York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 27th May 2026
Time: 9:00am – 12:45pm
Venue: Boardroom, York Hospital

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 29 April 2026** To be agreed as an accurate record.	Chair	Report	5	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	17	
6.	**Patient's Story** To consider.	Dr Roisin Bradley, Consultant Radiologist	Verbal	-	9:05
7.	**True North Report** To review the report.	Chief Executive	Report	18	9:25
8.	**Chair's Report** To review the report.	Chair	Verbal	36	9:40

Item	Subject	Lead	Report/ Verbal	Page No	Time
9.	**Chief Executive's Report** To receive the report.	Chief Executive	Report	38	9:45
10.	**Quality Committee Report** To receive the May meeting summary report.	Chair of the Quality Committee	Report	82	10.00
11.	**Resources Committee Report** To receive the May meeting summary report.	Chair of the Resources Committee	Report	84	10.10
12.	**Group Audit Report** To receive the May meeting summary report.	Chair of the Group Audit Committee	Report	88	10:20
13.	**Well-Led Action Plan Progress Report** To consider the report.	Chief Executive	Report	91	10:30
14.	**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 & Chief Nurse Deputy Director of Workforce Chief Digital & Information Officer Finance Director	Report	137 142 188 204 215 223	10:40
Break 11:25					
15.	**CQC Compliance Update** To consider the report.	Chief Nurse	Report	236	11:40

Item	Subject	Lead	Report/ Verbal	Page No	Time
16.	**Maternity and Neonatal Report**	Chief Nurse - Executive Maternity Safety Champion	Report	240	11:55
17.	**Staff Survey Improvement Plan** To consider the report.	Deputy Director of Workforce	Report	267	12:05
18.	**Research and Innovation - Annual Report** To consider the report.	Medical Director	Report	278	12:20
Governance					
19.	**Emergency Preparedness Resilience and Response (EPRR) Action Plan Update** To consider the report.	Chief Operating Officer	Report	287	12:30
20.	**Corporate Governance Update** • Proposed Changes to the Constitution	Chair	Report	294	12:35
21.	**Questions from the public received in advance of the meeting**	Chair	Verbal	-	12:40
22.	**Time and Date of next meeting** The next meeting held in public will be on 24 June 2026 at 9.30am at Scarborough Hospital.				
23.	**Exclusion of the Press and Public** 'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960.				
24.	**Close**				12:45

Minutes
Board of Directors Meeting (Public)
29 April 2026

Minutes of the Public Board of Directors meeting held on Wednesday 29 April 2026 in the PGME Discussion Room, Scarborough Hospital. The meeting commenced at 9.30am and concluded at 12.35pm.

Members present:

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

Executive Directors
- Miss Clare Smith, Chief Executive
- Mr Andrew Bertram, Finance Director and Deputy Chief Executive
- Ms Tara Filby, Interim Chief Nurse and Executive Maternity Safety Champion
- Ms Claire Hansen, Chief Operating Officer
- Ms Lydia Larcum, Interim 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:
- Miss Nicola Topping, Deputy Medical Director *deputising for* Dr Karen Stone, Medical Director
- Ms Nicola Coventry, Chief Nursing Information Officer *deputising for* Mr James Hawkins, Chief Digital and Information Officer
- Mrs Sarah Coltman-Lovell, Interim Director of Strategy
- Mr Joe Hague, Chief Nurse Designate *(Via Teams)*
- Ms Sascha Wells-Munro, Director of Midwifery (For Items 6 and 15)
- Ms Alex Kilbride, Programme Manager for Maternity and Neonatal Services (For Item 6)
- Ms Stefanie Greenwood, Freedom to Speak Up Guardian (For Item 16)
- Mrs Barbara Kybett, Corporate Governance Officer (Minute taker)

Observers:

- Ms Linda Wild, Elected Governor and Lead Governor - Public
- Mr Graham Lake, Elected Governor - Public
- Ms Julie Southwell, Elected Governor - Staff
- Ms Ros Shaw, Elected Governor - Public
- Two members of the public

1 Welcome and Introductions

Ms Charge welcomed everyone and advised that she would chair the meeting until Mr Barkley joined the meeting as he had been delayed.

Round the table the introductions were made.

2 Apologies for absence

Apologies for absence were received from:
Dr Karen Stone, Medical Director
Mr James Hawkins, Chief Digital and Information Officer

3 Declaration of Interests

There were no new declarations of interest.

4 Minutes of the meeting held on 25 March 2026

Ms Hansen advised that references to the new Acute Model of Care in the minutes should read “the first phase of the new Acute Model of Care”.

With these amendments, the Board approved the minutes of the meeting held on 25 March 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.*
A paper had been presented to the Resources Committee at its meeting on 28 April. The action was closed.

BoD Pub 52 *Bring a recommendation to the Board on a future strategy for Community Services.*
The paper would be presented at the Private Board meeting. The action was closed.

BoD Pub 56 *Include more details about the Hospital Standardised Mortality Ration (HSMR) in the next report, including why it is significantly different from the SHMI.*
A paper had been presented to the Quality Committee. The action was closed.

BoD Pub 59 *Ensure that the scoring of BAF risks is discussed by Executive Directors.*
This action had been completed.

BoD Pub 62 *Allocate time in a Board Development Seminar for further discussion on consideration of patient experience reports.*
Mr Taylor would discuss with Mr Barkley that week. The due date was deferred.

BoD Pub 64 *Add comparative figures from month to month in the National Operational Framework rank oversight in the TPR.*
This was still being discussed by Ms Hansen and Mr Hawkins. The due date was deferred.

BoD Pub 65 *Present the new approach to reporting performance for 2026/27.*
A paper describing the new approach would be presented at the Private Board meeting. The action was closed.

BoD Pub 67 *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.*
The figures were included in the TPR. The action was closed.

BoD Pub 68 *Provide an update on discussions to progress the hybrid theatre and VIU projects.*
The paper would be discussed at the Private Board meeting. The action was closed.

BoD Pub 70(25/26) *Bring a recommendation for the True North metrics for 2026/27 to the next meeting.*
Miss Smith advised that a recommendation would be presented at the meeting in May. The due date was deferred.

BoD Pub 71(25/26) *Arrange a demonstration of the Robotic Process Automation tools, Esther and IRIS, for Mr Barkley.*
This action had been completed.

BoD Pub 72(25/26) *Clarify if there has been a previous error in reporting non-elective length of stay or whether the national guidance has changed.*
Ms Coventry advised that there had not been an error in the reporting of non-elective length of stay but clarification on the guidance had been sought, the result of which was that maternity data was not now included in the reporting. The action was closed.

BoD Pub 73(25/26) *Present an improvement plan for 2-hour Urgent Community Response compliance.*
It was agreed that the due date should be deferred to June.

BoD Pub 75(25/26) *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.*
The Associate Medical Director had attended the meeting of the Quality Committee on 21 April. The action was closed.

6 Colleague's Story

Ms Wells-Munro and Ms Kilbride joined the meeting to share their experiences of leading work in Maternity Services to improve colleague experience. Ms Wells-Munro outlined the approach which had been successfully used in other organisations and which she had worked with Ms Kilbride to implement when she joined the Trust.

Ms Kilbride shared details of the improvement journey which began in 2023 with an engagement event, where colleagues were asked their views on actions needed, the impact of these actions and how this would be measured. At the next engagement event, an action plan was presented, and colleagues' views were also sought on how to improve communication. Two further engagement events were held, in March 2025 and April 2026. Ms Kilbride described the format of the events and the areas of focus.

Ms Wells-Munro explained how the impact of the actions was monitored to ensure they were sustained and moved to "business as usual" once senior leaders were confident that they were embedded. The model of improvement was one in which all staff could engage, and this was key to its success. It was closely aligned to the national maternity and neonatal framework.

Miss Smith referenced the unannounced CQC inspection of the Maternity and Neonatal Service which had taken place recently: initial feedback demonstrated that staff were engaged and proud of the Service. This was clearly the result of the consistent and focussed improvement work led by Ms Wells-Munro which would inform similar work in other areas as part of the Continuous Quality Improvement (CQI) model.

Mr Barkley joined the meeting and took over as Chair from Ms Charge.

Ms Grantham highlighted the need for the Trust to build on the success of the strategic approach to the improvement of colleague experience as implemented in Maternity Services. Ms Larcum noted that Ms Wells-Munro and Ms Kilbride had already been asked to contribute to a Trust-wide approach.

In response to a query about the external partner selected to lead the CQI programme, Miss Smith assured the Board that the Trust would take ownership of the programme with the aim of building on good practice already in place. There was some discussion on how engagement from all staff would be secured.

Dr Boyd confirmed that, in her visits to Maternity Services as the Non-Executive Maternity Safety Champion, the positive difference in staff engagement was palpable.

Directors thanked Ms Wells-Munro and Ms Kilbride and they left the meeting.

7 True North Report

Miss Smith reminded directors that the True North metrics would be reviewed for 2026/27. She highlighted the following:

- there had been some improvement in the Staff Survey results but there was clearly still work to do, the pace of which needed to be accelerated; there had recently been events to promote the inclusion agenda which would continue to be a focus;
- there had been a marked improvement in the Emergency Care Standard metric and a reduction in the number of patients waiting more than 12 hours in the Emergency Departments; the reduction in average ambulance handover times had been sustained through 2025/26;
- there had also been a marked improvement in the Cancer Faster Diagnostic Standard in February;
- there had been significant activity to reduce the number of patients on Referral to Treatment (RTT) waiting lists.

Ms Filby advised that there had been a reduction in the number of Category 2 pressure ulcers although the trajectory had not been met. The number of Trust onset MSSA Bacteraemia was below trajectory in March which was positive; there had been a reduction of 12% in the number of cases over the year and this improvement had been recognised externally.

Miss Smith reported that approval had been received for the implementation of the new Electronic Patient Record (EPR). Ms Coventry advised that the period since the last planned go-live date had been used to test and refine the product.

Miss Smith also reported that the Trust had begun a tendering process for a CQI external partner. She referenced the use of model hospital and Getting It Right First Time (GIRFT) data to inform productivity and efficiency improvements.

Mr Floyd and Mr Taylor, as new Directors, shared reflections on the Board papers. Mr Barkley explained that the True North report contained the indicators considered most relevant to the Trust's ambition of providing "an excellent patient experience every time" and was an executive summary in itself. Further narrative linked to the metrics was available in the TPR. The aim was to reduce the number of metrics overseen in the TPR report by the Board in detail as sustained improvement was evidenced. Mr Taylor queried whether the improvements noted in the True North metrics were linked to the end of winter pressures. Miss Smith responded that Statistical Process Control (SPC) charts provided oversight of longer term trends; there had been some purposeful actions in last quarter which had improved performance, notwithstanding the easing of winter pressures. Ms Hazelgrave noted that the improvement in a number of performance metrics had been discussed by the Resources Committee.

8 Chair's Report

Mr Barkley advised that there was no written report in April as he had been on leave for the month.

Mr Barkley reported that Professor Nick Bosanquet, a Governor for the Trust and a well-known and respected public figure, had sadly passed away.

Mr Barkley noted that Miss McMeekin, former Director of Workforce and Organisational Development, had begun a new role with Leeds Teaching Hospitals NHS Trust and he wished her well on behalf of the Board.

Mr Barkley welcomed new Non-Executive Directors, Mr Floyd and Mr Taylor. He extended a welcome to interim and deputising directors, and recorded his thanks to Ms Charge for deputising as Chair of the Board in his absence.

9 Chief Executive's Report

The Board received the report.

Miss Smith highlighted:

- her continued focus on engagement with the Trust's people and partners: she had met with representatives from Healthwatch and other local stakeholder groups, which would inform the development of the Trust's Clinical Strategy;
- discussions with regional and national colleagues about the Trust's financial position: a £7m reduction in the forecast deficit had been proposed which would

increase the savings target to £62m; the Annual Plan had not yet been approved, and the Trust would move into NHS England's Challenged Provider Programme;
- the report from the unannounced CQC inspections at Scarborough Hospital had been published: the report reflected progress made but also highlighted areas for improvement in Urgent and Emergency Care; CQC officers had recorded their appreciation of the engagement demonstrated by Trust staff and had highlighted the strengths of Multi-Disciplinary Team working, good governance, compassionate care, the depth and breadth of specialist care and the continuity of care;
- the EPR go-live planned for May;
- the resident doctors' industrial action which had taken place from 7 to 13 April; ballots on further action were planned;
- changes to the Executive team: Miss Smith welcomed Ms Larcum and Mrs Coltman-Lovell and thanked Ms Filby for her support as Interim Chief Nurse.

Finally, Miss Smith highlighted the examples of exceptional patient care reflected in the Star Awards.

In response to a question, Ms Larcum confirmed that the national pay award for Agenda For Change staff had been applied in the April payroll. She would check if a pay award for resident doctors had been implemented.

Action: Ms Larcum

10 Quality Committee Report

Dr Boyd highlighted the key escalations from the meeting of the Quality Committee on 21 April 2026. The Committee had received a presentation from the Medicine Care Group. Whilst performance metrics in Emergency Departments were improving, the reliability of quality and safety assurance mechanisms deteriorated under pressure. Complaints about the Care Group's services were an area of concern: the number of complaints continued to increase whilst complaint handling timescales were falling below expected standards. Mr Barkley queried whether a monthly dashboard relating to complaints was produced. Ms Filby confirmed that a monthly complaints dashboard was reviewed by each Care Group's Patient Experience group and at the Care Group performance meetings. Dr Boyd noted that the dashboards were included in Care Groups' presentations to the Quality Committee. Ms Filby described the issues, and actions taken to improve the timeliness of complaints handling which would be reported to the Board in due course. A rapid process improvement event had been held, and the policy had been reviewed. The quality and timeliness of responses were beginning to improve.

11 Resources Committee Report

Ms Grantham highlighted the key discussion points from the meeting of the Resources Committee on 28 April 2026:

- the Committee had received a presentation on how performance against the Annual Plan would be monitored, with the new approach offering better grip and control; Ms Grantham described the processes which provided better assurance in principle; Ms Hansen shared further details, noting that Care Groups must flag in good time where trajectories would be missed and what actions would be taken;
- the Committee had received a presentation on staff wellbeing which provided good assurance on the work in progress;
- the Committee had received the quarterly assurance report from York Teaching Hospitals Facilities Management which was mainly positive, with some areas for

improvement in compliance with statutory and mandatory training, in levels of sickness absence, and in cleaning standards;
- there had been a robust debate on the financial plan; a new reporting approach to the Committee would be in place from May and the Committee had noted the very significant challenge represented by the increased £62m savings target;
- the Committee had received the Research and Innovation team's quarterly update which was positive;
- an update on Sexual Safety had been received.

Ms Grantham expressed some concern that the escalation process from the Digital Sub-Committee to the Resources Committee was not as robust as it might be and planned to discuss this further with the Chair and the Associate Director of Corporate Governance.

12 Trust Priorities Report (TPR)

The Board considered the TPR.

Operational Activity and Performance

Ms Hansen highlighted the improvement in the Emergency Care Standard, in the reduction of 12 hour waits and in average ambulance handover times, the latter of which remained consistently ahead of trajectory.

Ms Hansen reported that the Cancer Faster Diagnosis Standard (FDS) metric, which reached 76.2% in February, was the highest recorded by the Trust since the metric was introduced. The 62-day performance was the best for 12 months and 31-day performance metric remained compliant. Ms Hansen noted that the performance of Cancer services remained a focus overall, but the direction of travel was positive.

Ms Hansen advised that the "Did not attend" rate for outpatient appointments stood at 4.4% and remained consistently better than average. The continued growth in demand would be a subject of discussion with primary care colleagues at specialty level. The total waiting list number remained above trajectory and the number of patients waiting more than 52 weeks for treatment was high and presented a risk. Ms Hansen advised that there were fortnightly meetings to monitor the position and intensive support was in place for challenged specialties.

In terms of Diagnostic performance, Ms Hansen reported that this had improved from January but had not met the year-end trajectory. Performance had been impacted by ageing equipment and workforce challenges.

Ms Hansen cautioned that the reduction in the number of patients with No Criteria To Reside had stalled due to delays in discharge processes. She was optimistic that the new EPR would support better patient flow, along with future work to reduce length of stay and eliminate corridor care, which was linked to the Miss Smith's 100 day report.

In summary, Ms Hansen reported that the Trust was still operating below the required national standards in several core areas. Escalation and governance processes had been strengthened and there were early signs of improvement in some key areas. There continued, however, to be risks around the backlog of patients on the RTT waiting list, those waiting for diagnostic procedures and around patient flow through the wider system.

Ms Hazelgrave queried the reason for the high number of attendances at Emergency Departments. Ms Hansen confirmed that this had continued throughout April and that

further analysis was being undertaken to determine the reasons and to then discuss them with system partners. Mr Taylor emphasised that the issue of high demand needed to be addressed in a strategic and systematic way.

It was noted that the Chief of Allied Health Professionals, as the lead for Health Inequalities, was working with Primary Care Networks on the health inclusion agenda and high intensity users. More information would be brought to the Board on this.

Action: Ms Hansen

Mr Barkley was pleased to note the much reduced number of 12 hour trolley waits.

Dr Boyd referred to the action being taken to reduce demand for colorectal cancer services whereby referrals with no Faecal Immunochemical Test (FIT) were being returned to primary care. She sought assurance that no harm to patients would result from this. Ms Hansen would check the mitigations in place and report back.

Action: Ms Hansen

Quality and Safety

Ms Filby highlighted:

- the Trust's performance was better than the annual objective for cases of C.Difficile and it had reported 26 cases fewer than the previous year;
- performance to reduce cases of other infections was mixed, indicating that there was still work to be done in infection prevention and control; Ms Filby described the actions underway;
- in terms of Category 2 pressure ulcers, a number of hotspots had been identified which would be a focus for improvement.

Maternity

There were no questions or comments on this section.

Workforce

Ms Larcum reported that the monthly sickness absence rate had decreased; benchmarking data had been included in the narrative for information. Ms Larcum noted that it was positive to see reductions in the top four reasons for sickness absence. She advised that there had been a small reduction in February in the number of Whole Time Equivalents (WTE) which included substantive, bank and agency colleagues.

Ms Larcum highlighted the improved compliance with statutory and mandatory training and noted that changes to locally mandated training would release 21k hours back to the organisation.

Ms Larcum described the actions being taken to address the high vacancy rate for Health Care Support Workers, mainly in the Medicine Care Group. This would continue to be monitored as the actions began to take effect.

In response to a question, Ms Larcum explained that the increase in administrative bank activity in March was linked to the rollout of the new EPR and to long term sickness which would impact on patient safety if not covered by temporary staff.

Ms Hazelgrave asked that the TPR include a graph showing actual WTE compared with the Plan so that this could be tracked.

Action: Ms Larcum

Mr Barkley expressed concern regarding the high Health Care Support Worker vacancy rate which had continued to deteriorate since the recruitment process for this cohort of staff was de-centralised. Ms Filby responded that the high vacancy rate was an issue only for Medicine Care Group as they had paused recruitment, an error which was now being addressed. It was noted that support for recruitment was overseen centrally and that Health Care Support Worker vacancies were covered by bank staff.

Digital and Information Services

Ms Coventry highlighted the new Single Point Of Failure which had been identified when a contractor had damaged external connections between York and Scarborough.

Ms Coventry was asked if there were any significant concerns about the planned EPR go-live. She responded that, although training compliance had reached 80%, it was vital that all staff on duty on the go-live days had completed the training. She noted that feedback from the recent go-live at another local Trust would be very valuable.

Finance

Mr Bertram reported that the Trust had met the re-forecast deficit position of £28.5m at year-end. This was composed of the non-receipt of sparsity funding and the Elective Recovery Fund (ERF) overtrade for 2024/25, totalling £13m, with the other £15m linked to the non-delivery of the Cost Improvement Programme. The Trust had delivered £40.5m of savings in 2025//26 against the target of £55.3m, the majority of which was non-recurrent. The non-recurrent savings were being reviewed in case they could be made recurrent in 2026/27. Mr Bertram reported that the year-end accounts had been produced and the external audit had begun.

Referring to the cash position, Mr Bertram advised that of the year-end total of £27m, £22m was a favourable variance from capital creditors. Mr Bertram also highlighted the significant pay variance which was a technical adjustment relating to the full impact of the Trust's employer pension costs and would be offset by equivalent income. The recovery actions in Quarter 4 totalled £6.5m. Mr Bertram highlighted the significant reduction in costs relating to agency staff.

Mr Bertram advised that there was no ERF risk carried into 2026/27 and that the small overspend in capital in 2025/26 had been permitted due to the underspends of other providers in the system.

13 Quarter 4 Annual Reporting Plan Progress Report

The Board received and noted the report.

14 CQC Compliance Update

Ms Filby presented the report, drawing attention to the letter from the CQC dated 20 April 2026 in which feedback from the CQC inspection of Maternity Services at both York and Scarborough Hospitals was shared.

Ms Filby confirmed that the action plan developed following the October 2025 inspection at Scarborough Hospital had been submitted by the deadline. She reported that an inspection of Surgery at York Hospital scheduled for 21 April had been postponed.

Mr Barkley noted that the content and tone of the CQC letter were positive overall.

15 Maternity and Neonatal Report

Ms Wells-Munro presented the report and highlighted the following:

- there had been a slight reduction in the perinatal mortality rate to 3.9% which was average for similar Trusts; the MBRRACE report would be shared at the next meeting;
- the rate of Post-Partum Haemorrhages over 1500mls for February was 4%; based on national data, the Trust was not an outlier;
- the appeal around Safety Action 1 of the Maternity Incentive Scheme had not been successful and therefore the Trust remained compliant with 7 out of 10 of the actions;
- there was a risk that the Service would not receive the funding requested from NHS Resolution in full to progress the implementation of transitional care and to deliver on two key elements with the Saving Babies Lives Care Bundle;
- key concerns included roster vacancies, the Waste Reduction and Productivity target for Maternity Services, and the reallocation of the Maternity and Neonatal Programme Manager to support another organisational programme.

In response to a question, Ms Wells-Munro confirmed that the level of detail in the report was a requirement for Boards to receive. The report contained a snapshot of capacity and demand, with performance being reported in the TPR. A new maternity dashboard was being developed as the Board needed to be sighted on 27 key metrics; these would be accompanied by an explanatory narrative.

Mr Barkley asked about the reasons for the relatively low number of births recorded given the Trust's catchment population. Ms Wells-Munro explained that the Service was impacted less by the birth rate than by the high rate of pregnancies not proceeding to full term often due to health inequalities. She would bring further information to the Board on the local birth rate in relation to the population, age range and other measures.

Action: Ms Wells-Munro

16 Freedom to Speak Up Quarterly Report

Ms Greenwood presented the report, noting that there had been an increase in FTSU activity which was positive as it reflected staff engagement with the process. FTSU resource had been boosted with an increase in the Guardian's hours to full-time which would allow for more proactive and strategic work.

Mr Floyd suggested that the increase in reporting might reflect more concerns rather than simply better engagement, and there was a balance to be found. Ms Greenwood agreed and observed that reporting concerns to the FTSU Guardian might indicate that local avenues for reporting concerns were not working well and this was being addressed with support for managers and leaders to better respond to concerns.

Mr Barkley noted that the number of concerns raised by Trust staff direct to the CQC was low which was positive and suggested that staff had confidence in FTSU Guardian, whilst also reflecting that some staff did not feel able to raise concerns with their manager. Staff Survey results indicated that there was much to do for staff to feel confident about raising concerns with mangers and that those concerns would be acted upon.

Mr Taylor asked how Ms Greenwood interpreted the concerns raised to her. Ms Greenwood explained that, after five years in the role, she had formed good relationships across the organisation and was able to triangulate themes of concerns. Miss Smith added

that the Guardian reported on these themes to the Chief Executive, whilst the details of individual concerns were of course kept confidential to the Guardian.
Ms Greenwood was thanked for her report and she left the meeting.

17 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

Ms Larcum presented an update on the WRES and WDES action plans, noting that the key objectives rated red in the plans had now been addressed.

Ms Larcum advised that her team had begun to analyse the Staff Survey results in relation to the WRES Metrics *Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public, or from staff, in the last 12 months*. There had been a reduction where this related to harassment, bullying or abuse from other members of staff but not from patients. Ms Larcum underlined the importance of accelerating the implementation of actions to address this issue.

In response to a question, Ms Larcum confirmed that the two actions at the end of the plans were national actions which were added to the local plan. All actions were cross referenced to NHS England's Equality, Diversity and Inclusion improvement plan.

Mr Barkley referred to the action to ensure Black Minority Ethnic (BME) representation on recruitment panels at Band 7 which was still not complete. Ms Larcum explained that work had now commenced to train BME staff for interview panels and advised that BME colleagues would be represented on recruitment panels from June.

Mr Barkley also referred to the action to explore career pathways through the British Association of Physicians of Indian Origin (BAPIO) and emphasised that, in his experience, forming a formal partnership with this and its sister organisation, the British Association of Indian Nurses (BINA), would have a positive impact on the some aspects of culture in the Trust.

Ms Abeysekera advised that the Anti-Racism Steering Group met regularly every other month with Miss Smith now chairing the meetings.

Miss Smith was of the view that the Trust underestimated the number of neurodiverse colleagues and she had initiated work for better provision for them. In response to a question, she advised that it was difficult to establish if sickness absence was linked to neurodiversity as colleagues did not always declare this information for the Electronic Staff Record.

18 2025/26 Q4 Board Assurance Framework

The Board received and approved the Quarter 4 Board Assurance Framework.

Mr Taylor, Associate Director of Corporate Governance, would discuss with Mr Barkley how the Board Assurance Framework would be updated for 2026/27.

Action: Mr Taylor

19 Corporate Governance Update

Quality Committee Annual Report and Effectiveness Review

The Board of Directors received the review. Dr Boyd reflected that the Committee had improved accountability and the assurance it received was now more relevant. The attendance of Care Group leaders at meetings had been discussed and whilst this was considered valuable, the length of the meetings was an issue. With this in mind, there had been a commitment to reducing the length of the meeting.

Mr Barkley asked how the Committee received assurance that the results of clinical audits were acted upon. Dr Boyd advised that this had been discussed at the last meeting. Mr Taylor would add this function to the terms of reference.

Action: Mr Taylor

Group Audit and Quality Committees Terms of Reference

The Board of Directors approved the terms of reference for the Group Audit Committee and the Quality Committee, subject to the amendment discussed above.

20 Fire Safety Policy and Strategy

The Board of Directors approved the Fire Safety Policy and Strategy, subject to proof reading to correct grammatical and spelling errors.

21 Questions from the public received in advance of the meeting

There were no questions from members of the public.

22 Date and time of next meeting

The next meeting of the Board of Directors held in public will be on 27 May 2026 at 9.00am at York Hospital.

Action Ref.	Date of Meeting	Item Number Reference	Title (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / comments	Due Date	Status
BoD Pub 62 (25/26)	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	Update 29.04.26: Mr Taylor would discuss with Mr Barkley that week. The due date was deferred.	May 26 from Mar 26	Delayed
BoD Pub 64 (25/26)	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	Update 29.04.26: This was still being discussed by Ms Hansen and Mr Hawkins. The due date was deferred.	May 26 from Apr 26	Delayed
BoD Pub 70 (25/26)	25-Mar-26	7	True North Report	Bring a recommendation for the True North metrics for 2026/27 to the next meeting.	Chief Executive	Update 29.04.26: Miss Smith advised that a recommendation would be presented at the meeting in May. The due date was deferred.	May 26 from Apr 26	Delayed
BoD Pub 73 (25/26)	25-Mar-26	13	Trust Priorities Report	Present an improvement plan for 2-hour Urgent Community Response compliance	Chief Operating Officer	Update 29.04.26: It was agreed that the due date should be deferred to June.	Jun-26	On Track
BoD Pub 74 (25/26)	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 76 (25/26)	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 (25/26)	25-Mar-26	17	Staff Survey Annual report	Present the Staff Survey improvement plan to the Resources Committee and to the Board for approval	Interim Director of Workforce & OD		May-26	On Track
BoD Pub 01	29-Apr-26	9	Chief Executive's Report	Check if a pay award for resident doctors has been implemented	Interim Director of Workforce & OD		May-26	On Track
BoD Pub 02	29-Apr-26	12	Trust Priorities Report	Bring more information to the Board on the Chief AHP's work with primary care networks on the health inclusion agenda	Chief Operating Officer		TBC	On Track
BoD Pub 03	29-Apr-26	12	Trust Priorities Report	Report to the Board on the mitigations in place re: returning colorectal cancer referrals with no FIT to primary care	Chief Operating Officer		May-26	On Track
BoD Pub 04	29-Apr-26	12	Trust Priorities Report	Include a graph in the TPR showing actual WTE compared with the plan	Interim Director of Workforce & OD		Jun-26	On Track
BoD Pub 05	29-Apr-26	15	Maternity and Neonatal Report	Bring further information to the Board on the local birth rate in relation to the population, age range and other measures.	Director of Midwifery		May-26	On Track
BoD Pub 06	29-Apr-26	18	2025/26 Q4 Board Assurance Framework	Discuss with Mr Barkley how the Board Assurance Framework will be updated for 2026/27	Associate Director of Corporate Governance		May-26	On Track
BoD Pub 07	29-Apr-26	19	Corporate Governance Update	Add to the Quality Committee's terms of reference, a funtion to gain assurance around the implementation of actions arising from clinical audits	Associate Director of Corporate Governance		May-26	On Track

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 7

True North Report

May 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’.

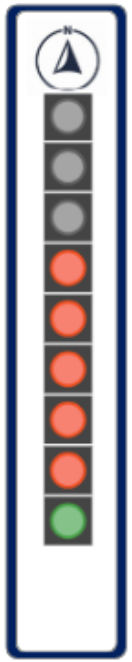
This is the single point of reference to measure our progress.

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)

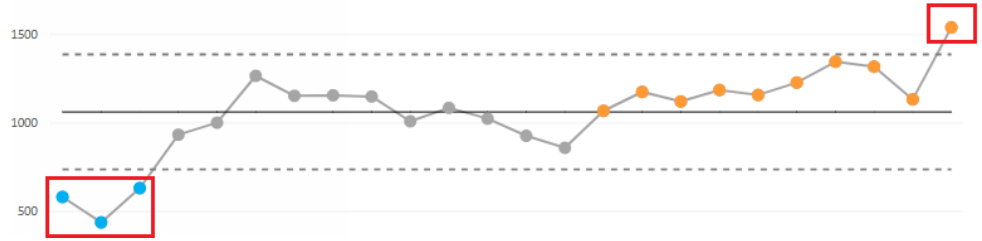
The indicator does not have a trajectory assigned

Upper and Lower Control Limits:

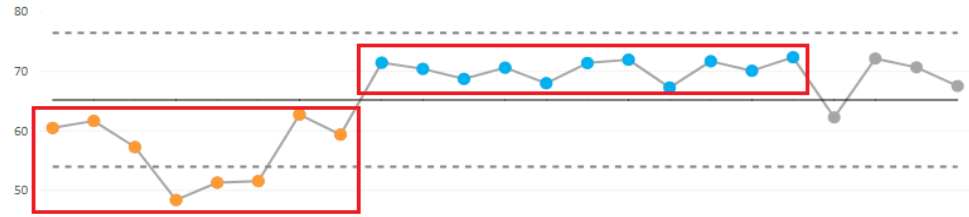
These lines (limits) help to understand the variability of the data and are ser to 3 sigma. In normal circumstances you would expect to see 99% of the data points within these two lines. The section below provides examples of when there has been some variation that isn't recognised as natural variation.

Types of Special Cause Variation:

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

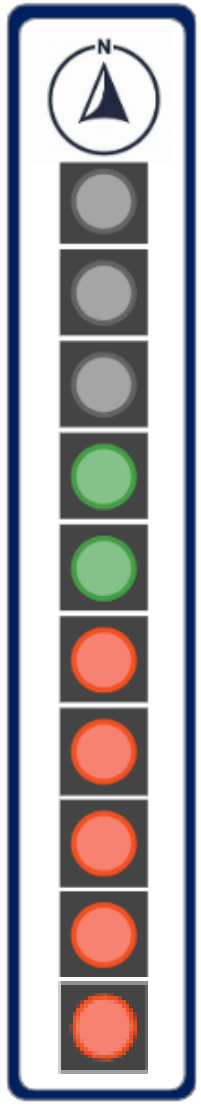


Shift: Counts the number of occasions there is a run of 7 consecutive points above OR below the mean.



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

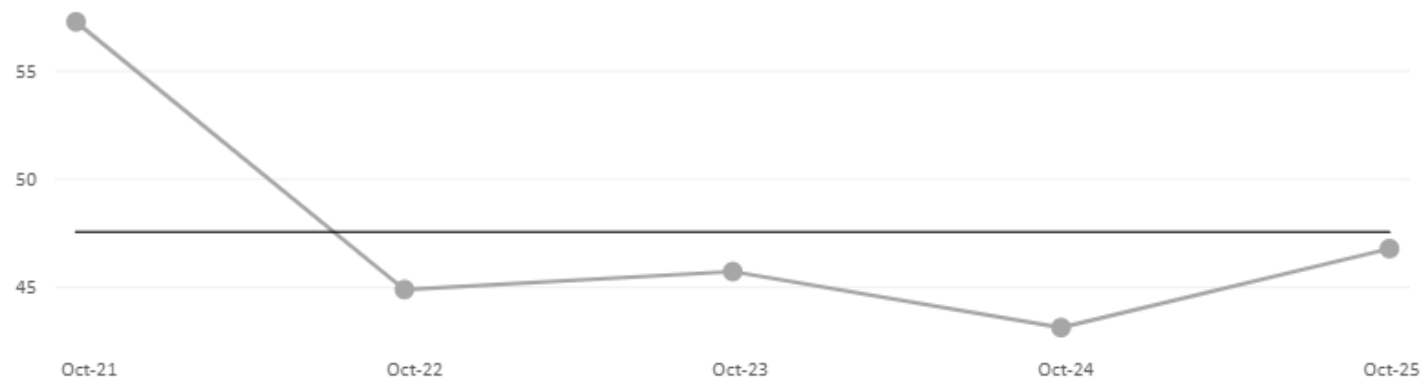
Staff Survey: Recommend Care

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

Lead Director: 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

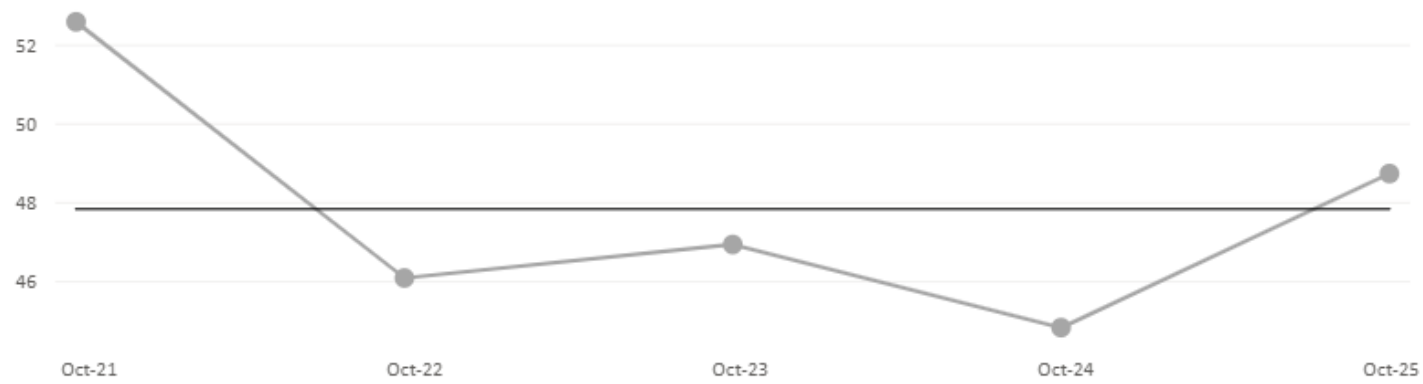
Staff Survey: Recommend Work

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

Lead Director: Lydia Larcum

Operational Lead: Vicky Mallows

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

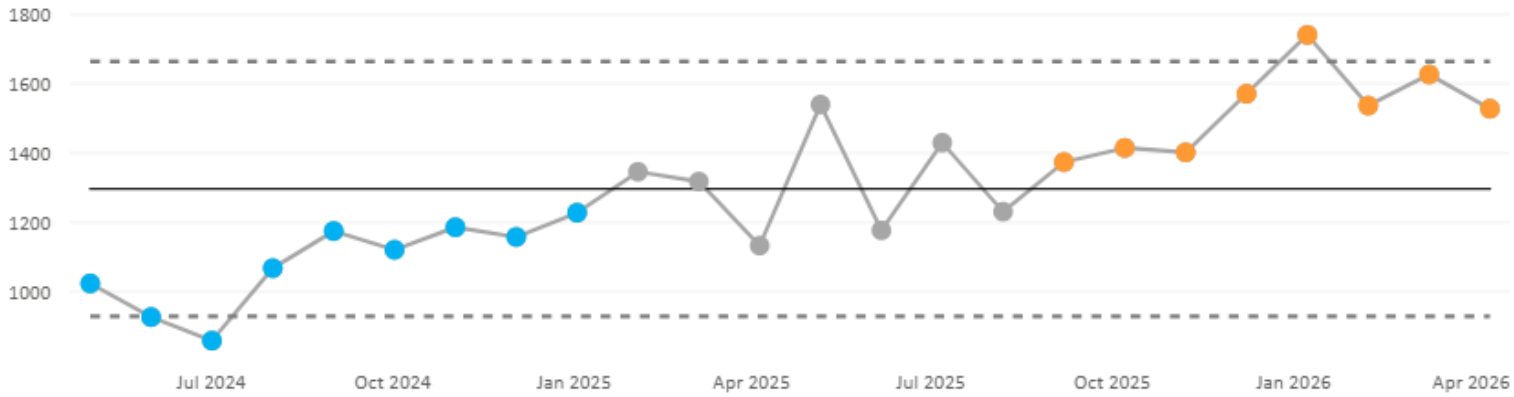
True North Report

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)?

3 found

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

Occurs

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

Does Not Occur

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Target Mar 2027
Value	1130	1537	1174	1427	1228	1371	1412	1399	1568	1738	1534	1624	1525	
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?

- Close working to ensure all partners proactively seek packages of care.
- Regular monitoring at patient level to ensure outcomes.
- Partnership with the system to look into innovative integrated pathways

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 assessment on wards causing delays
- Availability of nursing home placements in the area

What are we doing about them?

- Stronger escalation and operational grip including 1st and 2nd line daily escalation meetings.
- The team are working on a Super discharge and senior clinical challenge.
- Working in partnership with the system to operationalise Pathway 1 Bridging Services across York and North Yorkshire.

True North Report

Objective Status Up Is Good

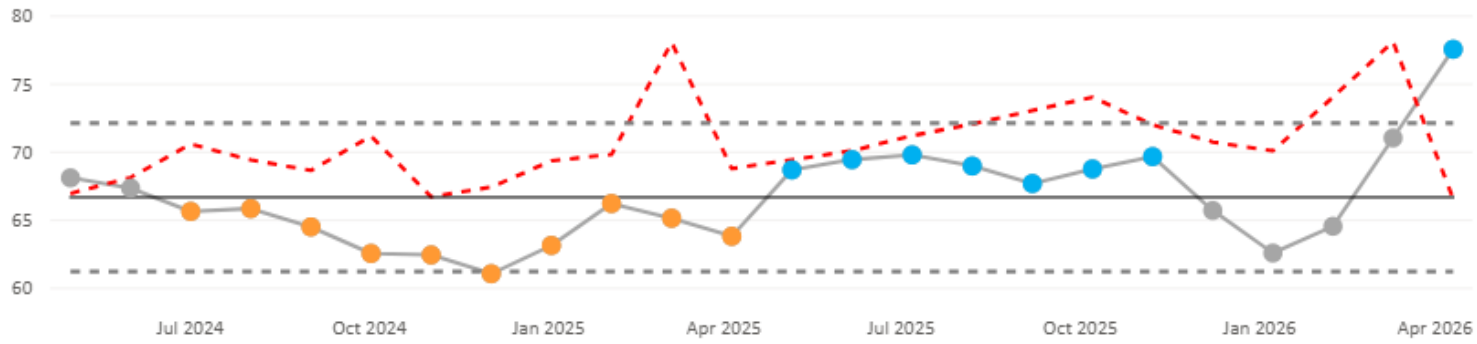
Urgent Emergency Care: Improve Emergency Care Standard (ECS)

Decrease the percentage of people waiting 4 hours or more in our emergency departments to achieve ≥ 82% by March 2027. Please note, as per a national mandate for 2026/27 100% of Bridlington and 50% of Whitby UTCs are mapped to the Trust for performance purposes

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

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Target Mar 2027
Value	63.8%	68.6%	69.4%	69.7%	68.9%	67.6%	68.7%	69.6%	65.7%	62.5%	64.5%	71%	77.5%	82%
Trajectory	68.7%	69.4%	70%	71.1%	72%	73%	74%	71.9%	70.7%	70%	74%	78%	66.5%	

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?

- Front door service redesign took place mid-March 2026 and is being closely monitored. Ongoing refinement of pathways is underway.
- 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.
- Financial constraints limiting options for testing new ways of working.

What are we doing about them?

- We launched two new pathways at each Emergency Department in March 2026 and have been closely monitoring them. Opportunities for further improvement and refining are being progressed.
- Progressing a business case for a second middle grade doctor overnight at Scarborough ED substantively.

True North Report

Objective Status Down Is Good

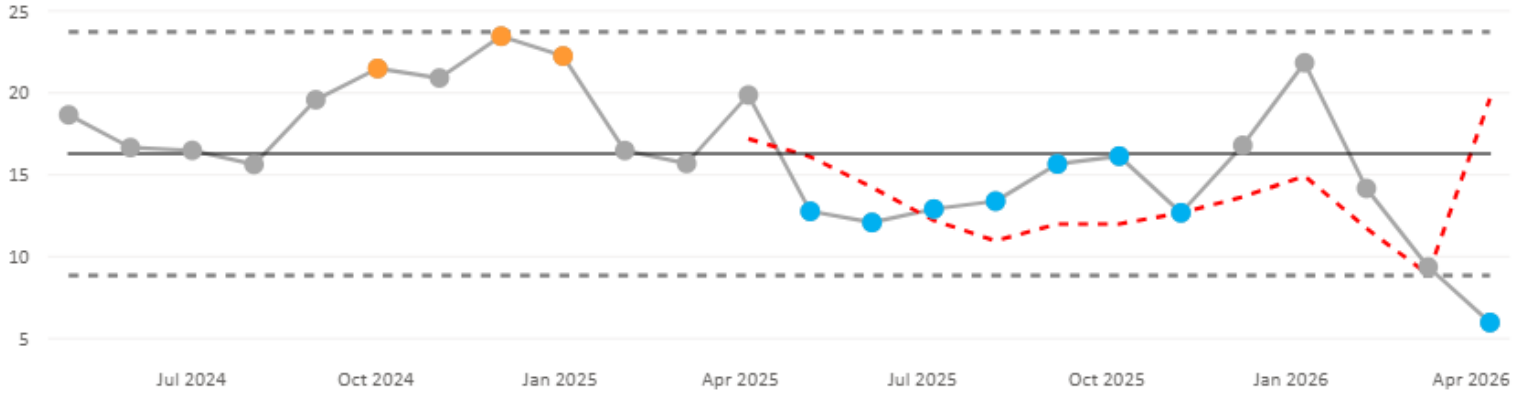
Urgent Emergency Care: Reduce 12 Hour Waits in ED

Reduce the number of people who wait in our EDs for longer than 12 hours to achieve ≤ 5% of all type 1 attendances by March 2027

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

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Target Mar 2027
Value	19.8%	12.7%	12%	12.9%	13.3%	15.6%	16.1%	12.6%	16.7%	21.8%	14.1%	9.3%	5.9%	5%
Trajectory	17.1%	16%	14.2%	12.2%	10.9%	11.9%	11.9%	12.6%	13.6%	14.9%	11.7%	8.9%	19.6%	

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
- Financial constraints mean limited options for testing new ways of working.

What are we doing about them?

- The launch of EAU has supported a significant reduction in 12 hours delays in ED. This is an important step in managing our flow and working towards eradicating corridor care.
- As of 08/05/26, EEMAC at Scarborough hospital has extended from 8 hours to 24 hours, 7 days a week. This will further help improve 12 hour performance.

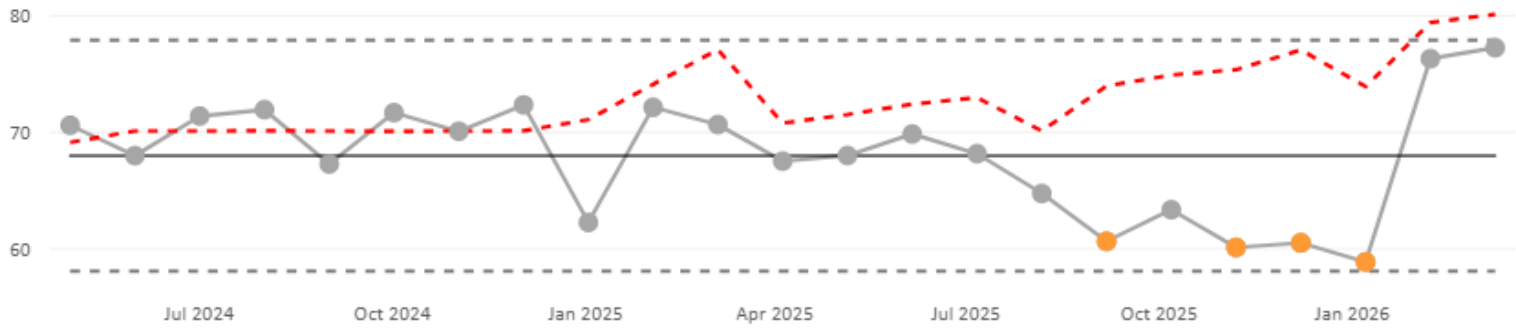
True North Report

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 an average of ≥ 80% over 2026/27

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

	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	70.6%	67.4%	67.9%	69.8%	68.1%	64.7%	60.6%	63.3%	60%	60.4%	58.8%	76.2%	77.2%	84.3%
Trajectory	77%	70.7%	71.4%	72.3%	72.9%	70%	73.9%	74.8%	75.3%	77%	73.8%	79.3%	80.1%	

What are the organisational risks?

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

How are we managing them?

- Weekly Trust cancer PTL meeting with a focus on patients breaching FDS with clear escalation routes. 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)
- Increase in suspected cancer referrals month on month from May 2025. 5% increase in April 26.

What are we doing about them?

- Continued prioritisation of cancer activity in Q1 25/26.
- ICB implementation of dermoscopy local enhanced service (LES) commenced, 85% of referrals now received with image.
- Delivery of cancer system development funding scheme (£900k). Initial schemes to commence June 2026
- Ongoing support around PTL management with additional weekly meeting to review thematic issues by tumour site.

True North Report

Objective Status — Up Is Good

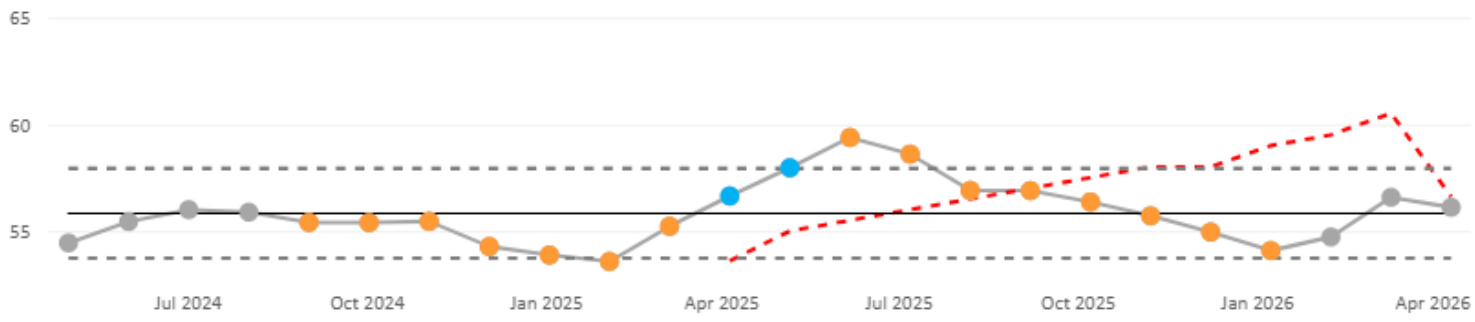
Elective: Improve RTT

Increase the percentage of incomplete pathways waiting less than 18 weeks to achieve ≥ 67.5% by March 2027

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

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Target Mar 2027
Value	56.6%	58%	59.4%	58.6%	56.9%	56.9%	56.4%	55.7%	55%	54.1%	54.7%	56.6%	56.1%	67.5%
Trajectory	53.6%	55%	55.5%	56%	56.5%	57%	57.5%	58%	58%	59%	59.5%	60.5%	56.6%	

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?

- Undertaking focused validation of cohorts of patients that could result in clock stops.
- Implementation of service delivery plan with oversight at monthly delivery boards.
- Commenced fortnightly performance and activity meeting with each care group to identify corrective actions.
- Reviewing high performing Trusts to understand additional action.
- Increase validation resource through patient not present tariff.
- Undertaking targeting insourcing.

True North Report

Objective Status — Down Is Good

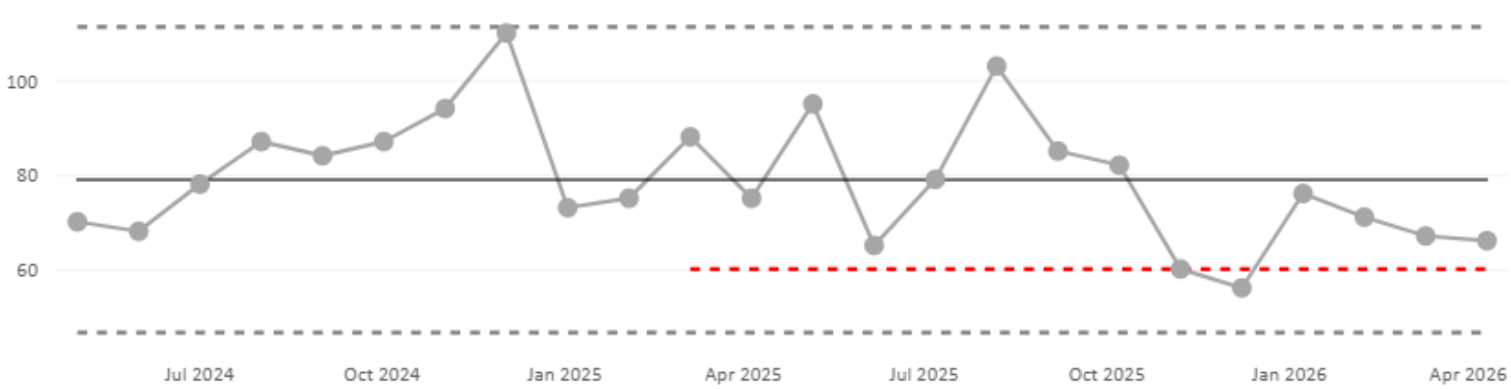
Q&S: Reduce Category 2 Pressure Ulcers

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

Lead Director: Joe Hague

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

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Target Mar 2027
Value	75	95	65	79	103	85	82	60	56	76	71	67	66	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?

- 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 continued to be 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 ward 15 ortho, G1 surgery and 28 elderly
- 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 a small number high-risk bedside chairs.
- Agreement established with mattress supplier to install retro fits to all mattresses across Q1 and Q2.
- 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.
- TVN commenced virtual sessions to support accurate identification and engagement with Skin champions.

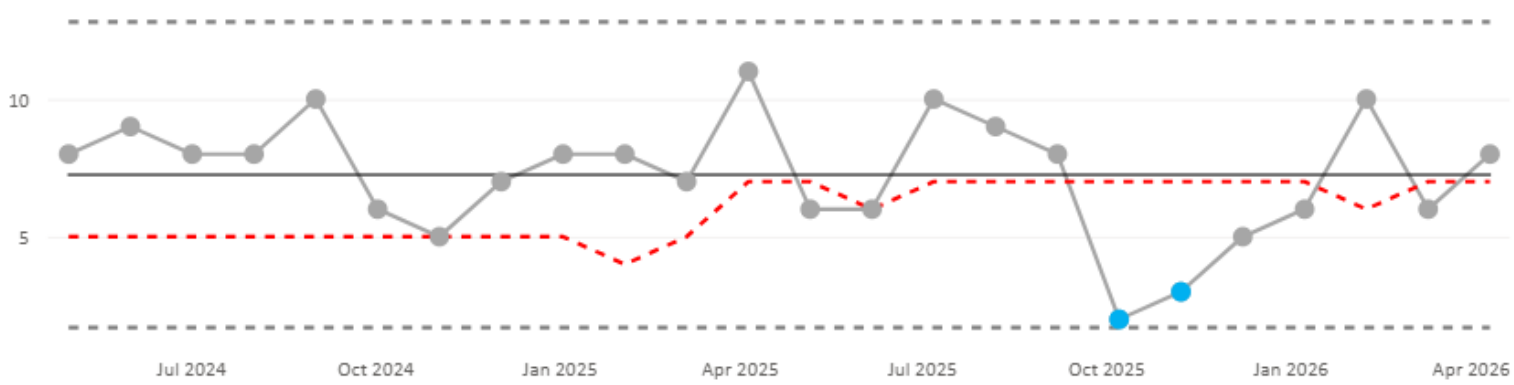
True North Report

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: Joe Hague
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

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Target Mar 2027
Value	11	6	6	10	9	8	2	3	5	6	10	6	8	7
Trajectory	7	7	6	7	7	7	7	7	7	7	6	7	7	

What are the organisational risks?

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

How are we managing them?

- All cases are reported by the IPC team on Datix to the relevant Care Group Handler.
- Cases are managed locally however 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

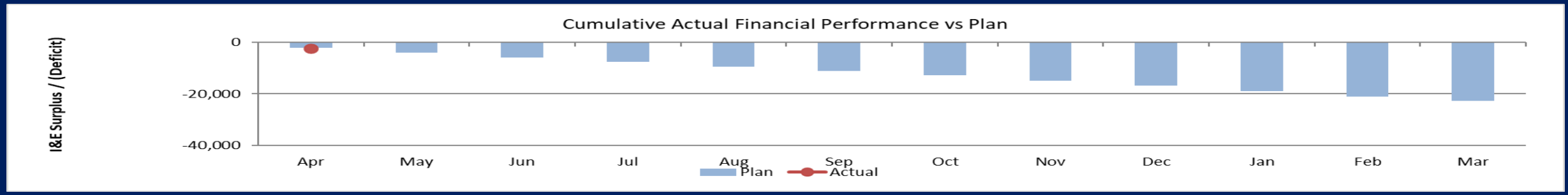
Finance: Achieve Financial Balance

Meet our obligation to deliver the financial plan for 2026/27

Lead Director: Andrew Bertram

Operational Lead: Sarah Barrow

Committee: Resources



Indicator	Target £'000	Apr-26 £'000	May-26 £'000	Jun-26 £'000	Jul-26 25 £'000	Aug-26 £'000	Sep-26 £'000	Oct-26 £'000	Nov-26 £'000	Dec-26 £'000	Jan-27 26 £'000	Feb-27 £'000	Mar-27 £'000
Meet our obligation to deliver the financial plan for26/27	-22,646	-2,087	-4,068	-5,950	-7,685	-9,443	-11,170	-12,884	-14,881	-16,885	-18,956	-21,014	-22,646
Actual Position		-2,470											
Variance		-383											

What are the organisational risks?

- **Failure to Deliver the 2026/27 Financial Plan** - The most critical financial risk is the Trust's potential failure to deliver the 2026/27 financial plan.
- **Waste Reduction & Productivity Programme Delivery Risks** – delivery of the financial plan is reliant on delivery of £61.6m WRAP programme.

How are we managing them?

The following controls maintain in place to ensure delivery against the plan

- Business as usual controls: PRIM / FRM / Exec Comm / SFI / SoD.
- Further to the above, newly introduced Financial Improvement Boards (FIB) are in place for each Care Group and Corporate function for specific focus on delivery of the WRAP programme.
- KPMG work coming to a close, with final findings and recommendations expected shortly

What are the current challenges?

- In April WRAP delivery falls £1.9m short of the April target.
- There is currently a planning gap of £3.9m (6.3% of overall target)
- £15.3m WRAP plans are High-Risk and £9.4m Amber

What are we doing about them?

- The shortfall in WRAP delivery has been managed through the deferral of planned investments
- Continue to monitor delivery of plan / WRAP against monthly target. Commitment to redirect investment funds where delivery of WRAP falls behind target.
- Where the position recovers in future months, reinstate investment fund.
- Closely monitor the above in line with activity delivery, as any underperformance may reduce income and adversely affect the net I&E position.

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 and started 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 continues, 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.

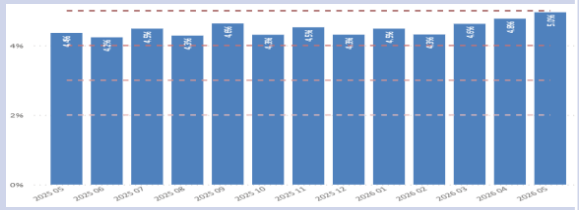
2. Continuous Improvement Update Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- Following approval of our consultancy application to NHS England, we went ahead to open tender on 30th March 2026.
- The request for tender submissions closed on 30th April 2026. Application review, moderation and presentation processes are now in place. We are looking to appoint and secure a Strategic Partner to start on site in early July 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

Project	Current position	Actions completed	Actions for next month
004 PIFU Utilisation – achieve 6.6%	4.8% in April 2026 against a plan of 6.6% in 26/27 plan. Highest ever rate of PIFU. 	• Project leads identified for all target specialities • Analysis of PIFU v discharge rate • Provision of high-level action delivery plans by care groups • Project manager support to delivery of workshops	• Delivery of cardiology workshop • Plan workshops for respiratory and T&O • To liaise with digital team on report for PIFU v discharge rates • Review GIRFT benchmarking • Review of pain management
003 Outpatient Utilisation – achieve 90%		• Stakeholder engagement • Designated leads for outpatient clinics identified • Review of lowest-performing specialities completed	• Detailed speciality level action plans • Liaise with BI to improve data quality gaps • Root cause analysis of specialities reporting <65% • Report on KPI's for specialties
009 Referral pathways – reduce referral demand (10% reduction in consultant to consultant and maintain no more than 2% increase in GP referral demand)	Development of an approach to roll out of single point of access (SPoA). Consultant to consultant referral rates	• SpoA project roll out plan to be presented to executive committee, with suggested 10 priority specialties) • Proce for rejecting inappropriate internal referrals commenced in Pain.	• Executive committee approval for SPOA roll out plan. • Establish project group and primary / secondary care interface. • Commence engagement with clinical teams. • Review pain C2C referrals and impact
006 Diagnostic Pathways – Increased diagnostic activity	To be agreed.	• Commenced engagement with ACOO's and meetings with CSCS established	• Establish a lead care group as project lead • Detail review of care groups stated actions and identification of opportunities for additional activity • Identification of performance indicators
008 One stop clinics – reduced new:FU ration (TBC)	To be agreed	• Initial engagement with ACOO's	• Review of current service delivery plan for identification of opportunities

4. Efficiency Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Trust Waste Reduction and Productivity Programme

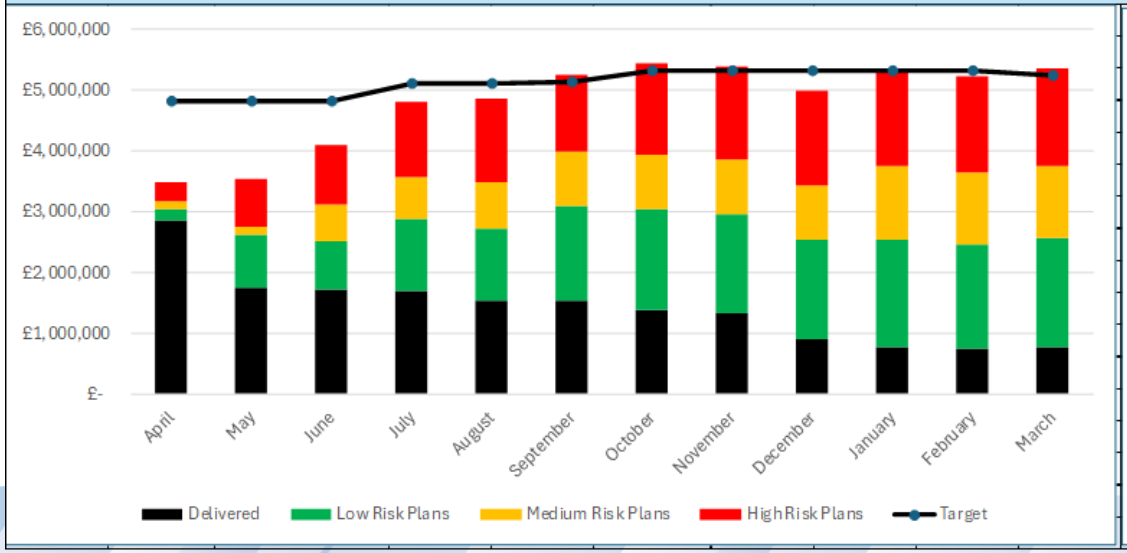
Executive Summary

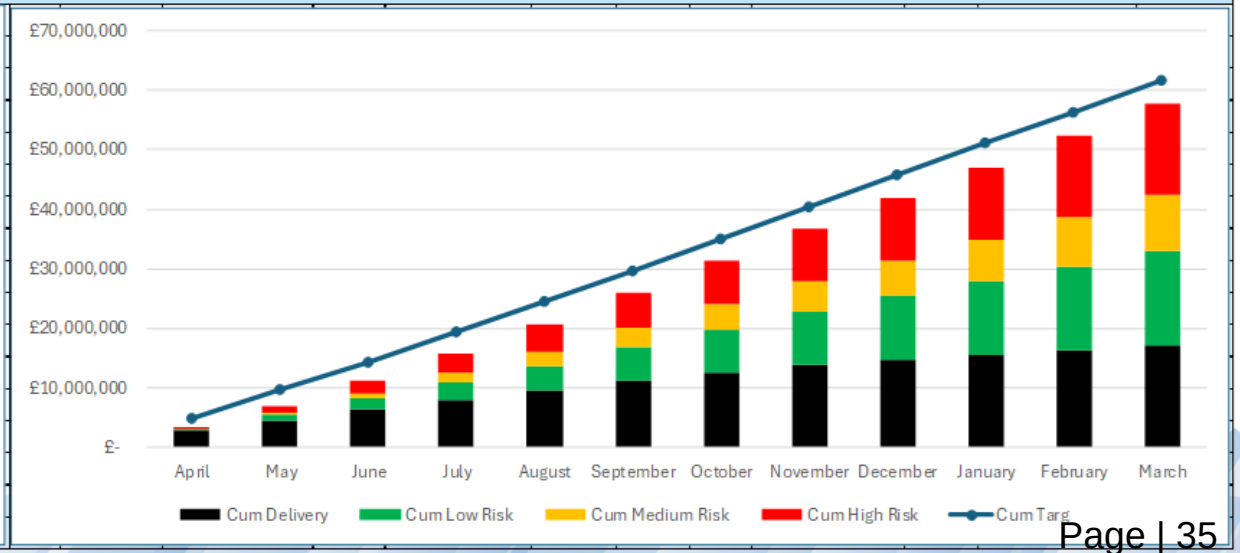
Programme Summary Position	Full Year	YTD Position
Target	£ 61,639,999	£ 4,807,922
Delivered	£ 17,059,521	£ 2,865,532
Variance	**-£ 44,580,478**	**-£ 1,942,390**
Addititional Plans to be delivered		
Planned Low Risk	£ 15,952,139	£ 165,091
Planned Medium Risk	£ 9,434,179	£ 138,083
Planned High Risk	£ 15,289,756	£ 327,101
Total Additional Plans	**£ 40,676,075**	**£ 630,275**
(Planning Gap)/Over delivery	**-£ 3,904,403**	**-£ 1,312,115**

Scheme Governance											
Total Number of Live Schemes							138				
EQIA Outstanding							54	39%			
Pre-Pipeline							55	40%			
Opportunity							5	4%			
Plan in Progress							15	11%			
Fully Developed							63	46%			
	Plans	**%**	**Delivered**	**%**			**Plans**	**%**	**Delivered**	**%**
Recurrent	£ 38,376,258	62%	£ 14,704,843	24%		**Pay**	£ 25,541,176	41%	£ 3,915,705	6%
Non Recurrent	£ 19,359,338	31%	£ 2,354,678	4%		**Non Pay**	£ 31,879,057	52%	£ 12,924,453	21%
Total	**£ 57,735,596**	94%	**£ 17,059,521**	28%		**Income**	£ 315,363	1%	£ 219,363	0%
						Total	**£ 57,735,596**		**£ 17,059,521**	

WTE Plan		WTE Delivered		YTD Period Name	April 2026

In Year Plan Profile





NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	27 May 2026
Subject:	Chair's Report
Director Sponsor:	Martin Barkley, Chair
Author:	Martin Barkley, Chair

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

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

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

No ☒ Yes ☐

Report History
Board of Directors only

Chair's Report to the Board – May 2026

1. I have continued to visit various wards and services at Scarborough and York Hospitals, not least of which have been with Head Nurse of Theatres and the Volunteers Coordinator. Through conversations with colleagues during these visits, I pick up valuable insight and issues which I share with the Chief Executive as appropriate.

2. I recently met with attendees of the York deaf café to brief them about the Trust, but more importantly to respond to their questions and make notes of the very valuable feedback and suggestions they made that would improve the experience that people who are deaf have when receiving appointments, attending ED and being an in-patient. I am sharing these improvement possibilities to relevant colleagues as implementing them will take us further to our ambition of "providing an excellent patient experience every time".

3. Since my previous report to the March Board meeting, another Governor (Mr Foxley) has stood down because dates of Council of Governors meetings and Governor Forums clash with his other commitments.

4. At a recent meeting of the Council of Governors Nomination Committee, it was agreed to commence recruitment of a non-executive Director to fill the vacancy we have.

5. Rukmal Abeysekera has agreed to Chair the Organ Donation Committee. Jane Hazelgrave has agreed to be the lead MHPS NED, and Richard Reece has agreed to be the nominated NED for the Resident Doctors 10-point plan implementation and the lead NED for Safeguarding.

6. I want to express my heartfelt thanks to the Nervecentre project team, colleagues in the digital Directorate and all colleagues who are adapting and getting used to the new electronic patient record system. This is the biggest change programme since the merger of Scarborough and York to create the present Trust. Another phase of implementation will take place in the autumn. Everyone has been brilliant, great teamwork and going that extra mile to ensure the implementation of the new system has gone smoothly and that all colleagues receive the support they need to use the new system and get used to the way it works.

Martin Barkley
Trust Chair 15.05.2026

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	27 May 2026
Subject:	Chief Executive's Report
Director Sponsor:	Clare Smith, Chief Executive
Author:	Clare Smith, Chief Executive

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

☒ To provide timely, responsive, safe, accessible effective care at all times.
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☒ 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, Nervecentre go live, Planning Update, Bridlington Care Unit, SHARC Annual Conference, welcome to our new Chief Nurse, HYMS Teaching Excellence Awards, and April'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

I have continued to ensure I make the time each week to meet with colleagues and visit different sites and services.

This month I have spent some more time with colleagues who work in our community services in and around York.

What stood out to me, and reaffirmed my established view, is the vital role our community services play - often less visible than our hospital work, but essential in supporting patients closer to home, keeping people well or supporting rehabilitation, and helping avoid unnecessary admissions. The commitment and connection these colleagues have to the communities we serve really came through, and it is something we should be incredibly proud of as a Trust.

It is really important to me that we are visible and present across all of our sites. We are one Trust, serving a wide and diverse geography, and I want to make sure this is reflected in how we work as a leadership team. We will be ensuring that as an executive team we have a more regular presence at our community hospital and acute sites on rotation so that we can ensure that we have the opportunity to get out and meet as many colleagues as possible, and be available for colleagues who may want to meet with us.

In addition to meeting with colleagues I have continued to meet with MPs, local councillors and patient groups, which is of particular importance in understanding the views of the communities we serve as we progress with the development of our clinical strategy, and helps us to understand what matters most to our patients as well as colleagues in terms of how we are delivering care.

Since we last met as a Board I have also shared with colleagues my reflections from my first 100 days in the Trust.

In sharing these reflections I have been honest about the challenges we face, whilst also recognising the huge amount of good care, commitment, and kindness I have seen across the organisation.

I have set out the priorities I believe we need to focus on together - reducing corridor care, strengthening culture and leadership, improving timeliness of care, developing our community services, and achieving financial sustainability by developing a clear clinical strategy and embedding continuous quality improvement across the Trust.

This is not intended to be a finished answer or a top-down plan, but the start of an ongoing conversation about where we go next as one Trust.

2. Nervecentre go live

I am delighted to report that we have successfully completed the first phase of the Nervecentre Electronic Patient Record (EPR) roll out in York, Scarborough, Bridlington and our community inpatient units at Selby, White Cross Court, Nelson's Court, and St Monica's. This is a major achievement for our organisation and a major step forward in how we care for our patients.

This was not simply a technical implementation, it was a complex transformation carried out at the heart of our busiest clinical environments. Delivering this safely, while continuing to provide high-quality patient care, is a testament to the professionalism, dedication and resilience of our staff.

Feedback from our partners at Nervecentre has further underscored the strength of this achievement, with colleagues describing this as one of the best planned and smoothest go-lives they have experienced to date.

This success has been built on meticulous preparation over many months and years. Behind the scenes, teams have worked tirelessly to design, test and train, ensuring that when the moment came, the organisation was ready. What has stood out above all is the way in which the Trust has come together. Colleagues from across clinical, operational, digital and corporate services working side by side, supporting one another and responding with pace, compassion and professionalism at every stage.

The scale of this achievement cannot be overstated. Thousands of colleagues have played a part, and across our sites there has been a visible and reassuring presence of digital champions, floorwalkers and clinical leaders, helping colleagues build confidence and adapt to new ways of working. This collective effort has embodied the very best of our Trust: teamwork, commitment and an unwavering focus on patient care.

While this marks a major milestone, it is also the beginning of the next chapter. We have two further phases of our EPR deployment ahead of us, and we will approach these with the same rigour, discipline and care that have defined this first phase. The experience and confidence gained through this go-live give us a strong foundation as we continue this journey.

I would like to extend my sincere thanks to everyone involved. In particular, we recognise the outstanding contribution of the Y&S Digital team, whose leadership and expertise have been central to this success under the direction of James Hawkins, Chief Digital and Information Officer; Nicola Coventry, Chief Nursing Information Officer; Kev Beatson, Head of Applications and Clinical Systems Architecture, Donald Richardson, Chief Clinical Information Officer, Helen Foy, Programme Manager, Gary Hardcastle, Head of Business Intelligence and Insights, and Nicky Slater, Operational Support Lead. Their leadership has been fundamental to the positive way in which the rollout has happened, not least when we have faced some major bumps in the road. I also want to mention Chief Pharmacist Stuart Parkes and Lead Digital Pharmacist Gemma Nichols and the transcribing teams, predominantly staffed with pharmacy colleagues, who worked around the clock to manually input the medicines records from CPD into Nervecentre for every patient in our hospitals during the go live.

This collective achievement is something the whole organisation can take real pride in. It reflects not only what we have delivered, but who we are as a Trust. As we move into stabilisation and optimisation, we remain focused on realising the full benefits of this transformation, creating a safer, more connected and more efficient service for our patients, our staff and the communities we serve.

On the subject of digital developments, colleagues may have seen the introduction of the NHS Modernisation Bill in the King’s Speech to Parliament earlier this month. A key element of the Bill is the proposal to create a single patient record to improve information sharing across NHS providers, with the intention of enabling safer, faster and more coordinated care.

We will share more about this as further detail emerges and as the Bill makes its journey through Parliament and into legislation.

3. Planning update

Since last month we have met with national and regional NHSE colleagues to discuss our financial plan. The message is really clear in that we should work to deliver the current plan approved by the Board of Directors.

To finalise the position regarding the expected in-year deficit, and to agree any deficit support funding, we will be participating in a national plan escalation meeting in London with Sir Jim Mackey, Penny Dash, and NHS England's Regional Director and Regional Chair, along with other NHSE colleagues.

At the meeting we will be required to present and discuss the action we are taking and the decisions we will need to make to ensure delivery of our financial plan and to achieve plan compliance.

This level of challenge and scrutiny makes it all the more important for us to focus our attention on delivery of our Waste Reduction and Productivity (WRAP) programme, and we are already nearly two months into this year's plan. We are continuing to work closely with Care Groups and Corporate teams to maintain grip on WRAP delivery and expenditure, and we are being clear that we cannot overspend and we must live within the resources available to us.

4. Bridlington Care Unit

The Bridlington Care Unit was established in 2021 as part of the system's response to the COVID-19 pandemic, providing step-down capacity for patients who were medically fit for discharge but unable to return home due to delays in care arrangements. The model was designed as a temporary intervention to support flow within the acute hospital system, particularly at Scarborough Hospital.

Staff consultation began earlier this month with a view to redeploying the colleagues current based on the unit. Although neither the Trust or the ICB regard the closure as a substantial variation in service, there is still an expectation that engagement takes place with key stakeholders including East Riding Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee, the local MP, and other interested parties.

Despite best intentions of colleagues, the correct sequence of events for this engagement was not followed as colleagues were advised of the change before stakeholders had been briefed, resulting in them learning of the plans before being formally notified and before discussions could take place.

The Health, Care and Wellbeing Overview and Scrutiny Sub-Committee convened an extraordinary meeting on the matter on 11 May where a number of concerns were raised and recommendations made.

As a Board we will need to consider our response to the recommendations and feed back to the Committee about our proposed next steps. We will also need to do significant work to regain the trust of some of our partners and stakeholders, and some of these discussions have already begun, with further opportunities to do this through the

widespread engagement work we have committed to do as part of our clinical strategy development.

5. SHARC Annual Conference

The first annual Scarborough Coastal Health and Care Research Collaborative (SHARC) event took place last month in Scarborough.

SHARC aims to better understand and improve the health and care needs of people living in our coastal communities. It is a collaboration between our Trust and York St John University, supported by a steering group from across our region and along the east coast. SHARC combines clinical experience with academic research, but it also recognises something equally important: that the people who live in our coastal communities are the real experts in their own lives.

The event was an opportunity to bring together community representatives, researchers, health professionals and partners to share progress, celebrate achievements, and shape the future of health, care, and research across our coastal region.

As a NHS organisation, we have a duty to think about how our decisions affect people's health and wellbeing, and to reduce inequalities wherever we can. That means paying particular attention to those who face the biggest barriers whether that is due to disability, ethnicity, or living in more deprived areas.

People in coastal and rural areas often face additional challenges, and that can lead to unwarranted differences in health and access to care. SHARC is about listening to those voices and working together to find solutions through research.

Highlights from SHARC's achievements in this first year include the launch of the National Institute for Health and Care Research Elevate project in Scarborough, national recognition at a major research conference, and perhaps most importantly, initiatives like the Community Grant Scheme and Community Voices which are helping to support local organisations and ensure people have a real say in research and decision-making.

6. Welcome to our new Chief Nurse

Welcome to Joe Hague who has now started in post as Chief Nurse.

Joe is an experienced senior clinical and operational leader, most recently holding the role of Deputy Chief Nurse at King's College Hospital NHS Foundation Trust and Clinical Care Professional Lead for Urgent and Emergency Care for The South East London ICB.
Joe began his nursing career in the Emergency Department at St Thomas' Hospital in London, later gaining experience in critical care before moving into senior operational leadership roles.

I am sure you will join me in making Joe feel welcome.

I also want to thank Tara Filby for stepping in to the Interim Chief Nurse role following Dawn's retirement. Tara brought calm leadership, clarity and real commitment during a busy time for the Trust, and I am grateful for her support.

7. HYMS Teaching Excellence Awards

Earlier this month, the Hull York Medical School (HYMS) community came together to celebrate exceptional medical education and support provided to students across the undergraduate Medicine and MSc Physician Associate Studies programmes.

The student-led Clinical Teaching Excellence Awards recognise colleagues who have gone the extra mile to support students in teaching, clinical placements, pastoral support and wider development.

This year saw 130 nominees and 19 winners announced across seven categories, and I am proud to share that our Trust was represented across three award categories, including the Secondary Care Teaching Award, Administrative Excellence Award and Clinical Teaching Fellow of the Year Award.

Congratulations to everyone nominated: Dr Laura Cowlbeck, Dr Aaditya Dayal, Dr Holly Hellawell, Prof Vijay Jayagopal, Dr Rebecca Lightfoot, Dr Daniel Lilley, Dr Kyaw Linn, Dr Emily Nicholson, Dr Malcolm Proudfoot, Dr Ho Tin Wong, Sara Laurie, Eleanor May, Donna Perrin, Matthew Wheelen and Dr Emily Maude.

I must also give a special mention to Donna Perrin, winner of the Administrative Excellence Award. Comments from her nomination included:

- *"helped me feel prepared and supported from the beginning"*
- *"her organisation, responsiveness, and kindness made a genuine difference"*
- *"always available if we needed to reach out with any questions"*

What really comes through in these comments is the difference thoughtful, reliable and compassionate support makes to people's experience. Congratulations and thank you to Donna, and to all colleagues who were recognised with a nomination.

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

Date: 27 May 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

STAR AWARD

April 2026

Katarina Vozarova, Assistant Facilities Operational Manager | **Malton** | **Nominated by colleague**

Kat is the manager of one of the first areas within YTHFM to move over to using Healthroster. When we began the roster implementation process in December 2025, Kat approached the plan with positivity and enthusiasm. Unfortunately, there have been some unforeseen issues with the transition to using Healthroster, but Kat has remained calm, pragmatic, and fully engaged in the process.

Kat has demonstrated the Trust values continuously in all our meetings, being kind, striving for excellence, and being open to support and solutions to ensure the system will work for the areas within her remit. I would like to personally thank Kat for working with me over the previous three months, and a Star Award nomination seems fitting to acknowledge her hard work and engagement.

Bethany Greaves, Recruitment Advisor, and Katy Barker, Recruitment Advisor | **York** | **Nominated by colleague**

Beth Greaves, Katy Barker, and I have been planning the arrival of the final cohort of international nurses. The last Kerala cohort, who were scheduled to arrive on 3 March, suffered a last-minute flight cancellation due to the ongoing global conflicts. This meant that the nurses who had left their homes and jobs in India were left in limbo. They were frightened and worried that they would be unable to join us as planned. Thankfully, Katy had been able to secure alternative flights for 16 March and move all the arrangements around, including accommodation, induction plans, and exams.

At 9pm on 16 March, we received a message letting us know the flights had been delayed, which caused further worry for the nurses, who were temporarily stranded in the airport after a connecting flight. Beth rang the nurses straight away and helped to put them at ease. We contacted the airline, which advised there would be transport and accommodation available if the flight was cancelled. We were notified at midnight that the nurses had been able to board hours later than planned. This meant that their arrival in Scarborough was significantly delayed, too.

Beth drove out to Scarborough and arrived there just after 8pm. She took bedding, towels, and food for the nurses, and settled all eight nurses into their new homes. She stayed with them until 10pm to make sure they had everything they needed after an incredibly stressful 24 hours. Beth provided support to the nurses throughout the night to help keep them calm and informed.

Pastoral care forms part of the welcome that our team provide as standard to international recruits; however, these actions are shining examples of commitment and dedication to their roles, but mostly the wellbeing of our colleagues. For Beth and Katy, this highlights how going well beyond expectations for the benefit of others is second nature. I am truly humbled by the passion to care shown by these two individuals.

Kathleen Merrick, Consultant in Obstetrics and Gynaecology | **York** | **Nominated by colleague**

Dr Merrick is well known for her hard-working nature and the excellent care she gives to those under our care. She is also exceptionally supportive of her colleagues. While she was working a week of day shifts that should have finished at 5.30pm, she stayed extra hours on many days to help the evening and night shifts with the high level of acuity.

On one day, she stayed well past her shift to support the night team with a pregnant woman who needed to be cared for in the ICU and was ultimately transferred to Leeds. Her support was invaluable.

Maternity Ward Clerks | **York** | **Nominated by colleague**

The Maternity Ward Clerks have shown outstanding teamwork and commitment throughout a recent departmental trial. This was to remove the intercom from the main reception area to trial adapting to become an outpatient area. They worked collaboratively to adopt new processes that have improved their work environment, and created wider positive effects across multiple teams, as well as improving patient experience. Throughout the trial, the ward clerks took on additional responsibilities, going above and beyond to ensure the trial's success.

Patient feedback during the trial period has also been overwhelmingly positive, with many patients commenting on how the changes have positively improved their experience. The team has shown commitment and dedication to improving the department, while exemplifying our values of kindness, openness, and excellence throughout the trial.

Samah Abdelatti Elfaki, Specialty Registrar | **Scarborough** | **Nominated by colleague**

I am nominating Samah for a Star Award to recognise her contribution to the team and for her patient care. Samah consistently demonstrates exceptional teamwork, integrating seamlessly with colleagues across the department. She is always willing to assess patients and goes above and beyond her role. Samah is compassionate and has such a warm and approachable manner. Patients and colleagues feel well supported, and Samah creates a positive and reassuring environment.

Samah is always enthusiastic about teaching and supporting others' development and takes time to share knowledge, fostering a culture of learning within the team. After a busy shift on Monday where Samah demonstrated all the above, I felt it was important that she knows how valued she is.

Mary Miller, Healthcare Assistant, and Nishad Nazeer, Healthcare Assistant | **York** | **Nominated by colleague**

I would like to say a huge well done to Nishad and Mary on Ward 24. Despite being short-staffed and in high demand, they continued to provide exceptional care with the biggest smiles. Their kindness, professionalism, and dedication did not go unnoticed! You are both amazing!

Megan Dillenger, Clerical Officer **Scarborough** **Nominated by colleague**

Megan has demonstrated exceptional resilience and dedication during a particularly challenging period marked by high levels of staff sickness. Despite the increased pressure, she has remained positive and focused, never complaining and consistently stepping up to meet the demands of the role. Her strong work ethic and willingness to go above and beyond have been instrumental in ensuring that the service continues to run smoothly. Megan's commitment and professionalism have not gone unnoticed, and her contribution has made a significant difference to the team. Thank you, Megan.

Lung Screening Team **York** **Nominated by colleague**

This is a new service which will be celebrating its first full year of helping communities diagnose and treat lung cancer and other incidental findings earlier, improving patients' experiences and outcomes.

As with any new service commencing, there have been bumps along the way, but the team have come together in a supportive and patient-focused way to meet those challenges head-on and overcome them. They take that learning and use it to drive the service provision forward. Well done, team, and great job in modelling the Trust values.

Nataliia Shevko, IT Service Desk Analyst **York** **Nominated by colleague**

I work as a community midwife, and I have been having connection problems when working remotely. I rely heavily on my laptop being able to work remotely, as I am rarely on the York Hospital network.

I rang the IT service desk this week when I was having login problems. Nataliia was helpful and really tried to get to the root of my connection problems. She was on the call with me for over 90 minutes trying to solve the problem. She was tenacious, and as she could not work out the problem on the call, she ensured I had workarounds and that everything worked again before we finished the call. She is good at her job and at talking to people.

Hanna Masangya, Healthcare Assistant **York** **Nominated by colleague**

Hanna is an exceptional and approachable colleague who is always willing to help, no matter how busy she is. Whenever I have needed support, she has always been there to assist. Nothing is ever too much trouble for her, and she always helps with kindness, patience, and professionalism. She is such a valued member of the team and makes a real difference every day, which is why I feel she deserves recognition for the kindness and effort she puts in day in, day out.

One of her greatest strengths is her calm and understanding nature with patients, no matter the situation. Even under pressure, she remains professional and reassuring, which is such an important quality in our workplace. Hanna is a role model and someone whom I look up to. She is dedicated to providing the best care to patients and understands the importance of spending time with them. She makes sure patients feel listened to and supported, and she takes the time to understand what they need so that care can be delivered in the best way for each individual.

Rhea Trower, Healthcare Support Worker, and Clare Ladle, Healthcare Support Worker | **Bridlington** | **Nominated by colleague**

I am nominating Rhea and Clare after witnessing exceptional care towards one of our service users at Bridlington Hospital's Phlebotomy Department. The service user had visited the day prior, with her two carers, but, unfortunately, the blood form was unavailable as it was from a different trust, which meant she needed to return the following day. This service user has severe mental health challenges and autism. Upon learning that she would have to come back to get her blood sample, her anxiety increased, and she ultimately voiced that she would not be returning.

Rhea and Clare went the extra mile by inviting her for coffee the next day at the department with her two carers and assured her that they both would be there to perform the venepuncture. The service user returned, and as promised, Rhea and Clare did not disappoint. They had a coffee and a laugh after her blood test; Clare even ended her lunch early, which she didn't need to think twice about. The service user is looking forward to coming for her blood sample again so she can update her matching sticker with Rhea.

Rhea and Clare provided exceptional care; they both went above and beyond to exemplify the Trust values. They are both wonderful individuals who are always compassionate and kind to colleagues and service users, who they are both so popular with.

Katie Smallwood, Admin Assistant | **York** | **Nominated by colleague**

I wanted to say thank you to Katie for being so amazing. I appreciate all the support she's given me; it honestly makes such a difference. It doesn't go unnoticed, and I'm grateful to have worked with her as a colleague. My time in the Car Parking team has been great, and Katie has been a huge part of it.

Andre Robles, Healthcare Assistant | **Scarborough** | **Nominated by colleague (1), colleague (2), and colleague (3)**

Nomination 1

Andre has been helpful and bent over backwards when the ITU team was busy with eight patients. He was helping the domestic team clean the rooms, bringing meals, teas, and snacks for the patients, and watching agitated patients to help the nurses, alongside completing his own tasks diligently. He showed up for the team in many ways and was an amazing team player.

Nomination 2

Andre has been going out of his way to help the domestic team in very busy periods. He has been supportive and did everything he could to help with the workload across the nursing, medical, and domestic teams. He has been an amazing team player and a pleasure to work with.

Nomination 3

Andre is a new Healthcare Assistant in the ICU, and he is amazing in his job. He is a good learner and is developing skills fast. He is hard-working and a good team player. He was helpful when we had a busy shift. He received good feedback from patients and other team members for his participation as a team member.

Ashley North, Mechanical Supervisor | **York** | **Nominated by colleague**

Ashley made a tangible and immediate difference during a critical incident involving a medical gas leak in the main theatres. His swift, calm, and highly competent response ensured the continued safety of patients, visitors, and colleagues, and demonstrated the Trust values throughout.

Ashley rapidly assessed the situation, quickly identifying the affected section of oxygen pipework and safely isolating it. By doing so, he maintained an uninterrupted oxygen supply to patients and minimised the risk of fire in what could have become an oxygen-enriched environment. His decisive actions prevented disruption to clinical activity at a time of high operational pressure.

Demonstrating exemplary teamwork and professionalism, Ashley coordinated a Medical Gas Specialist to attend and complete the repair the same night. He worked closely with the pharmacist to certify oxygen quality post-repair, ensuring all safety standards were met before reinstatement. He also protected operational areas, kept clinical teams fully informed, and helped maintain a calm and safe environment for staff and patients throughout. Further reflecting the Trust value of excellence, Ashley ensured that all associated repair costs were correctly charged back to the responsible contractor, safeguarding public funds and supporting accountability.

Ashley’s actions show kindness through his care for patient and staff wellbeing, openness through clear and timely communication, and excellence through his technical expertise, leadership and dedication. His response unquestionably went the extra mile and exemplifies the very best of our Estates team.

Ward 36	**York**	**Nominated by colleague**

Ward 36 is an amazing ward, full of equally amazing staff who are deeply committed to caring for their patients. I want to mention Laura Dodd's leadership of this team, how calm she is, and how involved in the care of the patients. Also, a big mention to Tracey Wall and Dawn Rhodes, both healthcare support workers, who are always welcoming on the ward (as are all the other colleagues). I have had the pleasure of supporting the ward in my role as a clinical educator, and it has been a privilege to work with such an amazing team.

Nicky Harris, Patient Services Operative, Karen Potter, Patient Services Operative, Oluchukwu Emiola, Healthcare Support Worker, and Poppy Kemp, Student Nurse	**White Cross Court**	**Nominated by colleague**

The Arts Team coordinates weekly music sessions with musician Chris Bartram, for the benefit of patients recovering from stroke at White Cross Court. When supporting staff get involved, they encourage patients to join in, often adding humour, joy, energy, and a sense of connection.

Nicola Harris (Nikki) has continued to be a vital part of the music sessions at White Cross Court since they started in 2022. Nikki is so joyful and likes to get everyone laughing. She was also Chris' right hand through all the early sessions as they worked out and developed the best way to run the sessions. She chatted with patients during the gaps, supporting them to help choose the next songs. She was the first colleague to provide the solid tambourine beat that adds so much to the music, and which Chris continues to make an ongoing feature of the music. He couldn't have made the early sessions work without her assistance.

Karen Potter has been a wonderful support to the music sessions, providing the solid beat on the tambourine, adding so much to the feel of each song, which also helps the patients to join in more confidently on their percussion. She sings along enthusiastically with all the songs, again modelling participation for the patients. She engages with the patients between songs, bringing a lot of humour and energy. As soon as Chris knows Karen will be in the session, he's assured of full and fun support!

Although relatively new to her role, Oluchukwu Emiola (Connie) has been a great help to the patients, particularly with her singing. Twice now she has led the patients in performances of 'Lean on Me', singing with a passion, engagement, and real musicality. As patients have commented to Chris, these moments are real highlights of the session. It's great for the patients and visitors to see a colleague joining in so enthusiastically.

Poppy Kemp gives full-on energy, singing along and playing percussion. She always brings a smile and good humour to the sessions and engages fully with the patients. She cheers them on to sing and play percussion alongside her, and chats to them about the music, supporting them to contribute to the discussions between songs.

I'd like to thank Nikki, Karen, Connie, and Poppy for their excellence in engaging patients with their energy and enthusiasm and providing quality care for patients.

Marina Platts, Consultant in Neurology, Sarah Taylor, Advanced Clinical Specialist, Jodie Young, Clinical Lead Occupational Therapist, and Beverly Clapson-Walker, AHP Senior Support Worker

York

Nominated by colleague (1), colleague (2), and colleague (3)

Nomination 1

We had a complex patient admitted from home who had been living in a dark room and bed-bound for several years. This patient was admitted to the Trust, was unable to remove their eye mask and neck collar, and was extremely hypersensitive to sound, light, and touch. These four individuals have worked with this patient for over two months and managed to enable this patient to remove her neck collar and eye mask and significantly improve her range of movement in her limbs.

The patient can now tolerate clothing and noise, and she has been successfully taken off the ward in a supportive wheelchair. She has also managed to tolerate her first shower. These four colleagues have given this patient a new chance at life, and I would like to nominate them for a Star Award to recognise this outstanding achievement and a real example of going above and beyond.

Nomination 2

I would like to nominate Jodie, Sarah, Marina, and Bev for a Star Award in recognition of the truly outstanding care, dedication, compassion, and advocacy they have shown in supporting a highly complex patient with Functional Neurological Disorder (FND). This lady was admitted from home after having spent several years bedbound and living in an almost entirely darkened room, isolated by the severity of her condition. At the time of admission, she was unable to tolerate even minimal sensory stimulation. She wore an eye mask continuously, relied on a neck collar, and experienced extreme hypersensitivity to light, sound, touch, clothing, and movement. Her world had become incredibly small, and her quality of life had been profoundly affected.

From the very beginning, these four colleagues approached her care with extraordinary patience, empathy, clinical skill, and determination. They recognised that progress for this patient would not come quickly or easily, and that every small step forward would require not only professional expertise, but also immense trust, consistency, reassurance, and emotional support. Over the course of more than two months, they have worked tirelessly to build that trust and advocate for what this patient needed, often in circumstances that required creativity, persistence, and unwavering belief in her potential for recovery. They did not simply deliver care – they truly championed this patient. They listened to her, respected the reality of her symptoms, and ensured that her care remained person-centred, compassionate, and hopeful at every stage.

Because of their commitment and the therapeutic relationship that they built, this patient has made progress that once may have seemed impossible. She has been supported to remove her neck collar and eye mask, something that represented not just a physical change, but a huge emotional and psychological milestone. Her range of movement in her limbs has improved significantly, and she is now able to tolerate far more stimulation than she could on admission.

Most importantly, these colleagues have helped her begin to re-engage with life again. She can

now tolerate clothing, sound, and touch to a much greater extent. She has been able to sit out in a chair and has even been taken off the ward in a supportive wheelchair, allowing her to experience being outside of her room and reconnect with the world around her. She has also achieved something so many of us take for granted – she has tolerated her first shower, which was a major and meaningful step forward in her recovery and dignity. They have also supported her in rebuilding relationships with her family, whom she had lost touch with due to her difficulties, allowing her to regain her role as mother to her two children.

What makes this achievement so remarkable is not just the clinical progress itself, but the way in which it was achieved. These four colleagues have shown incredible kindness, perseverance, teamwork, advocacy, and belief in this patient throughout every challenge. They have remained calm and encouraging through setbacks, celebrated every small success, and consistently gone above and beyond to ensure this lady felt safe, respected, and supported. Their care has not only improved this patient's physical function but has also helped restore something even more important: hope. Through their dedication, they have given this lady an opportunity to begin living again rather than simply existing. This is a truly exceptional example of what compassionate, patient-centred care looks like at its very best. Their work has made a profound difference to this patient's life, and I cannot think of a more deserving team to receive recognition. These four remarkable professionals deserve a Star Award for this outstanding achievement and for embodying everything that excellent care should be.

Nomination 3

The care and dedication demonstrated in supporting this young patient's recovery have been truly outstanding. Upon admission, the patient was in an extremely neglected and vulnerable state - unable to move, to tolerate sensory input such as light or touch, or manage even the most basic aspects of personal care. They had not washed, dressed, or engaged with the outside world for several years and had remained confined to bed, unable to cope with any physical or environmental stimuli.

Through unwavering commitment, compassion, and patience, Marina Platts, Sarah Taylor, Jodie Young, and Bev Chapson-Walker have provided exceptional support tailored to both the patient's functional and cognitive needs. Their approach has been deeply person-centred, focusing not only on physical recovery but also on rebuilding trust, confidence, and tolerance to the world around them. They have taken the time to develop a meaningful rapport, advocating consistently for the patient and introducing gradual, carefully paced interventions. These included helping the patient begin to tolerate clothing, light, touch, and essential care equipment such as slings and hoists.

Their efforts extended beyond the clinical setting - supporting the patient to re-engage with everyday life, including trips to the shop to choose personal care items, empowering them with choice and independence. Over the course of weeks, their dedication has led to remarkable progress. The patient is now able to wear clothes, engage in personal hygiene, including showering, and has recently transitioned into a shared bay environment. These achievements, which many may take for granted, represent life-changing milestones for this individual.

The team's unwavering support, kindness, and belief in the patient's potential have laid a strong foundation for continued recovery. Their work exemplifies the very best of compassionate care, and it is clear that, thanks to their efforts, this patient's journey will continue to progress from strength to strength.

Dawn Banks, Associate Practitioner | **Community** | **Nominated by colleague**

I have nominated Dawn for a Star Award in recognition of all her hard work since joining our team. It has been a pleasure to observe her passion and enthusiasm for the speciality. Nothing has been too much trouble. She has embraced everything she has been asked to undertake and has managed to do it well and with a smile! She has shown great flexibility when requested to cover the service and has made a fantastic achievement in reducing the continence waiting list so quickly and efficiently. She is a credit to our team.

Children's Therapy Occupational Therapy Team | **Scarborough** | **Nominated by colleague**

I'd like to nominate the SWR Children's Occupational Therapy Team for a Star Award in recognition of the amazing work they do every day. They are a very small team working across a huge area – Scarborough, Whitby, and Ryedale – and are currently managing significant demand on the service. Despite this, they continue to show real commitment to delivering the best possible support for children and young people, always keeping them at the centre of their work.

Over the last few months, the team has worked incredibly hard and took on a full caseload cleanse, which is no small task, and used it as an opportunity to really reflect on how they work and look at better use of universal, targeted, and specialist interventions, helping them to support more families in a more effective way. They've also introduced PIFU, which has helped empower parents and carers to feel more confident and involved in their child's journey.

What really stands out is how the team has managed all of this while still providing a caring, supportive, and child-focused service. Their teamwork, positivity, and willingness to adapt under pressure are genuinely impressive. They truly deserve recognition for the difference they are making.

Zoe Dunning, Medical Secretary, and Megan Emmott, Medical Secretary | **York** | **Nominated by colleague**

Despite working in a very busy, fast-paced department with ongoing staffing pressures, Zoe and Megan were tasked with updating and creating the Ophthalmology Admin Team's SOPs. They worked tirelessly and collaboratively, completing the full set within two weeks while maintaining their usual workloads and supporting the wider team.

Following review by central managers, the SOPs were approved and recognised as gold standard. This is a significant achievement and has resulted in a clear, standardised training resource for the Ophthalmology Admin Teams. Zoe and Megan's hard work and attention to detail deserve recognition, and they should be celebrated in the Star Awards.

Medicine Care Group Admin Team **York** **Nominated by colleague**

This small team of three has worked one team member down on several occasions in the past months, for extended periods of time. They have covered the work for each other, picking up all tasks and delivering them to the same high standard as when there are three of them doing the work.

They have ensured the service provided to the Care Group has continued smoothly and gone above and beyond to achieve this at times. They have been flexible in their availability, changing leave at short notice to accommodate the needs of the service without hesitation or complaint. They demonstrate kindness daily to each other and those they work for, and excellence through the standard of work they provide. I am very proud of them and grateful for their support of me and each other.

Adam Spray, General Manager **York** **Nominated by colleague**

I am a Specialty Doctor in General Surgery, and I have worked in three healthcare systems - Sri Lanka, Pakistan, and the United Kingdom. The NHS is my third. When I made the decision to move to the UK with my husband in 2019, my guiding vision was learning and growth. As I started my fifth year in the NHS (three years in Hull and now my second year in York), I faced the most challenging period of my career. A culmination of many factors led me, as a clinician, to make a difficult but necessary decision to step away from work for my own safety and wellbeing.

By this time, I already knew Adam as my manager. I understood his role within the department, and I knew he was a true professional. He was the first person I called. Throughout my journey to return to work, Adam supported me at every step - at times single-handedly. His involvement was essential in ensuring that processes moved forward during what was an extremely uncertain and vulnerable period for me.

I am now in the third week of my phased return, and although it still has its challenges, I can come back to the workplace, log in, and feel hopeful. I feel that this return is sustainable and aligned with my core values of learning and growth, now strengthened by a deeper appreciation of safety. What inspires me most about Adam is the standard of professionalism he upheld. Even when he went on sick leave himself, he ensured that every document, every piece of communication, and every step of the process was handed over to me and continued smoothly. His commitment never wavered.

Across the three healthcare systems I have experienced, I see a common thread: we live in a time where problems are identified, and countless tools, resources, and systems are available. Yet the true answer, the one that makes the real difference, is human values. That is something no technology can ever fully replicate. Adam embodies those values. On a personal note, to him: Thank you, and please take care.

Juniper Ward **Scarborough** **Nominated by colleague**

I am consistently impressed by the kindness and dedication displayed by colleagues on Juniper Ward, particularly when caring for people at the end-of-life. We frequently facilitate fast-track discharges for patients who wish to be cared for at home at the end-of-life. Whether that means oxygen needs ordering, medications reviewed, or complex conversations held, I am so impressed that the whole team (with support from Discharge Hub and Palliative Care) can come together to ensure this happens.

For those patients who are remaining on the ward for end-of-life care, I am touched by the kindness that everybody shows to patients. From having a chat whilst cleaning a patient's room or supporting the Autumn Room project, to escalating concerns about symptoms so they can be rapidly reviewed or to sitting down with family members to explain what is happening, the team makes a real difference to patients and their loved ones in so many ways.

Thank you to all colleagues on Juniper Ward, as well as those in Palliative Care, the Pharmacy Team, and Toni from the Discharge Hub, for helping with recent end-of-life discharges. Thank you to everybody who contributes to a culture of kindness. It is wonderful to work with you all. Be proud of the difference you make.

Acute Oncology Team **Scarborough** **Nominated by colleague**

The Acute Oncology Team make a massive difference to patients living with cancer in our community. I have frequently had to contact Acute Oncology for support when treating patients experiencing serious complications, including neutropenic sepsis and metastatic spinal cord compression. Despite severe staffing pressures, the team is consistently professional and patient-centred.

The team ensures that clinicians on the wards can access accurate information about patients' cancer diagnoses (as often patients' records are held by Hull or other tertiary centres) and ensure that patients' oncologists are made aware of their condition. The team help facilitate emergency treatment and urgent radiotherapy. Additionally, team members are consistently patient-centred and provide emotional support and symptom management alongside urgent care and recognise if the impact of chemotherapy or radiotherapy is becoming too burdensome for a patient.

I am so impressed by the team and have learnt such a lot from my encounters with them whilst working on Juniper Ward. Patients speak highly of the team and the support that they access in the community via the phone line. During scary times, patients appreciate the compassion and professionalism that the Acute Oncology Team bring. Thank you for the difference you make.

Faye Ollis, Head of Clinical Coding **York** **Nominated by colleague**

I sat two exams at York Hospital – a three-hour paper in the morning and a three-hour paper in the afternoon. A personal unprecedented and unfortunate event happened during the morning exam. Faye approached the room, intending to inform me of the bad news. I asked her if she could wait until I finished the remaining questions, not realising the seriousness of what she needed to tell me. In that moment, she made a deeply compassionate decision: she chose to protect my focus and emotional state so that I could complete the exam I had worked so hard for.

Faye waited until after I had finished the afternoon theory exam before sharing the bad news. She did not want to burden me with distress that might affect my performance. Her kindness, her sensitivity, and her compassion in such a critical moment are something I will always remember. It was an act of humanity and care that will stay with me for the rest of my life. I believe Faye deserves more than this Star Award.

Phoebe Baines, Mental Health Support Administrator **York** **Nominated by colleague**

I would like to nominate Phoebe for a Star Award in recognition of her outstanding contribution and unwavering support to our team. Phoebe currently balances three roles across the Iris Team, Amethyst Team, and Birth Reflections, consistently demonstrating the Trust values in everything she does. She brings enthusiasm, a willingness to learn, and a positive attitude that has a meaningful impact on those around her. Phoebe is always ready to help and is a reliable, supportive presence within the team. Her contribution is truly invaluable, and she plays a significant role in supporting us all.

Phoebe went above and beyond to support me during the remembrance service at York Hospital on Mother's Day. She gave up her own time, on a very personal day for her, to ensure the service ran smoothly, while also taking the time to check in on my wellbeing. This level of compassion and dedication speaks volumes about her character. Phoebe, thank you for all your hard work. We recognise how busy you are and deeply appreciate everything you do for us. Your efforts do not go unnoticed, and we are incredibly grateful to have you as part of our team.

Katherine Wray-Eccles, Bereavement Specialist Midwife **York** **Nominated by colleague**

I have nominated Katherine for a Star Award as she is truly exceptional, and we are incredibly fortunate to have her as part of our team. Katherine recently joined our Bereavement Midwife (Iris) Team and, in a short space of time, has made a remarkable impact. Since her arrival, we have managed several highly complex and emotionally challenging cases. Despite being new to the role, she has fully immersed herself in the team and consistently demonstrates the Trust values of being kind, open, and honest.

Katherine brings enthusiasm, compassion, and a strong desire to learn. She provides outstanding care to bereaved families during some of the most difficult times of their lives, always placing them at the centre of everything she does. Her calm, sensitive, and thoughtful approach ensures families feel supported, listened to, and cared for. She has also been an incredible support to me personally, assisting with training, contributing to patient information leaflets, and supporting the ongoing development of the service. Katherine is continually learning and always goes the extra mile to ensure the care we provide is of the highest possible standard. She has truly been a breath of fresh air within our team.

There are two main reasons why I wanted to nominate Katherine. First, as a new Bereavement Midwife, she has taken the lead on an exceptionally complex case involving multiple members of the multidisciplinary team. While I have supported her throughout, Katherine has carried the day-to-day responsibility for over four weeks, and the case is still ongoing. The care, compassion, patience, and time she has dedicated to this family have been truly outstanding.

Secondly, when Katherine joined the team, we identified a need for additional bereavement equipment for our Snowdrop Suite at Scarborough Hospital. Katherine took the initiative to organise and lead a fundraising event, raising a significant amount of money. This will directly benefit our bereaved families and make a meaningful difference to the care and environment we can provide. I cannot thank her enough for the time, effort, and dedication she put into making this happen.

Katherine’s contribution to the team has been invaluable, and I can honestly say I do not know what we would do without her. Thank you, Katherine, for your hard work and daily support. You are a true asset to our team. Even during the most challenging times, you uplift those around you, and I am so grateful for everything you bring.

Lucy Powers, Bed Manager, Liam Coxon, Clinical Support Worker, Chris Harris, Porter, Connor Owston, Porter, John Calvert, Porter, Mercedes Gamble, Domestic Team Leader, and Hayley Potts, Cleaning Operative	**York**	**Nominated by colleague**

On Friday, at approximately 12.20am, we had an incident at the main entrance at York Hospital where a gentleman had made his way to the front door and collapsed against the front door. Liam Coxon and Lucy Powers managed to force the door open to find the man had been stabbed and was bleeding quite a lot. In the meantime, Chris Harris had gone for gloves and a blanket. Connor Owston and Jonny Calvert were assisting under Liam's and Lucy's instructions on how to help to get this gentleman to the ED. Then, Mercedes Gamble and Hayley Potts were on hand to clean up afterwards. I am led to believe this gentleman is now recovering.

Phoebe Plant, Screening Manager & Junior ROG, Emma Precious, Martin Whipp, Retinal Screener/Grader Team leader, Jack Tansley, Retinal Eye Screener, and Joanne Booth, Administrative Team Leader	**York**	**Nominated by colleague**

On Saturdays, our team runs multiple clinics at Selby Hospital to screen patients for diabetic eye disease. Frequently, patients may not be suitable for fundus photography. Where possible, we will screen, grade, and move patients to have their slit lamp examination done on the same day, which saves patients from returning in three months for another appointment. This is a team effort.

Jack and Emma first performed routine screening and detected that a patient had cataracts and, therefore, was not suitable for fundus photography. Emma spoke with the rest of the team, and we all agreed to work together to grade the patient and transfer to a slit lamp appointment (done by Phoebe). Joanne, as admin manager, then rebooked the patient onto the slit lamp clinic for the same day, where Martin examined the patient. This saved her from having to arrange transport to return for a future appointment.

Both clinics were full, and this process can be time-consuming, but with the patient’s best interests in mind, the team pulled together to provide the best care and outcome for the patient, as well as keeping both clinics running smoothly for other patients.

Lara Allen, Patient Admin Officer | **York** | **Nominated by colleague**

Lara has made an amazing addition to the team, and she has picked up the role quickly. She always has a positive attitude and is a joy to work with. She is hard-working, flexible, and happy to tackle any challenge given to her.

Rob Turnbull, Medical Education Technology Assistant, Lucy Glanfield, Consultant in Emergency Medicine, Zoe Whiting, Associate Educator - Healthcare Support Worker, Amy Watson, Clinical Educator, Rebecca Calpin, Theatre Practitioner, Alexandra Clark, Theatre Team Leader ODP, and Lucy Coates, Senior Healthcare Assistant | **York** | **Nominated by colleague**

For over two years, the Staff Psychology Service has been needing to create a training video for use in Post Event Pathway training, for colleagues across the Trust. This group of dedicated people helped us to finally create this video, allowing us to demonstrate a mock Post Event Check-In. They each gave us their time and expertise, bringing validity and authenticity to the video, which will have an indirect impact on many colleagues across the Trust.

Their courage to act in front of a camera, despite nerves, showed their dedication to promoting excellent practice and kindness and compassion to fellow colleagues, along with being open about their own experiences on the frontline. A massive thank you to them all - what a group of stars!

Bethany Greaves, Recruitment Advisor **York Hospital** **Nominated by colleague**

When relocating to a new role thousands of miles away from home, uncertainty and anxiety are inevitable. From the moment we arrived in 2023 to the present day, Beth has been nothing short of exceptional. She played a pivotal role in helping us settle—not only into the Trust, but into life in a new country. From supporting us with house hunting to even acting as a guarantor when needed, her kindness and generosity have gone far beyond expectations. Beth is the kind of person you can always turn to, no matter the issue. She consistently offers guidance and ensures you are signposted to the right support or solution. Her approachability, reliability, and genuine care for others make a lasting difference to everyone around her.

Although this nomination comes from me, it reflects a sentiment shared by every international nurse I have spoken to. Beth's support has had a wide-reaching and deeply positive impact on so many of us. In fact, her kindness and reassurance are among the reasons some international nurses choose to remain within the Trust. She creates a sense of safety and belonging, making people feel valued and supported during what can otherwise be an overwhelming transition.

If there is one individual who truly embodies the Trust's values in their entirety, it is Beth. Her impact is both profound and enduring, and she is thoroughly deserving of this recognition.

Intravitreal Injection Team **Community** **Nominated by colleague**

The Intravitreal Injection Team at York Community Stadium provide sight-saving eye injections for patients with Wet Macular Degeneration (Wet AMD) and other conditions affecting the retina. In the year January 2025 to January 2026, this small team completed 19,093 injections without a single proven post-injection infection. The national rate of infection following an eye injection is around 1 in 2000.

This shows the diligence and skill with which the Stadium injection team go about their work, all while ensuring patients have the best experience possible through what can be an anxiety-inducing procedure. These stats are amazing, and both injectors themselves (largely nurses and allied health professionals) and their support teams (healthcare support workers) are a credit to their department and the Trust. Keep up your amazing work!

Johanna Stones, Midwife **Bridlington** **Nominated by colleague**

I would like to nominate Jo for a Star Award for her amazing support as a Professional Midwifery Advocate (PMA). Jo has supported me on many occasions as a PMA and has gone above and beyond to provide support, care, and reassurance through challenging experiences. Jo is always so kind and caring, providing a friendly face whenever it's needed. She goes the extra mile to make others feel seen, heard, and supported.

From my own experience, words can't describe how amazing she was and how much she helped me through challenging situations. Thank you so much, Jo, for everything you do and the difference you make to those around you.

Nick Griffiths, Security Officer, Mark Carson, Security Officer, and James Smith, Security Officer | **Scarborough** | **Nominated by colleague**

I am nominating Nick Griffiths, Mark Carson, and James Smith for the care they showed to an elderly female who was distressed when her vehicle rolled into another one whilst she was visiting Scarborough. They showed great kindness and compassion in settling her and aiding her to leave the hospital safely once she had returned to her vehicle.

Chris Williams, Anatomical Pathology Technician | **Scarborough** | **Nominated by colleague**

When a patient loses their baby (under 14 weeks) and wants the baby returned to them, Chris prepares the baby/pregnancy tissue for us to collect, so we can then meet with the parents and give this to them. For years, we had to put this in tissue paper and a small envelope (this is all we had available at the time). Around eight years ago, Chris started to wrap this in the mortuary in a nice little package and put it in a sleeping bag and then a tiny wooden box.

I have decided to nominate Chris for a Star Award because he does this without question and maybe doesn't realise how much this has changed and improved the journey for the patient. People appreciate it, and it is much nicer for them to collect. We would like Chris to know that we appreciate all his help. These people are the ones who are in the background and don't often get the recognition that they deserve. From all the EPAU staff in Scarborough.

Claire Le Bourhis, Midwife | **York** | **Nominated by colleague**

Claire was working her usual shift when maternity triage was contacted by another NHS Trust about a woman who needed urgent antenatal care.

Recognising a potential language barrier, Claire - who speaks the woman’s first language - kindly made initial contact to offer reassurance and support her to attend. She then gave up her break, with colleagues covering her workload, to accompany her in the antenatal day unit and assist with communication during urgent assessments. As the situation developed, it became clear that a full antenatal booking was also needed. Without hesitation, Claire stayed nearly two hours beyond her shift to support this.

Claire’s presence made a significant difference. Her ability to communicate directly helped ensure the woman felt comfortable and understood, while enabling the team to provide timely, personalised care. Throughout, Claire demonstrated exceptional kindness, dedication and teamwork. She went above and beyond for both the patient and her colleagues, and her contribution had a genuinely positive impact on the care provided.

Aaqid Akram, ST3-ST8 Anaesthetics | **York** | **Nominated by colleague**

Aaqid always goes above and beyond for junior members of the team, providing support and teaching. He has a calm manner while teaching, allowing junior colleagues to build confidence. He also has an excellent bedside manner with patients, with multiple patients verbally reporting how he has improved their care and made them feel safer during their procedure.

OPAT Team **Scarborough** **Nominated by colleague**

Working on Juniper Ward, I encounter many patients with complex infections. Many of these patients are living with other life-limiting conditions and are often fed up with bouncing in and out of hospital. For these patients, the OPAT team provide an invaluable service, allowing them to go home with outpatient antibiotic follow-up.

I would like to thank the OPAT team for their help and support with recent referrals. I would also like to thank Dr Hamilton (Consultant in Microbiology). I really appreciate his thoughtful advice for complex patients and for explaining the rationale behind antibiotic choices (and for being patient when I ask questions for my learning). Dr Hamilton recently arranged an OPAT follow-up for a complex patient with recurrent meningitis, and it was reassuring to know that he had that safety-net for support. Thank you all for the difference you make.

Acute Medical Unit **York** **Nominated by colleague**

I am a student paramedic who was put on placement on the AMU at York Hospital for two weeks. Prior to starting, I was anxious, but I was immediately made to feel so welcomed by all the nurses who took the time to explain everything I needed to know. All the nurses and support workers are a credit to the profession.

Nicky Richards, Ward Sister **Scarborough** **Nominated by colleague**

Nicky is an inspiration. She always welcomes new colleagues on the ward with compassion and patience. Her management skills are underrated, and she always goes that extra mile to support her colleagues and the families of her patients. I had to leave due to ill health, and Nicky has supported me through the whole process. She still checks in on me today. Nicky is a nurse I would aspire to be like. Her care and compassion have no boundaries, and I think she deserves to be nominated for a Star Award.

Olivia Elliott, Patient Services Assistant **York** **Nominated by colleagues**

Liv is an incredible member of staff and a lovely new addition to the Haematology and Oncology inpatient unit. She goes the extra mile for all our patients. Nothing is ever too much for her - she pops to the shop for our patients, sits with them individually, and ensures everyone feels heard and validated. She surprised all the patients on the ward with an Easter egg each this weekend.

When Liv is on the ward, the mood of colleagues and patients is always uplifted - she has a bubbly and positive personality and is such an asset to the team. She is always looking for things to do and ways to help colleagues on the ward - even when it isn't within her job role. She has learned so much in the short time that she has been on the ward and is always proactive towards learning opportunities! We feel very lucky to have such a dedicated and deserves to be recognised!

Hope Christie, Occupational Therapist | **York** | **Nominated by colleague**

Hope has recently joined our team on ward 24 as a newly qualified occupational therapist and is thriving in her role. Her positive working attitude is a breath of fresh air, and her hard work and contributions within the team do not go unnoticed. Hope is kind, caring, and considerate and is always willing to help others. She is an asset to our team.

Emma Robinson, Deputy Sister | **York** | **Nominated by colleague**

Emma has gone out of her way to make sure palliative patients receive the best possible care. She goes the extra mile for families and goes beyond excellence and kindness. She gives each patient at the end of their life a blanket which are homemade and funded by herself to ensure that they are the most comfortable and that their families have something to take once their family member has passed away. She also provides hearts, one for the patient and one for the family member, so that when the patient dies, they're never separated because they have a heart each.

Emma goes out of her way to spend time with families during a difficult time. She sits with them and asks questions about the person as she feels it's incredibly important to remember the person they are and were. There have been many times she has left a shift late just so she can offer that extra dose of kindness before she goes home. She truly believes that the end of a patient's life is as special as the beginning, and she carries each patient with care and kindness and ensures the team prioritises the family as well as the patient.

I feel so lucky to have started my first year of nursing with her guidance and expertise. Her passion for palliative care is something every family that has been lucky enough to have her at the bedside of their family member will remember for the rest of their lives.

Lynsey Hamer, Clinical Skills Educator | **York** | **Nominated by colleague**

Lynsey joined the Trust as Lead Paediatric Educator and has embraced the role with enthusiasm and drive. She approaches every challenge with determination and commitment, demonstrating a strong 'can-do' attitude. Lynsey consistently delivers and exceeds expectations in all aspects of her work. She has settled into the role quickly and is respected by her colleagues.

Beth Loseby, Breast Imaging Admin Manager **York** **Nominated by colleague**

Beth recently went above and beyond for a patient and made their experience visiting the hospital a positive one. The patient arrived at the Breast Imaging Unit reception for an appointment. They were blind and informed Beth that they hadn't been for an appointment within the department since before they lost their sight. Beth checked the patient's details and realised they were in the wrong location and that their appointment was elsewhere within the Unit, but rather than cause more confusion and distress for the patient by informing them of this, Beth spoke with her colleagues and immediately arranged for the patient to be seen in the Breast Imaging Unit.

After the appointment, Beth sat with the patient and arranged a taxi to come and collect them, and she then escorted the patient all the way through the hospital to the main entrance and waited with the patient until their taxi arrived. Beth's role isn't usually patient-facing, but she chose to put aside her own work to assist this patient and made sure they had a constant, friendly presence throughout their whole appointment during what could have been an incredibly confusing and stressful experience. Beth consistently lives by the Trust values, and occasions like this highlight just how much of an asset she is to our organisation.

Grace Taylor, Staff Nurse **York** **Nominated by colleague**

As the Learning Environment Manager (LEM) for the unit, Grace consistently goes above and beyond to support students, creating a positive, inclusive, and highly supportive learning environment. She is approachable and makes students feel a part of the team, making this one of the only placements that has greatly enhanced my confidence and development. Grace never hesitates to support me with a learning opportunity, guiding me through the process and encouraging me to meet my goals. She meets the standards of an LEM, making me feel welcome and showing kindness while remaining professional. I feel comfortable talking to Grace about anything that makes me feel anxious, and, without hesitation, she provides reassurance, easing the situation.

Caroline Cushen, Healthcare Support Worker **York** **Nominated by colleague**

Caroline has been supportive of a complex patient. She has supported this patient to attend appointments and to return for investigations within our department and in Radiology. Caroline has given her time willingly to support this patient. While I have not spoken to the patient specifically about this nomination, the patient has also expressed their grateful thanks to Caroline and that they would not have attended these appointments without Caroline being there to support them at a difficult time. Caroline embodies the Trust values in all aspects of her work, but especially when caring for this patient.

Maisie Luckhurst, Outpatient Services Administrator **York** **Nominated by colleague**

Maisie has been exceptional in training a team member who has been on long-term sick leave. Her patience and kindness do not go unnoticed. One afternoon, she was training two colleagues on two different tasks, but took it all in her stride. She really shows our Trust values in everything she does.

Eva Dsouza, Outpatient Services Administrator **York** **Nominated by colleague**

Eva is incredible at everything she does. She will change tasks at a moment's notice and adapts to whatever the service needs. She is also the trainer in our office and will train members of the team whilst also working on other tasks. Her work is amazing, and she's always there to help anyone with patience and kindness. Eva is an asset to our team and this hospital, and this doesn't go unnoticed.

Audiology **York** **Nominated by colleague**

I would like to nominate the Audiology team for their outstanding support and patient-centred care. A patient was transferred to a rehabilitation hospital to review and progress his mobility. Unfortunately, during his stay, his hearing aid was misplaced, leaving him unable to communicate effectively with staff. This significantly impacted his ability to understand instructions and engage with his rehabilitation. The patient also lives with dementia, and the sudden loss of hearing made his cognitive impairment appear more advanced, causing understandable distress and frustration for both him and his family.

Recognising the profound effect this was having on his wellbeing and rehabilitation progress, I contacted the Audiology department to explore whether any temporary support could be provided while the family attempted to resolve the issue. The response from Audiology was exceptional. They promptly arranged a temporary hearing solution and confirmed that the patient was already registered on their system for hearing aid replacement. Understanding the urgency, they placed a priority order, ensuring a replacement hearing aid was delivered within just one week.

Hearing is one of the most critical senses, particularly for individuals living with dementia, where sensory impairment can significantly worsen cognitive function and communication. The Audiology Team’s efficiency, empathy, and clinical insight played a vital role in preserving the patient’s current cognitive ability, restoring meaningful communication, and enabling him to once again participate in his essential rehabilitation. Their actions helped prevent further deconditioning and greatly reduced distress for both the patient and his family. This level of responsiveness and understanding exemplifies outstanding care and truly highlights the positive impact Audiology has on patient outcomes.

Nicola Lockwood, Head of Children's Nursing **York** **Nominated by colleague**

Nicola has driven improvements in standards, ensuring that PILs and policies remain current and up to date. She introduced regular meetings to prevent policies from lapsing, while strengthening staff ownership and accountability. These meetings provide colleagues with the opportunity to present and review their work in a supportive, collaborative environment, where ideas can be explored collectively. Nicola consistently maintains a positive and enthusiastic approach, helping to enhance engagement and productivity. The meetings have proven successful, with an effective system now in place that promotes best practice and strengthens governance.

Claire Brown, Simon East, Laura Atkinson, and Richard Bond, Surgical Care Practitioners | **York** | **Nominated by colleague**

Surgical care practitioners should be recognised with a Star award for their exceptional commitment throughout all 15 strike periods, during which they consistently went above and beyond to maintain safe, high-quality patient care. Despite increased pressure, uncertainty, and extended demands on their roles, they demonstrated professionalism, adaptability, and unwavering dedication to their patients and colleagues.

Their willingness to step up, support surgical services, and ensure continuity of care during such a challenging time reflects the very highest standards of the profession and makes them truly deserving of this recognition.

Spencer Pelucci, Mechanical Services Supervisor | **Scarborough** | **Nominated by colleague**

Spencer has worked above and beyond over the last few months. He has supported the core services of the Mechanical Team by covering for a colleague while he was off for an extended period. While already stepping up to support the department, Spencer also kept on top of his own responsibilities and delivered two complex oxygen shutdowns to make the infrastructure at Scarborough more resilient.

The work he has done has helped to make the system more compliant and resilient and will help safeguard patients for the coming decades. Spencer has gone above and beyond in the spirit of the Trust values, demonstrating kindness for others and excellence in his practice.

EAU/SDEC **York** **Nominated by colleague**

I am nominating my team for a Star Award in recognition of the outstanding commitment, teamwork, and dedication they have shown over the past month. One month ago, I was asked to lead the development of the new EAU area at York Hospital, with little time available for planning. I shared my vision with the team, and they have worked tirelessly to turn that vision into a reality. This has not been an easy task, and notably, this is the third new area my team has been asked to help set up and work within. Despite this, every challenge has been met with positivity, resilience, and professionalism.

What makes this achievement truly remarkable is how naturally the team embraced the challenge. They simply took it in their stride and ran with it, ensuring the area became operational and successful in a short time. Their adaptability and motivation have been exceptional. This success would not have been possible without the teamwork of every single staff member involved, including ward clerks, patient service assistants, domestics, porters, healthcare support workers, nurses, matrons, doctors, consultants, our Head of Nursing, and the Operations team. Everyone has played a vital role, and together they have achieved incredible results in the first few weeks of this new service.

Alongside the successful launch of the new EAU area, the team has continued to keep SDEC operating, all while seeing record numbers of patients. Managing this workload safely and effectively is an outstanding achievement and demonstrates their unwavering commitment to patient care. No matter what has been asked of them, the team has risen to every challenge, always doing their very best and consistently keeping the patient at the centre of everything they do. I could not be prouder of my team or more grateful for their dedication, teamwork, and professionalism. They truly exemplify the Trust values and are incredibly deserving of recognition.

Karen McPherson, Healthcare Support Worker **Scarborough** **Nominated by colleague**

I would like to express my thanks and gratitude to Karen for going above and beyond to support the safe running of clinics over the last few months. In the face of significant staffing pressures, Karen has been such a fantastic support in ensuring our services continue to operate smoothly and efficiently. Changing your plans at short notice and swapping shifts, annual leave, and days off to accommodate existing and additional clinics is truly recognised and hugely appreciated. Thank you.

Gail Tindall, Healthcare Support Worker **Scarborough** **Nominated by colleague**

I would like to express my thanks and gratitude to Gail for going above and beyond to support the safe running of clinics over the last few months. In the face of significant staffing pressures, Gail has been such a fantastic support in ensuring our services continue to operate smoothly and efficiently. Changing your plans at short notice and swapping shifts, annual leave, and days off to accommodate existing and additional clinics is truly recognised and hugely appreciated. Thank you.

Amanda Norris, Orthopaedic Practitioner **York** **Nominated by colleague**

Late afternoon, a colleague and I (physios) were bleeped and asked to review a day surgery patient and apply an Aircast boot with three wedges. We tried many different wards and were unable to find the appropriate boot and heel wedges. We eventually tried orthopaedic outpatients, where we came across Amanda, who offered to assist. Amanda took us to her storerooms and showed us the boot with heel wedges. Understanding we had not come across this type of boot before, Amanda offered to take time out of her afternoon and come to see the patient with us on day surgery. She did this and helped the patient be discharged home that day.

Amanda saw that we were rushed and offered to help by assisting us with a patient. She also took the time to educate us on this boot and how to fit it correctly with heel wedges. Thank you, Amanda!

Kiran Ali, Deputy Sister **York** **Nominated by colleague**

Due to staffing challenges, Kiran has supported Children's Clinic in Scarborough by undertaking a nurse-led clinic requiring her specialist skill set. This kind gesture has benefitted patients in the Scarborough area, enabling them to receive their treatment in a timely manner. Thank you.

Annabel Waterman, Operating Department Practitioner, and John Mensah, Consultant in Anaesthetics **Scarborough** **Nominated by patient**

Annabelle and Dr Mensah could see I was nervous as I had never been in a hospital before. They quickly calmed my nerves. Dr Mensah came to see me on Haldane Ward, where I mentioned I was nervous, and he had a little singsong with me and spoke about his life and asked what I do, which made me feel very calm. He has an energetic personality, and you can really tell he loves his job.

I met Annabel down in the theatre, where she was super calm, which instantly made me feel calm. She was amazing at what she does. She kept me chatting, which distracted me while the canula went into the back of my hand. She asked me questions about myself and what I like to do in my free time. Both Dr Mensah and Annabel were an absolute pleasure to meet, and if I were to come back in for any type of surgery again, I know I would be in the best possible hands. You can tell how much they enjoy their job.

Meghan Hodgson, Healthcare Assistant **Scarborough** **Nominated by patient**

Meg was looking after me on Oak Ward for two night shifts, and despite it being busy, stressful, and chaotic, she managed to keep a smile on her face and just kept going. Bright and cheerful in every conversation and encounter I had with her and always keeping me laughing. A real shining star. She was also patient with a confused lady in the bed next to me and had more than enough time for her.

Keith Wu, Consultant in Dermatology **York** **Nominated by patient**

Dr Wu has listened to me and understood my skin problems. They have gone above and beyond what any other specialist has done.

Sarah Katsarelis, Medical Secretary **York** **Nominated by patient**

I am a patient who regularly attends the eye clinic and recently had a couple of issues. Sarah always replies to my emails in a timely manner. She understands my concerns and will seek advice from the consultant and feed this back to me. It is reassuring as a patient to know someone will take the time to help, whether it be arranging an earlier appointment or sorting a medical query. Thanks again, Sarah. It is much appreciated.

Gladys Jonah-Owen, Staff Nurse **York** **Nominated by patient**

Gladys was lovely and helpful to me when I was on Ward 34. She quietly and diligently got on with her job in a challenging environment. Most of all, she helped me with advice to speed up my discharge. She was part of a great team that also included Laura, Rosie, and so many others.

Alex Ward, Specialist Physiotherapist **York** **Nominated by patient**

Alex was brilliant. She managed to encourage and support me with a balance of humour and sensibility. She visited me on the ward after being discharged from the ICU and came to wish me luck as I was leaving to go to rehabilitation. I have now regained the ability to walk unaided, and as much as I have a fantastic team supporting me now, her words still run through the back of my mind in most sessions! This is a testament to her kindness, patience, and compassion. Thank you, Alex and all the ICU.

Endocrinology **York** **Nominated by patient**

This morning, I was delighted to find out our third IVF transfer was successful. Due to concerns around my thyroid during infertility testing, I am under the care of endocrinology. My IVF clinic asked me to contact the department as my thyroid will need closer monitoring now that I am pregnant.

When I called the same day, the lady who answered at reception was nothing short of delightful. She was kind, congratulatory, and understanding. She was able to get me an appointment the same day due to a cancellation, which was greatly appreciated. She expressed that she completely understood my situation, and it was clear she genuinely cared. In addition, the gentleman who did my blood pressure and weight was also lovely and friendly, as was the consultant I saw in my appointment. What a wonderful team - credit where credit is due!

Coronary Care Unit **York** **Nominated by patient**

I was admitted to the Coronary Care Unit (CCU) on 9 March. I was told I would need a pacemaker, which was quite unexpected for me. The staff on the unit spoke to me in a kind and compassionate way, as I was afraid and unsure of things. They would take the time to talk to me and explain things, and that they were there watching me through the night, which helped me a lot.

Elizabeth was lovely and friendly and brightened up the days she looked after me. Ben, Katie, Sam and all the staff on the CCU were amazing, calm, professional, and empathetic. They made my stay easier and less scary. I would like to say a massive thanks to all of them.

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

I'd like to nominate Helena, a Phlebotomist at York Hospital, for a Star Award because she made such a big difference to my experience. I'm scared of needles, especially blood tests, and it's been something I've been dreading and putting off for the past four weeks. However, Helena was amazing from start to finish.

As soon as I told her how nervous I was, she was so understanding and kind. She talked me through everything step by step, so I knew exactly what was happening, which helped calm me down. While she was taking the blood, she kept chatting to me about other things to distract me, which made it much easier than I expected. Afterwards, I felt a bit dizzy, and she was so patient, letting me sit and take my time until I felt okay again. She also gave me advice on what to do after to help myself feel better - the full-fat Coke was a game-changer!

What might seem like a small, routine thing to some people has been a huge source of anxiety for me, and Helena made it so much more manageable. I genuinely couldn't have asked for a better person that day, and I'm grateful for how supportive she was. She deserves recognition for how she treats her patients - thank you, Helena!

Hysteroscopy Team **York** **Nominated by patient**

I was referred for a hysteroscopy after having an abnormal ultrasound due to post-menopausal bleeding. I am a nurse who works for the Trust, and I have had some previous personal patient experience.

From the beginning, the team was supportive and understanding. They explained everything that was going to happen and talked me through the whole procedure. The healthcare assistant who looked after me ensured that my personal privacy was of utmost importance and offered to get me different gowns from the ward if I wanted. This was an understanding of my needs and anxieties and was not a problem for her. They made me feel comfortable and understood that the procedure can be uncomfortable and painful.

The healthcare assistant held my hand while they inserted my coil and took biopsies, as it was quite uncomfortable having it done. This was even before they knew I worked as a nurse at the Trust. I am not normally an anxious person, but I was nervous beforehand. I have had IUDs fitted previously, and they have been quite traumatic and painful experiences at my previous GP practice. Ailsa Atkinson inserted the coil with minimum pain, and this was a massive relief, which was due to her excellent clinical skills.

The team that looked after me that day made the experience less stressful, and I felt included and supported throughout my visit. I know that people are just doing their job, but for me, the experience made me feel that they deserve recognition for the wonderful work they do.

Marie Lawrence, Healthcare Assistant, and Kennedy Hudson, Staff Nurse **York** **Nominated by patient**

I would like to send a thank you to Kennedy and Marie for the treatment and care I received from them. I was at the ward for several hours to have knee surgery. From the beginning to the end, they were supportive and caring, making me feel calm and looked after. It's truly amazing to see that, regardless of their long hours, they had high energy and a smile to help others. This is why they deserve to be praised and told that they are amazing people. Thank you so much for everything!

Orlagh Mulholland, Consultant in Dermatology, and Dermatology Outpatients **York** **Nominated by patient**

I had a positive interaction with the staff I encountered when undergoing an investigation for skin cancer. Dr Mullholland was friendly and approachable and took the time to listen. I felt confident and appreciated the time given to discuss any concerns.

When having biopsies, I was supported by Tracey and Neets (Anita). They provided a friendly, warm, and supportive service, taking time and not rushing the procedure, as well as giving clear instructions on how to manage the wounds. Both ladies went above and beyond to make me feel comfortable and confident in the service. I appreciated their support.

The reception team were friendly and efficient in their dealings with me.

Matthew White, Senior Healthcare Assistant **York** **Nominated by patient**

I have been visiting the Diabetes department at York for over 23 years and have always had great service and support from the team. However, there is one individual, Matthew, who always goes that extra mile, not only with me, but with everyone he encounters. He is friendly, polite, and supportive of me. He listens and responds with a friendly smile, nothing is too much trouble, and he is happy to help with my queries or questions.

Helene Morton, Midwife **Scarborough** **Nominated by patient**

We had Helene for my whole labour. It wasn't easy, and many things didn't go to plan, but Helene kept me and my birthing partners informed and at ease. She was friendly and kept me calm when I was terrified. She made sure I was always comfortable and knew what was going on.

After my birth in theatre, she looked after me so well and went above and beyond to care for me and my baby. We stayed overnight, and she even came to see me on the ward to check that the baby and I were doing okay. She really made my birth as special as it could be, and I can't thank her enough. She will always have such a special part in the memories of my labour.

Shirley Ross, Midwife **York** **Nominated by patient**

I received outstanding care from Shirley before and after labour! Her support and advice meant everything to me and got me through my anxiety. An amazing midwife and a credit to the profession!

Marybeth Brockway, Midwife **York** **Nominated by patient**

Marybeth stayed with me, from my waters breaking and through my full labour, when she was working on the G2 maternity ward night shift. I was about to give birth alone with just the midwives as my labour progressed fast, and my birthing partners wouldn't make it. Having Marybeth stay with me out of kindness was something I will treasure. She was so supportive, and I can't thank her enough! An amazing birthing partner to have throughout it all! Thank you.

Jawad Freites, Consultant in Gynaecology **York** **Nominated by patient**

I met Mr Freites for the first time last year at my outpatient assessment appointment for gynaecology/urology surgery in Malton. From the outset, I was struck by his reassuring, kind, and open nature when discussing my problems. I left feeling listened to, clear about the surgical option I chose and confident about future surgery. I attended for surgery at York Hospital in March 2026 and was gowned and ready for theatre. Unfortunately, it was cancelled at the last minute. Mr Freites came and told me this in person, and whilst I was disappointed, his personal approach in handling matters was appreciated. These things happen, but it is the way it is handled and communicated that makes the difference, and it did that day. The surgery was rescheduled and thankfully went ahead in April 2026.

I am nominating Mr Freites because, quite frankly, I have never been cared for in such a lovely, kind, thorough, and professional manner. I had total confidence that he would do his utmost for me, whatever the outcome or success would be, and he went beyond all expectations in looking after me. He saw me before and after surgery and said he would aim to personally ring me after I was discharged, which I didn't expect. He rang me at home following my discharge as promised to check on my progress, guide me through my recovery, and reassure me about what to do if I had any problems. This was so appreciated.

Following a few wound concerns, I contacted the Specialist Nurse, Janette, who is also wonderful. She arranged for me to be assessed on the Gynae Assessment Unit. Again, what a fantastic and thorough service. Mr Freites rang me a couple of days later, out of the blue, to say that he had been apprised of matters by his colleagues and to check on my progress. Again, a much-appreciated call, and he guided me on things I needed to do if I had further issues or concerns.

As a patient (and retired nurse and NHS manager in York), I feel so privileged in the way I have been cared for by Mr Freites. His manner, his kindness, his dedication, and professionalism left me feeling so well looked after as an individual, not just a patient, for which I am grateful. He went above and beyond from the outset to post-discharge, and I feel fortunate to have him as my surgeon. While my nomination relates to Mr Freites, I also want to say how excellent the service has been overall. The help from the Specialist Nurse, Janette, has been so good, and again, her personal follow-up, checking on my progress, and guiding me on things to help my recovery were so helpful and useful. Vicky, the Secretary, has been lovely, and having that direct contact number if I needed any advice was reassuring. I appreciate that waiting list management never gets much of a mention, and Alison in the Gynaecology Team was so helpful over the last year. Thank you.

Victoria Finn and Lisa Hemmingway, Urgent Care Practitioners **Malton** **Nominated by patient**

On Monday afternoon, I attended Malton Eye Clinic. My wife was to drive me home, but as we walked back to the car park, she tripped and fell. She cut her head and was disoriented and unable to sit up. I sought help, and Victoria from the Urgent Treatment Centre took charge, reassuring my wife, who at one point passed out.

Victoria was brilliant in the way she took control of the situation in a calm and professional yet caring way. She calmed both me and my wife. She arranged for an ambulance to be summoned, and then she and Lisa (her colleague) treated my wife's facial injuries while carrying out an ECG and other monitoring. I cannot praise Victoria and Lisa enough; they more than fulfilled the ethos of the hospital. They are a credit to their hospital and the NHS. Pass on our grateful thanks.

Day Unit **York** **Nominated by patient**

I spent a morning on the day ward and was impressed with the professional care given to all patients from all team members. Nothing was too much, and their care and compassion were outstanding. They demonstrated caring skills and provided the required information.

Joanne Davey, Midwife **Bridlington** **Nominated by patient**

Over the course of three pregnancies in just 2.5 years, Joanne has gone above and beyond for me, from advocating for me to ensuring the care I needed was met. Joanne has been someone who has supported my physical and mental health throughout all three difficult pregnancies, ensuring all three babies have the best start to life.

During my recent pregnancy, Joanne has been invaluable in ensuring I received the appropriate diagnosis and treatment for gestational pemphigoid. Throughout, she has been a pillar of support emotionally and ensured that medication has been covered correctly and effectively. Even just the emotional support during a painfully difficult time was truly incredible. During a difficult birth and stay in SCBU, Joanne took the time to come see me in the hospital, ensuring I had everything I needed and making sure I was well looked after and comfortable. Postnatally, Joanne has always ensured both me and the babies have been well cared for; however, this last pregnancy, I can't put into words my gratitude for how well cared for, supported, and guided we have been by Joanne during a traumatic and heartbreaking period.

Joanne truly is an incredible lady who I believe is worth her weight in gold for the love, compassion, and care she delivers constantly. Without her, I truly do not know where I would be both physically and mentally. She is such a credit to the NHS, and I shall hold onto her love and compassion for eternity. Thank you.

Gemma Hodge, OPAT Clinical Nurse Specialist **York** **Nominated by patient**

I suffer from memory loss, so if it hadn’t been for the kindness and patience of Gemma, I don’t think I would have survived spinal sceptic arthritis. I was slow to respond to my treatment and felt very low at times. Gemma was informative and could answer all my questions. She was reassuring and was a big factor in my return to health. I am on the last leg now and hope to be infection-free within the next two weeks. I know all this has been a team effort, but Gemma was one of the two nurses who came to my home to administer treatment and were present at the hospital when I was there for my appointments.

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

Tammy is the second of two nurses who I think absolutely deserve this award; there is no choosing between them. I suffer from memory loss, so without Tammy and her kindness and patience, I probably wouldn't have survived spinal sceptic arthritis. I was slow to respond to treatment and felt very low at times. Tammy was open to my questions and always answered them. She showed great patience and gave useful tips on how I could make myself more comfortable with my line. She was a big factor in my return to health. I am almost there now and hope to be infection-free in the next two weeks. I am aware that this is a team effort, but Tammy is one of two nurses who came to my home to administer treatment and were present at the hospital when I was there for my appointments. It was always a joy to see them.

Josie Mewburn, Midwife **Scarborough** **Nominated by patient**

Every time I see Josie, she puts me at ease and makes me feel comfortable and listened to. I was in triage this week due to being unable to feel my baby move, and she made me feel relaxed and stopped me from panicking over it. She organised a growth scan for my peace of mind because I was so unsure, and everything was fine. She didn't once make me feel like I was just being silly. Her kindness genuinely meant a lot at the time.

In 2020, I had my first child during COVID times and had to stay in for three days because she wouldn't take to breastfeeding. If my baby didn't feed in the next few hours, she was going to need a feeding tube. Naturally, this put me into a dark place, feeling like I had already failed my baby, but then Josie came to see me. I don't know whether she could tell I wasn't OK, but she sat on the bed with me and said the words I still hold close to me even to this day, "It does not matter what anyone else thinks. What matters is you and your baby. No one can tell you how to feed your baby, not even a midwife." She encouraged me to give her formula, which my daughter took and wouldn't stop feeding on. She thrived after that.

Josie really did more than she may have even realised at the time, and for that I am forever thankful. It's been a pleasure whenever I've bumped into her with my children; she truly is a credit to the team in Scarborough.

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

Having been admitted to the ED, I was agitated and emotional. As soon as Julie saw me, she went above and beyond to ensure that I was calm. Julie is so pleasant, knowledgeable, and caring. Her interactions with all the patients I heard her dealing with, as well as with me, were so kind. She puts people at their ease and is professional.

I didn't feel like eating because I was upset about being in hospital. Julie made sure that she knew what I liked just to be sure that I would eat something. As I have been in many hospitals during the last couple of years, I have had incredible support from so many amazing NHS staff. Julie is one of the best. She demonstrates all the values of the Trust: kindness, openness, and excellence. I would like Julie to get the recognition she deserves.

Alex Manson, Autism Liaison Practitioner **York** **Nominated by relative**

A parent expressed their sincere appreciation for the exceptional support provided to their autistic child with complex needs during a recent hospital procedure. They highlighted that, from the very beginning, a highly coordinated and anticipatory approach was evident. The child's hospital passport had been clearly communicated to the clinical team, appropriate reasonable adjustments were implemented, and the allocation of a quiet side room significantly reduced sensory overload and anxiety. These measures demonstrated a deliberate, needs-led approach grounded in a strong understanding of autism-specific presentation.

On the day of the procedure, the standard of care delivered was described as exemplary. Staff demonstrated a calm, responsive and attuned manner, and the anaesthesia team provided care that was both clinically effective and sensitive to the child's individual needs. The parent reported that clear, proactive communication had enabled all professionals involved to engage in a consistent, informed, and autism-aware way.

Central to this positive experience was the work of Alex Manson, the Autism Liaison Practitioner, whose ability to translate the child's functional and sensory profile into practical, implementable adjustments was described as highly specialised and instrumental to the successful outcome. Through anticipatory planning, environmental adaptations, and effective coordination across teams, the child was able to participate in the procedure without distress or escalation.

The parent emphasised that this person-centred and child-centred approach has been consistently demonstrated across multiple hospital visits, including a previous procedure, where the same high standard of thoughtful and effective support was provided. They noted that such positive outcomes would have been unlikely without this consistent input. Additionally, practical considerations, such as arranging accessible parking at a critical point in the care pathway, were recognised as meaningful adjustments that reduced stress for the family.

The parent concluded that this experience clearly illustrates the value of Autism Liaison support within acute healthcare settings, demonstrating how well-coordinated, sensory-informed practice can transform the experience and outcomes for autistic children with complex needs and their families. They expressed profound gratitude for the support received, stating that it had a significantly positive impact on their child's overall experience.

Catherine Greenwood, Staff Nurse **Scarborough** **Nominated by relative**

On the evening of Sunday 15 March, I attended the Emergency Department with my 15-year-old daughter who needed some urgent care. Cath always treated her with kindness and dignity, while giving her the treatment she needed. She kept us up to date as much as possible with how long we would need to wait and made sure our stay was as comfortable as possible.

Christine Starr, Staff Nurse **York** **Nominated by relative**

My daughter was admitted to Ward 17 in York Hospital on Friday 27 March. Christine was so kind; first and foremost, she made sure my daughter was comfortable. She showed me around the ward, making sure I knew where everything we might need was. When my daughter was in pain, she dealt with it promptly, making sure it was relieved as quickly as possible. Her kind and caring nature put my daughter at ease, and I am sure the professional way in which Christine works sped up my daughter's recovery. Thank you so much, Christine.

Julia Sulik, Trust Doctor ED **York** **Nominated by relative**

My elderly and very frail father and I had been waiting a while overnight for him to be admitted to SDEC. Julia then called us in, and she was the loveliest person to us. She apologised for our wait and made us feel at ease that she would get my dad in for treatment as soon as possible. Within half an hour, he was X-rayed, in a bed, and had a plan in place.

Julia was amazing; she was the only doctor on in SDEC, and yet she gave us as much time as we needed to ask questions and have things explained to us. We did not feel rushed, and she did not show any sign of stress despite working in stressful conditions. I work for the NHS, and I know how short-staffed places are, but Julia is an absolute credit to York and should be recognised for her hard work, dedication, care, and compassion for the patients.

Steph Williams, Head of Nursing **York** **Nominated by relative**

Steph was outstanding when we were in the ED with my daughter, who had dislocated her knee. We were leaving and had to hold up our daughter's leg as we moved, as the wheelchair didn't hold it up. She was in extreme pain, and we were struggling. Steph clocked us and proceeded to hold Sophie's leg with me and crab walk (crouching) with us all the way outside and to the car. We were then also joined by a helpful paramedic! Steph was calm, empathetic, and kind. It was much appreciated at what was a traumatic time.

Belinda Smale, Nurse Practitioner **York** **Nominated by relative**

My son had hurt his shoulder by falling over while playing football. My son is autistic, and this is his first time (in his memory) of attending the ED. On the drive, he was nervous, telling me that he would not believe doctors if they said he had broken something. I was on high alert for him having a meltdown, as the hospital environment is new in terms of sights, smells, noise, and procedures. I was worried how he would respond to staff who would need to give him instructions, as he has a demand avoidant profile.

Thankfully, we were met by Belinda, who had the perfect approach to my son. I'm not sure if she knew he was autistic from his file, could tell from his behaviour, or if that is just her approach to all young people. Belinda was straight-talking to him and made sure she addressed him first. She used a playful approach while explaining in detail how his shoulder and muscles worked, which helped with explaining why he was in pain. Belinda sent him for an X-ray, which confirmed his shoulder was broken, and took his phone to take a photo of the X-ray. This helped him to understand what had happened, and he accepted this immediately, which surprised me! Belinda was again humorous but clear with my son about what he needed to avoid doing, and what he needed to do exercise-wise to help with his healing.

Belinda was approachable and made the experience as smooth for my son as I could have hoped. It can be incredibly difficult for neurodiverse children to cope with new surroundings, and hospitals and their machinery can feel scary. I am confident that neurodiverse children in York will have the best experience possible with staff like Belinda. I am so grateful for how she treated my son. She would be a worthy recipient of the Star award, as that is exactly what she is - a star!

Matthew Pepworth, Associate Practitioner **Scarborough** **Nominated by relative**

Matt was helpful and put my mum at ease while in Lilac Ward at Scarborough Hospital. She was worried about what was happening and the operation. Matt always showed excellent care and compassion, as well as the Trust's values, while caring for her.

Sherrie France, Healthcare Support Worker **Scarborough** **Nominated by relative**

Sherrie was amazing with the patients who were on the bay. My mum was moved onto the ward late Thursday evening, and Sherrie listened to our concerns and was empathetic. She looked after my mum, treating her as an individual in a person-centred way.

I have noticed that Sherrie works in a person-centred way and treats every patient with respect and dignity. Nothing is too much trouble for her and will help with anything. She works very hard. I wanted some answers to some questions about my relative’s illness, and she was open and honest with her answers, which I appreciated so much. She is an asset to this ward.

Ama Agyepong, Staff Nurse **York** **Nominated by relative**

Ama attended to my child promptly when he was crying with an earache. They made him comfortable and calm straightaway. My child started feeling better soon after. We did not need to see the doctor as my child was feeling better, and the nurse went above and beyond to help us.

Multidisciplinary Team **York** **Nominated by relative**

I would like to nominate the following individuals and teams for a Star Award in recognition of the outstanding care provided to my son during his dental surgery at York Hospital: the Security Team, Dawn (GA Lead), the anaesthetist, nursing staff, theatre team, Alex Manson (Autism Liaison), Suzie (Consultant Dentist), the Recovery Team, and the Paediatric Day Team.

My son is non-speaking and autistic, and attending hospital is an extremely complex and challenging process for him. A significant amount of planning and coordination was required to make this admission possible, and the care we received demonstrated the Trust's values of kindness, openness, and excellence throughout.

From the moment we arrived, the Security Team were calm, compassionate, and understanding. They took the time to listen to us as parents and approached my son with patience and respect, helping to reduce what is usually a distressing experience. They took the time to understand his needs and approached him with gentleness and compassion. This kindness was evident across all teams involved, with staff consistently showing empathy and genuine care for my son and our family. Staff worked in true partnership with us, listening to our knowledge of our son and being open to adapting their approach to meet his needs. There was clear communication and collaboration throughout, and we felt fully involved and heard at every stage. This openness made a significant difference in building trust and ensuring our son's care was tailored appropriately.

The coordination and teamwork among all colleagues were exceptional. I would particularly like to recognise Dawn, the anaesthetist, Theatre Team, Alex Manson, Suzie, Toby (Dentist), the Community Dental Team, the Recovery Team, and the Paediatric Day Nursing Team. It was evident that many staff had gone above and beyond, including coming in early before the start of their working day, to give my son the best possible chance of a successful outcome. Their flexible, person-centred approach meant he was able to undergo his surgery successfully, something that would not have been possible without such high standards of care.

As both a parent and a member of staff within the Trust for over 20 years, I felt incredibly proud and reassured by the care we received. The team demonstrated the very best of what the NHS stands for. This experience made a significant difference to my son, and I believe this team is highly deserving of recognition through a Star Award.

Emma Heelbeck, Patient Services Assistant **Scarborough** **Nominated by visitor**

We are nominating Emma Heelbeck for a Star Award for the hard work, love, and dedication she showed to our elderly friend, who was on Chestnut Ward for three weeks, is deaf, and can only read lips. Emma's patience and caring approach to our friend to ensure he understood things was not just seen as another elderly patient did not go unnoticed. We also observed her showing the same care to other patients on the ward. Our friend certainly had a soft spot for her!

Unfortunately, our friend is widowed and has no children or direct family, so he relied on us to visit from Bridlington as often as we could after work. Emma knew this, and always made an extra fuss of our friend, chatting to him and encouraging him to eat his meals. She was also the first to tell us about his day and how he had eaten his meals (or not) when we visited, too. Deafness is hugely isolating; however, we believe Emma went above and beyond to engage with our friend to make him feel cared for (including a card game or two!) and comforting him during his tearful times - as he just wanted to get back to Bridlington.

Just knowing Emma was there on shift, looking out for him, really put our minds and worries at rest back in Bridlington. She truly is a credit to Chestnut Ward and Scarborough Hospital, and our friend will miss seeing her smiley face!

Item 10

Committee Report

Report from:	Quality Committee
Date of meeting:	19 May 2026
Chair:	Martin Barkley

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

ALERT

- Delays in the opening of Scarborough Community Diagnostic Centre (CDC) until June 2026 resulting in diagnostic delays for patients and delays in construction work to accommodate a new CT scanner and 3rd MRI scanner both at York Hospital.
- Significant radiology workforce shortages and vacancy rates impacting diagnostic capacity. Interim mitigation via insourcing and international recruitment; long-term workforce solutions in development. Capital delay (3rd CT scanner) compounding capacity constraints.
- 1400 Datix incident report closures are overdue across the Trust, and the Committee is requesting this backlog of Datix report completion from all Care Groups and Directorates is addressed and progress monitored by the Quality Committee each month.

ASSURE

- A month-on-month reduction in overdue complaints by CSCS. March 92% and April 96% achievement in closing complaints within 30 days.
- The Maternity Incentive Scheme (MIS) training compliance is to be reported to Board in September following the last reporting of compliance in November (two reference points are required to be reported each year).
- Nursing Workforce and Impact on Quality of Care discussion on triangulation of workforce and quality, data anomalies, skill mix and limitations of staffing metrics.

ADVISE
- Histopathology performance times as an indicator of quality of patient care is to be considered by the Committee to be included in future reports from CSCS Care Group. - Multi-agency input is required and ongoing to update the Baby Abduction Policy to ensure further strengthening, which will be concluded by September 2026. - There is an opportunity for NHS Resolution to provide a Board workshop session on Year 8 of the Maternity Incentive Scheme (MIS) that is to be investigated further.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
- Several Corporate Risk Register (CRR) risks are requiring updating beyond their review date ahead of the next reports to the Assurance Committees of the Board. Material data quality issues identified within risk register (including missing target scores and inaccurate dates) and some updates not appearing on the register. - SSNAP performance concerns identified with requirement for escalation via Patient Safety & Clinical Effectiveness Sub-Committee and potential escalation to Board by the Quality Committee.
ASSURANCE GAINED
- The new format of the Nursing Workforce and Impact on Quality of Care report was well received by the Committee in the insight it provided, and similarly the Maternity Dashboard.

Committee Report

Report from:	Resources Committee
Date of meeting:	19 May 2026
Chair:	Helen Grantham

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

ALERT

- **2026/27 WRAP delivery**
  - Month 1 WRAP delivery was £1.9m behind target (£2.9m delivered with a £17.1m full year impact - £14.7m recurrent). The current planning gap is £3.9m and 46% of plans are fully developed – *see ASSURE below for additional information.*
- **2026/27 plan**
  - 2026/27 plan has not yet been agreed by NHS England – the Trust is working to it
  - Month 1 is £0.4m behind plan, having reflected £1.5m as income (deferral of planned investments) in line with NHS England discussions. Decisions on deferral of investment and impact on broader plan to be discussed by the Trust Board.
- **Diagnostics – progress report**
  - DM01 has declined at the start of 2026/27 - April performance at 73% (below March 2026 position of 77% and the April trajectory of 74.8%).
  - The most significant impact on performance is within CT - sustained capacity and workforce pressures and equipment shortfalls. Actions are in place to sustain the current position (no further deterioration), although it is unlikely Q1 trajectory will be met, due to delay in CDC opening and CT3 replacement.
  - See ASSURE below.
- **Workforce**
  - while sickness absence has reduced due to the time of year, the annual sickness rate remains higher than previous year and the national benchmark. Vacancy pressures persist, particularly for Health Care Support Workers, with some good progress to reduce medical/dental vacancies.

ASSURE

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- **2026/27 WRAP – focussed review**
  - a focussed review was undertaken on the 2026/27 WRAP programme
  - a written report (showing progress against budget) was provided along with details of the high delivery risk schemes and risk mitigation
  - Where delivery was off track the Committee was provided with information on the amount of slippage, the reasons for it and details of the recovery action

plan – further information was requested on recovery action plans to ensure an appropriate level of assurance could be provided to the Committee. The importance of recovering early slippage in the year, to maximise full-year impact, was discussed.
    - The need to look at transformational change and the importance of involving and empowering colleagues to make change happen, as well as ensuring good leadership and communication, was, again, noted.
    - A discussion took place on adopting a coaching mindset and to support colleagues to achieve success, as well as ensuring individuals had access to appropriate wellbeing support
    - *See also Risk section below.*
- **Strategic partnerships – focussed review**
    - a focussed review was undertaken on strategic partnerships
    - the various networks and committees in place were highlighted including:
        - a Trust Strategy and Partnership Sub-committee – overseeing partner engagement
        - the North Yorkshire Directors Meeting, which is chaired by the Trust COO
        - the progress being made with operational partnership work e.g. YAS
        - the Trust clinical strategy would be shared with partners as it developed
        - the engagement with partners relating to the Bridlington Care Unit
    - the Committee requested a partnership map with key areas of engagement, Trust relationship lead etc.
- **Workforce – colleague survey improvement plan and TPR**
    - a focussed review was undertaken on the colleague survey improvement plan
    - the key themes from the free text comments were highlighted
        - broadly similar to those in 2024
        - focus on workforce pressure, burnout, patient safety, behaviours, leadership visibility and quality of appraisals with pride in teams, colleagues and professional purpose also coming through
        - the free text comments have been triangulated with the Chief Executive's 100 Day report, and feedback from stakeholder groups and the messaging was broadly consistent
    - the Trust has improved its ranking out of the 121 peer Trusts in all 9 key metrics, by between 21 and 50 places, although significant improvements are still required
    - a high-level plan was shared covering 26/27 priorities focussing on:
        - values, culture and behaviours; including leadership capability, accountability for all and psychological safety
        - patient safety, care and dignity
        - ability to influence decision making and drive improvements
        - ensuring the workforce has access to the fundamentals to support them at work
    - each Care Group, corporate directorate and YTHFM would also be working with their teams on their own improvement plans
    - questions were taken from the Committee on the TPR people metrics.
- **Diagnostics – progress report**
    - There has been material improvement during 2025/26, with performance reaching 77% by year end, the second highest level since February 2020.
    - Long waits have reduced significantly:
        - 13-week waits reduced from 15% to 5% of the waiting list during 2025/26.
        - Sustained reduction in breaches compared to the previous year.
    - Modality-level recovery plans are in place across all key services, supported by:

- Weekly and daily operational oversight of capacity utilisation
- Fortnightly care group review meetings
- A formal Diagnostics Delivery Board for escalation and governance

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ASSURANCE GAINED

- **2026/27 WRAP and 2026/27 financial plan**
  o While delivery was currently off track, the Committee did receive more detailed information on performance, the drivers for the underperformance, developed/to be developed areas for the WRAP and where performance was off track more detail on actions planned to correct
  o The Committee had some feedback on the reporting which was being shared with the Trust Finance Director.
- **Diagnostics**
  o While there are material risks relating to workforce, capacity and capital delivery, there is a credible plan to return to trajectory by end of Q12026/27.
- **Urgent and Emergency Care performance**
  o the TPR shows a continuation of the improvement in UEC performance (including 12 hour waits) following the introduction of new UEC pathways and in ambulance handover.
- **Emergency preparedness, resilience and response core standards annual assurance**
  o The EPRR assurance report was last considered by the Board in January 2026 when performance was at 82% of the standards being fully compliant and an organisational grading of PARTIAL. The compliance rating has since increased to 86% with the expectation of SUBSTANTIAL compliance by September 2026.

ADVISE

- **Digital**
  o Nervecentre Tranche 1 had been successfully deployed across the Trust.
  o The team were congratulated on the smooth roll out with zero-downtime and the commitment of all colleagues was noted.
  o The need for ongoing and optimisation amongst individuals was discussed with the need for ongoing support.
- **Committee papers**
  o **Financial reporting** – new financial reporting had been introduced for the Committee. The Committee were positive on the revised format and shared initial feedback with additional feedback to be provided after the meeting.
  o **Capital project reporting** – a revised format for reporting on major capital projects was discussed and would be introduced going forward
  o **Corridor care data** – it was requested that data on corridor care would be included within the TPR
  o **TPR and True North report** – these reports were being reviewed.
- **2026/27 plan – drug costs**
  o A discussion took place on “in tariff” and “pass through” arrangements relating to drug costs and how this fed through to financial performance. Additional commentary to be provided in future reports.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
- **WRAP and financial plan** – the risk of meeting the 26/27 plan and delivering the planned savings was discussed – see ALERT and ASSURE above - **Corporate risk register** – the current draft of the corporate risk register had been provided. - **Diagnostics** – the risk to meeting Q1 trajectory including capacity constraints driven by workforce gaps, particularly in CT, Echocardiography and Urodynamics; delays to capital schemes and equipment replacement; and data limitations in certain diagnostic pathways (e.g. outpatient-based diagnostics).

Committee Report

Report from:	Group Audit Committee
Date of meeting:	12th May 2026
Chair:	Jane Hazelgrave

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

ALERT

Six internal audit reports have been issued to the Group since the last meeting. Two with significant assurance and four with a limited assurance rating (see below).

ASSURE

External Audit

- The external audit was progressing well, facilitated by timely responses and engagement from the Finance team.
- Following receipt of the draft financial statements, the materiality calculation has been updated from £18.4m to £19m. There were no changes in terms of significant risks.
- The Trust's self-assessment had been received to inform the Value for Money work. The significant weakness relating to financial sustainability identified in 2024/25 was likely to continue into 2025/26 but would include reference in the commentary to recovery actions, the Waste Reduction and Productivity Scheme and other mitigating actions which had been introduced.

Internal Audit.

- **YTHFM.**

Seven recommendations were overdue; 25 recommendations have been completed. One report has been issued since the last meeting relating to backlog maintenance which received a significant assurance opinion. It should be noted this report relates to the system for BLM not the value of BLM which is high.

- **Trust**

Nine recommendations were overdue.
Four reports issued to the Trust since the last meeting.
One report received significant assurance: IPC Improvement in Care Groups
Four reports were issued with a limited assurance rating: People Management Information (Trust-wide and YTHFM), Mental Health Training Paediatric Nurses, Matrons Handbook, Performance Appraisal Process of Managers

A new approach to outcomes from internal audits, whereby recommendations would be replaced by management actions, which would be prioritised by a target date rather than a grading was discussed. These would be agreed by management, as would the

evidence required for closure. The focus would be on closing recommendations by the target date. Concerns about the proposed process was discussed. It was agreed Audit Yorkshire need to do some further work with clients before this is implemented.

Fraud

It was reported that online training, previously known as Masterclasses, had been rebranded as Fraud Awareness and Prevention Training, with the aim of increasing attendance. A new training session had been introduced: *Imposter Workers and ID Checking*.

A report was presented about concluded investigations, including a phishing email to the Y&S Hospitals Charity where a fraud was averted due to management action. Other clients have been advised about the incident.

The risk of "reference farms," which were fake companies used to supply employment references, was on the increase and action would be taken to ensure that Trust staff were aware of this type of fraud and given support to identify it.

Other items

The Chief Digital & Information Officer attended the meeting and provided the following assurances.

- Internal Audit Actions Update: All four overdue IA actions are DSPT-related. Evidence for closure is being prepared and will be submitted to IA. There are no issues to report.
- Cyber Risk Context: increased cyber risks are being experienced across the NHS due to global instability and recent supply chain attacks. The Trust continues to manage the rapid evolution of AI-driven threats, such as automated phishing and vulnerability exploitation.
- DSPT Submission Timeline: evidence for the next DSPT submission is being finalised, with the annual deadline at the end of June. The audit committee will be updated on risks and progress, and the submission will reflect current cyber concerns.
- National and Local Cyber Governance: the 'defend as one' national cyber strategy, and the role of the National CSOC was discussed. The Trust is working to secure funding for improved management of cyber risks.

- A report on tender waivers was produced for YTHFM and the Trust. A new process is being adopted across the procurement consortia which will improve data capture and reporting.

- A draft annual report, annual governance statement and change to accounting policies was brought to the meeting. Further drafting changes are in progress with the final reports expected in line with the national requirements.

- BAF and Risk register: the Quarter 4 Board Assurance Framework and the Corporate Risk Register was presented. A new approach to these documents which was now set

out in the Committee's revised terms of reference. It was confirmed the lessons learned from the recent internal audit on the Board Assurance Framework and Risk Management Benchmarking report would also feed into the process.
ADVISE
External Audit advised that the significant weakness relating to financial sustainability identified in 2024/25 was likely to continue into 2025/26 but would include reference in the commentary to recovery actions, the Waste Reduction and Productivity Scheme and other mitigating actions which had been introduced. A new process for the changing of IA action dates was discussed. It was agreed that second changes to completion dates should require audit committee approval.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
There are no new risk to escalate to the board.
ASSURANCE GAINED
The four overdue actions for the Chief Digital & Information Officer were on track to be closed shortly with no risks to highlight. Detailed updates were provided for each action. A draft overall 'significant assurance' was provided for the Head of Internal Audit Opinion which will be reported in the annual report. The draft annual fraud standards submission is 'Green.'

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	27 May 2026
Subject:	Well-Led Action Plan Progress Report
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:

Reports of progress against the External Development Well-Led Action Plan are to be provided quarterly to Board. Updates on the last quarter actions and those approaching completion in Q1 2026/27 are provided in this report as follows:

- End of 25/26 Actions (20) - 20 completed.
- Q1 Actions (52):
  - 13 completed
  - 39 updates provided
- Q2, Q3 and Q4 Actions (27) - progress updates provided where applicable

Recommendation:

The Board of Directors is asked to note the Well-Led Progress Update Report.

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

Meeting/Engagement	Date	Outcome/Recommendation
Well-Led Action Owners	April/May 2026	Updated

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Well-Led Developmental Review

York and Scarborough Teaching Hospitals NHS Foundation Trust

December 2025

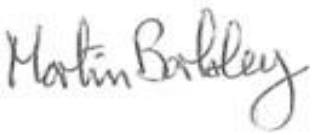
Version: Final Draft Report

Strengths, development areas, recommendations and actions by Quality Statements.

Executive Summary

Trusts should commission an independent developmental well-led review every 3 years, but this has not happened in this Trust for some years. The report was received at the end of December.

This paper describes how NHS Providers (the organisation the Trust commissioned to carry out the review), undertook the review, their findings, strengths and development opportunities identified and recommendations for each of the eight quality statements, together with an action plan approved by the Trust Board that takes forward the recommendations. Apart from the wording of the actions, the remainder of the wording in this report is that of NHS Providers Review Team.



Chair

Chief Executive

Introduction

The aim of this review was to assess the leadership and governance of the Trust as described in the published well-led guidance for Trusts under the Single Assessment Framework jointly developed by the Care Quality Commission (CQC) and NHS England (NHSE).

As described in the well-led guidance the aim of this review is to identify areas of developmental action to secure and sustain future performance as part of continuous improvement and development. This review should inform further targeted development work by the Trust.

We undertook the review in line with the well-led guidance and considered existing and planned practice against the eight quality statements set out in the guidance:

1. Shared direction and culture.
2. Capable, compassionate, and inclusive leaders.
3. Freedom to speak up.
4. Workforce equality, diversity and inclusion.
5. Governance, management and sustainability.
6. Partnerships and communities.
7. Learning, improvement and innovation.
8. Environmental sustainability.

Our report is structured around the eight quality statements described above with each section of the report detailing existing good practice, our findings and further developmental areas.

Overview – summary of findings

York and Scarborough Teaching Hospitals NHS Foundation Trust is an organisation in evolution and facing a number of legacy issues. The Trust is demonstrating progress across a number of well-led domains including leadership, learning and improvement and environmental sustainability with more variable progress in evidence in others such as engagement and governance. On the remaining domains of culture, freedom to speak up and Equality, Diversity, and Inclusion (EDI) there is more work to do to 'shift the dial' on what are clearly historic and deep seated issues.

Positively, staff including senior leaders describe the current Board leadership team as the strongest in years, with a number of individuals being identified as highly visible, passionate, values-driven and being seen to be making a difference. This provides a basis for further and sustained improvements moving forward.

However, to deliver sustained improvement, the leadership team need to grip a number of legacy and deep seated concerns; notably a deep seated suspicion of 'management' including a clear disconnect and lack of visibility between the Board and executive team and the rest of the organisation, historic failure to address a number of cultural concerns, poor communication and feedback loops and a lack of clarity over accountability and roles and responsibilities that appears to have led to a lack of buy-in by operational leaders to the Trust 'ask'.

As the Trust develops a clearer sense of its strategy and its strategic objectives, there is a need for the Board to ensure that it focuses on building the necessary capacity and capability within the Trust to deliver this. Elements of this are cultural, but this will also require the building of capabilities to deliver localised and large-scale improvement and transformational change, supported by an up to date and coherent digital infrastructure and environment. Much of the required governance to support delivery is in place although the effectiveness of this can be improved by addressing the concerns raised within this report.

Quality statement 1: Shared direction and culture

TABLE: STRENGTHS AND DEVELOPMENT AREAS

Strengths	Development areas
• Increasing recognition of the importance and elevated profile of strategy and planning.	• Continued socialisation of strategy and values including through strengthened planning processes.
• Increasing oversight over strategy delivery.	• Clarification and capacity of senior lead for strategy and planning.
• True North approach provides clearer quality ambition and transparent performance narrative.	• Ensure total Board time is appropriately balanced between strategy, oversight of delivery and culture.
• Recognised shift to proactive and prioritised estates investment.	• Ensure full suite of enabling strategies is in date, aligned and include sufficient detail to monitor delivery.
• Enthusiastic and committed staff who value their local teams.	• Prioritise cultural development programme with clear deliverables and ownership by Board.
• Passionate change makers.	• Sustained focus on improving staff communication including two-way processes.
	• Reinforce leadership standards and values behaviour framework.
	• Model medium term financial sustainability.
	• Evidenced escalation response to adverse performance.

Recommendations

TABLE: RECOMMENDATIONS

Number	Recommendation
1	The Trust should consider strengthening senior leadership capacity and ownership of strategy and planning to help raise socialisation of the Trust strategy and drive through formal front-line to Board objective delivery connectivity.
2	The Trust should ensure that it has a full suite of in-date and aligned enabling strategies which support delivery of the Trust strategy and provide sufficient detail to enable clarity of understanding how they are to be delivered and are capable of measurement, monitoring and oversight over delivery.
3	The Trust should consider ways in which it can further socialise the Trust's strategic objectives and values alongside reinforcement of the values and behaviour framework.
4	The Trust should consider ways in which it can ensure that appropriate focus is given over to strategy, oversight of delivery and ensuring that an appropriate culture is in place.
5	The Trust should consider development of a renewed cultural and organisational development (OD) plan that targets considerations contained within this report, and in particular strengthens cultural oversight and focus along with staff feedback and engagement processes including improvements in connectivity of senior leaders with the Trust.
6	The Trust should look to develop a medium term financial plan once the suite of enabling strategies are sufficiently developed and respond accordingly to its outcomes in terms of ensuring the necessary capacity and capability is in place to deliver its requirements (including transformation).

Ref	Recommendation	Action	Responsible Officer	Completion By (2026/27 unless specified)	Progress Update May 2026
1	**The Trust should consider strengthening senior leadership capacity and ownership of strategy and planning to help raise socialisation of the Trust strategy and drive through formal front-line to Board objective delivery connectivity.**	1.1 Appointment of Executive Director of Strategy by Q2 of 26/27.	Chief Executive	End Q2	
		1.2 Executive development workshop to ensure clear Executive sponsorship of supporting strategies.	Chief Executive	End Q2	
		1.3 As part of the Trust's review of organisational engagement approach develop and implement plan to socialise the Trust strategy through leadership forums, communications, Board discussion and visible executive leadership.	Director of Communications	End Q1	See 3. Underway. A plan to refresh The Senior Leadership Forums has been agreed through Executive Committee, with the themes of the sessions to more explicitly aligned to the 6 strategic objectives and overall strategy delivery. The visibility plan has been agreed and outlines the forums for leaders to engage with and involve colleagues in delivery of the Trust's priorities. Opportunity to reconnect colleagues with the values and ambition through the Big Conversation. The communications strategy has also been reviewed and updated to align to the Trust's strategic objectives, to support their

					delivery and to support socialisation of the strategy with colleagues. On track to complete End Q1.
		1.4 Develop and implement a Trust-wide Performance Management and Accountability Framework, aligned to a defined organisational development plan to support high quality objective setting, appraisal, and consistent and escalation and delivery monitoring.	Chief Executive	End Q1	The tender for CQI includes a requirement for an embedded IAF and will be delivered via that route.
2.	**The Trust should ensure that it has a full suite of in-date and aligned enabling strategies which support delivery of the Trust strategy and provide sufficient detail to enable clarity of understanding how they are to be delivered and are capable of measurement, monitoring and oversight over delivery.**	Develop and align strategies which in turn have measurable plans with scorecards, defined ownership and assurance mechanisms. Supporting strategies will be: • Clinical Strategy – Medical Director • Quality Strategy – Chief Nurse • Estates Strategy – YTHFM Managing Director • Financial Sustainability Strategy – Finance Director • Organisational Development – YTHFM Managing Director • Sustainability – YTHFM Managing Director	Chief Executive	End Q3	
3.	**The Trust should consider ways in which it can further socialise the**	As part of the Trust's review of organisational engagement strategy, it	Director of Communications	End Q1	See 1.3. Underway. A plan to refresh The Senior Leadership Forums has

	Trust's strategic objectives and values alongside reinforcement of the values and behaviour framework.	will develop and implement plan to socialise the Trust strategy through leadership forums, communications, Board discussion and visible executive leadership.			been agreed through Executive Committee, with the themes of the sessions to more explicitly aligned to the 6 strategic objectives and overall strategy delivery. The visibility plan has been agreed and outlines the forums for leaders to engage with and involve colleagues in delivery of the Trust's priorities. Opportunity to reconnect colleagues with the values and ambition through the Big Conversation. The communications strategy has also been reviewed and updated to align to the Trust's strategic objectives, to support their delivery and to support socialisation of the strategy with colleagues. On track to cmplete End Q1.
4.	**The Trust should consider ways in which it can ensure that appropriate focus is given over to strategy, oversight of delivery and ensuring**	4.1 (also 1.1) Appointment of Executive Director of Strategy by Q2 of 26/27.	Chief Executive	End Q2	
		4.2 (also 1.2) Executive development session in Strategy development to	Chief Executive	End Q2	

	that an appropriate culture is in place.	ensure clear executive sponsorship of supporting strategies.			
		4.3 The timetable of Board development sessions will be reviewed and sufficient time give to the review, development and discussion of strategies will be scheduled.	Associate Director Corp Governance	End Q1	Underway. Feedback requested from Board members on a draft 2026/27 Board Development Action Plan with proposed actions, outcomes, external support and target timeframes. Review, development and discussion of strategies to be timetabled accordingly.
		4.4 Executive development sessions will be held four times a year focused on strategic development.	Chief Executive	End Q1	All dates are scheduled for the year.
		4.5 Review and rebalance Board agendas and assurance processes to ensure appropriate focus on strategic delivery, outcomes, culture and performance against agreed scorecards.	Associate Director Corp Governance	End Q4 25/26	Completed. Draft monthly Board agendas provided to Chair and Chief Executive for comment. Strategy focus at the Board Development Seminar meetings included in Board Workplans.
		4.6 Strengthen organisation development and a programme of strategic leadership development for all sub Board leaders.	Director of Workforce & OD	End Q3	Strengthen organisation development - Appointment of Chief Culture and People Officer planned. Work being undertaken to clarify OD aims and priorities, with

					focus on releasing capacity for BAU work to support ownership and empowerment across teams. Big Conversation planned to underpin cultural development. Strategic leadership development for all sub Board leaders - first step of 360 feedback/appraisals in progress. Plan to use this as a LNA to then design and commission support for development.
5.	**The Trust should consider development of a renewed cultural and organisational development (OD) plan that targets considerations contained within this report, and in particular strengthens cultural oversight and focus along with staff feedback and engagement processes including improvements in connectivity of senior leaders with the Trust.**	5.1 Develop and implement a Chief Executive lead deep and meaningful approach to staff engagement across the Trust.	Chief Executive	End Q1	This will be delivered as part of the Big Conversation and links to the pending appointment of the Chief Culture and People Officer.
		5.2 Full review and revision of the Trust's approach to Organisational Development including leadership and management.	Director of Workforce & OD	End Q2	Informed by work referred to in 4.6. Internal leadership and management offer being reviewed in line with launch of national M&L Framework.
		5.3 Development and implementation of a revised senior leadership visibility programme to strengthen connectivity with staff across sites and services.	Director of Communications	End Q4 25/26	Completed.

		5.4 Full review of all corporate meetings with the aim of releasing 30% back to focus on engagement and transformation.	Associate Director Corp Governance	End Q4 25/26	Completed. Proposal for the reduction of 30% of corporate meetings provided to Corporate Directors in March. Next steps agreed to combine with the review of Care Groups meetings. Final report in draft to be reported to Executive Committee in June.
6.	**The Trust should look to develop a medium term financial plan once the suite of enabling strategies are sufficiently developed and respond accordingly to its outcomes in terms of ensuring the necessary capacity and capability is in place to deliver its requirements (including transformation).**	6.1 Develop through co-production a comprehensive clinical strategy in order support the development of a financial sustainability plan.	Chief Executive Medical Director	End Q1 for framework End Q3 for detail	Interim Director of Strategy in post, workshops held and on track.
		6.2 Commission and then embed a continuous improvement approach across the Trust to support transformation of services with clear expected outcomes and KPIs.	Chief Executive	End Q1 for commission	Currently going through the tendering process.
		6.3 Develop Trust Performance Management and Accountability Framework.	Chief Executive	End Q1	As per 1.4.

Quality statement 2: Capable, compassionate, and inclusive leaders

TABLE: STRENGTHS AND DEVELOPMENT AREAS

Strengths	Development areas
• Strengthened Board demonstrating increased collegiate working.	• Board development as a unitary Board.
• Well respected and highly visible Chair.	• Structured induction for Board members.
• Broad range of skills across NEDs.	• Board member visibility and connection into Trust.
• Executive clinical leadership seen as a notable strength.	• Re-energise Leadership Framework and measure/monitor impact.
• Board seminars.	• Ensure senior leaders are seen to live the Trust values.
• Leadership Framework in place.	• Formalise Board Development Programme, Board Skills Matrix and Succession Planning.
• Care group clinical leadership model in place.	• Balance of quantitative and qualitative feedback to triangulate assurances.
	• Executive silo working.

Recommendations

TABLE: RECOMMENDATIONS

Number	Recommendation
7	The Board should consider formalisation of its capability assessment via a structured Board Development Programme that includes team building, development of a formal Board Skills Matrix to demonstrate suitability of skills/experience and identify gaps, and an associated Succession Plan which sets out the forward look regarding Board requirements and known churn.
8	The Trust should consider how it can strengthen Board connectivity into the Trust, paying particular attention to executive visibility across sites and all services.
9	The Trust should consider how it might increase the voice of stakeholders (staff, patients and external partners) into Board and committee to provide improved triangulation of assurances.
10	The Trust should consider introducing a more formalised NED induction process addressing the points raised within this report.
11	The Trust should consider how it might further strengthen collegiate working within the executive team and ensure that briefings/reports into Board and committee meetings have been socialised, discussed and owned across the executive team.
12	The Trust should consider the relevance of the existing Leadership Framework and how it might re-energise it and monitor take up and impact.

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update May 2026
7.	**The Board should consider formalisation of its capability assessment via a structured Board Development Programme that includes team building, development of a formal Board Skills Matrix to demonstrate suitability of skills/experience and identify gaps, and an associated Succession Plan which sets out the forward look regarding Board requirements and known churn.**	7.1 Commission a Board Development Programme agree requirements, scope and timescales.	Associate Director Corp Governance	End Q1	Underway. Feedback requested from Board members on a draft 2026/27 Board Development Action Plan with proposed actions, outcomes, external support and target timeframes.
		7.2 Strengthen Board assurance arrangements and Fit and Proper Persons Test annual report to be on CoG agenda	Associate Director Corp Governance	End Q4 25/26	Completed. Fit and Proper Test annual requirements scheduled for completion in line with national deadline of 30 June. Scheduled on the June Board of Directors meeting and the September Council of Governors meeting.
		7.3 Maintain and refresh Board and Executive succession plans, taking into informed by skills gaps, anticipated churn and diversity considerations.	Associate Director Corp Governance	End Q4 25/26	Completed. Subsequent consideration at the Nominations and Remuneration Committee and Remuneration Committee respectively.
8.	**The Trust should consider how it can strengthen Board connectivity into the Trust, paying particular attention to executive visibility across sites and all services.**	8.1 See actions 5.3 and extend executive and senior leader visibility arrangements consistently across Care Groups and services.	Director of Communications	End Q4 25/26	Completed.
		8.2 Executive Directors meeting to be held at each Hospital site with purposeful 'back to the floor' time prior to each meeting.	Chief Executive	Complete	Completed.

		8.3 Schedule a Board meeting in 2026 at Malton and Selby followed by Board visits to clinical areas.	Associate Director Corp Governance	End Q3	Underway. Dates and specific venues being considered for future meetings at Malton and Selby.
9.	**The Trust should consider how it might increase the voice of stakeholders (staff, patients and external partners) into Board and committee to provide improved triangulation of assurances.**	9.1 Patient story at start of each Board meeting.	Chief Nurse	Complete	Completed. Patient or colleague story now scheduled for the start of each public Board meeting. This action can be closed.
		9.2 Patient survey results to be reported to Board.	Chief Nurse	Start Q1	Results from national patient surveys to continue to be shared at Trust Quality Committee with onward presentation to Trust Board as required. Themes will continue to be triangulated with other sources of patient feedback and addressed via the Trust-wide patient experience improvement plan.
		9.3 Patient complaints and PALS reports to Board every three months.	Chief Nurse	End Q1	Combined patient experience/complaints/PALS report completed for Q4 - viewed at Quality Committee April 2026 and then for onward presentation to Trust Board.
		9.4 Increase Freedom to Speak Up reporting to the Board every three months supported by triangulated themes with other workforce and quality intelligence	Associate Director Corp Governance	End Q1	Completed. A first quarter report in April 2026 with forthcoming reporting at each quarter documented in the work plan approved at the March Board of Directors.

		9.5 Develop and implement a structured stakeholder management plan for 26/27, including objectives, engagement cadence, escalation routes and feedback loops.	Director of Communications	Start Q1	Underway. Detailed mapping of stakeholders, engagement forums/meetings and current relationship 'owners' complete. The plan is being developed with recommendations based on this mapping. Completion date delayed to End Q1. See 30 and 29.1.
10.	**The Trust should consider introducing a more formalised NED induction process addressing the points raised within this report.**	Develop and implement new and strengthened Non-Executive Director induction plan. All NEDs who have commenced in the last 18 months to undertake in addition to new starting colleagues.	Associate Director Corp Governance	End Q2	Underway. A revised induction programme currently under development for future Board of Directors proposal.
11.	**The Trust should consider how it might further strengthen collegiate working within the executive team and ensure that briefings/reports into Board and committee meetings have been socialised, discussed and owned across the executive team.**	Corporate Directors meeting to be restructured with scheduled areas of focus each week along with a clearly communicated requirement for papers to be socialised and agreed prior to submission to Board.	Chief Executive	Complete	Completed.
12.	**The Trust should consider the relevance of the existing Leadership Framework and how it might re-energise it and monitor take up and impact.**	12.1 Undertake a full review of the leadership and development programme across the organisation (see 4.3)	Director of Workforce & OD	End Q2	Informed by work referred to in 4.6. Internal leadership and management offer being reviewed in line with launch of national M&L Framework.
		12.2 Provide digital literacy and AI training for managers and leaders where this is identified on their PDP	Chief Digital Officer	End Q4	

		12.3 (see 5.1 and 5.2) Undertake detailed scrutiny of staff wellbeing, absence trends and workforce processes, identifying root causes and targeted interventions.	Director of Workforce & OD	End Q1	Absence reduction plan has been developed and has been shared with Resources Committee. An update on this plan is due to go to Resources in July. Absence rates are reducing.
		12.4 KPIs for completion of HR processes with points of escalation for additional support	Director of Workforce & OD	End Q1	KPIs are in place as per policy timelines. Cases outside of expected timescales are reported via PRIMs.

Quality statement 3: Freedom to speak up

TABLE: STRENGTHS AND DEVELOPMENT AREAS

Strengths	Development areas
• Committed and passionate FTSU Guardian.	• Capacity of FTSU resources to deliver in role.
• Increasing FTSU capacity through Fairness Champions.	• Formalising triangulation of FTSU data with people practices and quality arrangements to drive cultural change and quality improvement.
• Engaged NED sponsor and Trust Chair and direct report into CHIEF EXECUTIVE.	• FTSU process hosted within the DWOD portfolio.
• Staff happy not to raise issues anonymously.	• Frequency/profile of FTSU reporting at Board.
• Informal triangulation of themes with wider sources of information.	• Staff perception of feeling that they may suffer detriment from speaking up remains a barrier to open reporting.
• Anonymous reporting tool offers alternative, confidential route for staff to raise concerns.	

Recommendations

TABLE: RECOMMENDATIONS

Number	Recommendation
13	The Trust should consider the overall FTSU resource and ensure adequacy of cover across sites/services to meet the needs of staff and the Trust.
14	The Trust should consider frequency and triangulation of reporting into Board across a number of assurance areas to help identify areas of cultural concern and/or themes.
15	The Trust should consider the appropriateness of hosting the FTSU process within the DWOD's portfolio and the effect on perceived independence.
16	The Trust should consider ways in which it can strengthen feedback from the FTSU process to demonstrate impact of speaking up to encourage take up of the service.

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update May 2026
13.	**The Trust should consider the overall FTSU resource and ensure adequacy of cover across sites/services to meet the needs of staff and the Trust.**	13.1 Benchmark with a view to increase if required FTSU capacity across the Trust	Associate Director Corp Governance	End Q1	Completed. The FTSU Guardian full-time hours secured for 2026/27.
		13.2 Review administrative support to FTSU Guardian	Associate Director Corp Governance	End Q1	Underway. Currently under review with the FTSU Guardian documenting the specific requirements needed of administrative support.
		13.3 (see 12.1 and 12.4) Training for managers to be expanded beyond the current offer to include listening compassionately and responding constructively to concerns, avoiding defensiveness, and providing full responses in a timely way.	Director of Workforce & OD	End Q2	The LMF training has been updated to include this e.g. in relation to Stay Conversations 'Listen actively and avoid defensiveness', in relation to Appraisals 'Actively LISTEN to the answers – show interest, patience, understanding'. Further work on the broader training offer is ongoing.
14.	**The Trust should consider frequency and triangulation of reporting into Board across a number of assurance areas to help identify**	14.1 Dedicated session at Board on the staff survey outputs and what it is telling us about the culture of the organisation.	Director of Workforce & OD	End Q1	Staff Survey results discussed at Board March 26. Action plan due in May 26.
		14.2 Clear and Board owned engagement plan led focused on improving how people experience work and care in YSFT	Chief Executive	End Q1	This is linked to the Big Conversation, which will be delivered in Q2.

	areas of cultural concern and/or themes.	14.3 Reportable issues log to include themes of grievances along with triangulation of FTSU data.	Director of Workforce & OD	End Q4 25/26	Themes are now included and background triangulation happens via joining the dot's meetings and regular 1:1's.
		14.4 To further embed the Managing Violence and Aggression policy launched in 2025 to manage patients who are racist or discriminatory to colleagues	Medical Director and Chief Nurse	End Q1	We are supporting the MVA policy through promotion with staff via digital messaging, posters around the site and investigations into incidents. We are training staff in deescalation techniques. Where appropriate we are using the full detail of the policy to help manage patients who are repeatedly racist or discriminatory toward staff.
		14.5 Support staff networks to fulfil their potential through clarifying their role, support they can expect and executive sponsorship.	Director of Workforce & OD	End Q1	Executive Sponsor role description developed. Ongoing support is provided to the Networks via the Executive Sponsors and Head of EDI.
15.	**The Trust should consider the appropriateness of hosting the FTSU process within the DWOD's portfolio and the effect on perceived independence.**	Host FTSU process via the CHIEF EXECUTIVE	Chief Executive	Complete	Completed.

16.	**The Trust should consider ways in which it can strengthen feedback from the FTSU process to demonstrate impact of speaking up to encourage take up of the service.**	16.1 FTSU report to Board every three months (as per 9.4).	Associate Director Corp Governance	End Q1	Completed. A first quarter report provided in April 2026 with forthcoming reporting at each quarter documented in the work plan approved by the March Board of Directors.
		16.2 Quarterly article in *Staff Matters* on positive changes resulting from FTSU.	Director of Communications	End Q1	Underway. Quarterly meetings in place with communications team and FTSU Guardian to plan content. On track to deliver End Q1.
		16.3 At quarterly Board meetings where FTSU report will be received substitute a patient story for a colleague story in an anonymised way to evidence how learning from FTSU has been taken.	Director of Workforce & OD	End Q1	Completed. Colleague story shared at April 26 Board and colleague identified for July 26. This will be ongoing every quarter.

Quality statement 4: Workforce equality, diversity and inclusion

TABLE: STRENGTHS AND DEVELOPMENT AREAS

Strengths	Development areas
• Growing commitment to addressing EDI concerns.	• Clearer overview and map of inclusion activities and systematic evaluation of EDI interventions and their effectiveness.
• Cultural competence inclusive recruitment training in place.	• Greater demonstrable Board attention to address concerns and drive through improvements in this area.
• New suite of EDI training which is now mandated and being delivered by an external agency.	• Board / senior leader diversity.
• Increased EDI resource availability including EDI champions, EDI educators and values ambassadors.	• Greater explicit executive sponsorship of staff networks and use of feedback to target improvement activities.
• Values and Behaviour Framework in place.	• Deep dive into sickness absence and targeted interventions to mitigate causes including appropriateness of staff wellbeing resource availability.
• BAME Leadership Programme in place.	• Medical staffing appraisal rate.
• AHP development days.	

Recommendations

TABLE: RECOMMENDATIONS

Number	Recommendation
17	The Trust should consider strengthening alignment of EDI actions with feedback concerns and ensure systematic evaluation of the effectiveness of interventions.
18	The Trust should ensure that EDI issues form part of the overall Trust approach to improving culture including Board oversight and scrutiny of EDI matters.
19	The Board should consider how it can further improve the diversity of inputs at Board and senior leadership levels of the Trust.
20	The Trust should ensure that executive sponsorship of staff networks leads to meaningful inputs, dialogue and effective outcomes.
21	The Trust should undertake deep dive scrutiny over staff absences and ensure that the Trust wellbeing offer helps address and mitigate the root causes.
22	The Trust should seek ways in which it can improve medical staffing appraisal rates.

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update May 2026
17.	**The Trust should consider strengthening alignment of EDI actions with feedback concerns and ensure systematic evaluation of the effectiveness of interventions.**	Full review of key themes arising from the staff survey for colleagues with protected characteristics leading to a targeted plan that is co-produced with the staff networks	Director of Workforce & OD	End Q1	The analysis is on track and if there is a need additional actions will be added to the WRES and WDES action plans.
18.	**The Trust should ensure that EDI issues form part of the overall Trust approach to improving culture including Board oversight and scrutiny of EDI matters.**	Progress against plan to be reported back to the Board every six months on progress to date via the Executive Sponsors.	Director of Workforce & OD with Exec Sponsors	End Q2	WRES and WDES action plans were shared with Resources and Board in April and updates will continue as per the schedule.
19.	**The Board should consider how it can further improve the diversity of inputs at Board and senior leadership levels of the Trust.**	Increase the diversity of Board members to be more reflective of the organisation.	Associate Director Corp Governance	Q1	Underway. Considerations under development.
20.	**The Trust should ensure that executive sponsorship of staff networks leads to meaningful inputs, dialogue and effective outcomes.**	20.1 CHIEF EXECUTIVE to set clear expectations of role of Executive Sponsors of the staff network groups (also see 18).	Chief Executive	End Q4 25/26	Completed.
		20.2 Each executive Director to have a meaningful and measurable EDI objective set at annual appraisal	Chief Executive	End Q1	On track as part of appraisal season.
21.	**The Trust should undertake deep dive scrutiny over staff absences and ensure that the Trust wellbeing offer helps**	Undertake ongoing scrutiny of staff wellbeing, absence trends and workforce processes, identifying root causes and targeted interventions	Director of Workforce & OD	End Q1	Absence reduction plan has been developed and has been shared with Resources Committee. An update on this plan is due

	address and mitigate the root causes.	feeding through to the Resources committee.			to go to Resources Committee in July. Absence rates are reducing.
22.	**The Trust should seek ways in which it can improve medical staffing appraisal rates.**	N/a	Medical Director	Complete	Completed.

Quality statement 5: Governance, management and sustainability

TABLE: STRENGTHS AND DEVELOPMENT AREAS

Strengths	Development areas
• Evidence of NED challenge.	• Unitary Board role, and role of Board and committees.
• Constitutional governance framework in place.	• Effectiveness of challenge.
• Committed governors.	• Escalation of concerns through sub-committees into committees and Board.
• Quadrumvirate divisional leadership teams including allied health professionals.	• Clarity of purpose of deep dives.
• Effective meeting 'hygiene' factors in place.	• Resources Committee breadth and coverage.
• Improving Board/committee scrutiny and accountability being exerted.	• Evidence of escalation and proportionality of performance concerns.
• Use of deep dives.	• Digital oversight at Board.
• Use of Statistical Process Controls (SPC) and formatting of Trust Performance Report (TPR).	• Performance Management & Accountability Framework.
• Oversight of subsidiary company.	• Digital literacy and engagement.
• Elements of good governance at care group level.	• Digital resource capacity constraints.
	• Risk maturity and use of risk appetite.
	• Consistency of approach and coverage at PRIM and care group management meetings.

Recommendations

TABLE: RECOMMENDATIONS

Number	Recommendation
23	The Trust should seek to clarify the role and purpose of the unitary Board and its committees and ensure an appropriate focus is maintained at each level supported by strengthened governance processes as identified within our report.
24	The Trust should consider the appropriateness of oversight of the digital agenda including the existing arrangements for EPR implementation given the level of risk such a transaction presents to the Trust.
25	The Trust should consider how it can assure itself over the adequacy of data capability and capacity both within the digital function and wider Trust to deliver the forward requirements of the digital transformation agenda.
26	The Trust should consider introducing a Performance Management and Accountability Framework supported by appropriate roll out training and support.
27	The Trust should consider strengthening its approach to risk management in line with our report observations including the operationalisation of risk appetite to support risk escalation / de-escalation within the Trust.
28	The Trust should consider implementing a more consistent and Trust-wide approach to PRIM and care group management level meetings which includes clear 'do minimum' expectations regarding inputs (agenda, coverage, paper format, and attendance) and outcomes (minutes, action logs, escalations) in line with our report observations.

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update May 2026
23.	**The Trust should seek to clarify the role and purpose of the unitary Board and its committees and ensure an appropriate focus is maintained at each level supported by strengthened governance processes as identified within our report.**	23.1 Review Terms of Reference and work plan of the Trust Board meeting and Committees including frequency, scope and attendees.	Associate Director Corp Governance	End Q2	Completed. All Board Committees revised terms of reference for 2026/27 and the Board of Directors workplan approved by the March and April Board of Directors.
		23.2 Clarify inclusion or exclusion of the BAF at committees via review of the terms of reference.	Associate Director Corp Governance	End Q1	Underway. Currently considered at Committee meetings and reported to Board of Directors.
		23.3 Board development session to be scheduled on the role and optimal function of a unitary Board and highly functioning committees.	Associate Director Corp Governance	End Q2	Underway. To be included in a forthcoming Board Development Seminar provided by an external partner.
		23.4 Improve action plan/log hygiene through standard work e.g. specific dates not 'asap' and only complete when it can be evaluated (i.e. not an intention)	Associate Director Corp Governance	End Q1	Completed. All action logs have specific dates of actions to be completed. Where this is not defined at each action at Board and Committee meetings, the Chair of the meeting and the Executive responsible are consulted.
		23.5 Board Committee escalation reports to include a heading "Assurance Gained".	Associate Director Corp Governance	End Q4 25/26	Completed. The revised 2026/27 Board Committee escalation template has an 'Assurance Gained' heading communicated to

					all Committee Chairs during April 2026.
		23.6 Capital expenditure report in the monthly financial report to include forecasts	Director of Finance	Complete	Completed.
		23.7 Strengthen Programme Management and reporting arrangements	Chief Executive	End Q1	On track via the interim Director of Strategy.
		23.8 Consider annual joint working programme with Council of Governors	Associate Director Corp Governance	End Q1	Underway. To be discussed and agreed at the June Council of Governors meeting.
		23.9 Governor questions to be on the public agenda of CoG and categorised by: governance, public, staff, stakeholder	Associate Director Corp Governance	End Q1	Completed. Commenced with the March Council of Governors.
24.	**The Trust should consider the appropriateness of oversight of the digital agenda including the existing arrangements for EPR implementation given the level of risk such a transaction presents to the Trust.**	24.1 EPR as standing item on Risk Committee Meeting.	Chief Executive	Complete	Completed.
		24.2 Increase Board visibility and assurance over EPR delivery via Monthly Board report, including risks, readiness, dependencies and post-implementation requirements.	Chief Digital & Information Officer	Start Q1	Completed. EPR reports provided monthly to the Board of Directors.
25.	**The Trust should consider how it can assure itself over the adequacy of data capability and capacity both within the digital function and wider Trust to deliver the forward requirements of the digital transformation agenda.**	Undertake a comprehensive review of the current data and analytics capability across the Digital function and the wider Trust, including skills, capacity, operating model, and data quality maturity. Using the findings, develop and implement a Trust-wide Data Capability and Capacity Framework that sets out required competencies, resource levels, training pathways, role clarity (including information asset ownership), and an	Chief Digital & Information Officer	End Q3	

		approach to improving data literacy across all levels of the organisation. This framework will also define the model for business intelligence service delivery and ensure alignment with the Trust's digital and clinical strategies.			
26.	**The Trust should consider introducing a Performance Management and Accountability Framework supported by appropriate roll out training and support.**	26.1 (Also 6.3) The Trust will develop an Integrated Accountability Framework from ward to Board that has clearly defined roles and responsibilities.	Chief Executive	End Q1	Will be completed via the roll out of the IAF as part of the CQI tender.
		26.2 Each lead executive responsible for a pillar of delivery (Quality, finance, workforce, service delivery) will work to streamline and strengthen assurance processes from ward to Board through good governance.	Chief Executive	End Q1	As above
		26.3 Launch of the IAF will be supported by organisational development so roles and responsibilities at all levels are understood.	Director of Workforce & OD	Start Q2	This will form part of the latter stages of the 'Big Conversation' programme of work, which is on-track to commence in May 26.
27.	**The Trust should consider strengthening its approach to risk management in line with our report observations including the operationalisation of risk appetite to support risk escalation / de-escalation within the Trust**	27.1 Risk Committee terms of reference to be reviewed to become a subcommittee of the Board	Associate Director Corp Governance	Start Q1	Completed. The Risk Committee reports directly to the Board of Directors as approved at the March Board of Directors.
		27.2 Ensure consistent format of reports from Care Groups and Directorates	Associate Director Corp Governance	End Q1	Completed. All Care Groups and Corporate Areas communicated and requested to use the standard risk report template during March and April. Incorrect

					templates reported are rejected.
		27.3 Develop and deliver a comprehensive risk management training package	Associate Director Corp Governance	End Q2	Underway. CSCS Care Group training provided to all specialities. Offer provided to all Care Groups and Corporate Areas at Executive Committee.
		27.4 Resolve, explain difference between SHMI and HSMR	Medical Director	End Q1	Closed at April Quality Committee.
28.	**The Trust should consider implementing a more consistent and Trust-wide approach to PRIM and care group management level meetings which includes clear 'do minimum' expectations regarding inputs (agenda, coverage, paper format, and attendance) and outcomes (minutes, action logs, escalations) in line with our report observations.**	28.1 (Also 26) Review of PRIM and approach to accountability framework to be undertaken, including roles and responsibilities.	Chief Executive	End Q1	Will be undertaken as part of the IAF review in conjunction with the CQI.
		28.2 Develop 'standard work' for agendas and minutes etc of PRIMs and Care Group Management Boards.	Chief Operating Officer	Start Q2	Review of Care Group meeting structures underway against previously agreed TOR and structures. Reviewing PRIM approach, and exploring other trusts ways of working to inform.

Quality statement 6: Partnerships and Communities

TABLE: STRENGTHS AND DEVELOPMENT AREAS

Strengths	Development areas
• Constituency meetings held by the Trust Chair.	• Profile of patient experience including patient voice at Board.
• Strengthening relationships with system partners, particularly in urgent care, maternity, public health and safeguarding.	• Proactive and structured stakeholder management approach to shift from reactive problem driven engagement towards strategic, long-term relationships.
• Annual awards ceremony.	• Communications Strategy refresh.
• Positive relationships with Higher Education sector.	• Anchor institution role and health inequalities.
	• Briefing of deputies when representing the Trust at system/partner meetings.

Recommendations

TABLE: RECOMMENDATIONS

Number	Recommendation
29	The Trust should consider how it might raise the profile and voice of stakeholder feedback as part of triangulation of assurances. This should include the voice of staff, patients and system partners.
30	To support the above, the Trust should consider the development of a more proactive and structured approach to stakeholder management.
31	The Trust should ensure that its Communications Strategy refresh exercise takes into consideration the findings within this report, the work of the Trust change makers as well as wider engagement with internal and external stakeholders.
32	As part of the shift to proactive and more strategic partnership relations, the Trust should consider its anchor institution role and what this means for the Trust alongside how it can best support improvements in health inequalities.
33	The Trust should ensure that deputies are well briefed and able to represent the Trust when deputising for Trust officers at system meetings beyond any immediate operational needs.

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update May 2026
29.	**The Trust should consider how it might raise the profile and voice of stakeholder feedback as part of triangulation of assurances. This should include the voice of staff, patients and system partners.**	29.1 See recommendation 9.	Director of Communications	Start Q1	Underway. Detailed mapping of stakeholders, engagement forums/meetings and current relationship 'owners' complete. The plan is being developed with recommendations based on this mapping. Completion date delayed to End Q1. See 9.5 and 29.1.
		29.2 Seek specific partner stakeholder feedback annually prior to appraisal.	Director of Communications	Start Q4	
30.	**To support the above, the Trust should consider the development of a more proactive and structured approach to stakeholder management.**	See 9.5	Director of Communications	Start Q1	Underway. Detailed mapping of stakeholders, engagement forums/meetings and current relationship 'owners' complete. The plan is being developed with recommendations based on this mapping. Completion date delayed to End Q1. See 9.5.
31.	**The Trust should ensure that its Communications Strategy refresh exercise takes into consideration the findings within this report, the work of the Trust change makers as well as wider**	31.1 Refresh the Communications Strategy to strengthen two-way communication and visible feedback loops.	Director of Communications	Start Q1	Underway. Refreshed strategy developed and shared with internal stakeholders. A number of changes already implemented to improve two-way communication to

	engagement with internal and external stakeholders.				support the new Chief Executive's First 100 Days engagement plan and in response to recommendations from the colleague survey carried out in partnership with the Change Makers.
		31.2 (See 1, 3 and 5) detailed and deep staff engagement exercise to be completed with the aim embedding a strong and supportive culture across the organisation.	Chief Executive	End Q1	Will be completed via the Big Conversation which is being planned in Q1 and delivered in Q2.
32.	**As part of the shift to proactive and more strategic partnership relations, the Trust should consider its anchor institution role and what this means for the Trust alongside how it can best support improvements in health inequalities.**	32.1 Director of Strategy to take Executive responsibility in advancing the role of the Trust as an Anchor Institute with an annual report to Board on progress and plans.	Director of Strategy	End Q3	
		32.2 Clinical Strategy to contain focused work on helping to address health inequalities across the Trust's geography.	Medical Director	End Q2	Clinical strategy discussions ongoing with clinical leaders. Meetings 13th May and 8th June.
33.	**The Trust should ensure that deputies are well briefed and able to represent the Trust when deputising for Trust officers at system meetings beyond any immediate operational needs.**	Individual Executives are to ensure that deputies who attend understand meetings on their behalf are able to attend meetings in an informed way with a clear understanding and pre agreed level delegated authority.	Executives	End Q4 25/26	Completed but will be monitored

Quality statement 7: Learning, improvement and innovation

TABLE: STRENGTHS AND DEVELOPMENT AREAS

Strengths	Development areas
• Relaunch of QI within the refreshed Quality Strategy.	• Rollout of QI methodology and building of QI capacity.
• Emergent examples of service level improvement projects.	• Dissemination of learning inter and intra care groups.
• Launch of QI community/network.	• Triangulated learning across multiple data points.
• Maturity assessment for adopting Quality Management System.	• Assurance over nurse staffing levels.
• Nationally commended PSIRF implementation with structured thematic reviews and weekly oversight.	• Transformation capacity and capability.
• 'Trust of us' review against national maternity review terms of reference.	• Senior lead for transformation.
• Healthcare Academy.	• Profile of Research and Innovation Committee.

TABLE: RECOMMENDATIONS

Number	Recommendation
34	The Trust Board should ensure appropriate oversight and assurance of the rollout of QI methodology and building of QI capacity given that it is one of the Trust's breakthrough objectives for 2025/26.
35	The Trust should consider ways in which it can strengthen the dissemination of learning within and across care groups. This should also include consideration of the formal mechanisms and processes for triangulating learning across multiple data points.
36	The Trust should consider its approach to assuring itself that it has sufficient transformational change capacity and capability to support its forward agenda. This should include clarity of leadership of transformation and Board/committee reporting for assurance purposes.
37	The Trust should consider whether the existing profile and membership of the Research & Innovation Committee is commensurate with the Trust's teaching status and stated desire to increase research activities as part of delivering the Trust's strategy.

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update May 2026
34.	**The Trust Board should ensure appropriate oversight and assurance of the rollout of QI methodology and building of QI capacity given that it is one of the Trust's breakthrough objectives for 2025/26.**	Initial rollout plan to be monitored Resources Committee and reported to Board.	Chief Executive	After commissioning and commencement	
		Strengthened PMO oversight, clear benefit realisation and assurance framework to be developed as part of the programme and reported to Board via Resources and Quality committees.	Chief Executive	After commissioning and commencement	
35.	**The Trust should consider ways in which it can strengthen the dissemination of learning within and across care groups. This should also include consideration of the formal mechanisms and processes for triangulating learning across multiple data points.**	35.1 Approach to shared learning across care groups will be agreed via Senior Leaders Forum and mapping conducted in how sharing is already conducted.	Director of Quality, Improvement and Patient Safety	End Q1	Mapping our learning opportunities and current learning approaches underway.
		35.2 Executive Committee and Senior Leaders Forum will be used for triangulation purposes and a schedule of areas of focus will be devised (supported by data) in order to direct and focus on continuous quality improvement.	Director of Quality, Improvement and Patient Safety	End Q1	The Trust is pursuing the development of a Quality Management System part of which is to help us maximise the use of data and intelligence to support improvement. Our Clinical Outcomes and Effectiveness Group has started an annual programme of thematic reviews and areas of focus such as Diabetes Care.
36.	**The Trust should consider its approach to assuring itself**	Chief Executive to review programme management, project management and continuous	Chief Executive	Start Q2	

	that it has sufficient transformational change capacity and capability to support its forward agenda. This should include clarity of leadership of transformation and Board/committee reporting for assurance purposes.	improvement capacity and capability, including approvals, reporting and accountabilities arrangements as well as benefit realisation			
		Commission a follow-up internal audit of the Quality Assurance Framework	Associate Director Corp Governance	End Q3	To be concluded. Discussion required at the Audit Committee for a change to the Internal Audit annual plan to incorporate a review of the Quality Assurance Framework.
37.	**The Trust should consider whether the existing profile and membership of the Research & Innovation Committee is commensurate with the Trust's teaching status and stated desire to increase research activities as part of delivering the Trust's strategy.**	37.1 Review the profile, membership and reporting of the Research and Innovation Committee to align with strategic ambition and teaching status.	Associate Director Corp Governance	End Q1	Underway. Current Research and Innovation Group terms of reference under review with a proposal to be provided to the Board of Directors to align with the strategic ambition and teaching status of the Trust.
		37.2 Agreed and including role as MEDICAL DIRECTOR as Chair or Deputy Chair of R&I Committee	Associate Director Corp Governance	End Q1	Underway. Current Research and Innovation Group terms of reference under review with a proposal to be provided to the Board of Directors to align with the strategic ambition and teaching status of the Trust.

Quality statement 8: Environmental sustainability

TABLE: STRENGTHS AND DEVELOPMENT AREAS

Strengths	Development areas
• Easy to read Green Plan which incorporates clear measurement.	• Review Green Plan against latest NHSE guidance.
• Green Champion Network.	• Demonstrable whole Board ownership of agenda including nominated Board champion.
• 'Green' modules on e-learning hub.	• Appointment of clinical lead for sustainability.
• Staff travel plan including subsidised bus fares.	

Recommendations

TABLE: RECOMMENDATIONS

Number	Recommendation
38	The Trust should review its Green Plan against the latest NHSE guidance to ensure compliance with requirements.
39	The Trust should consider how it might demonstrate increased whole Board interest and ownership of sustainability including the appointment of a Board level sustainability champion.
40	The Trust should consider the merits of appointing a clinical lead for sustainability to support wider engagement with services.

Ref	Recommendation	Action	Responsible Officer	Completion By	Progress Update May 2026
38.	**The Trust should review its Green Plan against the latest NHSE guidance to ensure compliance with requirements.**	Review the Green Plan against the latest NHSE guidance.	Managing Director YTHFM	End Q2	
39.	**The Trust should consider how it might demonstrate increased whole Board interest and ownership of sustainability including the appointment of a Board level sustainability champion.**	Agree a Board level sustainability champion.	Associate Director Corp Governance	End Q1	Underway. Conversations with Executives.
40.	**The Trust should consider the merits of appointing a clinical lead for sustainability to support wider engagement with services.**	Appoint a clinical lead for sustainability.	Medical Director	End Q1	Meeting planned with Head of Sustainability.

OTHER CONSIDERATIONS - MISCELLANEOUS

Ref	Action	Responsible Officer	Completion By	Progress Update May 2026
M1	Board Assurance Framework - Resolve inconsistencies; cause/effect/controls/ assurances - Identify lead Executive Directors for each principal risk Board to review 1 principal risk each meeting led by lead Executive Director	Associate Director Corp Governance	Apr 26	Completed. Q4 2025/26 Board Assurance Framework approved by April Board of Directors. BAF principal risks reviewed by Committees currently (linked to action 23).
M2	Action logs to be completed in advance of meeting sent out with agenda papers (standard work 23.4)	Associate Director Corp Governance	Apr 26	Completed. Action logs provided for all action owners to update prior to all Committee meetings.
M3	Coaching to be provided to presenters of Board reports to bring insight into what the paper a paper is telling the reader and where discussion should be focussed.	Associate Director Corp Governance	Apr 26	Completed. Presenters of papers contacted to inform on the action commenced with FTSU Guardian at the April Board of Directors meeting. Separately, a document to advise authors on writing of papers reported to Board and Committees currently in development.
M4	Update Constitution, Standing Orders etc to ensure consistency and to represent the Group structure in relation to the LLP.	Associate Director Corp Governance	May 26	Completed. Recommended for approval at 27 May Board of Directors and 10 June Council of Governors

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 14

TRUST PRIORITIES REPORT

May 2026

Table of Contents

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 - 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"):
Workforce – Annual absence rate.
Workforce – Monthly sickness absence.

A True North metric page is included in this month's report. Please refer to the True North Report for detailed summary on each metric.

Information of the Trust's **National Operating Framework (NOF)** performance is included. The page provides the Trust's overall ranking and position nationally against each of the 22 metrics at the end of 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

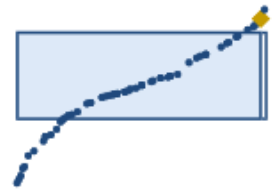
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Inpatients - Lost bed days for patients with no criteria to reside	2026-04			1525		
ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)	2026-04			77.5%	66.5%	82%
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-04			5.9%	19.6%	5%
Cancer - Faster Diagnosis Standard - Declared Position	2026-03			77.2%	80.1%	84.3%
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position	2026-04			56.1%	56.6%	67.5%
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position	2026-04			1.9%	1.8%	0%
Total Number of Trust Onset MSSA Bacteraemias	2026-04			8	7	7
Inpatient Acquired Pressure Ulcers - Category 2	2026-04			66	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

May 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 continuing to show early, measurable improvement.

ECS performance was 77.5% (includes Trust share of Bridlington and Whitby UTCs) a significant improvement since the implementation of the new models of care (EEMAC and EAU) that 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. As well as the positive impact on ECS, 12-hour in department performance has seen a vast improvement with April 2026 performance of 5.9%, the lowest since the metric was introduced.

Cancer performance for FDS and 62-day standards have shown improvement but remain off trajectory however March 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, provisionally achieving trajectory, challenges include significant GP referral growth with a 5% rise seen in April 2026 compared to April 2025 this is on top of the 5% growth the Trust saw for 2025/26 versus 2024/25. 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 reduced further to 4.3%.

Diagnostics DM01 performance was 73%, 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 has continued into 2026/27.
- 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 continue 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, tight grip from corporate and operational teams.
4. Support staff safety, morale and core clinical standards with new clinical strategy.
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

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 incl. Trust share of Bridlington and Whitby UTCs 77.5% vs year end 66.5% trajectory. Average Ambulance Handover ahead of trajectory. Long stays reduced; 12 hr waits in department (T1) 5.9% (ahead of 19.6% 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. High intensity users over the age of 75 has been shared (under a data sharing agreement) with the Frailty Hub team, further support will be provided. 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 77.2% vs 79.3% monthly trajectory; this FDS position is the highest the Trust has achieved since the standard was introduced. February 62-day 72.4% vs 73% monthly trajectory. Diagnostic performance, in particular endoscopy and imaging is impacting faster diagnosis performance due to delays in diagnostic pathways.	Process in place for returning referrals with no FIT to primary care. New colorectal cancer lead appointed. Ongoing discussions with endoscopy around pilots to improve TAT and provide additional capacity. Initial scoping discussions around COLOFiT. STT CT model in haematuria commenced implemented. 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 55,223 provisionally ahead of trajectory of 55,422 Provisional <18w: 56.1% vs 56.6% trajectory; Trust was ranked 111/118 in February. 52-week waiters improved to 1,064 (Provisional position) v trajectory of 964. GP Referral growth +5% April 2026 v April 2025.	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 expanded in April 2026 to monitor full pathway metrics rather than focus on longest waiters	Improvement expected in RTT under 18 week, TWL and RTT52 week waits.
Diagnostics	DM01 73%, 1.8% below trajectory of 74.8%. Impact from MRI workforce shortages, CT3 removal, mobile breakdowns, NOUS MSK backlog, audiology staffing gaps.	Endoscopy: Recruitment drive in Q4 2025/26 resulted in sufficient staffing to run room 7, 2-3 days per week by June 2026. Staffing vacancies in MRI are being mitigated by use of RMS insourcing to retain core capacity until recruitment can be completed to return to full substantive establishment. CT3 replacement awaited, delayed until circa Autumn 2026. MRI4 installation awaited, delayed until at least Q2 2026/27. DEXA patients impacted by field safety notice. Engineer scheduled for 18th May to apply fix to trust equipment to resolve the issue.	Improvement through Q4 but recruitment and equipment risks remain.
Outpatients	PIFU 4.7% vs 5.1% trajectory. RACP 14-day performance 74.5%, below 99% target. DNA rate reduced to4.3%% (national average 5.6%).	"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 4 off trajectory of zero. CYP ECS 84.1%	The introduction of the new model of care for adults should reduce congestion in departments which may lead to more timely assessment of children Weekly RTT review; ENT/OS on target for zero 52 week waits by end of May .	Improved ECS for CYP; zero RTT40 week waits across all specialties in 2026/27.
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. Business Case underway. 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 April 2026 Emergency Care Standard (ECS) position was provisionally 77.5%, ahead of the monthly planned improvement trajectory of 66.5%. Please note, as per a national mandate for 2026/27 100% of Bridlington and 50% of Whitby UTCs are mapped to the Trust for performance purposes and are included in the 77.5% as their performance was incorporated into the Trust's 2026/27 planning submission. **ECS performance is a True North metric.** In the latest available national data (March 2026) the Trust ranked 81st out of 118 providers and 7th out of the 11 Trusts (incl. YSTHFT) in our Model Hospital peer group (February performance saw the Trust at 94th and 10th respectively). ECS Performance for Trust controlled sites was 75% in April 2026.

- Average ambulance handover time in April 2026 was ahead of trajectory at 19 minutes 33 seconds against trajectory of 20 minutes 52 seconds.

- 5.9% of Type 1 patients spent over 12 hours in our Emergency Departments during April 2026, ahead of the monthly improvement trajectory of 19.6%. In the latest available national data (March 2026) the Trust ranked 54th out of 118 providers (February: 62nd). **This is a True North Metric.**

- The average non-elective Length of Stay (LoS) acute for patients staying at least one night in hospital was 6.7 days during April 2026 behind the trajectory of 6.5 days. This means the Trust made a 0.3 days improvement against April 2025 compared to the target of 0.5 days.

- The proportion of patients discharged on their 'Discharge Ready Date' (DRD) during April 2026 was 88.1%, ahead of the trajectory of 87.8% submitted as part of the 2026/27 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 (3.8 days).

Factors impacting performance:

- Developed using new national guidance, we launched the EEMAC and EAU pathways at each Emergency Department in March 2026. The changes have resulted in significant improvements in ECS and 12-hour performance levels and the opportunity to further refine the pathways through a continuous improvement approach is being maximised.

- There are ongoing community health and social care constraints causing delays to discharges for patients requiring onward care.

Actions planned in May 2026:

- An after-action review is underway because some concerns were raised about the pace with which EEMAC and EAU were implemented. Four face-to-face sessions are being held, along with a short survey for those who cannot attend. The review will be completed by mid-June and will be used to support future project work.

- Nervecentre goes live in May 2026 which will include a partially automated 'discharge readiness form' that should increase quality of information passed between system partners and reduce 'back and forth' discussions and document amendments. This will be closely monitored.

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 - Total waiting 12+ hours - Proportion of all Type 1 attendances * ED - Total waiting 12+ hours - Actual number of all Type 1 attendances * ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs) * ED - Emergency Care Standard (Type 1 level) - Declared Position * ED - Proportion of Ambulance handovers over 15 mins * ED - Proportion of Ambulance handovers waiting > 45 mins * ED - Ambulance average handover time (number of minutes)
COMMON CAUSE / NATURAL VARIATION		* ED - A&E attendances - Type 1 - Declared Position	* ED - 12 hour trolley waits - Declared Position
SPECIAL CAUSE CONCERN			

Acute Flow (1)
Scorecard

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
ED - Proportion of all attendances having an initial assessment within 15 mins	2026-04	H		82.1%		
ED - Proportion of all attendances seen by a Doctor within 60 mins	2026-04			31.5%		
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2026-04	L	F	5.9%	19.6%	5%
ED - Total waiting 12+ hours - Actual number of all Type 1 attendances	2026-04	L	F	740	2116	558
ED - 12 hour trolley waits - Declared Position	2026-04		F	77		0
ED - Emergency Care Attendances - Declared Position	2026-04			18705		
ED - Emergency Care Standard (Trust level incl. share of Bridlington & Whitby UTCs)	2026-04	H	F	77.5%	66.5%	82%
ED - Emergency Care Standard (Trust level) - Declared Position	2026-04	H		75%		
ED - A&E attendances - Type 1 - Declared Position	2026-04		?	11456		10999
ED - Emergency Care Standard (Type 1 level) - Declared Position	2026-04	H	F	62.2%	40%	70.1%
ED - A&E Attendances - Types 2 & 3 - Declared Position	2026-04			7249		
ED - Median Time to Initial Assessment (Minutes)	2026-04	L		4		
ED - Conversion Rate (Proportion of ED attendances that result in an admission to hospital) - Type 1 only	2026-04			42.5%		

Summary MATRIX 2

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

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			
COMMON CAUSE / NATURAL VARIATION		* Overnight general and acute beds open * Of those overnight general and acute beds open, proportion occupied * Community bed occupancy/availability	* Patients receiving clinical Post Take within 14 hours of admission * Inpatients - Proportion of patients discharged before 5pm * Number of non-elective admissions
SPECIAL CAUSE CONCERN		* Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	

Acute Flow (2)
Scorecard

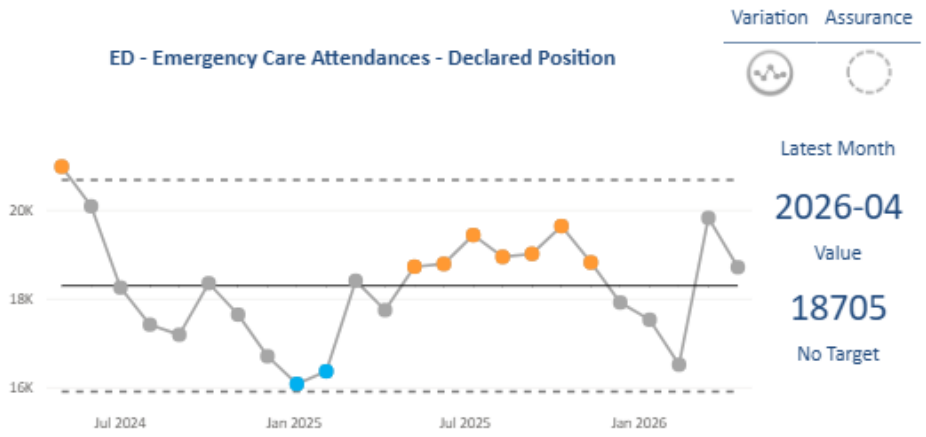
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of SDEC attendances	2026-04			4207		
Proportion of SDEC attendances transferred from ED	2026-04			80.3%		
Proportion of SDEC attendances transferred from GP	2026-04			14.6%		
Proportion of ED attendances streamed to SDEC Within 60 mins	2026-04			72.9%		
Proportion of SDEC admissions transferred to downstream acute wards	2026-04			41.6%		
Number of RAFA attendances (York Only)	2026-04			136		
Number of attendances at SAU (York & Scarborough)	2026-04			1064		
ED - Proportion of Ambulance handovers within 15 mins	2026-04			38.7%		
ED - Proportion of Ambulance handovers over 15 mins	2026-04			61.3%	65.7%	49.6%
ED - Proportion of Ambulance handovers waiting > 30 mins	2026-04			13.9%		
ED - Proportion of Ambulance handovers waiting > 45 mins	2026-04			2.1%	3.6%	0%
ED - Proportion of Ambulance handovers waiting > 240 mins	2026-04			0%		0%
ED - Number of ambulance arrivals	2026-04			4818		
ED - Ambulance average handover time (number of minutes)	2026-04			20	20	19

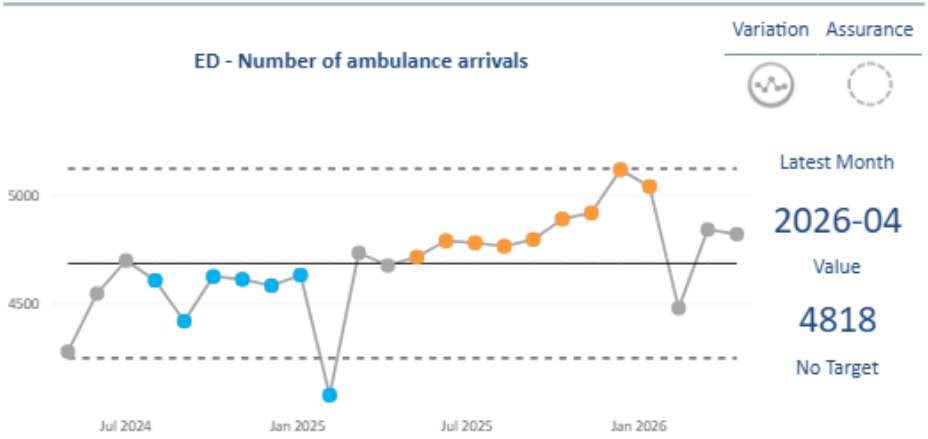
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

The latest months value has **improved** from the previous month, with a difference of **1113.0**.



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

The latest months value has **improved** from the previous month, with a difference of **21.0**.

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

What actions are planned?

The Trust's lead for Health Inequalities continues to work with Primary Care Networks to seek General Practice groups keen to explore their health inequality and high intensity user cohorts, with a view to supporting these people in a different way.

The latest data about high intensity users over the age of 75 has been shared (under a data sharing agreement) with the Frailty Hub team. They will proactively add these patients to their caseload and offer more support to keep them out of hospital.

YAS is carrying out further communications and engagement work with crews, to reiterate the alternative pathways available before considering ED.

What is the expected impact?

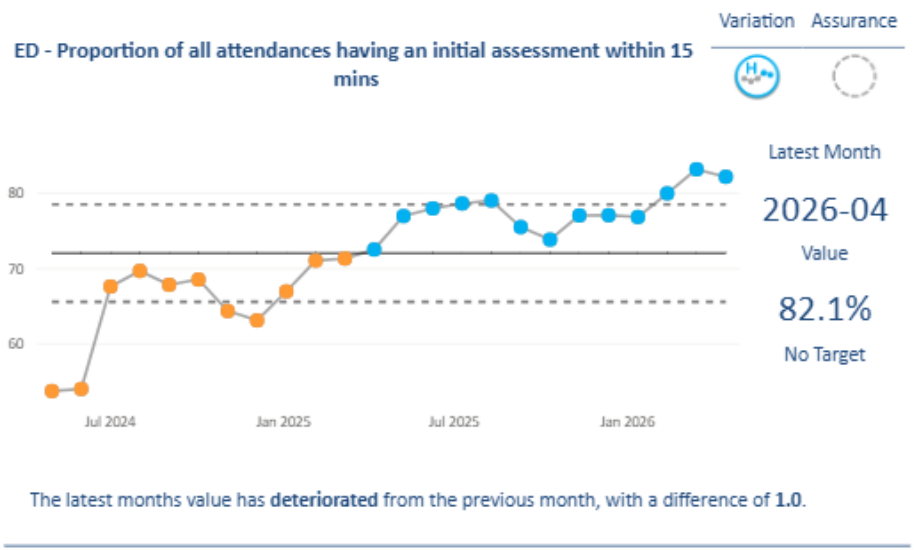
Increasing use of non-ED pathways may reduce or slow the increase of ambulance arrivals and attendances.

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



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

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

What actions are planned?

The proportion of patients having an initial assessment within 15 minutes remains above 80%. Monitoring of the new EEMAC and EAU pathways continues, and teams are asked to consider further quality improvement opportunities as they embed.

What is the expected impact?

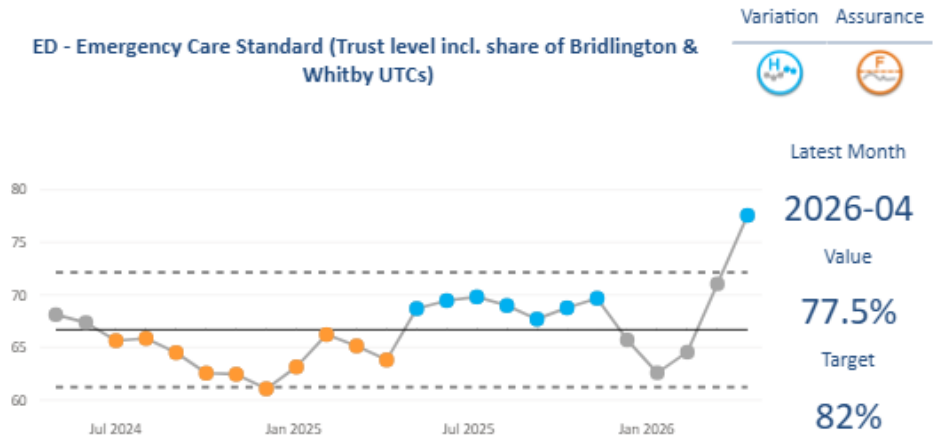
It is expected that multiple key metrics relating to our Emergency Departments hold improvements as the new pathways fully embed and staff refine them.

Potential risks to improvement?

- Continued high attendances
- Increasing ambulance arrivals

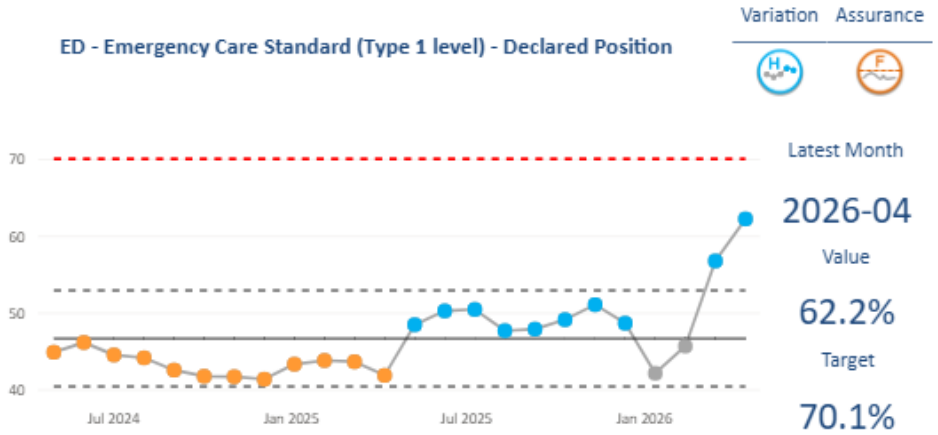
Executive Owner: Claire Hansen

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 **improved** from the previous month, with a difference of **6.5**.



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

The latest months value has **improved** from the previous month, with a difference of **5.5**.

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 82% of patients are seen within 4 hours by March 2027. **This is a True North Metric. SPC2:** Modelling showed that to achieve 82% as a Trust Type 1 performance needs to be at least 70%.

Please note, as per a national mandate for 2026/27 100% of Bridlington and 50% of Whitby UTCs are mapped to the Trust for performance purposes.

What actions are planned?

In April, the two new front-door pathways were fully embedded in both Emergency Departments which has had a positive impact on ECS, particularly at York Hospital where overall ECS is around 8 percentage points higher than at Scarborough Hospital.

Weekly continuous improvement calls ran throughout April to give all involved staff the opportunity to drop-in and share ideas for further refining and improving the pathways.

The after-action review is fully planned with sessions booked in May and early June. This will aim to learn lessons about how we communicate changes and involve staff in them.

What is the expected impact?

We expected ECS performance to increase by 3% in April and it increased by 4%. We expect that performance level to hold in May rather than increase further.

Potential risks to improvement?

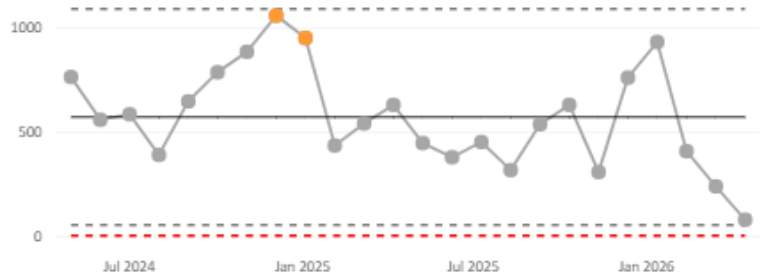
- Potential disruption caused by Nervecentre go-live in early May.
- High attendance levels likely to continue based on recent trends
- Financial constraints jeopardise the long-term workforce plan required to maximise the impact of the model.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

Variation Assurance

ED - 12 hour trolley waits - Declared Position



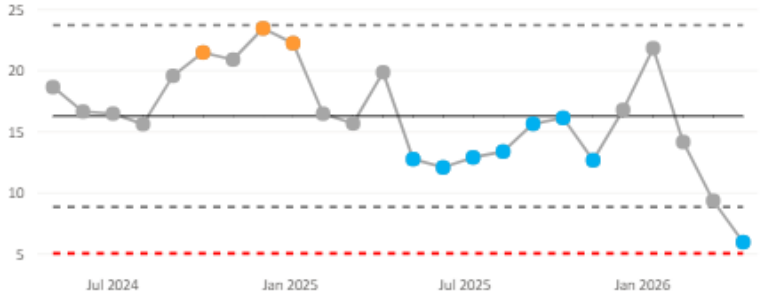
Latest Month
2026-04
Value
77
Target
0

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 **160.0**.

Variation Assurance

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



Latest Month
2026-04
Value
5.9%
Target
5%

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

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

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 5% of patients should wait more than 12 hours by end of March 2027. **This is a True North Metric.**

What actions are planned?

The Emergency Assessment Units have supported a reduction in patients spending over 12 hours in ED. This is because medical patients awaiting admission are being managed in the Emergency Assessment Unit by Acute Physicians and receiving timely senior reviews.

In order to maximise this opportunity there needs to be continued flow out of EAU through both discharges home and admission to the main bed base. Work to refine these pathways continues since this is important for managing flow and eradicating corridor care.

What is the expected impact?

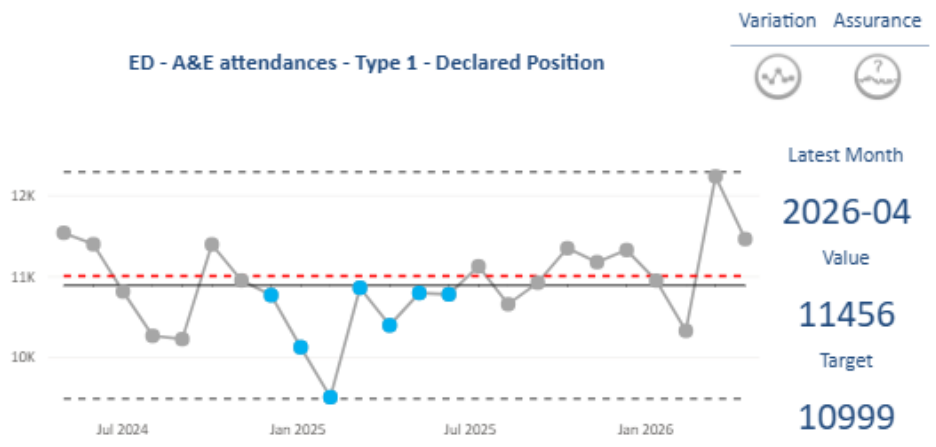
Both sites saw further reduction in 12hr breaches in April 2026, as predicted. It is expected that the position holds in May 2026.

Potential risks to improvement?

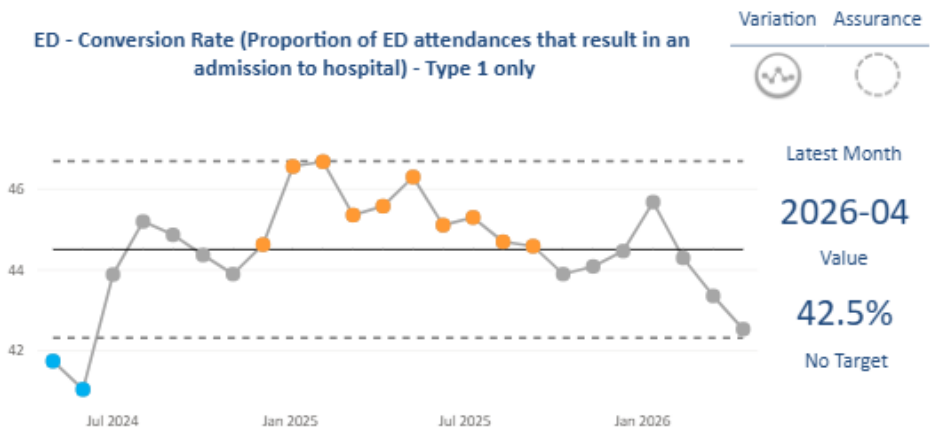
- Bed occupancy levels remain high, and the capacity required on wards could be higher than escalation spaces can support.
- Community health and social care capacity remains challenged.
- While the new model reduces patients waiting 12 hours in ED, some patients are waiting for the same time in EAU which can quickly become full if patients are not discharged or moved to AMU and/or the main bed base.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



The latest months value has **improved** from the previous month, with a difference of **775.0**.



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

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

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.

What actions are planned?

The new model of care has brought senior decision making closer to the front door and appears to have successfully supported a reduction in the proportion of patients being admitted. This will continue to be monitored over the coming months, and further data analysis will be carried out to understand the causes of the correlation. This work requires support from the Business Intelligence team and as such will be completed after the initial launch of Nervecentre.

What is the expected impact?

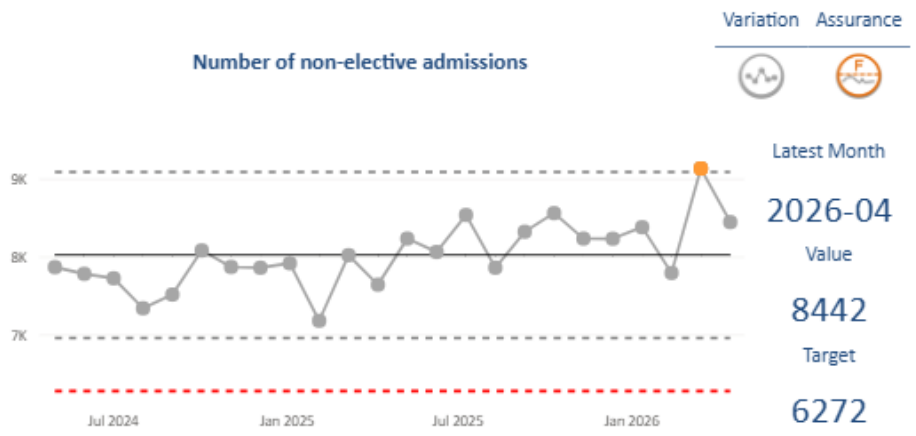
The reduction in admissions should hold now that the EAUs have been in place for a full calendar month. There is potential to reduce admissions further by investing in more senior decision makers at each site, for Emergency Department medics and Acute Physicians and Geriatricians leading the EAU pathway. A business case is being prepared for considering in June 2026.

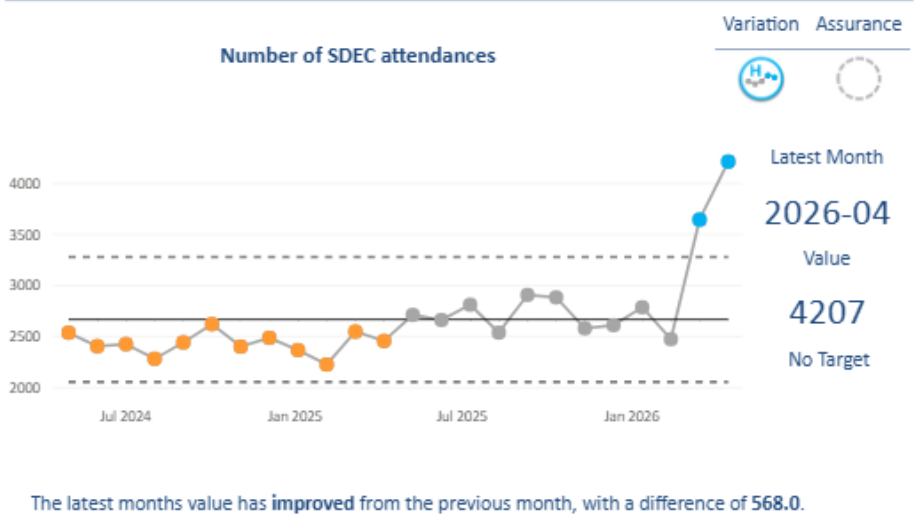
Potential risks to improvement?

There is a risk that the total request for additional recurring funds will be unavailable and a reduced position will be achieved.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi





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

Note: The total admissions data includes admissions to all Same Day Emergency Care (SDEC) units.

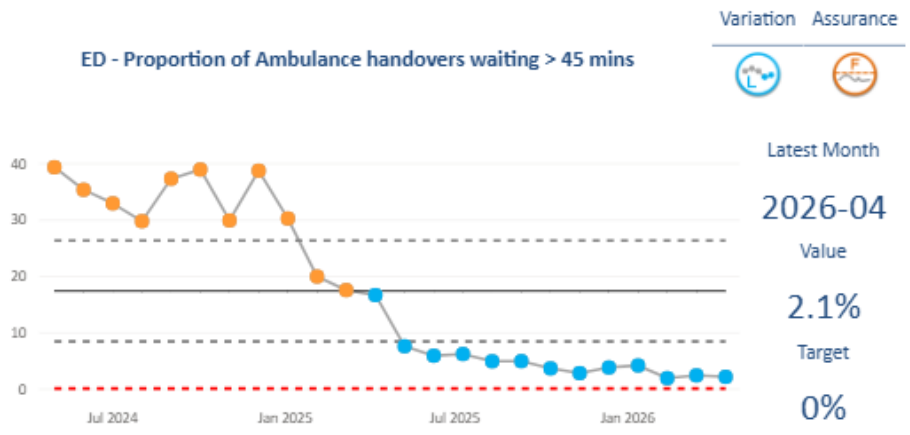
What actions are planned?

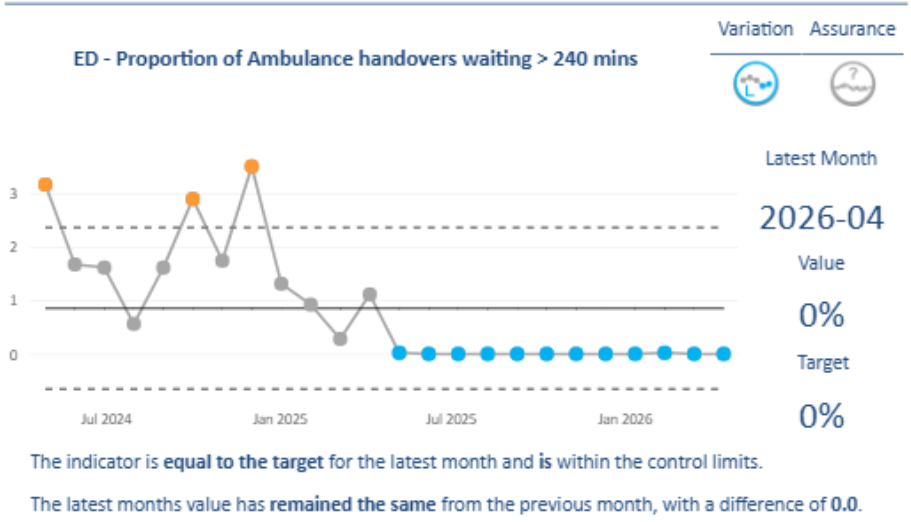
Midway through April 2026 the Medical SDEC at York Hospital started to close overnight, with the last admission at 10pm and full closure at 2am.

Despite this reduction in hours, the total number of SDEC attendances has increased which is encouraging. This change is being monitored, and learning will support further developments. The increase is also seen due to opening of EAU.

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.

What actions are planned?

EEMAC and EAU pathways are supporting a reduction in overcrowding and are designed to ensure patients move to the right place with minimal delay. This in turn supports 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

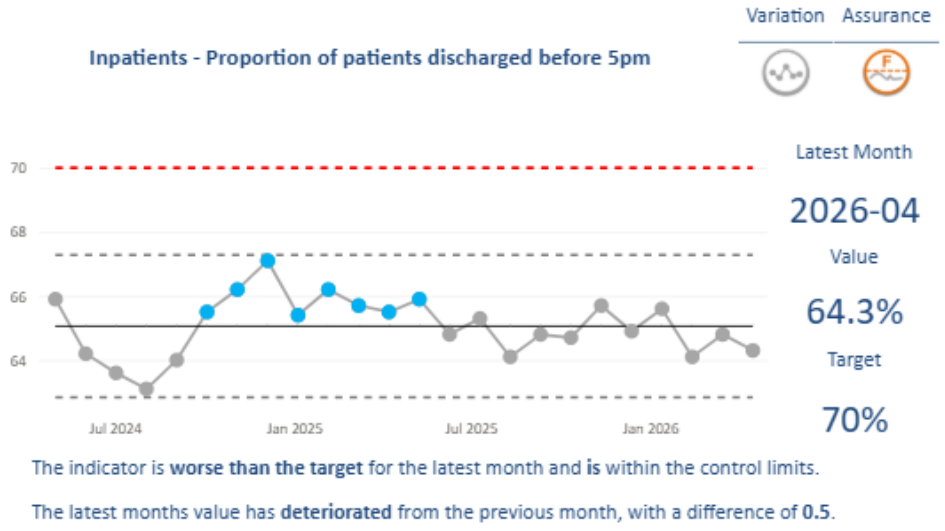
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-04		F	78.4%		90%
Patients with Senior Review completed at 23:59	2026-04	L		44.7%		
Inpatients - Proportion of patients discharged before 5pm	2026-04		F	64.3%		70%
Inpatients - Lost bed days for patients with no criteria to reside	2026-04	H		1525		
Inpatients - Proportion of adult G&A beds occupied by patients not meeting the criteria to reside	2026-04	L		16.5%		
Inpatients - Average number of bed days spent in hospital after a patients discharge ready date (DRD)	2026-04	H	?	4.5	3.5	3.7
Number of non-elective admissions	2026-04		F	8442	7393	6272
Number of zero day length of stay non-elective admitted patients	2026-04			2830		
Inpatients - Super Stranded Patients, 21+ LoS (Adult)	2026-04			120		
Overnight general and acute beds open	2026-04		?	872	843	843
Of those overnight general and acute beds open, proportion occupied	2026-04		?	91.4%	93%	93.2%
Community bed occupancy/availability	2026-04		?	86.8%		92%

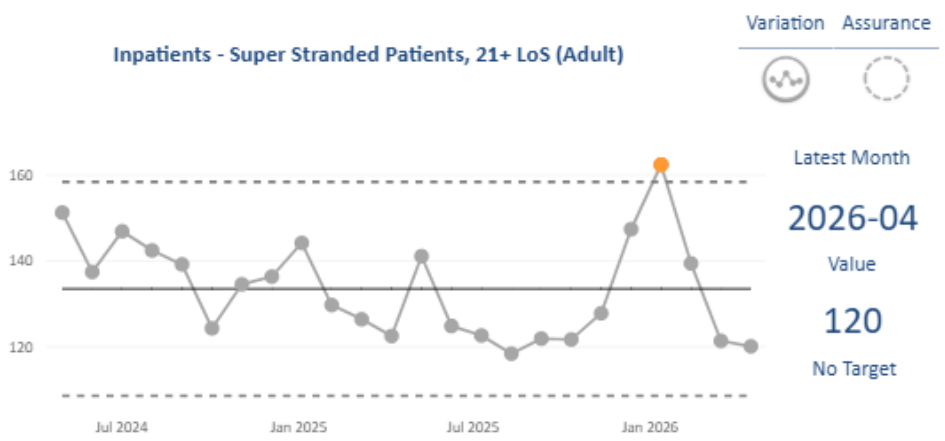
Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi



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

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



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

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

What actions are planned?

- The process for reviewing patients with a length of stay over 21 days has been updated and will focus on medically unfit patients whose clinical management plans are at risk of having stalled.
- In the lead up to the Nervecentre rollout the concept of "Think Thursday, Focus Friday" - which was shared by another Trust - is being tested. A super discharge team will attend rounds on a Thursday to ask teams to think about who can go home ahead of the weekend and what actions are required to make that happen. On the Friday the super discharge teams follows up to ensure there is focus on completing all of the required tasks, and practical support given where possible to unblock delays. Learning will be gathered from this test and if successful the Discharge Improvement Group will consider how this can be built into normal practice.

What is the expected impact?

- Improvement in the super stranded percentage pf occupancy.

Potential risks to improvement?

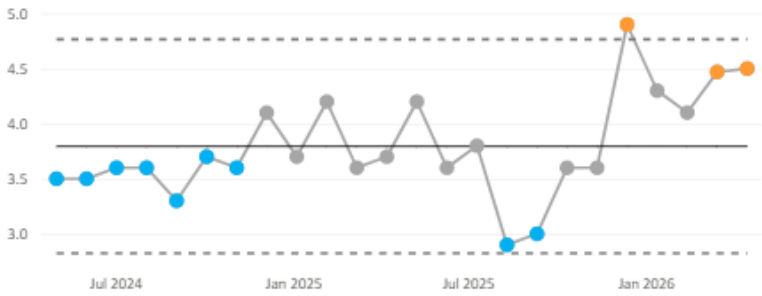
- More high acuity patients arriving to our hospitals, which could lead to longer lengths of stay.
- Limited community health and social care capacity to release patients no longer meeting the criteria to reside.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi

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

Variation: H | Assurance: ?



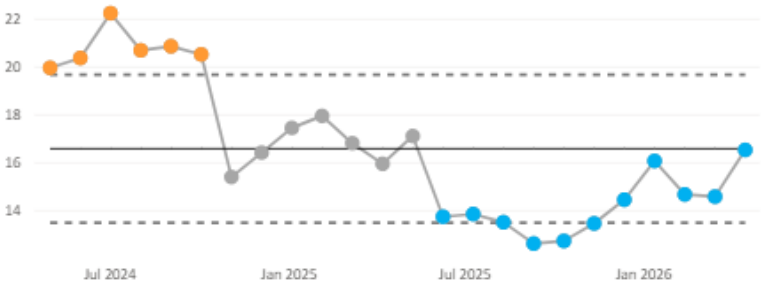
Latest Month: 2026-04
Value: 4.5
Target: 3.7

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**.

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

Variation: L | Assurance: –



Latest Month: 2026-04
Value: 16.5%
No Target

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

The latest months value has **deteriorated** from the previous month, with a difference of **1.9**.

Rationale: Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore which are unavailable due to discharge issues.
Target: SPC1: 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 3.7 days by March 2027.

What actions are planned?

- The new Discharge Readiness Form will go live 7th May with Nervecentre. This will support automation of required fields and should increase the quality of the information, leading to fewer checks and updates required.

Potential risks to improvement?

- Limited community health and social care capacity to release patients no longer meeting the criteria to reside.

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		* Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	
COMMON CAUSE / NATURAL VARIATION		* Cancer 31 day wait from diagnosis to first treatment - Declared Position	* Cancer - Faster Diagnosis Standard - Declared Position * Cancer - 62 Day First Definitive Treatment Standard - Declared Position
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	2026-03		F	77.2%	80.1%	84.3%
Cancer - 62 Day First Definitive Treatment Standard - Declared Position	2026-03		F	72.4%	75%	80%
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2026-04			159		
Proportion of patients waiting 63 or more days after referral from cancer PTL	2026-04			7.1%		
Cancer 31 day wait from diagnosis to first treatment - Declared Position	2026-03		?	99.2%		96.1%
Total Cancer PTL size	2026-04			2300		
Proportion of Lower GI Suspected Cancer referrals with an accompanying FIT result	2026-04	H	?	78.6%		71.4%

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

- The Cancer performance figures for March 2026 saw performance against the 28-day Faster Diagnosis standard (FDS) of 77.2% (up almost 17% from the January position of 60.4%), failing to achieve the monthly improvement trajectory of 79.3%. In the latest available national data (February 2026) the Trust ranked 99th out of 119 NHS providers nationally and 8th out of 11 against our Model Hospital peer group (January: 111th and 11th respectively). **This is a True North Metric.**

- 62 Day waits for first treatment service standard in March 2026 was 72.4% (up circa 10% from the January position of 62.8%), with the monthly trajectory of 73% not achieved. In the latest available national data (February 2026) the Trust ranked 58th out of 119 providers nationally and 4th out of 11 against our Model Hospital peer group (January: 73rd and 5th respectively). 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.

Factors impacting performance:

- The following cancer sites exceeded 80% FDS in March 2026: Breast, Haematology, Head and Neck and & None Site Specific. Urology and Colorectal achieved above their internal trajectories.

- The following cancer sites exceeded 75% 62-day service standard in March 2026: Breast, Haematology & Urology. Colorectal & Gynaecology achieved over internal trajectories.

- 31-day treatment standard was 99.2% overall, which achieved the national service standard of 96%.

- At the end of March, the proportion of patients waiting over 104+ days equates to 2.6% of the PTL size with 58 patients, this position is stable between 2% and 2.6% over the last 6 months. Colorectal, Skin and Urology remain 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.

- Diagnostic performance, in particular endoscopy and imaging is impacting faster diagnosis performance due to delays in diagnostic pathways.

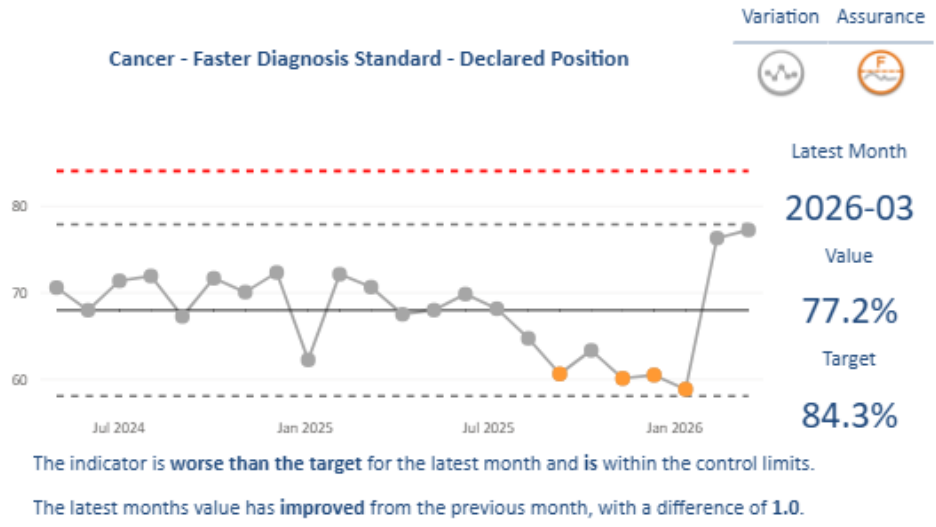
- Referrals received with FIT has seen deteriorating performance. The Cancer Alliance have been tasked with leading ongoing system work, including the appointment of a new Lower GI system clinical lead. Data has been provided to the Alliance GP lead for targeted sessions with practices and additional prompts have been added to Gateway referral form.

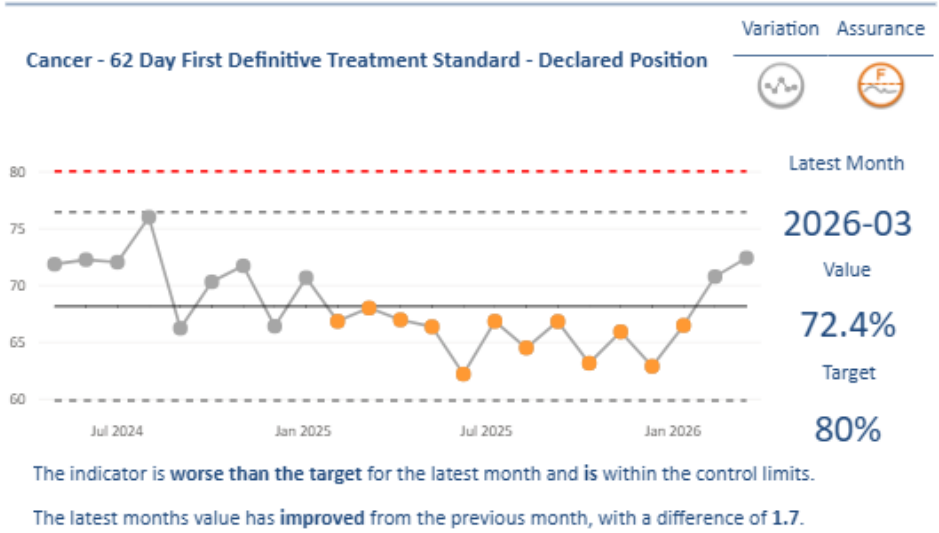
Actions:

- 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 2026/27 is to continue improve performance against the headline 62-day standard**.**
Target: SPC1: 80% as an average for the whole of 2026/27. **SPC2:** 80% by March 2027.

What actions are planned?
Demand and capacity 1st OPA for all tumour sites via IMAS modelling completed and provided to specialities and 2nd weekly Trust wide meeting implemented to review specific FDS cohort and newly diagnosed patients

Colorectal Plan
Highest ever achieved since FDS standard introduced in February and March. Additional registrar educational session planned for fast-track decision making, alternative FiT negative pathways and conversion rates to endoscopy. Process in place for returning referrals with no FIT to primary care. New colorectal cancer lead appointed. Ongoing discussions with endoscopy around pilots to improve TAT and provide additional capacity. Initial scoping discussions around COLOFiT.

Urology Plan
STT CT model in haematuria commenced implementation, additional funds until mid April for additional consultant sessions to support. Ongoing discussions for implementing standardised discharge post Likert score and scope and consult model for TP biopsy, however workforce rota changes required alongside clinical governance review and support. Target date for implementation end of Q1 26/27.

Gynaecology Plan
PMB pathway implementation on both sites, Pipelle commenced on York site in CDC. East Coast lead clinician absent for extended period. Arrangements made for consultant and CNS cover at MDT to present patients, 6 additional colposcopy lists provided in May alongside 1 hysteroscopy and 2 fast track clinics. Working group to be initiated for IOTA ADNEX one stop model. Senior operational gaps mitigated in part with involvement of head of cancer running tumour site PTL meetings.

Skin
Ongoing risk around dual running of telederm and non telederm pathways, alongside consultant sickness. Team exploring with interim clinical lead around step down options for patients on pathway, MOP's continued to be prioritised on clinical urgency. Scoping for community models pre-LES expiry in December 2026.

What is the expected impact?
Focus on maintaining and sustaining improved performance, whilst transformational actions also run in parallel.

Potential risks to improvement?
- Financial constraints impacting ability to provide additional activity- SDF cancer sprint activity planned
- Cancer performance dependent upon diagnostic and pathology capacity and recovery plans. Particular risk around pathology TAT in gynaecology, Urology and Breast and application of endoscopy booking rules. Endoscopy recovery plan in place, pathology improvement plan currently on much longer-term basis.

Headlines (Provisional performance):

- **Please note: RTT figures for April 2026 are provisional in line with NHSE national RTT performance submission timetable they will not be finalised until the 14th working day of the following month.**

- At the end of April 2026, the Trust had zero **Referral To Treatment (RTT) patients waiting over sixty-five weeks**.

- The Trust's **RTT Total Waiting list position** provisionally ended April 2026 ahead of the trajectory submitted to NHSE as part of the 2026/27 planning submission: 55,223 against the trajectory of 55,422.

- The Trust was provisionally behind the trajectory for the proportion of the **patients on an RTT waiting list under 18 weeks** at the end of April: 56.1% against 56.6%. Validation before submission is expected to deliver the trajectory. In the latest available national data (February 2026) the Trust ranked 111th worst out of 118 NHS providers and 10th worst out of 11 in our Model Hospital peer group (January: 107th and 8th respectively). **This is a True North Metric.**

- The Trust is provisionally behind the **RTT52 week** trajectories submitted within the 2026/27 planning submission; 1,064 waiters and 1.9% of the total RTT Total Waiting list against the trajectories of 964 and 1.8%, respectively. Validation before submission is expected to deliver the trajectories. In the latest available national data (February 2026) the Trust was ranked 93rd worst out of 118 NHS providers and equal 8th worst out of 11 in our Model Hospital peer group for the proportion of the TWL waiting over 52 weeks (January: 88th and 7th respectively). Nationally at the end of February 2026 there were 6,688,208 patients on the national TWL, of which 118,246 (1.8%) were waiting over 52 weeks.

- The Trust was behind the trajectory for **RTT patients waiting no longer than 18 weeks for a first appointment** submitted to NHSE as part of the 2026/27 planning submission with performance of 62.9% ahead of the end of April 2026 ambition to be above 60.1%. There is currently no nationally available comparative data for this metric.

Factors impacting performance:

- April 2026 saw a 5% rise in GP Referrals compared to the same period in 2025. There were significant rises to several specialties namely; Pain Management (+39%), Breast Surgery (+37%) and Gastroenterology (+33%). The Trust is engaging with the ICB to understand the drivers and the opportunities to mitigate. Direct Cancer GP referrals (not including upgrades, incidental findings etc.) were up 10%, this impacts the ability to see routine RTT patients.

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 - Provisional Position	* RTT - Waits over 65 weeks for Incomplete Pathways - Provisional Position * RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position * RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks
COMMON CAUSE / NATURAL VARIATION			* RTT - Waits over 52 weeks for Incomplete Pathways - Provisional Position * RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position
SPECIAL CAUSE CONCERN		* RTT - Total Waiting List - Provisional 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 - Provisional Position	2026-04	H	?	55223	55422	49360
RTT - Waits over 78 weeks for incomplete pathways - Provisional Position	2026-04	L	?	0		0
RTT - Waits over 65 weeks for Incomplete Pathways - Provisional Position	2026-04	L	F	0		0
RTT - Waits over 52 weeks for Incomplete Pathways - Provisional Position	2026-04		F	1064	964	0
RTT - Proportion of incomplete pathways waiting less than 18 weeks - Provisional Position	2026-04		F	56.1%	56.6%	67.5%
RTT - Mean Week Waiting Time - Incomplete Pathways	2026-04	L		17.8		
RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position	2026-04	L	F	1.9%	1.8%	0%
RTT - Proportion of patients waiting for first attendance who are waiting under 18 weeks	2026-04	H	F	62.9%	60.1%	67.1%
Proportion of BAME pathways on RTT PTL (S056a)	2026-04	H		2%		
Proportion of most deprived quintile pathways on RTT PTL (S056a)	2026-04	H		12.5%		
Proportion of pathways with an ethnicity code on RTT PTL (S058a)	2026-04	H		68.8%		

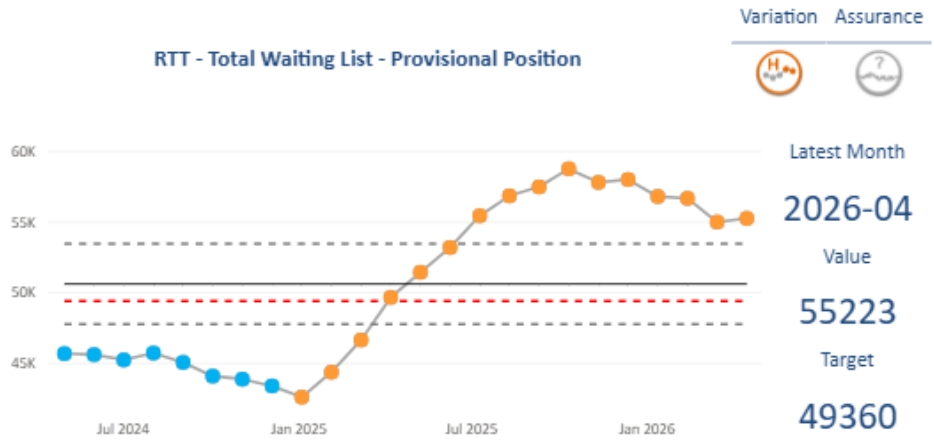
KPIs – Operational Activity and Performance

Referral to Treatment RTT (1)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

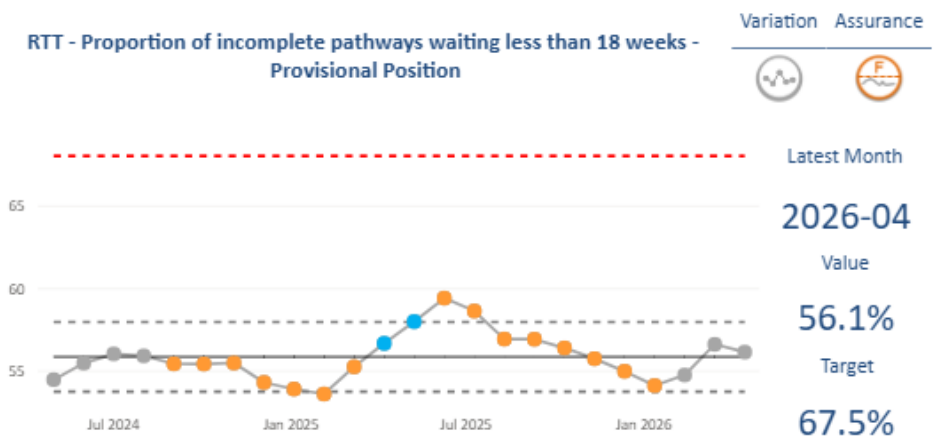
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

The latest months value has **deteriorated** from the previous month, with a difference of **258.0**.



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

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

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 49,360 patients waiting by March 2027 as per activity plan. **SPC2:** National constitutional target of 92% of patients should be waiting less than 18 weeks. Target for March 2027 is to be above 67.5%. **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.
- The service delivery plan has a comprehensive list of actions to support the delivery of increased productivity and RTT performance improvement, these are monitored through the RTT delivery Group.
- 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?

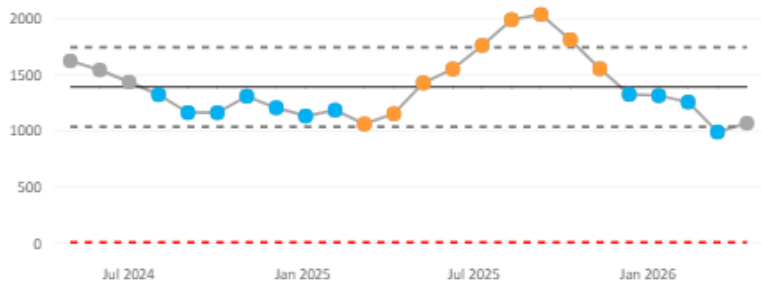
- Increase in GP referrals in April 2026 compared to April 2025 (up 5%), which is above 26/27 planned increased.
- Impact of delayed capital builds (CDC, Hybrid theatre, MRI, VIU, SGH Roof and RAAC), resulting in reduction in capacity and increasing waiting times.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

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



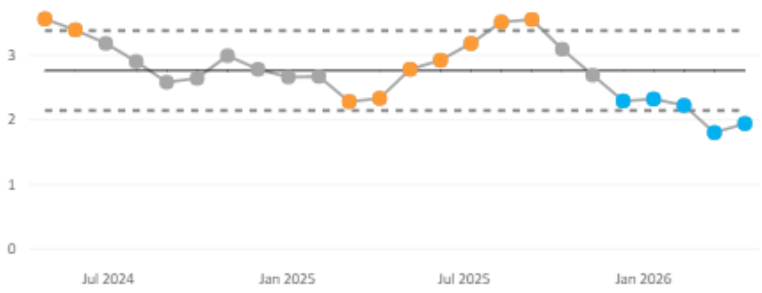
Latest Month
2026-04
Value
1064
Target
0

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

The latest months value has **deteriorated** from the previous month, with a difference of **78.0**.

Variation Assurance

RTT - Proportion of the incomplete RTT pathways waiting > 52 weeks - Provisional Position



Latest Month
2026-04
Value
1.9%
Target
0%

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

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

Rationale: To measure and encourage compliance with recovery milestones for the RTT waiting list. Waiting times matter to patients.
Target: SPC1 & SPC2: Aim to have zero patients waiting more than 52 weeks by March 2027 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 expanded in April 2026 to monitor full pathway metrics rather than focus on longest waiters. Maintaining zero RTT65 week waits remains a priority.
- Fortnightly meetings with Care Groups to review in month performance against activity and performance targets.
- Focused on improvement actions for Pain Management who are area with most significant variance from plan.

What is the expected impact?

- Reduced RTT long waiters.
- Activity Related Investment Panel to focus on requests for funding for 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

Headlines:

- For the month of April 2026, the Patient Initiated Follow Up (PIFU) the Trust was behind the improvement trajectory of 5.1% with performance of 4.7%. 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 74.5% below the target of 99%. As at the start of May the service are reporting that all patients on the waiting list are booked within 14 days.

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 reduced to 4.3% in April 2026. The Trust has one of the lowest DNA rates in the country, the national average is 5.6% (NHSE).

- Digital letters for Radiology is due to complete the roll out by the end of May 2026. Clinical letters went live on 29th January, but the pilot had to be halted and the software re-written due to an issue with TPP and special characters in the letters. The revised form went live on the 29th of April, trial temporarily paused for piloting of ambient voice technology. Date for re-commencement of trial to be agreed before the end of May 2026.

- Delivery of the 2026/27 elective activity plan; initial analysis shows that at the end of April 2026 the Trust delivered the funded (excludes OP follow ups without procedure) plan.

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	* Outpatients: Follow Up Attendances (Activity vs Plan) * Proportion of elective admissions which are day case	* Outpatients - DNA rates * 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

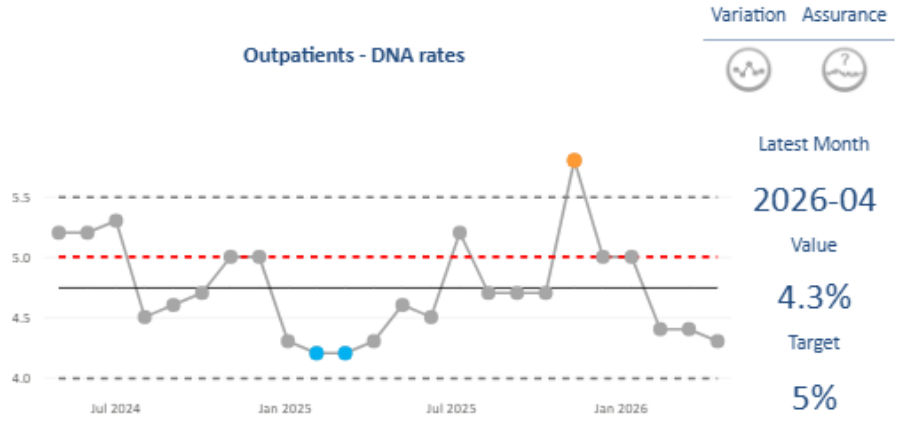
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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)	2026-04	H	F	22.5%		25%
Outpatients - DNA rates	2026-04		?	4.3%		5%
Outpatients: 1st Attendances (Activity vs Plan)	2026-04	H	?	19752	19892	23266
Outpatients: Follow Up Attendances (Activity vs Plan)	2026-04		P	43597	46456	55935
Outpatient procedures	2026-04	L		10421		
Outpatients: Follow-up Partial Booking (FUPB) Overdue (over 6 weeks)	2026-04		F	27597		0
Outpatients - Proportion of patients moved or discharged to Patient Initiated Follow Up (PIFU)	2026-04	H	F	4.7%	5.1%	6.6%
Trust waiting time for Rapid Access Chest Pain Clinic (seen within 14 days of referral received)	2026-04	H	F	74.5%		99%
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days*	2026-04		?	3		0
Day Cases (based on Activity v Plan)	2026-04		?	8031	6538	7781
Electives (based on Activity v Plan)	2026-04		?	749	654	660
Proportion of elective admissions which are day case	2026-04		P	91.5%		85%
Outpatients: All Referral Types	2026-04			24000		
Outpatients: Consultant to Consultant Referrals	2026-04			2614		
Outpatients: GP Referrals	2026-04			10599		

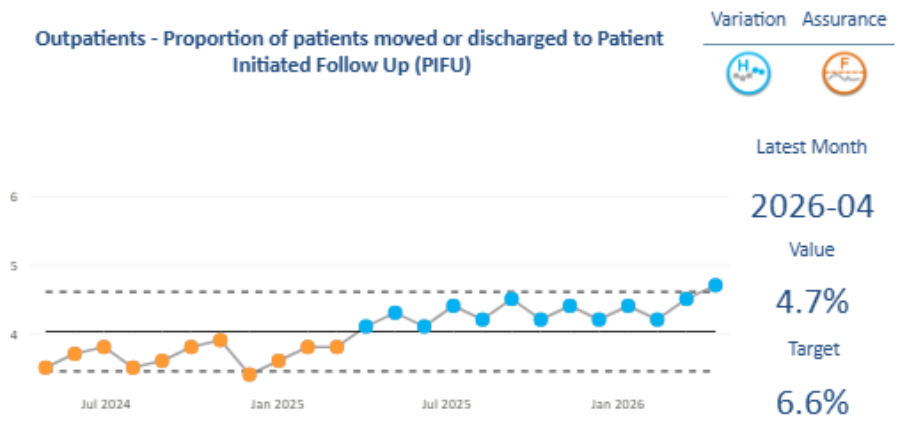
Executive Owner: Claire Hansen

Operational Lead: Kim Hinton



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

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



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

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

Rationale: SPC1: Need to reduce instances where people miss their outpatient appointments ('did not attends' or 'DNAs') to improve patient experience, free up capacity to treat long-waiting patients and support the delivery of the NHS's plan for tackling the elective care backlog. **SPC2:** Helps empower patients to manage their own condition and plays a key role in enabling shared decision making and supported self-management in line with the personalised care agenda.
Target: SPC1: Internal target of less than 5%. **SPC2:** Above 6.6% by March 2027.

What actions are planned?

- 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. This is supported by the Project Management Office team.

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

- Outpatient utilisation project commenced to increase utilization to 90%.

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?

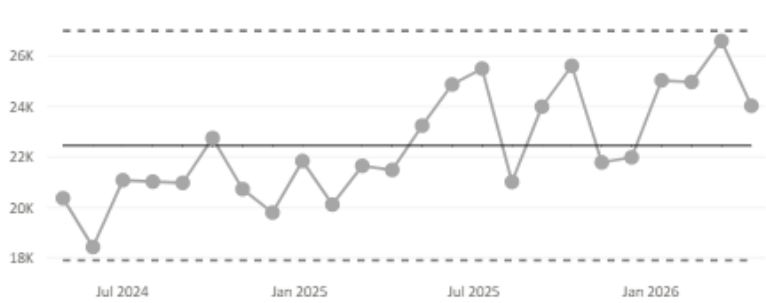
- Patient administration processes to ensure PIFU is appropriate actioned through worklist on CPD and patients are given unnecessary follow ups.

Executive Owner: Claire Hansen

Operational Lead: Kim Hinton

Variation Assurance

Outpatients: All Referral Types



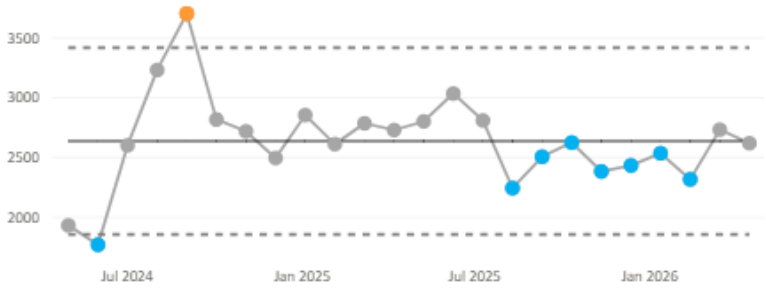
Latest Month
2026-04
Value
24000
No Target

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

The latest months value has **improved** from the previous month, with a difference of **2571.0**.

Variation Assurance

Outpatients: Consultant to Consultant Referrals



Latest Month
2026-04
Value
2614
No Target

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

The latest months value has **improved** from the previous month, with a difference of **113.0**.

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). Focus area in May will be pain referrals.
- 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?

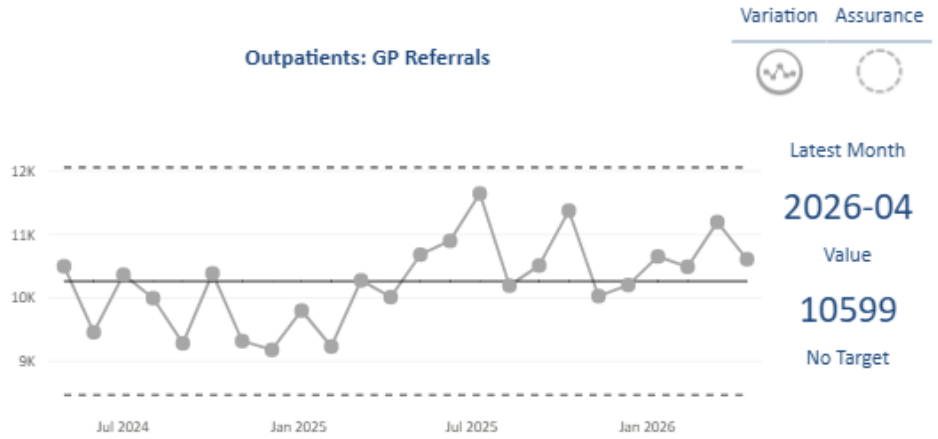
- Reduction in internal demand and reduction in open referrals.
- Reduction in GP demand.
- Improved redirection of referral direct to test or to other services to reduce requirement for outpatient attendances.

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 **improved** from the previous month, with a difference of **587.0**.

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

Please see previous page

Headlines:

- Trust DM01 performance at end April 2026 was 73% against the planned trajectory of 74.8%.
- The total waiting list reduced in April, but there was a small increase to patients over 6 weeks and 13 weeks.
- In the latest available national data (February 2026) the Trust ranked 80th worst out of 118 NHS providers and 8th worst out of 11 in our Model Hospital peer group (January: 82nd and 8th respectively).

Factors impacting performance:

- Deterioration in April performance is largely due to significant performance issues within CT which accounts for over a quarter of the total waiting list, and almost half of all breaches of the 6-week target. While we have seen improvements in some other modalities this has not been sufficient to support performance to trajectory.
- The issues within CT are caused by staffing shortages due to Radiographer vacancies, maternity leave, and sickness all lead to insufficient capacity to meet demand.
- Mitigations in place using staffed mobiles and WLIs however this is only sufficient to support performance and not to recover. Tests are being prioritised by clinical urgency so routine tests are being delayed which is impacting DM01.
- Delays in implementation of additional Audiology booths to allow extra clinical space to deliver activity. While the Malton and Bridlington booths are now in use, the site identified for the York booths is unsuitable due to noise levels, so these are not yet able to be used.
- While the outpatient element of Cystoscopy is performing well, there is a cohort of patients requiring inpatient procedures due to clinical or anaesthetic requirements and there has been insufficient theatre and related staffing availability to maintain performance in this pathway which brings overall performance down.
- Significant increase in elective demand across multiple modalities following additional activity in Q4 to support RTT and Cancer position.
- Prioritisation of cancer in line with trust guidance has led to longer routine waits which impacts DM01 performance.
- 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.

Summary MATRIX

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

MATRIX KEY

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

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

DIAGNOSTICS – National Target: 95%

Scorecard

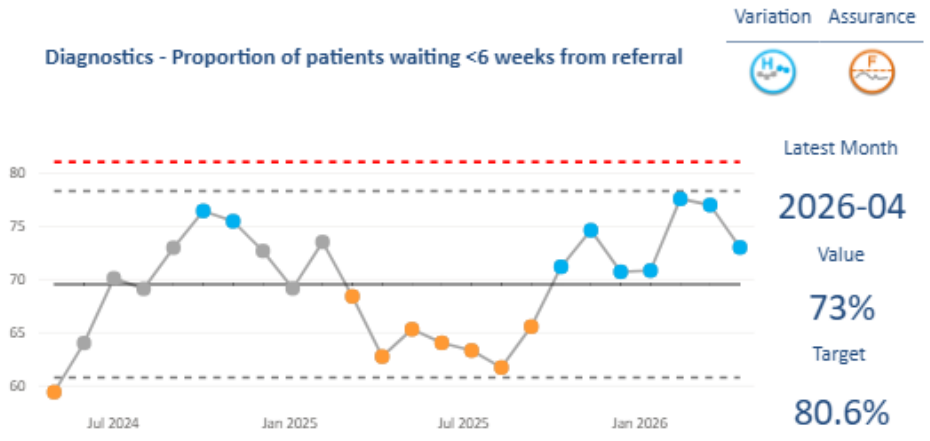
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-04	H	F	73%	74.8%	80.6%
Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI	2026-04	H	F	91.3%	78.1%	90.1%
Diagnostics - Proportion of patients waiting <6 weeks from referral - CT	2026-04		F	55.2%	86.3%	91.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound	2026-04		?	78.4%	75.7%	77.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema	2026-04		F	84.1%	84%	95.2%
Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan	2026-04	H	?	82.8%	94.3%	86.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology	2026-04	H	F	72.9%	74.9%	80%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography	2026-04	L	?	30.8%	72.3%	79.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral	2026-04		?	87.2%	95.7%	95.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies	2026-04		?	82.5%	94.7%	94.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics	2026-04		F	56.9%	68.7%	84.7%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy	2026-04	H	F	90.5%	80%	86%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy	2026-04	H	F	86.5%	82%	85.9%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy	2026-04		?	65.9%	64.5%	69.5%
Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy	2026-04	H	?	87.8%	83.1%	86%

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 80.6% by end of March 2027.

What actions are planned?

Endoscopy: Recruitment drive in Q4 2025/26 resulted in sufficient staffing to run room 7, 2-3 days per week by June 2026. Introduction of new staff will be a gradual process, and we will reduce then cease insourcing as we introduce more staff. Recruitment continues with the aim to staff room 7, Monday to Friday by December 2026. Clinical endoscopist in training and expected to be signed off as independent PR actioner in Q2 2026/27. Centralised preassessment clinics in Bridlington expected end Q2 2026/27, to release 3 RN in York to support staffing of room 7. Cystoscopy service are working with the inpatient waiting list team to identify opportunities to clear the backlog, consultant availability dates identified between May and July so potential for dates to be added pending theatre availability and related staffing.

Imaging: Staffing vacancies in MRI are being mitigated by use of RMS insourcing to retain core capacity until recruitment can be completed to return to full substantive establishment. YSJ scanner increased from 2 days to 4 days per week from end April. CT service leads developing plans for what capacity would be required to staff all scanners 7 days per week, 12 hours per day to allow recovery. Independent sector have taken on all long waiting DEXA patients impacted by field safety notice. Engineer scheduled for 18th May to apply fix to trust equipment to resolve the field safety notice going forward. Bank registrar commenced in post mid January 2026 focusing on NOUS soft tissue cohort which has now been cleared. Registrar continues to support via bank shifts to focus on patients requiring guided injections from start of Q1 26/27.

Physiological: Bank post advertising imminently for 2 days of an echocardiographer resulting in 20 additional slots per week at York. Utilising additional outpatient room wherever possible to increase echo capacity. Plan in place to increase Stress Echo and Echo capacity when new VIU opens - through physiologist led stress echos with RACP nurse support. Respiratory pathways are being redesigned to include pre-appointment diagnostics where appropriate for patients on an open RTT pathway.

What is the expected impact?

Increased capacity leading to increase in activity, reduction in backlogs and improvement to DM01 performance and deliver the 2026/27 trajectory.

Potential risks to improvement?

Ongoing issues with equipment breakdown and recruitment challenges.

Summary MATRIX

Children & Young Persons: *please note that any metric without a target will not appear in the matrix below*

MATRIX KEY

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

VARIATION	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT			* Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Ages 0-16) * Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks * Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways
COMMON CAUSE / NATURAL VARIATION		* Children & Young Persons: ED - Patients waiting over 12 hours in department	
SPECIAL CAUSE CONCERN			

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)

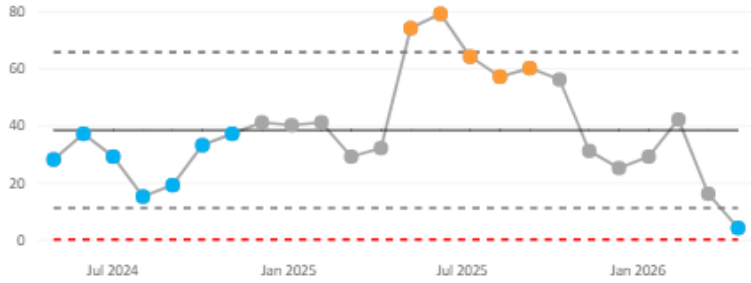
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Children & Young Persons: ED - Patients waiting over 12 hours in department	2026-04			1		0
Children & Young Persons: ED - Emergency Care Standard - Type 1 only (Ages 0-16)	2026-04			84.1%	92%	95%
Children & Young Persons: ED Attendances - Type 1 only (Ages 0-16)	2026-04			1601		
Children & Young Persons: RTT - Total Waiting List	2026-04			4153		
Children & Young Persons: RTT - Proportion of incomplete pathways waiting less than 18 weeks	2026-04			64.8%		92%
Children & Young Persons: RTT Waits over 52 weeks for incomplete pathways	2026-04			4	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



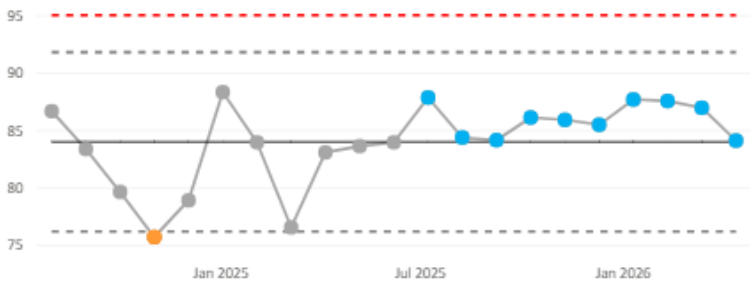
Latest Month
2026-04
Value
4
Target
0

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 **12.0**.

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

Variation Assurance



Latest Month
2026-04
Value
84.1%
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 **2.8**.

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: Internal aim to have zero patients waiting more than 52 weeks by end of quarter one 2026/27. **SPC2:** Internal objective to improve A&E waiting times so that no less than 95% of CYP patients are seen within 4 hours by March 2027.

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:

- 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		* Total Urgent Community Response (UCR) referrals * 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	* 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 * Number of people on waiting lists for CYP services per system who are waiting over 52 weeks
COMMON CAUSE / NATURAL VARIATION	* Attended Community Care Contacts	* Proportion of intermediate care beds occupied by people with no criteria to reside * Proportion of Virtual Ward beds occupied	* 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
SPECIAL CAUSE CONCERN		* Number of open Virtual Ward beds	

COMMUNITY
Scorecard (1)

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
Proportion of intermediate care beds occupied by people with no criteria to reside	2026-04		?	18.7%	25.5%	20%
Number of open Virtual Ward beds	2026-04	L	?	33	33	33
Proportion of Virtual Ward beds occupied	2026-04		?	78.8%	82%	82%
Community Response Team (CRT) Referrals	2026-04	H		571		
Total Urgent Community Response (UCR) referrals	2026-04	H	?	535	488	514
2-hour Urgent Community Response (UCR) care Referrals	2026-04	H		238		
2-hour Urgent Community Response (UCR) Compliancy %	2026-04			77.7%		
Attended Community Care Contacts	2026-04		P	37298	39275	41283
Number of District Nursing Contacts	2026-04			21424		
Number of Selby CRT Contacts	2026-04			2506		
Number of York CRT Contacts	2026-04	L		2857		
Referrals to District Nursing Team	2026-04			2102		

COMMUNITY
Scorecard (2)

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 Adults (18+ years) on community waiting lists per system	2026-04	L		602		
Number of CYP (0-17 years) on community waiting lists per system	2026-04	L		1596		
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	2026-04		F	58%	59.5%	78%
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	2026-04	H	?	100%	99.6%	99.6%
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	2026-04	H	F	42.1%	41.6%	63.7%
Number of people on waiting lists for CYP services per system who are waiting over 52 weeks	2026-04	L	F	550	570	0

Executive Owner: Claire Hansen

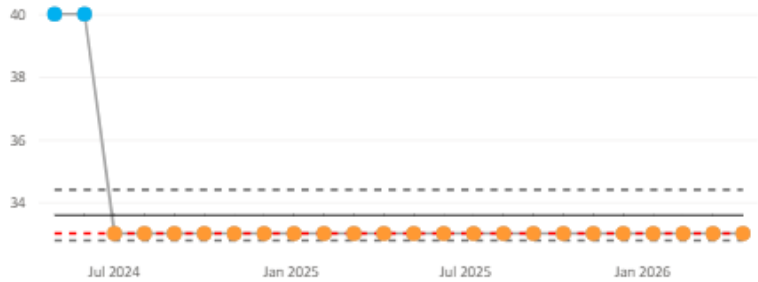
Operational Lead: Abolfazl Abdi

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

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

Number of open Virtual Ward beds

Variation Assurance



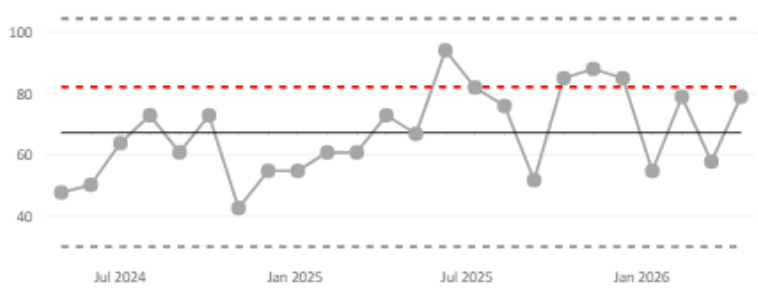
Latest Month
2026-04
Value
33
Target
33

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

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

Proportion of Virtual Ward beds occupied

Variation Assurance



Latest Month
2026-04
Value
78.8%
Target
82%

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 **21.2**.

What actions are planned?

The Frailty Virtual Ward / Hospital at Home model remains keen to expand to Selby following a successful test. Funding for a Band 7 nurse is required and not able to be found within existing resources. In the meantime, the Selby Integrated Urgent Care Response work continues with Selby Community response Team.

The Heart Failure Virtual Ward continues to successfully run its admission avoidance pathway at York, and the service model has recently expanded to include early support discharge.

Potential risks to improvement?

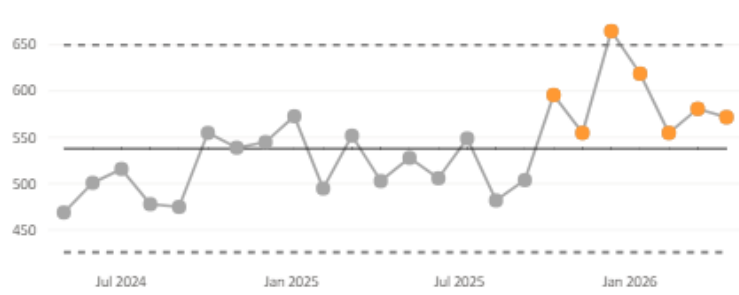
- There remains no service for Selby; funding for additional senior nurse to establish a 5 bedded Selby H@H service is not available. The team is working to establish source of funding. The system partners are supportive of this approach as part of the Selby neighbourhood model.

Executive Owner: Claire Hansen

Operational Lead: Abolfazl Abdi/Kim Hinton

Variation Assurance

Community Response Team (CRT) Referrals

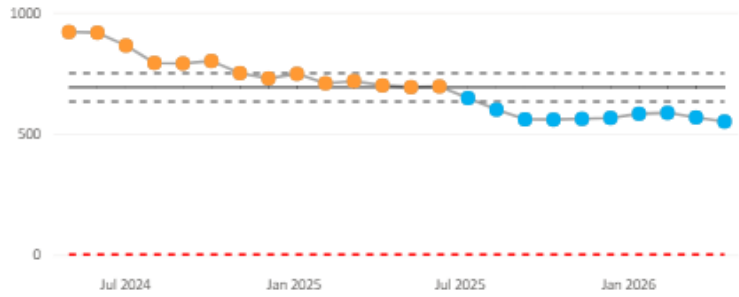


Latest Month
2026-04
Value
571
No Target

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

Variation Assurance

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



Latest Month
2026-04
Value
550
Target
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 **17.0**.

Rationale: To monitor demand on Community services.
Target: SPC1: No target. **SPC2:** zero waiting over 52 weeks by end of March 2027 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. Additional WTE mitigation included in 2026/27 plan, Care Group working through Business Case for implementation by end of Q2.

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

May 2026

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Karen Stone and Joe Hague

Highlights: IPC

- E.coli bacteraemia **3 cases under** the year-to-date threshold
- IPC training packages have been reviewed for delivery in 2026/27
- The IPC Hierarchy of Control Audits for all in-patient wards commenced in April 2026

Concerns / Risks :

- C.difficile **2 cases over** the year-to-date threshold, however, a reduction on the previous month's cases.
- MSSA bacteraemia **1 case over** year-to-date threshold and an increase on previous month
- Pseudomonas bacteraemia - **1 case over** the year-to-date threshold.

Next Steps:

- 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 April, 67 Category 2 pressure ulcers were reported, the same as the previous month. Performance remains above the monthly target of 60.

Concerns / Risks:

- Key hotspot areas this month were identified as Ward 15 (Orthopaedics) with 7 cases, G1 (Surgery) with 4 cases, and Ward 28 (Elderly Care) with 4 cases.
- An increase in mattress failure due to cell twisting has been identified, impacting equipment reliability and requiring targeted remedial action.

Next Steps:

- The Tissue Viability Nurse (TVN) team has commenced virtual sessions to support accurate identification and categorisation of pressure ulcers, alongside engagement with ward skin champions.
- Funding has been secured through charitable sources for the purchase of high-risk specialist chairs.
- Preparation for mattress refurbishment at Scarborough is in the final approval stage, with completion planned for Q1.
- Identified areas of concern will be escalated and discussed at the Professional Quality Standards Group (PQSG) this month for oversight and assurance.
- The introduction of NerveCentre will strengthen referral pathways including access to photographic evidence to support assessment and escalation.

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 * Harmful Incidents per thousand bed days * Total Number of Never Events Reported * Monthly SHMI * Monthly HSMR	
SPECIAL CAUSE CONCERN		* Patient Safety Incidents per thousand Bed Days	

Quality & Safety
Scorecard (1)

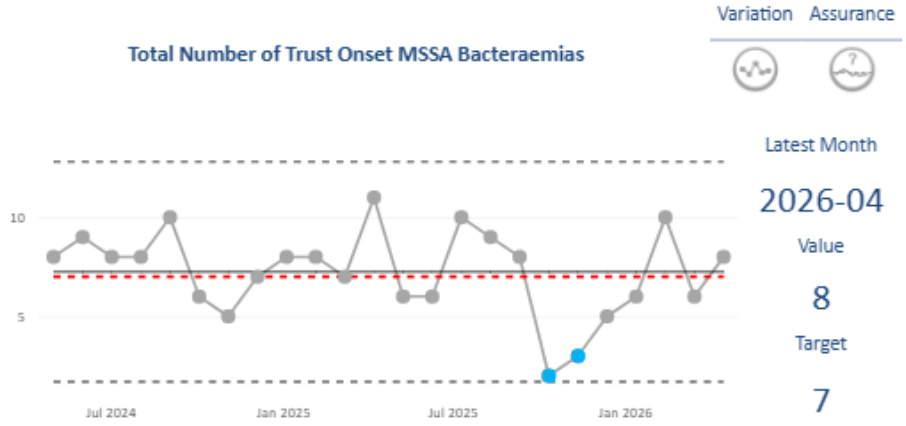
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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	2026-04			8	7	7
Total Number of Trust Onset MRSA Bacteraemias	2026-04			0		0
Total Number of Trust Onset C. difficile Infections	2026-04			14	12	12
Total Number of Trust Onset E. coli Bacteraemias	2026-04			11	14	14
Total Number of Trust Onset Klebsiella Bacteraemias	2026-04			5	5	6
Total Number of Trust Onset Pseudomonas Aeruginosa Bacteraemias	2026-04			2	1	2
Pressure Ulcers per thousand Bed Days	2026-04			4.5		4
Patient Falls per thousand Bed Days	2026-04			8.1		8.7
Medication incidents per thousand bed days	2026-04			5.1		6

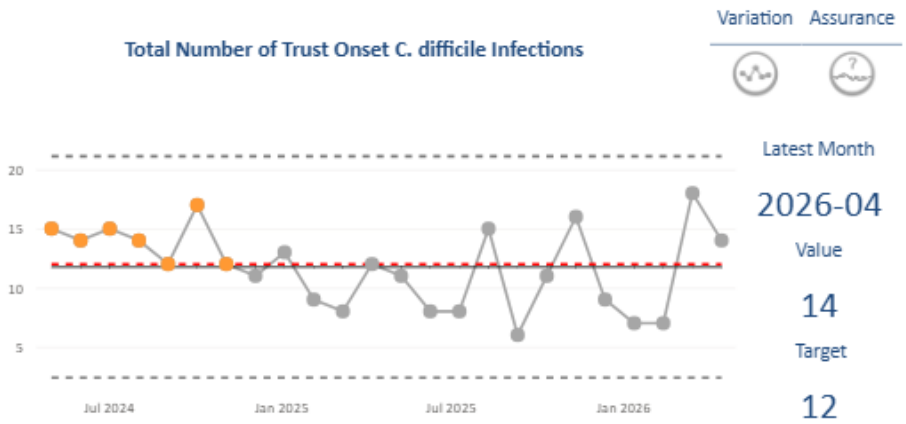
Executive Owner: Joe Hague

Operational Lead: Sue Peckitt



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

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



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 **4.0**.

Rationale: To drive reduction in avoidable health care associated infection (HCAI), facilitate patient safety and improve patient outcomes

Target: National thresholds for 2026/27 not yet been released so we are working to the thresholds of the previous year. As a Trust we have recommended MSSA bacteraemia has an internal 5% reduction on the 2025/26 year-end position. **MSSA is a True North Metric.**

Key Risks:

- C.difficile **2 cases over** the year-to-date threshold, however, a reduction on the previous months cases.
- MSSA bacteraemia **1 case over** year-to-date threshold and an increase on previous month
- Pseudomonas bacteraemia - **1 case over** the year-to-date threshold.

Key assurances/brilliances

- E.coli bacteraemia - 3 cases **under** the year-to-date threshold.
- There is a Hospital Acquired Infection review process in place led by the Corporate IPC lead nurses and the Care Group senior team to identify key learning opportunities and key actions.
- The Deputy Director of Infection Prevention & Control (DIPC) reports against the agreed strategic IPC improvement plan to the Infection Prevention Strategic Advisory Group and to Quality Committee.
- The IPC Hierarchy of Control Audits for all in-patient wards commenced in April 2026
- IPC training packages have been reviewed for delivery in 2026/27

Next Key Improvements:

- The IPC improvement plan is being refreshed for 2026/27 in recognition of the further stretch improvements required.
- The deputy DIPC has recommended that stretch targets for MSSA bacteraemia (5%) and E.coli bacteraemia (7%) are included within the True North metrics/Trust priorities – awaiting confirmation.
- 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.

Quality & Safety
Scorecard (2)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Owner: Adele Coulthard/Joe Hague **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	2026-04			55.8		56
Harmful Incidents per thousand bed days	2026-04			18.2		17
Total Number of Never Events Reported	2026-04			1		0
In-Hospital Deaths	2026-04			163		
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	2026-04			119		
Antepartum Stillbirths	2026-03			1		
Intrapartum Stillbirths	2026-03			0		
Early neonatal deaths (0-7 days)	2026-03			2		
PPH > 1.5L as % of all women - York	2026-03			2.8%		
PPH > 1.5L as % of all women - Scarborough	2026-03			2.6%		
Proportion of fractured neck of femur patients treated within gold standard timeframe (a month in arrears)	2026-03			67.8%		

Executive Owner: Adele Coulthard/ Joe Hague /Karen Stone

Operational Lead: Dan Palmer/Alice Hunter

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Rationale: The Trust is committed to learning from incidents and improving the patient experience
Target: No target identified as the reporting of incidents is an indicator of an open reporting culture

Incident reporting activity remains within expected control limits, demonstrating normal variation.

Great-ix, 41 submissions in April. Highlights:

"His interactions with patients was exemplary and his ability to problem solve and think laterally was an asset to the management of the Ward"
"What stood out most was his proactive approach and team-oriented mindset. He did not wait to be asked for help but instead identified areas where support was needed and acted immediately"
"X is a great all round individual, adding joy, encouragement and energy to the team"
"She took each patient around the grounds and spent time chatting about their lives and things they enjoyed. Each patient came back looking and feeling fresher and happy, they all had big smiles on their faces"

Patient Safety Incident Response Training

The Patient Safety Team has successfully delivered its in-house, two-day PSIRF systems course, replacing the previously externally provided programme by Morgan Human Systems Ltd and we are planning the dates for both the engagement and oversight training. Upon completion of this course, staff will be equipped to conduct Patient Safety Incident Investigations (PSIIs).

PSIRF Systems Course feedback - 16 & 17 April

Thank you so much for the training last week — I really enjoyed it and found it extremely helpful. It was a great introduction to PSIRF, and the sessions explained the learning response process really clearly. The examples were especially useful and helped bring everything together.' Thanks also for sharing the resources and follow-up information."
Thanks again — it was a really well run and valuable couple of days. Extremely satisfied "

Executive Owner: Joe Hague

Operational Lead: Vicky Mulvana-Tuohy

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

The latest months value has **improved** from the previous month, with a difference of **16.0**.

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Rationale: The Trust is committed to learning from complaints and improving the patient experience

Target: 90% of complaints to be resolved in 30 working days (45 working days for complex complaints) and 10 working days for concerns

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

71% of complaints were closed in 30 days (compared to 65% in February 2026) and 47% of complex complaints were closed in 45 days (compared to 50% in February 2026) showing an improvement in complaint response times. Performance remains below the expected compliance rate of 90% that was to be achieved by the end of April 2026.

Key risks and emerging risks

- Complex complaints remain a concern with a need to continue to focus on improving the timeliness of investigation and responses
- 205 cases (81%) of the backlog of concerns have been closed. Of the 49 cases that remain open, 44 relate to surgery.

Key assurances

-- PALS are supporting with closing the backlog open concerns for surgery whilst maintaining the timescales on new concerns reported to the Trust.
- 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.
- Recruitment of the new Concern and Complaints Officer in the forthcoming months will bring more stability to the team following the sustained long-term absence of a member of the PALS team.

Next key improvement actions

The following priorities have been identified to improve complaints performance alongside continuing to provide timely resolution of complaints within policy timescales:
- May - education for Investigating Officers to equip them with the confidence and capabiility to deliver against their responsibilities
- June - culture and communication, promoting a Trust-wider shift to addressing concerns in the moment, prevent escalation of complaints and improve patient experience
- June/July - triangulation of complaint themes and insights to drive patient experience.

The baseline review of the NHSE Experience of Care Framework has identified 6 key areas for the improvement of patient experience against which we are developing a patient experience dashboard for the Trust, with concerns and complaints performance embedded within the Trust wide patient experience KPI's.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

MATERNITY

May 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		* L/W Co-ordinator supernumerary % - Scarborough * Number of Maternity and Newborn Safety Investigations (MNSI) referrals - Scarborough	
COMMON CAUSE / NATURAL VARIATION	* Bookings - Scarborough	* No. of women delivered - Scarborough * Births - Scarborough * Induction of labour - Scarborough * Elective caesarean - Scarborough * Emergency caesarean - Scarborough * BBA - Scarborough * Neonatal Death - Scarborough * SCBU at capacity - 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	2026-03		P	95		169	Target
No. of women delivered - Scarborough	2026-03		?	112		112	Target
Births - Scarborough	2026-03		?	114		113	Target
Induction of labour - Scarborough	2026-03		?	42%		44.1%	Baseline
Elective caesarean - Scarborough	2026-03		?	15.8%		16.4%	Baseline
Emergency caesarean - Scarborough	2026-03		?	22.8%		28.3%	Baseline
BBA - Scarborough	2026-03		?	0		2	Target
Total number of Stillbirths - Scarborough	2026-03			0			No Target
Neonatal Death - Scarborough	2026-03		?	1		0	Target
Number of maternity diverts/unit closures - Scarborough	2026-03			4			No Target
Homebirth service suspended - Scarborough	2026-03		F	31		3	Target
SCBU at capacity - Scarborough	2026-02		?	0		0.3	Baseline
% of 3rd and 4th degree tears - Scarborough	2026-03			1.8%			No Target
L/W Co-ordinator supernumerary % - Scarborough	2026-03	H	?	100%		100%	Target
Breastfeeding Initiation rate - Scarborough	2026-03		?	80.7%		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	2026-03			0		0	Target
% of women seen within 15 minutes in triage - Scarborough	2026-03			90.1%			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - Scarborough	2026-03			3			No Target
Number of babies born with an Apgar of 7 at 5 mins - Scarborough	2026-03			2			No Target
Number of maternal deaths - Scarborough	2026-03			0			No Target
Number of midwifery red flags - Scarborough	2026-03			2			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 * Breastfeeding Initiation rate - York * Number of Maternity and Newborn Safety Investigations (MNSI) referrals - York	
SPECIAL CAUSE CONCERN		* Homebirth service suspended - York	

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	2026-03			261		295	Target
No. of women delivered - York	2026-03			249		242	Target
Births - York	2026-03			252		245	Target
Induction of labour - York	2026-03			38.2%		40.8%	Baseline
Elective caesarean - York	2026-03			19.4%		17%	Baseline
Emergency caesarean - York	2026-03			25%		22.9%	Baseline
BBA - York	2026-03			0		2	Target
Total number of Stillbirths - York	2026-03			1			No Target
Neonatal Death - York	2026-03			1		0	Target
Number of maternity diverts/unit closures - York	2026-02			0			No Target
Homebirth service suspended - York	2026-03	H		25		3	Target
SCBU at capacity - York	2026-02	L		0		0	Baseline
% of 3rd and 4th degree tears - York	2026-03			3.6%			No Target
L/W Co-ordinator supernumerary % - York	2026-03	H		100%		100%	Target
Breastfeeding Initiation rate - York	2026-03			88.4%		75%	Target

Maternity York
Scorecard (2)

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	2026-03			1		0	Target
% of women seen within 15 minutes in triage - York	2026-03			85.2%			No Target
Number of Avoiding Term Admissions into Neonatal Units (ATTAIN) cases - unexpected admissions of term babies to NNU - York	2026-03			7			No Target
Number of babies born with an Apgar of 7 at 5 mins - York	2026-03			4			No Target
Number of maternal deaths - York	2026-03			0			No Target
Number of midwifery red flags - York	2026-03			5			No Target

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

WORKFORCE

May 2026

Executive Owner: Lydia Larcum

1. Highlights

- Sickness absence reduced in March as seasonal illness continued to fall, with cold and flu accounting for a smaller proportion of total absence compared with February.
- Recruitment activity remained strong, including new senior medical appointments, a high volume of student nurse applications, and successful outcomes from international nurse recruitment.
- Action to reduce premium medical staffing costs is showing impact, with fewer rate escalations outside industrial action and ongoing reductions in high-cost bookings.

2. Concerns

- The annual sickness absence rate ended the year 1% above plan, resulting in reduced workforce availability and continued pressure on services, with mental health and musculoskeletal conditions the leading causes.
- Despite active recruitment pipelines and internal support arrangements, there have been increases in Health Care Support Worker vacancies, driven by establishment growth in April 2026.

3. Future

- Plans are in place to reduce sickness absence over the next year with a target to increase workforce availability by 40 WTE over the year.
- Preparations are underway for resident doctor changeover and continued pipeline recruitment, including internal programmes to stabilise Health Care Support Worker staffing.
- Recent changes to appraisal arrangements and strengthened senior manager reviews aim to support better quality conversations and organisational development over the 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	* Overall corporate induction compliance * A4C staff corporate induction compliance	* 12 month rolling turnover rate Trust (FTE) * Overall vacancy rate * Midwifery vacancy rate * Medical and dental vacancy rate * Registered Nursing vacancy rate * A4C staff stat/mand training compliance * Medical & dental staff corporate induction compliance	* Total Agency Whole Time Equivalent Filled * Overall stat/mand training compliance * Medical & dental staff stat/mand training compliance * Appraisal Activity
COMMON CAUSE / NATURAL VARIATION		* Monthly sickness absence * AHP vacancy rate * Total Bank Whole Time Equivalent Filled	
SPECIAL CAUSE CONCERN		* HCSW vacancy rate	* Annual absence rate

Workforce
Scorecard (1)

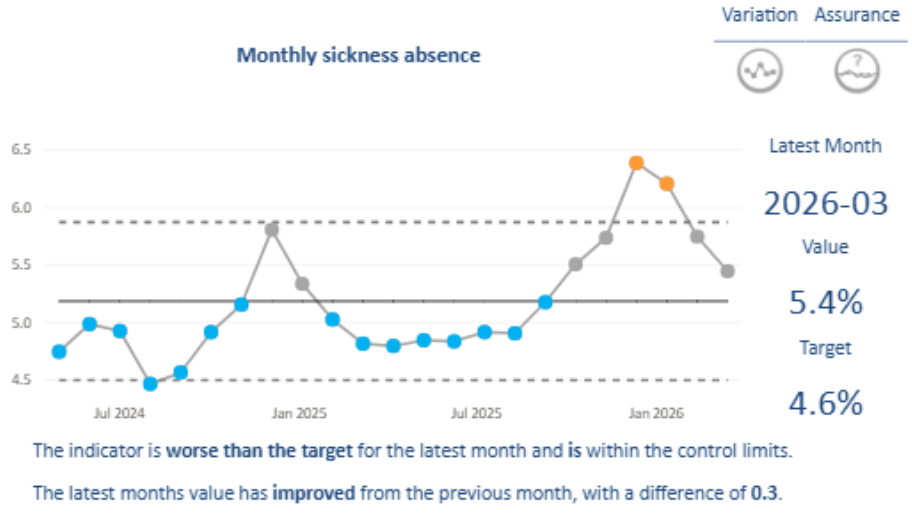
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

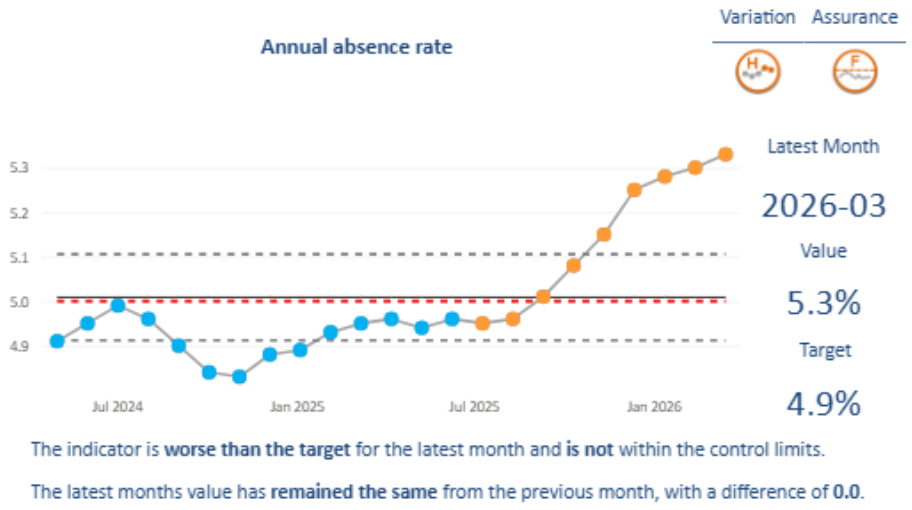
Executive Owner: Lydia Larcum **Operational Lead:** Amy Messenger/Will Thornton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Monthly sickness absence	2026-03			5.4%	4.2%	4.6%
Annual absence rate	2026-03	H	F	5.3%	4.9%	4.9%
Total Agency Whole Time Equivalent Filled	2026-03	L	F	45.4		52
Total Bank Whole Time Equivalent Filled	2026-03			624.8		536
12 month rolling turnover rate Trust (FTE)	2026-04	L		7.5%		8.5%
Overall vacancy rate	2026-04	L		5.3%		7.7%
HCSW vacancy rate	2026-04	H		16.5%		8%
Midwifery vacancy rate	2026-04	L		-10.8%		0%
Medical and dental vacancy rate	2026-04	L		1.9%		6%
Registered Nursing vacancy rate	2026-04	L		2.3%		5%
AHP vacancy rate	2026-04			8.1%		7%

Executive Owner: Lydia Larcum

Operational Lead: Nicola English





Rationale: Reduce absence resulting in greater workforce availability.
Target: 4.9% annual absence rate (March 2027)

Factors impacting performance and actions:

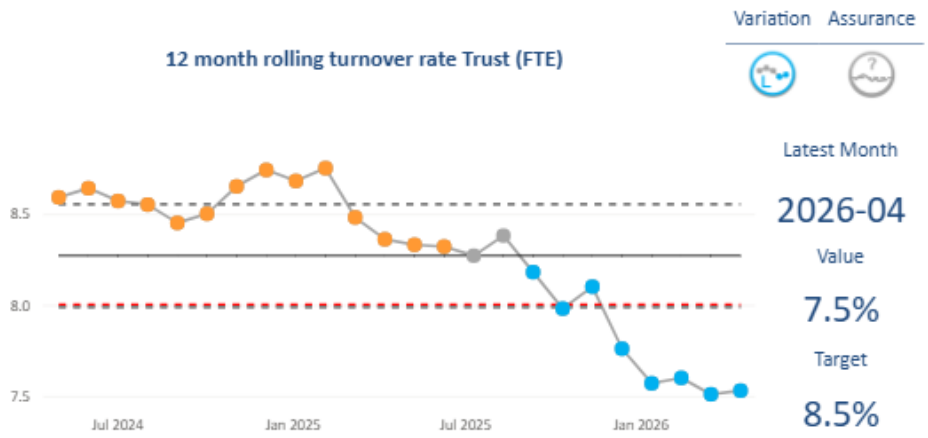
In March, the 5.4% absence rate equated to a reduction of 511 WTE in workforce availability. As the seasons changed, cold and 'flu absences reduced further. They contributed to 9% of the absence total compared with 11% (of a higher total) in February. Musculoskeletal (12%) and mental health problems (27%) remain the two leading reasons for sickness absence.

The position in March contributed to an annual absence rate of 5.3% across the Group. The annual plan had been for a 4.3% rate.

The Group has planned for a 4.9% absence rate in the 12-months up to and including March 2027 (a 0.4% reduction from the current annual rate). Achieving the reduction would increase workforce availability by 40 WTE over the year.

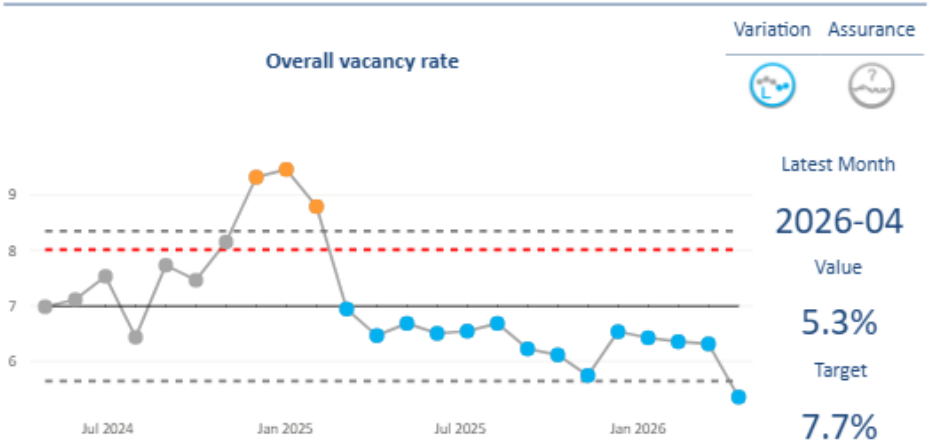
Executive Owner: Lydia Larcum

Operational Lead: Will Thornton



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

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



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 **1.0**.

Rationale: Reduce turnover resulting in greater workforce availability.
Target: Turnover 8.5% Vacancy Rate 7.7%

Factors impacting performance and actions:

In the 12-months to March 2026, the Group's total workforce WTE average was 10,029 compared with a plan for an average of 10,050 WTE. This breaks down as follows:

Type	WTE Plan (12-month average)	WTE Actual (12-month average)	WTE Variance with plan	%age change from 24-25
Substantive	9363	9370	+7	+3%
Bank	587	591	+4	-8%
Agency	100	68	-32	-49%

The net change in workforce size between 2024-25 and 2025-26 was +21 WTE. This was mainly driven by increases in the number of non-medical clinical substantive colleagues.

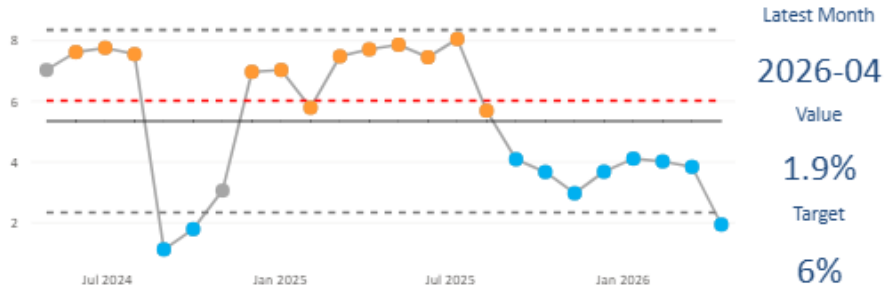
A reduction in budget (-115 WTE) from March 2026 accounts for the fall in vacancy rate, as the actual number of colleagues in post remained relatively consistent between the two months. The effect of this can be seen in the Medical and Dental (-22 WTE) and Midwifery (-10 WTE) vacancy charts on the following pages.

Executive Owner: Lydia Larcum

Operational Lead: Amy Messenger

Variation Assurance

Medical and dental vacancy rate



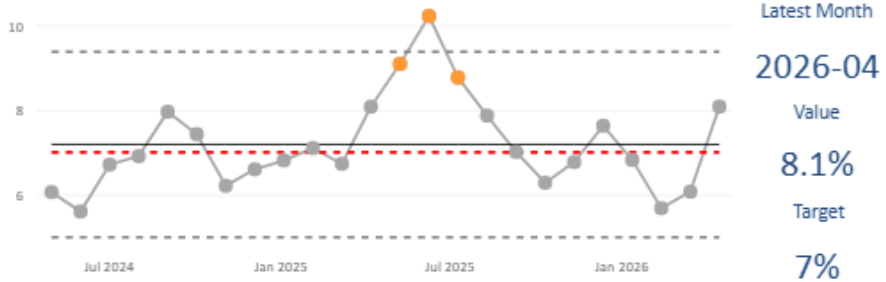
Latest Month
2026-04
Value
1.9%
Target
6%

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 **1.9**.

Variation Assurance

AHP vacancy rate



Latest Month
2026-04
Value
8.1%
Target
7%

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

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

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: M&D vacancy rate 6%, AHP vacancy rate 7%

Factors impacting performance and actions:

In April, the Trust welcomed seven new medical colleagues, including two permanent Consultants within Emergency Medicine and Radiology. In addition, 28 offers of employment for medical posts were made, including 12 permanent Consultant posts within Respiratory, Oncology, Orthodontics and Anaesthetics.

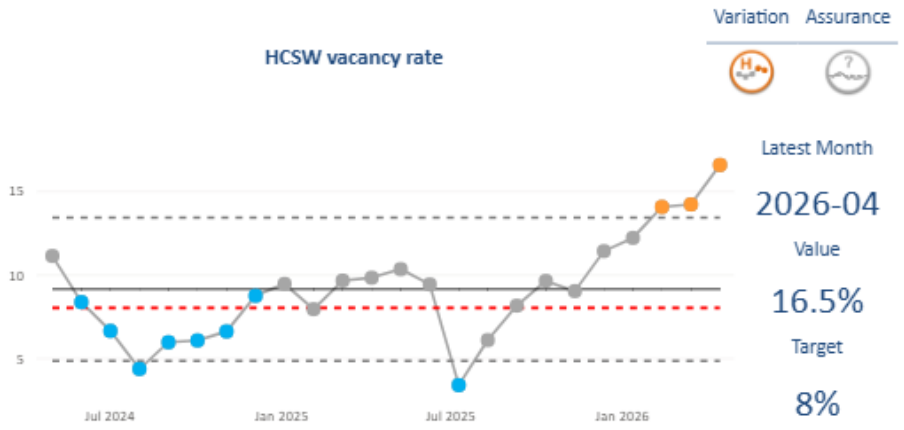
The Trust has started preparations for resident doctors' changeover in August and will be commencing parallel recruitment to cover training gaps.

202 applications have been received for Staff Nurse positions from student nurses who are due to graduate from local higher education institutions in the Autumn. The next stage will involve interviewing applicants during the coming weeks.

The Trust's final international cohort of eight nurses that arrived in March have undertaken their OCSE assessment with an 88% first time pass rate.

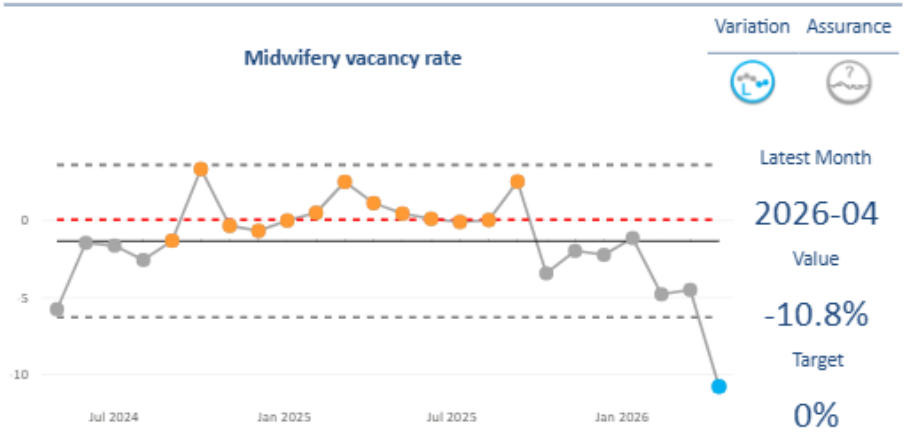
Executive Owner: Lydia Larcum

Operational Lead: Amy Messenger



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 **2.3**.



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 **6.2**.

Rationale: Reduce vacancy factor resulting in greater workforce availability.
Target: HCSW vacancy rate 8%, Midwifery vacancy rate 0%

Factors impacting performance and actions:

In April, the Health Care Support Worker establishment in the Trust increased by 30 WTE, causing an increase to the vacancy rate.

In response to the increase in vacancies since November, an internal program has been set-up to support and monitor recruitment to HCSW roles in the Medicine Care Group.

The HCSW recruitment pipeline currently includes 17 WTE undertaking pre-employment checks, and 13 WTE who are booked onto the next Academy in June.

The Group is continuing to run a Sector-based Workforce Academy Program in partnership with Job Centre Plus. A new cohort of 24 people have signed-up for the initiative, which includes pre-employment training and a guaranteed job interview. The latest cohort are working towards the possibility of a job offer in the Estates and Facilities Team.

Between July 2025 and March 2026, the SWAP has supported the employment of 24 people in HCSW roles, with 79% of those being retained in position (19 colleagues).

The number of Nursing Associates within the Trust remained static between March and April at 50 (this number does not include Nursing Associate Apprentices).

Executive Owner: Lydia Larcum **Operational Lead:** Amy Messenger

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	Mar-26
Medical & Dental	1164	1121	1134	1133	1150	1149	1145	1155	1167	1169	1156	1157	1161
Nursing & Midwifery	2677	2620	2653	2640	2667	2660	2689	2743	2741	2706	2732	2734	2743
Scientific, Therapeutic & Technical	1274	1312	1307	1313	1324	1323	1347	1354	1351	1344	1358	1356	1370
Support to Clinical Staff*	2355	2304	2337	2330	2356	2328	2254	2204	2220	2175	2199	2164	2174
NHS Infrastructure Support Staff*	2565	2564	2559	2550	2560	2568	2559	2590	2586	2594	2622	2638	2634
Total	10035	9920	9989	9967	10057	10027	9995	10045	10066	9988	10067	10049	10089

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

Factors impacting performance and actions:

The Trust has been monitoring the number of rate escalations for medical bank shifts after changes to the rate escalation process were implemented in August 2025. For context, in the final week prior to the change of process, 432 shifts had rates escalated. The number of rate escalations requested in April (outside any industrial action) reduced again to an average of 42 shifts a week, down from 56 shifts a week on average in March. For week commencing 6th April, which covered resident doctor industrial action, there were requests to escalate rates on 585 shifts, of which 531 shifts were covered at a higher than standard rate.

The Trust continues to negotiate with agency providers and high-cost medical bank bookings to reduce rates. Over the last 3 months, the Trust has successfully agreed reductions across several medical bank and agency bookings, saving just under £60 per hour in total, which based on the volume of work being undertaken, equates to over £10k in cost reduction a month for the organisation. In addition, the Trust's highest cost agency booking has also come to an end as the organisation continues to focus on removing or reducing its high-cost, long-term bookings.

Administrative bank activity in April remains high at 809 shifts worked in the month, a slight reduction from the 866 shifts recorded in March.

Workforce
Scorecard (2)

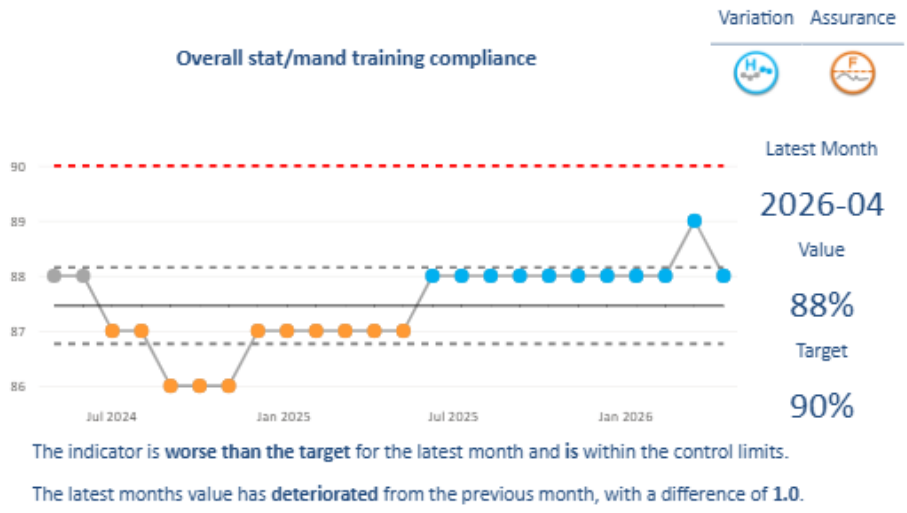
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

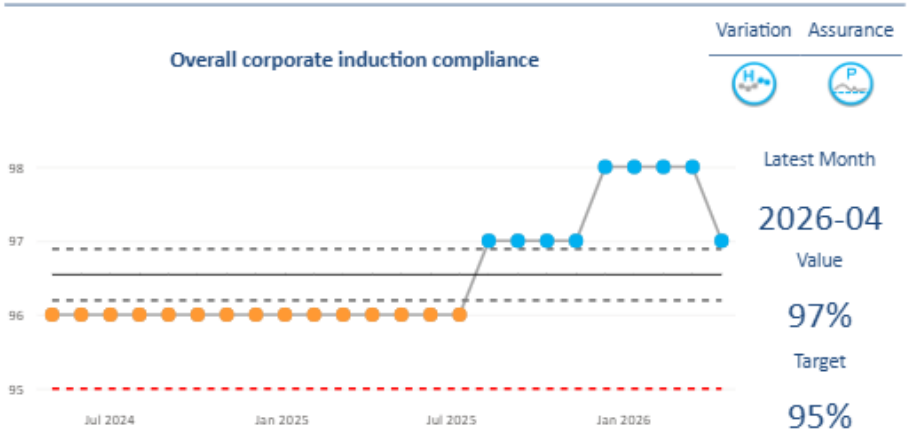
Executive Owner: Lydia Larcum **Operational Lead:** Will Thornton

Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Overall stat/mand training compliance	2026-04	H	F	88%		90%
Overall corporate induction compliance	2026-04	H	P	97%		95%
A4C staff stat/mand training compliance	2026-04	H	?	90%		90%
A4C staff corporate induction compliance	2026-04	H	P	98%		95%
Medical & dental staff stat/mand training compliance	2026-04	H	F	78%		90%
Medical & dental staff corporate induction compliance	2026-04	H	?	96%		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: Lydia Larcum

Operational Lead: Will Thornton





Rationale: Trained workforce delivering consistently safe care
Target: Mandatory Training 90% and Corporate Induction 95%

Factors impacting performance and actions:

Last year, 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. In April, mandatory training compliance reduced back to 88% following an increase in March. This was because of a small amount of repeat training falling due.

The Group has updated its guidance for colleague appraisals. In response to feedback about the six-month window for completion which some colleagues felt detracted from the quality of conversations, appraisals will now be undertaken across the duration of the financial year. In addition, Senior Manager appraisals have been strengthened with changes including the incorporation of 360 feedback.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Y&S digital

May 2026

Executive Owner: James Hawkins

Highlights

EPR implementation:

- Nervecentre went live at Bridlington and Scarborough as planned between the 7-10 May. The implementation went very smoothly with no major issues to report. As with all EPR implementations there were minor issues raised and addressed as users became familiar with the new business processes.
- Nervecentre also went live at Selby, St Monica's, Nelsons Court and White Cross Court on Thursday the 14 May.
- York will go live between the 14-16 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 Trust and Nervecentre are working through finalised 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 Ambient Voice Technology in 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

- 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.
- Continue hyper-care support for nervecente T1, including provision of additional clinical, operational and digital staff (including floorwalkers and digital champions as system is further optimised.
- Progress Nervecentre Tranche 2 and Tranche 3.

Wider Digital Portfolio:

- Overall cyber security posture: Track progress against independent Data Security and Protection Toolkit audit actions.
- Progress trials of AVT in outpatients.
- Finalise 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	* Percentage of FOIs and EIRs responded to within 20 working days (monthly)	* Number of P1 incidents*	
SPECIAL CAUSE CONCERN		* Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	

Executive Owner: James Hawkins

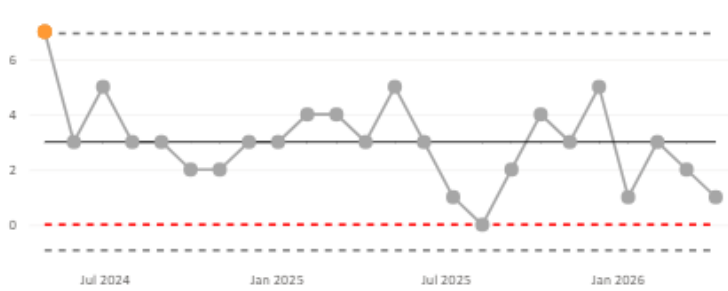
Metric Name	Month	Variation	Assurance	Current Month	Monthly Trajectory	Year End Target
Number of P1 incidents*	2026-04			1		0
Total number of calls to Service Desk	2026-04			3872		
Total number of calls abandoned	2026-04			1239		
Number of information security incidents reported and investigated	2026-04			57		
Number of patient Subject Access Requests (SAR) received (monthly)	2026-04			293		
Number of patient Subject Access Requests (SAR) completed (monthly)	2026-04			245		
Percentage of patient Subject Access Requests (SAR) processed within 1 calendar month (monthly)	2026-04			55%		80%
Number of FOIs and EIRs received (monthly)	2026-04			58		
Number of FOIs and EIRs completed (monthly)	2026-04			58		
Percentage of FOIs and EIRs responded to within 20 working days (monthly)	2026-04			98%		80%

Executive Owner: James Hawkins

Operational Lead: Stuart Cassidy

Variation Assurance

Number of P1 incidents*



Latest Month

2026-04

Value

1

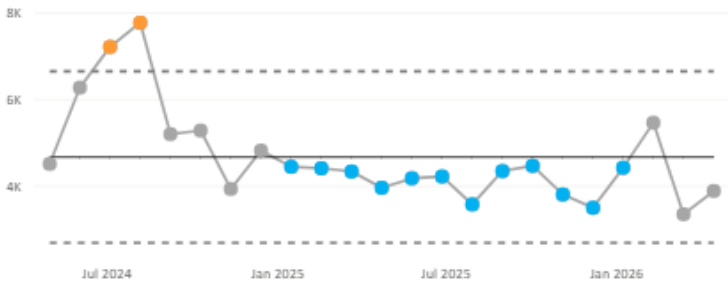
Target

0

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

Variation Assurance

Total number of calls to Service Desk



Latest Month

2026-04

Value

3872

No Target

The latest months value has **deteriorated** from the previous month, with a difference of **537.0**.

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

Target: 0 P1 Incidents

Factors impacting performance:

1x P1 incident occurred in April.

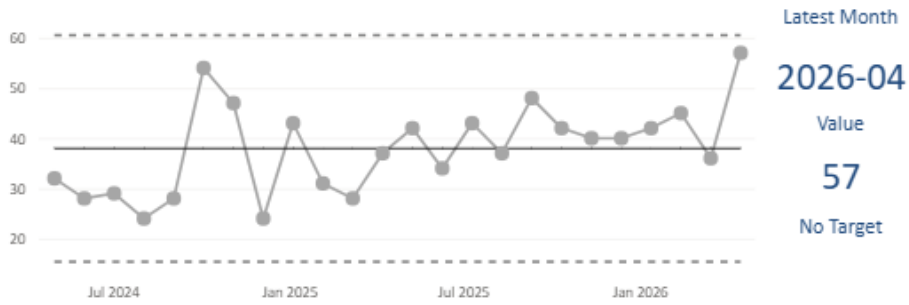
1. 30/4 Scarborough Radiology CT & ED X-Ray reported issues with worklists not populating from CPD. Mitigated after 2 hours with workaround to manually input. Issues escalated with Philips UK support for resolution.

Executive Owner: James Hawkins

Operational Lead: Rebecca Bradley

Variation Assurance

Number of information security incidents reported and investigated



Latest Month
2026-04
Value
57
No Target

The latest months value has **deteriorated** from the previous month, with a difference of **21.0**.

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

Number of information security incidents reported and investigated

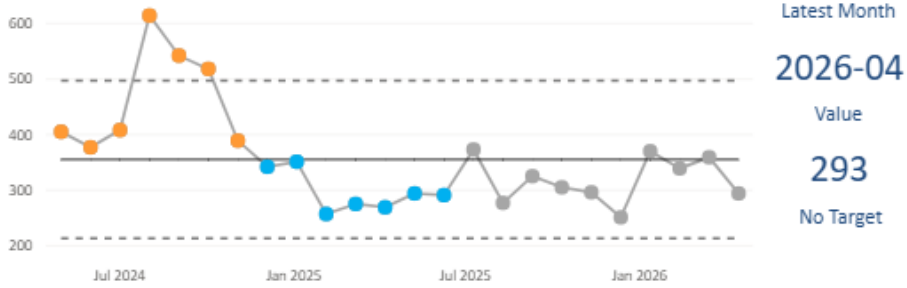
Factors impacting performance:

Information security incidents have increased significantly in April. April's increase is largely attributable to documentation and patient-identification / disclosure-type incidents, with IT security issues representing only a small fraction.

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
2026-04
Value
293
No Target

The latest months value has **improved** from the previous month, with a difference of **65.0**.

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 decreased slightly, however we are still seeing high volumes 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

Variation Assurance

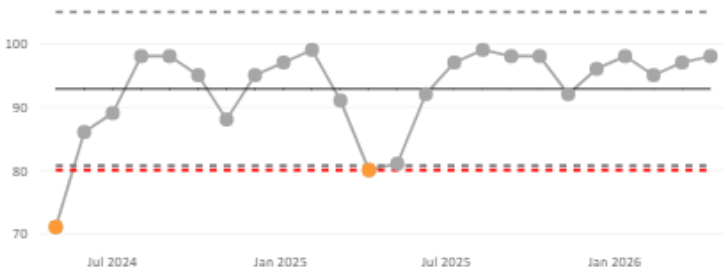
Number of FOIs and EIRs received (monthly)

Latest Month
2026-04
Value
58
No Target

The latest months value has **improved** from the previous month, with a difference of **8.0**.

Variation Assurance

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



Latest Month
2026-04
Value
98%
Target
80%

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

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

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

Factors impacting performance:.

Number of FOIs Received

The number of FoIs the Trust received has decreased 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

May 2026

Executive Owner: Andrew Bertram

Highlights

Income and Expenditure Position

The Trust's M1 position is £0.3m behind plan. The Trust have delivered £2.9m of WRAP savings in M1, with a £17.1m full year impact (£14.7m recurrent). However, in month delivery falls £1.9m short of the April target. The shortfall in WRAP delivery has been managed through the deferral of planned investments. As a result, the associated funding has not been spent and is reflected as £1.5m of income brought forward into the April position.

Waste Reduction & Productivity Programme (WRAP)

The Trust has delivered £17.1m WRAP in full year terms against a target of £61.6m (28%). Of the £17.1m delivered, £14.7m is recurrent (86%; 24% of total target).

There is currently a planning gap of £3.9m (6.3%)

Cash Position

The closing balance for April is £19.2m against a plan of £18.6m, £0.6m favourable.

There are no significant cash concerns at present.

Future / Next Steps

Continue to monitor delivery of plan / WRAP against monthly target. Commitment to redirect investment funds where delivery of WRAP falls behind target.

Where the position recovers in future months, reinstate investment fund.

Closely monitor the above in line with activity delivery, as any underperformance may reduce income and adversely affect the net I&E position.

Executive Owner: Andrew Bertram

Key Financial Risks

Key Risk Area	Board Level Risk Statement
Waste Reduction & Productivity (WRAP)	Risk that the WRAP is not delivered in full and / or schemes are not delivered recurrently
Workforce sustainability	Risk that pay and temporary staffing costs exceed plan assumptions, impacting delivery of the financial plan
Drugs and devices	Risk that growth in drugs and devices exceeds contract for 'in-tariff' drugs
System affordability	Risk that system plans remain unaffordable, increasing delivery expectations at Trust level

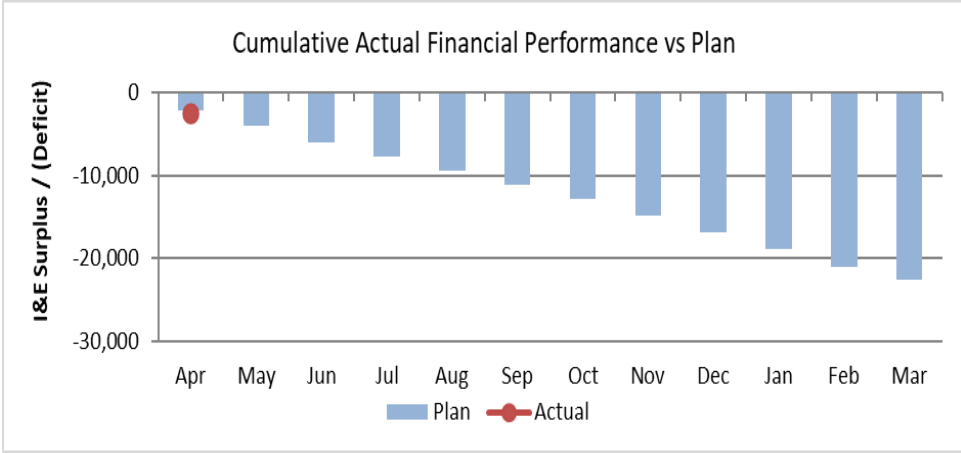
Board Assurance Framework

BAF Principal Risk	How this report provides assurance
Financial sustainability	Month-end I&E, forecast outturn, key variance analysis and cash position
Delivery of recovery plans	WRAP delivery, high-risk schemes, slippage and recovery actions
External financial compliance	Agency and bank controls, capital and cash management, system reporting

	Plan	Plan YTD	Actual YTD	Variance
	£000	£000	£000	£000
Clinical Income	806,754	67,230	67,962	732
Other Income	81,946	6,829	7,480	651
Total Income	888,700	74,058	75,441	1,383
Pay Expenditure	-638,225	-51,667	-50,484	1,183
Drugs	-68,301	-5,708	-6,774	-1,066
Supplies & Services	-98,770	-8,125	-7,419	705
Other Expenditure	-146,299	-11,258	-11,966	-708
Outstanding WRAP	44,580	1,942	0	-1,942
Total Expenditure	-907,015	-74,815	-76,643	-1,828
Operating Surplus/(Deficit)	-18,315	-757	-1,202	-445
Other Finance Costs	-12,677	-1,056	-996	60
Surplus/(Deficit)	-30,992	-1,813	-2,198	-385
NHSE Normalisation Adj	8,346	-272	-271	1
Adjusted Surplus/(Deficit)	-22,646	-2,085	-2,470	-384

The I&E table confirms an actual adjusted deficit of £2.5m against a planned deficit of £2.1m, leaving the Trust with an adverse variance to plan of £0.4m.

The forecast outturn position assumes that the Trust will deliver to plan.



The income and expenditure plan profile shows an expected cumulative deficit throughout the year with an outturn deficit of £22.6m at the end of March 2027. This plan has not met the requirements stipulated by NHSE and is subject to further discussion. The Trust is not currently eligible for further Deficit Support Funding.

The actual I&E performance at the end of April 2026 is an adverse variance of £0.4m

Key Subjective Variances: Trust

Finance

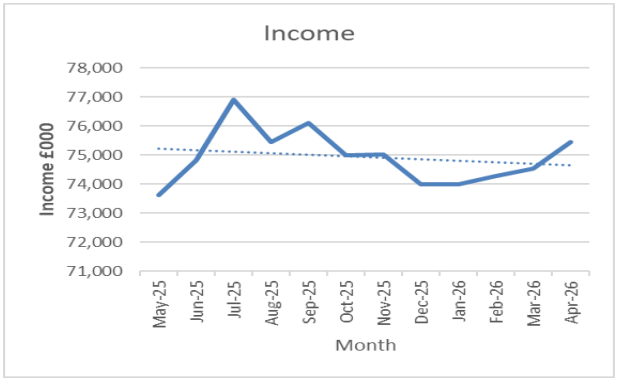
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

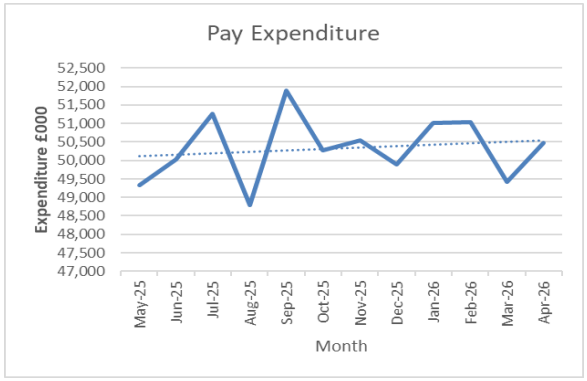
Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	-£3.3m	NHSE under trade linked to services which have been delegated to ICBs to commission. There is a corresponding over trade on the ICB line below.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27.
ICB Income	£4.0m	ICB over trade linked to services which have been delegated from NHSE to ICBs to commission. The position also includes additional income to fund the increased agenda for change pay award.	Confirm contracting arrangements and ensure plans and actual income reporting align in 2026/27.
Other Income	£0.7m	£1.5m income brought forward to compensate shortfall in delivery of WRAP scheme. This approach has been agreed with NHSE. Offset by £0.7m write back of previous year accrual.	Shortfall in WRAP delivery needs to be recovered, this may be delivered through delay / avoidance of investments included in plan.
Employee Expenses	£1.2m	Favourable variance on pay budgets largely due to vacant Support to Clinical Staff posts. At the end of April there were 419 WTE vacant posts. The favourable variance has been partially offset by Redundancy costs in April £152k.	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. Vacancy control measures in place.
Drugs and Devices	-£1.0m	The adverse variance is largely due to the use of high-cost drugs in Cancer and Specialist Medicine. The contract with commissioners for 2026/27 re-introduces pass through arrangements for excluded drugs and devices. In addition, several former high-cost drugs have been moved to 'in tariff'. Tariff prices have been increased to account for this change. The Trust can expect to be reimbursed in full for this expenditure	Continue to closely monitor drug expenditure.
WRAP	-£1.9m	Savings of £2.9m have been delivered in April 2026 compared to a target of £4.8m. This is a shortfall of £1.9m. In full year terms, £17.1m has been delivered against the target of £61.6m.	Continued focus on delivery of the WRAP overseen through the Finance Improvement Boards.
Other Non Pay	£0m	Favourable variance on clinical supplies and services £0.7m offset by adverse variance on other costs including insourcing £0.7m.	Variances at cost category offset. Coding will be reviewed and costs moved to the correct category as appropriate.

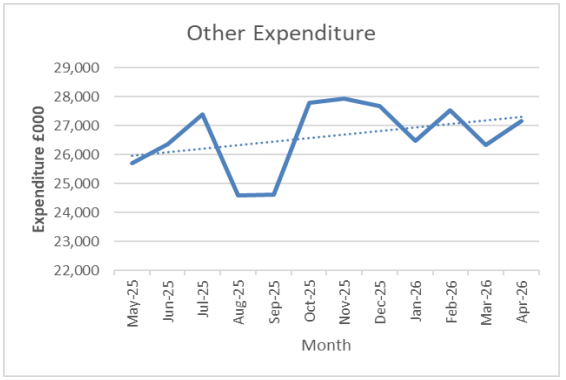
Income and Expenditure Run Rate

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust







	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD Average	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income	73,619	74,806	76,912	75,443	76,095	74,981	75,011	73,986	74,000	74,268	74,525	75,441	74,877	564
Pay Expenditure	49,340	50,028	51,273	48,784	51,884	50,282	50,548	49,895	51,005	51,041	49,416	50,484	50,318	166
Other Expenditure	25,721	26,376	27,404	24,599	24,629	27,807	27,945	27,683	26,486	27,538	26,333	27,156	26,593	563

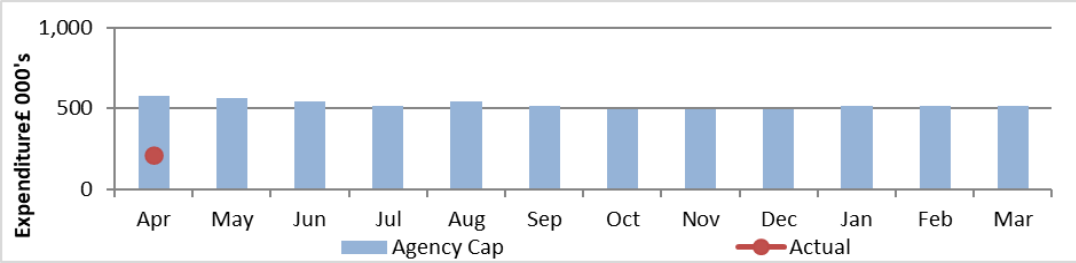
The graph and table above show the monthly run rate for income, pay and other expenditure. The figures for 2025/26 have been normalised through the removal of one – off items including increased pension contributions, impairment, ERF overtrade from 2024/25 write off and sparsity funding.

Income in April was £75.4m, which was £0.5m higher than the average monthly income for May 2025 to March 2026. The income position in April includes £1.5m income brought forward from future months to offset shortfall in delivery of WRAP. This increase is offset by the write back of an accrual from 2025/26 £0.7m.

Pay expenditure in April 2026 was £50.5m which was £0.2m higher than the average monthly pay expenditure for May 2025 to March 2026. The increased costs in April linked to pay awards for agenda for change staff have been offset through the continued impact of agency and bank staffing reductions.

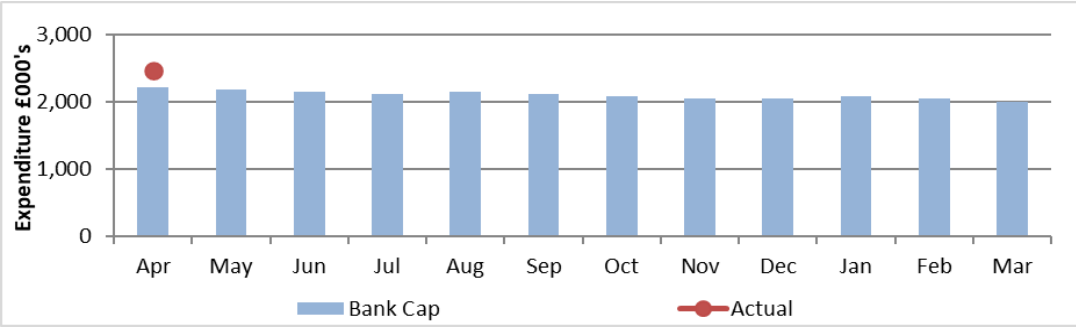
Other expenditure was £27.2m in April 2026, which was £0.6m higher than the average monthly expenditure for May 2025 to March 2026. The increase was largely due to increased CNST and depreciation charges which were included in planning. In addition, there is an increase linked to approved continuation of insourcing, particularly in Surgery and CSCS.

Agency, Bank and Workforce
Finance



Agency Controls

The Trust has an agency staffing spend limit of £6.3m in 2026/27. This represents a reduction of 4% on the 2025/26 expenditure level. The year-to-date expenditure on agency staff at the end of April 2026 is £0.2m, compared to a plan of £0.6m, representing a favourable variance of £0.4m.



Bank Controls

The Trust has a bank staffing spend limit of £25.2m in 2026/27. This represents a reduction of 45% on the 2025/26 expenditure level. The year-to date expenditure on bank staff at the end of April 2026 is £2.5m, compared to a plan of £2.2m, representing an adverse variance of £0.3m.

	Establishment			Year to Date Expenditure		
	Budget	Actual	Variance	Budget	Actual	Variance
	WTE	WTE	WTE	£0	£0	£0
Registered Nurses	2,655.52	2,568.62	86.90	13,311	13,264	48
Scientific, Therapeutic and Technical	1,336.80	1,282.61	54.19	6,715	6,666	48
Support To Clinical Staff	1,923.27	1,503.99	419.28	5,876	4,726	1,150
Medical and Dental	1,125.85	1078.95	46.9	13,607	14,043	-435
Non-Medical - Non-Clinical	3,187.41	3,009.53	177.88	12,076	11,585	491
Reserves				-101	0	-101
Other				182	200	-18
TOTAL	10,228.85	9,443.70	785.15	51,667	50,484	1,183

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 underspend is vacant Support to Clinical Staff roles. At the end of April there were 419 WTE vacant posts.

Variable Activity – Trading Position – NHSE / ICB Contracts

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Trust Variable Activity Performance Report vs Commissioner Values in Contract.

Commissioner	Value VAPR scope Indicative Weighted Values at 26/27 prices	VAPR Month 1 Phase (Av %)	Weighted Activity to Month 1 Actual	Variance - (Clawback Risk) M1
Humber and North Yorks	£175,760,397	£13,586,951	£13,830,576	£243,625
West Yorkshire	£1,579,629	£122,111	£150,411	£28,300
Cumbria and North East	£263,424	£20,377	£31,966	£11,589
South Yorkshire	£146,877	£11,201	£10,529	-£671
				£0
All ICBs	***£177,750,327***	***£13,740,640***	***£14,023,483***	***£282,842***
NHSE Specialist Commissioning	£4,623,000	£385,250	£273,570	-£111,680
Other NHSE	£285,266	£21,963	£18,009	-£3,954
All Commissioners Total	**£182,658,593**	**£14,147,853**	**£14,315,062**	**£167,209**

Variable Activity Performance Report

The Trust is monitoring the weighted financial value of activity that falls within the scope of the variable element of the contract. This is in line with the 2026/27 National Payment Scheme Guidance. The weighted value of activity is calculated on an early 'heads-up' approach using partially coded data and extrapolating this for the year-to-date position. The scope of variable activity includes, Elective IP, Day case, Unbundled Radiology, First Outpatient and Outpatient attendances with a Procedure.

Although the funding for the variable activity is now reimbursed on a cost per case arrangement, it is important to note that under the contract terms, the Trust will be required to work in line with the agreed Indicative Activity Plan (IAP). Any identified "material" variance to the IAP in year will need to be formally notified to the commissioners, with further discussions to establish the key drivers of any variance. This may then require a joint Activity Management Plan (AMP) to be agreed with commissioners, which may include the management of activity back within system resource where possible.

At Month 1, across all commissioners, the weighted activity position is slightly above the target weighted value by £167k. This is provisional data and includes some estimated data where activity is not yet coded, so the variable position is subject to change when the final Month 1 activity is fully coded and costed.

Trust Waste Reduction and Productivity Programme

Executive Summary

Programme Summary Position

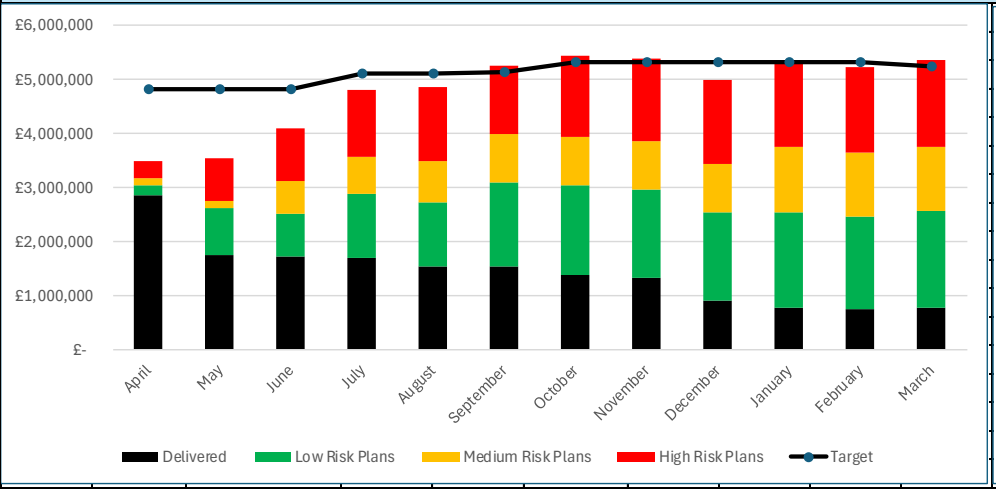
	Full Year	YTD Position
Target	£ 61,639,999	£ 4,807,922
Delivered	£ 17,059,521	£ 2,865,532
Variance	**-£ 44,580,478**	**-£ 1,942,390**
Addititional Plans to be delivered		
Planned Low Risk	£ 15,952,139	£ 165,091
Planned Medium Risk	£ 9,434,179	£ 138,083
Planned High Risk	£ 15,289,756	£ 327,101
Total Additional Plans	**£ 40,676,075**	**£ 630,275**
(Planning Gap)/Over delivery	**-£ 3,904,403**	**-£ 1,312,115**

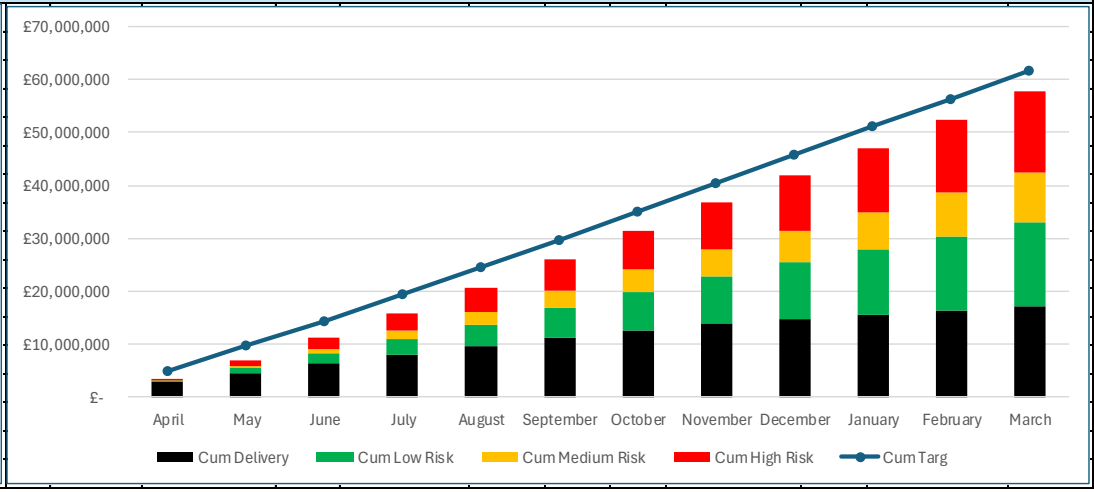
Scheme Governance

Total Number of Live Schemes							**138**				
EQIA Outstanding							54		39%		
Pre-Pipeline							55		40%		
Opportunity							5		4%		
Plan in Progress							15		11%		
Fully Developed							63		46%		
	Plans	**%**	**Delivered**	**%**				**Plans**	**%**	**Delivered**	**%**
Recurrent	£ 38,376,258	62%	£ 14,704,843	24%			**Pay**	£ 25,541,176	41%	£ 3,915,705	6%
Non Recurrent	£ 19,359,338	31%	£ 2,354,678	4%			**Non Pay**	£ 31,879,057	52%	£ 12,924,453	21%
Total	**£ 57,735,596**	94%	**£ 17,059,521**	28%			**Income**	£ 315,363	1%	£ 219,363	0%
							Total	**£ 57,735,596**		**£ 17,059,521**	

WTE Plan		**WTE Delivered**	
YTD Period Name		April 2026	

In Year Plan Profile





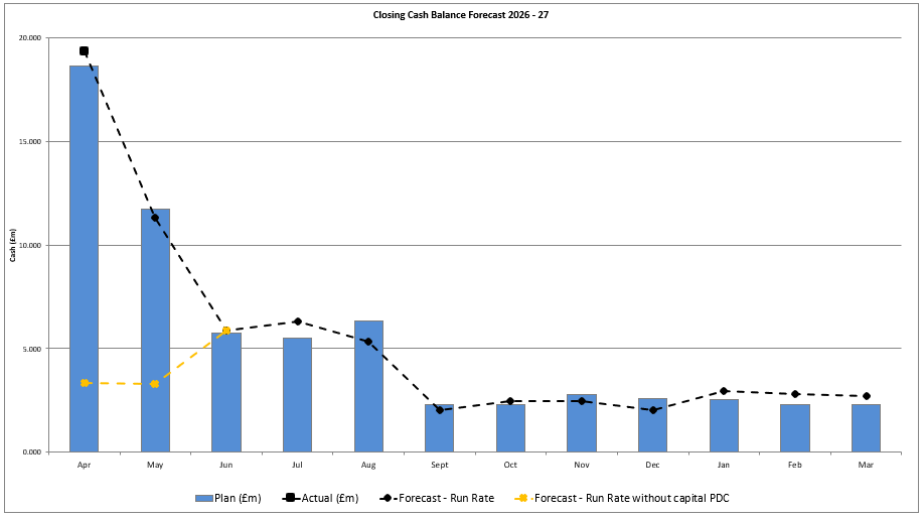
Current Cash Position and Better Payment Practice Code (BPPC)

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Group's cash plan for 2026/27 is for the cash balance to reduce through the year resulting in a closing balance of £2.3m 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	18,649	11,726	5,776	5,486	6,358	2,286	2,318	2,784	2,581	2,552	2,309	2,309
Actual	19,199											



Closing cash was £19.2m against a plan of £18.6m, which is £0.6m above plan. There are no significant variances of concern.

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

The closing April cash balance includes a £16m timing gain from receipt of capital PDC funding drawn in line with NHSE deadlines in March, where capital invoices will become due for payment during 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 requirement for cash support isn't currently anticipated for Q1 or Q2, but this is reliant on continued financial management within the organisation to live within the 2026/27 financial plan.

<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 April the Group managed to pay 89% of its suppliers within 30 days, consistent with the M11 & M12 positions.

Current and Forecast Capital Position

Finance

York and Scarborough Teaching Hospitals NHS Foundation Trust

Annual Plan £000s	YTD Plan £000s	M1 Actual £000s	YTD Variance £000s
58,892	1,574	919	(655)

The M1 position is £655k behind plan.
This is mainly due to the RAAC schemes running behind the planned phasing.
There are no significant issues to report at M1.

The board approved capital plan for 2026/27 is £63m. After adjustments for donated & grant funded and the planned disposal of Clarence Street, net CDEL for the year is £59m.

The main schemes within the plan are:

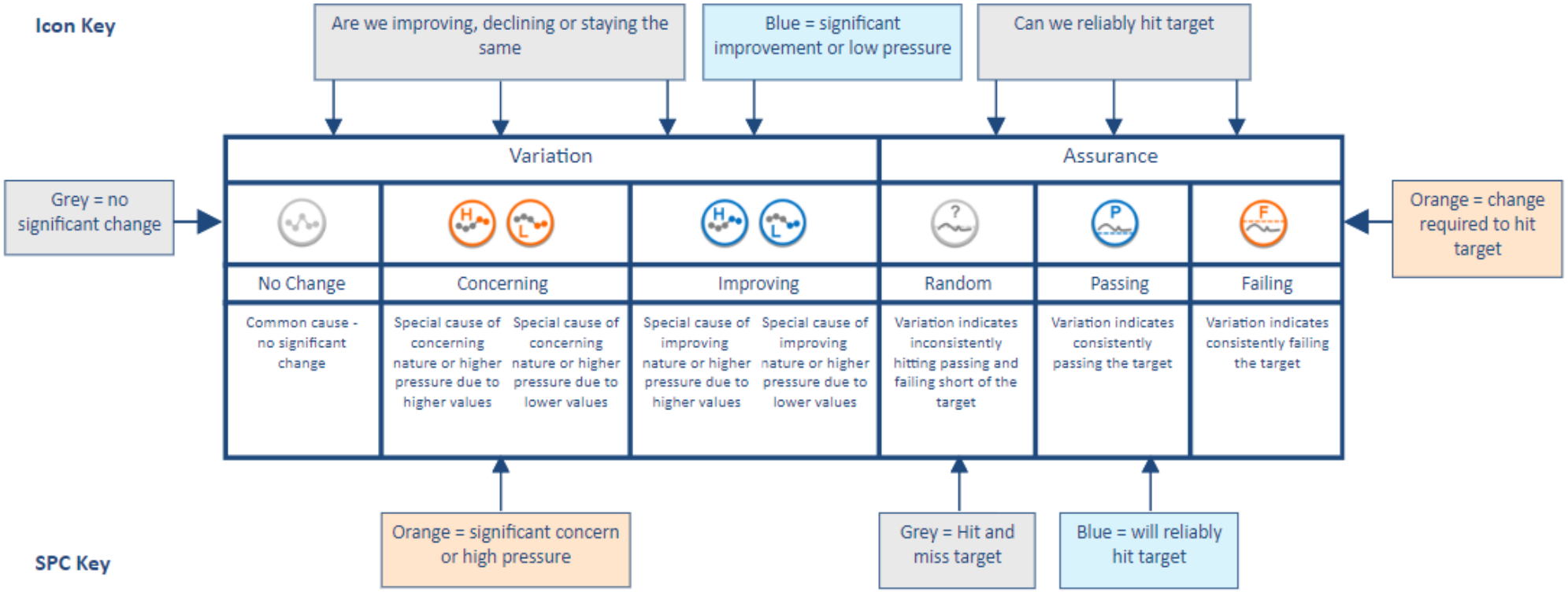
- £25m – Scarborough RAAC
- £2.1m – York PACU / Hybrid Theatre
- £7.2m – Electronic Patient Record
- £3.8m – Scarborough Hospital PSDS4 Decarbonisation Project (Salix Grant)
- £4.8m – Constitutional Standards Schemes Diagnostics
- £2.2m – Safer Estates Funding
- £5.6m – Leasing programme Equipment, Vehicles, Buildings

2025/26 Capital Position	Annual Plan £000s	YTD Plan £000s	M1 Actual £000s	Variance to YTD Plan £000s
PDC Funded Schemes	33,586	1,300	18	(1,282)
IFRS 16 Lease Funded Schemes	5,600	-	-	-
Depreciation Funded Schemes	20,031	274	901	627
Charitable & Grant Funded Schemes	4,160	0	178	178
Total Capital	**63,377**	**1,574**	**1,097**	**(477)**
Less Charitable & Grant Funded Schemes	(4,160)	-	(178)	(178)
Less Sale of Clarence Street	(325)	-	-	-
Less PPE / Lease Disposals	-	-	-	-
Total Capital (Net CDEL)	**58,892**	**1,574**	**919**	**(655)**

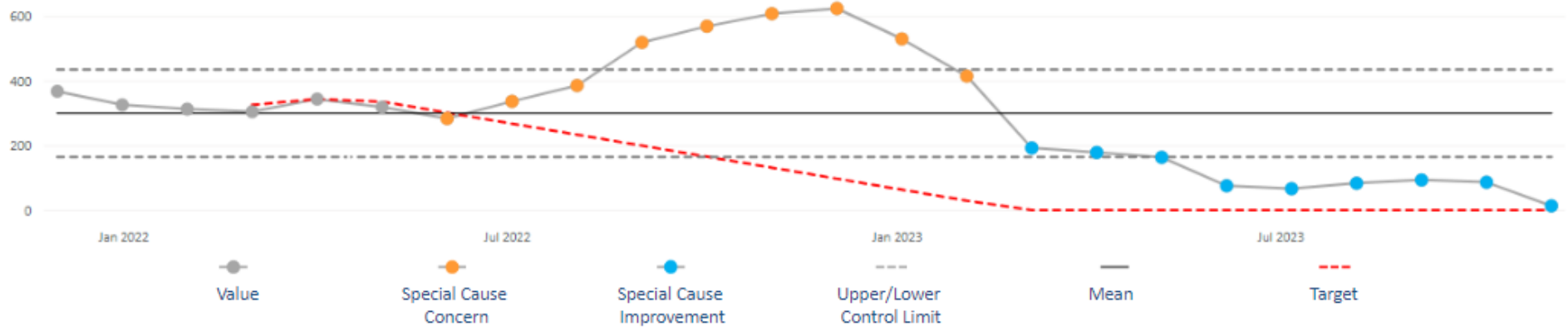
Keys

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

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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 15

Report to:	Board of Directors
Date of Meeting:	27 May 2026
Subject:	Care Quality Commission (CQC) Update
Director Sponsor:	Joseph Hague, Chief Nurse Adele Coulthard, Director of Quality, Improvement and Patient Safety
Author:	Emma Shippey, Head of Compliance and Assurance

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The Trust has undergone significant CQC activity across multiple services since October 2025. This includes the recent unannounced maternity inspection at York and Scarborough in April 2026, with initial feedback received and supporting evidence submitted on time.

An IR(ME)R inspection at York identified no breaches with two recommendations being addressed. Inspections of urgent and emergency care and medical care identified regulatory breaches at both sites, with responses submitted and ongoing oversight in place.

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 (April 2026)

On Tuesday 14 April 2026, the Care Quality Commission (CQC) notified the Trust of an unannounced onsite inspection of Maternity Services. The CQC inspection team attended York Hospital on 14 and 15 April, and Scarborough Hospital on 16 and 17 April. The inspection formed part of a planned re-assessment following the 2023 inspection, during which services were rated as inadequate.

A letter confirming the verbal feedback provided at the conclusion of the onsite inspection was received on 21 April 2026. The letter was presented at the public meeting of the Trust Board of Directors on 29 April 2026 and through the Trust quality governance structure in May 2026.

Following the inspection, the CQC requested additional evidence which was all submitted by the deadline of 6 May 2026.

1.2 York Hospital Ionising Radiation (Medical Exposure) Regulations (IRMER) Inspection : Nuclear Medicine (January 2026)

The CQC conducted an onsite inspection of Nuclear Medicine at York Hospital on 28 January 2026 as part of its proactive Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) programme.

No breaches of IR(ME)R 2017 were identified that met the threshold for regulatory action; however, two recommendations were made. IRMER reports are not published on the CQC website.

An action plan to address these recommendations was submitted to and approved by the IR(ME)R inspection team by the deadline of 7 April 2026. Progress against these actions will be monitored and reported through the Trust Regulations and Accreditations Group.

1.3 Scarborough Hospital Inspection of Urgent and Emergency Care and Medical Care (October 2025)

There was an unannounced CQC inspection of Urgent and Emergency Care and Medical Care Services at Scarborough Hospital between 7 and 9 October 2025. The final report was published on 20 March 2026 click here to view.

Six legal breaches in regulation were identified. A response to these breaches was submitted to the CQC by the deadline of 10 April 2026. Feedback on the Trust response has yet to be received.

1.4 York Inspection of Urgent and Emergency Care and Medical Care (January 2025)

In response to the CQC inspection report published on 2 July 2025 (click here to view), 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.

1.5 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 recent inspection activity but aim to complete in May 2026.

1.6 Ongoing CQC Engagement

Quarterly engagement meetings are scheduled with our CQC colleagues and a workplan for 2026 has been developed. An on-site visit to York Hospital and specifically Surgery on 21 April 2026 was deferred due to the CQC being onsite for the Maternity inspection the week before. The visit will be re-scheduled.

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 7 May 2026, there are 32 open CQC. Nine cases have had responses submitted, and we are awaiting feedback from the CQC. The capacity to respond to CQC cases has been impacted by team absence and recent inspection activity. Responses to CQC cases will be prioritised over the next month.

Date: 7 May 2026

Report to:	Trust Board of Directors
Date of Meeting:	27th May 2026
Subject:	Maternity and Neonatal Safety Report
Director Sponsor:	Joseph Hague, Chief Nurse (Executive Maternity and Neonatal Safety Champion)
Author:	Sascha Wells-Munro OBE, Director of Midwifery and Strategic Clinical Lead for Family Health (Maternity Safety Champion)

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

Approve ☒ Discuss ☒ Assurance ☒ Information ☒ Regulatory Requirement ☐

Trust Objectives

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☒ Transformative Services
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☐ Financial Balance
☐ Effective Governance

Implications for Equality, Diversity and Inclusion (EDI)

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity and neonatal services team. The data shared is for the month of March 2026 for performance metrics and April 2026 for workforce, unit diverts and homebirth service provision.

Key Assurance

- Maternity services are in receipt of 470K form NHS Resolution for the action plan to deliver against safety action 3 and 6 form year 7 maternity incentive scheme, this money will be used to progress these safety actions, in line with the action plan that was submitted and signed off by trust board in February 2026.
- Maternity services are successfully delivering the RSV vaccination programme in terms of offer to women in pregnancy. The national uptake is 64.1% with York and Scarborough's uptake at 79%. This will have an impact on the number of babies and children presenting via ED with RSV in the winter months. This activity will be monitored to track the impact of the vaccination in York and Scarborough hospitals.
- A report published by Sands and Tommy's Policy unit in 2023 in Board oversight of maternity services focussed on the ability of Trust Boards to fully understand and monitor the quality and safety of the services. A guide has also been published for Boards to use to ensure all key elements of safety are shared with Trust Boards. All elements within this guide have been shared with York and Scarborough's Trust board since November 2023. (Annex 3) All actions and recommendations arising from maternity and neonatal reviews are tracked through internal governance and also the corporate patient safety meeting as well as Maternity assurance group and quality committee. All actions that require greater work for implementation are incorporated into the maternity and neonatal single improvement plan.

Key Risks

- There has been an increase of PPH over 1500mls to 5.1% which is 16 cases. All cases have been reviewed and no care issues of common themes have been identified. Ongoing monitoring remains in place through audit and will be supported through element five of the maternity care bundle. The service remains within the national average for England.

Key Concerns

- Extensive recruitment is underway to appointment midwives following the significant investment this year. There has been many applicants, but largely from newly qualitied midwives. The concern is related to how many the service can safely support without adding additional clinical risk to frontline services.
- 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 ☐

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 March 2026, and data for April 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 March 2026 is provided in a separate paper.

Perinatal Deaths

There was one stillbirth at York and Scarborough in March 2026.

Maternity and Newborn Safety Investigations (MNSI)

There was one case that met the criteria for reporting to the Maternity and Newborn Safety Investigation (MNSI) programme during March 2026. No new draft or final reports were received into the service.

Moderate Harm Incidents and above

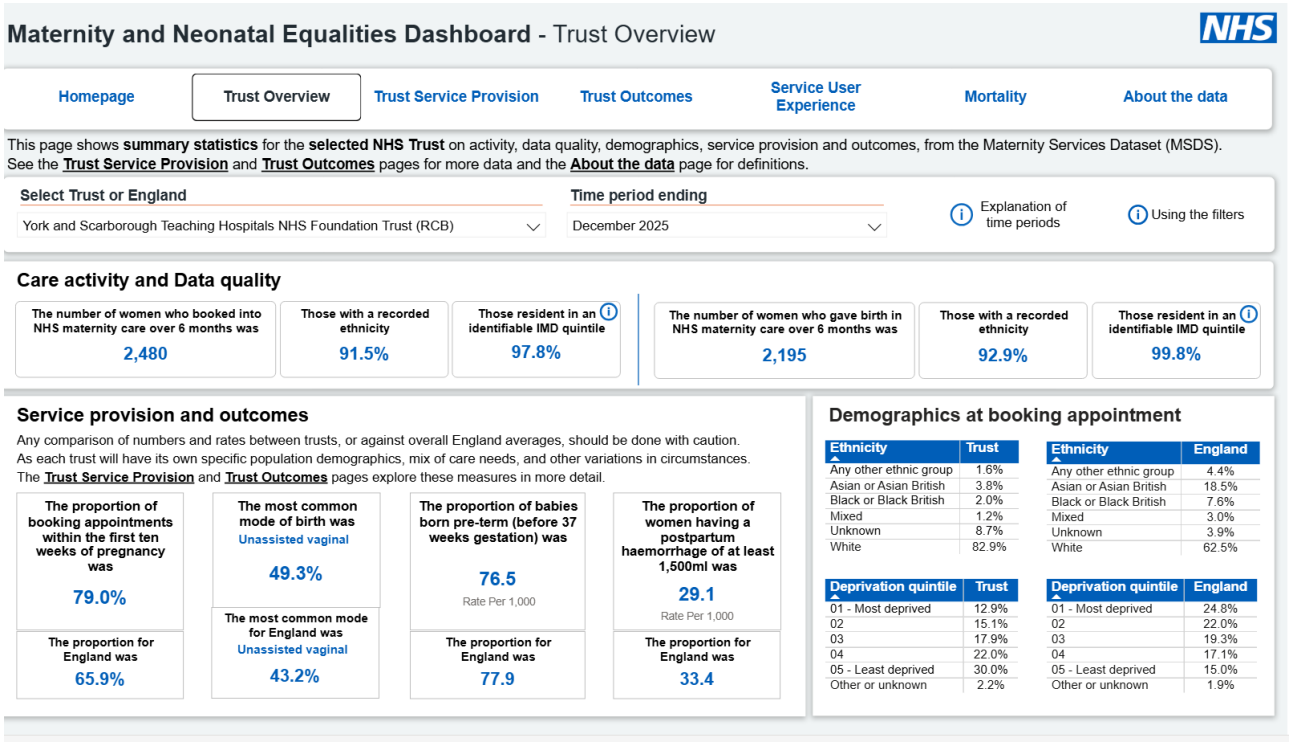
There were 13 incidents graded moderate or above in March 2026 along with 6 red flags as per NICE guidance reported which was one delay in Artificial of Membranes for more than 24 hours, two delays in assessment in maternity triage unit within the required 15 minute assessment standard, two delayed planned caesarean sections and one delay to receiving an epidural within 30 minutes. All red flag incidents are reviewed by the ward managers with oversight form the matrons for areas for immediate learning and improvement.

Maternity Unit diverts/ closures and suspension of services

In April there were no unit diverts or closures.

In March there were 0 days where a 24-hour homebirth service could be provided on the East Coast, and 8 days where a 24-hour homebirth service was provided across York and Selby. A daytime service for Homebirth was available for 15 days for Scarborough and the East Coast and 27 days for York services due to the need to provide continuity of antenatal care and staffing sickness/vacancy rates within the teams which continue to be the challenge to providing a sustainable 24hour homebirth service.

Heath Inequalities, Data and Quality Improvement



The above data is from June to December 2025. The data shows that in this timeframe York and Scarborough maternity services are not an outlier against the overall position for England. Current data shows a compliance of an average of 70%. This is an area for improvement in relation to booking appointments within the first 10 weeks of pregnancy as the sooner a woman is in the care of maternity services appropriate care plans and provision can be in place to address any individual health needs and reduce inequalities and improve access. This is being monitored across the services on a weekly basis and thematic reviews occur to understand when this standard has not been met. This will be improved with the increase in the community midwifery workforce following the first round of investment.

National Maternity and perinatal Audit 2025 (Annex 2)

The data for the report published at the end of 2025 is related to activity from January to December 2023.
In the five areas reported York and Scarborough are not an outlier for any of the metrics however there is opportunity for improvement to be made in the number of babies receiving breast milk and data quality for recording of PPH. These improvements are outlined with in the maternity and neonatal single improvement plan.

MBRACE- UK Perinatal Mortality Report: 2024 Births Summary

- **Summary:** The report covers 3,937 births at ≥24 weeks' gestation (excluding terminations) and confirms that the Trust's perinatal mortality outcomes are in line with the average for comparable Trusts.

Overall, there is no indication of outlier performance. Mortality rates remain stable over time, data completeness is high, and established review processes (PMRT) are reinforced as the primary mechanism for learning and improvement.

- **Key Outcomes:**

For births in 2024, the Trust recorded:

- 9 stillbirths, 4 neonatal deaths, and 13 extended perinatal deaths.

The stabilised and adjusted mortality rates, which account for case-mix and provide the most reliable comparison, were:

  - **Stillbirth rate:** 2.84 per 1,000 total births
  - **Neonatal mortality rate:** 1.11 per 1,000 live births
  - **Extended perinatal mortality rate:** 3.95 per 1,000 total births

All rates are assessed as around the average for similar Trusts and Health Boards.

When excluding deaths due to congenital anomalies, rates remain comparable with peers:

  - **Stillbirth rate:** 2.66 per 1,000 total births
  - **Neonatal mortality rate:** 0.80 per 1,000 live births
  - **Extended perinatal mortality rate:** 3.45 per 1,000 total births

- **Key points:**
- Most extended perinatal deaths occurred at earlier gestations, with rates at later gestations comparable to or below UK averages.
- Causes of death were predominantly related to placental, fetal, or neonatal factors, broadly reflecting national patterns, though small numbers limit interpretation.
- Post-mortem examinations were offered in 89% of stillbirths and 100% of neonatal deaths occurring within the Trust, indicating good compliance with national expectations, though stillbirth offer rates are slightly below the UK average.

Maternity Incentive Scheme Year 8

- NHS resolution launch event on 23rd April outlined changes to the scheme and associated documentation.
- Shift from process focused to focused on impact and outcomes.
- 6 safety actions reorganised by theme and intention (previously 10)
  - Safety Action A – Workforce and Capacity
  - Safety Action B – Training
  - Safety Action C – Learning from reviews and incidents.
  - Safety Action D – Service-user voice and equity
  - Safety Action E – Care Bundles
  - Safety Action F – Board oversight, governance, culture, and leadership
- Mandatory components of each action set out the expectations – Outcome, Why and What
- Trusts can decide local priorities, evidence and assurance required by board– How, When and Who
- Focus on assurance against outcomes rather than processes.
- Reporting period aligns to Q1-Q3 but the requirements are a year-round responsibility.

Midwifery Workforce

Midwifery vacancy and recruitment – current position April 2026

	Band 5/6	Band 3/4
Establishment budget	174.61 WTE	42.96 WTE
Staff in post	165.84 WTE (of which 30.09 WTE are band 5)	41.91 WTE
Substantive Vacancy	8.77 WTE	1.05 WTE
Maternity Leave	8.80 WTE (5.67 WTE York & 3.13 WTE Scarborough)	2.60 WTE (1.60 WTE York & 1.00 WTE Scarborough)
Roster vacancy	17.57 WTE	3.65 WTE

The above figures include the phase 1 investment for FY2627

Improvement and Transformation in April 2026

- A Hot Topics Quality Improvement project has commenced to help birthing partners to support their families on our postnatal wards outside of ward visiting hours.
- Following the Neonatal Support Group feedback review, the BadgerNotes app will be the primary form of parent communication. This change in process was enacted in April 2026.
- Bereavement services have mapped their short, medium and long-term improvement priorities based on the National Bereavement Care Pathway self assessment tool.
- Work has commenced with the corporate communications team to agree a process for updating the maternity services website in line with the approved proposal at April's Maternity Directorate committee.
- The refreshed cross site escalation policy implementation plan was developed and the trust on-call staff training complete.
- A draft Maternity and Neonatal behavioural has been created based on feedback at the 'kindness is our culture' event held in February 2026. This will be reviewed by facilitators from the 4th engagement day and then distributed to all colleagues for comment/further input.
- NEWTT2 tool after implementation audit commenced
- MEWs project brief approved at Maternity Directorate
- A project brief setting out the short-, medium- and long-term ambition for our estates improvement works at the Scarborough site was presented at April's Maternity Directorate meeting. An exercise to cross-reference the outlined estate requirements against approved capital prioritisation funding will now commence to support project managing the short term work requests.
- A second trial to open the main doors on G3 main entrance reception between 09:00-16:00 commenced on the 20th April and is supported by the maternity records admin team. The trial is due to end on 17th May 2026. the findings will help support our case for change to alter the G3 main door security during daytime hours on a permanent basis.

- Antenatal wards at York and Scarborough have reviewed medication trollies and confirmed they are available to support postnatal drug-round re-implementation.

The Maternity and Neonatal Single Improvement Plan (MNSIP)

April 2026 Position

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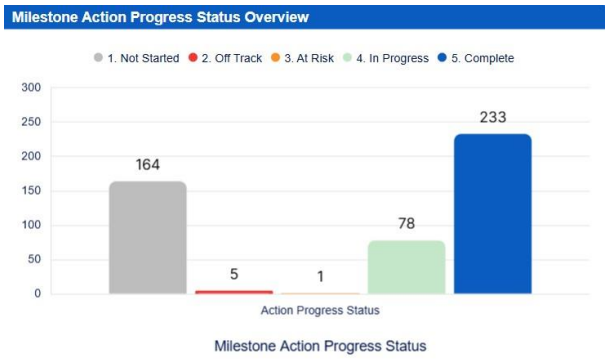
NHS Foundation Trust

- 228 out of 481 milestone actions have been completed to date (5 completed in April 2026)
- 75 milestone actions are in progress
- 5 milestone actions are off-track as the delivery date has passed, and the action has not been completed
  - 3 off-track actions have plans in place to deliver these in May 2026.
  - 2 off-track actions relate to the review of the pre -existing diabetes service offer to meet Saving Babies Lives Care Bundle compliance. The project group is meeting on 7th May 2026 to assess delivery timescales.
- 1 milestone action is marked as at risk. This relates to the development of a proposal for an MDT one -stop pre-existing diabetes clinic in line with the Saving Babies Lives Care Bundle. The operational and clinical team capacity is limited due to volume of caseload in clinics currently impacting on time to develop the proposal. The project group is meeting on 7th May 2026 and an assessment on the delivery schedule will be carried out.
- 165 milestone actions are not scheduled to start yet



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 dlivery	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*

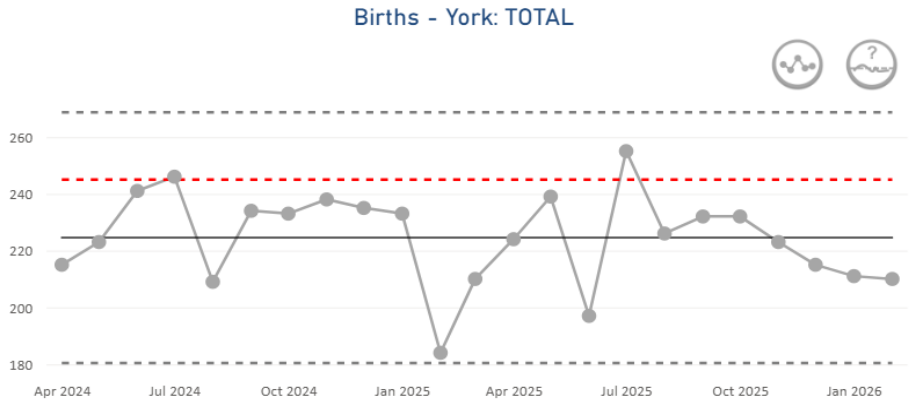
Loss of key staff impacting programme delivery	There is a risk that key members of the programme leadership team (SRO's, Workstream leads, subject matter experts, programme team, MNVP etc.) may: leave the organisation, move roles, be reallocated to support alternative programmes of work or may not have 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*

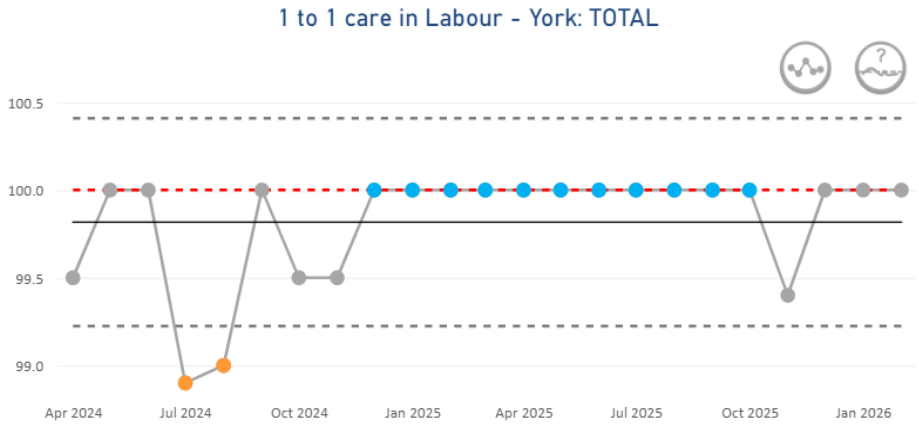
Recommendations to Trust Board

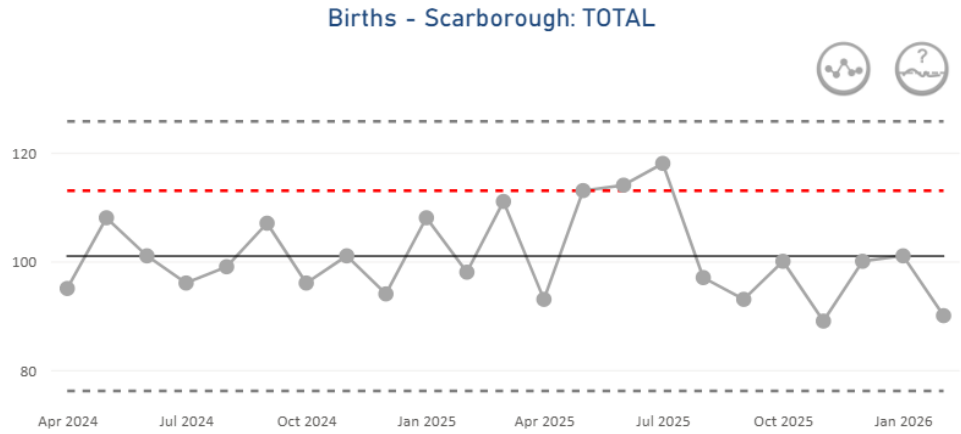
To note the contents of this report

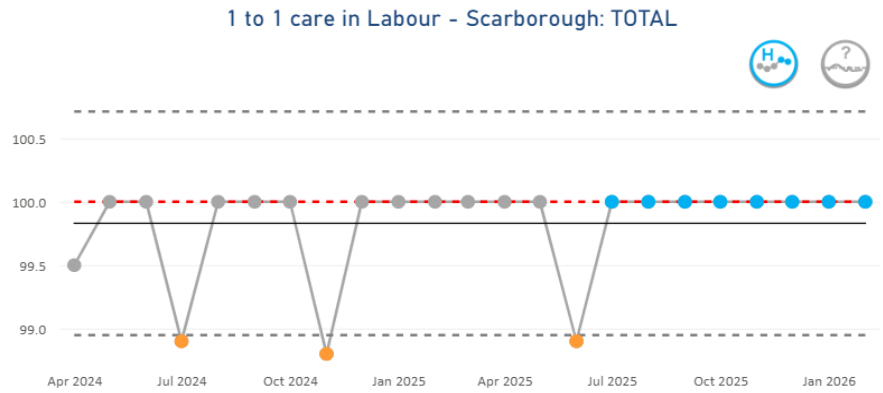
Date: May 2026

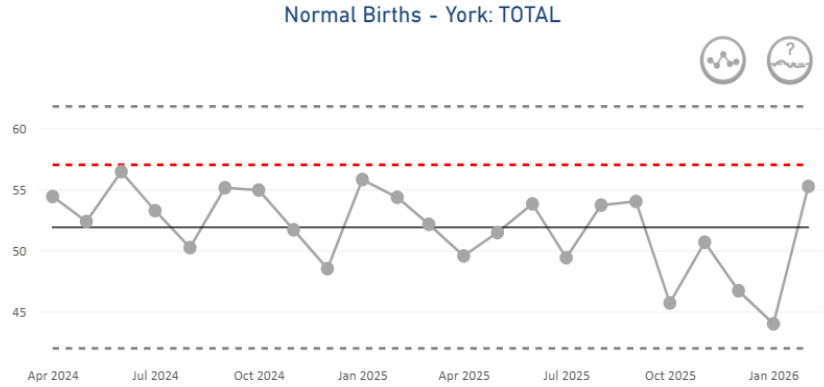
Annex 1 Summary of Maternity & Neonatal Quality & Safety Metrics Delivery March 2026

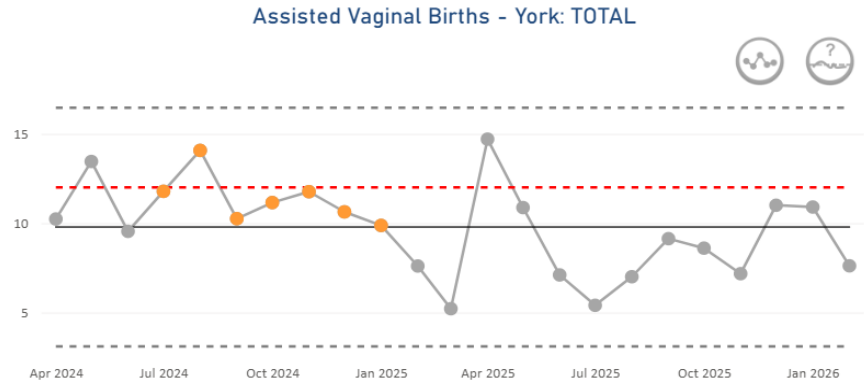


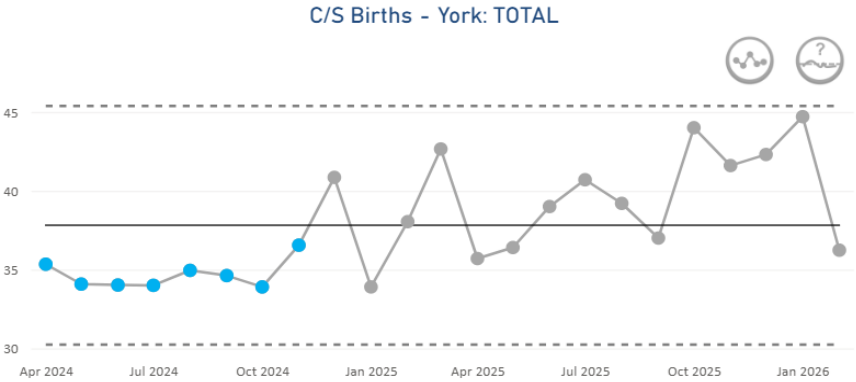


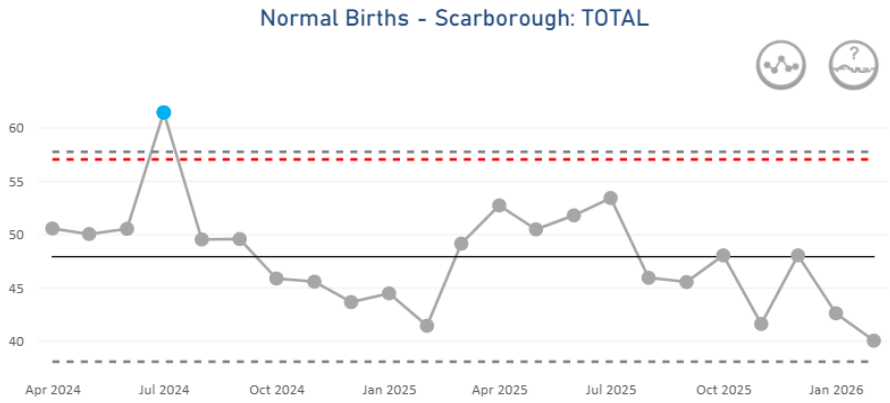


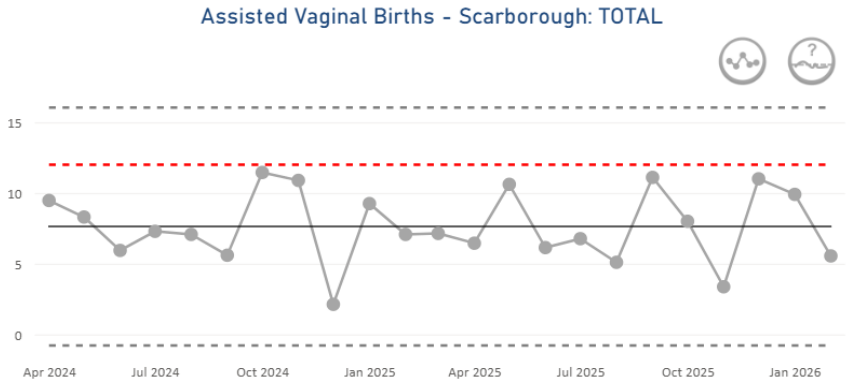

1 to 1 care in Labour - Scarborough: TOTAL
100.5
100.0
99.5
99.0
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

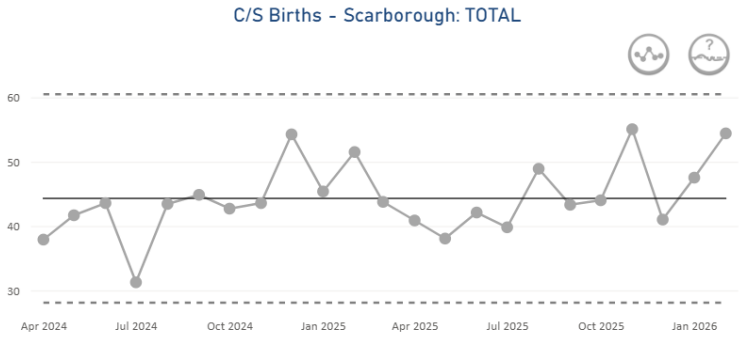

Normal Births - York: TOTAL
60
55
50
45
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

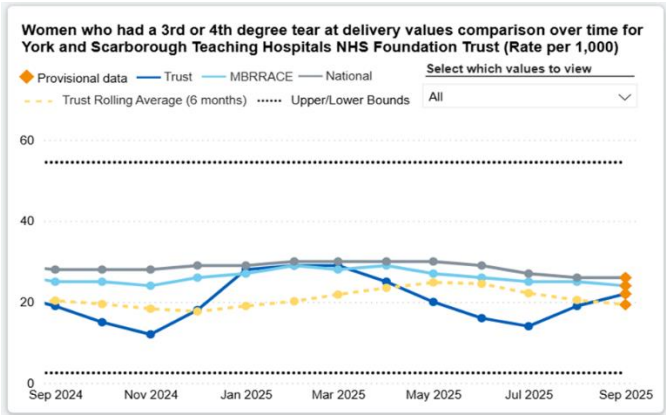

Assisted Vaginal Births - York: TOTAL
15
10
5
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

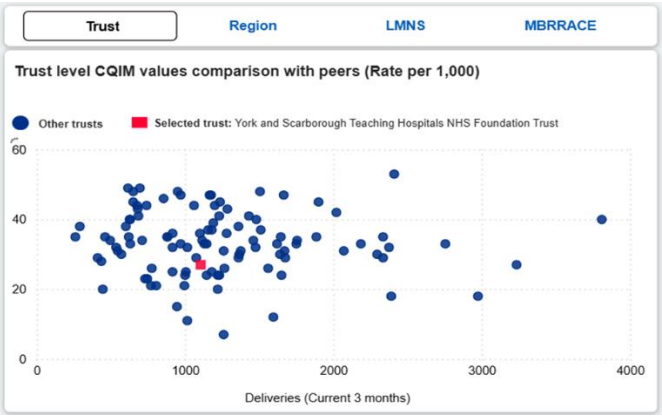

C/S Births - York: TOTAL
45
40
35
30
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026


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

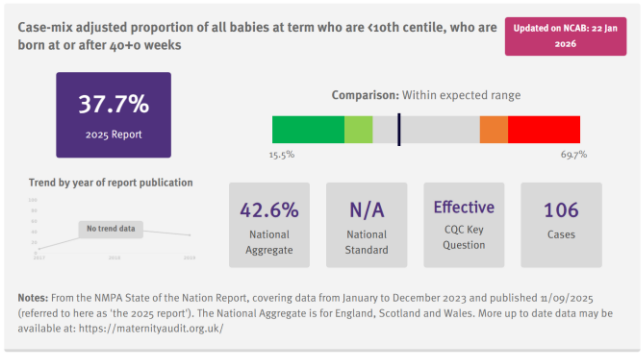

Assisted Vaginal Births - Scarborough: TOTAL
15
10
5
0
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

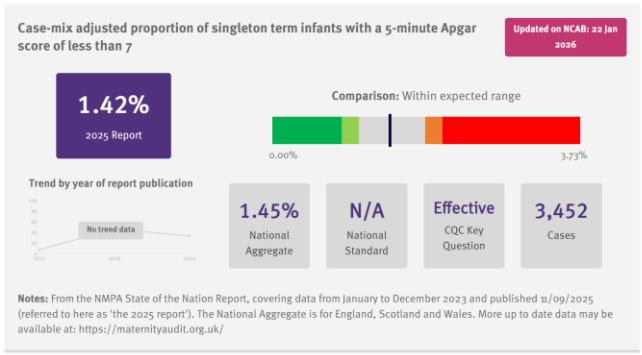

C/S Births - Scarborough: TOTAL
60
50
40
30
Apr 2024
Jul 2024
Oct 2024
Jan 2025
Apr 2025
Jul 2025
Oct 2025
Jan 2026

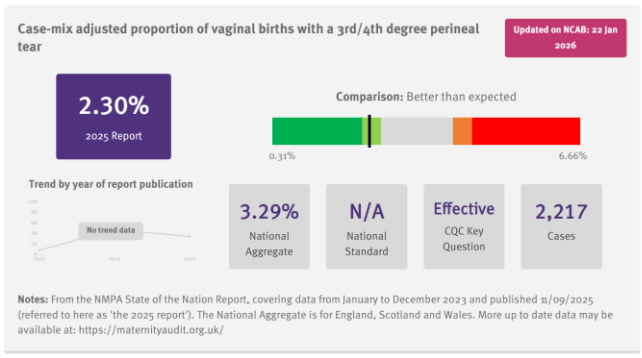

Women who had a 3rd or 4th degree tear at delivery values comparison over time for York and Scarborough Teaching Hospitals NHS Foundation Trust (Rate per 1,000)
Provisional data
Trust
MBRRACE
National
Trust Rolling Average (6 months)
Upper/Lower Bounds
Select which values to view
All
60
40
20
0
Sep 2024
Nov 2024
Jan 2025
Mar 2025
May 2025
Jul 2025
Sep 2025

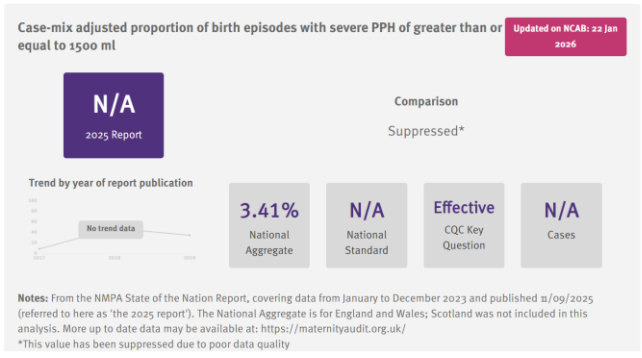

Trust
Region
LMNS
MBRRACE
Trust level CQIM values comparison with peers (Rate per 1,000)
Other trusts
Selected trust: York and Scarborough Teaching Hospitals NHS Foundation Trust
60
40
20
0
0
1000
2000
3000
4000
Deliveries (Current 3 months)

Annex 2



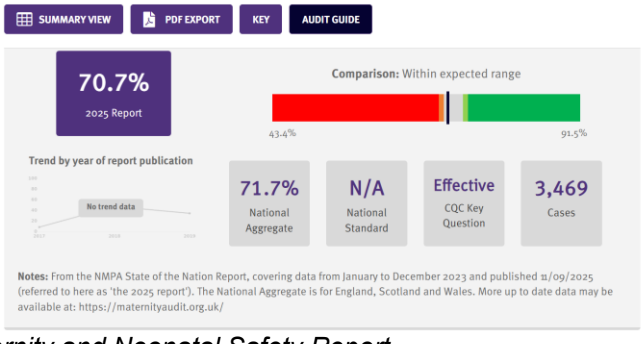






National Maternity and Perinatal Audit

York and Scarborough Teaching Hospitals NHS Foundation Trust



Annex 3

Guide: for Trust board members – sources of data on your maternity and neonatal services

Purpose

Consistent concerns have been raised about the effectiveness of Trust board oversight of their maternity and neonatal services. Our report has raised questions about the ability of Trust boards to fully understand and monitor the quality and safety of these services.

We have provided this short guide to support board members; offering an overview of the key data sources available to them, with a focus on Trust level data relevant to perinatal mortality. Our aim is to help board members easily navigate the information they need and support them to carry out their oversight role with confidence.

Accessing data on baby deaths in your Trust

MBRRACE-UK (Mothers and Babies: Reducing risk through audits and confidential inquiries across the UK) – surveillance data

Data on stillbirths, neonatal deaths and maternal deaths are available publicly here, displayed as an interactive national dashboard, where data can be filtered by country, region, neonatal network and Trust/Health Board. National perinatal surveillance data are published annually, typically in May, and accompanied by a State of the Nation report, available here.

In addition to the annual UK-wide perinatal mortality surveillance reports, MBRRACE-UK produces tailored reports for each Trust/Health Board, and which are only available to registered users of the MBRRACE-UK surveillance system. For information on how to access the report, please see p.33-34 of this guidance.

There is a two-year time lag in the reporting perinatal surveillance data, so 2024 data will be published in 2026. However, MBRRACE also has a real-time data monitoring tool which allows organisations to filter and summarise the perinatal deaths as they are reported to MBRRACE. More detail on how to use the tool is

available here, on p.35-42.
Both the tailored reports and real-time data monitoring tool can be accessed on the MBRRACE-UK website. For details on how to log in, please see p.7 of this guidance.

Maternity Outcomes Signal System (MOSS)

MOSS is NHS England's near real-time safety signal system that uses statistical methods to detect unusual patterns in routinely collected intrapartum outcome data – including term stillbirths, neonatal deaths and wider adverse event trends to identify emerging safety issues early. MOSS tracks whether there are more adverse events than expected, issuing an amber (95% chance that the increase in events is real and not due to chance) or red (99% that the increase is real and not due to chance) alert. MOSS automatically emails registered users from Trusts, ICBs, and regional and national leadership when a signal occurs. Trust board members who should be registered, given their accountability for maternity safety and oversight, include:

- Executive Trust Board Safety Champion
- Chief Medical Officer
- Chief Nurse

Each alert should trigger a rapid safety check, which must be completed within eight working days.

A guide to how authorised viewers can access MOSS is available here.
An interpretation guide for MOSS charts are available here.
Information on the MOSS standard operating procedures are available here.

Insight into other maternity and neonatal outcomes in your Trust

NHS England – National Maternity Dashboard

The National Maternity Dashboard, available here, is an interactive dashboard that displays Clinical Quality Improvement Metrics (CQIMs) from the Maternity Services Data Set (MSDS), National Maternity Indicators (NMIs) from external audits, and provider-level demographic data such as maternal age, BMI, ethnicity, bookings, and births. It is specifically designed to support benchmarking and identify areas for clinical quality improvement across maternity services.

National Neonatal Audit Programme (NNAP)

NNAP reports on key aspects of neonatal care in NHS neonatal units across Great Britain, including outcomes such as mortality and major morbidities, as well as optimal perinatal care measures, such as maternal breastmilk feeding, parental partnership, and neonatal nurse staffing. Annual reports are published online, available here, and data are available at individual unit and neonatal network level via the NNAP data viewer, alongside summaries of the audit's core performance metrics.

National Maternity & Perinatal Audit (NMPA)

The NMPA is a large-scale national clinical audit covering maternity services across England, Scotland, and Wales. Its purpose is to evaluate maternity and neonatal care processes and outcomes, identify unwarranted variation, and highlight areas for improvement using clinical audit data. NMPA provides risk-adjusted Trust-level comparisons and outlier flag for metrics with case-mix adjusted proportions such as small for gestational babies (all babies at term who are <10th centile, who are born at or after 40+0 weeks), Apgar score <7 at 5 minutes, third and fourth perineal tears, post-partum haemorrhage >1500ml, and breast milk (live born babies who receive breast milk for the first feed). The audit uses routinely collected clinical data to assess adherence to guidelines and quality standards, supporting system-level insight and long-term quality improvement. Trust-level data can be accessed here.

Maternity and Neonatal Equalities Dashboard

The Maternity and Neonatal Equalities Dashboard, accessible here, brings together MSDS, CQC, and MBRRACE-UK data to highlight disparities in maternity and neonatal care in England. The dashboard includes service provision data – such as gestational age at booking and mode of birth – alongside data on service user experience and outcomes (stillbirths, neonatal deaths, maternal deaths, and preterm births). All measures are disaggregated by deprivation and ethnicity.

Patient and staff experience

NHS England Staff Survey

NHS England's staff survey is published annually and provides a snapshot of people's experience working in the NHS. Detailed results are available for each NHS Trust here, which can be benchmarked against the national results and compared with previous years. Data can also be disaggregated by staff group, although for maternity and neonatal services it is only possible to disaggregate results for midwives and no other professional group.

Care Quality Commission (CQC) Maternity Survey

The CQC survey looks at the experience of people accessing maternity services. Data are available for individual Trusts here, alongside a comparison to the national data, and are published annually. It is important to note that the survey does not include the experience of parents whose babies are stillborn or die in the neonatal period.

Learning from reviews and investigations in your Trust

Perinatal Mortality Review Tool (PMRT)

The PMRT aims to standardise hospital reviews of perinatal deaths, to enable parents to be part of the process, if they choose, and follow a structured process of review, learning, reporting and actions to improve future care. The tool can generate Trust-level summary reports which summarises:

- The deaths reviewed, by gestational age and type of death
- The grading of care (whether the care provided was deemed to have contributed to the outcome), by gestational age and type of death
- The causes of death
- The issues raised by reviews
- The number of staff involved in reviews, and their specialities
- The top contributory factors identified as relevant to the deaths.

The report can be access through the MBRRACE-UK website. For further information on the reports please see p.42-43 of this guidance. There are also training courses on how to use the tool, which can be accessed here.

Maternity and Newborn Safety Investigations (MNSI)

The Maternity and Newborn Safety Investigations (MNSI) programme independently investigates serious maternity and newborn safety incidents, such as intrapartum stillbirths, early neonatal deaths, severe brain injuries, and maternal deaths, to understand what occurred, why, and what improvements are needed.

MNSI provides external insight into the safety and quality of Trusts services, enabling board members to evaluate the effectiveness of escalation, risk management, and governance processes, confirm whether key safety risks are being addressed, and use independent learning to drive targeted improvements and strengthen oversight.

MNSI gives Trust boards access to independent investigation reports, national safety findings, thematic learning, and strategic guidance, available here or will be shared directly with Trusts following investigations.
Useful links:
Report board oversight Nov 2023
Indigestible and illegible: the sorry state of board safety reports

Better board oversight needed to save babies' lives

Sands & Tommy's Policy Unit

Working together to save babies' lives

Board oversight: at a glance

Trust boards' regular oversight of the quality and safety of maternity and neonatal services has been the subject of successive inquiries and reviews. We reviewed publicly available board papers and minutes for seven NHS Trusts in England to analyse whether the information presented to boards, the process for review and actions taken enabled boards to deliver on this responsibility. Our findings across these three areas raise questions about boards' ability to have a full understanding of the performance of maternity and neonatal units under their direction under the current system.

Our review has highlighted the need for:

- Further guidance on the minimum metrics to be submitted to boards, including any new measures identified by the Maternity and Neonatal Outcomes Group to provide an early warning of service quality and safety declining;
- Better ward-to-board communication to contextualise data, including more analysis from Clinical Service Leaders to interpret metrics and more board member engagement with wards and staff;
- Reports which reflect on and contextualise metrics and trends over a longer time frame in addition to regular service monitoring dashboards;
- A review of current systems and processes in each Trust and whether they allow boards to have meaningful oversight over the quality and safety of services;
- Transparent reporting of issues discussed outside of public board meetings, such as at sub-committee level;
- A review of whether the maternity incentive scheme prioritises financial certainty and reputation management over a culture of learning and improvement;
- Clarity over the role of Local Maternity and Neonatal Systems in oversight of quality and safety and the implications for Trust boards' responsibilities.

While our findings relate to Trusts in England, other reports suggest that there is an opportunity for all of the devolved health services to review and improve board oversight processes.

Introduction

The safety and quality of maternity and neonatal services are the responsibility of the board in each Trust. However, the actions (or inactions) of leadership have come up frequently in inquiries and reviews[i]. The Ockenden review[ii] into maternity services at Shrewsbury & Telford Hospital NHS Trust, found that the Trust board did not have oversight, or a full understanding of issues and concerns within the maternity service. This led to a lack of strategic direction, a failure to make effective changes and an absence of accountable implementation plans.

Three themes related to board oversight have been reoccurring in recent inquiries and reviews: intelligence provided to boards; the process by which boards review the data and information; and the actions that are taken as a result (see Figure 1).

Data & intelligence	Robust & candid review process	Early action to address concerns
Relevance & coverage of metrics	Scrutiny of data and intelligence	Request for further information
Quality and accuracy of data	Problem-sensing	Mitigation actions agreed
Breadth of intelligence	Interest in safety & quality of care, workplace culture and staffing	Action plans monitored
Presentation & analysis	Safety champions at board level	

Figure 1. Building blocks for board oversight of quality and safety of maternity and neonatal services.

Data & intelligence

To provide boards with regular oversight of the quality and performance of their maternity and neonatal services, progress and exception reports must be presented by clinical services. The Ockenden review recommended that all maternity serious incident reports (and a summary of key issues) must be sent to the Trust Board and the Local Maternity System (LMS) for scrutiny, oversight and transparency at least every 3 months.

NHS England has set out minimum data measures for maternity and neonatal dashboards. Although most metrics are consistent, there are some discrepancies between different documents such as the Revised Perinatal Surveillance model[iii] and the role descriptor for the non-exec board safety champion[iv]. A combined list would include the following metrics:

- All maternity and neonatal Serious Incidents;
- Incidents graded as moderate harm or higher;
- Trust position in meeting national ambition trajectories for stillbirth, brain injury, maternal mortality, neonatal mortality and preterm birth rates; implementation rates of the Saving Babies' Lives Care Bundle Version 2 (now Version 3) and continuity of carer;
- Safe staffing levels;
- Staff feedback from frontline champions and walkabouts;
- Staff survey feedback;
- Service user feedback;
- Progress against maternity incentive scheme requirements;
- Correspondence or concerns raised by Regional Chief Midwife and Lead Obstetrician, Coroners, Deaneries, national bodies including NHS Resolution, the Care and Quality Commission (CQC), Health Safety Investigation Branch (HSIB) or the Invited Review process.

Robust and candid review processes at board level

The Maternity Incentive Scheme (Safety Action 9) states that Trusts must "demonstrate there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues."[v] This includes the importance of regular and thorough reviews of data and intelligence (including concerns from staff and service users) on Trust safety performance in maternity and neonatal services. Review processes should actively seek out weaknesses or challenges in the system by requesting a range of data and intelligence and being "problem-sensing"[vi].

Review processes should not be "comfort-seeking" by taking undue confidence in the data available and being unwilling to seek out further information that might disrupt this view.

Trust leadership at the executive and board level is reviewed by the CQC during inspections, to monitor when reputation management is superseding transparency. However, board failures continue to be identified. The Kirkup review of maternity and neonatal services in East Kent[vii] found that, among other issues, the Trust board missed several opportunities to properly identify the scale and nature of problems and to put them right. Patient safety inquiries for other NHS services found instances where boards appear more concerned with financial performance and the potential for reputational damage, compared with the safety and quality of care, workplace culture and staffing levels[viii].

Knowledge and engagement are critical components in a board's ability to provide a robust review of maternity and neonatal services' data and intelligence. In its responses to the Kirkup report (Recommendation 4ii)[ix], the Government stated that Trusts must ensure there is proper representation of maternity care on their boards. CQC has noted[x] the important role that an engaged and knowledgeable safety champion can play to facilitate communication from ward-to-board. One of the immediate and essential actions outlined in the Ockenden review included the appointment of a non-executive director (NED) as a maternity safety champion for each board. The NED board maternity safety champion should have a specific responsibility to ensure that women and family's voices across the Trust are represented at board level and to collaborate with the maternity and neonatal Safety Champions.

Early action to address areas of concern

Actions to address concerns could include requests for further information or an action plan to mitigate the risks identified. The Ockenden review found no thorough scrutiny of reports at board level and an acceptance of statements without evidence. For example, the Trust reported that the maternity incentive scheme training requirement were achieved but no evidence was shared with, nor asked for by, the board.

The Kirkup report also noted that despite the Trust board endorsing a succession of action plans, the plans and the way in which the Trust board engaged with them "masked the true scale and nature of the problems"[xi].

Our aim

Each Trust and its board, supported by senior maternity and neonatal staff and the board-level perinatal safety champion, are ultimately responsible for the quality of services provided and for ongoing improvement. The aim of this research was to review whether the information presented to boards - and subsequent review and discussion – enabled boards to deliver on this responsibility.

Methodology

We reviewed publicly available board papers from seven NHS Trusts in England to analyse board oversight of maternity and neonatal services. We limited the scope to Trusts in England to tailor the policy implications because health care is a devolved matter.

We used Trust-level data from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) on stillbirth and neonatal mortality rates, excluding congenital abnormalities, from 2019 to 2021 to select the sample of Trusts. Mortality rates can vary between different Trusts depending on the level of care they provide, so we used the MBRRACE-UK comparator groups red, amber and green (RAG) rating to identify Trusts that were performing better and worse than their comparator group. Using a series of rules, we identified 10 higher and lower performing Trusts and Boards. Two were outside of England and excluded. Board papers for one Trust were not available online.

A summary of the profile of the seven remaining Trusts which were reviewed is included in Table 1.

Trust	Region	Comparator group	Extended perinatal mortality rating (2021)[xii]
Trust 1	South East	Level 3 NICU & neonatal surgery	6.64
Trust 2	Midlands	2,000 – 3,999 births	4.17
Trust 3	North East and Yorkshire	4,000 or more births	4.46
Trust 4	London	Level 3 NICU & neonatal surgery	5.29
Trust 5	North East and Yorkshire	Level 3 NICU & neonatal surgery	5.78
Trust 6	East of England	4,000 or more births	4.02
Trust 7	North East and Yorkshire	Level 3 NICU & neonatal surgery	7.81

Table 1. Summary of Trusts reviewed

Although we used perinatal mortality data to select the sample, our review focused on whether board reporting and discussions were robust and candid, rather than on the Trust's performance. CQC ratings, National Neonatal Audit Programme (NNAP) metrics and mortality data from MBRRACE-UK were included as contextual information after the Board papers had been analysed.

We developed a framework (see Appendix 1) to review the quality and content of reports and data presented to the sample of boards, the oversight the boards demonstrated and whether any actions were agreed to address identified issues.

This work was not intended to single out particular Trusts. Instead, we wanted to find common themes between Trusts to inform policy recommendations. For this reason, we have focused on the findings and anonymised the Trusts in this document. However, the completed analysis for each Trust is available on request.

Key findings

Quality and safety intelligence

Across the sample of public board papers, a large amount of information is submitted for each meeting covering the breadth of the Trust's services. Despite the amount of work that goes into this preparation, the papers are not always effective at helping to give the board an understanding of how maternity and neonatal services are currently performing and the challenges that they are facing. This is critical for boards to be able to fulfil their role and to drive a culture of learning and improvement.

Some of the key findings included:

Varying coverage of data presented through local dashboards: Despite the list of minimum data measures for Trust board overview set out in the Revised Perinatal Surveillance model[xiii], the data included in board papers varied widely.

Compared to the minimum metrics:

- Nearly all Trust (6 out of 7) consistently included mortality data in reports to the board; however, none reported against the ambition to halve mortality rates in England relative to 2010 rates.
- All Trusts reported the number of serious incidents and most (5 out of 7) reported the number of incidents graded moderate harm or higher.
- All Trusts reported on their compliance with the Maternity Incentive scheme – which also covered compliance with other national initiatives such as the Saving Babies Lives' care bundle.
- Most Trusts (6 out of 7) reported on the number of cases which were referred to HSIB and 4 out of 7 Trusts reported themes and lessons from external sources including the HSIB, Perinatal Mortality Review Tool (PMRT), CQC and NHS Resolution. Trust 5 included the top five themes from PMRT and HSIB reviews in every maternity dashboard.
- Most Trusts (5 out of 7) reported on safe staffing levels, and the remaining two presented some staffing data. Fewer Trusts reported staff feedback – only one included a detailed review of the NHS staff survey for midwifery and two included detailed staff feedback from other sources.

This variation means that boards are not consistently being presented with the key metrics which NHS England has suggested to provide an overview of maternity and neonatal service performance.

A wide range of additional metrics are reported by many Trusts, without explanation: Related metrics are not clustered together e.g. grouping public health data (e.g. smoking at time of delivery); morbidity data (e.g. 3rd degree tears); mortality data or operational data, which could help the reader understand what message(s) the disparate metrics are offering. The inclusion of some metrics, such as caesarean section rate and induction rate, and the implication for service safety and quality may require further explanation.

Large quantities of hard to digest information: The board papers were typically long and detailed, with many presented in one pdf document. This creates issues with readability and navigation. Some reports to the board included large quantities of repeated information with only short regular updates which are not clearly signposted. For example, reports on progress against the immediate and essential actions recommended by the Ockenden review included several pages of background information related to the review which was repeated in each report rather than provided as supplementary information. This makes it hard for the reader to identify the relevant updates that require their attention. Most Trusts (5 out of 7) also had reports which included charts or diagrams which were not legible.

Data and intelligence are spread across multiple reports: This makes it hard for board members to have oversight of what is going on in maternity and neonatal services.

Lack of analysis for board to understand trends or detect early warning signals: Although some papers included trend analysis or RAG ratings, reports included little to no additional analysis to draw attention to metrics or trends which might suggest the services are off-track or declining. Clinical service leaders have the knowledge to be able to contextualise the data and help board members to understand the implications. However, from the reports we reviewed it appeared that this knowledge was not currently translating into the submissions to the board. Board Assurance Frameworks are one opportunity for risks to be flagged to board members; however, the matrixes can place equal weight on patient safety, reputational and financial risks.

No data on health inequalities: Despite the stark and persistent inequalities in pregnancy outcomes according to ethnicity and areas of deprivation nationally, there was no data or information on inequalities at Trust level. While trends in mortality data can be harder to identify at Trust level due to the small sample size, there was no discussion of experiential or operational data according to different demographics.

Variable coverage of external data and reviews: Few board papers included external data, such as from NNAP, MBRRACE-UK or the Office for National Statistics (ONS). While most dashboards used local data systems to provide mortality and clinical data, external data is an opportunity to review progress annually against the national target in England and to discuss other themes such as health inequalities. Many papers included the number of cases referred to HSIB, PMRT and other reviews; however, only a few provided any insights on the findings from the reviews. This prevents the board from having oversight of any recurring issues.

Robust and candid review process

The minutes of public board meetings show that discussion of the papers related to maternity and neonatal services was often limited during board meetings. Papers are often noted for approval without discussion or refer to more detailed discussions which have happened elsewhere.

Some of the trends identified included:

Short, allocated meeting time often spent presenting the reports: Trust boards review information from across the Trust which makes focusing on particular services challenging. Across the meetings reviewed, agendas allocated between 5–30 minutes to discuss maternity services. Often, although not always, meeting time was spent presenting messages rather than discussing the implications. For example, Trust 1 allocated 15 minutes for the East Kent Report and the Maternity Services Update report – both items were noted by the board without discussion.

Detailed discussions happening elsewhere: Sub-committees, such as Safety and Quality Committees, appeared to discuss service performance in more detail. However, reports to the board often referred to "actions" or "themes" emerging from discussions but with no further details. For example, in relation to rising neonatal infection rates in Trust 1, the board papers noted that "No single cause had been identified but actions were being taken to address areas identified by the review." No further detail was provided on some of the issues or mitigating actions which had been agreed. This lack of detail makes it hard for boards to identify common themes between different reports or reviews, or issues from across the Trust.

Variable scrutiny from board members: Just over half of the Trusts which were reviewed (4 out of 7) had limited discussion of the maternity and neonatal reports. However, this was not the case for all boards. Board members in Trust 2 were particularly engaged – citing recent national reports or statistics and asking how the Trust performed in relation to those concerns. This board also showed engagement and curiosity where metrics were positive – for example, noting "the majority of indicators are showing green and queried if there were any areas of concern."

Visibility of NED maternity champion: Some board minutes noted NED maternity champion activities including ward visits, chairing committees and attendance at monthly Maternity Surveillance groups (e.g. Trust 3) and insights which NED maternity champions were able to provide (e.g. Trust 6). However, this role is not uniformly positive or visible – for example, the board safety champion was not identified in the papers or minutes for Trust 5 and did not appear to provide additional context or challenge to the reports presented to the Board.

Early action to address concerns

Mitigating actions were not decided by board members: While some board members did ask questions or for further information, no actions were decided by board members. More often the reports included mitigating actions which had been decided by the services themselves, although boards did not offer much scrutiny as to whether they were sufficient or request updates on previous actions.

Questions or clarifications are rarely revisited: When board members do ask for clarifications, updates were rarely followed up on. The threshold to adding an item to an action log appears to be high as very few comments result in a new action. This means that legitimate questions are not publicly responded to.

Conclusions and policy implications

This review raises questions about Trust boards' ability to deliver the level of oversight and scrutiny that is currently expected of them. Boards typically meet every two or three months to review large amounts of information from across a wide range of services which limits the time available to engage with the performance of maternity and neonatal services specifically.

Our review has highlighted the following policy and practical needs:

Guidance on the minimum metrics to be submitted to boards: Clearer guidance on the minimum metrics required by boards should be developed and socialised with Trusts. Minimum metrics should include any new measures identified by the Maternity and Neonatal Outcomes Group[xiv] to provide an early warning of service quality and safety declining.

Better ward-to-board communication is required to contextualise data and findings: Effective monitoring of services requires familiarity with services and data. This requires integrating more insights from Clinical Service Leaders in reports to the board to contextualise the metrics presented, as well as board members' engagement with wards and staff.

Reports to the board should include reviews over a longer time frame: While dashboards are critical to ongoing monitoring of services, there is also a need to step back and reflect on metrics and trends over a longer time frame. This could include reporting on external metrics from MBRRACE-UK, NNAP or others, progress against national targets, or recurring issues highlighted by external reviews (e.g. PMRT, HSIB).

Review current systems and processes in each Trust and whether they allow boards to have meaningful oversight over the quality and safety of services: The data and intelligence that is provided to boards must be used to take meaningful action to improve services. Given the breadth of topics board meetings currently include, there is a lack of time for meaningful scrutiny and discussion. Without this scrutiny, there is a risk that reports to the board become tick-box exercises which do not paint a true picture of service performance and are not used to identify required mitigating actions. There is a need to review the meeting frequency and/or length to ensure sufficient time for meaningful scrutiny or to delegate this scrutiny further, alongside improved transparency of committee-level discussions.

Transparent reporting of the issues discussed outside of public board meetings, such as at sub-committee level: It may be necessary to delegate some scrutiny to sub-committee level but reporting to the board needs to synthesise the issues and risks that are discussed, rather than reporting that discussions have taken place. This fits into the wider need for more transparency, which is core to a culture of learning and improvement. All too often boards appear to seek comfort from reports rather than encouraging open and honest reporting of problems.

Review the maternity incentive scheme: There is a need to review the extent to which the maternity incentive scheme in its current form incentivises transparent reporting of performance issues so that they can be addressed in a timely way. There is a risk that the boards and services focus on demonstrating compliance with the scheme rather than supporting the improvements in safety. Without a system which incentivises transparent reporting and provides support for areas of need, Trusts may prioritise financial certainty and reputation management over a culture of learning and improvement.

Clarity over the role of LMNS: Local Maternity and Neonatal Systems (LMNS) were created in 2016 following the recommendations made in the Better Births Report[xv] to bring together providers of services in the same local areas. LMNS are asked to measure progress on reducing stillbirths, neonatal death, maternal death and brain injuries, as well as promoting personalised care and choice amongst other measures. More clarity is needed over what this oversight means for Trust boards' responsibilities and how the two governance systems intersect.

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While our findings relate to Trusts in England, other reports from across the UK nations have noted similar challenges. An Independent Review of neonatal services at Cwm Taf Morgannwg University Health Board in Wales[xvi] found that board assurance of safe services was based on an absence of safety issues that were escalated to board level, rather than evidence of a safe and efficient service and recognised the need to improve "ward-to-board" assurance processes. These commonalities suggest that there is an opportunity for all the devolved health services to review and improve board oversight processes.

Appendix 1: Reporting framework

Name of Trust	
Trust comparator group[1]	
Date of review	
Review period	

Board reporting

Person responsible for reporting to Board	
Local maternity and neonatal dashboards	
Discussion of external mortality data (MBRRACE-UK)	
Reporting of serious incidents	
Discussion of external reviews (PMRT, HSIB)	
Maternity / neonatal improvement programmes	
Staffing	
Other	

Board actions

Board oversight	
Actions agreed to remedy issues identified by reviews (PMRT, HSIB, Serious Incidents)	
Board review of agreed actions	

Metrics of Trust performance

MBRRACE-UK (Rates stabilised & adjusted)	
National Neonatal Audit Programme (NNAP)[1]	
CQC	

1. Five metrics reported by NNAP are:
   - Mothers who deliver pre-term (24–34 weeks gestation) and were given any dose of antenatal steroids
   - Mothers who deliver babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery
   - Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5°c and 37.5°c
   - Documented consultation between parents/carers and a senior neonatal team member within 24 hours of admission.
   - Babies <32 weeks gestation or of very low birthweight who received appropriate screening for retinopathy of prematurity (ROP)

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xii. MBRRACE-UK (2023). *MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths for Births from January to December 2021.* Available from: https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/ [Accessed on 29.08.23].

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Report to:	Board of Directors
Date of Meeting:	27 May 2026
Subject:	2025 Staff Survey Results and Colleague Experience Improvement Plan
Director Sponsor:	Lydia Larcum, Interim Director of Workforce & Organisational Development Clare Smith, Chief Executive
Author:	Vicki Mallows, HR Workforce Lead for Corporate Services

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

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☒ Yes

☐ No

☐ Not Applicable

Executive Summary:

As part of the Trust's objective to create a great place for our people to work, learn and thrive we wish to see colleague experience match or exceed the best of our peer group Trusts, as benchmarked by the annual national staff survey results. This paper summarises the 2025 survey results, the free text comments, and includes the Colleague Experience Improvement Plan for 26/27 for the Board's consideration. These have already been reported to Resources Committee.

Key Assurances:

- The survey response rate significantly increased in 2025 meaning the results are more representative of the whole workforce, and the response rate is above the peer average for the first time since 2018.
- The nine key metrics (People Promise element/theme) have all improved slightly.
- We are above the peer group average for one key metric (We work flexibly).
- We are still below the peer group average for the other eight key metrics but have started to close the gap in all those areas.
- The key themes from the free text comments are broadly similar to those in 2024, albeit the themes are often being described in a more emotive way which speaks to the impact they are having on colleagues.
- Triangulation of the 2025 Staff Survey data, free text comments, the Chief Executive's 100 Day report, and feedback from stakeholder groups is broadly congruent and has informed the priorities for the improvement plan.
- The Trust has improved its ranking out of the 121 peer Trusts in all nine key metrics, by between 21 and 50 places, despite being in a very challenged position.
- Although significant improvements are still required to match the national average in the eight metrics where we are currently below, the increased scores since 2024 demonstrate that positive change is possible with continued effort and focus.

Key Risks:

- Inconsistency of leadership and management of behaviours
- Inconsistency of skills to hold difficult/supportive conversations
- Unconscious bias
- Continued delays with 'fixing the basics'

Key Opportunities:

- Recommitting to our values and behaviours through a big conversation.
- Embedding a continuous improvement model will support and can underpin many of the cultural changes needed to make consistent and sustainable improvements.

Key Concerns:

- Underlying gap in psychological safety to speak up / raise concerns
- Leadership & Management capability
- The impact of financial challenges and workforce reductions on morale

Recommendation:

The Board is asked to review the findings and support the delivery of the 26/27 Colleague Experience Improvement Plan in all areas of the Trust.

Report Exempt from Public Disclosure

No ☒ Yes ☐

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
Initial results and update on 25/26 Improvement Plan went to Resources Committee.	February 2026	Report back when received nationally benchmarked results.
Nationally benchmarked results went to Resources Committee.	March 2026	Report back when received free text comments and have a draft Colleague Experience Improvement Plan.
The free text comments and draft improvement plan went to Resources Committee.	May 2026	

2025 NHS Staff Survey Results and Colleague Experience Improvement Plan

a) Introduction and Background

The Staff Survey was open between 3 October and 28 November. It measures how engaged staff are and provides insight into how colleague experiences can be improved. Evidence shows that more engaged staff result in better staff retention, patient experiences and outcomes.

b) Considerations

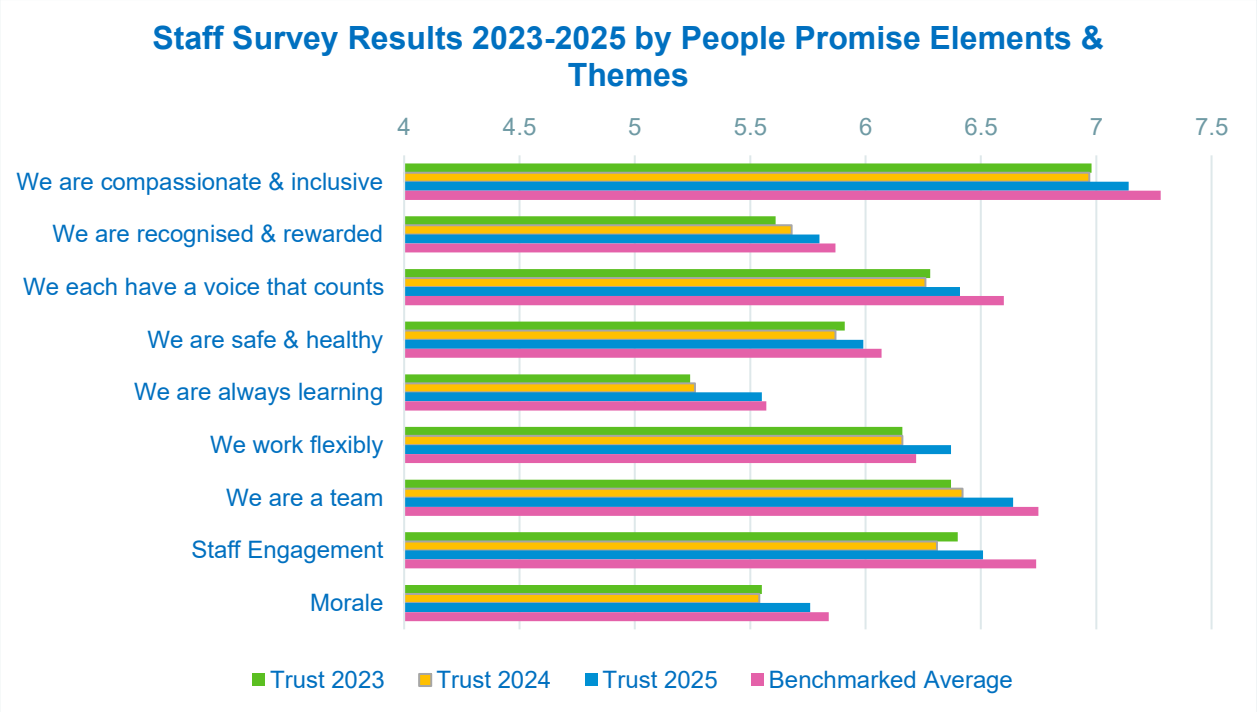
The nationally benchmarked results, free text comments, the analysis requirements of the NHS England medium-term planning framework, and the Colleague Experience Improvement plan have all been shared with Resources Committee.

c) Where we are now – 2025 Results

- Our response rate improved significantly in 2025 to 55% (from 36%) and is above the peer group average (47%) for the first time since 2018.
- Incentives were used (£3.50 voucher for all completing the survey and entry into a prize-draw) to encourage greater participation and make the results more representative.
- In terms of aspiring to excellence, the highest response rate amongst our peer group in 2025 was 74%.

Analysis by People Promise element

We have **improved** since 2024 in all nine key metrics by between 0.12 – 0.29. Compared to our peer group average in 2025 we are **above average** in one metric, 'We work flexibly'; in all other areas we remain **below average**.



[score out of 10]

- The gap between the Trust and the national average was smaller in 2025 in all key metrics compared to 2024, except for 'We work flexibly' where we have closed the gap completely and are now exceeding the average performance.

- We are now within the top 100 acute Trusts for all nine key metrics whereas in 2024 we were outside the top 100 for all but one of them.
- We have improved our scores for 74 out of 101 individual survey questions
- However, we are still below average for 59 out of the 101 individual questions
- Also, we are significantly below average for key questions such as whether colleagues would recommend the Trust as a place to work (only 48.7%) or be happy with the standard of care provided if a friend or relative needed treatment (46.7%).

Workforce Race Equality Standard & Workforce Disability Equality Standard

The questions relating to the WRES standard continue to show that staff from all other ethnic groups have a worse experience than their white colleagues, and worse than the peer average. It is positive to note however that bullying and harassment from other colleagues and discrimination from managers has decreased since 2024.

The questions relating to the WDES standard continue to show that staff with a disability / long term health condition have a worse experience than their colleagues; when compared to the peer average the Trust is better for some questions but worse for others. It is positive to see that bullying and harassment from managers has decreased, as has pressure from managers to attend work whilst unwell.

Questions not linked to a People Promise Element / Theme

In relation to questions about errors/near misses/incidents, the Trust performs worse than the peer average for the number of errors etc observed, feeling that staff involved will be treated fairly, and that the organisation takes action to ensure they are not repeated. On a positive note, there has been a 6% increase in the number of colleagues saying they are given feedback about changes made if they have reported something.

For the fourth year running the Trust is better overall than the peer average at making reasonable adjustments where required, although it should be noted that our performance has deteriorated by 2% since 2024.

Variations by Staff Group

Both response rates to the survey and results scores vary by staff group. The results have been shared with the professional leads (or deputies) for the largest groups (nursing, allied health professionals and medical) to consider what actions need to be taken.

2025 free text comments

- Many people made more than one comment, but overall, 1362 peoples' comments have been received, an increase of 34% compared to 2024.
- Colleague experience is under significant strain with negative feedback outweighing positive comments. However, it is good to note that the proportion of wholly or mainly positive comments has more than doubled since 2024 (10% v 4.5%).
- Workforce pressure, patient safety and leadership visibility are the dominant themes.
- Despite this, there is strong pride in teams, colleagues and professional purpose, with many staff describing their immediate teams as the main reason they remain in post.
- There is a clear distinction in colleague feedback between supportive local line management and a perceived disconnect at senior / corporate leadership level.

Key challenges:

- Staffing, Workload and Burnout
- Patient Care, Safety and Dignity (corridor care is normalised)
- Leadership, management, and visibility

- Culture, behaviour, bullying and discrimination
- Facilities, environment, basic enablers (toilets, changing, parking, food, space, equipment, IT)
- Pay, recognition and feeling valued
- Career progression, development and fairness
- Communication and change management (including recent restructuring)

Positive comments relate to:

- Pride in team and colleagues
- Commitment to patients and professional values
- Some positive experiences of local line management
- Pockets of improvement and hope

The themes are broadly unchanged from 2024 albeit there is a greater degree of emotion in the comments e.g. referencing corridor care or being fearful if relatives need our services, rather than just talking about staffing levels/patient safety in general.

Medium-term planning framework

A requirement of the medium-term planning framework is that 'every NHS Board will be expected to use the 2025 Staff Survey findings to commit to a full and detailed analysis of all free text comments generated through their staff survey. Identifying, as a minimum, 3 areas where the data shows the greatest staff dissatisfaction, generating a detailed analysis where those issues impact most within their organisation, and developing detailed action plans to resolve those issues within the year wherever possible.'

When considering both free text comments and quantitative data the most common sources of dissatisfaction are:

- Frustrations about staffing levels, time pressures, and workload; and the resulting impact on patient safety, care, and dignity
- Burnout – including physical, mental and emotional exhaustion
- Quality and visibility of leadership and management
- Behaviours - including bullying, discrimination, and a lack of psychological safety
- Quality of appraisals – not helping individuals improve how they do their job

These themes have been triangulated with the Chief Executive's 100 days report and the key themes of good practice from other Trusts with good scores for staff experience.

d) Aspirations

As part of the Trust's objective to create a great place for our people to work, learn and thrive we wish to see colleague experience match or exceed the best of our national peer group Trusts, as benchmarked by the annual national staff survey results.

We recognise that good practice recommends focusing on a small number of key priorities and delivering them in a sustainable way before moving to the next set of priorities. The key issues in the attached plan are relevant across the Trust rather than just in a small number of 'hot spot' areas. Care Groups, Corporate Directorates, and YTHFM are also identifying a small number of additional key priorities specifically related to their own teams as we recognise that different specialties and sites may have some priorities for change that are not common to all teams across the whole organisation.

The key priorities have been identified by triangulating the 2025 staff survey results, the Chief Executive's 100 Day report, and feedback from stakeholder groups. It also includes targets for improvement (above the national average score), and metrics to track progress.

Some of the concerns identified in the key challenges section do not appear on the key priorities plan. These will be addressed in the following ways:

- Frustrations about staffing levels, time pressures, and workload – will be addressed through service and establishment reviews.
- Burnout: including physical, mental and emotional exhaustion – the Occupational Health & Wellbeing service will look at how to address this further through the Emotional Wellbeing Group.
- Improve and protect basic enablers, including food provision. We will ensure that improvements made to food provision are communicated effectively and are more visible to all colleagues. The previous focus of addressing the basics will continue as business as usual.
- Equality, Diversity & Inclusion. The on-going work around inclusion will continue. The work on values, leadership behaviours and accountability will enhance this.

e) Summary

Survey results should be treated as progress reports to evidence whether ongoing plans to improve colleague and patient experiences, and patient quality and safety outcomes are working or not. They should be triangulated with other metrics (related both to the workforce and to patient experience and outcomes).

Each Care Group, Corporate Directorate and YTHFM is updating their own improvement plans and continuing to involve team members in driving the changes that will make the biggest impact on them. Progress with plans will be monitored via PRIMs/EPAM.

All managers from the Board down to first-line supervisors, need to take responsibility for applying the improvements in their own teams if we are to see widespread and sustainable improvement.

f) Next Steps

The Board is asked to review the plan, propose any amendments, and approve for implementation.

Date: 19 05 2026

Trust Colleague Experience Improvement Plan – 26/27 priorities

<table>
<tr><th>Priority Theme</th><th>Drivers</th><th>Executive Lead (Operational Lead)</th><th>Timescales</th><th>Progress Updates (once plan is approved)</th><th>Measures of Improved Colleague Experience (targets are above either the 2024 or 2025 peer national average – whichever is highest)</th></tr>
<tr><td rowspan="3">Values, culture and behaviours including leadership visibility and capability, accountability for all, and psychological safety across the Trust.</td><td>Undertake a big conversation to
Check the values are still relevant given many colleagues were not with the Trust when last reviewed.
Review and refresh behaviour framework.
Create an accountability framework</td><td>Director of Workforce & OD and Director of Communications</td><td>Commence June 26</td><td></td><td rowspan="3"><table><tr><th colspan="2">Compassionate Culture</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>6.50</td><td>7.1</td></tr></table><table><tr><th colspan="2">Compassionate Leadership</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>6.92</td><td>7.1</td></tr></table><table><tr><th colspan="2">Inclusion</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>6.80</td><td>7.0</td></tr></table><table><tr><th colspan="2">Raising Concerns</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>6.00</td><td>6.5</td></tr></table><table><tr><th colspan="2">Appraisals</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>4.77</td><td>5.3</td></tr></table><table><tr><th colspan="2">Line Management</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>6.76</td><td>7.1</td></tr></table></td></tr>
<tr><td>Use the Senior Management appraisal process to assess the leadership and management capability needs of the Trust, to direct changes to the Trust's leadership and management development offer.
Utilise the national management and leadership framework to embed consistent standards across the Trust and alignment with the wider NHS.</td><td>Director of Workforce & OD (Head of OD)</td><td>September 26

As per national timescales once announced</td><td></td></tr>
<tr><td>Appraisal for senior leaders to include 360 feedback
Remove appraisal window for all but most senior leaders –allowing time for quality appraisal discussions</td><td>Director of Workforce & OD (Head of OD)</td><td>April 26 - ongoing</td><td></td></tr>
</table>

<table>
<tr><td rowspan="3"></td><td>Ensure the Change Makers are used to support the key priorities, particularly values and culture; and that they are utilised to support effective communication of improvements across the Trust.</td><td>Chief Executive (Head of OD)</td><td>June 26 - ongoing</td><td></td><td rowspan="2"><table><tr><th colspan="2">Recommend place to work</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>48.7%</td><td>66%</td></tr></table></td></tr>
<tr><td>Senior leaders to ensure robust communication channels are in place including two-way communication i.e. opportunity for questions and challenge not just transmitting information to teams.</td><td>Director of Communications, Director of Workforce & OD. CG Quads, Directors and Deputy Directors</td><td>August 26</td><td></td></tr>
<tr><td>Establish new starter forum to support retention of new colleagues.
Make greater use of leaver data to increase retention</td><td>Director of Workforce & OD and Chief Executive
Director of Workforce & OD</td><td>July 26
July 26</td><td></td><td>Ongoing monthly assessment of Turnover data.<table><tr><th colspan="2">My immediate manager encourages me at work</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>71.1%</td><td>75%</td></tr></table><table><tr><th colspan="2">I often think about leaving this organisation</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>31.2%</td><td>26%</td></tr></table></td></tr>
<tr><td>Patient safety, care and dignity</td><td>Trust-wide decision that corridor care is not acceptable. Removal of corridor care (separate plan being developed).
Supporting workstreams:</td><td>Chief Nurse and Medical Director</td><td>September 26</td><td></td><td><table><tr><th colspan="2">Happy with the standard of care if need treatment</th></tr><tr><td>2025 score</td><td>Target</td></tr><tr><td>46.7%</td><td>64%</td></tr></table></td></tr>
</table>

	• Trust wide engagement – recognition this is an issue we all need to solve together – living our values • LOS reduction work to ensure bed base is appropriate for demand (bed base review as needed) • Site model and operational meetings refreshed to maximise oversight and flow – review of escalation processes • DOS review to support better pathways into alternative/more suitable care pathways (Selfcare/Community/Primary Care/SDEC etc) • Partner engagement work to support discharge pathway including ICB and Local Authorities/Social Care • Criteria led discharge work				
Ability to influence decision making and drive improvements that are meaningful and sustainable.	• Implement a continuous quality improvement system • Develop a clinical strategy • Strengthen clinical leadership	Chief Executive and Director of Quality, Improvement & Patient Safety	August 26		**Autonomy & Control** 2025 score: 6.83 / Target: 7.0

Ensure our workforce have access to the fundamentals	• Improve access to:
	  ○ Rest
	  ○ Facilities and environments that are fit for purpose
	  ○ Food provision across all sites
		Chief Digital and Information Officer, Managing			**There are enough staff at this organisation for me to do my job properly** (and therefore take breaks)

to support them at work.	○ Communications as a core element of our infrastructure. • Improve IT access: ○ Working equipment (log-ins, devices, smartcards, peripherals) ○ Systems that perform and are usable ○ IT support that is timely, human and proportionate • Improve access to advice and support for career development	Director of YTHFM, Director of Workforce & OD, Director of Communications			2025 score: 27.8% / Target: 34% **I have adequate materials, supplies and equipment to do my work** 2025 score: 51.6% / Target: 57% **I can eat nutritious and affordable food while I am working** 2025 score: 55.0% / Target: 60% **I always know what my work responsibilities are** (i.e. communication is effective) 2025 score: 84.9% / Target: 89% **I feel supported to develop my potential** 2025 score: 54.0% / Target: 59%

Report to:	Board of Directors
Date of Meeting:	27th May 2026
Subject:	Research & Innovation Strategy - Annual Report
Director Sponsor:	Karen Stone, Medical Director
Author:	Lydia Harris, Head of Research & Innovation

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☐

Trust Objectives

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

Board Assurance Framework

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

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

☐ Yes

☐ No

☒ Not Applicable

Executive Summary:
The Trust has a strategic objective to "challenge the ways of today to develop a better tomorrow through research, innovation and transformation". As part of oversight and focus on this objective, this annual report, aligned to the Trust's Research and Innovation Strategy (2025–2028), is presented to the Trust Board in May 2026, alongside a six-monthly update to the Resources Committee.

This report therefore highlights updates from April 2025 to March 2026.

Recommendation:
The Committee is asked to read the report and provide any comments to the author.

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

Research and Innovation: Annual Update to Board of Directors (April 25 – March 26)

1. Introduction and Background

The Trust has a strategic objective to "challenge the ways of today to develop a better tomorrow through research, innovation and transformation". As a teaching hospital, research and innovation should be part of business as usual within the Trust. Activity is coordinated by the Research and Innovation (R&I) Team, and research takes place in specialities across all Care Groups. In total, the team comprises around 60 staff across York and Scarborough, and we also have research funded laboratories and pharmacy staff.

As part of oversight and focus on this objective, this annual report, aligned to the Trust's Research and Innovation Strategy (2025–2028), is presented to the Trust Board in May 2026, alongside a six-monthly update to the Resources Committee. The strategy was published in spring 2025 and has five workstreams: workforce, infrastructure, partnerships, excellence, and finance.

This report therefore covers the period from April 2025 to March 2026. A significant change during this period is that the department has changed from "Research and Development" to "Research and Innovation". This report is therefore divided into Research activities and Innovation activities.

2. Strategic Scorecard

The R&I strategy includes a scorecard for key metrics, and the end-of-year figures are as follows:

Metric	2025/2026 target	Actual
Number of patients recruited into clinical trials	3500	5385
Number of research champions and innovation champions trained	5	6
Number of home-grown innovation ideas received • Digital ideas • Device ideas • Model of Care ideas • Other innovations	4 1 2 0 1	7 4 3 0 0
Number of Innovation grants submitted to external funders where a Trust member of staff is an applicant	2	5
Number of home-grown research ideas sponsored by the Trust	18	24
Number of home-grown research ideas received	5	35
Number of Research grants submitted to external funders where a Trust member of staff is an applicant	30	29
Number of clinical academic posts	2	2
Innovation projects supported	15	15
Amount of research income awarded from external funders	£1,601,411	£1,668,096
Amount of commercial research income awarded	£307,361	£607,155
Research Delivery Funding	£1,266,743	£1,415,505
Total external funding	**£3,175,545**	**£3,690,756**

3. Update - Research

These are the highlights for consideration and review from the last 12 months regarding research activity.

Research Excellence, Metrics and Finance

- The Trust received confirmation of its budget for the coming 12 months from the National Institute for Health and Care Research (NIHR) as a member of its Research Delivery Network (RDN). This budget has been confirmed as £1,501,530. This is the highest allocation the Trust has ever received and represents a 5.2% increase from 2025/26.
- R&I has more than doubled the Trust's commercial research portfolio, generating £607,155 and evidencing sustained expansion in line with the national ambition to double commercial research activity.
- According to the Trust's commercial income policy, a proportion of the profits from this income is distributed to our Care Groups as follows:
    - CSCS £81,217
    - Medicine £27,625
    - Surgery £11,649
    - Family Health £0
- The clinical trials the Trust hosts also led to cost savings within Care Groups (for example paying for some drugs/scans the trust would normally pay for); these are calculated as follows:
    - CSCS £91,633
    - Medicine £4,547
    - Surgery £1,605
    - Family Health £0
- The Trust has recruited 5,385 patients into clinical trials, which is the highest total ever. This is largely a consequence of recruitment into two large studies: a one-off gastroenterology study called Best 4 and a large birth cohort study called Babi .
- Agreement has been reached for a new R&I management system called Florence. This will see the Trust align with larger university hospitals and institutions that also use the system. Florence will increase the quality of trial administration, reduce the need for paper archiving and create opportunities to charge costs to commercial studies that utilise the system.
- The new national metrics launched on 1 April and the monthly R&I report has changed to reflect this. The key changes are that the number of patients recruited into clinical trials is no longer a metric. The majority of the metrics are now focused on how quickly a Trust opens an trial and recruits its first patient into that trial.
- The Trust has now surpassed 60,000 patients accrued into our trials historically since the CRN/RDN was created, which is a major milestone.

Partnerships leading to grant applications and awards, some contributing to our Infrastructure, and enhancing research capacity and capacity in our workforce

- The Trust has been awarded £595,234 by the NIHR as part of its Capital Investment Fund. This is a highly competitive fund and the successful bid will provide for pharmacy and other equipment to support the Trust's growing commercial portfolio.
- In the past 12 months, 29 grants have been submitted to a value of £15,936,863. Of this, £1,085,254 has been secured, and results are awaited for grants totalling £648,2504. Of the totals we secured, £841,986 was allocated to the Trust. Of the

grants awaiting results, an additional £97,885 of these costs were direct costs allocated to the Trust, if successful

  - List of winning grants:
    - Dr James Turvill (Medicine), submitted to Humber and North Yorkshire Cancer Alliance. Title: Evaluation of the Yogi Dataset. Total awarded: £34,165; Awarded to Trust: £12,970 with £21,195 to allow for a Statistical Analysis Research Fellow.
    - NIHR Capital Bid. Awarded to Trust: £595,234.
    - Esther Taylor (Surgery), submitted to NIHR PSDRA. Title: Evaluation of Martha's Rule. Total awarded: £6,473.88 Awarded to Trust £6,473.
    - Will Quarm (Medicine), submitted to NIHR Patient Safety Research Development Award Title: Patient Safety Evaluation of at Home Interventions. Total awarded: £4,448; Awarded to Trust: £4,448
    - NIHR Strategic Grant for hybrid roles. Awarded to Trust: £71,907
    - NIHR Strategic Grant for commercial delivery staff. Awarded to Trust: £31,884

  - List of winning Career development awards
    - Lucy Fettes (SHARC/Medicine), submitted to the NIHR Fellowship Development Award, for the Senior Clinical and Practitioner Research Award. Total awarded: £97,875; Awarded to Trust: £73,170.

- The Trust is now in the top 20% of trusts nationally based on income from successful NIHR grants.
- R&I has appointed Dr Ben Ward as the new Gastroenterology Research Fellow, to work alongside Professor James Turvill. The post is the first of its kind for the Trust and has been created in collaboration with the Medicine Care Group via the research income generated by Professor Turvill. Dr Ward will support the research portfolio under Professor Turvill.
- A commercial genetically modified organism study for patients with xerostomia post-radiotherapy has been opened.
- R&I delivered the Trust's first gene therapy study, exceeding targets and demonstrating recruitment performance on par with UCLH, who are also recruiting to the study.
- The Trust's Elsie May Sykes Awards funded two internal projects in 2025:
  - Dr Andrew Chamberlain, Consultant in Critical Care, Anaesthesia and Perioperative Medicine. Study title: "Is combining ECG-guided CVC placement with ultrasound as safe and accurate as the current standard of chest X-ray?" Award: £11,293.
  - Allison Bradley, Advanced Clinical Specialist Physiotherapist in Frailty. Study title: "What is the impact of attending an Ageing Well fair on the adoption of health-promoting behaviours in older adults?" Award: £4,955.
- BABI has recruited 2640 participants in the past 12 months, and both York and Scarborough Hospitals continue to be the top recruiting site in England for this study.
- COLOCAP (a Trust-sponsored study which received just over £3 million in funding from NIHR and is led by Professor James Turvill) continues to progress well, with over thirty sites actively recruiting patients across the UK. The study is managed by a team based within R&I.
- MenSH-IBD (a Trust-sponsored study which received funding from the Research for Patient Benefit NIHR scheme) has successfully completed this year on time and

above target. Dr Sara Ma (PhD), the Chief Investigator, is a Trust-employed nurse and a York St John University academic.
- Our £1.2m Elevate-UEC NIHR funded study, which focuses on the identification of innovations in rural and coastal areas, has completed its first year and met NIHR-required milestones. The team has recently published the study protocol and is currently finalising the next publication on the first year's findings. The team has developed a front-facing website focused on community-co-designed policy advice, study updates, and resources for Trusts, ICBs, and policymakers, including individual innovations in rural and coastal emergency departments.

Research Partnerships and projects enhancing research capacity and capacity in our workforce

- A launch event for the Scarborough Coastal Health and Care Research Collaborative (SHARC) was held on 1 April 2025 at the Palm Court Hotel. The event was opened by Simon Morritt and gave attendees an opportunity to find out what SHARC is. Presentations were given by Dr Phil Dickinson, Professor Garry Tew, Bex Blakey, Lisa Ballantine and Dr Arabella Scantlebury. The event showcased our joined-up approach and community involvement in SHARC's vision to better address the health and care needs of our coastal populations through high-quality collaborative research.
- R&I appointed a SHARC Programme Manager on a two-year fixed-term contract.
- As part of SHARC, R&I has created a Community Grant Scheme with York St John University. This will offer a matching service to VCSEs on the east coast with academics at the University to help develop an idea. The team is currently shortlisting applications.
- R&I is involved in leading the 'Community Voices' work on the East Coast, which has now completed its preparation stage. We now enter the community engagement stage, where we will meet with partners to try and understand what is important to the communities that the Trust serves (in terms of health inequalities). This work has seen SHARC work with over 100 organisations to discuss how we will organise the 'Community Voices' work and a real showcase project of what SHARC can achieve
- R&I supported an inaugural writing retreat, jointly run between University of York, University of York St John and Tees Esk and Wear Valleys Trust for researchers. Five Trust staff attended.
- R&I awarded the annual collaborative PhD Award between the Trust and York St John University to Dani Marinkovic, following an application for a longitudinal study of the microbial quality of a hospital water distribution system.
- The NIHR Associate Principal Investigator scheme has seen a rise in participants, with 20 clinicians being trained during the past FY, 13 of whom are in active training.
- During this period, R&I has become a regular feature at resident doctors' induction and receives enquiries from resident doctors about joining the NIHR Associate PI scheme. R&I is also now part of the Trust medical appraiser training days to inform appraisers of opportunities they can signpost consultants and SAS doctors to, to develop their careers in R&I. The team continues to contribute to the New Consultant and Specialist Development Programme.

Research Engagement and Excellence

- Research and Innovation's Lisa Ballantine, in collaboration with Bex Blakey (Community Engagement Officer), was awarded Best Overall Abstract at RDF25, a national NHS research conference.

- The Trust won the most informative exhibition stand at the Scarborough STEM (Science, Technology, Engineering and Mathematics) week for their engagement with parents and children on careers in the NHS.
- The annual celebration event was held on 19 November. This was another sold-out event, with over 200 attendees.
- The Trust had publications by 179 unique authors in the last 12 months, as follows:

Medicine	47
Surgery	59
CSCS	46
Family Health	10
Corporate	1
Medical Director (HYMS/Research)	15
Unknown	1
Total	179

Comparisons to demonstrate our research excellence

Of the nine trusts in the country of similar size and scope for research, the Trust is outperforming six of them in terms of the number of studies and eight in terms of accruals.

In the region, in terms of number of studies in specialities, the Trust has the following top-three rankings:

- Imaging- 1st (joint with Leeds Teaching Hospitals)
- Anaesthetics- 2nd
- Dementia and Neurodegeneration- 3rd
- Dermatology- 3rd
- Ophthalmology-3rd
- Surgery- 3rd

In the region, in terms of number of participants in specialities, the Trust has the following top-three rankings:

- Dementia and Neurodegeneration- 2nd
- Gastroenterology- 2nd
- Imaging- 2nd
- Ophthalmology- 2nd
- Renal- 2nd
- Trauma and Emergency- 2nd
- Neurology- 3rd
- Mental Health- 3rd

4. Update - Innovation

These are the highlights for consideration and review within the last 6 months regarding Innovation activity.

Internal Innovation Engagement

- The team has had a suite of innovation training videos developed for all staff, which can now be accessed on the Trust intranet. These videos are designed to provide an overview for all staff of the benefits of innovation and its definition within the Trust.
- R&I have aligned the definition of innovation with the Department for Health and Social Care which is “An idea, service or product, new to the NHS or applied in a

way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied". This definition ensures flexibility of what is innovation but also highlights the differences between QI activities and innovation whilst being easily understood.
- R&I has started developing an online ideas hub (iHub), which will have Trust-wide input from staff and departments to create a one-stop shop for support with innovation within the Trust.
- An inaugural innovation competition launched Trust-wide in January. This has now closed, with 90 applications submitted by staff from across the Trust. There is a wide variety of applications, with ideas ranging from pathway innovations to digital tools and devices. Six applications have been shortlisted, and awards will be given in May.
- R&I and Digital & Informatics have collaborated to amend the Artificial Intelligence and Data Ethics Sub-Committee, so the Committee can review, oversee and include innovation going forward.
- R&I has appointed Dr Cameron Stockwell as Innovation Manager within the Trust, to work alongside the team to develop the Trust's innovation portfolio. This is the first innovation manager post within the Trust and was underpinned by our R&I strategy to support the development, implementation and adoption of innovations.

External Innovation Engagement

- R&I is currently working with organisations across the region to create an Innovation Cluster. This aims to create a service which supports collaboration between clinicians and SMEs to generate and develop innovation and commercial ideas. There are currently about 25 organisations involved in the initial stages of developing the cluster. This work will be supported by an Innovation Manager who has been recruited within the Trust.
- R&I was represented on the Health Innovation Humber and Yorkshire's Strategic Advisory Board panel to help formulate the Yorkshire region's priorities for embedding innovation and streamlining adoption processes across NHS trusts. We are awaiting the outcomes and continue to work closely with colleagues in the Health Innovation Network.
- The Trust is involved in the Regional Health Innovation Zone meetings led by the Health Innovation Network and chaired by Professor Richard Stubbs. The aim is to position Yorkshire as a centre of innovation excellence through combined working across regions, combined authorities and trusts, as set out in the Fit for the Future Plan. Representatives are developing a pitch for prevention excellence within the region, reflecting our ageing population and varying demographics across Yorkshire.

Innovation Projects and Funding

- R&I has submitted Dr Rosin Bradley's MammoBot project to the Medipex Health Innovation Award 2026. MammoBot is a robot that helps wheelchair users, who are usually excluded from breast screening programmes, to have a mammogram by supporting them physically during the scan.
- The innovation team have submitted 2 collaborative innovation bids with Santara Vision, a NHS spin-out company, focused on developing assistive AI tools for ophthalmology which can be rolled out to community care and opticians, to shift from hospital to community. We are awaiting the outcome of these applications.
- R&I have continued to develop working relationships with other regional small and medium-sized enterprises to develop validation and testing pipelines for devices within our region. This includes continuing partnership with Respiro Diagnostics on

the Breath Test for Breast Cancer, which won last year's Medipex Innovation Award, and working closely with Scarborough-based SME TestCard. This has resulted in one grant submission and another in preparation.
- Several innovation grants have been submitted, and we are in the process of registering the Trust with UKRI in order to allow access to further innovation funding, as until we are registered as a site we cannot apply to their funding calls

5. Plans and priorities for the next 12 months, alongside their challenges

The Trust, led by the R&I department, will continue to work through the action plan that runs alongside the R&I strategy and strive to continue to deliver against its key performance metrics. The key priorities for the next 12 months are as follows

- To develop the Trust's innovation strategy and, hopefully, support another innovation competition for the Trust through returns on investment.
- To support the development of the Trust's clinical strategy and be involved in the Trust's new continuous improvement programme.
- To secure additional income through grants. R&I has many staff funded through external funding, so there is a need to continue winning income to retain the excellent staff and expertise it has. This is increasingly difficult, as only a handful of staff within the Trust have the time and expertise to support grant writing.
- To deliver against the new NIHR RDN metrics, that are around opening studies in a timely fashion (especially commercial) and to focus on highly intensive studies (interventional clinical trials). The monthly report has been amended to reflect these new metrics, please note accruals are no longer a metric.
- R&I would like to double its commercial research portfolio again this year to match the national ambitions for increasing commercial research. This is a challenging ambition given it is particularly dependent on increasing consultant job planned time. This is difficult given competing clinical demands on time, but releasing time would create opportunities for income generation.
- SHARC continues to grow. The priority for the next 12 months is to secure more income to support the one member of staff currently running this initiative. Its reach continues to expand and is increasingly recognised nationally, but to be a trailblazer in coastal health outcomes and inequalities there is a need to strengthen engagement with academics. There is also need to support staff on the East Coast to develop SHARC and its research ideas by creating time to support research within their roles.
- Babi is another initiative that needs further development. The Trust is the top recruiting site in England for this study; Trust midwives are recruiting hundreds of mothers and babies, and R&I are working hard to identified academics interested in partnering with us to use this data in their research.
- The Trust has a vision to embed clinical research in our hospitals and the care the Trust provides. In addition, Research and Innovation will have contribution to make to the Trust's clinical strategy and objectives. There is much positive work happening across the Trust and opportunities to expand. A significant challenge for the achievement of the strategic objectives is to be able to support research within staff roles, and enabling those interested in research the time to develop a research portfolio.

Date: 15th May 2026

Report to:	Board of Directors
Date of Meeting:	27 May 2026
Subject:	Emergency Preparedness, Resilence and Response Core Standards Annual Assurance – Action Plan Progess
Director Sponsor:	Accountable Emergency Officer - Claire Hansen
Author:	Head of EPRR – Richard Chadwick

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ Regulatory Requirement ☒

Trust Objectives

☒ To provide timely, responsive, safe, accessible effective care at all times.
☒ To create a great place to work, learn and thrive.
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☐ Through research, innovation and transformation to challenge the ways of today to develop a better tomorrow.
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Board Assurance Framework

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

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

☐ Yes

☒ No

☐ Not Applicable

Executive Summary:

The Emergency Preparedness, Resilience and Response Core Standards Annual Assurance process was completed in Jan 2026. The Board of Directors approved the assurance submission of 82% of the standards being fully compliant on 28th January 2026 which achieved an organisational grading of PARTIAL.

An action plan has been developed to remediate the partially and non-compliant standards and this report is the first in 2026 to chart the progress of work against that action plan.

The assessment in Sep 25 of the 62 standards resulted in 82% being classified as fully compliant and the organisational grading improving to PARTIAL compliance. It is

assessed that by Sep 26, when the annual assurance is required to be submitted to NHS E, that the organisational grading will have again improved to SUBSTANTIAL compliance.

Since the February 2026 progress report the compliance rating has risen from 82% to 85%.

A further progress report will be submitted to the Board in Aug 26.

Recommendation:

The Board is requested to note the progress of the work conducted against the action plan.

The Board is requested to note the requirement to complete an Emergency Preparedness, Resilience and Response resource review and to report the number of commissioned providers and suppliers who do not have an appropriate Business Continuity plan on the next progress report.

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

Meeting/Engagement	Date	Outcome/Recommendation
Resources Committee	19 May 2026	Noted

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS – ACTION PLAN PROGRESS REPORT

1. Introduction and Background

NHSE conduct an annual assurance of the Emergency Preparedness Resilience and Response Core Standards. There are 62 core standards that are grouped into the 10 domains of: Governance, Duty to Risk Assess, Duty to Maintain Plans, Command and Control, Training and Exercising, Response, Warning and Informing, Cooperation, Business Continuity and Chemical, Biological, Radiological and Nuclear. The overall assurance organisational grading is determined as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

2. Current Position

The annual assurance for 2025-2026 was conducted within a robust governance and assurance framework coordinated by the Emergency Preparedness, Resilience and Response at the Integrated Care Board as follows:

Date	Action
Aug – Sep 25	Trust Emergency Preparedness, Resilience and Response Team complete self-assessment.
24 Sep 25	Integrated Care Board Acute Providers conduct peer review
26 Sep 25	Self-assessment endorsed by Emergency Planning Steering Group as a draft submission for the Integrated Care Board
30 Sep 25	Trust submit draft to Integrated Care Board
14 Nov 25	Integrated Care Board and Trust Accountable Emergency Officers confirm Trust submission
20 Nov 25	Local Healthcare Resilience Partnership confirm all Trust submissions in Integrated Care Board
03 Dec 25	Emergency Preparedness, Resilience and Response Core Standards Report to Executive Committee
16 Dec 25	Emergency Preparedness, Resilience and Response Core Standards Report to Resources Committee
28 Jan 26	Emergency Preparedness, Resilience and Response Core Standards Report to Board of Directors

The annual assurance for 2025-2026 reported the following:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	1	3	0
Cooperation	4	3	1	0
Business Continuity	10	9	1	0
Hazmat/CBRN	12	8	4	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	51	11	0

This is a fully compliant rating of 82% against total standards and therefore is an improvement on last year's NON-COMPLIANT organisational rating to PARTIALLY compliant.

3. Action Plan Progress

The action plan to remediate the partially and non-compliant standards is at Appendix 1. Using the progress to date on the action plan it is assessed that the change to gradings against the annual assurance reported position as of May 26 would be:

Domain	RAG	Aug 25	Feb 26	May 26	Aug 26
Governance	(G)	5	5	**Completed**	
	(A)	1	1		
	(R)				
Risk Assessment	(G)		**Completed**		
	(A)	2			
	(R)				
Duty to Maintain Plans	(G)	9	10	10	
	(A)	2	1	1	
	(R)				
Command & Control	(G)	**Completed**			
	(A)				
	(R)				
Training & Exercising	(G)	**Completed**			
	(A)				
	(R)				
Response	(G)	**Completed**			
	(A)				
	(R)				
Warning & Informing	(G)	1	1	1	
	(A)	3	3	3	
	(R)				
Cooperation	(G)	**Completed**	3	3	
	(A)		1	1	
	(R)				
Business Continuity	(G)	8	9	9	
	(A)	2	1	1	
	(R)				
CBRN / HAZMAT	(G)	8	8	9	
	(A)	4	4	3	
	(R)				
% of standards assessed as fully compliant		77%	82%	85%	

4. Points to Note On Progress

The increase in 3% compliance is a result of:

- Waste Disposal Arrangements (Standard 62) being completed with a contract arranged with a waste disposal company to respond to any Chemical, Biological, Radiological and Nuclear or HAZMAT incident in respect of providing a chemist for specialist advice and the removal of any contaminated waste.
- Attendance at Local Healthcare Resilience Partnership meetings (Standard 37) by the Accountable Emergency Officer and/or Deputy Chief Operating has been achieved.

The small increase in progress is a result of the Emergency Preparedness, Resilience and Response Team being diverted to the Trust response to Resident Dr Industrial Action and the planning for EPR Implementation.

Notes on progress for those actions still not fully compliant are below and are unchanged since the last report.

- **Governance.** Standard 5 relates to the organisation having sufficient resources to ensure it can fully discharge it's EPRR duties and remains AMBER. Sufficient resources relates to number of staff assigned to the portfolio, the resources to implement an effective On Call framework and the finance available to update, service, calibrate and repair Emergency Preparedness, Resilience and Response equipment.

  The Emergency Preparedness, Resilience and Response team are confident there are sufficient resources available to run an On Call framework and to provide in date operational Emergency Preparedness, Resilience and Response equipment such as the Chemical, Biological, Radiological and Nuclear capability. Sufficient personnel in the Emergency Preparedness, Resilience and Response Team to fully cover the portfolio is more difficult to define. It is recommended that a separate paper is submitted to the Resources Committee to quantify the gap between resource and capability and to articulate the mitigation required to tolerate gaps.
- **Duty to Maintain Plans.** All the plans held by the EPRR Team will be reviewed this year. One plan, Countermeasures (Standard 14) remains in draft. The plan outlines how the Trust will deliver the provision of vaccination and prophylaxis to staff and patients and will support local authorities in a mass vaccination and/or prophylaxis plan. The local authority plans are very immature and are being considered this year which will then allow the completion of the Trust plan. It is expected this plan will be published in 2026.
- **Warning & Informing.** A draft Major Incident Communications Plan has been written and has been reviewed by the Director of Communications. There is a small amount of work to be completed to determine and document how communications will be issued to staff and the general public out of hours after which the plan will be ready for endorsement and publication. This plan will be published this year and will ensure compliance with all standards in this domain (Standards 33, 34 and 36).
- **Business Continuity.** The Assurance of Commissioned Providers and Suppliers standard requires assurance through evidence of that business continuity plans are in place for all our providers and suppliers. The number of suppliers and providers to the Trust is significant and work has begun with the Deputy Director of Procurement to work through the critical providers and suppliers to gain assurance. It is expected that this work will take at least 12 months. The number of Commissioned Providers and Suppliers who do have appropriate Business Continuity plans is yet to be identified and will be reported at the next progress report.
- **Chemical, Biological, Radiological and Nuclear / Hazardous Material.** The Training Resource (Standard 63) will be completed this year as the Chief Instructor for Chemical,

Biological, Radiological and Nuclear implements the national training curriculum from Yorkshire Ambulance Service. A programme of exercising the Chemical, Biological, Radiological and Nuclear capabilities for both sites is set for this year and, dependant on the availability of staff, this will be completed by October 2026.

5. Residual Risks

The residual risks to the completion of the action plan are as follows:

- **Emergency Preparedness, Resilience and Response Team Resources.** The Emergency Preparedness, Resilience and Response Team consists of 3 staff members. Competing "non-core" priorities for the team include responding to incidents such as industrial action, conducting training and exercising to comply with core standards, implementing change programmes, managing the annual work schedule and running the Emergency Preparedness, Resilience and Response governance and assurance processes. In addition, in 2026 a member of the Emergency Preparedness, Resilience and Response Team will be absent on leave for a significant period of the year; a backfill of that post is planned.
- **Staff Availability.** The development and implementation of plans and then the testing of them through training and exercising relies on the availability of clinical and nursing staff. When individual training programmes are designed, there is a reliance on colleagues taking the opportunity to sign up for those events. Mitigation measures for this risk include:
    - Training and exercising are targeted at senior managers and clinicians to minimise disruption on the shop floor. Where operation procedures are required to be tested then longer lead in times to roster staff to activity are considered.
    - Work is ongoing to develop training packages that can be delivered on Learning Hub to minimise the time staff take to conduct training and prevent disruption to services. Experience this year has indicated that although the opportunities for individual training have been provided online and in person, the take up from colleagues has been at best limited. This has improved with the introduction of portfolios of evidence of completion of training for Health Commanders and conducting a formal audit process.
    - Activity conducted when responding to incidents is being recorded on logs to minimise the need for training and exercising events.

6. Summary

Significant progress has been made in 2025 in developing the Trust readiness to respond to emergency and business continuity incidents. There is much more to do in addition to maintaining the compliant standards already achieved. It is assessed that the Trust position will be 93% of standards being fully compliant in October 2026 which will attract an organisational grading of SUBSTANTIAL compliance. Much will depend on how the non-core activity through the year, i.e. winter planning, implementation of EPR and incident management, will distract the Emergency Preparedness, Resilience and Response team.

A further progress report will be submitted to the Resource Committee in Aug 2026.

Date: 5th May 2026

Appendix 1 – EPRR Core Standards Action Plan – Current Non-Compliant Standards

Ref	Domain	Standard name	Standard Detail	ICB Final Grading 2024	ICB Final Grading 2025	Trust Action 2025	Trust Action 2026	Actionee	Target Date	Assessed Grade 2027	Remarks / Updates
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	A	A	2 - Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	1 - Complete a review of EPRR Resource versus portfolio and prepare a brief for AEO (R)	RC	Q2 - 26	A	2 - (08/04/25) - RC to speak to KH and see how this can be taken forward in light of Trust challenges and the political NHSE landscape.
14	Duty to Maintain Plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	R	A	8 - Capture specific Countermeasures Training in the central training log. (R) 9 - Write a new policy to consider mass vaccination and issue of prophylaxis. (A)	2 - Capture specific Countermeasures Training in the central training log. (R) 3 - Write a new policy to consider mass vaccination and issue of prophylaxis. (A)	CR RC	Q4- 25 Q2 - 26	G	1 (19/11/25) - Draft plan to be circulated internally and externally to achieve final draft. To Executive Committee in early 2026.
33	Warning and Informing	Warning and Informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	A	17 - Determine 24/7 Comms capability and include in Incident Comms Plan (A)	5 - Determine 24/7 Comms capability and include in Incident Comms Plan (A)	RC	Q4 - 26	G	17 (08/04/25) - Included in draft with Comms Team. 17 - (05/06/25) - Chaser sent to LB. 5 - (19/11/25) - RC to meet Comms Team to finalise draft.
34	Warning and Informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	A	A	18 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comms action cards. c) review social media guidance and deliver media training to Executive members. (G) 19 - Write Incident Comms Plan (A)	6 - Comms Team to deliver: a) Deliver training on training action card to 1st and 2nd On Call and submit Lessons Identified Template for each event. b) Deliver in and out of hours exercisies to practice comms action cards. 7 - Write Incident Comms Plan (A)	Comms Team RC	Q4 - 25 Q4 - 25	G	18 (08/04/25) - RC to include a comms slide in induction training, familirisation training and C2 training. 19 (08/04/25) - With Comms team for comment. 19 - (05/06/25) - Chaser sent to LB. 6 & 7 - (19/11/25) - RC to meet Comms Team to finalise draft.
36	Warning and Informing	Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	A	A	20 - Write Incident Comms Plan (A)	8 - Write Incident Comms Plan (A)	RC	Q4 - 25	G	20 - (05/06/25) - Chaser sent to LB. 8 - (19/11/25) - RC to meet Comms Team to finalise draft.
53	Business Continuity	Assurance of Commissioned Providers / Suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	33 - Review required of process and included in Trust BC Plan. (A)	12- Review required of process and included in Trust BC Plan. (A)	CR	Q3 - 26	A	33 (14/07/25) - Meeting programmed with IW and review post that meeting. 12 (19/11/25) - Number of contracts significant. Will capture new contracts going forward and work through historial contracts at best effort.
59	Hazmat/CBRN	Decontamination Capability Availability 24/7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	A	A	40 - Design an automated system for annotating who is CBRN trained when a incident occurs. (A) 41 - Amend CBRN Plan to include guidance provided in CBRN Audit (G)	13 - Design an automated system for annotating who is CBRN trained when a incident occurs. (A)	EC-S	Q3 - 26	G	40 (08/04/25) - Manual process in place whilst automation is explored. 13 (19/11/25) - EC-S to get comptency added to Health Roster.
63	Hazmat/CBRN	Hazmat/CBRN Training Resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	A	47 - CI CBRN to comply with guidance provided in CBRN audit.	16 - CI CBRN to comply with guidance provided in CBRN audit.	EC-S	Q3 - 26	G	16 (19/11/25) - EC-S to action and report to RC quarterly.
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	A	50 - Complete actions as per CBRN Audit guidance. (R)	17 - Complete actions as per CBRN Audit guidance. (R)	EC-S	Q3 - 25	A	17 (19/11/25) - LIVEXs planned for both sites in Jun 26.

Report to:	Board of Directors
Date of Meeting:	27 May 2026
Subject:	Corporate Governance Update - Proposed Changes to the Constitution
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 Trust's constitution is reviewed annually as standard governance practice.

The following amendments to the Trust's constitution are proposed:

- Reference to the Group Structure
- Clarity on joint meetings of the Board of Directors and the Council of Governors
- Consistency of statutory framework referencing
- Code of Governance for NHS Provider Trusts referenced
- Appointment of Committees clarity
- Appointment of Vice Chair consistency
- References to standard NHSE terminology throughout

Recommendation:
The Board of Directors is asked to approve the proposed amendments to the Trust's constitution.

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting/Engagement	**Date**	**Outcome/Recommendation**
Constitution Review Group	14 May 2026	Recommended for Council of Governors approval

Corporate Governance Update - Proposed Changes to the Constitution

1. Amendments of the Trust's Constitution

Any proposed amendments to the Trust's Constitution are required to be approved by the Board of Directors and Council of Governors.

2. Trust Constitution

After annual constitution review the following amendments are proposed:

Area	Section and Amendment
Page 7 - Name	2.3 The Trust is the parent undertaking of a group which includes subsidiary undertakings established to support the exercise of its functions, including York Teaching Hospital Facilities Management Limited Liability Partnership. *Sentence added to reference the Group structure.*
Page 23 – Meetings	10.5 Joint meetings of the Council of Governors and the Board of Directors Joint meetings between the Council of Governors and the Board of Directors will be held **as required**. ~~at least once a year~~
Page 108 Annex 4 – Standing Orders of the Council of Governors	Statutory Framework York and Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) is an NHS Foundation Trust and a public benefit corporation constituted in accordance with Schedule 7 of the National Health Service Act 2006 (as amended). The Trust operates under a provider licence issued by NHS England. *Sentence re-worded for consistency in the Trust been constituted.*
Page 124 Annex 5 – Standing Orders of the Board of Directors	Foreword The Board of Directors is responsible for establishing and maintaining effective arrangements for the governance of the Trust in accordance with the NHS provider licence issued by NHS England and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. *Sentence re-worded for clarity and consistency throughout the Standing Orders concerning the Health and Care Act 2022.*
Page 127 Annex 5 – Standing Orders of the Board of Directors	Statutory Framework York and Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) is an NHS Foundation Trust and a public benefit corporation constituted in accordance with Schedule 7 of the National Health Service Act 2006 (as amended).

	NHS Foundation Trusts are established and operate in accordance with the National Health Service Act 2006 (as amended). *Sentence re-worded for consistency in the Trust been constituted.*
Page 128 Annex 5 – Standing Orders of the Board of Directors	NHS Framework NHSE's (formerly Monitor's and NHS Improvement's) Code of Governance for NHS Provider Trusts requires that Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to staff. *Code of Governance for NHS Provider Trusts reference included.*
Page 138 Annex 5 - Standing Orders of the Board of Directors	5.1 Appointment of Committees Subject to the Licence and the Constitution and any direction given by NHSE the Board of Directors may appoint committees of the Trust, consisting wholly of Directors of the Trust. The Board of Directors may only delegate its powers to such a committee if that committee consists entirely of Board Directors. *Sentence re-worded for clarity of appointment of Committees.*
Page 123 Annex 4 - Standing Orders of the Council of Governors	Appointment of the Vice Chair of the Council of Governors and the Board of Directors For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Board of Directors shall, following a recommendation from the Chair and in consultation with, and subject to the approval of, the Council of Governors, appoint a Non-executive Director to the role of Vice-Chair for such period, not exceeding the remainder of their term of office as a Non-executive Director, as the Board of Directors may determine. *Sentence re-worded for consistency.*
Page 132 Annex 4 - Standing Orders of the Board of Directors	Appointment of Vice Chair of the Board of Directors For the purpose of enabling the proceedings of the Trust to be cond the absence of the Chair, the Board of Directors shall, following a recommendation from the Chair and in consultation with, and subje approval of, the Council of Governors, appoint a Non-executive Dir the role of Vice-Chair for such period, not exceeding the remainder term of office as a Non-executive Director, as the Board of Director determine. *Sentence re-worded for consistency.*
	References to NHSE consistently throughout

The full constitution is provided on the Board of Directors Teams Channel for reference.

3. Recommendation

The Board of Directors is asked to approve the proposed amendments to the Trust's constitution.