision of escape routes, signage, the provision of firefighting non-medical equipment and system that comply with the minimum requirements of NHS fire-code and the general standards relating to fire safety[8]. York Teaching Hospital Limited Liability Partnership – Estates will ensure all components of the Trust fire safety is maintained and managed including but not limited to ensuring relevant fire safety equipment is identified and labelled via CAFM/MiCad.

5.4 Fire Risk Assessments

[7] Detailed in Y&STHFT Group Master Service Agreement and Specific Service Specification – Estates Schedule F

[8] Detailed in Y&STHFT Group Master Service Agreement and Specific Service Specification – Estates Schedule F

5.4.1 Life Safety Fire Risk Assessments

Lifesaving fire risk assessments are a statutory requirement under the Regulatory Reform (Fire Safety) Order 2005 and are routinely conducted by the Fire Safety Officers (Advisors) for all areas within the Trust. Local managers are expected to support the fire safety risk assessment process through their knowledge of local hazards, risks and control measures.

Fire risk assessments are conducted in accordance with HTM 05-03: Part K. To manage the fire safety risk assessment process on an annual basis, larger sites (York and Scarborough Hospitals) are divided into smaller areas. This is typically by Ward area, but also includes other areas by activity and by occupancy. The fire safety risk assessment process is based on the widely accepted, 5-Step Approach being risk based, with identification of areas being assessed falling into to complex or low risk.

For clinical areas, and areas with greater levels of risk (e.g. multi-storey sites, higher risk activities etc.) the fire safety risk assessment for these areas are classed as complex premises and require in depth review and assessment of fire risk. For smaller, lower risk sites (and low-risk areas within larger sites), the fire safety risk assessment utilises a low risk assessment.

As part of a proactive risk-based approach to managing fire safety, lifesaving fire risk assessments will be reviewed on the following basis:

- Complex areas annually.
- Low risk areas every three years.
- At the request of local managers when there are changes to risks, hazards and, or control measures.
- Following a significant incident and, or adverse event (locally or nationally).
- When there is any reason to believe the risk assessment is no longer suitable and, or sufficient.

5.4.2 Scope of lifesaving fire safety risk assessments[9]

The fire safety risk assessments carried out by Trust Fire Safety Officers (advisers) cover the following scope, with the limitations expressed below:

- Fire safety risk assessments are limited to the assessment of general fire precautions for the protection of life safety.
- Recommendations made under the fire safety risk assessment are those measures considered necessary to meet minimum legal requirements to comply with the Fire Safety Order 2005 for general fire precautions.

[9] Type 1 & 3 non-destructive

- Alternative measures may be appropriate, where considered to be suitable and sufficient.
- Fire safety risk assessments do not explicitly assess risks to property protection and, or business continuity, but may do so where appropriate and mutually beneficial to life safety.
- Fire safety risk assessments cover general fire precautions, as defined in the Fire Safety Order 2005, (Article 4).
- Fire safety risk assessments DO NOT extend to process risks arising from work processes, as defined in the Fire safety Order 2005 (Article 4 (2) & (3)).
- Fire safety risk assessments rely on assumptions made from service level agreements with Estates, for the servicing and maintenance of fire safety arrangements (fire alarm systems; fire extinguishers; fire compartmentation and fire doors).

5.5 Specific Fire Arrangements

5.5.1 Liaison with Fire and Rescue Service (F&RS)

The Fire Safety Officers/Manager is to liaise with the F&RS to ensure that emergency response fire plans are up to date. Liaison will include fire safety visits and familiarisation of the Trust premises. Fire drills and rescue procedures will be coordinated with the F&RS to ensure that effective emergency procedures are maintained.

5.5.2 Premises Information Boxes (PIBs)

The majority of the Trust does not currently provide building or premises information in secure boxes, available to the fire service on a 24/7 emergency basis. Relevant premises information will be provided as soon as reasonably possible, when requested by the fire service. The Trust will keep this position under constant review and is currently considering the best way to meet the requirements of providing such information in a readily available format, for use in emergencies.

Boxes are situated at Malton Hospital and Selby War Memorial Hospital with the current fire safety risk assessments and evacuation plans in them.

5.5.3 Enforcement

The F&RS Officers may visit premises at any reasonable time to conduct fire safety checks. Their role to provide advice and guidance is also one of enforcement. In the event of serious concerns, for example where fire escape routes are blocked or where unsafe activities are taking place that may lead to fire risks then an enforcement notice may be served on the Responsible Person. The impact of an enforcement notice being served may affect service delivery of the hospital and so it is essential that all persons follow the fire safety guidance contained in this strategy.

5.5.4 Liaison with Contractors

All contractors are to be provided with safety information and fire procedures before commencement of work on hospital premises. (Induction training) They are required to book into the Hospital site (Estates office) and on exiting the site to return keys and ID badges. They are to understand the fire alarm procedure, use of call points, firefighting equipment and evacuation procedures. It is the individual responsibility of managers and staff who have arranged for a contractor or visitor(s) to come onto Trust premises to liaise with them to ensure that fire safety instructions are adhered to.

Estates shall ensure Sub-Contractors provide such information, as the Trust may reasonably require from time to time to enable it to meet its obligations to provide reports and returns pursuant to regulations, directions or guidance applicable to the NHS or as required by external agencies including, without limitation, reports and returns regarding the physical condition of buildings occupied by the Trust under the NHS Fire code.

5.5.5 Hot Work

Hot work is only permitted through prior arrangement and agreement with Estates. Absolutely no hot work may be carried out until full approval is gained, and a local risk assessment produced. Hot work must be a last resort when all other options are either not possible or excessively cost prohibitive. **Any Hot Works will require a Trust Hot Works Permit to be obtained and issued by the Trust estates department.**

Routine checks must be made following any hot work, in line with the hot work permit. This must include a minimum of an immediate check of the area, as well as further checks not less than four hours after work has ceased. Further checks may be required under local risk assessment. *Note that some materials can smoulder for over 12 hours before flaming combustion is evident. In the case of hot ashes and coals, fires can start more than 24 hours after flaming combustion has stopped.*

5.5.6 Reporting and Investigating Fires

In the event of a fire occurring on any Trust premises, an incident report is to be completed using the Datix reporting system. The initial report is to be completed by the attending Estates engineer, with further investigation completed by the Trust fire safety officers in conjunction with the relevant department manager or incident handler.

All outbreaks of fire in Trust must be reported within 48 hours to the Department of Health, using the on-line efm-information system (www.efm.nhsestates.gov.uk).

All fires are to be investigated to identify the root cause, ensuring that a report is made to the Trust fire safety group. Any departmental non-compliance will be raised as appropriately through the head of department and services area as appropriate.

The emergency services will treat any fire as a potential crime scene until the cause is established. No person is to intentionally disturb the scene of a fire, move or take away any item. Witnesses are to be interviewed and statements taken where necessary to establish the cause of any fire.

5.5.7 Reviewing Fire Safety Arrangements

Fire safety arrangements detailed in this strategy will be subject to safety considerations taken as a result of changing legislation, enforcement action and suspension of coverage from emergency services. Fire safety arrangements may be amended by the Fire Safety Team, agreed by the Trust Fire Safety Group and Trust Health and Safety Committee.

In the event of, or at any time in order to react to unforeseen situations that presents a risk to life or fire safety, the fire safety team, in consultation with officer or manager may change arrangements for fire safety, in this event temporary or permanently decided, will be notified through management arrangements above.

5.5.8 Fire Wardens

The Fire Warden should act as a focal point on fire safety issues for local staff; organise and assist in the fire safety regime within local areas; and raise issues regarding local area fire safety with line management.

In the event of an incident Fire Wardens will act as Fire Marshalls to assist with the evacuation response as necessary for their areas, in line with the local evacuation plan.

Fire Wardens will assist local managers with making sure any local fire safety checks are carried out within the department. On completion the checklist should be raised with the line manager and / or estates, and if necessary, raised to the fire safety officers or fire manager.

5.5.9 Fire Drills and Training

It is a mandatory requirement that fire drills, or other suitable training, should be carried out in all Trust premises. This is to test communications, staff reaction and effectiveness of training in line with HTM 05-03: Firecode (Operational provisions).

The Fire Safety Officers/Manager will liaise with responsible persons and departmental managers to arrange for fire drills to be conducted appropriate to the area of responsibility. The ward / department managers are responsible for making sure staff fully participate in these procedures. A Training Needs Analysis (TNA)

identifies the levels of training required across the Trust.

Where practical drills are not feasible in some clinical areas, evacuation exercises may be desktop, supported with practical training at walk-through pace to “prove” routes for evacuating dependent / very highly dependent patients. When it comes to evacuation several groups of staff (Porters, Nurses, Sisters, Matrons etc.) move patients in beds, trollies, and wheelchairs daily throughout the hospital, and also, transfer patients from chairs to beds to trollies etc. so staff are well practiced in moving people in a timely manner.

If a fire alarm occurs and an evacuation has taken place, this can also be documented as a drill and recorded via the Datix system. As it recorded we can review what went right and what improvements need to be made.

5.5.10 Fire Doors

Fire doors are important safety features of a building that provide fire barriers between compartments, delaying the spread of fire and smoke. Fire doors must be managed by ward and department staff to ensure that they are effective.

Fire doors are not to be wedged open unless for a specific safety related reason, or for practical purposes for short duration. When fire doors are held open, they must be managed at all times. Managed means that appropriate arrangements are in place within the department to close the doors on hearing the fire alarm or discovering a fire or smoke.

Where required, appropriate automatic hold open devices may be fitted as these will be linked to the fire alarm system enabling then to automatically close on the fire alarm sounding. Appropriate hold-open devices include the use of standalone devices, such as Door guards, where these meet current approvals.

Fire doors must always be closed whenever they cant not be supervised or on a evening / night when a building / department is unoccupied.

5.5.11 Means of Escape

Means of escape refers to horizontal and vertical routes, corridors and stairs that are marked up as escape routes with appropriate signage. Means of escape must be available at all times were they may be required (i.e. whenever the building or area is in use). It is important to remember that areas of some buildings may form part of the means of escape from adjacent areas, through the release of security devices, but are not used on routine basis.

A minimum of 1.2m is to be maintained in a clear route at all times. Emergency lighting and escape routes are to be fitted in accordance with the requirements of The Health and Safety (Safety Signs and Signals) Regulations 1996. Emergency

lighting and fire exit signs are not to be covered up or be obscured in any way. Fire doors are not to have vision panels obscured by any coverings so that hazards may be detected without having to open doors.

5.5.12 Electrical Safety

Electrical equipment provides a risk of fire, when they are faulty or used in incorrectly. Portable appliance testing will be conducted for all portable equipment to ensure that basic electrical safety checks are maintained. This is to be managed by the York Teaching Hospital LLP estates department. This is conducted on a 2 yearly inspection, unless there is identified high risk equipment, where a specific assessment will dictate the electrical safety regime. New electrical appliances carry a manufacturing warranty and will be picked up for inspection on the following year.

The use of unapproved multi-socket adaptors are not to be used on Trust premises. Extension leads are authorised for use where they have been subjected to portable appliance testing and where they are correctly fused. Personal electrical equipment is not allowed to be used for any purpose or tasks assigned to their employment. No alterations and additions to wiring or fittings may be carried out apart from those carried out by authorised electricians from the Estates Maintenance team or authorised contractors.

Reporting of defective electrical equipment is essential for fire safety. Staff should report defective electrical equipment and are to remove them from supply by switching off and unplugging any portable electrical equipment that they find defective.

Fire and explosions may occur from use of unprotected electrical equipment used in specific fire hazard areas where flammable and dusty atmospheres may be present. Electrical equipment used in these areas must conform to the ‘Equipment and Protective Systems Intended for Use in Dangerous Substances, Explosive Atmosphere Regulations 2002.

Some medical equipment may be provided with battery a back-up supply (Lithium-ion). The risk of fire from a defective or damaged battery is always present but is mitigated by the fact that equipment is in regular use and any faults are easily reported and rectified.

5.5.13 Management of Waste

Waste must be carefully controlled so that a build-up, including dry waste materials and highly combustible packaging does not occur. Waste materials soaked in oils and grease are a particular hazard and may be prone to spontaneous heating and ignition. Therefore, frequent removal to a safe place of disposal is required. Overall disposal is to be conducted in accordance with the Trust Waste disposal procedures to minimise the risk of arson or blocking of evacuation routes.

Management of waste materials must extend to management of waste outside buildings. Waste materials should not be stored adjacent to buildings where a fire could spread into the building. This requires a separation of 1.8 metes horizontally and 9 metres vertically from any door, window or opening (ventilation inlet / outlet points).

5.5.14 Plant and Switch Rooms

Plant and switch rooms are normally only accessed by trained and authorised staff. Means of escape from these areas may exceed normally accepted distances and methods, such as the use of vertical ladders. In all cases, staff who are authorised to access plant and switch rooms must be familiar with all routes and confident in using the available means of escape.

The risk of fire and explosions from plant and switch rooms is considered a process risk, as defined within the Regulatory Reform (Fire Safety Order) 2005. Therefore, specific measures for protecting against fires and explosions are considered beyond the scope of the fire safety risk assessment process and are subject to industry specific standards and expectations.

5.5.15 Kitchens

Kitchen activities are amongst the biggest causes of fires. All staff working in kitchen areas are to be trained and instructed on understanding risks, and available control measures to prevent fires and react to any fires that start.

All ward kitchens that prepare patient meals, through the use of microwave ovens and, or regeneration ovens, must have a minimum of a fire blanket available. Portable fire extinguishers must be available within the immediate area or ward. Larger kitchens with hobs and ovens must have dedicated fire extinguishers for specific risks. Commercial scale kitchens with deep fat fryers and larger hobs and ovens require specific assessments for fixed installations to manage the process risk from fires.

5.5.16 Furniture and furnishings

Furniture and furnishings provide a source of fuel for fires. Therefore, furniture and furnishings must comply with relevant standards expected within healthcare premises.

The trust will ensure when procuring furniture and fixings that full details for the relevant standards are contained within HTM 05-03: Part C are met. In summary furniture and furnishings should meet the standards laid out in BS 7177 for Mattresses, divans and bed bases; and BS 7176 for upholstered furniture.

Both British standards lay down test criteria for resistance to ignition, based on prevailing risks. The risk rating criteria suggested in HTM 05-03: Part K for most healthcare premises is medium risk. High-risk criteria generally applies to secure psychiatric units/wards and areas where the risk of arson is considered much higher than normal will apply.

5.5.17 Storage of Dangerous Substances (including Flammables)

Flammable substances are defined by the HSE within guidance for Dangerous Substances and Explosive Atmosphere Regulations (DSEAR). The three categories of flammable substances are:

Extremely flammable*: Liquids which have a flashpoint lower than 0°C and a boiling point lower than or equal to 35°C.*

Highly flammable*: Liquids which have a flashpoint below 21°C but which are not extremely flammable.*

Flammable*: Liquids which have a flashpoint equal to or greater than 21°C and less than or equal to 55°C.*

Materials that are not classed as flammable (including extremely and highly flammable) are considered combustible (wood, paper, plastics etc) or non-combustible (bricks, steel etc.).

The storage and processing of flammable substances (all types) is considered a process risk and will be stored and processed in line with HSE guidance and regulations for dangerous substances and the relevant sections of the Fire Safety Order.

If there are any concerns regarding flammable substances the Trust health and safety team are to be contacted to review the potential risk.

5.5.18 Portable Oxygen Cylinders

Oxygen cylinders present a special hazard in any workplace. Contrary to popular belief, oxygen is not a flammable substance but is a potent oxidiser that promotes the combustion and explosion of other materials.

The storage and processing of oxygen cylinders is considered a process risk and will be stored and processed in line with HSE guidance (INDG459) and NHS England guidelines.

6.0 Monitoring Compliance

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
The whole document	Fire Safety Manager		Every 2 years	Fire Safety Group
Any changes to legislation	Fire safety Manager		Review legislation and update document as and when required.	Fire Safety Group & H&S Committee

7.0 Associated Trust Documents

List all related policies / other trust documents that are related. These documents should ideally have the same review date as this policy so that all are reviewed in conjunction.

- Health and Safety Policy.
- Control of Contractors Policy.
- COSHH Policy.
- Serious Incidents Policy.
- Manual Handling Policy.
- Door Closing Policy.
- York Teaching Hospital Facilities Management Limited Liability Partnership Health and Safety Policy.
- Electrical Safety Policy.
- Ventilation Systems procedure.
- Medical Gas Services.

8.0 Equality Impact Assessment

Complete an Equality Impact Assessment for the document and highlight key findings here.

Appendices

Appendix 1: Fire Watching – SOP

Appendix 2: Vertical Evacuation (lifts) SOP

Appendix 3: Vertical Evacuation (stairs) SOP