# Agenda

# Council of Governors (Meeting held in Public)

Wednesday 10 June 2026

Malton Rugby Club, YO17 7EY
at 10.00am

# COUNCIL OF GOVERNORS MEETING

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

On: Wednesday 10 June 2026

Venue: Malton Rugby Club, YO17 7EY

| TIME | MEETING | LOCATION | ATTENDEES |
|---|---|---|---|
| 09.15 – 10.00 | Governors meet General Public | Malton Rugby Club | Council of Governors<br>Members of the Public |
| **10.00 – 13.00** | **Council of Governors meeting held in public** | **Malton Rugby Club** | **Council of Governors<br>Non-executive Directors<br>Executive Directors<br>Members of the Public** |
| 13.30 – 14.00 | Private Council of Governors | Malton Rugby Club | Council of Governors<br>Non-executive Directors |

# Council of Governors (Public) Agenda (10.06.26)

| Item | Subject | Lead | Report/ Verbal | Page No | Time |
|---|---|---|---|---|---|
| 1. | **Introduction, apologies for absence and quorum**<br><br>To receive any apologies for absence | Chair | Verbal | - | 10.00 |
| 2. | **Declaration of Interests**<br><br>To receive any changes to the register of declarations of interest | Chair | Report | 6 | |
| 3. | **Minutes of the meeting held on 11 March 2026**<br><br>To approve the minutes from the above meeting | Chair | Report | 11 | |
| 4. | **Matters arising from the minutes and any outstanding actions**<br><br>To discuss any matters or actions arising from the minutes or action log | Chair | Report | 19 | |
| 5 | **Chief Executive's Update**<br><br>To receive the report | Chief Executive | Report | 20 | 10.05 |
| 6 | **Chair's Report**<br><br>To receive the report | Chair | Report | 29 | 10.20 |
| 7 | **Performance Report**<br><br>To review the report | Chair / Chief Operating Officer / Chief Nurse | Report | 76 | 10.30 |

| Item | Subject | Lead | Report/ Verbal | Page No | Time |
|---|---|---|---|---|---|
| 8 | **Cancer update**<br><br>To receive the report | Chief Operating Officer | Report | 95 | 10.50 |
| 9 | **Patient Experience Quarterly Report**<br><br>To consider the report | Chief Nurse | Report | 102 | 11.05 |
| | | **BREAK 11.20** | | | |
| 10 | **Staff Survey Report**<br><br>To consider the report | Interim Director of Workforce & OD | Report | 118 | 11.30 |
| 11 | **NED Assurance Questions**<br><br>To receive an update from the NEDs | NEDs | Report | 129 | 11.50 |
| 12 | **Reports from Board Committee Chairs**<br><br>12.1 Quality Committee<br>12.2 Resources Committee<br>12.3 Audit Committee | Chairs of the Committees | Report | 132 | 12.05 |
| 13 | **Governance Update**<br>To receive an update on the following:<br><br>13.1 Constitution changes<br>13.2 Governor Elections | Assoc. Dir. Corporate Governance | <br><br><br>Report<br>Report | <br><br><br>149<br>154 | 12.20 |
| 14 | **NomRem Committee Update**<br><br>To receive the report | Chair | Report | 159 | 12.30 |
| 15 | **Governor Activities Report**<br><br>To receive the report | Governors | Report | 162 | 12.40 |

| Item | Subject | Lead | Report/ Verbal | Page No | Time |
|---|---|---|---|---|---|
| **16** | **Items to Note** | Chair | | | 12.50 |
| | 16.1 CoG Attendance Register | | Report | 166 | |
| | 16.2 NED Attendance Register | | Report | 169 | |
| **17** | **Any Other Business** | Chair | Verbal | - | 12.55 |

**18** **Time and Date of Next Meeting**

The next Council of Governors meeting held in public will be on Wednesday 9 September 2026 at 10.00am at Malton Rugby Club

**19** **Close** **13.00**

Register of Governors' interests
June 2026

**Item 2**

**Additions:** **Jim Cannon - YOPA**

**Deletions:** **Nick Bosanquet**
**Ian Foxley – resigned**
**Bernard Chalk – resigned**
**Jill Quinn - resigned**

**Modifications:** **Sandra Fox – add member of the Derwent Practice PPG**
**Linda Wild – add member of Eskdale PPG, delete Chair of Finance Cttee and HR Cttee at Whitby Town Council**

# Register of Governors' interests 2026/27

| Governors | Relevant and material interests | | | | | | Other |
|---|---|---|---|---|---|---|---|
| | Directorships including non -executive directorships held in private companies or PLCs (with the exception of those of dormant companies). | Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS. | Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS. | A position of authority in a charity or voluntary organisation in the field of health and social care. | Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services. | Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, | Any connection with other organisations. |
| **Rebecca Bradley** (Staff: Community) | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
| **Jim Cannon** (Stakeholder: YOPA) | Nil | Nil | Nil | **Chair**: York Neighbours | Nil | Nil | **Member:** Labour Party; **Member:** Fabian Society; **Member:** Co-operative Party; **Chair:** Citizens Group Age Friendly York; **Member:** National Trust; **Member:** English Heritage; **Member:** Explore York; **Member:** Y&S Hospital Trust |

| **Mary Clark**<br>(Public: City of York) | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
|---|---|---|---|---|---|---|---|
| **Elena Clerici**<br>(Staff: York) | TBA | | | | | | |
| **Cllr Liz Colling**<br>(Appointed: NYCC) | Nil | Nil | Nil | **Councillor:** NYCC | **Councillor:** NYCC | **Councillor:** NYCC | **Governor & VC:** Childhaven Nursery School Scarborough<br>**Chair:** NY Constituency Ctte Scarborough & Whitby<br>**VC:** NYCC Scrutiny of Health Committee<br>**Member:** Scarborough Town Deal Board |
| **Adnan Faraj**<br>(Staff: SGH & Brid) | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
| **Jean Flanagan**<br>(Public: East Coast) | Nil | Nil | Nil | **Trustee:** Spectrum Futures, wholly owned subsidiary of Voluntary Action Rotherham. | **Volunteer:** Great North Air Ambulance | Nil | Nil |
| **Sandra Fox**<br>(Public: Ryedale & EY**)** | Nil | Nil | Nil | Nil | Nil | Nil | **Member:** Derwent Practice PPG |
| **Paul Gibson**<br>(Public: East Coast) | Nil | Nil | Nil | **Chair:** Humber Primary Care PPG | Nil | Nil | **Member**: Bridlington Health Forum |
| **James Hayward**<br>(Public: East Coast) | **NED:** Government Facilities Services Ltd<br>Engineering | James D Hayward Building Services | Yes | Nil | Nil | Nil | Nil |
| **Gary Kitching**<br>(Staff: York) | Nil | Nil | Nil | Nil | Nil | Nil | Nil |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Graham Lake**<br>(Public: Ryedale & EY) | Nil | Nil | Nil | **Member:** TEWV NHS | Nil | Nil | **Member:** European Lung Fd PAG |
| **Wendy Loveday**<br>(Public: Selby) | Nil | **Shareholder**: Fleetways Taxis which is on the Trust's procurement system. | Nil | Nil | Nil | Nil | Nil |
| **Elizabeth McPherson**<br>(Appointed: CarersPlus) | **CEO:** CarersPlus | Nil | Nil | **CEO:** CarersPlus | **CEO:** CarersPlus | Nil | Nil |
| **Peter Morley**<br>(Public: Selby) | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
| **Cllr Tim Norman**<br>(Appointed: ERYC) | **Director:** Coast Holidays Ltd &<br>Quilt Sandwich Ltd | Nil | Nil | Nil | **Trustee & Treasurer:** Bridlington Health Forum<br>**Councillor:** ERYC | Nil | Nil |
| **Carol Popplestone**<br>(Staff: SGH & Brid) | Nil | Nil | Nil | Nil | Nil | Nil | Nil |
| **Gerry Richardson**<br>(Appointed: University of York) | Nil | Nil | Nil | Nil | Nil | Nil | **Employee:** University of York |
| **Cllr Jason Rose**<br>(Appointed: CYC) | Nil | Nil | Nil | **Councillor:** NYC | **Councillor:** NYC | **Councillor:** NYC | Nil |
| **Ros Shaw**<br>(Public: York) | **Director**: Conbrio Ltd | Nil | Nil | Nil | Nil | Nil | Nil |
| **Julie Southwell**<br>(Staff: York) | Nil | Nil | Nil | Nil | Nil | Nil | Nil |

| **Linda Wild**<br>(Public: East Coast) | Nil | Nil | Nil | Nil | Nil | Nil | **Councillor**: Whitby Town.<br>**Chair:** Pannett Art Gallery Cttee (WTC)<br>**Chair:** Trustee Whitby Lobster Hatchery<br>**Trustee:** United Charities Board<br>**Member:** Whitby Town Deal Board<br>**Member**: Esk Valley PPG<br>**Volunteer:** RNLI |
|---|---|---|---|---|---|---|---|

ITEM 3

# Minutes
## Public Council of Governors Meeting
## 11 March 2026

**Chair:** Martin Barkley

**Public Governors:** Linda Wild, East Coast of Yorkshire; Jean Flanagan, East Coast of Yorkshire; Peter Morley, Selby; Nick Bosanquet, City of York; Mary Clark, City of York; Ros Shaw, City of York; Graham Lake, Ryedale & EY; Sandra Fox, Ryedale & EY

**Appointed Governors:** Elizabeth McPherson, Carers Plus; Cllr Jason Rose, CYC; Gerry Richardson, University of York

**Staff Governors:** Elena Clerici, York; Julie Southwell, York; Gary Kitching, York; Carol Popplestone, Scarborough/Bridlington

**Attendance:** Clare Smith, CEO; Andrew Bertram, Finance Director; Claire Hansen, Chief Operating Officer; Dawn Parkes, Chief Nurse; Lucy Brown, Director of Communications; Julie Charge, NED; Lorraine Boyd, NED; Rukmal Abeysekera, NED; Helen Grantham, NED; Jane Hazelgrave, NED; Richard Reece, NED; Mike Taylor, Assoc. Director of Corporate Governance; Tracy Astley, Governor & Membership Manager

**Public:** 2 members of the public

**Apologies:** Adnan Faraj, Scarborough/Bridlington; James Hayward, East Coast of Yorkshire; Cllr Liz Colling, NYC; Wendy Loveday, Selby; Paul Gibson, East Coast of Yorkshire; Bernard Chalk, East Coast of Yorkshire; Ian Foxley, Ryedale & EY; Cllr Tim Norman, ERYC; Rebecca Bradley, Community

### 26/01 Chair's Introduction and Welcome

Mr Barkley welcomed everybody and declared the meeting quorate.

### 26/02 Declarations of Interest (DOI)

The Council acknowledged the changes to the Declarations of Interest.

### 26/03 Minutes of the meeting held on the 10 December 2025

The minutes of the meeting held on the 10 December 2025 were agreed as a correct record.

### 26/04 Matters arising from the Minutes

<u>Action Log</u>

25/55 Mr Barkley informed the Council that NHSE advised that the implementation of Nerve Centre cannot go ahead and has been deferred until May.

The Council acknowledged that all other actions have been completed.

## 26/05 Chief Executive's Report

Miss Smith gave an overview of her report which had previously been circulated with the agenda and highlighted the following.

- **Staff and Stakeholder Engagement:** Ongoing efforts to meet with colleagues across the organisation are ongoing, including hosting sessions with senior leaders, medical leaders, and change makers, as well as engaging with MPs, families, and patients to gather diverse perspectives for organisational development.
- **Organisational Development Reflections:** Outline plans will be produced to synthesise insights from the first 100 days into a catalyst for the next stage of organisational development, emphasising the importance of staff and the need to maintain patient safety and service quality during ongoing changes.
- **Patient Care:** Corridor care within the Trust will be eliminated, and reducing length of stay remains the single most important action required to achieve this aim.
- **CQC update:** The Trust has now received the draft report from the unannounced CQC inspection of Scarborough Hospital last October. Once reviewed by both parties, a final version of the report will be published and shared with the Governors.
- **Planning update:** The Trust has advised NHSE of the year-end position of £28.5m deficit, and have submitted a recovery plan which will return the Trust to a balanced position in three years.
- **Electronic Patient Record (EPR) rollout:** It was a huge disappointment that the roll out of phase one has been paused. An update will be given in due course.
- **Capital Planning:** York SCBU refurbishment has started, and planning permission has been granted for new pathology facilities at Scarborough Hospital.

Miss Smith thanked Mrs Parkes, Chief Nurse, for her incredible contribution to the organisation and wished her well as she retires on 18 March.

**The Council:**

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

## 26/06 Chair's Report

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

- **Leadership Transitions:** Dawn Parkes, Chief Nurse, will be leaving the organisation with her final meeting being this session, and Mr Barkley expressed appreciation for Dawn's contributions over nearly three years, noting the positive position in which Dawn leaves the organisation. Jenny McAleese, Deputy Chair, leaves after 9 years fantastic service to the Trust. Noel Scanlon, NED, has resigned.

- **New Board Appointments:** Matthew Taylor will join the board as a non-executive director from 1st April, bringing experience from NHS Alliance, and Ian Floyd will join as an associate non-executive director, leveraging his background as the retiring chief executive of York City Council.

No questions were asked by the Council.

**The Council:**

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

### 26/07 Performance Report

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

- **Acute Flow:** Reducing 12-hour trolley waits and average length of stay are identified as key priorities. Recent improvements in ambulance handover times has been significant. Ongoing challenges exist in reducing overall waiting times in urgent and emergency care.
- **Referral to Treatment:** A significant increase in the waiting list size is attributed to the transition from the in-house electronic patient record to Nerve Centre, which resulted in 15,000 patients being newly timed, and the organisation is working to reduce the number of patients waiting over 52 weeks.
- **Diagnostics:** Community Diagnostic Centres and outsourcing (including radiology and histopathology reporting) are being utilised to address long waits, though the types of procedures available at CDCs do not always match the needs of those waiting longest, requiring a tailored approach.
- **Cancer Services:** The organisation is leveraging the new cancer plan, which includes positive recognition for home-based care initiatives, and is working to adapt national recommendations to the local context, particularly given the unique challenges of serving both York and Scarborough.
- **Workforce:** Sickness absence has increased with the main causes being recorded as stress and musculoskeletal issues. HCSW vacancy rate is high but will be significantly reduced in the coming months with a new cohort of staff. Further development on engagement is ongoing.
- **Patient Complaints:** An increase in patient complaints, particularly relating to waiting times for treatment and follow-up, has been observed, correlating with the operational challenges and reinforcing the need for ongoing service improvements.

**<u>Finance</u>**

Mr Bertram detailed the organisation's significant financial deficit, the shortfall in efficiency savings, technical income issues relating to the Scarborough sparsity payment, and the operational and technical measures being taken to address these challenges.

- **Current Financial Position:** There is a year-to-date deficit of £12.8 million against a planned £800,000 deficit, with the organisation projected to finish the year with a £15–16 million operational shortfall, primarily due to the under-delivery of efficiency savings and operational pressures.
- **Efficiency Programme Shortfall:** The organisation aimed for £55 million in efficiency savings but is expected to achieve around £39 million, representing about 4% of operational expenditure, which, while significant, falls short of the required 6% and contributes to the financial gap.
- **Technical Income Issues:** A technical shortfall of £8 million arose from the Scarborough sparsity payment not being fully passed on by the ICB, and an additional £4.6 million is outstanding for work completed at the end of the previous year, both of which are being addressed through ongoing contract discussions.

- **Cost Pressures and Mitigations:** Operational cost pressures include high agency doctor expenditure, increased use of high-cost medical devices, and energy costs, with the organisation implementing expenditure controls, participating in national energy procurement, and seeking to reduce agency spend through recruitment and service redesign.
- **Contingency Planning and Cash Support:** If the organisation continues to operate with a deficit plan, emergency cash support may be required, which involves a formal process with significant board-level scrutiny, though this has not been necessary in the current year.

The Council discussed how performance can be improved to meet NHS national standards. Ms Hansen replied that a number of initiatives are taking place including:

- **Workforce:** Reconfiguration of care groups and looking at the different leadership and cross-site leadership, looking at innovative ways of working together across specialisms, stepping out of silo work and doing things differently.
- **Diagnostics and Equipment Investment:** Investment in diagnostic equipment, with new resources expected to come online in 2026–27, is anticipated to improve the speed of diagnosis, which is identified as a critical factor in cancer outcomes.
- **Cross-Border Patient Flows:** The team is monitoring the impact of neighbouring trusts being placed in special measures, with ongoing discussions with partners to ensure continuity of care for patients who may be affected by changes in service provision.
- **Waiting Times and Prioritisation:** Efforts are underway to reduce waiting times for cancer treatment, with a focus on diagnostics and targeted pathway redesigns, and the organisation is using additional funding and revised booking processes to address backlogs.
- **Data Management and Reporting:** The business intelligence and IT teams manage statistical reporting using national standards, with ongoing efforts to ensure data is accurately represented and comparable, and to provide more granular analysis of waiting list profiles for internal and external benchmarking.

The Council inquired about staff absence due to stress and asked about the actions being taken to mitigate the situation. Ms Hansen replied that there are a number of ideas that are being looked at, including:

- The use of digital enablement in order to do things once rather than having to do things three times.
- Reduce the number of patients that are waiting in need and also waiting for beds on wards.
- Reducing mandatory training to what staff need to have to carry out their role effectively.
- Team working with professional movements to what is required and investing in our own workforce and reduce agency spend.

Empowering teams to work differently with effective processes in place, should pay dividends for staff morale and reduce sickness absence.

**The Council:**

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

### 26/08 Chief Operating Officer Update

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

- **Operational Plan Submission:** The submission of the operational plan for 2026–27 has been developed through detailed specialty-level planning, incorporating productivity data, workforce statistics, and projected demand to align services with a reduced financial envelope while maintaining quality outcomes.
- **Pathway Redesign and Service Development:** The plan includes targeted redesigns in gynaecology, urology, lung cancer, and colorectal pathways, with an emphasis on sharing best practice, developing workforce roles (including advanced nursing and AHPs), and implementing personalised, stratified follow-up protocols.
- **Digital Enablement and Scheduling:** Implementation of the Nerve Centre electronic patient record is expected to improve appointment scheduling, patient communication, and pathway management, with ongoing work to ensure the system addresses local needs, such as appointment location preferences and access routes for patients without smartphones or computers.
- **Workforce and Leadership Initiatives:** Plans include further development of management and leadership, cross-site team working, digital enablement to reduce administrative burden, and strategies to reduce agency reliance and staff sickness, with a focus on supporting new staff and fostering innovation.
- **Collaboration with Commissioners and Partners:** The organisation is engaging with commissioners to review which services should continue to be provided as secondary care, exploring opportunities for shared care protocols with primary care, and considering the role of independent sector providers and outsourcing to manage demand.

The Council agreed that digital transformation has the potential to improve patient empowerment and service efficiency, but would like assurance that support would be available for patients who are not digitally enabled. Mrs Hansen reaffirmed the Trust's commitment to providing human contact and support for patients who are not digitally enabled, ensuring that digital transformation does not exclude those without access to smartphones or computers.

**The Council:**

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

### 26/09 Complaints Report (half-yearly)

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

- The organisation is moving from a standalone complaints report to a broader Patient Experience Report which will triangulate data from complaints, national surveys, friends and family scores, compliments, and concerns to provide a more robust understanding of patient feedback.
- Although the number of complaints has increased, they represent less than half a percent of patient contacts, and the rise is proportional to increased patient interactions across outpatient, community, and acute settings.
- There has been a reduction in repeat concerns following complaint responses, attributing this to improved response quality and a shift towards meeting with families

or patients for detailed discussions, rather than relying solely on written communication.
- Efforts have been made to improve the timeliness of complaint responses, with a target of 90% on-time responses by the end of April; two care groups are on track, and quality improvement methodologies have been applied to streamline processes and reduce delays.

The Council raised concerns about capturing complaints from individuals unable to self-advocate, particularly the elderly and the vulnerable. Mrs Parkes responded by outlining multiple feedback channels, including the friends and family test, PALS, and surveys, while acknowledging the challenges in ensuring all poor experiences are reported.

The Council inquired about support for less experienced investigating officers. Mrs Parkes confirmed the existence of a complexity matrix for complaints and ongoing training for investigating officers, with plans to enhance handholding and support based on feedback.

The Council discussed the adoption of Biosimilar drugs and whether the shift is driven by cost savings, and to what extent does the patient have a choice. Miss Smith confirmed that biosimilar drugs are being introduced as original drugs come off licence, with ongoing monitoring of their use and cost-effectiveness. She clarified that patients must be fully informed and have the opportunity to discuss treatment options, even if direct consultant contact is limited in some clinics. Patients can opt out of biosimilar treatment at any point if they experience negative effects, and that the decision to switch is based on safety evidence, with mechanisms in place for patients to raise concerns.

**The Council:**
- **Received the report and noted its content.**

## 26/10 NED Assurance Questions

Mr Barkley explained that the Q&As had been circulated prior to the meeting. Further discussions took place on the following.

- **Transport Services:** The Council discussed issues related to patient transport, specifically when patients are discharged overnight. Mr Barkley discussed the changes in ambulance service commissioning, eligibility criteria, and the role of voluntary transport. He also explained the restrictions on booking transport after certain hours.

  The Council discussed how these changes have led to difficulties for patients, particularly those attending Leeds and Hull for cancer treatments, with some gaps being partially filled by charities but overall access remaining problematic. The limitations of voluntary transport schemes were highlighted, including restricted hours, limited coverage, and long waiting times, which can leave elderly or vulnerable patients stranded after appointments.

  Mr Barkley reported that these issues have been escalated to the chair of the Integrated Care Board, who commission ambulance services, with ongoing correspondence from local charities and stakeholders to seek improvements.

- **Cancer Performance and Recovery Plans:** The Council raised concerns about declining cancer treatment performance metrics, the impact of diagnostic delays, resource allocation, and the need for detailed recovery plans, with responsibilities

assigned to specific executives and committees. Mr Barkley clarified that responsibility for improvement lies with the Chief Operating Officer with the Resources Committee having oversight and receiving detailed updates at meetings.

Mrs Hazelgrave highlighted that changes in dermatology referral practices, such as reduced use of dermatoscopes by GPs, has contributed to increased referrals and delays, impacting overall cancer pathway performance.

There was agreement to focus the next meeting on detailed cancer recovery plans, including site-specific actions and timelines.

- **Resource & Funding Allocation:** The Council discussed the complexities of NHS funding allocation, the lobbying efforts for fairer resource distribution, and the challenges faced by trusts with persistent performance and financial issues.

**Action: Chief Operating Officer to provide Cancer update detailing cancer recovery plans, including site-specific actions and timelines, at next CoG meeting in June.**

## 26/11 Reports from Board Committee Chairs

Quality Committee

Mrs Boyd summarised the Quality Committee's work on principal risks, including effective clinical pathways and patient experience, with efforts to use data to inform discussions and link assurance to risk management.

Resources Committee

Mrs Grantham highlighted the committee's focus on operational, financial, and workforce performance, the need for improved financial data throughout the year, and the importance of acting on staff survey results in collaboration with the executive team.

Group Audit Committee

Mrs Hazelgrave described the Audit Committee's role in overseeing internal and external audit, fraud, and assurance processes, with a risk-based audit plan, tracking of recommendations, and efforts to ensure continuous improvement and compliance.

The Committee discussed the triangulation of Quality and Risk data and the importance of linking quality issues with risk registers and audit findings, ensuring that persistent problems are identified, tracked, and addressed through coordinated committee oversight. Mr Bertram confirmed that any internal audit recommendations are tracked until completed.

**The Council:**

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

## 26/12 Governors Activities Report

- **Community & Neighbourhood Network:** Mrs McPherson described a productive recent meeting where governors gained valuable information on East Riding health care, particularly in Bridlington, and discharges into the community. Both were excellent presentations with Mrs McPherson noting the high level of energy and

constructive questioning among the group. She asked that if any governor wanted to join the group then contact her or Mrs Astley.

- **Constitution Review Postponement:** Mr Taylor explained that the Constitution Review Group meeting was postponed to align with the outcomes of the well-led review, ensuring that any proposed changes are considered in the appropriate organisational context.

**The Council:**

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

### 26/13 Items to Note

The Council noted the following items:

- CoG Attendance Register
- NED Attendance Register

### 26/14 Any Other Business

No further business was discussed.

### 26/15 Time and Date of the next meeting

The next meeting is on Wednesday 10 June 2026 at Malton Rugby Club

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Follow-up tasks:

- **Cancer Performance Reporting:** Include a detailed agenda item at the next Council of Governors meeting to specifically review the current status of cancer performance, and outline improvement plans including site-specific actions and timelines. (COO)
- **Cancer Performance Report:** Distribute a copy to Governors of the Cancer Recovery Plan paper that was presented at the recent Resource Committee. (Tracy)

**Council of Governors**
**Action Log**

| Committee / Group | Ref No. | Date of Meeting | Action | Responsible Officer | Due Date | Updates |
|---|---|---|---|---|---|---|
| Public CoG | 26/10 | 11.03.26 | Provide cancer update detailing cancer recovery plans, including site-specific actions and timelines, at next CoG meeting in June. | Claire Hansen | June'26 | Added to June CoG. **Action closed.** |

York and Scarborough
Teaching Hospitals
NHS Foundation Trust

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10 June 2026 |
| **Subject:** | Chief Executive's Report |
| **Director Sponsor:** | Clare Smith, Chief Executive |
| **Author:** | Clare Smith, Chief Executive |

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

Approve ☐ Discuss ☐ Assurance ☐ Information ☐ Regulatory Requirement ☐

**Trust Objectives**

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

| **Board Assurance Framework** | **Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)* |
|---|---|
| ☐ Effective Clinical Pathways<br>☐ Trust Culture<br>☐ Partnerships<br>☐ Transformative Services<br>☐ Sustainability Green Plan<br>☐ Financial Balance<br>☐ Effective Governance | ☐ Yes<br><br>☐ No<br><br>☐ Not Applicable |

**Executive Summary:**
The report provides an update from the Chief Executive to the Council of Governors in relation to the Trust's priorities. Topics covered include: My First 100 Days, Planning update, Electronic Patient Record (EPR) rollout, Bridlington Care Unit, Bridlington Surgical Hub Optimisation Week, Care Quality Commission (CQC) Updates, SHARC Annual Conference, and Changes in the Executive Team.

**Recommendation:**
For the Council of Governors to note the report.

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

## Chief Executive's Report

### 1. My first 100 days

Since the last meeting of the Council of Governors I have completed my first 100 days with York and Scarborough Teaching Hospitals, and as Governors are aware, I committed to spending as much time as possible getting out and about during this time.

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 advocacy 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.

In April I was able to share with colleagues my report out of my reflections from the first 100 days in the Trust. In doing so 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. Thank you to the Council of Governors, as the conversations I have had with a number of you, and the stories and examples you have shared with me, have contributed to shaping my priorities.

In my report I set out the priorities I believe we need to focus on together - reducing corridor care, strengthening culture and leadership, improving timeliness of care by developing our community services, and achieving financial sustainability by developing and delivering 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, and the Governors will continue to have an important role to play in these conversations.

### 2. Planning update

We have had a number of recent meetings 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, given we are yet to reach a conclusion to the planning conversations.

At the time of writing we are preparing to attend 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 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 must live within the resources available to us.

### 3. Electronic Patient Record (EPR) rollout

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, 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.

## 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 commenced, 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.

The Board of Directors considered the recommendations made by the Scrutiny Sub-committee, along with feedback from patients, staff, local residents and stakeholders, and has agreed to review the planned closure while further work is undertaken.

Over the coming months, we will work with Humber and North Yorkshire Integrated Care Board and our partners to provide further assurance about community services, strengthen engagement, and clearly set out our longer-term vision for healthcare services in Bridlington. We are committed to ensuring that local people have the opportunity to understand the proposals, share their views and help shape future plans.

Our priority remains providing safe, sustainable and high-quality care for local people.

## 5. Bridlington Surgical Hub Optimisation Week

In May the Surgical Team at Bridlington Hospital joined more than 100 elective surgical hubs across England as part of a national initiative aimed at improving efficiency, increasing theatre productivity and helping more patients receive treatment sooner.

The Trust took part in Getting It Right First Time (GIRFT) Hub Optimisation Week, giving surgical hubs across the NHS the opportunity to showcase what can be achieved when

theatres and clinical pathways are working at their very best, while also sharing learning and best practice with organisations across the country.

Throughout the week, colleagues at Bridlington delivered increased theatre sessions and expanded the range of specialties running surgical lists. Both theatres operated every day from Monday to Saturday, with extended 10-hour operating lists supporting multiple specialties.

The initiative highlighted the growing role Bridlington Hospital continues to play in helping reduce elective waiting times and improve access to planned care closer to home for patients across the region.

It also showcased the teamwork behind the scenes, with theatre and ward colleagues, surgeons, pre-operative assessment teams, administrative staff and operational teams all working together to maximise the number of patients treated safely and efficiently.

During the Hub Optimisation Week, surgical teams at Bridlington delivered a 76 per cent increase in activity, performing 74 procedures compared with a typical baseline of 42 during an equivalent operating week.

Alongside improving productivity, the week focused on the whole patient journey - from screening and pre-operative assessment through to theatre flow, recovery and follow-up care - with surgical hubs benchmarking performance and sharing learning nationally.

This was a fantastic opportunity to showcase the important role Bridlington Hospital plays in helping us reduce waiting times and provide high-quality planned care closer to patients' homes.

The commitment shown by colleagues throughout the week has been exceptional. By working together across specialties and teams, we've been able to maximise theatre capacity, improve efficiency and help more patients access the treatment they need sooner.

Bridlington continues to go from strength to strength as an elective surgical hub, and initiatives like this demonstrate what can be achieved through teamwork, innovation and a shared focus on delivering the best possible care for our patients.

The Trust will continue building on the learning from the initiative as part of its wider work to improve patient access, reduce waits for planned care and make the best possible use of surgical facilities across the region.

## 6. Care Quality Commission (CQC) Updates

**Medicine and urgent and emergency care pathways (Scarborough Hospital)**

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

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

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

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

At the same time, urgent and emergency care services have been rated *'Requires Improvement'* overall. The report highlights areas of good practice, including teamwork and a positive learning culture, but it is also clear about the ongoing pressures in urgent and emergency care, particularly around safety and access. These are challenges we recognise, and they remain a priority for us to address.

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

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

**Maternity services**

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

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

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

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

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

## 7. SHARC Annual Conference

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

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.

## 8. Changes in the Executive Team

There are two updates to share with the Governors. Firstly, please join me in welcoming 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.

Thank you to 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.

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

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

Lydia Larcum, Deputy Director of Workforce, has stepped into the role on an interim basis, and at the time of writing we are imminently launching the recruitment process for a Chief Culture and People Officer.

**Date:** 10 June 2026

Item 6

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10 June 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 ☒ A 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** | **Equality Impact Assessment Concluded** *(please document in report)* |
|---|---|
| ☒ Effective Clinical Pathways<br>☒ Trust Culture<br>☒ Partnerships<br>☒ Transformative Services<br>☒ Sustainability Green Plan<br>☒ Financial Balance<br>☒ Effective Governance | ☐ Yes<br>☐ No<br>☒ Not Applicable |

**Recommendation:**
The council of Governors is asked to note the report.

Chair's Report to June 2026 Council of Governors meeting.

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

1. A few changes to the membership of the Council of Governors since our last meeting to report. The first is the untimely passing of Prof Nick Bosanquet who was taken ill a few days after the April Board meeting (which he attended as an observer). He has had a distinguished career as an academic and national policy advisor. I must also report that both Jill Quinn and Bernard Chalk have stepped down due on-going health problems, and Ian Foxley has also stepped down due mainly to family commitments. Today we welcome a new Stakeholder Governor from the voluntary sector succeeding Jill Quinn, Jim Cannon who has a long significant association with York Older Peoples Assembly.

2. Since our last meeting, we have welcomed three new members of the Trust Board: Matthew Taylor as a NED succeeding Jenny McAleese, Ian Floyd as an additional Associate NED, and Joe Hague our new Chief Nurse who succeeds Dawn Parkes.

3. Recently with our Lead Governor we have appraised the NEDs, the last of which took place on 5th June. All of whom were appraised as being high performing making an important contribution to the effectiveness of the Trust Board to improve the Trust and take the Trust further towards achieving our ambition (True North) of "providing an excellent patient experience every time".

4. At the time of writing this report I still cannot let you know the denouement of our financial plan with NHS England regarding our financial obligations for the year that started on 1st April 2026. Evidently, we are one of just 16 NHS organisations (out of 245) that are deemed to not have an acceptable plan.

   Along with our Chief Executive and Director of Finance I will be attending a meeting in London on Wednesday 3rd June with our three counterparts of NHS England. This is a serious but not altogether unexpected concerning development. We do not know what this means, but I suspect it is to establish whether we can go further and faster to reduce our costs, by more than the £62m already required this year.

   Lots of very difficult decisions will be necessary in order to achieve our obligation given that we do not have the right to spend money we do not have. One of these difficult measures is the intention to close a ward at Bridlington Hospital, which was established during the covid pandemic, but the funding is no longer available, but there is going to be investment in increasing the capacity of the local community health services. This is consistent with the government's recent new Strategy for the NHS – one of its fundamental 3 elements is moving some services out of hospitals into local communities.

   More public and stakeholder engagement will take place over the next couple of months to share, explain and discuss the plan. By the time of our CoG meeting on

10th June, I with executive colleagues will be able to brief you on the outcome of the meeting with NHSE.

5. At the May meeting of the Trust Board, the Board received a progress report on the actions being taken in response to the findings and recommendations made by NHS Providers who carried out the Independent Developmental Well Led Review September/October 2025 that we commissioned. The report is attached as annex 1. I am sharing this with you because I believe it is important you know what remains to improve since the Trust received a rating of Inadequate following the CQC inspection at the end of 2022 and early 2023 and you holding me to account as Chair of the Board.

6. I have now received a copy of the internal audit report regarding the effectiveness of objective setting and appraisals of managers. Predictably it assessed present arrangements as providing “Low Assurance” of their effectiveness. An action plan has been agreed which is starting to be implemented which includes revised pro-formas and clear expectations/requirements.

7. I have continued to visit a variety of wards, teams and services.

8. I would also like to propose that on the afternoon of the September Council of Governors meeting that a joint meeting of the Trust Board and Council of Governors takes place to discuss two main items; the Trust’s emerging Clinical Strategy; and if the government does abolish Councils of Governors what type of arrangements should we start planning to have instead. Do Governors agree that such a meeting and discussion takes place in September?

9. Finally, we had a tremendous boost to morale on Tuesday 26th May, with a visit by King Charles. He is Patron of the Macmillan Cancer Charity and came to see the new £2.4 Macmillan Cancer Centre which the Charity has mainly funded with support from one or two very significant donors. It is located at York Hospital and is known as the Sir Robert Ogden Macmillan Cancer Centre and will open in June. King Charles was truly excellent with everyone he met, friendly, interested and approachable.

Martin Barkley

1st June 2026

**Annex 1**

# 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<br>(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 |

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| | | | | | 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:<br><br>• Clinical Strategy – Medical Director<br>• Quality Strategy – Chief Nurse<br>• Estates Strategy – YTHFM Managing Director<br>• Financial Sustainability Strategy – Finance Director<br>• Organisational Development – YTHFM Managing Director<br>• 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. | | | |
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| | | 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 |

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| | | | | | focus on releasing capacity for BAU work to support ownership and empowerment across teams.<br>Big Conversation planned to underpin cultural development.<br>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.<br>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. |

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|---|---|---|---|---|---|
| | | 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<br><br>Medical Director | End Q1 for framework<br>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.<br>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. |

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|---|---|---|---|---|---|
| | | 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.<br>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 | |

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| --- | --- | --- | --- | --- | --- |
|  |  | 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. |

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| 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 |

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| | **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 |

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|---|---|---|---|---|---|
| | | | | | 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 |

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|---|---|---|---|---|---|
| | | | | | 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 |

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| | **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<br>- Resolve inconsistencies; cause/effect/controls/ assurances<br>- Identify lead Executive Directors for each principal risk<br><br>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 |

Item 7

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10 June 2026 |
| **Subject:** | Performance Report |
| **Director Sponsor:** | Martin Barkley, Chair |
| **Author:** | Martin Barkley, Chair |

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

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

**Trust Objectives**

☒ 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** | **Equality Impact Assessment Concluded** *(please document in report)* |
|---|---|
| ☒ Effective Clinical Pathways<br>☒ Trust Culture<br>☒ Partnerships<br>☒ Transformative Services<br>☒ Sustainability Green Plan<br>☒ Financial Balance<br>☒ Effective Governance | ☐ Yes<br>☐ No<br>☒ Not Applicable |

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

# Performance Report key metrics

June 2026 Council of Governors meeting

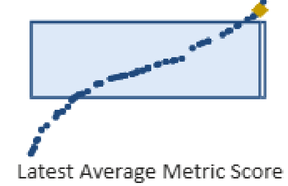
# National Operational Framework

## Rank Oversight

| 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

Reporting Month: Apr 2026

# Acute Flow

| Metric Name | April 2025 | April 2026 | Year End Target |
|---|---|---|---|
| Number of 12+ hour trolley waits | 628 | 77 | 0 |
| Proportion of ambulance handovers waiting > 45 mins | 16.6% | 2.1% | 0 |
| Proportion of patients seen and treated in ED waiting < 4 hours | 63.8% | 75% | 78% |
| Lost bed days for patients with no criteria to reside | 1130 | 1525 | |

Reporting Month: Apr 2026

# Cancer

| Metric Name | April 2025 | April 2026 | Year End Target |
|---|---|---|---|
| First treatment within 62 days | 68% | 72.4% | 75% |
| Faster diagnosis 28-day standard | 70.6% | 77.2% | 80% |

Reporting Month: Apr 2026

# Referral to Treatment (RTT)

| Metric Name | April 2025 | April 2026 | Year End Target |
|---|---|---|---|
| Total waiting list | 49,621 | 55,223 | 38,992 |
| Waits over 65 weeks | 38 | 0 | 0 |
| Waits over 52 weeks | 1149 | 1064 | 389 |
| Mean waiting time (wks) | 18 | 18 | |

Reporting Month: Apr 2026

# Diagnostic 6-week standard

| Metric Name | April 2025 | April 2026 | Year End Target |
|---|---|---|---|
| Patients waiting <6 weeks from referral | 62.7% | 73% | 95% |

14 types of diagnostic work are in the statistics with levels of attainment ranging from 31% re Echocardiography to 91% for MRI. Details are shown as annex 1.

Reporting Month: Apr 2026

# Children & Young Persons

| Metric Name | April 2025 | April 2026 | Year End Target |
|---|---|---|---|
| RTT waits over 52 weeks | 32 | 4 | 0 |

Reporting Month: Apr 2026

# Workforce

| Metric Name | April 2025 | April 2026 | Year End Target |
|---|---|---|---|
| Monthly Sickness Absence | 4.9% | 5.4% | 5% |
| Rolling 12-month staff turnover rate | 8.3% | 7.5% | 10% |
| Overall Vacancy Rate | 6.5% | 5.3% | 6% |
| HCSW Vacancy Rate | 9.8% | 16.5% | 5% |
| RN Vacancy Rate | 6.3% | 2.3% | 5% |
| Midwifery Vacancy Rate | 1.1% | -10.8% | 0% |
| Medical & Dental Vacancy Rate | 7.7% | 1.9% | 6% |

Reporting Month: Apr 2026

# Patient Experience: Complaints

| Metric Name | April 2025 | April 2026 | Year End Target |
|---|---|---|---|
| No. of Complaints | 95 | 119 | |

Reporting Month: Apr 2026

## 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.

## 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 |

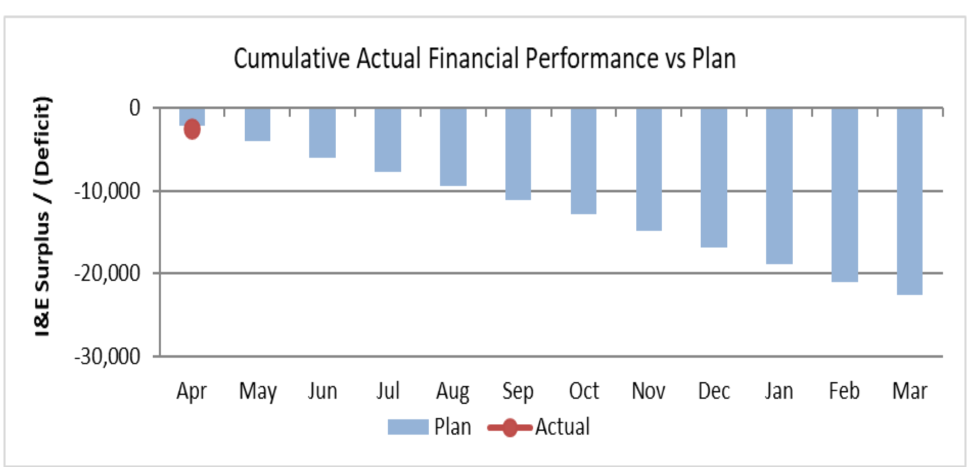
## Board Assurance Framework

| 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 |

# Summary Dashboard and Income & Expenditure

## Finance

| | 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

| 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. |

# Variable Activity – Trading Position – NHSE / ICB Contracts

Finance

## 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.

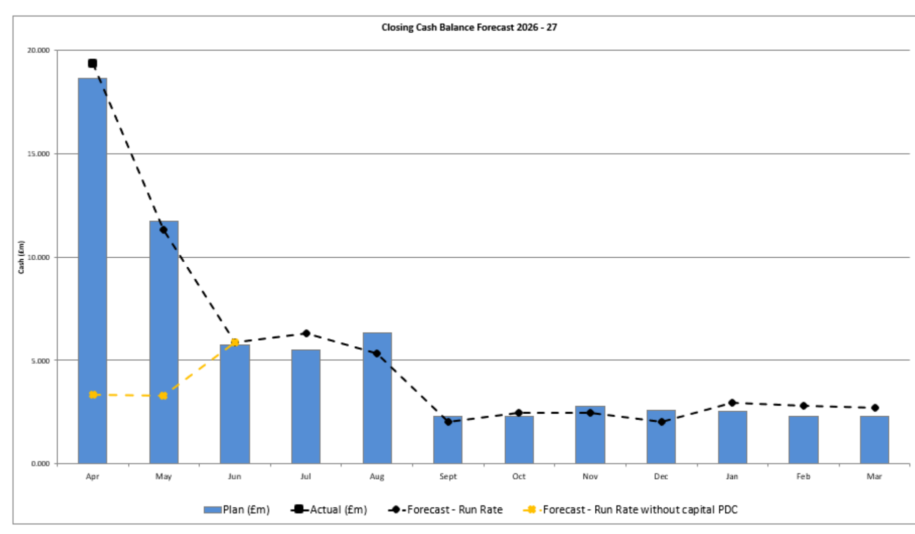
At Month 1, across all commissioners, the weighted activity position is slightly above the target weighted value by £167k. This is provisional data and includes some estimated data where activity is not yet coded, so the variable position is subject to change when the final Month 1 activity is fully coded and costed.

# Current Cash Position and Better Payment Practice Code (BPPC)

## Finance

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.

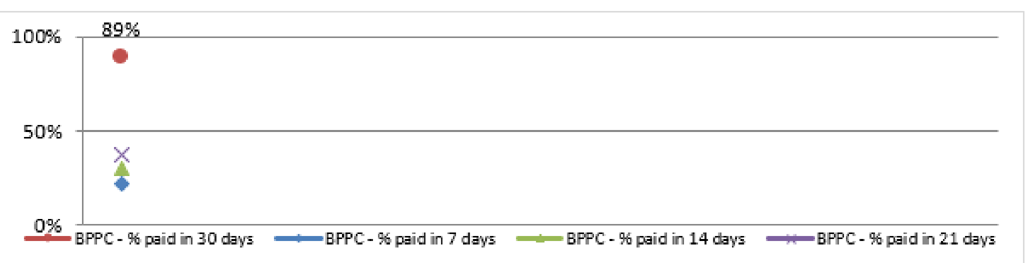
The orange line illustrates the run rate forecast adjusted for unspent PDC. It is assumed that all PDC funded scheme invoices will be paid by June.

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.

Better Payment Practice Code

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

The graph illustrates that in April the Group managed to pay 89% of its suppliers within 30 days, consistent with the M11 & M12 positions.




Reporting Month: April 2026

# Current and Forecast Capital Position

## Finance

| 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)** |

# ANNEX 1: DIAGNOSTICS – National Target: 95%

## Scorecard

| 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% |

# DIAGNOSTICS – National Target 95%

| Metric Name | Month | Variation | Assurance | Current Month | Monthly Trajectory | Year End Target |
|---|---|---|---|---|---|---|
| Diagnostics - Proportion of patients waiting <6 weeks from referral | 2025-04 | | F | 62.7% | 68.9% | 82.7% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - MRI | 2025-04 | | F | 58.4% | 66% | 90% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - CT | 2025-04 | | ? | 60.7% | 68% | 78% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Non-obs Ultrasound | 2025-04 | | ? | 68.5% | 65% | 75% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Barium enema | 2025-04 | L | ? | 51.1% | 80.7% | 90.1% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - DEXA Scan | 2025-04 | H | ? | 79.9% | 50.9% | 67.9% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Audiology | 2025-04 | L | F | 47% | 76.7% | 94.7% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Echocardiography | 2025-04 | H | F | 70.1% | 91.9% | 95.8% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Neurophysiology peripheral | 2025-04 | | ? | 96.4% | 90.5% | 95.2% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Sleep studies | 2025-04 | H | ? | 79.1% | 84.3% | 94.6% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Urodynamics | 2025-04 | | F | 30.2% | 54.8% | 95.3% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Colonoscopy | 2025-04 | | F | 55.9% | 80.6% | 90% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Flexi Sigmoidoscopy | 2025-04 | H | F | 68.6% | 81% | 95.1% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Cystoscopy | 2025-04 | | ? | 53.8% | 83.2% | 94.5% |
| Diagnostics - Proportion of patients waiting <6 weeks from referral - Gastroscopy | 2025-04 | | F | 74.4% | 79.6% | 90% |



Reporting Month: Apr 2025

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 8

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10th June 2026 |
| **Subject:** | Progress Update: Cancer Performance Improvement Actions |
| **Director Sponsor:** | Claire Hansen, Chief Operating Officer |
| **Author:** | Beth Eastwood, Head of Cancer |

**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** | **Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)* |
|---|---|
| ☒ Effective Clinical Pathways<br>☐ Trust Culture<br>☐ Partnerships<br>☐ Transformative Services<br>☐ Sustainability Green Plan<br>☐ Financial Balance<br>☐ Effective Governance | ☐ Yes<br>☐ No<br>☒ Not Applicable |

**Executive Summary:**

The Trust has demonstrated measurable improvement in cancer performance during 2025/26, with its highest ever Faster Diagnosis Standard (FDS) delivery achieved in February (76.3%) and March (77.3%), and a 20% improvement in 62-day performance across Q3–Q4, closing the year at 72.5%. The 31-day standard remains consistently delivered above 96%, providing a stable foundation for recovery.

Despite this progress, performance remained below national targets for FDS and 62-day standards at year end, reflecting sustained system pressures and variability across tumour pathways. A deterioration in April FDS (71%) highlights fragility in delivery, although the unvalidated position indicates improvement in May (76%, unvalidated).

The Trust continues to operate under NHSE Tier 1 oversight, providing access to national and Cancer Alliance support. A review at the end of Q1 will determine whether oversight arrangements change.

Key Risks to Delivery
Delivery risk is driven by a combination of structural and operational pressures:

- Sustained demand growth: 11% year-on-year increase in referrals, exceeding planned levels in most months
- Diagnostic capacity constraints: workforce gaps, equipment limitations and reliance on high-demand modalities (CT, MRI, endoscopy)
- Referral quality and pathway inefficiencies, particularly impacting colorectal and dermatology pathways
- Workforce fragility, including vacancies, sickness absence and reliance on outsourcing and locum cover
- Competing clinical priorities, requiring prioritisation of cancer and long-wait pathways within finite capacity

These factors continue to constrain consistent delivery of FDS and 62-day trajectories and create variation between tumour sites.

Governance and Assurance
Governance arrangements have been strengthened to support delivery and oversight, including:

- Monthly Cancer Delivery Board and bi-monthly Programme Board
- Twice-weekly Trust-wide cancer PTL meetings, alongside tumour site-level forums
- Oversight through PRIM, Diagnostics Board and Cancer Delivery Board
- A clear service standard delivery plan aligned to NHSE targets

These arrangements provide clear accountability, escalation routes and performance grip, with increased visibility of pathway risks and operational delivery.

Forward View and Assurance Position
The Trust has a comprehensive recovery plan in place for 2026/27, aligned to national standards:

- Deliver 80% FDS (average)
- Sustain ≥75% 62-day performance, improving to 80% by March 2027
- Maintain ≥96% 31-day performance

There is evidence of progress and strengthened delivery infrastructure; however, achievement of trajectories remains subject to risk, particularly in relation to diagnostic capacity, workforce and demand management.

Conclusion
The Trust is taking appropriate and comprehensive action to improve cancer performance, with demonstrable progress and strengthened governance. The Trust can provide reasonable but not yet high assurance that cancer performance will improve during 2026/27. Delivery of national standards remains at risk, particularly dependance on diagnostic capacity and sustained demand management.

**Recommendation:**
Council of Governors notes progress to date, proposed mitigations to risks to delivery and next steps.

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

| Meeting/Engagement | Date | Outcome/Recommendation |
|---|---|---|
| | | |

## Progress Update: Cancer Performance Improvement Actions

### 1. Introduction and Background

Cancer performance remains a key national priority and an important indicator of timely access to diagnosis and treatment.

During 2025/26:

- **FDS improved significantly (achieving its highest ever in March 2026 of 77.3%) but remained below the 80% national standard**
- **62-day performance improved to 72.5% (a 20% improvement from Q3 to Q4)**
- **31-day standard remained consistently above 96%**

The national targets for 26/27 are:

- Achieve 80% **FDS** (this is currently monitored as an average position throughout the year and is reflected in improvement trajectory)
- Maintain 75% **62 day** standard, rising to 80% by March 2027
- Maintain 96% **31 day** standard

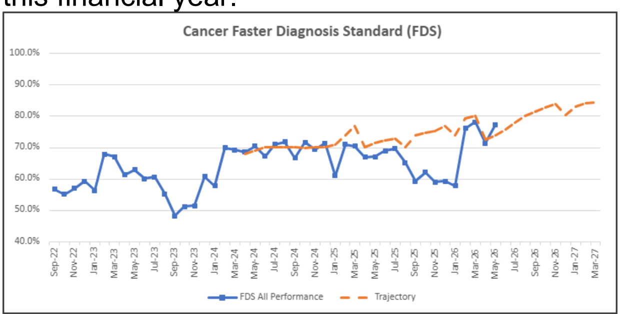
In 25/26 targeted NHSE and cancer alliance investment in Q4 (over £500,000) helped to support delivery of additional appointments and theatre lists. Just under £1 million has been identified via the Cancer Alliance for 26/27, along with a capital replacement and recruitment plan being in place and plans have been designed with this in mind.

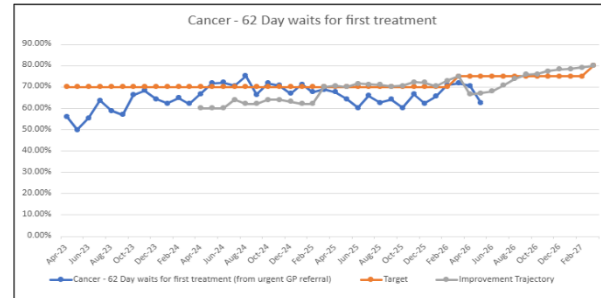
Capacity in particular however continues to be challenging due to a number of things including:

- There has been a sustained growth in demand, with referrals increasing by approximately 11% year-on-year, exceeding planned levels.
- Referral quality and pathway inefficiencies, particularly impacting colorectal and dermatology pathways
- Workforce (Pathology, Oncology, Radiology and endoscopy) shortages meaning outsourcing and locum expenditure
- Exacerbated with equipment limitations in CT and MRI
- Limited regional mutual aid availability
- National planning suggests a 5% increase year on year.
- The Trust's ability to manage cancer demand is constrained by national guidance with Cancer waiting times guidance states only the referrer can downgrade urgent suspected cancer referrals, which limits the demand management options.

Due to this context, while improvement is evident, performance is not yet at the level required to meet national standards consistently.

The Trust remains ambitious and committed to delivery of the below improvement trajectories in this financial year.




### 2. Performance Overview

The Trust was placed into Tier 1 monitoring status by NHSE for cancer, Elective and Diagnostics in December 2025. A national review will take place at the end of Q1 as to whether the Trust can move into Tier 2, with the potential for a different national performance approach to be implemented. The cancer improvement team have taken opportunities through Tiering to request cancer alliance and national support in pathway improvement for factors outside of Trust influence, such as GP referral qualities and tertiary pathway challenges.

### a) Tumour site specific performance context

Performance varies across tumour sites, and targeted improvement actions have been implemented to address specific challenges. Areas of good practice from both within and outside of the Trust are being shared across the tumour sites.

**Breast**: Consistently achieves strong performance, regularly exceeding the national standard, supported by early diagnosis and effective multidisciplinary oversight

**Non-site-specific pathways**: Benefit from streamlined “one-stop” models, again exceeding the national standard.

**Upper GI** and **Head & Neck** are often within a couple of percentages of internal trajectories, with Upper GI being close to national standard.

#### More challenged Tumour sites:

**Dermatology (Skin)**

- Skin pathway was high performing prior to August 2025. GPs used dermoscopy to send high quality images with referrals, and referrals could be triaged and returned to GPs if the image was not clinically suspicious.
- This has deteriorated due to GP collective action being undertaken which meant GPs stopped using the images. In December 25 a block temporary Tele-dermatology Local Enhanced Service (LES) payment to GP’s was introduced, which has resulted in approximately 65% of referrals being received again with an image, although some of varying quality.
- However, there has also been a significant increase in referrals (approx. 36%)

Actions:

- Introduction of an incentivised tele-dermatology enhanced service beyond the current LES expiry in November 25
- Ongoing work with system partners to improve referral quality

Performance is recovering but remains sensitive to primary care behaviour and commissioning arrangements.

**Colorectal**

- Performance impacted by pathway delays and referral quality issues

Actions:

- Strengthening adherence to referral criteria (including FIT requirement)
- Introduction of more rapid diagnostic staging processes
- Returning non-compliant referrals to improve pathway efficiency

These actions aim to reduce delays early in the diagnostic pathway.

**Gynaecology**

- Pathway redesign introduced in late 2025 increased referral volumes, which was anticipated
- Workforce challenges in some areas

Actions:

- Straight-to-ultrasound pathway for post-menopausal bleeding
- Focus on early clinical review and improving first appointment timeliness

Performance improvement is expected but remains dependent on workforce availability.

**Urology**

- Introduction of new pathways created short-term capacity pressure

Actions:

- Implementation of straight-to-test CT haematuria pathway
- Implementation of streamlined discharge post MRI reporting on prostate pathway
- Gradual transition from previous pathway model

Performance has improved as the new pathway has stabilised.

**Lung**

- Performance impacted by additional demand from screening activity
- Timeliness of PET CT provision (nationally commissioned service)

Actions:

- Continued pathway adaptation to accommodate increased demand
- Escalation to NHSE regional and national team via Tiering, resulting in temporary additional PET CT provision offer for Scarborough.

**Upper GI and Head & Neck**

- Performance generally close to internal trajectories

Actions:

- Ongoing pathway optimisation and diagnostic prioritisation

## b) Cross Cutting Actions to Improve Performance

**Improvements to referral quality**

In Q3 25/26 an agreement was made at Executive Committee to simultaneously strengthen adherence to NG12 referral criteria from primary care referrals by returning referrals which were not compliant with NG12, e.g. referrals which should be accompanied by a Faecal Immunochemical Test (FiT) under NICE criteria but were received without and did not detail extenuating patient factors. This is specifically targeted at Colorectal, which has for the first time returned referrals to GP practices. These returns are accompanied by a standard letter to the practice and patient which details the reasoning. This was launched in conjunction with the Cancer Alliance and ICB Primary Care Lead, and via the Trust primary to secondary care interface group. The expected impact of this change is in Q1 26/27, a reduction of referrals without a FiT and an improvement in quality of referrals with a FiT, supporting the streamlining of diagnostics on the suspected cancer pathway.

Further work is being undertaken around education with practices through the cancer alliance primary care incentive scheme in 2026/27 and the Cancer Alliance GP lead is undertaking sessions at specific practices to target referral behaviours. A recent example is communications sent out to encourage patients to have a full blood work up prior to Urology referrals, to allow patients to go straight to imaging. The expected impact in Q1-Q2 2026/27 is longer term behavioural changes in referral patterns, to improve the quality of fast-track cancer referrals and to signpost to other referral routes where appropriate.

Internal audits are also being considered to outline specific issues and practice behaviours, to allow more targeted work with primary care.

**External Investment**

The Trust has been successful in being awarded £956,000 service development funding (SDF) from the Cancer Alliance. This is to provide sustained pathway improvements and transformations but can be used to support operational recovery plans. Challenged tumour sites have been provided a specific allocation to support additional, above plan activity to support any unplanned shortfalls in all areas of the pathway, from 1st OPA to post MDT clinics to surgical lists.

**Scheduling of Patients**

In line with clinical priority, patients on cancer pathways or at risk of 65-week RTT breaches are being expedited for diagnostics, often ahead of more routine cases.

In addition, routine outpatient slots are being converted to fast track outpatient slots.

## 3. Governance & Oversight

The key indicator of success of these actions will be an improvement in the Trust's Faster Diagnosis Standard, and following subsequently, the Trust's 62-day position.

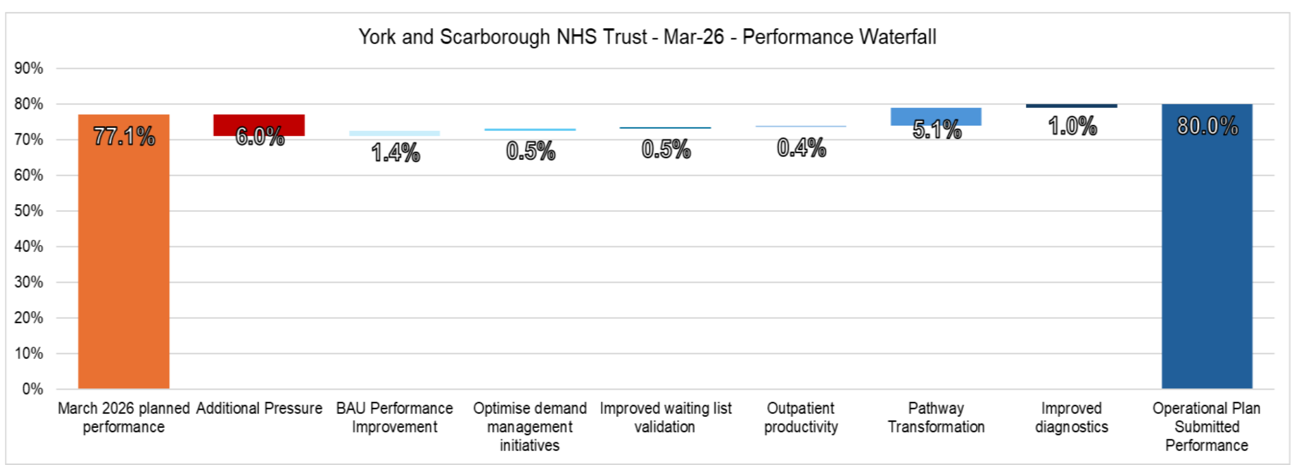
Tumour site and diagnostic operational teams remain responsible for delivering agreed improvement actions, with support of cancer improvement team.

Specialities and diagnostics performance arrangements remain unchanged, however is under review given the Trust's Cancer, Diagnostics and Elective Tiering status. Performance meetings will continue to take place and escalation through care group governance, with monthly oversight and assurance at Performance Recovery and Improvement (PRIM), Cancer Delivery Board & Diagnostics Board. An additional weekly trust wide PTL meeting has been trialled in Q1, learning from high performing trusts, meaning there are now two meetings a week.

An overarching service standard delivery plan has been developed which outlines the actions beng undertaken to improve the service standards and deliver the NHSE success measures.

In May 2026 Getting It Right First Time (GIRFT) have refreshed a number of best practice timed pathways, and the Trust is following implementation of initiatives such as discharge post-LIKERT, remote PSA monitoring, Straight to test (STT) optimisation (CT/haematuria, colon), MDT streamlining and navigator process; alongside optimising clinical nursing roles for diagnostics and fast track clinics with continued prioritisation of cancer.

Timed pathways, straight-to-test models, and robust PTL management reduce delays and improve treatment timelines. The expected impact of the actions on the delivery of the service standard is:




A clear governance structure underpins the delivery of this recovery plan, to provide assurance and accountability.

- Monthly Cancer Delivery Board and bi- Monthly Cancer Programme Board, chaired by Chief Operating Officer and Associate Medical Director for Cancer, which brings together operational colleagues and system partners.
- Two weekly Trust wide cancer PTL meeting takes place, chaired by Head of Cancer and attendance face to face mandatory from each specialty. A second weekly meeting was introduced in Q1 26/27.
- In addition weekly tumour site service led PTL meetings have also been instructed to take place.

## 4. Conclusion and Recommendation

In conclusion, the Trust has implemented a structured, targeted tumour site recovery plan for 26/27 that seeks to address the core challenges. The Trust has expanded capacity through internal

initiatives, engaged with system partners to manage demand, successfully sought external funding to support additional activity and created a more visible and accessible cancer PTL to serve multiple purposes for colleagues across the organisation. Governance mechanisms are in place to monitor progress and ensure accountability for results.

By March 2027, the ambition is to show significant improvement in current FDS and 62-day position, and maintenance of the high performing 31-day standard. Council of Governors are asked to note the contents of this report and take assurance that a robust plan is being executed at a speciality, cross speciality and corporate level to improve cancer performance at pace.

Item 7

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10 June 2026 |
| **Subject:** | Q4 Patient Experience Report 2025/26 |
| **Director Sponsor:** | Joseph Hague, Chief Nurse |
| **Author:** | Krishna De, Head of Patient Experience & Involvement |

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

Approve ☐ Discuss ☐ Assurance ☐ Information ☒ A 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** | **Equality Impact Assessment Concluded** *(please document in report)* |
|---|---|
| ☒ Effective Clinical Pathways<br>☒ Trust Culture<br>☒ Partnerships<br>☒ Transformative Services<br>☒ Sustainability Green Plan<br>☒ Financial Balance<br>☒ Effective Governance | ☐ Yes<br>☐ No<br>☒ Not Applicable |

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

# Quarter 4 (Q4) Patient Experience Report 2025/26

## 1. Introduction and Background

The Trust's vision is to 'deliver an excellent patient experience every time.' This Q4 report updates the committee of progress against key priorities and highlights emerging good practice and risks in relation to delivery of the patient experience agenda. Members are asked to note the progress within Q4 and support actions as required.

## 2. Progress Against Key Priorities

Significant progress has been achieved regarding the actions outlined in the action plan. However, it is important to acknowledge that certain actions were not implemented this quarter due to capacity constraints resulting from operational restructures within the corporate teams and care groups. Additionally, momentum was impacted during this period as staff uncertainty regarding job security led to reduced team capacity for advancing improvement initiatives.

| Quarter 4 Actions | Outcome |
|---|---|
| **Effective Communication** | |
| • Roll out posters and business cards across all wards with key contacts, including ward manager and matron details, to support early resolution of concerns. | Care Group Surgery have introduced ward welcome letters which has the ward contact information, ward routine and outlines the normal routine and expectations. This will be piloted across all Care Groups in Q1 of the next financial year. The roll out of posters and business cards have been paused as a result of Care Group restructuring. |
| • Empower you and involve you in decisions about your care and services -we will provide health coaching training to clinically facing staff across the Trust to enable staff to have "what matters to you" conversations | 338 staff have attended Health Coaching/Person Centred Care training between 1.4.25 and 31.3.2026 169 staff have completed the full Health Coaching 8-hour programme between 1.4.25 and 31.3.2026. |
| • Defining what good communication looks like and develop a communication (stimulation and eLearning) skills matrix and implementation plan for all staff within the Trust | Delayed will be picked up in Q1 |
| • Explore process for Trust Members interaction to be involved/ engaged in quality improvement work, to ensure we listen to concerns and | Process has been defined and will be implemented in Q1 of the next financial year |

| | |
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| suggestions and collaborate to make sustainable changes, and we will capture people interested in codesigning<br><br>• Provide complaints training to our staff to enable high quality communication and responses of concerns and complaints (60 places in total for the financial year - 20 of the places subsequently agreed to be delivered by the end of Q4)<br><br>• Support completion of the Ombudsman complaints training | 55 delegates attended the complaint writing training with provision made for 60 places (4 staff did not attend and 1 person cancelled) this financial year. The programme evaluated strongly.<br><br>There have been some updates from Care Group complaints Investigating Officers for this training but we do not have assurance that all relevant staff have completed the training. All staff managing complaints will be expected to complete this training by the end of quarter 1 and this will be reinforced in an IO meeting to be scheduled early in Q1 for the next FY. |
| **Unpaid Carers**<br>• Promote the Carer Champion role to Trust volunteers at Scarborough Hospital. Deliver Carer Champion training to Scarborough volunteers.<br><br>• Continue promotion of the Carer Charter and strengthen identification and support for carers.<br><br>• Involve carers in the codesign and development of new builds and services, seeking ongoing feedback as we make changes<br><br>• Embed Carer case studies with carer training and communications<br><br>• Implement a process that ensures carer involvement within discharge planning as required by the Care Act<br><br>• Explore the opportunity for Care Groups to provide unpaid carers, and those who rely on | Volunteer Carer Champion role, charter, leaflet and training was promoted at the last volunteer drop in in Scarborough with good engagement. Those who attend the training will be appointed. Training will be undertaken in the next financial year.<br><br>Education and visibility of the Carers Charter have continued through ward walk arounds in York and Scarborough on 2 occasions within Q4.<br><br>Three carers/carer representative organisations took part in Access Audits.<br><br>Carer representatives have been appointed to support the menu re-design task and finish workstream.<br><br>Carer case studies are embedded in the training that will be delivered through the year. They will also be used in ongoing communication e.g. for Cares Week and Carers Rights day.<br><br>Carers are supported by working in partnership with York Carers Centre and Social prescribers, to provide holistic support to unpaid carers on patient discharge.<br><br>This programme of work is deferred until the implementation of Nervecentre |

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| unpaid carers, with multiple same day appointments where possible and appropriate (outpatient transformation). | |
| • Explore the opportunity to include recording/flagging unpaid carers status on new EPR (and those reliant on others for care) | This will be explored as we look at digital flags as part of the development of Nervecentre in Q1 |
| • Use patient experience information to triangulate with other intelligence across wider quality agenda enabling themes and trends to be identified which indicate where a service may not be delivering to the expected standard or quality | Where system and service changes are planned for or service improvement is required, services are directed to patient experience information including FFT, national patient surveys, local intelligence, Healthwatch reports, health inequalities and concerns and complaints data |
| **Managing Concerns and Complaints** | |
| Improve visibility and access to the PALS service, including telephone and walk-in support, to enhance patient and carer experience. | With the appointment of an interim resource through a secondment to the PALS team we have been able to extend the hours the phone is covered and enabled in person/phone appointments for patients to meet with the PALS team |
| Continue to improve complaint response times. | We are continuing to progress towards the delivery of meeting complaint time frames within the 30 and 45 timelines, with the aim that this will be achieved by end of April. Overall care group performance in responding to complaints within agreed timescales in 2025/26 was 57%, an improvement from 49% in the previous year. For the month of March 65% complaints, 50% of complex complaints and 45% concerns were addressed within timescales. While there has been progress, the overall position reflects the ongoing challenges associated with increased complaint volumes and wider service pressures. |
| Use Care Opinion to seek patient feedback to share good practice and areas for improvement feedback with teams | Care Opinion feedback shared with relevant Care Groups |
| **Healing Environment**<br>• Complete the review of PLACE audit outcomes and identify priority actions. | PLACE actions have been assigned to relevant leads<br><br>Q4 referrals = 810 (Q3 = 813). For the first time in 6 years, we exceeded 300 referrals in January 2026. |

| | |
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| • We will support patients with their spiritual needs by increasing referrals to the chaplaincy service supported by education of clinical staff by Chaplaincy. | Referrals were impacted by technical issues on CPD because of the system change to Nervecentre (71% of referrals are made through CPD).<br><br>Total referrals: 2025/2026: 3162, an increase of 9.9%against the previous year |
| **Accessibility** | |
| • Complete the Accessible Information Standard (AIS) gap analysis and develop an action plan to address identified gaps. | Elements of the AIS standards are already reflected in the reasonable adjustment flags guidance. To bring this together, a single action plan has been developed to address both reasonable adjustments and AIS standards. This will help ensure full compliance with reasonable adjustment standards by September 2026. |
| • Introduction of open visiting for families and carers. | This has been postponed until Q1 due a delay in agreement of communications and the development of an accompanying Patient Visiting Charter. |
| • Ensure that patients facing crisis have access to clothing and care packs. | In Q4 we have completed an inventory of the clothing that has been donated by local organisations and established a process to distribute the clothing to wards supported by Trust volunteers initially at York hospital. |
| • Review of patient letters inviting to appointments to ensure that they are clear, accessible and include directions on how to attend the appointment. | Outpatient letters are in a clear and accessible format. There is a pilot of a new letter template for those on the waiting list. |
| • Develop accessible information for patients on the website e.g. how to access translation services, BSL videos, sensory environment video for York ED, highlight availability of Reachdeck. | We have developed an area on the Trust website called the 'Accessibility Hub' where information on the support available to patients and carers can be found. |
| • Implement spending areas aligned to assistance animals' policy – York. | Spending area is now available at York hospital and signage in place with funding provided by the hospital charity. This has also been promoted through patient communications on the website |
| • Embed 5S plus safety across the Trust - The physical environment will be clean, tidy and comfortable and care and treatment will be timely, | Between April 2025 – March 2026: 86 Staff completed 5S + Safety training. Examples of where 5S+ Safety has been used in the last year include: |

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| effective and respectful to patients' needs and expectations. | **Beech Ward – Acute ward store area – Scarborough Hospital**<br>5S techniques were used to tackle clutter and over stocking within ward stores. An indexed list of all stock was created and displayed at the entrance to the store so items can be quickly identified and located. Over stocked medication was returned appropriately and surplus furniture was re used elsewhere via Warp It.<br>Impact: Improved visibility of stock and faster access to equipment, helping to save time and improve efficiency. Safer, more organised storage areas with reduced clutter. Significant cost avoidance achieved, with estimated savings of around £70,000 through returning excess stock and re use of furniture.<br><br>**Ward 36 – 'Dandelion Room – York Hospital**<br>After attending 5S+ Safety training, ward staff used 5S+ Safety principles to review a room that was largely being used as a store and not serving a clear purpose. Items were sorted and cleared, and the intended use of the space was agreed. Following a successful charitable funding application, the room was fully renovated.<br>Impact: Creation of a calm, light and welcoming space for patients and visitors, with new furniture and wall murals. The room is now a positive, purposeful environment rather than a storage area.<br><br>**Renal and General Medicine Ward – York Hospital**<br>Following 5S training, ward teams applied 5S+ Safety principles to address clutter, over stocking and inefficient use of space. Unneeded items were removed, storage was reorganised, and a small clinical room was redesigned to make better use of the available space. Equipment was arranged to be easier to find and access.<br>Impact: A more organised and functional clinical environment, with improved storage and quicker access to equipment. Ongoing improvements continue as part of a sustained approach to maintaining a safer and more efficient ward environment.<br><br>**Location/5S area: York Improvement Office**<br>5S+ Safety techniques implemented to tackle clutter in office, improve safety of storage and create environment easier to clean and maintain.<br>Impact: Shows that we practice what we preach! Improvements have been safer and more appropriate storage, a tidier environment, improved efficiency in locating resources, a more pleasant workplace where it's easier for everyone to find what they need and we didn't need to spend a penny to do it. Ongoing |

| | |
|---|---|
| | sustained improvements for > 3 months after initial 5S+ Safety work was carried out.<br><br>**Location/5S area: PACU Theatre Team – digital filing systems**<br>A bespoke 5S+ Safety session was delivered, adapted to focus on digital 5S principles. The team applied 5S+ Safety concepts to the way electronic files are stored, labelled and version controlled. Regular monthly team discussions were introduced to agree file locations, archiving decisions and maintain a document log for new or updated files.<br>Impact: Improved structure and consistency of digital files, making information much easier to find and maintain. Tasks have been streamlined for the team and other users, with admin support helping to reduce duplication and inefficiency. The approach is ongoing and continues to support sustained improvements in how digital information is managed. |

## 3. Highlights to Note

### Interpretation and Translation contract update

Provider Transition

The initial timeline for awarding the contract was reported in Q3. Following legal challenge and acting on legal advice provided by solicitors retained by the participating Trusts, the procurement collaborative completed a re-evaluation of the tender submissions. The contract with the current provider was extended to 30 June 2026, with an option to extend by another 3 months to ensure service continuity.

A preferred supplier has been selected. The standstill letters have been reviewed by the solicitor's firm assisting with the procurement process, and will be distributed to bidders prior to 13 April 2026, marking the commencement of the standstill period. Further legal challenges are anticipated.

We have recommenced plans to deliver staff drop-in sessions and have informed staff of the impending change via internal communications, meetings and walk arounds, directing staff to the intranet page for up-to-date information on the transition. An SOP has been drafted, and template emails and communications are ready for use when we are in the position to announce and introduce the successful provider.

The timelines provided by North Yorkshire Procurement Collaborative are shown below. Please note that the contract start date has been postponed by one month to May 2026.

| Milestone | Date |
|---|---|
| Tender opportunity published | 16/12/2025 |
| Deadline for clarification questions | 23/12/2025 – 12pm |
| Deadline for submissions | 13/01/2026 – 12pm |
| Technical evaluation | 16/02/2026–22/02/2026 |
| Moderation | 24/02/2026–13/03/2026 |
| **Contract start** | **01/05/2026** |

Interpretation Audit

The 2026 audit of interpretation devices identified 11 working tablets and demonstrates some local improvements, including clearer identification of responsible staff, improved user confidence in departments such as Emergency Department, Audiology and Maternity, and greater awareness of the different interpretation routes such as telephone services. However, the fact that we have reduced the access from the original 34 tablets to 11 currently in use does have an impact of ease of access to an interpreting device and needs to be reviewed and addressed.

WiFi connectivity continues to limit use in some clinical areas, and an additional 9 devices were identified but inactive, indicating ongoing weaknesses in device monitoring, escalation and maintenance processes. The audits indicate that the current provision does not provide consistent, reliable or equitable access to digital interpretation across sites, presenting potential risks to patient experience and compliance with the Equality Act.

We have been advised by the Trust's digital team, that the tablets currently used for interpretation have been in use for several years and are out of date and they recommend that they are decommissioned by the end of April 2026. The lifetime of new tablets will be for a minimum of 4 years. An options paper was developed for discussion at the Chief Nurse meeting in terms of how to provide adequate access to translation tablets moving forward. We are exploring the use of current Trust devices on wards and departments including tablets to be used for the service and will identify where additional devices are required with the plan to approach the hospital Charity for funding.

## Equality Diversity and Inclusion

Equality Delivery System

In Q4 the Equality Delivery System 2 (EDS2) was undertaken for:

- York Emergency Department – Found to be developing/achieving across the 4 elements
- Musculoskeletal Outpatients and community days (MSK) – found to be achieving across the 4 elements
- Scarborough Paediatric Speech and Language Therapy, Community (SLT) – found to be developing/achieving/excelling across the 4 elements.

An action plan was developed and with actions incorporated within Care Group Improvement plan reporting.

Widgit Online Communication Tool

We have invested in the purchase of a communication tool that will benefit both staff and patients "Widgit Online", which will provide staff with access to reusable resources and templates, ensuring a consistent communication approach across the Trust. It will support nonclinical interactions, help patients express preferences and needs, and aid understanding of tasks and treatment plans. "Widgit Online" symbols are clear images paired with simple text, which can be translated into over 80 languages supporting communication in the Trust.

An initial pilot began in York in December 2025. Key areas were identified based on concerns and complaint data and areas of high need: Audiology, the complex needs team, Admiral Nurses and Emergency Department staff. The initial meeting focused on presenting the tool and assisting teams with registration, while the follow-up meeting was dedicated to evaluating its usage. Due to limited engagement resulting from system pressures within this period, the pilot re commenced in Q4 focusing on initial delivery within the Complex Care Team.

## Friends and Family Test

During Q4, the Trust continued the roll-out and embedding of its digital Friends and Family Test (FFT) system using the Trust SMS platform provided by the FFT provider across Emergency Departments, inpatient pathways, and outpatient services.

Q4 results demonstrate that Trust SMS-enabled FFT collection consistently achieved higher response rates than the national NHS FFT return, confirming that digital engagement is now the primary mechanism through which FFT feedback is captured and submitted nationally.

## Complaints and Concerns

This remains an area of concern and requires prioritised, focused improvement to support delivery of the Trust's strategic objective of providing excellent patient experience every time.

### 1. New concerns and complaints received in Q4

A total of 940 concerns were received. Of these, 226 were registered on Datix for care groups to resolve. The remaining 714 were managed directly by the Patient Advice and Liaison Service (PALS).

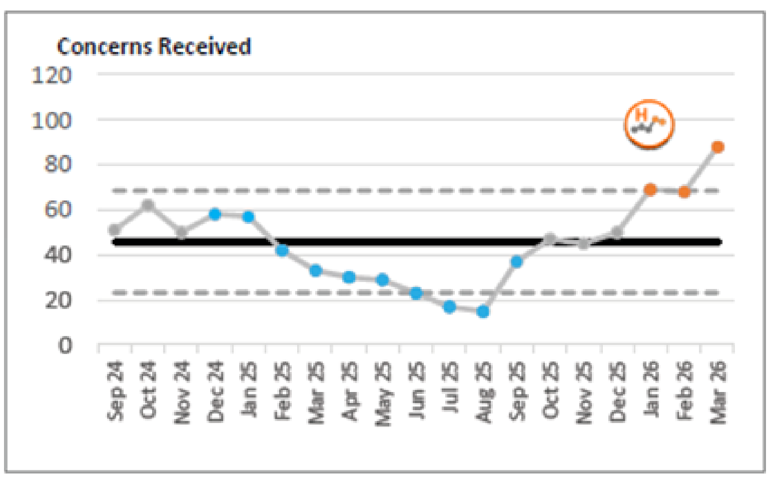
319 complaints were received, an increase of 7% vs Q3.

101 complex complaints were received compared to 85 in Q4, an increase of 19% vs Q3.

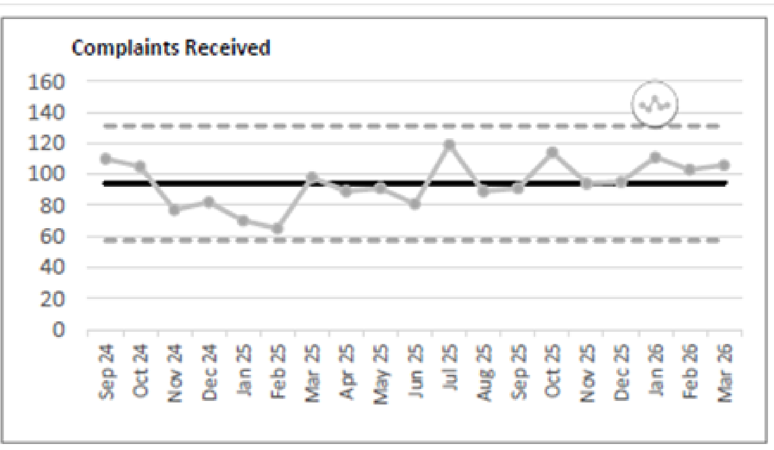
| New cases Q4 | Concerns | Complaints | Complex Complaints | Total |
|---|---|---|---|---|
| York Hospital (including Community) | 174 | 237 | 72 | **483** |
| Scarborough Hospital | 47 | 75 | 29 | **151** |
| Bridlington Hospital | 5 | 7 | 0 | **12** |
| **Total** | **226** | **319** | **101** | **646** |

| New cases by Care Group in Q4 | Concerns | Complaints | Complex Complaints | Total |
|---|---|---|---|---|
| Cancer, Specialist and Clinical Support Services (CSCS) | 50 | 53 | 8 | **111** |
| Corporate Services | 10 | 13 | 3 | **26** |
| Family Health | 23 | 46 | 6 | **75** |
| Medicine | 65 | 111 | 65 | **241** |
| Surgery | 78 | 96 | 19 | **193** |
| **Total** | **226** | **319** | **101** | **646** |

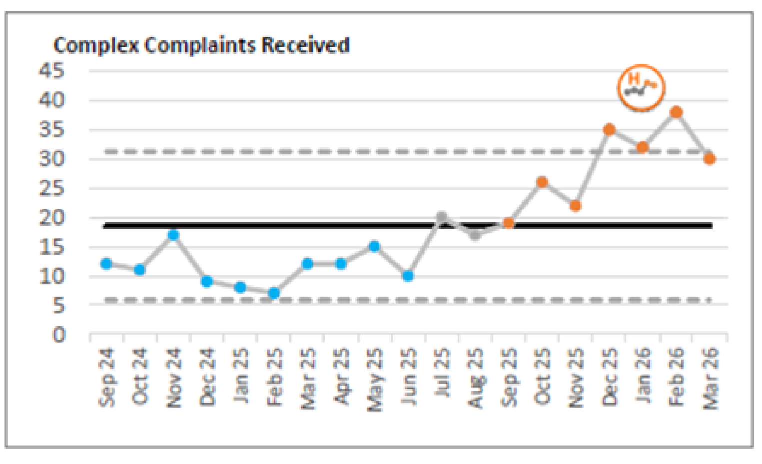
**Concerns Received** (226 logged on Datix)




## Complaints Received




## Complex Complaints Received




## 2. Main themes

This quarter the majority of people contacting us were concerned about:

| Complaints | Concerns | Complex Complaints |
|---|---|---|
| Delay or failure in treatment or procedure | Communication with patient | Delay or failure in treatment or procedure |
| Attitude of medical staff | Delay or failure in treatment or procedure | Discharge - unsafe discharge |
| Communication with patient | Referral issues | Delay or failure to diagnose |
| Delay or failure to diagnose | Attitude of medical staff | Inappropriate care setting |
| Referral issues | Appointment cancellations | Communication with relatives/carers |

**Communication remained the most significant and recurring issue:** across all Care Groups, patients and families reported poor, delayed or inconsistent communication. This included not being kept informed, receiving conflicting messages between teams, difficulty contacting services, and insensitive or unclear explanations at critical points such as diagnosis, deterioration, discharge and end of life. Communication failures were often described as compounding distress and undermining trust, even where clinical care was otherwise appropriate.

**Delays across the patient pathway:** delays in diagnosis, investigations, treatment, follow-up and access to services were frequently cited. These delays occurred at multiple stages, including waiting list management, appointment cancellations, missed follow-up, and slow escalation of concerns. Patients described these delays as avoidable and poorly explained.

**Staff attitude and compassion significantly influenced patient experience:** A high proportion of complaints focused on perceived dismissive, abrupt or unempathetic behaviour. Patients and relatives described feeling unheard, minimised or judged when raising concerns or advocating for themselves. This was particularly evident in areas such as maternity, paediatrics and emergency care.

**Basic care and dignity failures:** issues relating to hydration, nutrition, toileting, pain relief, pressure care, cleanliness and call bell response featured across inpatient settings. These were often experienced as fundamental failures of care.

**System and process weaknesses:** administrative and process failures were an issue across care groups, including poor record-keeping, appointment handling errors, unclear ownership of actions and fragmented care between services. These issues frequently resulted in patients and families having to chase information or act as coordinators of their own care.

## Care Group Themes

**Medicine:** Feedback commonly relates to delayed investigations and treatment, inconsistent medication administration, poor pain management, and weak discharge planning. Families reported having to escalate concerns repeatedly to secure basic care or updates, particularly for complex or frail patients.

**Surgery:** Key issues included short-notice cancellations of procedures, long waits for surgery, inadequate post-operative care and unclear aftercare arrangements. Patients described distress caused by poor communication and lack of empathy during cancellations or complications.

**Family Health:** themes included delayed diagnosis, dismissal of parental concerns, poor follow-up and lack of continuity. Maternity and paediatric complaints describe emotional harm caused by not being listened to, with some cases escalating to emergency intervention after deterioration.

**Cancer, Specialist and Clinical Support Services:** complaints highlighted delays in diagnosis and treatment, poor coordination between services, inaccurate or delayed communication of results, and consent-related concerns. Patients consistently described anxiety and uncertainty caused by fragmented pathways and unclear ownership of care.

**Corporate Services:** issues related to record accuracy, administrative errors, communication failures and access concerns. These complaints often centred on loss of trust.

Across all Care Groups, complaints point to systemic issues rather than isolated incidents. Patients consistently described feeling unheard, delayed and unsupported at times when they are most vulnerable. Improving communication, strengthening pathway ownership, ensuring reliable basic care, and addressing administrative robustness are central to improving patient experience.

## Reopened Complaints

The Trust is committed to being open and honest where care has fallen short and to applying the principles of duty of candour consistently when responding to complaints. All final responses are subject to a robust review process to ensure they are compassionate, reflect that the complainant's concerns have been fully heard, and provide a clear explanation and outcome wherever possible.

This quarter, 4% (18 cases) of closed complaints were reopened at the request of the complainant and further investigations undertaken.

The main reasons given by complainants for returning following the response they received were:

- Unhappy that investigating officer investigated their own department
- Factual errors/inaccurate information and omissions
- Trust did not fully address concerns
- Unsatisfactory explanation.

It is important that investigating officers agree on terms of reference with complainants at the outset and manage expectations. Every effort should be made to fully and robustly answer all the concerns raised before a response is sent. We will continue to monitor the number of returning complaints and ensure these are reviewed to allow learning to occur in respect of the complaint handling and refresher training will be rolled out this year for investigating officers.

## Parliamentary and Health Service Ombudsman (PHSO)

As part of the complaints process, individuals are informed of their right to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) should they remain dissatisfied with the Trust's handling of their concerns.

During Q4, one new full investigation was initiated related to rehabilitation services at White Cross Court.

Two cases registered in 2025/26 were concluded this year, each being partially upheld.

**Case 463:** this case concerned care in the Emergency Department at Scarborough Hospital. The PHSO concluded that the Trust's investigation appropriately identified the issues and that learning had already been taken. Since the patient's admission, environmental improvements have been made, access to take-home medication has improved, and learning was shared with the clinician involved, reinforcing the need for examinations to take place in an appropriate clinical setting. A payment of £1,200 was made in recognition of the distress caused.

**Case 23976:** related to care provided by the Surgery Team at York Hospital, involving a delay in bringing forward a follow-up appointment after the patient developed complications. The Trust acknowledged that the delay caused avoidable distress and anxiety for the patient and her family. In line with the Ombudsman's recommendations, the case was reviewed at the Surgery Quality and Safety Meeting, recognising that delays can arise from wider service capacity pressures rather than individual clinical decision-making. These issues were escalated to the relevant management teams responsible for consultant job planning and outpatient clinic capacity. A payment of £250 was made in recognition of the distress experienced.

## 3. Care Group Performance

Overall care group performance in responding to complaints within agreed timescales in 2025/26 was 57%, representing an improvement from 49% in the previous year.

For the month of March 2026 65% complaints, 50% of complex complaints and 45% concerns were addressed within timescales. While progress has been made, the overall position reflects the ongoing challenges associated with increased complaint volumes and wider service pressures.

Work is ongoing to achieve consistent compliance with the 10, 30 and 45 working day response timescales, with the expectation that this position will be reached by the end of April 2026. As previously reported, Care Groups are taking action to improve performance through strengthened governance arrangements, clearer accountability for investigations, and enhanced oversight of response quality and timeliness.

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

Demonstrating learning from complaints and using this learning to improve services is essential because it shows that patient feedback is taken seriously and leads to meaningful change. Complaints provide direct insight into where services may not meet patient

expectations or required standards. Using this information helps the Trust identify gaps, reduce the risk of repeat issues, and improve the quality and safety of care.

**Care Group Examples of Learning and Responding to Complaints**

**Family Health:**

- Patients are provided with clearer explanations of the outcome and next steps, including signposting back to primary care where appropriate.

- Work underway to improve communication consistency with review of patient-facing letters and responses is ongoing to improve clarity and consistency of messaging.

## 5. Conclusion and request for the committee

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

## 6. Our Data

The findings in this report are derived from data provided by the Quality and Safety Datix Team.

### National Patient Surveys

During Q4, no new national patient survey fieldwork or results were due for publication under the national survey timetable. Activity in the quarter therefore focused on assurance, triangulation, preparation and continued governance and preparatory work for upcoming national surveys which would include Maternity 2026 and Urgent and Emergency Care surveys.

### Health Inequalities

A 0–3 year programme of work has been developed to address the Health Inequalities Self-Assessment Framework recommendations, delivered through four workstreams: Health Inequality Enablers, Health Promotion, Accessible Information, and Continuous Improvement. Governance and reporting arrangements have been established, with key activities progressed in Q4 as below:

| Quarter 4 Actions | Outcome |
|---|---|
| **Health Inequality Enablers**<br><br>• Ethnicity recording has been promoted across patient facing areas through new self-selection sheets, with early improvements seen; this work will continue into Q4 and 2026/27. | This work has expanded into community clinical areas in Q4<br>Regular walkarounds to promote recording in Q4 and into 26/27<br><br>Care Groups in the final process of agreeing projects ready for 2026/27 |

| | |
|---|---|
| • Care Groups to identify projects to support in 2026-27<br><br>• ICB Community of Practice for Health Inequalities - development of a standardised training package<br><br>• Defining data to support health inequalities<br><br>• Collaboration with 'Integrated neighbourhood teams' – sharing data on high intensity users (HIU) of Emergency Department | Final training package agreed and for review internally to start to develop education requirements in 2026/27<br><br>Reviewing the core measures from the NHSe statement on information for health inequalities. Core measures will be displayed in contextual dashboards once completed<br><br>Data sharing continues with GP practices to identify HIU of ED |
| **Accessible information**<br><br>• Reasonable adjustment flags (incorporating AI) compliance by Sept 26 | A reasonable adjustments flags working grp has been established and is working through the RA (incorporating AI) requirements to ensure compliance in all our EPR systems by Sept 26. An action plan has been developed |
| **Health Promotion**<br><br>• Alcohol Dependency<br><br>• Smoking Dependency | The ASN is providing clinical support on identified pilot wards (Ward 36, AMU and some ED intervention) and undertaking patient assessments using an evidence-based alcohol screening tool to optimise clinical management.<br><br>An 'identification and brief advice' tool has been created and approved for use at York.<br><br>Ongoing communication around smoke free environment.<br><br>Access to nicotine replacement therapy has been made easier for inpatients, reducing the need to leave the ward areas |
| **Continuous Improvement**<br><br>• Care Group health inequalities projects | We are working with our Care Groups to finalise the health inequalities projects for 2026/27:<br><br>Care Group Medicine<br>• High Intensity User improvement |

| | • Inclusion Health in ED<br><br>Care Group Surgery<br>• Waiting well service for patients on the waiting list<br>• Addressing health inequalities in MSK service<br><br>Care Group CSCS<br>• Ophthalmology Missingness (DNA's)<br>• Dermatology – distance to appointments<br><br>Care Group Family Health (Lucy Flatley)<br>• Smoking in pregnancy<br>• TBC |
|---|---|

## 4. Key risks/mitigations

**Risk 1: Complaints Handling Capacity and Compliance**

Persistent delays and backlog in complaints handling undermine confidence in the Trust's ability to listen and respond, creating reputational damage if patients and carers feel ignored or unsupported. Failure to meet the 30-day and 45-day closure targets (against national standards and Trust objectives) increases the risk of non-compliance with NHS complaints handling regulations and Care Quality Commission (CQC) expectations.

**Mitigations:**

- Targeted backlog reduction plan to clear outstanding concerns.
- We have strengthened PALS team capacity with a short-term secondment which has enabled us to extended telephone hours and reinstate in-person appointments.
- Embedding a zero-tolerance approach to complaints timescales, including Investigating Officer (IO) early contact within three working days.
- Use of AI tools to support complaint workflows and improve efficiency.
- Enhanced DATIX dashboards to enable real-time monitoring, allocation, and management of complaints by Care Groups.
- Additional complaints-writing training for Investigating Officers, completed in March 2026.
- IO meting to take place in Q1 to reinforce and remind IO's of their res - possibilities.

**Risk 2: Delays to interpreting Services Procurement**

A legal challenge to the tender for the new interpreting contract has delayed transition from Autumn 2025 to Summer 2026. The current provider's contract was originally due to end in December 2025, creating a risk to service continuity. The announcement of the new provider is due to take place in April 2026.

- Contract extension agreed with the current provider, with further extension options if required, ensuring continuity of translation and interpreting services.
- All assessors were trained on the evaluation process by Hempsons Solicitors, with re-evaluation overseen by the procurement lead. This was completed in March 2026.
- Communications, IT, and Information Governance teams on standby to implement changes once a new provider is confirmed.
- Transition plan in place, with Care Groups aware of potential timescales and impacts.

**Risk 3: There is a risk to patient experience and safety because we are unable to comply with parts of the NHS England (NHSE) Accessible Information Standard (AIS).**

There is a risk to patient experience and safety due to partial non-compliance with the NHS England Accessible Information Standard, which requires organisations to identify, record, flag, share, meet, and review individuals' information and communication needs, and to make reasonable adjustments under the Equality Act 2010.

**Mitigations:**

- Completion of an AIS baseline staff survey, with feedback currently being analysed and mapped against the revised AIS framework.
- Development of a Trust-wide AIS improvement plan.
- Delivery and assurance managed through the Health Inequalities Steering Group, with progress reported to the Patient Experience Steering Group.

## 5. Next steps

Our programme of work over the next year will align to the Trusts patient experience framework and focus on four key areas that will enhance responsiveness, strengthen accountability across care groups, and embed a culture of early intervention and learning:

1. **Education**, to equip staff with the confidence and capability and personal accountability to communicate effectively.
2. **Culture and communication**, promoting a Trust wide shift towards addressing concerns in the moment to prevent escalation and improve patient experience.
3. **Triangulation and prevention**, using themes and insights to drive patient centred improvements, reduce avoidable harm, and address health inequalities.
4. **Timely resolution**, ensuring that any concerns or complaints that cannot be resolved immediately are managed within policy timescales.
5. **Co production and stakeholder engagement**, hearing and embedding the voice of the patients and carers.
6. **Improving overall patient experience** – enabling holistic care.

**Date:** 31 March 2026

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 10

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10 June 2026 |
| **Subject:** | 2025 Staff Survey Results and Colleague Experience Improvement Plan |
| **Director Sponsor:** | Lydia Larcum, Interim Director of Workforce & Organisational Development<br>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** | **Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)* |
|---|---|
| ☐ Effective Clinical Pathways<br>☒ Trust Culture<br>☐ Partnerships<br>☐ Transformative Services<br>☐ Sustainability Green Plan<br>☐ Financial Balance<br>☐ Effective Governance | ☒ Yes<br>☐ No<br>☐ 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. These have already been reported to Resources Committee and the Board during May.

**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:**

**Report Exempt from Public Disclosure**

No ☒ Yes ☐

| **Report History**<br>(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 2025 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 | Minor updates to the plan prior to going to Board. |
| This report went to Board. | 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

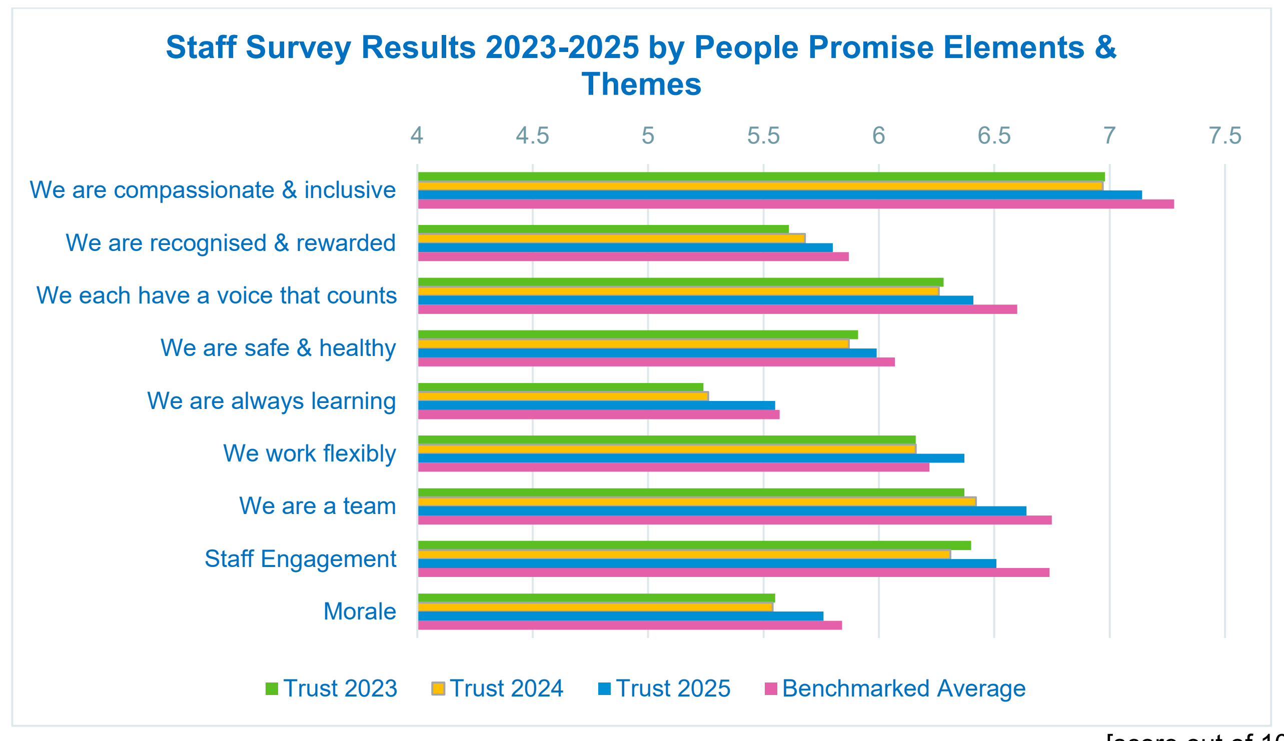
The nationally benchmarked results, free text comments, the analysis requirements of the NHS England medium-term planning framework, and the Colleague Experience Improvement plan have all been shared with Resources Committee and the Board.

## 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.

**Date:** 28 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<br>• Check the values are still relevant given many colleagues were not with the Trust when last reviewed.<br>• Review and refresh behaviour framework.<br>• 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.<br>• 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<br><br>As per national timescales once announced</td><td></td></tr>
<tr><td>• Appraisal for senior leaders to include 360 feedback<br>• 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>

| | | | | | |
|---|---|---|---|---|---|
| | 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. | Chief Executive (Head of OD) | June 26 - ongoing | | **Recommend place to work**<br>2025 score: 48.7% / Target: 66% |
| | 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. | Director of Communications, Director of Workforce & OD. CG Quads, Directors and Deputy Directors | August 26 | | |
| | • Establish new starter forum to support retention of new colleagues.<br>• Make greater use of leaver data to increase retention | Director of Workforce & OD and Chief Executive<br>Director of Workforce & OD | July 26<br>July 26 | | Ongoing monthly assessment of Turnover data.<br>**My immediate manager encourages me at work**<br>2025 score: 71.1% / Target: 75%<br>**I often think about leaving this organisation**<br>2025 score: 31.2% / Target: 26% |
| Patient safety, care and dignity | Trust-wide decision that corridor care is not acceptable. Removal of corridor care (separate plan being developed). Supporting workstreams: | Chief Nurse and Medical Director | September 26 | | **Happy with the standard of care if need treatment**<br>2025 score: 46.7% / Target: 64% |

| | | | | | |
|---|---|---|---|---|---|
| | • Trust wide engagement – recognition this is an issue we all need to solve together – living our values<br>• LOS reduction work to ensure bed base is appropriate for demand (bed base review as needed)<br>• Site model and operational meetings refreshed to maximise oversight and flow – review of escalation processes<br>• DOS review to support better pathways into alternative/more suitable care pathways (Selfcare/Community/Primary Care/SDEC etc)<br>• Partner engagement work to support discharge pathway including ICB and Local Authorities/Social Care<br>• Criteria led discharge work | | | | |
| Ability to influence decision making and drive improvements that are meaningful and sustainable. | • Implement a continuous quality improvement system<br>• Develop a clinical strategy<br>• Strengthen clinical leadership | Chief Executive and Director of Quality, Improvement & Patient Safety | August 26 | | **Autonomy & Control**<br>2025 score: 6.83<br>Target: 7.0 |
| Ensure our workforce have access to the fundamentals | • Improve access to:<br>○ Rest<br>○ Facilities and environments that are fit for purpose<br>○ 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) |

<table>
<tr>
<td>to support them at work.</td>
<td>
<ul>
<li style="list-style:none">
<ul>
<li>Communications as a core element of our infrastructure.</li>
</ul>
</li>
<li>Improve IT access:
<ul>
<li>Working equipment (log-ins, devices, smartcards, peripherals)</li>
<li>Systems that perform and are usable</li>
<li>IT support that is timely, human and proportionate</li>
</ul>
</li>
<li>Improve access to advice and support for career development</li>
</ul>
</td>
<td>Director of YTHFM,<br>Director of Workforce & OD,<br>Director of Communications</td>
<td></td>
<td></td>
<td>
<table>
<tr><td>2025 score</td><td>Target</td></tr>
<tr><td>27.8%</td><td>34%</td></tr>
</table>
<table>
<tr><td colspan="2">I have adequate materials, supplies and equipment to do my work</td></tr>
<tr><td>2025 score</td><td>Target</td></tr>
<tr><td>51.6%</td><td>57%</td></tr>
</table>
<table>
<tr><td colspan="2">I can eat nutritious and affordable food while I am working</td></tr>
<tr><td>2025 score</td><td>Target</td></tr>
<tr><td>55.0%</td><td>60%</td></tr>
</table>
<table>
<tr><td colspan="2">I always know what my work responsibilities are (i.e. communication is effective)</td></tr>
<tr><td>2025 score</td><td>Target</td></tr>
<tr><td>84.9%</td><td>89%</td></tr>
</table>
<table>
<tr><td colspan="2">I feel supported to develop my potential</td></tr>
<tr><td>2025 score</td><td>Target</td></tr>
<tr><td>54.0%</td><td>59%</td></tr>
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</td>
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NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10 June 2026 |
| **Subject:** | NED Assurance Questions from Governors |
| **Director Sponsor:** | Martin Barkley, Chair |
| **Author:** | Tracy Astley, Governor & Membership Manager |

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

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

**Trust Objectives**

☒ 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

**Equality Impact Assessment Concluded**
*(please document in report)*

☐ Yes

☐ No

☒ Not Applicable

**Recommendation:**
This paper provides the questions collated from the Governors for the NEDs to answer at the meeting. The Council of Governors is asked to note the report and the authors will respond to any questions or comments, as appropriate.

# NED Assurance Questions from Governors

- **Questions from Public Governors**

| CLINICAL STRATEGY |
|---|
| **Q1:** Are the NEDs assured that there will be sufficient public participation in the formulation of the Trusts Clinical Strategy? Can you explain to the Governors how you came/ how you will come to this assessment. |
| **PATIENT CARE** |
| **Q2:** Are the NEDS assured that in services where there are long waits for a first appointment ( 48 weeks for an Ophthalmology Appointment provides an example ) there is equity of access to the service across the different hospital sites of the Trust? What data could they provide to demonstrate this assurance to the Governors. |

- **Questions from Staff Governors**

| WORKFORCE |
|---|
| **Q3:** Are the NEDs assured that we have a grip on the Appearance and Workwear Policy when so many members of staff arrive and leave the hospital in scrubs? |

- **Questions from Stakeholder Governors**

| PATIENT CARE |
|---|
| **Q4:** As Governors of the Trust, it is of course incumbent on us to always act in the best interest of the Trust, however, the potential removal of the BCU (Bridlington Care Unit) strikes at the heart of the people of Bridlington, Driffield and the environs. The majority of the 'patients' in the unit have been from this locality and many have been readmitted back to Scarborough Hospital following a period in the BCU. So, please can the following questions be asked:-<br><br>1. It is understood that funding for the BCU was split between the ICB and YST on a ratio of approximately 70 - 30. Which organisation forced the issue by withdrawing their funding first?<br>2. it has been publicly announced that the funding for the BCU has been diverted elsewhere however, there has been no further information provided around the destination of the funds. Please can the destination of the diverted funding be disclosed.<br>3. It has been rumoured that additional beds have been provided since the soft closure of the BCU in Scarborough to provide capacity for those patients who would ordinarily have been moved to the BCU. Please provide an update on the bed situation in Scarborough where potential overcrowding has been implemented into certain wards.<br>4. How was the decision made to commence the closure of the BCU without proper 'public engagement' (especially within the guidance in B1762 Working in Partnership with People and Communities). Has it been established that the |

| |
|---|
| Care in the Community is robust and mature enough to cope with the closure of the BCU?<br>5. Please can the Directors update the Governors on the progress of meeting the Recommendations from the HOSC at East Riding of Yorkshire Council from May 11? |
| **Q5:** Please can the Trust update Governors on the progress of the Palliative Care Pilot at Bridlington Hospital. |

Item 12

| Report to: | Council of Governors |
| --- | --- |
| Date of Meeting: | 10 June 2026 |
| Subject: | Reports from Board Sub-Committees |
| Director Sponsor: | Martin Barkley, Chair |
| Author: | Tracy Astley, Governor & Membership Manager |

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

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

**Trust Objectives**

☒ 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** | **Equality Impact Assessment Concluded** *(please document in report)* |
| --- | --- |
| ☒ Effective Clinical Pathways<br>☒ Trust Culture<br>☒ Partnerships<br>☒ Transformative Services<br>☒ Sustainability Green Plan<br>☒ Financial Balance<br>☒ Effective Governance | ☐ Yes<br>☐ No<br>☒ Not Applicable |

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

**Reports from Board Sub-Committees**

# Quality Committee Reports

| | |
|---|---|
| **Date of meeting:** | April 2026 |
| **Chair:** | Lorraine Boyd |

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

| ALERT |
|---|
| Sustained emergency care pressure, including the continued use of corridor and temporary escalation spaces, presents an ongoing risk to patient dignity, experience and the reliability of quality controls.<br><br>Complaints handling capacity and timeliness remain inconsistent, creating a gap in assurance relating to responsiveness, learning and patient trust. |
| **ASSURE** |
| **The Quality Overview within Emergency Departments Report** provided strong assurance that patient safety and quality of care within Emergency Departments at York and Scarborough are being actively managed despite sustained operational pressure. Core safety standards are maintained; harm prevention standards are effective and patients with long waits are identified and monitored. Targeted audit identified no evidence of harm attributable to delay. It was noted however that the reliability of quality and safety assurance mechanisms deteriorates under extreme pressure, reducing the strength of assurance.<br>**Maternity and Neonatal services** remain broadly in line with national benchmarks, including stillborn and neonatal mortality rates. Strong multidisciplinary governance, training compliance and case review processes are in place. It was noted, however, that workforce pressures, particularly midwifery vacancies, continue to constrain resilience and the pace of improvement delivery.<br>**Nursing and AHP Quality Assurance Framework** continues to evolve to provide data driven triangulated assurance across the Trust. Governance arrangements are robust and there is evidence of improvements. However, assurance is weakened by persistent fundamental care issues and inconsistent data capture.<br>**Q3 and Q4 Patient Experience** reports demonstrated reasonable assurance that controls, actions and improvements are in place and are progressing. Significant improvement in Friends and Family Test engagement, now well above national benchmarks, indicate an embedded process providing reliable, real-time feedback. Triangulation with other data sources give good assurance that the Trust has strong mechanisms to hear the patient voice and identify themes and trends. However, complaints handling remains a significant cause for concern with poor and inconsistent performance evidenced, resulting in a gap in assurances that handling capacity and timeliness is under sustained control.<br><br>**Clinical Effectiveness Report** provided assurance that the Trust remains compliant with mandated national clinical audit requirements and has effective governance in place to manage participation, data quality and outlier reports. Identified outlier reports are understood, actively managed and appropriately overseen. Processes for sharing national audit findings and NICE guidance are established. While some actions remain under external review, no immediate gaps in assurance were identified. |
| **ADVISE** |
| **Medicine Care Group** provided assurance on current and emerging risks, mitigating actions and progress. Improvements as a result of flow initiatives, speciality recovery actions and governance oversight were noted. Ongoing risks relating to emergency demand, RTT fragility and rehabilitation capacity were acknowledged.<br>The **Corridor Care briefing** reaffirmed the Trust position, recognising that corridor care is unacceptable and must not be normalised. It should only occur in exceptional circumstances for the shortest possible time following a robust risk assessment process. SOPs and governance processes have been |

| strengthened, and work continues to align with national expectations, but assurance gaps remain, which are being addressed. A more comprehensive report will be provided for discussion and assurance next month.<br>**Learning from Deaths** confirmed the rationale for adoption of SHMI, replacing routine use of HSMR, in line with national best practice.<br>**Pressure Ulcer Performance Data** (a True North Metric) was discussed and noted to remain above trajectories. A focused update report was requested. |
|---|
| **RISKS DISCUSSED AND NEW RISKS IDENTIFIED** |
| PR1 – Quality and Safety in Emergency Care is exposed to increased clinical risk at times of extreme pressure, with narrow safety margins and reduced reliability of assurance mechanisms<br>PR1 – Complaints handling capacity and compliance is challenged and risks compromising patient safety and trust, as well as potential regulatory and reputational risk.<br>PR1 - communication failures remain a top theme of complaints, risking patient harm and poor experience<br>PR3 – system level risks compromising patient flow continue to impact on ED and throughout the hospitals, resulting in increased clinical risk and fragile quality and safety assurance.<br>PR4 –'Services, pathways and support functions are not designed and improved in a sufficiently transformative way across the Trust for the benefit of patients' was subject to a focused review and no obvious gaps in control and assurance were identified.<br>PR4 - multiple quality improvements (eg deteriorating patient, consistent documentation, MCA visibility) are reliant on Nervecentre delivery, representing a potential emerging risk.<br>CRR 866 relating to hospital acquired bacteraemias has been added to the CRR and will continue to be monitored through the quarterly IPC report to the Committee.<br>CRR 728 'deteriorating patient and Paediatric ED' risk was discussed and improvements to staffing model and triage processes with regular reporting through Patient Safety and Clinical Effectiveness Group has reduced this risk which will be reviewed in the Risk Committee |
| **ASSURANCE GAINED** |
| The Committee is assured that patient safety remains a priority, risks are appropriately escalated and governance arrangements remain effective, albeit increasingly constrained by system pressure.<br><br>**Overall Position**<br>Services reviewed remain safe, but assurance is increasingly constrained by cumulative operational, workforce, estate and digital pressures. |

| **Date of meeting:** | March 2026 |
|---|---|
| **Chair:** | Lorraine Boyd |

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

| **ALERT** |
|---|
| * **Maternity & Neonatal Voices Partnership (MNVP)** future commissioning and funding arrangements remain unclear, which represents a risk to Maternity & Neonatal Single Improvement Plan Workstream 1: Listening to and working with service users and families with compassion |
| **ASSURE** |
| * **Surgery Care Group** shared a concern over a high number of overdue Cancer Harm Reviews (CHRs) resulting in increased risk of delays in starting treatment and delays in identifying any issues in pathways that might affect other patients. There is a focus on improvement and progress is being monitored |

through the Cancer Delivery Group and Directorate Management Groups. Update will be provided to Quality Committee in July.

* **Critical Care Peer Review November 2025** identified that GPIC standards for AHP staffing levels were not being met and consequently insufficient rehabilitation available, impacting on Length of Stay and potentially limiting optimum outcomes. Consideration of ways to address this within current resources is underway.

* **MSSA levels** remain within trajectory for Surgery Care Group and are significantly improved on last year, providing assurance that the IPC Improvement actions are impacting and becoming embedded.

* **Maternity and Neonatal Single Improvement Plan** continues to make progress with 209 of 383 actions now completed. 13 off track actions expect to be completed by end of April 2026. 4 at risk actions related to stalled implementation of in house tobacco dependency service, which remains under discussion with partners.

* **Maternity Heatmap** was discussed and a greater understanding of the data that sits behind the scores gained. The data encompasses varied and lengthy timeframes. Assurance was gained that the Trust is already well cited on the component elements and working appropriately towards relevant improvement.

* **Complex Needs Amalgamated Q3 Report** included activity data, training compliance and performance data covering the 4 specialist services within this portfolio : Mental Capacity Assessments (MCA) & Deprivation of Liberty (DOLs), Mental Health Care, Learning Disability & Autism Liaison and Admiral Dementia Service. Increased demand and complexity across the board were demonstrated eg 463 referrals to Admiral Nurses were received in 2025, a 68% increase on 2024. In this context, strong progress in training, quality assurance and pathway development were evident, underpinned by the Complex Needs Implementation Plan.

* **Mental Health In Patient Assessment Tool** has been fully implemented and a digital ED triage process is in place, supporting identification of mental health needs and routine daily monitoring of patients detained under the Mental Health Act.

* **Dementia Services** received excellent patient and family feedback indicating improved safety and communication, better discharge planning and high levels of compassion and specialist advocacy.

* **Enhanced Therapeutic and Observation Care ( EHOC) Programme** was implemented in June 2025. A point prevalence audit was undertaken across a number of wards in December to evaluate effectiveness and implementation. A number of opportunities for improvement were identified and will be addressed through the Complex Needs Implementation Plan in Q4 to address the assurance gaps.

* **Internal Audit Report** provided a summary of the Internal Audits commissioned for 2025/26 under the Quality & Safety Agenda and updates on their progress. IA Open Actions were shared and progress towards completion discussed. There are 21 open actions. Extension has been requested for 2 relating to document approval. 6 are due to be completed by the end of March and Responsible Officers have been contacted with reminders. An update on these will be provided at the next Quality Committee meeting providing strengthened assurance regarding the oversight process. Executive Summaries of completed Internal Audits were shared and discussed supporting transparency and assurance.

* **Q3 Mortality and Learning from Deaths ( LfD) Update** was discussed. It was noted that information from the Hospital Episode Data (HED) information system was no longer available to the Trust impacting in the timeliness of the data and consequently the level of assurance available. Crude mortality rates were seen to be trending downwards allowing for seasonal variation. The Summary Hospital Mortality Indicator ( SHMI) is now the only risk adjusted indicator of mortality being used nationally. The values are always adjusted by NHS Digital- SHMI such that the Trust average across England is always 100. Values below 100 represent lower mortality ie better outcome and vice versa. The current Trust SHMI to August 2025 is 90.96 and trending downwards across both sites, providing good assurance. SHMI data is also broken down into its component diagnostic groups and data identifying outliers is triangulated with other information sources eg learning from Trust mortality reviews by the LfD group to ascertain any further investigation or action required. Currently no diagnostic groups are flagging concern and positive assurance is also noted in the Septicaemia category, an area of focus for improvement, with fewer observed septicaemia deaths than expected reported. Some further work is being undertaken to

strengthen the SJCR process and gain further assurance that they are representative of the level of care the Trust is providing and learning opportunities are maximised.

* **Sepsis Update Report** highlighted strong performance in early identification of potential sepsis but assurance on timely response to this resulting in administration of antibiotic treatment within 1 hour is limited, with multiple compounding delays evident in the pathway. It is anticipated that this will improve as a result of changes to the UEC pathways in the coming months. The risk to patient safety in the current situation is significant so close ongoing monitoring to ensure the anticipated improvements materialise will be important.

* **Quality Committee Annual Report and Effectiveness Review** was discussed and confirmed that the meeting had been quorate throughout the year, had covered all areas of its duties and had fully delivered the agreed work plan. The Committee Effectiveness self-assessment provided high scores across all areas, consequently there is no proposal currently to amend the Terms of Reference. There was discussion on the need to maintain and improve the focus on Quality and Safety assurance and avoid becoming drawn into operational detail. Length of meeting, attendees and future work programme were also discussed and proposed changes will be presented to Trust Board in April.

**ADVISE**

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

* **Maternity Incentive Scheme (MIS) Year 8** is anticipated to have a greater focus on outcomes and supporting assurances and an increased emphasis on Board accountability. The Board Executive and Non-Executive Maternity & Neonatal Safety Champions are scheduled to attend a MIS Year 8 Launch Event in April to support understanding of the requirements.

* **.CQC Update** led to a discussion on the recently received CQC report on the inspections of Urgent and Emergency Care and Medical Services and we were advised that plans to address the areas of concern are being formed and will be agreed and reported in due course. Ongoing engagement with the CQC continues and non-inspection visits are planned for April and October 2026

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

**PR1** was addressed through discussion of the Maternity Reports, Complex Needs Q3 Update, Sepsis Report, Mortality & Learning from Deaths Report and the Surgery Care Group Assurance papers.

| **Date of meeting:** | February 2026 |
|---|---|
| **Chair:** | Lorraine Boyd |

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

**ALERT**

* **Mid Year Complaints Report** demonstrated rising levels of complaints with a 12% increase in total complaints and a 45% increase in complex complaints compared with the preceding 6 months. This represents a significant workload to manage in a timely manner and the data indicates an opportunity to improve both the response times and quality of responses. This has been an area of focus with good engagement from the Care Groups and Corporate Nursing Team. Complaints themes identified, particularly delays to investigations, diagnosis and treatment and communication with patients, carers and colleagues, triangulate with other assurance sources eg performance challenges and incident management findings.

* **Maternity Regional Heatmap** was presented for the first time and gives York & Scarborough an overall amber rating with a score significantly worse than the regional average. More work needs to be undertaken to fully understand how the score is influenced and how to use the information to target and support improvement.

* **Maternity Incentive Scheme( MIS) Year 7** evidence will be validated, as required, by the LMNS on 23rd February confirming compliance with 6 of 10 Safety Actions.

**ASSURE**

* **Family Health Care Group** shared the progress they are making to address inequalities and appropriately strengthen the voice of the child in Children's Services.

* **Pressure Ulcers in Community** were discussed, in particular noting the significant backlog of completed After Action Reviews (AARs), resulting in an assurance gap. There was a confidence that important learning was being identified and actioned early but the reporting standards and documentation requirements are onerous. Consideration is being given to clustering reviews and streamlining reporting, which should strengthen assurance and close the gap.

* **CQC Maternity Services Survey 2025** outcome was shared and plans to address the principle areas of concern, particularly pain relief, were discussed.

* **Maternity Quality and Safety Dashboard Metrics** were reviewed providing assurance on sustained training compliance and PPH and 3rd/ 4th degree tears ( outcome measures of quality care) below national averages.

* **Maternity Incentive Scheme ( MIS) Year 7 Submission** was reviewed, providing assurance that areas of non-compliance are understood with plans in place to work towards future compliance.

* **Infection Prevention and Control Q3 report** highlighted a recent Internal Audit of governance and effectiveness of IPC meetings with an opinion of significant assurance. Recommendations of areas of improvement were noted. The formal response was discussed at IPSAG ( Infection Prevention Strategic Assurance Group) and is being coordinated by the Deputy Director of IPC.

* **Clostridium Difficile ( CDI) and Methicillin Sensitive Staphylococcus Aurius ( MSSA)** infection data continues to demonstrate improvement, with National Oversight Framework Q2 data identifying the Trust as a strongly improving performer on CDI: a testimony to the hard work of the teams to engage and improve. CDI and MSSA rates, however, remain a concern contributing to PR1 and continued focus on the improvement work streams required.

* **Gram Negative Blood Stream infections ( GNBSI** ie. Methicillin Resistant Staphylococcus Aureus ( MRSA), E. coli bacteraemia, Klebsiella bacteraemia and Pseudomonas bacteraemia) data continues to raise concerns, which are being addressed by the IPC team and Care Groups, with a focus on 4 key categories for improvement: education & professional standards, clean and appropriate healthcare environment, device related Health Care Acquired Infections( HCAI) and surveillance of HCAI.

* **IPC Board Assurance Framework** was shared, demonstrating full compliance with 40 elements and partial compliance with 14. No elements of full non-compliance were demonstrated.

* **Integrated Safeguarding Q3 Report,** encompassed activity, risks and progress across Children's, Maternity and Adult Safeguarding Services, highlighting significant increases in demand, persistent workforce and training pressures as well as progress in system and governance improvements. Contingency plans to ensure essential safeguarding work is prioritised were discussed and from April, safeguarding training will move to a competency based, experience driven model, which should improve accessibility and compliance.

* **Nerve Centre EPR Implementation** was discussed in some detail in Patient Safety and Clinical Effectiveness Sub Committee and verbally reported to the Quality Committee in response to the concerns raised in January. PSCE saw detailed hazard logs and EPMA cut over plans with planned pharmacy support. The Clinical Safety Officer presented the clinical safety findings and mitigations enabling constructive discussion and assurance to be gained.

* **Deterioration in 12+ hour delays in ED** was discussed and assurance sought that mitigations previously articulated to support safe care and patient experience remain adequate in this context. Corridor Care and the risks associated with temporary escalation spaces remain a concern and a gap in assurance. An assurance paper is scheduled to come to Quality Committee next month to address this and recommend a route for ongoing assurance.

**ADVISE**

* **Family Health Care Group** attended and shared their new and ongoing risks & mitigations, with a particular focus on Children's Services and Community Services.

* **Maternity Personalised Care Plans** were launched on 2nd February. They were co-produced with the MNVP, ensuring they support the needs of both the service users and professional care givers.

* **Maternity Transitional Care** remains a risk to MIS compliance ( Safety Action 3). Whilst the timeline is off track, progress continues with current focus on securing workforce through a Business Case which is in train.

* **Major Trauma Peer Review Update** was presented and demonstrated good progress, highlighting increased trauma theatre capacity at Scarborough, strengthened Major Trauma Registry ( TARN) coordination and oversight through the Major Trauma Delivery Group. The importance of the Business Case to address the remaining areas of concern, particularly rehabilitation service, 7 day Major Trauma coordination service and support for elderly trauma was noted.

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

* **The risk of Non compliance with Safeguarding Accountability & Assurance Framework** as a result of not having Named Nurse for Children in Care has now been resolved through a Service restructure.
* **PR1** in the context of health care acquired infections, 12+ hour trolley waits and mid year complaints review.
* **CRR65** relating to routine paediatric SALT delays to assessment and intervention was discussed. Recent analysis showed that service capacity meets only 35% of demand. Despite ongoing innovation and pathway improvements, the position remains unchanged and the trust is in continuous dialogue with commissioners and NHS England to address the persistent gap, with discussions about whether the issue should remain on the risk register for visibility. Quality Committee were firmly of the belief that, in spite of the seemingly intractable nature of the challenges, visibility of the significant risk should not be lost.

# Resources Committee Reports

| **Date of meeting:** | April 2026 |
|---|---|
| **Chair:** | Helen Grantham |

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

| ALERT |
|---|
| - **2026/27 WRAP delivery**<br>o A verbal update was provided on progress towards the WRAP and the current status of the live tracker was shared at the meeting. While at the time of sharing, the Trust was only part way through the first month of the financial year, planned savings on the tracker did not equal the full requirement for April and cover would therefore be required for the Trust to meet its required I&E position. The importance of delivery throughout the year and the need for good phasing and reporting was emphasised.<br>o For future meetings, a written report (showing progress against budget, YTD and in month, by budget holders and project type) was requested to be provided so the committee could gain assurance on delivery. Where delivery was off track the committee requested that information be provided on what action was being taken to make up any shortfall.<br>o The impact of the additional £7m improvement on the Trust's proposed plan following recent discussions with NHSE and the ICB was noted and a discussion took place on whether this would be met by increased efficiencies or reduction in investment. While there was consensus that the Trust could not spend money it did not have, it was noted that investment was key to improving trust performance and that discussions on delay in, or non-delivery of, investment should involve the Board.<br>o The need to look at transformational change was noted, as was the importance of delivery early in the year to maximise full-year impact.<br>o It was noted that for 25/26 the efficiency programme delivered £40.5m out of a plan of £55.3m with 75% non-recurrent and a significant underperformance against corporate projects.<br>- **2026/27 plan** – the plan had not yet been agreed. The Trust was working to the plan which it last proposed following the latest challenge from NHSE – with an additional £7m reduction in deficit to £22m. The Trust was in the Challenged Provider Programme – this was a new programme and clarity was being sought on what this entailed.<br>- **Operational performance** – the trust remained behind trajectory on the key metrics relating to ED (ECS at 94 out of 118 providers nationally), Cancer (111 out of 119 nationally for 28 day faster diagnosis and 73 out of 119 for 62 day waits) and RTT (107 out of 118 providers nationally for <18 week waiters), although there had been some significant improvement in ECS over the last month following the introduction of revised pathways (and despite increasing attendances), and in cancer performance (although the latter had dropped back slightly with the cessation of the additional funding received in the final quarter of the 25/26 year). The trust ranks 131 out of 134 in the national operational framework<br><br>- **Digital**<br>o NHS England approval had not yet been received to progress with the launch of Nervecentre. Planning remained on track for launch 7-10 May in York and 14-16 May in Scarborough<br>[*NOTE: FOLLOWING THE MEETING APPROVAL HAS BEEN RECEIVED*]<br>o The escalation report from the Digital Committee was noted. A discussion took place on the level of scrutiny and assurance provided to the Resources Committee and Board on digital projects, their governance and their potential to have a transformational impact on the Trust's operations. The Committee Chair would discuss this further with the Trust Chair. |

- **Workforce** – sickness absence remains high compared to national benchmark, vacancy pressures persist, particularly for HCSW, and premium rate spend on medical and dental workforce remained a key driver for operational pay overspend. The importance of aligning consultant job plans to demand was discussed. Details of the sickness absence reduction action plan would be provided to the Committee as scheduled.

**ASSURE**

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- **Three-year service standard delivery plan –** a detailed update and discussion took place on the revised approach to monitoring delivery across the Trust following significant delivery challenges across multiple areas in 2025/25.
  - The focus was on a single service delivery plan across care groups and corporate teams to delivery success measures and productivity operational measures, with a strong emphasis on substantive pathway transformation, delivering measurable and sustainable improvements month-on-month with a strong governance and accountability framework, including a change control process, clear corrective actions to be identified when off track and consequence model for sustained under performance.
  - Digital transformation was a major enabler of improvement over the next 3 years, including the optimisation of Nervecentre.
  - Person responsibilities had been co-designed and agreed by team members including a “solution-first mindset” and the need to “role model behaviours”. There would be quarterly workshops to celebrate success and share learnings. The need for leadership at all levels was discussed and the importance of a strong culture
  - *See also Risk section below*
- **Colleague health and wellbeing** – the Committee received the annual activity report for 2025 covering occupational health, colleague health and wellbeing and manual handing. The following points were highlighted/discussed:
  - That OH and WB were being properly managed and that colleagues are fit, safe and supported at work
  - There had been some improvement in colleague survey scores in this area, although more to do to continue the improvement
  - The Colleague Benefits team had moved to sit within the OH&WB team giving opportunities for more strategic work in this area
- **YTHFM Assurance Report – Q4** – the Committee received the regular quarterly report providing assurance on the performance of YTHFM and capital projects.
  - A verbal update was provided on key capital projects. It was agreed that additional information would be provided on major capital projects, so the Committee could gain assurance on delivery of the plan against expectations over time.
  - Challenges remained with statutory and mandatory training, sickness absence and cleanliness in some areas.
  - Financial performance was favourable to plan
  - The Committee would be updated on how departmental structure develops
- **Sustainability Q4 Report** – A positive written report was received on sustainability – this area was well managed (with governance framework noted), there was some leading practice being undertaken by the Trust and good partnership working. The Trust also had some good success in bidding for funds to support the Trust’s Green Plan. This was an area where the Trust had a legal obligation to meet targets by 2032. The Committee confirmed its support for the ongoing work
- **Outpatient referrals overview** – following a query at a previous meeting, a written update was provided on outpatient referrals demand and makeup.
  - 8% increase (25,000 referrals) in referrals in 2025/26, following 9% growth 2024/25
  - Increase was placing pressure on clinic capacity, diagnostic services, consultant job planning and administrative/patient access functions
  - Key drivers were:

- 5% increase in GP referrals
- 11% increase in urgent cancer fast-track referrals
- 10% increase in consultant-to-consultant referrals
- 5% increase in other reasons – e.g. following lung screening.

- The Committee was assured that there was a comprehensive set of demand management actions in place or in development for 2026/27. Key controls/mitigations
  - Advice and guidance
  - Elective SPoA
  - Cancer referral quality controls
  - Commissioning aligned C2C controls

- **Medical workforce report (including guardian of safe working hours)** – the regular report on medical and dental workforce was received the following points of note
  - the difference in colleague survey results for this cohort of colleagues v others
  - the high level of exception reporting for safe working hours
- **WRES and WDES** – an update was provided on progress against the 2025/27 action plans. Assurance was provided relating to anonymous reporting, training, managing violence and aggression policy awareness, review of the civility and respect policy, staff network engagement and some development opportunities and mentoring programmes
- **Sexual Safety Update** – an update was provided on the actions being taken to prevent sexual misconduct following an NHSE audit of sexual safety across the NHS. The Trust has already taken significant steps including adopting the Sexual Safety Charter in 024 and Sexual Misconduct Policy in March 2025 and implementing an anonymous reporting tool for concerns about sexual misconduct. Action is planned to train specialist investigators in September 2026.

**ASSURANCE GAINED**

- **2025/26 financial plan**
  - The Committee was assured that the Trust had delivered its revised plan (as agreed with NHSE) for 2025/26
  - There was a small overspend on capital which would be compensated for by lower than planned spend across the region
- **Occupational Health and Wellbeing –** the Committee was assured that this area was being well managed (noting the risks and concerns in the paper)
- The regular **Nursing Safer Staffing Report** was presented, and it was noted that the Trust continued to meet the national requirements for safer staffing reporting. There was an improving picture relating to fill rates for both registered and non-registered colleagues and in relation to red flags. A robust plan was in place regarding HCSW vacancies. Nursing continues to contribute to the Trust's financial recovery plan via reduction in agency usage with associated costs. The Committee Chair would speak with the Chair of Quality Committee to establish which committee was best placed to gain assurance in this area.
- **Research and Innovation Update Report** – the bi-annual update report was provided – a positive report with the trust ahead on its scorecard metrics in almost all areas
- **Outpatients** – the report provided assurance that this area was being robustly understood and actively managed (see risks below)

- **Sexual safety and misconduct** – the report on this area provided assurance that this area was being well managed and while additional actions needed to be taken the Trust was clear on its approach in this area.

**ADVISE**

- **Committee papers** – a discussion took place amongst the non-executive members of the Committee relating to the approach to committee papers – it was agreed that this could be improved to ensure information was presented in a clear and succinct format drawing out key points – the Committee Chair would follow up with the Trust Secretary
- **Urgent and emergency care performance** – it was noted that the initial improvement seen following the introduction of new UEC pathways had been sustained and there had been a very significant improvement seen, although performance remained behind trajectory. York was outperforming Scarborough and there was ongoing work to address these disparities
- **Workforce** – sickness absence and use of temporary staff continued to reduce

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

- **Three-year operational plan delivery** – the following risks (with associated mitigations) were highlighted and noted: capacity/workforce shocks, diagnostic constraints/equipment downtime, flow and bed base mismatch, governance drift, financial delivery risk, operational and clinical engagement and estates/capacity constraints
- **Colleague health and wellbeing** – the key risk identified in this area related to colleagues choosing not to engage with OH&WB and using the support available to support them stay healthy and in work - the biggest cohort of referrals related to mental health, stress relating to understaffing, low staff morale, issues with management and moral injury. The team was also relatively small and it was noted that improvements in this area required a whole-trust approach
- **Outpatients** – risks highlighted included:
  - system driven growth outside trust control
  - dependence on ICB enforcing commissioning rules
  - workforce capacity
  - digital constrains during EPR transition
- **Medical and dental workforce** – the level of vacancy rate in some specialities in Scarborough in particular
- **WRES and WDES** – Whilst the paper reported some actions had not yet begun a verbal update provided assurance that these had now been undertaken, other actions remained ongoing e.g. actions to address bullying and harassment and require cross-organisational behaviour change which takes longer to embed
- **Corporate risk register** – an additional risk had been added relating to objectives relating to bacteraemia

| **Date of meeting:** | March 2026 |
|---|---|
| **Chair:** | Helen Grantham |

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

**ALERT**

- **Year-end operational performance**
  - As previously reported, the originally planned year-end trajectories relating to cancer, diagnostics and referral to treatment would not be met, however, it was anticipated that performance was on track to meet the revised trajectories for cancer and diagnostics (updated from 1 March 26). Whilst small improvements seen in RTT it remains behind the revised trajectory.

- There was some significant improvement, particularly in diagnostics and cancer performance, diagnostics being key to meeting cancer and treatment targets – with referral to treatment performance remaining the most challenging area.
- The Committee discussed the need for accurate planning and reporting to demonstrate progress and secure assurance.

- **Digital**
  - NHS England approval had not yet been received to progress with the launch of Nervecentre and it was unclear when this would be obtained. Implementation and associated benefits had been built into the 2026/27 plan and there would be an impact of the delay and additional costs which will need to be mitigated.
  - Digital robots, 'Esther' and 'Iris', had been introduced to support recruitment and assignment code creation (through Robotic Process Automation), aiming to reduce workload for line managers and improve efficiency.

**ASSURE**

- **Urgent and emergency care – focussed review**
  - A focussed review was provided to assure the Committee that a credible and deliverable recovery plan is in place for urgent and emergency care ahead of the start of the 2026/2027 planning year
  - Details of short and long-term actions were provided along with the challenges faced across the York and Scarborough sites (increased demand, bed availability, financial constraints, workforce challenges and level of diagnostic requests) and risks and mitigations to achievement
  - The proposed plan has been developed by Trust colleagues working in the UEC (being shaped by NHSE preferred acute model of care)
  - Recent changes to the "front door" model of care had shown positive initial signs and, assuming this was sustained, Q1 ECS trajectories should be met
  - A more detailed plan was being developed (available in April 26) and the Committee requested that it receive additional information so it could
  - understand expected actions and impact on performance and monitor this over time. An update was provided on the governance processes and oversight of the plan.
  - Priority actions include close monitoring and refinement of the new acute model, preparation for further reconfiguration of the medical and surgical bed base, re-procurement of Urgent Treatment Centre services to strengthen performance and accountability, continued improvement in discharge processes (including Trusted Assessment Forms and length of stay reduction), and deeper collaboration with system partners to address demand and admission avoidance.
  - The strong improvement over recent months in ambulance handover was noted and this continued to be sustained. Discharge was also improving.
- **Embedding culture, leadership and behaviours**
  - A focussed review was provided on work to embed a positive and empowering culture within the Trust and to improve leadership and behaviours
  - The NHS Management and Leadership Framework would support in identifying and addressing development needs and would work alongside the Trusts own work as part of *Our Voice, Our Future,* which was co-created with our Change Makers. The importance of considering values in recruitment and development/appraisal conversations was discussed.
  - While there remained more to do, the recent colleague survey measures linked to this area had seem some improvement
  - upcoming activity was noted and the Committee requested further details of the plan including timelines, responsibility, expected outcomes and how success would be measured and could be monitored by the Committee
- **Staff Survey Results**
  - The Committee was updated on the nationally benchmarked 2025 Staff Survey results and proposals for improving colleague experience further.
  - The survey response rate significantly increased in 2025 meaning the results are more representative of the whole workforce, and the response rate is above the peer average for the first time since 2018.
  - The scores by People Promise element/theme have all improved slightly and the importance of moving to positive improvement following several years of decline was discussed
  - The team were realistic that there was more to do, with the Trust still below the peer group average in a number of key areas

- The key risks, opportunities and concerns were discussed – in particular how embedding a continuous improvement model could support progress
  - More detailed plans were being produced to address issues highlighted – a focus on a small number of key areas to drive impact was planned – change makers, colleague networks and unions would be engaged to co-create the plans
- **Equality Delivery System**
  - A report was received providing a high-level overview of the Trust's performance against the NHS Equality Delivery System (EDS) 2022 for 2025/2026, which is an equality improvement tool comprising eleven outcomes spread across three Domains, which are:
    Domain 1 Commissioned or provided services
    Domain 2 Workforce health and well-being
    Domain 3 Inclusive leadership
  - The 2025/26 review has demonstrated improved accessibility, patient experience and feedback regarding workforce health and well-being; strengthened safety and governance; continued progress on inclusive leadership. The Trust has identified areas of improvement through internal and external engagement.
  - The Organisational Rating for 2025/2026 is 'Developing'.
- **2025/2026 Financial Plan**
  - An update was provided on performance against the revised 2025/26 financial plan as proposed to NHSE and in particular progress of the cost-improvement programme. The Finance Director was confident of delivery of the revised plan
  - A review of the capital plan was undertaken and it was expected that the year-end position would be in line with plan
- **2026/27 WRAP**
  - The Committee received an update on the WRAP progress for 2026/27.
  - Plans had been identified totalling £47.2m of the £54.6m target for the year
  - An explanation was provided of how projects to meet the improvement gap (£7.4m) would be identified
  - The approach to monitor performance on a month-by-month basis, with clear accountabilities, was shared and where performance was not in line with expectations clear plans to get back on track would be expected. Robust governance was being put in place and the Committee would be provided with relevant information so it could track performance on a month-by-month basis and seek assurance on mitigating action if performance was off track. The Committee were shown the WRAP Tracker and how it was being populated, how it provided a single point of truth analysis and how the various reporting dashboards and actions were integrated. The methodology being used was being shared with other teams so that best practice could be implemented in operational areas
  - An update was provided on the work being undertaken by KPMG and their output to date. The Committee would be provided with a report when the work had concluded.
- The regular **Nursing Safer Staffing Report** was presented, and it was noted that the Trust continued to meet the national requirements for safer staffing reporting. There was an improving picture relating to workforce fragility, particularly with healthcare support worker vacancies, although fill rates had declined slightly with a slight increase in red flags. The picture was anticipated to improve as winter pressures subsided.
- Following a request at the February meeting, a paper was presented on the increase in **sickness levels** and the action being taken across the Trust to support colleagues who were experiencing sickness, as well as the wellbeing offering to support colleagues to remain well at work. Reduction in sickness absence is a key priority for the Trust. Variances across the Trust workforce were noted and discussed.
- **Sustainability Q4 Report** – A positive written report was received on sustainability – this area was well managed (with governance framework noted), there was some leading practice being undertaken by the Trust and good partnership working. The Trust also had some good success in bidding for funds to support the Trust's Green Plan. This was an area where the Trust had a legal obligation to meet targets by 2032. The Committee confirmed its support for the ongoing work.
- The Committee reviewed and approved its **annual report and effectiveness review** and terms of reference which would be presented to the Board. A discussion took place on the areas where there was some variation in the survey responses. It was planned to add a specific agenda item to ensure that the Committee reflected on the meeting – what went well and what could be improved.

**ADVISE**

- **Financial reporting** – as requested at the previous meeting, the Committee continued to engage with the Finance team on the best approach to reporting on financial performance and cost

improvement so that the Committee could track performance monthly and understand corrective actions when performance was off track projects

- **Committee papers** – feedback was provided on the content of papers and how these could be improved. Executive summaries were good in many, but not all, areas and engagement continued on ensuring plans presented to the Committee were clear on actions, impact, responsibilities, timelines, etc, which would enable the Committee to monitor performance against plans as the 2026/27 year progressed.
- **YTHFM** – consideration of the YTHFM Business Assurance Report was delayed due to unavailability of colleagues. This was deferred to a future meeting
- **Work plan** – The 2026/27 work plan for the Committee was being worked up and would be available for discussion at the next meeting.

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

- No new risks identified
- See above for risks discussed

| **Date of meeting:** | February 2026 |
|---|---|
| **Chair:** | Helen Grantham |

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

**ALERT**

- **Elective RTT** - a committee focussed review was undertaken on RTT performance. The Trust continued to experience significant operational pressures and RTT performance had been impacted by increased GP referrals, diagnostic constraints, delayed capital builds and validation activities linked to EPR readiness. Following agreement with NHSE revised trajectories had been agreed for TWL, the proportion of patients waiting more than 18 weeks for and those waiting over 52 weeks for treatment (see ASSURE below on revised trajectories)
- **True North metrics** – while there was significant focus and activity being undertaken, 5 out of the 6 True North metrics with a monthly trajectory were off track
- **Cancer Progress Report** – performance against FDS and 62-day standard remains off trajectory (with the 31-day treatment standard trajectory being achieved). See ASSURE below for update on plans for significant improvement to March 2026

**ASSURE**

- **Elective RTT**
  - Revised trajectories had been agreed with NHSE
  - Additional funding and support (including targeted support for key specialities with the longest waiting lists) had been put in place to support recovery actions and plans were in place to meet the revised trajectories up to the end of the 25/26 year.
  - RTT performance is being monitored through daily tracking, weekly recovery plans, and monthly oversight, with fortnightly review meetings with NHS England
  - A draft three-year RTT recovery plan is due in March, aiming to set a sustainable route back to constitutional standards
  - The Executive were asked to provide a breakdown of RTT and total waiting list by individual specialty in future reports to enhance visibility and monitoring.
- **Colleague Survey Results and Update on 2025/26 action plan:**
  - initial results from 2025 colleague survey were provided – covering response rate and key response areas – results were currently embargoed
  - a narrative and RAG rated update was also provided on delivery against actions identified following the 2024 colleague survey
  - a discussion took place on culture, leadership development and expectations, accountability as well as the importance of staff engagement and well-being and colleagues feeling confident to raise concerns and that action would be taken in response.
  - the process for developing the action plan following the latest survey results was highlighted and the involvement of colleague networks, trade unions, and staff governors noted

- Key elements to support culture change were discussed encompassing consistent and visible leadership, colleague involvement and engagement and open communication. Implementation of a continuous quality improvement methodology was considered to be an important step, and the Trust was awaiting approval from NHSE to progress

- **2025/2026 Financial Plan** – an update was provided on the revised financial plan as agreed by the Board and presented to the ICB and NHSE. The Finance Director was confident of delivery of the revised plan and this was supported by information provided to the Committee on recovery action plans and the approach relating to accountability for and tracking of delivery, with weekly updates and monthly financial tracking. The position relating to cash forecasts and current and forecast capital position was also reviewed.
- **Cancer performance** – a paper was presented covering current performance against trajectory for the three key standards relating to cancer – FDS, 62 day wait and treatment within 31 days. The stabilisation in diagnostics (below trajectory in January but a small improvement on prior month) and improvements in CT and MRI turnaround times and in first outpatient appointments for key cancer specialities were noted. Action plans for the most challenged tumour sites were shared along with the expected impact on performance against standards along with the support being provided by partners, additional financial support secured and the improvements being made in data and visibility of the patient tracking list. A robust governance framework was also shared to monitor delivery. While the planned trajectories for FDS and 62 day wait standards were not expected to be delivered by Q4, the plans being implemented were expected to result in significant improvement of these standards while achieving performance of the 31-day treatment standard.
- The regular **Nursing Safer Staffing Report** was presented and it was noted that the Trust continued to meet the national requirements for safer staffing reporting, although for the December period had seen some significant workforce fragility particularly with non-registered staffing, leading to an increase in red flags and reduced fill rates, due to unprecedented levels of sickness absence and increased vacancies. A number of mitigations were discussed, which were overseen by the Eroster Assurance and Efficiency Group. Active recruitment campaigns were ongoing to close gaps in non-registered workforce.
- **Digital** – The Committee received a Chair's report from the Digital Committee, which was noted and the COO provided a verbal update on Nervecentre implementation covering training, readiness and risk management.
- A paper was presented on **Emergency Preparedness, Resilience and Response Core Standards Annual Assurance – Action Plan Progress.** Good progress continued to be made on actions and it is expected that when the next annual assurance plan is submitted the grading will have improved to substantial compliance. A further progress report will be considered by the Committee in May 2026.

**ADVISE**

- **Financial reporting** – the Committee requested that for 2026/27 a revised approach be taken to reporting on financial performance and the identification and prioritisation of cost improvement projects, their phasing and how progress/risk to delivery would be tracked and reported to the committee. This would be followed up with the Finance Director
- A discussion took place on the increase in **sickness levels** across the Trust and the Committee was advised a paper will be presented at the next Resources Committee providing the range of measures to reduce absence by 0.4% as detailed in the plan.
- While below target (95%), **children and young person's emergency care standard** was improving (currently at 87.7% for January)

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

# Group Audit Committee Report

| **Date of meeting:** | March 2026 |
|---|---|
| **Chair:** | Jane Hazelgrave |

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

**ALERT**

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

**ASSURE**

**External Audit**

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

**Internal Audit.**

- **YTHFM.**

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

- **Trust**

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

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

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

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

**Fraud**

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

**Other items**

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

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

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

**ADVISE**

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

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

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

There are no new risks to escalate to the Board.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 13.1

| | |
|---|---|
| **Report to:** | Council of Governors |
| **Date of Meeting:** | 10 June 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 Council of Governors 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 |
| Board of Directors | 27 May 2026 | Approved |

**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.<br><br>*Sentence added to reference the Group structure.* |
| Page 23 – Meetings | 10.5 Joint meetings of the Council of Governors and the Board of Directors<br><br>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<br><br>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).<br><br>The Trust operates under a provider licence issued by NHS England.<br><br>*Sentence re-worded for consistency in the Trust been constituted.* |
| Page 124 Annex 5 – Standing Orders of the Board of Directors | Foreword<br><br>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.<br><br>*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<br><br>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).<br><br>*Sentence re-worded for consistency in the Trust been constituted.* |
| Page 128<br>Annex 5 –<br>Standing Orders of the Board of Directors | NHS Framework<br><br>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.<br><br>*Code of Governance for NHS Provider Trusts reference included.* |
| Page 138<br>Annex 5 - Standing Orders of the Board of Directors | 5.1 Appointment of Committees<br><br>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.<br><br>*Sentence re-worded for clarity of appointment of Committees.* |
| Page 123<br>Annex 4 - Standing Orders of the Council of Governors | Appointment of the Vice Chair of the Council of Governors and the Board of Directors<br><br>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.<br><br>*Sentence re-worded for consistency.* |
| Page 132<br>Annex 4 - Standing Orders of the Board of Directors | Appointment of Vice Chair of the Board of Directors<br><br>For the purpose of enabling the proceedings of the Trust to be con 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.<br><br>*Sentence re-worded for consistency.* |
| | References to NHSE consistently throughout |

## 3. Recommendation

The Board of Directors is asked to approve the proposed amendments to the Trust's constitution.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 13.2

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10 June 2026 |
| **Subject:** | Corporate Governance Update – Council of Governors Elections |
| **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** | **Implications for Equality, Diversity and Inclusion (EDI)** *(please document in report)* |
|---|---|
| ☒ Effective Clinical Pathways<br>☒ Trust Culture<br>☒ Partnerships<br>☒ Transformative Services<br>☒ Sustainability Green Plan<br>☒ Financial Balance<br>☒ Effective Governance | ☐ Yes<br><br>☐ No<br><br>☒ Not Applicable |

**Executive Summary:**

The Trust conducts elections to the Council of Governors on at least an annual basis to fulfil its responsibilities and duties as a Foundation Trust.

The report whilst provides details of the elections scheduled for 2026 with vacancies across the following constituencies:

- Public: York, Hambelton, Ryedale and East Yorkshire
- Staff: Scarborough & Bridlington, York and Community

It also sets out a proposal to pause the elections until April 2027 (if it is appropriate to do so).

| **Recommendation:** |
|---|
| The Council of Governors is asked to consider the proposal to postpone elections until April 2027. |

| **Report History**<br>(Where the paper has previously been reported to date, if applicable) | | |
|---|---|---|
| **Meeting/Engagement** | **Date** | **Outcome/Recommendation** |
| N/a | | |

**Corporate Governance Update – Council of Governors Elections**

## 1. Introduction

The Trust conducts elections to the Council of Governors on at least an annual basis to fulfil its responsibilities and duties as a Foundation Trust.

The report provides details of the forthcoming Summer 2026 elections.

## 2. Council of Governors Vacancies

The Council of Governors will have the following current vacancies across all constituencies as at 30 September 2026 following resignations and end of terms of existing governors:

| Public Governors Constituencies | No. of Seats | No. of Vacancies | No. of existing governors whose term of office could be extended for 6 months |
|---|---|---|---|
| East Coast | 5 | 1 | 0 |
| York | 5 | 3 | 0 |
| Hambleton | 1 | 1 | 0 |
| Ryedale & EY | 3 | 1 | 0 |

| Staff Governors Constituencies | No. of seats | No. of Vacancies | No. of existing governors whose term of office could be extended for 6 months |
|---|---|---|---|
| Scarborough & Bridlington | 3 | 2 | 1 |
| Community | 1 | 1 | 1 |

James Cannon is our newly appointed Stakeholder Governor from the Healthcare Volunteer Constituency.

## 3. Rationale for Proposal to Postpone Elections

Governors will be aware that the government intend to persuade Parliament to abolish the requirement for Foundation Trusts not to have a Council of Governors. This is a provision contained within the Health Bill recently presented to Parliament.

At the same time NHS England wrote to Foundation Trusts (letter dated 6 May 2026) attached at annex 1.

Given the very, very serious financial requirement the Trust has to achieve in this financial year, and the doubt whether the Council of Governors will continue beyond March 2027 it is considered prudent not to proceed with the elections, unless and until it is known whether this section of the Health Bill becomes law.

If the elections are postponed, it is also proposed that we extend the term of office of Governors whose appointment was due to expire on 30 September for a further 6 months up to 31 March 2027.

## 4. Recommendation

The Council of Governors is asked to consider the proposal to postpone elections until April 2027.

To: NHS foundation trust chairs

cc. NHS foundation trust chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

6 May 2026

Dear colleague,

**NHS foundation trust governors**

I am writing to provide clarification on the role of governors in light of the proposals set out in the 10 Year Health Plan to remove the requirement for NHS foundation trusts to have councils of governors.

Any removal of governors – whose role is set out in law – will depend on government introducing legislation, the will of Parliament to approve it and an agreed start date. We recognise the uncertainty this brings but, until then, the role of governors is unchanged and NHS foundation trusts should continue working with them, in line with their constitutions.

If, in due course, Parliament does remove the statutory role of governors, we will expect NHS foundation trusts to continue to have mechanisms in place to engage with public and patients. We will also seek to understand organisations' plans for this as part of assessments for advanced foundation trust status.

Finally, I am aware that there may be questions about running elections as governors' 3-year terms expire. During this uncertain period, and until there is clarity on the matter, NHS foundation trusts may consider their constitutions and whether they are able to pause these elections while still ensuring a quorate council.

Should you have any further queries on this matter, please do not hesitate to contact Miranda.Carter2@nhs.net, Director of System Architecture for NHS England.

Yours sincerely,

**Glen Burley**
Deputy Chief Executive

**York and Scarborough Teaching Hospitals**
NHS Foundation Trust

Item 14

| **Report to:** | Council of Governors |
|---|---|
| **Date of Meeting:** | 10 June 2026 |
| **Subject:** | Nominations and Remuneration Committee Update |
| **Director Sponsor:** | Martin Barkley, Trust Chair |
| **Author:** | Mike Taylor, Associate Director of Corporate Governance |

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

Approve ☐ Discuss ☐ Assurance ☐ Information ☒ Regulatory Requirement ☐

**Trust Objectives**

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

**Board Assurance Framework**

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

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

☐ Yes

☐ No

☒ Not Applicable

**Executive Summary:**

An update of the 6 May 2026 Nominations and Remuneration Committee is provided on the recruitment of a Non-executive Director with a clinical background.

The Committee agreed to aim for advertising in early June, subject to further discussions with a recruitment partner and other colleagues.

**Recommendation:**

The Council of Governors is asked to note the update.

| **Report History**<br>(Where the paper has previously been reported to date, if applicable) | | |
| --- | --- | --- |
| **Meeting/Engagement** | **Date** | **Outcome/Recommendation** |
| Nominations and Remuneration Committee | 6 May 2026 | N/a |

**Nominations and Remuneration Committee – Update**

## 1. Introduction

The Nominations and Remuneration Committee met on 6 May 2026, and this report provides an update to the Council of Governors.

## 2. NED Recruitment

The Board of Directors have a current NED vacancy due to Noel Scanlon's resignation and the Committee discussed the need to recruit an additional clinician to maintain board composition.

The Committee agreed to aim for advertising in early June, subject to further discussions with a recruitment partner and other colleagues.

## 3. Role Description

A role description for a NED has been drafted by the Associate Director of Corporate Governance to include the expectation for the role to be a member of the Quality Committee.

The role description has subsequently been shared with Committee members and will be finalised ready for the forthcoming recruitment.

## 4. Next Steps

Timescales are to be confirmed for forthcoming advertising, shortlisting and interviews with the recruitment panel to be appointed. A recommendation will subsequently be provided by the Nominations and Remuneration Committee for Council of Governors approval of a preferred candidate to be appointed.

## 5. Recommendation

The Council of Governors is asked to note the update.

Item 15

| **Report to:** | Council of Governors |
| --- | --- |
| **Date of Meeting:** | 10 June 2026 |
| **Subject:** | Governors Activities Report |
| **Director Sponsor:** | Martin Barkley, Chair |
| **Author:** | Tracy Astley, Governor & Membership Manager |

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

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

**Trust Objectives**

☐ 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

**Equality Impact Assessment Concluded**
*(please document in report)*

☐ Yes

☐ No

☒ Not Applicable

**Recommendation:**
This paper provides an overview of Governor Activities. Reports are provided by the Lead Governor, Chair of the Committees and the governors on their activities.

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

**Governors Activities Report**

## 1. Lead Governor Report

Hello everyone, it has been a busy period! I would like to report back on the various activities I have attended/been involved with.

1. NomRem Committee Meetings
2. Public Board meetings via Teams
3. Y&S Live weekly update from CEO
4. Monthly 1to1 Meetings with the Chair
5. Chairing the Governor Forum
6. Annual Chairs Appraisal with Senior Independent Director Lorraine Boyd
7. NED Appraisals with the Chair, Martin Barkley
8. Submitted Lead Governor Statement for the Trust Annual Report
9. Attended the SHARC Conference 22 April 2026. Information here
10. Attended the NLGA (National Lead Governors Assoc) National Event on 27 April 2026 on Future Role of Governors
11. Liaison with Governors
12. Attendance as a member of Egton and Danby Surgeries PPG (Patient Participation Group) Meetings.
13. Wrote to Alison Hume MP and James Murray, Secretary of State for Health and Social Care ref: NHS Modernisation Bill 2026 - Proposed Abolition of Foundation Trust Governors
14. Attended as a member, the NHS Humber & North Yorkshire ICB - Good Experience Steering Group meeting

Like Governors of other Trusts across the Country, I am disappointed that the NHS Modernisation Bill 2026 proposes to abolish the Council of Governors in the NHS. If it should happen it will strip away a layer of governance that holds the Board to account for the running of patient services and hospital sites within its region.

For information, I attended the National Lead Governors Association National Event on 27 April 2026, (Graham Lake was also present). This was to discuss how we can voice our objections to the Government proposals to abolish Council of Governors. It was made clear that we can only do this as individuals and to write to our local MPs. To this end, I have written to Alison Hume MP and James Murray, Secretary of State for Health & Social Care to voice my objections to abolishing Council of Governors from the NHS. Governors of the Trust have been encouraged to do the same and members of the public also.

It is hoped that if enough objections are received, the Government may consider reversing its proposal and realise that there is value in having a Council of Governors in the NHS and that we can continue serving our communities, ensuring that local people have a say in the running of their hospitals.

I would like to thank the Chair and the NEDs for their continued efforts to work with the CoG to improve patient care. I would also like to thank Tracy, Governor & Membership Manager, for her ongoing support to the Council of Governors.

Linda Wild
Lead Governor

## 2. Community and Neighbourhood Network (CaNN) (03.06.26)

At the CaNN meeting in June members received presentations from Lisa Pope, Deputy Place Director North Yorkshire, HNY ICB.

- **Catterick Integrated Care Centre Development:** Lisa outlined the flagship neighbourhood health centre developed in partnership with the Ministry of Defence, serving over 10,000 troops and their families, and designed to fulfil nearly all criteria of the national neighbourhood health guidance. She discussed the ongoing organisational development work, including team integration and workforce preparation, with the building designed to facilitate integrated working and a planned move-in by the end of October, marking the start of the operational journey. Discussions took place about its features, challenges, and future plans

- **Selby Community Health and Wellbeing Worker Programme:** Lisa outlined the programme, inspired by the Brazilian approach, detailing the deployment of community health and wellbeing workers in high-need neighbourhoods areas to address health, social care, and other statutory needs.. Discussions took place about its operation, outcomes, and potential expansion.

Both initiatives have been well received in the pilot areas and it is hoped that these models of care will expand into areas identified as having the highest need and leveraging the use of mobile hubs and existing community assets. Both presentations were very informative.

Lisa, in her new role as Director of Commissioning for North Yorkshire and York, volunteered to become a regular member at the CaNN meetings. The network is continuing to grow and the Chair encourages membership from both governors and stakeholders who can make a positive contribution to the group.

Elizabeth McPherson
CaNN Chair

## 3. Membership Engagement Group (MEG) (14.04.26)

This was my first meeting as Chair of this group. We discussed at length the new Membership Action Plan and potentially adopt it.

The group conducted a detailed review focusing on updates to constituency boundaries, population data sources, and the status of ongoing objectives, with actions assigned for further clarification from the Deputy Director of Corporate Governance, Mike Taylor. It was noted that Objective 2, increasing the diversity of membership, could not be finalised until a decision was made on which population data set to use.

It was decided to adopt the plan as it stands and modify it once a decision on the constituency boundaries and a decision on using MSOA data sets was made. It was felt that this approach was better than deferring a decision again.

We also decided to ask the Communications Team to investigate use of more localised public websites, such as "In your Area" and "Next Door" to promote membership.

It was also noted that attendance at this MEG meeting and previous meetings had been inconsistent, with low turnout and irregular participation. At the meeting in April only four members were present. The chair pointed out that one of the Governors primary roles is to increase public engagement and that it was the membership who had elected the current Public Governors. The Chair undertook to email all governors to remind them of this and to request as many as possible attend the next meeting on 20 August.

Peter Morley
MEG Chair

**4. Governor Activities**

Jean Flanagan – Public Governor East Coast of Yorkshire

- Governor contacts / feedback from Scarborough community since last meeting.
  - Meeting with CEO and Save Scarborough Hospital Group at Scarborough Town Hall.
  - The group welcomed the trust CEO, Claire, to the locality. A wide range of issues were discussed including their ongoing hope for flexibility in delivery of acute stroke early intervention for East Coast Population, as well as the importance of the Clinical Strategy. Claire will meet with the group again in the future.
  - Meeting with Alison Hume MP regarding health needs of Scarborough Population (with Save Scarborough Hospital Group)
  - I have received Positive feedback from a number of people about the Emergency Department at Scarborough Hospital –
    - Assessment and treatment of acute AF by nurse consultant ? Senior Nurse ? working in partnership with patient and family leading to a good outcome.
    - Assessment and treatment of a patient on the recent May Bank Holiday with infected burn. Prompt treatment within one hour for minor injury. Excellent communication skills of attending doctor
  - Meeting with new Trustee of Bridlington Health Forum as part of her induction to communicate and understand shared experiences of individuals living in Scarborough and Bridlington when accessing health services.
- I have received feedback from a number of areas/ examples from a range of East Coast patients who have recently been offered appointments at York Hospitals site when the service is available at Scarborough Hospital site. This is an ongoing issue. I was given specific examples where this involved the Gastroscopy service.

Graham Lake – Public Governor Ryedale & East Yorkshire

I attended with Sandra Fox the May 2026 meeting of the Derwent Practice Patient Participation Group in Malton and gave an update on Trust activities.

We were disappointed to learn of the resignation of Ian Foxley, the third Public Governor for Ryedale and East Yorkshire.

| Name | 02.05.25 XCoG | 11.06.25 CoG | 06.08.25 XCoG | 10.09.25 CoG | 10.12.25 CoG | 16.01.26 XCoG | 11.03.26 CoG | 10.06.26 CoG | 09.09.26 CoG | 09.12.26 CoG | 10.03.27 CoG |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Martin Barkley (Chair) | √ | √ | √ | √ | √ | √ | √ | | | | |
| Rukmal Abeysekera (Public Governor – York) | √ | √ | √ | √ | | | | | | | |
| Cllr Jonathan Bibb Stakeholder Governor - East Riding CC | Ap | | | | | | | | | | |
| Nick Bosanquet Public Governor - York | | | | | √ | Ap | √ | | | | |
| Rebecca Bradley (Staff Governor - Community) | Ap | √ | √ | √ | √ | Ap | Ap | | | | |
| Bernard Chalk (Public Governor - East Coast) | | √ | √ | √ | Ap | Ap | Ap | | | | |
| Mary Clark (Public Governor - York) | Ap | √ | √ | Ap | √ | Ap | √ | | | | |
| Elena Clerici (Staff Governor - York) | | | | | √ | Ap | √ | | | | |
| Cllr Liz Colling (Stakeholder Governor - NYC) | Ap | √ | √ | √ | √ | Ap | Ap | | | | |
| Beth Dale (Public Governor - York) | √ | Ap | √ | Ap | √ | Ap | | | | | |
| Abbi Denyer (Staff Governor - York) | Ap | √ | √ | √ | | | | | | | |
| Adrian Faraj (Staff Governor - Scarborough/Bridlington) | Ap | √ | √ | Ap | Ap | Ap | Ap | | | | |
| Jean Flanagan (Public Governor - East Coast) | | | | | √ | √ | √ | | | | |

| Name | 02.05.25 XCoG | 11.06.25 CoG | 06.08.25 XCoG | 10.09.25 CoG | 10.12.25 CoG | 16.01.26 XCoG | 11.03.26 CoG | 10.06.26 CoG | 09.09.26 CoG | 09.12.26 CoG | 10.03.27 CoG |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sandra Fox (Public Governor - Ryedale & EY) | | | | | √ | √ | √ | | | | |
| Ian Foxley (Public Governor - Ryedale & EY) | | | | | Ap | Ap | Ap | | | | |
| Paul Gibson (Public Governor - East Coast) | Ap | Ap | √ | √ | Ap | Ap | Ap | | | | |
| James Hayward (Public Governor - East Coast) | √ | √ | √ | √ | √ | Ap | Ap | | | | |
| Graham Healey (Staff Governor - Scarboroug/Bridlington) | Ap | Ap | Ap | Ap | | | | | | | |
| Gary Kitching (Staff Governor - York) | √ | √ | √ | √ | √ | Ap | √ | | | | |
| Graham Lake (Public Governor - Ryedale & EY) | | Ap | √ | √ | √ | √ | √ | | | | |
| Wendy Loveday (Public Governor - Selby) | Ap | Ap | √ | Ap | √ | Ap | Ap | | | | |
| Elaine McNichol Public Governor - East Coast) | | √ | √ | √ | | | | | | | |
| Elizabeth McPherson (Stakeholder Governor - Social Care) | Ap | √ | √ | √ | √ | √ | √ | | | | |
| Peter Morley (Public Governor - Selby | | | | | √ | Ap | √ | | | | |
| Cllr Tim Norman Councillor - ERYC) | | | | √ | √ | Ap | Ap | | | | |
| Carol Popplestone Staff Governor - SGH & Brid) | | | | | √ | Ap | √ | | | | |
| (Stakeholder Governor - Dementia Forward) | Ap | Ap | Ap | Ap | Ap | Ap | | | | | |

| Name | 02.05.25 XCoG | 11.06.25 CoG | 06.08.25 XCoG | 10.09.25 CoG | 10.12.25 CoG | 16.01.26 XCoG | 11.03.26 CoG | 10.06.26 CoG | 09.09.26 CoG | 09.12.26 CoG | 10.03.27 CoG |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Michael Reakes (Public Governor – York) | √ | √ | √ | √ | | | | | | | |
| Gerry Richardson (Stakeholder Governor – York University) | Ap | √ | √ | Ap | Ap | √ | √ | | | | |
| Cllr Jason Rose (Stakeholder Governor - CYC) | Ap | √ | √ | √ | √ | √ | √ | | | | |
| Ros Shaw (Public Governor - York | √ | √ | √ | √ | √ | √ | √ | | | | |
| Julie Southwell (Staff Governor - York) | √ | √ | √ | √ | √ | √ | √ | | | | |
| Catherine Thompson (Public Governor- Hambleton) | √ | √ | √ | √ | | | | | | | |
| Franco Villani (Staff Governor - Scarborough/Bridlington) | Ap | √ | √ | Ap | | | | | | | |
| Linda Wild (Public Governor - East Coast of Yorkshire) | √ | √ | √ | Ap | √ | √ | √ | | | | |

| Name | 11.06.25 CoG | 10.09.25 CoG | 10.12.25 CoG | 11.03.26 CoG | 10.06.26 CoG | 09.09.26 CoG | 09.12.26 CoG | 10.03.27 CoG |
|---|---|---|---|---|---|---|---|---|
| Martin Barkley (Chair) | √ | √ | √ | √ | | | | |
| Jenny McAleese | √ | Ap | √ | | | | | |
| Lorraine Boyd | √ | √ | √ | √ | | | | |
| Jim Dillon | √ | | | | | | | |
| Steven Holmberg | Ap | | | | | | | |
| Matt Morgan | Ap | | | | | | | |
| Julie Charge | √ | √ | √ | √ | | | | |
| Helen Grantham | √ | Ap | √ | √ | | | | |
| Jane Hazelgrave | √ | √ | Ap | √ | | | | |
| Noel Scanlon | √ | √ | √ | | | | | |
| Richard Reece | | √ | Ap | √ | | | | |
| Rukmal Abeysekera | | | √ | √ | | | | |
| Matthew Taylor | | | | | | | | |
| Ian Floyd | | | | | | | | |

| Name | 11.06.25 CoG | 10.09.25 CoG | 10.12.25 CoG | 11.03.26 CoG | 10.06.26 CoG | 09.09.26 CoG | 09.12.26 CoG | 10.03.27 CoG |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |